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Health-Related Aspects of Post-conflict Reconstruction

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Introduction

The health-related aspects of post-conflict reconstruction (PCR) are embedded in a complex, multifaceted context of post-conflict transition. The nexus of public health and post-conflict reconstruction can be discussed in diverse conceptual frameworks and in terms of multiple research agendas. This entry aims to provide an overview of these. Discussing the conceptual foundations of the nexus, it ultimately proposes its own approach and addresses the relevance of public health-related aspects of post-conflict reconstruction by examining contextual links to health policy. The entry looks at the practical aspects of the topic, through the lenses of risk assessment and health responses, and discusses how the realities of these aspects are shaped by key dilemmas of humanitarianism. Further, it highlights the importance of public health-related data and information and discusses data collection methods and analytical techniques relevant to the post-conflict setting.

Conceptual Foundations of Health-Related Aspects of Post-conflict Reconstruction

Health-related aspects of post-conflict transition are embedded in the context of public health, understood as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (Acheson 1988). Public health, as an interdisciplinary field, covers a wide spectrum of activities targeted at various populations. Among various items on the public health agenda, the concepts of primary health care and universal health coverage may be especially helpful in structuring thinking about the development of health care in post-conflict contexts. Developing primary health care has been recognized as a basic organizing principle in the rehabilitation of health systems in post-conflict settings (Buwa and Vuori 2007), while the notion of universal health coverage as a public health goal provides a framework for rebuilding post-conflict health systems along the broader

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objectives of health equity (Martineau et al. 2017).

Post-conflict reconstruction is the process that "supports the transition from conflict to peace in an affected country through the rebuilding of the socioeconomic framework of the society" (World Bank 1998). Integrated in the peace and development agenda, post-conflict reconstruction is embedded in a complex multi-sectoral context covering the security (disarmament demobilization and reintegration), sociopolitical (reconciliation, reintegration), and economic (reconstruction) sectors (Castillo 2008). Therefore, the intersections of broader PCR segments such as the reconstruction of physical infrastructure (including power, transportation, and telecommunication) as well as food security (including the reconstruction of markets and agricultural activities) are interlinking contextual conditions for health-related reconstruction efforts.

Besides these complex, multi-sectoral aspects of PCR, understanding it in a transitional perspective is fundamental for interpreting its post-conflict attribute. Transitional perspectives on post-conflict settings imply a dynamic continuum. At the same time, transitions – especially in protracted cases – are hardly linear, and relapse into conflict can occur (Collier and Hoeffler 2004). Conceptualization of this continuum as "war-immediate post-war-post-conflict" (Koselleck 2006) suggests different levels of acuteness and emergency regarding health-related aspects of the process. The need to build synergies between short-term relief and long-term recovery and development programs calls for the application of the guiding principle of linking relief, rehabilitation, and development (LRDD) (Ramet 2012; Cunningham 2017). With a view to other frameworks for post-conflict reconstruction (CSIS and AUSA 2002; Waters et al. 2007), and remaining within the LRRD framework, the following may certainly be necessary as part of the overall process: (1) relief activities, as initial response to humanitarian emergencies and immediate health needs; (2) rehabilitation, as transformational activities to create the foundations for future development; and (3) institutionalized development and sustainability through consolidation of long-term recovery efforts involving the rehabilitation of the health system itself. However, rather than adopting a strictly linear interpretation of such transitional stages, the case-specific application of any framework requires flexibility and understanding complementarity within stages, since "in a post-conflict setting, it may not be possible to work through the stages in order" (Pantuliano and O'Callaghan 2006, p. 29).

This article argues, therefore, that understanding health-related aspects of post-conflict reconstruction requires a dynamic transitional approach that is attentive to the complex, multi-sectoral, and interlinking nature of the processes of reconstruction.

