Brief: Strengthening Health Systems in the Humanitarian-Development Nexus Experience and Lessons Learned from Pakistan and Sudan

December 16, 2019

Background

Nearly 132 million people are in need of humanitarian assistance with one of every four children in the world living in a country affected by conflict or disaster[1]. While it is well recognized that *"important, systemic changes…can be made in international assistance efforts to meet and lessen the need for aid while also complementing local development efforts*,"[2] there remains consistent challenges in the transitional periods between humanitarian relief and development that potentially undermine local stability and burden systems capacity. 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). CORE Group has partnered with Save the Children and Medair to specifically address the operational evidence gaps around health and nutrition in the humanitarian-development nexus and strengthen research around effective interventions or adaptations. The HDTF and CORE Group aim to improve the understanding of transition points within dynamic states of protracted conflict, which inherently fluctuate between humanitarian relief and development, and vice versa. The focus of this brief is to summarize Save the Children's health system strengthening emergency and nutrition programming in Sudan and Pakistan to:

1. Recommend opportunities for improving HSS in its EHN programs;
2. Share gaps and lessons learned to inform on "how" to improve the strengthening of systems for health-capacity, sustainability, and resilience - while responding to the immediate needs required in emergencies

Emergency Health and Nutrition (EHN) projects often are characterized by externally driven events and crises (i.e. political, economic, natural events and disasters), multiplicity of actors (i.e. donors, implementers), weak national systems and large amounts of funding marked by short time frames. Both implementation and evaluation of health systems strengthening (HSS) are challenged by the strong demand for achieving results to lessen human suffering due to emergency combined with a rapid influx of resources. The systems effects of EHN programming require further examination, given less is known and documented about these effects within these contexts. Two Save the Children-led case studies, carried out in Sudan and Pakistan examined the interaction between project efforts and observed

[1] Global Humanitarian Overview: United Nations Coordinated Support to People Affected by Disaster and Conflict, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2019; https://www.unocha.org/sites/unocha/files/GHO2019.pdf
[2] "The Humanitarian and Development Nexus" webpage, ImpactfulAid, https://impactfulaid.com/the-humanitarian-and-development-nexus/

changes in critical health systems functions over the duration of each project (Saraswati et al., 2019, Sarriot et al, 2019, Sarriot et al, 2019).

Methods

A systematic, embedded case study design was used to examine systems effects of two 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. This brief describes case studies from 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. In addition, feedback on the brief's content and usefulness was conducted through rapid assessment interviews (n=4).

Key Findings

Country level impressions of the content of the brief are summarized and Table 1. Findings according to health systems elements, across eight analysis themes (Sarriot et al. 2019; Khalsa et al. 2019, Sarriot, et al. 2019- submitted) in projects that prioritized service delivery are summarized in Table 2. 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.

Projects in 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. 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 and 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. 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 systems orientation 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. The case studies and this brief were largely found to be useful for program design, yet challenges in ascertaining health systems strengthening were noted by country advisors. Findings from interviews on the content of the brief was assessed below in Box 1:

Box 1 Rapid Feedback Assessment, on Brief Content

Usefulness of brief and case study content	*The brief was noted to **help in program design, program development and can aid with advocacy efforts with donors and government**.* *"gives a bird's eye view of what happened for the project- in crisp, clear manner"* - Pakistan "*makes emergency responders more conscious of documenting and reporting health system strengthening effects of humanitarian programs'* – USA
Content of brief and case study content	*The brief was seen **as comprehensive**.* *It pretty much covers the health systems elements and key goals –[provides] a broad base understanding of where we started off and what we were able to achieve"* – Pakistan
Key lessons and challenges for health systems strengthening	**Need to understand the priorities of the government and implementing partners** for advocacy "*While responding to emergencies, [important to] build capacity of health care workers to address challenges facing service delivery and advocate to the government allocate more fund to strengthening health systems.*" - Sudan "*The weaknesses in the planning for strategic plans for health and nutrition…-sometimes is based on a narrow scope on what we feel we can get funding for….. the actual context and content of what we learnt is on the backburner*" – Pakistan *"Advocacy at the national level takes time and may not happen quickly….the amount available at national level is not enough to fund gaps in health funding [seen in health systems strengthening], especially if we want to replicate a model in other areas.* – Pakistan

Limitations

Both Pakistan and Sudan case studies, were limited in data availability on health systems elements, given health systems strengthening was not donor mandated nor collected systematically. In addition, data were collected retrospectively and limited to availability of country personnel and available information in project reports and documentation. Finally, country rapid assessment interviews on feedback on content of this brief and the associated case studies was only from a few countries.

