



ASIA PACIFIC  
PANDEMIC  
PREPAREDNESS AND RESPONSE  
REGIONAL FORUM



WORLD BANK GROUP



Ministry of Economy  
and Finance

# OPENING REMARKS & SETTING THE STAGE

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# THE CHALLENGE

- Investments in PPR can be *cost-effective* but since successful investment avert things from happening, this is REALLY *hard to see*
- Countries emerging from major epidemics *understand* the value of PPR now (it has not been a priority prior to COVID-19) but their economies are *ravaged* and they have numerous competing (and more immediate) priorities
- Thus, PPR has been and remains *chronically underfinanced* in most countries regardless of income level
- To be effective, four objectives must be met:
  1. Countries must recognize the *value of intensified public health and preparedness efforts working alongside* routine health service delivery
  2. Preparedness and public health must be *prioritized* given the country context and available financing, and *seamlessly integrated* into health systems
  3. About *80% of preparedness costs are recurrent*. It is cheap to train health workers and set up labs and expensive – in the long term – to maintain them. Preparedness and public health funding must be planned, recurrent, long-term and built into national health budgets.
  4. PPR and public health performance must be measured in more dynamic ways



# WHY HAVE FEW COUNTRIES SUCCESSFULLY INTEGRATED PUBLIC HEALTH INTO PHC?

Public health (PH) and PHC typically separate institutions, leadership, funding, reporting and training



PHC workers often too overwhelmed by what's in front of them to look beyond to PH

PH and PHC components not integrated into overarching HS, intersections, not systematized and coordination mechanisms limited

PHC workers are frontline of clinical suspicion and pivotal for bi-directional detecting, reporting and response but their training and responsibilities emphasize treatment and discharge. They're ill prepared and supported for their PH role



## THE PPR PARADOX

Countries **who need the most** PPR investments **can afford it the least**

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Countries who **need the least** PPR investments **can best afford it**

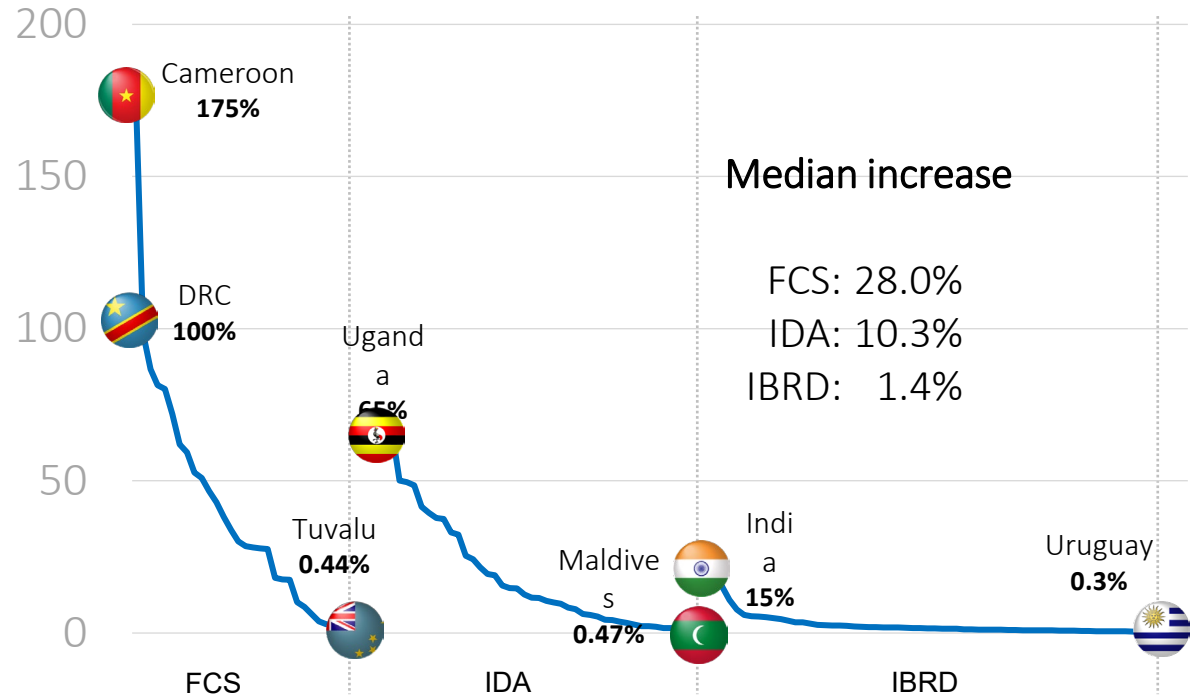
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Yet our global **guidance and assessment tools** seldom reflect this reality



