SECOND INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE

Terms of Reference: Background Paper on primary health care and emergencies

Product of World Health Organization

Overview

These terms of reference are for the development of a background paper on primary health care and emergencies. This work is being commissioned by WHO as part of the technical series for the Second International Conference on Primary Health Care, which will take place in Astana, Kazakhstan on 25-26 October 2018. This Conference is cohosted by UNICEF and the Government of Kazakhstan. The timeframe for completion is 2 months (31\textsuperscript{st} August 2018).

Background and purpose

On the occasion of the 40th Anniversary of the Declaration of Alma-Ata, the Government of Kazakhstan with WHO and UNICEF will host the Second International Conference on Primary Health Care. In the Declaration of Alma-Ata, a generation of leaders expressed their commitment to achieve health for all through primary health care. That commitment remains as relevant and essential today as it was when it was first articulated in 1978. Ensuring people-centred care that offers universal access, social equity and financial protection with a primary health care-led approach is critical to the attainment of Universal Health Coverage (UHC) and the health-related Sustainable Development Goals.

While there have been great strides toward UHC in the last four decades, the vision set forth in the Declaration of Alma-Ata has not always been translated into effective transformation of health systems. Achieving UHC has two main strands to firstly ensure that people are protected from financial hardship when they access services, and secondly that they are able to access the health services they need, when they need them. UHC will not be achieved if people cannot access quality services, and this means improving service delivery.

This Conference provides Member States and other stakeholders the opportunity to renew support for primary health care, considering the significant changes in the social, epidemiological, and demographic landscapes as well as evidence for what works. A renewal of primary health care is important for all countries, rich and poor, and is essential for improving health, social stability, sound national economies and health security. The Conference aims to strengthen primary health care as the foundation for UHC, building on lessons learnt over the past four decades. On the occasion of this momentous anniversary, Member States, people, civil society and international partners must commit to transforming this new vision into a practical reality—a reality that everyone can share, believe in, take action upon, and benefit from.

For WHO, this vision is strongly aligned with the 13th Global Programme of Work, 2019-2023, and makes progress on the mandates to the secretariat in WHA resolutions 62.12 on “Primary health care, including health system strengthening” and 69.24 on “Strengthening integrated people-centred health services”. In addition, it builds on numerous regional resolutions on universal health coverage, health system strengthening and primary health care.

In support of implementation of the Conference Declaration, WHO is developing a series of technical background documents that will describe best evidence and best practices on key policies and practices to advance primary health care. These documents will succinctly present a situation analysis; potential policy options/mechanisms; evidence on impact and contextual factors/conditions for implementation (both successful and less successful cases); and recommend most effective policy options/mechanisms.
Main objective

To develop a background paper on primary health care and emergencies in support of implementation of the Second International Conference on Primary Health Care, which will take place in Astana, Kazakhstan on 25-26 October 2018.

Specific objectives

- **Specific objective 1**: To lead the development of a global briefing document (under the technical oversight of WHO).

- **Specific objective 2**: To conduct a rapid scoping review of seminal literature on the linkages between primary health care and public health events and emergencies. The desk review will provide references informing and supporting the issues examined and recommendations described in the global briefing document. The results of the desk review will be synthetized in a structured excel table of resources reviewed.

Brief description of the rapid desk review work

The rapid desk review is not an exhaustive piece of work, given budget and time constraints, but will focus on key interventions and contextual factors identified and listed in the annotated outline, which has been developed through a rapid WHO expert consultation. All efforts will be focused on synthetizing seminal literature on the subject area. The methodology should be informed by appropriate WHO approaches to rapid desk reviews. WHO colleagues will provide any essential guiding technical resources and materials.

Materials to be reviewed include published scientific journal articles and grey literature including technical reports, evaluations, case studies, and other write-ups by Governments, multilateral system partners, research institutes and NGOs/civil society. The bulk of the review will entail searching electronic databases including: PubMed, Medline, WHO Index Medicus, WHOLIS (KMS), SCOPUS, and the Cochrane Library. A detailed search plan will be jointly elaborated by WHO and the contractual partner.