Table 1 Case Study Findings, by Health Systems Element, Sudan and Pakistan		
Health Systems Elements[3] *(key goals)*	**Sudan**	**Pakistan**
Country Context	• Ranked 5th highest on the world fragility index, constant state of crisis post-independence from South Sudan • Used community-based strategies to build capacity of health system across Health; Nutrition; Water, Sanitation, & Hygiene (WASH); and Child Protection (CP) sectors **Darfur – Two projects** • *Promoting Resilience among Community in Darfur Environment (PRIDE) I-III and Partnering to Respond to the Needs of the New IDPs and Conflict Affected Populations (PRECAP) I-II* • $6 million USD 4 years+ to reach 926,000 beneficiaries **Kordofan – Two projects** • *Greater Kordofan Lifesaving Intervention Package (GKLIP) I-III and Partnering for Effective Emergency Response in Greater Kordofan (PEER) I-II* • $6.1 million over 4 years targeted to reach 2.1 million beneficiaries	• Known as 4th largest population of IDPs worldwide due to conflict forced migration + natural disasters • EHN program mobilized to meet emergency health needs with a focused effort on FP in Pakistan's vulnerable populations by scaling up health facility services in 3 regions • Used multi-level capacity building intervention to strengthen responsiveness to RH needs, through building capacity *within* Save the Children systems, systematic integration of FP in SC, developing, implementing, and monitoring FP programs serving IDPs • In Sindh and KPK provinces, Pakistan, there were three phases of project • $2.9 million USD for 7 years and 92,942 beneficiaries (new acceptors of FP) • Evolution of project was to increase the number of new modern FP clients and improve quality of treatment • Use management information data for programmatic decision-making
Direct Health and Health Services Achievements - ***Achievements (services coverage and quality, outputs, and outcomes)***	**(+)** Central focus on increasing accessibility of quality health care services to internally displaced populations (IDPs) and host communities, inclusive of infrastructure, human resources, management and technical support, health facility commodities, nutrition centers and mobile outreach services **(+)** Complemented with utilization of community networks for WASH and child protection **(+)** Designed to hand over health facilities and activities to the MOH or local community- based organizations **(-)** Limited information available on whether achievements realized under the project were sustained post-implementation	**(+)** Expanded emergency health services and supplies for FP (FP) to refugees **(+)** Supported facilities, which expanded services and uptake of FP to both displaced and host populations **(+)** Additional needs of the community identified by trend analyses in facility reports, shared with DOH and donors, to identify additional community needs

[3] (+) are positive aspects of HSS elements, followed by (-), which were negative aspects

National coordination and policy setting - ***Evolution toward humanitarian polices at the national or regional level*** - ***Signs of ownership and commitment to policy, through different levels of health system***	**(+)** Government coordination with humanitarian partners ultimately enabled and supported the implementation of health interventions by the MOH, Save the Children, and other partners **(+)** Fostered MOH ownership through strong relationships and close coordination of activities, all signs of commitment to national policies to deliver an essential package of health services **(+)** Updated national guidelines for health interventions as a result of project activities	**(+)** Obtained project approval with central and provincial levels and primarily coordinated at district level to implement at frontline and community levels. Central level advocacy was a secondary to implementation and was predominantly carried under the FP2020 movement **(+)** Demonstrated the value and possibility of expanding FP services within MOH structures, and attracting more implementing partners of reproductive health services, such as IRC, CARE< Medical Emergency Relief International and Columbia University **(-)** Contributed indirectly to central policy and governance capacity
Decentralization and Management Capacity – - ***Decentralized MOH system uses processes for program learning and management course correction based on information and limits or corrects displacement of other essential routine services by emergency response***	**(+)** Designed ENH program to expand essential primary care services in geographical areas where no services existed/ services very weak **(+)** Several indicators— service delivery outcomes, transition strategies, and handover of activities and facilities to the MOH— show some gain in MOH capacity **(+)** Service delivery sites were eventually handed over to the MOH as Save the Children progressively transitioned out of these areas. **(-)** Restrictive national level policies on NGO movement and program monitoring **(-)** Changes in the MOH's use of processes for program learning at decentralized levels, and program management course correction were not formal objectives of the projects and were not formally documented **(-)** Limited measures of success in maintaining quality in the transition	**(+)** District health departments were the natural operational counterparts of implementing partner during all three phases **(+)** Evolving system management issues which ranged from basic coordination of emergency response (Phase I), to development activities by Phase III, with a greater articulation of 'transition' needs **(-)** Decentralized policies and national decisions established the importance of working in closer coordination with the province's DOH and the PWD **(-)** Increased role of implementing partner in capacity building for training, supervision, and use of information for management decisions, through without explicit systematic design and evaluation. Implementing partner did not see themselves as major actor for systems strengthening **(-)** Involved trial and error for country/project decisions with overarching orientation toward capacity building **(-)** Without more explicit evaluation of system capacity and transition steps, it is difficult to assess whether the project's strengthened the leadership of provinces' DOH and districts

