WORLD BANK GROUP

Strengthening Health Service Delivery Resilience in FCV Settings

PROGRAM SUMMARY

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Cover photo: A portrait of Helena D. Sayuoh a nurse, wearing protective clothing while working at C.H. Rennie Hospital in Kakata, Margibi County in Liberia on March 4, 2015. Photo © Dominic Chavez/World Bank

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PROGRAM SUMMARY

Arielle Agrokannoun (left), a nurse in the health center at Athiémé, a city of 40,000 people 100 kilometers from Cotonou, the capital of Benin, examines an 18-month-old boy whose mother has just given birth to another child. In this health center, malaria is the most common illness among children.

Photo: © Stephan Gladieu / World Bank

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In Memory of
Aaka Pande.

Acknowledgements

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Registered nurse, Vanie Boyajian vaccinates a child for polio at the Howard Karagheusian primary health care center, in Beirut, Lebanon on March 23, 2016.

Photo © Dominic Chavez/World Bank

Fragility, Conflict, and Violence (FCV) constitute one of the most pressing challenges to the Sustainable Development Goals (SDGs).

Background

Fragility, Conflict, and Violence (FCV) constitute one of the most pressing challenges to the Sustainable Development Goals (SDGs). An estimated 50 percent of the global poor will live in Fragile and Conflict-affected countries by 2030[1]. FCV settings are home to one third of the global disease burden for HIV, TB and malaria; the majority of maternal, newborn and child deaths; and overall some of the poorest health outcomes globally, particularly for vulnerable populations – women, children, and minorities. FCV contexts present a pressing and unique challenge to pro-poor growth, human development, human capital and ensuring the sustainability of development gains.

For FCV countries, service delivery in the health sector is a challenge. Many countries in active conflict, or with periodic flare-ups of conflict, have health systems that are doubly burdened, by supply disruptions and by acute surges in trauma and injuries. In such settings, vulnerable groups, especially ethnic minorities and others who may already be disadvantaged, often end up being disproportionately excluded from receiving services. Furthermore, FCV countries can be vulnerable to shocks imposed by pandemics, with for example the recent Ebola epidemic leading to more than 10,000 deaths. The ability of these health systems to contain new, and possibly deadlier outbreaks is uncertain.

There are important interactions between fragility and health. Conflicts and instability can rapidly erode health systems. The civil wars in Sierra Leone and Liberia in the 1990s not only directly killed hundreds of thousands but also decimated the health systems of both countries, setting the stage for the rapid spread of Ebola and threatening global health security. The converse is also true. There is growing theoretical and empirical evidence that investing in health can contribute not only to improving health status but also to mitigating fragility, due to the peace building and state building externalities of these investments. First, investing in health systems can promote social cohesion as health is a "super-ordinate" value that widely shared, irrespective of ideology or political affiliation. Second, "investing in health promote reliable provision of essential health services while demonstrating a commitment to equity, strengthening government accountability to citizens, and building the capacity of government to manage core social programs"[2]. A model for the role of health systems in post conflict settings is shown in table 1.

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[1] OECD, 2018. *https://www.oecd.org/dac/conflict-fragility-resilience/docs/OECD%20Highlights%20documents_web.pdf*

[2] Kruk et al, 2010. *http://www.sciencedirect.com/science/article/pii/S0277953609006339*

There is increasing attention to development work, beyond immediate humanitarian response, in FCV settings. This idea, currently called "working in the humanitarian-development nexus" or "bridging the humanitarian-development divide," isn't new. It emerged in the 1990s under the concept of linking relief, rehabilitation and development (LRRD)[3]. Initial models conceptualized a relief-development continuum: sequenced action between humanitarian and development work post crisis. But, more recently, a contiguum model has gained favor[4]: instead of a linear or temporal view that reflects a 'transition' from one to another, the idea is to approach the interactions between humanitarian and development aid as complex and ongoing with a focus on synergies between short-term relief measures and longer-term development programmes.

Table 1. Role of health systems post-conflict

Program	Outputs	Outcomes
Functioning, equitable health system: • National government stewardship • Rehabilitated primary care facilities • Re-established health workforce • Fair financing • Guaranteed package of health services • Equitable allocation of services	Improved access to quality, reliable health services for priority health problems Enhanced social solidarity and cohesion Greater confidence in government and support for social contract Stronger government capacity to administer public programs	Reduced mortality and morbidity More capable, resilient state Reduced risk of conflict recurrence

Source: Kruk et al. Social Science & Medicine 70 (2010) 89–97

Despite these challenges, and the increasing focus on FCV, the current state of global knowledge on how to strengthen health service delivery resilience (HSDR) in conflict settings, and in fragile settings with potential vulnerability to pandemic threats, is surprisingly poor. Bridging the humanitarian-development divide remains challenged by important knowledge, institutional, conceptual, and strategic gaps. For example, Liberia, Sierra Leone, and Guinea were vulnerable to the rapid spread of Ebola and cholera because of their inadequate health systems, stemming in large part from insufficient global knowledge on how to adequately reinforce HSDR in these settings. Although there are now ongoing efforts to strengthen the health systems of these countries, and in FCV more generally, there remain major gaps in knowledge on how to do this effectively, in the context of systemic problems, including damaged economies and health systems and limited domestic resources available for health.

