IASC

GLOBAL HEALTH CLUSTER
Subgroup on Management and Coordination

Health Cluster Guidance Note
on Health Recovery

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LIST OF ABBREVIATIONS

CAP Consolidated Appeal Process
CCA Common Country Assessment
ECH-European Commission Humanitarian Aid Department
EPI Expanded Program on Immunization
FBO Faith-Based Organisations
GAVI Alliance GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization)
GFATM Global Fund to Fight Aids, Tuberculosis and Malaria
HMIS Health Management Information System
HSS Health System Strengthening
IDP Internally Displaced People
JAM Joint Assessment Mission
JNA Joint Needs Assessment
LRRD Linking Relief, Rehabilitation And Development
MDG Millennium Development Goal
MDTF Multi-donor trust funds
MoH Ministry of Health
MSF Médecins Sans Frontières
NGO Non Governmental Organization
OFDA USAID’s Office of Foreign Disaster Assistance
PCNA Post Conflict Needs Assessment
PDNA Post Disaster Needs Assessment
PRSP Poverty Reduction Strategy Paper
TB Tuberculosis
TRM Transitional Results Matrix
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Program
UNFPA United Nations Population Fund
UNHCR United Nations High Commission for Refugees
UNICEF United Nations Children's Fund
USAID United States Agency for International Development
VAM Vulnerability Analysis & Mapping
WHO World Health Organization
WFP World Food Programme
INTRODUCTION

When disaster strikes or if a population suffers from the effects of a protracted conflict, a first priority is to provide humanitarian relief. For the health sector this means to reduce morbidity and mortality through a set of appropriate health services, primarily guided by the well-known humanitarian principles of humanity and impartiality. In these situations rapid impact humanitarian interventions are needed. Equally needed, and often overlooked, is a strategic, long term engagement for state building.

As soon as the immediate needs are addressed, other activities become possible that aim to restore or even improve pre-existing health services. Those recovery activities, small or big, should not wait for formal, large scale reconstruction and development programmes that are likely to be implemented in a later phase. These are activities that should already take place during the humanitarian relief phase and will continue in the period thereafter. They will assist in the recovery of the health sector, prepare for the return of normality, and create building blocks for future development.

Protracted emergencies and transition situations are critical periods in which considerably fewer resources are available yet the needs are immense. Usually, the rapid turnover of partners in the affected areas and the winding up of many essential healthcare services creates a vacuum that undermines achievements made during the emergency relief phase and poses a threat to sustaining health services until longer-term development begins. There is the need to carry out activities aimed at protecting lives and reducing disease, malnutrition and disability; and setting the foundations for strengthening the national capacity to pursue long-term health related development goals. These activities overlap in the recovery phase. Challenges emerging during transition situations should be addressed strategically in order to minimize the deterioration of health services, enable the introduction of initiatives for the recovery of health systems, and allow for a smooth transition with the reconstruction and development phase.

While a natural disaster usually comes with an immediate prospect to recovery and reconstruction, this is typically not clear during a prolonged conflict. The uncertainty as to the duration and outcome of the conflict often paralyses thinking about recovery. This often results, when looking back at a time the conflict does end, in the realization that opportunities to work on recovery during the conflict were missed. This guidance aims to stimulate thinking about the need for and the opportunities that can be seized to initiate recovery activities as early as possible in a crisis. It seeks to provide a number of practical applications. It wants to contribute to the process of ‘building back better’.

This document aims to provide guidance to the various actors within the health cluster so they can get increasingly involved in recovery of the health sector as part of their cluster work. It summarizes the most important ideas and guiding principles in delicate situations, where short term actions have long term consequences and well meant but inappropriate interventions may contribute to creating intractable problems.

1. DEFINITIONS, PRINCIPLES AND IMPLICATIONS OF THE RECOVERY PROCESSES

While most practitioners have not much difficulty to understand the concept of ‘recovery’, it is not very easy to give a precise definition. One reason is that relief and development are linked to funding mechanisms, while recovery is not. Also, the term recovery is often used interchangeably with terms like reconstruction and rehabilitation.
And, finally, every context is different, and the local context may determine in part what recovery entails. Below a few working definitions of relevant terms are given.

**Humanitarian relief** primarily aims to ‘save lives, alleviate suffering and maintain human dignity during and in the aftermath of man-made crises and natural disasters’\(^1\).

**Transition** can be defined as the period between the immediate aftermath of crisis (relief) and the restoration of pre-crisis conditions or their improvement to a satisfactory level (development).

**Recovery** is 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.’\(^2\) There will be parallel needs to assure the humanitarian imperative, that is, to plan and carry out activities aimed at protecting lives and reducing disease, malnutrition and disabilities among the vulnerable populations in the affected areas, and to set the foundations for the developmental imperative. The latter should strengthen the institutional capacity to pursue longer term health development goals, to discharge the essential public health functions and development of the health care delivery system within an environment of good governance, to assure human security and extend social protection in health.

**Early Recovery** efforts need to be activated in all sectors since the very initial phases of relief so the necessary foundations for fully fledged recovery work takes place during the prolonged periods of protracted emergencies and the long transition that follow both the aftermath of natural disasters and the post conflict situations.

Even though the Humanitarian Reform introduced the Early Recovery cluster as one of the nine clusters activated at Global Level, the need of mainstreaming recovery aspects in the guidance from other Global Clusters and in the work of each and all of the other clusters at country level since the beginning of the relief period has been identified as a critical priority.

There is no clear-cut boundary between the relief and the recovery periods. It is important to emphasize that the disaster-management cycle is an unbroken chain of human actions whose phases overlap.

