TOWARDS A FRAMEWORK FOR HEALTH RECOVERY IN TRANSITION SITUATIONS

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Background Document

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I. INTRODUCTION

Each year, one in five of WHO member states experiences a crisis that endangers the health of its people due to natural disasters and unending armed conflicts. Whether from natural disasters or political instability and conflict, the recovery from these crises generally takes longer than initially perceived. The impact of the events on health status is exacerbated by secondary effects of the crises, which can include serious interruptions and even collapse of the health care systems to deal with every day needs as well as the increased needs related to the crisis.

In the case of natural disasters, the damage may be limited to specific parts of the country while the central or national health authorities maintain their capacity to deal with the new health emergencies in addition to their regular public health functions. There may well be opportunities to “build back better” and to strengthen national preparedness and mitigation activities. In cases of extended periods of armed conflict, the negative effects on health may be reflected in some loss of previous achievements in Millennium Development Goals (MDG) including those made through development efforts. Attempts to accelerate achievements may be hampered by the loss of capacity and in some cases, near collapse of the public health systems. In parallel, instruments of development work in other fields linked to health and health care delivery may be affected in the same way, so that the relief and reconstruction efforts are hampered by a range of problems, from communications and logistics to governance at national and local levels.

The transition from relief to development poses unique challenges for the health sector that warrant specific responses whether the crisis results from conflict to peace or from a disaster to the reestablishment of the regular course of economic and social life. 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.

Key issues in Health Recovery

Need for simultaneously:

– protect lives and reduce disease, malnutrition and disabilities among the vulnerable populations in the affected areas (the humanitarian imperative),
– strengthen the institutional capacity to pursue longer term health development goals, to discharge the essential public health functions, to provide critical health services and to extend social protection in health (the developmental imperative).
Health occupies a particularly prominent role in both the humanitarian and developmental objectives as it requires continued interventions with life-saving implications rather than time-limited efforts involving mainly the reconstruction of infrastructure. The importance of dealing with health during the transition situations has been highlighted in a recent study by the RAND Corporation on securing health recovery. With the focus on long-term health reconstruction rather than immediate humanitarian and relief efforts, the study covered efforts to rebuild the public health and health care delivery systems in seven countries, from Japan and Germany after World War II to more recent and current post conflict situations in Kosovo, Afghanistan and Iraq.

The RAND study puts forth the argument that nation-building efforts cannot be successful unless adequate attention is paid to health, as improvement in health can have an independent impact on reconstruction and development while other sectors can impact on health. Health can also have an important effect on security.

As noted in the RAND study, successful health reconstruction requires coordination and planning, as well as infrastructure and other resources. These components can and indeed should promote coordination between the host government and development partners. The study showed that policy-makers and the development partners often failed to adequately coordinate and plan health reconstruction and to provide sufficient infrastructure and resources. That is, health was not given sufficient attention and opportunities for sustainable recovery and development were lost.
II. THE CONTEXT OF HEALTH RECOVERY IN TRANSITION SITUATIONS

Transitions have been defined as sometimes prolonged periods in emergencies and crises when intensified efforts of capacity building are needed and where partnerships of the international community are most crucial for supporting efforts to overcome adverse situations, and create conditions for stability, human security, governance and protection of human rights. In this regard health in transition and recovery situations is a potential bridge for peace, constitutes a source of social stability, represents a key contribution to improving the quality of life of the affected populations and offers significant opportunities to advance the concept of "building back better".

Transitions:
- prolonged periods in the middle of chronic conflict or following conflict or natural disasters often times associated to chronic underdevelopment
- partnerships of the international community are crucial for supporting efforts for overcoming adverse situations and building foundations for sustainable solutions
- need for creating conditions for stability, human security, good governance and protection of human rights
- the agenda of reducing the fragility of the State and of building institutional capacity should be central to the recovery efforts

Paradoxically, 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 at large, 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 recovery occupies a singular and prominent role in transition 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.

Health recovery efforts need to recognize the complexities in terms of the direct and immediate results of the conflict or natural disaster on health, the indirect and longer-term effects of trauma and resulting disabilities, and the impact of the conflict or disaster on the health care system and the provision of services.

The treatment and rehabilitation of injuries carried out in the immediate or acute humanitarian relief stage become increasingly complicated when lives of family members have been lost, homes have been destroyed or people have been displaced by the conflicts. Those treated need to return to temporary shelter, often in conditions which do not promote effective rehabilitation physical rehabilitation let alone psychological rehabilitation. The loss of livelihoods among their families places further
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constraints on accessibility to health care and to basic goods and services. Hazardous environmental conditions such as unsafe water and poor sanitation, and inadequate living conditions remain a threat to the health of the population.

When conflict and political instability have gone on for many years, we may find neglect of essential functions by the public health authorities and partial collapse of the health system, with a lack of communication between central and regional levels. Any lack of accountability mechanisms in the absence of legitimate or stable government will have spread to the health authorities. The health functions that are still operational are likely to be supported mainly by external funds, through a limited number of vertical interventions or through funds from bilateral donors or international non-government organizations (NGOs) that have remained operational in the country. In spite of such efforts, immunizations levels of the traditional preventable communicable diseases, such as DPT, poliomyelitis and measles may have decreased.

In countries in which most health services are provided through government owned facilities, the failure to provide the necessary services, from primary health care to key hospitals, is likely to be more acute, particularly in the remote and rural parts of the country. The provision of services may be negatively affected by the disruption of the supply of drugs and medical supplies linked not only to the weak capacity and lack of funds in the Ministry of Health, but also to damage to roads and bridges and the lack of fuel. Even without these daily difficulties, the health workers in these facilities are likely to have low motivation because of late and partial salary payment. In some countries, the unpaid health workers may have sought compensation by demanding cash from patients before treatment.

In the interim, there may be uncontrolled growth of private practice of questionable quality. Private for-profit services have in part grown to fill the vacuum caused by the collapse of public health care and may take advantage of the population’s dire health care needs. The for-profit providers tend to cover goods and services which are considered lucrative and in areas for which demand can be easily generated, such as consultations, diagnostic services and prescription drugs and sometimes unnecessary surgery. Since the health authorities tend to neglect compliance with regulations on establishment and licensing of health facilities and practitioners during a long period of conflict, there is virtually no control of this private sector. At the same time, the public and non-profit provider sectors face problems of shortages in health workers in occupations not considered lucrative, such as sanitary engineering and health facility maintenance.

