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Health Strategic Response: Relief, Rehabilitation and Development

*Report from a meeting
18-19 June 1998
WHO, Geneva*



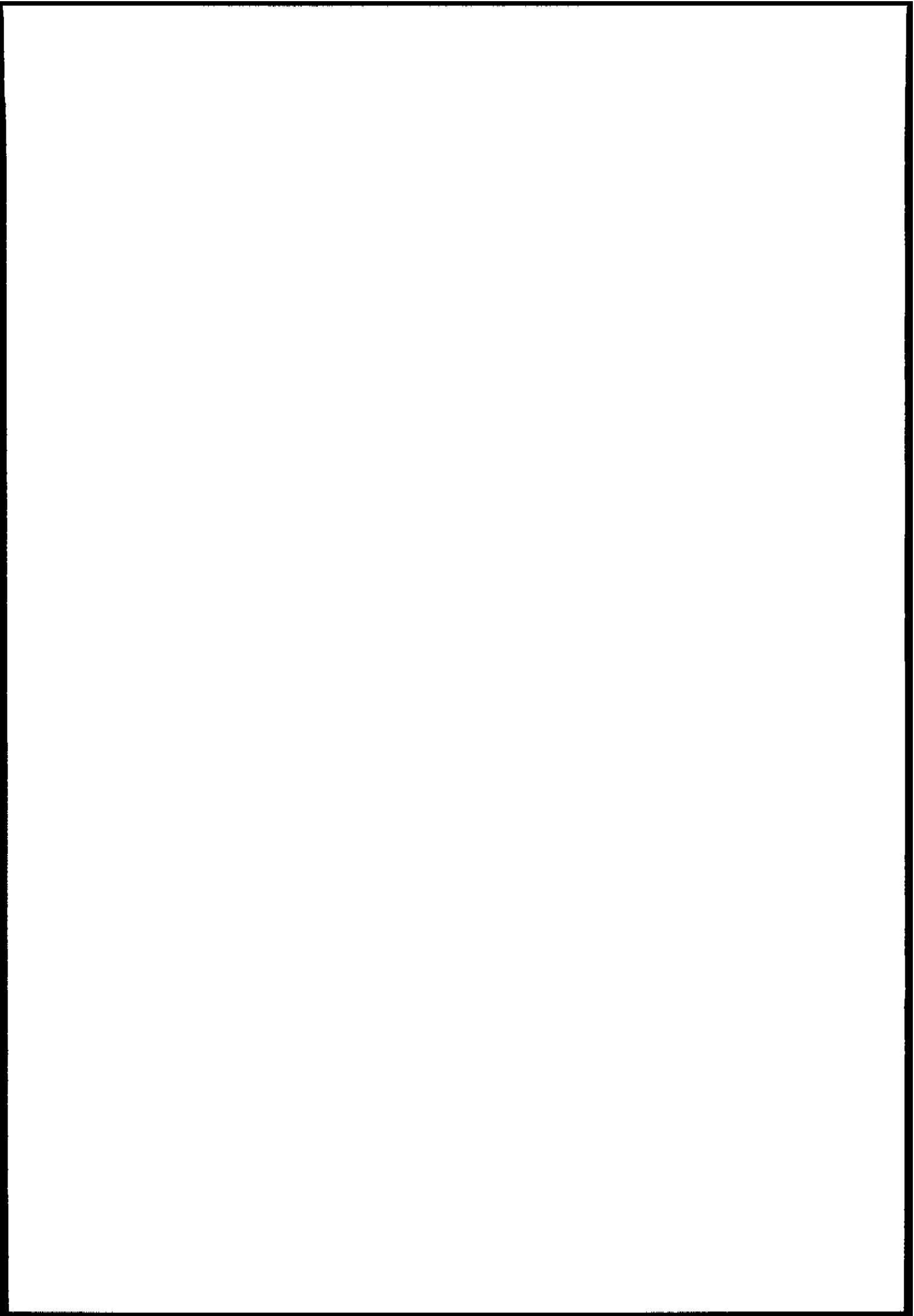
**World Health Organization
Division of Emergency and Humanitarian Action
Inter-Agency Cooperation**

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I. INTRODUCTION

1. An experts meeting on **"Health Strategic Response: Relief, Rehabilitation and Development"** was organised by the WHO Division of Emergency and Humanitarian Action (EHA) in Geneva on 18-19 June 1998 to discuss and elaborate policies and strategies on linkage between relief and development, during and following emergencies. The Agenda of the meeting is attached as Annex 5 and a list of participants as Annex 6.

2. The meeting represented one stage of a project on **"Health Strategic Response: Relief, Rehabilitation and Development"** for which documents on **"Guiding Principles"**, **"WHO Strategies"**, case studies and an annotated bibliography are the expected outputs. The purpose is to raise awareness on this important issue with particular regard to health.

3. This WHO effort has been carried out in accordance with overall UN reform initiatives. UN General Assembly resolution 46/182 proposed that emergency assistance should be provided in ways that would support recovery and long-term development. In July 1995, the Economic and Social Council (ECOSOC) urged the UN humanitarian system to review its capacity to respond to crisis and to establish linkages between relief and development. Since then strategic approaches have been elaborated, with the ACC Consultative Committee on Programme and Operational Questions (CCPOQ) acting as a secretariat on this issue in close collaboration with the Inter Agency Standing Committee (IASC). The UK Department for International Development (DFID) has provided funding to WHO for this particular project.

II. OPENING

4. Dr Jean-Paul Menu, Chief EHA/DAC, on behalf of Dr Fabrizio Bassani, Director EHA, welcomed the participants. Dr Harald Siem, Chief EHA/ICA, described the complexity of current crises, the difficulties experienced by agencies in prolonged unstable situations and the need for linkages between relief and development. Dr Takako Yasukawa, EHA/ICA, briefly explained the overall project and the objectives of the meeting.

III. THREE PRESENTATIONS AT THE PLENARY SESSION

(a) **"UN initiatives in enhancing linkage between relief and development"**
(Mr Derrick Deane, WHO/RMB and Mr Eckhard Hein, CCPOQ)

5. Mr Deane, the CCPOQ Secretary from 1993 to early 1998, presented the background to the development of the project under discussion. He recalled that in 1995, following a UN-convened International Colloquium on Post-Conflict Strategies held at Stadt Schlaining in Austria, CCPOQ had been invited to explore more coherent and coordinated approaches by the UN system to crisis situations. This had translated into the compilation of a Survey of the UN System's Capabilities in Post-Conflict Reconstruction, published in April 1996, which included a matrix of the principal sectors of activity and the organizations involved.

6. Following review of the Survey, CCPOQ had determined to pursue its work along two lines: a) through the development of an integrated strategic framework for responses to crisis situations, and b) through the development of guidelines for sectoral action in six selected pilot areas. More urgency had been attached to the first line of action, which progressed through (i) CCPOQ's agreement in September 1996 on the conclusions of a consultancy study by Mr Hugh Cholmondely that relief and development action should be linked; (ii) subsequent interaction with IASC to ensure complementarity in the policies and procedures for humanitarian and development assistance; and (iii) submission to ACC in April 1997 of detailed recommendations for application of a strategic framework including notably the political

dimension and the involvement of all external partners (World Bank, bilaterals, NGOs, etc.). Following endorsement of the recommendations, ACC had decided to test application of the strategic framework in Afghanistan.

7. The sectoral work - to be undertaken by lead organizations in areas such as financial infrastructures (IMF), human settlements (HABITAT), employment generation (ILO) and health (WHO) - had progressed more slowly for various reasons: UN reform priorities, reduced resources for interagency consultations, the need to dovetail with the conclusions of the strategic framework, etc. The WHO project currently represented the most advanced study and presented the greatest potential for development of practical and pragmatic guidelines, in a given sector, on the action to be taken, the actors involved and the role of the UN system therein. It was hoped that its swift completion and review by CCPOQ would encourage similar action in the other sectoral areas.

8. The current CCPOQ Secretary, Mr Eckhard Hein, also underlined the timeliness and relevance of the WHO-led project. He noted that the interagency mission to Afghanistan had taken place only in September 1997 and that its report was therefore only reviewed by ACC at its 1998 spring session. Due to complications arising mainly in the area of gender discrimination in the country in question, further work on the strategic framework had been requested for further review by CCPOQ and ACC in October. The development of principles and guidelines for action in the health sector would provide a very useful demonstration of how to translate conceptual approaches into specific action at the country level.

