War & Health

Defining the protection of health in war zones

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INTRODUCTION

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For civilians caught in the devastating reality of conflict and war, daily life is not only threatened by unspeakable fighting and violence, but is also severely impacted by the lack of access to essential services that provide food, water, sanitation, health and emergency aid.

It is in these settings of instability, from the break-down and destruction of state institutions and infrastructure, where the urgent need to deliver critical, life-saving interventions is usually provided through humanitarian assistance and international development and peace-keeping efforts. In the fragile setting of conflict zones, malnutrition and the spread of disease become highly prioritized concerns, particularly in vulnerable areas that are already experiencing food shortages and a high burden of disease.

The 2011 World Bank Development Report on Conflict, Security and Development called attention to the health of populations in fragile states torn by conflict where under-nourishment and child mortality was doubled in comparison to conflict-free states. The lack of health services to address these severe, life-threatening needs can exacerbate already existing tensions of inequity, further threatening the possibility of a peaceful and stable future. And while development efforts often aim to support institutions weakened from conflict, such as healthcare settings, these efforts can easily be derailed from continued violence and war.

Additionally, new challenges arise from the protracted wars and conflicts of the past five years that have seen a major shift in the cyclical nature of violence and the methods of warfare that now alarmingly includes the increased and direct assault on civilians and healthcare workers. This shift now poses an even greater threat to the protections enshrined in international human rights law and requires an urgent re-evaluation of the approaches previously used to address the protection of health and development in challenged and fragile settings.

Every conflict is unique in its context, dependent on numerous causal factors, and often requires rapid humanitarian and development assistance interventions that are nimble, adaptable and flexible. These challenges require an inter-sectional approach that addresses health, conflict and development to improve the drivers of poor health outcomes and poverty. The United Nations Sustainable Development Goals (SDGs) calls for a coordinated and collective effort to reduce poverty and improve health, promote peace and build accountable institutions by 2030.

War & Health: Defining the protection of health in war zones, is a monograph of collaborative effort and represents a multidisciplinary assessment from experts and academics working in the fields of international development, human rights, humanitarian assistance and public health. The publication is the result of the high-level international policy conference jointly organised in Barcelona by CIDOB and ISGlobal in June 2016, with the support of the Europe for Citizens programme of the European Commission. The conference critically assessed the current global policy debates at the intersection of conflict and war, healthcare, development and poverty. The aim of this monograph is to identify policy alternatives, challenge current approaches, and re-evaluate strategic objectives, existing data and research.

The first two contributions examine the links between conflict, health and development. Bayard Roberts highlights the importance and gaps in knowledge, of evidence based research to establish empirically grounded linkages between conflict and the increase in poor health outcomes, including mental health disorders that develop as a result of violence. Primus Che Chi and Rachel Irwin present the World Health Organization´s (WHO) recommendations on strengthening health systems and examine the building of resilient health systems in conflict areas that not only address short-term emergency needs but also consider long-term responses to the changing burden of disease and continuous care for noncommunicable diseases such as cancer.

The following two chapters deal with health as a cause of conflict. Marine Buissonniére calls to attention the increasing attacks on healthcare facilities, such as the bombing of the Médecins Sans Frontiéres' Kunduz Trauma Center in Afghanistan in 2015, which violate International Humanitarian Law and challenge the principles of impartiality. Preeti Patel provides insight into how health can cause conflict through the insecurity of pandemics. Migration can also be seen as a potential source of conflict as migrants are perceived to strain health services in host countries, but health systems can actually be used as an opportunity to construct peace through the building of stronger institutions.

The final chapters focus on the development of health in post-conflict situations. Debarati Guha-Sapir considers how basic health services can serve as a stabilizing factor in fragile settings and highlights successful projects that avoided parallel health systems and created a sense of ownership within the community. André Griekspoor argues that health system strengthening needs to begin during the period of conflict to ensure both the right to health and the collaboration of national health authorities. Egbert Sondorp highlights that post-conflict recovery efforts

require a long term view of planning to ensure the careful transition of health services from humanitarian organizations to state institutions, with several different modalities to be considered.

This monograph reflects the current challenges of delivering health and development services in war that can often lead to an increase in poverty and higher disease burden. One of the recurring observations throughout the chapters is the lack of sufficient data and the need for new areas of research to better establish the causal links between war and health in the current landscape. In times when conflict and war are at the origin of massive displacement, affecting for the first time in history more than 60 million people, the majority of the population living under conflict remains without any protection and proper access to essential health services. The aim of CIDOB and ISGlobal has been to start a debate on the need to approach new responses to conflict that are more flexible, achievable and innovative to reduce the gaps in health disparities and poverty while exploring how humanitarian access to health facilities could be strengthened.

