Health Systems Resilience - a shared need for tackling health emergencies & universal health coverage

30 May 2019

Global Learning Laboratory for Quality UHC
Global webinar

World Health Organization

Agenda

15:00 CEST	Framing of the webinar	Dr Shams Syed
15:10 CEST	Health systems strengthening for health emergency preparedness	Dr Sohel Saikat
15:30 CEST	Health systems strengthening for health emergency response and recovery	Dr Dirk Horemans
15:50 CEST	Question and answer	All
16:15 CEST	Close	

Health Systems Resilience

Health systems strengthening

for

health emergency preparedness

Dr Sohel Saikat
Health Service Resilience
UHC and Life Course
WHO Headquarters

World Health Organization

Outline

- Health systems and service resilience – Concepts
- Recent/ongoing outbreaks and emergencies
- Current level of preparedness and health coverage
- WHO - GPW13 and context specific support strategy
- Examples of ongoing country support

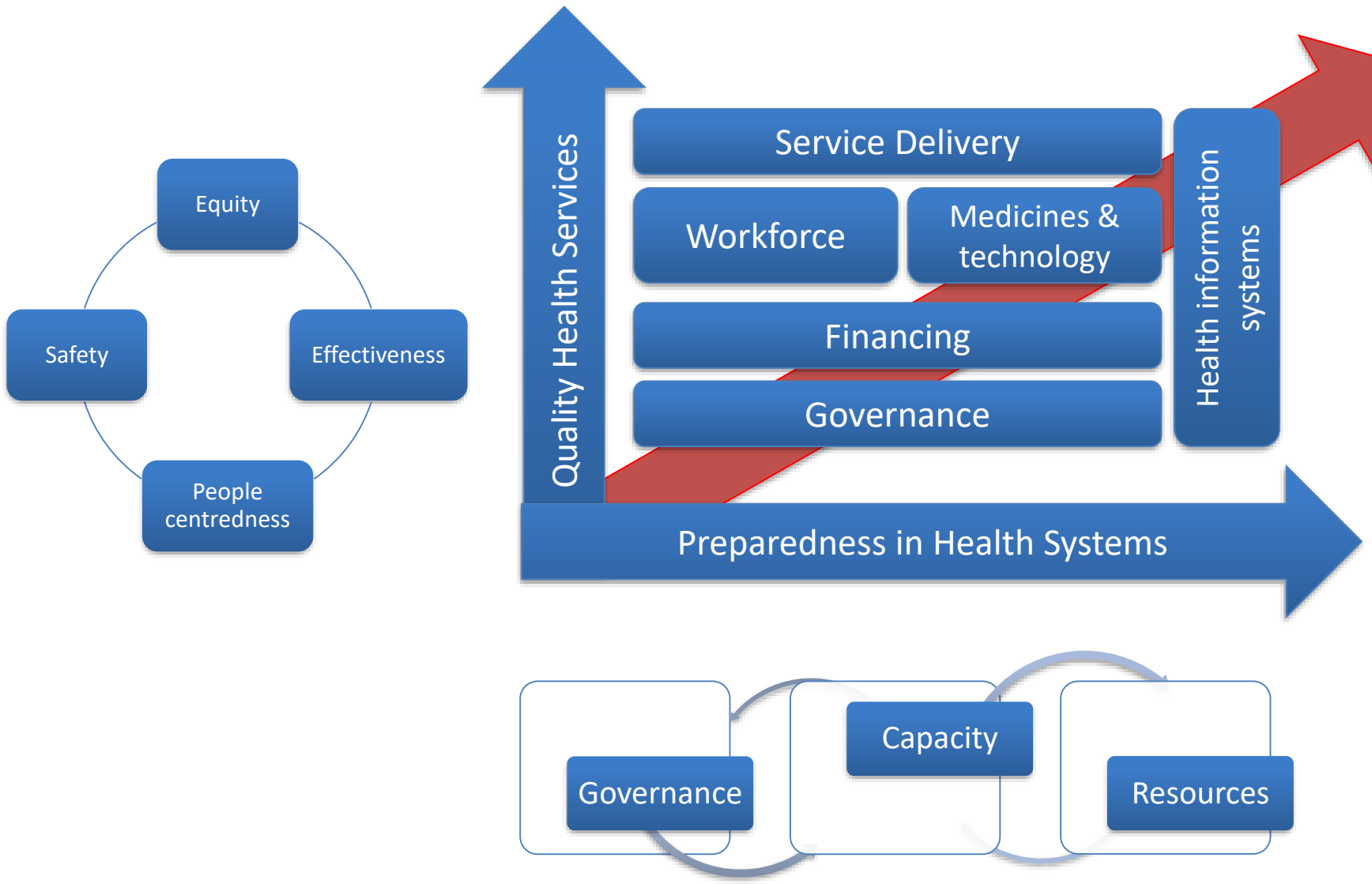
What is Health Systems Resilience?

The capacity of health actors, institutions, and populations to *prepare* for and effectively *respond* to crises; *maintain* core functions when a crisis hits; and, informed by lessons learned during the crisis, *reorganise* if conditions require it (Kruk *et al*. 2015).

Functions:

- ✓ **Maintain quality routine health services (promotion to palliation) in all contexts;**
- ✓ **Capacity for emergency specific health care;**
- ✓ **Public health response to emergency/crisis;**
- ✓ **Respond to changing epidemiology**

Resilient Health Services

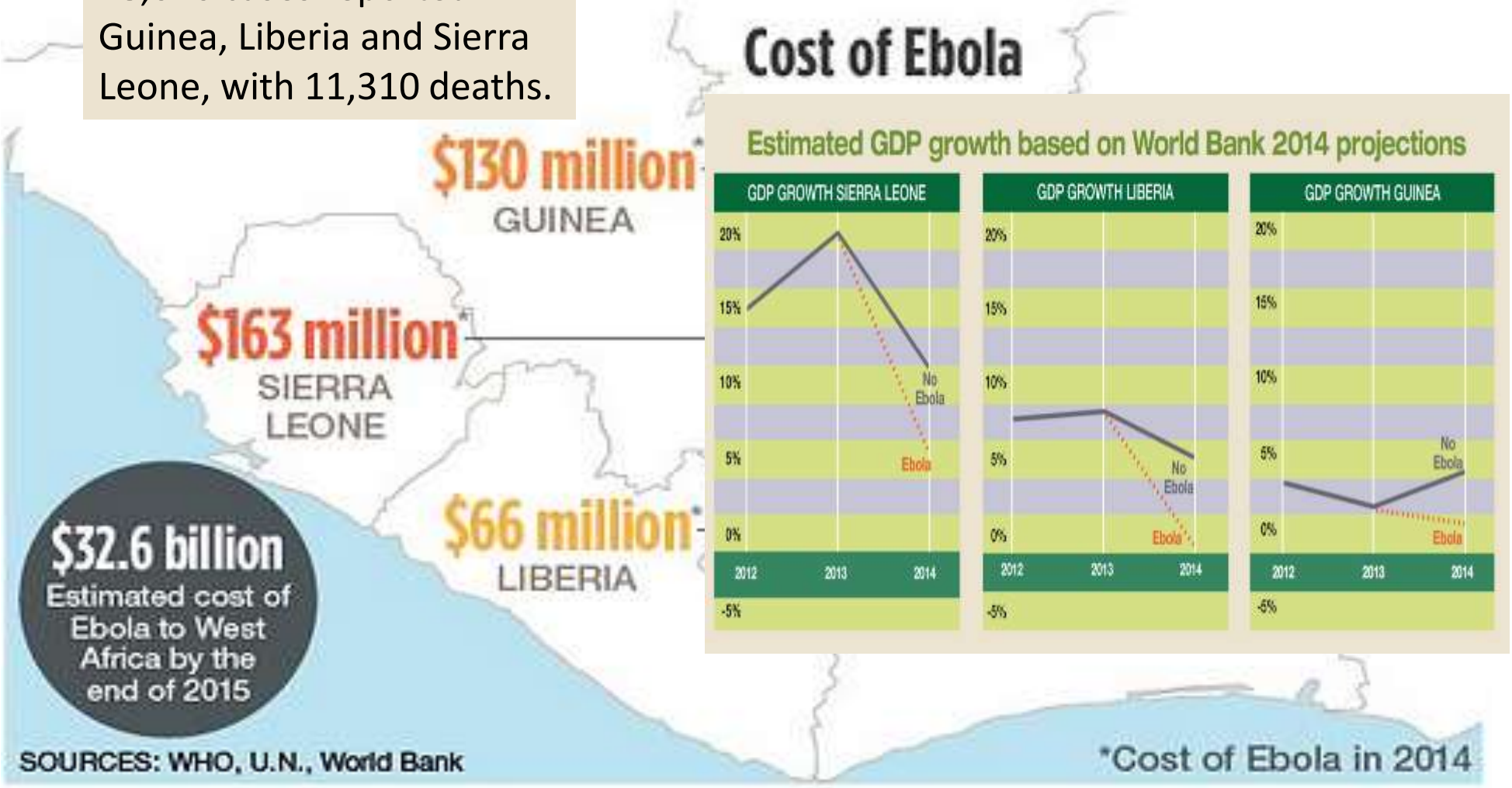


Resilient health services are quality routine and emergency-specific health services that are delivered prior to, maintained during, and improved upon following an emergency event in a people-centred manner

Examples of recent/ongoing outbreaks and emergencies

Ebola – cost to economy, 2014-15

28,616 cases reported in Guinea, Liberia and Sierra Leone, with 11,310 deaths.



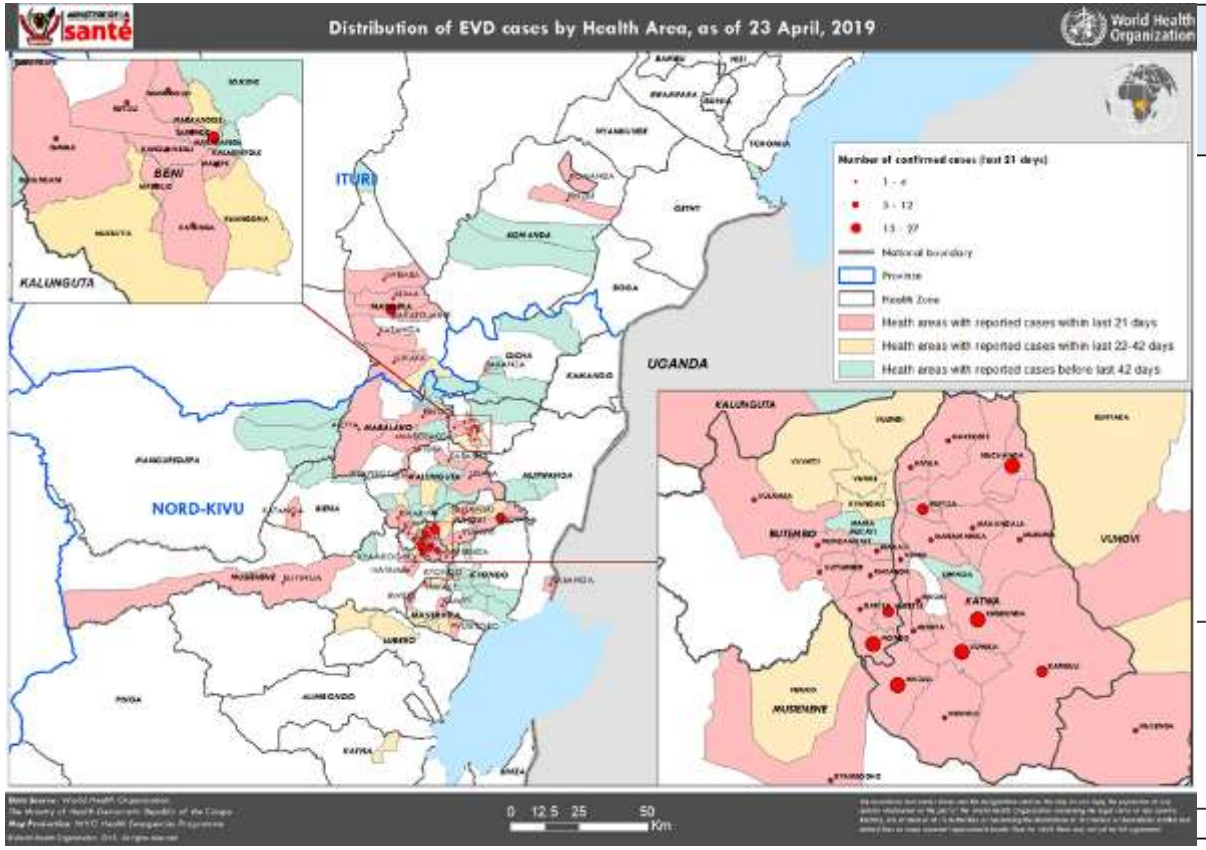
Ebola 2014-15– Impact on People & Health Systems