(b) **"Post-conflict health policy: emerging lessons"**
(Dr Anthony Zwi, London School of Hygiene and Tropical Medicine)

9. Dr Zwi and his colleagues from the London School of Hygiene and Tropical Medicine had undertaken post-conflict research projects in several countries such as Uganda, Ethiopia and Cambodia. Based on this research, he listed the following key challenges in post-conflict situations: developing a clear framework to guide health sector development; establishing participatory and transparent policy making processes; maximising the value of international community inputs to policy formulation and implementation; promoting evidence-based policy; recognition of both the limitations and the potential of key stakeholders.

10. Dr Zwi noted that the promotion of evidence-based policy required information on a range of services, needs and demands, including the political and economic context and the perspectives of affected communities. This approach was more and more required in the current circumstances such as declining foreign assistance budgets, recognition of significant failures or increased demands of accountability, but was impeded by the complexity of the scientific evidence and the intricacy of the policy process.

11. Health systems had different features in different phases, such as damage, adaptation and innovation in the pre-conflict phase, and emerging health needs, new actors, resource constraints, political realities and unclear orientation (rebuild or redefine) in the post-conflict phase. Elements such as underlying values, the objectives of reform, the roles of key actors, financing and provision, and the organisational form of a system needed to be taken into account.

12. The Cambodia example had shown that the majority of the external assistance to the health sector was executed by NGOs and multilateral agencies; that geographical disparities could develop in NGO's assistance (Phnom Penh and five main resettlement received substantial parts of the assistance) and that NGO assistance tended to focus on supplies and provisions, rather than training.

(c) **"Analysis of contexts of a crisis environment"**

(Dr Paul Spiegel, Johns Hopkins School of Hygiene and Public Health)

13. Dr Spiegel emphasised that in current crisis situations, phases are not linear, but dynamic. He proposed a Relief-(Re)construction-Development dynamic (R2D2) model, where phases can change from one to either of the other two as well as occur simultaneously within the same geographic area or between areas. Using Liberia as an example, he pointed out, that there are different conflict patterns in different geographic areas, occurring simultaneously, which can change independently of each other over time. It would therefore be more appropriate to design specific interventions according to different sections of the country (using the largest possible subdivisions which are in similar "phases" (i.e. provinces, counties, etc.)).

14. Dr Spiegel noted certain dilemmas that faced international non-governmental organizations (INGOs) as well as the local population. For instance, local populations were often looted when resources were brought in by INGOs. Local health workers were targeted by factions as traitors or abducted and forced to treat soldiers. Populations fled to the forest, where they sought to survive, relying on the elderly for advice on food and herbal medicines. He accordingly suggested that a fourth phase, "community survival training", may be appropriate in some circumstances where there is prolonged conflict and instability. This phase would fit in between the relief and the post-emergency/(re)construction phases. The community survival training should be directed towards the general population, particularly the mothers. It would consist of basic health education, first aid, diarrhea control and treatment, herbal treatment for fever, malaria and ARI, and nutrition education with respect to appropriate bush foods to consume.

15. The review of the INGO's community work in Liberia from 1990 to 1998 had identified the following lessons:

- NGOs should have well trained professionals who can provide services and training simultaneously in all of the phases;
- NGOs should cooperate and communicate with all actors, including local government, in order to avoid duplication of services and to share resources and training (this includes not overpaying local workers and thus removing the most competent health care providers from the government);
- NGOs should present a unified position to local governments and factions and be careful not to feed the war;
- NGOs should adopt similar protocols/standards and create a self-evaluation committee which critically evaluates the appropriateness and effectiveness of NGO activities;
- NGOs should think sustainability from day one of their interventions and simultaneously consider the short and long term effects of their actions, following the imperative "Do No Harm" .

16. Dr Spiegel recommended that further research should be undertaken into the type of appropriate responses and training needed for each of the four phases, keeping in mind the dynamic nature between these phases.

IV. GUIDING PRINCIPLES

17. Dr Yasukawa presented a draft of guiding principles elaborated on the basis of a review of relevant literature, a series of consultations and various case studies. She summarised the problems and dilemmas in linking relief and development responses both in general and in a health context. Poorly conceived responses with different priorities, agendas and stakeholders added to the complexity. Examples included interventions with short-term perspectives; the absence of any exit strategy on the side of relief agencies; and inexperience of development agencies in working in a crisis environment which created gaps when relief agencies withdrew from the scene. The guiding principles were proposed in an effort to respond to these identified dilemmas.

18. There are two basic ideas behind the guiding principles:

- the treatment of an emergency phase and a post-conflict phase as part of one crisis spectrum, with the design of responses that are appropriate to each different context of a crisis spectrum;
- the incorporation of development objectives during an emergency: the extended duration of complex emergencies creates opportunities and situations where relief, rehabilitation and development exist simultaneously; relief agencies needed to manage prolonged low-intensive unstable situations in cooperation with development agencies in order to lay the basis for sustainable development.

19. The reasons for the above ideas were:

- (i) There is no clear division between combat and peace in a post-conflict transition. Warfare can continue in some parts of the country even after conclusion of a peace agreement. There might not be any functional government at national level;
- (ii) If an emergency phase is separated conceptionally from the post-conflict, and only the post-conflict is considered for development, opportunities will be missed to support local development activities in pockets of peace during an emergency. On the other hand if the "post-conflict phase" is considered full normalization, irrespective of the situation on the ground, and developmental work is started "as business as usual", the work might fail and investments are at risk of being lost;
- (iii) Carefully designed actions in emergency could prevent or mitigate post-conflict problems. The emergency actions have impacts on the potential for development and hence it is reasonable to treat them as one.

20. The draft guiding principles accordingly propose: (1) awareness of both the humanitarian imperatives and long-term health needs, (2) coordination and collaboration among relief and development agencies, (3) information strategies, (4) sustainable and equitable health reform through the crisis, (5) capacity building.

21. As consultant to the project, Dr Penelope Key challenged the participants to review both the draft guiding principles and their justification; to comment on their relevance by referring to their own experiences, and to add or modify them as necessary. The participants were divided into four groups to discuss the guiding principles, with reference to health status and services, health information, planning and coordination, and local capacity and sustainability. The resulting suggestions and comments were presented by each working group in plenary (Annex 2) followed by discussion.

22. Following the detailed review and discussion, revised draft principles were elaborated, as set out in Annex 1, for validation through case studies.

V. CASE STUDIES

23. Dr Yasukawa introduced the three case study presentations on Angola, Cambodia and Liberia, by describing how they were selected, their purpose and approach. She explained the methodology of the program common to the case studies (Annex 4). The studies sought to identify critical factors of health change. Case studies used a participatory approach and were undertaken by a country study team comprising those involved in relief, rehabilitation and development on the ground. The framework included context understanding, description and analysis of health status and infrastructure, stakeholders' analysis and missed opportunity analysis. Based on these reviews, the team would propose a list of those actions that could have been done differently in the interest of linkage between relief and development. Criteria for country selection for case studies were that the country be in a complex emergency, that WHO has a significant presence in the country and that this review would not substantially overlap with others.

24. Team leaders for each case study presented their initial findings, which are set out in Annex 3. The meeting expressed its satisfaction with the efforts undertaken and the value of the lessons learned for defining the optimal responses in the health sector to crisis situations.

VI. CONCLUSIONS

25. It was agreed to complete the case studies in the three countries under review, with particular reference to validation of the draft guiding principles. The representative of WHO's Eastern Mediterranean region also volunteered to undertake case studies in his region. The decision on this point will be made by taking into consideration the criteria of selection of countries for case studies, outcomes of the current case studies and availability of funds.

The following were proposed and agreed:

- all regions of WHO should be included in this process;
- this WHO initiative should be interlinked with other similar projects;
- EHA/ICA will standardise the framework for the analysis of case studies so that cross country comparisons could be possible. The framework should be linked to the guiding principles, with a view to further their utilization within WHO and the UN system. It is envisaged to review the principles on the basis of their experience;
- to organise a workshop to bring case study groups together to facilitate cross sectional strands; possibly in September 1998.
- the guiding principles will be modified further based on the discussion of the September meeting; in the meantime, the guiding principles would be referred to CCPOQ for its information and comments.
- the guiding principles will furthermore be the basis for training and an element of the WHO reform process. It was recommended to make them available to national authorities.

Annex 1

Guiding Principles

HEALTH IN RELIEF AND DEVELOPMENT

<< a strategic framework for emergency and post-crisis needs >>

Introduction

UN General Assembly resolution 46/182(1991) proposed that emergency assistance should be provided in ways that would support recovery and long-term development. In July 1995 the Economic and Social Council urged the UN humanitarian system to review its capacity to respond to crisis and to establish linkage between relief and development. Since then UN agencies, as well as the World Bank and the EU, have worked on their own position papers in this field ⁽¹⁾.

