



STRATEGIC FRAMEWORK

This strategic framework sits above a separate document outlining plans for the current year.

- **The strategic framework** summarises Health Poverty Action's role and principles, identifies some key priorities, and maps out the direction of travel we (currently) aspire to.

It is a living document, subject to ongoing 'informed reflection' – and this may result in revisions in the light of experience or new developments.

The framework recognises the complexity of health and development, resisting the temptation to reduce this to a small set of key indicators. Deliberately, it is not a traditional Strategic Plan. Rather than attempt to determine in advance what will be achieved by when in an unknown future, it affirms that good strategy continually evolves, and emerges as much as it is pre-planned. The framework is a tool to enable an ongoing process of 'strategising'.

- **The accompanying work plans** are more specific, focusing primarily on just the next 12 months (based on our financial year – 1 April to 31 March).

The plans relate to specific departments. They set out the key activities these departments anticipate undertaking at the start of the year, along with a summary of the rationale for these and what they hope to achieve by them.

This strategic framework comprises 4 sections:

1. **Who we are** – our history, role and values
2. **What we do** – how these values translate into action
3. **Capacity to do it** – how we will generate the capacity and resources we need
4. **Informed reflection** – the data we will capture in order to reflect on progress and learn how to be more effective

1. WHO WE ARE

Health Poverty Action has been working to strengthen poor and marginalised people in their struggle for health for over 30 years.

In this time much has been achieved, but much more remains to be done. We go forward with hope. And we go forward with our passion and commitment as strong as ever!

Part of the People's Health Movement

We draw strength from the knowledge we are not alone, but part of a global movement for health justice – the *People's Health Movement (PHM)*.

The PHM is today's embodiment of the primary health care movement that achieved ground-breaking success at the UN Alma-Ata Conference in 1978.

Such was the power of this moment, that over 30 years later the radical vision it set out continues to rally health workers and policy makers worldwide.

The elements of this vision are known as the **Alma-Ata Principles**. They emphasise:

- *Justice-oriented approach*
Health justice cannot be achieved without social and economic justice. The principles call for a new international economic order, and the conversion of military expenditure to investment in health care.
In particular, they emphasise equity and proclaim the vision of "**Health For All**".
- *Strong community roots*
The Alma-Ata Principles emphasise the importance of accountability, and community participation in health care.
Health care must be easily accessible, irrespective of people's ability to pay, and must be culturally appropriate.
- *Comprehensive health systems*
The principles call for a comprehensive and integrated approach (as opposed to concentrating on selective vertical interventions).
- *Social determinants of health*
They call for a co-ordinated multi-sector approach, emphasising health cannot be achieved without addressing factors such as poverty, discrimination and inadequate access to key health determinants such as food, water/sanitation, and education.

The Alma-Ata principles also *re-affirm the WHO definition of health* as not merely the absence of disease or infirmity, but "*a state of complete physical, mental and social well-being*".

They emphasise **the right to health** – meaning not a right to be healthy, but a right to access and control over the determinants of health, so that all people can enjoy the best health they reasonably can.

Health Poverty Action (then called Health Unlimited) was set up in the early years following Alma-Ata, very much a child of the primary health care movement. The Alma-Ata Principles have always been part of the organisation's life blood.

Today these principles are as relevant and challenging as they have ever been. Our commitment to them is undimmed.

In 2000, with the participation of Health Poverty Action, the Alma-Ata Principles were expanded and updated in the form of the *People's Charter for Health* (the founding document of the PHM). In the words of the Charter:

"Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful vested interests have to be

challenged, and that political and that economic priorities have to be drastically changed. This Charter encourages people to develop their own solutions, and to hold accountable local authorities, national governments, international organisations and corporations.”

This is the call Health Poverty Action continues to take up – working with poor and marginalised communities around the world to develop and implement their own solutions, and to challenge the power imbalances that currently deny the right to health to so many.

2. WHAT WE DO

This section sets out how the Alma Ata Principles translate into action – driving what we do through our programmes and advocacy.

A) JUSTICE-ORIENTED APPROACH

i) Prioritise the populations missed out by others

We believe in Health For All. It is not acceptable for any to be excluded. However international initiatives often cluster in particular places. This can leave large numbers of people – often among the poorest and most marginalised in the world – with almost no external support whatsoever. We re-affirm our commitment to these neglected populations. They are Health Poverty Action’s highest priority.

These people often (but not always) live in remote or hard to reach places – and may be living in a current or post conflict situation. They may be indigenous communities or ethnic minorities, or a section of rural or urban society marginalised for some other reason.

