5
STRATEGY DEVELOPMENT AND PLANNING

Key points:

- ✓ Agreement on a health sector response strategy, including specific objectives and activity-level strategies, is essential for coherent, coordinated humanitarian health action. All main health actors should be engaged in defining these elements and they must be understood by all stakeholders. They must be agreed with the national and local health authorities, whenever possible.
- ✓ Assessment, analysis, strategy development and planning are iterative processes. The response strategy statement, which provides the cornerstone for all Cluster activities, should be developed and refined progressively (see figure 3b in section 3.1):
  - A *preliminary*, response strategy ***outline*** should be prepared early, within the first few days, and provide the basis for initial responses by Cluster partners and a framework for the Flash Appeal [see section 7.1] and a package of proposals for any CERF application [see section 7.2].[19]
  - A first, *more detailed* health sector response strategy statement should be prepared on the basis of the findings of the initial rapid assessment (IRA). It should be linked with development of the revised flash appeal and later the common humanitarian action plan (CHAP) that is required for the first consolidated appeal, if any, typically after within 2 months of onset [see section 7.3].

That strategy should be *updated* as and when necessary on the basis of new information from subsequent sub-sector assessments and situation monitoring, following any major change in the situation, and prior to the preparation of any new CHAP (and CAP).

[19] A preliminary "working scenario" can help in preparing such a preliminary, outline strategy – see section 3.3 and annex B8 of *Managing WHO Humanitarian Response in the Field*, Geneva: World Health Organization, 2008.

- ✓ The overall strategy, objectives and individual activity-level strategies must be reviewed and up-dated as and when needed.
- ✓ The HCC should guide partners in their choice of areas to work and activities to prioritize, and any pooled resources available to the Cluster should be used to fill the most critical gaps.
- ✓ Contingency plans should be drawn up to deal with foreseeable threats to health or health services.

Expected Health Cluster outputs

- ✓ A joint, regularly updated, health crisis response strategy with clear priorities and objectives for addressing priority health problems, risks and gaps in an equitable manner and promoting early recovery (including building capacity)
- ✓ Distribution of responsibilities among partners based on capacities to deliver in the field.
- ✓ A joint contingency plan for response to future events that could impact on the populations' health or partners' response activities

"HEALTH CRISIS RESPONSE STRATEGY" AND "ACTIVITY-LEVEL STRATEGIES"

A *health response strategy* is a concise statement of the overall approach to which Cluster partners should contribute with the aim of *reducing avoidable mortality, morbidity and disability* and *restoring the delivery of, and equitable access to, preventive and basic curative health care as quickly as possible and in as sustainable as possible a manner*. It should define the priority areas to be addressed during a given time period, the specific objectives of the Cluster/sector, and the approaches adopted to accomplish those objectives within that period.

Individual, *activity-level strategies* are the approaches adopted to accomplish specific objectives (such as preventing – or reducing the risk of – a measles outbreak, assuring a continuous supply of essential drugs, or re-establishing and upgrading the health information system) within a defined period.

In a crisis, planning horizon tends to contract and its scope becomes reduced to projects. The result is fragmentation, with proliferation of

special planning units that work in isolation. An agreed upon strategy, and the development of an overall macro-plan, can help reduce the fragmentation.

Selecting activity-level strategies is deciding how to address particular priority problems and risks in order to achieve the objectives and avoid any potential negative effects. For example:

- To limit the risk of a measles outbreak, one option would be a mass measles immunization campaign. But, if you deem that the current coverage is good enough, it may be better to strengthen the routine immunization systems while focusing effort and resources on other health priorities.
- If there is a shortage of drugs, options could be to import drugs in bulk, import drug kits, or purchase drugs locally. A choice has to be made taking account of various factors including speed of deliveries and the likely effects on drug supply arrangements in the medium term.

Some additional examples, and examples of unintended negative effects, are provided in Annex G.

Common "gaps" in relation to planning
Findings from 10 country case studies (2004-07)

Examples	Proposed remedies
No implementation plan relevant to the phase of the response (particularly structural rehabilitation) addressing the whole affected area. Implementation driven by agency capacities and mandates, availability of funds, and 'contextual opportunism', rather than needs (e.g. support to hospital capacity and tertiary care over primary care).	Conduct a joint evidence-based prioritization exercise, identifying major causes of morbidity and mortality, prioritizing preventive and curative health services to these causes. Agree on a minimum package of health services (including reproductive health MISP) to be delivered by each level of health facility, appropriate to the phase of the emergency. Develop a common action plan together with NGOs, affected community, and MoH, focused on health priorities, within the principles of primary health care, and, particularly in the early recovery phase, finding the balance between urgent service delivery needs and longer term system building.

5.1 DEVELOPING A HEALTH SECTOR RESPONSE STRATEGY IN CRISIS

The health sector response strategy in crisis is the principal tool for ensuring that the actions of all health actors are coordinated and, in particular, the actions of external health actors are well coordinated with, and appropriately support, those of the national and local health authorities and other local actors. It provides a framework for planning health response throughout the affected area(s), including the allocation of resources among areas.