WHO has a clear mandate to assist member countries to protect the health of their citizens at all times, including immediate relief in emergency situations. WHO initially focused on recovery and long term development in an effort to develop effective assistance in health to countries emerging from devastating conflicts, so that they can be back on the development path as promptly as possible. However, considering the complex and lengthy nature of modern conflicts and post-conflict transition, it has become clear that:

- (a) problems faced during the post-conflict transition are attributable not only to the consequences of the conflict, but also to poorly conceived responses by both relief and development agencies during an emergency;
- (b) introducing development-oriented approaches in health response during an emergency can make a positive impact, not only on needs in the long term, but also on short-term needs.

Accordingly WHO will also attempt to increase the development-oriented impact of response activities taken during an emergency.

Goal of the document

The goal of this document is to contribute to the development of a more strategic response to complex emergencies, so as to protect the health of the population and at the same time to foster effective, equitable and sustainable health service and systems development.

⁽¹⁾ WFP/EB.A/98/4 May 1998 From Crisis to Recovery; UNDP Building Bridges Between Relief and Development; ILO Aug. 1997 Role of the UN System in Post-Conflict Recovery; FAO 1997 FAO's Emergency Activities; World Bank 1997 Framework for World Bank Involvement in Post-conflict Reconstruction; EU: Relief - rehabilitation - development in the field of health: proposed guidelines for action, Luxen 1997.

Purpose and scope of the document

This document is intended for use at country level by all decision makers in health, including national and local governments, external partners (UN, bilateral aid agencies and non-governmental organisations), professional organisations, national non-government organisations and politicians, especially those facing or in the midst of a complex crisis.

It seeks to:

1. present a framework for consideration in establishing post-crisis interventions to achieve effective, equitable and sustainable health
2. promote better understanding of the dynamic context of a complex crisis environment, especially in relation to health and health systems.
3. make available to partners a set of generic guiding principles for their response to emergencies in a way that introduces a solid development-oriented foundation, without sacrificing humanitarian imperatives, and contribute to smoother post-conflict transition and to sustainable development.

The core message to all partners is that health-related and other interventions in emergencies need to be tailored with care, keeping in mind that parallel structures, often with generous funding for a short period of time, can do more harm than good. External agencies involved only in relief and rehabilitation must agree with key stakeholders at an early stage their own exit strategy; development agencies need to re-evaluate their conditions for assistance in accordance with these principles, so that early opportunities for co-ordinated action are not missed.

Understanding the complexity

First, it is important to clarify our understanding of terms. ECOSOC has defined a complex emergency as a humanitarian crisis in a country, region or society where there is a total or considerable breakdown of authority resulting from internal or external conflict, and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing UN country programme. CDC Atlanta has suggested that complex emergencies are situations affecting large civilian populations, usually involving a combination of war and civil strife, food shortage and population displacement, resulting in significant excess mortality. WHO's Pan-African Emergency Training Centre places more emphasis on politics, describing a complex emergency as a situation in which the cause of the emergency, as well as the assistance to the affected, are bound by intense levels of political considerations.

Relief after emergency means action taken to reduce suffering and save lives, aimed at maximising the survival of the greatest number of victims in a limited time, by focusing on reduction of life-threatening conditions and in directly helping those affected by the emergency. Relief is temporary, although in many situations of chronic instability (e.g. South Sudan), may continue for many years. Development, on the other hand, is a process of capacity building to bring about sustainable improvement in socio-economic and health conditions and systems. Development is long-term. They are not mutually exclusive. Each can take place in the presence of the other.

The key to understanding the complexity of relief and development lies in reviewing the preparation and performance of external interventions by better or less prepared relief and development actors. Emergencies have traditionally been treated as sudden onset events, with a crisis followed by resolution and reconstruction. Traditional relief response has treated complex emergencies essentially as an abnormal short term event distinct from development. Most agencies who are involved with relief have realised that this perspective is inadequate in addressing the needs of people who are trying to stabilise and secure their lives and livelihoods in a conflict situation, or in a crisis environment that lasts, with varying intensity, for years.

A linear model which considers emergency, relief, peace, rehabilitation, reconstruction and development as a programmable sequence is not applicable to the majority of the current crises. Contemporary conflicts are complex realities, with little or no clear division between violence and peace. Fighting may continue in some areas after a national peace agreement has been signed e.g. Angola; alternatively, pockets of stability e.g. Nimba in Liberia, may exist during a war which might seem to affect the entire country. Various phases of relief, rehabilitation and development exist in an intricate web in lengthy or cyclic conflicts. This complexity touches governance too: in some areas even failing states never cease functioning (and governance at local level may be very effective), while peace agreements do not necessarily bring back legitimate and effective national governments.

Under these circumstances, the image of distinct 'emergency' and 'post-crisis' phases does not reflect reality; nor does it help to conceptualise phased and balanced strategies for response. As already mentioned, pockets of stability may exist during a country-wide emergency, and new forms of community action and local governance may emerge even while national authorities are absent e.g. Angola, Liberia, Somalia and Tigray. These positive opportunities can be utilised by the international community. Early development-oriented health activities can support wider efforts in reconciliation and peace-building.

Strategically it may be more useful to envisage emergency, intra- and post-crisis realities as one dynamic spectrum. Responses appropriate to each different context as it may emerge through the spectrum need to be designed, rather than differentiating phase by phase and proposing fixed approaches for each. A clear analysis and focus on context will enable partners to identify, and modify, actions and modalities for meeting the health system and service needs within one broad frame of relief and development.

Although traditionally there has been a sharp division between those who provide immediate humanitarian relief and those involved in health development, this categorisation no longer holds, the reality being that there is a full spectrum from very short-lived relief agencies and people, who come and go, through organisations like UNICEF, WHO and some NGOs, who are present before, during and after a crisis; and finally UNDP, World Bank, some bilateral aid agencies and some non-governmental organisations, with a clear development emphasis.

In April 1996, the Consultative Committee on Programme and Operational Questions (CCPOQ) of the UN Administrative Committee on Co-ordination (ACC) undertook a survey of the UN System's capabilities in post-conflict reconstruction ⁽¹⁾. The report represents an inventory of the range of capacities present in the UN system, demonstrating that the entire UN system has

⁽¹⁾ CCPOQ April 1996 Survey of the UN System's Capabilities in Post-Conflict Reconstruction

something to offer in post-crisis situations. It makes a positive contribution towards the development of an integrated UN system framework and strategy for post-crisis recovery. This document represents a further step in development of a health-specific sectoral strategy.

Problems and Constraints in Complex Crises

General country context

Protracted complex emergencies are increasingly common, composed of various phases of reconciliation, recovery and deterioration, often concurrently. It is often difficult to bridge the gap between emergency and post-conflict (or post-crisis) phases.

The precise moment when a crisis situation becomes post-crisis, as opposed to in-crisis, may be perceived differently by different stakeholders. For instance, once a peace accord is signed and elections announced some nationals consider themselves post-crisis, but the international community, perhaps because of security problems, may consider the country still in-crisis.

The country situation and the environment within a fragile peace process is characterised by volatility, uncertainty and a complex geopolitical context.

National governments may have insufficient political commitment and limited capacity to manage post-conflict transition.

There may be many external actors with different agendas, both explicit and hidden: media, political, religious, international agencies - government and non-government, private companies, commercial enterprises, etc.

There is limited co-ordination of actors involved, due to failure to collaborate, lack of overall analysis of the situation, and lack of shared priorities. The UN Inter-Agency Standing Committee (IASC) has recently agreed on mechanisms for co-ordination in complex emergencies situations.⁽¹⁾

Relief and Development Context

External agencies traditionally focus their attention on short-term relief interventions. Unplanned, even unwelcome, relief interventions and unplanned exit of relief agencies without handover to nationals is typical and may be harmful.

There may be hesitation by external agencies to undertake development-oriented work during an emergency situation without security in the country as a whole or the presence of a legitimate national authority.

Developmental approaches are also not always helpful; in some cases these may be inappropriately offered by agencies which are not adapted to complex emergency contexts, e.g.

⁽¹⁾ IASC Recommendations related to the review of the capital of the UN system for Humanitarian Assistance 1998.

their staff may be inexperienced.

Relief and emergency-oriented funding by external agencies typically by-passes government channels both during the emergency and in the post-conflict transition. This may have unintended consequences, notably the erosion of state and local capacity to govern, assess needs, plan, and deliver, or co-ordinate the delivery of, services.

