Increasing Global Capacity for Coordinating, Integrating and Transitioning Community Health and Nutrition in Response to Protracted Crisis and in Transition to Recovery:

Experience and Lessons Learned

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CORE Group's Humanitarian-Development Task Force is a consortium-led effort to increase community health and nutrition program learning and augment the evidence for community based approaches in the humanitarian and development contexts; increase global participation, coordination, and organizational collaboration to improve knowledge and build strategic capacity of stakeholders at the global and country level; and share relevant learning with USAID Missions, host governments, implementing partners and other key stakeholders.

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Introduction

Increased frequency and longevity of humanitarian crises and chronic complex emergencies due to disasters, forced migration, and disease outbreaks has left ~ 347 million people in need of assistance (i.e. 172 million people by armed conflict and 175 million people, by natural disasters each year, respectively). [1] Due to the cyclical nature of crises, there is a recognized need to improve the transitioning and exiting from humanitarian work to longer term routine services, once the crises has ended. Yet, few practical tools exist to guide these transitions and ensure progress to date is not jeopardized.[2] Moreover, little guidance exists on useful metrics to practically plan for transitions within the humanitarian-development nexus.[3,4,5]

Recent attention by the global community on the 'nexus' between humanitarian and development work has been instrumental in the creation of CORE Group's Humanitarian-Development Task Force (HDTF), with support from the U.S. Agency for International Development (USAID), Office of U.S. Foreign Disaster Assistance (OFDA). While there is not consensus on a harmonized definition of the nexus, the nexus can be defined as a way of connecting or linking humanitarian and development efforts, and to provide " *a reference frame for humanitarian and development actors to contribute to the common vision of supporting the furthest behind first and a future in which no one is left behind*" to transcend divides between the two areas, anticipate crises and work with local systems.[6]

This case study research is part of OFDA-funded collaborative with CORE Group entitled "*Addressing Gaps in the Evidence for Health and Nutrition in the Humanitarian-Development Nexus*." The purpose of this initiative is to increase global capacity for coordinating, integrating and transitioning community health and nutrition services in response to protracted crises and transition from crises to recovery. The overall program included the development of two tools (i.e. matrix exit tool and community health service delivery framework tool), accompanied by two prospective case studies and corresponding briefs, and two retrospective case studies on health systems strengthening (HSS) within the nexus and one HSS brief synthesizing findings. A CORE Group-led literature review included published and grey literature on primary health care approaches in the humanitarian development nexus and identified existing tools and approaches used in health systems strengthening, monitoring exiting and transitioning, and the adaptation of development approaches that impact the community level for emergency settings (i.e. Care Groups and integrated community case management (iCCM).

Objectives of this work

The **overall objective** of this work is to gain an understanding of health systems strengthening within the development-humanitarian nexus and develop tools for usage during protracted emergencies and in transitioning from chronic complex emergency contexts. In addition, we determined their usefulness for country program implementers during humanitarian emergencies, and transitions within health and nutrition within the humanitarian development nexus and documented these experiences in case studies and briefs.

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[1] Samarasekera, Udani et al. (2017) The Lancet, Improving evidence for health in humanitarian crises, Volume 390, Issue 10109, 2223 – 2224; DOI: 10.1016/S0140-6736(17)31353-3

[2] Gardner, A. Greenblott, K., and Joubert, E. What we know about exit strategies—practical guidelines for developing exit strategies in the field. C-Safe, September 2005.

[3] URD. Quality Compass Companion Book. June 2009.

[4] URD. Quality and Accountability Compass, 2018.

[5] Relief International. Systems approach: Relief International's systems approach in fragile settings – integrating relief and development.