Some basic principles

- ✓ Focus on ensuring the delivery of essential services initially; plan to broaden the scope only when essential services have been assured. It is easier to scale up the provision of health care than scale it down.
- ✓ When resources are insufficient to meet all needs – as is almost always the case – concentrate effort and resources where they can make difference. Diluting scarce resources across the board can be ineffective.
- ✓ Produce an initial strategy rapidly and improve it and make it more specific as more solid information becomes available, consensus with stakeholders is reached and resources materialize. Don't waste time preparing very detailed, comprehensive plans that could quickly become irrelevant.
- ✓ There must be clear, demonstrated links among (i) the identified priority problems, risks and gaps, and (ii) the specific objectives and chosen strategies. Alternative options for addressing the priority problems must be examined and the reasons for the choice of particular strategies explained in the strategy document.
- ✓ Seasonal variations and their usual effects on diseases patterns and service delivery and access, must be taken into account. This includes rainy and lean seasons, and seasonal upsurges in violence in some complex emergencies.
- ✓ The crisis response strategy should include phasing to ensure effective coverage of minimum initial services before providing broader essential services. It should address all aspects: human resources, facilities, equipment and supplies.

- ✓ Recovery should be promoted from the earliest possible moment, implying long-term thinking in the planning. Efforts must be made to use and strengthen existing structures and (re-)build local capacities, whenever possible. Potential negative effective must be considered and minimized.
- ✓ Cross-cutting concerns such as gender, HIV/AIDS, the environment and protection must be integrated into the planning process.

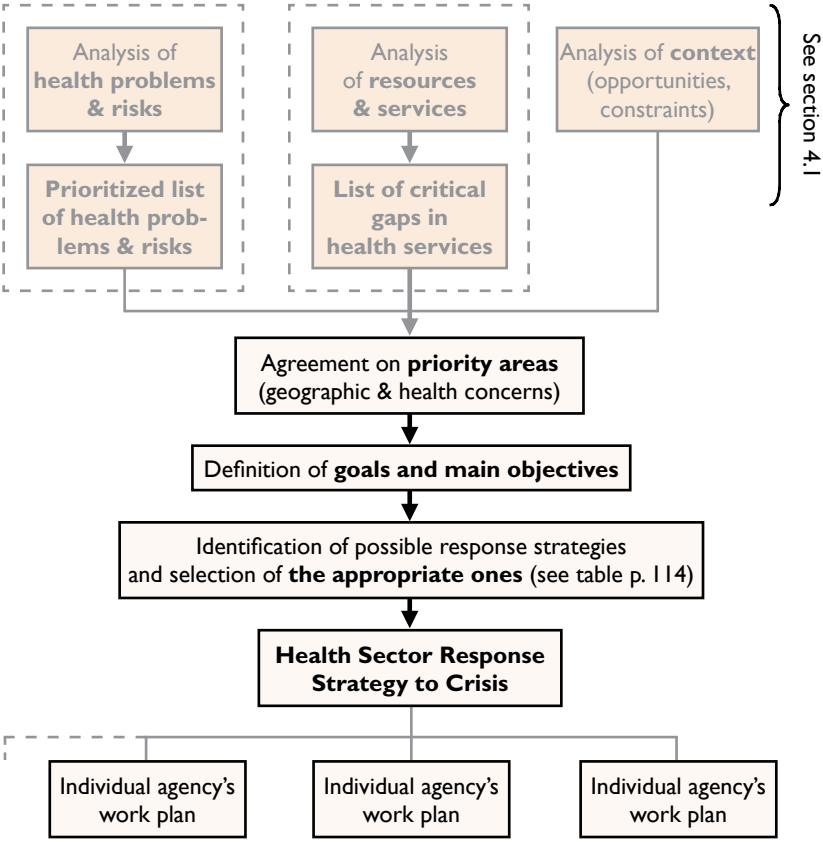
Steps in developing a health sector response strategy in a crisis situation

The process of developing a health sector response strategy based on the situation analysis is shown schematically in Figure 5a.

The context analysis, including issues of capacities, resources and constraints, is critical to the definition of objectives (which must be realistic), the analysis of response options and selection of activity-level strategies (which must be both appropriate and feasible), and the preparation of the overall health sector response strategy (which must also be realistic).

Fortunately, it is not always necessary to start from scratch when defining priority areas and strategies. Certain responses may be "givens" in many contexts on the basis of long experience in many crisis and the required managerial decisions are clear. For instance, a campaign of measles immunization is often an appropriate response in settings where routine systems have been disrupted. The probable need for such responses must be recognized and analysed. This is important, especially during the first, acute phase of response when time is at a premium. In general, however, specific objectives must be defined and activity-level strategies chosen on the basis of assessment findings and careful prioritization in order to achieve maximum health benefits with the resources expected to be available during the particular planning period.

Figure 5a From analysis to a health sector response strategy



Defining priority areas

☑ Define affected geographical areas in relation to the priority health problems and risks. They should focus on addressing the main causes of death and illness in the local context and the major constraints to delivery of and access to health care services.

Initially the focus will be on *ensuring that life-threatening humanitarian needs are met*, while always looking for opportunities to promote recovery and rebuild systems. As soon as *life-threatening needs* are met, the focus should shift progressively towards *re-building national systems and capacities* while ensuring that any remaining humanitarian needs are met.

Defining objectives

☑ Ensure that objectives address coherently the priority problems and risks identified in assessments, are tailored for specific phases of the response take account of:
- the context, the capacities and resources available;
- seasonal variations and the expected evolution of the overall situation; and
- any protection and human rights issues, the impact of HIV/AIDS, security conditions, any limitations on access, and any other constraints on people and the delivery of services, and differentiate among men and women, girls and boys.

