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TITLE: POST-CONFLICT RECOVERY AS AN IMPETUS FOR STRENGTHENING HEALTH SYSTEM RESILIENCE IN AFRICA: EXPERIENCES AND LESSONS FROM THE NORTHERN UGANDAN HUMANITARIAN CRISIS

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Abstract

Between the 1980s and 2000s, Northern Uganda experienced over twenty years of armed conflict between the Government of Uganda (GoU) and Lord's Resistance Army (LRA). The resulting humanitarian crisis led to the displacement of over 90% of the population of the then Acholi sub-region and a lesser percentage of the population of Lango sub-region into IDP camps. Living conditions in the camps were extremely poor with very high prevalence rate of HIV and tuberculosis, violence and gender based violence.

In 2006, the two warring parties signed a landmark Cessation of Hostilities Agreement which brought relative peace to the area and triggered population return from IDP camps to original homelands where they are closer to their land and sources of livelihood. The prevailing peace and population return in the region catalyzed the launching of a Peace, Recovery and Development Plan (PRDP) by the Government of Uganda (GoU) and its development partners in October 2007; the plan (PRDP) is a broad framework and strategy aimed at addressing the causes of the conflict and set the pace for transition and recovery in all 40 conflict affected districts in the northern part of the country

To provide a platform for operationalizing the plan in the health sector, Ministry of Health of Uganda in collaboration with health partners developed and implemented a health sector recovery strategy and plan. The UN agencies working in the health sector also developed a UN support strategy to the PRDP which outlines how they (the UN agencies) will support GoU to implement the PRDP and health recovery strategy.

In this paper, we discuss the post-conflict health system recovery process, including integration of DRR into health recovery interventions, its strengths, challenges and lessons learnt as a way to inform the post 2015 HFA post-conflict/disaster health system recovery agenda in Africa

Introduction

Armed conflicts are common events which continue to negatively affect the wellbeing of the World's population. From the 1960s to 2008, about 24 sub-Saharan countries of Africa (almost half) experienced armed conflicts (Grasa R and Mateo O, 2010). One in every three African is said to be directly or indirectly affected by conflicts which may delay the attainment of international development goals (World Bank, 2002). In recent times, increased disputes over land, resources, ethnic identity, political and religious ideology have fuelled an increase in the occurrence of armed conflicts on the continent with attending increases in conflict associated morbidity and mortality. Murray et al (2002) identified the deaths and injuries which are associated with armed conflict as major contributor to the global burden of diseases while Krug et al projected that armed conflict related morbidity and mortality will be among the top ten contributors to the global disease burden in the next 10 years (2000).

Armed conflicts almost always impact the health of affected populations, health systems and social determinants of health in affected areas negatively. They (armed conflicts) have been shown to occur more frequently in low income countries of the world where their impact is more severe (World Bank, 1998); thus further compounding the poor situation of the social determinants of health and weak health systems which are usually associated with such countries. Impact of conflict on health could be direct or indirect ; direct impact of conflicts on health include physical trauma, destruction and looting of health infrastructure, equipment, medicines and supplies which renders health facilities non-functional resulting in disruption of health services, reduced access to and utilization of health services (Vreeman R et al, 2009).

The disorganized and stressful conditions which are associated with armed conflicts may also exacerbate pre-existing chronic health conditions among affected populations (Waters H, Garrett B, and Burnham G, 2007) and activate new health problems such as psychological trauma and mental health illnesses (Murthy R and Lakshminarayana R, 2006) thus increasing demand for health services. The population displacement which are accompany armed conflicts are often into places where living conditions are poor, overcrowded and there is inadequate access to health and social services such as water and sanitation hence the increased risk of outbreaks of communicable diseases especially cholera and measles (Waters H, Garrett B, and Burnham G, 2007). Other impacts of armed conflict on the health system have also been documented. Poor coordination of health service delivery, disruption of medicines and medical commodity supply chain system and lack of reliable health information and data for decision-making have been known to occur because of disasters (Zwi et al, 1999). Furthermore, disasters may result in displacement of health workers, increased dependence on donor aid, weak health policy development and implementation and inadequate health financing (Waters H, Garrett B, and Burnham G, 2007).

