

INVITATION FOR PUBLIC COMMENT
GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELL-BEING FOR ALL

Accelerator Discussion Paper 7: Innovative Programming in Fragile and Vulnerable Settings and for Disease Outbreak Responses

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Disclaimer: These documents are working papers and subject to change. They do not necessarily reflect the views of the 12 Global Action Plan signatory agencies. Key elements of the accelerator discussion papers will be used as inputs to the Global Action Plan.

INTRODUCTION

This Accelerator aims to increase coordination and effectiveness in joint humanitarian and development action for improving health in fragile settings. Given the multidimensional challenges faced by countries affected by fragility, violence, and conflict, there is a need for innovative programming for these settings. Participating GAP agencies will commit to undertake joint actions to strengthen governance and coordination, sustainable and flexible financing, service delivery, emergency preparedness, and disease outbreak response.

PROBLEM STATEMENT

The scale and complexity of humanitarian crises are increasing. More and more crises are linked to unresolved and intractable economic and socio-political disputes that lead to protracted humanitarian situations. These crises increasingly display complex interactions between economic, environmental, climatic, political, security, and societal factors that complicate efforts to provide essential health services to vulnerable populations, while undermining human, food and health security.

SDG3 is out of reach unless fragile settings are addressed

Fragility is defined by the Organisation for Economic Co-operation and Development, (OECD) as the combination of exposure to risk and insufficient coping capacity of the state, system and/or communities to manage, absorb or mitigate those risks. Fragile settings need a special approach - as distinct from low-income countries¹ - because they are the most likely to face acute health crises, while insecurity further limits access to vulnerable populations. Protracted conflict, weak governance, and lack of national capacity mean that many countries cannot deliver essential health, food and nutrition, and social services to large parts of their populations.

An estimated two billion people live in countries with settings affected by fragility, crises, and conflict and by 2030 at least half of the global poor will live in these types of contexts. It is in these crisis-prone settings where most deaths among children under 5 years of age occur; the highest rates of maternal mortality, sexual and gender-based violence, mental disorders,

¹ In fact, the majority of fragile context are classified as middle-income. https://www.oecd.org/dac/conflict-fragility-resilience/docs/OECD%20Highlights%20documents_web.pdf, p. 7.

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and under-immunization. More than 80% of epidemics occur in fragile contexts and 60% of people affected by food crises are living in countries affected by war, violence, and hostilities.

Working in these environments is a priority for the international global health community, however, it presents special challenges. Fragile settings often have a confluence of issues to be addressed, including weak health systems; insufficient health workforce; conflict and insecurity; high levels of hunger; weak infrastructure (including a lack of adequate water, sanitation, and hygiene (WASH) in health facilities); forced migration; lack of trust in public institutions; and multiple – and competing – national authorities.

On the frontline of an outbreak response are local health care workers; they have an essential role in detecting outbreaks, clinical management and community engagement. Health care workers are also among the most at risk of exposure to emerging pathogens, and in violent settings may themselves become targets. Keeping health care workers and patients safe by preventing the spread of disease through Infection, Prevention and Control (IPC), Occupational Safety and Health (OSH) and Water, Sanitation and Health (WASH) in health care settings is critical.

To achieve the Sustainable Development Goal for health, leaving no one behind, it is clear that partners must find innovative ways to provide essential health services and strengthen underlying health systems to reach vulnerable communities in fragile settings and do so in a way that promotes health worker safety and community-level resilience.²

Protracted conflict is a major driver of fragility

The number of crises directly related to or caused by armed conflict has doubled since 2013. More civilians live in states where violence is part of everyday life than at any time in the past two decades.

Global forced displacement is at the highest levels since World War II - currently estimated at 68.5 million, of whom 25 million are refugees. The average length of time of displacement for refugees has grown to 17 years. These populations are particularly vulnerable, with limited access to health services and often the worst health outcomes.

Challenges of delivering services in fragile contexts

Working in an increasing number of fragile settings, humanitarian and development actors are not always engaged in coherent longer-term planning to transition away from emergency programming and towards rebuilding and recovery.

