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International Health Partnership

COVID-19 and fragile settings

Adapt global guidance on COVID-19 health strategies to context-specific and evolving needs in fragile settings, focused on reducing all-cause excess morbidity and mortality

Urgently protect funding for health in fragile settings

Six emergent lessons to enhance COVID-19 response and recovery

UHC2030 Fragile Settings Technical Working Group

Summary: Health priorities for COVID-19 response and recovery in fragile settings

In all countries, the COVID-19 pandemic has created a four-fold challenge: how to control transmission of the SARS-CoV-2 virus; how to provide care to COVID-infected individuals at different levels of existing health systems; how to protect essential health services; and how to mitigate the political, social, and economic consequences of the pandemic. Fundamental limitations in governance and legitimacy add to the challenge in fragile contexts, with pre-existing weaknesses in health services delivery and inadequate financial and human resources.

This policy brief has **three main messages**.

First, global guidance on COVID-19 response strategies should be adapted to context-specific and evolving needs in fragile settings.

To date, most countries with fragile settings have not seen overwhelming numbers of severe COVID-19 cases. However, health service disruptions have been substantial and barriers on both the supply and demand sides have increased, resulting in increased morbidity and mortality risk from non-COVID-19 causes. Health actors working on and in fragile settings should focus on reducing all-cause excess morbidity and mortality, based on local understanding of the pandemic's severity and other health needs. Health strategies may now need to prioritise protecting and safely restoring non-COVID-related essential health services, alongside feasible and proportionate COVID-19 control measures.

Second, an urgent call to protect funding for health in fragile settings.

The pandemic is having a severe economic impact in all countries. There are already signs that funding levels for humanitarian response plans are lower than for previous years. Almost two billion people live in fragile settings. It will be impossible to meet their health needs, protect against impoverishment (including due to health service user fees) and "build back better" if resources are not made available from both domestic and external sources.

Third, despite many unknowns in fragile settings, important practical lessons are emerging about how to enhance COVID-19 response and recovery.

The underlying principles for health responses to the pandemic in fragile settings are not fundamentally different from those in other countries. However, fragile settings call for specific implementation approaches, with a substantial proportion of health services delivered through the humanitarian system and the private and informal sectors. Evidence and approaches to date – which should be continually reviewed as epidemiological and other societal trends evolve and better data becomes available – point to **six emergent lessons:**

i. Strengthen and adapt **information systems** to better understand COVID-19 spread, access to and utilization of essential health services, and all-cause morbidity and mortality.

ii. Include **civil society organizations and communities** in shaping, communicating, and implementing response measures, to build trust and address barriers to health services and other threats to survival and dignity.

iii. Invest in **"common goods for health"**, including International Health Regulations functions, and **emergency risk management** to protect service delivery, to build foundations for both UHC and health security.

iv. Strengthen **connections and coordination mechanisms** across epidemic control and health and multi-sectoral humanitarian and development approaches, to ensure coherence and involvement of all relevant actors.

v. Monitor impacts on **fragility and on vulnerable groups, especially women and girls**, and uphold humanitarian principles and equity, to leave no one behind.

vi. Plan proactively for **coherent COVID-19 vaccination approaches**, to support restoration of essential health services and wider recovery without fragmenting health systems.

1: Global guidance on COVID-19 response strategies should be adapted to context-specific and evolving needs in fragile settings

Not all COVID-19 response policies are needed in the same way, or are equally effective, in all places at all times. Health actors working on and in fragile settings should focus on reducing all-cause excess morbidity and mortality. Strategies should be guided by local understanding of the severity of the pandemic, non-COVID-19 essential health needs, and communities' wider concerns including alternatives for income generation and meeting other basic needs. Actions to safely protect and restore other essential health services may now need to be prioritized, alongside feasible and proportionate COVID-19 control measures.

Through the first eleven months of the pandemic, the direst predictions regarding its direct health impact in countries with fragile settings do not seem to have been borne out. There is little doubt that there has been widespread community transmission of the virus in most countries. Official surveillance data in most fragile settings indicate lower incidence of COVID-19 than in non-fragile and high-income countries, but are likely to be unreliable. Modelling suggests lower infection-fatality rates due to younger population age structures, but there is no empirical evidence for this. With few exceptions, primary care facilities and hospitals do not appear to have been overwhelmed by patients with COVID-19.

