INTERNATIONAL RESCUE COMMITTEE

IRC Health Strategy

FY2023-2027

Photo: Dr. Mohammed Isa Goni at the Mashamari Stabilization center in Nigeria with Hafsat Muhammad and her 10-month-old baby, Muhammad Ali, who was discharged after recovering from severe acute malnutrition.

ACRONYM LIST

AIDS – Acquired Immunodeficiency Syndrome

AMR – Antimicrobial Resistance

AMU – Awards Management Unit

BMGF – Bill & Melinda Gates Foundation

CBMNC – Community-Based Maternal and Newborn Care

CDC – Centers for Disease Control and Prevention

CHW – Community Health Worker

ConCACE – Contraception & Comprehensive Abortion Care in Emergencies

CRRD – Crisis Response, Recovery, & Development

CVA – Cash and Voucher Assistance

CYP – Couple Years of Protection

EH – Environmental Health

ERT – Emergency Response Team

EHAU – Emergencies & Humanitarian Action Unit

EU – European Union

EWARS – Early Warning, Alert, and Response

FCDO – Foreign, Commonwealth, and Development Office

FP – Family Planning

FY – Fiscal Year

GEDI – Gender, Equality, Diversity, & Inclusion

GOAT – Grant Operations and Analytics Team

GPS – Global Positioning System

GPPS – Global Partnerships & Philanthropic Services

GRIP – Global Research & Innovation Priorities

GSC – Global Supply Chain

HIV – Human Immunodeficiency Syndrome

HSS – Health Systems Strengthening

HU – Health Unit iCCM – Integrated community case management

IMPACT – Informed, Measure, Partner, Adapt, Client-centered, Transformative

IDPC – Infectious Disease Prevention & Control

IPC – Infection Prevention & Control

IPP – International Philanthropy and Partnerships

IRC – International Rescue Committee

LARC – Long-Acting Reversible Contraception

LDC – Least-Developed Country

MEAL – Monitoring Evaluation Accountability & Learning

MHM – Menstrual Hygiene Management

MHPSS – Mental Health and Psychosocial Support

MISP – Minimal Initial Service Package

MNH – Maternal and Newborn Health

MOH – Ministry of Health

MU – Measurement Unit

NCD – Non-Communicable Disease

PPE – Personal Protective Equipment

REACH – Reaching Every Child in Humanitarian Settings

RUTF – Ready-to-Use Therapeutic Foods

SBCC – Social Behavior Change Communication

S100 – Strategy 100

SRHR – Sexual and Reproductive Health Rights

TA – Technical Advisors

TU – Technical Units

VPRU – Violence Prevention and Response Unit

WHO – World Health Organization

ZDC – Zero-Dose Children

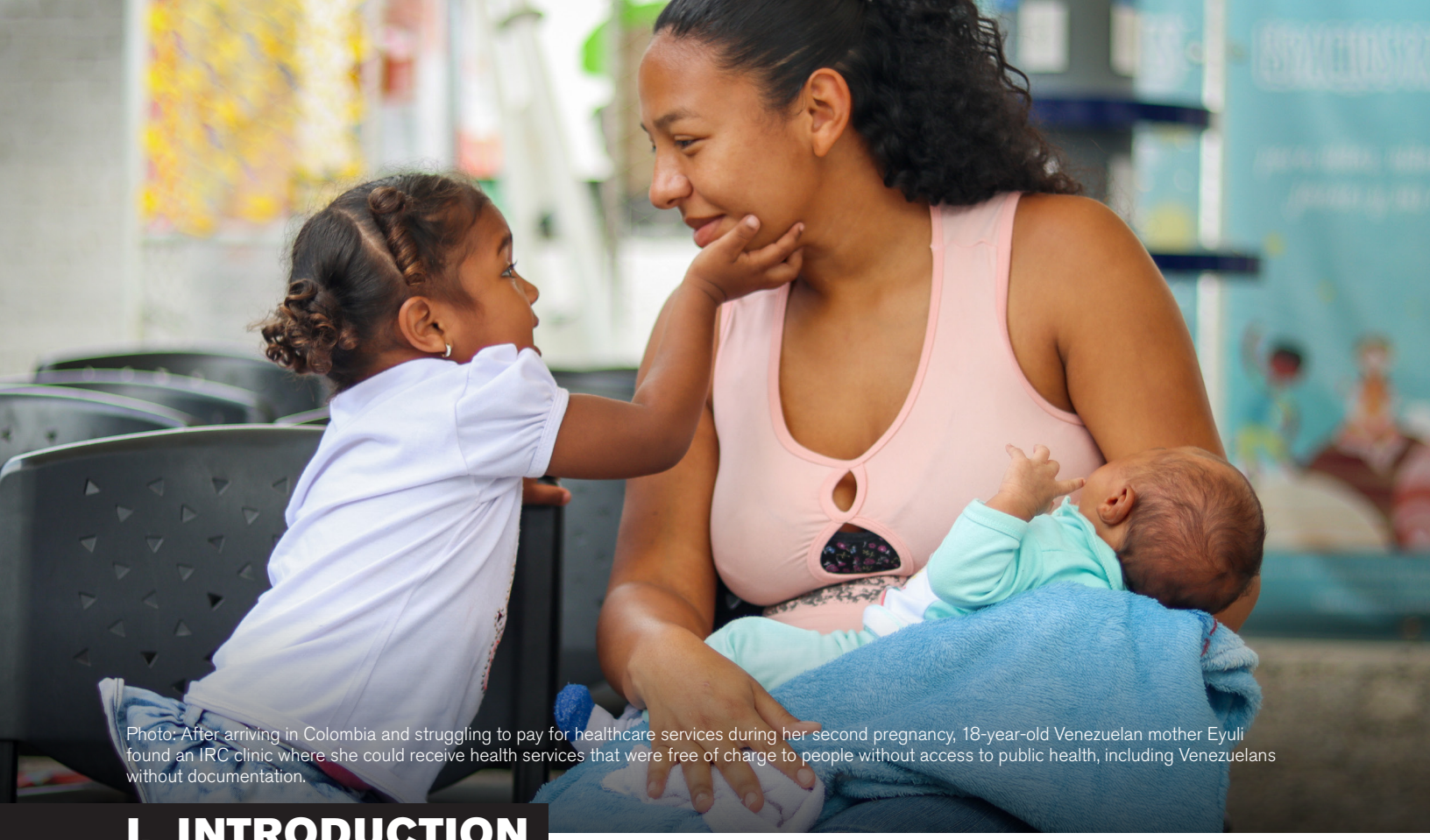

Photo: After arriving in Colombia and struggling to pay for healthcare services during her second pregnancy, 18-year-old Venezuelan mother Eyuli found an IRC clinic where she could receive health services that were free of charge to people without access to public health, including Venezuelans without documentation.

