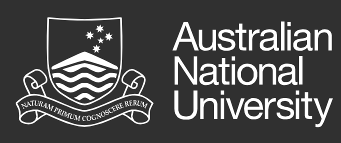

Strengthening the Health Emergency Preparedness Planning for Communities across China

--- Policy Brief

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Content

1. My Research
2. Problem Analysis
3. Objectives of the Policy Brief
4. Stakeholder Analysis
5. Theory of Change
6. Policy Influence Plan

1. My research

I. Research background
II. Research objectives
III. Major results
IV. Major recommendations
V. Potential impact of the recommendations
VI. The institutions I plan to work with

I. Research background

- MoH issued Health Emergency Preparedness Plan Guideline for Community (HEPPGC) in 2006.
- Investigation found that HEPPGC was not effective.
- Poor planning influence the health emergency preparedness at community level.

II. Research objectives

- Revising HEPPDC based on evidence and offering policy recommendations for disseminating and implementing the guideline, to improve health emergency preparedness for community level.
  - Analysis the problems existed in HEPPDC and supply the evidence for revising.
  - Find the causes that the communities did not use the guideline and supply the policy recommendations.
  - Find the demand for planning and supply the policy recommendation.

III.Major results

- HEPPDC has too complicated content and no Standard Operation Procedure (SOP).
- HEPPDC is short of accessibility.
- Most of communities are short of organization, mechanism, financial support and trained planners needed by implementing HEPPDC.

IV.Major recommendations

- HEPPDC should revised on the evidence.
- The dissemination and promotion of HEPPDC should enhanced.
- The organization, mechanism, planner and funding for planning should be strengthened.

V. Impact the recommendations will have

- The preparedness planning will be enhanced and the plan quality will be improved.
- The health emergency preparedness will be improved.
- The health emergency response capacity will be enhanced.

VI. The institutions I plan to work with

- MOH: To accept the recommendations and issue the policy.
- Local Health Bureau: To disseminate and promote HEPPDC, supply the support to community.
- CHC: To improve planning process.

2. Problem analysis

I. Main problem
II. Decision makers
III. Scoping problem
IV. Causes analysis
V. Solution of the problem

I. Main problem

Weak preparedness for health emergencies at the community level.

II. Decision makers

- Deputy Minister of MoH
- Director of health emergency response office, MoH
- Director of general office, MoH

III. Scoping problem

effects

Lower trust government and health service

Higher social and economic costs

Higher morbidity and mortality

Delayed recovery

Ineffective risk mitigation

Weak response capacity

Poor risk evaluating

Weak leadership organizing and mechanism

Weak simulation training and exercising

Lack of equip. and stock piles

problem

Weak preparedness for health emergencies at the community level

Poor quality preparedness plans

Poor quality preparedness planning process

Guidelines used

Guidelines not used

Guidelines lacking detail on planning process

Lack of planning capacity

causes

IV. Causes analysis

Weak preparedness for health emergencies at the community level

Poor quality preparedness plans

Poor quality preparedness planning process

Guidelines used

Guidelines not used

Guidelines lacking detail on planning process

Lack of planning capacity

Content incorrect
- ➢Content rigid/
- ➢Content complicated
- ➢Content not comprehensible
- ➢Content not well-structured
- ➢Content not pilot-tested or evaluated

Guidelines not received:
- ➢· Poor dissemination
- ➢· Poor promotion

- ➢Guidelines did not include details on how to go about the planning process
- ➢Guideline did detail the process, but this was not followed
- ➢Planning process deficient on planning process

Lack of
- •Planner
- •funding
- •Mechanism
- •Organization
- •……

V. Solution of problem

problem

Weak preparedness for health emergencies at the community level

causes

Poor quality preparedness plans

Poor quality preparedness planning process

Guidelines used

Guidelines not used

Guidelines lacking detail on planning process

Lack of capacity to mobilise and coordinate process

solutions

strengthen the guideline Develop a checklist

Improve the accessibility of he guideline

Add planning process in detail to guideline (SOP)

Improve planning mechanism and coordination process

•As the base for monitoring and evaluation plans

•Research team

Policy brief
for Government

• Government
• Research team

3. Objectives of the policy brief

- Offering recommendations to implement the guideline so that the quality of the preparedness at community level is strengthened.