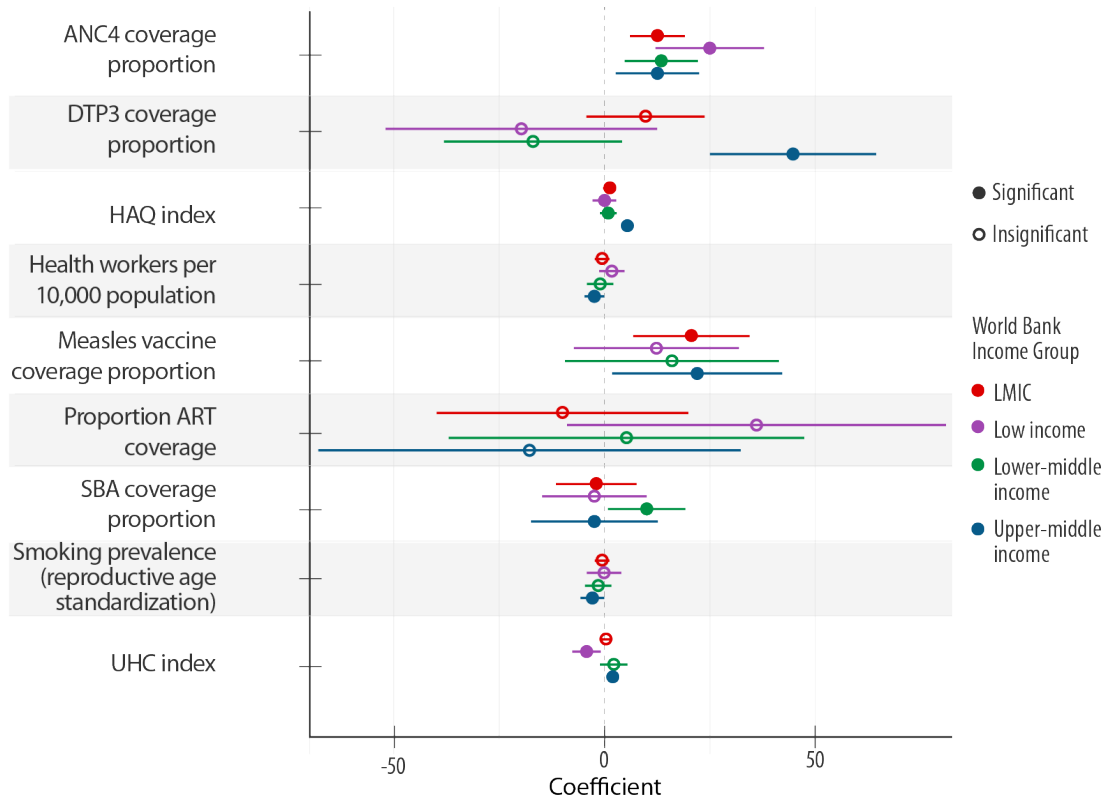
Finding an additional \$3.2 per capita for preparedness is a huge challenge, especially for low-income countries

% INCREASE IN GOV. HEALTH EXPENDITURE, PER CAPITA



## INCREASES IN PHC INVESTMENTS HAVE NOT RESULTED IN SIGNIFICANT CHANGES IN PUBLIC HEALTH OR POPULATION HEALTH

- Between 2007 and 2017, PHC expenditure per capita in LMICs doubled from \$41 to \$90
- PHC expenditures in LICs plateaued since 2014 at \$17 per capita
- As national income increased, % of health expenditures on PHC generally decrease
- Increases in % of health expenditures on PHC was associated with lower maternal mortality rate, improved coverage of antenatal care visits, measles vaccination and increase in Health Access and Quality index
- Increases in % of health expenditure on PHC was not associated with all-age mortality, communicable disease burden, smoking rates, or NCD burden
- i.e., to date, no effect of PHC expenditure increases on population or public health outcomes




# EXTREME PRIORITIZATION

## ON PRIORITIZATION:

- We prioritize because resources are scarce
- No real science for this
- Much depends on the country context, especially country risks

## TO KEEP IN MIND:

- Since most preparedness costs are recurrent, countries must integrate and sustain preparedness through routine services delivery



In a context of limited resources, how can countries make **meaningful, sustained** preparedness investments?





