Relief and Rehabilitation Network

Network Paper 12

Dilemmas of `Post'-Conflict Transition: Lessons from the Health Sector

Joanna Macrae

September 1995

Please send comments on this paper to:

Relief and Rehabilitation Network
Overseas Development Institute
Regent's College
Inner Circle
Regent's Park
London NW1 4NS
United Kingdom

A copy will be sent to the author.

Comments received may be used in future Newsletters.

ISSN: 1353-8691

Acknowledgements

Many thanks are due to colleagues at the London School of Hygiene and Tropical Medicine, particularly Anthony Zwi, who supported successive studies on health sector rehabilitation. John Borton, Martin Griffiths, Kelley Lee and Catherine Spencer cast their critical gaze over earlier reports and papers resulting from the studies reported here, and with their usual insight enriched the paper. Finally, thanks to Vivienne Forsythe who has proved a trusted mentor. Any weaknesses which remain are my own.

Dilemmas of `Post'-Conflict Transition: Lessons from the Health Sector

Joanna Macrae

Contents

Abstract

A significant number of countries worldwide are described as entering a phase of `post'-conflict transition. Drawing on the experience of the health sector, this paper argues that the nature of the rehabilitation task is often misunderstood. In particular, it is often equated with reconstruction of war-damaged infrastructure and assets. Such an approach derives from a misconception of the origins and nature of contemporary warfare. It also serves to reinforce a linear approach to the transition from relief to development.

This paper attempts to redefine the rehabilitation task in situations of `post'-conflict transition, drawing on examples from Cambodia, Ethiopia and Uganda. It argues that the direct effects of military action on the social sector are less significant than the indirect effects of political, economic and social changes which both underlie and are precipitated by conflict. Therefore, rehabilitation needs to go beyond reconstruction and tackle the root causes of instability.

Such a reinterpretation of the rehabilitation task raises a number of dilemmas, particularly for international actors concerned to contribute to a sustainable peace. These dilemmas are rooted in both the uncertainty about the legitimacy of incoming governments in transitional situations, and in the organisation of the aid system itself. The paper concludes that confronting these dilemmas implies a fundamental change in the orientation and delivery of aid in `post'-conflict situations.

Dilemmas of `Post'-Conflict Transition: Lessons from the Health Sector[1]

1. Introduction

`Post'-conflict situations lie at the interface of the states of war and peace, and of relief and development. This paper argues that experience of responding to the challenge of `post'-conflict recovery reveals weaknesses in our understanding of the nature of conflict and of international aid responses to instability. In particular, drawing on examples from the health sector, it suggests that far from linking relief and development interventions as is increasingly claimed in the upsurge of attention to the `continuum', rehabilitation strategies often sustain emergency-type responses which focus on material supply issues at the cost of addressing underlying structural problems. It argues that inappropriately designed rehabilitation strategies can *obstruct* rather than *enable* the development of sustainable health systems. The paper suggests that the failure of many rehabilitation programmes to achieve their objectives of paving the way to peaceful development needs to be understood in relation to the policy environment within conflict-affected countries themselves and to the organisation of the aid system itself.

The paper draws on research undertaken by the author in collaboration with colleagues in the UK, Cambodia, Uganda and Ethiopia, and a wider literature concerning health sector rehabilitation in `post'-conflict situations. The remainder of the paper is divided into two substantive parts.

The first is concerned to define the challenge of transition, the function and organisation of rehabilitation assistance and the key issues facing conflict-affected health systems. It highlights the political, bureaucratic and operational dilemmas confronting health planners and aid organisations working in these environments.

---

[1] This paper draws on an earlier paper (Macrae *et al*, 1995), which reported on research funded by the UK Overseas Development Administration and Health Net International, a sister organisation of Médecins sans Frontières Holland. The views reflected here are, however, those of the author and do not necessarily reflect those of the funding organisations.

The following section reviews experience of health sector rehabilitation in a number of countries, highlighting key issues and recommendations for policy-makers and planners working in these environments are highlighted.

2. We May Not Know the Answers, But What's the Question?

2.1 The Changing nature of war

The persistence of conflict in the post-Cold War era has prompted a reappraisal of its causes. Until the late 1980s, explanations of conflict in the Third World focused largely upon the role of international factors, particularly the superpowers in promoting conflict. During this period, relatively little attention was focused on understanding the national and local factors which maintained the dynamics of violence (Stockton, 1989)

The withdrawal of the superpowers from the proxy battlefields of the South and of the Soviet empire in the former Eastern bloc, has revealed sharply the internal dynamics of conflict[2]. Declining economic and environmental resource bases have placed acute pressures on populations as they seek to sustain their livelihoods. As competition has intensified, so the potential for political manipulation of resources, often along ethnic or national lines, has increased.

The declining capacity of formal economic and political systems to sustain and protect livelihoods in many countries has stimulated alternative mechanisms of survival to emerge. Most harmful of these has been the development of parallel economies which rely upon high levels of violence to extract resources. Keen (1991) and Duffield (1991; 1994a; 1994c) have recorded extensive examples from Sudan, Angola and Bosnia which demonstrate the linkages between the maintenance and acquisition of political power and economic survival. Importantly, they have described how international assistance can become incorporated into these violent economies.

[2] These "internal" dynamics continue to be profoundly shaped by international factors including political intervention, militarization, aid, and the organisation and regulation of the global economy.

As the power of states has weakened, conflict has become identified less with the process of state formation, the common theme of an earlier generation of ideologically-motivated nationalist and revolutionary struggles. Rather, conflict is associated increasingly with a process of state disintegration, where the quest for power is linked to the economic and political ambitions of armed groups, not to the achievement of a clearly articulated socio-political agenda (Surhke, 1994, quoted in Duffield, 1994b; Kaplan, 1994). In situations such as Somalia and Liberia, and in the weakening states of West Africa and the former USSR, the dividing line between political violence and crime is becoming increasingly fine (Kaplan, 1994; Keen, personal communication).

It is therefore possible to distinguish, at least in theory, between two broad types of conflict. First, ideological struggles, centred on the state where usually two competing military forces are linked to civilian populations through a shared political commitment, such as in the liberation wars of Eritrea and Nicaragua. The second type are more fragmented conflicts, where violence becomes acutely decentralised and its political economy extractive and exploitative, as for example in Somalia and Afghanistan. This comparatively crude categorisation does not imply that the two `types' of conflict are mutually exclusive. Indeed, during the course of a relatively structured ideological struggle, fragmentation can occur, as for example, in southern Sudan. Equally, it cannot be assumed that in fragmented, resource wars, there is a total lack (apparent or real) of ideological base: however, resolving these wars will depend as much on confronting groups with an economic interest in sustaining violence as achieving or isolating `political settlement'. Given the intense pressures on formal economies in large parts of Africa and the former eastern bloc, creating sufficient financial incentives for peace will constitute a major challenge.