[3] Otto and Weingärtner, 2013. Linking relief and development: More than old solutions for old problems? IOB Study. Netherlands. Ministry of Foreign Affairs.

[4] Mosel and Levine, 2014. *https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8882.pdf*

The World Bank Group (WBG) recognizes that in order to make meaningful progress towards achieving the twin goals of ending poverty and boosting shared prosperity[5], and towards attaining the SDGs more generally, doing effective development work in FCV settings is essential. The 2011 World Development Report on Conflict, Security and Development[6] proposed a roadmap to breaking cycles of violence at country level by building and strengthening national institutions. At the World Humanitarian Summit in 2016[7], the WBG endorsed the Action Plan and committed to help bridge the "humanitarian-development" by implementing a "new way of working" that meets people's immediate humanitarian needs while reducing risk and vulnerability by working together towards collective outcomes over multiple-year time frames. FCV was designated a special-theme under IDA18[8] and key initiatives are undertaken to increase IDA's effectiveness in FCV settings: deepening IDA's knowledge on FCV and learning from operational experience; designing integrated WBG strategies addressing FCV drivers and building institutional resilience; improving staffing, operational effectiveness and flexibility; promoting partnerships for a more effective response; and enhancing financing to support FCS/FCV, including a greater than 3.5-fold increase in funding allocation to these settings.

The WBG is currently designing its overarching strategy in FCV settings. The strategic approach, operational tools and interventions in FCV are focused on the following four components: (i) *pivoting to prevention*[9] and proactively managing FCV risk factors; (ii) *remaining engaged to preserve essential institutions and maintain service delivery*[10] in situations of crisis and conflict; (iii) *helping countries escape the 'fragility trap'*[11] and emerge out of FCV-affected situations; and (iv) *mitigating externalities and the impact of FCV*[12], especially on the most vulnerable populations.

To deepen the global knowledge base and to inform HNP GP's engagement with the WBGs commitment to substantially strengthen IDA's effectiveness in addressing FCV, the World Bank launched in 2016 the *Strengthening Health Service Delivery Resilience in FCV Settings* Program (P157931). This Global, Programmatic Approach, Advisory Services and Analytics (ASA) aimed to engage in catalytic, transformational activities that to both deepen the knowledge base for WBGs growing engagement with FCVs in the health sector and to lead to larger-scale funding from other sources for new FCV-oriented approaches.

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[5] *https://openknowledge.worldbank.org/handle/10986/20384*

[6] World Bank, 2011. *http://siteresources.worldbank.org/INTWDRS/Resources/WDR2011_Overview.pdf*