[6] United Nations office for the Coordination of Humanitarian Affairs (OCHA) Organization. https://www.unocha.org/es/themes/humanitarian-development-nexus and Agenda for Humanity www.agendaforhumanity.org

Methods and Process

CORE Group-led Literature Review

The literature review confirmed that little evidence-based information, tools or guidance was available on two areas—use of exit indicator tools to guide humanitarian relief to development transitions, and guidance for the adaptation of more developmental community-based health approaches in relief contexts. The literature review also showed that community health service delivery approaches, such as Care Groups, integrated Community Case Management (iCCM), Infant and Young Child Feeding (IYCF) and Community-based Management of Acute Malnutrition (CMAM) Surge, mother to mother support groups and social accountability efforts can work in both humanitarian and development contexts.

Development of Save the Children's Case Studies – Sudan & Pakistan

A retrospective, systematic case study design was used to examine systems effects of two Emergency Health and Nutrition (EHN) programs in Pakistan and Sudan, focusing on the last decade (2011-2018) . Selection criteria for the countries included: ability to retrieve documentation, availability of key informants and project experience to provide key lessons learned. Both case studies were synthesized in a brief that describes Save the Children country programs which were in implemented in Pakistan from 2011 to 2018 and Sudan from 2013 to 2018.

The case studies were developed according to the following steps: (1) theory of change development, which included context, project response, health systems constraints and capacity and systems effects, (2) case selection, (3) data collection by case, (4) data analysis by case, (5) individual case report writing, (6) country case report writing, (7) country case report review and key informant interviews, and (8) cross-country analysis (Yin, 2014). An extensive literature review on the intersection between EHN programs and health systems strengthening, included 36 peer-reviewed articles, was the basis for the theory of change. Reviews of 63 program documents and relevant materials from Pakistan and Sudan were conducted. A codebook was developed, which included eight themes: quality of health services; coordination and policy setting; decentralization and management capacity; engagement with community organizations and societal partnerships; costing and financing; human resources; supply chain management; and monitoring and evaluation. Documents were analyzed according to the codebook using NVivo 11.0. In addition, to feedback from country technical teams, key informant interviews were conducted with project staff involved in implementation. A summary brief of the case studies from Sudan and Pakistan was also developed.

Development and Roll Out of Medair's Tools – Community Health Service Delivery & Matrix Exit Tool

A prospective case study design was used to examine the use of Community Health Service Delivery (CHSD) frameworks and matrix exit tools. There were several steps in the development of these case studies, as follows:

- The development of the CHSD tool was based on the literature review of key community-based approaches, to develop a summary of the evidence-based interventions and considerations for adapting or using approaches for emergency contexts.
- The matrix exit tool "spider diagram" was first developed in Democratic Republic of Congo (DRC) in 2012 and then adapted for wider use in fragile settings in low- and middle-income countries with incorporation of a new exit indicator menu of options, which were gleaned from global and country specific indicator reviews[7]

[7] Reviewed the following documents: Sphere, Interagency Standing Committee, WHO's Global Reference List of 100 Core Health Indicators, OCHA Humanitarian Response Indicators Registry, People in Aid's IndiKit, and internal documents: Medair Triggers for Response in DRC, Medair

- Rapid key informant interviews (n=4 for CHSD and n= 8 for matrix exit tool) with country staff from Middle East, Asia and Africa Medair country programs[8], following use and/or review of the tool (October/November 2019). NGO interviews were also conducted to garner feedback on the CHSD (n=2) and the matrix exit tool (n=2)
- Key informant interview data was triangulated with feedback during Medair workshop discussions in Nairobi, Kenya from 10 country programs (November 2019).
- Rapid interviews with external partner organizations were held to offer input on the usefulness of each of the final briefs (n=4)

These rapid, remote interviews were recorded by Skype and transcribed. The transcripts were analyzed and coded by hand, assigning labels which represented ideas in the text. Extensive notes were taken during country discussions at the Medair workshop. The following themes emerged from these compiled analyses: applicability of tool/plans , any unclear elements of tool, strengths of tool, weaknesses of tool, sustainability of the tool and suggestions for improvement.