Given the profound impact of conflicts on health systems, it is imperative that post-conflict health system recovery is supported in a systematic and sustainable manner. A well-recovered health system can contribute to addressing the root causes of conflicts, facilitate

conflict resolution and peace building and also support strengthening of community and health system resilience to disasters. Conversely, poor social services (including health) may be part of the root causes of conflicts and also increase vulnerability of affected populations. Post-conflict rebuilding of disrupted health systems usually constitute a major challenge due to lack of understanding of health system recovery, inadequate national capacity and the high cost of recovery (Cometto G, Fritsche G, Sondorp E, 2010). This was the scenario that played out following the more than 20 years of armed conflict in northern Uganda which resulted in major disruption of its health system.

In this paper, we discuss the 20-year northern Uganda war, its impact on the health system and the post-conflict health system recovery process. The key lessons learnt during the recovery effort and how Disaster Risk Reduction (DRR) was integrated into the health recovery interventions are higligthed and used to propose the post-2015 agenda for post-conflict/disaster health system recovery in Africa

Methodology

This paper is a retrospective analysis of the health system recovery process which followed the northern Uganda crisis with emphasis on lessons learnt and how the recovery process was used as an opportunity to strengthen health system and community resilience. The methodology used is a descriptive and qualitative review of the planning, implementation, supervision, monitoring and evaluation of the health system recovery process in the country. An online search (using PubMed and other search engines) was conducted using the terms ["health impact of armed conflicts"], ["post conflict health system recovery"], ["northern Uganda armed conflict"], and ["post conflict recovery in northern Uganda"]. The search yielded a wide variety of references documents out of which ten were selected and reviewed. A list of existing documents such as the PRDP document[1], northern Ugandan health recovery strategy and plan, reports and commentaries on the implementation of the PRDP and health strategy were also compiled and reviewed. Participant observations of several meetings to discuss the conceptualization, implementation, supervision, monitoring and evaluation of the PRDP and the health system recovery strategy were done and the minutes of some of the meetings were reviewed. To validate information or gain further insights into grey areas, key informant interviews of selected actors involved in the implementation of the PRDP and health recovery strategy was also done using semi-structured questionnaire where necessary.

[1] Northern Uganda Peace, Recovery and Development Programme (PRDP); available at: http://www.internal-displacement.org/8025708F004CE90B/(httpDocuments)/F9933A32534907A8C12573B700779C11/$file/PRDP+Sep+2007.pdf (accessed on 9th January 2014)

The Northern Ugandan Context

The Lords Resistance Army (LRA) War and its Impact on Health

Between the 1980s and 2000s, Northern Uganda experienced over twenty years of armed conflict between the Government of Uganda (GoU) and LRA (ICG, 2004). The resulting humanitarian crisis led to displacement of a large percentage of the populations and disruption of the health care system of the area. At the height of the conflict, over 90% of the population of Acholi sub-region (which then comprise Gulu, Kitgum and Pader) and a lesser percentage of the population of Lango sub-region (comprising Apac, Lira and now Oyam, Amolatar and Dokolo districts) were displaced into Internally Displaced Persons (IDP) camps. Overcrowding, limited access to social services such as health, water and sanitation, violence and insecurity were major problems in the camps. The style of the LRA was particularly brutal with abduction of mainly women and young children who were either forced to be child soldiers or wives of rebel commanders. After visiting some of the IDPs camps in November 2003, the then Emergency Relief Coordinator, Mr Jan Egeland said *""I am deeply shocked by what I have seen… northern Uganda is one of the worst humanitarian crises in the world. The situation cannot be allowed to continue for another 17 years"* which aptly described the situation in the IDP camps (Wendo C. 2003).

Living conditions in the IDP camps were extremely poor. The latrine to population ratio was as bad as 1 to 310 persons and access to water as low as 4.2 litres per person per day in some of the camps (Wendo C. 2003) as opposed to the SPHERE standards of 1 latrine per 20 persons and 15 litres of water per person per day. The result of a mortality survey which was conducted in 2005 in three districts of Acholi namely Gulu, Kitgum and Pader[2] showed high crude mortality rates (CMRs) of 1.54 and Under Five Mortality Rate (U5MR) of 3.18/10,000/day among the Internally Displaced Persons (IDPs), figures which are well above the respective emergency thresholds of 1 per 10 000 per day and 2 per 10 000 per day recommended by the SPHERE standards. The high CMR were directly linked to malaria/fever, high HIV and TB prevalence rates, violence and rape including Gender Based Violence (GBV). According to the 2004/5 HIV prevalence survey in the country[3] the north central region (which comprise of Apac, Gulu, Kitgum, Lira and Pader districts) had a prevalence rate of 8% which was second only to Kampala (9%). The survey showed that bednet coverage among children under five years of age was between 26-31% which was far short of the 60% Roll Back Malaria (RBM) targets at the time.