Finally, **development** may be defined in operational terms as ‘operations that have long-term objectives, extending beyond two years, and presume conditions of security and a functioning administration pursuing national objectives and strategies in partnership with external actors’\(^2\)

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1. Principles and Good Practice of Humanitarian Donorship, Stockholm 2003
2. Adapted from UNDP (DP/2001/14, Paragraph 48).
1.1 **KEY PRINCIPLES OF RECOVERY**

1.1.1 Long-term thinking

No operation can be considered a success if "lives are saved" in the short term but the system supposed to care for them is bypassed, neglected and, ultimately, incapacitated. Humanitarian activities, planned and carried out in the immediate, must have an eye pointing to what happens afterwards. The urgency of "saving lives", the cavalier approach of many intervening organizations make "short-termism" and fragmentation a common feature. Decisions and investments made in the initial phases of a crisis, may have detrimental long term consequences well extending into the recovery and reconstruction phases:

- Health units may be built or expanded in towns or safer areas and become redundant when the situation reverts to normal;
- Low level health workers may be formed with ad hoc, short courses and their expectations of being integrated in the health system will have to be dealt with;
- Multiple drug supply channels may be used to the detriment of the official ones;
- Multiple information systems may be put in place undermining the functioning of a uniform one, etc.

But how long is "long term"? The specificity of each context doesn't allow a blanket answer to this question. The United States Agency for International Development (USAID) "Fragile States Strategy" talks of "… at least ten years" (USAID 2005). A study published at the beginning of 2008 by the Center for Global Development (CGD) suggests that, in the best case scenario, donors can successfully disengage from a post-conflict state after a period spanning between 15 and 27 years (Chand and Coffman 2008). This period of long term planned active engagement, close collaboration and active capacity building, should allow local institutions to develop and mature. It is obvious that aid per se and mere "donor presence" do not offer any long term guarantee. The quality and effectiveness of that aid and presence are even more important.

1.1.2 New actors/partners

For years, external interventions in protracted crises were of exclusively humanitarian nature, built around the "humanitarian imperative" of "saving lives", limited to the short term and de-linked from wider considerations. Things changed in the early '90s, when "humanitarian" and "development" actors started to look for ways of linking their work in what came to be called a "relief - development continuum". The aim was to identify and exploit complementarities between relief and development aid, in search for greater effectiveness and long term results (Harmer and Macrae, 2004).

This means that during recovery new actors come into play while others who provide purely humanitarian action leave. For one, the government and national authorities play a central role, as will be discussed below. International NGOs often play a major role in health care provision during crisis situations. Some are willing to continue during recovery and development, with the increased emphasis of working within a
governmental framework, while the mandate of others will prompt them to leave once a crisis subsides. National NGOs may play a role during acute (natural disaster) crisis, but usually less so during prolonged conflict induced crisis. However, during recovery their role may increase, and this may lead to increased support and capacity building efforts by the international community.

1.1.3 Role of national authorities/ Need for intensifying institutional capacity building

An important process is the change in engagement by the international community. While international humanitarian relief after an acute onset disaster may work side-by-side with national actors, in conflict affected areas humanitarian relief may hardly be connected to government services or may even operate in areas outside government control. Recovery aims to restore the lead role of the government, but (re)building the capacity of the government to do so may take considerable amounts of time and effort.

The "recovery" process has been defined in several ways. Its focus, according to UNDP, is "... to restore the capacity of national institutions and communities to recover from a conflict or a natural disaster, enter transition or "build back better" and avoid relapses" (UNDP, 2008). The efforts in recovery will need to be recognized as a new phase, in which the interventions are planned in full collaboration with the national authorities and the activities can be carried out under the full responsibility of national agencies and with the respective health programmes.

The approach is generally an integral part of the Country Assistance Framework (CAF) initiated by the United Nations system, and therefore guarantees parallel efforts into all the pillars that form the basis for poverty reduction and national development. In particular, the efforts in health and other basic social services need to be planned and implemented in parallel with activities to achieve good governance and community recovery. There needs to be increased leadership by nationals of the affected country, who are indeed the main stakeholders. National counterparts at both central and sub-regional levels need to be brought on board, particularly when the recovery occurs in parallel with constitutional changes enabling greater decentralization in government than before the crisis or conflict period. Through the increased involvement of national counterparts, the scope of the health effort could be increased, with several purposes:

- To identify well functioning agencies and enterprises in the affected countries that can serve as models or support for malfunctioning health facilities or services
- To demonstrate the existence and willingness of national agencies to take on significant roles in the recovery process, and thereby accelerate the shift from dependency on external sources to self-reliance
- To accelerate capacity building within national agencies rather than capacity building of nationals within international agencies, and thereby minimize the potential loss of capacities acquired in the development process.
- To enable national agencies and enterprises to fulfil crucial roles in the rebuilding of facilities and services and thereby accelerate the process of national ownership in the process and results.

1.1.4 Coordination
In the absence of a strong Government, UN Agencies, International and National NGOs, religious organizations, often act in an uncoordinated manner, through fragmented interventions and with different agendas. All this inevitably creates a chaotic situation, full of inefficiencies, inconsistencies, duplications and waste. In Kosovo, in 1999, more than 400 foreign NGOs flocked "to help". Many of them offered what they had, not what was needed. Most of them were, conceptually and technically, equipped for interventions in much poorer countries. Their approach was inadequate and, therefore, resented by the local population.

Coordination during this phase is as important as it is elusive. According to the World Bank, many recovery processes were hampered by "... a lack of an overarching nationally-driven plan to which all donors agree, resulting in fragmentation, gaps or duplication in aid-financed programs" (World Bank, 2005).

The presence of a "Lead Actor", displaying a clear vision and able of sharing it, inspiring and overseeing joint assessments, helping to draft policies, strategies and broad plans, is instrumental. The National Government of the host country should be the "Lead Actor". If it still lacks the adequate capacity, a major donor or, better still, a respected International Agency could/should play this role in agreement with the government itself. Whoever is in charge must be trusted and respected for integrity, technical competence, political clout, and track history of success to ensure meaningful levels of real coordination, and not a mere and futile exchange of irrelevant details on fragmented activities.

Such essential and instrumental "Leading Role" cannot be "taken" by any agency. It can only be "granted" by the other actors (and potential partners). Given the abundance of rivalries, disagreements, sometimes open mistrust between various "actors", this isn't an easy thing to happen. And it cannot happen by decree. Coordination cannot be imposed. It can only be inspired.