I. INTRODUCTION

The International Rescue Committee (IRC) is a leading humanitarian agency dedicated to helping people whose lives have been shattered by conflict and disaster to survive, recover, and gain control of their future. Health comprises nearly half of IRC's program portfolio globally and encompasses three sectors: **1) Primary Health** (including child health, sexual and reproductive health and rights, and mental health); **2) Nutrition**; and **3) Environmental Health**. IRC health programming across its portfolio, in terms of the size and breadth, responds to significant needs in crisis affected settings, improving health and wellbeing while reducing causes of ill-health.

This five-year Health Strategy sharpens our focus on where we can have the most impact. It guides our efforts in planning, technical assistance, business development, advocacy, and internal and external collaboration. Through this strategy, we will invest and grow in areas that will help us achieve high impact at scale for our clients. For the next five years these priorities will include:

1. **Nutrition**
2. **Immunization**
3. **Contraception**
4. **Infectious Disease Prevention and Control**
5. **Last Mile Delivery of Primary Health Care**
6. **Clean Water**

Our strategy aligns with Strategy 100 (S100) and Strategy Action Plans (SAPs). It lays out how IRC, through health, nutrition, and Environmental Health (EH) programming, will advance the IRC's S100 ambitions, respond to global trends, and capitalize on our value add. The strategy will be complemented by delivery plans that detail investments, actions, and roles and responsibilities to advance our priorities. At the end of FY24, we will take stock of the implementation of the strategy, measure progress towards achieving our goals, and review if it continues to be fit for purpose.

Problem Statement

A new axis of inequality is emerging in global health. Disparities between East and West, North and South, high- and low-income countries are becoming less pronounced. At the same time, gaping inequalities have emerged between stable settings and those affected by crisis, including the climate crisis and conflict.

Dramatic improvements in global health indicators have been driven by progress in stable settings, but people affected by crisis and conflict are being left behind. Scaling up solutions including immunization, contraception, oral rehydration salts, and skilled birth attendants has resulted in a 60% reduction in child mortality and a 47% reduction in maternal mortality over the last two decades. In stable settings, these gains have been achieved largely by working through health facilities and government-led health programs and systems. In fragile settings, even the most basic facilities may be inaccessible to clients or unable to sustain service delivery in the face of conflict and crisis. Likewise, government programs are frequently unable to reach humanitarian populations.

As a result, in places where the IRC works, maternal and child mortality remain up to 5 times higher than global averages. Also, the 20 countries where IRC has prioritized sexual and reproductive health and rights (SRHR) in their SAPs represent just 14% of the global population, but 30% of the global unmet need for contraception. People living in fragile contexts are twice as likely to lack access to safely managed water and sanitation services. Inequalities are exacerbated for women and girls who face both crisis and harmful gender norms.

The COVID-19 pandemic put health systems under immense pressure and highlighted critical weaknesses. It also resulted in a backlog of other health needs, reversed decades of progress on key interventions such as childhood immunization—resulting in 25 million children un- or under-vaccinated—greatly impacted mental health[1], and exacerbated food insecurity, worsening health and nutrition outcomes. As a result, global public health actors have renewed their focus on recovery and transformation through strong calls to re-imagine how we deliver public health and rebuild more resilient health systems.

The core challenge facing global health today is ensuring that the solutions and delivery systems that result in improved health around the world reach people in fragile settings. Overcoming this challenge is squarely aligned with IRC's mission to help people whose lives are affected by crisis and conflict, including the climate crisis, to survive, recover and gain control of their future.

Photo: Liudmyla, a resident of Spodobivka village, Kharkiv Oblast, Ukraine, at an appointment with Dr. Oleg. The medical situation in her village is very dire, with the closest hospital 15 kilometers away and buses only going to the town twice a week. The IRC medical team provides basic medical help such as various checkups and prescribing medications.

The IRC's Value Add in Health

Our greatest contributions to the humanitarian health ecosystem lie at the **nexus of our programming and our influence**. This is well aligned with IRC's vision statement which aims to achieve reach through the combined impact of our programs and the power of our influence.

Health Programming

The IRC is a leading humanitarian agency dedicated to the health and wellbeing of the most vulnerable people in fragile and humanitarian settings. The IRC has a robust portfolio of health, nutrition, and EH programs in 35 countries aimed at helping those who are experiencing or recovering from conflict and disaster reduce their risk of falling ill and receive treatment when they do get sick. The IRC's health programming can also serve as a critical entry point and/or enabler for programming in other outcome areas such as violence prevention & response (VPRU), early childhood development, and economic recovery & development.

In 2022, IRC country programs supported 3,137 health facilities making essential health services available to 29.2 million people, reached 2.9 million people with nutrition programming, and served 2.7 million people with built or rehabilitated water supply. The IRC's health programming is helping to enable the achievement of IRC's organizational scale and reach goals as it tends to target large catchment areas with a wide range of services and respond to critical needs among full populations. Partnership is at the core of the IRC's health programming, acknowledging that we contribute to greater impact and scale and more sustainable outcomes when we partner with local actors. A full overview of our health, nutrition, and EH programming can be found here.

Influence

Within the scope of humanitarian health organizations, the IRC is mid-sized with a track record of working in some of the most challenging and fragile settings. For example, we are about twice the size of International Medical Corps (serving 18M people through 1,600 facilities vs IRC's 29.2M through 3,137 health facilities) but half the size of Medecins Sans Frontieres (12.6M consultations vs IRCs 6.1M consultations).[2] While we are a mid-sized organization, the IRC is known in the humanitarian public health sector for exerting outsized influence through the strength of our voice and the power of our ideas. This is particularly the case in areas like nutrition and SRHR where our combined efforts in delivery, research, and influence have been most focused to date. In these areas we have the potential to deliver impacts for many more clients than we can serve directly by strengthening systems, reforming policies, and influencing the flow of resources at national and global levels.

Why have a Health Strategy?

The purpose of the IRC Health Strategy is to give clear direction and focus for the organization's health scaling, impact, and influence ambitions in line with S100. **With this strategy, we aim to give a roadmap for IRC teams to work toward a shared vision, make informed decisions, optimize and allocate resources, and effectively communicate with stakeholders.** We also aim for this strategy to guide how we make additional investments by accessing strategic resources from the organization to achieve S100.