The distinction between structured, state-centred wars of ideology and the `privatised' resource conflicts is important in relation to situations of `post'-conflict transition, since it determines the impact of conflict on national systems of public finance and administration, and governance. In relation to the health sector, this determines the feasibility of (re)creating a viable public health system in the `post'-conflict era.

2.2 Defining `post'-conflict situations

The majority of countries commonly identified as entering a period of `post'-conflict transition (see Table 1) have experienced relatively structured conflict. These countries were the focus for the proxy wars of the Cold War era, and, in the case of Mozambique, the attempt to exert regional hegemony by the apartheid regime in South Africa. These conflicts therefore centred around the state: while conflict may have weakened and eroded the legitimacy and capacity of existing political and administrative structures in relation to national and international actors, at least they were maintained. In the `post'-conflict period, there was something to work with. Any lessons which can be learned from these countries therefore need to be applied with extreme caution to situations such as that in Somalia and Afghanistan where state structures have effectively collapsed, or in the case of Rwanda have been eliminated by genocide[3] and exile.

Table 1 Countries experiencing `post'-conflict transition

Cambodia
El Salvador
Ethiopia
Eritrea
Mozambique
North West Somalia (Somaliland)

Defining when wars are `over' is a hazardous undertaking, Three factors define the process of transition:

i) The signing of a formal peace agreement (military transition);
ii) A process of political transition by elections, a negotiated or military transfer of power (which may include secession);
iii) A perception among national and international actors that there is an opportunity for peace and recovery.

[3] Cambodia also experienced a genocide. Remarkably little literature has been found which describes the process of rehabilitation following the Vietnamese invasion/liberation of the country: no doubt further study of this process would be insightful.

Not all of these factors may be present: for example, where there is a military takeover of power there may be no formal peace agreement, as was the case in Ethiopia in 1991, or in Uganda in 1986. The above conditions do not necessarily imply that security will improve in all areas of the country concerned.

The process of `post'-conflict transition is highly unstable. Neither the signing of peace accords nor changes in the system of governance guarantee the permanence of peace. Indeed, this process of political transition may bring with it new threats to stability. For example, in Afghanistan, the withdrawal of the Soviet army paved the way for an intensification of the struggle between the different factions of the Mujahadeen. In Angola, despite the UN-supervised elections in 1992, UNITA was responsible for plunging the country into a devastating new phase of the civil war after its defeat in the elections. Thus, as superpower intervention in Third World countries has diminished, internal conflict may increase as national and local political groups strive to consolidate new political opportunities (Utting, 1994).

Political settlements themselves may be an incremental process: in Palestine, for example, the status of the West Bank and Jerusalem and of Palestinian refugees outside Palestinian territories have yet to be agreed. Peace is also often a geographically diffuse phenomenon: certain areas of a country may be relatively secure, while others become the focus for on-going or new military action.

> *The first dilemma for those concerned with `post'-conflict recovery is, therefore, to determine who is defining the peace, and to assess its viability and sustainability.*

For international actors, such an analysis implies decisions about the legitimacy and capacity of a new regime, and a calculation as to whether investment in recovery will contribute to peace-building and reconciliation, or will become the target of renewed military action.

2.3 Rehabilitation: international assistance in the twilight zone

Rehabilitation assistance lies in the twilight zone of the international aid system: its relative obscurity can be explained in relation to the uncertain legitimacy of transitional regimes and the organisation of the international aid system itself.

The state-centric nature of the international aid system implies that unless and until a government is in place, the scope for developmental assistance will remain limited, a point explored further in this paper. However, while the presence of a government is a necessary condition for the release of development funds, it is not sufficient: the new regime must be seen to be legitimate in the eyes of the international community. In the case of countries where a transitional authority is put in place to supervise elections, as was the case in Cambodia, Mozambique and El Salvador, this implies waiting until the electoral process is complete. In other countries, such as Ethiopia after May 1991, the new regime was recognised relatively quickly by the international community.

Historically, the principal partner for development assistance from multilateral and bilateral sources has been the government of the recipient country. While the 1980s saw considerable shifts in debates concerning the role of the state in the financing and delivery of social services, access to international development finance continues to rely largely upon the presence of an internationally recognised government. By contrast, access to emergency relief is not subject to the same conditions. Humanitarian aid is increasingly delivered outside formal government structures and may be delivered without its formal approval (Borton, 1994).

The transformation from relief to development assistance therefore implies reestablishing formal relationships between the international community and the recipient government, which both recognise and legitimise the regime. If rehabilitation is seen primarily as a developmental activity, rather than a relief intervention, then the presence and recognition of a legitimate national government will be a necessary condition for international finance. Alternatively, rehabilitation may be conceived as an activity which lies between relief and development, and which does not confer legitimacy on either the government or other recipient partners.

It is the questionable legitimacy of transitional governments which raises acute dilemmas for the management of international assistance in `post'-conflict situations, and which is in part responsible for maintaining the discontinuum of relief and development aid.

The uncertain legal status of *de facto* governments (as in Eritrea between 1991-1993 and North West Somalia since 1991), or their uncertain legitimacy prior to elections, (as in Cambodia from 1991-1993) presents major difficulties for the organisation and management of international assistance. In particular, it raises questions as to who holds the responsibility for identifying policy priorities and for determining the allocation of international and external resources.

Uncertainty regarding the legitimacy of recipient `post'-conflict states reflects a wider set of conceptual and organisational weaknesses within the international aid system in responding to instability. At a conceptual level there is increasing recognition that the objectives and strategies of relief and development are frequently incompatible. Duffield (1994b) has argued however, that both derive from a developmentalist model which perceives the development process as a linear, necessarily progressive process, defined primarily in terms of economic growth. Disasters, including those related to conflict, have been conceived as temporary interruptions to this process, and it has been assumed that once the hazard has passed, `normal' development can be resumed (Duffield, 1994b; Borton personal communication). Drawing largely on experience of drought and other natural disasters in the 1970s, relief operations have largely concentrated on the delivery of material inputs, such as food and medicines to enable physical survival during periods of (temporary) crisis.

These developmentalist approaches have not been able to respond to the challenge of political disasters for three key reasons. First, underlying existing approaches to relief are the assumptions that the crisis is primarily material and that emergency aid is politically neutral. In complex political emergencies, it is important to realise that the primary factor limiting access to basic resources is political and that within these contexts relief is a political resource. Thus, while in principal relief aid is not

seen to endorse or legitimise a particular regime or group, *de facto* it can strengthen violent and oppressive groups (Keen and Wilson, 1994).

Secondly, models of conventional relief assume that once the hazard has passed, people will be able to resume `normal' social and economic activities. The nature and duration of complex political disasters critically reduce the economic, human and institutional resource base required to provide financial and social security. This suggests that even once the hazard (conflict) has passed, conflict-affected communities will remain extremely vulnerable.