Despite the health care needs, the majority of the population face serious barriers in access to health care because of the user charges that have been introduced during the period of conflict and inadequate government funding. These user charges are often applied without respect for fixed fee schedules set by government. The typical scenario is that the primary health care facilities lack resources and hospitals operate at low occupancy and with serious technical maintenance problems. Utilization of the entire spectrum of services, including preventive services, is low and many patients come at a late and serious stage of illness, resulting in higher fatality rates and residual disability.

The affected countries already have a significant proportion of their populations living below the poverty line. After long periods of armed conflict and violence, we are likely to find more vulnerable populations besides the low-income households. These are
women who have suffered sexual assault and children who have been conscripted into armed combat. In the transition and recovery stages, the demobilized soldiers may constitute another group needed special attention, with focus on their successful absorption into community life.

During the conflict period, it is likely that some parts of the population have benefited financially so that inequities in access to health care may be greater than before. In addition, we may find social cleavages between groups manipulated by parties to the conflict which interfere with the normal solidarity mechanisms which may exist in the society prior to the conflict.

All of the above scenarios above have implications for the approach to providing health support in the transition and recovery stages. The efforts for development in this period need to take into account not only the level of health indicators but also the level of confidence and trust in government among the population. The development efforts in this period should also be assessed as to their potential to promote confidence and trust, through activities which are visible to the people and create a commitment between the population and the providers of health care. The efforts need to increase the motivation and knowledge of health workers, and strengthen responsible management of the improved infrastructure resulting from support of government and the development partners.

While national institutions and national unity may have suffered from extended conflict and political instability, the affected countries all have human resources waiting for chances to restore their country to greater self-reliance. The health efforts during transition and recovery need to identify these resources and to plan activities which will enhance self reliance and reduce dependency on external agencies. The real challenge is to move from a perceived dole-out approach among development partners and the national representatives involved in the planning of support, to a framework and development process that emphasizes sustainability and stability through national efforts, effectively and efficiently supported.

From the standpoint of the multisectoral global architecture for supporting recovery programs in transition situations there is a need of defining and consolidating a platform of coordination of the multiple stakeholders involved in the process. A platform and an institutional framework for this coordination and concerted action exists during the relief phases of emergencies and crises: UNDAC, OCHA, the IASC ,the Humanitarian Coordinator System, the Cluster Approach and the CERF. However there is no clear platform for coordinating recovery in transition situations. The challenge is to accommodate, in addition to the U.N. and non U.N. stakeholders, the increased leadership role and involvement of the affected countries, even as well as the engagement of other critical actors like the International Financing Institutions (IFIs).

In principle, within the U.N. the task falls within the remit of the UNDG. However, this implies that a virtual entity is charged with undertaking the structural coordinating role of recovery when UNDG is, in and of itself, a mechanism of coordination. A Secretariat for the System Wide Coordination Recovery in Transition Situations may be necessary. There is no single agency that has exclusive responsibility for this process. Multiple inputs from the different UN agencies and bodies need to be articulated, globally and at country level. All of the above points in the direction of the need of
either: a) having UNDP fulfilling the role of Secretariat of a System Wide Platform of Coordination of Recovery as one of the central pillars of its mandate, or b) having OCHA expand its role and mandate so it also encompasses the coordination of Recovery initiatives and not only of emergency relief operations, or c) strengthening the role of DGO as Secretariat of the System Wide Platform of Coordination. It also requires a process for ensuring the engagement, participation and effective contribution of the different specialized UN agencies in the process and a mechanism similar to the IASC for bringing together the pertinent stakeholders, both UN and non UN, including the IFIs, which have greater level of involvement of the affected Member States, to ensure harmonization and alignment in the recovery efforts during transition situations.

Another important issue in the transition situations is the operation of the clusters in recovery actions going beyond their role in 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 a good 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 much more relevant role of the IFIs, in this phase, differently to what happens 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 subnational level, since they constitute the axis of the recovery programs both in terms of leading operations and in terms of being the object of institutional building efforts. As far as the health cluster is concerned this is a fundamental strategic dimension of the recovery work
III. TOWARDS A FRAMEWORK FOR HEALTH RECOVERY IN TRANSITION SITUATIONS

There is a need of articulating a health recovery framework build as a consensus among the national actors in countries affected by transition, the development partners in the United Nations family, the major International Financial Institutions (IFIs), the international donor community and the non-governmental organizations (NGOs) that make major contributions to humanitarian action. Such an approach to health Transition recovery highlights the critical need for coordination and collaboration among the stakeholders involved.

The following pages set out some basis for the formulation of such framework, with the idea of stimulating the discussion during the Global Consultation on Health Recovery in Transition Situations. It attempts to provide or strengthen mechanisms and arrangements to cover the current gaps in our efforts to move from humanitarian assistance to recovery programmes. There is also a need for intensified or accelerated action for the attainment of the health related MDGs which are lagging behind in countries affected by protracted crises. More attention to the MDGs could be useful in defining targets for the recovery work with more specific assignment of responsibility among the national authorities.

The approach requires more intensive coordination among partners than during acute emergencies, while involvement of the national authorities in all stages of assessment and planning is crucial to the process. The absence of a legitimate government can pose a special problem in the involvement of national authorities and therefore more intensive efforts are required to identify and bring the appropriate national authorities into the process.

Health recovery in transitional situations:
- Should contribute to peace building becoming part of the peace dividend
- Has the potential of being a source of social stability and of legitimacy of the new foundations of the relationship of the State and Civil Society,
- Needs to improve the quality of life of the affected populations
- Offers an opportunity of "building back better".
- Should address short term actions in light of longer term goals and strategies
- Although reliant on external aid has to incorporate gradually the internal funding flows to create sustainability

Principles of the Health Recovery Framework

The approach to health care and health system strengthening in the recovery and transition stage following decades of conflict needs recognizes several inputs or phases, which form a set of basic principles. The approach should first allow for weaning from extended periods of humanitarian aid. If the aid provided has been effective at local and national levels, the plans for the recovery stage will need to preserve the credibility
established during that period regarding both development partners and activities. The planners of the recovery stage will need to evaluate which interventions need to be maintained for a longer period, as a continuation of humanitarian aid but with greater involvement of national counterparts who should now be responsible officials in the new government.