[7] *https://www.agendaforhumanity.org/summit*

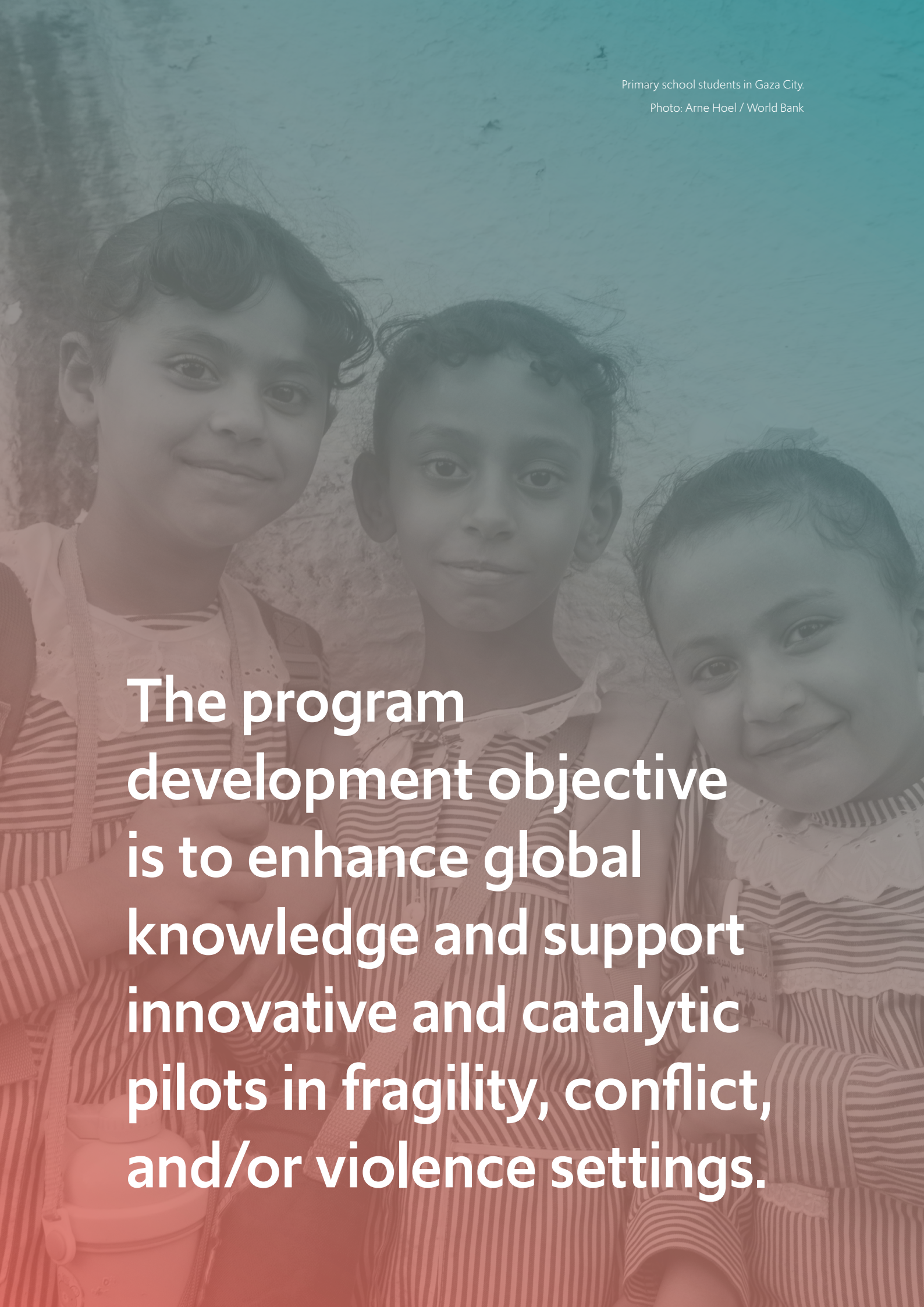
[8] *http://documents.worldbank.org/curated/en/652991468196733026/pdf/106182-BR-IDA18-Fragility-Conflict-and-Violence-PUBLIC-IDA-R2016-0140.pdf*

[9] https://worldbankgroup.sharepoint.com/sites/FCV/Pages/pc/FCV-Priorities-/Pivoting-to-Prevention-10222018-033251.aspx

[10] https://worldbankgroup.sharepoint.com/sites/FCV/Pages/pc/FCV-Priorities-/Remaining-Engaged-10232018-081607.aspx

[11] https://worldbankgroup.sharepoint.com/sites/FCV/Pages/pc/FCV-Priorities-/Escaping-the-Fragility-Trap--10232018-082853.aspx

[12] https://worldbankgroup.sharepoint.com/sites/FCV/Pages/pc/FCV-Priorities-/Mitigating-Externalities-and-Impact-of-FCV--10232018-164656.aspx



Primary school students in Gaza City.
Photo: Arne Hoel / World Bank

The program development objective is to enhance global knowledge and support innovative and catalytic pilots in fragility, conflict, and/or violence settings.

Program

Program Development Objective (PDO)

The program development objective (PDO) is to enhance global knowledge and support innovative and catalytic pilots in fragility, conflict and/or violence (FCV) settings, aiming to strengthen health service delivery resilience (HSDR) in participating countries.

Components

To meet the challenges of accessing, delivering and financing lasting improvements in the health of populations in fragile contexts and humanitarian crises, the Program aims to both broaden the global knowledge and provide direct support to strengthen the resilience of health service delivery through innovative pilots and knowledge products in diverse FCV contexts and settings. The Programmatic Approach rests on five components : (1) Innovative approaches to improve emergency care in active conflict; (2) Development of a rapid assessment tool to measure the cost of conflict in the health sector; (3) Development of innovative approaches and tools to build up a fledgling g health sector over the medium- term active conflict settings; (4) Development of new operational tools to conduct appropriate initial assessments regarding service delivery constraints and possibilities in active conflict settings; and (5) Understanding the impact of health system strengthening efforts in improving HSDR in post-pandemic countries. The work was planned in close collaboration with the Governments involved, relevant CMUs, and development partners.

A key focus of the activities is to develop better approaches for local health providers, strengthening local institutions, supporting more effective, transparent and accountable use of public resources, and improving the capacity to deliver services. Furthermore, the activities aim to enhance global knowledge and its dissemination, and their findings will feed into the development of relevant aspects HNP GP Strategies and into the WBG FCV strategy under development.

Component 1

Innovative approaches to improve emergency care in active conflict (Palestine) aims to improve quality of emergency care services in Palestine through identification of gaps in emergency care practices and strengthening key emergency care functions. The interventions were designed and implemented with available existing resources. Thus, they could be replicated across relevant FCV settings. The project design included three phases: (1) instrument design for data collection to identify areas that can be improved in select Palestinian emergency departments; (2) intervention design, based on baseline results; and (3) implementation of interventions to improve quality of emergency care services.