They may also need to take account of *expectations* that must be met – the policies and values of the various stakeholders that will affect the evolution of the overall situation and the implementation of health-related activities. Specific objectives may include improving information and reinforcing systems as well as achieving direct health outcomes.

Selecting activity-level strategies

Response strategies must be *appropriate* – address the priority problems and risks effectively, coherently and efficiently in a manner suited to the local context, *and feasible* – able to be implemented in the local context and with the resources expected to be available. To the extent possible, they should contribute to "building-back-better".

☑ Choose strategies on the basis of an explicit, recorded analysis of the advantages and disadvantages of the available response options – the possible alternative ways of addressing specific problems and accomplishing particular objectives.

☑ Analyse options carefully to identify the most appropriate strategies – ones that will achieve the defined objectives while minimizing any potential negative effects (especially in a conflict situation). Note that short-term actions taken to address an immediate systemic problem in service delivery may have significant distorting effects on the entire health system in the longer term – see the examples in Annex G.

☑ Draw on experience in previous crisis in the same area or among similar populations in neighbouring countries. If actions are proposed on the basis of experiences further a-field, ensure a thorough analysis of the differences as well as the similarities

between the two contexts. What worked (or failed) in one context will not necessarily work (or fail) in another!

Identifying and choosing among alternative response options requires an analysis of the context as well as relevant health sector information. It also requires abilities to compare the current situation with other, similar contexts, to learn from the past, and to engage with a broad range of stakeholders possibly including new players (civil society, non-state actors, etc) as appropriate and relevant. It involves value judgements and requires diplomacy and political wisdom to ensure that the perspectives of all main stakeholders are recognized in the process of analysis and taken into account in the final strategy.

A matrix such as the one below may be helpful to map out and record the main issues/problems and response options.

Problem/ risk/ issue	Key situation analysis points	Specific objectives	Response options	Advantages (arguments for)	Disadvantages (arguments against)	Relevant experience from similar contexts
			1:	1:	1:	
			2:	2:	2:	
			1:	1:	1:	
			2:	2:	2:	

HCC and Health Cluster action

During the first few days

☑ *Where an inter-agency/health-sector contingency plan exists* for the type of crisis concerned, review the objectives and strategies envisaged in that plan and adjust them to the current initial working scenario. *Where no relevant contingency plan exists*, develop initial objectives and strategies from scratch based on the initial working scenario.

☑ Prepare a very concise statement of the overall goals of the health response, the priority problems to be addressed during the initial plan period (perhaps 1 month), the specific objectives for that period, the principal strategies to be applied, who will do what where, and the principal gaps (uncovered priority needs/activities).

Ensure that the initial objectives are realistic and focus on life-threatening humanitarian needs while capitalizing on any opportunities that may exist to initiate recovery straight away.

Focus on filling gaps in critical life-sustaining services in areas where large numbers of people are known, or believed, to be seriously affected, and filling gaps in information that are critical for determining needs and planning an appropriate response.

Try to make sure each organization taking responsibility for a particular area or activity has, or will have, the capacity and systems to support the planned field activities.

Once the initial assessment has been completed

☑ Elaborate objectives for the coming 6 to 12 months on the basis of the initial rapid assessment and as new information becomes available. Include both continuing humanitarian response and a progressively increasing focus on recovery. Take account of foreseeable seasonal variations and the expected evolution of the overall situation.

☑ Include projects/activities to consolidate or enhance, where needed, the capacity assure and manage health information and facilitate coordination while working to progressively reduce dependence on external assistance, as and when possible.

☑ Re-examine the defined objectives and strategies at regular intervals in the context of periodic progress reviews. Check whether

they are still appropriate and realistic. Revise/refine them if and when necessary in agreement with all concerned stakeholders.

☑ Prepare contingency plans for events (contingencies) that could impact on the health of the population and/or the ongoing humanitarian assistance operations of health-sector actors during the coming months. See section 5.5.

At regular intervals or after any significant change in the overall situation

☑ Review the strategy and the impact of the activities implemented, and make adjustments as needed, ensuring that it is adapted to the context as it evolves.

Strategies that are directed towards the humanitarian goal of reducing excess [avoidable] mortality, for example, can become inappropriate in a recovery or transitional context when excess mortality is under control and the goal has shifted to the reactivation of essential health services. Activity-level strategies can, and should be changed if they prove ineffective to achieve the set goals/objectives. If necessary, objectives may need to be re-adjusted, often reducing their ambition and scope.

WHAT TO INCLUDE IN A HEALTH SECTOR RESPONSE STRATEGY DOCUMENT

The document must present the priority areas, the objectives and response (activity-level) strategies and the rationale. The rationale must explain, concisely, the reasons – the justification – for the priorities and the chosen strategies. This will be very brief for the preliminary strategy document, more detailed for subsequent ones. It should:

- provide a concise analysis of the situation including the prioritized list of the main problems and their underlying causes, and explain the choice of priority areas;
- present the objectives for each main area of intervention (e.g. prevention and control of communicable diseases, injury rehabilitation, surveillance, drug supplies management) and the strategies proposed to achieve the objectives, showing how the objectives and strategies derive from the assessment findings and situation analysis; *and*
- highlight the operational constraints and inter-sectoral cross-cutting concerns that have been identified as being particularly important for health in the current situation and explain how they have been taken into account, and show how general emergency programming principles have been applied.