# START WITH WHAT'S MOST URGENT

- What are my major risks?
- What am I most likely to get hit with next time?

Countries need to do an assessment of what they are most exposed to in terms of public health emergencies, more specifically in terms of pathogens:

- Domestic, every day, recurring events
- My immediate neighbors
- Rest of world

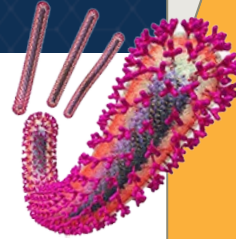




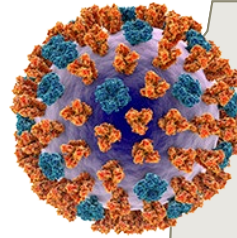


- At the highest priority, a country should be able to prevent, detect & respond to outbreaks they are most at risk of
- Followed very closely by protecting borders from what's happening in neighboring countries (points of entry)

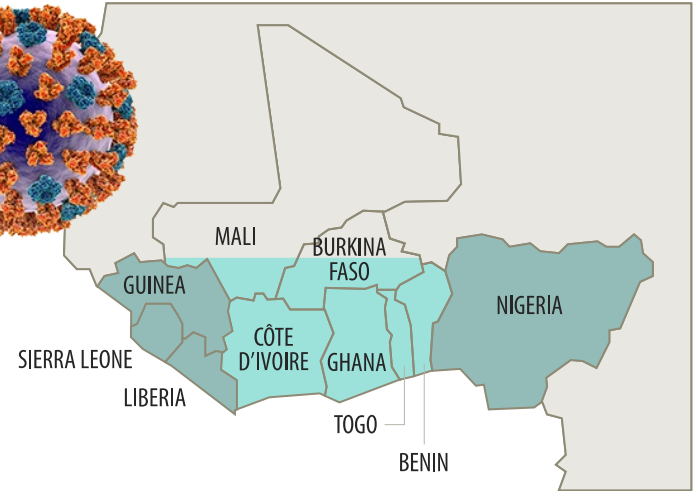
### EBOLA



### LASSA FEVER



- Countries reporting endemic disease and substantial outbreaks of Lassa Fever
- Countries reporting few cases, periodic isolation of virus, or serologic evidence of Lassa virus infection
- Lassa Fever status unknown



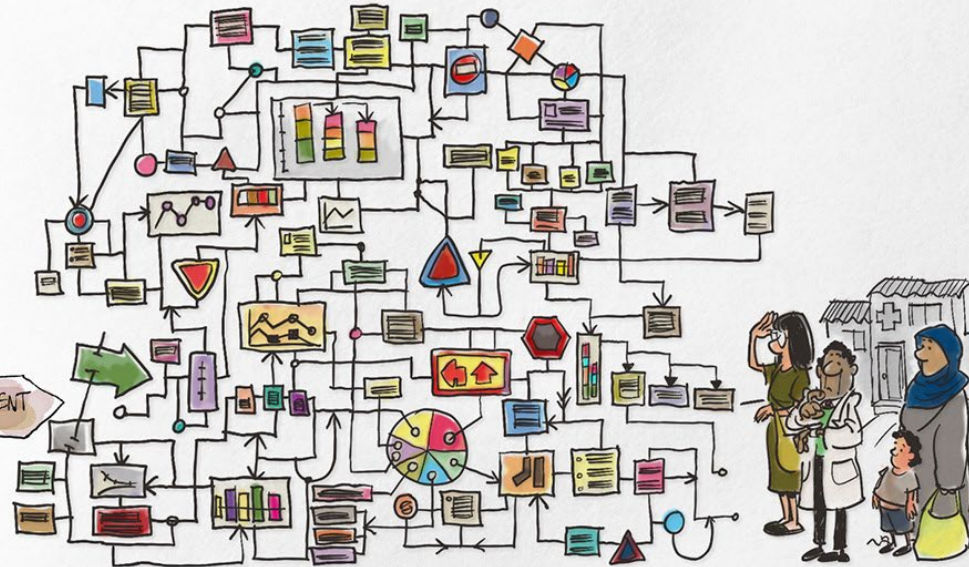


# FROM INPUTS TO DYNAMIC RESULTS

Existing assessment tools are input-based, static, linear (e.g., JEE, SPAR), reflect broad capacities, are uncontextualized and impede prioritization, critical needs assessment and real-time performance measurement



ASSESSMENT  
TOOL



Move from inputs to results...