The repeated delivery of humanitarian services tailored for emergency settings often has unintended consequences, including disrupting the recovery of the health system. Examples of this include: hiring health workers away from local primary care systems, displacing local markets, distorting wages and creating parallel health systems. The focus on reactive service provision often means prevention and resilience-building are not prioritized or funded.

² Since different agencies use different terminology to describe these settings, for simplicity the term “fragile settings” is used in this document

Fragmentation within and across the Humanitarian and Development Sectors

Despite the valuable work of international agencies, efforts to address health crises in fragile settings remain fragmented because of agencies' differing agendas and mandates; a lack of coordination and oversight with the operations of other actors; and differing timeframes for intervening in a crisis. Furthermore, agencies face short-term, highly earmarked funding, donor and provider-driven agendas, and funding that is reactive rather than proactive. As a result, critical activities are often under-funded. The lack of coherence and long-term planning between the humanitarian and development approaches may result in gaps and inconsistencies in service delivery and a lack of service provision to the most vulnerable populations.

Fragmentation can undermine the response to a health crisis, create difficulties for overstretched national governments and in some cases may cause lasting harm to the health system. During a health crisis, the lack of a coherent approach across agencies can lead to governments expending time and energy dealing with the demands of donors and aid agencies. Once a crisis is over, the government's recovery efforts are often hampered as departing agencies leave behind remnants of programmes, systems and agendas.

Multi-sectoral collaboration needs to be scaled-up

Health, humanitarian and development actors have struggled to engage in coordinated approaches that meet immediate lifesaving needs while at the same time address root causes in a comprehensive, strategic way that goes beyond regional or sectoral approaches.

In recent years, several global initiatives between humanitarian and development actors such as the Busan New Deal, the Paris Declaration, Universal Health Coverage 2030 (UHC2030), the Grand Bargain, the New Way of Working (Humanitarian-Development Nexus) and Deliver Accelerated Results Effectively and Sustainably (DARES) have been put in place with the aim of improving results in fragile settings. In addition, many partners such as WHO, UNICEF, GFATM, Gavi, have developed or are developing their own strategies for fragile settings. Efforts to align and scale these initiatives will be vital to succeed in advancing SDG3 objectives.

On financing, donors and multilateral development banks including the European Investment Bank and World Bank are showing increased interest in investing in fragile settings, particularly in the areas of service delivery, health systems strengthening, outbreak preparedness and response, research and innovation. An overarching, coherent, multi-sectoral approach based on emerging lessons learned from these initiatives would enable the acceleration of these efforts and opportunities.

JOINT ACTIONS TO BE TAKEN

As part of the Global Action Plan for Healthy Lives and Well-Being for All (GAP), partner agencies commit to working together in the following areas in fragile settings, including outbreaks:

1. Multi-sectoral governance and coordination

Where appropriate, and based on local contexts, international agencies will bring greater coherence to humanitarian and development action by strengthening and expanding existing platforms (or supporting the establishment of new ones if needed) to enable multi-sectoral coordination for health impact that promotes, monitors and ensures harmonized planning,

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analysis, and service delivery. Whenever possible, coordination platforms will include governments and integrate with existing national and local systems, with a view towards transitioning to local authorities through early recovery approaches.

This approach will leverage the comparative advantages and relative strengths of partner agencies to improve efficiency and reduce overlap and optimize for scale, speed and flexibility. GAP agencies will work collaboratively to conduct joint risk and needs assessments, iterative and agile planning, implementation and performance monitoring. GAP agencies will ensure that there is collective decision-making and risk management, as well as coordinated timetables, external relations, and communication.

GAP agencies will strengthen the use of interagency coordination mechanisms, such as the IASC, to conduct joint simulation exercises, train, disseminate guidelines and implement standard operating procedures in line with the International Health Regulations (IHR) (2005).³ A critical part of IHR compliance is strengthening and maintaining core public health capacities, as well as the monitoring and evaluation of these capacities. This is part of a cyclical process of planning, implementing and assessing designed to help countries improve their capacities for prevention, detection and response.

- **Joint analysis and planning**

GAP agencies will use agreed platforms to share information on acute humanitarian needs, stakeholders, health outcomes, and developmental context with an eye to the root causes of fragility, conflict, and violence.

