

# Global emergency financing and health system strengthening

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## Executive summary

The 2005 International Health Regulations (IHR) adopted by member states in the World Health Organization (WHO) require that all countries have the ability to detect, assess, report and respond to potential public health emergencies of international concern at all levels of government, and to report such events rapidly to the WHO to determine whether a coordinated, global response is required. Recent epidemics have strengthened the demand to improve the capacities to implement the IHR and the effectiveness of health system prevention and detection of and responses to epidemics. Evidence from ESA countries suggests that this demands effective communication between local levels of health systems and national responses, and capacities for prevention, detection and response at community, primary care and district level. In 2016 two new global financing mechanisms were introduced to support emergency responses, the WHO Contingency Fund for Emergencies (CFE), that aims to fill the gap from the beginning of a declared emergency and a World Bank Pandemic Emergency Facility (PEF), to support follow up measures after initial CFE funding.

This report provides information on the new CFE and PEF financing mechanisms, to explore any stated or implied links with the IHR goals and health system strengthening in the response to emergencies. It is based on a desk review of available literature by the University of Sheffield and the Training and Research Support Centre, under the umbrella of the Regional Network for Equity in Health in East and Southern Africa (EQUINET). The report aims to inform African policy-makers and stakeholders about the CFE and PEF financial mechanisms and their relationship to the IHR to locate areas where links could be more explicitly made between the new financial mechanisms, the IHR and the health system strengthening needed for longer-term preparedness for and prevention of emergencies.

The PEF, expected to be operational in 2016, aims to fill the existing financing gap between the limited funds available at the early stages of an outbreak of a infectious diseases epidemic and any full scale level of assistance that could be mobilised once an outbreak has reached crisis proportions, namely, when a disease has become a global pandemic. The PEF covers outbreaks of infectious diseases most likely to cause major epidemics, defined as the worldwide spread of a new disease, and all countries eligible for financing from the International Development Association- the poorest countries- are target beneficiaries of the PEF. It funds through two delivery 'windows': An insurance window aims to provide up to \$500 million in any single disease outbreak that meet specific health data, epidemic severity and other yet to be defined activation criteria, while the cash window will provide more flexible funding of between \$50 and \$100 mn to address a larger set of emerging pathogens, which may not meet these activation criteria. Payments will be guided by principles of country ownership, speed, adequacy and flexibility, although the details remain unspecified and funding decisions will be guided by and held accountable through a steering body responsible for core decision making, a group of 'experts' to vet applications and an advisory committee that will meet annually on pandemic responses.

The WHO CFE funds the response covering all countries regardless of income to two emergency conditions: preventing an infectious disease from escalating into a public health emergency of international concern (PHEIC), as defined in the IHR and responding to other events with substantial public health consequences, whether disease related or not. Triggered and with funding levels decided on a case by case basis, it funds leadership and coordination of the emergency health response, including personnel; information technology and information systems; medical supplies; and field and local government support. It is financed and can be replenished through flexible voluntary contributions from a broad range of sources, that may remain with the source funder and be withdrawn when needed, provided that there are agreed indicators for disbursement. A WHO web portal will report on how CFE funds are sourced, programmed and spent, with oversight of the fund from an Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, advisory to the WHO Director-General and reporting to the World Health Assembly and subject to WHO's rules and operating procedures.

The two funds have some cross linkages and cross reference to each other, with the CFE implemented as first response and the PEF as the deeper resource package. However only the CFE has a formal relationship with the IHR, is available for all WHO member states, covers all cross border public health risks covered by the IHR, beyond infectious agents, and explicitly supports areas such as health information, planning, health worker mobilisation that may strengthen wider health systems. The PEF, in contrast, only focuses on specific infectious agents, and is not directly related or fully integrated within the WHO Health Emergency Programme, despite its aim to coordinate global responses. The World Bank indicates that the PEF will also stimulate efforts by countries and development partners to build better core public health capabilities for disease surveillance and health systems strengthening, toward universal health coverage, but it is unclear on how it will achieve this, especially as the funds are not directly for this purpose.

It is not exactly clear how the PEF insurance market will achieve its claim of bringing *greater discipline and rigor to pandemic preparedness and incentivize better pandemic response planning*. At the moment, it is unclear how compliance standards will be incentivised, unless the criteria and pre-existing health system conditions that must be in place to access funds are seen as a stimulus for countries and partners to build better core public health capabilities and health systems. It is unclear whether this includes longer-term health system strengthening to prevent epidemics or surveillance and other mechanisms to contain them. With the current available evidence, it could be argued that the PEF, despite its stated intentions, has less stated links with the IHR, less explicit direct funding support for system capacities, and less integration within existing intergovernmental frameworks than the CFE.

In both the CFE and the PEF while there is clear reference to mobilising external health personnel, it is unclear whether these will be drawn from and build response capacities within regions, thus also building national capacities. It is unclear where the investment in community level communication, social mobilisation and cross sectoral co-operation will come from, needed for more sustained prevention, early detection and control.