PHASED PLANS AND INCREMENTAL APPROACHES

In some situations it may be possible to define – and agree – from the outset a *phased plan* to address a particular problem. For example: "In a particular recovery context, there is a serious imbalance in the workforce, with a large shortfall of midwives, mainly in rural areas. A substantial investment is required to accelerate the training of new staff in this category. In the meantime, a package of incentives is envisaged for midwives willing to move to underserved areas for the next 3 years, when new midwives will have been trained. A comprehensive human resource development plan for the next 10 years will be launched with technical assistance provided by donor X."

In many cases, especially where there are conflicting perspectives and pressures, it is necessary to adopt an *incremental approach* and proceed gradually towards the set goals, taking into account the resistance and opportunities that emerge during the process. This involves getting consensus on *intermediate* objectives, achieving them, and then moving to a higher objective as soon as the context is conducive. Good monitoring, and perhaps a real-time evaluation, is essential to track the intermediate outcomes and facilitate agreement on the next, follow-on phase.

Additional guidance

- Annex G, on the CD-ROM – *Analysing response options; examples of negative effects*, adapted from *Managing WHO humanitarian response in the field*. Geneva: World Health Organization, 2008.
- IASC. *Need analysis framework, strengthening the analysis and presentation of humanitarian needs in the CAP*. Inter-Agency Standing Committee, CAP Sub-working group, April 2007.
- IASC, GHC. *Health Cluster guidance note on health recovery*. Inter-Agency Standing Committee, November 2008 (final version expected for 2010).
- Pavignani E, Colombo A, *Analysing disrupted health sectors – A modular manual*, Geneva: World Health Organization, 2009.
- UNDG, ECHA. *Transitional strategy guidance note*. United Nations Development Group and ECHA Working Group on Transition, 25 October 2005.

- Cluster Working Group on Early Recovery. *Guidance note on early recovery*. Cluster Working Group on Early Recovery in cooperation with the UNDG-ECHA Working Group on Transition, April 2008.
- United Nations. *Integrated mission planning process guidelines*. United Nations, 13 June 2006.
- UNDG, World Bank. *An operational note on transitional results matrices*. United Nations Development Group and World Bank, January 2005.
- IASC. *Women, girls, boys and men, different needs, equal opportunities. Gender Handbook in Humanitarian Action*. Geneva: Inter-Agency Standing Committee, 2006..

5.2 PREPARING THE HEALTH COMPONENT OF A COMMON HUMANITARIAN ACTION PLAN

The common humanitarian action plan (CHAP) is an overall strategic plan for humanitarian response covering all relevant sectors. It constitutes the core of a consolidated appeal (see section 7.3) but can also serve as a reference for organizations that decide not to participate in such an appeal. A CHAP includes:

- an analysis of the context and humanitarian consequences (humanitarian needs and risks taking account of the capacities and vulnerabilities of different affected population groups);
- scenarios – best, worst, and most likely scenarios;
- strategic priorities including clear statements of longer-term objectives and goals; and
- prioritized plans for each sector (of which health is one).

The CHAP/HAP is developed by the IASC/Humanitarian Country Team under the leadership of the Humanitarian Coordinator. Non-IASC members, such as national NGOs, can be included. Other key stakeholders in humanitarian action should be consulted, in particular the host government and donors.

HCC and Health Cluster action

Contributing to overall, inter-sectoral elements

The HCC will lead the discussion among the health cluster partners and consult with the national/local authorities in order to develop: (i) the section on the overall context and humanitarian consequences; (ii) strategic

priorities for the humanitarian operation as a whole, and (iii) general criteria for selecting and prioritizing projects.

In doing so, it should be ensured that:

- ✓ all current and potential health consequences are adequately taken into account;
- ✓ inter-relationships among public-health-related needs and risks are clearly recognized; *and*
- ✓ the situation and vulnerabilities of all distinct population subgroups are taken into account (depending on the context, subgroups might be based on ethnicity, disability, gender, age, HIV/AIDS, etc.).

Drawing up a CHAP health strategy

- ☑ The cluster should agree on a two-page strategy for the health sector (including psycho-social needs). The summary from a health sector Needs Analysis Framework (NAF) report may be used or information from an alternative, evidence-based, inter-agency needs and response analysis.
- ☑ Projects to support critical health system elements and health coordination should be included, when needed, as well as projects for the delivery of supplies and services. All should take account of cross-cutting issues (protection, gender and age considerations, etc.)

Selecting and prioritizing projects (for inclusion in the CHAP)[20]

- ☑ Arrange a special meeting to select and prioritize projects for inclusion in the CHAP and consolidated appeal. If the cluster is large, it may be useful to form a *technical working group* for this purpose including representatives each main group of stakeholders, e.g. government, large INGOs, large NNGOs, small INGOs, small NNGOs, other national institutions, donors. Elect a chair and co-chair at least one of which from an NGO or the Red Cross/Crescent.
- ☑ Review the criteria established by the Humanitarian Country Team for the selection and prioritization of projects in general and agree on the specific criteria to be used for health projects.
- ☑ Ask organizations participating in the cluster to prepare 1-page project sheets following the CAP technical guidelines and submit them to the chair and co-chair. Emphasize that the projects

[20] Edited from *Guidance for CAP Project Selection and Prioritisation*, IASC June 2004

should address agreed priority needs and support the implementation of the agreed health sector strategy.