1.2 IMPLICATIONS FOR THE HEALTH CLUSTER

Protracted emergencies and transitions have to face major gaps, where the regular instruments of developmental work are not fully operational yet and where the acute phase of relief linked to humanitarian action has generally come to an end. This has programmatic and institutional implications for the Humanitarian Reform, and for the work of the UN System, including the specialized agencies. It also has important funding challenges for affected countries and for international partners since it implies covering the cost of meeting less visible but perhaps more critical needs closely connected with sustainable peace building processes. Health occupies a singular and prominent role in transition and recovery situations since it requires continued interventions aimed at shielding the fundamental public health action that can protect lives and reduce avoidable disease and disability while at the same time calls for intensified or accelerated action for the attainment of the health related MDGs which are lagging behind in countries affected by protracted crises.

1.2.1 Operation of the Cluster beyond the relief phase

An important issue in the transition and recovery situations is the operation of the clusters beyond the more acute relief phase of humanitarian action. This process is crucial as a tool for forging articulated partnerships and coordination of all the relevant
stakeholders and represents the best possible mechanism for advancing the agenda of harmonization and alignment in complex environments where the regular mechanisms that operate in developmental work are not fully fledged. However, the conformation and operationalization of the cluster approach in transition situations needs to incorporate the role of the IFIs, which is much more relevant in this phase, differently to the situation during relief operations. It also needs to blend, in much greater degree than during the acute response to an emergency or a crisis, the increased leadership role of the national counterparts, at national and sub-national level, since they constitute the axis of the transition and recovery programs both in terms of leading operations and in terms of being the object of institutional building efforts.

Health Cluster, when facing the development of strategies and plans in protracted emergencies and transitions has to make a concerted effort to identify "foundational activities" of recovery early on in its work so the initial steps for building a health recovery platform can be accomplished. As far as the health cluster is concerned this is a fundamental strategic dimension of the recovery work in the aftermath of natural disasters or man made crises as it is revealed in the Tsunami affected countries, in Pakistan, Myanmar, Sichuan, and Lebanon. It has also been a critical element of the health cluster work in the four countries where the pilot roll out of the cluster approach was undertaken: DRC, Liberia, Uganda and Somalia. The current challenge in the implementation of the health cluster in all countries in protracted emergency with a Humanitarian Coordinator is to adequately mainstream health recovery in its work.

1.2.2 Platform for coordination

From the standpoint of the global architecture for supporting recovery programs there is a need of taking some steps forward and defining and consolidating a platform of coordination of the multiple stakeholders involved in the process. There is a platform and an institutional framework for this coordination and concerted action during the relief phases of emergencies and crises: UNDAC, OCHA, the IASC and the cluster approach. There is no clear platform for transition and recovery that accommodates, in addition to the U.N. and non U.N. stakeholders, the increased leadership role and involvement of the affected countries as well as the engagement of other critical actors like the IFIs.

1.2.3 Contextual factors during recovery

Of note is that recovery processes will be highly influenced by the context of the crisis at hand. Recovery may follow a spectrum of events ranging from a relatively localized, single impact natural disaster to decades of war with consequent destruction of institutions and government and even the very fabric of society. Of particular importance are the overall socio-economic conditions, the institutional capacity of government and non-state actors and the nature of the crisis. So, Recovery processes are also compounded by the fragile conditions frequently seen when a crisis caused by conflict starts to subside. Frequent setbacks or differences between geographical areas are commonly encountered.
1.3 **PLANNING FRAMEWORK AND FUNDING MECHANISMS IN TRANSITION SITUATIONS**

During recovery usually a change of international players takes place. Typical humanitarian donors, like ECHO and OFDA, and pure relief NGOs, like MSF, will be replaced by donors and NGOs with developmental mandates. Recovery activities and budgets are also influenced by increasingly common joint assessments of post-crisis needs. Examples are the JAMs (Joint Assessment Missions), PCNAs (Post-conflict Needs Assessments) and PDNAs (Post Disaster Needs Assessments).

The process of assessment, planning and implementation has a series of steps, some of which have been tried while others are still in the experimental stage. The Post Conflict Needs Assessment (PCNA) has emerged as a critical instrument to plan strategic interventions in support of transitions. The PCNA is usually led by the UN and the World Bank and is carried out in close consultation with the national authorities of the country in transition, including the opposition party when there is a power sharing agreement (e.g. Sudan and Somalia). The end result of the exercise is a prioritized recovery programme, which is intended to inform donors pledging decisions during the reconstruction conferences. A logical framework – the Results Based Transition Matrix- is usually developed and used to help all concerned to plan actions and monitor progress towards outcomes.

Funding is a major issue in the health effort in transition situations. There is no funding bridge between the relief phase, the fully fledged rehabilitation stages and the regular circuits of financing the development agenda. Indeed, there are gaps between these stages that pose special problems in carrying out a comprehensive needs assessment and development of sound action plans. The process of mobilization of funds for the health efforts in transition and recovery does not have the same response to urgency as the acute humanitarian aid phase, which relies mainly on the Flash Appeals or access to the new Central Emergency Response Fund (CERF). This new facility, established by UNGA Resolution A/RES/60/124, represents an important international multilateral funding instrument aimed to save lives through the provision of quick initial funding for life-saving assistance at the onset of humanitarian crises. It is, however, currently restricted to early action and response to save lives and is aimed at strengthening core elements of humanitarian response in under-funded crises following disasters and protected emergencies.

While a good part of humanitarian funding will be channelled through the Consolidated Appeals Process (CAP), which may or may not have provisions for recovery activities, larger recovery and reconstruction budgets are usually covered by bilateral or multilateral agreements. Multi-donor trust funds (MDTF) have become a common phenomenon in post-crisis situations. The current sources of financial support for the needs assessment, planning and formulation recovery are the humanitarian pooled funds, multi-donor trust funds and consolidated appeal processes (CAPs) in chronic or complex emergencies. However, the CAPs tend to be a slow process with relatively low yield. Multi-donor Trust Funds, generally administered by the World Bank, also disburse very slowly and do not meet the
funding needs in a timely manner. These Trust Funds have large transaction costs and do not match the immediacy required in the availability of resources for the most pressing humanitarian needs in transition and recovery situations. Post-conflict, the instrument of a Multi-Donor Trust Fund is increasingly used. In addition to MDTFs a number of initiatives may be directly funded by bilateral donors.