There are many such populations outside the 14 countries we currently work in. Over the next 5 years we will therefore explore possibilities of opening programmes in **new countries**. We will identify places where we can add value, where we find communities and partners who want to work with us, and where opportunities for funding are likely to be significant in the years ahead.

ii) Progressive voice and positioning

Our passion for justice runs through all we do. Just as we will not shy away from difficulty in our programmes, neither will we do so in our policy work and campaigning. We have a moral duty to speak out where we believe we can make a difference. As in our programmes, we will look for issues of strategic importance missed out by others – or where we can add value by bringing a new dimension to the debate. We will seek to be a progressive and challenging voice within the sector – aiming not to work in isolation, but to forge alliances and look to influence others.

iii) Transforming unjust power relations

The most fundamental reason people are poor and denied their health rights is not unfair distribution of resources, but unfair distribution of power. Inequity of resources is incredibly

important – and is indeed a major cause of inequity of power. But ultimately the world is unfair because the concentration of power is unfair.

Access to health rights is affected by unjust power relationships at all levels – including within families and communities, at regional/national levels, and at global level. Our work is about addressing inequality of power – helping poor and marginalised women, men and children take control over the determinants of their health, and tackling factors that might prevent them doing so.

We recognise power takes several forms:

- status / authority (eg over policies and resources)
- knowledge / understanding
- skills / confidence
- collective power (by joining with others)

In all we do, we will pay close attention to the effect of our work on power relationships – not just in terms of *what* we do, but also *how* we do it and the ways we work with communities (including the role played by our own power in these dynamics).

iv) Communications consistent with our values

We will treat both the victims of injustice and the audience we are communicating to with respect. We will not resort to generating pity, and will not use patronising images or messages, or portray people as helpless victims.

We will describe Health Poverty Action's contribution with humility.

Applying learning from the sector's *Values and Frames* research, we will appeal to the best rather than the worst in people – invoking not a feeling of pride at being a benefactor of the poor, but engaging their sense of justice and desire to work for a fairer world. We will take people to a deeper engagement and more political understanding, communicating not just the consequences of injustice, but also the causes and solutions. Within this deeper engagement – and seeking to deepen it further – we will provide people with opportunities to become agents of change themselves, eg by campaigning, personal giving, and fundraising from others.

B) STRONG COMMUNITY ROOTS

i) Long term trust and commitment

Our work must be strongly rooted in and driven by the communities we serve. This in turn is rooted in dialogue and accountability – and a good relationship can take time to develop.

Many of the communities we work with have learnt through bitter experience not to trust outsiders. The close relationships and understanding we have developed over many years, not only with communities but also other key stakeholders such as local authorities, constitute some of our most valuable assets. We will strive to never betray this trust. We are serious about working with them to achieve real and sustainable change, and the nature of the challenges they face means this is usually a long term commitment. We will work as hard as possible to continue to support communities as long as we are wanted and needed.

Nevertheless there are occasions when it is necessary to stop working in a particular place or country. When assessing such difficult decisions we will consider factors such as:

- whether anyone else would provide the support if we did not (eg a local NGO), and any effect this might have on power relationships;
- any potential consequences of our staying (which could be positive or negative) for our work with communities elsewhere.

ii) Culturally appropriate

We know that health care provided in culturally insensitive ways can be as bad (or even worse) than no health care at all – effectively denying access and creating distrust of advice given. We will work with communities and service providers to ensure the health system is adapted to the priorities and demands of local populations, that the healthcare is culturally and linguistically appropriate, and that it is provided respectfully without discrimination. We will build bridges between traditional and state / local authority service providers, enabling transitions to new ways of working where the two operate in partnership and are mutually reinforcing.

iii) Community education and empowerment

We will support communities to take control over determinants of health they can affect. We will increase their access to knowledge, and the confidence, skills and resources they need to organise and bring about change. Employing participative methodologies such as community conversation, we will help them identify and overcome barriers to behaviour change, and work to make healthy choices easier choices.

iv) Accountability

We will work to ensure policy makers and service providers are accountable to the communities they are there to serve.

We will similarly work to ensure Health Poverty Action is truly accountable to the poor and marginalised women, men and children whose rights we exist to serve. This is far easier to say than it is to do – and further complicated because of inequalities and injustices within the communities themselves.

These are issues we must repeatedly challenge ourselves about, with deep and honest consideration of how power operates.