The desk review will result in a summary table in excel, printable in A3 format which will be drawn on to support and inform the background paper. These are briefly described below.

**Summary table.** The table will include the full text sources meeting eligibility criteria, with the following information covered for each source:

- a. Reference
- b. Relevance to the different topics covered in the annotated outline
- c. Type of data in source: primary, secondary, quantitative, qualitative, mix, and information on sampling framework (if relevant) and level of stratification
- d. Brief description of measure/intervention described
- e. Brief reference to key findings (focusing on promising components, challenges)
- f. Summary of main thrust of recommendations (e.g., for further research, monitoring and/or programmatic/policy implications).

Brief description of background paper

The background paper and brief, will provide a rapid summary of what is known.
This brief will evaluate policy options and interventions, providing a succinct description of the present situation, of what can be done to strengthen PHC resilience and of prioritized options with actionable recommendations for implementation.

- Based on available data and experiences elucidate 1) the role of PHC in public health events emergencies (acute and protracted) including for prevention, detection, response and recovery), and 2) the impact of public health events and emergencies on PHC provision.
- Analytical description (structured around health systems components) on how to make national PHC systems resilient for public health events and emergencies. This could include example case studies outlining good practices.
- Discuss the responsibilities of national and global institutions for making PHC resilient and what should be the national and the global priorities for intermediate (next 3-5 years) and longer term (5-10 years).

The document will follow the structure of the annotated outline, which is a product of a rapid WHO expert consultation process. The group of experts included WHO HQ technical staff from different teams whose work focuses on health emergency preparedness, health emergency response, PHC and health services resilience. The structure and content of the annotated outline will be refined during the drafting of the background paper – any such changes will be made in consultation with the dedicated WHO expert team.

Box 2. Structure of the background paper

| I. Executive Summary (4 pages) – brief summary and key messages |
| II. Report (15 pages) |
| a. Background and context |
| b. Role and challenges of PHC in public health emergencies |
| c. Building PHC resilience using health system components |
| d. PHC & public health emergencies – the capacity building process |
| e. Resilient PHC on national and global agendas - AA40 and next steps |
| f. Glossary and Acronyms |
| g. Reference list |

Estimated total length: 20 pages

Coordination of work

This work is led by WHO Headquarters. Regular coordination calls (at least once every two weeks) will be convened between WHO Headquarters and the contractual partner. The input from counterparts within WHO that will be engaged in this work will be overseen by Dr Dirk Horemans, Programme Officer in close connectivity with the WHO AA40 Secretariat.
Timeline, deliverables and payment schedule

- Deliverable 1: A detailed description of the methodology that will be used for conducting the scoping review of literature, sources/databases, a draft analytical framework, the search terms for each set of approach/mechanisms, and the skeleton of the summary table including 2-3 example inputs (with columns in excel). Deadline: July 13th
- Deliverable 2: A report describing the findings of the scoping review, covering the methodology applied, a structured narrative summary of the findings, the excel table structured as specified as well as a plan for adapting the report of findings into the briefing document paper. Deadline: July 20th
- Deliverable 3: First draft of the global briefing document. Deadline: July 31st
- Deliverable 4: First draft of the global briefing document taking into account comments from reviewers and the first draft of the summary 4-pager. Deadline: August 18th
- Deliverable 5: Revised draft of the summary 4-pager taking into account comments from reviewers. Deadline: August 31st

The payment schedule foresees four instalments:

- A first installment against deliverable 1: 25%
- A second installment against deliverable 2 & 3: 25%
- A third installment against deliverable 4: 25%
- A fourth and last installment against deliverable 5: 25%

Budget

The total amount for this work is estimated at 45 person days and corresponds to 10,000 USD.

Copyright and authorship issues

It should be noted that research and reports commissioned by WHO have WHO copyright and WHO reserves the right to use the final outputs or not. The contractual partner will receive due recognition in acknowledgements, as will the overseeing and contributing WHO staff and any reviewers. Any interest by the contractual partner to use the findings of the research for their own publications/purposes must be discussed and agreed on by WHO, and the original WHO-commissioned work cited appropriately.