The Relevance of Public Health-Related Aspects of Post-conflict Reconstruction

Given the complex and interlinking nature of post-conflict reconstruction, the focus on public health-related aspects requires assessing their relevance for the broader objectives of post-conflict reconstruction processes. Within such a perspective, it is a fundamental assumption that a population's health and economic prosperity and the political regime's legitimacy and stability are inexorably connected (Youde 2007). This assumption implies that public health issues are affecting not only the health of the population but indirectly impact on the economic, social, and security sectors of the state (Katz 2012). As such, public health issues (including their impact on demographic distribution and human capital) are contributing to state power as well as regime stability (or the lack thereof: e.g., youth bulges increase the risk of instability). This conforms to the Foucauldian notion of biopolitics. The politics of the health-related aspects of post-conflict reconstruction can be relevant for international affairs and geopolitics as well. Take, for instance, the Allies' perceptions regarding the importance of the restoration of public health services in Germany following the Second World War (Schleiermacher 2019).

The politics of health aspects thus constitute a key item on the post-conflict peacebuilding,

state-building, and nation-building agendas. The progress toward primary health care and universal health coverage through health interventions and the rehabilitation of health systems is a potential tool for achieving objectives of stabilization, through confidence-building, and by communicating social values (Kruk et al. 2010; Smith 2014). As such, health financing can contribute to peacebuilding objectives through enhancing "social solidarity (through cross-subsidies and risk-pooling); inclusion (e.g. in targeting poorer areas); equity (e.g. in reducing financial barriers); reconciliation (e.g. in resources allocated to opposition areas); human rights (e.g. in establishing constitutional rights to health care); political participation (e.g. in civil society involvement); and confidence in public stewardship (e.g. in donor resources channeled through public systems)" (Bertone et al. 2019, p. 216). Overall, the focus on health can help win "hearts and minds" and thus contribute to nation-building (Jones et al. 2006).

Connected to the politics of health-related aspects of reconstruction, the humanitarian debates around the topic are centered around the question of to what extent public health is "a politically neutral place" (Kruk et al. 2010, p. 94) and, as such, whether it could contribute to peacebuilding. Humanitarian aid providers such as MSF or ICRS refer to the principle of neutrality, independence, and impartiality in order to ensure that health needs are met unconditionally (Birn and Solórzano 1999; Krähenbühl 2004; Brauman 2012; Bussmann and Schneider 2016). However, maintaining these principles can be challenging, since humanitarian activities are also constrained by political calculations, and thus they cannot escape the effects of the sociopolitical context within which they occur (Gordon 2011; Ahmad and Smith 2018; Whittaker et al. 2018). Neutral intentions in health service delivery can result in unintended political consequences, such as restoring the capacity of militias to fight (Davies 2010).

The Practical Foundations of Post-conflict Health: Risk Assessment and Health Responses

Key pillars of the health-related aspects of PCR are risk assessment and the necessary follow-up in terms of health responses. In the assessment phase, a framework for the synergy of needs can be constructed based on immediate survival needs (i.e., basic necessities) combined with awareness of general as well as context-specific risk amplifiers related to these needs. In the health response pillar, the concepts of appropriateness, optimal health interventions, and health priorities can support decision-making and analysis of health responses.

The direct and indirect effects of conflict can result in health risks, which can be assessed from the perspective of health security. The indirect public health impact of conflict is typically greater than direct mortality resulting from hostilities (Lacina et al. 2006), since health problems resulting from chronic and infectious diseases may claim more lives than direct violence (Caballero-Anthony and Amul 2014). War-related conditions also highlight the necessity of an epidemiological approach in assessing the risk of epidemics of communicable diseases at the levels of their transmission, progression, and lethality well into the post-conflict contexts (Checchi et al. 2007). Therein lie certain inevitable contradictions. Partly with a view to the primacy of infectious disease threats, and risks related to noncommunicable diseases, the broader health system development goals (those of establishing primary health care) are often scheduled as but a secondary tier of objectives (Caballero-Anthony and Amul 2014). In the meantime, the lasting effects of conflict, e.g., traumas, have implications for psychosocial well-being and mental health (Mollica et al. 2004). The disruption of social norms also presents risk factors for public health in post-conflict settings, through sexual violence and the related spread of sexually transmitted infectious diseases (Elbe 2002; Smith 2014).