II. STRATEGIC PRIORITIES FY2023-2027

Strategy Framework

The starting point for the development of the strategic priorities was a review of global trends and IRC value add - including a review of our current portfolio and opportunities - and feedback from consultations across IRC. Following this analysis, we examined the IRC's Outcomes and Evidence Framework (OEF) and how its five health outcomes were prioritized by country programs in their SAPs[3]. The five health outcomes in the OEF are:

1. Children survive and are healthy
2. Children are well nourished and protected from all forms of undernutrition
3. Women and girls achieve their sexual and reproductive health and rights
4. Adolescents and adults are physically and mentally healthy
5. People access water, sanitation, and hygiene services and live in an enhanced environment

To select the strategy's six priority areas, we assessed all health interventions IRC employs to achieve the broader OEF outcomes, narrowing the interventions down based on the following criteria:

- A track record of programmatic **impact** including innovative approaches to improving quality and client-responsiveness
- The potential for **scale**, reaching more people across more contexts with evidence-based solutions and strategic partnerships
- **People** on our teams with world-class expertise, drive, and support to meet ambitious goals
- The **influence** – rooted in the example of our programs and the power of ideas to drive systems change that amplifies our impacts beyond the scope of direct service delivery
- A competitive edge for large-scale, sustained **funding** needed to fuel each of the above
- The opportunity to meet **unmet needs**, in keeping with IRC's exit/entry criteris

As a result, the priorities in this strategy have been selected based on linkages with interventions where we have sufficient evidence and can leverage learning; demonstrated expertise and global leadership; knowledge of scale of need; best design for wide geographic reach; and highest potential to ensure outcome-focused programming at scale. Based on this comprehensive analysis, for the next five years these priorities will include: Nutrition, Immunization, Contraception, Infectious Disease Prevention and Control, Last Mile Delivery of Primary Health Care, and Clean Water.

These six priorities do not encompass all of IRC's work on health, nutrition, and EH. We will continue to be country and client led and context specific. We will also continue to support country programs to achieve their SAP ambitions and the IRC's OEF health outcomes. The six priority areas in the Health Strategy are where and how we envision focusing our efforts on high-impact strategy projects, evidence gathering, fundraising, and advocacy - to achieve maximum and outsized impact and achieve the organization's S100 ambitions.

Priority interventions:

Photo: Dr. Sila Monthe, an IRC health manager for the IRC in Kenya, checking 1-year-old Vanessa for malnutrition in the Kakuma refugee camp who was showing signs of malnutrition and has been receiving treatment ever since.

1. Nutrition

In FY23-27 we will focus on **scaling wasting treatment** through programs, impact, and influence.

We will prioritize fundraising, resources and technical assistance to significantly accelerate progress on the treatment and prevention of wasting. We aim to scale IRC's reach on wasting treatment and to influence the global sector to increase treatment to 80% of all wasted children in fragile contexts by 2030 through program impact, evidence, and advocacy. In FY22, the IRC, directly and indirectly through the Ministry of Health (MOH) and in partnership, reached 2.9M clients to prevent, detect, and treat multiple forms of undernutrition including 453,344 children under five with wasting. Scaling delivery of high coverage and cost-efficient wasting treatment through health systems is a programmatic, research, and policy priority.

The ambition to scale wasting treatment is informed by IRC-led research on a simplified community-based management of acute malnutrition treatment protocol, which is safe, effective, and efficient. We want the best available evidence to scale up wasting treatment in line with global and national priorities. Additionally, the IRC's policy and advocacy work are targeting key stakeholders and decision makers to adopt this simplified approach and address the policy and practice bottlenecks to achieving it. While nine country programs prioritized the nutrition outcome in the OEF, countries who prioritized child health also provide nutrition services through integrated approaches. Twenty-one country programs provided nutrition interventions in FY22.

We are currently implementing a 3-year $20M Community Management of Acute Malnutrition Avancé project—funded by GiveWell—which aims to demonstrate improved coverage and cost-effectiveness of treatment for acute malnutrition for 150,000 children through health systems in Burkina Faso, Chad, DCR, Niger, and Somalia. This project will demonstrate a high coverage and cost-efficient treatment model that can be replicated across health systems and transferred to partners to scale-up. We anticipate supporting other countries to design, assess, learn, and scale up similar models in their contexts. IRC has alos served as a technical and coordination partner for the USAID-UNICEF partnership to provide technical assistance on simplified approaches in 6 of 13 high burden countries.

The IRC has been identifying and addressing malnutrition scaling challenges including building resilience of under resourced health systems; poor availability of treatment; lack of access to and high cost of ready-to-use therapeutic foods (RUTF); lack of sustainable and sufficient financing; lack of clear guidance and policies on simplified approaches; and lack of progress on scaling. We aim to influence the sector on evidence-based models of high quality, coverage and cost-effective wasting treatment that treats moderate and severe wasting until full recovery in humanitarian contexts and to see significant progress in closing the wasting treatment coverage gap globally.

We will also **explore, develop, and build the evidence base** around wasting prevention; micronutrient deficiencies; multisectoral approaches linking health, EH, livelihoods, food systems, and early childhood development interventions; innovative supply chain solutions; and the intersection of climate change and malnutrition in fragile contexts. We will continue to invest in evidence generation of what works to achieve nutrition outcomes including learning on what it takes for simplified approaches to be scaled-up through health systems.