Submission of proposals

Interested candidates will submit their CV as well as a proposed methodology and timeframe. The proposal and all correspondence and documents relating thereto shall be prepared and submitted in the English language.

Information which the bidder considers confidential, if any, should be clearly marked as such.

The bidder shall submit the complete proposal to WHO in writing no later than Friday, 29th June 2018 at 17:00 hours CEST time ("the closing date"), by email at the following address: horemansd@who.int.
RESILIENT PRIMARY HEALTH CARE AND PUBLIC HEALTH EMERGENCIES

AA40 background paper -

EXECUTIVE SUMMARY (4 PAGES) including key messages

MAIN REPORT (15 PAGES)

A. BACKGROUND AND CONTEXT

1. Nzerekore story setting the scene: The first Ebola cases\textsuperscript{12} in Nzerekore Guinea. Highlight the linkage of trust & use of PHC. Draw out points on diagnosing/detection, reporting, treatment and referral. Include mention of IPC measures to protect workers and patients. Emphasize community engagement aspects. Round off with points on the collapse of the already challenged functionality of routine provision of essential health services.

2. Devastating impact of the Yemen conflict on the national health system including PHC: Description of the impact of this protracted emergency on the population, on the disease burden, on the support functions (supplies, workforce, infrastructure, the community functioning, etc.) of the health systems and how that influences the provision of health services to address the increased disease burden.

2. Public health emergencies can take many forms (link to definition box), with multiple considerations for PHC services. Localised, vs regional/national/international. Outbreaks, natural disaster, conflict, mass casualty events, CBRN, health system failure. Acute vs protracted. PHC may be provided in dedicated PHC facilities (health centres), in hospitals/secondary care facilities, and by community-based teams.

3. PHC system roles in emergency risk management: PHC systems roles with regards to emergencies are multiple and crucial. Prevention, detection, response, recovery, engagement, maintenance of routine services. Example of role of PHC providers in next Influenza Pandemic Disaster. Environments particularly prone to public health emergencies may also have increased routine care needs. Link to communities – communities as key to resilience and response, and PHC as critical link between health system and communities.

4. Link with broader health system response: Acknowledge that PHC is only one aspect of the broader health emergencies system. But within this it clearly plays a key role, and it is of critical importance to ensure PHC is a key consideration in all-hazards emergency planning.

\textsuperscript{2} http://www.ibtimes.com/ebola-patient-zero-emile-ouamouno-guinea-first-contract-disease-1714698
5. **Impact on routine services**: public health events and emergencies can have an impact upon provision of PHC services through multiple means, such as damage to infrastructure and access, increased demand for care, effects on healthy and health-seeking behaviours, and wider systems effects. Examples from West Africa Ebola affected countries and Yemen, e.g. increase in malaria deaths, cholera morbidity and mortality. Introduce concept that there are likely to be several factors that determine the degree to which PHC systems and services are resilient.

6. **IHR2005 and GHSA on the global agenda**: recent IHR2005 highlights and trends

7. **Challenges of providing PHC during public health emergencies**: dealing with emergency (new or little-used skills and knowledge, mass casualty management, facility readiness, damaged or overstretched systems and infrastructure), impact on staff, financial implications, coordination challenges (across health system and between multiple actors).

8. **Link with humanitarian/NGO sector**: In fragile and conflict affected settings, humanitarian actors and NGOs may be providing PHC and related services. This has implications for these providers (ability to provide required quality and range of services, local knowledge, sustainability etc.) as well as for the wider health system (coordination, referral, planning, coverage, interaction with public services).

9. **Opportunities for PHC in emergencies**: Sometimes total system collapse (Syria and Libya), but even when not total collapse, emergency/crisis can be opportunity to replace a previous fragmented specialist based health system by a system with PHC as cornerstone – note principles of Build Back Better. There are examples of PHC services that have remained resilient in face of crisis – polio, NTDs, vaccination. These can be important vehicles for reaching populations with essential services during protracted crises, and there is much to learn from the approach if we are to develop effective PHC that is resilient in the face of challenging circumstances.

