CHAPTER X, EARLY RECOVERY AND RESILIENCE (OF THE REVISED GLOBAL HEALTH CLUSTER HANDBOOK)

INTRODUCTION

While an acute natural disaster such as an earthquake or a hurricane usually comes with an immediate prospect of recovery and reconstruction and the subsequent phasing-out of relief activities, this is typically not clear during a protracted emergency due to conflict. Thinking about transition and recovery is often considered still inappropriate when there is uncertainty as to the duration and outcome of the conflict, or when many areas are still not accessible due to insecurity. However, 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, such as harmonising a package of essential health services. At the same time, short term humanitarian actions can have long term consequences, and well-meant but inappropriate interventions may contribute to creating intractable problems that hinder longer term recovery. For example, when training new cadres of health workers, but without being able to offer accredited diplomas, countries can be left with significant challenges to absorb these health workers after the conflict.

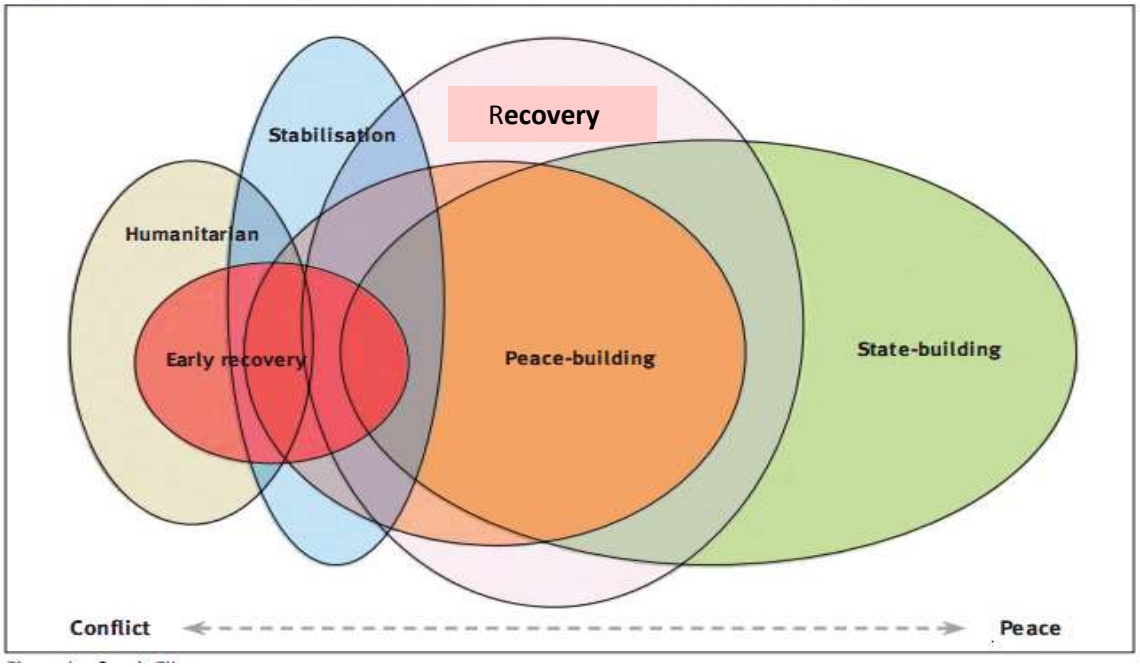
While the need to carry out activities aimed at protecting lives and reducing disease, malnutrition and disability should remain the humanitarian priority, early recovery approaches can and should be integrated in the programming to create connections with, and avoid obstacles toward, longer term health system strengthening and contribute to the process of 'building back better' and/or the resilience of communities and the health system.

Early recovery begins in a humanitarian setting, and early recovery activities should not wait for formal, large scale reconstruction and development programmes. They will assist in the recovery of the health sector, prepare for the return of normality, and create building blocks for future development.

DEFINITIONS

There are processes that overlap with early recovery in content and time, and don't always have clear boundaries between them.

