*ABC of conflict and disaster***Conflict recovery and intervening in hospitals**

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This is the 10th in a series of 12 articles

Conflict recovery

The essence of conflict is the actual or implied use of violence. Recovery implies a return to a previous state. Recovery may be rapid (measured in months) or may take many years. The timing of recovery varies: it may start during the acute phase of a crisis (provision of humanitarian assistance in the midst of conflict can be the earliest manifestation of recovery) but usually begins in the post-emergency phase, when a degree of stability and safety allows a more comprehensive approach.

Time line and phases

Recovery from disaster or conflict can be considered as having a series of phases—emergency response and transition, early recovery, medium term recovery, and long term development.

Emergency response and transition—The emergency humanitarian response in the crisis phase is the aspect of humanitarian work most widely observed by the media and best understood by the general public. Aid agencies deploy and work in the full glare of publicity. This phase passes, and a transitional phase begins, often characterised by the departure of many of the immediate response agencies and the media. The tragedy slips from public consciousness.

Early recovery—This phase starts with the ending of hostilities. It is a period of relative safety, but money, staff, and equipment often become scarce—despite earlier promises of aid, the tap is turned down, if not off. There then starts a period of uncertainty, which is open ended, difficult, and unglamorous.

Medium term recovery—By now, the affected region should have some form of government, even if this is externally imposed. The process of rebuilding infrastructure has begun, and recognisable instruments of a functioning state become evident, such as health and education ministries, the emergence of a civil service, and police. This period requires specialised aid.

Long term development—Long term recovery should have as its end point not just a return to the pre-conflict state but a state where the accepted instruments of good governance are in place and the region is capable of independent existence. The process may take decades, and in some cases the target is never reached. This is typically the case in so called failed states.

Intervention in hospitals

Non-governmental organisations and intergovernmental organisations generally work effectively in basic health care. Money spent here has a greater impact on the population as a whole than money spent on hospitals. Restoring a water supply and providing food and a sanitation system are more important, technically easier, and cheaper than restoring and maintaining a failed general hospital in a conflict setting.

Hospitals, irrespective of their location, are notoriously expensive to run with heavy consumption of scarce resources. They are complex organisations requiring a long term multi-agency commitment and can fail again if support is withdrawn prematurely. There is little evidence that restoring hospital services improves population survival immediately after a conflict or disaster. There is, however, a price to pay in the medium and longer term if hospitals are not assisted.

Levels of healthcare intervention after conflict or disaster**Emergency needs**

Basic curative care needs of residents of emergency settlements are typically

- Treatment of diarrhoea
- Treatment of acute respiratory infections
- Treatment of other prevalent conditions (such as malaria)
- Therapeutic feeding
- Care of wounds
- Psychological counselling or the equivalent

During recovery phases

Basic model for organising health service systems is three tiered:

Primary care

- Clinics for children < 5 years old, routine immunisation, rehydration centres, malaria screening and treatment, diagnosis and treatment of pneumonia, outreach programmes, antenatal and delivery care
- Training and supervision of community health workers, traditional birth attendants, and traditional healers, who can play an important role, especially for collective health awareness and notification of cases during epidemic outbreaks

Secondary care

- Inpatient services for severe cases requiring triage and surveillance—such as treatment for complications of childbirth

Tertiary care

- System of referral to hospitals for surgery and severely ill patients, and access to laboratory facilities for diagnosis and disease confirmation
- Arrangement and payment for transportation and other logistical details must be agreed in advance by administrators of the emergency settlement community health programme and the hospital administration, usually through the ministry of health

Adapted by Eric K Noji from: University of Wisconsin Disaster Management Center: *First international emergency settlement conference: new approaches to new realities*. April 15-19, 1996. Madison WI: University of Wisconsin Disaster Management Center, 1996

Empty shelves in the pharmacy of a failed hospital in Afghanistan

It is also important to understand the degree to which a hospital has failed; hospitals in post-conflict areas may be

- Functioning—retaining most or all of their pre-conflict capability and capacity
- Compromised—having lost some capability or capacity
- Failed—having no residual capability or capacity.

Intervention priorities

Hospital needs assessment requires expert involvement if aid interventions and use of scarce resources are to be effective, and inappropriate equipment donations and projects avoided.

Security—No assistance is possible if dangers have not been addressed. This may entail the exclusion of armed gangs and militias from hospital buildings and making safe unexploded ordnance. Staff and patients may need physical protection.

Repair of infrastructure—Electrical power for lighting and heating or air conditioning; water supply; food provision, storage, and preparation; and sanitation are immediate needs.

Clinical and professional staffing—Key staff may be found locally and supplemented by aid agency health workers, at least for a time. There are financial issues; in a failed state the assisting agency may have to pay local staff a small stipend, at least enough for food and life's essentials for staff and their families. Negotiated collaboration between agency and local staff may be necessary and requires diplomatic handling.

Management and administrative structure—This may still survive, at least partially, or be non-existent. If aid agency staff take over, careful liaison is needed to avoid conflict.

Agreement on immediate clinical priorities—This can only be considered when all of the above have been accomplished. This will be a multi-agency task. As a rule, salvage of life and limb will be the priority.

Hospital equipment and supplies—These will be determined by agreeing immediate clinical priorities. Occasionally, however, the situation may be reversed, with clinical priorities being determined by the availability of scarce resources.

Parallel systems

In the new climate of humanitarian assistance, particularly in the context of intrastate conflict and failed states, a climate of danger may be present. This has resulted in the increasing involvement of military medical personnel in providing humanitarian assistance, including hospital care.