10. **Relationship between SDGs, UHC, (GPW13), PHC in emergencies**: Based on the above and populations sizes (IDP, refugees, populations in fragile settings) highlight the importance of emergency response PHC to assure access to quality services and hence its importance for the UHC agenda and for achieving the SDGs.

11. **Disease X and PHC**: The role of PHC during the next Disease X Pandemic Global Health Security ↔ National Health Security ↔ PHC PHE preparedness ↔ community and Individual Health Security

**Purpose of this paper** is to examine the role of PHC in public health emergencies, discuss the impact of public health emergencies on PHC provision, and explore how PHC provision before, during and after emergencies can be strengthened.
B. ROLE AND CHALLENGES OF PHC IN PUBLIC HEALTH EMERGENCIES

1. PHC systems roles with regards to emergencies are multiple.
   • Preventing, detecting, reporting and monitoring outbreaks and other health emergencies.
   • Initial triage, treatment and referral
   • Assuring safety for staff and patients from outbreaks (IPC/ facility-WASH)
   • Assuring safety for staff and patients from attack (security)
   • Assuring the continuation of routine essential health services
   • Assuring case-management for cases resulting from an emergency not requiring specialist/secondary care, e.g. cholera cases in country X.
   • Assuring that quality and safety of services are guaranteed during emergencies
   • Providing access to vulnerable groups often impoverished populations
   • Facilitating effective engagement and communication with the local community
   • Provision of services to meet emerging and post emergency care needs (e.g. mental health, disability)

2. Deep dives focusing on the following topics (supported by literature review):

   I. Continuation of routine health services during emergencies
      1. What is the impact of public health emergencies on routine PHC services?
      2. What strategies can be used to boost PHC resilience?
      3. What role can humanitarian actors play in supporting continuation of routine services?
      4. What should be the prioritized essential package of health services to be provided during public health emergencies?
      5. What is the role of effective referral mechanisms?

   II. Case-management for selected PHE related diseases & conditions
      1. What are the most likely PHE related diseases and conditions to be encountered in PHC?
         a. What is the role of PHC in managing these?
         b. What can support effective PHC management of these priority diseases and conditions? (e.g. guidelines, training, financing, local/district/national support, specialist and humanitarian services)

   III. Quality of services provided
      1. What do we know about the quality of PHC services provided during emergencies?
         a. What factors can affect the quality of services provided?
         b. What measures could be put in place to assure and improve quality of PHC services in the context of public health emergencies (both routine services and those dealing with the emergency)?
         c. IPC and WASH – critical foundations for safe and effective response to public health emergencies
IV. Training the PHC workforce in essential aspects of emergencies
   a. Are there examples of where this has been done well?
   b. Who to train and how to train?
V. Beyond health centres – other sources of primary care during emergencies
   People may access treatment (related to PHE or routine care) from pharmacies, community teams, disease programmes, traditional practitioners.
   a. What role can these services play, and how can they contribute to resilience of PHC? What are the challenges for public health emergency response and recovery presented by these other aspects of the primary care system?
VI. Who pays for PHC services during public health emergencies and how?
   a. Provider payment mechanisms
   b. Availability and use of emergency funds
   c. Ensuring funds are spent appropriately and that there is the correct balance between funding emergency-related and routine services.
VII. People centeredness and community engagement
   a. The role of PHC in engagement activities in relation to public health emergencies
   b. Why is patient-centeredness important in the context of PHC in public health emergencies, and how can it be improved?
VIII. Role of Humanitarian Assistance NGOs
   a. Coordination of multiple actors involved in emergency response and provision of PHC services, including coordination mechanisms, alignment behind national plans/EPHS, speed and funding of response, national/sub-national coordination, and engagement of existing local services.
   b. Assuring quality of health service provision among humanitarian actors
   c. The role of humanitarian organizations in building sustainable PHC systems during and after initial response
IX. Health system recovery
   c. What are the implications for PHC, and the ongoing challenges?
   d. Building back better – how to make the most of this opportunity
IX. Providing PHC services in an insecure environment
   a. Attacks on clinics and health care workers
   b. Using mobile clinics and teams, community health workers, and referral systems
C. BUILDING PHC RESILIENCE USING HEALTH SYSTEM COMPONENTS

This section will define what is required to build PHC PHE preparedness capacities, describing different elements structured around health systems components.