The rights-based framework of the "Sphere requirements," which provide the oldest set of universal minimal standards for humanitarian relief efforts, may be appropriate in guiding the process of assessment. It designates five basic sectors – water sanitation and hygiene promotion, food security, nutrition, shelter and settlement, and health – covering the immediate survival needs of people (Sphere Project 2018). As Checchi et al. argue, defining risks through indicators depends on the aims of observation, and, as such, the related expressions of relative risk may rest on ratios of incidence, prevalence, and mortality as well. Furthermore, relative risks are often bidirectional, with the presence of certain factors mutually constituting a relative risk of being exposed to the other, to the people exposed to either of the two factors – a process developing in vicious circles. Such is the relationship between malnutrition and disease (Checchi et al. 2007). In a transitional post-conflict context, assessing the mutually enhancing relationship of risks for a population's health can be supported by identifying the general risk amplifiers which expand the impact of conflict on health by affecting the immediate survival needs of the population. Such prominent and universal risk amplifiers are displacement, food crises, and natural disasters. Displacement into camps or into host communities contributes to the spread of infectious diseases, and a displaced population is more prone to be deprived of basic necessities. Food crisis (due to armed conflict disrupting supply and production or due to parallel natural disasters) can result in famine and malnutrition weakening the health conditions of the population, exacerbating the effects of diseases. As an external (non-conflict-induced) amplifier, natural disasters' effects on access to clean water, food, and shelter can be a major disruption to daily lives. These general amplifiers exert their effect together with context-specific risk factors as further amplifiers, such as geography, climate, and cultural norms and values. Among these contextual factors, the importance of urban settings (where the population is concentrated and vulnerable to the disruption of services they are highly dependent on) has also gained increasing recognition (Patel and Chadhuri 2019).

When health responses aim to reduce excess morbidity and mortality (as an outcome/impact or relief), they thus constitute action toward universal minimum standards (based on the Sphere basic requirements). More specific health responses require case-specific adaptation, and they need to be informed by risk assessment (Checchi et al. 2007). Case-specific adaptation of risk assessment is not only relevant for emergency and relief activities, but it is important for the quality of health responses throughout the whole transitional spectrum of post-conflict reconstruction. Therefore, existing conceptual frameworks of quality measurement can benefit decision-making as well as the analytical evaluation of health responses. As such, a combination of benchmarking to "optimal health interventions" (Checchi et al. 2007) and the assessment of "appropriateness of humanitarian response" (Abdelmagid et al. 2019) can serve well the analysis of health responses. As standards of optimal health interventions in emergencies, Checchi et al. highlight feasibility, maximum opportunity benefit, minimum opportunity cost, maximum effectiveness, maximum cost-effectiveness, and timeliness (Checchi et al. 2007). According to the conceptual framework proposed by Abdelmagid et al., the appropriate humanitarian assistance is "a combination of (1) an intervention/package of services that addresses objective needs and threats to the health or welfare of crisis-affected populations; (2) a modality of delivery that reflects the context, enhances user acceptability and promotes sustainability where possible; and (3) a target beneficiary population that is clearly defined, sufficient in size and prioritised according to need" (Abdelmagid et al. 2019, p. 11).

In post-conflict reconstruction, the rehabilitation of the health system is a multifaceted challenge influenced by the assessment of needs and risks, priorities, and the qualities of (optimal and appropriate) health responses. The impact of conflict on the health system reduces the productivity of health systems and causes the

deterioration of the survival chances and life prospects of the population affected. This impact also manifests at times in health systems being a direct target of fighting or in the collateral destruction of health infrastructure, the interruption of medical supplies, and strained health capacities (resulting in increased morbidity and mortality) (Betsi et al. 2006; Kruk et al. 2010).