☑ Review the proposals – discussion facilitated by the designated chair and co-chair. Send back to the originating organizations any proposals that do not meet the agreed criteria.

☑ Submit the selected proposals to the Humanitarian Coordinator/OCHA. The chair and co-chair should then participate in a peer (inter-cluster) review to ensure overall consistency in the proposals for different sectors.

The HC makes the final decision and is accountable to the Emergency Relief Coordinator for ensuring that projects included in the appeal are in line with the agreed overall humanitarian needs and strategic priorities.

Note that any support needed to assure the effective functioning of the health cluster, and the ability of the cluster lead agency and coordinator to fulfil their responsibilities, must be included in the package. Budget lines may be needed for, e.g. information management, communications, and evaluations.

WHAT SHOULD BE INCLUDED IN A HEALTH STRATEGY FOR A CAP/CHAP

A CHAP – section 3 of a CAP – should normally include:

✓ the priority health needs and risks;

✓ a corresponding health strategy with no more then five *objectives* for the health sector and no more then five key health *indicators* for measuring progress towards objectives;

✓ a list of the organizations that will contribute to this health strategy, and a outline or chart showing the complementarity between proposed activities;

✓ a brief explanation of how the cluster/sector group will monitor implementation and the achievement of objectives;

✓ the implications if the health strategy is not implemented.

The strategy must be evidence-based and clearly linked to one or more of the agreed overall strategic humanitarian priorities, and include the main organizations working in the health sector.

Individual projects must be reviewed and agreed upon by the health cluster/sector group and support the defined health response strategy (see next box below).

[Adapted from *Technical Guidelines for Consolidated Appeals*, IASC 2006]

SAMPLE CRITERIA FOR PROJECT SELECTION/ PRIORITIZATION

- ✓ Strategy: the project addresses priority areas in the agreed health crisis response strategy and will help to achieve specific agreed objectives using agreed activity-level strategies.
- ✓ Organizational capacity: the appealing organization has the technical expertise in country, capacity, and mandate to implement the project, or can mobilize this operational capacity as required.
- ✓ Population: the project targets one or more of the priority, vulnerable population groups identified by the IASC/ Humanitarian Country Team.
- ✓ Geographic area: the project will be implemented in a region that is considered to be a priority for humanitarian health action.
- ✓ Timing: the project can make a measurable impact in the time-frame of the appeal (usually one year).
- ✓ Other context-specific criteria: e.g. projects that promote gender equality, include a focus on HIV/AIDS (where this is a major concern) and/or help to build local capacity.

[Adapted from *Guidance for CAP Project Selection and Prioritisation*, IASC June 2004]

Additional guidance

📖 See the IASC web page devoted to the Consolidated Appeal Process at: http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=12. See also on the CD ROM, the documents Consolidated appeals 2009 guidelines and Consolidated Appeal for Liberia 2007.

5.3 SUPPORTING HEALTH SYSTEM RECOVERY

Following a *sudden-onset disaster*, the strengthening/re-building of local health systems and capacity can be initiated from day-1 by designing and implementing all emergency health programmes and activities in ways that contribute to that objective. The recovery

phase after a disaster provides a window of opportunity for "building back better" – ensuring an appropriate, sustainable health system, building preparedness systems and capacity to deal with future crisis, and instituting vulnerability reduction measures.

After a *prolonged crisis*, or towards the end of one, recovery is a complex and long process. Internal and external partners need to work together to rebuild the State's capacity to deliver health and other essential services while also re-establishing economic activities. Planning health system recovery should start early. Formulating sound policies, adequate strategies and flexible plans, are essential steps to provide a framework for action in a highly fragmented environment.

The post-disaster or post-crisis period offers important opportunities. The enthusiasm for reconstruction may be high, the generosity of donors considerable, and resistance to change reduced. Gender roles and responsibilities may have changed during a protracted crisis and there be opportunities for women's empowerment and increased levels of gender equality. If the health system before the crisis contained (as it is often the case) distortions and inequities, the recovery phase may offer the possibility of laying the ground for improvements. These opportunities must be seized.

Guiding principles

The following are a few basic principles:

- ✓ ***Think long-term***: be aware that decisions and investments made in the initial phases of a crisis may have detrimental long-term consequences extending well into the recovery and reconstruction phases.[21]
- ✓ ***Adopt a "systems" approach and focus on the six building blocks***: recognize that there are many inter-related components that contribute to the delivery of health care and that action affecting one component may affect all the others. Analysis and understanding of all health system components and of their interactions are the necessary basis of sound, non-disruptive interventions. Knowledge and understanding of the historical, political, economic and social background signifi-

[21] For example: health units may be built or expanded in towns or safer areas and become redundant when the situation reverts to normal; low-level health workers may receive ad hoc, short-course training leading to expectations of being integrated in the health system; multiple drug supply channels may be used to the detriment of the official ones; multiple information systems may be put in place undermining the functioning of a uniform one, etc.

cantly strengthen the analysis of the health system and, consequently, the effectiveness of interventions. The box at the end of this section outlines some key issues in relation to the six core building blocks of a health system, as defined by WHO.[22]