Nonetheless, the indirect consequences of the pandemic, including those due to restrictive pandemic control measures, have led to significant reductions in the availability and utilization of essential health services. These have been linked with an initial (and often ongoing) lack of personal protective equipment to ensure safety for staff and patients, and with inadequacies of local supply chains. Patients with non-COVID-19 conditions seem to be deterred from seeking care. Demand-side obstacles include fear of contracting COVID-19 at health facilities or of being detained, isolated or stigmatized; restricted movement; and reduced ability to pay for transportation or user fees due to income loss. It is likely that severe economic disruption will worsen these in the months ahead.

As a result, total all-cause excess morbidity and mortality is likely to be far greater than that due to COVID-19 alone, with an increasing proportion due to non-COVID-19 related causes.

In addition, not all COVID-19 policies currently recommended can feasibly be implemented effectively in fragile settings. Management of severe cases is only realistic in the larger cities, and even supplemental oxygen is not widely available. Testing capacity is limited and isolation at home of mild and moderately ill cases and their contacts is, for the most part, not feasible, especially in the absence of social safety nets or other measures to protect against income loss. In all settings, realistic health strategies should be integrated in the overall multi-sector response.

2: An urgent call to protect funding for health in fragile settings

In the face of unprecedented global humanitarian needs, every possible opportunity must be taken to encourage domestic spending on health in countries with fragile settings, and donors must sustain their health support. This is crucial for rapid recovery – to restore services at least to pre-COVID-19 coverage, protect against further impoverishment due to healthcare costs, build resilience against future shocks, and make progress towards both UHC and health security goals.

All countries have suffered major economic losses during the pandemic. It is likely that domestic tax revenues and public spending on health, already insufficient in most fragile settings, will be further reduced.

The pandemic has created unprecedented humanitarian needs. A record 235 million people will need humanitarian assistance and protection in 2021, a near 40 per cent increase on 2020. OCHA is warning of the "bleakest and darkest" projections yet.

In addition, flows of external assistance are slowing and it is not clear that current levels of development assistance will be maintained. There are already signs that funding for humanitarian

response plans, despite additional needs for COVID-19 preparedness and response, will be less than in previous years.

At the same time, the costs for implementing regular services have increased due to COVID-19. This is largely to improve infection prevention and control in health facilities to deliver services safely for both staff and patients, and to make other adaptations required to comply with recommended non-pharmaceutical interventions. In addition, procurement and implementation costs for COVID-19 vaccination programmes will be significant. Most funding made available comes from existing development budgets, squeezing available funding for planned investment in health development even further.

Ambitions to build back better, and to ensure that the 1.8 billion people who live in fragile settings are not left further behind, depend on sustained commitment and support. Without sufficient funding, individuals and communities will be left vulnerable to ill health due to poor service coverage and impoverishment due to out-of-pocket healthcare costs, and populations and health systems will be left vulnerable to large scale epidemics and other emergencies within existing protracted crises. These can have significant knock-on effects for all countries.

The case for adequate domestic and international funding for health is compelling. COVID-19 has shown in stark terms that investment in health saves lives and protects the economy. The costs of inaction are huge, since preparing for emergencies and reducing risks in advance is far less expensive than responding to major crises and the economic recessions they can trigger.

3: Six emergent lessons to enhance COVID-19 response and recovery in fragile settings

Fragile settings are inherently challenging. Recommendations are easier to make than to implement. With that in mind, these emergent lessons include actions to consider based on experience to date of what is possible in some contexts, and early indications of good practice.

i. Strengthen and adapt **information systems** to better understand COVID-19 spread, access to and utilization of essential health services, and all-cause morbidity and mortality.

There is limited reliable data on the evolution and impact of the epidemic in many fragile settings. Existing COVID-19 surveillance data often do not reflect the on-the-ground reality, due to limited testing capability and reporting systems. Under-reporting in these settings is probably significant, and possibly biased by greater testing capacity in urban settings. We do not have a good grasp of COVID-specific incidence, infection-fatality, hospitalization, or mortality rates. Operational indicators, such as on testing, contact tracing and bed occupancy, are lacking.