ASSESSING THE LINKS BETWEEN CONFLICT, HEALTH AND DEVELOPMENT

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Is conflict bad for health? The intuitive answer is yes. However, it is generally difficult to epidemiologically prove a direct causal link between armed conflict and worse health outcomes among civilians. This is largely because of contextually driven methodological limitations such as uncertain and limited baseline and longitudinal data that could help demonstrate temporal patterns over underlying secular trends (HSC, 2011). However, these epidemiological limitations should clearly not prevent us from drawing plausible, evidence-based associations between conflict and health. A large volume of descriptive data has highlighted that health outcomes are generally significantly worse among populations exposed to conflict and forced displacement when compared to those who are not exposed. Mortality (including maternal mortality) and malnutrition rates are often significantly elevated as a result of exposure to conflict, with high profile examples including the Democratic Republic of Congo Iraq, Somalia, Sudan, Syria, and Uganda (Checchi & Roberts, 2005; Salama, 2004; World Bank, 2011). Exposure to conflict and forced displacement are also associated with at least a doubling of the prevalence of common mental health disorders (WHO, 2013a), while other mental disorders such as post-traumatic stress disorder can rise even more substantially (Steel, 2009).

Could health outcomes improve despite conflict? Some studies have shown improved population-level health outcomes during times of conflict, but these studies are generally few in number or methodologically limited (HSC, 2011; Devkota & Van Teijlingen, 2010). Evidence also suggests that conflict may be protective against the spread of some diseases such as HIV/AIDS (Spiegel *et al.*, 2007). Fundamentally, the health impacts of conflict will vary depending on the intensity of the conflict; demographic and epidemiological profiles; socio-economic circumstances and available resources, and coverage and effectiveness of the health sector response.

What is the impact of conflict at the global health level? The Global Burden of Disease Study suggests that armed conflict has a fairly negligible impact – indeed it reportedly accounts for less than 1% of the Global Burden of Disease – either as deaths or Disability Adjusted Life

Years (DALYs) (G.B.D. Risk Factors Collaborators, 2015). However, the study only includes direct deaths from conflict, rather than the indirect deaths which can account for up to 90% of the excess deaths arising from conflict. It also excludes conflict as a risk-factor for physical and mental morbidity and disability. The broader health effects of conflict, such as on health systems, are also not captured.

It is difficult to empirically map the pathways explaining the impact of conflict on health outcomes because of the contextual constraints and methodological limitations noted above. However, credible explanations clearly exist. These include the direct impact on the deaths, injuries, and psychological trauma that occur from the war-fighting itself. They also include the indirect impact on physical and mental morbidity and malnutrition from: impoverishment; reduced access to shelter, health services, food, potable water, and sanitation; higher exposure to disease vectors; sense of loss; and disruption to key health system functions. These key health system functions include: damaged or destroyed health services, medical supplies, and essential public health functions; reduced human resources due to attacks on health workers and disrupted training; reduced disease surveillance and other information systems; compromised stewardship; and diverted government funding and diminished international funding as donors invest in safer and more stable countries (Patel *et al.*, 2016).

In terms of poverty reduction and development, at the individual level, conflict and forced displacement can lead to the loss of assets and income which is exacerbated by the long-term and cyclical nature of conflict and forced displacement. In addition, the cost of health care, particularly for more complex treatment of non-communicable diseases, can also risk bankrupting households through catastrophic health expenditure – such as is happening with Syrian refugees today (Spiegel *et al*., 2014). Permanent physical disability from injuries and long-lasting mental disabilities can severely compromise the ability of individuals and their families to function, including economically, at their full potential (Makhashvili *et al.*, 2013; WHO, 2013b). At the district and national levels, conflict impedes economic growth and deters investment, thereby slowing or reversing progress in poverty reduction and development (World Bank, 2011).

However, we must be careful to guard against making assumptions on the health impacts of conflict and forced migration without using reliable evidence. Perhaps the clearest example of the failure to use evidence was the assumption by many governmental, non-governmental and UN agencies that conflict and forced migration would inevitably spread HIV/AIDS (UNGA, 2001). In fact, evidence suggests the opposite was generally the case (Spiegel, 2007). This failure likely resulted in substantial misallocation of scarce resources and further stigmatized forcibly displaced persons.

It is also important that we use evidence to not only better understand the impact of conflict on health and development, but, crucially, to also strengthen the effectiveness of humanitarian health interventions. There remain large evidence gaps on the effectiveness (and cost-effectiveness) of humanitarian interventions in improving health outcomes (Blanchet *et al.*, 2015). There are also very few studies which have sought to evaluate

the effectiveness of inter-sectoral interventions – such as for health and education or income generation and how they can improve health and other development outcomes (Blanchet *et al.*, 2015). Indeed, the failure to generate and use evidence to better understand the health needs and effectiveness of humanitarian health responses remains a critically neglected area in the humanitarian system.

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Since the new millennium, the nexus between health, peace and security has been heavily investigated in academic and policy arenas, especially since the first UN Security Resolution 1308 on a health issue - HIV and peacekeeping (UNSC, 2000). More recently, Francoise Holland, the French President stated, "Our commitment to eradicate extreme poverty by 2030 is at stake; as is the cohesion of the international community at a time when health risks represent one of the major threats to peace and security" (Hollande, 2016). His statement is not surprising especially in the aftermath of UNMEER, the first UN mission to combat the Ebola outbreak, which was considered a threat to peace and security, not only to the most affected countries in West Africa, but also globally (Heymann *et al.*, 2015).