Finally, given that conflict is an expression of previously existing political and economic structures, there will be a need to redefine, not simply resume, pre-conflict development strategies.

The limitations of existing international approaches to relief and development have three key implications for the design of rehabilitation interventions in conflict-affected societies. First, rehabilitation has been conceived as the link between relief and development. This assumes that the content and strategies of relief and development are sufficiently compatible to enable their linkage - a problematic assumption. The criteria applied to planning relief operations are primarily concerned with the physical survival of individuals[4], by contrast development activities are planned with respect to the sustainability and appropriateness of social and economic systems. These are two different categories of objectives which the concept of rehabilitation cannot easily reconcile.

Secondly, there is a risk of assuming a linear and progressive movement from relief to rehabilitation to development. Given the chronic nature of instability in many countries and its complex geography, it is often difficult to distinguish whether aid strategies should be concerned with relief, rehabilitation or development (Seaman, 1994). Existing distinctions between these three categories of activity tend to reflect

[4] For many international relief agencies, such as the International Committee of the Red Cross, maintaining the purity of this basic humanitarian objective is contingent upon not engaging in debates and interventions concerned with long-term economic and political development of groups.

the organisational concepts of international agencies, and do not necessarily capture the more complex and volatile reality of conflict-affected populations (Davies, 1994).

Finally, given that conflict can be seen as an expression of the failure of previously existing social and economic systems, there will be a need not to restore pre-conflict institutions, but to reorientate them to the new conditions and expectations of the `post'-conflict period.

> *In a period of uncertain legitimacy of a transitional regime, who can and should define the framework for and direction of rehabilitation? Should rehabilitation efforts seek to recreate or reform pre-conflict institutions and systems, including health services?*

The division of institutional labour and mandates has given rise to considerable confusion as to whom rehabilitation objectives should belong within the international aid system. Figure 1 maps out the position of different international agencies in relation to both changing modalities of aid and to the

changing security conditions and perceived legitimacy of the state as seen by national and international actors. It suggests that while at the extremes of insecurity and security and of decentralisation/centralisation of authority, mandates and responsibility are relatively clear; in between lies a large grey area where different types of actor may or may not be engaged.

Rethinking the mandates of international agencies and the divisions which lie between relief and development budget lines implies overcoming the legitimacy dilemma outlined above.

The way in which these dilemmas have been confronted in relation to the health sector will be analysed in section 3. As a prelude to that discussion, section 2.4 identifies the main challenges confronting health systems in `post'-conflict situations.

2.4 Health sector rehabilitation: defining the problem

Violence exerts direct and indirect effects on health status and health systems (Zwi and Ugalde, 1989). Direct effects are those related to military action and include death and injury, and destruction of the health infrastructure and equipment. However, more significant in terms of aggregate mortality and morbidity, are the indirect effects of the social, political and economic changes which both underlie conflict and are precipitated by it.

Zwi and Cabral (1991) have identified conflict with `high risk situations' inimical to health. For example, the risk of rape by military personnel, the increased levels of prostitution which may occur as women seek cash income in the absence of other productive activities, and the breakdown in health services and the subsequent reduction in opportunities for treating sexually transmitted diseases, all increase the vulnerability of conflict-affected populations to HIV infection (Zwi and Cabral, 1991; Smallman-Raynor and Cliff, 1991; Bond and Vincent, 1990).

In the case of health systems, conflict tends to exacerbate structural weaknesses which existed prior to conflict. Figure 2 attempts to summarise the impact of

conflict on health systems. What is noticeable about the diagram is the complexity of the problems facing health services in these environments: what is at issue is far more than a problem of a broken infrastructure. To highlight a few of the most critical problems, some examples are presented:

Impact of conflict on the human resource base

Informants in Soroti, a northern district of Uganda affected by conflict between 1986 and 1992 described the impact of conflict on the human resource base as follows:

> "[There were] three different factors which affected the human resource base for health: some health workers who were not from Soroti, particularly Bantu health workers [from the south] fled because they were targeted by the rebels. Most of these fled the district...they were often the most highly trained staff and prior to the war had made up 50% of the established staff. Others feared that they would be forced to treat rebels if they remained in the rural areas. If they had been caught they would have been punished by the NRA (the government army). In Soroti hospital we currently have one doctor for a 250 bed hospital and even he is disabled by a war injury" (quoted in Macrae et al, 1993).

This extract demonstrates how a combination of ethnic division, fear of reprisals and injury affect the distribution and availability of health resources in conflict-affected communities. Particularly important is the transfer of resources from rural to urban areas, and the fact that it is the most senior and skilled health professionals who are likely to leave first. Many interviewed in Soroti in 1993, when the conflict was substantially over, thought that the problem was likely to intensify rather than improve in the future: the disruption to the education system, combined with high levels of poverty in the immediate `post'-conflict period has meant that relatively fewer people are leaving secondary school in the area and entering university.

Impact of conflict on policy and management

The effects of the brain-drain, fear and a breakdown in the financing of health systems, have a major effect in terms of national capacity for policy-making, planning and management in conflict-affected countries. In Uganda, in addition to the loss of key human resources, the environment of oppression and political chaos also meant that "...for years (health) policy was established by decree, no- one knew what the health policy really was, over the years it had become an ad hoc collection of declarations rather than an integrated legal framework for government action" (interview with senior health professional, reported in Macrae et al, 1993). Uganda's isolation during the 1970s and early 1980s meant that it was denied opportunities to participate in international health debates, particularly those relating to primary health care. The combination of these effects of conflict on policy and management meant that when relative peace returned to most parts of the country in 1986, national capacity for policy development to guide the rehabilitation process was extremely limited.

Impact of conflict on health financing

Measuring the economic impact of conflict is complex, not least because it is often difficult to distinguish between economic stress as a factor promoting vulnerability to violence and economic stress caused by violence: they are clearly mutually reinforcing. The most important features to note in terms of the economics and financing of health care in conflict-affected societies are: the reduction in the public budgets available for health; the privatisation of finance and provision and finally, changing modalities of international support for health financing.

The availability of public finance for health care typically declines substantially in conflict-affected societies. Stewart (1993) notes that there are substantial variations in the economic performance and policies of war-affected countries, and of their capacity to sustain public revenue, and so finance public services. Once again, these variations appear to be linked with the type of conflict and in particular the capacity of governments to regulate the economy. Interestingly, she suggests that it is tax capacity and government choices of expenditure which are more important

in determining the availability of finance for public sector than the effects of militarisation (p369). In both Uganda and Cambodia the capacity of the central government to raise taxes was significantly interrupted by conflict: in 1986 in Uganda, for example, revenue from taxation accounted for only 6% of GDP in contrast with the regional average of over 20% (Lateef, 1990).