- **Liberia: 61% decline in outpatient visits.**
- **Sierra Leone: 39% drop in children treated for malaria & 21% drop in children immunizations.**
- **Guinea: primary medical consultations and hospitalizations dropped by > half and vaccinations by one-third compared to 2013.**

By May 2015, over 500 health workers died; over 10,000 survivors of EVD

Source: http://www.undp.org/content/undp/en/home/librarypage/crisis-prevention-and-recovery/recovering-from-the-ebola-crisis---full-report.html

DRC Ebola - *Ongoing*: Weak health systems, conflicts, concurrent outbreaks & displacement

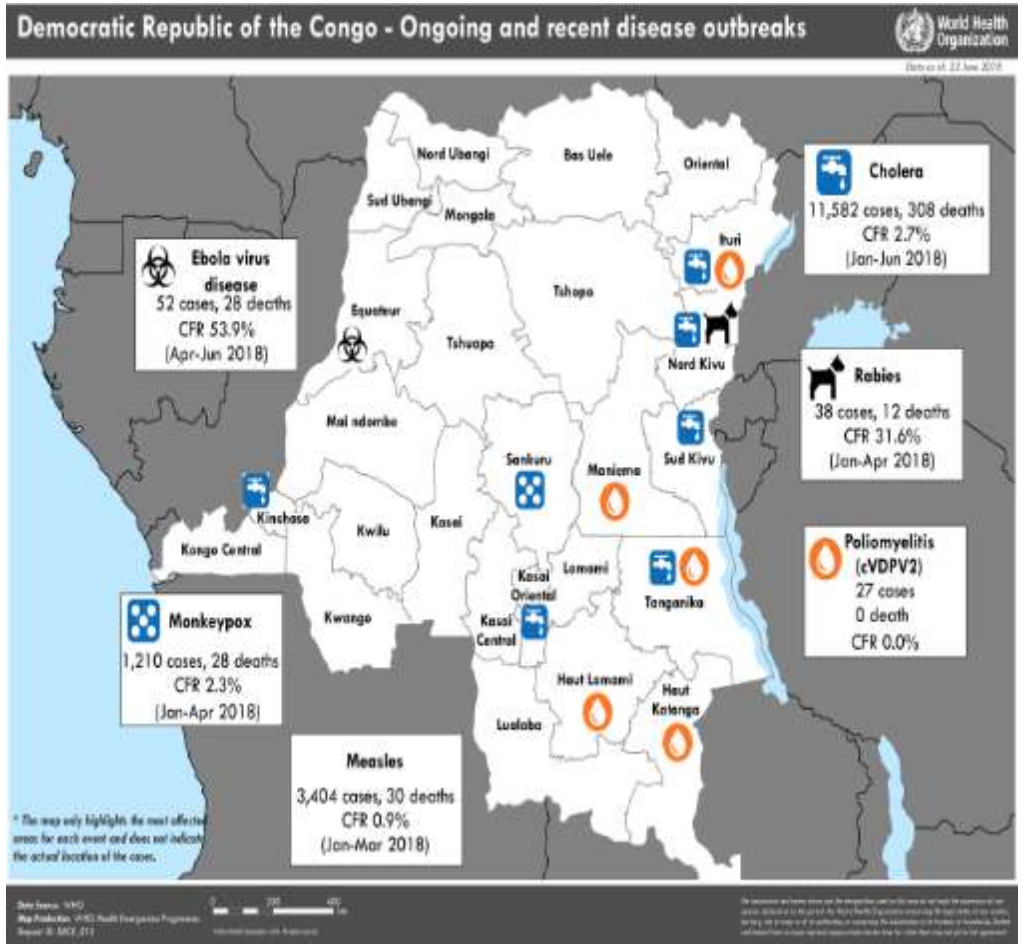


Province	Health Zone	During the last 21 days (3 – 23 April)		Cumulative to date				
		Cases reported	Health areas: reporting at least 1 case / Total areas in zone	Confirmed cases	Probable cases	Total cases	Deaths among confirmed cases	Total deaths
North Kivu	Beni	15	10/18	255	9	264	137	146
	Biena	0	0/14	6	0	6	6	6
	Butembo	29	9/15	129	0	129	138	138
	Kalunguta	6	4/18	54	13	67	24	37
	Katwa	132	16/18	450	11	461	298	309
	Kayna	0	0/18	7	0	7	3	3
	Kyondo	1	1/22	17	2	19	12	14
	Lubero	0	0/18	4	0	4	1	1
	Mabalako	9	4/12	99	16	115	62	78
	Manguredjipa	0	0/9	5	0	5	4	4
	Masereka	5	4/16	33	1	34	12	13
	Musienene	6	4/20	12	1	13	6	7
	Mutwanga	0	0/19	4	0	4	3	3
	Oicha	2	1/25	40	0	40	20	20
	Vuhovi	29	4/12	77	0	77	28	28
Ituri	Bunia	0	0/20	1	0	1	1	1
	Komanda	0	0/15	27	9	36	10	19
	Mandima	21	5/15	77	4	81	50	54
	Nyakunde	0	0/12	1	0	1	1	1
	Rwampara	0	0/11	1	0	1	1	1
	Tchomia	0	0/12	2	0	2	2	2
Total		**255**	**62/339 (18%)**	**1301**	**66**	**1367**	**819**	**885**

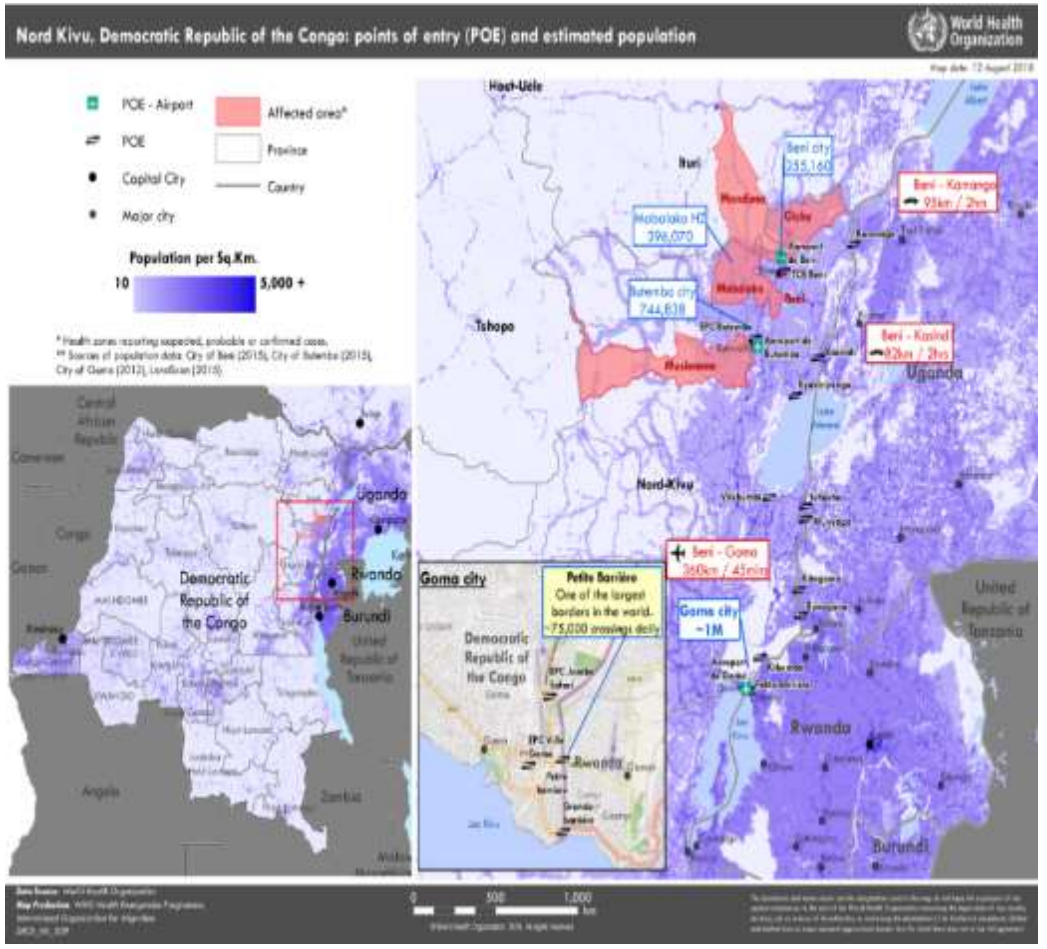
The number of healthcare workers infected is 90 (7% of total cases), including 33 deaths.

DRC Ebola - *Ongoing*: Weak health systems, conflicts, concurrent outbreaks & displacement