Component 2

Measuring the cost of conflict in the health sector (Syria) aims to develop and test innovative and operational rapid assessment tools to measure the cost of conflict on the health sector in Syria, with tools applicable across sectors and to a range of countries in conflict. The tools use cutting edge technology such as satellite imagery triangulated with social media analytics and third-party ground reports to assess damages. The component combines "Known Data" comes from satellite imagery which is triangulated with social media analytics and third-party reports, with "Unknown Data" is inferred through co-location with other sites on which we have data (i.e. "inference") or through the use of statistical tools based on known distributions (i.e. "imputation") to improve the accuracy of estimates.

Component 3

Innovative approaches and tools to build up a fledgling health sector (South Sudan) aims to strengthen innovation and build resilience in health for increased confidence in nation building. The original proposal was three-pronged intending to look at the effect of FCV in implementing health interventions in South Sudan and linked to the current Health Rapid Results Project (HRRP) that was under implementation: (1) to fill knowledge gap regarding cultural factors, specific vulnerabilities that hold back women in their demand for reproductive health (RH) services; (2) explore innovative models to addresses the problem of financing and provision of a reliable pharmaceuticals system in conflict settings where delivery is a challenge due to insecurity or geography; and (3) monitoring methods linked to performance based contracting/ financing with a focus on alternatives to regular verification, costs, and external verification and strengthening local systems. Due to project implementation stalling because of the conflict in the country, followed by delays and challenges in recruiting firms for the planned activities, the component activities were reconfigured in 2018, resulting in three new objectives: (1) Exploring which factors have impeded gains in improving access to health care, with a particular focus on project implementation arrangements; (2) How can Results-Based Financing be tailored to the specific

context of South Sudan to address the factors affecting service delivery; and (3) How non-traditional and non-state actors can potentially be mobilized to address both emergency health needs of the population and contribute to system strengthening and resilience.

Component 4

Operational tools for service delivery constraints and possibilities assessment (Autonomous Region in Muslim Mindanao, ARMM, Philippines) aims to develop a new operational tool to conduct appropriate initial assessments regarding service delivery capacities and constraints while supporting the ARMM Ministry of Health (MOH) to improve access to and the quality of health services in areas most affected by conflict and where the most vulnerable population are clustered with the purpose of expanding Universal Health Coverage despite continuing conflict and violence in certain areas. It has 2 tasks: (1) An assessment tool that will be appropriate for use in the five conflict-affected provinces, developed specifically for use in the ARMM but complementary to other existing tools and used for an initial systems inventory that will determine the service delivery network's adequacy and capacity to deliver required basic services. It will result in a comprehensive needs assessment of health facilities that the ARMM Department of Health (DOH) can use to identify which areas are most under-served and what the most critical investment gaps are; and (2) A feasibility study of the potential for the ARMM DOH to contract with the private sector, as well as its own providers, to improve service delivery, especially in the under-served areas identified in the first activity. The model will seek to demonstrate how to maintain the integrity of the service delivery network in times of conflict or violence.

Component 5

Health system strengthening in post-pandemic countries (Liberia, Sierra Leone, and Guinea) aims to assess the practical implications and resilience of the Ebola response and post-Ebola health systems interventions in Liberia, Guinea and Sierra Leone. All three countries carried out national scale responses during the Ebola outbreak while making significant efforts to sustain essential health services at the height of the pandemic, and after the outbreak have developed plans to significantly scale up their health workforce over the medium and longer term to improve health services delivery and its resilience of the health system to future shocks. The component has 2 tasks: (1) Analysis and study of the current post-Ebola workforce scale up plans (and systems strengthening more generally); and (2) Review of the World Bank's Ebola responses in containing the disease and sustain health systems to draw lessons learned for future pandemic and other emergency responses.

Funding

The five Program components comprise 6 activities, in 7 FCV settings, costing $US 1 million. Funding was provided through the ***State and Peace-Building Fund*** (SPF)[13], the World Bank's largest global multi-donor trust fund established to finance innovative approaches to state and peace- building in regions affected by FCV. Regions, covered, leads and funding allocations for each of the five Program components is illustrated in **table 2**.