Underlying high-level declarations on health and (in)security is an overwhelming fear of instability and civil conflict as a result of pandemics, destruction of health systems, and an increasing concern of attacks on healthcare facilities and workers (Patel *et al.*,2016). Within these discourses however, there has been much less investigation on the specific role of health as a cause of conflict or state breakdown. Numerous multidisciplinary, theoretical and empirical studies have investigated the role of ethnicity; religion; extremism; exploitation of natural resources; and structural determinants of conflict such as horizontal inequalities; the failure of the social contract; the green war hypothesis; colonial legacies and political issues such as leadership and corruption (Stewart, 2002; Patel, 2012). Most studies have demonstrated the multiplicity and intertwined nature of the causes of conflict based around concepts such as greed and grievance. As country case studies on the causes of conflict have illustrated, new conflict drivers appear, decline, and perhaps re-appear alongside historical, political, and social factors whose impacts also wax and wane over time (Lewis & Patel, 2012). A key lesson is that causality is one of the most complex issues to pinpoint with the root causes of conflict in each context.

Health as a cause of conflict could potentially be linked to the breakdown of the social contract that populations have with their state authority. Conflict-affected countries typically have histories of weak

social contracts, or a once-strong social contract that has degenerated as non-state actors fill the void left by state breakdown or fragility (Murshed & Gates, 2005). Several donors assert that investment in the health sector can help consolidate peace through state-building activities such as promoting social cohesion through equitable health systems, restoring accountability and increasing government capacity (Kruk *et al.*, 2010). This is viewed as having the potential to legitimize the state through creating or reinforcing a social contract that is inherently stabilizing. The state-building assumptions are generally rooted in a belief that enhancements to the governance of the fragile state's various health sector institutions have wider consequences that may extend beyond the direct delivery of health services; spilling over from the health sector into civil society whilst also stimulating the state to develop capacities in other sectors from the raising of tax revenues (Kruk *et al.,* 2010).

The functions of the state are important in maintaining the cohesiveness of society, which in turn is central to maintaining the social contract (Murshed, 2009). Health is often seen as a positive political good alongside education, economic opportunities, employment, and security reflecting Weberian or neo-Weberian ideals of how a 'successful' state should function (Mcloughlin, 2012). Most nation-states exist to deliver political goods although there usually a hierarchy of positive state functions (Rothberg, 2003). State collapse can occur when governments can no longer deliver positive political goods to their people, losing legitimacy in the eyes and hearts of its citizens. However, this is based on the strong assumption that positive political goods such as health are state-financed and state health care provision will enhance the prospect of peace and mitigate the risk of conflict. In reality, non-state organizations and the private sector are responsible for a significant proportion of health provision in several fragile and conflict-affected countries, so the ideological notion of the social contract is questionable in terms of building government legitimacy and trust.

So what does current evidence on health as cause of conflict suggest? The Middle East and North Africa (MENA) region has seen a chronic failure of governance in key services such as: health, education, utilities (power, water, etc.) which have contributed to crises in many countries across the Arab Spring region (Cordesman *et al.*, 2013). Warnings from a decade ago in the Arab Development Report suggested that demographic pressures, failures in economic development and the combination of challenges related to income distribution, corruption and nepotism, and discrimination were compounding pre-existing grievances over a lack of freedom, threatening regional stability and creating significant challenges to some of the countries in the region (ibid).

Large scale forced migration resulting from the Syrian conflict has increased tensions between host and refugee communities living in urban areas in some of the neighboring countries. As a result, health services are being scaled-up to reduce tensions between host and refugee populations in Lebanon, where host populations have traditionally not had access to a high-level of state-provided services (WHO, 2016). Much more research is necessary on the causes of tensions and conflict in urban settings such as in MENA and elsewhere, given the changing patterns of conflict and displacement in recent years.

Inequality and landlessness played a central part in motivating and sustaining the conflict in Nepal, which also had a strong ethnic and caste dimension. Many indigenous populations faced discrimination in access to health care during the civil war, alongside discrimination in access to education and public-sector employment (Murshed & Gates, 2005). Econometric analysis from census and other population-level survey data suggests that horizontal inequalities were also influential in the 1997 – 2001 communal conflict in Indonesia (Mancini, 2005). Districts with larger disparities in child mortality between ethnic groups in 1995, as well as districts where these inequalities widened between 1990 and 1995, tended to be those where deadly conflict occurred. Horizontal inequality in child mortality is a very visible type of inequality, which was used instrumentally by ethnic elites to mobilize ethnic hostility particularly among the poorest groups in Indonesian society (ibid). However, it is important to note that child mortality reflects other dimensions of socio-economic inequality such as education and income. These limited examples illustrate that health is not a cause of conflict per se, but a strong indicator of the intertwined nature of societal grievances and inequalities.

Overall, there are few reliable population-level data on key government services such as health, education, housing, water and refuse removal, and infrastructure, and their relationship to the causes of conflict across conflict-affected countries (Cordesman *et al.*, 2013). Where the state is the main provider of essential services, far better data is needed in key areas such as population perceptions of the state´s role in providing such services which, in turn, determine perceptions and expectations on the quality of governance (ibid). Spatio-temporal analysis for monitoring inequalities in relation to access to health care, as well as their change over time, may provide some useful data as to where and when destructive violence may be likely to erupt (Mancini, 2005). However, it is important to stress that this is highly complex research given the multitude of contributing factors to any conflict.

