

World Health Assembly 2018

Universal Health Coverage (UHC) in emergencies – a call to action

Meeting summary of official side event, 21st May 12:30-14:00

This report has been prepared by Chatham House as a summary of the session. It includes the main points made by speakers, however, this is not a verbatim record so must not be used as the basis for references or quotations without authorization of the speaker.

Summary of themes emerging from session

1. Questions around UHC in emergencies are part of a wider policy debate about the **humanitarian-development nexus**; how to bridge this divide, between short-term humanitarian and longer term development goals, was at the heart of discussions.
2. The need for common principles and **joined up efforts at country level**, under one plan and/or framework is a key step towards this.
3. **Success is possible**: strategies for UHC in crises include implementing packages (Afghanistan, Somalia), focusing on district health systems (CAR), and strong country stewardship (across all).
4. The importance of generating **evidence** to inform UHC during and after crises; we also need to consider how interventions during crises may impact longer-term outcomes.
5. The issue of **financing** UHC in countries where domestic resource mobilisation is a challenge, and may not be a sufficient option in the short to medium-term.

Background

To deliver on our commitment to the goals of Universal Health Coverage (UHC) and leaving no one behind, we must redouble efforts for over a billion people affected by fragility and conflict. There is an urgent need for more coherent approaches bringing together humanitarian and development actors, to expand coverage in conflict and crisis-affected situations. However, health systems are under attack in the very places where they are needed most, undermining any efforts to achieve UHC. No sustainable progress can be made without addressing the issue of health systems that are being attacked.

In response to these challenges, this multi-stakeholder event brought together Member States (Afghanistan, Switzerland, Somalia, Central Africa Republic, Canada, Netherlands), the World Health Organisation (WHO), the World Bank Group (WBG), the International Health Partnership for UHC 2030 (UHC2030), the International Committee of the Red Cross (ICRC), The International Federation of Red Cross and Red Crescent Societies (IFRC), ReBUILD Consortium, and the Centre on Global Health Security at Chatham House. The objectives of the session were two-fold: to raise the profile of the UHC agenda in emergencies; and to learn from countries present (Somalia, Afghanistan, CAR) what it means to deliver, and advance towards UHC in fragile and conflict affected settings.

Presidential Segment

Mr. Alain Berset, President of the Swiss Confederation

UHC in emergencies is a priority issue for the Swiss Confederation. The disruption of health services in crises exasperates suffering. Those who suffer most are the most deprived and vulnerable. Ensuring continuity of quality care by supporting, protecting and strengthening national health systems is the only way to address the long-term consequences of crises. Any concrete action requires a holistic and multi-sectoral approach. It is crucial that we honour common commitments embedded in the Sustainable Development Goals (SDGs) and ensure access to medical services for those who need them most.

An important dimension under the umbrella concept of UHC in emergencies concerns attacks on healthcare in armed conflicts. Despite the legal obligations of all parties to armed conflict to protect the medical mission, and despite ever repeated strong public condemnations, attacks on healthcare remain an increasingly worrying phenomenon. Attacks on healthcare – on patients, medical personnel, medical facilities and transports - deprive people of urgently needed care. These attacks undermine health systems and contribute to the deterioration in the health and wellbeing of whole populations. For every healthcare professional who dies or flees, for every hospital that is destroyed, tens of thousands of people are denied healthcare.

The United Nations Security Council Resolution 2286, adopted two years ago, constitutes a significant achievement at multilateral level. Together with Canada, Switzerland is coordinating an informal group in Geneva on the follow-up of the Resolution. However, many incidents still go unreported and we need to better understand the extent of the problem, as well as its impact on health service delivery and public health. The WHO Project “Attacks on Healthcare” is an important step towards the collection of reliable data on attacks. The implementation of international norms at national level is what matters and what will save lives. We need to ensure that illegal attacks on healthcare do not go unpunished, and that accountability mechanisms for attacks are established.

Together with Afghanistan, Switzerland would like to suggest a process for developing a concrete Call for Action: a commitment to accelerate progress towards UHC in emergencies.

Ministerial Segment

Dr. Ferozuddin Feruz, Minister of Public Health (MoPH), Afghanistan

In Afghanistan, both humanitarian and development contexts exist alongside each other. This presents both challenges (for example, ongoing and protracted insecurity), but also opportunities (for example, to bridge the ‘divide’). The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) have demonstrated success in improving access and health outcomes across the country. Despite insecurity, aggregate data shows life expectancy has increased, and maternal mortality has decreased; 85% of health facilities are functioning; while increased training and recruitment of female health workers has helped overcome cultural barriers to care-seeking. The model is based on contracting: the government contracted NGOs to deliver agreed packages of health services. Citizen scorecards have helped improve downward accountability.