C) COMPREHENSIVE HEALTH SYSTEMS

i) Comprehensive and integrated approach

There are times when an initiative focusing on a particular intervention or disease can be helpful. However, in the absence of a well functioning comprehensive health system, eliminating one threat can simply result in people falling prey to another. Our priority will therefore be to develop and strengthen **comprehensive health systems**, recognising the six building blocks of an effective health system:

service delivery; medical technologies and supplies; health information system; health workforce; health financing; leadership and governance.

When disease specific interventions are appropriate, and when resources are available for these, we will seek to use those resources in ways that reinforce, rather than undermine, the development of integrated and comprehensive health systems.

We will seek to adopt an integrated approach as much as the nature of our funding allows. We will encourage integration not just within the health system, but a holistic multi-sectoral approach that also encompasses the social determinants of health. (This should include addressing social determinants from within the health system.)

ii) Continuum of care

We believe in the principle of continuum of care, and will work to support this in three ways:

- THROUGH LIFE – from conception to death;
- THROUGH THE REFERRAL AND TREATMENT SYSTEM – from isolated communities right through to advanced institutional care;
- THROUGH THE DISEASE CYCLE – prevention, treatment and rehabilitation.

iii) Both supply and demand

Wherever possible, we will work to strengthen both the supply and demand side of health care – supporting a community to demand and use high quality services, while simultaneously helping service providers develop the capacity to provide them. This powerful approach builds confidence and expectation on all sides, and helps towards sustainability after a project ends.

iv) Resources for health care

We will work to ensure health services are provided with the resources they need – including buildings, staff, equipment, medicines and other supplies, training, cultural awareness, and good community links.

v) Building on what's already there

We will not set up parallel systems, or promote one-size-fits-all solutions. We will support local people to build on what is already there, to develop strong, sustainable, accountable and culturally appropriate comprehensive health systems.

D) SOCIAL DETERMINANTS OF HEALTH

i) Essential services and resources for health

We will work to ensure poor and marginalised communities have access to the knowledge and resources they need to take positive control over the determinants of their health, including food, nutrition, water, sanitation, livelihoods and education.

ii) Emergencies and disaster preparedness

When a crisis emerges, and when we are in a position to add value, we will work with local and international partners to mobilise resources and respond as rapidly as possible. We will do so while adhering to the same values and principles that drive all our work. We will seek to strengthen rather than weaken the voice of poor and marginalised women, children and men, and respond to emergencies in ways that integrate as well as possible with longer term programmes. We will think not just of the current crisis, but also what might lie beyond, and begin preparing for that.

Many problems can be anticipated. As well as responding appropriately to emergencies when they happen, we will seek funding to support communities and service providers to help ensure they are as equipped as possible to deal with emergencies before they happen.

iii) Gender justice, ethnicity, and forms of discrimination

It is often women and girls who suffer the most when health rights are denied. Women are also often the ones best able to bring about changes to improve the health of their families and communities – while at the same time already carrying unfair burdens of unpaid work.

Health Poverty Action attaches very high priority to addressing gender inequality, and enabling women to take greater control over the determinants of their health, as well as having a proper say in factors affecting the health of their families and communities. This includes working to tackle gender-based violence, eradicating FGM, and addressing harmful local practices such as child marriage.

We especially recognise the rights of ethnic and cultural minorities, such as Indigenous People – and the consequences for their health when their culture is not respected.

iv) Poverty eradication and equity

Health levels and poverty levels are inextricably linked. Each is both a cause and a consequence of the other. Health Poverty Action believes it is possible to make great progress on both – and that this is the only way great progress will be made on either. This integrated approach is central to the Alma-Ata Principles, and we aim to incorporate it throughout all our work.

We especially recognise the importance of equity. The focus of MDGs on average figures often worked to the detriment of marginalised communities, who could remain completely neglected. So that we can one day realise the vision of Health For All, Health Poverty Action will strongly emphasise the need to reduce inequality and inequity.

3. CAPACITY TO DO IT

a) Continue to diversify and increase institutional funding

- We will seek to deepen our relationships with existing donors, and where possible access new budget lines.