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.

While the approach should be pro-poor in terms of priorities, the plans should recognize the importance of multi-sectoral partnerships to assure health development with yields in other sectors, mainly economic development and education. The interventions applied should be simple and cost-effective, with a record of success. At the same time, new and innovative interventions with high potential to succeed should be tried, and where relevant.

When consensus is reached action plans and estimated costs and when financial resources have been secured, the activities should be done with national agencies and organizations with minimal on-site assistance of expatriate personnel.

Effective health interventions should be replicable throughout the country and not limited to small pilot projects in selected areas and populations. If pilot projects are applied, the mechanisms for rapid evaluation and scaling up should be part of the planned activities.

On the basis of the framework and activities proposed, funding commitments for at least 5 years should be secured. It is anticipated that there will be adequate resources or investment in the economic activities in the country to allow for takeover of the funding of public services in five years, and the establishment of social protection for health for most population sectors.

While the framework for health sector development during the transition stage may be defined within a global concept, the approach, strategy and plans for each country should be determined with country specific considerations, and take into account the political, economic and cultural factors related to the countries' circumstances.
Basic premises

- The impact of purely humanitarian health and nutrition relief interventions approaches its limits
- Need for intensifying actions of institutional capacity building among national counterparts in order to scale up the priority public health interventions that need to be put in place

The Cluster Approach as the mechanism for stakeholder collaboration

The Cluster approach denotes a group of agencies that are interconnected by their respective mandates, and that come together around a set of humanitarian interventions in a common area for purposes of synergies, surge, effectiveness, efficiency, and accountability. The technical cluster approach was created by the Inter-Agency Standing Committee (IASC), the primary mechanism for inter-agency coordination of humanitarian assistance, in order to streamline the work, based on the findings of the UN Humanitarian Response Review. In accordance with General Assembly Resolution 60/124, a single United Nations agency is given the responsibility of Lead Agency for each area. According to the key principles of the cluster approach, the cluster lead agencies must be seen to look after the interests of all implementing partners, including NGOs.

The lead agencies need to re-prioritise their own resources, and not to expect donors to meet all new needs emanating from cluster activity. The cluster partners need to agree how donors should fund the Cluster system: vertically, i.e. by objectives or horizontally, i.e. by levels and/or functions. In addition, cluster partners need to agree on how to measure the Cluster's performance.

The proposed approach to health recovery builds on the continued operation of clusters to deal with specific sectors and to assure attention to and coordination of cross-cutting areas beyond the relief phase of humanitarian action. Working through the cluster approach in the acute relief phase of humanitarian action has been shown to be an effective mechanisms for advancing the agenda of harmonization and alignment in complex environments.

The approach calls for several changes in the health cluster approach.

First is the need to incorporate the international financial institutions (IFIs) whose roles are relevant in this phase, due to the usually longer duration of their involvement and linkage to multi-sectoral development.

Second, there is a need for increased dialogue and coordination with the two other health-related clusters: Water and Sanitation, and Nutrition.

The third area for change and the one most relevant to this approach, relates to the need to have not only increased involvement of national counterparts, but 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.

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.

Since 2001 in Afghanistan, WHO has played an active role in the PCNAs, acting as the lead agency in the health sector in Iraq, Liberia, Sudan and Somalia. In Liberia, a top WHO officer was seconded to the UNDG as UN senior coordinator for the whole exercise. WHO has either seconded HQ or Regional Offices staff or appointed country office staff to lead the sector in the assessment. In all cases, support has been critical in ensuring that the sector leadership had the adequate mix of knowledge of the context and of the analytical and methodological skills needed.

The PCNA can offer opportunities of work in health system development in transitional contexts and open access to new funding sources. The PCNA is, however, a time and resource-consuming

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. This may not be the optimal categorization, as it could be argued that HIV/AIDS and water and sanitation should be part of a broad health pillar. However, this structure could promote more focused attention to water and sanitation and HIV/AIDS, which are major concerns in some of the countries. Fitting into the CAF at country level guarantees broader discussion across the pillars that have been defined, allows for informal discussion of the feasibility of ideas and prevents duplication. At the same time, the WHO input needs to take into consideration the work done in other related UN system processes, such as the Common Country Approach (CCA), UNDAFs and WHO’s Country Cooperation Strategies (CCS).

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.

Based on the concept papers and national outcomes, the specific outputs and activities that need to be undertaken by the UN agencies are identified and incorporated into a results matrix. The indicators, targets and baselines that will be used to measure the impact of the specific outputs and activities are then put into the monitoring and evaluation matrix. At this point in time, the mechanism and responsibilities for long-term monitoring and evaluation have not yet been finalized.

The final papers for each of the pillars are then circulated to the CAF donors while the UN Working Group convenes a Joint Strategy meeting with global and regional level offices of the UN agencies and the World Bank. The final steps are resource mobilization to support the recommended activities in each pillar.

The proposed health in recovery framework seeks to refine the post-conflict needs assessment and other instruments such as the CAFs by:

- Probing additional areas requiring health efforts
- Broadening the content of the health effort to deal with the major issues
- Identifying additional national partners
- Strengthening the WHO technical inputs
Probe of additional areas requiring health support

The CAF is a priori committed to using the PRSP as the foundation for the review of needs. The basic health indicators are generally well documented in the PRSPs and at the beginning of the CAF work in the affected country, these may need to be updated. Attempts need to be made to obtain disaggregated data, particularly in the areas most affected by the conflict or disaster. While the PRSP is an extremely relevant document, it may not adequately reflect the health situation and the health system problems in the post-emergency stage and may not adequately serve the needs for a comprehensive sector diagnosis. In addition, it may not suffice to predict problems in the transition stage. To provide the broadest possible sector wide diagnosis, a minimal list of areas to be reviewed as part of the assessment in planning of the health effort in the development of a health recovery strategy is proposed in the table below:

Table 1 – Expanded check list for post-conflict health sector analysis

<table>
<thead>
<tr>
<th>Area</th>
<th>Details</th>
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<tbody>
<tr>
<td>Capacity for planning and management in the Ministry of Health and the</td>
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<td>major shortcomings including organizational issues and capacity at</td>
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<td>regional and local level in the most affected areas</td>
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<td>Existence of recent plans developed by national authorities for health</td>
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<td>system strengthening.</td>
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<td>Technical capacity of specific health programmes, mainly including</td>
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<td>the main causes of morbidity and mortality, mental health,</td>
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<td>reproductive health.</td>
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<td>Capacity for carrying out Essential Public Health Functions (EPHF)</td>
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<td>in the Ministry of Health and other government authorities, at</td>
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<td>national, regional and district levels and current levels of</td>
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<td>mandatory immunization.</td>
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<td>Early warning and disease surveillance systems at central, sub-regional</td>
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<td>and local levels.</td>
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<td>Existence and relevance of basic health laws, and legislation on</td>
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<td>the establishment of health facilities, training and licensing of</td>
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<td>health professionals.</td>
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<td>Capacity for identifying areas requiring new legislation and</td>
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<td>drafting of the legislative tools</td>
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<td>Factors impeding the supply of essential drugs and supplies to the</td>
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<td>public health facilities, including weak management of the</td>
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<tr>
<td>procurement, storage and distribution functions</td>
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<td>Factors impeding the recording and transfer of information/directives</td>
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<td>from central to sub-regional and local authorities and transfer of</td>
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<td>reports from local to sub-regional and central authorities</td>
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<tr>
<td>Needs for reconstruction and renovation of public health facilities,</td>
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<td>focusing on primary health care, key hospitals, and facilities to</td>
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<td>support storage and distribution of essential drugs and medical</td>
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<td>supplies.</td>
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<td>Problems in the supply and maintenance of medical equipment</td>
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<td>resulting from lack of uniformity and dependence on external sources</td>
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<td>National and international agencies involved in previous assistance</td>
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<td>in the preparedness and response stages, as well as continued</td>
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<td>humanitarian action, with details of interventions, financial and</td>
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<td>human resources, by location and by intention to continue involvement</td>
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<td>in the country.</td>
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<td>Availability of private sector facilities, focusing on non-profit</td>
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<td>providers that can assist in the provision of health care and training</td>
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<td>Capacity to handle maintenance and management in running of public</td>
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<td>health facilities</td>
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<td>State and private enterprises that could assist in the provision of</td>
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<td>maintenance and</td>
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<td>execution of maintenance and management</td>
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management services in the health sector,

Causes of morbidity and mortality – all available data at national, regional and district levels.

Current activities for the major causes of mortality and morbidity, by agencies involved, including the GFATM and agency interest in continued involvement.

Reasons for admission to a sample of hospitals (district and provincial level) with classification of severity, through rapid hospital census surveys

Human resources for health: overall availability, geographic imbalances, occupational imbalances, 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.

Current sources of health care financing, including level of external financing

Government commitment to increase health expenditure

User charges in the public health system: levels and adherence to fee schedules, use of the money collected at local level

Informal charges by health workers (as income in place of unpaid salaries, or other practice)

Existing social health protection in the formal and informal economies, and current labour laws regarding the provision of health care

Traditional social solidarity mechanisms in the community and assess their current impact on access and delivery of health care.

Agencies/associations with mutual assistance programmes and micro-credit facilities.

Vulnerable population groups with major problems in access to health care

Areas for investment and creation of health related enterprises (production of common pharmaceuticals, food production, housekeeping services for health facilities, logistics, and maintenance of services)

Local level success stories in the provision of health care during the conflict and their relevance for future activities

Problems in coordination of efforts in sub-sectors, due to problems in organizational responsibilities and funding (such as local authority responsibility for water and sanitation)

Problems in specific areas: blood safety, sterilization in health facilities, disposal of injections and sharp medical supplies, and medical waste disposal

### Content of the health effort to deal with the major issues

Following the needs assessment and presentation of the major problems within the CAF groups, the proposed framework presents ideas to deal with the major issues, within the major categories. Some may require rapid feasibility assessment before the cluster formulates the action plans and develops budget estimates.

Formulation of the plans needs to refer back to the context or situation faced by the affected country and the expected changes in the immediate and mid-term period. These changes are linked to factors outside the health sector, such as the return of refugee populations, shifts to urban centres in the search for new employment opportunities, the changing needs of the vulnerable populations created by the disaster or conflict, other in- and out-migration including the potential return of professionals to work in the country and government commitments to shift spending to social services.
The Fundamental Tasks of Health Recovery Strategies in Transitional Situations and Ongoing Emergencies

- Maintain critical lifesaving interventions
- Accelerate the pace for the attainment of the health and nutrition related MDGs
- Strengthen the steering role (stewardship) of the health authority
- Shield essential public health functions
- Tackle the main bottlenecks of the disrupted health systems
- Intensify the processes for scaling up the delivery of health and nutrition services
- Ensure adequate public infrastructures for the operation of the health system

There is likely to be some dilemma in the considering the areas to be included. The general approach is not to spread efforts across too many areas. The proposed framework suggests that action plans be developed for the priority problems as well as some less important but identified areas in which the potential for rapid success is high, using cost-effective interventions and national resources. The selection of such areas is aimed at increasing the chances for engagement of national resources, establishing national ownership and increasing self-reliance. Before final selection, all the areas selected for the development of action plans should be assessed as to their potential for:

- Achieving the MDGs in the country
- Achieving equity in access to health care
- Cost-effectiveness
- Sustainable national involvement, and building national self-reliance
- Opportunities to “build back better”

The range of areas will obviously be different in each country, as the reasons, scope and duration of the crises are different. The categorization of areas and the action plan objectives suggested in the table below can serve as a guideline, but should not be considered an inclusive list.