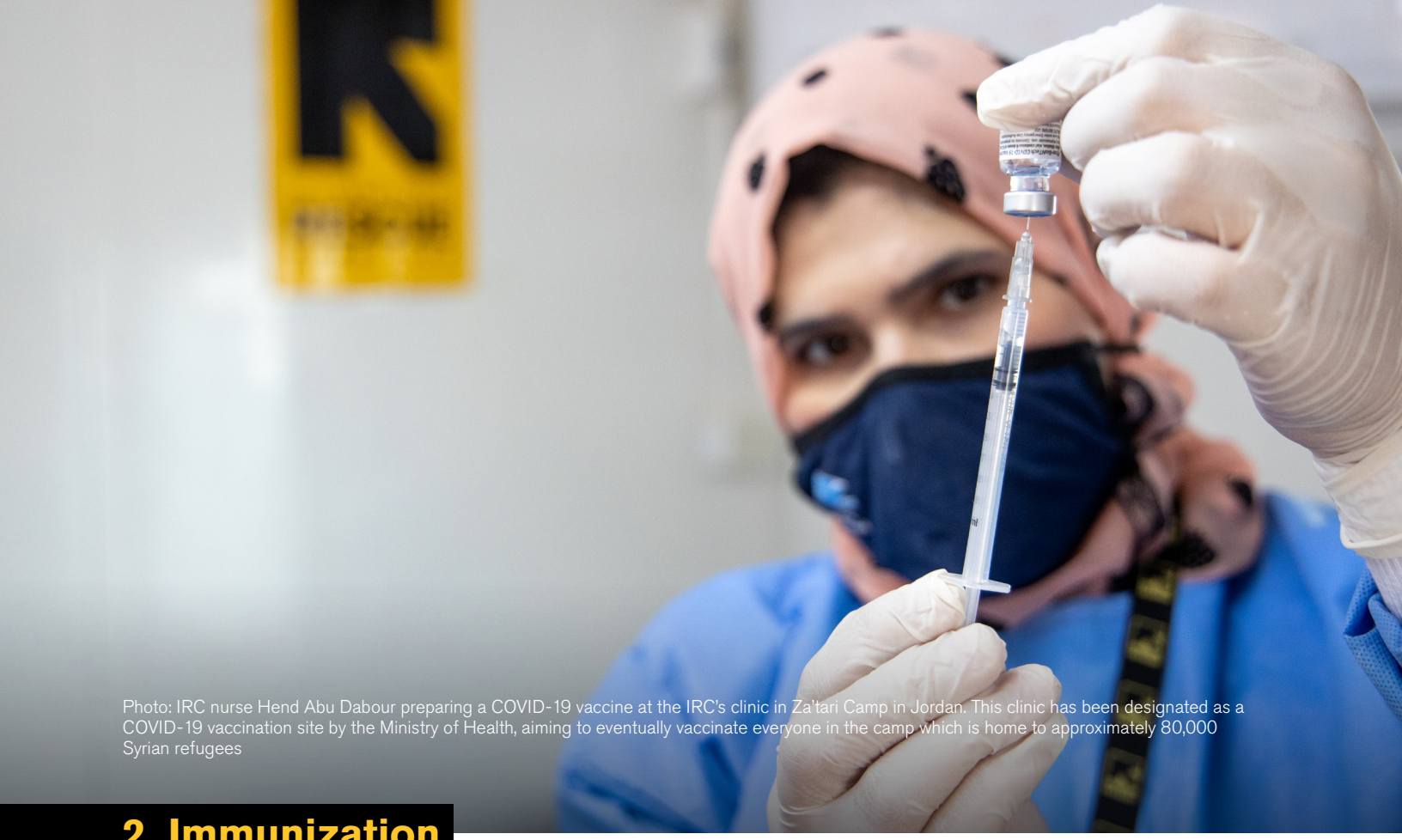

Photo: IRC nurse Hend Abu Dabour preparing a COVID-19 vaccine at the IRC's clinic in Za'tari Camp in Jordan. This clinic has been designated as a COVID-19 vaccination site by the Ministry of Health, aiming to eventually vaccinate everyone in the camp which is home to approximately 80,000 Syrian refugees

2. Immunization

In FY23-27 we will focus on **scaling delivery of childhood immunizations** to zero-dose children (ZDC)[4] and missed communities[5].

Health systems have left behind millions of children unprotected from vaccine preventable diseases because of remoteness, insecurity, social norms, exclusion from government programs, and marginalization. According to the World Health Organization (WHO) and UNICEF, an estimated 25 million children worldwide were un- or under-vaccinated in 2021. Efforts to close the immunization gap will help address health system challenges and strengthen primary health care at the local level. Eleven country programs prioritized the child health outcome in their SAPs, though 16 country programs are currently implementing immunization services, including integrated services within other prioritized outcomes.

The IRC has successfully lobbied Gavi to engage NGOs as delivery partners to extend the reach of government systems, and in 2022, the IRC was awarded the US$50 million Gavi-funded Reaching Every Child in Humanitarian Settings (REACH) project, which aims to reach ZDC in four countries in the Horn of Africa. This project is using innovation and partnerships to extend the reach of health systems and increase the number of vaccinated children.

Plans for scaling immunization will benefit from successful implementation of REACH to enhance our reputation in the space and document and use learnings to attract more funding from Gavi and other public and private donors. With this, we will continue building relationships with key donors, including Gavi, to expand our long-term immunization programming andsupport country programs to access funding through donor allocation mechanisms at the country level, all in efforts to ensure no child misses life-saving vaccines.

We will also **explore, develop, and build the evidence base** for integration of vaccination with primary health care, cross-border delivery, local partnerships, innovative approaches to demand creation, and harnessing data to drive coverage and equity. REACH is already contributing to these efforts – the project's central learning question is how to scale our work to best reach ZDC through community-centered immunization services that build resilient demand for immunization, including addressing gender-related barriers, using a quality and client-centered approach to integrating them into the routine system. The program uses data and evidence for decision making, to enhance existing evidence and learning, harnesses innovation, and use evidence to make a case for political attention and increase resources allocation for ZDC.

Photo: Midwife Khodaja Khatun explaining the methods of safe contraception to Rohingya women at the IRC center in Bangladesh.

3. Contraception

In FY23-27 we will focus on **scaling reliable access to contraception**, particularly long-acting reversible methods, extending reach and resilience of contraception services through community-based and self-care.

Many of the world's 257 million women with unmet contraception needs are displaced by conflict or natural disaster, with the highest level being among adolescents. Approximately 40 million women and girls of reproductive age need humanitarian assistance, including contraception services to prevent unintended pregnancies and improve women's agency and gender equality in fragile and conflict-affected settings.

> The IRC has experience implementing several large, multi-country strategic programs in this area including ConCACE and WISH2ACTION as well as research and innovation work on self-care. SRHR is a SAP priority for 20 IRC country programs, with the prevention of unintended pregnancies through contraception as a core strategy. The IRC currently supports the provision of 400,000 couple years of protection (CYP) annually.

The key to cost-effectively scaling contraception is strengthening the demand and supply of these services, especially long-acting methods. To achieve our scaling goal, we will implement different combinations of cost-effective strategies for improving demand and supply based on the unique contextual barriers and our experiences in each country, while integrating efforts to strengthen local systems and the enabling environment in partnership with other feminist civil society organizations and MOHs. Strategies to improve demand include strong engagement with the community, youth, men, religious leaders, and people with disabilities. Strategies to improve supply include improving service provider capacity to counsel and provide long-acting methods in a sensitive way and with quality of care, securing commodity supply, ensuring equipment and infrastructure conducive for providing all methods, and diversifying service delivery channels including self-management (e.g., injection of family planning (FP), self-administration of medication abortion) and self-care.

We will also **explore, develop, and build the evidence base** to maximize CYP from pregnancy among those most in need by reaching youth and adolescents; integrating contraception within primary health care, particularly maternal and newborn health (MNH), as well as women's protection and empowerment; shifting power to local, women-led organizations, transforming harmful gender norms, and changing policies that inhibit SRHR.

Photo: An IRC staff member washes their hands in chlorinated water outside an IRC Ebola triage space in the hospital in Goma, Democratic Republic of Congo.

4. Infectious Disease Prevention and Control

In FY23-27 we will focus on **scaling 1) facility-based infection prevention and control (IPC) and 2) community-based WASH solutions** to prevent and control the spread of infectious disease (e.g., handwashing in health facilities, schools, and households, promoting safe hygiene and sanitation practices, regular IPC monitoring).

IPC is a practical, evidence-based approach to preventing patients and health workers from being harmed by avoidable infections. IPC is an independent marker of quality-of-care, but also a proxy for the overall quality of our health programs. It ensures clients and health workers at health facilities are safe from facility acquired infections, preventing outbreaks, and reducing the risk of antimicrobial resistance (AMR). Robust IPC practices in health facilities are critical for preventing and controlling outbreaks and ensuring overall quality of care, as are community level WASH activities that promote access to and use of clean water and proper sanitation and hygiene practices.