Figure 1: International approaches to conflict and transitional settings



Adapted from Untangling Early Recovery Briefing paper - HPG Policy Briefs 38, October 2009

Early recovery is an approach that addresses recovery needs that arise during the humanitarian phase of an emergency, using humanitarian mechanisms that align with development principles. It enables people to use the benefits of humanitarian action to seize development opportunities, builds resilience, and establishes a sustainable process of recovery from crisis. (GCER 2016) [1] [2]

For disasters, recovery is defined as the restoration (back to normal) and improvement where appropriate (building back better) of facilities and systems (including health), livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors. (UNISDR 2009)

Recovery from conflicts is defined as 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 programs to ensure that their inputs become assets for development'. Adapted from UNDP (DP/2001/14)

[1] Guidance note on inter-cluster early recovery. Global Cluster for early recovery. January 2016. http://www.earlyrecovery.global/sites/default/files/Guidance%20Note%20-010816.pdf
[2] See one minute video http://www.earlyrecovery.global/news/early-recovery-one-minute

Health systems **resilience** can be defined as the ability the health system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions. (Adapted from UNISDR, 2009)

The term transition is often used to describe the change from conflict to peace, and is a complex non-linear process, with unclear beginnings, unpredictable outcomes, and high risks of falling back into a new conflict. Transition signifies the shifts

- from humanitarian aid modalities that may act in parallel to the state, to a development aid modality that regards the state as the primary partner and channel.
- from a short term focus on life-saving activities to a longer term engagement aimed at establishing sustainable peace and viable state structures
- from respecting humanitarian principles of humanity, neutrality and impartiality to actors that make explicit political choices towards peace and state-building objectives
- from working mainly with international organisations to working with local partners.

OBJECTIVES FOR EARLY RECOVERY AND RESILIENCE

Interpreting early recovery for the health sector means that, building on the initial lifesaving interventions (to those most in need), an approach is taken to optimizing the quality and coverage (to most of those in need) of health services provided to affected populations collectively by all health actors using all available resources, while laying the foundation for longer-term health system recovery and resilience, and supporting health emergency risk management capacities.

To achieve this, the following objectives need to be met:

1. Progressively expand access, coverage and quality of an Essential Package of Health Services (EPHS) to populations at risk,
2. Progressively shift to an area and population based approach through District Health Management (DHM), supported by community engagement
3. Use the WHO (2007) health system analysis framework to identify priorities and opportunities for early recovery
4. Plan toward collective health outcomes to guide humanitarian programming and that are also used for development.
5. Strengthen capacities to detect and respond to outbreaks of infectious diseases;
6. Strengthen capacities of MOH, national and international health partners and communities to prepare for, respond to and recover from emergencies arising from all hazards
7. Strengthen national capacity for coordination of humanitarian partners and district health management, and creating links with health development partners and engage in new partnerships that would support ER
8. Develop or update a health transition strategy that addresses humanitarian, recovery and development needs, and their interactions.

PRINCIPLES FOR EARLY RECOVERY

Within the mandate and humanitarian imperative for saving lives, humanitarian responses can and need to take into account longer-term consequences of their actions, and see how interventions interface with, and can contribute to, longer-term recovery and development.

The following set of principles for the integration of early recovery approaches in emergency health responses is adapted from the general guiding principles for early recovery in the Guidance Note on Inter-Cluster Early Recovery, from the Global Cluster on Early Recovery, 2016.[3]

There can be tensions between these early recovery principles and the humanitarian principles of independence, impartiality and neutrality. Often there is no simple answer to the dilemmas posed by this tension and partners need to re-evaluate choices made over time as the political context and needs change.

1. Do not hinder the lifesaving humanitarian objective
Work towards an aspirational better future should not come at the expense of attending to the emergency related lifesaving health needs.

2. Do not undermine the national systems
Emergency interventions which function as substitution to the health system may temporarily serve to fill gaps in service coverage for affected populations, however, they may, by their design, undermine future recovery of the health system by fragmenting existing systems, implementing actions that are impossible to sustain with national resources, and/or disempowering the roles of local and national health authorities:

3. Work with national health authorities and partners where and when possible
Providers of humanitarian interventions should work with national health authorities and partners whenever possible while respecting humanitarian principles.[4] While international humanitarian relief after an acute onset crisis may sometimes establish service delivery capacity and coordination that are parallel to or substitute government, most interventions support service delivery through the existing health facilities through collaboration with subnational health authorities.

4. Integrate early recovery approaches from the beginning
Early Recovery efforts need to be activated and welcomed from the very initial phases of relief. From the early stages of any intervention, consider the foundation for longer-term health system recovery and resilience, and support health emergency and disaster risk management capacities. Early Recovery aims to restore the lead role and ownership of the government, and identify opportunities for (re)building the capacity of the

[3] http://www.earlyrecovery.global/
[4] IASC 2011. Operational guidance for cluster lead agencies on working with national authorities

government, where this supports the humanitarian priorities and/or when this facilitates transition or an exit strategy.