DRC - Ongoing and Recent Outbreaks



DRC – Points of Entry and Estimated Population

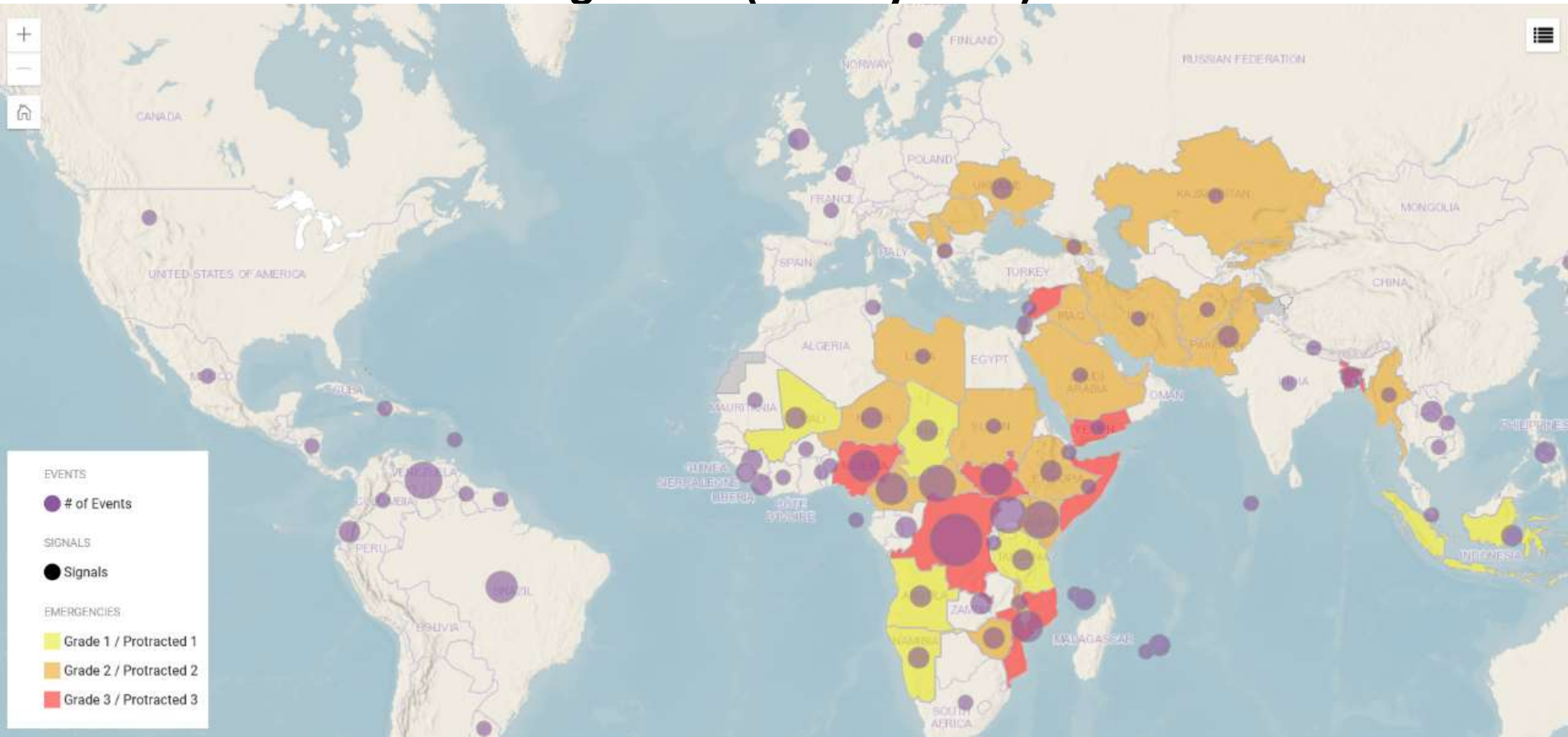


Spotlight on MERS CoV South Korea, 2015

- Inter and intra hospital spread - of the 186 confirmed cases, 183 are hospital acquired (?)
- 36 deaths, many of which were preventable with preparedness, training and application of the national guidelines
- Disconnect between Public Health and health care facilities

Global Health Emergencies Map: Emergencies (27 May 2019)

World Health Organization



Current Level of Emergency Preparedness and Health Coverage

World Health Organization

IHR-MEF

Self-Assessment & Reporting

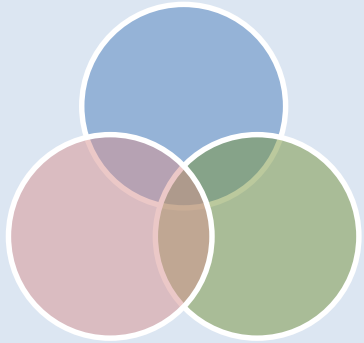
External Evaluation

After-Action Review

Simulation Exercises

National Action Plans

One Health

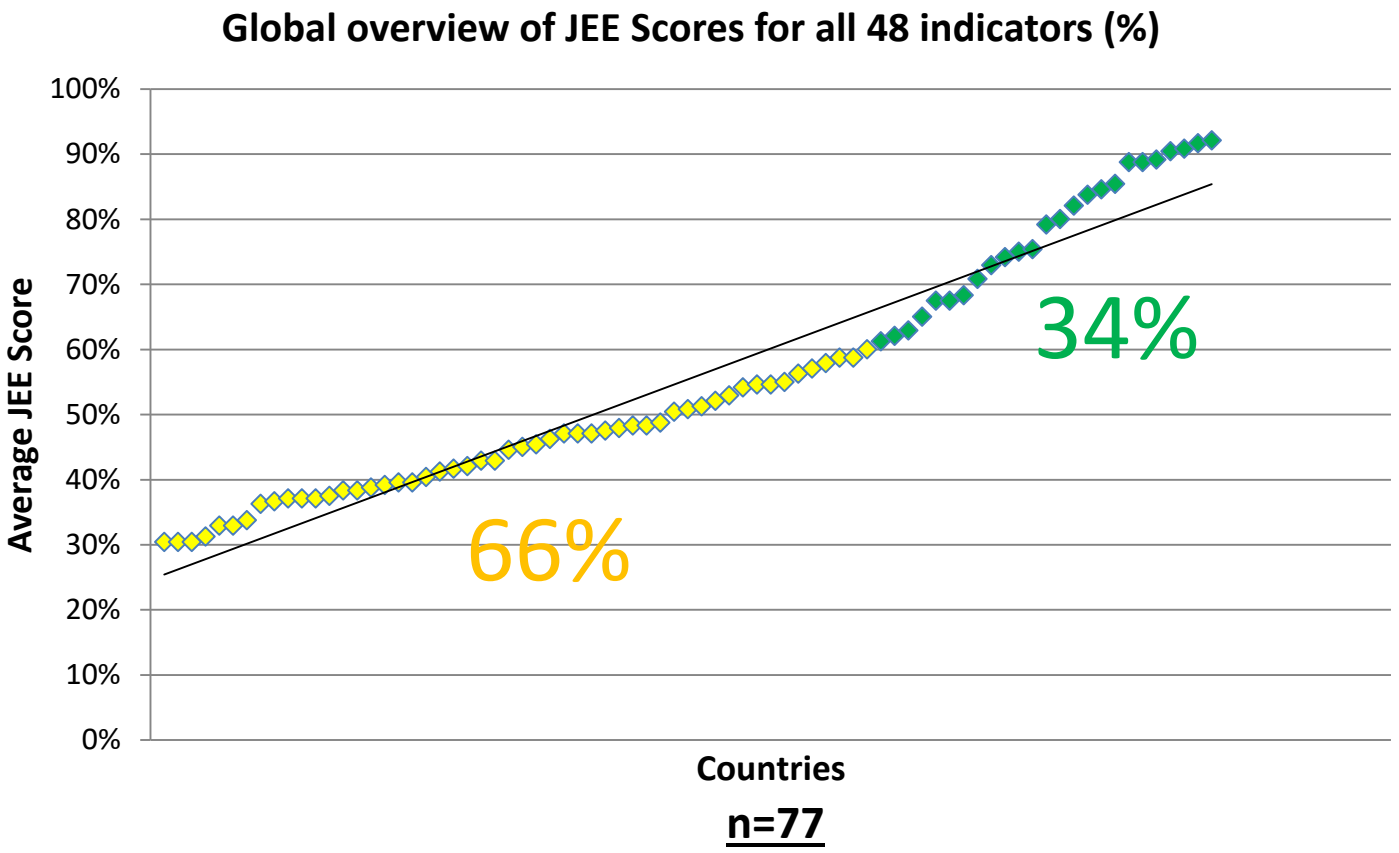


National Bridging Workshops

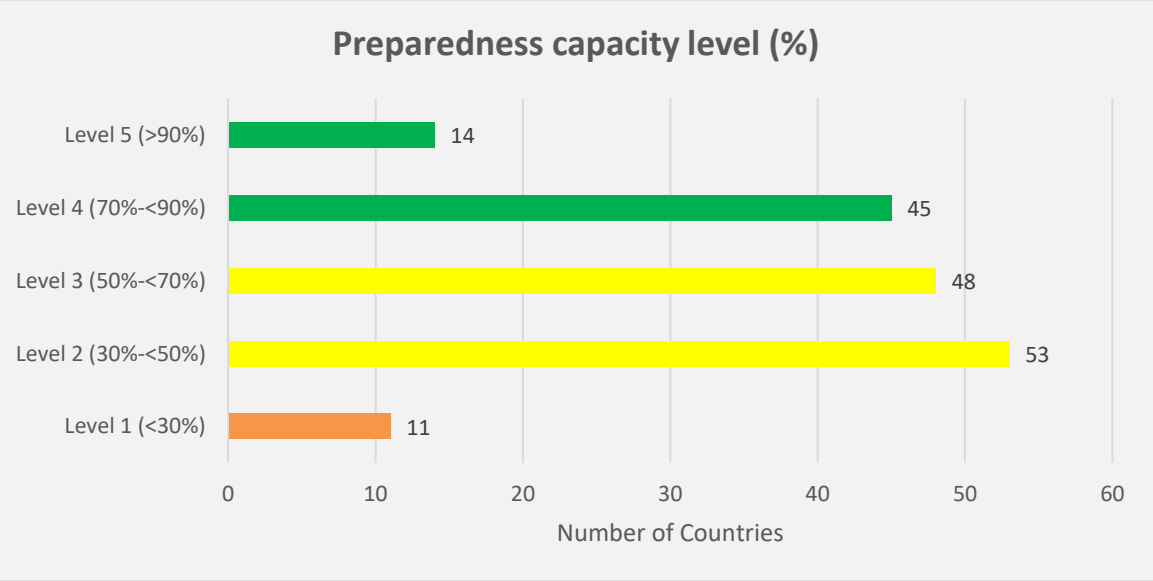
Increase in capacities for IHR

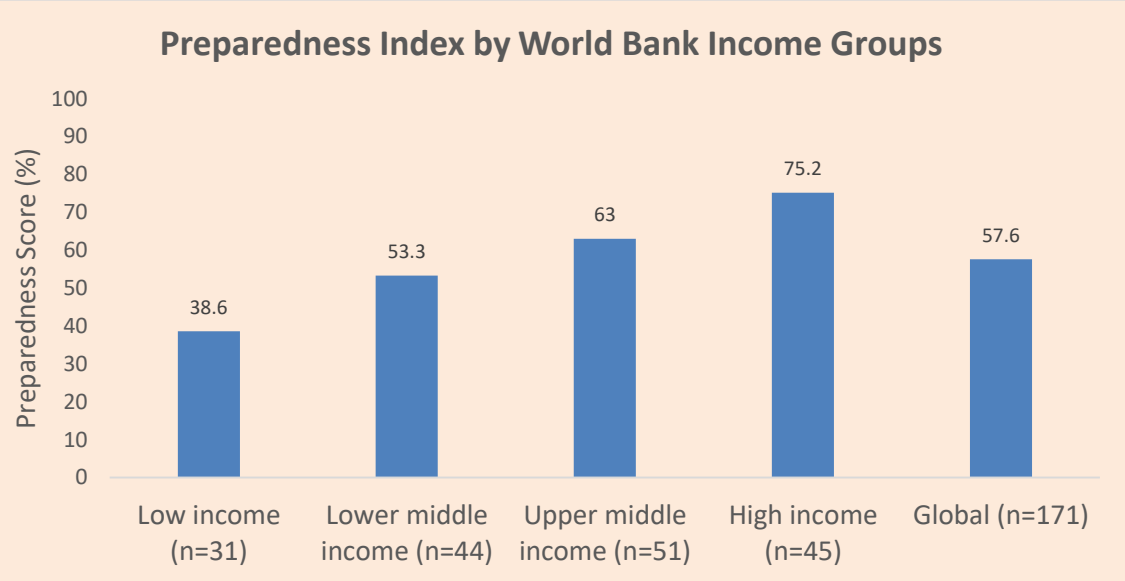
Current level of Health Security Preparedness (1)