In Uganda, in the 1986 fiscal year, the value of the Ministry of Health budget was only 6.4% of its 1970 (pre-war) levels. Even by 1988/9, when relative security had been achieved, the per capita value of Ministry spending was just 16.1% of its 1970 levels (UNICEF, 1989). As a Save the Children Fund (1993) report points out, what was alarming about these figures was not their absolutely low levels, but the fact that they had been much higher than in the past. The Ugandan experience stands in contrast with that of countries such as Nicaragua and Mozambique where levels of taxation were maintained at high levels enabling sustained levels of public expenditure in the social sector (Stewart, 1993).

As public capacity for health financing diminished in Uganda, so private provision increased. Whyte (1990) points out that self-management - the most extreme form of privatisation - was often the only option available to people. At the same time, the role of traditional healers increased. In both Uganda and Cambodia, health workers previously working in the public health system resorted to private practice in order to maintain their incomes as government salaries deteriorated below subsistence levels (ibid, de Sweemer personal communication). In Ethiopia, however, despite incremental declines in the overall health budget during the 1980s, health worker salaries were fixed above subsistence rates and were paid regularly, enabling health workers to remain in place and within the public health system (interviews by the author, E Hararghe; Christian Gunnenberg, personal communication).

A final aspect of privatisation is the changing role of international NGOs in provision of health services in conflict-affected countries. Where international donors are not prepared to engage with national authorities, NGOs become a primary means of channelling resources, particularly for health. Hanlon (1991) has documented this phenomenon in Mozambique, arguing that it has resulted in

considerable distortions in the health system. The proliferation of NGOs, each working within their own micro-policy domains, bounded by project areas rather than national guidelines, can threaten the development of a coherent and efficient health system. Duffield (1991) has similarly commented on the emergence of the NGO-driven welfare-safety net put in place to maintain basic services in conflict zones. The key issue which emerges in the transitional period is whether and how NGO services can be integrated within a national health system.

In sum, `post'-conflict situations are characterised by a high burden of disease and injury; at the same time, the capacity of health systems to respond to increased needs is critically reduced by the erosion of national capacity for health financing and provision. There is therefore a need to expand capacity for health service delivery. This expansion often takes two forms; first the rehabilitation of damaged infrastructure and/or the incorporation of health units which have been out of government control in rebel held areas. Secondly, there is likely to be a need to expand health systems to include previously underserved populations. This latter point is intimately linked with the process of peace-building as new governments aim to strengthen their legitimacy.

However, capacity to finance this expansion and to provide adequate human and management resources are likely to be extremely limited.

> *This is the third dilemma in rehabilitation planning: namely, how to expand the health system in an environment where the resources available for health are likely to be lower than those available in the pre-conflict period?*

Confronting this final dilemma will be contingent upon developing priorities for rehabilitation which are in line with future and existing capacity.

3. Responding to the Dilemmas of Rehabilitation: Experience to Date

This section reports on the experience of a number of countries in confronting dilemmas of rehabilitation planning outlined above. At the end of each sub-section, recommendations are given for future strategy.

3.1 Confronting the dilemma of legitimacy

The legitimacy dilemma has two distinct, but related, implications for health planning: first, who should be responsible for determining the allocation of national and international health resources in the transitional period? Second, through which institutions should resources, particularly aid resources, be channelled? These questions are particularly urgent in transitional situations because large sums of assistance relative to the scale of government finance are released quite suddenly into resource-poor environments where a national policy framework to guide resource-allocation for health is absent.

Ensuring the coherence of rehabilitation interventions during the transitional period is important in order to address the fragmentation of financing and provision characteristic of health systems during conflict. This fragmentation is typically institutional, in the sense that many different actors - government, rebels, NGOs and multilateral organisations - are all doing different things in different places. It is also geographical in that different populations have differential access to health resources because of historical, security and political reasons. Coherence of health planning is also important because the pattern of investment during the transitional period will influence the long-term prospects for health systems development.

Meier (1993), writing about macro-economic reform, has highlighted the need to identify what he calls `constitutive mechanisms' of decision-making in order to define and implement policy change. In other words "...decisions have to be made about how decisions can be made" (ibid, p387). Such a constitution needs to identify mechanisms which define both how different actors relate to a national authority, and how agencies relate to each other.

In situations such as that in Ethiopia, where the new political regime was recognised very quickly by the international community and where bureaucratic structures

remained relatively intact throughout the war, the donor community was willing to channel the majority of its resources for rehabilitation interventions through government channels. Through the mechanism of the World Bank-led Emergency Recovery and Rehabilitation Programme (ERRP), essential drugs valued at approximately US$40 million were channelled through the Ministry of Health to facilities throughout the country. This programme, rapidly designed and implemented, came at a time when the country's supply of drugs had been reduced to a critical level because of a shortage of foreign currency and interruption of local production. By providing drugs, health facilities could return quickly to providing a basic level of services, encouraging health staff to stay in post and restoring levels of utilisation. Critical to the success of the programme were: the availability of relatively large levels of finance at short notice, the umbrella for donor coordination provided by the World Bank, and adequate capacity within the public administration at central and local levels for the design and implementation of the programme.

The Ethiopian experience of rehabilitation provides an increasingly rare example of a transitional regime which had both the authority and competence to steer the process of recovery. It stands in sharp contrast to that of a number of other countries where national mechanisms for decision-making have been either absent or not seen to be legitimate or sufficiently competent. In these contexts, a number of strategies have been developed to accommodate the conditions of transition.

In Cambodia, for example, the Paris Accords, which laid the legal framework for the transition, provided for the creation of the Supreme National Council, comprising representatives of all the major factions in the country. Under the peace agreement, it was determined that the authority for ensuring implementation of the accords and for initiating rehabilitation would be delegated to the United Nations Transitional Authority in Cambodia (UNTAC) This responsibility would cease when a constituent assembly had been elected.

Echoing the principles of the Paris Accords, the World Bank stressed the importance of starting from the premise that public services are delivered by public administrations not by NGOs or international agencies. It also cautioned against

the creation of parallel but similar programmes for different population groups such as returnees, internally displaced populations and demobilised soldiers (World Bank, 1994a; CCC, 1992).

At a Ministerial Conference in Tokyo in June 1992 pledges of more than US$800 million were made by donor countries and international aid agencies, an amount far in excess of the appeal made by the UN secretary-general (Curtis, 1994).

Despite the warnings of the World Bank, aid flows to the health sector during the transitional period largely bypassed central government. Bilateral and multilateral donors both sought to support public health facilities at local level, often by disbursing funds through NGOs (World Bank, 1994a). The transitional period saw a rapid expansion of the role of NGOs in health provision. In 1988 it was estimated that 27 NGOs provided approximately US$10 million per year in relief and development assistance, a high proportion of which went to the health sector. A recent survey indicated that in 1992 US$28 million was channelled to the health sector through NGOs (Cambodia, 1992).