PROMISING APPROACH TO RESULTS IS the 7-1-7 approach and now country-led alliance

# EVERY PUBLIC HEALTH EVENT IS AN OPPORTUNITY TO LEARN AND IMPROVE



Identify and address bottlenecks

- ✓ Make immediate improvements to prepare for the next outbreak
- ✓ Prioritize strategies for longer term systems improvement (e.g., NAPHS)



Coordinate outbreak management



Monitor for potential outbreaks



Investigate suspected outbreak and assess risk



# LEARNING FROM GLOBAL HIV SUCCESS: 90-90-90



There are 38 million  
people living with HIV



81% know they are  
HIV-positive  
The rest do not



Two out of three people  
living with HIV are on  
antiretroviral therapy



Only 59% of people living  
with HIV have undetectable  
levels of the virus

## 90-90-90 HIV treatment targets

30 million people  
on treatment  
by 2020

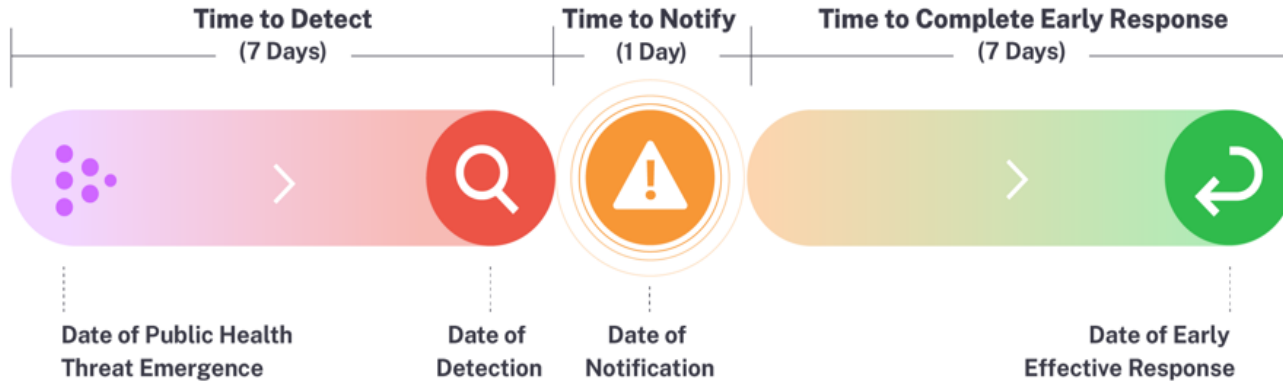
90% of people  
living with HIV know  
their status

90% of people who  
know their HIV-positive  
status are on  
antiretroviral therapy

90% of people  
on antiretroviral  
therapy are virally  
suppressed



# 7-1-7 TIMELINESS METRICS AND TARGETS





## INPUTS VS. RESULTS

- COVID-19 impetus for change but lessons are not new
- JEE-process not performance measure
- Performance indicators encompass politics, people and processes-all of which determine performance



Assess



Create a  
Costed  
Plan



Finance  
the Plan







## 7-1-7: AMBITIOUS BUT ACHIEVABLE

- Evidence to date + effectiveness of early response
  - Review of 296 outbreaks from 2017-2019 found median of 8 days for detection and 3 for notification
- Internal consistency in bottlenecks and enablers
- Promotes systems analysis across health system
- Identifies immediate, concrete issues for action.





# PRIORITIZE FOR PERFORMANCE

NAPHS typically generates 400-800 activities

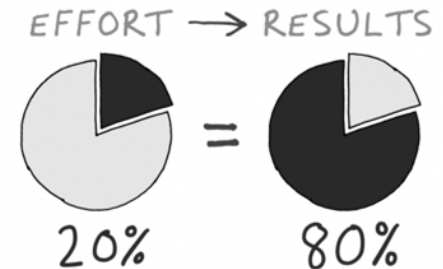
Previous attempts :

- Quick wins
- Do what you have resources for
- Even distribution across technical areas
- Focus on core 4
- Integration of all assessments

7-1-7 systems lens

- Functional grouping
- Bottleneck analyses
- Pareto principle

THE PARETO PRINCIPLE



## 7-1-7 PERFORMANCE REVIEW

- **24% of events met the entire 7-1-7 target**

	<b>Detect (target: 7)</b>	<b>Notify (target: 1)</b>	<b>Respond (target: 7)</b>
<b>Median</b>	6	0	8
<b>Proportion meeting target</b>	54%	68%	49%