As the Consolidated Appeal Process (CAP) has become the main instrument for mobilizing and coordinating external resources around priority humanitarian needs in ongoing emergencies, for recovery actions the process is expanded to fit into the Country Assistance Framework (CAF). As a part of the UNDAF, the CAF builds on needs assessment but attempts to plan the activities as strategies to achieve MDG goals and to respond to priorities identified in the Poverty Reduction Strategy Papers (PRSP) of the affected country. The PRSPs are not only available in most developing countries, but also represent some degree of consensus and government commitment. The CAF has been developed so far as a tool for an Internal UN Working Group to formulate a harmonized assistance framework for helping the country rapidly achieve the MDGs through the financing of key PRSP priorities. The pillars correspond to PRSP priorities and are Good Governance, Pro-poor growth, Basic social services, HIV/AIDS and Community Recovery. Health is one of the sub-pillars within Basic Social Services, along with Education, Water and Sanitation and Social Protection.

The process of development of the CAF promotes innovation in thinking by allowing the lead agencies in each pillar to produce “big ideas” for discussion. The big ideas are defined as policies and activities that, if implemented, will dramatically accelerate the implementation of the PRSP and achievement of MDGs. Based on the merits of the ideas, their feasibility and the inclusion of components in each pillar, concept papers are developed with attention to linkages across the pillars. These papers are developed by the UN lead agency in the affected country, with the assistance of consultants recruited by the lead agencies when necessary. On the basis of the consensus reached by the UN Working Group at country level, specific actions are defined, broken down into immediate actions (within the next two years) and medium-term actions over a three-five year timeframe. The final papers are refined and edited with the support of the World Bank and are then circulated to the CAF donors.

The last decade saw the emergence of a number of global health initiatives typically targeted at specific diseases and supposed to bring additional resources to the health sector. Best known are the Global Fund (GFATM), GAVI, Roll Back Malaria and Stop TB, but there are quite a few others. While the latter three also implement activities, the Global Fund is a financing mechanism. It is set up ‘as a partnership between governments, civil society, the private sector and affected communities, and represents an innovative approach to international health financing’. Its mode of operation allows it to relatively early enter post-conflict countries and Global Fund monies may become available during the transition phase. Next to core activities directly targeting Aids, TB, and Malaria and immunization respectively, the Global Fund increasingly pays attention to health system strengthening, as is so much needed in fragile post-conflict countries.

Also the GAVI Alliance may play a prominent role early on during recovery. Immunisation services are often the first health services that can be restored. GAVI recognised the need to also invest in health system strengthening.
2. **Health Systems in Health Recovery**

2.1 **System Thinking**

It will be important that the approach taken by the health cluster during recovery is system oriented. A "system" is a set of interconnected components working together for the same purpose. An action affecting one component will affect all the others. Thinking "systemically" means anticipating and considering the systemic effects of actions targeting one or few system components. The WHO World Health Report published in 2000, gives the following definition of a health system:

"... health systems are defined as comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health" (WHO 2000).

The analysis and understanding of all health system components and of their interactions, are the necessary basis of sound, non-disruptive interventions. Systemic thinking must not embrace the health sector alone. The health system is part of the overall "state system". It cannot function satisfactorily in the framework of an overall failing public administration. Health system recovery must be part of a wider recovery process embracing the whole state. In any given situation, the knowledge and understanding of the historical, political, economic and social background significantly strengthen the analysis of the health system and, consequently, the effectiveness of interventions.

To promote a common understanding, in 2007, WHO produced a "Framework for Action" indicating six building blocks of a health system (Figure 1). These blocks are: leadership and governance, service delivery, health workforce, information, medical products, vaccines and technologies and financing (WHO, 2007).


2.2 Functions of the Health System during Recovery

Sometimes, in particular post natural disaster, humanitarian health relief can be stopped once the crisis subsides, to be taken over by the pre-existing health services. The latter may or may not need reconstruction to its former level of operation, but does not need substantial changes. Possibly some more emphasis needs to be placed on specific post-disaster needs like services for the disabled and mental health.

Following more protracted crises, the closure and hand-over of humanitarian health relief is usually more complex. While pre-existent, usually government run health services have dilapidated, humanitarian relief organisations will have started to run clinics and other health activities next to and within the pre-existing health infrastructure. This may have resulted in an uneven distribution of fragmented and often vertical health services. While the government may still be ill-equipped to take the lead again in the health sector, the humanitarian agencies face uncertainty as to their continued role, in terms of the country’s predicted health policy and strategy, changes in financial (donor)
resources and issues around their mandate. Against a background of still existing humanitarian health needs, the health sector needs to make a transition towards a developmental approach, with health services run by or on behalf of a legitimate government. Health services prove to be vulnerable during this recovery period and may even contract in a post-crisis period, as has been described in a number of settings.

Apart from the need to transit from humanitarian health provision to renewed government engagement, the health sector faces another problem during the recovery phase after a protracted crisis. It is rare that health services can be rebuilt as they were before the crisis. More or less extensive reforms are invariably needed, causing further difficulties to deliver basic health services during the recovery period, while health needs as well as population expectations are high. These reforms will partly be guided by the desire to achieve the health-related Millennium Development Goals (MDG). While the many uncertainties during the recovery phase may make it difficult to have a longer term outlook, the health MDGs may provide a useful beacon to assess strategies and programmes during recovery.

3. **Critical Issues in Operationalizing Health Recovery**

During the reestablishment of disrupted health systems, a few important issues must be tackled with particular attention and caution. This chapter presents some critical issues within the health system framework.

### 3.1 Leadership and Governance

Leadership and governance are key to set overall health policy and translate this into health strategies and annual plans that can be resourced and implemented. This is the function that most often is seriously affected during prolonged conflict. Ideally, leadership and governance of the health sector is taken up by a government, willing and able to establish and implement pro-poor policies. On behalf of the government, a Ministry of Health would do this for the health sector and ensure equitable access to basic health services.