[2] Health and mortality survey among internally displaced persons in Gulu, Kitgum and Pader districts, northern Uganda; available at: http://www.who.int/hac/crises/uga/sitreps/Ugandamortsurvey.pdf (accessed on 9th January 2014)

[3] Uganda HIV/AID sero-behavioural survey; available at: http://www.measuredhs.com/pubs/pdf/AIS2/AIS2.pdf (accessed on 9th January 2014)

The crisis had severe impact on the health system of the affected district districts. The particular brutal nature of the LRA and its penchant for abduction of women (who comprise a significant percentage of the health workers population in the area) resulted in most health workers abandoning their posts for safer parts of the country. The rebels looted most of the health facilities in the areas resulting in disruption of health services while the prevailing insecurity fractured the medicines, supplies and essential commodities supply chain of the area. A health Services Availability Mapping (SAM) survey (unpublished data) which was conducted in Acholi region in 2007 showed that none of the health centres III and IV met the staffing norms which was recommended by the Health Sector Strategic Plan I (HSSP I) which the country was implementing at the time. The doctor to district population ratios were 1 doctor to 11,318, 21,519 and 53,291 respectively in Gulu, Kitgum and Pader districts. In the three districts, health facilities that experienced a stock-out for tracer drugs ranged between 8% and 49%, during the first quarter of 2006

The peace process and Peace Recovery and Development Plan (PRDP)

Following several months of negotiation, a landmark Cessation of Hostilities Agreement was signed between the GoU and LRA in 2006. The agreement resulted in a ceasefire and relative peace in the area which triggered population return from IDP camps to either transit camps or original homes where they are closer to their land and sources of livelihood. The prevailing peace and population return in the region catalyzed the launching of a Peace, Recovery and Development Plan (PRDP) by the Government of Uganda (GoU) in October 2007; the plan (PRDP) which is a broad framework and strategy aimed at addressing the root causes of the conflict and instability, set the pace for transition and recovery in all 40 conflict affected districts of north central (Acholi and Lango sub regions), north east (Karamoja and Teso sub-regions) and north west (West Nile sub-regions).

The plan which had an overarching goal of regaining and consolidating peace and laying the foundations for recovery and development in northern Uganda, committed GoU to improve socio-economic indicators in the conflict affected regions to the national standards. The plan had four main objectives namely: 1. Consolidation of state authority through cessation of armed conflict, provision of security and re-establishment of rule of law 2. Rebuilding and empowering communities through improvement in living conditions in the displacement camps and completing the return and reintegration of displaced populations 3. Revitalization of the economy and 4. Peace building and reconciliation. Health was identified as one of the community empowerment and recovery programmes under objective two.

The implementation of the plan started in 2008 and continues to date. In 2011, the Office of the Prime Minister with support of the Development Partners commissioned a mid-term external review of the PRDP[4]. The findings of the review showed that the four strategic objectives of the PRDP were still relevant, the interventions were effective especially in the social sectors but the time frame of 3 years for implementation of the plan was unrealistic. The review however concluded that the functionality of the investments were poor.

[4] Mid-term Review of the PRDP for Northern Uganda, OPM, June 2011 ; available at http://www.opm.go.ug/search-results.html (accessed on 10th January 2014)

The Health Recovery Planning Process

To provide a platform for operationalizing the health component of the PRDP, the Uganda Ministry of Health (MOH) and District Health Management Teams (DHMT) in collaboration with health partners developed a detailed health sector recovery strategy and plan. A health recovery concept note which described what needs to be done to plan for and recover health in the conflict affected districts was developed and presented to stakeholders within the health sectors of the country in November 2007. Feedbacks obtained during the stakeholders' meeting were used to finalize the concept note and develop a roadmap for health recovery planning in the country. A health recovery strategy was finalized and all 40 designated PRDP districts were supported to develop and cost district specific health recovery plans. The UN agencies working in the health sector also developed a UN support strategy to the PRDP which outlines how they (the UN agencies) will support GoU to implement the PRDP and health recovery strategy.