A dependency expectation may be created. Costs of relief interventions are often out of proportion to long term affordable health service costs. The economic aspects of relief and rehabilitation need the same emphasis as is currently given during development.

Donor agencies may have a division in their country budget between relief and development programmes. Relief funds are often centralised. Donors may have no funds which can be used for rehabilitation. The mechanism for taking decisions on point of transition from relief to development in a post-crisis situation is generally unclear. Current mechanisms of funding require attention.

Health context

Health does not improve readily in the aftermath of violent conflict. Demobilisation, repatriation, crop failure and economic stagnation lead to increased incidence of infectious diseases, such as malaria, STD's, HIV/AIDS, TB, and other conditions, such as under-nutrition and unwanted pregnancies.

There is typically a breakdown of health infrastructure (financial systems, communications, disease surveillance, information system, policy formulation and implementation, planning, management, human resources, health facilities, logistics) as a consequence of conflict.

Limited, partial, scattered and even false health information causes gaps, duplication and imbalances during the emergency and in the post-crisis transition phase.

Population movements during and after emergencies may lead to new exposure to disease (e.g. malaria, STDs), but also may overwhelm existing service provision, as in Luanda, where there has been a massive urban population inflow.

Fragmentation or disruption of health service activities lead to increasing cohorts of unvaccinated children, interruption of control programmes for tuberculosis, malaria, reproductive health, and dislocation of essential drugs system and other medical supplies.

Disruption of other services, such as the provision of water and sanitation, the removal of sewage and solid waste, and destruction of infrastructure, may all lead to additional health burdens.

Parallel health services and systems established by relief agencies may undermine the local health service capacity and the ability to effectively identify needs and develop appropriate responses.

There are long gaps in time, and sometimes no availability of health services, between the withdrawal of relief agencies and the early functioning by local/national authorities and development agencies after the crisis.

There are inadequate and insufficient human resources. Many health workers may have fled or been killed. Skilled and motivated national staff are hard to mobilise, in part due to lack of funds for salaries and training in the national sector, in part due to competing external agency projects, which offer a better income. There is also loss of skilled health workers to cities or other countries, or to private for-profit and not-for-profit agencies.

Human resource management capacity is inadequate. Numbers, categories and location of health workers may not be known but is often skewed. Competencies vary . There is difficulty in reintegration of health personnel into one cadre with defined standards.

The system is unable to meet new needs, such as surgical care for land-mine victims and other trauma; the response to violence and injuries may be limited and short-term.

Slow progress in recovery of the health system, in relation to the end of the conflict, economic growth, and social services provision, often leads to frustration and disenchantment of international partners; expectations of all players are often unrealistically high and this needs to be tempered by experience from elsewhere.

GENERIC GUIDING PRINCIPLES FOR EXTERNAL ASSISTANCE TO COUNTRIES IN COMPLEX EMERGENCIES

(1) People's health must be protected in both the short and long term

An overriding goal for all partners responding to an emergency and post-crisis transition is to protect the health status of the population, namely to ensure the survival and reduce the suffering of the population, in terms of both immediate survival and long-term sustainability.

There is no doubt that humanitarian imperatives come first during an emergency. However, due to the intricate and protracted nature of conflicts, a focus solely on preserving lives even in the short term is neither sufficient nor appropriate. Relief agencies must be prepared to work in prolonged, low-intensive, unstable situations where various elements of relief, rehabilitation and development coexist. Victims of protracted conflict think about survival in both the present time-frame and the longer aftermath of crisis. Thus response to crisis should aim to protect both short- and long-term health, as the context permits.

Health protection and access to health care is a human right and all people must be given equal opportunity for health protection regardless of status, race, geographical location, tribal group, gender or political affiliation. Partners intervening to protect or improve the health of specific groups must bear in mind the needs of the whole population.

(2) Accurate information is essential

A multi-sectoral country situation analysis is the basis for a strategic response.

An effective health information mechanism is a prerequisite for the country health situation analysis, consolidating and analysing information on health status, services and systems. Normally this takes place as a routine part of planning in the national ministry of health. International agencies should first make use of what is already available. Only if information does not exist or is seriously out-dated should agencies embark on additional data collection.

The analysis will need to cover economic, social and political issues, coping mechanisms, war damages, conditions that may allow developmental activities, and direct or indirect impact on health systems, infrastructure, supplies and professional staff.

The UN Agencies have developed their own round-table system for resource mobilisation in post-crisis countries. Other external partners and major NGOs usually take part. A situation analysis is presented as part of the consultation documentation. World Bank similarly produces a country note with country data, including a public expenditure review.

An agency (possibly WHO) should be designated as an open access library to house all available and on-going health-related, data-collection reports, studies, papers and instruments. These include qualitative and quantitative studies, financial flows, epidemiological and health service data. Any health information held prior to the crisis by international agencies should be accessed early to replace what may have been lost locally.

(3) Preparedness is possible

It is essential for health workers, local communities and agencies to be ready to relieve human sufferings from health hazards in an emergency.

It is possible to foresee the likelihood of major communicable diseases specific to the country even under complex emergencies. Accordingly, it is possible to take protective action against predictable diseases in a period of less intensified conflict and in pockets of peace. Provision of early warning and good health information will enable health workers to prepare their interventions. Initiatives could well be taken by development agencies in areas of co-ordination, policy-setting and contingency planning; epidemiological & anthropological information collection, both quantitative and qualitative; in the training of health staff ; stockpiling drugs and supplies; and in identifying key agencies, both local and international, which can play a key role in supporting on-going service delivery.

In an acute phase of population displacement, an existing country disaster plan can help to mitigate human suffering. It should cover lifesaving needs, such as food, water, shelter, basic health services and logistics. In WHO, the HINAP project (Health Intelligence Network for Advanced Contingency Planning) is being developed in order to provide country-specific preparedness information for the use of relief agencies.

(4) Plan for development throughout the emergency and transition

Clear goals and objectives with prioritised actions are an essential pre-requisite to programme activities and should be drawn up with consensus of all possible stakeholders, based on objective assessment of needs, resources, health risks and determinants. Projection beyond the immediate to the medium and long term is required.

Sharing of objectives among all actors is of critical importance in consolidating efforts in a complex crisis spectrum. Once the priorities are clear and shared, activities to meet the needs are more likely to be agreed in a co-ordinated manner. A stakeholder analysis is an important part of this discipline. It will identify early potential actors, both local and external, national and international, formal and informal. Also, it allows for careful assessment of their objectives and possibly conflicting goals.

During an intense conflict period, people move rapidly and squat in crowded quarters with poor hygiene. The major causes of death are measles, diarrhoeal disease and respiratory infection, may also be malaria. As conflict and movement of people continues, malnutrition and micro-nutrient deficiency become significant causes of disease and death. Relief agencies are accustomed to these; development agencies are not. Over a period of time other health problems require attention, such as TB, STDs, HIV/AIDS and trauma due to land mine injuries, interpersonal and collective violence and road traffic accidents. They demand a more systematic and sustainable approach which development agencies can offer. As the peace process moves forward, repatriation, resettlement, demobilisation, reintegration of health staff, and construction begin. Systematic public health planning is essential for these events.

Agencies involved in the health sector during and following a crisis, whether having either a relief or development label, should be aware of and able to address both categories of health problems. This wider approach will enable both relief and development agencies to prioritise health interventions in a co-ordinated way.

Planning also involves resource mobilisation, which is best done when the need is understood and correct response determined. The available resource base must be known to stakeholders for effective planning to be undertaken. This not only allows better ownership of the process, but also ensures accountability for use of resources by workers to donors and clients.

Establishing an effective mechanism for co-ordination of partners, including NGOs, is an essential part of development and relief planning. In a development scenario, the national authority will certainly take the lead role; in post-crisis transition neither the national planning department nor the health ministry may have the capacity or political will to undertake this important co-ordination function. Co-ordination needs then to be ensured under the auspices of the UN, through a UN Resident co-ordinator, a humanitarian co-ordinator or a lead agency. Lack of compliance by external partners to any agreed effort of co-ordination is often the major reason for failures.

A logical framework approach (or other appropriate planning instrument) should cover a situation of emergency response as well as development action. It will ensure identification of target population, clear definition of goals and purpose, as well as setting proposed outputs and actions needed to achieve them. Relevant and appropriate work-plans for involved implementers more easily follow on. It also calls for disciplined monitoring with measurement of planned outcomes. However, the logframe must not be allowed to hinder the planning process; to be seen as a threat by those unfamiliar with it; or to impose plans. It should be used as a planning tool for full and thorough consultation at all levels and among all stakeholders.