5. Create a collaborative environment with peacebuilding and development actors
Welcome and provide hooks or facilitation for development actors and resources to engage in emergencies. Consider how development partners can connect from the earliest phases and lobby for the handover of high and long-term humanitarian action investments in areas that no longer correspond to an emergency. This can include doing joint risk analysis and seeking complementary in planning toward collective outcomes or the alignment of standards and policies in the emergency response with those used for development.

EFFECTS OF CRISES ON HEALTH SYSTEMS AND IMPLICATIONS FOR EARLY RECOVERY APPROACHES IN HUMANITARIAN PROGRAMS

In addition to facing increased morbidity, mortality and disability, health systems are often severely affected by a crisis, in many aspects and ways. Crises interfere with health service delivery through damage and destruction of health facilities, interruption of health programmes, loss of health staff, and overburdening of clinical and preventive services. A single emergency can set back development gains by several years, including progress made on health system strengthening.

Emergencies may result in severe disruptions of the health system, depending on:
- The type, scale and length of the emergency
- The numbers of people affected
- Existing weaknesses, including lack of capacity, of the health system
- The damage and disruption to the health system caused by the emergency

Natural disasters generally cause short term disruptions of the health systems, though recovery to restore services and health system functions back to pre-disaster levels may take several years, as seen in Haiti, in particular if there was significant damage to the health infrastructure. Usually governments plan for such reconstruction and recovery period from between three to a maximum of five years.

The disruption of health systems in conflicted affected countries is generally much more substantial, and even when conflicts come to an end, recovery may take more than ten years. [5]

The following six sections give examples how the health system building blocks may be affected during crises, either caused by acute natural disasters or during protracted conflict contexts. In reality the distinctions are not always as clear as many sudden

[5] See for more details Analysing disrupted health sectors, a modular manual. WHO, 2009

natural disasters occur in conflict context. From 2005-2009, more than 50% of people impacted by natural hazard related disasters lived in fragile and conflict affected states.[6]

Practical examples are then given for early recovery approaches that can be integrated in the emergency response by what humanitarian partners. See also the Sphere handbook for additional standards on the health system building blocks[7], and annex 1.

1. Service delivery

Most natural disasters, such as floods, earthquakes, and hurricanes, primarily cause direct damage to the health infrastructure and its physical assets, and thus disrupt service delivery. Geographic access to still functional facilities may be reduced when bridges are destroyed or access roads have flooded.

Insecurity and/or deliberate exclusion or discrimination of population groups can constrain access to still functional facilities. Health facilities are often targeted during conflict, leading to significant damage and destruction, which can causes services to be interrupted, either temporarily or permanently. In particular, when conflicts become protracted over decades, there are practically no investments done any more on the maintenance of its infrastructure, as seen in South Sudan and Central African Republic. The health network capacity may no longer be appropriate in case there were large scale population movements. Health service delivery can become fragmented when health facilities provide different packages of services depending on which humanitarian agency provides support.

Practical early recovery approaches for service delivery

- While the humanitarian package of interventions and services may be more focused and narrow in range, humanitarians should ensure that the services in their packages and lists of medicines and equipment are aligned with the EPHS in the national health plan, national guidelines and protocols
- Avoid establishing parallel service delivery points unless necessary. These should then be on a temporary bases, or become integrated in the existing health network (for example in protracted displacement settings).
- Support capacity building for clinical services, such as management of conflict related trauma which will support mass casualty management, or the training of staff in the introduction of a range of quality assurance instruments such as Infection Prevention and Control measures, medical waste management, sterilization protocols, safe childbirth, anesthesia and surgery checklists, that can be justified under the lifesaving minimum standards, but will have longer term benefits as well.
- Make sure that such training provided is aligned with and recognized by the national authorities so integration or re-integration of trained staff can be an asset for the future.

[6] ODI report 2013, http://www.odi.org/publications/7257-disasters-conflicts-collide-improving-links-between-disaster-resilience-conflict-prevention

[7] The Sphere Handbook. Humanitarian Charter and Minimum Standards in Humanitarian Response, 2011. Chapter on Minimum standards in health action. http://www.sphereproject.org/

- Support, when feasible, programs run directly by local health authorities such as EPI, TB, HIV, blood transfusion, etc, when these overlap with humanitarian health needs.