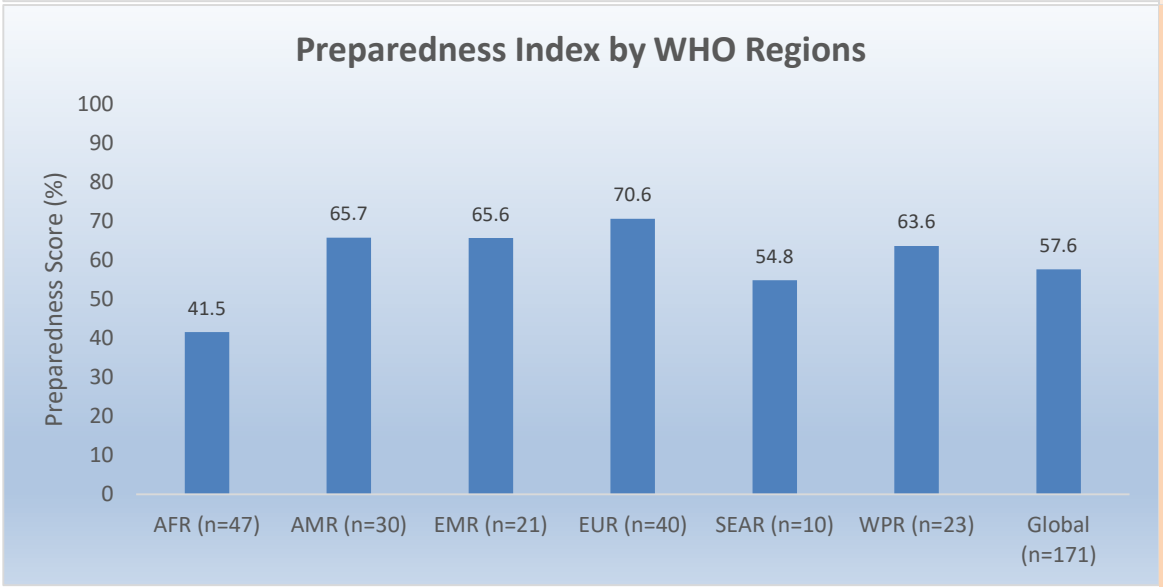
- Preparedness levels vary significantly between regions and countries;
- Average global JEE scores show that the majority of countries (66%) have either ‘limited’ or ‘developed’ capacities;
- 34% have ‘demonstrated’ or ‘sustainable’ capacities;
- Most countries that have performed JEEs are in AFRO and EMRO



Current level of Health Security Preparedness (2)

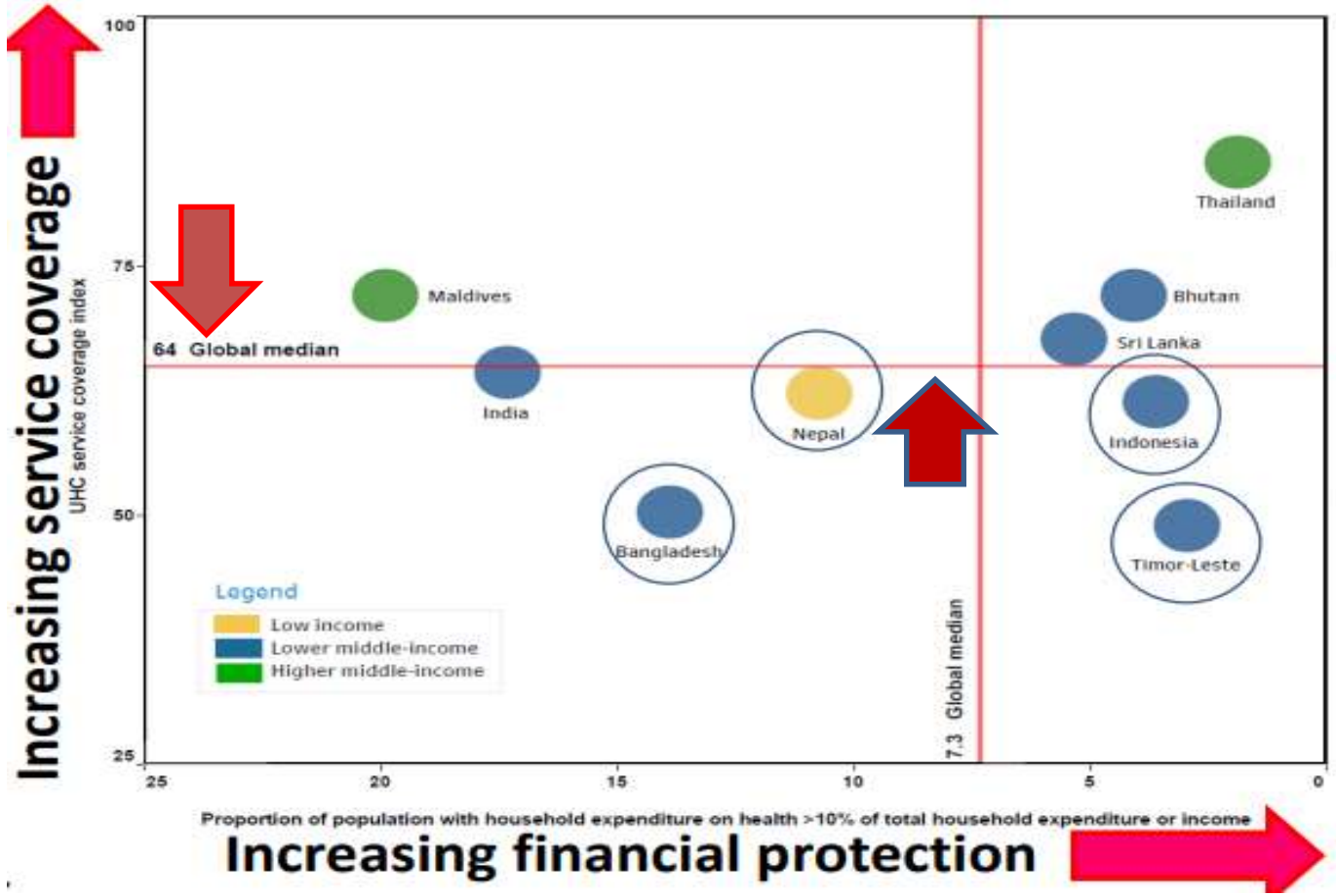






- Countries with greater levels of national income have higher levels of national preparedness;
- This is likely related to the ability of countries to invest higher levels of domestic funding toward preparedness measures;
- However managing health emergencies & preparedness is still a critical issue for all countries irrespective of economic development.

Current status of Health Coverage (UHC)



Key facts

- >50% world's population still do not have full coverage of essential health services;
- ~ 100 million people are still being pushed into extreme poverty because they have to pay for health care;
- > 800 million people (~ 12% of the world's population) spent >10% of their household budgets to pay for health care.
- Between 5.7 and 8.4 million deaths are attributed to poor-quality care each year in LMICs, which accounts for up to 15% of overall deaths in these countries.

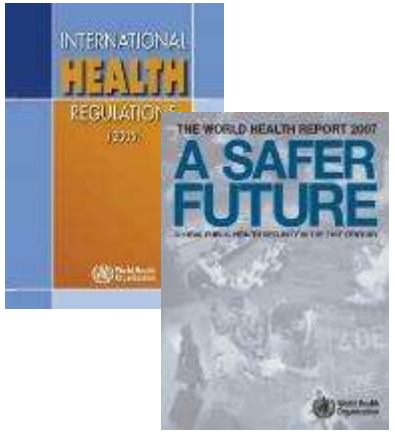
*"UHC and health emergencies are **two sides of the same coin**... Outbreaks are inevitable, but epidemics are not. Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics."*

Reflection on Current Status

- Inadequately prepared for emergencies and health care access to all;
- Fragmented approach and institutions – good practice ad-hoc;
- Greater global awareness of preparedness and higher investment post-Ebola 2014-15;
- One Health Approach (FAO, OIE & WHO) is gaining momentum;
- Advocacy to non-health policy makers is limited;
- Lack of clarity on roles and responsibilities between stakeholders;
- Domestic funding remains limited and funding is still siloed.

Integrated Approach – still in its beginning

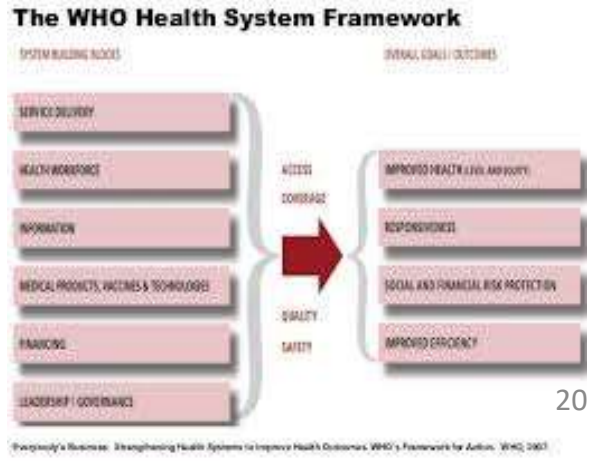
IHR Capacity building



Response & Recovery

Vertical Diseases & Life Course Health Programs

Health Systems Strengthening

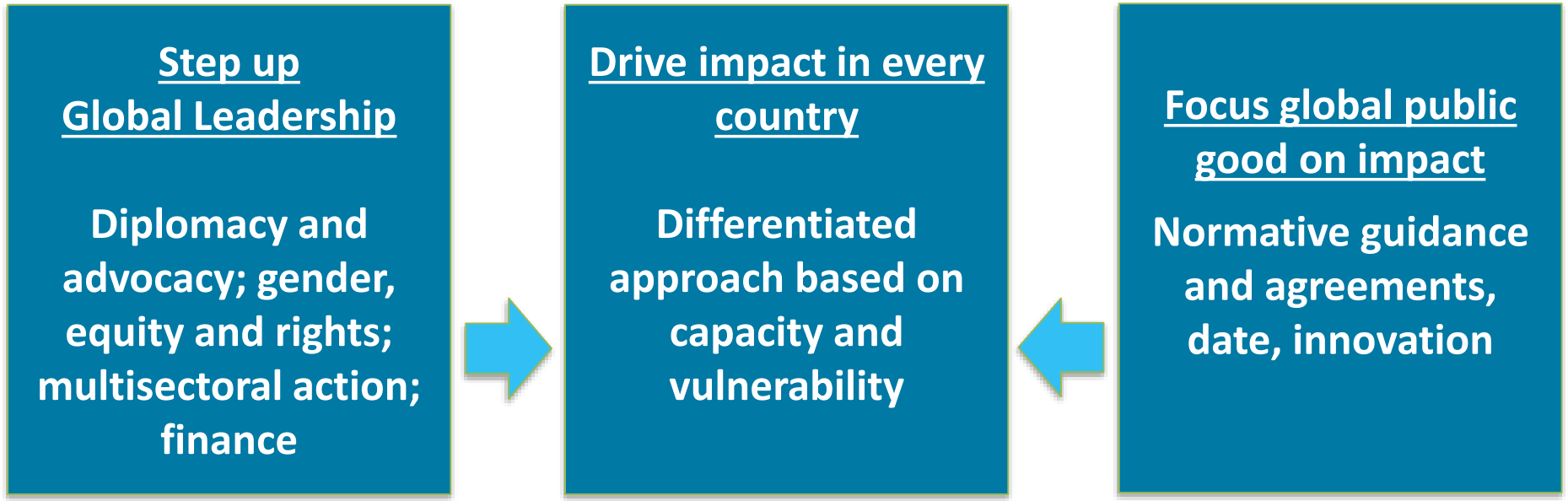


WHO GPW13: Triple Billion Target

WHO General Programme of Work 2019-23 Based on SDGs

Strategic Priorities (and goals)

- 1 billion more people enjoying better health and well-being
- 1 billion more people better protected from health emergencies
- 1 billion more people benefitting from universal health coverage



Joint working – Responsive/Context specific country support

Grade 3			South Sudan, N. Nigeria, DRC, CAR Syria, Somalia, Yemen
Grade 2		Sudan	Iraq, Libya, OPT
Grade 1			Afghanistan
Non graded	e.g. N. America; EU; Saudi Arabia, Iran, Qatar, UAE, Bahrain, Kuwait, Oman	e. g. Morocco, Tunisia, Egypt, Lebanon, Jordan, Djibouti, Pakistan	