The goal of the health sector recovery strategy was to ensure equitable access by people in conflict and post-conflict situations to the Uganda National Minimum Health Care Package (UNNMHC) through strengthening health systems and revamping health services that collapsed during the conflict and by gradually expanding coverage in areas, where access is limited. It was believed that these would contribute to stabilizing peace and security and supporting people in restoring their livelihoods. The strategic approach was to simultaneously combine the recovery interventions with ongoing relief efforts by using the existing humanitarian programmes as a foundation for recovery. The objectives of the strategy was expected to be achieved through strengthening of government health stewardship functions (leadership, governance, monitoring capacity, generation and efficient allocation of resources (human, medicines, supplies, equipment and finance) and delivery of primary and secondary health care services. The strategy is being implemented as an integral part of PRDP in all the conflict affected districts of the country.

Discussion

The health system as the basis for health system recovery, disaster risk reduction and resilience building

To understand the concept of health systems recovery and how it was used as an impetus for health system resilience building and health disaster risk reduction in northern Uganda, it is important to define a few disaster terminologies such as recovery, resilience and disaster risk reduction relates them to the WHO health system framework.

Disaster recovery is defined as the restoration (back to normal) and improvement where appropriate (building back better) of facilities and systems (including health), livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk

factors.[5] Recovery from conflicts is defined as the process of restoration of the capacity of the government and communities to rebuild and recover from crisis and prevention of relapses. In so doing, recovery seeks not only to catalyze sustainable development activities but also to build upon earlier humanitarian programmes to ensure that their inputs become assets for development.[6] Recovery after armed conflicts is often part of broader peace and state building objectives, combined with a focus on restoring service delivery.

The UN International Strategy for Disaster Reduction (UNISDR) defines resilience as *"the ability of a system, community or society exposed to hazards to resist, absorb, accommodate and to recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions"*[1]. While UNDP defines resilience as "*transformative process of strengthening the capacity of people, communities and countries to anticipate, manage, recover and transform from shocks*"[7]. Resilience is a disaster risk reduction function which can be used to address disaster preparedness, response and recovery while recovery is a component of resilience.

DRR is defined as *"the concept and practice of reducing disaster risks through systematic efforts to analyse and manage the causal factors of disasters, including through reduced exposure to hazards, lessened vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events"*[1]

WHO defines a health system as a "*system which consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health*"[8]. This system encompasses the determinants of health and all direct health improving activities; it includes health activities at the home, community and formal health sector level. WHO has defined a health system framework comprise of six main building blocks namely health service delivery, health workforce, health information systems, medical products including vaccines and technologies, health financing and health leadership/governace (figure 1). Good access, coverage, quality and safety of all the six building blocks should guarantee improved health outcomes among communities. This framework is the basis for health sector disaster risk management and is used as the structure for health recovery, disaster risk reduction and resilience building.

[5] http://www.unisdr.org/we/inform/terminology

[6] Health cluster guidance note on health recovery ; available at : http://www.who.int/hac/global_health_cluster/guide/117_iasc_global_health_cluster_recovery_strategy_guidelines.pdf

[7] Towards human resilience: sustaining MDG progress in an age of economic uncertainty; available at: http://www.undp.org/content/dam/undp/library/Poverty%20Reduction/Towards_SustainingMDG_Web1005.pdf

[8] Everybody's business. Strengthening health systems to improve health outcomes; WHO's framework for action. World Health Organization; 2007