**Table 2 – Main categories for the development of action plans**

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Action Plan objective</th>
</tr>
</thead>
</table>
| Governance, planning and management capacity | Improve governance within the Ministry of Health through development and compliance with new directives  
Up-date and distribute the national policy and plans for health system development, and guidelines for health system strengthening at all levels  
Strengthen the planning and managerial capacity at the district and the state/provincial levels |
<p>| Legislative tools                    | Revise and update the legislative framework for the health sector in order to improve management, control of supply, establishment of health facilities and training institutions, supervision and monitoring functions as well as sector and inter-sectoral coordination. |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity in access to health care</td>
<td>Assure health care for all the population without financial barriers through the development of stable and sustainable mechanisms, involving the state, the population and external sources</td>
</tr>
<tr>
<td>Stable and balanced human resources for health</td>
<td>Assure a balanced supply of human resources for health, with mechanisms to assure appropriate geographic and occupational distribution of health workers with high quality of training and appropriate remuneration and working conditions.</td>
</tr>
<tr>
<td>Reporting and information transfer</td>
<td>Mainstream epidemiologic surveillance and early warning system into the regular operations at all levels, from district to sub-regional and central</td>
</tr>
<tr>
<td>Primary health care and essential referral systems</td>
<td>Strengthen primary health care through an essential package that covers priority programs of disease prevention and control as well as reproductive health and mental health; Sustain actions for maintaining water quality, basic sanitation and waste disposal Update and disseminate protocols for common diseases Ensue adequate referral systems to secondary and tertiary care</td>
</tr>
<tr>
<td>Low immunization levels</td>
<td>Conduct campaigns to rapidly improve immunization levels through NIDs and strengthen of national and local systems to ensure routine immunization services</td>
</tr>
<tr>
<td>Essential services</td>
<td>Secure a continuous and regular supply of drugs and medical supplies, through improved existing and new mechanisms Secure a basic laboratory, radiology, and blood transfusion services infrastructure</td>
</tr>
<tr>
<td>Maintenance of health facilities and medical equipment</td>
<td>Assure improved levels of facility management and maintenance through: - Skills training for logistics and personnel management, procurement, inventory control and distribution, accounting and financial management, equipment and infrastructure management and maintenance - Development of small enterprises as livelihood projects in health: Water and sanitation, Food security and food production (also in hospitals and schools), Maintenance and health facility cleaning services - Guidelines on accreditation and contracting with NGOs, enterprises on service provision and for donors on the selection and procurement of medical equipment as part of donor support</td>
</tr>
<tr>
<td>Vulnerable population needs</td>
<td>Ensure appropriate and continued services and support for women following sexual assault, ensure nutrition, and support for orphans and elderly left on their own Community based rehabilitation and national education services for children after conscription into armed combat and demobilized soldiers</td>
</tr>
</tbody>
</table>
Coordination with development partners

Develop coordination platforms with all critical stakeholders around action plans using the cluster approach
Generate support for new Ministry of Health directives regarding the procurement of drugs, medical supplies and equipment
Generate support for reporting of good practice and up-scaling of successful pilot projects

Linkages with other pillars in the CAF

Strengthen the linkages with action plans in other pillars: governance, pro-poor growth, all basic social services, HIV/AIDS and community recovery

New national partners in the health effort

The proposed framework for health recovery calls for action plans to deal with priority health and health system problems that will enhance national responsibility and accountability, and pave the way for increased and sustainable self-reliance. Long periods of political instability, poverty and conflict can generate over-dependence on external support. There may even be some latent resistance to self-reliance, particularly when external funding has provided income supplements for senior decision maker in the public health system. The efforts in transition and recovery need to assure state building as a national goal, with increasing self-reliance and ability of national resources to assure the capacity and adequate remuneration.

The analysis and action plans for health need to assure involvement of national institutions as a basic principle of the work. This is not a simple task when the formal health systems may be near collapse and when legitimate government has not yet been established. In the interim, the work of the health cluster in developing the CAF should include the identification of national institutions, enterprises and individuals who have demonstrated ability to maintain operations during the difficult periods, have national development interests as their major goals, and have a legitimate basis and the respect of the community. These institutions and individuals may be in government, academic institutions, charitable organizations providing social services and commercial enterprises. Their roles in the transition and recovery stages can be varied, as they may serve as models of good practice, they may extend their services to assist in logistics and the renovation of health facilities, and they may provide appropriate and ready resources for training.

Strengthening WHO technical inputs into the process

The CAF is a process which starts in the affected country, through a UN Working Group, first with input from the country level and with regional and global representatives of the agencies involved coming at a later stage. This means that the leadership of the Health Cluster / Sector at the country level requires technical capacity in a broad range of health areas, as well as commitment to inter-agency work and skills in joint planning. WHO Headquarters (HQ) and Regional Offices need to intensify support to the country offices to carry out this role of lead agency in this critical phase of the CAF. The task may be further complicated when the country is still in need of humanitarian action and its continued implementation leads to some resistance to spreading effort to
the recovery actions in transition stages. The measures to intensify support by all levels of WHO need to take this factor into account. WHO as lead agency has to assure the inter-agency group that the resources are in place to carry out the needs analysis and the project formulation despite the continued need for humanitarian aid. In some countries, there may be a need for skills training and sensitizing of the staff who assume the major responsibilities in the CAF process. The sensitizing should cover the principles of the approach, the optimal coordination mechanisms and identify the contacts at country, Regional Office and HQ levels who can provide rapid support. The contacts should also include WHO technical officers who have already gained experience in the process. All the contacts need to be alerted to the process in the affected country and to be able to provide the rapid technical advice. To provide this support, WHO has to adjust the normative and operational capacities of the Organization.

The proposed approach for health recovery emphasizes the need to reinforce capacity and credibility in providing health care, through processes which ultimately lead to national self-reliance through sustainable mechanisms. The processes recognize the need for well coordinated support from the development partners, based on the assessment of needs for action and resources agreed with the governments involved. The cooperation in carrying out the agreed plans, within the country specific framework puts the interests of the country before interests of partners and focuses on building the societal capacities to deal with the long term effects of the crises and to accelerate achievement of development goals.

The framework recognizes the need to maximize the use of WHO inputs at all its levels. In both developing action plans and mobilizing resources at global level and in the affected countries, this approach seeks technical cooperation with existing technical expertise in WHO at global, regional and country level. This coordination is sought to assess needs and determine activities related to specific diseases or health themes and in planning the activities related to the reconstruction and strengthening of health systems.
Major gaps in transitional situations and ongoing emergencies

- Ownership of sectoral development plans by national stakeholders is limited
- Institutional and financial capacity for undertaking critical sectoral actions are not present
- Regular instruments of developmental work and aid effectiveness are not fully operational
- Acute phase of relief linked to humanitarian action has come to an end
- Funding of the CAPs is low and slow.
- Funding for recovery is patchy and delayed
- International Financial Institutions have increasing involvement but delayed disbursements
- Multi-donor trust funds do not meet the funding needs in a timely manner, and have large transaction costs.
- A fast track international financing facility that can disburse quickly is required.