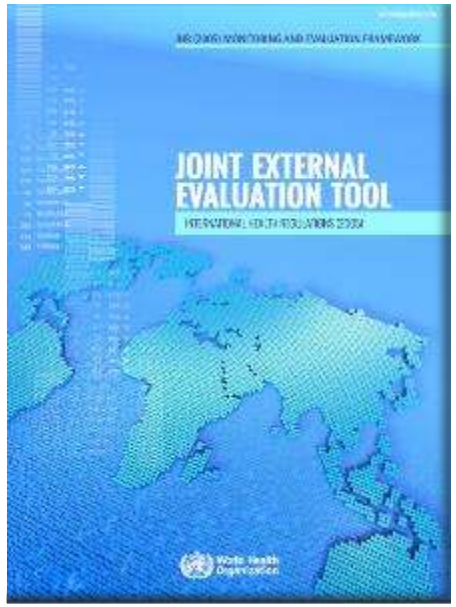
Mature health system ***Fragile health system***

Three Broad Different Country Contexts
Three Types of HSS and Preparedness Support Strategies

HSS country strategies including IHR core capacity and preparedness should be tailored to different country contexts:

- **Strategy 1**: Substitution of health **services delivery** and (re)building health systems and security **foundations** in FCV settings
- **Strategy 2**: Providing **technical assistance** to strengthen health system and security **foundations** and build system **institutions** in least developed countries
- **Strategy 3**: Supporting policy dialogue to support **foundations** building, **institution** strengthening and health system **transformation** in countries with mature health systems

Health System input in IHR implementation



Health Systems Participation

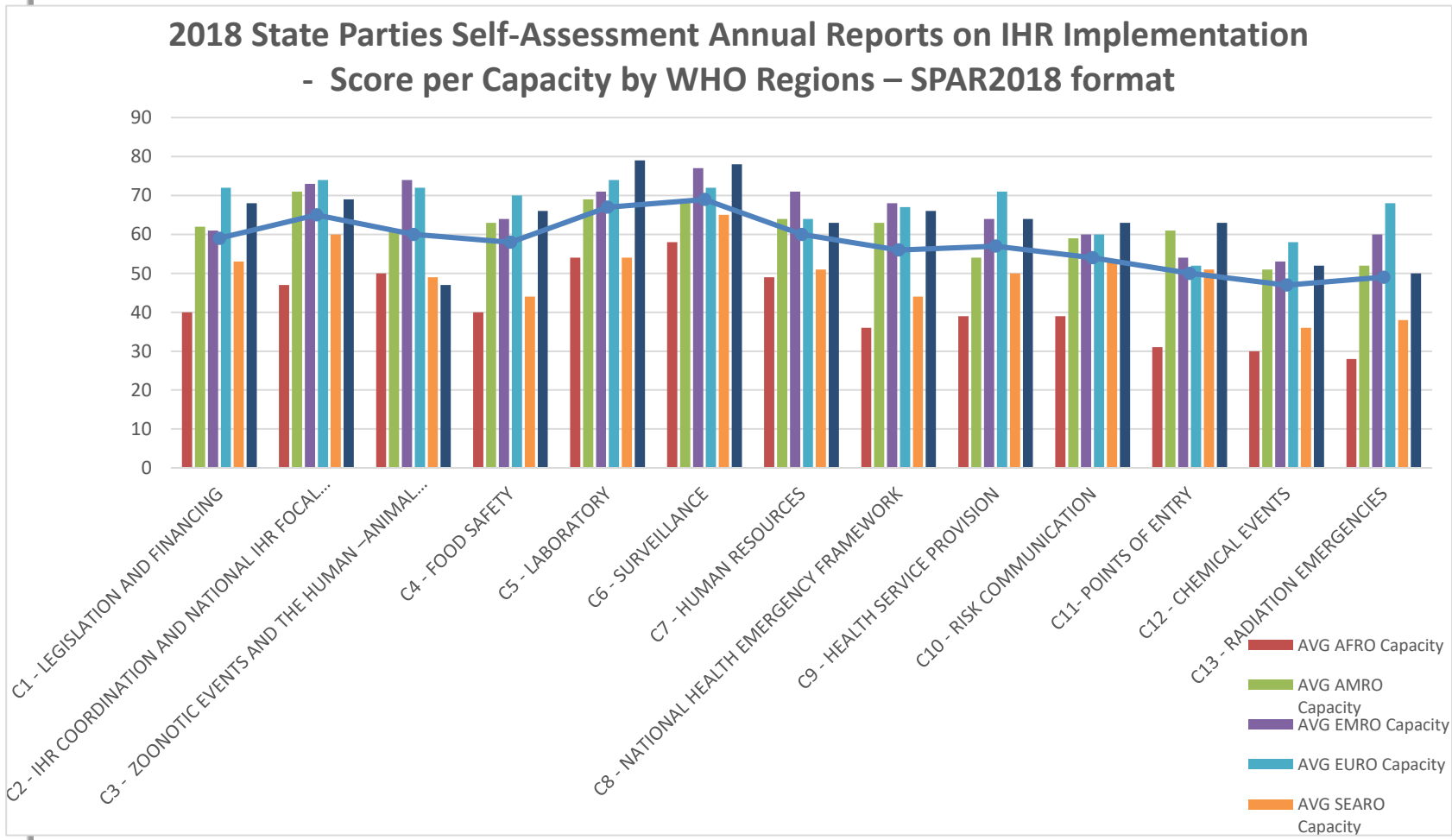
JEE : Pakistan, Liberia, Eritrea, Maldives, Saudi Arabia, Malawi, Togo.

Post-JEE Country Planning for Health Security: Tanzania, Eritrea, Pakistan, Senegal, Ethiopia, Kenya, Ghana.

Health system objectives

- Jointly identify **critical gaps** in HS resilience at country levels;
- Develop **entry points** for input into health security needs and vice versa, at policy, technical and operational levels;
- Influence a **systematic approach** to country planning for IHR (2005) implementation that consider HS resilience.

SPAR - Global Overview



C9. HEALTH SERVICE PROVISION

- Resilient national health systems and intermediate & local level health service delivery are essential for countries to prevent, detect, respond to and recover from public health events.
- Particularly in emergencies, health services should ensure capacities for event-related case management in addition to the provision of routine health services.
- To minimize the risk of onward transmission, clinical care should at all times adhere to optimum infection prevention & control (IPC).

- Indicators

1. Case management capacity for IHR relevant hazards;
2. Capacity for IPC and chemical & radiation decontamination;
3. Access to essential health services.

	Indicators	
Level	**C9.1 Case management capacity for IHR relevant hazards**	
Level 1	Nationally recognized case management guidelines[66] for priority epidemic-prone diseases are under development	❑
Level 2	Access to case management services according to nationally recognized guidelines for priority epidemic-prone diseases are available at national, intermediate and local levels	❑
Level 3	Access to case management services[67] according to nationally recognized guidelines for all-hazards[68] are in place at the national level	❑
Level 4	Access to case management services according to nationally recognized guidelines for all-hazards are in place at national, intermediate and local levels	❑
Level 5	Access to case management services according to nationally recognized guidelines for all-hazards are reviewed and updated on a regular basis	❑
Level	**C9.2 Capacity for infection prevention and control and chemical and radiation decontamination**	
Level 1	A national IPC programme and WASH standard for infectious diseases are under development	❑
Level 2	Access to health services according to national IPC programme and national WASH standards for infectious diseases are in place at major hospital centres	❑
Level 3	Access to health services according to national IPC programme and national WASH standards for infectious diseases are in place at all health care facilities	❑
Level 4	Designated health care facilities for chemical events have access to the capacity to decontaminate	❑
Level 5	Designated health care facilities for radiation emergencies have access to the capacity to decontaminate	❑
Level	**C9.3:Access[69] to essential health services[70]**	
Level 1	Less than 50% of catchment areas have access to essential health services.	❑
Level 2	At least 75% of catchment areas have access to essential health services.	❑
Level 3	All of catchment areas have access to essential health services.	❑
Level 4	Level of service utilization[71] : number of outpatient contacts per person per year ≥ 2.0 visit/person/year.	❑
Level 5	Level of service utilization: number of outpatient contacts per person per year ≥ 3.0 visit/person/year. AND Delivery of essential health services is evaluated and updated on a regular basis.	❑
Additional comments		

Tackling Deadly Disease in Africa Programme (TDDAP)

To enhance capacity for health security and emergencies in the WHO African Region within the broader actions of building foundations of robust, responsive and resilient health systems

Goal

To reduce impact of communicable disease outbreaks and epidemics on populations in Africa

Country Objectives

1. To strengthen and sustain the capacity of all Member States to prevent, prepare for, respond to and recover from outbreaks and other health emergencies.
2. To ensure that Member States' health systems and services integrate critical components of health security and health systems foundations for more robust health systems that can surge to handle crisis.

Making health services resilient in Ethiopia and Liberia

Goal Systematic consideration of quality and emergency preparedness in health service delivery

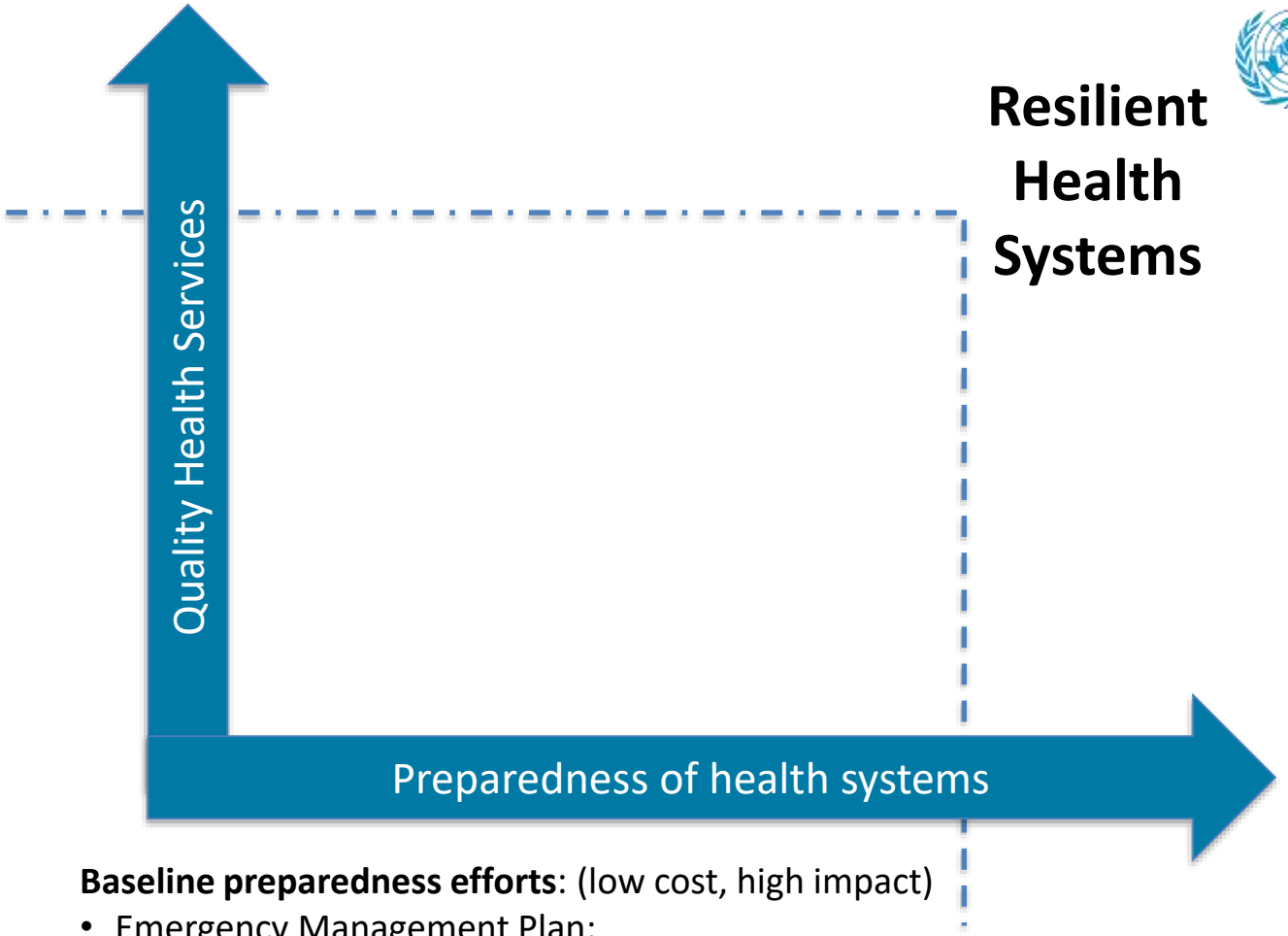
1. Enhanced knowledge on quality service provision during and between emergencies and its critical linkage to resilience & emergency preparedness.
2. Improved capacities of countries to monitor, evaluate & report on health service quality and resilience as part of emergency preparedness under IHR (2005) SPAR and GHSA.
3. Increased fit for purpose health workforce with capacities to detect and respond to emergencies with quality health services.
4. Adopted national plans for quality and resilience of healthcare facilities for emergency preparedness.
5. Knowledge and experiences to be shared globally through the WHO Learning Laboratory (GLL) for Quality UHC.