IRC has adapted and digitalized the WHO-UNICEF WASH-FIT tool to support monitoring and strengthen IPC standards in fragile settings with the tool currently in use in 25 countries. Advancing this work across all IRC country programs is critical for strong health systems that are safe and prepared for outbreaks and pandemics. Scaling IPC and strengthening systems for surveillance and early warning requires integration of IPC as an integral part of outbreak preparedness and response. Community sensitization, mobilization, and behavior change are essential to support IPC at health facilities.

We will **explore, develop, and build the evidence base** on achieving and sustaining adherence to facility level IPC standards in fragile settings through a system strengthening approach, and leveraging human-centered design and behavioral science to improve hygiene and sanitation practices. The IRC-adapted, digitalized WASH-FIT tool and data visualization used in our IPC approach can be shared as a tested tool with other partners, and an approach we could therefore scale via evidence and influence among the wider humanitarian community. The rollout of WHO's global IPC strategy also presents an opportunity, as the IRC is well placed to support that rollout considering more than 80% of health facilities supported by IRC are either partner- or MOH-owned. There is work to be done on identifying the key drivers of adherence to IPC standards from a healthcare provider perspective. Knowledge, attitude, and behavior change at community level is also paramount, working through community health workers (CHWs) and using proven community engagement and communication approaches; effective Social Behavior Change Communication (SBCC) across the health portfolio starts with formative learning and analysis.

Photo: IRC community health worker, Ma Hla Hla May, gives Health Education sessions to her neighbors in Da Paing IDP camp in the outskirts of Sittwe, Myanmar.

5. Last Mile Delivery of Primary Health Care

In FY23-27 we will focus on **scaling delivery of essential health services and interventions through integrated, community-level models** such as Integrated Community Case Management (iCCM), community-based maternal and newborn care (CBMNC), SBCC and community engagement, self-care, community-based care for mental health and psychosocial support (MHPSS), non-communicable diseases (NCDs), HIV/TB.

Last mile delivery is a critical modality to achieve the health outcomes outlined in the OEF including child health and women and girls. It is about making it easier for people to access services, information, and providing them with greater power and influence when it comes to their own health. We acknowledge the benefits of integrated and community-centered approaches to designing and implementing solutions to achieve scale. Additionally, the IRC's value add in many contexts is our positioning and ability to access the hardest to reach people in need, including the most vulnerable groups such as people living with disabilities, the elderly, pregnant and lactating women, children under 5, and others, whether directly or in partnership.

iCCM brings services and medicines to people's doorstep, taking treatment for common under-5 illnesses closer to the community through trained CHWs. Building on IRC successes with iCCM to date, we will further innovate around how to sustain supply chain for iCCM medicines and how to enhance integration of iCCM with other CHW activities. CHWs are also integral for last-mile delivery via CBMNC, which includes assessment for complications, medicines and referrals, and follow-up visits during the postnatal period. The policy environment for this work is favorable in many countries where the IRC works and is also a Global Research and Innovation Priority (GRIP) priority with research already underway in Somalia and South Sudan.

The IRC has made good strides in advancing self-care in humanitarian settings to fill critical service gaps in fragile health systems and extend health coverage and will continue to invest in integrating self-care for scaling key interventions such as FP. However, more work needs to be done to develop these areas. Within a health system, self-care includes self-management (e.g., as with FP noted above, self-injection of insulin by diabetes patients, self-medication for chronic care patients, etc.); self-testing (e.g., self-monitoring of blood pressure and blood sugar by NCD patients); and self-awareness (e.g., through patient education, management of diabetic foot disease, etc.). Community-based chronic care aims to incorporate self-care in follow up by CHWs to ensure treatment adherence and management of complications. This work by CHW's has been implemented successfully in refugee settings in, e.g., Jordan, Kenya, Tanzania, and Thailand, we have research from Jordan and DRC. Innovation and digital approaches will also be critical for this area and we are already working to test new approaches in Somalia.

We will also **explore, develop, and build the evidence base** for sustaining health services during shocks through adaptations including CHW delivery, self-care models and emergency preparedness as well as multisectoral approaches that integrate health programming with that of other sectors including economic well-being, VPRU, and early childhood development.

Photo: IRC staff in Somalia are scaling up programs to address the current drought and rising food insecurity. The team provides health, nutrition, water, sanitation services and more to drought-affected populations across the country.

6. Clean Water

In FY23-27 we will focus on **scaling the delivery of safe water** for multiple outcomes, including through emerging innovations and climate adaptation to improve the reliability, carbon footprint and long-run costs of water systems[6].

Access to clean water is critical for health, economic opportunity, and safety. Water insecurity, exacerbated by climate change, is of increasing concern in many countries where IRC works. As demand for water increases so too does the potential for conflict and/or displacement over scarce natural resources. Building on IRC's experience in fragile environments, we will scale approaches that consider the multiple sources and uses of water and sustainable management of water resources. We will focus on services, infrastructure, and technologies which have resilience to withstand more frequent and severe climate shocks such as floods and drought. Key to success is the engagement of users and local authorities in decision-making around water systems planning, resource management and service delivery to ensure sustained improvements.

In FY 22 IRC made access to clean water possible for almost 3.5 million people through construction and rehabilitation of water supplies. Seventeen country programs prioritized the WASH outcome in their SAPs making it the second most prioritized outcome.

We will also **explore, develop and build the evidence base** on how to design systems for increasingly frequent climate events from the outset, integrated programming that links water access, health, economic support and protection, and leveraging technology including GPS, mobile phones and remote sensing to collect and manage data on water systems.

Cross-Cutting Areas

Strengthening the resilience of health systems, including quality of care; continuity of care (including MHPSS and ensuring a reliable supply chain of medicines, medical supplies, and commodities); and climate change adaptation, cuts across the priority interventions and are critical to the achievement of the IRC Health Strategy.

To sustain the gains made through our impact in these areas, we must invest in approaches that enable long-term change to address pressing client needs and respond to contextual realities. Key entry points the IRC uses for **strengthening systems** in fragile and conflict affected settings include horizontal, integrated support at the sub-national level; strengthening the role of communities in health systems, including support to community-based health workers and committees; and engaging throughout the transition of acute emergency to post-conflict development. In these efforts, emphasis is given to working with partners to strengthen systems and build resilience in both traditional and community-based health systems.

Health systems are more resilient when they are able to deliver and maintain quality services, which will be further supported across the strategic priorities with the rollout of the Quality Improvement Framework and regular **quality assessments and improvements** across health interventions.

The IRC works across the arc of a crisis, from providing direct service delivery during an acute emergency to ensuring **continuity of care** from crisis through recovery. The IRC delivers a basic package of services aimed at meeting the short and long-term health needs of our clients and ensuring their survival and dignity. Continuity of care encompasses a range of critical interventions including our work to integrate MHPSS into primary health care services; ensure continuous access to services for people living with NCDs at the onset of a crisis; ensure access to safe and quality medicines, medical supplies and commodities; and prevent and respond to gender-based violence (GBV). We will continue to invest in the continuity of care by ensuring service delivery excellence and integrating the best evidence and learning in our work.