- ✓ ***Focus on goals and outcomes***: give attention to the quality, coverage, access and safety of services to ensure that they are responsive and efficient and produce improved health for all (equity).
- ✓ ***Promote –and capacitate – national leadership***: the planning and implementation of recovery activities must be led by relevant national authorities and agencies at central and sub-national levels. (Re-)Build the capacity of these entities, as needed, taking account of any constitutional changes that enable greater *decentralization* than before the crisis.[23]
- ✓ ***Work with new actors/partners***: develop working relations with international financial institutions and other development-oriented entities.
- ✓ ***Ensure coordination with other sectors***: efforts in health (and other basic social services) need to be planned and implemented in parallel with activities to achieve good governance and community recovery.
- ✓ ***Use the Millennium Development Goals* for health** (mid-decade goals) as targets to focus recovery activities following a protracted crisis. In such cases, it is rare that health services can be rebuilt as they were before. More or less extensive reforms are invariably needed. The Goals may provide a useful beacon to assess strategies and programmes during recovery.
- ✓ ***Work with and strengthen the capacity of local partners and civil society***, including those from poor and marginalized groups, to engage in health service delivery including management, monitoring and the development of accountability mechanisms.

[22] WHO, *Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, World Health Organization, 2007.

[23] There is need for an overarching, nationally-driven plan to which all donors agree, with a "lead actor" who provides and shares a clear vision, inspires and oversees joint assessments, and prepares policies, strategies and broad plans. The MoH should normally be the "lead actor" but, if it still lacks the adequate capacity, a respected international agency may play this role in agreement with the government.

- ✓ ***Promote a locally-driven and -owned reform and change agenda.***
- ✓ ***Ensure appropriate phasing***: policy and sector reform must not overload fragile institutions or overwhelm existing weak capacity.
- ✓ ***Align donor-supported activities with the government's strategy, policy and systems***. If this is not possible, donors should harmonize their approaches with an emphasis on developing mechanisms that will enhance not undermine the government's role in the stewardship of the health sector.

Note that *efficiency* must sometimes be neglected to achieve *equity*, for instance, using mobile units to deliver services in isolated and underserved areas.

HCC and Health Cluster action

Protecting and reinforcing local capacities from the outset

- ☑ Work together and with the MoH, as appropriate, to ensure that all emergency health programmes and activities are designed and implemented in ways that contribute to re-building local capacities. Try, in particular, to ensure that:
  - existing facilities and systems are used, reactivated and repaired, whenever possible – and that new, parallel systems are avoided, unless absolutely necessary;
  - existing in-country competencies are identified and used as much as possible;
  - local personnel are involved in all assessment, planning and response activities;
  - (re)training needs are identified and appropriate, task-oriented training provided as early as possible;
  - there is equality of opportunity in participation and training for women and men.
- ☑ Try to get agreement among all the main health actors on:
  - the importance of maintaining and, where possible, strengthening the MoH and sub-national level health structures; and
  - how to avoid denuding these structures. (Possibilities might include paying incentives to MoH staff to stay at their posts. Use imagination to find ways, together with partners.)
- ☑ Discourage all health actors from creating new parallel systems, unless absolutely necessary.

- ☑ Facilitate international/ national partnerships with and among NGOs to help build local capacity.
- ☑ Promote the Principles of Partnership reproduced in section 1.1.

Promoting the early recovery of health systems

- ☑ While still assuring public health action to protect lives and reduce avoidable disease and disability, give progressively increasing attention to recovery taking account of overall socio-economic conditions, the institutional capacity of government and non-state actors and the nature of the crisis, and differences between different geographical areas.
- ☑ Collaborate in post-conflict needs assessments (PCNAs) – usually led by the UN and the World Bank and carried out in close consultation with the national authorities – and other inter-agency, recovery-oriented, post-crisis assessments such as joint assessment missions and post-disaster needs assessments (PDNAs).
- ☑ While using the CAP to mobilize resources for some initial early recovery activities, when agreed with the HC and humanitarian country team, explore possibilities for funding more substantial recovery-related activities through bilateral or multilateral agreements including multi-donor trust funds (MDTF) and include priority activities in the UN Country Assistance Framework (CAF).
- ☑ Accelerate capacity building within national agencies to enable them, and national enterprises, to take the lead in rebuilding facilities and services and thereby accelerate the process of national ownership of the process and results. (Demonstrate the existence and willingness of national agencies to take on significant roles in the recovery process, and thereby accelerate the shift from dependency on external sources to self-reliance.)
- ☑ Identify well-functioning local agencies and enterprises that can serve as models or support for malfunctioning health facilities or services.

When the emergency is over and some external health actors are leaving, handover of health services to the government should be carefully planned – sequenced progressively, step-by-step over a defined period of time.

- ☑ Promote/support health workforce mapping/needs in light of health sector gap analysis.
- ☑ Promote (support the MoH) in the mapping and tracking of financial investments/contributions to the health sector.
- ☑ Encourage all health sector stakeholders to base financial commitments and recovery plans on evidence from recent health sector analysis and especially HeRAMS data as a basis for estimating drug and other material needs.
- ☑ Support the MoH and other health sector actors to develop a clear evidence-based stance on user fees (including identification / securing alternative funding where user fees are abolished or significantly reduced).