The systemic effects of conflict on the health workforce result in the flight of human capital, mismatches between skills and service needs, the breakdown of pre-service training, and lack of human resource data (Roome et al. 2014; Fujita et al. 2011). Therefore, health system reconstruction includes key building blocks of providing for the availability of human resources for health, health service delivery (Nagai et al. 2007), and appropriate health financing (Witter 2012). Health financing supports health service delivery through resource allocation, regulation, and public financial management, the rehabilitation of human resources for health through payment systems and incentives at the facility and health worker levels, and making available health information systems in a post-conflict context (Witter 2012; Cometto et al. 2010).

Dilemmas Shaping Public Health-Related Aspects of Post-conflict Reconstruction

Dilemmas of health equity (typically between coverage and efficiency) and questions regarding the division of roles and responsibilities of external and local actors shape the public health-related aspects of post-conflict reconstruction.

The concepts of effectiveness and coverage are key quantities used in epidemiology in determining the impact of health responses. As measurement standards, they are adaptable for assessing the effect of broader public health rehabilitation efforts in a post-conflict context. Although the impact of a health response is the greatest when coverage and effectiveness are both maximized at the same time, in practice, there are fundamental feasibility challenges in achieving high coverage and high effectiveness simultaneously. Such constrains on health responses can range from scarce funding and difficult working conditions to denial of access on various grounds by various actors, posing the need to choose between higher effectiveness (e.g., advanced treatment to few) and more extensive coverage (e.g., making basic treatment available to many) (Checchi et al. 2007). This dilemma of coverage and effectiveness highlights the questions and problems of health equity in the context of health system rehabilitation processes in a post-conflict environment (Macrae et al. 1996). Dealing with challenges to health equity requires a tiered prioritization of health problems (Martineau et al. 2017) and, depending on who carries influence in this respect in the given context, may lead to the prioritization of health risks from the perspective of "the West," i.e., the major (typically Western) donors (McInnes and Lee 2006). Therefore, donor choices are key shapers of these dilemmas, for example, when there is a decision "to restore urban tertiary care hospitals before restoring networks of far-flung primary care centres" (Kruk et al. 2010, p. 92). Pro-equity policies can help in dealing with the coverage/effectiveness dilemma, by aiming to ensure a balance across sectors and in terms of geographical distribution, as well as by actively reducing access and participation barriers for excluded groups (Martineau et al. 2017; Percival et al. 2018; Bornemissza et al. 2010).

The dilemmas of coverage and effectiveness are intertwined with questions regarding the role of local and external actors in post-conflict settings. Transition periods such as shifts from donor dependency and transitions from NGO-managed to government-managed health services can increase the vulnerability of health rehabilitation processes. The local actors' capacity to absorb reforms of the health-care system might prove insufficient, and this can destabilize the very system that the health reforms aimed to strengthen (Buwa and Vuori 2007; Fujita et al. 2011). This problem is apparent in the difference between how international humanitarian nongovernmental organizations and local actors form their own perspective about the nature of the humanitarian needs and priorities (Cunningham 2017).

In this regard, two key humanitarian paradigms can highlight inconsistencies in the perception of the role of external and local actors (Hilhorst 2018). The classical humanitarian paradigm (particularly the Dunanist tradition and the notion of exceptionalism) centers on the discontinuities, the disruptions, and the needs for outside assistance through principled aid provided by international humanitarian agencies. The resilience paradigm focuses on continuity through local actors and local response capabilities. As Hilhorst argues, both approaches "underrate the relational and negotiated nature of aid, which remains an impasse between support and abandonment, between enabling the self-reliance of crisis-affected populations and refugees, and depriving them of basic protection" (Hilhorst 2018, p. 10). In practice, the two paradigms should thus operate in parallel, with a dynamic and negotiated balance needed between the two approaches (and the respective actors involved).

Public Health-Related Information in Post-conflict Settings: Methods and Techniques

Timely collection of public health data is a prerequisite for risk assessment and public health responses in post-conflict settings, although access to timely and quality information is often limited (Checchi et al. 2017). Methods and techniques in the collection of public health data contribute to supporting decision-making as well as help research and the evaluation of health responses.