Engagement with Community Organizations & Societal Partnerships - ***MOH engages in effective societal partnerships and with community organizations to improve efficiency and resilience of community systems and facility-based services*** - ***Stakeholders develop stronger accountability mechanisms*** - ***The health system has mechanisms in place to mobilize community volunteers during emergencies (+ paid CHWs)*** - ***Signs of increased trust and social capital between community leaders/organizations and the health system***	**(+)** Built program partnerships with community assets—including community health workers (CHW's), volunteers, volunteer networks, and community health committees (CHC's)—which were successful in enhancing community mechanisms and resources and strengthened linkages and accountability mechanisms between the MOH, health facilities, the community, and health system stakeholders **(+)** Strengthened community as a partner /asset to MOH through gains in service delivery and community utilization of services, engagement with the formal health system through CHC meetings, community level monitoring, surveillance, and referrals by volunteers and CHWs **(+)** Expected to increase trust between the community and the health system	**(+)** Worked through the government LHW's program- clearest contribution to the community component of systems strengthening over projects **(+)** Expanded the community approach progressively, through training of its own outreach staff, and more national partners- in parallel with an increased involvement of the government in managing the LHW program, through the DOH and PWD for training. Recommended redesign of the community approach as late as Phase III (2017) **(+)** Engagement with and strengthening of community structures was viewed as successful by stakeholders and program staff **(+)** Strengthened on-the-ground relationships between the community and the MOH **(-)** This occurred even as national politics detracted from the ability of the humanitarian community to support the MOH in providing services **(-)** Implementation did not immediately follow the comprehensive vision of the project proposal for engaging LHWs along with communities themselves **(-)** Difficult to discern how much these efforts will be maintained after end of project
Costing and Financing - ***Progressively increased domestic funding for services with reduced financial hardship on users, without displacement of resources from other essential public goods***	**(+)** Induced some local financing for health staff and clinics for handover to MOH. **(+)** Increased the number of functional facilities managed by MOH **(+)** Contributed to the federal government's allocation for states' health budgets and community-owned local-level financing initiatives	**(+)** Progressively, by Phase III, government and project efforts, due to national devolution, into provinces' policy channeled more costs to PWD and DOH budget lines, including payment of salaries and training costs **(-)** Project did not initially seek to address sustainability issues related to costing and financing.

	(-) Projects not designed to address large scale sustainable financing for health services in project areas	**(-)** Small costs were not integrated in devolution plans, and raise questions about post-project continued operations, given possible end to emergency funding or transition to development funding.
Human Resources - ***The health system is expanding its human resources for health through domestic resources, including through incorporation of CHWs. The health system appropriately uses task shifting to ensure a more efficient use of staff time and skills***	**(+)** Proxy measures indicated expanded human resources contributed to task shifting (i.e. service delivery rates achieved reflect MOH's expansion of presence and performance of healthcare providers and saw strengthened linkages between MOH staff and community resource staff (i.e. CHWs, village midwives etc.) for health promotion, monitoring, surveillance and referrals **(-)** No direct measures to gauge human resource contributions in program areas. More centralized, national level contributions towards strengthening human resources and task shifting beyond program areas were not documented	**(+)** Launched broad human resources development strategy that focused on clinical service providers and LHWs **(+)** Expanded beyond these cadres and addressed a number of supportive functions, notably use of information and supervision **(+)** To rapidly introduce new services (FP) and generate demand, recruited and trained its own staff first, and progressively involved more MOH staff (who made up the majority of trainees by end of Phase III). This also fit the donor and organizational mandate to expand the capacity of the agency in a set of countries (not just Pakistan) **(+)** National and provincial ownership and coordination were strengthened when the MOH required full PWD endorsement of trainings, which were responded by implementing partner **(+)** Phase II project invested in a true systems effort - assessing the distribution of roles and improving the complementarity between community and facility staff (both implementing partner and DOH's)
Supply Chain Management - ***Increased capacity and autonomy of the health system to manage procurement and supply of commodities***	**(+)** Implementing partner operated its own supply chain management in coordination with partners and donors, as the MOH did not have a supply chain management system respond to service delivery needs **(+)** Supported MOH facilities in program areas with appropriate cold storage infrastructure. (-) No indication that health system's ability to manage procurement and supply of commodities was strengthened	**(+)** Implementing partner built its own capacity through the FPC project funds and ensured commodity availability for services. (+) Projects coordinated with government and aligned with regulations on local procurement of medical supplies **(+)** By the end Phase III, the project approach actively supported government-operated FP procurement and supply chain management. At the same time, the project still provided support (e.g., direct recruitment to operationalize the establishment of a pharmacovigilance system) and strengthening supply management system to protect the ability to deliver services **(-)** Gaps in government procurement and supply chain, implementing partner developed own "parallel" systems