Minimum requirement that support quality health services

Effective: providing evidence-based health care services to those who need them

Safe: avoiding harm to people for whom the care is intended;

People-centred: providing care that responds to individual preferences, needs and values.



Baseline preparedness efforts: (low cost, high impact)

- Emergency Management Plan;
- Risk identification with development of risk specific guidance;
- SOPs for laboratory confirmation for identified risks;
- Identification of resources for surge capacity (equipment, supplies, HCPs);
- Integrated surveillance network (local, national, global; private/public);
- Desk top exercises with post review action planning;
- Risk communication plan.

World Health Organization

Health Systems Resilience

Health systems strengthening

for

health emergency response and recovery

Dr Dirk Horemans
Health Service Resilience
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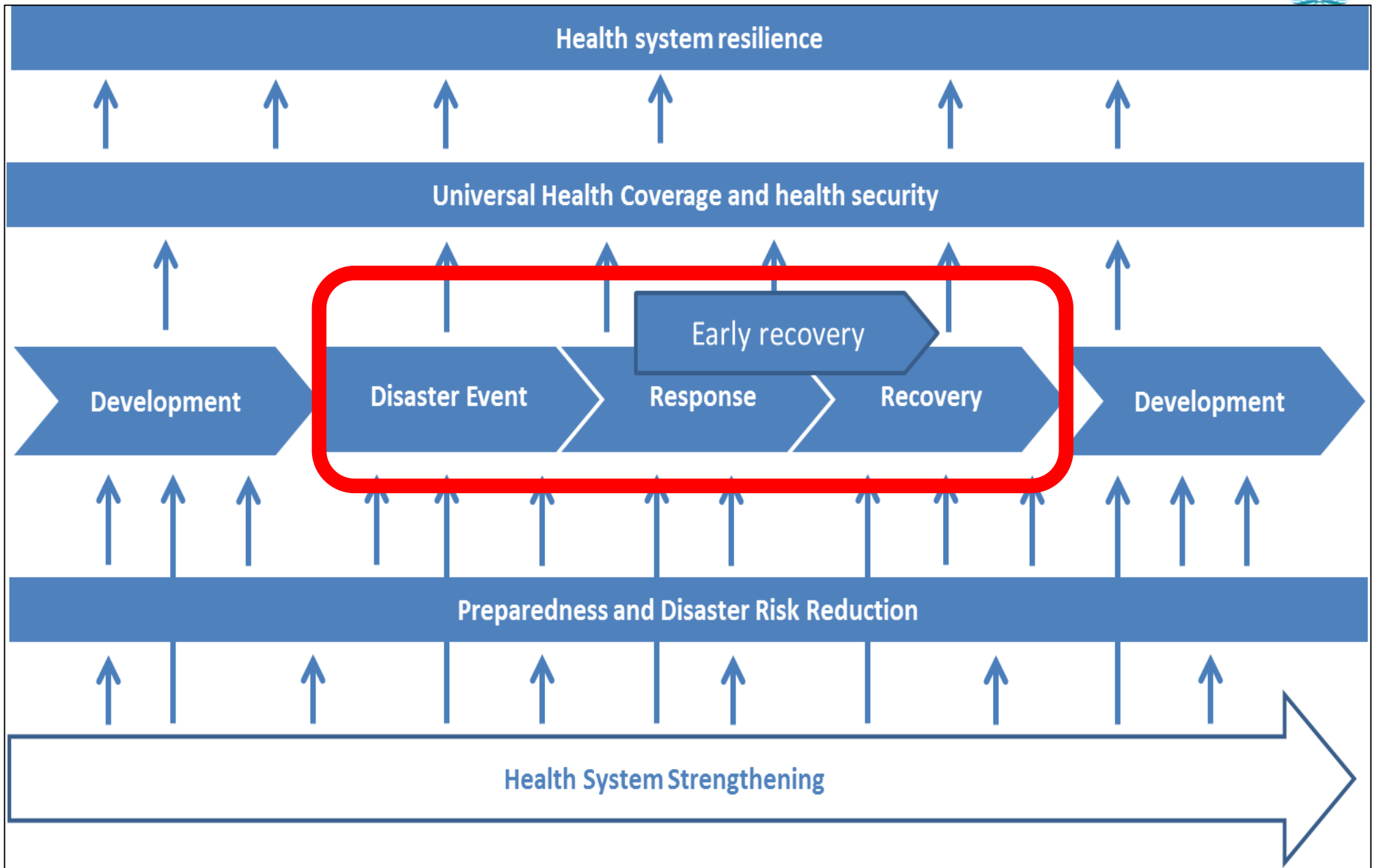
Outline

- Thinking through phases
- Health system strengthening for UHC in “Fragile conflict-affected and vulnerable (FCV) settings”
- Humanitarian Development Nexus – New Way of Working
- Examples of country support work
- Quality of care in FCV settings
- Emerging technical resources

Health system resilience during “Response & Recovery”



Acute and Protracted Emergencies

Acute Emergencies

(Outbreaks, natural disaster, nuclear plant event, terrorist attacks, etc.)

- Limited longer term HSS during acute phase
- Emergency medical teams network structure, strong focus on QOC through pre-qualification and assessments

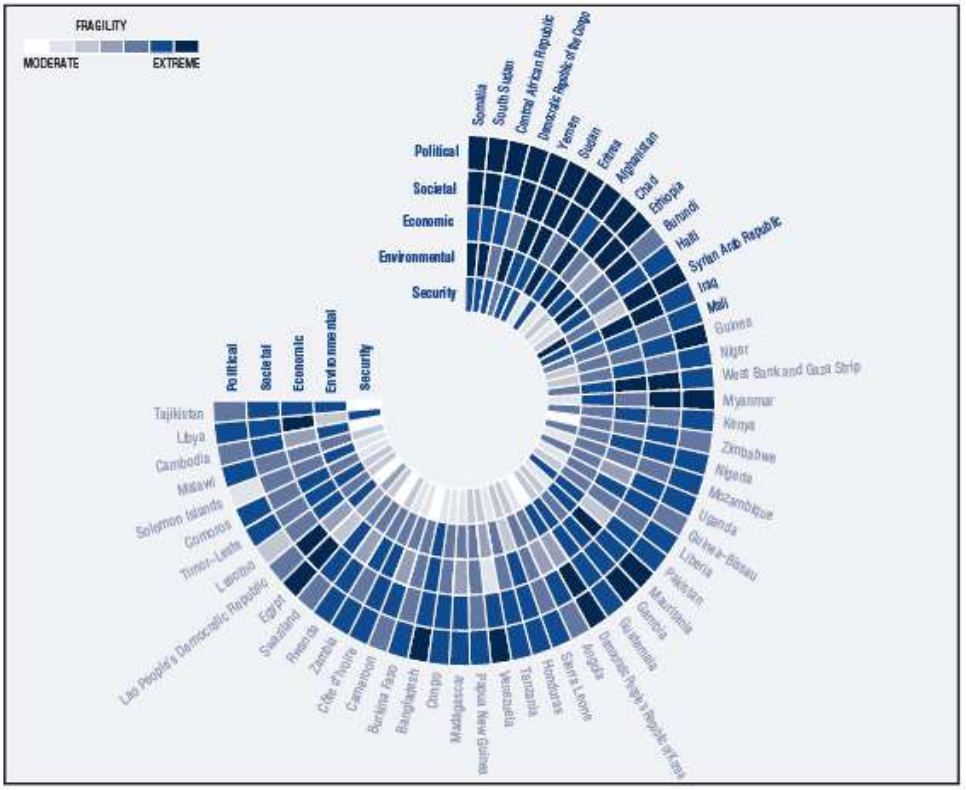
Protracted Emergencies

(Conflicts in Syria, Yemen, DRC, NE Nigeria, South Sudan, etc.)

- Informal definition: beyond 9 months with no end in sight
- Most often conflict related
- Average length of humanitarian crisis > 9 years (OCHA 2019); assume conflicts will become protracted
- Often compounded by outbreaks
- Main role of humanitarian organizations

Main focus of health service resilience response work

Fragile Conflict-affected and Vulnerable (FCV) Settings



- No internationally agreed list, terminology or definition
  - Fragile - Conflict - Vulnerable (WHO)
  - Fragile and conflict-affected states (WHO)
  - Fragility – Conflict - Violence (WB)
  - Extreme Adversity (NHIS and EMRO)
  - Fragile States (UHC2030)
  - Fragility Framework (OECD)

Most frequent used term=> «**FCV settings**»

http://www.oecd.org/development/conflict-fragility-resilience/docs/fragility%20framework%202016.pdf

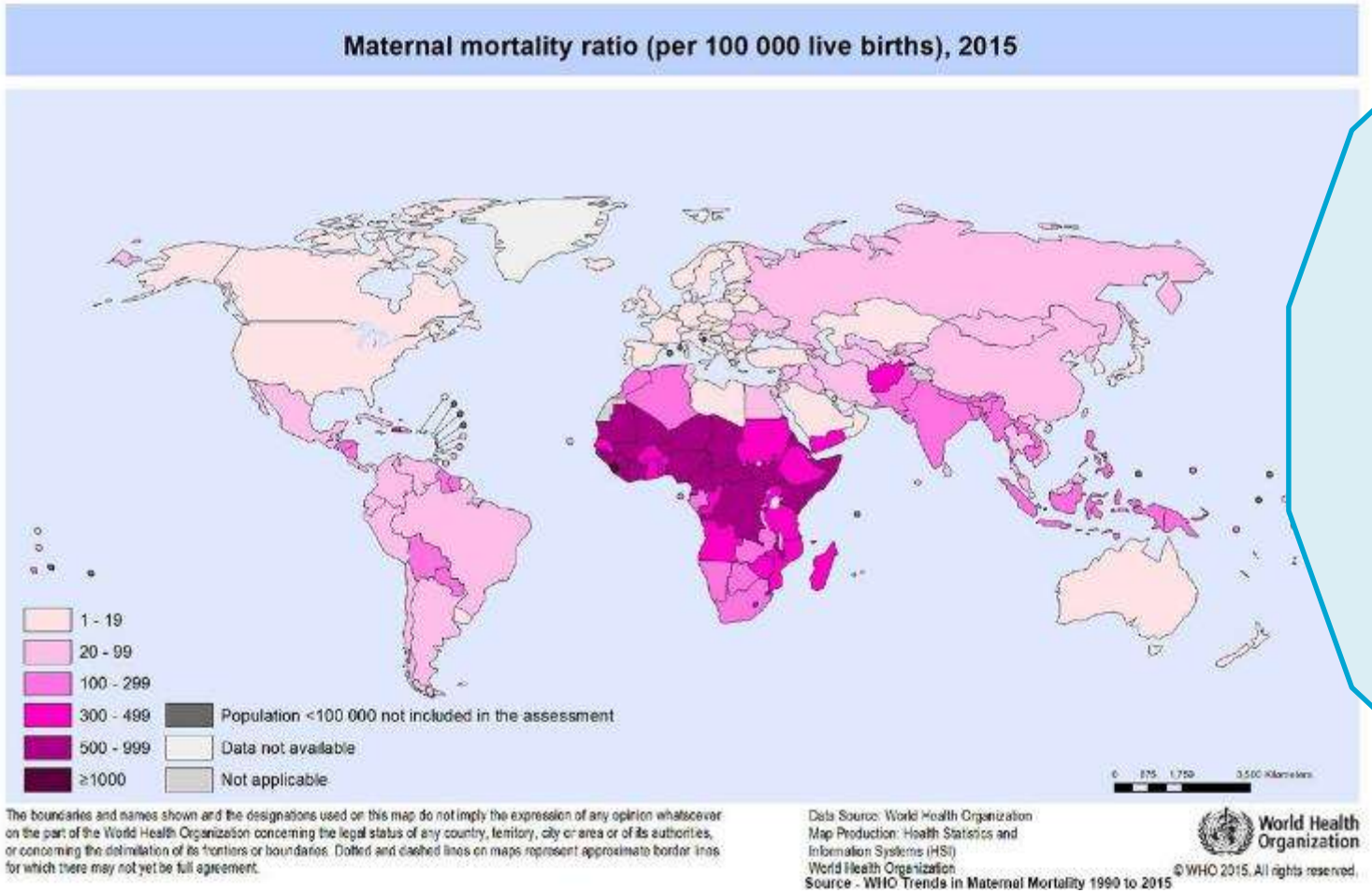
Strong linkages between FCV status and protracted emergencies …. a vicious cycle