(5) Integrate relief, rehabilitation and development activities for the same objective

Strategic response, which integrates appropriate relief and development approaches to the different contexts of an emergency maximises the effectiveness and the sustainability of response. Early introduction of development workers and educators while relief operations are under implementation will pay dividends.

Relief efforts aim to reduce human suffering directly. Development oriented activities can contribute to the same objective by creating effective support systems, a healthy environment and behaviour, vulnerability reduction, sustainable and equitable access to health services, and understanding of the critical need for local institutional capacity building.

The introduction of developmental approaches, components or agencies in a dialogue during emergency will enhance effectiveness of activities by relief agencies. In Somalia, during the ongoing complex crisis, development agencies set up a comprehensive cholera control system, composed of strategic stockpiling, training and contingency planning. The case fatality rate was drastically reduced and is now much lower when compared to stable neighbouring African countries. Many relief agencies dig wells to make available safe water to displaced people. But their objective of preventing diarrhoeal disease and saving lives will not be achieved unless their action is combined with establishment of effective, community-based sewage and solid waste disposal systems, and with promotional hygiene education (developmental activities). Relief and development approaches need to be combined in this case. For instance, the massive inflow of Rwandan refugees into Tanzania provided an ideal opportunity for external agencies to combine immediate relief activities with sustainable improvements to the local health services.

(6) Verify the key health hazards and their root causes locally

Awareness among relief and development agencies of key health problems associated with various contexts of an emergency and post-crisis transition opens the way to sharing views and to eventual consolidation of efforts. It is necessary to confirm what are the burdens in each setting. An effective disease surveillance system must be established if not already in place.

The key insight in making decisions about relief programmes is not just to address urgent needs but to find and address the root causes of health problems, in order to place resources where they are most effective. An appropriate, if only rudimentary, surveillance system must be able to identify shifting needs as population groups move and changes in service provision occur.

Health problems relate to immediate life-threatening hazards to health: food insecurity, malnutrition, serious infectious diseases, lack of safe water, clothing and shelter, poor sanitation. These are traditionally targeted by relief activities. Others relate to the destruction of basic (primary and secondary) health care systems, deficient determinants of health (water, sanitation, housing,) limited and scattered health information, depletion and inadequate management of human resources, lack of health policy directives and health financing assurances. These are traditionally targeted by the development-oriented agencies.

(7) Use the opportunity to introduce systemic changes to reduce disparities in health status and improve access to health care

Conflicts can offer opportunities for wide-ranging social and health system changes, facilitating more equitable and sustainable health development. It may seem naive to propose an equity guideline in crisis situations, when warring factions actively pursue inequity, seeking advantages in health care for their own groups and positive discrimination for rebels and their enemies. But it is possible to pursue at least an equitable distribution of available resources to accessible population groups and to consider how interventions can contribute to the reduction in inequalities in health and access to services in the long term.

A rehabilitation response should avoid the temptation of bringing health and other services back to the pre-conflict state of affairs, or to the very practices which may have contributed to the crisis. Based on insight into the nature and root causes of a crisis or conflict, and an understanding and respect for local coping mechanisms and health expertise which exist, the response should aim at effective, equitable and sustainable health development.

For example, it may not be desirable or necessary to rehabilitate all the hospitals in a capital city. It would be wiser to look at country-wide health coverage and use the funds to provide basic health services to previously deprived rural areas. This proved an important lesson for Ugandan health officials after a post-conflict health sector case-study. In Cambodia it was possible to introduce an integrated disease control approach in the national development health plan in the post-conflict transition. In the southern part of Yemen, a decentralised health system with community participation has been developed during a conflict. In Tigray, the involvement of local government in Intersectoral health promotion activities developed during the conflict with Ethiopia.

There is need to be especially gender aware in a complex crisis situation. Women have many extra demands made on them during crisis and conflict while men are away. Some of the coping strategies may increase the risks to their health e.g. from violence, landmines, and STDs/HIV. They often take lead roles in the family and community, but then are required to relinquish authority again. When competition for employment is high, men may be given preference in traditionally female jobs, such as nursing and even midwifery, leading to later constraints to effective health care delivery.

Use of gender-sensitive planning approaches, including for instance the logical framework, may contribute to overcoming such potential problems.

(8) Use localised relief activities for capacity building and further development

There are risks related to external interventions. Parallel structures may compete with local capacity and may undermine the coping mechanisms in local populations and systems. Support at local level lays a solid foundation for decentralisation and local capacity-building. Involvement of ministry of health and local structures in community-level support is a key to the sustainability of local development.

Pockets of stability may exist in the midst of a country-wide emergency, and community action and local governance may emerge even while national authorities do not exist. Support could be directed at these local government structures without waiting for complete national reconciliation. Such support aims at community empowerment and collaboration with all partners on the ground: Noting that a pre-conflict status in some cases was characterised by a centralised system, a conflict may offer potential to health system improvement through support at local level. Moreover, decentralisation backed by community empowerment can create safeguards against a resurgence of political turmoil and a domination and misuse of power by the privileged few.

One example of supporting local initiatives during crisis is the BMD (basic minimum development) programme, implemented by WHO in both stable and unstable developing countries. Under the BMD, development interventions are designed with the aim of eradicating poverty. They include programmes which integrate health, sanitation, income-generation, adult literacy and training programmes, and increased agricultural production. Participatory techniques are employed, aimed at assuring sustainability and ownership of the work by the community. This BMD programme could be introduced in on-going crisis.

(9) Support local health workers across political and non-political divides

The key to smooth post-crisis transition is support to national health workers across political or other local divisions throughout emergency and transition. Sustainable recovery of the health care services will depend on the quality and quantity of health workers.

National health workers can play a role as mediators of peace and reconciliation, by being effective providers of care to victims, partners for capacity building and facilitators of community participation and empowerment. Therefore it is worthwhile to provide them with strong support. This may include salary support, accommodation, transport, communications, equipment & essential drugs, training opportunities and technical assistance.

Skilled health workers may be seriously depleted or have moved from rural to urban locations. Introducing improved health worker management at an early stage may improve motivation and prevent further depletion of staff from where they are most needed. Health worker training programmes, both pre-service and in-service need urgent support, especially where there has been huge loss, as in Cambodia and Rwanda. But it should not go unrecognised that in some cases health workers have actually perpetrated abuses and, therefore, that not all health workers merit support just because they are health workers.

Designing the modality of capacity-building of health workers, however, requires careful planning, as health workers at different levels under different administrations require different approaches. A quantitative and qualitative assessment of available human resources and training institutions is to be undertaken as early as an emergency context permits.

Information concerning the educational curricula of health workers provided by various UN agencies and NGOs should be continuously shared and updated. This information sharing will give ideas on equivalence and necessary upgrading of training courses, enabling nationals and development agencies to be prepared for reintegration of health workers with various backgrounds. The educational needs of health worker trainers should be addressed early to ensure consistency, quality and sustainability of externally supported training programmes.

Health and management institutions may exist outside the government structures; given adequate support, these may be used throughout the crisis situation and may confer institutional stability and sustainability. They should also be an early focus for development activities in the post-crisis spectrum. Failure to address the needs of the training institutions early in the post-crisis period will delay achieving health worker training targets.

(10) Nurture and Strengthen Local Health Worker Capacity

Retaining national health staff in their work is of importance to the health development of the country as a whole. External interventions need to be carefully arranged not to divert the health workforce from essential work.

National health service staff may be poorly motivated to work on ministry priorities due to extremely limited salaries and a real need to earn a living wage. International agencies will often pay them well and they become busy with project planning and implementation or, in some cases, may move to outside jobs. Institutional destruction may result from project proliferation and the local capacity is thus reduced for setting policies and implementing national work programmes.

In order to improve health worker capacity, the international community needs to co-ordinate their projects and share local resources. Coherence in the health worker remuneration system needs to be agreed. One tested mechanism is for the national government to contract with external partners for use of national staff (e.g. Cambodia). In addition, plans for out-of-country training for nationals should be in accordance with an overall national training plan and selection for such training should be based on firm, open criteria.

While working for external agencies with a humanitarian mandate, local staff must respect the rules of impartiality, but it would be naive to believe that they, in their hearts, will be totally neutral. External humanitarian actors need to focus on the health tasks and remain impartial and apolitical.

(11) Establish transparent monitoring systems for resource flows

Monitoring external and internal resource flows is a vital task in strategic response, providing a firm basis to long term improvement in overall management of health resources, including finances.