The information to date raises questions therefore on the direct support to system capacities, especially for the PEF. It suggests that more active processes are needed to provide information on these funds, on their implications for health system strengthening and their alignment to the IHR and to national policy, including on the development of indicators in 2016. With many of the design decisions being made in 2016, countries in the region should already be seeking this information through capitals and embassies, to give time to propose process or design changes that would improve this alignment and effectiveness. This would include information on

- What are the roles of regional and country actors in relation to how resources will be raised, managed, disbursed, inputs procured and country and regional capacities built?
- What targets are being proposed to activate funding and review funding results using what sources of evidence and with what relationship to indicators of IHR capacities or health system strengthening?
- For the PEF what constitutes a 'severe' outbreak, and what set of emergency criteria would trigger the decision that a country is undergoing 'crisis'?
- What implications does an insurance type funding arrangement have for premiums and responses of countries getting an intermediary level alert; and how will funding proactively address capacities for prevention?
- What measures are being taken to bring the PEF and its performance within the intergovernmental framework for performance on the IHR?

The regional intergovernmental bodies in east and southern Africa provide an important vehicle for senior officials and policy actors to raise these questions, to share learning from countries with experience of the funds and to monitor their performance in relation to national strategies.

# 1. Introduction

## 1.1 Health system responses to health emergencies

The International Health Regulations (IHR) were adopted by member states in the World Health Organization (WHO) on 23<sup>rd</sup> May, 2005 (WHO 2005). They require that all countries have the ability to detect, assess, report and respond to potential public health emergencies of international concern at all levels of government, and to report such events rapidly to the WHO to determine whether a coordinated, global response is required. Countries were given to 2016 to develop core capacities to:

- Rapidly determine the control measures required to prevent spread of risks;
- Provide specialized staff, laboratory analysis of samples and logistic assistance;
- Provide on-site assistance as required to supplement local investigations;
- Provide a direct operational link with senior health and other officials to rapidly approve and implement containment and control measures;
- Provide direct liaison with other relevant government ministries;
- Provide, by the most efficient communication available, links with hospitals, clinics, airports, ports, ground crossings, laboratories and other operational areas for dissemination of information and recommendations from the WHO on events;
- Establish, operate and maintain a national public health emergency response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of international concern; and
- Provide the above on a 24-hour basis (WHO 2005).

Epidemics in the past decade in Africa have pointed to the importance of implementing the IHR, and to strengthening the health system and its interaction from local to national level in effective responses (Young 2013; WHO 2015; Loewenson et al., 2015). Effectiveness in the response to epidemics in ESA countries appeared to relate to effective communication between local levels of health systems and national responses, and to the strength of systems for prevention, detection and response, particularly at community, primary care and district level (SEATINI, TARSC 2016). These features appear to be important for health systems to *both* prevent and manage such emergencies.

The IHR required all States Parties to have established the minimum public health core capacities by June 2016. From self-assessment reports sent to WHO in 2015, African countries have made progress since 2012, most notably in surveillance and laboratory capacities, in legislation and in human resources (WHO 2015a), including through an Integrated Disease Surveillance Response (WHO Afro 2015). Less progress was reported in preparedness, in capacities at points of entry, and in dealing with chemical and food safety risks, suggesting less preparedness in dealing with other public health risks (SEATINI and TARSC 2016).

A regional meeting of senior government officials and health diplomats from ESA countries in 2016 noted the need to strengthen implementation of the IHR, as the primary umbrella in the global health security agenda. They noted that doing so needs short, medium and long term strategies and targets that work in a complementary manner, with funding directed to the full set of implementation capacities and more emphasis on sustainable funding for longer term health systems strengthening to prevent and manage emergencies on a more sustained basis (ECSA HC, EQUINET 2016). The delegates noted that the IHR has strength in that they are not limited to addressing emergencies *after* they have happened but also build public health capacities and actions to detect, prevent and control them. As an umbrella, other 'global health security' measures should be aligned to it, and to measures in countries and at regional level to build / strengthen local / national health systems to detect, prevent, manage and respond to public health risks and emergencies (ECSA HC, EQUINET 2016).

## 1.2 Global financing for emergency responses

While emergency responses are in the main resourced from national health and other systems, including in terms of the personnel and range of interventions to manage their immediate impact, their cross border nature and solidarity-driven support have led to international support for responses to emergencies. For example the West African Ebola epidemic in 2014-5 had led to US\$600mn support from African sources and a total of \$4558 mn in total from all sources by May 2015 (Loewenson et al., 2015).

In 2016 two new global financing mechanisms were introduced to support emergency responses. The first, the WHO Contingency Fund for Emergencies (CFE), aims to fill the gap from the beginning of a declared emergency until resources from other financing mechanisms begin to flow. The second, the World Bank Pandemic Emergency Facility (PEF), has been proposed as an insurance mechanism that seeks to support follow up measures in emergencies after initial CFE funds have been mobilized. This raises attention to how far the two new financing mechanisms invest in both the immediate responses and the wider capacities needed to prevent and manage risk on a more sustained basis as indicated in the IHR.