4. Stakeholder analysis

I. Stakeholders in this case
II. Alignment, interest and influence Matrix (AIIM)
III. Stakeholder classes
IV. Power interest matrix

I. Stakeholders

No.	Stakeholder	function	type	marker
1	MOH	Decision maker	Support	
2	Health bureau • At provincial • At prefecture • At county	dissemination	Neutral	
3	Governments • At higher level • At county Community leadership	Coordination and advocacy	Support	
4	Community health center Health center staff	Implementation	Oppose	
5	Policy researchers	Policy research	Support	
6	media	Promotion	Neutral	
7	Community resident	Participation	Neutral	

II. Alignment, interest and influence Matrix (AIIM)

(1) Distribution of the stakeholders in the AIIM matrix

high

alignment

low

interest

high

(2) Dealing with stakeholders in different quadrant

high

alignment

low

- Communicate and make them aware of the issue and its importance to them.

- This actor regularly participates in meetings on the subject, publicly supports the objectives of the intervention, commits funds towards achieving them, etc

- Use successful pilots and evaluations to change their minds.

- Challenge beliefs and value, lobby, negotiate or neutralize them.

interest

high

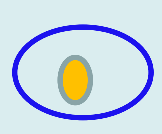
(3)dealing with every stakeholder

high

alignment

- This actor agrees with the intervention but does not commit time or resources towards the achievement of its objectives; it does not show up at meetings, does not make its views public – it is not on its agenda, etc.

- Develop an alliance or community of practice



- This actor publicly opposes the intervention's objectives, has its own initiative to achieve different results or through different means, disagrees with the intervention's assumptions and theories, etc.

low

interest

high

(4)Identifying the most influential stakeholder on the policy process.

- In my case there three key stakeholders
  - MOH: policy maker
  - CHC: policy executive
  - County health bureau
- which are influential and accessible to the policy process.
- They will be marked with a star.

Key stakeholders and their location

high

alignment

low

interest

high

(5) In the diagram I added arrows suggesting desired change pathways for all of the stakeholders.

high

alignment

low

interest

high

(6) Using AIIM for monitoring

- After the influencing actions for the policy was carried out, the location of key stakeholders changed along the direction expected by the policy researchers.

AIIM: intervention plan

high

alignment

low

interest

high

AIIM: monitoring the intervention

high

alignment

low

interest

high

(7)Using AIIM evaluating

- The first action is to increase the stakeholders' interest
  - plan becomes the performance indicator of county health bureau and CHC
- The second action is to enhance their alignment
  - Held workshop for county health bureau and CHC

The Alignment, interest and influence Matrix (AIIM)

high

First action

alignment

Second action

First action

low

interest

high

III. Stakeholder classes

① Dormant stakeholder
- Governments at provincial, prefecture and county
- Community leadership

② Discretionary stakeholder
- Media
- Community citizen

③ Dominant stakeholder
- Health bureaus at provincial, prefecture and county
- Community health center (CHC), Staff of CHC

④ Dependent stakeholder
- Research team

⑤ Definitive stakeholder
- MOH

Stakeholders in this case

No.	Stakeholder	function	type	marker
1	MOH	Decision maker	Support	
2	Health bureau • At provincial • At prefecture • At county	dissemination	Neutral	
3	Governments • At higher level • At county Community leadership	Coordination and advocacy	Support	
4	Community health center Health center staff	Implementation	Oppose	
5	Policy researchers	Policy research	Support	
6	media	Promotion	Neutral	
7	Community resident	Participation	Neutral	