Acute needs assessments will be linked to broader development context analyses that assess the root causes of conflict, underlying vulnerabilities across multiple systems, and patterns of marginalization and discrimination. A number of field-tested analysis tools exist, and the exact combination of assessments performed will depend on local context and country need.

Joint analyses will identify priority areas for intervention and inform medium- and long-term planning by humanitarian and development actors. Joint vulnerability mapping is needed to understand the operating environment, particularly in the areas of security and accessibility.

Based on joint analyses, an agreed set of short, medium, and long-term collective outcomes that align with national health development plans and SDG3 targets will be defined. These outcomes should include a focus on the transition to local authorities through early recovery approaches where possible.

- **Monitoring and accountability**

A unifying monitoring and evaluation framework will be established, and regular joint reviews will be held to ensure implementation is being achieved. Key performance indicators will be established for joint planning, analysis, definition of activities, implementation rates, assessments and lessons learned, to ensure goals and objectives are achieved and improvements constantly fed into the agile planning cycle.

³ The International Health Regulations (2005) is a legal framework endorsed by 196 WHO Member States and territories, to implement a set of procedures to prepare and respond to public health threats

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Spotlight on Yemen:

A WHO Vulnerability Matrix was devised that aggregated over fifty indicators based on factors which exacerbate vulnerability: hazards, impact on exposed population, health system capacity, morbidity, nutrition, food security, WASH, and social determinants of health. A vulnerability score was defined for each district, which was then used by partner agencies to prioritize Minimum Service Package delivery and implementation.

- **Sustainable and coordinated financing**

As response and recovery efforts in protracted settings require a long-term and sustained approach, with enough flexibility to address changes in context over time, emergence of new crises, challenges with access, and risk for re-escalation, GAP agencies will take a proactive, longer-term perspective on country engagement, while avoiding short-term planning and budget cycles. A greater focus will be placed on multi-year, flexible programming with less earmarking, aligned with the Grand Bargain commitment to increase efficiency, effectiveness, and transparency in humanitarian action. Approaches to this may include expanding the availability of contingency financing for emergency settings; utilizing different types of pay-financing mechanisms; expanding the donor base; and utilizing innovative financing mechanisms such as insurance.

Increasing government capacity for paying health care workers will be a high priority in this GAP strategy, both to deliver essential health services during a health crisis and to provide resilience against future shocks.

Spotlight on innovative financing mechanisms

The Contingency Fund for Emergencies (CFE): WHO's CFE was launched in 2015 as part of WHO's emergency reform. The CFE is designed to release funds (in an initial tranche of up to US\$ 500 000) within 24 hours of an emergency request. This unique ability saves lives, helps prevent unnecessary suffering and dramatically reduces the costs of controlling outbreaks and emergencies, as well as the wider social and economic impact.

The Central Emergency Response Fund (CERF): The UN's CERF was established by the UN General Assembly in 2005 to ensure a more predictable and timely response to humanitarian emergencies. The three primary objectives of the Fund are to 1) promote early action and response to reduce the loss of life; 2) enhance response to time-critical humanitarian requirements, and 3) strengthen core elements of humanitarian response in underfunded crises. CERF grants are meant to complement other funding by kick-starting operations within the first weeks and months of an emergency.

The Pandemic Emergency Financing Facility (PEF): The PEF was developed by the World Bank Group in 2017 in collaboration with the World Health Organization. It is funded by Japan, Germany and Australia as well as private sector partners. It makes pay-outs early during an outbreak cycle—before it becomes a pandemic—through two windows, insurance and cash. Funding requests are assessed based on three criteria: pathogen type, epidemiological thresholds and a technical assessment.

Spotlight on financing in Yemen:

In support of the 2018 Humanitarian Response Plan, a block grant was provided to UN agencies. This pooling of funding allowed the humanitarian operation in Yemen to become one of the largest

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and most impactful UN-managed operations. Among other major achievements, the block grant facilitated WFP's management of one of the largest, fastest and most difficult assistance scale-ups – increasing the number of people reached with food and nutrition assistance per month from 3 million to 10 million. It also permitted WHO and UNICEF, with Gavi-support for oral cholera vaccines and an integrated outreach to maintain Primary Health Care (PHC) services, and in close partnership with local institutions, to manage one of the largest cholera outbreaks in modern history.