Key Findings

Literature Review

Key findings from the CORE Group literature review, showed that for adaptation of development of community-based models for use in emergency settings, key drivers of success include the community's ability to safely participate and willingly mobilize during times of crises. For example, during the Ebola crisis, CHWs remained active and continued to provide health services. In addition, factors for success for community-based models within the development- humanitarian nexus are approaches that prioritize the leveraging of community level participation, mobilization of community-based health providers, and country ownership. Other findings on community-based models for protracted crises in the development-humanitarian nexus include the following (shown in Box 1):

Transition and Exit Guidelines (Iraq), Medair Health Location Exit Benchmarks (Iraq), Medair Country Strategy Plans, and Draft Guidelines for Transition from Health Facilities to Development (S. Sudan)

[8] Countries are not named, due to security and protection of country staff

Box 1. CORE Group Literature Review Key Findings

- Use of CHW AIM is critical to provide guidance on how to build capacity of CHWs during humanitarian crises, who provide much needed services in communities.
- Care Groups have proven effective in achieving positive health and nutrition outcomes in both humanitarian and development contexts. Specifically, in the humanitarian context, Care Groups have demonstrated effectiveness for behavior change and rapid dissemination of information, peer support, and created a system for monitoring, screening and referrals, when the model is adapted.
- iCCM is gaining momentum as an effective, integrated community-based strategy to reduce morbidity and mortality. Leveraging the participation and mobilization of CHWs is central to iCCM.
- Infant and young child feeding (IYCF) including IYCF-E (emergencies), have been identified as a critical to prevent child malnutrition through integration across different sectors including food security, WASH, education, and child protection.
- For CMAM surge, the support of government through existing integration of CMAM programming into the health system is key.
- Coordination and collaboration across all stakeholders, departments and sectors is a key gap and missed opportunity. There is a need for greater evidence and learning on coordination and collaboration.
- There is a need to strengthen monitoring and evaluation efforts and document program learning around the Humanitarian Development Nexus.

Summary of Save the Children's Case Studies – Sudan & Pakistan

Findings are summarized in Table 1, according to health systems elements, across eight analyzed themes on health service delivery. In Sudan, programming centered on primary care, including integrated management of childhood illnesses (IMCI), malaria and malnutrition treatment, vaccinations, antenatal care (ANC), delivery care, and postnatal care (PNC). Programming in Pakistan involved the introduction and expansion of Family Planning (FP) services in select facilities.

While not explicitly studied, both countries progressively increased their orientation towards systems support and strengthening, with financial transition of facilities (Sudan) and staff (Pakistan) to the government over cycles of implementation. In addition, projects in both countries generally respected fundamental principles of alignment to national policies (sometimes supporting the updating or operationalization of policies) and coordination with government structures. At decentralized levels, this coordination may have contributed to building some capacity through learning-by-doing, notably through regular and joint reviews of data for management decision. Building human resources was seen as a major contribution of projects to health systems, notably by developing technical skills of health providers and task shifting/sharing, and via management and information systems. Projects in both countries contributed to quality improvements in health services. While health financing wasn't directly addressed per se, some project activities resulted in positive evolutions in health financing. In both countries, some parallel systems were initially set in place (i.e. in Sudan and Pakistan, set up a parallel procurement and supply chain management system). Not enough information was found on establishing quality assurance systems, even if/when quality of care was deemed a priority. Informant interviews shared that the system shifts of the projects evolved over time, and was negotiated based on

opportunity and constraints, rather than being strategically established. In both countries, local- and district-level government coordination was, at least initially, stronger than with national entities.