- **Capacity building**
  To enable a MoH to take up this role, along with the many other tasks it has to fulfil, technical assistance at the short run, and capacity building activities for the longer run, will be almost invariably needed.

- **Formulating policies and strategies (negotiation and sharing as important as final product)**
  The early formulation of sound policies, strategies and plans, although not sufficient, is necessary to give a sense of direction and provide a common framework for action. In protracted crises governments, often, lack the capacity of formulating sound policies and strategies. The information basis is fragile and grossly incomplete. The political clout of the Ministry of Health is, usually, weak. This could make considerations of potentially controversial choices more difficult: introducing or not introducing user fees; going for decentralization or waiting to strengthen the central government first, expanding the
health network or consolidating the existing (often dysfunctional) one. Again, the role of an authoritative and trusted "Leading Actor" is instrumental.

- Developing coordination platforms with all critical stakeholders around District Master Plans using the cluster approach
During and early on after crisis, leadership and governance may be lacking, or, at best, may be shared by a number of stakeholders, including several agencies from the international community. In a number of cases this has proven to work, provided there is good coordination. In particular in those cases where the crisis resulted in a new government that may still lack the capacity but has the will to address the needs of its citizens. When ‘willingness’ is largely absent, coordination between all key stakeholders is of even greater importance. The concept of ‘shadow alignment’ has been coined, where ‘structures, institutions or systems that are compatible with the existing or potential organisation of the state’ are being used by those stakeholders.

- Decentralization and strengthening planning and managerial capacity at provincial and district level
Considered a cornerstone in any package of public sector reforms, it is, often, introduced too early and without enough attention to the specific context. The transfer of real power to newly formed peripheral government structures, only makes sense if there is something to be decentralized. That is, if there is a strong central state, with solid power structures, clear administrative procedures and, last but not least, adequate resources (human and financial) to allow the functioning of the decentralized structures. On the other hand, to confirm the complexity of this issue, there are cases where, during long conflicts, certain areas have been locally controlled for years, in the total absence of the central state. Similar situations make the devolution of power unavoidable even in the absence of the above mentioned conditions. In these cases the power and the responsibilities of the central and local governments should be described very clearly, as well as the distribution of resources. It would further be recommended to deploy small teams (1 to 3 persons) in each affected District and/or at the Provincial Level for supporting capacity building efforts in terms of management, planning, health systems development and surveillance and early warning.

- Contracting
Contracting introduced with some positive results in Cambodia, was seen by some as the only option in Afghanistan, contracting is defined as “… the practice of the public sector or private firms of employing and financing an outside agent to perform some specific task rather than managing it themselves” (Kinnon et al, 1995). Formulating adequate contracts and adequately monitoring them, involves considerably high costs and requires competencies almost always absent after protracted crises. Arguably useful when the State is virtually absent, it should be used with caution not to jeopardize the long term development of the State itself. This strategy should be accompanied by a simultaneous effort aimed at providing support for ensuring that essential public health functions, normally not carried out by providers of health care, are discharged by local health authorities.
3.2 **Human Resources**

Revitalization of disrupted health systems involves shielding essential public health functions, accelerating the pace for the attainment of the health and nutrition related MDG’s, coordination amongst stakeholders, institutionalization of emergency preparedness, and the alignment of health with other health related interventions. Implementation of these pillars requires a competent functioning health workforce and it must be borne in mind that the health workforce will almost invariably be affected to a varying extent dependent on the individual circumstances.

- **Health worker stock**
  Early identification of the health worker stock and its capacity is crucial and it is necessary to plan strategies to achieve this in the early post-conflict phase. Whilst identifying the HR stock it is more effective to link this to registration of health workers and the establishment of a human resources database. It is also important to know the distribution of health workers and identify where mal-distribution occurs both in category, qualification and quality. Other issues to assess include salary issues, including compatibility with national minimum wage laws, need for incentives, recent trends in training, in and out-migration and potential recruitment and training of lay personnel for specific tasks. Early development of a simple effective HR information system provides essential information for both short and long term HR Planning (Smith 2007).

- **Plan early for human resources**
  In many fragile situations, human resources are insufficient, poorly trained, inadequately distributed. Today's plans for human resources development are likely to yield results in about ten years time. Neglecting a sound reflection on and analysis of these essential aspects may lead to an unduly expansion of the health network (without the human resources to manage it adequately) or to a flurry of inadequate ad hoc training activities.

- **Training of health staff**
  Training new cadres and retraining (or retrenching) old ones sometimes, training of lower level health workers may be justified in the short term but long term planning for pre-service training is essential. On needs to be aware that the workforce might be oversized in relation to the health network, but at the same time underskilled.

- **Financial aspects of human resources**
  The development of a health workforce is the product of long-term investments, for the most part sunk, that is, unrecoverable. Additionally, salaries account for the largest part, mainly fixed, of recurrent expenditure. Furthermore, human capital requires continuous maintenance to control its spontaneous decay; maintenance which is expensive, technically demanding and specifically sensitive. These financial aspects of human resources for health are often neglected by policy-makers and donors. A considerable investment is required, which may be instrumental in keeping the sector in shape and in paving the way for recovery. It huge cost can be partially footed by savings obtained from stopping unplanned, piecemeal and usually expensive in-service training initiatives.
The size and composition of the health workforce that the country could afford depend on the overall resource envelope to be allocated to the health sector in the future. Misconceived policies, political pressures or lack of HR planning often result in a financially unaffordable workforce. Squeezing salaries is the usual response of troubled health sectors to this problem, with the predictable impact on the behaviour of workers. A bloated workforce is resistant to correction. Trying to prevent aberrant growth before it is too late seems a better option.

3.3 FINANCING

During the transition to post-conflict, the limited humanitarian health services that exist often come under threat of contraction. This is caused by a reduction in humanitarian funding for health combined with a slow inflow of development aid (Canavan et al. 2008). Recovery usually comes with increased complexity of the ways health is financed. Humanitarian funding may co-exist with new development schemes; bilateral donors, GFATM and GAVI may come in and debates around (re-)introduction of user fees may come up. It will be needed to obtain an overview of available resources and ways these are pooled (or not) and allocated to the various service providers.