The challenge now is to maintain progress in the face of increasing instability, violence, and poverty. Corruption remains a cross-cutting issue. The health system is under-funded. As a result, out-of-pocket expenditures are increasing, with serious implications for equity and financial protection. Non-communicable diseases (NCDs) represent a major unmet burden of disease: over 60% of OPD visits and over 50% of all mortalities are due to NCDs. However, the BPHS is not aligned with the local burden of disease, and does not adequately address NCDs or mental health.

In terms of UHC, the main challenges concern ensuring quality and equity, as well as raising domestic revenues. Yet despite the challenges of the context, there is political will in Afghanistan, and specific efforts towards UHC include exploring social health insurance schemes, co-payments, advocating for health to be allocated a bigger share of the national budget, and potentially exploring 'sin taxes' for example, on sugary drinks to help fund the health system.

Ms. Sigrid Kaag, Minister of Foreign Trade and Development Cooperation, the Netherlands

Many countries are subject to the 'triple whammy' of conflicts, disasters and fragile governance. In these contexts we need to establish a credible 'nexus' – where humanitarian and development efforts go hand in hand towards SDG progress. Quality healthcare is part of humanitarian assistance and development, and is essential for ensuring long term wellbeing.

The articulation of rights is fundamental. In humanitarian crises and emergency settings, it is the most vulnerable that risk being excluded further. Despite Security Council Resolution 2286, in today's world the gap between compliance and lack of respect is growing. Accountability mechanisms are often lacking.

In terms of healthcare provision, speed, quality and continuity are central. The fact that the situation is challenging does not mean that people are not entitled to optimum quality care in the long run. The Netherlands has committed to scorecard every action and every decision around the lens of gender and will focus particularly on access to sexual and reproductive health and rights in such settings, looking particularly at access to care for women who are survivors of gender based violence (GBV).

The Netherlands will also focus investment on the 'silent crisis' of mental healthcare in emergency settings. Donors such as the Netherlands recognise that the current model of earmarked funding does not reflect the reality in the field. Agility and flexibility are key. Wherever the context, UHC needs to be seen as crucial to the overall SDG agenda.

Dr Pierre Somse, Minister of Public Health and Population, Central African Republic

UHC is a bond of trust between the State and its citizens. This point is especially important in conflict-affected areas such as CAR. However, where trust may be broken, UHC represents an opportunity to rebuild confidence in the State, and to reaffirm the social contract. Health can be an 'incubator' for peace and reconciliation in Africa and elsewhere.

However, the reality in CAR is bleak: half of the 4.5 million population is displaced, it has the second highest maternal mortality globally, and 60% of the country is in need of humanitarian assistance. The health system is fragmented and uncoordinated. In all of the country, the security of health workers and facilities remains a grave issue, and attacks are common.

Taking inspiration from places like Rwanda, ‘the worst can lead to the best’, and in CAR progress towards UHC is underway. A National Plan of Recovery and Consolidation for Peace in CAR has been aligned with the SDGs. Principle-based leadership is being implemented, based on: integration and synergy; accountability for results; efficiency; innovation; human rights and equality; partnerships and multi-sectoral collaboration. Coordination is happening under the ‘three ones’: One National Health Authority, One Results-based National Framework, and One Monitoring & Evaluation plan. Consolidation of partnerships has also begun: there is now a multi-partner health steering committee to help manage financing as well as to help decide on priority interventions.

CAR is at a crossroads of emergency, recovery and development. In this fragmented context, the health system is slowly re-emerging. Next steps for CAR towards UHC include: consolidating health system development in stable areas, while working with humanitarian actors in conflict zones; operationalizing the District Health System as a driver for UHC; developing an investment case and a costed operational plan for reducing the maternal mortality rate across the country; and for engaging partners for their comparative advantage and technical expertise.

Dr Fowsiya Abiikar Nur, Minister of Health and Social Care, Somalia

The health sector in Somalia is recovering from years of under investment and ‘brain drain’. Despite the concerted efforts by the government and partners (national and international), major challenges remain due to access issues, frequent droughts, seasonal devastating floods and institutional shortcomings. Challenges relate to all components of the health system, but steps are being taken.

Somalia has adopted an essential package of health services and a delivery model that prioritises quality services for all. Under the governance domain, they are addressing policy issues related to the federal system of governance, as well as the coordination challenges posed by fragmented health development assistance. Somalia is also updating its health laws and standards, developing a regulatory framework for a growing private sector, strengthening accountability and oversight, and improving inter-sectoral action across line ministries. In health financing, the government share of the healthcare expenditure is progressively growing (however, the high share of out-of-pocket payments is a major concern). In human resources, while a critical shortage of health workers exists in many health professional categories, the capacity at universities for training future cohorts is growing. However, health workforce migration, distribution and retention challenges around the urban-rural imbalance remain significant. In health technologies, Somalia is working to streamline and strengthen its national regulatory authority.