The use of rapid qualitative methods during and after complex health emergencies is especially relevant in post-conflict settings, particularly in immediate relief activities. Rapid qualitative research uses qualitative methods in collecting and analyzing data within a short period of time; "rapidity" is of course relative and has to be interpreted according to the exigencies of the given context (Beebe 2014). Johnson and Vindrola-Padros point, for example, to the use of such data collection in inventorying existing infrastructure in order to plan humanitarian assistance and to evaluate the effectiveness of response strategies. That said, the results may suffer from "the low quality of the collected data, small sample sizes, and little time for cross-checking facts with other data sources to reduce bias" (Johnson and Vindrola-Padros 2017, p. 70). Other micro-level methods can be utilized to complement rapid qualitative methods, such as narrative inquiry, to study how conflict transforms the lives of people (Ssali and Theobald 2016). This can support the in-depth assessment of the health aspects of post-conflict reconstruction.

Practices of policy and the implementation of health responses are often studied from the "arena perspective," which entails the analysis of a large number of case studies of humanitarian praxis in different settings and types of crises (Hilhorst and Jansen 2010). This perspective has been used ranging from the everyday politics of aid and institutions, through peacebuilding and community-driven reconstruction, to issues of the governance of refugee camps (Hilhorst 2018). The arena perspective can be well complemented with relational-network analysis, particularly in topics connected to humanitarian assistance, such as stakeholder analysis in aid coordination (Cometto et al. 2010) aid actors and aid effectiveness (Ssengooba et al. 2017), health financing trajectories (Bertone et al. 2019), and "aidonography" as the ethnographic study of aid-society relations (Hilhorst 2018). Studying practices of aid from this perspective can show how post-conflict reconstruction is shaped through the social negotiation of actors in and around the aid chain (Hilhorst and Serrano 2010).

Technological developments in communication, computing, and digitalization indicate a new methodological agenda for public health information research. The increasing role of digital communication tools for diagnostic, risk communication, and coordination activities highlights the relevance of the empirical use of such technologies in humanitarian response. For instance, high-resolution satellite imagery-based methods can help in the estimation of displaced populations (Checchi et al. 2013) and facilitate the assessment of shortest travelling distance and time for devising optimal, accessible locations in

setting up preventive health-care facilities (Gu et al. 2010). Remote imagery-based methods can also support developing representative community health survey sampling frames in order to evaluate the effects of health responses, although some limitations to such estimates are apparent in urban settings, for instance, where the connected and complex pattern of roofs and multi-level buildings limit applicability (Wagenaar et al. 2018). Besides satellite imagery-based methods, the development of "big crisis data analytics" is relevant for supporting and complementing traditional humanitarian data collection methods by processing large user-generated datasets (Qadir et al. 2016).

Conclusion

This article argued that understanding the health-related aspects of post-conflict reconstruction requires a dynamic transitional approach that is attentive to the complex, multi-sectoral, and interlinking nature of reconstruction processes. This approach can facilitate addressing risks in the nexus of public health and post-conflict reconstruction, while it also highlights how the politics of health and humanitarian dilemmas structure and shape this field. Since both decision-making and analysis depend on access to public health-related information, identifying working combinations of traditional methods and digital data analytics tools can contribute to increasing our knowledge about the health-related aspects of post-conflict reconstruction.

Cross-References

- ▶ Health System
- ▶ Public Health in Breakaway Regions

References

Abdelmagid, N., Checchi, F., Garry, S., & Warsame, A. (2019). Defining, measuring and interpreting the appropriateness of humanitarian assistance. *Journal of International Humanitarian Action, 4*, 14. https://doi.org/10.1186/s41018-019-0062-y.

Acheson, D. (1988). *Public health in England. The report of the committee of inquiry into the future development of the public health function*. London: HMSO.

Ahmad, A., & Smith, J. (2018). *Humanitarian ethics and action*. London: Zed Books.