WHO’s mandate for health action in crisis in connection with recovery

WHO is mandated to support countries in their efforts to save lives and minimize the consequences of disasters, conflicts and other humanitarian crises as well as preserve the achievements made through sustainable development efforts. In the past, WHO focused its work related to these crises on the unpredictability of the events, their recurrence and the health care needs during the time of acute need. This meant that the focus was on preparedness and on emergency humanitarian assistance. However, the recognition of the increase in scope, complexities and the long duration of the period of need led to an institutional establishment of a far broader structure within the organization. The trigger to the discussions on the need to expand activities was the tsunami of 2004, with its scope of destruction involving more than 2 million people affected in over six countries.

The lessons learnt from the post-tsunami relief and recovery experience highlighted the linkage between country level preparedness and response and the ability to cope. Difficulties in response appeared to be linked to long standing gaps and inefficiencies in the public health systems of the countries affected. These gaps in governance were reflected for example, in weak or undeveloped policy and legislation, funding mechanisms, human resources and community involvement. One conclusion of the analysis was that unless these public health system issues could be addressed in the context of emergency and post-emergency assistance, the recovery would take much longer, and the potential to cover the majority of the population affected would be adversely affected. Furthermore, in the event of recurrence of a disaster, the gains of support could well be lost.

WHO member states expressed their recognition of the complexities of emergency humanitarian action and shifted towards a broader approach to health action in crisis, through WHA 58.1, at the 58th World Health Assembly in May 2005. The resolution
emphasized the need to formulate disaster management plans in three stages: Preparedness, response and recovery.

**Resolution WHA 58.1** gave WHO the mandate to:
- Enhance capacity to support countries in developing and implementing health-related emergency preparedness plans
- Enhance capacity to respond to the critical health needs during crises and
- Mobilize WHO health expertise for response operations
- Enhance capacity to assist countries in planning and implementing transition and recovery programmes

The Member States were requested to formulate national emergency preparedness plans with WHO support in needs assessments, health coordination, filling gaps and restoring public health functions as well as capacity building.

Resolution 58.1 provided a new impetus for WHO’s work in emergencies, and thereby strengthened the Programme to Improve the Performance of the Organization's Response in Health Action in Crises which was initiated in April 2004. The discussions with partners following the Resolution laid the framework for the changes and reinforced the broader scope of the mandate through a resolution passed by the WHO General Assembly in the following year.

**Resolution WHA 59.2 on Emergency Preparedness and Response** calls on the Member States to further strengthen national emergency mitigation, preparedness, response, and recovery programs, with a special focus on building health systems and community resilience. As part of the development of measures to enhance the Organization's participation in the overall humanitarian response, WHO was requested to provide necessary technical guidance and support to Member States for building their health sector emergency preparedness and response programme and to ensure that WHO responds effectively to emergencies and crises by collaborating with the UN and other partners. Resolution WHA 59.2 stipulated more specific tasks for WHO in Health Recovery in Transition situations:

- Support the development of plans, strategies and interventions for sustainable health development in post natural disasters and post-conflict situations
- Generate norms, standards, methodologies, tools and guidelines for health recovery action in transitional phases after acute emergencies and crises.
- Develop institutional capacity at country, subregional, regional and global levels, for planning and implementing transitional and recovery actions related to health in countries affected by emergencies and crises.
- Orchestrate WHO's action at global, regional and country level in support to Member States' needs during the transition and recovery phases.
- Develop inter-agency collaboration and partnerships, specially with NGOs, for the transition and recovery phases of health action in crisis with special emphasis on the joint work of the Health Cluster
- Mobilize resources for WHO's work in Transition and Recovery Programs and support Member States in their resource mobilization efforts for health related matters in transitional and recovery phases.
- Establish bridges with International Financial Institutions (World Bank and Regional Development Banks)
The time factor in the health effort in transition and recovery

In the period since HAC has developed in WHO, understanding of the time factors in humanitarian action has increased. Lessons from past efforts show that we should not wait for the end of need for emergency action and that the humanitarian and development imperatives should be considered in parallel. There is a risk of facing major gaps during the transition or Early Recovery period since the regular instruments of reconstruction and rehabilitation for longer term development are unlikely to become fully operational within a short time. We therefore need to identify the critical window period with good potential for cost-effective interventions to assure or re-establish essential health services.

Planning for the health effort in transition and recovery should start as soon as the scope of the disaster or conflict situation can be appraised. It should begin immediately in cases where conflict has gone on for many years, or where repeated natural disasters have occurred in the same location, and the longer-term needs have so far been neglected. Prolonged periods of distress without visible efforts to restore the health system not only defer health improvement but increase the loss of credibility in the national and international institutions.

Additional time factors are acknowledgement of the beginning of the transition and a timetable for the process. As noted in the UN Transitional Guidance note (drafted in October 2006), the indication of when to move beyond the Recovery Strategy to the Transitional Strategy is determined by country circumstances. It may follow an agreed political timetable (for example, an interim period leading up to elections) or linked to a UN process (for example, the phasing out of a UN Peacekeeping Mission). Post-conflict countries that have suffered severe human trauma, and institutional and physical destruction will generally want to have a longer transitional framework – over 18 months, to encompass recovery from the emergency phase, whereas a country recovering from a natural disaster may only need a 6-12 month transition period before they can once again return to a longer-term framework in which recovery and reconstruction components can be part of the regular development programme.

The RAND study also looked at the duration of support in the recovery period. Support to rebuild health after major combat or disaster may be needed for at least five years, unless the health systems in the affected area were fairly developed before the event. The study points out that extended assistance may not guarantee success, while leaving early usually assures failure. Continued conflict and political instability may cause the development partners to look for an “exit strategy” long before the impact of the efforts is evident and before the tipping point has been reached. In the proposed approach this tipping point could be defined as the stage at which national government has assumed responsibility for all the essential public health functions and local buy-in of the health facilities, including those renovated or built in the reconstruction phase. This point is not necessarily the termination of activity, but the inclusion of the health activities in the regular development framework.
Coordination in the health effort in transition and recovery

The importance of coordination in the health efforts in all the stages – preparedness, response and recovery - is well recognized. The first area for the strengthening of coordination and collaboration is within WHO, which by the very nature of its structure and the range of health issues to be tackled in transition and recovery require collaboration between a large number of technical units, and between the three levels of WHO: Headquarters, Regional Offices and Country Offices. Coordination is crucial not only for a coherent and single front to the national and international development partners, but also to assure that the optimal technical resources from the within WHO are garnered. The WHO Approach to the health efforts in the transition and recovery stages will need a new internal coordinating mechanism, which focuses on:

• Reporting of events including plans and results of needs assessment for the short term and medium term objectives of the health cluster in the country
• New agreed systems for monitoring and evaluation with linkage to programme execution
• Exchange of information on experiences, results and problems encountered
• Soliciting information on experiences in the affected countries, within WHO, other UN specialized agencies and other development partners.
• Creation of a data base on the above, with regular updating and including information on suitable consultants.