Stakeholder classes

IV. The power, interest and influence Matrix

	interest	
power	•Community health center; •Staff of CHC •Health Bureaus at provincial, prefecture and county;	•MOH (HERO)
	•Media •Community residents	•Community leadership •Government at county level •Governments at high level •Policy research institutes and team

low

high

5. Theory of change

Weak preparedness for health emergencies at the community level

Main problem

This situation will be changed

Strengthened preparedness

Better preparedness plan

Revised policy

Policy brief

Updated guideline

Recommendation for dissemination and implementation of guideline

Research result

Assumptions

Plan is implemented effectively

Policy is implemented well

yes

Policy is accepted by government

Stakeholder consultations

no

Valid and adequate to revise policy

6. Action plan

I. Goal of the policy brief
II. Objectives of the policy brief
III. Policy Influence Plan (PIP)

I. Goal of the policy brief

- The policy brief will be adopted by the Ministry of Health and well implemented by the health bureaus and communities.

II. Objectives of the policy brief

① MoH adopt the policy brief;

② Local Health Bureaus disseminate and promote the policy and supply supports to community.

③ Community Health Center implement the policy.

III. Policy Influence Plan (PIP)

Objective1: Ministry of Health adopt the policy brief					
Activity	Stakeholder	Time	Indicator(process/outcome)		Risk/control
1.Supply the research report to HERO and get feedback. 2.Consult technical experts from health emergency and community health. 3.Present the research results at the experts discussion meeting	1. Training Staff of the HERO. 2.Experts in different field. 3.officials from departments of MoH. 4.Officials from provincial, prefecture and county health bureaus. 5.Members of research team.	1. By end of Oct, 2012 2.To end of Nov, 2012 3.By end Nov. of 2012	1.Research report. 2.Number of experts consulted. 3.Number of revising suggestion received. 4.summing-up of experts discussion meeting.	1.Research report accepted by HERO. 2.Report accepted by experts. 3.Policy accepted and issued by MoH.	1.Research result is not good enough to be accepted by the experts, training staff of HERO and MoH. Receive the suggestions from different sides to revise the policy. 2.Training staff of HERO was changed this year. Communicate with him.

III. Policy Influence Plan (PIP)

Objective2: Health bureaus at provincial, prefecture and county level disseminate and promote the policy and supply supports to community.					
Activity	Stakeholder	Time	Indicator(process/outcome)		Risk/control
1.Meetings attended by staff from local government and health bureaus. 2.Held training workshop for county health bureau staff	1. Staff of local health bureaus. 2.Local financial departments. 3.Local governments 4.MoH.	1. By end of 2012 2.Early of 2013	1.number of meeting and attendant. 2.Minutes of meeting. 3.The documents issued by government. 4.Number of workshop and trainee.	1. To develop requirement for this plan to be performance indicator of local health bureau. 2. To develop matching policy suitable for local situation. 3.Each county has a trained health bureau staff.	1.The situations vary around the country and guideline is not suitable for all situation. Local health bureaus make matching policy suitable for local situation. 2.Communities are short of

III. Policy Influence Plan (PIP)

Objective3: Community health center implement the policy.					
Activity	Stakeholder	Time	Indicator(process/outcome)		Risk/control
1.Meetings attended by staff from local government and community health center. 2.Held training workshop for planner of community	1. Staff of local health bureaus. 2.Staff of community health center. 3.Local governments 4.MoH.	1. By end of 2012 2.Early of 2013	1.number of meeting and attendant. 2.Minutes of meeting. 3.The documents issued by government. 4.Number of workshop and trainee.	1. To develop requirement for this plan to be performance indicator of community health center. 2. CHC has organization, mechanism and funding for planning. 3.Each community has a trained planner.	Some communities in middle and west parts of China are leak of planning capacity. Central government give financial and technical support to this areas.

Thank you!