Spotlight on financing in Uganda and Sudan:

In 2014, the Global Fund introduced the Emergency Fund to provide quick and flexible access to funds to prevent disruptions to the continuity of essential prevention and treatment services that cannot be funded through reprogramming, during certain emergency situations. Over the past 5 years, the ability to quickly provide additional financing proved to be an effective mechanism to provide essential HIV, TB and Malaria prevention and treatment services to affected populations, including refugees and internally displaced people, during emergencies. Recently, Uganda and Sudan portfolios were able to access the Emergency Fund to support their Malaria programs in responding to extra needs related to South Sudanese refugees' influx. Adopting a similar approach to the Global Fund, Gavi has used the flexibilities of its Fragility, Emergencies, Refugees policy to provide additional vaccines for refugees from South Sudan.

2. Emergency Preparedness

As a priority, and where most needed, GAP agencies will support the strengthening of emergency capacities through preparedness actions to reinforce the ability of the health system to handle the impact of new and recurrent emergencies. Many of the capacities to prevent and manage outbreaks require cross-sectoral coordination, such as in the areas of core public health functions including legislation, workforce capacity, infectious hazard management, functioning emergency operations centres, laboratory and surveillance systems linked to rapid response actions. Other focus areas will include simulation exercises to test capacities, community surveillance and engagement, rapid response, isolation centres, and case management capacities.

At the core of emergency preparedness is a strong health system. Efforts will be made to ensure that the health system can continue to provide essential health services and has the trust of its citizens – this will ensure a level of resilience when a crisis strikes. Minimum health services include immunization, family planning, pregnancy and delivery care, TB, HIV, Malaria treatment, WASH, infection prevention and control measures, a trained health workforce with strong community outreach. A critical area for pre-emptive action is ensuring WASH facilities in health centres - without this, infection control is nearly impossible; this is a highly beneficial investment.

Spotlight on Ethiopia:

Vulnerability Risk Assessment Mapping (VRAM) identifies the top health emergency risks in a context. Based on the identified risks, standard hazard specific guidance is used to compile readiness activities and develop an Emergency Preparedness and Response Plan (EPRP). A VRAM was conducted in Ethiopia, and an EPRP was developed, identifying priority readiness activities, including for Pandemic Influenza and Ebola. These activities were then mapped and linked to the National Action Plan for Health Security (NAPHS), allowing the country to maximize efficiencies and plan maintenance in each capacity for the next five years.

3. Outbreak Response

Disease outbreaks have a disproportionate impact on the world's most vulnerable countries and regions. GAP agencies will work together to support countries with fragile settings better prepare, prevent, detect and respond to disease outbreaks, as outlined in IHR 2005, particularly to reinforce the connection between the surveillance systems and rapid reaction mechanisms including the establishment of both coordination and emergency financing mechanisms (such as the CFE⁴ and PEF⁵), risk assessments, prepositioning of supplies, and expert deployments (e.g. through GOARN, the Global Outbreak Alert and Response Network, a collaboration of over 200 institutions and networks with multidisciplinary experts ready to deploy when an outbreak strikes).

Following the do no harm principle, all these efforts should leverage existing local and international partners already operating in fragile settings – rather than displacing them; short-term solutions should not lead to long-term problems.

Planning should anticipate that an acute event in a fragile setting is often accompanied by other disease outbreaks and health problems (such as maternal health, NCDs, and mental health), as an already over-stressed health system can no longer provide basic care for the population.

To promote accountability of GAP agencies, emergency response plans will have integrated monitoring, evaluation, and after-action reviews.