The 2016 regional meeting of senior government officials and health diplomats from ESA countries noted the need for more information be provided on these funds, their implications for health system strengthening and their alignment to national policy to support policy engagement, with the aim of aligning them with national policies, plans and measures. There was concern for how far these funds are harmonized within global measures to fund the strengthening of core country capacities for implementation of the IHR, on the implications for wider sustainability and health system financing goals in their funding arrangements and on their impact on AU, regional and country level institutional arrangements to for public health and emergency responses.

## 1.3 Aims of this paper

This report seeks to provide information on the new CFE and PEF financing mechanisms as available in the public domain, to explore any stated or implied links with the IHR and the IHR goals and the implications for health system strengthening in the response to emergencies. It has been produced by the University of Sheffield and the Training and Research Support Centre, under the umbrella of the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It uses a desk review of available documents to:

1. Summarise the financing arrangements in the new World Bank Pandemic Emergency Facility (PEF), the new WHO Contingency Fund for Emergencies (CFE) in terms of the stated purpose / goals of the funds, the fund collection and disbursement arrangements; any targets identified for measurement of and reporting and accountability on fund effectiveness;
2. Indicate within the PEF and CFE any stated or intended links indicated
  - a. Between the two funds
  - b. Between the funds and the global, regional or country mechanisms being applied for strengthening implementation of the IHR
  - c. Between the funds and health system strengthening with the measures indicated if stated for achieving these links, and relations between the governance and review mechanisms for the funds and those for the IHR, Regional organisations and national authorities;
3. Identify from the analysis above the synergies, gaps, overlapping mandates and areas of policy ambiguity between the CFE, PEF and the IHR.

The report aims to inform African policy-makers and stakeholders at national and regional level about the CFE and PEF financial mechanisms and their relationship to the IHR. It locates areas where links between the new financial mechanisms and the IHR could be more explicitly made, particularly in relation to how/whether they strengthen health systems in ways needed for longer-term preparedness for and prevention of emergencies.

## 2. Methods

The information was drawn from a desk review of available online documents in line with terms of reference for the work. The research employed a qualitative methodology to ensure understanding, Internet searches were implemented of online libraries in May 2016 using as key words: International Health Regulations, WHO emergency health funding, world bank emergency health funding, PEF, CFE and combinations of these terms. Papers were reviewed and those relevant to the objectives included, with 23 papers sourced and included in the reference list. The online libraries and databases covered were the official institutional websites of the WHO and the World Bank, and articles in Google, Google Scholar, and PubMed/Medline databases. Where-ever possible, policy information was drawn or validated from the WHO and World Bank websites as the institutions responsible for the funds. There may be gaps in the information that is not made available online or in public domain that would need to be obtained through follow up, such as through key informant interview. However, we consider the information sourced to provide a sufficiently accurate outline of the funds to be able to address the questions in the objectives or to identify gaps in evidence to address or questions that stakeholders may need to raise. All dollar figures cited are in US dollars.

## 3. Outline of the two funds

This section outlines the main features of the two funds. The next discusses their links with the IHR and their implications for health system strengthening.

### 3.1 The World Bank Pandemic Emergency Facility

While the basic principles and objectives of the PEF have been outlined by the World Bank, there are limited specific details available, with further information expected at the end of 2016. The PEF is expected to be operational before the end of 2016.

The PEF **aims** to fill the existing financing gap between the limited funds available at the early stages of an outbreak of a infectious diseases epidemic (such as from CFE), and any full scale level of assistance that could be mobilised once an outbreak has reached crisis proportions, namely, when a disease has become a global pandemic. It aims to do this by providing a surge of funding for response efforts to prevent infectious disease outbreaks from becoming costly pandemics with a high global death toll. The PEF covers outbreaks of infectious diseases most likely to cause major epidemics, defined as the world-wide spread of a new disease. It notes for example epidemics due to new orthomyxoviruses (new influenza pandemic virus A, B and C), coronaviridae (SARS, MERS), filoviridae (Ebola, Marburg) and other zoonotic diseases (Crimean Congo, Rift Valley, Lassa fever) (World Bank, 2016a, 2016b). Unlike the CFE which covers Grade 3 emergencies (see below), the PEF does not specifically mention funding for non-infectious disease related health emergencies such as chemical poisonings. As a result, it remains unclear whether these sorts of health related emergencies would be covered under PEF guidelines.

A 'surge' response is seen to contribute to saving lives, but also costs to households and economies. The annual global cost of moderately severe to severe pandemics is estimated to be about \$570 billion, while a severe pandemic like the 1918 Spanish flu is estimated to cost up to 5 percent of global gross domestic product, further motivating a quick response fund to mitigate these costs (World Bank 2016a).

All countries eligible for financing from the International Development Association (IDA), the World Bank's fund for the poorest countries, are **target beneficiaries** of the PEF (World Bank, 2016a, b). They are eligible to receive funding in the event of an outbreak that meets the activation criteria (shown below) for PEF financing. The PEF can also fund qualified international agencies involved in the response to a major outbreak in affected countries, although which agencies with what nature of response is yet to be clarified.