The Somali Government is committed to UHC, and believes it is best achieved when all sectors include health and well-being as a key component of their development plans, known as Health in All Policies. Key approaches towards UHC include:

- Establishing programmatic synergy and coherence between humanitarian and development plans and interventions, through country-owned and country-led partnership. The goal is to create a single platform for all partners, including bilateral and multilateral agencies involved in the health sector.

- Leveraging more results from existing resources; for example, working closely with the Global Financing Facility, as well as increasing the total volume of financing from domestic resources.
- Reviewing existing partnership programs with the Global Fund, GAVI, and other International health partnerships, to reorient collective efforts towards the achievement of UHC.
- Reinforcing stewardship capacity in line with the Paris declaration, and Busan partnership principles. Somalia is committed to the agreements articulated in the Addis Ababa Action Agenda for financing for the Sustainable Development Goals agenda 2030.
- Enhancing engagement with the private sector, particularly in service delivery for UHC, and to help increase access to essential health services for underserved and difficult to reach areas.
- For accountability, empowering community and civil society organizations to create an effective coalition for UHC is a priority.

Moderated Discussion

Dr Pete Salama, Executive Director of Health Emergencies Programme, WHO

This discussion could not happen at a more auspicious time. It is no coincidence that Democratic Republic of Congo (DRC) has faced multiple Ebola outbreaks. DRC is a fragile state: there is mass displacement, systems are weak, and there is widespread food insecurity.

UHC and global health security are two sides of the same coin. The majority of recent outbreaks have been in fragile states; this is entirely predictable. Primary healthcare is the first line of defence. The number one lesson from the Millennium Development Goal era was that we have made the least (if any) progress in fragile states. Looking at the SDGs, 50% of unmet needs are in a small number of fragile and conflict-affected states.

We leave fragile states behind at our own peril. Ensuring UHC for these places is not only the right thing, it is the smart thing to do. For example, from the economic and trade perspective, Ebola cost \$3billion. A pandemic influenza virus could cost the world trillions.

Yet success is possible, as shown by Afghanistan and others. Five key components are essential to success in these contexts: a national plan; an essential package of services; a commodities system; financial resources; and independent monitoring and evaluation.

In order to truly bridge the humanitarian/development divide, we need to put away labels, and to focus on joined up multi-year planning and funding.

Health is a protection issue. Data from Syria shows the unacceptable number of attacks on healthcare since 2014. WHO is leading on a new global surveillance system. But we need to go beyond technical approaches; we need robust actions.

Dr Emanuele Capobianco, International Federation of Red Cross and Red Crescent Societies (IFRC)

One of the IFRC's key areas of focus is on preparedness for disaster and outbreaks. Natural disasters are largely predictable: we know where cyclones occur and the hot spots for cholera for example; we know where we should be preparing for crises.

Health systems are important for preparedness, but so is community level preparedness, which should be at the core of the UHC in crises agenda. As we learned from Ebola, it is at community level where disease outbreaks are identified and resolved. The IFRC believes that disease outbreaks start and end in communities and therefore developing community level capacity, especially in areas of disease detection and surveillance is key.

Community health workers and volunteers are crucial, and their role in aspects of UHC should not be neglected. The renewed focus on the Alma-Ata declaration is timely in that, once again, we need to be reminded that primary healthcare really is the key to the attainment of the goal of Health for All. However, we cannot ignore the global crisis of human resources for health and the important role that community health workers and volunteers will need to play with regards to issues of task-shifting, for example.

If we are serious about reaching ‘the last mile communities first’, we need to increase our risk tolerance and ensure that we’re delivering on our collective commitments to a ‘no regrets approach’. The threats we face as an international community demand such an approach.

IFRC’s access through local volunteers is important in both war and peace time. As part of the Red Cross Red Crescent network, protection is central to IFRC’s work.

Dr Michele Gragnolati, World Bank Group (WBG)

WBG has been working in fragile and violence affected countries such as Afghanistan for a long time. However, what has changed recently is the massive population displacements: there are 24 million refugees and asylum seekers, as well as 42 million internally displaced in the world today.

As part of a specific allocation of USD\$ 33 billion to countries affected by fragility, conflict and violence, WBG has substantially increased its commitments and funding for UHC in emergencies.

To help build resilience, WBG focuses on prevention and preparedness in the pre-crisis. During crises, they help manage changes for host communities and reduce vulnerabilities for the displaced, as well as identifying long-term developmental options. These are part of WBG support for countries in health systems strengthening.

In terms of partnerships, WBG has provided concessional funding in Lebanon and Jordan, is part of the DARES initiative in Yemen, Djibouti, Libya, CAR and DRC, and is the co-lead for the UHC2030 global partnership.