Addressing the **impacts of climate change** on outbreaks, disease burden and other health concerns, the resiliency and sustainability of health outcomes, the movement and mobility of populations, natural resources, food security and the health systems we support is critical to achieve our ambitions. Climate change poses a grave threat to our clients' lives and livelihoods and is an increasing driver of migration, crisis, and negative health outcomes, particularly for women, girls and children. With this, it is critical that we build internal capacities to effectively use a climate change lens to shift to more forward-thinking, sustainable program design and implementation that better incorporates the contexts where our clients live.

Photo: 7-year-old Farah* and her family were displaced by conflict in Syria. Now, they face the challenges of climate change as they live in makeshift tents in a resettlement camp that collapses under the weight of snow.

What Success Looks Like (these are indicative targets to be finalized during delivery planning)

Priority Intervention Area	Total Estimated Need	IRC's Current Annual Reach (2021)	Target Annual Reach by 2027	Total Annual INDIRECT Reach through influence & systems change by 2027
Nutrition (wasting treatment)	18M children in fragile settings	400,000 children	930,000 children (aggregate SAP target from CPs)	Flip the 80% wasting treatment gap to 80% coverage by 2030
Immunization (ZDC or under- vaccinated children)	25 million (globally)	240,300 children received DPT3 Vaccine	5 million children received DPT3 vaccine	Increased allocation of Gavi's funding to local and frontline implementing agencies (~25%)
Contraception	53 million women with unmet need	392,838 (clients starting modern contraceptive methods) 110,239 (unintended pregnancies averted)	3.2M Couple Years of Protection (CYP) 921,000 unintended pregnancies prevented	-MISP is implemented in every emergency response
Infectious Disease Prevention and Control - health facility WASH systems (IPC) - community level WASH systems	50% of health facilities lack access to basic water and 63% of health facilities lack basic sanitation services in LDCs[7]	27% of IRC supported Health facilities met 80% on IPC score (2021)	80% of IRC supported health facilities achieve 80% on IPC evaluation tool 3.3 million clients receiving direct hygiene promotion (aggregate SAP target from CPs)	This is a new influence area. Influence goal is being developed.
Last Mile Delivery of PHC	A projected shortfall of 10 million health workers by 2030	15,328 CHWs deployed (trained, resourced, supported) 806,413 Clients reached by CHWs/ community-based services	30,000 CHWs deployed (trained, resourced, supported) 5 million Clients reached by CHWs/ community-based services	This is a new influence area. Influence goal is being developed.
Clean Water	771 million people lack access to basic drinking water services [8]	3.49M clients provided with access to clean water in FY 22	5.5 million reached WASH infrastructure (aggregate SAP target from CPs)	This is a new influence area. Influence goal is being developed.

III. HOW WE ACHIEVE SUCCESS

Responsible for providing global leadership in health programming, research, advocacy, and influence, the IRC's Health Unit (HU) strides towards equitable access to health for people affected by conflict and disasters. The HU), country programs, and other IRC departments partner to deliver effective health, nutrition, and EH programs that achieve the best possible outcomes for our clients.

The HU supports IRC country programs with program design, business development, implementation, knowledge & learning, and external influence. The HU brings the best available evidence, implementation experience & data, new ideas, and important questions to help colleagues design high quality, high impact interventions. Additionally, the HU supports teams in designing submissions, cultivating donor relations, and positioning IRC for technical success. We also support hiring and training technical staff, solving implementation challenges, monitoring key indicators, and assessing implementation quality. We share learning, elevate and share research and learning and refresh our evidence base. Lastly, we drive influence at IRC, peer agencies, and donors to use proven interventions, share new evidence to inform new approaches, and influence policy.

The HU's role in this strategy is to:

+ Drive the overall implementation in consultation and partnership with other IRC teams;

+ Pursue scale for the six priority interventions through program delivery and the country SAP process, leadership on multi-country strategic projects, and influence to promote policy and practice shifts in the humanitarian health sector more broadly;

+ Ensure program quality by engaging country programs on technical matters, supporting IMPACT standards, and providing Monitoring, Evaluation, Accountability, and Learning (MEAL) support, tools and guidance to all health programs;

+ Develop strategic partnerships for funding, delivery, and influence, recognizing that civil society, government, and private sector actors closest to crisis are the main agents of response and recovery;

+ Conduct research and learning to inform evidence-based programming and answer novel questions relevant to the quality and impact of IRC's health work.

In leading the advancement of impact, scale, and influence for health, the HU will continue to identify internal and external barriers and opportunities to inform approaches with the best chance of success.

Strategy Delivery in Partnership

The HU plays a central role in IRC's Health Strategy, but not a solo role. In the coming five years, we will focus on the following areas of partnership and collaboration internally to achieve outcomes aligned with the health strategy:

Photo: Anila* and her friend play in the IRC medical camp area in Dadu, Sindh where IRC mobile health clinics were dispatched during the 2022 Pakistan Floods.

CRRD

Country Programs: The HU will work with **Country Programs** to adapt these organization-wide health strategy priorities; set ambitious scale goals in country-level SAPs; develop context-appropriate scaling strategies; and further develop technical, policy, and advocacy capacities. Whether for scaling priority interventions through strategic projects or other key interventions prioritized in country SAPs, the HU is an important partner for country programs to set and achieve scale ambitions across the health outcomes. The HU is committed to supporting country programs with donor engagement and strategic business development efforts to advance agreed priorities. The HU will work with country programs to assess which of their interventions or models are ready for scale - in line with their SAPs - and will advise on scaling design and implementation. The HU is committed to continue working with the CRRD **Impact at Scale team** to address operational barriers and delivery challenges to scale priority intervention. The HU is also committed to supporting country programs in achieving their SAP ambitions.

Technical Units (TUs): The HU will continue to work with TechEx leadership and **other TUs** to ensure the new Technical Advisor (TA) model and regionalization equips and empowers global and regional health practice leads and Technical Advisors (TAs) to influence country-level design work to advance impact, scale, and quality. One area of particular focus for TU collaboration is cash and voucher assistance (CVA) as this continues to be a rapidly expanding modality for humanitarian assistance. Twenty- three IRC country programs have prioritized CVA for health within their SAPs.

While progress has been made in **multi-sector programming** across IRC technical sectors, more work is needed. Multi-sector and integrated programming have long been on the agenda given its impact on client outcomes. The HU will continue working with other TUs to develop or adapt frameworks for deciding when multi-sector programming is the solution and clarifying specific approaches based on experience and evidence, including on good project design and joint assessments. Examples of such frameworks include the Nurturing Care Framework, which informs IRC's multi-sector approach to health, nutrition, protection, and early childhood development, and the IRC MHPSS Framework, which was developed across TUs and aims to establish standards, competencies and entry points across contexts. The HU will also collaborate to capture lessons learned and share best practices through case studies on multi-sector interventions and help to advance best practices on co-design and co-implementation.