- We will also reach out to new donors.
- We will aim to achieve larger clusters of projects in the same geographical areas. This brings many benefits, including:
 - reduces match funding risk by providing greater scope for project overlap
 - supports an integrated approach (which can fuel innovation)
 - helps us achieve scale as the lead local agency
 - helps us develop stronger and more sustainable management structures (by consolidating contributions from a larger number of projects)
- We will aim to establish in more countries the critical mass and negotiating power we have achieved in Somaliland and East Asia.
- We will seek to consolidate in regions we are currently strong (eg Greater Mekong), opening up possibilities of regional bids.
- We will maximise core cost recovery.
- We will also endeavour to use institutional funds to enhance our technical capacity.

b) Private fundraising

- We will combine predictable but long term payback streams (eg direct marketing) with investment in streams that might generate surpluses more quickly but also carry more uncertainty (eg events, partnerships and high net worth individuals).
- We will continue to develop the size and depth of engagement of Health Poverty Action’s supporter base, with an emphasis on new recruitment and increasing lifetime value.
- We will support and encourage people to rise up the pyramid of engagement:



- When resources allow, we will consider increased investment in fundraising.

c) New forms of income

- We will explore further the possibility of social enterprise as a potential source of funding for our work.
- We will also explore the possibilities of corporate partnerships. We will analyse carefully the full direct and indirect consequences of any potential partnership, to avoid the risk of doing more harm than good by undermining other just causes or our own values and reputation.

- We will explore ways of generating funds from our buildings, land and other resources.

d) Partnerships and alliances

It is increasingly important to work with others in order to achieve the necessary scale and influence – and to open up new opportunities. We will develop our network of potential partners, and increase our capacity to negotiate and participate successfully in consortia bids, implementation partnerships, and advocacy coalitions.

e) Develop links with health worker constituency

Having strong links to a particular constituency can make a big difference to the success and long term sustainability of an organisation like Health Poverty Action. In our case we are an organisation rooted in the primary health care movement – a network of health workers. We will therefore develop our links with the health worker constituency, in order to strengthen our income generation, our technical capacity, and our ability to influence. Within this we will look to use and develop our special relationship with Medact, our sister organisation in PHM (UK) and a membership organisation of health professionals who share our values.

f) Consider doing some work with poor and marginalised people in the UK

There are three reasons we should think about this:

- We might be able to add value to work with poor and marginalised people in the UK.
- Doing some work in the UK, even if only on a small scale, would provide opportunities to increase Health Poverty Action's profile and support here – and consequently increase income and resources for our work worldwide.
- There is a risk (even though no longer using that language) of helping perpetuate old notions of 'First World' and 'Third World, where the role of northern-based INGOs is to work in poor countries but not in their own. The truth is today extreme inequality exists, with associated denial of health rights, in virtually all countries – and the UK is no exception.

It may be possible to explore possibilities in the UK with our contacts in PHM UK.

g) Importance of opportunism

For the world's poorest and most marginalised communities, opportunities are in short supply. They cannot afford to be wasted. Opportunism is a very important part of Health Poverty Action's strategy.

Opportunities are often unpredictable, and with very short timescales. Therefore (as well as a strong internalised sense of our own direction of travel), key to our effectiveness will be the depth of knowledge and understanding we share with poor and marginalised communities and associated local stakeholders. This is what will enable us to react not only quickly, but also strategically.

h) Strengthen internal capacity

We will work to strengthen our capacity in key areas, including:

- technical and policy capacity
- management and programmes support structures
- finance systems

Increased capacity in these areas may mean they are serviced by:

- more staff
- more highly qualified or better trained staff
- new or improved external resources such as consultants or systems providers
- improved technology

Possible ways to achieve this strengthening include:

- growth in the level of funding we are able to allocate to core costs
- sourcing restricted funding for it
- consolidating larger numbers of projects in the same places, so that systems/structures receive contributions from more budgets
- partnering with other organisations to share expertise and resources
- increased sharing and linkages between different parts of the organisation (eg between similar projects in different countries, and between programmes and policy/campaigns)
- volunteers and pro bono support
- possible draw on unrestricted reserves (if the costs are a one-off investment rather than recurrent)

i) Value our people

We aspire to treat people internally according to the same values we wish to see in the world. We will foster an internal working culture that is positive, supportive and compassionate. We will seek to be inclusive and respectful of difference – and to practice anti-discriminatory behaviour.

Within the limits of resources available, we will support people in their personal development. We aim to be a community supporting each other to be at and give of our best.

j) Keep bureaucracy to a minimum

We recognise staff time is a scarce and valuable resource. While rigorously safeguarding our financial resources and the integrity of work, we will endeavour never to waste staff time with unnecessary obstacles or bureaucracy.

We will aim to foster an organisational culture that makes Health Poverty Action an exciting and supportive place to work – an organisation that makes it as easy as possible to get things done and make things happen.