- Public Financing
  Available data about government contributions are in most cases unsatisfactory. Upon preliminary exploration, budgets may be found incomplete, flawed, unreadable, or just missing. Striking contradictions between budget documents issued by different government agencies are commonplace. In certain cases, some of the main inconsistencies can be corrected through the patient triangulation of available sources, and a rough estimate of the government budget can be formulated (Pavignani and Colombo 2008).

- External assistance
  Donor contributions to health vary dramatically across countries, according to political rationales not always transparent to the outside observer. In some cases, present funding levels are conditioned by past decisions. It is usually very difficult to get a more or less reliable picture of what monies are available and for what. There is usually an expectation that money is coming forward for the health sector post-crisis. But reality shows that sometimes less money is available, compared to the humanitarian phase.

- Forecasting the future resource envelope in a recovery perspective
  Future financing levels depend on many factors, none of which are easy to predict. Economic and fiscal performance, political constraints, military spending or conversely the “peace dividend”, competing social expenditures, government commitments, donor generosity and external shocks are certainly aspects to be considered when formulating projections. However, without credible resource forecasts, policy discussions are devoid of content (Pavignani and Colombo 2008).

- User Fees
  The debate on user fees had been and is often blurred by ideology. In poor settings user fees are an obvious barrier to services utilization for large portions of the population.
Their introduction may seriously compromise equity. The amount of revenues that can be raised through them is usually, and understandably, minimal and of very marginal significance. When they are retained at the point of collection, they are particularly appreciated by health workers as they complement their meagre salaries on one hand, and are resources of easy and immediate utilization, without bureaucratic red tapes on the other hand. However, it must be kept in mind that everything has a cost and someone has to pay for it. Abolishing user fees, or not introducing them, must be accompanied by the injection in the system of adequate (additional) financial resources.

- Consider the long term financial implications of policies and strategies

At the beginning of the recovery process it is of paramount importance to make as much as possible accurate estimates of the costs of the recovery process and of the resources likely to be available for it, from donors as well as from domestic sources of revenues. Elaborating strategies and formulating plans without linking them to the resources realistically going to be available, is a futile exercise; and a deceptive one. "Be obsessed with resources" is a commandment never to be neglected.

3.4 MEDICINES AND TECHNOLOGY

Supply lines of drugs and other medical material will usually have changed considerable during prolonged conflict. While there may have been a pre-existing system of a central pharmaceutical store or similar mechanism, this has usually been overtaken by health providers, like the NGOs, ensuring their own procurement and import of drugs. While the set up of new, more centralised systems will be required in the future, this is a cumbersome process, which may not be a first priority during recovery. However, the points listed below will be crucial. It will also be important to identify factors impeding the supply of essential drugs and supplies to the public health facilities, including weak management of the procurement, storage and distribution functions.

There might be a fragmented and expensive pharmaceutical sector, requiring a centralized purchasing system of generic drugs through international competitive bidding. It will further be necessary to promote the essential drug concept and standardized treatment protocols.

3.5 INFORMATION

Crisis typically comes with a collapse of health information. Not only are data on morbidity and mortality missing, but also basics like number, type and status of health facilities, staffing etc are missing. A first priority during recovery is to enable collection of relevant data and putting together a sound information basis, accuracy being more important than precision. An early need will be to do health facility assessments. Furthermore, other baseline data will need to be collected, either through the use of existing, possibly still useful data or the collection of new data, eg. through surveys. In the longer run a full fledged, appropriate Health Management Information System (HMIS) will need to be (re)established. This includes the identification of factors impeding the recording and transfer of information from central to sub-regional and local authorities and transfer of reports from local to sub-regional and central authorities. In the meantime it will be necessary to mainstream epidemiologic surveillance and early warning systems into the regular provincial and district operations.
3.6 **SERVICE DELIVERY**

During recovery it will be crucial to strengthen primary health care services with emphasis in the services provided in the table below. This includes planning the restoration of service delivery, including expansion to underserved areas (difficult balance between politics, equity and efficiency) as well as introducing new service delivery models. Here, it will be important to mix lessons from other countries and understanding of local context. Specific areas such as blood safety, sterilization in health facilities, disposal of injections and sharp medical supplies and medical waste disposal will need to be addressed.

### Health Services Check List, by level of care, by health sub-sectors at point of delivery (health facility or mobile clinic)