This expansion in NGO assistance reflects the increased availability of international finance for Cambodia, and the reluctance of bilateral donors, and to a lesser extent multilateral organisations, to engage directly with the government until or after the elections in mid-1993 (ibid). This pattern of donor assistance mirrors the experience of Uganda and Somaliland where rehabilitation interventions largely comprise NGO-led interventions at the micro-level. While enabling an expansion of service provision, these NGO interventions were not implemented within a coherent national policy framework (Macrae et al, 1993; Forsythe, personal communication).

In Cambodia, an attempt was made to develop such a framework. In 1991, the Coordinating Committee for Health (CoCom) was established which drew on high level representation from the Ministry of Health and from international and non-governmental agencies (Cambodia, 1992). The World Health Organisation provided support for the CoCom secretariat (WHO, 1994). The development of this mechanism for coordination of health policy in Cambodia in the transitional

period is potentially of significant international interest. CoCom represents one of the few attempts to work with existing health authorities to provide a coherent management framework for health services rehabilitation to guide international aid interventions.

Its capacity to influence internationally-financed health programmes, however, was constrained by a number of factors. Biberson and Goemare (1993) argue that because CoCom was chaired by the Vice-Minister for Health, a member of the Vietnamese-backed government, UNTAC was reluctant to work with it. UNTAC strictly interpreted its mandate to work equally with the different factions, causing it to avoid being seen to legitimise the capacity of one authority, in this case the Ministry of Health, to develop policy (Utting, 1994). It might also be argued that international agencies, particularly NGOs empowered with relatively substantial resources, and encouraged by the example of UNTAC, could safely ignore policy prescriptions and guidelines developed by CoCom (World Bank, 1994a; Macrae and Zwi, 1994a).

The experience of Cambodia is echoed in Palestine where a different strategy has emerged. The Palestinian Economic Council for Economic Reconstruction (PECDAR) was established in October 1993 by the Palestinian National Authority with support from the World Bank, as a semi-autonomous organisation with central responsibility for managing international aid for reconstruction and development. A major motivating factor behind the creation of PECDAR was the desire to separate the technical elements of policy development and political decision-making (Forsythe and Zwi, 1994). Such a division has not been sustainable in practice and the increasing politicisation of PECDAR has undermined donor confidence, slowing the pace of disbursement of funds. Under these conditions, NGOs - seen as politically neutral and bureaucratically efficient, become an attractive mechanism to increase implementation rates. However, in the politically complex environment of Palestine, where different groups aim to maximise their political credibility, NGOs can become an instrument through which to raise resources and generate popular support. In this environment, assumptions about the neutrality of NGOs require careful scrutiny.

In sum, rehabilitation assistance in many `post'-conflict situations is characterised by a proliferation of actors and activity, primarily outside government channels, and by an absence of a clear policy framework and mechanisms for coordination. In such an environment, the risk that resources will not be used in an efficient way is considerable.

Box 1 identifies key issues for planners confronting the legitimacy dilemma.

Box 1

Responding to the legitimacy dilemma: key issues for future strategy

Defining objectives of rehabilitation

There is a paradox in that in many transitional situations there is a perceived need to promote the development of strong state institutions in order to promote stability; at the same time, because many rehabilitation interventions are implemented outside state structures, the rehabilitation process often does not serve to strengthen these institutions in the longer term. While the desirability of strong states may be debatable, their necessity in order to re-establish long-term development activities and implement economic and sectoral reform programmes is clear.

Box 1 (continued)

In order to increase capacity for planning and management in the health sector in the long-term, it will therefore be important to work with national civil servants and health professionals in order to increase the skills base in the country. In the transitional period, it will be important to work with civil servants, health professionals and community representatives to develop consensus on directions for health policy for the future. International aid agencies, including NGOs, can serve an important function in facilitating such a dialogue, which can contribute to wider aims of political reconciliation.

Finding a constitution for decision-making

Ensuring effective coordination of health sector rehabilitation implies establishing basic principles for different actors to follow, and designing a mechanism to enforce these principles. Where a recognised government is in place, providing support to the responsible central and local government ministries to define and monitor adherence to such guidelines is crucial. Where no central government is in place, donor and major multilateral agencies can exert considerable leverage in defining basic health planning rules (some of which are identified in more detail below). Identifying a neutral party, which can act as a mediator between governmental, multilateral and non-governmental agencies, such as the World Health Organisation, can be effective.

Both these strategies imply expanding investment in management and coordination functions: this should not be seen as diverting funds from operational activities, but as a precondition for increasing their effectiveness.

Conditionalities and leverage

In both Uganda and Ethiopia very few conditions for rehabilitation assistance were made. There is considerable scope to explore the potential use of conditionalities in transitional situations to promote accountability and define basic reform measures, for example, reallocation of military budgets to match international contributions to the health sector, develop strategies for decentralisation and health financing.

Such tools could be used to promote accountability of transitional regimes, and set the framework for future partnership with the international aid community.

3.2 Reconstruction, rehabilitation or reform?

Perhaps unsurprisingly, in most countries the major focus on rehabilitation initiatives in the immediate `post'-conflict period has been on rebuilding the physical infrastructure. In addition to providing the material base for the future development of the health system, restoration of buildings is also often seen to have important symbolic and psychological value, providing a sense of a return to normality.

However, the experience of a number of countries suggests that heavy investment in rebuilding health facilities has two major drawbacks: firstly, it presumes that the infrastructure in place prior to the conflict is appropriate in the `post'-conflict era. In Uganda, this was clearly not the case: prior to the war there were major inequalities in the distribution and type of health services in different areas of the country. In 1986, 41% of the health sector rehabilitation budget was allocated to the rehabilitation of the central teaching hospital in Kampala, despite the fact that this served only a fraction of the country's population. Overall, the majority of rehabilitation finances were spent on rehabilitating district hospitals, with comparatively little attention placed at health centre level. In this case, rehabilitation was identified with restoring the pre-conflict health system almost in its entirety with little emphasis on adjusting health service provision towards primary health care and increased equality of provision.

There has also been a tendency for health sector rehabilitation to be characterised by highly vertical programming (Macrae et al, 1993). While vertical programmes are common in many developing countries, particularly for the Expanded Programme of Immunisation (EPI) and the Control of Diarrhoeal Diseases (CDD), in countries recovering from conflict these often dominate the health sector. This is in part because vertical programmes form an integral part of many relief activities and are therefore easier to sustain and expand during the transitional period prior to the reestablishment of public health services. For incoming governments, vertical services, particularly EPI, are also popular because they are a visible demonstration of commitment and of the capacity to reach populations in areas they have not previously controlled. The potential problem in these contexts, as in

non-conflict affected areas, is that the promised integration of these vertical programmes into horizontal service delivery, is often illusive.