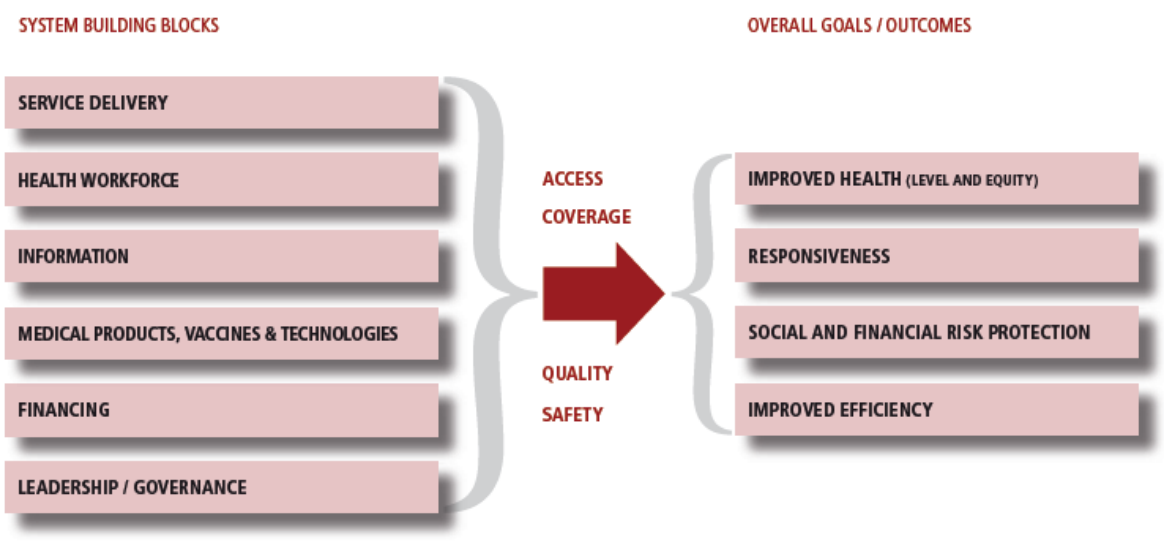

Figure 1: The WHO Health System Framework

The approach to the post-conflict health system recovery in northern Uganda was therefore to promote strong health systems which use sound primary health care principles as the cornerstone for addressing the vulnerabilities, health inequalities and limited access to health care which were consequences of the northern Uganda armed conflict. The approach used for the health recovery process was to strengthen the six building blocks of the health system at both health facility and community levels which then served as an platform to build health sector disaster resilience and ultimately contribute to health DRR.

The recovery effort was planned and implemented in a manner which enhanced reduction of the health system and community vulnerability and exposure to the health impact of hazards while also enhancing capacity. As a result of the systems and structures which were put in place during the recovery process, the health system of northern Uganda is better able to absorb and recover from the impact of hazards and disasters. For instance, the health system recovery exercise was used as opportunity to include elements of health disaster risk reduction into the Health Sector Strategic Plan III (HSSP III) which the country is currently implementing; thus resulting in better public health emergency policy environment, governance, leadership and oversight for health disaster risk management. In addition, the human resources, health infrastructure and equipment which were installed as part of the recovery process strengthened the health system's capacity to withstand and spring back from the impact of hazards thus strengthening resilience. For instance, during the health recovery period the health facility building codes were applied in the siting and building of new health facilities or renovation of old ones to ensure that they can withstand the impact of disasters. The northern Uganda health recovery programme provided an opportunity for building the capacity of MOH and health partners in health system recovery and the lessons learnt will be used to document a framework for post-conflict health system recovery for African countries.

Challenges and lessons learnt from development and implementation of the health system recovery strategy

The health recovery planning process in Uganda presented many lessons and challenges which are important and have implications for the success of the health recovery and resilience building efforts not only in the country but in other conflicts in Africa.

Important lessons learnt

The health recovery planning and implementation process in Uganda showed that recovery is a process which should span the humanitarian, transition and development phases of a disaster and should start as early as possible following a disaster. Health system recovery is a slow and non-linear process and consultation and consensus building is difficult and time consuming. It may take a considerable number of years to see the outcome and impact of the activities so patience and perseverance on the part of recovery actors is key. Finding the right balance between investments in development of health infrastructure and strengthening the health systems functional capacity for governance, supervision, monitoring and service delivery is often a challenge. The ambition to build the system back better may result in ambitious plans without a comprehensive analysis of absorption capacity of the local authorities, communities and available resources.

The health systems of countries emerging from conflicts are often weak and have low capacity to lead the recovery process. In such situations, there is the tendency for international partners to propose politically oriented policy options or apply standard solutions that may have worked elsewhere, rather than using context specific solutions. In this regard, the importance of government commitment, leadership and ownership of health recovery process at all levels is critical (Fan L, 2013). Planning, implementation, coordination and monitoring of recovery activities goes beyond the mandate of humanitarian organizations and requires close collaboration between the cluster and sector in countries where the sector wide approach is being implemented and where the sector and cluster are separate entities. While international humanitarian partners may provide effective response during the emergency phase of a conflict even in the absence of government commitment, this is near impossible during the recovery phase.