Additional guidance

- 🕮 Cluster Working Group on Early Recovery. *Guidance note on early recovery*. Cluster Working Group on Early Recovery in cooperation with the UNDG-ECHA Working Group on Transition, April 2008.
- 🕮 Pavignani E, Colombo A. *Analysing disrupted health sectors – A modular manual*. Geneva: World Health Organization 2009.
- 🕮 Smith JH, Kolehmainen-Aitken RL. *Establishing human resource systems for health during post-conflict reconstruction*. Management Sciences For Health (MSH), occasional paper No.3, 2006.
- 🕮 WHO. *Strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World Health Organization, 2007.
- 🕮 Islam, M (ed.). *Health systems assessment approach: A how-to manual*, Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project and Rational Pharmaceutical Management Plus. Arlington, VA, Management Sciences for Health, 2007.
- 🕮 Smith J. *Guide to health workforce development in post-conflict environments*. Geneva: World Health Organization, 2005.
- 🕮 WHO (2007) *Towards a framework for health recovery in transition situations*. Global Consultation on Health Recovery in transition situations. Montreux, Switzerland, 4-6 December 2007. World Health Organization, background Document.

THE SIX CORE HEALTH SYSTEM BUILDING BLOCKS – KEY CONSIDERATIONS DURING RECOVERY

The following are the core building blocks defined in *Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, WHO 2007. All need to be considered during recovery without loosing the essential focus on health outcomes:

1. *Leadership and governance*

Leadership and governance are key to set overall health policy and translate this into health strategies and annual plans that can be resourced and implemented, but are often seriously affected during a prolonged crisis/conflict. The following are some elements to consider:

- ✓ Capacity building to enable a MoH to assure the necessary leadership (may need technical assistance in the short term, and capacity building activities for the longer term).
- ✓ Formulating policies and strategies to give a sense of direction and provide a common framework for action (negotiation and sharing being as important as final product)
- ✓ Developing coordination platforms involving all critical stakeholders.
- ✓ Supporting decentralization by strengthening planning and managerial capacity at provincial and district levels. Responsibilities and procedures must be clear, adequate resources (human and financial) distributed, and management support provided.

Encourage health sector partners (including donors) to engage in strengthening health management capacity (at whatever level) as a standard part of any recovery plan/project proposal.

2. *Human resources*

To assure a competent, functioning, affordable health workforce it is necessary to:

- ✓ ensure the early establishment of a human resources database and information system for both short- and long-term HR planning;

- ✓ examine salary issues and recent trends in training and in- and out-migration, and potential recruitment and training of lay personnel for specific tasks; and
- ✓ plan early for appropriate human resources and their development based on sound reflection and analysis.

Avoid an undue expansion of the health network (without the human resources to manage it adequately or the funds to meet future recurrent expenditures) and ensure appropriate training and retraining activities. But avoid a host of inadequate *ad hoc* training activities. (Training of lower-level health workers may be justified in the short term but long-term planning for pre-service training is essential.)

The *contracting out* of services is sometimes proposed to scale up coverage of essential health services in an insecure environment and poorly resourced health sector (e.g. Afghanistan in 2008). It may indeed be useful when the State is virtually absent but contracting should be used with caution so as not to jeopardize the long term development of the State itself.

3. *Financing*

Realistic estimates are required for both the costs of recovery activities and the levels of funding likely to be available from the government budget, continuing (but diminishing) humanitarian funding, new development schemes, bilateral funding, various global funds, and loans from international financial institutions. Elaborating strategies and formulating plans without linking them to the resources realistically going to be available, is a futile exercise. The issue of user fees – whether they should be introduced, maintained or abolished – is likely to be contentious.

4. *Medicines and technology*

In case of a prolonged crisis, supply arrangements for drugs and other medical material will usually have changed considerably and become fragmented. The (re-)establishment of a central pharmaceutical store or similar mechanism must be carefully planned based on detailed analysis of the factors impeding the supply of essential drugs and supplies to the public health facilities. Promote the essential drug concept and standardized treatment protocols.

5. ***Information***

A first priority during recovery is to (re-)establish an appropriate Health Management Information System (HMIS) that collects relevant, reliable sex- and age- disaggregated data and provides a sound information basis for both short- and longer-term planning. Thorough health facility assessments will be needed to establish a baseline using existing data and through surveys. Factors impeding the recording and transfer of information from central to sub-regional and local authorities, and the transfer of reports from local to sub-regional and central authorities, must be identified. Epidemiologic surveillance and early warning systems must be mainstreamed into regular provincial and district operations.

6. ***Service delivery***

During recovery it will be crucial to strengthen primary health care services emphasizing the services listed in the table in Figure 3e (in section 3.3). This includes planning the restoration of service delivery, including expansion to underserved areas (difficult balance between politics, equity and efficiency) as well as introducing new service delivery models, where needed. Combine lessons from other countries with an understanding of local context. Specific areas such as blood safety, sterilization in health facilities, disposal of injections and sharp medical supplies, and medical waste disposal, will need to be addressed.

5.4 TAKING ACCOUNT OF CROSS-CUTTING CONCERNS

All activities must be planned taking account of human rights, gender and environmental concerns and risks and constraints related to HIV/AIDS.

Checklist for cross-cutting concerns[24]

Human rights and protection

☑ Do proposed strategies and implementation modalities assure equality of access to assistance and services for ALL population groups and adequate protection for beneficiaries and humanitarian/health workers?

☑ Might they reinforce existing patterns of discrimination or increase risks?