2. Human resources for health

The health workforce is often significantly affected by crises in many different ways, often exacerbating the general challenges which already existed before the crisis started:
Distribution of health workers: After emergencies, health workers may leave affected areas and concentrate in the capital. Better salaries and working conditions offered by international agencies may pull health workers from the remaining public system.
Shortages in providers: There can be absolute shortages in providers in emergency and post-emergency settings. For example in Liberia after the war ended there were less than 20 doctors in the country. Accredited production of new health workers may come to a halt when there is a lasting impact on the education system, as was seen in South Sudan.
Fragmented, unaccredited training: International aid agencies may train (new) cadres of health workers, but without being able to offer accredited diplomas countries can be left with significant challenges to absorb these health workers after the conflict.
Attacks on health workers: In some conflicts, health workers become targets of violence and/or are imprisoned. As a result, many are fearful to come to work or flee.

After disasters, several factors may prevent health workers to report to work. The homes of health workers and their families may also have been damaged by a disaster, and they may also suffer themselves from injuries and psychological trauma. Payment of salaries may become disrupted

Practical early recovery approaches for human resources

- Seek consistency in curricula and post descriptions, and where possible align the training during the relief phase to national standards so they can become accredited.
- Humanitarian partners should harmonize and adapt locally appropriate salary scales or incentive packages with the MoH to ensure standardization and consistency.
- Humanitarian actors can initially and temporarily be 'vehicles' for paying staff salaries that has been interrupted by the crisis, so the departure of staff for lack of means of subsistence can be minimized.
- Establish a Human Resources for Health database using HeRAMs as part of the overall mapping of availability of health resources for evidence based planning and forecasting of workforce requirements
- Address other HR challenges, such as support for (female/male) accommodation in the hospital or housing near a remote health facility.

3. Health information systems

Most routine data collection systems will be interrupted during the initial phases of a disaster, or when they remain functional, they are not per se adapted to inform decision making for the emergency response. Often the areas where no information comes from are the worst affected.

In most conflict affected countries, information systems have become disrupted, or fragmented as partners introduce their own simplified information systems that can be quickly introduced in a crisis or when they apply their own assessment methods. The quality of information is also affected, and in some cases, as data is not updated, information from more than five years old is still used, leading to ill informed decisions.

Practical early recovery approaches for health information systems

- Partners should first consider if the MOH already has developed such systems and use these rather than introducing their own. This is particularly the case when a country uses a standard system such as DHIS 2, to which the information systems of many partners can be made compatible and inter-operative with.
- All humanitarian health partners should apply the same tools in case new systems do need to be introduced, to avoid multiple parallel systems and fragmentation of information, and allow aggregation and joint analysis of data across different areas of operations. Such system would then be further improved during transition and recovery. This needs to be coordinated under the MoH, or by the health cluster if it was activated (also seeking participation from observer partners).
- Agree on standardised disease surveillance system, with an Early Warning component for diseases that are potentially epidemic
- Establish a system for mapping of the damage and functionality of health facilities covering the entire affected area and population.
- Agree and use the same sets of geographical/administrative denominators and demographics estimations leading towards harmonized information that is easier to integrate.
- Agree on health facility reporting tools, IT platforms for uploading data, and processes and incentives for reporting
- Work with District Health Offices for the analysis and weekly/monthly reports

4. Essential medical products and technologies

As infrastructure is damaged by a disaster, medical supplies and equipment may be equally damaged, or power outages affect the cold chain. Normal supply lines may have been affected due to damage to roads and bridges. Donations of medicines and equipment, as part of the response, may in some cases add additional stress to the system, when not compliant to the international guidelines for drug donations.[8] After the war ended in the Balkans, excess medical supplies had to be destroyed at high costs to the government, as it is classified as chemical waste requiring special incineration.

In conflicts, as centrally led procurements systems are interrupted and the regulatory capacity of the government is weakened, access to quality drugs is usually compromised.