Table 2. Program Component Funding

Components		Country/ regions	Lead*	Project #	SPF Grant Allocation ($US)**
1	Innovative approaches to improve emergency care in active conflict	Palestine	Emre Özaltin; Fernando Xavier Montenegro Torres	P158743	400,000
2	Development of a rapid assessment tool to measure the cost of conflict in the health sector	Syria	Aaka Pande; Fernando Xavier Montenegro Torres	P158744	150,000
3	Development of innovative approaches and tools to build up a fledgling g health sector over the medium-term active conflict settings	South Sudan	Noel Chisaka Jake Robyn	P158745	150,000
4	Development of new operational tools to conduct appropriate initial assessments regarding service delivery constraints and possibilities in active conflict settings	Philippines / Autonomous Region in Muslim Mindanao (ARMM)	Roberto Antonio Rosadia; Tomo Morimoto	P158746	150,000
5	Understanding the impact of health system strengthening efforts in improving HSDR in post-pandemic countries	Sierra Leone, Guinea, & Liberia	Christopher Herbst, Shunsuke Mabuchi; David Oliveira De Souza	P158747	150,000

* Leads separated by a comma designate concurrent and separated by semicolon designate consecutive leadership

** Initial allocations provided. During implementation $US 50,000 was transferred from component 3 to component 5 and $US 73,000 from component 2 to support activities of the HNP FCV WG (see below)

[13] *http://www.worldbank.org/en/programs/state-and-peace-building-fund*

Partnerships & Dissemination

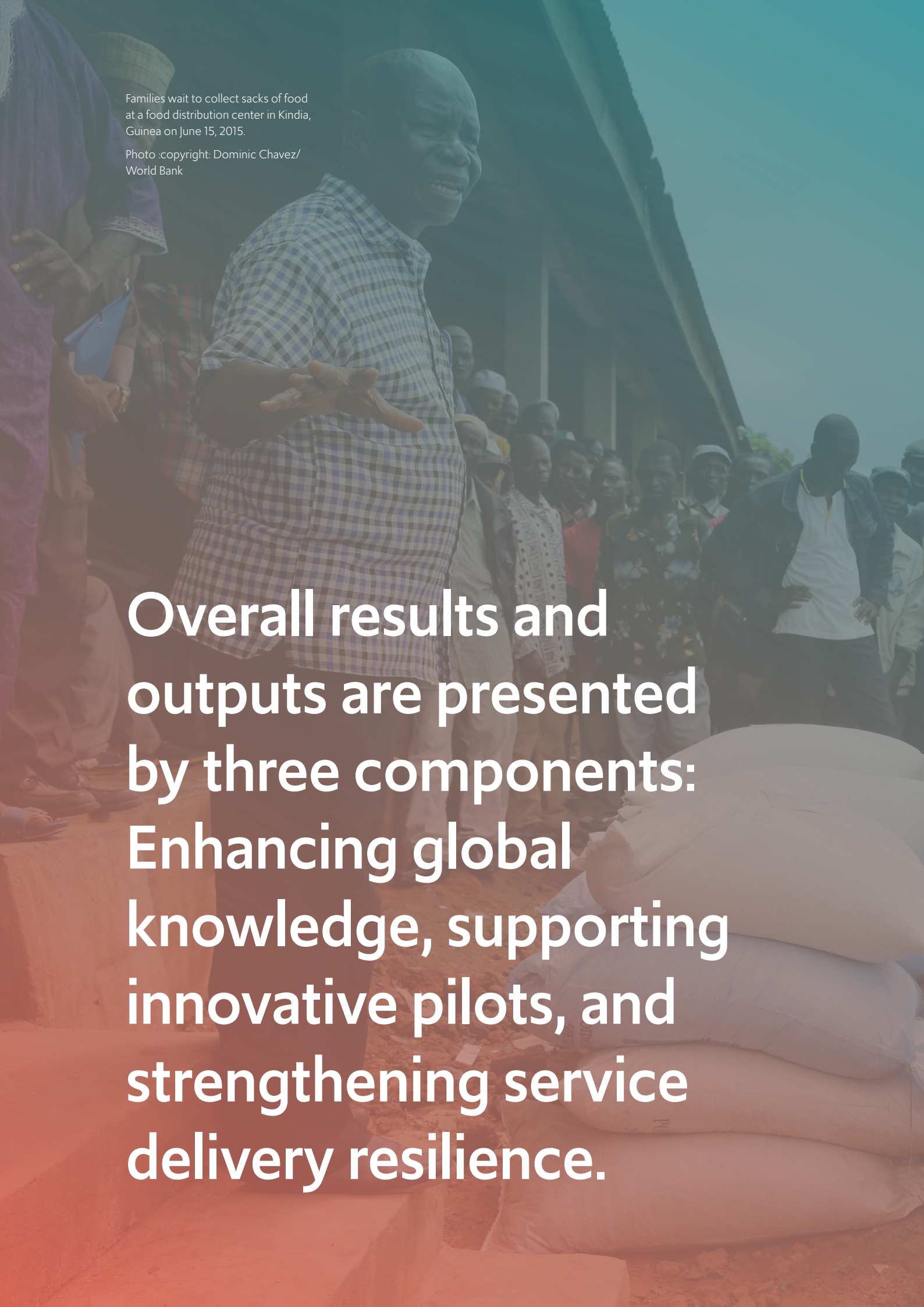
The overall work was carried out in partnership with the client and involved dialogue with different stake holders in areas of interest. Program components, where possible, were linked to ongoing or planned operations to ensure learning of the intrinsic factors that drive success in these settings. Involvement of local stakeholders and client institutions were critical for ownership of results and sustainability & replicability of approaches. For example, in Palestine, in addition to working through a local NGO[14], the team partnered with the National Institute of Public Health[15] for data management and analysis as well as using MOH personnel for data collection and for supervision. In the Philippines, the team partnered with local academic institutions partnering with an NGO or CSO based in the field to undertake the study and we are also coordinating closely with other donor partners (UNICEF and WHO in particular). The component sought to involve local academic institutions[16] partnering with local NGOs/CSOs in the conduct of the survey. The exercise improved the capacity of local institutions to undertake a similar undertaking in the future if the need arises and capacitated both the local institution and the ARMM MOH in analyzing survey data to improve its health care service delivery. The use of the Open Data platform established with the ARMM Regional Government further served as a potential platform to improve transparency in governance by making the survey results available to the public. In sierra Leone/Liberia/Guinea both activities drew on local institutions when generating the relevant knowledge on the health workforce and the Ebola response effort.