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Health needs in conflict

In conflict affected states, nutritional programmes, vaccination campaigns, and water and sanitation projects are essential. Additionally, there is a changing burden of disease in conflict settings along with an increasing recognition of the burden of non-communicable diseases. These require a long-term health systems response, rather than a short-term emergency one.

For instance, in Syria, aside from direct conflict-related deaths, which accounted for nearly 44% of deaths in 2012 – the most recent year for which data is available - the list of the top 10 causes of death is dominated by non-communicable diseases (NCDs), including cardiovascular diseases (which account for nearly a quarter of the deaths), cancers and kidney diseases (WHO, 2012). A case in point is a recent story of a Syrian boy who has been granted emergency medical admission to Switzerland (Shubert *et al*., 2016). Alyaman Daar is six, and has muscular dystrophy. This is a genetic disorder, characterised by muscle wasting – there are different types – some of which do not shorten life – but Alyaman will die soon. There is no cure, but there are medicines and therapies that can manage the illness and prolong life. Before being granted entrance to Switzerland, he and his family had been stuck at a camp near the Greek-Macedonian border, having left Syria because they could no longer receive care there.

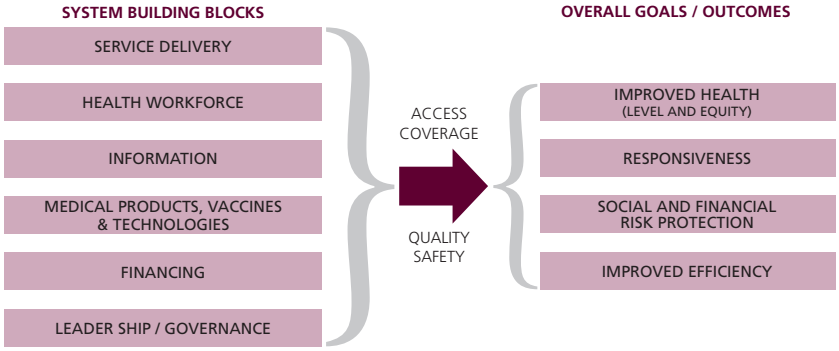
Just because there is a war, this does not mean people do not need treatment for genetic disorders, or that people do not need insulin to manage diabetes. Many people in emergencies have complex health conditions and care needs that are difficult to manage in a peaceful setting, let alone one of protracted conflict. Local health systems therefore need to adapt to crisis situations.

How to build a resilient health system?

Building a resilient health system that can address complex needs can seem overwhelming. In 2007, the World Health Organization (WHO) introduced the concept of health system building blocks, which provides a framework for breaking down the health system into constituent parts (see fig. 1) (WHO, 2007). This allows one to identify individual aspects and points to intervene, making a daunting task more manageable.

According to the WHO, a health system is "all people, institutions, resources and activities whose primary purpose is to promote, or maintain health". A good health system aims to be responsive towards the needs of staff, patients and changing needs. It should also protect users from catastrophic risks associated with treatment, and be efficient and equitable, with regard to access to treatment, services and outcomes.

Figure 1. The WHO Health system framework



Source: World Health Organization, 2007

With these goals in mind, a health system consists of six building blocks: The first, leadership and governance consists of oversight over the whole system and taking strategic decisions. The others are financing, health workforce, medical products, vaccines and technologies, and information, the latter of which includes building and maintaining good surveillance systems. Finally, these five building blocks serve to carry out the raison d'être of the health system: delivering health services. A resilient health system is one that is able to absorb shocks, adapt and continue regular service provision; although in times of crises, certain services may be reduced, a resilient health system limits these effects (Kruk *et al.*, 2015).

Health systems in crisis

Conceptual frameworks are useful in visualising and analysing key aspects, but translating and applying them to real life problems may prove challenging. How can a broken health system be rebuilt to fulfil its mandate? How can we discuss stewardship and governance in countries that are unable to fulfil any basic functions? We can begin by tackling a few aspects of the building blocks.

People and patients should be at the heart of every health system in order to attain one of its goals of "responsiveness". "Responsiveness" engenders trust in the health system. For instance, during the Ebola outbreak in parts of rural Guinea, rumours gained traction that the disease was spread by health workers, Westerners and the health systems. Although this mistrust centred on Ebola, it is also within a wider context of a long history of poor health service delivery and low funding for the health sector – as well as a long history of extractive industry exploitation by multinational companies (Foghammar & Irwin, 2015). This mistrust turned violent; in September 2014, eight members of an Ebola response team were killed by an armed crowd in south-eastern Guinea.

Building trust between management, the workforce and the community is also fundamental. A simple management strategy of ensuring the continuation of staff payments during crises is important. More challenging, however, is ensuring the safety of health workers. In a recent report from the WHO, between January 2014 and December 2015, there were 594 reported attacks on health care workers and infrastructure, resulting in 959 deaths and 1561 injuries in 19 countries with emergencies (WHO, 2016).