The next level of coordination is between the UN specialized agencies, again at all three levels. The priorities listed in Table 1 (Expanded check list for post-conflict health sector analysis) and Table 2 (Main categories for the development of action plans) include several areas which are in the programme of work of WHO and within the mandate of UNICEF and UNFPA, such as water and sanitation and reproductive health. Then there are areas which are within the mandate of the International Labour Organization (ILO), such as social protection, vocational skills training and micro-financing. Early discussion of ideas and feasibility of action plans between these agencies could be extremely helpful, particularly when one of the agencies has extensive experience in the affected country.

The more complex level of coordination is between the Health Cluster and all the other development partners, including the bilateral donors that have been major supporters in the affected country. Many developmental health efforts have been hampered by the lack of a comprehensive nationally driven plan to which all donors agree. The results have been fragmentation with scattering to an assortment of health projects in different parts of the country, for different populations, with both gaps and duplication of health efforts. The CAF process would also benefit from clear guidelines on the role of the IFIs and bilateral donors at each stage. The current situation is that the bilateral donors that have continued operations in the affected country are intensively involved throughout the process. While this may be useful for later commitment of funds, there may be some bias in the decisions on which priority areas to include in the CAF, based on the experience and interests of the various partners. This situation highlights the need to intensify coordination with all the stakeholders.

This paper does not cover the decision-making process to establish the role, but points out the urgency in establishing the function, which should ensure and strengthen collaboration and contributions from the different specialized UN agencies and other
non-UNstakeholders. The mechanism should be similar to that of the Inter-Agency Standing Committee (IASC) now dealing mainly with the acute relief phase. In addition to its regular membership comprising the relevant UN agencies, the IASC has Standing Invitees including InterAction; International Council of Voluntary Agencies, the International Committee of the Red Cross, the International Organization for Migration, the Office of the High Commissioner for Human Rights, the Office of the Special Representative of the Secretary General on Human Rights of Displaced Persons, the Steering Committee for Humanitarian Response (SCHR) and the World Bank.

The mechanism required for coordination in transition and recovery needs to respect the roles of each partner, at each level and each stage and to include appropriate participation of the national authorities. It needs to enable close coordination with the IASC so that the plans and their implementation can confirm progress in the early recovery stage and serve as measures to increase credibility within the country and among the development partners. In the event of the recurrence of disasters or conflict, this coordination should also facilitate the appropriate decisions on whether to go ahead or put the transition and recovery activities on hold. Exchange of information on the decisions can avoid any break in activities being perceived as an exit strategy by stakeholders, and leaves room for optimism regarding the continuation of transition and recovery efforts at an appropriate time.

**Performance measurement**

Based on the CAF concept papers, the national outcomes, the specific outputs and the activities that need to be undertaken by the UN agencies are identified and incorporated into a results matrix. The indicators, targets and baselines that will be used to measure the impact of the specific outputs and activities are then put into the monitoring and evaluation matrix, covering targets and benchmarks for recovery and transition. These instruments are in the process of development and trial, beginning with the CAF for the Democratic Republic of Congo. The final tools will also need to include monitoring of achievement of internationally defined goals, such as the Millennium Development Goals (MDGs) and indicators which are relevant for the national situation.

The WHO approach to the health efforts in transition and recovery proposes that the performance measurement be broadened to serve several purposes in addition to performance measurement of the interventions. The first and usually neglected area of the monitoring and evaluation is transparency in operations, with defined responsibility and accountability of all the agencies and individuals involved. Large amounts of money are usually involved, and often handled by individuals with limited knowledge of accounting and even more limited experience in programme and budget management. While computerized systems with appropriate software for the management of financial transactions can be put in place, we need to be concerned with the opportunities for mismanagement of funds in the specific context of assistance after periods of conflicts or disasters. Rigid regulations on procurement and contracting are generally not sufficient to prevent such mismanagement of funds.

The second major purpose of monitoring and evaluation is to be able to measure performance in terms of the process of the interventions. The plans of action are likely to be quite detailed with regard to the use of the funds, by specific executing agencies,
within a defined timeframe. The realities of the post recovery and transition stages will warrant some flexibility in measuring performance according to the agreed time-frame and the monitoring process should therefore document not only the changes but the reasons for change. This concerns, for example, changes in the executing agency, the location (as in the case of pilot projects) and the time-frame, or whether the implementation was delayed by absorptive capacity in the country or weak management skills. Recording of the changes and the reasons should facilitate rapid reprogramming of project funds, and avoid the very long delays now encountered in changing action plans.

Finally, the monitoring and evaluation needs to serve the purpose of a tool to support analysis of the management functions, and to assist in reaching self-reliance through the efforts in the recovery and transition. That is, the national authorities need to be the major stakeholders in the monitoring and evaluation process, and to be involved in a performance measurement framework that allows for rapid decision making on continuation, change and the scaling up of activities.

**Funding of the health efforts in transition and recovery**

Funding is a major issue in the health effort in transition and recovery. 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.

The current sources of financial support for the needs assessment, planning and formulation for transition and 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.

To carry out its role as lead agency for health, WHO needs access to a fast track financing facility that can disburse quickly. The prime objective of rapidly available funds is to restore basic public health functions and prevent death and disease in vulnerable populations. The assessment and formulation stages would be greatly assisted by a common fund for the transition and recovery programmes.
platform or mechanism is set up, the actual coordination of efforts in recovery and transition programmes would benefit from linkage with new funding mechanisms. One result of delay is the commitment for funding and start of projects by bilateral donors already working in the affected country, without waiting for inclusion of the project area in the CAF action plans. The common funds could therefore be useful in improving efficiency and effectiveness of donor coordination and financial support, as they could avoid such preliminary commitments made by the bilateral donors.