Key Elements of Medair's CHSD & Matrix Exit Tools and Relevance to the Nexus

1. The **CHSD framework tool** assists in the planning, assessment, and adaptation of community-based approaches and interventions traditionally used in the health development sector for use in humanitarian emergencies. The framework includes two key elements 1) a table which can be used to gain an understanding of key community-based approaches and interventions from the development sector for use and adaptation in emergencies and 2) a checklist which provides program considerations when selecting and adapting a specific community-based approach(es) for use in your country, which are aligned with current evidence and innovations. The aim of this tool is to: 1) Provide guidance on how these approaches, used in development settings, which are critical for improved health and nutrition outcomes, can be used during emergencies and 2) Provide key points to consider for applying these approaches for emergency contexts and can be helpful in creating country action plans. The framework is useful for any implementing partner such as a Ministry of Health/government, non-government organization (NGO) or other humanitarian organizations who want to use community health service delivery approaches in their emergency responses. The tool is relevant for the nexus, as countries are planning for use of community-based strategies and approaches during emergencies. In addition, the tool can help countries through how health systems (can be transitioned post-emergency, in terms of planning for workforce; which organizations to transition activities to, as well as cost and timeframe needed for successful transitioning. The tools is based on current evidence for health and nutrition community-based approaches; however evidence is limited on various approaches around health, with several nutrition approaches highlighted. In addition, the tool should continue to be tested with other countries and implementers, as the tool was only tested with a few countries and implementing partners, to see if additional modifications should be made.

2. The aim of the **matrix exit tool** is to provide visual metrics to monitor contextual readiness and guide planning for transition from humanitarian to development health and nutrition services. The usefulness of the adapted exit matrix tool for preparing and monitoring the transition from acute or chronic complex emergencies to long-term development health actors was assessed and documented, which informed further modifications to the tool. This tool is for use by stakeholders who implement humanitarian interventions. The purpose of this tool is to aid in developing and monitoring their health and nutrition exit strategy and transition readiness at customizable levels (facility, location, country exit), and over customizable periods of time--weeks, months, quarters. The tool and the results of the tool can be shared and adapted for community leaders, ministries of health and other government officials, health or nutrition clusters, local or international NGOs, donors and others.

   The matrix exit tool findings can be used to advocate for prioritized areas for the nexus with country governments at national and/or subnational level, as it provides a means to show progress over time, with regards to selected indicators and associated interventions. In addition, the tool can be useful in identifying and coordinating specific activities for continued support by the government and key implementing partners, as the data can be shown and discussed according to specific timeframes (weeks, months). Finally, once activities and timeframes have been discussed, the tool can be helpful in planning for discussing adequate financial and human resources for the transition with the government and implementing partners.

Key Lessons Learned from CHSD and Exit Tool Case Studies

Table 1. Key lessons from case studies on countries' experience with the CHSD Tool (n= 4)

▪ **Use of tool:** Somalia, Syria and Lebanon Medair country teams discussed how they used the tool to identify and prioritize areas to adapt community-based approaches, and to examine resources they could use to monitor alongside health facility interventions.
▪ **Plans to use tool** In terms of plans for using the tool, Bangladesh, and Jordan mentioned how the tool was used for preparedness in the design and implementation of community-based interventions, such as Care Groups.
▪ **Unclear components of the tool:** Some country members said the content could be more user-friendly and streamlined, including more clarity on purpose and '*how*' the tool could be applied. Most country implementers interviewed, mentioned that the CHSD tool was easy to follow, nicely organized and user-friendly, with clear short descriptions of interventions, which were easily digested by staff members.
▪ **Strengths of the CHSD tool** The tool was seen as comprehensive with different approaches laid out in one framework, and countries felt information was useful to improve/begin implementation and provided a good overview of intervention options. While countries felt that the tool would be useful for planning short-term emergencies and for longer term development activities, more resources/links to interventions (i.e. additional case studies or how to operationalize the checklist) was thought to be useful. Other strengths were that the tool: "*provides flexibility to country leaders to pick which intervention is applicable to their context," contains key summaries of global guidance [which] provides questions for reflection and good for "non-technical*" people.
▪ **Weaknesses of the tool:** Reported weaknesses of the CHSD tool varied from assumptions of a high level of country staff knowledge for the various community-based approaches to difficulty in compiling and showcasing all references and e-resources for various approaches to countries.
▪ **Suggestions for improving the tool:** A few countries mentioned more work could be done on clarifying the tool's purpose, with more information toward field use (e.g., including different categories of interventions), as shown in the below quotes. Country teams also relayed that key references and links should be available, at the end as an appendix. In terms of content, it was suggested to provide *do's and don'ts*/strengths and weaknesses in the third column of the table for each intervention and elaborate on descriptions and key considerations for each intervention. Countries also asked for restructuring of checklist, more user friendly guidance on how to use the checklist