Practical early recovery approaches for essential medical products and technologies

[8] http://www.who.int/selection_medicines/emergencies/guidelines_medicine_donations/en/

- Shift from the initial use of standard international kits for the supply of medicines and equipment to bulk procurement of emergency medical supplies based on consumption and caseloads, aligned to national standard lists for essential medicines and equipment.
- Where possible, procure these supplies from national manufacturers, provided these comply with international quality standards
- Where possible, bulk procurement should be done by one agency or through a common channel for cost savings and efficiency, rather than having each humanitarian partner procure their own drugs for their own projects.
- If included in their target countries , make use of supplies procured through global health initiatives as Gavi, the Vaccine Alliance, and the Global Fund to fight AIDS, TB and Malaria
- Explore the creation of subnational Central Procurements Centers if these would fit in the national pharmaceutical policies (as for example ASRAMES in North Kivu)

5. Health financing

Most disasters disproportionally affect poor people. When homes or livelihoods are damaged or lost by a disaster, their overall ability to pay for health services is diminished. In countries whose health financing depends largely on direct out of pocket payments, this adds financial barriers for accessing lifesaving services and increased risks for catastrophic health expenditures.

In case health insurance schemes existed, these are likely to be disrupted by crises, and health system financing in protracted emergencies usually relies mostly on direct out of pocket payments, and direct support from humanitarian partners to reduce user fees.

There is broad consensus in the humanitarian community and donors, that services supported by the international aid agencies should be provided for free at the point of delivery.[9] However, this may distort the existing public and/or private health providers, as patients no longer go to their clinics where they have to pay, so they have less revenue and in worst cases have to close their clinic.

Practical early recovery approaches for health financing

- Humanitarian stakeholders should support a policy discussion with MoH when changing user fee practices (including identifying or securing alternative funding where user fees were abolished or significantly reduced) and in developing more equitable financing mechanisms with the government.
- Any reform related to abolishing user fees must be introduced and monitored carefully, especially in complex situations.
- There is growing experience with the use of cash transfers and/or vouchers that patients can use to cover charges or reduce other indirect financial barriers such as costs for transport, or to incentivize utilization of free services.

[9] See http://www.who.int/hac/global_health_cluster/about/policy_strategy/position_paper_user_fees/en/

- Support from donors to finance early recovery approaches, or advocate for the creation of a hybrid health recovery or transition fund.

6. Leadership and governance

The offices of the MoH, at national and subnational level may also have suffered damage, and its staff affected as other health workers mentioned above. In case a MoH does not have in place systems to establish emergency management systems, it may take time for them to organise effective coordination and guide the response. In case of large scale disasters, where often more than 200 international health partners arrive to offer support, the capacity of the existing governing bodies may be overwhelmed to manage and task these.

In other cases, the governance structure may, remain strong but may be compromised by a lack of respect for humanitarian principles or International Humanitarian Law, such as when, governments deliberately exclude populations from services, or put constraints on cross border or cross front line support.

In particular for natural disasters, governments will increasingly insist that international emergency medical teams register with and report to them, and expect that partners are able to adhere to international quality standards.[10]

Increased ownership from national health authorities can serve several longer term purposes:

- To demonstrate the existence and willingness of national agencies who can take on significant roles in the recovery process, and thereby accelerate the shift from dependency on external sources to self-reliance
- 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

Practical early recovery approaches for leadership and governance

- Partners should align their interventions with national policies, guidelines and standards when possible. Involve national health authorities whenever possible when there is a need to adapt or update them.
- Support to District Health Management Teams functions that have a direct relation with the humanitarian programs, for example on HIS and EWARN, and supervision and quality assurance of service delivery in their districts
- Establish MoUs with district or provincial health authorities, on essential packages of health services, performance based incentives paid to healthcare staff, and joint supervision and training
- Support or create District Health Committees with stronger community engagement, to strengthen accountability to affected populations
- Transfer selected international coordination functions and responsibilities towards national/subnational health authorities

[10] See classification and minimum standards for Emergency Medical Teams in Sudden Onset Disasters http://www.who.int/hac/techguidance/preparedness/foreign_medical_teams/en/

Early Recovery and resilience

- Include when possible in every project elements of disaster risk management (including preparedness, contingency and disaster risk reduction) into the programming, and develop these plans with national health authorities, where possible complementary to a larger national disaster management program.
- Cluster inputs in the recovery planning through PDNA or PCNA/RPBA, and where appropriate use these plans to inform humanitarian programs so they can support recovery
- Connect with GHIs, as Gavi, GFATM, stopTB, RBM, etc.