A centralised mechanism is necessary for monitoring resource flows to the health sector from both relief and development agencies in the concerned country. This is not sector specific but will allow a comprehensive picture of activities in the health and health-related sectors. It will serve to identify areas of duplication, gaps and imbalances in health-related activities, which, in turn, will open the way for effective financial co-ordination, such as the establishment of special flexible trust funds for strategic response, and improved management of international resources

It is important also to capture financial information on the wider group of health-related agencies, such as those involved in water and sanitation, food security, disability and education, as they too may establish health activities.

(12) Review the need for external support on a regular basis, involving all national and community stakeholders

Partnerships need to be carefully modulated according to the context - from a high degree of external intervention to greater involvement of local agencies, community structures and national workers. External relief agencies should build exit strategies into their initial plans to ensure smooth handover to national authorities.

Their participation in consultations, planning, implementation and evaluation will ensure that local agency and national health staff gain ownership of health policy, planning and provision. External intervention is preferably explicitly temporary, and limited to a role of catalyst, model development, local capacity building, monitoring the local situation, and resource mobilisation.

However if a country has just emerged from a prolonged and devastating conflict, it usually has a seriously limited national capacity and expertise in health, while overwhelming challenges are to be tackled. The government may not be unified in reality, nor be ready to show commitment to the health of the population. Under this circumstance, initially intensive external intervention may be required. Facilitation of dialogue and consultations among local and national stakeholders comes first, in order to attain political consensus and commitment for the policy goals for health development. In South Africa, health policy fora brought together key stakeholders to debate and exchange views on their vision of the future system. Another externally-funded project enabled a journalist, working with a major national newspaper, to focus on health sector issues and debates. Once they are achieved, provision of technical and managerial assistance will effectively facilitate preparation of a national health development plan.

Initially, the nature of external assistance will be "involvement", rather than "advice"; joint actions with national authorities throughout the process of planning, implementation and monitoring. The degree of external involvement will be gradually reduced and focused to technical assistance, by reviewing jointly the situation of the country and capacity of local

authorities and agencies.

(13) Flexibility to move between relief and development activities is essential

The balance of relief and development activities and resources will change depending on the geography, time and political context; all partners need to have an in-built rapid and flexible response mechanism to such changes. Ongoing opportunity assessment, including careful analysis of the impact and risks of interventions determines the modalities of interventions.

Options for action in the context of a volatile crisis environment are available at each level: household, community, district/province and national. They include humanitarian relief, facilitation of dialogue, policy advocacy, technical advice, capacity building and capital projects. Choice of intervention at a particular point in time requires analysis of the specific context in terms of security, political stability, socio-economic condition, health status, self-reliance, institutional stability and community commitment. Developmental activities are more likely to function efficiently and less likely to fail if they are adapted to the emergency context. This might seem self-evident, but the point needs to be made that long, impact-oriented programmes sometimes need to yield to much shorter, possibly riskier projects.

The relief/development balance may vary from micro-level to macro-level, shifting towards development from individual to institutional, local to national, as the intensity of conflict decreases and as the stakeholders' commitment grows. Gradually, actions pass from a project-based to a programme focus and more strategic and policy-oriented approach. A violent conflict varies in intensity from place to place and time to time. Sometimes it may be possible to work with local counterparts and with longer-term objectives, but at other times it will be too risky. Ongoing reassessment of context should be carried out with the actors involved during programme implementation. (This is normally the function of the UN-led Disaster Management Team.) Emphasis again needs to be made on collaboration with national authorities.⁽¹⁾

In some situations (e.g. Palestine) well established local NGOs will provide valuable services. As the nature of the crisis changes, the relationship between these NGOs and the local and national state, and international partners, may need to adjust.

Primary Health Care (PHC) remains the crucial guide in initiating or expanding developmental health components in an emergency situation. PHC will reflect economic conditions, socio-cultural and political characteristics of the country and communities. It ensures development of local capacity and avoids establishment of parallel structures. To recall - PHC is essential health care, addressing the main health problems, at a cost that the community and the country can afford to maintain at every stage of their development.

(14) Evaluation must be adapted to the crisis situation

In a post-crisis scenario, evaluation against international health indicators may be more appropriate than against defined targets. People are moving around too much to make normal development evaluation valid. But, if we do not learn we will continue to commit the same faults

⁽¹⁾ Primary Health Care Concepts & Challenges in a changing world: Alma Ata revisited, WHO/ARA/97

and mismanagement. It is important to:

1. *Base policies on evidence*
2. *Promote documentation of good (and harmful) practices*
3. *Facilitate exchange of information between agencies and countries.*

Wherever the local situation allows, regular internal evaluation of activities and achievements against programme objectives and purpose (as in the programme Logframe) should be a regular feature of ongoing work of external and local agencies. Periodic, independent, external evaluation, preferably as a joint inter-agency exercise, needs to be scheduled; a clear consensus must be reached prior to such an exercise on evaluation tools and methods.

Efforts to document experiences of assistance during complex emergencies have been initiated by the international community, for example a joint evaluation of emergency assistance to Rwanda⁽¹⁾. However, a process of evaluation has not been routinely undertaken nor standardised because of the uniqueness of each emergency. Having noted the complexity of the still current Rwanda crisis and its consequent huge magnitude of human suffering and economic loss, valuable lessons for planning and implementing future assistance in similar situations have been derived. More recent initiatives to ensure accountability and standards are currently underway and should play a more important part of relief and post-crisis interventions in the future.

In any evaluation, consideration should be given to life-saving performance, approaches for sustainable and equitable development, accountability and co-ordination. Different weighting and different time frames need to be recognised both for emergencies and post-conflict or post-crisis.

(15) Decentralise and merge relief and development budgets of partner agencies

Overcoming existing divisions in budgets between relief and development programmes in an agency will facilitate dramatically the inclusion of developmental components in relief activities.

In the case of WHO, the regular country budget is managed by the relevant technical officers at the regional office even in conflict-affected countries like Angola and Liberia, while the emergency and humanitarian budget are basically managed by EHA/HQ. Sometimes it is difficult to keep consistency and coherence among two or more players.

But this centralisation of emergency funds and management (found not just in WHO but also in other UN agencies) is essentially a response to donor preferences. It will require close dialogue and readiness on the part of funders, as well as UN agencies, before change can be effected.

NGOs' plans of action are often bound to donors' budget lines. The current division of relief and

⁽¹⁾ Rwanda external evaluation 1998

development budgets of some donors refuses to cover the cost of training of local counterparts by relief funds, forcing NGOs to give up training. In this connection, donors' initiatives in consolidating relief and development desk officers in their structure will have a great impact on the modalities of relief activities.

Implementation Process

This is a policy document - not a plan of action nor a practical guide. It is submitted for the consideration of national health professionals and all partners who work in the health sector before, during and after emergencies, especially in post-crisis transition situations.

Annex 2

Notes from group work

Notes from Group 1: Health status and health services

The target of the guiding principles should be the international community and national/ local people.

One paragraph could be added on the need to ensure the minimum acceptable quality of external response teams, as quite often unexperienced and unqualified expatriates implement and supervise the operations.

Multi-sectoral, and at least inter-disciplinary country situation analysis should be a basis for a strategic response.

Preparedness is essential from the historical, sociological, psychological, environmental and infrastructure context and the epidemiological status of the population. Where a crisis threatens, agencies can prepare by coordination, policy setting, epidemiological and anthropological information collection, training of health staff and so on.

Goals and objectives involving all stakeholders can be developed in the early phases and during the continuation of the crisis.

Notes from Group 2: Health information

One should stop distinguishing 'relief' and 'development.' Properly done, relief is also development.

Agencies should move to develop a uniform data collection format for emergencies. The information needs were debated. The goal is to identify what data one needs. Relatively little data are sometimes needed to mobilize resources. The effort to achieve accuracy can only be taken to a certain cost, which can not easily be met early in an emergency.

Surveillance systems need to be established particularly early in time to monitor movements of populations. Malaria endemicity was mentioned as one example in order to understand the risk potential for creating a new epidemic.

Equally as important as information (e.g., data) is 'human intelligence.' There is a need for well informed persons who can foresee risk factors for different scenarios – for camps or for repatriation.

It was said that there might be hundreds of stakeholders with disparate mandates and interests. Many will be tied to private funding that commits them to a certain course of action. Questions were raised what is gained by complicated mapping exercises. Also there were questions as to the value of identifying all stakeholders.

Flexibility of actions in the field is clearly essential and worth keeping. However the concept of switching from one and back should be changed as it may reflect a linear concept. The reality is that it is all one and the same. Always work with long-term in mind.