Beebe, J. (2014). *Rapid qualitative inquiry: A field guide to team-based assessment*. Lanham: Rowman & Littlefield.

Bertone, M. P., Jowett, M., Dale, E., & Witter, S. (2019). Health financing in fragile and conflict-affected settings: What do we know, seven years on? *Social Science & Medicine, 232*, 209–219. https://doi.org/10.1016/j.socscimed.2019.04.019.

Betsi, N. A., Koudou, B. G., Cisse, G., Tschannen, A. B., Pignol, A. M., Ouattara, Y., et al. (2006). Effect of an armed conflict on human resources and health systems in Coˆte d'Ivoire: Prevention of and care for people with HIV/AIDS. *AIDS Care, 18*(4), 356–365.

Birn, A. E., & Solórzano, A. (1999). Public health policy paradoxes: Science and politics in the Rockefeller Foundation's hookworm campaign in Mexico in the 1920s. *Social Science & Medicine, 49*(9), 1197–1213. https://doi.org/10.1016/S0277-9536(99)00160-4.

Bornemissza, O., Ranson, M. K., Poletti, T. M., & Sondorp, E. (2010). Promoting health equity in conflict-affected fragile states. *Social Science & Medicine, 70*(1), 80–88. https://doi.org/10.1016/j.socscimed.

Brauman, R. (2012). Médecins sans Frontieres and the ICRC: Matters of principle. *International Review of the Red Cross, 94*(888), 1523–1535.

Bussmann, M., & Schneider, G. (2016). A porous humanitarian shield: The laws of war, the red cross, and the killing of civilians. *The Review of International Organizations, 11*(3), 337–359.

Buwa, D., & Vuori, H. (2007). Rebuilding a health care system: War, reconstruction and health care reforms in Kosovo. *European Journal of Public Health, 17*(2), 226–230. https://doi.org/10.1093/eurpub/ckl114.

Caballero-Anthony, M., & Amul, G. G. (2014). Health and human security: Pathways to advancing a human-centered approach to health security in East Asia. In S. Rushton & J. Youde (Eds.), *Routledge handbook of Global Health security*. New York: Routledge.

Castillo, G. d. (2008). *Rebuilding war-torn states: The challenge of post-conflict economic reconstruction* (1st ed.). Oxford: Oxford University Press.

Center for Strategic and International Studies & Association of the United States Army. (2002). *Post-conflict reconstruction task framework report*. Retrieved from https://www.csis.org/analysis/post-conflict-reconstruction-task-framework-report. Accessed 10 Oct 2019.

Checchi, F., Gayer, M., Freeman Grais, R., & Mills, E. J. (2007). *Public health in crisis affected populations. A practical guide for decision-makers* (Humanitarian

Practice Network Paper, Vol. 61). London: Overseas Development Institute.

Checchi, F., Stewart, B. T., Palmer, J. J., & Grundy, C. (2013). Validity and feasibility of a satellite imagery-based method for rapid estimation of displaced populations. *International Journal of Health Geographics, 12*. https://doi.org/10.1186/1476-072X-12-4.

Checchi, F., Warsame, A., Treacy-Wong, V., Polonsky, J., van Ommeren, M., & Prudhon, C. (2017). Public health information in crisis-affected populations: A review of methods and their use for advocacy and action. *Lancet, 390*(10109), 2297–2313. https://doi.org/10.1016/S0140-6736(17)30702-X.

Collier, P., & Hoeffler, A. (2004). Greed and grievance in civil war. *Oxford Economic Papers, 56*(4), 563–595.

Cometto, G., Fritsche, G., & Sondorp, E. (2010). Health sector recovery in early post-conflict environments: Experience from southern Sudan. *Disasters, 34*(4), 885–909. https://doi.org/10.1111/j.1467-7717.2010.01174.x.

Cunningham, A. J. (2017). Post-conflict contexts and humanitarian organizations: The changing relationship with states. *Journal of International Humanitarian Action, 2*, 7. https://doi.org/10.1186/s41018-017-0022-3.