Finally, international donors and non-governmental organisations may also have a role to play. For example, it is all too common in post-conflict settings for international organisations to 'poach' the best performing staff, thus taking them out of the public sector. These actors also can contribute to stewardship and governance by ensuring appropriate services and supporting a transition from short-term humanitarian assistance to long-term development and health systems support and strengthening as a government re-builds itself.

Conclusions

Health systems take years to build and moments to destroy. Building a resilient health system to withstand crises is challenging. However, using the building blocks provides us with a road map to identify and strengthen individual parts, whilst still keeping oversight over the whole system. In practice, the goal of a health system in crisis is to balance between emergency relief aid, while continuing to address NCDs and other complex care needs, with the overall goal of improving health and wellbeing.

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Kunduz & beyond

At 02:00 am on October 3rd, 2015, precise repeated strikes from a US airplane destroyed the Médecins Sans Frontières (MSF) Kunduz Trauma Center in Afghanistan. GPS coordinates were known by all parties. 42 people, including 14 staff, were killed. Patients burned in their beds. Some were shot from the air as they fled the burning building (MSF, 2015a).

That same month, 12 hospitals were bombed in Syria (MSF, 2015b). A staggering 94 attacks against MSF-supported facilities were recorded in 2015 (MSF, 2016b), the worst year on record with the Syrian and Russian forces responsible for 95% of assaults, according to Physician for Human Rights (SHCC, 2016). Meanwhile in Yemen, where the Saudi-led coalition has been active, MSF operations came under attack four times in the three months that followed the Kunduz attack (MSF, 2016 a).

Bombings only represent a splinter of violence against health care, and it remains difficult to speak about trends for lack of reliable historical data (Abu Sa'Da *et al*, 2013). Yet without needing to introduce a hierarchy of crimes or victims, hospitals attacks have been happening at an alarming rate and are horrific in their own right. And while each attack needs to be understood in its own specificities, it would be myopic not to ask what the overall picture reveals about the provision of care in conflicts.

Some of the traits of contemporary attacks stand out. While acknowledging non state actors' part in violence against health care, it is unsettling that four of the five permanent members of the UN Security Council (UNSC) have been associated to varying degrees with coalitions responsible for bombing hospitals (Liu, 2016a). Explanations range from mistakes, to denials, justification or simply silence. Whether the result of deliberate targeting or indiscriminate bombings, the destruction of hospitals and related loss of lives have prompted many to denounce the erosion of respect for existing norms, including International Humanitarian Law (IHL) (CPHHR, 2013). Attacks continued unabated as the UNSC was adopting resolution 2286 reaffirming the protection of civilians and health care in conflict on May 3, 2016.

Different dynamics

In Syria, the destruction of health care speaks to a larger reality that some have dubbed a "war on civilians" (The Lancet, 2014). The director of the destroyed Al Quds Hospital provided an on-point illustration: *"I understand the importance to call for respect for hospitals,"* he said, *"but soon there will be no patients to go for treatment there"*. Schools, markets, places of worships are all fair game, along with medical facilities. Each attack further depletes the ranks of local medical providers. Destruction leads to interruption of routine services and emergency care when people need it most. And with attacks come fear: people would rather forego the reopening of a hospital than risk further bombing (Liu, 2016b). Beyond the direct and indirect health outcomes (yet to be properly evaluated), bombing hospitals is inherently about destroying the last spaces of humanity in war. Eradicating the possibility of life by depriving people of essential survival means.

Another critical dynamic pertains to the notion of the enemy and his entitlements. Abiding by medical ethics and putting into practice the principle of impartiality underpinning the humanitarian act, doctors – including MSF ones – must treat all on the basis of needs, including those labelled as "criminals" or "terrorists". They do not dispense treatment based on the justness or morality of a cause. Yet it is this very approach which is being chipped away at when Assad's government passes laws de facto criminalizing the provision of care in opposition areas; when Afghan representatives insinuate that the presence of terrorists in Kunduz hospital justified the attack; or when the Saudi-led coalition spokesperson cites Houthis military activity to declare a hospital a legitimate target (HRC, 2013; CBS News, 2015).

Impartial care

At a time when aerial means replacing ground troops, when special forces operate outside traditional military hierarchies, and counter-terrorism measures escape public scrutiny, the revolutionary reciprocity of care enshrined in the Geneva conventions no longer seems as crucial as it once might have. Similarly, the basic tenant of medical ethics, the treatment of all on the basis of need, is being queried. A backdrop conducive to negating impartiality is emerging, with the lending hand of revisionist military ethicists (Calain, 2016). Questioning the Just-war Theory, they are refuting the concept of moral equality of combatants, and the once absolute distinction between civilians and combatants (McMahan, 2004). They offer interpretations which suggest "wounded or non-combatants from the *unjust* side have a responsibility that comes in degrees" and "that harming or killing them is a matter of proportionality rather than discrimination" (McMahan, 2004 & 2011). Pushed to their extremes, they imply that those treating all might appear complicit and could themselves become liable to defensive killings from *just* parties (Frowe, 2014).

At this testing moment for medical ethics, humanitarian medicine and the provision of care to all who need it, policy makers ought to take a stance against the complacent de-humanization of the enemy and reinforce the imperative of impartial care in conflicts – for the benefit of all and that of our collective humanity.