Why protracted emergencies …… Why UHC in FCV

- In 2016, over **1.8 billion** people or 24% of the global population were living in fragile contexts[1]
- By 2030, share of global poor living in fragile and conflict-affected situations is estimated to reach **46%**[2]
- Protracted emergencies account for approximately 85% of humanitarian aid.
- Extreme poverty, premature mortality and ill health are increasingly concentrated in FCV[5]
- FCV affected areas often dysfunctional health care systems, limited coverage and important QOC issues
- 60% of preventable maternal deaths, 53% of deaths in children younger than 5 years, and 45% of neonatal deaths take place in fragile settings of conflict, displacement, and natural disasters[3]
- Over **50% of unmet SDG needs** for key target areas, such as maternal and child mortality, as well as more than 80% of major epidemics, occur in fragile and vulnerable settings[4]

=> Biggest possible gains to achieve SDG3 and GPW13 goals are in FCV affected countries

Health indicators in fragile states



In Fragile States;

- '60%' of preventable maternal deaths
- 53% of deaths in children <5yrs
- 45% of neonatal deaths

Humanitarian Response Health Services

Functions:

- ✓ **Maintain quality routine health services in all contexts (business continuity);**
- ✓ **Assure specific health care addressing the health emergency pathologies;**
- ✓ **Assure health emergency preparedness and response avoiding and addressing compounding emergencies;**
- ✓ **Public health response to emergency/crisis;**

The Humanitarian-Development Divide

	Humanitarian	Development
Culture/Approach	Substitution/parallel	Complementarity
Outlook	6-12 months*	5-10 years
Coordination/Leadership	System-led, clusters	Government-led: IHP/UHC2030
Planning Frameworks/Tools	HRP/HNO	UNDAF/ CCA, NHSP
Legal Frameworks	Humanitarian Principles, IHL	Sovereign Law, Aid effectiveness principles
Types of Settings	Fragile/ Unwilling	Stable/Willing

New Way of Thinking: 2016 Global Processes

Agenda 2030

Agenda for Humanity

"Reduce risks and vulnerabilities"

"leave no-one behind"

Humanitarian- Development Nexus

From sequencing to fostering the interface

- Both prioritise areas and populations left behind, and most vulnerable
- No sequencing or transition, but alongside, managing complementarities between humanitarian and development activities and financing

Why HDN new way of working => A Win-Win

Humanitarian Win

- Better coverage of quality services produced in a more efficient and sustainable way

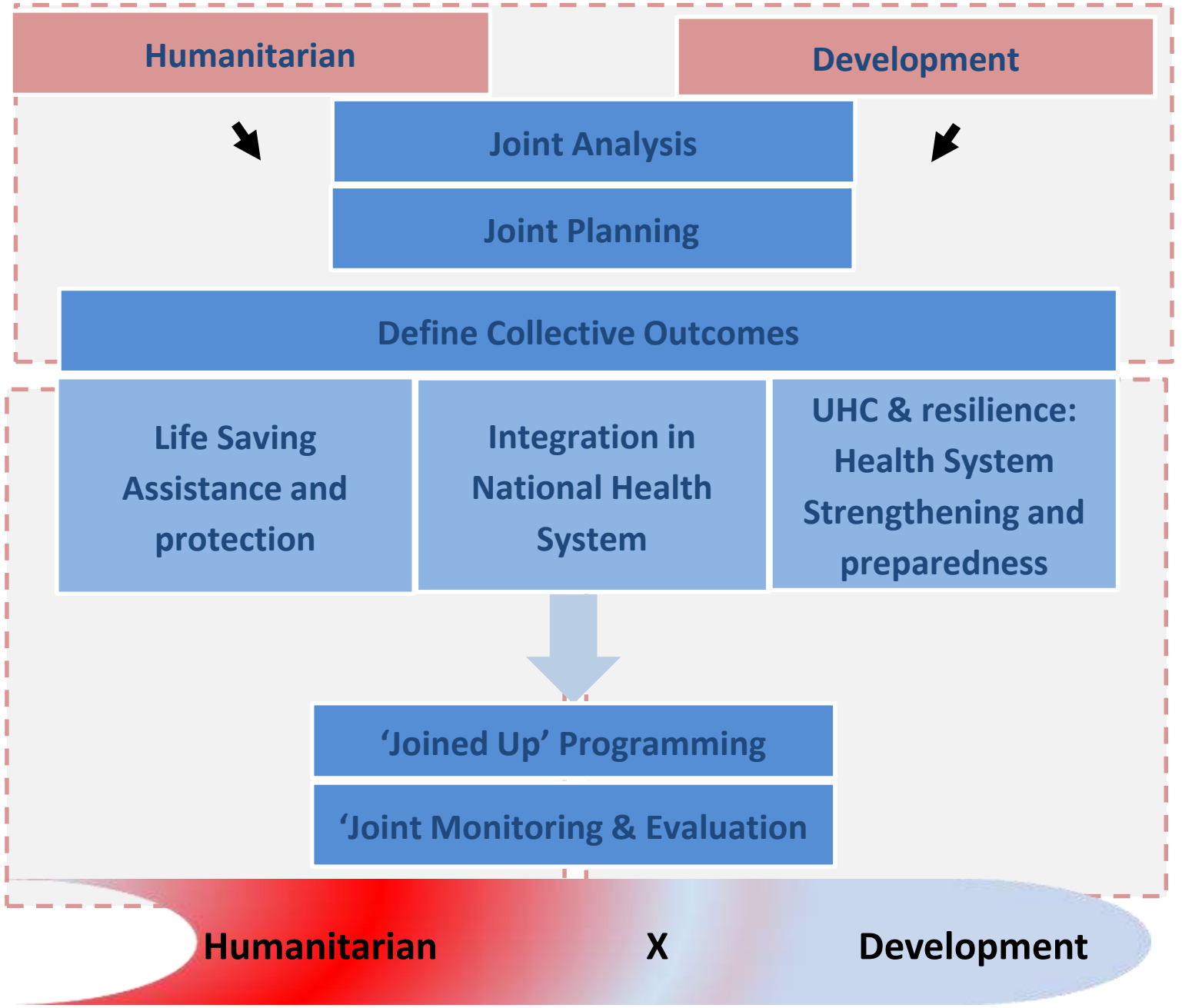
Health System Development Win

- Less harm to the national health system than through traditional parallel humanitarian service provision
- Joint contribution to early recovery and recovery
- Avoid the humanitarian development funding gap

Humanitarian-Development Nexus – New Way of Working

- Humanitarian interventions should apply early recovery approaches in the response, and seek integration with existing health services and transition of governance to local authorities.
- Development oriented workstreams should target fragile and conflict affected areas in a more operational manner, addressing key bottlenecks in health system performance that also constrain the humanitarian response, with more flexibility in contracts and adapted management of risks.
- Fostering the interface between them through connections in analysis, planning and coordination.

Humanitarian-Development Nexus - New Way of Working



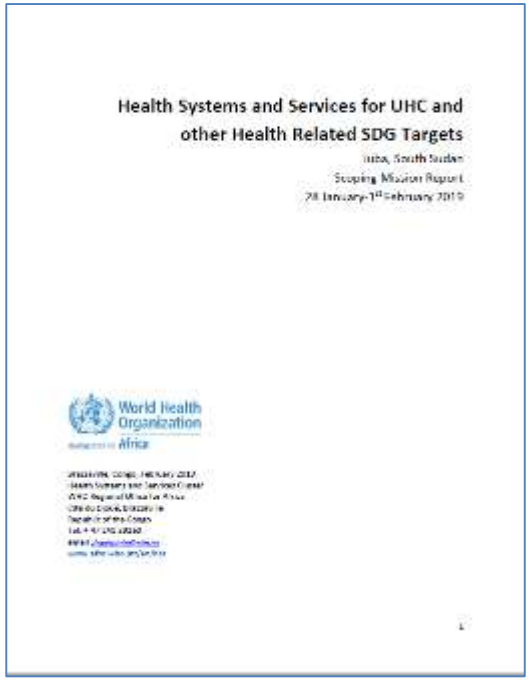
Key actions for innovative programming in FCV settings

Country support work and experiences informs development of global normative working

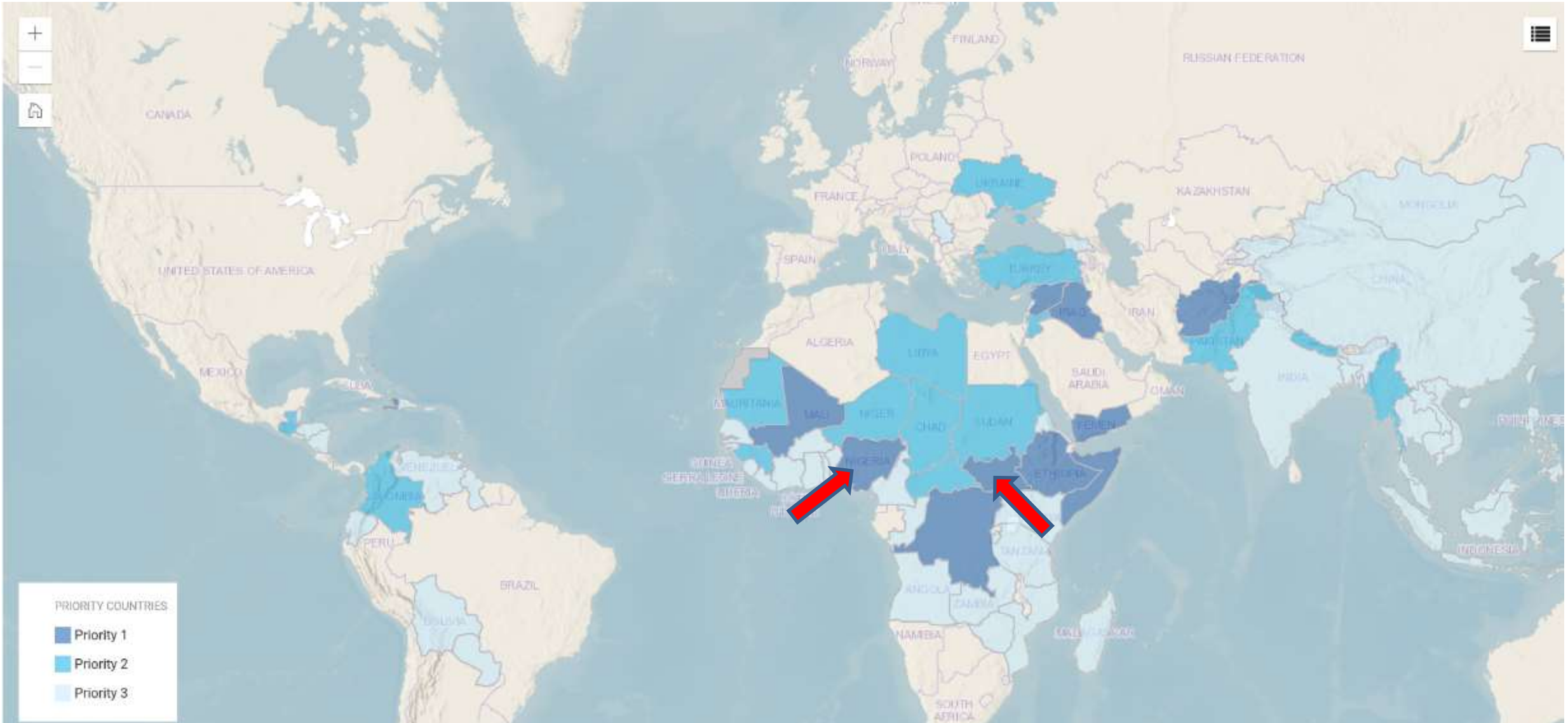
8 key actions for HDN new way of working