Davies, S. E. (2010). *Global politics of health*. Cambridge: Polity Press.

Elbe, S. (2002). HIV/AIDS and the changing landscape of war in Africa. *International Security, 27*(2), 159–177.

Fujita, N., Zwi, A. B., Nagai, M., & Akashi, H. (2011). A comprehensive framework for human resources for health system development in fragile and post-conflict states. *PLoS Medicine, 8*(12). https://doi.org/10.1371/journal.pmed.1001146.

Gordon, S. (2011). Health, stabilization and securitization: Towards understanding the drivers of the military role in health interventions. *Medicine, Conflict, and Survival, 27*(1), 43–66.

Gu, W., Wang, X., & McGregor, S. E. (2010). Optimization of preventive health care facility locations. *International Journal of Health Geographics, 9*(1), 17.

Hilhorst, D. (2018). Classical humanitarianism and resilience humanitarianism: Making sense of two brands of humanitarian action. *Journal of International Humanitarian Action, 3*, 15. https://doi.org/10.1186/s41018-018-0043-6.

Hilhorst, D., & Jansen, B. J. (2010). Humanitarian Space as Arena: A Perspective on the Everyday Politics of Aid. *Development and Change, 41*(6), 1117–1139.

Hilhorst, D., & Serrano, M. (2010). The humanitarian arena in Angola 1975–2008. *Disasters, 34*(s2), 183–201.

Johnson, G. A., & Vindrola-Padros, C. (2017). Rapid qualitative research methods during complex health emergencies: A systematic review of the literature. *Social Science & Medicine, 189*, 63–75.

Jones, S. G., Hilborne, L. H., Anthony, C. R., Davis, L. M., Girosi, F., Benard, C., Swanger, R. M., Garten, A. D., & Lsina, A. T. (2006). *Securing health: Lessons from nation-building missions*. Santa Monica: RAND Corporation.

Katz, R. (2012). Public health preparedness policy. In J. B. Teitelbaum & S. E. Wilensky (Eds.), *Essentials of health policy and law* (2nd ed.). Sudbury: Jones and Bartlett Learning.

Koselleck, R. (2006). Crisis. *Journal of the History of Ideas, 67*(2), 357–400.

Krähenbühl, P. (2004). The ICRC's approach to contemporary security challenges: A future for independent and neutral humanitarian action. *International Review of the Red Cross, 86*(855), 505–514.

Kruk, M. E., Freedman, L. P., Anglin, G. A., & Waldman, R. J. (2010). Rebuilding health systems to improve health and promote statebuilding in post--conflict countries: A theoretical framework and research agenda. *Social Science and Medicine, 70*(1), 89–97.

Lacina, B., Gleditsch, N. P., & Russett, B. (2006). The declining risk of death in battle. *International Studies Quarterly, 50*(3), 673–680.

Macrae, J., Zwi, A. B., & Gilson, L. (1996). A triple burden for health sector reform: 'post'- conflict rehabilitation in Uganda. *Social Science & Medicine, 42*(7), 1095–1108.

Martineau, T., McPake, B., Theobald, S., Raven, J., Ensor, T., Fustukian, S., & Witter, S. (2017). Leaving no one behind: Lessons on rebuilding health systems in conflict- and crisis-affected states. *BMJ Global Health, 2*(2). https://doi.org/10.1136/bmjgh-2017-000327.

McInnes, C., & Lee, K. (2006). Health, security and foreign policy. *Review of International Studies, 32*(1), 5–23.

Mollica, R. F., Cardozo, B. L., Osofsky, H. J., Raphael, B., Ager, A., & Salama, P. (2004). Mental health in complex emergencies. *Lancet, 364*(9450), 2058–2067.

Nagai, M., Abraham, S., Okamoto, M., Kita, E., & Aoyama, A. (2007). Reconstruction of health service systems in the post-conflict Northern Province in Sri Lanka. *Health Policy, 83*(1), 84–93.