- **Governance**
  - National and sub-national all-hazards emergency risk reduction (preparedness) plans and the all-hazards emergency response plans defining the role of PHC providers (based on national priority PHE risks including PHE case-management in EPHS for respective levels)
  - Develop response plans, service continuity/resilience plans, and SOPs for PHC level
  - Simulation/exercising of response plans
  - Coordination and collaboration including private sector PHC providers; multi-sectoral collaboration; One health at PHC level; local health authority support and coordination role; developing strong networks.

- **Health Services**
  - Well defined and resourced EPHS for PHC level
  - Prioritising delivery of quality EPHS during emergencies
  - Quality of clinical services
    - Routine and related to PHE
    - Use of evidence-based clinical guidelines and efforts to enhance clinical effectiveness (as a core quality domain)
  - Safety Facility-WASH and IPC
  - Triage and referral mechanism
  - Laboratory capacity (including sample referral)

- **Health information**
  - Surveillance mechanism, disease notification (including urgent and community-based mechanisms), integrated with national health information systems where feasible
  - Monitoring of routine health services during emergencies identifying drops in access and uptake alongside efforts to monitor quality of health services.

- **Health workforce**
  - Training of PHC professionals (preparedness and PHE case-management), simulation exercises
  - Staff safety (perimeters, vaccination, PPE, etc.)
  - Role of community health worker
  - Surge capacity and mutual support planning
  - Staff motivation
  - Retention of staff during crises
• **Medicine, medical supplies and devices, infrastructure**
  - Logistic supply chain (spare capacity, pre-positioned emergency stocks, last mile)
  - PPE
  - Emergency stock mobilization
  - Readiness for mass vaccination programmes

• **Financing mechanism**
  - Regular budget for emergency preparedness
  - Accessible flexible emergency fund
  - Provider payment mechanism; user fee waivers, etc.

• **Cross-cutting**
  - Community engagement
  - Traditional healers
  - Risk communication
  - Public health functions

**D. PHC & PUBLIC HEALTH EMERGENCIES – THE CAPACITY BUILDING PROCESS**

Moving from the “what” to the “how”. This chapter provides an overview of levers for action to improve PHC resilience, at the PHC facility level, at the sub-national health authority level and at the national level.

Draw out key items described in the preceding sections and develop a list of 6-10 potentially high yield levers for change to enhance capacity related to PHC and public health emergencies.

This should include considerations spanning from the facility level all the way to the national and global levels.

Potential illustrative examples that could be described:

- Effective assessment of PHE preparedness of PHC providers and systems and the inclusion of costed PHC PHE preparedness capacity building activities in the strategic & operational plans, budgets and M&E frameworks.

- Inclusion of regular “preparedness assessment of PHC for emergencies” in the service package, and integration of the related indicators into national health information system

- Align with IHR2005, JEE and NAPHS development and utilize these events as opportunities to insert PHC roles
- Utilize quality improvement methods and approaches to strengthen the role of PHC in public health emergencies.
E. Resilient PHC on National and Global Agendas - AA40 and next steps

Discuss and summarise the role of different actors (global, regional and national institutions, humanitarian actors, CSO and the private sector) in making PHC resilient to maintain its function during and between the emergencies. What are the challenges (policy, coordination, financing, conflict) and how could this be managed through concerted/united global outlook and actions. What should/can be done as priorities for next 3-5 year and 5-10 year twinned with UHC2030, the health security, the Humanitarian – Development – Peace Nexus (HDPNx), and other health related SDG goals? What are financial instruments that can be harnessed for immediate priorities for PHC.

Messaging “PHC Resilience” in the “AA40 Outcome Document”, at the UNGA 2019 and consecutive PHC, UHC and health security events.

Glossary and Acronyms

Clarifying terminology will be done through the glossary or, for a couple of key concepts, through text boxes; FCV; IHR2005, GHSA, resilience, prevention, preparedness, response, recovery, protracted emergencies, etc.; Public health emergencies (focus of this paper) versus medical emergencies (could be a small text box with two definitions).

References