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CAN BASIC HEALTH SERVICES SERVE AS A STABILISING FACTOR IN INSECURE AND FRAGILE SETTINGS?

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Health as a bridge to peace is an idea generated in the 1980s but that merits re-appraisal in these times of protracted crisis and persistent insecurity. Transition from emergency health responses by external humanitarian groups to ownership and strengthening of local health systems has not been adequately addressed in most post-conflict settings, setting the stage for renewed conflict fuelled by wide-spread discontent and hopelessness of the affected communities. Massive and sudden infusions of foreign aid and expertise compromise existing community public health operations by setting up parallel systems with different norms and resources (Leaning and Guha-Sapir, 2013).

Most active conflicts today have either been ongoing for years, perhaps decades, while some smoulder along with persistent insecurity, occasionally breaking out into active conflict. The history of conflict resolutions show a discouraging pattern of political accords and agreements that are often unable to bring about lasting peace, collapsing within a matter of years or even months. According to a report by the researchers from the Uppsala Conflict Data Programme, the numbers of civil conflicts have peaked in 2011, increasing by 20% from the previous year (Högbladh, 2012). Peace accords are difficult to bring about, taking years and most often do not last (Themné & Wallensteen, 2012; Högbladh, 2012). In general, in post-crisis situations lawlessness becomes a way of life in the absence of a return to systemic normalcy. Governments that are legitimately elected eventually lose authority and credibility, as they are unable to provide basic services to their people. In addition, inequities in provision of basic services can motivate conflict among different groups. In contrast, equity in services can generate confidence in the government and therefore stability.

Many of the insecure regions are characterized by their remoteness where health, food security systems, nutrition and basic education have broken down. In insecure settings, epidemics tend to be recognised well beyond their peak as surveillance systems do not function. For example, in Uige, Angola, international response came in nearly 3 months after the start of the epidemic of the highly virulent Marburg haemorrhagic fever outbreak, only when nearly 300 children died in the paediatric hospital. Identification of rare diseases still remains a major challenge in most conflict-affected regions where adequate laboratory services are unavailable.

These crises pose a moral imperative on the global community to provide help through humanitarian aid. But they also require effective action to stabilize the affected population, both in their own interests and that of global security.

The concept of Health as a Bridge for Peace, developed in the 1980s by the Pan American Health Organization (PAHO) integrated peace-building strategies into health relief and health development in post-conflict transitions. It is based on the idea that fundamental health needs is a universal concern transcending political, economic, social, and ethnic divisions among peoples and provides an entry point and nexus in the process of negotiation and dialogue (Guerra de Macedo, 1994). As a programme, it was adopted by the World Health Organization (WHO) in 1997 and used in many settings to bring warring parties around the table to begin discussions on local health problems. In 2009, the Human Rights Foundation of Turkey, the Norwegian and Turkish Medical and the World Medical Associations met to set up an operational approach to use Health as a Bridge to Peace in the Middle East. Cease fire days for vaccination campaigns have been highly successful in more than 20 conflict theatres, the descriptions of which can be found in the Health as a Bridge for Peace Humanitarian Cease-Fires Project (HCFP) website. This experience of the health humanitarian community and WHO provides compelling evidence in favour of including health services as an effective stabilising factor (Rushton & McInnes, 2006).

Today, more so than before, the importance of normalizing civil society through essential and universal services of health, education and other components of everyday life needs to be recognized as priority emergency services. Bøås, *et al* (2011) found that households ranked food, health and employment systematically higher than peace accords in opinion polls in nine conflict affected country. Providing health services consistently and in a visible way at the same time as peace negotiations can be a stabilizing approach at the grassroots level, providing civil society normalcy, care and reasons not to fight.

There are some studies that examine the importance of local ownership, local engagement, local financing and equity in access and distribution of health benefits in conflict settings (Aaby *et al.*, 1999; Mullany *et al.*, 2010). But we lack systematic evidence and research that illustrate the stabilizing potential of basic health services in a community and its contribution towards the pacification of a turbulent and chaotic situation. More importantly, lack of translational research that transforms normal health policies as guides to field humanitarian operations are stalling field operations at emergency services models.

Availability of health services in insecure areas play roles in other critical ways that are often not on the post-conflict policy radar screen. For example, non-state armed groups including extremist factions, often provide grassroots health services to the poor and disenfranchised in Afghanistan and some Middle Eastern countries. This reveals their understanding of the power of basic services, in this case, health as a pole of attraction and adherence. Services are also provided by other non-state groups, such as community traditional healers who replace the failed health structures, but who rarely form part of relief or

development aid policy. These issues are front line thinking, needing more attention and clear, evidence-based policy to apply to these situations. Health as a bridge to peace is unquestionably a promising approach. Peace accords come and go while communities remain victims of the war. Availability of basic and essential services is arguably a disincentive to fighting. Long-term political stability is dependent on civic services, especially health in tandem with high level political processes. Without civilian interest in peace, civil conflict will be difficult to end.