The total **level of funding** the PEF aims for is estimated, based on the resources needed to prevent previous epidemics from world-wide spread (up to \$500 million per outbreak). The World Bank claims that if there were an immediate release funding instrument in 2014 during the Ebola outbreak, \$100 million could have been mobilized as early as July 2014 to accelerate the emergency response. Instead current international systems of financing meant that money at the scale required did not begin to flow until three months after the epidemic onset– during which Ebola cases increased tenfold (World Bank, 2016b).

The PEF is financed through two **delivery ‘windows’**: an insurance mechanism and a cash injection. Funding under the insurance ‘window’ will be provided by reinsurers Swiss Re and Munich Re, combined with the proceeds of catastrophe bonds (capital-at-risk notes) issued by the International Bank for Reconstruction and Development (IBRD) and purchased by insurance-linked securities and catastrophe bond investors (Swissre.com, 2016). The insurance window aims to provide up to \$500 million in any single disease outbreak that meets the activation criteria (see below), for an initial period of three years. Contributions from development partners - which include international agencies such as GAVI, UNAIDS and Harmonization for Health in Africa (HHA)- will cover the cost of the premiums and bond coupons for insurance (World Bank 2016c).

To complement this insurance window, a cash window will provide more flexible funding of between \$50 and \$100 mn to address a larger set of emerging pathogens which may not meet the activation criteria for the insurance payments. The cash window aims to:

- i. provide supplementary financing for epidemics covered by insurance that merit larger or earlier payouts than provided by the activation criteria and allocation arrangements;
- ii. fund ‘severe’ single-country outbreaks (with ‘severity’ for activation not yet defined);
- iii. provide emergency funds for new or unknown pathogens not covered by insurance;
- iv. and serve as a conduit for efficient and effective surge financing for development partners to channel resources to affected countries in the event of a crisis (where ‘crisis’ has not yet been defined) (World Bank, 2016b).

The PEF’s insurance window will, according to the World Bank, rely on clear, parametric **activation criteria** designed with publicly available data, such as health indicators, that meet specific criteria relating to an epidemic’s severity. Indicators of this include outbreak size (cases, case fatality, or deaths), outbreak growth (rising incidence over a defined time period) and outbreak spread (with two or more countries affected). Once met, the affected countries and/or eligible international responders may submit a request for funding to the PEF. The World Bank indicates that the specific indicators and levels to be used will be provided prior to the PEF’s launch at the end of 2016.

**Payments**, it is indicated, will be guided by principles of country ownership, speed, adequacy and flexibility, although the details remain unspecified. The cash window is intended to provide more flexibility. The principles guiding its use will be similar to those used for the insurance window, but with greater flexibility in terms of payment amounts, earlier payments, and payments for diseases not covered by the insurance window. Details of the payment criteria will be released at the end of 2016.

In the long term (but an unspecified period), the World Bank has expressed anticipation that the PEF will create a new market for pandemic insurance that will bring ‘greater discipline and rigor to pandemic preparedness and incentivise better pandemic response planning’ (World Bank, 2016b). The World Bank claims that establishing a market for pandemic insurance will ‘stimulate efforts by countries and development partners to build better core public health capabilities for disease surveillance and health systems strengthening, toward universal health coverage’. Specific **targets** for measuring these aims for greater discipline and emergency preparedness have not been publicised. At the moment, the sole stated measure of success for PEF is the establishment of the new insurance market.

PEF funding decisions will be guided by and held accountable through the following **institutional arrangements**:

- A steering body responsible for core decision making, with members comprised of development partner contributors plus non-voting members from relevant agencies (e.g. WHO, WBG, IDA country, CSO representatives) to be agreed by the voting members. The exact selection criteria and entry requirements for these agencies has not been disclosed.
- A group of 'experts' who will vet and make recommendations on Request-for-Funds applications. The exact selection criteria for 'expert status' or for their selection has not been determined and/or disclosed.
- An advisory committee that will meet annually on pandemic response issues and oversee simulations and drill exercises to facilitate response readiness. Details such as who will be members of this advisory committee, the criteria for selection, the selection process, the frequency of meetings, and to whom the reports will be presented to are yet to be disclosed.

### 3.2 The WHO Contingency Fund for Emergencies

The WHO Contingency Fund for Emergencies (CFE) aims to fill the gap from the beginning of an emergency until resources from other financing mechanisms begin to flow, enabling immediate deployment of personnel and operations. The CFE aims to facilitate early entry of personnel from WHO's Global Health Emergency Workforce and from partners, including in the Global Outbreak Alert and Response Network and the Global Health Cluster. It funds the response to two emergency conditions:

- i. preventing an infectious disease from escalating into a public health emergency of international concern (PHEIC). This is defined in the IHR as an *extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response* (WHO 2005).
- ii. Responding to non-disease or disease related Grade 3 emergency, defined by WHO as 'a single or multiple country event with substantial public health consequences that requires a substantial WCO response and/or substantial international WHO response' (WHO, 2016f).