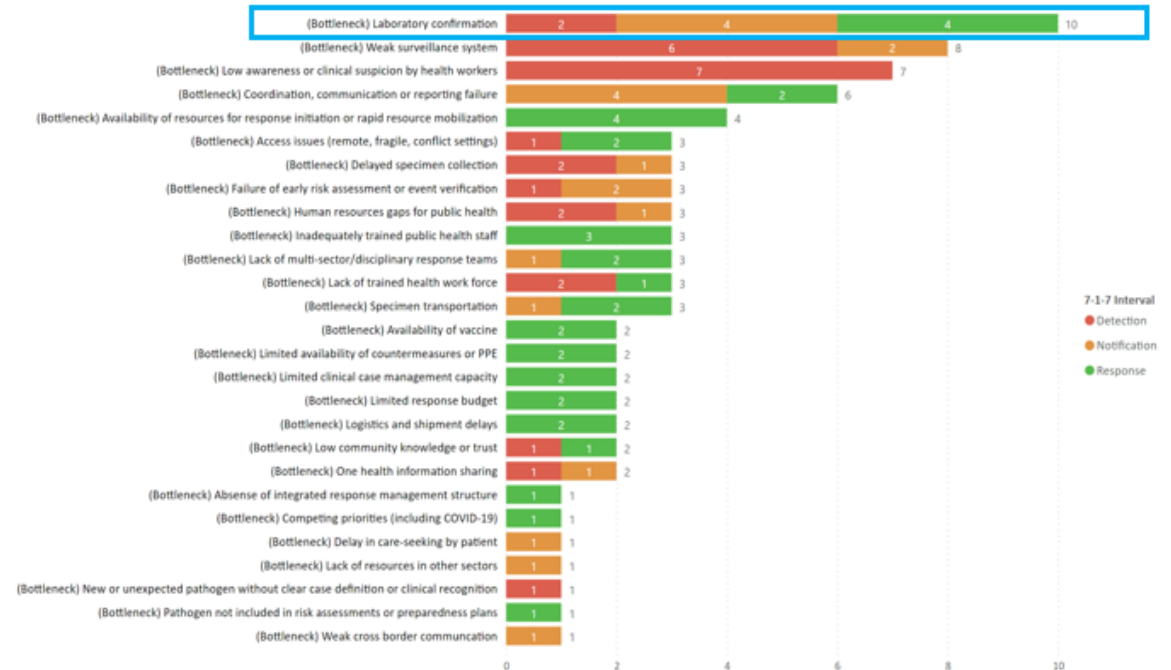
- **7-1-7 targets are measurable and achievable, across pathogens**

	<b># Events</b>	<b>Detect (target: 7)</b>	<b>Notify (target: 1)</b>	<b>Respond (target: 7)</b>	<b>Met 7-1-7 Target</b>
Food/waterborne	4	50%	25%	0%	0%
Other events	3	67%	33%	67%	0%
COVID-19	3	67%	100%	67%	67%
Vaccine-preventable	9	22%	44%	11%	0%
Viral hemorrhagic fever	11	55%	82%	91%	55%



## 7-1-7 BOTTLENECK ANALYSIS

- 7-1-7 identifies the major bottlenecks to rapid **detection** (7 days), notification (1 day), and **response** (7 days)
- Lab confirmation is the most frequent bottleneck for **detection** at the facility level, and for **notification** and **response** at the national level





## HOW CAN THE 7-1-7 TARGET IMPROVE PUBLIC HEALTH ACTION?



**A performance improvement framework:**

Delays and bottlenecks in the system are easily identified and quantified, and remedial actions are taken to drive rapid improvement



**A tool to prioritize financing and systems strengthening:**

Data on real-world system performance informs prioritization of available and further financing (complementing the JEE and SPAR)



**A communication and advocacy tool:**

Presented with simple metrics, political leaders and donors can clearly visualize resource needs and necessary policy interventions, substantiated by clear data



**An accountability and reporting tool:**

Reporting against simple metrics can monitor performance, evaluate interventions and improve transparency

## CONCLUSION

Effective preparedness requires us to **strengthen PHC and PH, integrate them into ERPHC, supported by expert surveillance and laboratories – and use every public health event to learn and improve**