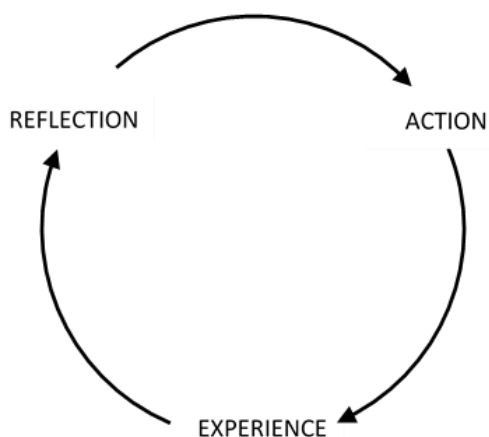
4. INFORMED REFLECTION

a) Reflection

Health Poverty Action's work is complex and unpredictable. Furthermore, developing and implementing good strategy is an ongoing process, rather than something that is done once every five years. Managing this complexity requires a deeper analysis than simply identifying a small number of key indicators and comparing them to a pre-determined target.

We therefore commit to a process of informed reflection – that not only captures key data, but seeks to understand the reasons underlying it. This will enable us to react in strategically effective ways to new developments, and assess our future options in the light of deeper knowledge and understanding.

This approach seeks to apply at organisational level elements of a cycle often used in our programmes:



b) Harvesting useful data for reflection

Each year we capture and report huge quantities of data. However it is currently difficult to usefully assimilate this and use it as a resource for organisational reflection.

We will seek to improve this in (at least) three ways:

- 1) To the extent allowed by donors, we will aim to **harmonise data fields across projects and throughout projects.**
This will mean progress and experience in different parts of the world can more easily be aggregated and compared. It will also mean baseline and endline measures will be consistent.
- 2) We will capture and collate qualitative as well as quantitative data, looking not just at outputs/outcomes but also at *process*.
- 3) Alongside our regular programme monitoring, we will gather data in greater depth on specific topics selected for organisational reflections – ensuring data is not just captured for its own sake, but feeds directly into a reflection process.

We aim to achieve the above in part through the further development and (eventual) organisation-wide implementation of new M&E databases.

We will capture data in cost effective ways, avoiding duplicating reporting requirements to donors.

c) Undertake programme of specific reflections

We will make more strategic use of board and management meetings by taking part in a series of in-depth reflections on selected aspects of our work. These reflections will not be a top down exercise operating at senior level, but a process involving the whole organisation (or at least those parts relevant to the topic).

In this way the reflections will feed directly into informing future action.

In order to make best use of such a valuable opportunity it will be important to be highly strategic and selective in choice of topic. Possibilities include:

- a key aspect of our values or working practice, such as accountability
- a particular thematic aspect of our work (eg women, influencing, innovation, etc)
- a key aspect of organisational development (eg new forms of income)
- our work in a particular country or region
- strengthening our technical capacity, management structures and/or finance systems

d) Analyse how we add value

Most of Health Poverty Action's funding comes from institutional budgets that would be allocated to other development initiatives if not given to us. There is no shortage of organisations applying to be implementing agencies of aid programmes – if the money does not fund our work, it will (usually) simply fund a development project of another organisation.

Therefore, when reflecting on the nature and value of our work, we will pay particular attention to ways we add value above and beyond what might happen anyway.

We aim to add value in (at least) 3 ways:

- a) *more inclusive allocation of resources* – ensuring populations are included who might otherwise be missed out;
- b) *innovation* – pioneering new techniques and approaches in order to be more effective;
- c) *influencing others* – using the political voice and influence we have as a result of our work and experience.

e) Track resources for organisational capacity

Within our organisational finances we will particularly monitor:

- Size and changing performance of income streams

- Total income allocated to core costs, broken down into its three components:
 - unrestricted income
 - project admin fees
 - core costs covered by direct charges to projects
 (The above should be monitored both numerically and as a percentage of total organisational income.)
- The level of unrestricted reserves

Assessment of each project grant will include:

- contribution to HPA's purpose
- contribution to core costs (head office)
- contribution to core costs (country)
- contribution to technical capacity
- match funding required
- match funding contributed to other projects

[We must not allow an organisational culture to develop in which the value of a grant is judged first and foremost on its contribution to core costs. That is important – but our first consideration will be its contribution to strengthening poor and marginalised people in their struggle for health.]

Also related to organisational capacity we will pay close attention to:

- Size and activity level of our supporter base
- Size and engagement level of audience reached by our communications

f) Emphasise our accountability to poor and marginalised people

Heath Poverty Action recognises accountability flows in all directions – and the most important is our accountability to poor and marginalised people. Their health rights are our greatest priority.

We will periodically review the nature and effectiveness of:

- how this accountability operates;
- how we identify the lessons we must learn;
- how we then take action to address them.