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POST-CONFLICT HEALTH SYSTEM RECOVERY SHOULD START DURING THE CONFLICT

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There have been several discussions on the potential of ensuring access to health services in post-conflict contexts to support security and stabilisation, or as peace dividend, and on the contribution of health system recovery towards state-building (Haar & Rubenstein, 2012; Pearson, 2010). While there is something to say on all these aspects of how health objectives may support political agendas, the primary health objective is to ensure the right to health of people through access to quality essential health services during and after crises.

When humanitarian action is necessary, relief efforts need to take into account interventions that are conflict sensitive, that they assist in equitable recovery and health system strengthening, which includes a functional ministry of health. For example, when post-conflict investments are made, any pre-existing projects or efforts under development need to be taken into consideration, or risk further marginalisation and exclusion that may have been reinforced during the conflict.

However, these issues should not wait to be addressed until there is a peace agreement and a more stable government in place. After the conflict ended in Liberia in 2003, the first national health policy only came into effect as of 2007, and during this time there was a significant risk for what was called the transition funding gap (Canavan *et al,* 2008). Progress is currently being made in the Central African Republic, where, despite all challenges, a transition plan was already under development alongside humanitarian efforts that were still working to stabilize the country.

Post-conflict Needs Assessments (PCNA), the joint assessments supported by the World Bank, United Nations, and European Union to assist new governments in post-conflict recovery and reconstruction planning, are now being done earlier when the crisis is not yet over. Recent examples of such assessments include eastern North-east Nigeria, Ukraine, and Yemen. The name is changing to reflect this from PCNA to Recovery and Peacebuilding Assessments (RPBA). The process looks at what can be done towards initial recovery in areas that are already relatively stable, and how to prepare for long-term recovery.

These developments coincide with a renewed acknowledgement to seek stronger connections between humanitarian, peacebuilding, recovery and development processes, and the recognition that these concepts are not sequential but overlap in time. The report of the Secretary-General for the 2016 World Humanitarian Summit 'One Humanity: shared responsibility' formulated five core responsibilities, including 'to leave no one behind', honouring the international community's commitment under the 2030 Agenda for Sustainable Development that requires reaching everyone in situations of conflict, disasters, vulnerability and risk, and 'Change people's lives – From delivering aid to ending need', which includes transcending the humanitarian-development divide (UNGA, 2016).

For health, this means that efforts should not wait until a post-conflict recovery plan is developed and needs to start taking long-term issues more into account during contexts of protracted emergencies and fragility. In these contexts, the aim should already be to optimise the quality and coverage of health services provided to affected populations collectively by all health actors using all available resources, while laying the foundation for long-term health system recovery and resilience, and supporting health emergency risk management capacities.

Within the mandate for saving lives, humanitarian partners can and need to take into account long-term consequences of their emergency actions, and see how their interventions interface with long-term recovery and development. Principles for such early recovery include efforts that:

- should not undermine the national systems, by delivering health interventions with and through the existing health system when possible;
- should work with national health authorities and partners where and when possible; and to develop national capacity when possible;
- should establish the foundation for coherent health system functions through early recovery approaches from the beginning;
- should create environment in which development partners can connect at earlier stages;
- should invest in national capacities for health emergency risk management.

This requires better collaboration with development partners through coordination mechanisms that are owned by national health authorities. The grand bargain calls for joint analysis, and joint planning toward collective outcomes. This can be done for areas where the government still has ongoing budget development assistance and where there are no concerns with respect to upholding humanitarian principles. For areas where this is not the case, the humanitarian assessments should at least be informed by development and peacebuilding analyses (CIC, 2016).

For health, this can be done by seeking synergies in the content of an essential package of health services (EPHS) and the core health systems functions of district health management teams, supported by community engagement and health emergency risk management capacities. Approaches used in post-conflict recovery, such as in Afghanistan and South Sudan, should be examined to see if they can

be brought forward and adapted during the crises. In areas where this would be possible, it would require a different way of doing humanitarian programming; the creation of pooled health emergency funds and performance based contracts with fewer partners that each work with one or more district health management teams, and that can support the implementation of a full EPHS across the different levels of health care, supported by the central procurement of medical supplies.

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THE LONG WAY TO POST-CONFLICT HEALTH RECOVERY

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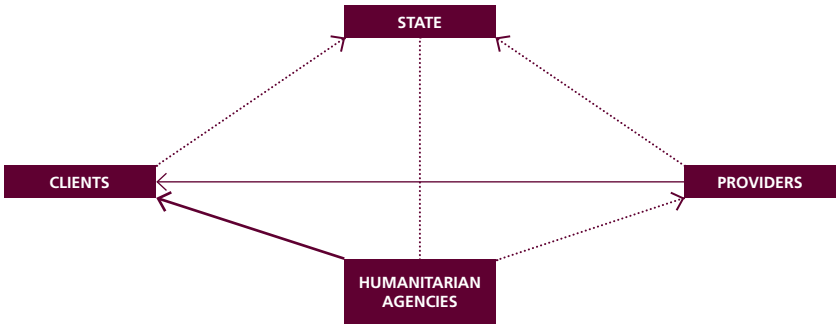
Most armed conflicts over the past decades have been characterised by prolonged civil strife, disproportionally affecting the civil population. Displacement, affected livelihoods, deteriorated health status and economic decline are only some of the consequences. Morbidity and mortality may increase substantially, due to the direct effects of warfare, but often predominantly due to indirect effects as a result of deteriorating determinants of health, including malnutrition, increased epidemic risks, and declines in preventive and curative health services. The government, usually party to the conflict, is often not able or willing to protect its citizens.