Measurement Unit: **Evidence and reliable data** are essential to ensuring the success of IRC's health programming, and the HU will work with the Measurement Unit (MU) to ensure the right systems and processes are in place for measuring scale and quality. Together, we aim to support teams to utilize data – from services delivered, assessments, surveys, client feedback, and research – to design, monitor, evaluate and learn from our programs, so that we are always working to ensure our programs achieve higher impact for more clients. We also aim to strengthen the capacity across the HU to ensure that the delivery of technical assistance is data driven and focused on measurement of scale and program quality. The HU and country programs face challenges in achieving MEAL ambitions around the availability, quality, and use of data. Streamlining approaches, methods, and systems is a key area of focus. To achieve this, we have developed a HU MEAL Strategy which will guide the advancement of MEAL across IRC health programs.

EHAU: The HU will work with EHAU to ensure that impact at scale for health is considered and prioritized in **emergency preparedness, readiness, response, and resilience building**, to lay a strong foundation for long-term programming. Ensuring health systems are able to prepare for and respond to epidemic and pandemic threats is a key value add area for the IRC. This includes layering an always-on capacity for emergency preparedness and response functions onto existing health system services and taking a multi-sector approach to epidemic/pandemic response thus leveraging varied expertise. It is important that the HU and EHAU engage starting from the planning phase in deployment decisions for emergency response. The HU will continue providing technical support in emergency preparedness and response in the areas of e.g., EH, nutrition, infectious diseases, SRHR, MHPSS and others, while it is critical that EHAU continue funding key health (PHC, nutrition, EH) positions in the emergency response teams (ERT). HU-EHAU coordination is also critical for quick decision-making during outbreaks and, also in collaboration with the MU, improving the collection and analysis of data for early warning and embedding Early Warning, Alert and Response (EWARS) indicators with health data monitoring.

Global Supply Chain (GSC)

Investing in a quality, pro-active, and predictable health supply chain is essential for achieving and sustaining our ambitions at scale. Ongoing collaboration between the HU and GSC will continue to strengthen our systems and establish best practices for managing medicines, medical supplies, personal protective equipment (PPE), equipment and nutrition supplies from forecasting to sourcing through transport and warehousing to the last mile and the client. We will work together to continue best practices such as

Photo: IRC staff members in Nigeria unload a truck filled with medical supplies at the Mashamari stabilization center where they provide health care services to malnourished children and their mothers.

building the capacity of our health and supply chain staff, specifically country pharmacists. We will leverage existing data and explore opportunities to invest in technology to digitalize and make best use of our data. We will target eradicating stockouts of all medical supplies at the last mile service delivery points through better demand planning (by country health leads) and management practices to ensure health care providers have the necessary resources to deliver quality of care.

The collaboration extends beyond the primary health sector, addressing supply chain barriers and issues in Nutrition and EH. This holistic approach recognizes the interconnectedness of various sectors and the importance of an integrated supply chain in supporting comprehensive healthcare interventions. Additionally, the HU, EHAU and GSC will together identify the right items and quantities for pre-positioning of goods and contracts at the global, regional or country level to respond to urgent needs and emergencies. By working together and through strategic investments, the HU and GSC can identify common challenges, share expertise, and develop solutions that transcend traditional boundaries, ultimately improving health outcomes for our clients.

Research & Innovation

The HU will continue to work closely with Airbel through the **GRIPs** on malnutrition, SRHR and MNH and through the **Research and Learning Agendas (ORLAs)** such as NCDs, MHPSS, HSS, Immunization and Menstrual Hygiene Management (MHM). The HU will also work with Research & Innovation to contribute to global research priorities and build evidence as described for each priority intervention, particularly in relation to multisectoral approaches and optimizing service packages for decentralized delivery and will solicit Airbel support in generating evidence cards for the six priority interventions. The HU will also make use of Airbel's in house expertise on human-centered design, behavioral science, and best use of resources practices for advancing priorities in the strategy.

Business Development

The **strategic project business development portfolio** – built in partnership with Awards Management Unit (AMU), International Philanthropy and Partnerships (IPP)/ Global Partnerships & Philanthropic Services (GPPS), Grant Operations and Analytics Team (GOAT), regional, and country program teams – continues to grow in size and scope. To achieve the health strategy and align with S100 ambitions, we must continue to expand flexible, stable, and diverse funding from private and public donors. The HU will work with the AMU to identify flexible, long-term funding particularly for priority interventions and multi-country strategic projects. The HU will also build on and deepen work with the partnerships team to gather evidence and build systems and relationships particularly with large scale health funders including Gavi, Global Fund, USAID, FCDO, and the EU. Committed to deepening relationships with existing private donors who have provided catalytic funding for e.g., malnutrition and SRHR, and to building relationships with large foundations such as the Bill and Melinda Gates Foundation (BMGF) who have the potential to give more, the HU and IPP will continue working together to identify private donors and foundations whose mission and funding approaches align with our strategic priorities.