Data – Health Information Systems, Monitoring & Evaluation (M&E) - ***Appropriate human resources are allocated to HMIS in the health system to inform decision makers. Data systems and information have been strengthened within the health system.***	**(+)** Implementing partner contributed to CMAM database and the WHO Early Warning System for disease surveillance **(+)** While not formally collected, some local capacity building was noted through data collection and management in facilities. Some evidence of regular management processes, led with country partners, advanced data use for decision-making **(-)** No documentation of a comprehensive program effort or effect on strengthening health management information systems	**(+)** From the initial project proposal to the implementation, emphasis was on data processes, data for decision-making, use of special studies and evaluation **(+)** Projects trained on data tools (registers, logbooks, reporting), ongoing joint reviews with facility staff, adaptation of DOH/PWD tools and introduction of new tools to support patient tracking, quality of care, or logistical flows, and use of information for decision-making **(+)** Included project implementer staff during Phase I, and then DOH facility staff as well. Coordination had started with DHOs, and then involved PWD **(+)** Contributed to a number of necessary but not sufficient systems elements to establish information systems and build a monitoring culture **(-)** Capacity building was not a measured objective, likely happened in good part from 'learning-by-doing' **(-)** Limited role of implementing partner on underlying systems issues that are dependent on DOH and higher levels
Quality of Service Delivery & Referral - ***Services that include host population (not just displaced population) in improved services*** - ***Services are responsive to community needs and adapted to context*** - ***Health system innovations for coverage of health services and preparedness for EHN needs***	**(+)** Strengthened quality of service delivery included improved facility preparedness, joint monitoring visits to facilities with program technical staff and MOH service delivery staff, and technical training to health workers **(+)** EHN programming was targeted towards and were effective in incorporating both IDP and host populations into service delivery, with both stationary and mobile services to adapt to population fluctuations **(+)** Responsive to the community needs with focused efforts on vulnerable populations and cultural context through adaptive and innovative programming to ensure the greatest reach for services in the community (i.e. trained village midwives in key interventions at	**(+)** Carried out FP health services development and built conditions for quality of services, included introduction of new care procedures and practices, extensive skills building of Save the Children and then government staff, training of national master trainers, collaboration with the PWD and institutionalization of standards, diffusion of learning and skills to support task shifting, attention to data and performance with remedial and adaptive steps, and measurement of client satisfaction **(+)** Positive client-provider interactions and quality of services supported by community engagement and demand generation drove the successful uptake of services in the eight target facilities. The projects progressively shifted to closer support of national structures

- ***Health system has the capacity to contribute to large EPI campaigns and outbreak responses***	birth and strengthened referral linkages to increase coverage and quality of care due to cultural barriers for facility delivery) **(+)** Effective in strengthening surveillance capacity, outbreak response, and MOH capacity to contribute to large EPI campaigns **(-)** While activities contributed to quality improvement, measures were not captured in program monitoring and reporting **(-)** Procurement of vaccinations and commodities were facilitated by the emergency programs as supply and financing within the MOH were not addressed; which limit MOH ability to deliver vaccination services after implementer's withdrawal	through alignment to the PWD (now the authority for FP clinical training) and coordination with DHOs and provinces **(+)** By end of Phase III, a possible Phase IV could accelerate systems strengthening, integration of quality improvement across services, and conditions for sustainability **(+)** Observed path chosen which allowed 'successful' project experience in terms of service expansion, and that the orientation toward systems strengthening progressed over time under strong government signaling **(-)** Findings from key informants indicated that deliberate engagement and operation through government structures may have fostered more systems strengthening and sustainability of project interventions, even if service delivery results take longer to reach target numbers **(-)** Assessing what implementing partner and its donor "should have done" given its resources and scope of case study

Recommendations

- 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 (i.e. Lady Health Workers, health providers) and coordination with government for progressive integration of staff within government payroll (i.e. in 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.
- Seek and develop better benchmarks, collaborative learning, mutual accountability, and commitment to evaluation to drive innovations and expand the capacity for local performance of health systems (i.e. 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

Shared systems and performance outcome metrics with stronger process and focused outcome metrics at the project level, can maximize learning from local/subnational efforts on systems strengthening. Global program and research efforts on the humanitarian to development nexus are critical. Implementation agencies and donors of mid-size projects can increase their contribution to national systems and to global learning, while maintaining the focus on addressing peoples' needs, as the ultimate driver of systems change.

Acknowledgements

This brief was developed by Dr. Justine A. Kavle, Kavle Consulting, LLC in partnership with Dr. Eric Sarriot, Senior Health Adviosr, Save the Children (STC), Elijah Olivas, University of Iowa, and Laura Tashjian, CORE Group. The content was based on STC case studies, and country rapid assessment.

Key references

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