Prolonged conflict in often already weak states at the beginning of conflict tends to erode all institutions in the country and will even affect the very fabric of society. Poor institutional capacity typically affects all levels of government, including health authorities at national and subnational levels.

These kinds of conflicts sooner or later will evoke a humanitarian response from the international community, to protect people, with the primary goal of saving lives. Humanitarian health agencies will aim to provide health services by setting up clinics and other services, directly or through pre-existing health facilities. These are often large scale operations that may last for many years. While usually some form of coordination with local health authorities takes place, the humanitarian agencies demand independent action and keep control over their own resources. In many cases, this is the only way to operate to protect citizens and save lives.

These types of 'humanitarian settings' are typically well portrayed in the following diagram. The humanitarian agencies build up direct relations with the population and tend to bypass the state.

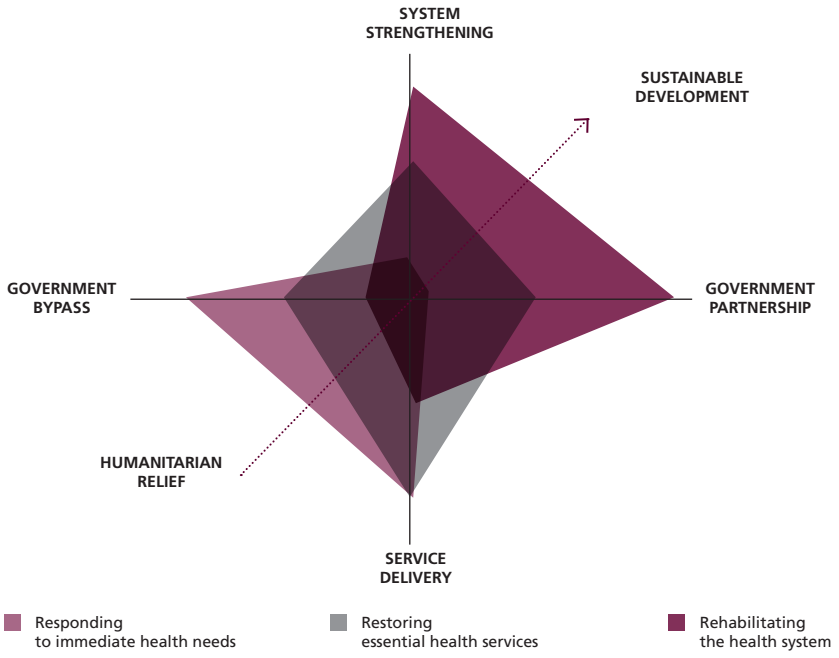
Figure 1. Relations in humanitarian settings



Post-conflict

Sooner or later conflicts will resolve through some form of political settlement. It is rarely an acute moment that leads to a peace treaty, but is rather a lengthy process in which the conflict may subside and re-occur until some lasting stability has been reached. This will also be the moment when the international community will need to change its approach. Humanitarian funding will be reduced, and, more importantly, there is a need to ensure that a viable state emerges able and willing to take care of its citizens. For the health sector this means that health authorities will need to be in charge again, set policy directions, and regulate the health sector. Since capabilities to do so will often be low, this means a lengthy transition process in which the state gradually takes on its role toward sustainable development. In health, there will also be a need to move from a pure focus on health service delivery towards a more comprehensive focus on the whole range of health system building blocks. The next diagram aims to illustrate the transition process.

Figure 2. Transition framework



The transition is never a smooth, linear process. Bouts of insecurity may reoccur, initial political settlements may not hold, and institutional capacities will only gradually improve.

This means that in the early years of recovery, modalities will have to be developed that can contribute to the long term goal of state building, while at the same time provide sufficient levels of health services that both start to improve health, as well as increase trust and legitimacy in a new government.

Low capacities within government, often coupled with low levels of accountability, call for hybrid approaches from the side of the international community and its donors. The aim is to support the emergence of government led policies and strategies. However, the implementation of the chosen strategy may involve NGOs, with an intermediate fund manager channelling the funds from donors to the NGOs outside the government financial systems.

A good example of the latter is the now widespread practice taking place in a range of post-conflict settings where NGOs are contracted to deliver health services on behalf of the government and within the scope of government set general health policies. Contracts, which are usually paid for directly by a donor or its non-state fund manager, may provide the NGOs with more or less autonomy to deliver the services. Local capacity building of health authorities and health providers is usually part of the contract.

This approach tends to lead to a largely supply driven model. A more recent development is to focus on the needs of the people in the communities undergoing health sector recovery. Appropriate involvement of communities, including close-to-community services, is leading to a more demand driven approach and increased accountability from the side of health authorities and providers, which, in turn, is believed to be an essential contributor to state building.

Figure 3. People at the centre of health systems