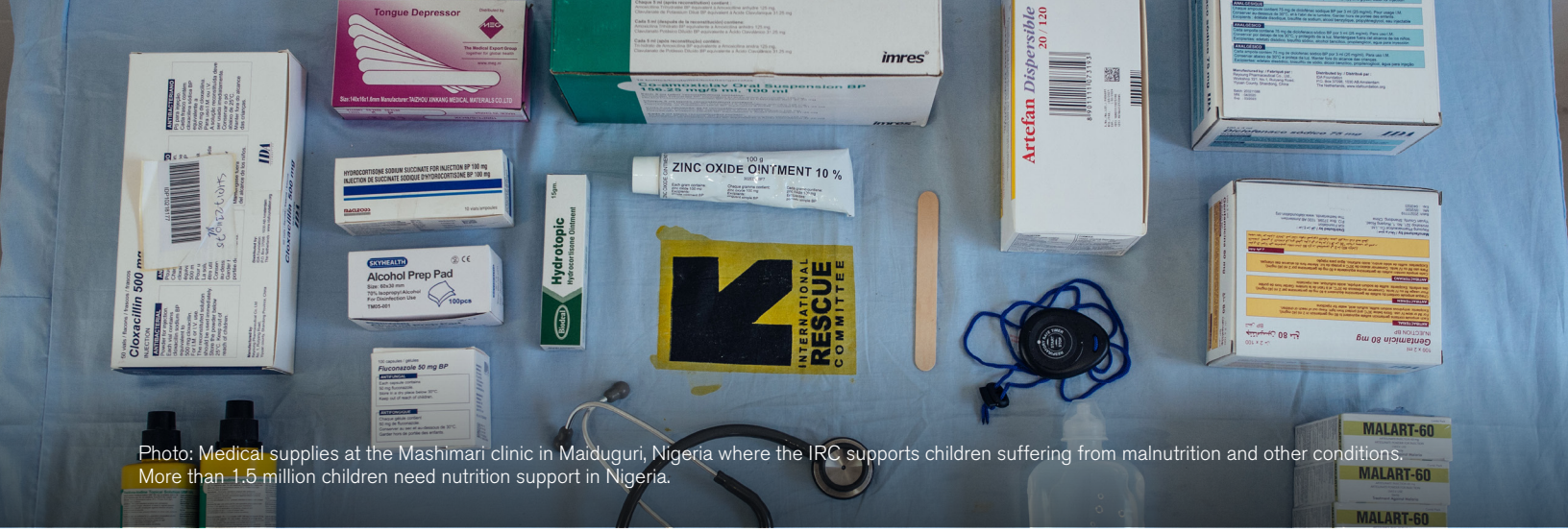

Photo: Medical supplies at the Mashimari clinic in Maiduguri, Nigeria where the IRC supports children suffering from malnutrition and other conditions. More than 1.5 million children need nutrition support in Nigeria.

External Relations

With the aim to do a better job of taking IRC Health expertise to a wider audience, the HU and External Relations will work closely to carry solutions and the voice of experts into the wider policy debate about the future not only of humanitarian provision, but also wider questions of global equity, global threats and global systems change. The HU and External Relations will work together to:

1) **Shape policy recommendations and solutions** for each of the six priority interventions,

2) Implement pre-defined **innovative and inclusive advocacy strategies** to create public pressure and support for policy solutions for the six priority interventions, and

3) **Mobilize resources** against these priorities for IRC and for sector scaling more broadly.

HU Policy, Advocacy (P&A) and Communications works hand in glove with IRC's External Relations teams to address systems level barriers and drive uptake of innovative solutions. The HU develops policy recommendations, advocacy strategies, and communications products which P&A and Communications advise on and help to advance through their networks. The HU also provides technical review of IRC-wide P&A and Communications efforts relevant to health. This work can have long term impact on our clients by changing the health ecosystem in which they receive their services. We leverage IRC's technical expertise, service delivery experience, and research and innovation portfolio to identify solutions and conduct evidence-based advocacy and communications.

President's Office

The HU will support the President's **public and private engagement on Health**, committed to co-developing sharp content and solutions on timely health issues (e.g., pandemics, hunger) and the health implications of broader global issues (e.g., climate, gender disparities, impunity). The HU and President's Office will collaborate to raise the profile of IRC's health work with a focus on highlighting solutions in each of the priority interventions and mobilizing resources for scale.

Partnerships

(working with various IRC teams, Global Entities, Region, and Local Partners)

Delivery on the Health Strategy depends on developing and maintaining external partnerships working with IRC's Partnership, External Relations, AMU, GOAT, and regional and country program teams. Critically, the IRC Health Strategy will work across three levels of partnership, these are at the global, regional, and country level.

Partnerships with **global entities** include funding partnerships, partnerships for influence that help us drive policy and practice shifts in our priority areas, and implementing partnerships with global public and private sector actors that bring complementary skills sets. Key global-level partners include USAID, WHO, Gavi, Centers for Disease Control and Prevention (CDC), the Pandemic Action Network and the pandemic preparedness fund established within the World Bank, the Global Fund for TB, Malaria and HIV, and BMGF, among others.

There is a strong push, among key donors and organizationally, for the decolonization of global public health and meaningful localization. Our ability to deliver on this strategy will depend on recognizing this centrality of partnerships to our work, and reflecting our S100 commitment to ask 'why not partner' and partner as equals in our technical models and approach, resourcing, recruitment and communications. Working with local and regional organizations and consortiums that shift power, resources and decision making to country and community level stakeholders is essential to the success of the health strategy. This shift is necessary to achieve scale and meet growing needs.

Photo: 70-year-old Sakhi Dad Agha getting his blood pressure checked during his checkup with the doctor at the IRC free medical camp set up in Killah Abdullah, Pakistan.

Some **important regional partners** include Africa CDC, Africa IPC Network, Pan American Health Organization, and the Asia Disaster Preparedness Centre. The HU will develop strategic partnerships with key regional partners and networks to facilitate this collaboration. Partnerships with local health ministries, civil society organizations and private sector providers are already central to our global health work. Support to IRC **country-level partner engagement** will continue, including the development of health partnerships guidelines and technical support in the mapping and selection of local actors toward increasing quality, effective local partnerships for achieving impact at scale. The HU will explore how to enhance technical support to country programs 1) in stakeholder mapping, assessing, developing, and maintaining strategic partnerships for health with relevant local institutions, and 2) in building and sustaining community health capacities. This will include guidance on effective capacity strengthening approaches for health service providers, CHWs, civil society actors, and other community level cadres.

People & Culture

Investing in IRC's people and culture is critical to meeting the needs of our clients and achieving this strategy. The IRC has invested significant work in improving team culture, ways of working, GEDI (Gender, Equity, Diversity, and Inclusion), and professional development opportunities and more work continues to be done. This includes pieces that can be advanced directly by TUs, while others need to be addressed and progressed with the People & Culture Team and Technical Excellence leadership. The implementation of this strategy will be aligned with ongoing IRC initiatives including the TA model, regional technical alignment, ongoing updates to the People & Culture work and the IRC's global GEDI Action Plan. We will also continue to support HU staff and country level staff to deliver this strategy, including through capacity sharing.

Endnotes

1 WHO estimates that the global prevalence of depression and anxiety increased by 25% in the first year of the pandemic (https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide).

2 It is worth noting in comparing IRC and MSF that MSF is mainly clinical and running their own hospitals and health centers, where IRC-supported health facilities are not always IRC-established or -run, and IRC health programming also includes a significant community health component.

3 SAP outcome prioritization alone does not necessarily fully reflect programming priorities and reach. Countries tend to take integrated approaches within outcomes that link to the most significant needs/priorities identified and considering that SAP guidance puts a cap on the number of prioritized outcomes.

4 As defined by Gavi: "Zero-dose children are those that have not received any routine vaccine. For operational purposes, Gavi defines zero-dose children as those who lack the first dose of diphtheria-tetanus-pertussis containing vaccine (DTP1)." https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities.

5 As defined by Gavi, "Missed communities are population groups that face multiple deprivations, including systematic constraints on their access to immunization and other essential health services. These may include socio-economic inequities such as gender-related barriers. Often the presence of zero-dose individuals, populations, or disease outbreaks are signals for missed communities as they are inextricably linked." https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities.

6 This could include technology that captures water where it falls to prevent flooding and maximize safe water during droughts, remote monitoring of boreholes, optimized siting to accommodate both human and livestock water need.

7 UNICEF/WHO data, 2021

8 https://blogs.worldbank.org/opendata/world-water-day-two-billion-people-still-lack-access-safely-managed-water