It is not unusual for military and non-governmental organisation emergency hospitals to be established in close proximity. Both may become involved in local hospital interventions, not always in harmony. There is an urgent need to establish “rules of engagement” for such eventualities. When collaborating and communicating well, these parallel ventures can yield enormous benefit.

Difficult decisions—long term hospital planning

Some hospitals will simply not survive the collapse of a state, and new solutions may be needed such as early closure decisions and a reorganisation of surviving institutions. This may require changes of site and relocation or require major structural rebuilding on original sites. Hospitals deemed unlikely to survive alone may retain their history and institutional memory while merging with more viable institutions. These decisions should be made by local officials and not be imposed by external agencies.

Case Study 1: Caucasus—Baku, Azerbaijan

The situation in Azerbaijan in 1997 can be summarised as

- 70 years of Soviet control
- Territorial war with Armenia and the former Soviet Union
- 20% loss of national territory

Why do hospitals fail?

- Loss of physical infrastructure—deliberate or accidental targeting of buildings by warring factions
- Loss of utilities—especially power, water, food supply, and sanitation
- Loss of skilled staff—attacked, stopped from working, or from across ethnic divide
- Failure of routine services with loss of planned procedures, chronic care, cancer care, complex surgery, and supporting services; followed by loss of emergency and urgent care
- Loss of emergency medical services and referral system, so patients cannot reach those facilities still functioning
- Loss of consumables, drugs, and related items
- Breakdown in morale and motivation—often associated with loss of pay and inability to provide essential services
- Forced closure, with or without ejection of staff by combatants—often associated with civil strife and “ethnic cleansing”

Hospital in Baku, Azerbaijan: operating in a theatre (left), and medical students preparing to view surgery (right)

Viewing x rays in a theatre in a Baku hospital

Common features in Baku hospitals

- Dereliction of hospital buildings
- Breakdown of hospital facilities
- Collapse of diagnostic and clinical support facilities
- Departure of senior professional staff
- Loss of morale and low self esteem among remaining medical staff
- Loss of local, national, and international professional networks, leading to professional and academic isolation
- Collapse of research and development programmes
- Loss of salary and reward, leading to institutional corruption
- Disruption of day to day medical care of patients

- Destruction of industrial, agricultural, and medico-social infrastructure
- One million refugees and internally displaced people
- Breakdown of the national health system.

Hospitals in the capital city, Baku, were geographically distant from the zone of conflict, but they felt the consequences of the collapse of the economy and social and medical infrastructure. In each hospital certain features were common.

Some hospitals fared better than others. Those that managed to remain functioning tended to have better staffing and some income from private practice or support from international aid agencies. Much depended on the efforts of individuals. In the Academic Trauma Institute, one consultant orthopaedic surgeon made his own instruments and external fixators in his small engineering workshop.

A consequence of the failure of central health care was that refugees and displaced people in camps throughout Azerbaijan were virtually cut off from any form of hospital care.

Azerbaijan is now a recovering nation with the prospect of oil and natural gas revenues to fund the restoration of its infrastructure. Pre-hospital and primary care is improving. Despite this, the country is still some way from entering a recognisable development phase. This impasse is due, in the main, to the unresolved territorial dispute with Armenia, resulting in the continuing presence of nearly one million displaced people in camps cared for by international aid agencies.

Case study 2: Balkans—Pristina, Kosovo

In the summer of 1999 Kosovo was in a well defined acute emergency phase with an expected rapid transition to early recovery phase. The territory had experienced civil war, population displacement, and NATO intervention. The returning population, displaced internally and to neighbouring countries, faced damaged and destroyed housing, a collapsed infrastructure, and no instruments of government. In such a vacuum, the United Nations interim administration became the government, with the World Food Programme feeding the population and the World Health Organization taking on the health portfolio. The World Bank took control of finance.

There was an immediate need to create the essentials of a new health system out of the surviving remnants of the centralised model that had existed before 1999. Agencies involved included NATO, United Nations, Department for International Development, and many non-governmental organisations. The position with regard to the territory's only teaching hospital, the 2400 bed University Hospital Pristina, shows the difficulties encountered when taking over a major general and specialist teaching hospital.

The emergency phase initially attracted considerable media interest, but this soon waned. With this passing interest, resources and international expertise dwindled. The initial optimism of a rapid move to early and medium term recovery, and later a development phase, was replaced by what one aid agency colleague termed the "long haul syndrome."

Summary

Practical and meaningful interventions during the recovery from a conflict or disaster are diffuse, complex, and open ended. The problems outlined in this article for hospitals might as easily be applied to restoration of other services (such as education systems), assistance to industry or agriculture, and restoration of vital government departments.

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Ward kitchen sink in a Baku children's hospital

Intervention in Pristina Hospital

- Securing and demilitarising the hospital and related facilities
Included removing barricades, booby traps, and anti-personnel mines
- Restoration of electricity, water, and food supplies and sanitation
Included provision of generators and water pumps and removal of a large collection of discarded clinical waste
Also included clearing the mortuary, which had failed refrigerators and was overflowing, with bodies lying in corridors and passageways
- Organisation of remaining staff and facilities. Problems included
Most pre-existing staff (mainly Serbs) had fled
Most incoming staff (Albanian) had no proof of identity or training, having been sacked by the Serbian government in 1991
Hospital records and important documentation had been destroyed
Clinical case notes had been destroyed
Clinical support facilities (imaging, laboratory, pharmacy, and intensive care unit) not functioning
Complete absence of a management structure
Complete breakdown of clinical teaching and medical education
- Establishment of a hospital management and administrative system
To avoid conflict, non-native aid workers were initially appointed to key positions
- Establishment of a medical provision and supply system
- Establishment of a postgraduate medical education programme

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