All outputs have been disseminated within-country where possible, through policy-notes and workshops. Academic disseminations will be/are being implemented through peer reviewed journal articles, World Bank working papers, and World Bank reports as well as through international Symposia and Meetings.

[14] *http://www.juzoor.org/en/*

[15] *http://pniph.org/site/*

[16] *https://www.povertyactionlab.org/partners/research-institute-mindanao-culture-rimcu*



Families wait to collect sacks of food at a food distribution center in Kindia, Guinea on June 15, 2015.

Photo :copyright: Dominic Chavez/ World Bank

Overall results and outputs are presented by three components: Enhancing global knowledge, supporting innovative pilots, and strengthening service delivery resilience.

Program Results & Outputs

Overall

Overall results & outputs are presented by the three components of the PDO: Enhancing global knowledge, supporting innovative pilots with catalytic effects, and strengthening service delivery resilience.

Enhancing global knowledge

Outputs are primarily aimed at governments who will use the generated knowledge directly to strengthen the resilience of health service delivery in their countries. Secondary audiences include the WBG (including upper management and TTLs working in FCV settings), the SPF, donor partners, NGO's and civil society, who are sectoral stakeholders and partners in policy implementation at the country level. Case studies on each component were conducted by the Health, Nutrition and Population Fragile, Conflict and Violence Working Group (HNP FCV WG) and are available for within the WBG and accessible widely as a Knowledge Note (see Annex 1 for the FCV Case Study knowledge note). The Program generated, or contributed to the generation of, six flagship reports: Strengthening Emergency Care in Palestine ; *The Syria Damage Assessment*[17] *; The Toll of War: The Economic and Social Consequences of War in Syria*[18] ; *Supply-Side Readiness of Primary Health Care in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM)* [19]; *Strengthening Post-Ebola Health Systems : From Response to Resilience in Guinea, Liberia, and Sierra Leone* [20]; and The Review of the World Banks Ebola Emergency Response (EERP).

[17] http://documents.worldbank.org/curated/en/530541512657033401/pdf/121943-WP-P161647-PUBLIC-Syria-Damage-Assesment.pdf

[18] http://documents.worldbank.org/curated/en/530541512657033401/pdf/121943-WP-P161647-PUBLIC-Syria-Damage-Assessment.pdf

[19] https://elibrary.worldbank.org/doi/pdf/10.1596/31947

[20] http://documents.worldbank.org/curated/en/707921513841518782/pdf/Strengthening-Post-Ebola-Health-Systems-From-Response-to-Resilience-in-Guinea-Liberia-and-Sierra-Leone.pdf

Kasomo Kavira, caregiver at the Ebola Treatment Center, feeds a child, who's mother is suspected of being infected by Ebola. 17 January 2019 - Beni, North Kivu region, Democratic Republic of Congo.
Photo: World Bank / Vincent Tremeau.

Throughout implementation, the Program has received attention both within the World Bank and globally. The Program was presented internationally at the 4th Global Symposium on Health Systems Research in Vancouver[21], 14-18 November 2016 during an organized session (see **Annex 2** for accepted organized session abstract). The Program has further been written up for a general audience in a blog that appeared in both the Huffington Post *Development Unplugged* Blog on "resilient and responsive health systems for a changing world" by the Canadian Society for International Health and Health Systems Global[22] and in the World Bank Investing in *Health; News and Views in Healthy Development* Blog[23]. Within the WBG, the Program was presented during a session during HD week May 3-11, 2017 (see **Annex 3** for session abstract).