The focus on infrastructure and the delivery of key services through vertical programmes, reflects a wider tendency of rehabilitation programmes to focus on the material crisis affecting health systems in conflict-affected countries, rather than the deeper, underlying crises of financing and management (Duffield, 1994b). It can be argued that in this sense, rehabilitation programmes are nearer in concept and design to the strategies of emergency relief than to those of long-term development.

What is at issue is not whether physical rehabilitation and immunisation should take place, but how they will be financed in the longer-term given the impact of conflict on national and household income. There is a risk that rapid expansion of the physical infrastructure (either by rehabilitating previously non-functioning facilities or by building new facilities in previously underserved areas) and the establishment of vertical programmes during the transitional period, cannot be sustained in the longer term.

In Cambodia, for example, in 1993 total health care spending by the public sector amounted to about US$7 million, less than US$1 per capita (World Bank, 1994a). It is estimated that in the same period donor expenditure on health services was in the region of US$35 million. Even if it is assumed that 40% of this amount is allocated to expatriate salaries, external resources still represent health expenditures of US$4.4 per capita, a figure which exceeds government budgets fourfold (ibid).

Similarly, in Uganda in 1985 it was estimated that to restore health service functioning to its 1970s levels would have required an expansion in the national health budget between 5 and 12 times (Scheyer and Dunlop, 1985). In Ethiopia, a similarly dramatic (and unlikely) increase in health budgets of 30% will be required to meet the recurrent costs of new and rehabilitated health facilities in the country (World Bank 1994b).

In both Cambodia and Uganda, donors are pressing national governments to enact a process of health sector reform in order to reduce high levels of aid dependency and the inappropriate patterns of provision which have reemerged, in part because of the process of rehabilitation (World Bank, 1994a; Okounzi and Macrae, 1995). Because rehabilitation programmes have tended to reinforce the urban, curative bias of the pre-conflict era, in the longer-term there is a need to reorganise the health system in order to increase the efficiency and effectiveness of health care expenditure. The scope for such a redefinition remains to be seen in countries where absolute levels of public health finance are well below the US$12/capita recommended by the World Bank (1993) to deliver a minimum package of health services.

Box 2 highlights key issues for consideration by planners in responding to this second dilemma.

Box 2

Rehabilitation or reform: issues for future strategy

Rehabilitation: relief or development?

Conflict exacerbates underlying weaknesses in health systems. Rehabilitation, if it is to provide the basis for long-term health services development, must include an analysis of the problems confronting the health system which is holistic - comprising both infrastructural and structural constraints to health service delivery. Moving beyond a relief-oriented, supply-driven approach to rehabilitation implies investing in policy, planning and management systems, and in human resource development. Such a strategy implies a time-frame beyond the usual 18-24 months which defines rehabilitation.

Box 2 (continued)

In situations such as Somalia and Afghanistan where state structures have collapsed and traditional institutions have re-emerged as an important force, there is a need to think beyond state defined models of health care. Even within this more fragmented framework for policy action, basic guidelines for resource allocation should be developed, particularly in relation to capital finance

Planning for health financing

Rethinking rehabilitation also suggests a re-examination of conventional expectations of national health systems in resource-poor environments. Assuming that impoverished and weak national governments will be able to sustain complex, resource-intensive health systems without very considerable international subsidy is likely to be unrealistic in most countries. Donors financing rehabilitation activities need to ensure a careful balance between capital and recurrent support for rehabilitation. Existing preferences for capital spending serve to promote investment in physical infrastructure often at the cost of maintaining salaries and drug supplies which are more important in determining the functioning of the health system. If donors wish to support rapid expansion of health systems in transitional situations, such investment needs to be planned with respect to a long-term framework for health planning which forecasts the availability of both national and international resources.

Building on the strengths of the indigenous private sector, which invariably burgeons during conflict, is an area of considerable potential; but it will be important to consider the impact of expanding private provision on the public health system, where it survives. Enabling communities to utilise private provision effectively through education concerning prevention and basic curative care should also be explored.

Box 2 (continued)

Experimentation and innovation

The policy vacuum which characterises situations of 'post'-conflict transition represents an opportunity as well as a threat. There is considerable scope during the transitional period for innovation and experimentation: for example, the establishment of pilot projects looking at different mechanisms for health financing. The scope for operational research in these environments is considerable: the poverty of the information base is such that there is a considerable need for experimentation with different models of financing and provision. The results of these experiments can be used to inform the process of policy development once a recognised government is in pla

Salaries of public health workers

The Ethiopian experience suggests that where health staff remain in place the capacity of health services to survive conflict and 'post'-conflict transition is enhanced. A key factor enabling staff to remain in post was that they continued to be paid. While this is explained in part by the fact that key bureaucratic institutions, including payroll departments continued to function in large parts of the country, also important is that resources were made available to pay them. As salaries were fixed above subsistence levels, the incentives to staff to work privately were reduced. In the immediate 'post'-conflict period, considerable attention should be placed on strategies to maintain salaries for public health workers.

3.3 Blurred mandates and the lost agenda[5]

A constraint to developing coherence and long-term vision of international rehabilitation assistance is that "...when it comes to rehabilitation, no-one has been sure who is responsible. Everyone is doing little bits" (interview, UN official, reported in Macrae et al, 1994a).

For example, "emergency rehabilitation" is defined as the responsibility of the Department of Humanitarian Affairs within the UN, and of the Emergency Aid Department of the British Overseas Development Administration. "Non-emergency" rehabilitation in the former falls within the remit of UNDP, and in the latter to the geographical desks. The distinctions employed are not very clear in

[5] Biberson and Goemare (1993) refer to the "lost agenda" of health care reconstruction.

principle and in practice are reflected in the wide range of agencies engaged in "rehabilitation".

The absence of a clear mandate for rehabilitation between the specialist agencies of the UN and the different desks of donor agencies and some NGOs has meant that agencies and personnel experienced in relief are increasingly engaged in rehabilitation initiatives. For example, UNHCR's involvement in reintegration of refugees in a number of countries has effectively extended its domain of activity beyond its traditional role in protection and relief for refugees and into one of community development. The rationale for this expanded involvement is grounded in an awareness that maintaining the durability of the repatriation solution is contingent upon meeting the basic needs of returnees and those of receiving communities. The potential difficulty, however, is that by their very nature these interventions are designed very quickly and for a short period of time (12-18 months); in the case of UNHCR, by an agency which may have experience of the returning refugee population but not of the community to which they return. In the case of the health sector, a typical "quick impact" project (QUIP) comprises the rehabilitation of a health facility and recurrent cost support for salaries and drugs for a one year period (UNHCR, 1994). Implicit in this strategy is that another authority will take over responsibility for these activities after the first year: experience suggests that this is often be problematic (van Brabant, 1994).