The CFE is already in use, with \$3.8 million disbursed from the fund following the Zika virus outbreak. The release of funds was to country level WHO Incident Managers, to rapidly mobilise staff and resources in line with the Zika Strategic Response Framework. In May 2016, a number of new disbursements from the CFE were made, with a \$100,000 award to Uganda WHO Country Office to support the country's response to yellow fever, which had been detected in three rural districts. A further \$300,000 was also released to fund the yellow fever incident management at the WHO headquarters, supporting regional and national responses to yellow fever outbreaks in Angola and DRC, and the unrelated outbreak in Uganda. The awards bring the total CFE funds allocated to yellow fever to \$2.24 million (WHO, 2016c). A CFE disbursement was made to Papua New Guinea following severe drought, heavy frosts, and sudden deluges of rain, following a World Food Programme vulnerability assessment in March 2016 estimating that 162,000 people in Papua New Guinea faced extreme food insecurity, and an additional 1.3 million people faced a high degree of food insecurity. An award of US\$483 000 was approved at the end of May 2016 to support the response to this situation. In total, the CFE has thus disbursed in its first year \$8.5 million (WHO, 2016c).

The CFE **target** is any country, regardless of income, which faces outbreaks or any emergency with health and humanitarian consequences, including natural disasters. It **funds** leadership and coordination of the emergency health response, including:

- recruiting and deploying 'surge' emergency personnel;
- coordinating emergency medical teams;
- technical expert travel to where they are needed;
- setting up of information technology systems where needed,

- procurement and delivery of medical supplies;
- compiling, analysing mapping and communicating health and emergency response information;
- establishing and operating field offices; and
- advising local authorities on all aspects of emergency response.

It is financed through flexible voluntary contributions and can be replenished, including through retroactive agreements with other emergency finance sources. Although this may include assessed contributions in principle, WHO member states have indicated resistance to this so it will be funded through voluntary contributions from a broad range of sources, including bilateral, humanitarian and health emergency donors, foundations, charities and philanthropies. The funds may remain with the source funder and be withdrawn when needed, provided that there are agreed indicators for disbursement. Private sector contributions may be sought within WHO policies, with WHO noting that *sectors that would be particularly negatively impacted by an emergency with health consequences or which have operations in high-risk areas may have an interest in contributing* (WHO (2015j):2).

The CFE aims for a total capital fund of US\$100 million. This amount was recommended by the Review Committee on the Functioning of the IHR in relation to the H1N1 pandemic in 2009 (WHO, 2011). It was approved following Ebola and other epidemics and as of June 2016, US\$31.5 million was contributed or pledged, mostly from national governments.

The **activation criteria** for case-by-case CFE disbursement are through three mechanisms, with the level of funding decided on a case by case basis (WHO, 2015g):

1. Initial amounts disbursed with minimal bureaucratic requirements when a request is made by national authorities by phone, email, or other means to the Global Health Emergency Workforce.
2. Higher level disbursements require a budgeted plan to be prepared within 24-48 hours from inception of the incident. Emergency programme information systems support rapid preparation of budgeted plans based on (yet to be prepared) WHO standard costing templates for various scenarios involving outbreaks and emergencies with health consequences.
3. Substantial levels of disbursement require preparation of a WHO-led Health Cluster joint agency action plan by the WHO Incident manager, as coordinators of WHO's incident management system at the country or regional level. This should be done within 72 hours, using pre-negotiated inter-agency agreements, protocols, and costing templates.

Although the CFE is already in use, the WHO states that *definitive standard operating procedures and performance standards await the finalisation of the new emergency business practices and the WHO Emergency Response Framework* (WHO, 2016d). More generally, the WHO states that **performance indicators** will be built into the standard operating procedures through adherence to WHO's tracking, information systems and monitoring and evaluation tools. A WHO web portal, still under development, will be used to report on how CFE funds are sourced, programmed and spent (WHO, 2015c).

There are various **institutional mechanisms** for governance and accountability.

- An Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, which covers the CFE, to provide oversight and monitoring of the development and performance of the Programme and to guide its activities (WHO, 2016e). The Committee advises the Director-General and reports its findings through the WHO Executive Board to the World Health Assembly. Its reports will also be shared with the United Nations Secretary General and Inter-Agency Standing Committee.
- The CFE is subject to WHO's Financial Regulations and rules, although with flexibilities to allow for rapid access. Fund finances will be included in WHO Financial Reports to the WHA, in the web portal to track resources, on the WHO website and to funders.

## 4. Linkages and implications for health system strengthening

From the outlines of these funds it is possible to identify the level of linkages between the funds, their explicit and indirect roles in relation to the IHR and in relation to the health system strengthening needed to prevent and manage epidemics. In discussing these issues it is important to note, as reported in section 3, that much information on the rules and functioning of the funds is still to be made available publicly and that this may reveal further synergies or deficits in the linkages and support of the IHR and health system strengthening in emergency responses.