Pantuliano, S., & O'Callaghan, S. (2006). *The 'protection crisis': a review of field-based strategies for humanitarian protection in Darfur* (HPG Discussion Paper). London: ODI.

Patel, R. B., & Chadhuri, J. (2019). Revisiting the sphere standards: Comparing the revised sphere standards to living standards in three urban informal settlements in Nairobi, Kenya. *Journal of International Humanitarian Action, 4*, 6. https://doi.org/10.1186/s41018-019-0054-y.

Percival, V., Dusabe-Richards, E., Wurie, H., Namakula, J., Ssali, A., & Theobald, S. (2018). Are health systems interventions gender blind? examining health system reconstruction in conflict affected states. *Globalization and Health, 14*(1).

Qadir, J., Ali, A., ur Rasool, R., et al. (2016). Crisis analytics: Big data-driven crisis response. *International Journal of Humanitarian Action, 1*, 12. https://doi.org/10.1186/s41018-016-0013-9.

Ramet, V. (2012). *Linking relief, rehabilitation and development: towards more effective aid*. Policy Briefing, European Parliament.

Roome, E., Raven, J., & Martineau, T. (2014). Human resource management in post-conflict health systems: Review of research and knowledge gaps. *Conflict and Health, 8*, 18.

Schleiermacher, S. (2019). Importance of Germany to countries around and to world economy makes it impossible to ignore. The Rockefeller Foundation and Public Health in Germany after WWII. *Business History, 61*(3), 481–497. https://doi.org/10.1080/00076791.2018.1432597.

Smith, F. L. (2014). Conflict instability and health security. In S. Rushton & J. Youde (Eds.), *Routledge handbook of global health security*. New York: Routledge.

Sphere Project. (2018). *Sphere handbook*. Retrieved from https://spherestandards.org/handbook-2018/. Accessed 10 Oct 2019.

Ssali, S. N., & Theobald, S. (2016). Using life histories to explore gendered experiences of conflict in Gulu District, northern Uganda: Implications for post-conflict health reconstruction. *South African Review of Sociology, 47*(1), 81–98. https://doi.org/10.1080/21528586.2015.

Ssengooba, F., Namakula, J., Kawooya, V., & Fustukian, S. (2017). Sub-national assessment of aid effectiveness: A case study of post-conflict districts in Uganda. *Globalization and Health, 13*, 32. https://doi.org/10.1186/s12992-017-0251-7.

Wagenaar, B. H., Augusto, O., Ásbjörnsdóttir, K., et al. (2018). Developing a representative community health survey sampling frame using open-source remote satellite imagery in Mozambique. *International Journal of Health Geographics, 17*, 37. https://doi.org/10.1186/s12942-018-0158-4.

Waters, H. Garrett, B. & Burnham, G. (2007). *Rehabilitating health systems in post-conflict situations*. United Nations University. UNU-WIDER Research Paper No. 2007/06. Retrieved from https://www.wider.unu.edu/sites/default/files/rp2007-06.pdf. Accessed 10 Oct 2019.

Whittaker, C., Frühauf, A., Burthem, S. J., Parry, R. S., Kotikalapudi, M., Liang, Y., Moffett Barker, M., Patel, P. R., & Kelman, I. (2018). A disaster diplomacy perspective of acute public health events. *Disasters, 42*(S2). https://doi.org/10.1111/disa.12306.

Witter, S. (2012). Health financing in fragile and post-conflict states: What do we know and what are the gaps? *Social Science & Medicine, 75*(12), 2370–2377.

World Bank. (1998). *Post conflict reconstruction: The role of the World Bank*. Washington, DC: World Bank. http://documents.worldbank.org/curated/en/175771468198561613/Post-conflict-reconstruction-the-role-of-the-World-Bank. Accessed 10 Oct 2019.

Youde, J. (2007). HIV/AIDS and democratic legitimacy and stability in Africa. In R. L. Ostergard (Ed.), *HIV/AIDS, the military, and the changing landscape of Africa's security*. New York: Palgrave Macmillan.