The absence of a clear mandate for rehabilitation is mirrored in many agencies by the lack of procedures to accommodate rehabilitation funding and activities. While the objectives of rehabilitation clearly envisage a movement away from the short-term, resource-intensive programming of relief, providing assistance relatively quickly to support the transition to peace does not conform with the usually stringent and time-consuming process of development programming.

The limitations of existing procedures have resulted in a number of adjustments within donor agencies. For example, in 1992, the European Commission established 100MECU Special Rehabilitation Programme for Africa, drawing on pre-existing relief and development budget lines (European Commission, 1993). Similarly, the new budget of US$20 million (1993/4) for the Office of Transition

Initiatives within USAID is drawn equally from relief and development lines. However, usual appraisal and administrative procedures to which development programmes are subject are largely bypassed in order to ensure rapid project identification and implementation, both the USAID and the European Commission's initiatives rely almost exclusively on NGOs to propose and implement projects. The strengths of these innovations is also their weakness: in the search for instruments which enable fast-disbursing support, the very procedures used to assess sustainability and efficiency are often bypassed.

In emergency situations, many bilateral and multilateral agencies cannot or do not carry out a country programming exercise to guide their strategy. The absence of mechanisms to link donors with a national policy framework, combined with the high degree of donor dependence on NGOs for project design and implementation, tends to reinforce the tendency for rehabilitation programmes to adopt the highly decentralised, unintegrated approaches of relief rather than those of development. The difficulties posed by the absence of a strong national government policy framework make it all the more essential that donors and international agencies develop their own clear strategies, and work to develop inter-agency consensus on priorities and guidelines for implementation.

Box 3

Blurred mandates and the lost agenda: issues for future strategy

- The lack of clear budget lines reflects the awkward place rehabilitation occupies within the international aid system. The chronicity of complex political emergencies and the increasing number of transitional situations suggests that the institutional abyss currently separating relief and development assistance cannot be sustained. The creation of special budget lines for rehabilitation may form part of the solution, but will not be sufficient, particularly if these special funds continue to replicate the strategies of relief (heavy reliance on NGOs and on material supply responses). Such budget lines will meet their objectives only if the speed of response is matched by simple mechanisms to assess criteria of appropriateness and sustainability at project level and at country level.

  Developing such a strategy would be facilitated by inter-donor and inter-agency assessment of needs to share information and analyses, promote a common vision and maximise leverage. Management of such a process could be delegated to DHA or the World Bank, and should be conducted over an extended period of several months rather than weeks. Sectoral needs assessment and coordination should be delegated to a specialist agency. Such an assessment procedure would require close collaboration with national political and professional actors: in the absence of consensus about resource allocation and use, successful implementation is likely to remain illusive. An overall review setting guidelines, for example in relation to capital and recurrent financing, coordination and cooperation with national professional and government institutions, could then be used as a basis to guide the development of sectoral strategies.

- Agencies and personnel who have developed expertise in relief, but who find themselves increasingly engaged in rehabilitation planning should expand their expertise in long-term health systems development, through training and cooperation with specialist agencies. Encouraging long-term development agencies to establish programmes during the transition period could be encouraged by extending the time-frame for rehabilitation programmes

4. Conclusion

The weaknesses of rehabilitation interventions in countries as far apart as Uganda, Cambodia and Ethiopia can be traced back to a misunderstanding of the nature of war and to the difficulties facing the international aid system in an environment of globalisation and weakening state structures.

Responding to the complex emergencies and their aftermath implies defining humanitarian crises not primarily in material supply crisis, but rather as a crisis of economic, political and social systems. It also requires acknowledging that neither relief nor rehabilitation nor development assistance are politically neutral: introduction of resources into these complex and resource poor environments necessarily implies strengthening one group, potentially at the cost of others (Keen and Wilson, 1994). The concern is therefore to ensure that the rehabilitation process strengthens the vulnerable rather than rewarding the violent, enables reconciliation rather than exacerbating inequalities and increasing political tension.

It appears that the international aid system is, as yet, unable to respond to the rehabilitation challenge. The dilemmas are profound and not amenable to a quick, technical fix. Rather, even responding to the apparently simple challenge of health services rehabilitation strains developmentalist models of aid which remain premised on the presence of strong states with strong formal economies (Duffield, 1994b). In the twilight zone of transition and rehabilitation there is a kind of institutional paralysis. At the same time, there is often a feeling of wanting to do something, anything to make things better.

Confronting the dilemmas of rehabilitation will imply a combination of pragmatism, modesty of purpose and of pace. Initiatives need to be planned in line with local resources and capacity. There is also a need for flexibility and sensitivity to the complex politics of peace-building, in other words an approach which integrates political and sectoral perspectives. This suggests a need to improve the quality of analysis of the nature of the rehabilitation task and to find ways of enabling recipient populations to define *their* priorities for a healthier peace. Cash and wishful thinking alone will not be sufficient.

References

Biberson P. and E.Goemare, (1993) "Health Care Reconstruction: the Lost Agenda", in Jean F [Ed], *Life, Death and Aid: the Medecins Sans Frontieres Report on World Crisis Intervention*, London and New York, Routledge.

Bond G. and J. Vincent, (1990) "Living on the edge: changing social structures in the context of AIDS", in Hansen H and M Twaddle [Eds] *Changing Uganda: the dilemmas of structural adjustment and revolutionary change,* London, James Currey.

Borton J., (1994) "NGOs and Relief Operations: Trends and Policy Implications", London, Overseas Development Institute, ESCOR Research Study R47774.

Cooperation Committee for Cambodia [CCC] (1992) "NGOs and the Rehabilitation of Cambodia", mimeo, Phnom Penh, July.

Cassels A., (1992) "Implementing Health Sector Reform", report prepared for the Health & Population Division, Overseas Development Administration, London

Curtis G., (1994) "Transition to What?": Cambodia, UNTAC and the Peace Process", in Utting P. op. cit., pp41-70.

Davies S., (1994) "Public Institutions, People and Famine Mitigation",*IDS Bulletin* **25**(4): 46-54.

Duffield M., (1991) "War and Famine in Africa", *Oxfam Research Paper* No 5. Oxford, Oxfam Publications.

Duffield M., (1994a) "Complex Political Emergencies: an exploratory report for UNICEF", School of Public Policy, University of Birmingham

Duffield M., (1994b) "Complex of Emergencies and the crisis of developmentalism", *IDS Bulletin*, 25(3): 37-45.

Duffield M., (1994c) "The Political Economy of Internal War: Asset transfer, complex emergencies and international aid", in Macrae J. and A.Zwi [Eds] *War and Hunger: Rethinking International Responses in Complex Emergencies,* London and New Jersey, Zed Press.