Table 2. Key lessons from case studies with countries' experience with the Matrix Exit Tool (n= 8)

How countries use or plan to use the tool: DRC and Iraq country teams discussed how they used the tool to identify and prioritize areas to monitor at the health facility level or at certain timepoints (i.e. quarterly).In terms of plans for using the tool. Bangladesh, Iraq and Somalia mentioned how the tool was used for preparedness with partners and making decisions for exiting.
Unclear aspects about the exit tool: While most countries stated that the exit tool was easy to follow with user-friendly indicators it was largely dependent on country staff's use and understanding of Microsoft Excel. Countries discussed the need for more guidance on definitions of indicators and scoring (i.e. set target indicators to a 1-5 scale); distinguish between "*program quality*" vs. "*quality*" with additional guidance on the spider graph.
Strengths of the tool: The main strengths of the tool was that it allowed countries to visualize progress and make objective decisions about monitoring/exiting. Countries also discussed the flexibility of indicators and the ability to customize and change indicators to the context. Other strengths mentioned were that it holds teams accountable for assessing progress/ensuring quality of interventions, can help to understand why interventions succeed or not, creates a formal process for monitoring/evaluation, can be reused for different interventions, and can aid in determining what indicators to focus on and foster preparedness at the earliest time possible. Another positive was the auto-filling function of the spider chart.
Weaknesses of the tool: Reported weaknesses of the tool varied from complexity of selecting/adapting indicators to the time/training for tool and the need to harmonize/compare across indicators. One limitation was that the tool didn't allow measuring and monitoring indicators within short timeframes (e.g. GAM rate).
How the matrix tool aids in thinking through sustainability of interventions: The exit tool was seen to be useful to show donors progress on exit criteria and demonstrate to partners on how to carry out services sustainably. Some drawbacks of the tool was that it specifically selects and examines health and nutrition indicators only not insecurity or environmental factors or capacity of partners unless these indicators are intentionally selected on exit. Not all reviewers were aware that the indicator menu was fully customizable on which indicators they could choose to use or not including indicators related to insecurity context and partner capacity. This speaks to the need to have additional training on the tool and its customizable drop down timeframes based on the emergency intervention, including that both short term and long term emergency intervention indicators are available within the tool.
Ideal timeline for use of the exit tool: Countries relayed that the exit tool was ideal for longer-term programs (e.g. minimum 6 months) rather than short term emergency responses. The tool was useful for determining exit indicators at the beginning of projects.
Suggestions for improving the tool: A few countries mentioned that additional instruction/clarifications on scoring indicators was needed. Others country suggested incorporating weekly/monthly monitoring.

Key Lessons Learned

For the CHSD case study, brief and tool, key lessons learned were:

- The CHSD tool provides resources for country teams to gain knowledge about the range and scope of community-based interventions for use and adaptation in emergency settings.

- For use of the CHSD Tool, assume that country staff possess varied levels of knowledge of community-based interventions used in development contexts. In addition, information is needed in countries on how to use and/or adapt these interventions to emergency settings in low- and middle-income countries.

- It's important to provide technical updates to country team members, implementing partners and government staff on evidence and experience with implementation of community-based interventions. This is important in making informed decisions about community-based programming for emergency use.

For the matrix exit case study, brief and tool, key lessons learned were:

- The matrix exit tool can guide emergency preparedness and exiting from an emergency to routine health services, through use and application of an exit tool

- The matrix exit tool can also be critical for:
    - For preparedness planning, in selection of evidence-based indicators for protracted, complex emergencies
    - For the collection and use of indicator data to guide future exiting efforts, monitoring and evaluation; as well as elucidate what has/what hasn't worked on a routine basis

For health systems strengthening, key lessons learned were:

- Advocate to influence policy makers, as part of preparedness planning, to facilitate work at local level and influence national level. This includes exploring synergies between national advocacy and program implementation.