Comments were made on the primary health care in the text. It implied that primary health care is an internal intervention and external interventions are non-PHC. It is possible for an NGO to come in and mount an excellent primary care program with local people as staff implementers but in the end nothing is sustainable when the NGO pulls out.

The document proposes to evaluate action "against program objectives and purpose." If ever there is a time when program objectives may shift and need to be re-invented, its during reconstruction, repatriation and transition. Hence, a new evaluation methodology is needed here, that compares program achievements against reasonable efforts that adapt over time but have the same general intent of the original plan.

Notes from Group 3: Planning and coordination

The group stated that the audience for the paper should be persons at headquarters and external partners, training institutions. National NGOs are the means to take this paper forward.

The core of the paper needs to express guidelines, how to change the mindset of external bilateral agencies and how to engage the nations. The group proposes to use the paper as a tool, to revisit the whole definition of development, and tailor specific chapters for specific audiences.

The projections should go beyond the immediate needs to address the long term potentials and impacts. That is, planning for development. Planning; coordination, consensus, transparency, accountability, compliance by external agencies, mechanisms for coordination will depend on capacity and political will and the local situation.

The language of the proposed guiding principles was felt not active enough.

To achieve changes and improvement in the health sector requires a certain stability. The bottom line is to make sure that the most vulnerable people receive most of the attention.

Flexibility is essential. The balance of relief and development activities and resources will change depending upon the geography, time and the political climate. All partners need to have some built-in rapid response mechanism and need to monitor changes.

Notes from Group 4: Local capacity and sustainability

Full consideration of local capacity and sustainability is uppermost important, and a conflict could be an opportunity to introduce social and health sector reform. Local understanding of health sector reform is critical and there is a need to address health sector improvement early with emphasis on human resource development. One separate section should be included related nurturing and strengthening local health work capacity.

Brain drainage needs serious attention and measures should be taken to minimise it.

One must seek ways to support national health workers across political and non political divides.

It was noted that there is a need to review external support on a regular basis, involving all national and community stakeholders. There is a need to state exit strategies.

Another section should be added on "gender specific awareness". In complex emergencies, women often run everything while the men are away, and then when the men return, all authority is stripped from them again. There is a need to achieve senior positions for women. Gender sensitive planning tools should be applied.

Annex 3

Case Study Reports

CAMBODIA CASE STUDY - Ms Joyce Smith, WHO/Cambodia

The Cambodia case study has not started yet, as the study team has not finally been composed. Ms Joyce Smith, a team member from WHO, reviewed impacts of the conflict in health and efforts taken following peace accords in 1991. She summarised important strategies for the post-conflict transition.

Ms Smith pointed out a fundamental and unique problem faced in the transition in Cambodia. That is a depletion of educated professionals, which were targeted between 1975 and 1979, resulting also in the loss of professional role models. In 1979 efforts were made for replacement of the lost health workers by emergency training and upgrading of health workers, which were done by surviving health professionals and health workers from Vietnam. Training curricula were developed as well, however they were for the most curative focused.

Following the peace accords in 1991, and even before the election, developmental work has been initiated in health involving all the political factions. To name a few, working groups to discuss important health issues were created, health workforce survey was conducted, coordination mechanism (CoCom) was established. Upon the establishment of a recognised government, development of national health policies, budget and MOH structure were undertaken. Under a national health coverage plan, the concept of a minimum health package is being implemented at health center level with cost recovery system. TORs of health workers have been made in accordance with these policies and plans. However health workers are not adequately trained to fulfil the TORs, which place huge burden on primary health workers. The success of the health care delivery system and cost recovery depends on the performance of the health workers.

She pointed out limited donors' support on human resource development (HRD), saying that HRD has been the lowest priority in health sector reform and that donors have continued to pursue an emergency approach neglecting developmental aspects of HRD. Donors have wrong assumptions on HRD, such as the existing level of health knowledge amongst trained health workers is good enough, or HRD methodology of other countries can be applicable in Cambodia, and so on.

Involving all factional health services in health planning, sustained support to HRD and donor coordination mechanism are listed by Ms Smith as some of the most important strategies. WHO, being a neutral venue, enabled all factions to discuss health issues together.

It was suggested by participants to draw up some type of mapping, and put into it all major events. The similarity and difference between Cambodia and Rwanda was discussed. A historical review of eastern block's assistance and early western inputs and analysis of impacts were commented.

ANGOLA CASE STUDY

Dr Nsala Domingos, Ministry of Health, Angola and Dr Rui Gama Vaz, UNAIDS, Angola

The study team has completed reviewing the geopolitical, socioeconomic and health situation, as well as the impact of the prolonged conflict. It has identified critical factors affecting the status of the transition to development in health and eventually it has listed up necessary actions to facilitate smooth coexistence. The current situation was quoted as no peace and no war.

The team illustrated the damages on economy and health by the 30 years of the conflict; infant mortality rate 195/1,000; maternal mortality rate 1,500 per 100,000; life expectancy of 42 years. The urban population growing fast, 61% of whom are below poverty line. 3.7 million war-affected, with approximately 2 million killed. 70,000 maimed due to landmines. 1,200,000 IDPs. 15,000 abandoned children. 12 million landmines and new landmines. Seventy percent of the health structures are destroyed. There is a big geographical disparity in access to health, due to the fact that there are 272 private clinics in Luanda, while some provinces have one health unit for 12,000 inhabitants. Traditional medicine is common. The main causes of death for all ages in 1991-1995 were malaria, diarrhea, measles and ARI. Vaccination coverage of poliomyelitis is 25 % (no access to the UNITA-controlled areas), and 170 cases of flaccid paralysis were found in 1993, compared to 14 cases/year in 1974-1988 and 86 cases/year in 1989-1994. Trypanosomiasis grew from 3 cases in 1975, up to 7,522 new cases because it is impossible to control vector and people went back to infected areas. 2,700 cases of HIV/AIDS were diagnosed in 1997. Prevalence of 12% among pregnant women was reported. The rates are expected to increase due to the growing number of blood transfusions of victims of damage from landmines, increasing blood donors for cash, low capacity for HIV screening in blood banks and substantial population movements.

Inappropriate distribution of human resources is seen. More than 50% of MOH staff work in Luanda, 10,000 health workers have moved from the provinces, 60% of doctors work in the military health division. Due to their low salaries, health workers work only half a day, for the rest of the time they work privately to supplement their salaries. There are 385 doctors in all, of which 73 are from abroad, most of the latter are involved in disease control, provision of medicines and training.

The team has identified the following factors as critical to the coexistence of relief and development efforts:

- A. *Political factors:* the peace process is not consolidated and there is a need to prepare three scenarios (peace, war, between), demobilisation is not completed, even new soldiers are recruited. Due to the uncertainty, actions for assistance are not forthcoming.
- B. *Lack of information:* there is poor coverage and poor quality of health information. No information comes from private nor from the military. Agencies have their own health information system, leading to fragmentation and making it difficult to decide on funds allocation.
- C. *Impacts on population:* there is an increase in the urban population with high rates of unemployment, the majority of the population remains in poverty. There are high prevalence of communicable diseases, high risk of HIV/AIDS, low literacy rates.
- E. *Limited capacity of authorities and its consequences:* there is little institutional capacity

of the authorities to coordinate in particular the emergency-oriented NGOs who ignore national law and local rules/cultures and represent vertical approaches.

- F. *Lack of policy/strategy/vision in health reform and health system:* lack of vision of rehabilitation of health and education infrastructures (rehabilitation should be planned in accordance with defined intervention priorities and long-term prospects), low allocation of state budget for social services. While a large amount is allotted to defence, only 1% of the state budget is allocated to water and sanitation.
- G. *Limited human resource management by authorities:* no strategy for the allocation of health professionals or human resource management. There is an increase of private clinics, destruction of public health centres, maldistribution of doctors to the military and in capital, and finally there is low morale in health workers due to the low salaries.

The team stressed that the rehabilitation of health and education structures requires not only restoration of infrastructures, but needs to be associated with definition of priority interventions, institutional strengthening, human resources development and management capacities and increase of the health budget.

LIBERIA CASE STUDY

Dr Brigitte Touré, Panafrican Training Centre, Dr Lawrence Sherman, MOH/Liberia and Dr Tabeah Freeman, WHO/Liberia

The study team reviewed the geopolitical, socioeconomic and health situation as well as causes and the impacts of the prolonged conflict. It has identified possibilities of undertaking developmental works in selected areas during the conflict.

After introduction of the process and structure of the case study by Dr Brigitte Touré, Dr Lawrence Sherman briefed on the geopolitical and historical context and pre-conflict health system, which only catered for 35% of the population was curative biased and urban biased. In 1989, US\$18.8 million, or 6% of whole government's budget was allotted for health.