<table>
<thead>
<tr>
<th>Levels</th>
<th>Sub-sectors</th>
<th>Health Services</th>
</tr>
</thead>
</table>
| Community Care | Collection of Vital Statistics | Deaths & births  
Others: eg.: population movements; registry of pregnant women and new-born |
| | Child Health | IMCI community component; IEC of child care taker+active case findings  
Home based treatment of: fever/malaria, ARIPneumonia, dehydration due to acute diarrhoea |
| | Nutrition | Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/treatments  
Screening of acute malnutrition (MUAC)  
Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters)  
Community Therapeutic Care of Acute Malnutrition |
| | Communicable Diseases | Community mobilization for and support to mass vaccinations and/or drug administration/treatments  
IEC on locally priority diseases (e.g. TB self referral, malaria self referral, others)  
Community leaders advocacy on STI/HIV |
| | STI & HIV/AIDS | IEC on prevention of STI/HIV infections and behavioral change communication  
Ensure access to free condoms |
| | Maternal & newborn health | Clean home delivery, including distribution of Clean Delivery (CD) kit to visible pregnant women, IEC & behavioral change communication, knowledge of danger signs & where/when to go for help |
| | Non-Communicable Diseases | Psycho-social support for: rape survivors, mental health disorders, terminal patients including AIDS patients, orphan & unaccompanied children, unaccompanied elders |
| | Environmental Health | IEC on hygiene promotion & water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities |
| Primary Care | General Clinical Services | Outpatient Services  
Basic Laboratory |
| | | Short hospitalization capacity (5-10 beds)  
Referral capacity: referral procedures, means of communication, transportation |
| | Child Health | EPI: Routine Immunization against all national target diseases & adequate cold chain in place  
Under 5 Clinic conducted by IMCI trained health staff  
Screening of under nutrition / malnutrition (growth monitoring or MUAC or W/H, H/A) |
| | Nutrition | Management of Moderate Acute Malnutrition  
Management of Severe Acute Malnutrition |
| | Communicable Diseases | Sentinel site of Early Warning System of epidemic prone diseases, outbreak response  
Diagnosis & treatment of Malaria  
Diagnosis & treatment of TB  
Other local relevant communicable diseases (eg: sleeping sickness) |
| | STI & HIV/AIDS | Syndromic Management of Sexual Transmitted Infections  
Standard Precautions  
Availability of free condoms |
| | | Prophylaxis & Treatment of Opportunistic Infections  
VCT  
PMTCT  
ART |
| | Maternal & Newborn | Family Planning  
Antenatal Care: assess pregnancy, birth & emergency plan, respond to problems (observed and/or reported), advise/counsel on breast feeding, nutrition, self care and family planning, preventive |
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<table>
<thead>
<tr>
<th>Health</th>
<th>Treatment(s) as appropriate</th>
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<tbody>
<tr>
<td>Skilled care during childbirth for Clean &amp; Safe Normal Delivery</td>
<td></td>
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<tr>
<td><strong>Essential Newborn Care:</strong> Basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care, KMC) + eye prophylaxis + clean cord care + early &amp; exclusive breast feeding 24/24 &amp; 7/7</td>
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<tr>
<td><strong>Basic Essential Obstetric Care (BEOC):</strong> Parenteral antibiotics + oxytocic &amp; anticonvulsivant drugs + manual removal of placenta + removal of retained products with Manual Vacuum Aspiration (MVA) + assisted vaginal delivery, 24/24 &amp; 7/7</td>
<td></td>
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<tr>
<td>Post partum care: examination of mother (up to 6 weeks), respond to observed signs, family planning</td>
<td></td>
</tr>
<tr>
<td>Comprehensive abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion complications, counseling for abortion and post-abortion contraception</td>
<td></td>
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<tr>
<td><strong>Clinical Management of Rape Survivors</strong> (including psychological support)</td>
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<tr>
<td><strong>Emergency contraception</strong></td>
<td></td>
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<tr>
<td><strong>Post Exposure Prophylaxis for STI &amp; HIV infections</strong></td>
<td></td>
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<tr>
<td><strong>Sexual Violence</strong></td>
<td>Clinical Management of Rape Survivors (including psychological support)</td>
</tr>
<tr>
<td><strong>Non Communicable Diseases</strong></td>
<td>Post Exposure Prophylaxis for STI &amp; HIV infections</td>
</tr>
<tr>
<td>Injury Care &amp; Mass Casualty Management</td>
<td><strong>Non Communicable Diseases</strong></td>
</tr>
<tr>
<td>Hypertension Treatment</td>
<td>Comprehensive Essential Obstetric Care: Basic Essential Obstetric Care + cesarean section + safe blood transfusion</td>
</tr>
<tr>
<td>Diabetes Treatment</td>
<td>’en <strong>Maternal &amp; Newborn Health</strong></td>
</tr>
<tr>
<td>Mental Health Care</td>
<td><strong>Non Communicable Diseases</strong></td>
</tr>
<tr>
<td>Environ. Health</td>
<td>Outpatient psychiatric care</td>
</tr>
<tr>
<td>Health Facility Waste Disposal &amp; Management</td>
<td></td>
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**Biological Health**

- **Basic health packages**
  In theory, the formulation of Basic Health Packages (BHP) should make priority setting and rationing of care rational and explicit. In recent years, many low and middle-income countries went through this exercise. The end results are of mixed value and range from overambitious collections of services, detached from the reality of scarce resources, to efficiency-oriented, low cost packages of modest ambition. Far from being a purely technical issue, the package concept is loaded with political considerations and open to abuses, as Tarimo argued back in 1997. Packages should be costed and should consider all the levels of health services delivery. Especially (but non only) in large countries, different packages could be necessary in different areas with different epidemiological profiles. The formulation of packages may be a long and expensive exercise. In resource stricken countries, the actual gains may be very limited.

- **Vertical programmes**
  The popularity of vertical programmes lies in their business-like result-oriented approach, their purely technical content and their arguably “neutral” goals. These features render them particularly attractive in protracted crises. Their “simple” and straight goals make them easy to be “sold” to the general public by politicians, lobbyists, journalists, pop stars and technocrats. The huge resources often made available for them and their very approach make them able of overcoming local constraints in spite of difficult environments. Their strengths in the short term are their weaknesses in the long term. Not
only they don’t contribute to the building of a strong health system but, often, they are an obstacle to it. In spite of decades of advocacy for an integrated approach to the delivery of health services, the advent of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria gave vertical approaches a strong boost. In recent years there have been some attempts of integrating vertical programmes in comprehensive national health services delivery systems. It is still too early to evaluate the potential of this approach.

- Ensuring equity, effectiveness and efficiency (compromises are inevitable)
Sometimes efficiency must be neglected to achieve equity, for instance, using mobile units to deliver services in isolated and underserved areas.

3.7 OTHER CONSIDERATIONS IN THE OPERATIONALIZATION

Introducing strong management systems is an all too often neglected cornerstone of recovery. During the recovery phase, when urgent and important activities are carried out and policies, strategies and plans are formulated, management systems are often neglected. Yet, they are an essential part of the engine that will keep the system going. Planning for sound management systems (Health Management Information System, Drugs and Supplies procurement and Distribution Systems, Human Resource Management Systems, Supervision and Support System, Quality Assurance System, etc.) is an essential step to ensure medium and long term success of short term decisions and actions.

In an ideal world, the first logical step would be to gather accurate (and precise) information for the sound formulation of policies, strategies and plans. In reality, it is rarely possible to proceed in this way. More often, several steps will have to be taken at the same time. Policies and strategies must be formulated on fragile and incomplete information basis, and plans will have to be broad, keeping a high degree of flexibility. Information gathering will continue, through surveys, ad hoc studies and the slow initiation of a routine Health Management Information System. This must be elaborated and thought of at the early stages of Recovery, initiated as soon as possible and strengthened with time. A few important and urgent actions can be taken on the basis of imprecise but accurate information, sufficient to make sure that the right direction has been taken. For instance, the rehabilitation of important secondary level hospitals in populated areas is an undisputed priority. Starting important operations early will boost the morale of health workers and the public as well. And will contribute to give legitimacy to the (new) government.