Spotlight on Nigeria:

Despite on-going insecurity in Borno State in 2017, WHO and partners reached 6.3 million people with essential health services, significantly increasing the proportion of consultations for those in need from 2016 to 2017. The efforts focused on health system recovery and resilience, 89 health facilities were rehabilitated in 2017 through the collective efforts of WHO and partners. Health sector support was also expanded from 195 facilities to 237, ensuring functional health facilities have the required supplies, medicines, and human resources to serve those in need. The starting assumption was that this was going to be protracted crisis concentrated on supporting health system pillars, rather than an emergency response providing the population in need with primary health care services by setting up a referral system that was paid for by the emergency response funds. This both served unmet needs and bolstered trust with the community. Recognizing the starting weaknesses in the health system, programmes to provide health services directly were set up. These contained some key characteristics: using locally recruited staff and training them with the idea that once the emergency was over they would transition to being normal health care workers, rather than only a temporary workforce. They also worked with the ministry to establish sufficient and regular payment levels for the health workers.

Spotlight on Bangladesh:

Persecution and violence in Myanmar's Rakhine State stand out among recent refugee crises due to a large number of people fleeing in an extremely short period of time: an estimated 655 000 Rohingya women, men and children fled to Bangladesh between 25 August 2017 and mid-December 2017, according to the United Nations. This level of displacement has not been seen in

⁴ WHO's contingency fund for emergencies designed to release funds (in an initial tranche of up to US\$ 500 000) within 24 hours of an emergency request

⁵ World Bank Pandemic Emergency Financing Facility

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decades. In taking on the outbreak of diphtheria among the Rohingya refugees, WHO used public health tools both old and new. Contact tracing was used to find all the people who may have been exposed to the disease. The establishment of diphtheria treatment centres was also critically important, to take care of those affected and keep the disease contained. A newly developed computer programme, known as the Early Warning, Alert and Response System (EWARS), allowed the quick collection of field data, geographical location, and affected populations so the response teams could act quickly. It was developed by WHO specifically for humanitarian and emergency settings and designed to be used by local people in at-risk communities. The tool works even without an internet connection.

Spotlight on Madagascar:

An After-Action Review (AAR) was done in Madagascar, following a plague outbreak. The AAR highlighted the need for risk-informed preparedness planning, linked with all existing plans, to have evidence-based programs for high-risk communities. A contingency plan was developed based on the readiness checklist assessment outcome from the AAR, and accordingly health system capacities were strengthened. Remarkable progress was made in the coordination of stakeholders and in cross border collaboration, linking with humanitarian interventions.

Spotlight on collaborative outbreak response in the Democratic Republic of the Congo:

During the Ebola outbreaks in the Equateur and North Kivu provinces of the Democratic Republic of the Congo, the WHO Emerging Diseases Clinical Assessment and Response Network (EDCARN) played a critical role by deploying clinical experts to the field to help Médecins sans Frontières (MSF) and the Alliance for International Medical Action (ALIMA) rapidly implemented the appropriate standards of care. EDCARN also worked with ALIMA on the design of safe, patient-centred supportive treatment units. In the particularly difficult contexts of these two outbreaks, WHO set up base camps for over 160 frontline responders, built office infrastructure for over 400 staff, set up the emergency operations centre and provided training to local and international frontline responders.

GAP agencies have come together to support WHO's medical response in a number of ways. Gavi has provided USD 15.1 million towards the vaccination drive. UNICEF has focused on: communication and community engagement to inform and protect local populations; water, sanitation and hygiene activities in communities, schools and health centers to help prevent further spread of the disease; psycho-social support to assist families, including children who are affected; and prevention measures in schools to create a protective environment. WFP has supported WHO and other partners by providing logistics, engineering, IT, camp management, and aviation support via the UN Humanitarian Air Service. WFP has also provided food assistance to over 308,689 people, of which 255,695 were contacts of confirmed cases and their households in order to prevent this health crisis from becoming a food crisis.

4. Service Delivery

Strengthening the local health system in fragile settings is a key part of emergency preparedness and response. A functional primary care system is the best chance for resilience in the face of health emergencies. In fragile settings, shoring up the health system will be a priority for GAP agencies, including, as a last resort, the delivery of an essential package of health services (EPHS) - the set of prioritized health services for restoring and maintaining access in fragile settings. Defining an EPHS explicitly, with a focus on the most vulnerable populations, reduces service fragmentation and improves resource allocation efficiency.

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For fragile settings, GAP agencies will agree on an EPHS, and services will be mapped to a responsible stakeholder for delivery. Where possible, EPHS implementation will be tied to the existing national health system.