European Commission (1993) "Special Rehabilitation Support Programme in Developing Countries", communication from the Commission to the Council and the European Parliament, COM(93)204, final, 12 May

Forsythe V. and A. Zwi, (1994) "Health Care in Situations of `Post'-conflict transition: a preliminary review of the Palestinian situation", mimeo, London School of Hygiene and Tropical Medicine.

Hanlon J., (1992) *Mozambique: Who Calls the Shots?*, London, James Currey

Kaplan R., (1994) "The Coming Anarchy", *Atlantic Monthly*, pp44-76, February.

Keen D., (1991) "A Disaster for Whom?: Local interests & international donors during famine among the Dinka of Sudan", *Disasters*, **15**(2): 150-165.

Keen D. and K.Wilson, (1994) "Engaging with Violence: A Reassessment of the Role of Relief in Wartime", Macrae J. and A.Zwi [Eds] *War and Hunger: Rethinking International Responses in Complex Emergencies*, London and New Jersey, Zed Press, pp209-221.

Lateef K., (1990) "Structural adjustment in Uganda: the initial experience", in Hansen H and M Twaddle [Eds] *Changing Uganda: the dilemmas of structural adjustment and revolutionary change*, London, James Currey.

Macrae J., A. Zwi and H.Birungi, (1993) "A Healthy Peace?: Post-conflict rehabilitation of the health sector in Uganda 1986-1992", final report, London School of Hygiene & Tropical Medicine & Makerere University

Macrae J. and A. Zwi (1994a) "`Post'-conflict rehabilitation of the health sector: a preliminary assessment of issues and implications for international aid policy", report prepared for the Health and Population Division, Overseas Development Administration, London School of Hygiene and Tropical Medicine.

Macrae J., with A. Zwi and V. Forsythe (1995) "Aid Policy in Transition: a preliminary analysis of `post'-conflict rehabilitation of the health sector", *Journal of International Development* (forthcoming).

Okounzi S. and J. Macrae, (1995) "Whose Policy is it Anyway?: International and National Influences on Health Policy Development in Uganda", *Health Policy and Planning*, **10**(2): 122-132.

Meier G., (1993) "The New Political Economy & Policy Reform", *Journal of International Development*, **5**(4): 381-389.

Sheyer S. & D. Dunlop, (1985) "Health Services Development in Uganda", in Dodge C and P Wiebe [Eds] *Crisis in Uganda: the breakdown in health services*, Oxford, Pergamon Press.

Sen A., (1986) *Famines and Poverty*, Oxford, Clarendon Press.

Seaman J., (1994) "Relief, Rehabilitation and Development: Are the distinctions useful?", *IDS Bulletin* **25**(4): 33-36.

Sivard R., (1993) *World Military and Social Expenditures 1992-3*, World Priorities

Smallman-Raynor M. & A. Cliff, (1991) "Civil War and the spread of AIDS in central Africa", *Epidemiology of Infectious Diseases*, **107**(1): 69-80

Stewart F., (1994) "War and underdevelopment: can economic analysis help reduce the costs?", *Journal of International Development*,**5**(6): 357-380.

Stockton N., (1989) "Understanding Conflict in Africa", unpublished mimeo, Oxford, Oxfam.

UNHCR (1994) Restricted document

UNICEF (1989) *Children and Women in Uganda: A situation analysis*, Kampala.

USAID (1994) "Strategic Plan", Office of Transition Initiatives, Office of Disaster Assistance, 11 May.

Utting P., (1994) *Between Hope and Insecurity: the Social Consequences of the Cambodian Peace Process*, Geneva, United Nations Research Institute for Social Development.

van Brabant K., (1994) "Bad Borders Make Bad Neighbours: the political economy of relief and rehabilitation in region 5", *Relief and Rehabilitation Network*, Network paper no 4.

Whyte S., (1990) "Medicines and self-help: the privatisation of health care in eastern Uganda", in Hansen H and M Twaddle [Eds] *Changing Uganda: the dilemmas of structural adjustment and revolutionary change*, London, James Currey.

World Bank (1993) *World Development Report: Investing in Health*, New York and Oxford, Oxford University Press.

World Bank (1994a) *Cambodia: From Rehabilitation to Reconstruction*, Washington, East Asia and Pacific Region, Country Department 1, February.

World Bank (1994b) *Ethiopia: Public Expenditure Review*, Washington, IBRD.

World Health Organisation (WHO) (1994) "The World Health Organisation in Cambodia 1980-1994", mimeo, Strengthening Health Systems Project, Phnom Penh, January.

Zwi A. & A. Ugalde, (1989) "Towards an Epidemiology of Political Violence in the Third World", *Social Science & Medicine*, **28**(7): 633-642.

Zwi A. and A. Cabral (1991) "Identifying `high risk situations' for preventing AIDS", *British Medical Journal*, **303**: 1527-9.

Acronyms

CCC	Cooperation Committee for Cambodia
CDD	Control of Diarrhoeal Diseases
CoCom	Coordinating Committee for Health
ECU	European Currency Unit
EPI	Expanded Programme of Immunisation
ERRP	Emergency Recovery and Rehabilitation Programme
HIV	Human Immuno-deficiency Virus
NGO	Non-Governmental Organisation
PECDAR	Palestinian Economic Council for Economic Reconstruction
QUIP	`Quick Impact' Project
UNHCR	United Nations High Commissioner for Refugees
UNITA	National Union for the Total Independence of Angola
UNTAC	United Nations Transitional Authority in Cambodia
USAID	United States Agency for International Development
WHO	World Health Organisation

Relief and Rehabilitation Network

The objective of the Relief and Rehabilitation Network (RRN) is to facilitate the exchange of professional information and experience between the personnel of NGOs and other agencies involved in the provision of relief and rehabilitation assistance. Members of the Network are either nominated by their agency or may apply on an individual basis. Each year, RRN members receive four mailings in either English or French. A Newsletter and Network Papers are mailed to members every March and September and Good Practice Reviews on topics in the relief and rehabilitation field every June and December. In addition, RRN members are able to obtain advice on technical and operational problems they are facing from the RRN staff in London. A modest charge is made for membership with rates varying in the case of agency-nominated members depending on the type of agency.

The RRN is operated by the Overseas Development Institute (ODI) in conjunction with the European Association of Non-Governmental Organisations for Food Aid and Emergency Relief (EuronAid). ODI is an independent centre for development research and a forum for policy discussion on issues affecting economic relations between the North and South and social and economic policies within developing countries. EuronAid provides logistics and financing services to NGOs using EC food aid in their relief and development programmes. It has 25 member agencies and four with observer status. Its offices are located in the Hague.

For further information, contact:

Relief and Rehabilitation Network - Overseas Development Institute
Regent's College - Inner Circle, Regent's Park
London NW1 4NS - United Kingdom
Tel: +44 (0) 171 487 7413 - Fax: +44 (0) 171 487 7590
Email: rrn@odi.org.uk