The risk that the Post-conflict Health Needs Assessments (PDNA) and recovery planning are done in isolation, not sufficiently linked to the humanitarian coordination or the longer-term health development coordination mechanisms and other sectors is a dilemma. As much as possible, health recovery planning should therefore be synchronized with recovery planning in the other health related sectors such as WASH, education and gender; for instance given the human resource for health problems in Uganda, the health sector engaged the education sector to discuss human resources for health development.

Key challenges

Adoption of a top-down approach in the planning of the PRDP and health recovery strategy resulted in little consultations with stakeholders, poor understanding of the plan (PRDP) and ultimately lack of ownership especially by district and local administrations at the initial stages. Getting the district stakeholders to buy into and get involved in the health recovery planning process thus proved difficult and this considerably slowed down the health recovery process. Inadequate local expertise on health recovery, lack of clarity on resource envelope to plan for and information gaps constrained informed decision making, accurate planning and realistic costing. In many instances, the cost of sectoral recovery plans surpassed the budget ceilings in the Medium Term Expenditure Framework (MTEF) thereby creating budgetary dilemma.

The funding mechanism for PRDP and the health system recovery was contentious; while the government preferred a budget support approach for funding, the donor community were wary of governments' capacity to timely and efficiently allocate and account for recovery resources, a fear which would later be confirmed. Within the MOH, there was ineffective linkage between the planning department which had primary responsibility for developing health strategies (such as the health recovery strategy) and the other units within the Ministry which resulted in poor coordination of the planning process.

Conclusions and recommendations for post-2015 HFA agenda for post-conflict health system recovery in Africa

Due to uncontrollable natural forces, increasing political, socioeconomic, ethnic and religious divide in Africa, disasters which have negative impact on the health systems will always occur. While the institutional capacity of African governments and institutions to respond to the health impact of these disasters has improved in recent times, weak capacity for health recovery, resilience building and disaster reduction remain a genuine challenge. The demarcation between the different phases of a disaster is thin and the various phases often overlap. As such health Disaster Risk Management (DRM) should be seen as a continuum of interrelated activities which span all the phases of the disaster cycle from preparedness/risk reduction to response and recovery (Waters H, Garrett B, and Burnham G, 2007).

A poorly recovered health system increases health vulnerabilities and poses challenges for effective emergency health response to future disasters ; while a well-recovered health system ensures equitable access to health services which contribute to reduced morbidity and mortality during the recovery phase of emergencies, ensures that risks to health are mitigated and reduced, and that the health system is resilient to future disasters.

Health system recovery is an opportunity to rebuild the health system even beyond pre-disaster levels. Although the health system recovery process is primarily geared toward

reconstruction of damaged infrastructure, replacement of lost assets, and restoring capacity for service delivery, it is also an opportunity to reduce health disaster risks and improve the resilience of communities and the health system for future hazards. The recovery period should thus be used to integrate health DRR and resilience into national health policies, strategies and plans, and establish DRR functions within the health sector if this is not already the case. If it had not already been done, the recovery period offer opportunities to get political and financial support to conduct Country Capacity Assessments for DRM and health Vulnerability and Risk Analysis and Mapping (VRAM), introducing the concept of safe hospitals and implementing health facility surveys using the Hospital Safety Index.

Based on the challenges and lessons learnt from implementing the health recovery strategy and plan in Uganda and other health recovery experiences in Africa (Cometto G, Fritsche G, Sondorp E, 2010) (Garfield R, Chu E, 2010) (Waters H, Garrett B, and Burnham G, 2007), (Haar R. Rubenstein L., 2012), [9], we proffer the following key recommendations for strategically positioning post conflict/disaster health system recovery, resilience building and health disaster risk reduction in the public health agenda of post-2015 HFA in Africa:

1. The importance of systematic health system recovery cannot be overemphasized ; a health system recovery framework which would shape future health system recovery efforts in Africa is therefore required. Such a framework should be based on durable and realistic Africa specific solutions which uses appropriate local technologies for health systems recovery. The framework should also include concrete modalities for systematically integrating resilience and DRR into health recovery planning and programming
2. A health system-based approach should be used for health disaster risk management to ensure that elements of health systems strengthening, recovery and resilience building are integrated into emergency health programmes right from the onset of an emergency. Such elements will provide the foundation on which health recovery interventions will be built and ensure that DRR and resilence are mainstreamed into health recovery planning
3. Development of detailed recovery strategies and plans are prerequisites for effective health system recovery and provisions for its development must be included in the overall health disaster risk management framework of African countries. To ensure sustainability, harmonozation and alignment[10], these (strategies and plans) should be written and implemented within the framework of National Development Plans (DDPs), Health Policies (NHP) and integrated into national health development planning processes. Such planning processes should be evidence-based, bottom-up and consultative to ensure ownership at all levels and by all stakeholders in the health sector (Fan L , 2013)