### 4.1 Links between PEF and CFE

There is explicit note of the link between the PEF and CFE, not least because the World Bank and WHO report working closely to design that they be complementary funds (WHO 2015g; World Bank 2016b). When an emergency is reported, the CFE provides the first response for early response efforts, to rapidly mobilise, equip and deploy WHO and Global Health Emergency Workforce assets for immediate control and containment of a disease outbreak or emergency with health consequences, working with country authorities and systems, before other funding mechanisms, including PEF are triggered. The WHO Director General can use the CFE to respond immediately to emergencies without having to wait for disbursement from another agency or organisation. PEF financing is then activated once an outbreak reaches a significant level of severity, with pay-outs managed by the World Bank and disbursed as described earlier.

It is not clear how far the funds will support dialogue across their individual institutional mechanisms, harmonise epidemic and performance indicators or co-invest in capabilities in countries to facilitate use of the funds. There is mention of the WHO facilitating alerts and in coordinating response teams in-line with existing national plans, but nothing further on this.

### 4.2 Linkages between the funds and the IHR

The IHR as an international legal instrument bind 196 countries globally, including all WHO member states (WHO, 2011). As noted in the introduction they aim to set standards for capabilities and duties to prevent and respond to acute public health risks that have the potential to cross borders and generate population health impact at international level, not only for infectious disease epidemics, but also public health risks from biological (zoonotic, food safety and other infectious hazards), chemical, radiological or nuclear hazards that may have a potential to have cross border impact. A key issue for the IHR is ensuring that the functional core capacities exist for its implementation and IHR monitoring involves assessment of the development and implementation of eight core capacities at points of entry and for IHR-related hazards, with a duty for countries to establish a focal point for the IHR. The IHR monitoring and evaluation framework for core capacities developed in 2016 combines annual reporting, after-action reviews, simulation exercises and independent (external) evaluation (WHO 2016 & WHO 2016f). Senior officials and diplomats in ESA countries have advocated having a regional approach to such assessment, to provide a means for greater focus on measures to strengthen capacities at regional level (ECSA HC and EQUINET 2016). They have further argued for a roster of experts within the region able to carry out reviews/assessments, to ensure regional support for the country implementation of assessments, with independent assessment focusing on core capacities where there are greater deficits, to identify measures and to focus investments on them.

Not surprisingly given the central role of WHO in both, there is cross referencing of the CFE in the policy dialogue on the IHR. Emergency funding generally and the CFE specifically were conceptualised and advocated within the discussions on the IHR, although with a role noted for the World Bank. Recommendation 13 of the 2011 IHR Review Committee proposed that *WHO create a contingency fund for public health emergencies. Member States should establish a public health emergency fund of at least US\$ 100 million, to be held in trust at an institution such as the World Bank. The fund, which would support surge capacity, not the purchase of materials, would be released in part or whole during a*

*declared Public Health Emergency of International Concern, based on approval of a plan for expenditures and accountability submitted by WHO. The precise conditions for use of the fund should be negotiated among the Member States in consultation with WHO.* (WHO, 2011:25). In 2014 a drafting group reiterated the link with the IHR, noting that the WHO emergency response at all levels be exercised according to international law, in particular with Article 2(d) of the WHO constitution and in a manner consistent with the principles and objectives of the Emergency Response Framework, and the IHR, and be guided by an all-hazards health emergency approach, emphasizing adaptability, flexibility and accountability; humanitarian principles of neutrality, humanity, impartiality, and independence; and predictability, timeliness, and country ownership (WHO, 2014). IHR Resolution EBSS3.R1 (25 Jan 2015) subsequently called for adequate resources for the preparedness, surveillance and response work of WHO. This resolution includes agreement *in principle to establish a contingency fund, taking into account recommendation 13 of the 2011 IHR Review Committee*, subject to a decision to be taken by the Sixty-eighth World Health Assembly” (WHO, 2015k: 9).

At an Informal Member States Consultation in 2015, participants noted that while a major focus of the CFE should be to ensure that WHO is positioned to respond to infectious disease outbreaks, the fund should also address other emergencies with public health consequences, as set out in the IHR and include associated prevention, preparedness and surveillance activities and health system strengthening activities related to outbreak and emergency preparedness and response (WHO, 2015j). In the consultation delegates expressed, that:

- The funds be deployable anywhere needed, without jurisdictional restriction;
- The fund support strengthening of IHR core capacities;
- Coherence be sought between the contingency fund and other elements of WHO’s emergency reforms, including the prospective Global Emergency Health Workforce, as well as WHO’s existing programmes, particularly health systems strengthening and infectious disease control programmes;
- The relationship with emergency funds in regions be clarified;
- A declaration of a Public Health Emergency of International Concern (PHEIC) may be too late as a trigger for the fund, as a principle objective should be to prevent the escalation of an event before it becomes a major emergency.
- The IHR provide guidance on triggers prior to a PHEIC designation, whilst noting the limitations in the current shortfalls in implementation (WHO, 2015j).

