

Principles of Health Systems Resilience in the Context of COVID-19 Response



Unless stated otherwise all photos, Abijan, Ivory Coast, April 1, 2020.

The COVID-19 pandemic presents an unprecedented challenge to health systems globally. This brief summarises key principles for promoting resilient health systems in the face of this challenge. It is based on evidence from recent research programmes commissioned by DFID and NIHR. A number of these principles point to the value of anticipation of shocks and appropriate preparation. However, a number also address means of responding in the face of adversity.

Three key processes of resilience

Three resilience processes are usefully distinguished: **absorption**, **adaptation** and **transformation**. Suitable preparation will allow a health system to **absorb** some shocks without major change or redistribution of resources. With greater demands, the system needs to **adapt** through reallocation of resources and changes to policies and procedures. Greater or prolonged demands may require innovation to **transform** a health system's service offer or way of working.

Principle 1. Develop flexible pathways for medical supplies.

Whether in response to the shocks presented by major disease outbreaks, conflict or natural disaster, resilient health systems secure continuity of provision through the capacity to source supplies flexibly. This involves developing flexibility in the main public procurement system or authority to draw on private sector suppliers (ensuring they meet the appropriate specifications available on WHO website). In the context of COVID-19 response, priorities include monitoring and building buffer stock of personal protective equipment, procuring and building stock of equipment and devices for intensive care, and establishing regional or local procurement or supply pooling arrangements.

Maintaining access to medical supplies during the Syria crisis. To ensure continuity of care in the context of the military conflict in Syria, UNRWA Syria put in place buffer stock of medical supplies across different regions and collaborated with other agencies in setting up mobile clinics that helped transport medicines and products to high risk areas.

Principle 2. Prioritise a list of essential health services.

In a system where resources are scarce, the resilience of health systems will depend on the capacity of healthcare managers to re-allocate existing resources (e.g. beds and staff) to the essential and most needed health services. These decisions need to be based on transparent and clear criteria (e.g. lifesaving interventions need to be preserved) to help patients and health care professionals understand the rationale for prioritising COVID-specific interventions and adapting the whole system to manage the risks of COVID. Anticipate adjusting priorities as needs evolve over time (e.g. increased mental ill-health as a result of fear, loss and isolation). Ensure that all priority services are free at the point of use for vulnerable population groups. This may be the whole population in the area at crisis points (when needs are highest and household incomes lowest).

Basic health care provision and coherence. In 2019, the Ministry of Health in Afghanistan adapted its basic package of health services to the rise of violence and the risk of an NCD epidemic. All healthcare providers shared a common vision and direction to serve the poorest and most in need.

Principle 3. Build trust with local communities.

Trust between communities and the health system emerges as a crucial resource in a wide range of crises. It strongly shapes the health behaviour of communities and outcomes, whether in influencing the way that the public accesses the health system or the processes that can shape how



health messages are communicated and interpreted. Dignity and respect for service users can serve to build trust, as does partnership with civic and religious leaders and groups.

Principle 4. Foster good communication at all system levels.

Crises are a time of confusion, threat, insecurity and often misinformation for staff and users alike. It is essential to strengthen the district health system, including supervision and other linkages between hospitals, centres and community health workers. Clear guidance with well-defined respective responsibilities will help ensure complementarity between different cadres. Establishing channels of communication (formal and informal e.g. chat groups between front line health workers) is a low-cost strategy, which can buoy morale and clarify guidelines in rapidly changing circumstances. It combats misinformation and keeps a sense of coherence and trust between staff at different organisational levels.



Principle 5. Support, recognise and encourage staff.

Staff commitment to the communities they serve and belong to can make a significant difference to health system's absorptive, adaptive and transformative capacities. This ethos can be cultivated by dedicated leadership, prosocial behaviour and modelling person-centred practices across the system. As much as possible, staff actions and achievements in challenging circumstances should be explicitly recognised and rewarded. Foster peer support, teamwork and supportive supervision through remote channels. Secure the continuity of payment for staff in case

the normal approach (e.g. via banks or via District Teams) is not possible.

Supporting staff during the Ebola epidemic. In Sierra Leone, a WhatsApp group set up by frontline health workers to provide peer support and encouragement provided an important way to maintain morale. Many were being infected, shunned by communities, and unable to have a normal family life because they were perceived as disease carriers.

Principle 6. Facilitate rapid resource flow to front line providers and greater flexibility in its use.

Conditions change quickly on the ground and local managers need to be empowered and have some flexible resources to adapt and innovate. This may be in relation to the ways funds are spent, extra staff are recruited and deployed, or changing service outlets and adapting supply lines. Within clear parameters, budget flexibility should allow increasing budget transfers to sub-national levels and frontline providers in a timely fashion. In some cases this will involve adopting more flexible spending procedures, accompanied by enhanced tracking. Finding an appropriate balance between flexibility and accountability is essential.

Principle 7. Ensure agile tracking of health information.

All health systems need to monitor and adapt, but this is critical in a fast-changing crisis. Health information systems may need to focus just on key indicators. Innovation in how data is gathered and shared (upwards but also with local managers and users) can also be important. Make use of existing surveillance and registry systems. Adapt lines for COVID-19, and then put in place mechanisms for learning from the data and feeding back regularly to frontline responders with updated information.



A Sierra Leonean health worker at Connaught Hospital, Freetown completes documentation to support effective data capture.

Principle 8. Cultivate effective partnerships and networks.

No organisation can manage all needs on its own, and especially in a crisis. Resilient organisations create, reinforce and draw on networks and allies for complementary actions – for example, from development partners, local leaders, the private and not-for-profit sectors, community and user groups, informal providers and religious leaders. Collaborating across sectors within or across countries is critical to effective response: in many studies, health system resilience was supported by engagement with social welfare and education providers. Intersectoral coordination is particularly important to identify and manage risks for vulnerable populations.

Strengthening district systems and primary care. In Pakistan, national and global funded programmes e.g. TB, hepatitis, malaria, Lady Health Workers, have been integrated and decentralised within the general health system. Guides and tools for improved quality and outcomes of care for other infectious and chronic diseases have been further added. In other contexts (including Ethiopia, India, Nepal, South Africa and Uganda) tools have been developed for collaborative design and strengthening of district health systems with a range of community and other local stakeholders using theory of change workshops.

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