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GLOBAL HEALTH CLUSTER
Subgroup on Management and Coordination

Health Cluster Guidance Note

on Health Recovery

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Prepared by the Department of Recovery and Transition Programmes. Health Action in Crisis. WHO

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LIST OF ABBREVIATIONS

CAP	Consolidated Appeal Process
CCA	Common Country Assessment
ECHO	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]

[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

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