Many of these concerns would appear to have been catered for in the design of the CFE, and the CFE appears to have close links to and to support the implementation of the IHR. Its links are strengthened in that

- It is applicable to any country where there is a public health emergency;
- It addresses any extraordinary event determined to constitute a public health risk to other States and not only infectious disease;
- It funds direct responses, but also the leadership and coordination of the emergency health response, and the information and management capacities for the response;
- The fund principles and rules follow those of WHO as the intergovernmental body charged with oversight of the IHR implementation;
- The performance indicators will be built into the standard operating procedures through adherence to WHO’s tracking, information systems and monitoring and evaluation tools.
- It works with national authorities and reports its findings through the WHO Executive Board to the World Health Assembly and to the Secretary General of the United Nations and with the United Nations’ Inter-Agency Standing Committee.

These features suggest a high potential for synergy between the CFE and IHR implementation. The operational practice and actual distribution of resources would however need to be assessed to determine the de facto synergies. This was beyond the scope of this desk review.

In contrast to the CFE, there is no explicit reference to the IHR in the existing PEF documentation. While the PEF does refer to building better core public health capabilities for disease surveillance and health systems strengthening (World Bank, 2016b), its performance measures do not (yet) include the core capacities in the IHR and the only existing PEF performance measure is the creation of a global pandemic insurance market. Policy dialogues on the IHR make no direct reference to the PEF, (beyond the reference to the World Bank in Recommendation 13 of the 2011 IHR Review Committee), despite the intention to more effectively bring together the strands of emergency finance. The lack of secondary discussion on PEF and the IHR may be due to the new emergence of the facility as well as its current level of ambiguity. While WHO will be present on the PEF decision making body, the *voting* members will come from development partner contributors, and WHO like CSOs and others will be non-voting members. How this mechanism will interact with the intergovernmental framework for the IHR is not clear.

With the PEF still in an early stage of development, several key trigger indicators have not been defined. These include what constitutes a 'severe' outbreak, and what set of emergency criteria would trigger the decision that a country is undergoing 'crisis'. As a result, it remains impossible to pinpoint exactly how the PEF can supplement national efforts to fortify the IHR and exactly when/where reliance on PEF support can be integrated into emergency response planning and contingency strategies. The PEF does not appear to include infectious disease related emergencies, excluding many of the public health risks covered by the IHR and in contrast to the CFE. This leaves a gap in longer term follow-up of these risks. While the cross referencing and links between the PEF and the CFE suggest a potential for strengthening the PEF links to the IHR, it would appear that this needs to be more explicitly framed and operationalised, particularly given the PEFs role in taking forward the more immediate interventions applied by the CFE.

### **4.3 Funding for health system strengthening (HSS)**

As raised in the introduction, countries with more rapid responses to emergencies suggest that this response cannot be isolated from the way systems function generally from community to local levels, nor from the duty states have to secure the public health of their populations, whether due to infectious diseases or environmental, occupational, food safety and other hazards. It calls for proactive communication and social mobilisation, for prevention and control of communicable and non-communicable diseases; for the organisation of services and co-operation across sectors and communities for health promotion, and for the prevention, early detection, diagnosis, management of disease. In some ESA countries it has motivated an updating of public health law to address new risks and approaches and ensure capacities to enforce it (SEATINI, TARSC 2016).

Whilst not making any direct reference to health systems strengthening before a potential pandemic is identified, the World Bank states that the PEF is 'expected to create a new market for pandemic insurance that will bring greater discipline and rigor to pandemic preparedness and incentivize better pandemic response planning. It indicates that the PEF will also stimulate efforts by countries and development partners to build better core public health capabilities for disease surveillance and health systems strengthening, toward universal health coverage' (World Bank, 2016b). However, the link between PEF, universal health coverage, core capabilities and health systems strengthening has not been specified by the World Bank, and the anticipation that the PEF will lead to greater preparedness seemingly rests on certain assumptions based on expected incentive structures linked to the global market. While there is thus a stated intention to strengthen health systems through 'core public health capabilities', the funds are not directly for this purpose.

The PEF stipulates that payments intend to be guided by principles of country ownership, speed, adequacy and flexibility, although the details remain unspecified. It is unclear how the insurance mechanism will interact with other health financing arrangements incentivising areas of system performance of funding system platforms. The World Bank claims that establishing a market for pandemic insurance will stimulate efforts by countries

and development partners to build better core public health capabilities and health systems strengthening, but the mechanisms for and assumptions behind this are not yet clear.

The CFE also does not directly include reference to health systems strengthening, although it does reference the IHR core capacities and has a wider focus on public health than infectious diseases only. It is also part of the WHO Health Emergencies Programme, which focuses on six areas;

- i. Unified WHO emergency programme
- ii. Global health emergency workforce
- iii. IHR core capacities and resilient national health systems
- iv. Improvements to the IHR
- v. Accelerated research and development
- vi. International financing/contingency fund

It is thus part of a wider programme that includes health system elements, although it is not clear how this will be operationalised, or how far these different programme elements are 'joined up' in common systems platforms issues in their functioning. In both the CFE and the PEF while there is clear reference to mobilising external health personnel, it is unclear whether these will be drawn from and build response capacities within regions, thus also building national capacities. It is unclear where the investment in community level communication, social mobilisation and cross sectoral co-operation will come from, needed for more sustained prevention, early detection and control.