[9] Health services delivery in post conflict States; available at: https://www.pksoi.org/document_repository/Lessons/HealthServiceDeliveryinPost-ConflictStates-LMS-648.pdf (accessed on 9th January 2014)

[10] Paris declaration on aid effectiveness : five principles for smart aid ; available at : http://www.oecd.org/dac/effectiveness/45827300.pdf (accessed on 10th January 2014)

4. Health recovery strategies and plans should describe and prioritize actions and activities which are required to restore normalcy within the health sector and identify funding sources and mechanisms. As much as possible the costing of health recovery plans should be based on the available resource envelope for recovery.
5. Health resilience building and disaster risk reduction are broad processes which should involve all health sector partners (both humanitarian and development). In this regard, there is need for more proactive engagement between development and humanitarian actors during all the phases of an emergency. The task of health system recovery and resilience building should not be left only to health emergencies actors but should be integrated into all health development programmes
6. Cross cutting issues such as gender, HIV/AIDS, mental health, reproductive health, age, equity, human rights and right to health should be mainstreamed into health system recovery strategies and plans and should be implemented within the framework of regional health initiatives and declaration such as the Ouagadougou declaration on Primary Health Care (PHC)

References

1. Cometto G, Fritsche G, Sondorp E. 2010. Health sector recovery in early postconflict environments: experience from southern Sudan. *Disasters* 34(4):885-909 doi:10.1111/j.0361-3666.2010.01174.x
2. Fan L. 2013. *Disaster as opportunity? Building back better in Aceh, Myanmar and Haiti.* Humanitarian Policy Group (HPG) London
3. Garfield R, Chu E. 2010. Building Haiti back better: health sector lessons from the 2004 Indian Ocean tsunami. *Humanitarian Exchange* No. 46: 31 – 33
4. Grasa R and Mateos O. 2010. *Conflict, peace and security in Africa: an assessment and new questions after 50 years of African independence.* ICIP discussion paper. Institut Catala Internacional Per la pau. Barcelona, Spain
5. Haar RJ and Rubenstein LS. 2012. *Health in Post conflict and fragile States*. Special report 301. United State Institute of Peace. Washington D.C, USA
6. International Crisis Group (ICG). 2004. Northern Uganda: *Understanding and solving the conflict.* ICG Africa Report No 77. Nairobi/Brussels
7. Krug EG. Sharma GK. and Lozano R. 2000. The Global Burden of Disease. A*merican J Public Health* 90(4): 523-26.
8. Murray CJL. King G. Lopez AD. Tomijima N and Krug EG. 2002. Armed conflict as a public health problem. *BMJ* 324: 346 - 349
9. Murthy R and Lakshminarayana R. 2006. Mental health consequences of war: a brief review of research findings. *World Psychiatry* 5 (1) : 25-30
10. Vreeman RC. Nyandiko WM. Sang E. Musick BS. Braitstein P and Wiehe SE. 2009. Impact of the Kenya post-election crisis on clinic attendance and medication adherence for HIV-infected children in western Kenya. *Conflict and Health* 3 (5): doi:10.1186/1752-1505-3-5
11. Waters H. Garrett B. and Burnham G. 2007. *Rehabilitating Health Systems in Post-Conflict Situations*. Research paper no 2007/06. United Nations University Worlds Institute for Development Economic Research (UNU-WIDER). Helsinki, Finland
12. Wendo C. 2003. Northern Uganda humanitarian crisis shocks UN Chief. *The Lancet*, 368 (9398): 1818
13. World Bank. 1998. *Post Conflict Reconstruction: The Role of the World Bank*. Washington D.C, USA
14. Michailof S. Kostner M and Devictor X. 2002. *Post-conflict recovery in Africa: An agenda for the African region.* Africa region working paper series no. 30. The World Bank. Washington D.C, USA
15. Zwi A. Ugalde E. and Richards P. 1999. Impact of War and Political Violence on Health Services. *Encyclopaedia of Violence, Peace and Conflict* 1:679-90.