- Create space for coordination and management of government and implementing partners.

- Invest in human resources, which involves training on clinical skills and supervision, coordination of different types of cadres (Lady Health workers, health providers) and coordination with government for progressive integration of staff within government payroll (Pakistan).

- Find efficiency gains in supply management, build conditions for quality of care, and balance between prevention and curative services for stronger health systems.

- Improve quality and utilization of data, including providers' use of data for decision-making

- Invest in quality evaluation for projects with a systems strengthening role. Combined with improved learning and evaluation, mid-size interventions have the potential for a positive impact on systems strengthening.

- Better benchmarks, collaborative learning, mutual accountability, and commitment to evaluation can help projects drive innovations, which expand the capacity for local performance of health systems. This can be through task sharing, developing new health cadres, expanding linkages to human capital, and new partnerships.

- Strengthen a key relationship or efficiency (i.e. coordination of task sharing) at sub-national level.

- Consider innovating to develop 'stress tests' for key structural health systems elements such as drug procurement, supply management, and health information systems. Though abolishing parallel systems is widely desirable, stress tests—if they can be developed and their reliability proven—could signal to projects whether to accept or reject gap-filling measures, based on data.

Conclusions

Limitations

There were a few gaps not addressed by the case studies. For the HSS brief, because systems elements were not documented from the beginning, there was a lack of data and documentation on several aspects of health systems strengthening in Pakistan and Sudan (i.e. information on large scale sustainable financing, human resources, and task shifting, for example). In addition, the case studies and brief for health systems strengthening were limited by donor mandates that did not include health systems strengthening as a component of data collection and program monitoring and evaluation, so the data was collected retrospectively. For the CHSD and matrix tool, there was little evidence or guidance on tools for exiting or adapting community-based approaches to emergency settings, therefore the tools were developed with little information. The CHSD approaches chosen for health and nutrition, were based on available evidence.

Opportunities to address structural and political limitations

The information presented in the case studies and briefs can be used to advocate to governments and donors, in terms of setting priorities for health systems strengthening, according to government priorities, allocated funding, agreed-upon timeframes, and through coordination with implementing partners. In addition, better metrics, and benchmarks are needed for the measurement of both process indicators and outcome indicators around the nexus. Further research is needed on "how" to collect and use of data for program design, implementation, and real-time decision making to inform on the nexus. These efforts should consider sustainability of implementation of activities and interventions post-emergency. In addition, during the transition from emergency to development efforts explore ways to continue to strengthen roll out of both preventative and curative interventions within routine health services.

Key Considerations for Future Programming Around the Nexus

- **Optimize options**: Tools are needed to help countries review and select community-based interventions at the start of an emergency or optimize community level options during an emergency response, such as the CHSD tool

- **Preparedness planning and program design**: Aiding in emergency preparedness planning and program design for emergency health and nutrition interventions at the community level in low- and middle-income countries is critical, and can be met by tools such as the CHSD tool

- **Coordination:** Use of the CHSD tool may facilitate coordination with government efforts and implementing partners/projects in the selection and implementation of the community-based interventions for emergency settings

- **Advocacy:** Both the CHSD and matrix exit tools can be used to advocate with government and implementing partners to explore and advance synergies and partnerships to ensure continued quality implementation and continuation of services

- **Collaboration:** Both the CHSD and matrix exit tools can create dialogue and advocate with the government, implementing partners, and donors to identify and meet needs of the population, in transitioning from emergency to development, through use of the information from either tool

- **Measurement and Data for Decision Making**: More metrics – on process and outcomes – for the nexus is needed, including better indicators and benchmarks of success and qualitative measures of "how" transitioning can occur, key gaps, including negative and positive aspects of the process for linking humanitarian to development efforts and vice versa

- **Structural:** Funding and government prioritization is needed to better understand health systems strengthening within the nexus, both at the global and at the country level

- **Evidence-Based**: Data is needed to invest in key actions for sustainability, for action planning and advocacy, to build on achievements, and to ensure continued health and nutrition services for the nexus