In addition, little harder data is available about the pandemic's impact on other health conditions. Anecdotes, rapid surveys and reports from routine facility-based health information systems, all suggest that levels of routine service coverage have been seriously disrupted, and morbidity and mortality from conditions including vaccine-preventable diseases (especially measles), malaria, tuberculosis, and many others, are likely to have increased.

Timely and better data is needed for strategic decision-making both within and outside of the health sector. Accurately assessing the pandemic situation and its effects on services enables tailoring of responses to the actual needs. Investments in data collection, analysis, and interpretation can result in life-saving adjustments such as rebalancing between priorities over time. This should include data governance and protections since identifying data can put individuals at risk, especially in conflict settings.

To "follow the science", and inform strategic and operational decision making, we need more reliable community- and facility-based data on epidemic spread, its effects on essential services, and needs related to the epidemic:

- Use proxy indicators for which data can be collected within existing capacities and systems, such as hospital occupancy rates for respiratory infections and syndromic surveillance at community and primary care levels

- Prioritize available limited testing capacity to clinical and hospital settings and severely ill patients, as test results affect treatment protocols. When rapid diagnostic tests become available at low cost, add these in sentinel sites at first
- Use routine health facility-based information to understand trends in disruptions and subsequent restoring of selected essential services (compared to pre-COVID-19 data sets and levels when available)
- Engage with multisectoral household or community surveys that monitor socio-economic impact and COVID-19 induced barriers to meet basic needs, including health.

ii. Include **civil society organizations and communities** in shaping, communicating, and implementing response measures, to build trust and address barriers to health services and other threats to survival and dignity.

A hallmark of fragile states is the mistrust that exists between those who control the machinery of government and those who do not feel they are being effectively governed. Risk communications, transmission control measures, community management of cases, and reducing demand side barriers for the utilization of essential primary health care services all depend to a large degree on communities trusting messages and agreeing to implement guidance of public health authorities. Where communities are marginalized or perceive corruption, or where there is lack of transparency in pandemic response measures, trust will be further undermined. Engagement with communities, and meeting their needs, should therefore be prioritized in response strategies.

Building and maintaining trust is a difficult task. It is becoming clear, even in high-income countries with legitimate governance, that pandemic control measures, especially ones that can be interpreted as restricting individual liberties, place a great strain on the relationship between authorities and the populace. Planning and decision-making must be transparent. Pandemic response measures need to be sensitive to communities' overall needs. They should be balanced and take into consideration barriers to other essential health care services, as well as to the ability of individuals to survive economically by pursuing income-generating activities. They should allow communities,

whenever possible, to maintain other essential societal functions such as education, and ensure protection from violence (including gender-based violence) and other threats to personal and communal security and dignity.

Communities and civil society organizations (CSOs) have a key role in shaping measures to address vulnerability, which is often concentrated in fragile settings. Those at highest risk for mortality from COVID-19 should be protected, for example by appropriate "shielding" measures.

All countries have seen a proliferation of misinformation through the course of the epidemic. The nature and extent of this, and mechanisms by which it is spread, are likely to be highly context-specific. Mistrust of statements and policies emanating from governmental authorities is commonplace in fragile settings. Alternate explanations for the pandemic and response measures can circulate rapidly and result in misguided actions on the part of the population. Responsible action depends on accurate information delivered by trustworthy sources who must be identified as early in the course of the pandemic as possible. In due course this will be especially important to address vaccine hesitancy.

To build trust and give communities and CSOs greater say in the design and implementation of measures that affect them:

- Maintain dialogue with communities on the need to adopt sound and feasible non-invasive and non-restrictive pandemic control measures, such as social distancing, face covering, frequent handwashing and respiratory hygiene, and protecting those at highest risk
- Design/update public health policies with appropriate input from trusted community representatives and engage communities in the adaptation and implementation of response measures, so they are feasible in their context, mitigate effects on livelihoods, and also respond to other health concerns and threats to their survival and dignity
- Where formal authorities cannot meet their responsibility to engage with communities, international partners need to step in and collaborate with CSOs

- Work with communities to understand the extent of incorrect and harmful information and how it circulates, and design and evaluate effective ways to combat the "infodemic".

iii. Invest in **"common goods for health"**, including International Health Regulations functions, and **emergency risk management** to protect service delivery, as foundations for both UHC and health security.