- **Joint Analysis**
- **Costed Essential Packages of Health Services based on PHC principles**
- **EPHS implementation plan**
- **Joint Coordination Platforms**
- **Supply Chain management**
- **EWARS and preparedness**
- **Monitoring Framework**
- **Knowledge agenda**

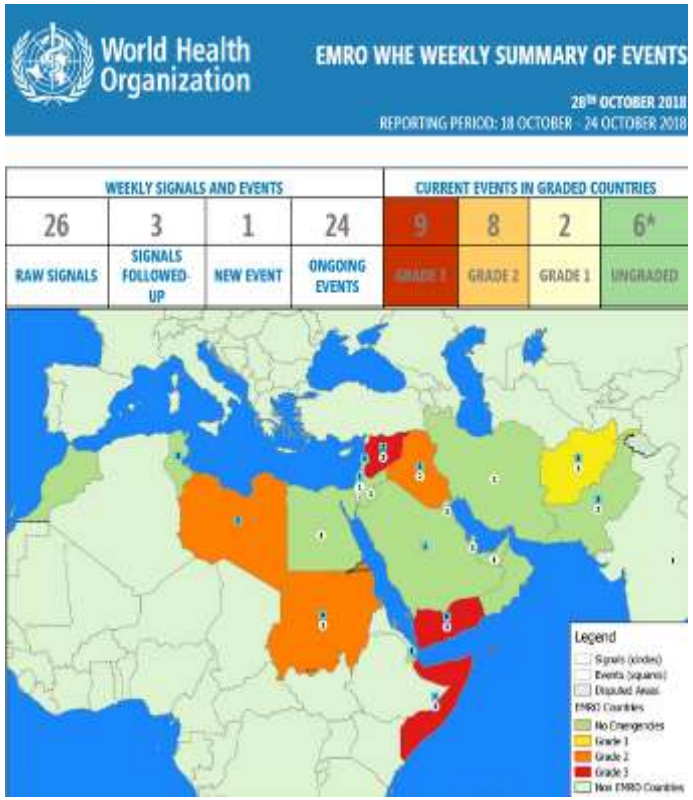
Informing the SDG3+ Global Action Plan work, in particular Accelerator 7



Focused support for African and Eastern Mediterranean Regional Offices and their FCV priority countries



Health Systems in Emergency Lab Emergency



HSEL
Health Systems in Emergencies Lab

- Intensive support and collaboration between EMRO and HQ.

- Strong focus on humanitarian – development nexus work.
- Ongoing development of “Regional Health System Recovery Framework”.

Post-Emergency Health System Recovery

UNITED NATIONS DEVELOPMENT GROUP

THE WORLD BANK

Joint Declaration
on
Post-Crisis Assessments and Recovery Planning

The European Commission, the United Nations Development Group and the World Bank seek to mobilize our institutions and resources to harmonise and coordinate post-crisis response frameworks to enhance country resilience to crises, by answering recovery needs of vulnerable populations and strengthening the capacity of national institutions for effective prevention, response and recovery. We believe a common platform for partnership and action is central to the delivery of an effective and sustainable international response after disaster- and conflict-related crises. We are engaged in significant work to reform the processes used by national and international partners to assess, plan, and mobilize support for recovery to countries and populations affected by natural disasters or violent conflicts.

A Common Platform for Action

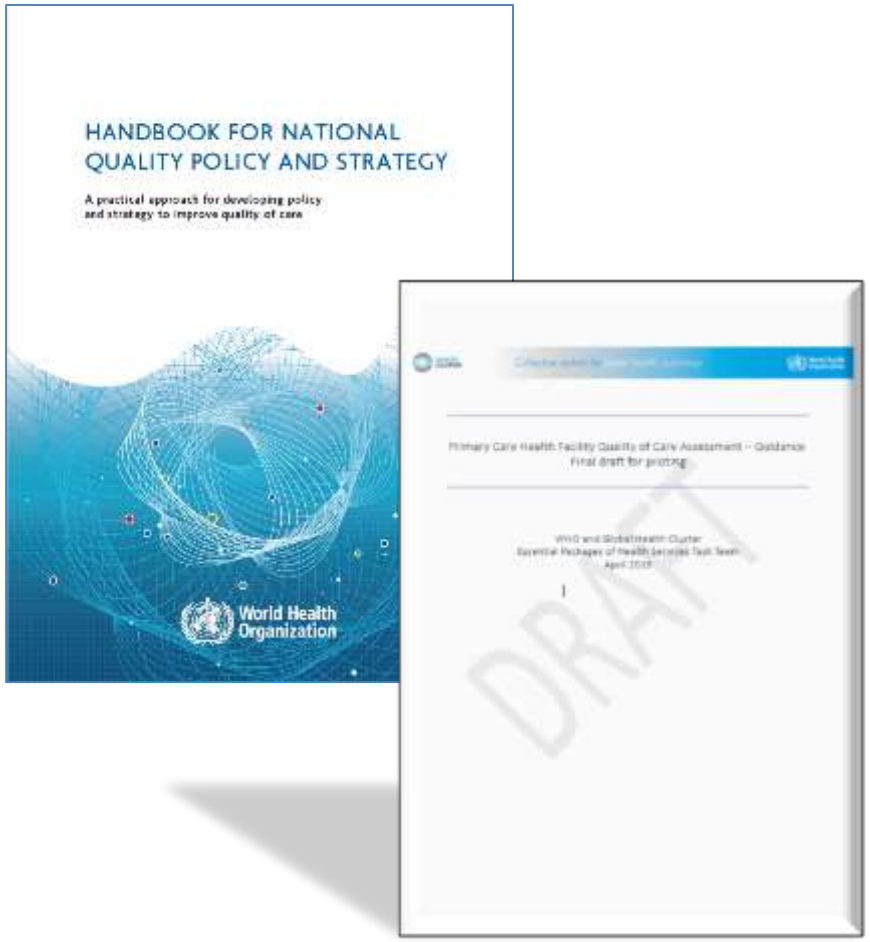
We recognize that early strategic dialogue and engagement is an essential foundation that can be built upon as crisis management and recovery efforts move from planning to implementation, and we decide to:

- Communicate strategically at both headquarters and field level as we monitor situations of fragility and conflict, and imminent or actual natural disasters, and identify opportunities for joint initiatives where our combined efforts may offer advantages;
- Participate in the relevant in-country planning processes and support the development and use of shared benchmarks/results frameworks and joint processes for monitoring and review;
- Support the development and use of the common methodologies for post-conflict needs assessments, and a common approach to post-disaster needs assessments and recovery planning;
- Invest in development of toolkits and staff training to deepen our collective and institutional capacity for these processes; and
- Monitor progress in the implementation of the common platform through a senior level meeting that would take place once a year

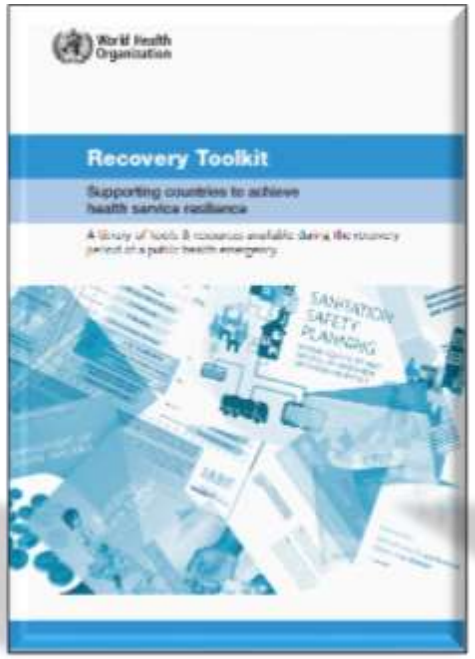
The European Commission	The United Nations Development Group	The World Bank

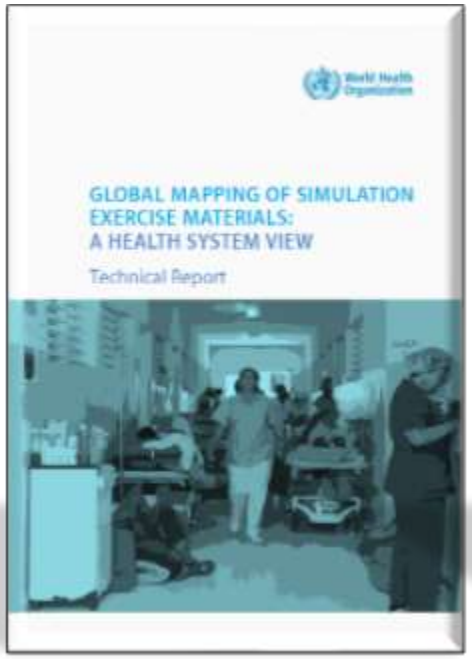
- Different recovery processes for different types of emergencies (conflict, natural disasters, outbreaks)
- Main focus on assessments, costing and planning: “post-disaster needs assessments” (PDNAs) and “recovery and peacebuilding assessments” (RPBAs) driven by the need for costing of recovery
- Recovery objectives need to be aligned to the National Health Strategic Development Plan and ongoing reforms
- Important to establish and strengthen processes to accompany implementation and monitoring of the recovery plans.
- Strong country preparedness and risk disaster measures facilitate recovery
- Always multi-sectoral process
- UN-WBG-EU are main players

Quality of Care in FCV settings



- Build on NQPS approach with an FCV lens
- Country support work (Yemen, Libya, NE Nigeria, …)
- Primary care health facilities quality (of care) assessment tool for FCV settings
- Eastern Mediterranean Regional Framework for “Quality and safety in extreme adversity”
- Establishment of the Global Health Cluster “Quality Improvement Task Team”





Emerging technical resources

Moving Forward…

- Need to learn from emerging country work on how to operationalize the HDN new way of working;
- Need to build on the emerging pool of products based on country needs;
- Need to focus on the technical foundations for quality health services in FCV settings;
- Need to advocate within national authorities (MoH, MoE, MoP, MoA and security sectors) for integrated approaches;
- Need to collate experiences & co-develop further thinking.

Question & Answer

To learn more about the work on health service resilience, email: GLL4QUHC@who.int