Dr Tim Martineau, ReBUILD Consortium

All strategies towards UHC in crises should be informed by evidence. In fragile and conflict-affected settings, this evidence needs to cover short term humanitarian situations, the medium term in protracted crisis and recovery, and the longer term.

The ReBUILD Consortium’s research has focused on the post-conflict/crisis period, but has captured lessons on what happened to health systems and access to healthcare during and immediately after the conflict/crisis period.

Examples of learning from this research includes:

- The significant resilience of healthcare workers (including community health workers) often despite attacks on them; and lessons on how they can be better supported to operate effectively through crises and afterwards, not just with incentives but through management and community support.
- The changing needs of populations during and after crises; for example, using a gender lens and looking at intersectionality, we found an increase in female headed households, which affects both healthcare needs and the ability to access health services, with implications for services to address these needs.
- Actions in the short term during and after crises, can have significant longer-term effects on health systems; for example, humanitarian needs may bring an influx of different funds and organizations, which may have impacts on current and future labour markets, but also on immediate and future resource flows, which has implications for coordination and ownership of these for appropriate health service delivery.

Although research may not be a high priority in the midst of crises, we are seeing it is important to better understand the longer term consequences of actions taken during this time. Research in these settings is both difficult and dangerous, but there is now some good collaboration between researchers and implementing agencies in the field. ReBUILD took more of a retrospective approach, with very effective use of life histories to understand the experiences of healthcare workers and communities during and after crises.

The impact of ReBUILD's work has gone beyond the specific countries we have worked in, and is informing a number of actors looking at current conflict/crisis settings. When ReBUILD started in 2009, there was very little work done in the area. But we have helped develop a thematic working group focused on health systems research in fragile and conflict-affected settings, through Health Systems Global, and have linked up with partners like UHC2030. There are now many more people working together; and together we are better placed to build the evidence needed to help move towards UHC both during and after conflict and crisis.

Concluding remarks

Ms Ginette Petitpas Taylor, Minister of Health, Canada

Canada is deeply concerned about what has been called the “weaponization of healthcare” and the prevention of access to healthcare and services in all types of settings and contexts. The overarching goal of the Department of Health is to strengthen Canada's publicly-funded, universal healthcare system. The principles governing the healthcare system are symbols of our underlying Canadian values of equity and solidarity, values that are shared throughout the world, as we work towards achieving the Sustainable Development Goals. It is an affront to each and every one of us when these values of equity are violated.

Upholding obligations to respect international humanitarian law is one of the most effective ways to help preserve healthcare in armed conflict. Canada is committed to continuing to champion compliance and respect for IHL and has spoken out to strongly condemn attacks on healthcare workers and the impacts on civilian populations.

Canada has endorsed a political declaration pledging to undertake practical measures to enhance the protection of, and prevent acts of violence against, medical and humanitarian personnel. The declaration calls upon the UN Security Council to adopt measures to respond to

acts of violence, including through sanctions. There is also agreement to review military doctrine to ensure that it takes into account the protection of civilians.

Canada believes that we must improve the implementation of international humanitarian law, tangibly mitigate the effects of armed conflict, and improve the protection of civilians, including their access to healthcare.

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Next steps

- The sponsors and organizers of the event are now planning the way forward for the Call to Action with a view to influencing intergovernmental and other processes, including the High Level Meeting on UHC in 2019.
- There may be a side event to launch the Call to Action at the UN General Assembly in September 2018
- Technical partners for this session will continue to collate and share evidence and learning on approaches, both individually and through the UHC2030 Technical Working Group on Fragile and Challenging Operating Environments and the HSG Thematic Working Group on Health Systems in Fragile and Conflict Affected States. Opportunities to move this agenda on include the Fifth Global Symposium on Health Systems Research in Liverpool in October 2018.

Agenda

Topic	Speaker
Introductions & setting the scene	Moderator – Ilona Kickbusch, Director of the Global Health Centre, The Graduate Institute, Geneva
Presidential Segment	Mr. Alain Berset, President of the Swiss Confederation
Ministerial Segment	<ol style="list-style-type: none"> 1. Dr. Ferozuddin Feruz, Minister of Public Health, Afghanistan 2. Ms. Sigrid Kaag, Minister of Foreign Trade and Development Cooperation, the Netherlands 3. Dr. Pierre Somse , Minister of Health, CAR 4. Dr. Fowsiya Abiikar Nur, Minister of Health, Somalia
Moderated discussion	Seated guests: <ul style="list-style-type: none"> • Dr. Pete Salama, WHO Emergency Programme • Dr. Emanuele Capobianco, IFRC • Dr. Michele Gragnolati, The World Bank Group • Dr. Tim Martineau, ReBUILD Consortium
Concluding remarks	Ms. Ginette Petitpas Taylor, Minister of Health, Canada

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