Health facilities were systematically destroyed during the conflict, and reduced by more than 60%. Health workers either fled, were killed or abducted, and only 1800 health workers remained after the seven-year conflict, compared to 5,000 before. One half of the 2.5 million population was displaced and over 150,000 persons were killed. Between 1990-1993 acute prevalence of malnutrition in Grand Gedeh County was 51%. Several outbreaks of haemorrhagic fevers were recorded. The national drug service (NDS) was not able to play its role of procurement and distribution of drugs for the country. Hence, with the consent of the government, the NDS became a NGO supported structure, supported by MSF/Belgium, UNICEF and European Union.

During the early days of the conflict, the government controlled about 95% of the country, hence law and order prevailed in most parts of the country with the exception of the fighting areas. However as the fighting spread to larger areas and numerous warring factions were created, the government lost most of its control. Numerous interim governments and peace accords were made and violated, causing serious distrust of the government and in sustainable peace among the international community. Eighty percent of the health services were provided by NGOs and UN agencies. For the coordination of NGOs activities, a local NGO, the Liberia Health Committee was organised. However the lack of policies and guidelines

at the MOH level regarding the operation of NGOs in the health sector undermined the functional coordination in health. External relief assistance was channelled either through NGOs or directly administered by various UN agencies. Although NGOs provided essential services, there were shortcomings such as sectoralism by NGOs or limited knowledge and experience of NGOs staff. Since the war went through Nimba county between 1989 and late 1990 and from 1992 onward there was no active fighting in Nimba county, which was considered a pocket of peace.

The team identified the following factors as critical:

A. Capacity building

Capacity building especially at the national level has been neglected due to the fact that even when an interim government was established, it did not have the necessary international recognition nor had resources. It did not have an access to all parts of the country. Even in the post-conflict time, many donors are adopting a "wait and see" attitude towards rehabilitation and development due to the lack of confidence. This lack of capacity means also lack of visions, policies and guidelines in health system development as well as in guiding and coordinating operational partners not only during a conflict but also in the current transition.

At field level, the external humanitarian community in their desire to help communities re-establish themselves has exacerbated the dependency syndrome.

B. Evaluation of performance of NGOs and UN

Most of the health services have been directly provided by NGOs and the UN system. However, there is no comprehensive track of funds and performance of NGOs and UN in the health sector. Sectionalism and limited qualification of NGOs are pointed out. National guidelines and policies were sometimes disregarded by NGOs. Accountability and transparency are missed.

C. Information

In Liberia, information meetings are chaired by the UNOCHA as a part of its coordination role. However, as pointed out above, a comprehensive picture of the relief, rehabilitation and development activities is not available.

D. Political factors

Although the general security situation in the country has improved, human right abuses are still reported. Donors hesitate to promote developmental programmes to some extent due to this.

E. Linkage between relief and development

Linking relief with development should begin with donors, who have unfortunate divisions between funds for relief and development. These divisions of funds hamper incorporating developmental work in relief programmes.

Annex 4

Outline for Case Studies **Strategic response in health in relief and development**

Background

Complex emergencies and post-conflict transitions are characterised by uncertainty. Authorities often need time to develop political consensus on the main policies, strategies and priorities. A wide range of external actors work under their own agendas with little coordination. An approach that incorporate elements of both relief and development activities is required to address the important issues in health.

Reference is made to "Health: guiding principles in health in relief and development" which has been drafted through a series of consultations with persons involved in an emergency and in the post-conflict transition. The following outline of case studies has been built on the guiding principles. The case studies will review dilemmas identified in the document, verify the principles, and propose actions and modalities to implement them. They might add other principles or might reject some of them as being not important nor feasible.

Goal of a case study

To identify critical health-related factors related to health in complex emergencies and in post-conflict transitions and make a proposal, in accordance with the given context, on how these factors could be facilitated during an emergency and in the post-conflict transition.

Objectives of a case study

- To review actual emergency responses which have taken place and analyse their link and impacts on health in the short and the long-run;
- To understand health problems faced in a post-conflict phase which inhibit smooth transition to development;
- To identify missed opportunities in health development;
- To propose appropriate health interventions during an emergency and in the post-conflict transition by external agencies.

There are two hypothesis a case study will look into:

- Current conflicts occur at different levels and intensities, during which some developmental work can be carried out. Quite often agencies work under prolonged low-intensive unstable conditions. Under such circumstances, agencies should seek for linkage between relief and development.
- The manner in which health response activities are implemented during an emergency, will strongly influence the scope for the post-conflict transition in health development.

The ambition for the case studies is to provide evidence to validate the guiding principles.

Methodology

Case studies will be undertaken by country study teams consisting of persons involved in relief, rehabilitation and development on the ground. The team could be composed of WHO staff, persons from the Ministry of Health, NGOs, UN agencies and researchers. The main outcome of the study is the preparation of a country health note.

Schedule

| | |
|--------------|---|
| April 1998 | Creation of a country study team and orientation of the task |
| April- Sept | Preparation of a country health note by the country study team |
| Mid-June '98 | Participation in a EHA/HQ workshop in Geneva to share the first draft country health note and other mid-term findings |
| August 1998 | Organization of a national conference by the study team to present and discuss the country health note |
| Sept- Oct | Final report and a project proposal of a specific health issue issemination of finding and recommendations (methods of dissemination to be identified) |

Guide for the country health note:

1. General and a short introduction: geopolitical and socio-economic review, type and course of conflict, cause, external political interest, historical background, government status, fighting parties, overview of the scale, scope and complexity of the conflict, location of violence, security situation, indigenous coping mechanisms and peace process.
2. Trend of health status over time and geographically; direct and indirect impact by the conflict on victims, health problems along the course of the crisis environment, health infrastructure (health system, human resource, etc.), and current problems and the status of health issues in the "post-conflict phase".
3. Health relief, rehabilitation and development actions during emergency and in the post-conflict phase; chronological listing of major events by major actors in critical areas*, assessment of roles, capacity and performance of the public, private and NGO sector and coordination.
4. Identification of critical factors affecting a smooth transition to development.
5. List of actions which could have been tackled during an emergency and which can be undertaken at present in terms of transition to development. The actions and modalities during

an emergency should be clarified in the social and political context, and if possible linked with life-threatening health problems. List up of expected or faced dilemmas if those actions take place.

6. A proposal for possible actions in general terms throughout the crisis in accordance with the guiding principles, for WHO and for other external actors.

Critical areas to be under review:

- Health information
- HIV/AIDS Control
- Capacity building for health

Annex 5

Agenda

| | |
|---------------------|---|
| 18 June 1998 | Chairpersons: Dr H. Siem, Mr D. Deane Rapporteur: Dr S. Hansch |
| 08:45 | Registration |
| 09:00 | Welcome by Dr J.-P. Menu, Chief DAC/EHA on behalf of Dr F. Bassani, Director EHA |
| 09:05 | Introduction by Dr H. Siem, Chief ICA/EHA |
| 09:10 | Briefing on project by Dr T. Yasukawa, EHA/ICA |
| 09:15 | Three presentations, followed by discussion |
| 09:15 | “UN initiatives in enhancing linkage between relief and development”, presentation by Mr D. Deane WHO/RMB and Mr E. Hein, CCPOQ |
| 09:30 | “Key issues and lessons learned on post-conflict challenges”, presentation by Dr A. Zwi, London School of Hygiene and Tropical Medicine |
| 10:00 | “Analysis of contexts of a crisis environment”, presentation by Dr P. Spiegel, Johns Hopkins School of Hygiene and Public Health |
| 10:30 | Coffee break |
| 11:00 | First Session: Guiding Principles <ul style="list-style-type: none">• Briefing on the draft document by Dr T. Yasukawa, ICA and Dr P. Key, Consultant• General comments• Working groups |
| 12:30 | Lunch |
| 14:00 | Working groups (continuation) |
| 16:30 | Presentations by working groups and discussion |
| 18:00 | End of the day |

19 June 1998

Chairperson: Dr H. Siem
Reporteur: Dr R. Gama Vaz

09:00

Second Session: Case study report

- Briefing on the methodology of case studies by Dr T. Yasukawa
- Presentations by study teams followed by discussion (45 minutes for each country) - Angola, Cambodia and Liberia.
- Suggestions for other countries and general comments.

10:30

Coffee break

11:00

Continuation of second session, case study reports

12:00

Lunch

14:00

Continuation of second session, case study reports

15:00

Summary of the meeting and discussion on future actions.

15:45

Closing

Annex 6

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