Finally, it appears that while there will be information exchange, the information platforms used by the two funds will differ, and may not support harmonisation of health information and reporting within countries. Further, neither the CFE nor PEF directly measure their performance in any indicators of impact on health systems strengthening, whilst noting that there is still to be further development and publication of indicators in 2016.

## **5. Conclusions and recommendations**

These two emergency funding mechanisms present important new platforms for health funding. They are motivated in part by a need to control the cross border spread of epidemics, and thus to support biosecurity as a dimension of global foreign policy. They are primarily organised to provide a more rapid and effective support for countries to contain outbreaks and their impact.

They do have some cross linkages, with the CFE implemented as first response and the PEF as the deeper resource package. They make reference to one another, and recognise the necessity for communication and interaction in order to deliver a robust health emergency response. However only the CFE has a formal relationship with the IHR. It was set up within the context of an IHR recommendation, and located within the wider WHO Health Emergencies Programme, as confirmed at the WHA 2016. It is available for all WHO member states, covers the full spectrum of cross border public health risks covered by the IHR, is managed under funding rules and institutional frameworks of the intergovernmental body and includes areas of support such as health information and planning, and health worker mobilisation that may support wider health system strengthening,

In contrast, the PEF is not included as a significant element of the WHO Health Emergency programme, and is mentioned only as a fund which the CFE should be careful not to replicate, despite the aim of the WHO programme to coordinate global responses.

There is also a lack of overlap in who is covered by the two funds. Whilst the CFE appears to apply to all countries, the PEF is only available to those who are eligible to borrow from the IDA. This means that some countries, for example India, which progressed from the IDA in 2014, would not be eligible for PEF funds. As a result, there remain questions in relation to how well the PEF can effectively cover health emergencies in all cases and about where health emergency relief can reliably be acquired in non-IDA cases.

One explanation for the apparent circumnavigation of the PEF of the institutional and intergovernmental mechanisms for the IHR could be its basis as an insurance market. The PEF intention to create a new market for pandemic insurance is named as a 'key expected benefit', but without clear performance indicators on its role as a new financial instrument, or its interaction with other health financing arrangements. It is, however, not clear how the PEF insurance market will achieve the claim of bringing *greater discipline and rigor to pandemic preparedness and incentivize better pandemic response planning*. At the time of writing, there was no indication that countries will have to pay premiums for PEF insurance, as the traditional mechanism for incentivising compliance standards. Nevertheless, the PEF as it is currently proposed does suggest that certain criteria must be met and that pre-existing health system conditions must be in place in order to have access to the facility (by governments and international responders). If these structural conditions are meant to act as compliancy criteria for PEF, then funding access may be the incentive intended to stimulate countries and partners to build better public health capabilities and systems.

However, incentives for structural reforms of these kinds can have unintended consequences and negative as well as positive externalities. Given the fact that the PEF currently does not list its trigger criteria for funding or provides details regarding its decision making process, it is impossible to speculate or determine exactly what kinds of externalities may arise from PEF. Incentivising reform is a key component of the PEF, and it is here that the fund will either support longer-term health system strengthening for prevention or give singular focus to surveillance and containment mechanisms.

The CFE covering the wider spectrum of public health risks fits well within the IHR framework and may align more easily with efforts to strengthen core IHR capacities and with the national response plan. There are areas that remain unclear, in terms of the strengthening of national and regional roles in the mobilisation of health personnel, in the monitoring and review process and in how some of the key areas of systems strengthening, including those relating to community, prevention and primary care systems, will be addressed. With the current available evidence, however, it could be argued that the PEF, despite its stated intentions, has less stated links with the IHR, less explicit direct funding support for system capacities, and less integration within existing intergovernmental frameworks than the CFE. Its features suggest that the PEF fits better within a securitization of health paradigm, particularly in its greater focus on containment and response over prevention and preparedness.

With many of the design decisions being made in 2016, this brief suggests that countries in the region already seek further information on the funds through capitals and embassies, to give time to propose process or design changes that would improve their alignment and effectiveness. This would include information on

- What are the roles of regional and country actors in relation to how resources will be raised, managed, disbursed, inputs procured and country and regional capacities built?
- What targets are being proposed to activate funding and review funding results using what sources of evidence and with what relationship to indicators of IHR capacities or health system strengthening?
- For the PEF what constitutes a 'severe' outbreak, and what set of emergency criteria would trigger the decision that a country is undergoing 'crisis'?
- What implications does an insurance type funding arrangement have for premiums and responses of countries getting an intermediary level alert; and how will funding proactively address capacities for prevention?
- What measures are being taken to bring the PEF and its performance within the intergovernmental framework for performance on the IHR?

The regional intergovernmental bodies in east and southern Africa provide an important vehicle for senior officials and policy actors to raise these questions, to share learning from countries with experience of the funds and to monitor their performance in relation to national strategies.

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