4. REFERENCES AND ANNOTATED BIBLIOGRAPHY

Key references


**Recommended reading (for the post-conflict health practitioner)**


A brilliant enquiry into the complexities of the Afghan health sector at a time of dramatic changes. Very perceptive discussion of policy-making and coordination in an extremely disrupted context. The relevance and applicability of experiences from abroad to the Afghan situation is realistically appraised. It includes valuable snapshots of the recovery processes of Uganda, Mozambique, Cambodia and Kosovo.


Synthesis of an important ongoing research, drawing attention to several crucial findings. “Aid is considerably more effective in augmenting growth in post-conflict situations than in other situations”. However, the way aid is provided has in many instances prevented the full tapping of this potential. In post-conflict environments, aid should also be preferentially directed to address social needs with commensurate social policies, at the expense of macro policies. A surprising priority ranking to be considered when aid is apportioned across competing demands.


Valuable review of recent trends in aid policy in protracted crises, discussing the challenges posed to governments and international agencies by fuzzy environments, and the approaches and instruments emerging in response. UN

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3 as example and starting point, based on Pavignani, HLF paper, Nov 2005
Health Cluster Guidance on Health Recovery

agencies, IFIs and the US are discussed in detail. Essential reading for anyone involved in tracking and/or coordinating aid flows to a conflict-affected country.


A long-term recovery strategy developed under pressure at the beginning of 2004, when the peace agreement for Sudan seemed imminent and stakeholders started exploring the health implications of the coming political deal. The main findings, goals and rationale of this strategy were later absorbed in the multi-donor Joint Needs Assessment finalized by the end of 2004. Despite this high-level endorsement, most of the measures recommended by the strategy to launch a recovery process started to be implemented more than one year later. A time lag between conception and implementation of policies of one or two years is commonplace in post-conflict settings.


This reconstruction strategy, developed before the end of the war by the Ministry of Health of Mozambique, was published by WHO as ‘best practice’. One decade later, it still deserves this title. Resulting from three years of studies and discussions and largely conceived by insiders, this document set a clear resource constraint for health sector recovery, planning what was at the time considered affordable in the long term. Its influence on the reconstruction process was vast. If the reconstruction of the health sector resulted in a (qualified) success, it was also because many autonomous actors tried vigorously to materialise the vision laid down in this document. Despite its age, recommended reading to every stakeholder of a health recovery process.
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Reduced version of the original research report, entitled “Aid, Change and Second Thoughts: Coordinating External Resources to the Health Sector in Mozambique”. 1997. The evolution of emergency-oriented aid management tools, as the sector moved from a war to peace context, the emergence of new ones, the obstacles met, the enabling factors and the results achieved are covered by the report.


An exploration of the diverging evolution of the health sectors of two war-torn countries, aimed at understanding the reasons behind their comparative success and failure. The challenges posed by and the lessons learned from the post-conflict reconstruction of Mozambique were discussed in relation to Angola and other countries embroiled in or emerging from conflict. Instructive for decision makers, health planners and aid officials called to face the dilemmas posed by protracted crises and war-to-peace transitions.


Developed to provide guidance to analysts of health sectors in crisis and emerging from crisis. Composed of 14 thematic modules, most of them relevant for the post-conflict health practitioner. Based on documented experiences, drawn from a variety of war-torn, as well as post-conflict, health sectors. To be finalized by mid-2006.


A refreshing discussion of a controversial issue. Almost two decades of experimenting with a variety of cost-sharing schemes in poor countries have produced lacklustre results. Despite the evidence collected in stable, if poor settings, and the lack of it in conflict-affected contexts, some donors are willing to condition their funding to health care projects implemented by NGOs in complex emergencies, to the inclusion of a cost-sharing component.
in their design.

The paper presents some documented cost-sharing mechanisms, under way in DR Congo and Liberia, finding them uniformly disappointing, in terms of revenue raising, efficiency and equity. Additionally, the paper offers a clear summary of the main sources of health care financing, of provider payment mechanisms, and of cost-sharing schemes.


Comprehensive analysis of the main aspects of the subject, which helps to put human resource development where it should be, i.e. at the centre of any post-conflict health recovery process. The discussion is based on true field experience, gathered in several health sectors in transition, and is backed by a wealth of helpful examples and relevant literature. A welcome guide, which fills a serious gap. It should help participants in a recovery process to approach the human resource field equipped with true insights of the issues at stake. To be disseminated beyond the small circle of human resource specialists.


Clear review of the contrasting features P.H.C. and E.M.A. should ideally present. Helpful to decision-makers and field practitioners, who might be unaware of the conceptual underpinnings and of the practical implications of the two approaches. In most transitional contexts, P.H.C. and E.M.A. coexist in various mixes, in response to changing demands and pressures, organizational preferences, or sheer expedience. The conceptual clarity advocated by the paper, if fully grasped by actors, should discourage many misconceived measures, and the ensuing pointless debates about sustainability, accountability, inclusiveness and the like, so often plaguing post-conflict work.

Williams G. and Hay R. Fiscal Space and Sustainability from the Perspective of the
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Insightful and realistic appraisal of issues of mounting relevance, presented in a way accessible to non-economists. Aid flows and government allocations for a group of 30 low-income countries are projected according to alternative scenarios. The conclusions are not rosy. Expanded aid flows will not be sufficient to boost health expenditure to the levels required to meet the health MDGs. Structural changes in the way donors and recipients finance health expenditure in poor countries are needed.


A recent example of solid situation analysis, on which any serious policy discussion about health service delivery in the DR of Congo should be built. Available in English and French

Additional references


Erasmus V. and Nkoroi I. Report on Cost sharing in Selected Counties of the New Sudan. “Someone has to pay . . . . .”. Health Secretariat of the New Sudan and International Rescue Committee. 2002.


Moreno Torres M. and Anderson M. Fragile States: Defining Difficult Environments
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