Focusing on knowledge generation activities of Program components, in post-pandemic settings, the Post Ebola Health Systems Strengthening Assessment has been published as a book in the WBG's Chief Economist Publication series, and the workforce assessment was published separately as a Journal article in *Human Resources for Health*[24]. The Social Return on Investment (SROI) on Health Professional Education paper, a pioneering analytical framework for health professional education, is currently being finalized for publication as an HNP discussion paper and will inform

[21] *http://healthsystemsresearch.org/hsr2016/*

[22] *https://www.huffingtonpost.ca/development-unplugged/humanitarian-development-divide_b_12849410.html*

[23] *http://blogs.worldbank.org/health/bridging-humanitarian-development-divide-health-sector*

[24] McPake et al, 2019. Never again? Challenges in transforming the health workforce landscape in post-Ebola West Africa. Human Resources for Health 17:19. *https://doi.org/10.1186/s12960-019-0351-y*

SROI analyses in several contexts moving forward. Similarly, the main aim of the recently completed Ebola response review is the generation and sharing of practical knowledge and lessons learned from the pandemic emergency response by the WBG, from the acute response phase to transition from emergency response to recovery and strengthening of preparedness capacities series. The analytical work in Syria was published via two multisectoral reports and covered in the Wall Street Journal[25]. In collaboration with the Center for Mediterranean Integration (CMI) and OECD, a major global workshop on the human resource requirements for Syrian refugees was organized, *Strengthening Human Resources for Health: Integration of Refugees into Host Community Health Systems*[26], designed for governments, organizations, and stakeholders who are affected and have experience, knowledge, and expertise in health issues to discuss challenges and opportunities for strengthening the numbers and competencies of refugee health professionals in host countries to better address prevailing local health needs. The event was which was headlined by the ex-President of Portugal and participants included Syrian refugee and host community health professionals; MENA and OECD governments; academia including deans of training centers and medical schools; donors; and associations and global medical education partnerships such as the Global Platform for Syrian Students. Challenges in South Sudan forced the team to revise objectives and approaches flexibly several times, finally gaining most traction through working with non-traditional actors and exploring alternative implementation arrangements for health service delivery. This experience, outlined in the case study, will be disseminated widely. In Palestine, the knowledge generated through the innovative assessment supported through the SPF have been shared widely in national for a with key stakeholders and are already informing policy. In the Philippines, the study was the first of its kind conducted in the conflict-affected provinces of the Autonomous Region of Muslim Mindanao (ARMM), where because of its autonomous governance structure it is usually detached from central level DOH data collection. The ARMM regional Government as well as the Secretary of health DOH-ARMM were particularly appreciative that the assessment provided a snapshot of all public facilities' supply side capacity in the region and the level of performance of each province/local government units/facility. The preliminary results from the data analysis have been presented through several consultative meetings and the final report has recently been completed and is being disseminated to internal and external audiences.

The Program further financed HNP FCV WG activities to provide catalytic support to TTLs and teams working in FCV-affected settings to enable HNP teams to deliver quality health inputs for clients affected by FCV (see **Annex 4** for HN HNP FCV WG achievements and outputs).

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[25] *https://www.wsj.com/articles/after-the-gas-and-bombs-the-health-crisis-thats-killing-syria-1523984870*

[26] *http://www.cmimarseille.org/knowledge-library/programme-strengthening-human-resources-health-hrh-integration-refugees-host*

Supporting Innovative Pilots with Catalytic effects

The Program has supported unique and innovative Pilots in four active conflicts and three post-pandemic settings. The SPF funding has, in several settings, provided critical "seed capital" for innovative work in extremely complex and fragile environments. The Program has been successful in leveraging other trust funds, Global Practices, and partnerships and, in several cases, seeding new engagements in the sector, including new IDA. Health policy, within country and within the WBG, particularly relevant to FCV settings, has been informed, and has either already led, or shows strong potential to lead, to activities at scale within-country and replication in other settings. For example, drawing the practical lessons from the Ebola response, as well as the post Ebola recovery effort, and providing guidance to carry out analyses to help justify needed health sector reforms (e.g., using SROI methods), will help improve speed, efficiency and effectiveness of our future emergency responses and post pandemic systems strengthening efforts. The work has already had a catalytic effect, with the post Ebola health systems assessment leading to a new $US 55 million operation in Guinea, which was approved by the board on April 24, 2018. The work further catalytically contributed to strengthening systems in the region in which the Ebola 2014 outbreak took place (e.g., the REDISSE project[27]), on pandemics (through the Pandemic Emergency Facility[28]) and led to new ways of working with the UN through the Global Support Team for UN Agency Engagement under World Bank Operations. The post-Ebola systems assessment and SROI paper, and the Ebola Emergency Response Project (EERP) review will help task teams plan and partner for these support efforts more effectively in other countries. In Syria, the SPF funding acted as seed funding for six analytical and convening activities on the impact of the Syrian crisis on the health system and the team leveraged funds from multisectoral collaboration led by GPSURR SIRIA and POV GP as well as partnership with OECD, namely Damage and Needs Assessment (DNA) of the impact of the war in Syria as well as Economic and Social Impact Assessment (ESIA) of the cost of war in Syria and was thus able to maximize impact of the work related to health and contributed to larger analytical pieces. In Palestine, devised methods and results already are planned to be implemented at scale (beyond the 11 hospitals originally envisioned) and have the potential to be replicated regionally. Linked with Program activities, WHO has expressed interest to bring their regional TA on Emergency Services to Palestine. In South Sudan, the exploratory work headed through the Program led to a new $US 105.4 million operation[29], which was approved by the board on February 27, 2019. The component further led to an innovative new approach for the WBG in FCV environments, resulting in the first operation that collaborated with ICRC through a prospective design and also led to better harmonization between donors and partners supporting South Sudan's health sector, in particular those contributing to the Health Pooled Fund, a multi-donor trust fund managed by DFID with contributions from the US, Canada, EU, UK, and Sweden. A national unified third-party monitoring system and a health functionality bulletin (a geo-referenced database that has close to