In health there is a clear need of a more rapid way of accessing funds for shielding basic public health functions and preventing death and disease ion vulnerable populations. The restructuring of the CERF facility offers a partial response but still is insufficient for the magnitude of the needs. A common recovery fund would be of great advantage for the health sector

A new funding mechanism could also support scaling-up of effective pilots and good practice and the transfer of experience and information. While coordination is not the prime objective of the funding mechanism, it can certainly be enhanced by working with a common fund with defined mechanisms for receiving and monitoring support.

**Risks to the health recovery efforts in transition situations**

The major risks are obviously related to political stability and steady economic growth in the affected country in the recovery and transition stages. However, there are certain factors that pose specific threats to the CAF process, the final drafting of the action plans, the estimation of financial resources required and their mobilization and sustainable implementation.

The CAF process formally starts with a UN Working Group, and not with the donor community. Countries that have gone through decades of conflict may have had several periods when humanitarian assistance to deal with crises was brought in and remained through periods beyond the acute phases. Some bilateral donors have maintained their involvement during many years of conflict and crises, and may want to continue with their project areas, and in selected locations of the country. While the bilateral agencies may have an excellent understanding of the health priorities, they may be reluctant to change their own priorities and may be pessimistic about replication of successful programmes through other agencies. Rather than supporting a fast track for replication of interventions that work well, the development partners with heavy involvement in the past may push for overall health sector reform and institutionalization of the sector wide approach. Such initiatives are positive but take time and should not cause delays in scaling-up interventions in the recovery stages.

Over time, the humanitarian action may have become somewhat institutionalized, and the organizations involved may have taken on planning and management functions in regional operations and even national health system development. Nationals trained in various areas may now have position in the international organizations and are reluctant to return to government posts. Such trends could create difficulties in finding national partners, while some of the international organizations, particularly NGOs with strong local commitment, may be reluctant to plan for the effective handover of functions.
The salary levels and working conditions in the public health sector have generally been a serious problem in most of the affected countries. There has always been sympathy and appreciation for the health workers who remain in remote rural posts and key hospitals absorbing most of the casualties of the conflict without receiving regular salaries. However, we have also seen provider behaviour which has had a negative impact on seeking health care by those in need by demanding payment before any attention is given. In some countries, donor programmes have been used to top up salaries for professional health workers in selected senior positions and selected areas. Health interventions which call for changes towards increased but standard grades of remuneration may even be challenged by the senior echelons in the Ministry of Health. To deal with the risk of negative provider behaviour, fair remuneration of health workers (without the limitations of external support) and improvement in working conditions need to be included as components of every health intervention in the transition and recovery efforts.

The problems in access to rapid funding were noted above. An additional risk is the ability to mobilize adequate funds for the entire span of priority areas. The comprehensive needs assessment is likely to yield a long list of priority areas with high implementation costs and some competition with needs of other social sectors. The risk of failure to secure funds is a particular concern in countries with large populations, in which the conflict has persisted for many years and areas not directly affected by the conflict have suffered years of neglect and reduction in government funds.
IV. CONCLUSIONS AND NEXT STEPS

The WHO approach to health in transition and recovery proposes several new aspects in both the underlying principles and the scope of the activities and coordinating mechanisms. These may be briefly summarized as follows:

- The health efforts should enable reinforcement of both capacities and credibility
- The process should promote national self-reliance through sustainable mechanisms.
- WHO’s input at all levels should be strengthened and maximized.
- Coordination mechanisms should be strengthened to enable effective collaboration within the organization, with other UN agencies, with the bilateral donors and with the national authorities, with new partners in the affected countries.
- New or adapted funding mechanisms should be put in place to enable the rapid start of actions and with adequate flexibility to facilitate rational and efficient changes in implementation.
- Interventions to promote improved support services and maintenance in the health system should be linked to income generating enterprises, with skills training and micro-credit components.
- Monitoring and evaluation needs to be expanded to cover transparency of transactions and changes in the implementation process.
- Before final selection, the priority areas in the CAF should be assessed as to their potential for:
  - Achieving the MDGs in the country
  - Achieving equity in access to health care
  - Cost-effectiveness
  - Sustainable national involvement, and building national self-reliance
  - Opportunities to “build back better”
  - Potential to replicate effective programmes through a planned scaling-up process.

The main purposes is to build "cluster institutional capacity" at country level and to conduct rapid needs assessment for the identification of short term and medium term outcome oriented objectives of the health cluster in the country. The results matrix will also be refined during this period. The next step will be to engage in a strategic and operational planning exercise with all the members of the cluster, in close coordination with the office of the HC, for producing an action plan before the end of the year.

The key elements of the action plan will then be incorporated in the CAP or equivalent, which will become the framework for defining projects to be submitted to donors or to the HC pool fund. At the same time, the coordinated implementation of health humanitarian activities will be continued.

The proposed approach views the opportunities for achievements in health and the delivery of health care in the transition and recovery stages as a potential bridge for peace and source of social stability. In addition to opportunities to “build back better”, the appropriate interventions can be a key contribution to establishing equity in access to health care and to improving the quality of life of the affected populations.
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Concept Note on Early Recovery and Reconstruction of the Health Sector in Lebanon

Strategy during the Early Recovery Period in Health in Earthquake Affected Areas in AKJ and NWFP, Pakistan
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CAF</td>
<td>Country Assistance Framework</td>
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<tr>
<td>CAP</td>
<td>Consolidated Appeal Process</td>
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<td>CCA</td>
<td>Common Country Assessment</td>
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<td>CCS</td>
<td>Country Corporate Strategy</td>
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<td>CERF</td>
<td>Central Emergency Response Fund</td>
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<td>CWGER</td>
<td>Cluster Working Group on Early Recovery</td>
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<tr>
<td>ERC</td>
<td>Emergency Relief Coordinator</td>
</tr>
<tr>
<td>EPR</td>
<td>Emergency, Preparedness and Response</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, tetanus and pertussis</td>
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<tr>
<td>GFATM</td>
<td>Global Fund for AIDS, Tuberculosis and Malaria</td>
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<td>ICVA</td>
<td>InterAction: International Council of Voluntary Agencies</td>
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<tr>
<td>IFI</td>
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<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
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<td>World Food Programme</td>
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