Many health systems were not adequately prepared, even those that had high scores in assessments such as the Joint External Evaluation for International Health Regulations (IHR) capacities. Progress towards UHC goals has been set back. These setbacks are particularly affecting countries with fragile settings, as they already had low health coverage and weak systems. Recovery will be especially challenging, due to limited economic growth, the weakness of social contracts between government and the people, and a grossly inequitable distribution of social services.

A coherent approach to strengthening health systems is needed. Population-based public health functions or interventions that require collective action and public (or donor) financing are known as "common goods for health"; for example, comprehensive surveillance, data and information systems, regulation, communication and planning/ oversight capacities. These are foundational for both UHC and health security, but have been neglected in many countries.

Preparedness also requires investment in risk management within essential health services. All the components must be developed in an inter-dependent and integrated manner: this is the only way to improve and to protect the health of the population.

Investments in "vertical" disease-specific programmes are insufficient to protect against shocks such as major outbreaks, and may contribute to fragmentation of health systems. Likewise, unbalanced investment in epidemic preparedness and control risks undermining abilities to provide essential health services to those who need them. Epidemic preparedness and response must include making health services

safe (i.e., reducing transmission risks) for staff and patients, flexibility to scale up epidemic treatment capacity by repurposing existing resources, and continuity of 'routine' essential services. Many adaptations made during the current pandemic to address these have the potential for longer term benefits, such as improved staff and patient safety, shifting services to community level and the use of digital platforms to improve access and adherence.

Opportunities to "build back better" towards both UHC and health security goals include:

- Prioritize investment in common goods for health
- Integrate risk management within the PHC approach, building on adaptations made in service delivery during the response to the pandemic
- Ensure improved coordination of investments and integration between health security and UHC goals as part of overall strategies to strengthen health systems
- In countries with fragile settings, where government structures are weak, consider developing or supporting alternative or shadow processes, with a clear plan for transition back to domestic institutions.

iv. Strengthen **connections and coordination mechanisms** across epidemic control and health and multi-sectoral humanitarian and development approaches, to ensure coherence and involvement of all relevant actors.

Fragile and conflict-affected states are distinguished from others by the presence of humanitarian actors who support and provide health services to people whose needs, to varying degrees and for varying reasons, are not met by government.

The 'triple nexus' seeks strategic and operational connections between humanitarian, development and peace-building planning and implementation. In practice there are many and fragmented policy and implementation mechanisms. Separate coordination mechanisms for epidemic response makes this even more challenging.

Specific challenges include gaps in both understanding and operationalization of different coordination mechanisms, lack of clarity on roles of different partners (especially NGOs and others

outside of the UN system), failure to share accurate strategic information in a timely manner, and lack of an agreed integrated multi-sectoral framework for outbreak response.

To strengthen and reinforce coordination across humanitarian, development and government actors (and including civil society and communities as noted above), both for the pandemic response and for "building back better":

- Integrate coordination mechanisms where possible (and at minimum improve communications across/between them), to promote a shared understanding of response measures and different actors' contributions to them
- Identify common solutions for shared operational challenges, such as a common supply chains for commodities such as diagnostic tests, therapeutics, personal protective equipment, other medical supplies and, eventually, COVID-19 vaccines
- Promote a 'whole-of-society' approach to coordination, specifically to position the health sector response within the broader socioeconomic response and recovery and identify specific roles/ contributions of actors beyond the health sector
- Integrate contributions to 'building back better' in ongoing preparedness and response plus wider development and humanitarian programming, for a shared integrated approach towards UHC and health security goals.

v. Monitor impacts on **fragility and on vulnerable groups, especially women and girls,** and uphold humanitarian principles and equity, to leave no one behind.

