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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