Annex 1: Health system synergies between humanitarian and development

	Early recovery **activities in emergency response**	**Health System recovery, development and resilience**
Leadership and Coordination	Humanitarian/emergency coordination: *Strengthen role of national and subnational health authorities, taking responsibility for the six coordination functions* Registration and mapping of all health partners: *Integrated in mapping of national response capacity, MoUs with MoH* Sub national emergency coordination: *Focused capacity building of District Health Management functions in support of delivery of the EPHS and life saving functions* *One or two lead NGOs per district to support DHM team* Accountability to Affected Populations; *Connect with PHC traditions (District and Village health Committees)* Emergency preparedness and contingency planning; *Strengthen role of national and subnational health authorities, HEOC, IHR core capacities*	Health development partner coordination (IHP+, etc.) Recovery coordination for Post Conflict Recovery and Peacebuilding assessments: *Led by health authorities* Coordination for the conflict recovery assessment and planning: *Led by health authorities* Core functions and capacities for district health management team Decentralisation policies, District operational planning People-centred and integrated health services; Guidance for district, community and village health committees Emergency and Disaster Risk Management program for health, (including HEOC & IMS) Implementation of IHR core capacities, legislation Integrated in national HSDP
HIS	Simplified morbidity surveillance; *aligned with IDSR* SMART surveys RHA/MIRA, HNO, multi sectoral analysis of needs All hazard risk analysis EWARNS; *Aligned with national EWARN, IHR core capacities* Health Resources Availability Mapping (HeRAMS): *baseline links with SARA* Selected HIS indicators; *Harmonised with HMIS*	Integrated Disease Surveillance and Response system (IDSR) Vital statistics ERM and IHR capacity assessment All hazard risk analysis; *led by health authorities, connected with NDMA* EWARNS Service Availability and resource Assessment (SARA) Health Management Information System (HMIS or DHIS 2)
Service delivery	Restore lifesaving services; special attention for excluded/marginalised groups	Restore basic services, and address pre-disaster constraints for access and performance

	Essential Packages of Health interventions and services; *Harmonised with BPHS, and national QA systems (accreditation of national health providers)*	Basic Package of Health Services (BPHS), accreditation, contracting
	Progressive expansion of coverage and quality	Universal Health Coverage
	Rapid response mechanism; *role of health authorities* Establish temporary treatment centres (e.g. Nutrition Rehabilitation Unit, Cholera or Ebola Treatment Centres): *build capacity of MoH in RRM and national medical teams*	Preparedness to scale up service delivery capacity Safe hospital program, Mass casualty management (MCM), national medical teams, mobile clinics
	Infection Prevention and Control (IPC); *aligned with national standards*	Risk reduction activities; Staff and Patient Safety, IPC, etc.
Pharmaceuticals and equipment	List of core lifesaving pharmaceuticals; *Aligned with national essential medicine list*	Essential medicine lists, by level of health facility
	Drug and equipment donation guidelines; *items aligned with national standards*	Essential medical equipment lists, by level of health facility Standards for diagnostics and laboratory by level
	Stocks of supplies linked with preparedness and contingency plans	Stocks of supplies linked with preparedness and contingency plans; *managed by national health authorities*
	Quality control of pharmaceuticals procured by international partners *From kits to procuring bulk items, common logistics through a dedicated procurement partner*	Prequalification of suppliers Regulation private pharmacies Central Medical Stores for national procurement
HRH	Standardised remuneration/incentives guidelines	A human resources for health unit with responsibility for development and monitoring of policies and plans.
	Staffing standards by level of health facility; *Aligned with national standards* Mapping available human resources by type through HeRAMS	Health workforce registries to track health workforce stock, distribution, flows, demand, supply, capacity and remuneration
		Established national health workforce accounts
		Bilateral and multilateral agencies that have integrated in their programming health workforce assessments, support and information exchange
	Scaling up education and employment of integrated teams of PHC workers,	CHW policy Standard post descriptions

	including community health workers); *Post description aligned to national HRH/CHW policy and post descriptions* Training of health workers; *aligned with national curricula, accreditation of training*	Accreditation mechanisms for health training institutions Training curricula for types of health workers, standard post description, licensing Training of health workers on ERM and IHR, IMS, etc. Training & exercises for emergency response, linked with preparedness plans SOPs for repurposing health workers for response
Financing	Services free at point of delivery (temporary) waiving of user fees Services financed by humanitarian donors/resources *Purchasing services in national health facilities (public or private) using pooled health risk funds , or other cash based programming, to access health services based on prepayment and risk sharing* *Admin systems connect with national admin for PBF systems*	Health financing policies, with shifts to pre-payment approaches Financial protection from catastrophic health expenditures Selective free services (vaccination, ANC, etc.) Emergency fund to reimburse costs for temporary waiving of user fees Financing preparedness and risk reduction Performance Based Financing PBF), contracting of services