☑ Could activities or implementation modalities be modified to better assure respect for human rights and protection, especially for groups determined to be at particular risk (e.g. female-headed households, women and men with disabilities, people living with HIV/AIDS, adolescent boys)?

☑ Is there effective collaboration between the health and protection clusters in ensuring protection, treatment and psycho-social support for the above-listed groups at particular risk, unaccompanied children, and survivors of sexual and gender-based violence?

Gender

☑ Do proposed strategies and implementation modalities promote gender equality and minimize risks of sexual and gender-based violence?

☑ Might they increase existing inequalities?

☑ Could activities or implementation modalities be modified to better promote gender equality?

HIV/AIDS

☑ Do proposed strategies take account of the prevalence of HIV/AIDS and minimize the risks of transmission in a culturally appropriate manner?

[24] This checklist is based on key questions in the CHAP guidelines + add-ons for HIV/AIDS and psychosocial support

- ☑ Could activities or implementation modalities be modified to better provide for people suffering from HIV/AIDS and reduce risks of transmission?
- ☑ Are standard precautions being effectively implemented in all areas (the first priority before considering any other measures)?
- ☑ Are arrangements in place to assure continuing treatment for patients already on ART?
- ☑ Are preventive strategies that were in place prior to the crisis being maintained?

Environment

- ☑ Do proposed strategies and implementation modalities assure protection of the environment and natural resource base?
- ☑ Might they create additional unnecessary waste?
- ☑ Could activities or implementation modalities be modified to better protect the environment?

Psychosocial support

- ☑ Do proposed strategies involve a coordinated, multi-sectoral response that involves providing basic psychosocial supports to the population?
- ☑ Do proposed strategies facilitate conditions for community mobilization, community ownership, community control, community self-help, community support, and cultural healing practices?
- ☑ Do proposed strategies and implementation modalities take into account social considerations (safe aid for all in dignity, considering cultural practices and existing community resources)?

Additional guidance

- 🕮 Annex F, on the CD-ROM, which summarizes the main issues in relation to these concerns.
- 🕮 IASC. *Guidelines for gender-based violence interventions in humanitarian settings focusing on prevention of and response to sexual violence in emergencies*. Inter-Agency Standing Committee, September 2007.
- 🕮 IASC. *Guidelines for HIV/AIDS interventions in emergency settings*. Inter-Agency Standing Committee, 2003.

📖 IASC. *Guidelines on mental health and psychosocial support in emergency settings*. Inter-Agency Standing Committee, 2007.

📖 IASC. *Women, girls, boys and men, different needs, equal opportunities. Gender Handbook in Humanitarian Action*. Geneva: Inter-Agency Standing Committee, 2006.

5.5 DEVELOPING (IN-CRISIS) CONTINGENCY PLANS

The contingency plans referred to here are "in-crisis" contingency plans prepared to deal with possible future events ("contingencies") that could further complicate the current situation.

Some basic principles

- ✓ Events that could further impact on the health of the population or on the ongoing humanitarian assistance operations during the coming months must be anticipated.
- ✓ Contingency plans must be prepared to respond to possible new health threats and to ensure, as much as possible, the continuity of services and humanitarian assistance to the target populations. They should be included as annexes to the health crisis response strategy.

Events (contingencies) that might need to be anticipated include, for example:

- secondary disasters: recurrence of the primary hazard or secondary phenomena such as epidemics of communicable diseases or a forthcoming cyclone season;
- deterioration of the security situation, notably the possibility that renewed conflict could affect certain health facilities, cause [further] population displacements, or disrupt supply corridors;
- breakdown of in-country supply chains due to overburdened provincial services.

N.B. Seasonal variations such as rainy and lean seasons, and their usual effects on diseases patterns and service delivery and access, must also be taken into account but this should be integrated in the basic health crisis response strategy. Contingency plans should cover other, more exceptional events.

HCC and Health Cluster action

In collaboration with the MoH and other stakeholders:

- ☑ Identify and prioritize possible contingencies that, during the coming months, could impact on:
  - the health of the population; or
  - the ongoing humanitarian assistance operations in the health sector.
- ☑ Decide within the cluster, in coordination with the MoH and other main health actors, how such events will be managed – how the new health needs will be responded to and how operational support and services will be maintained if/when such events occur.
- ☑ Estimate the additional resources – human, material, financial – that could be needed to respond to the new situation, determine how they would be mobilized and where to pre-position stocks.
- ☑ Ensure the constant, ongoing monitoring of contingency stocks and their replenishment whenever needed.
- ☑ Write up a joint health cluster contingency plan that describes the anticipated scenario(s), specifies arrangements for immediate joint assessment and planning, outlines the response strategy, actions and resources that would probably be needed, and assigns specific roles and responsibilities for action if/when such events occur and for immediate preparedness measures.
- ☑ Disseminate the plan to all stakeholders and ensure that all cluster partners take necessary measures internally to be ready to fulfil their role/responsibilities if/when such events occur. If needed, prepare specific projects to enhance preparedness and seek to mobilize the necessary resources from donors.
- ☑ Regularly review (i) the list of possible contingencies and scenarios, and (ii) the contingency plan. Update them when necessary.

Additional guidance

- 🕮 IASC. *Inter-agency contingency planning guidelines*, Inter-Agency Standing Committee, November 2007.
- 🕮 IASC. *Contingency planning.* Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.