To a greater degree than elsewhere, in fragile states the pandemic poses major threats to political, economic, and social stability. While
calls for a cessation or temporary suspension of armed conflict have perhaps been heeded in some places, there are indications that the pandemic is exacerbating tensions or worsening the security situation in others. This is a further example of the pandemic indirectly increasing other health hazards.

This is especially true where the pandemic can serve as an excuse for state suppression of protest, escalated violence by state and/or non-state actors, or postponed elections. There are cases of control measures being used to suppress protest or justify human rights abuses. The pandemic does not seem to have directly resulted (yet) in major escalations of the world's longstanding conflicts, but the political dynamics of most countries have been substantially affected, and significant economic disruption is likely to have indirect longer-term effects.

Although all people are susceptible to infection with SARS-CoV-2, the consequences of the pandemic are not equally distributed. The poor, socially and politically marginalized groups, and women and children everywhere have borne the brunt of the political, social, and economic impacts of the pandemic. There are suggestions that trafficking, child marriages, and sexual and gender-based violence have all been exacerbated by the pandemic.

This is worsened in fragile settings, where social protections are grossly inadequate and communities are deliberately excluded or live in areas not under government control. To help address these issues – and avoid unintentionally worsening them – response measures must be impartial and based solely on need and include meaningful participation for all parts of the population. Social safety nets may need expansion to help mitigate the impact of epidemic control measures. There is an increasing use of multipurpose cash grants within humanitarian programming, but no indications to date that these have been scaled up as part of the COVID-19 response.

Actions to adapt COVID-19 responses to these dimensions of fragility and vulnerability include:

- Intensify monitoring of human rights violations and attacks on health care
- Analyse and be sensitive to political/conflict dynamics as a core element of response planning
- Ensure response measures (especially goods and services) are distributed equitably, avoid "blind spots" in access/provision, and target more vulnerable groups throughout society, regardless of ethnic, religious, or political affiliation, to leave no-one behind.

vi. Plan proactively for **coherent COVID-19 vaccination approaches** to support restoration of essential health services and wider recovery without fragmenting health systems.

The development of several SARS-CoV-2 vaccines is a significant step towards pandemic control and ending the restrictive measures. Fragile and conflict-affected settings will largely depend on external assistance for vaccine procurement and distribution, for example cold-chain equipment and logistic capacity. Mechanisms such as COVAX are dedicated to this, while negotiations are ongoing for humanitarian stocks.

All countries are currently in the process of developing plans for vaccine roll-out, with suggestions that programmes may begin toward the end of the first quarter of 2021. Currently, the focus is on selecting high-risk groups to receive vaccine on a priority basis.

Successful implementation of mass vaccination campaigns is challenging in fragile settings and coverage, as has been seen with other antigens in many emergency settings, may be less than optimal. Large scale programmes and funding bring important opportunities but also risks of further fragmenting health systems.

These are emergent and fast-moving issues. As COVID-19 vaccination approaches are developed, priorities for planning and policy dialogue include identifying how to:

- Agree context-specific vaccination strategies in fragile settings – including appropriately prioritized/sequenced public health goals (for example, protecting health workers and vulnerable groups) and potential wider goals/impact (for example enabling lifting of social/economic restrictions)
- Identify and reach high-risk individuals, the elderly, those with exacerbating underlying conditions, and health care workers (in private and public sectors), including in areas not under government control, as well as those in areas under government control who may be excluded or not covered by the public health system (e.g. detainees, migrants and refugees, and stigmatized populations)
- Address vaccine hesitancy, misinformation and other demand-side issues
- Ensure vaccination supports re-establishment of other essential health services, without excessively diverting resources such that services are further disrupted
- Prioritize available vaccine stocks appropriately, globally and within countries, based on risks and vulnerabilities so that populations are reached progressively on basis of need.

Acknowledgements

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Universal health coverage means making quality health services available for all, ensuring people are not pushed into poverty by healthcare costs.

UHC2030 provides a multi-stakeholder platform to promote collaborative working in countries and globally on health systems strengthening.

We advocate increased political commitment to universal health coverage and facilitate accountability and knowledge sharing. A main purpose of UHC2030 is to encourage partners and related initiatives to coordinate their efforts on health systems strengthening.

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