Recognizing that fragile settings are the most vulnerable, they also need the most assistance to develop local capacity. Sending in international experts can never be more than a short-term solution. Ensuring the training and payment of salaries of a local health workforce will be a priority for GAP agencies. Establishment or maintenance of essential HRH governance and management systems, including maintaining a functional payroll, is critical to retain health workers during an acute onset or protracted crisis, as well as to sustain the capacity to absorb and utilize effectively and transparently both domestic and international resources. Protecting health workers from violence and harm is key to the uninterrupted provision of health services. In addition, substitutive emergency health care workers mobilized for temporary and/or mobile service delivery, such as mobile teams for hard to reach areas, should receive certification. This would allow these key providers to function as the health care providers in rehabilitated facilities in the future. Providers of substitutive services must assure that they are continuously building capacity.

It is well recognized that other key actions for strengthening the overall health system in fragile settings include the reconstruction and rehabilitation of infrastructure, particularly WASH; as well as the creation of health information systems to provide a common method of recording service delivery and monitoring information; underpinned by innovative supply chain partnerships to reach the most vulnerable at the last mile.

GAP agencies will work to assess, analyse and target critical service delivery activities where they are most needed.

Spotlight on Yemen:

To reach a large swath of the population in the short-term, a minimum service package (MSP) was extracted from the more comprehensive Essential Service Package (ESP). WHO, UNICEF, and other health actors selected the most cost-effective, priority interventions, comprised of six service categories: general services and trauma care, child care, nutrition, communicable diseases; reproductive, maternal and newborn health; non-communicable diseases and mental health. The MSP was costed, and a feasibility analysis was done to assess the extent to which the MSP could be implemented with the existing funding system.

Spotlight on Syria:

From humanitarian hubs in the country, the UN and accredited international nongovernmental organizations provide commodities to the Syrian Arab Red Crescent (SARC). SARC distributes these items directly through its 9,000 volunteers or through the Government of Syria-accredited Syrian partners. In addition, the UN and INGOs support local organizations directly. WFP dispatches around 40% of food through local NGOs and community-based organizations, with SARC permission. WHO provided essential health and nutrition services to over 2.7 million people in 2017 through work with NGO partners in besieged and hard-to-reach locations which remain off-limits to international agencies. Gavi has aligned with the Syrian Humanitarian Response Plan (HRP) to help partners purchase vaccines and cold chain equipment that protects all children living in war-torn Syria from deadly infectious diseases.

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Spotlight on Chad:

Since 2017, the World Food Programme (WFP), United Nations Development Programme (UNDP), and The Global Fund to Fight AIDS, Tuberculosis and Malaria have worked together to distribute over 7 million insecticide-treated mosquito nets across 13 regions. To make this possible, partners had to overcome challenges, ranging from lack of basic infrastructure and roads too dangerous and often unstable conditions.

Spotlight on Central African Republic (CAR):

In support of The Global Fund and their programmatic partners World Vision and the French Red Cross, WFP began managing in-country warehousing, logistics and delivery activities in the Central African Republic (CAR). In 2018, WFP transported 160 metric tonnes of medicines and health cargo to over 630 health facilities in CAR, ensuring that those in need received lifesaving HIV and TB medicines, and malaria protection

Spotlight on Yemen:

WFP also supported WHO's health response by delivering millions of litres of fuel to clinics, constructing cholera treatment centres, importing specialized health equipment, such as dialysis machines, and by providing food and nutrition support to those receiving care. The UN Population Fund (UNFPA) and WFP partnered to import dignity kits and health commodities for pregnant mothers. WFP worked with the Partnership for Supply Chain Management (a Global Fund partner organization) to deliver life-saving medicines and health commodities.

Spotlight on Mali:

The Health Resources and Services Availability Monitoring System (HeRAMS) is a collaborative approach, building on the participation of all health sector actors to define standards, report on health resources and services availability and establish a commonly agreed upon picture of gaps and priorities in support to decision-making. HeRAMS fosters the adoption of standard service packages and supports the monitoring and evaluation of their implementation. The World Bank utilized HeRAMS data in Mali and Yemen for the prioritization and reconstruction of facilities.