[27] Regional Disease Surveillance Systems Enhancement (REDISSE)

[28] *http://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility*

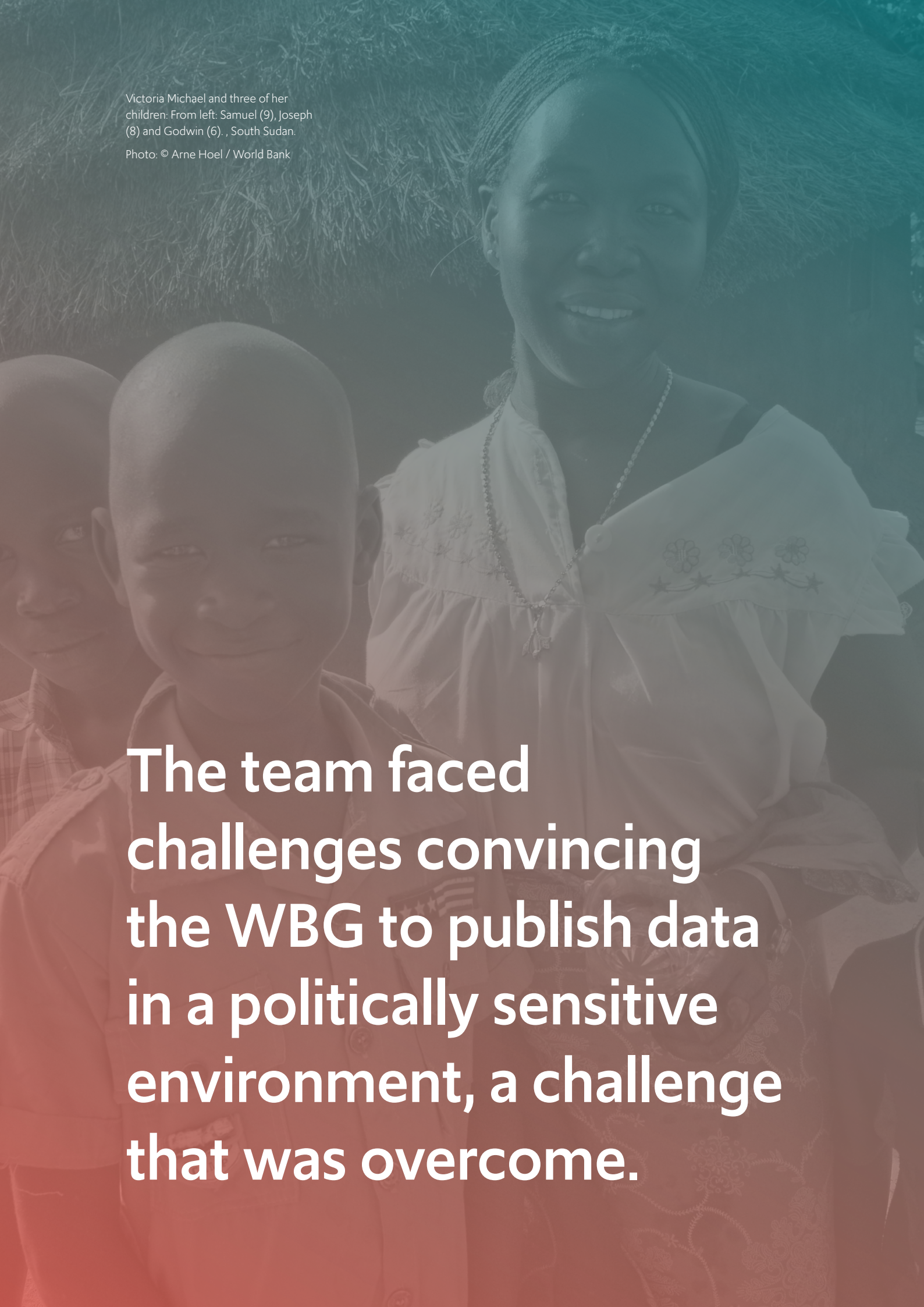
[29] Provision of Essential Health Services Project (PEHSP) P168926

real-time information on the level of functionality of health facilities across the country) were created and are currently being used in the country leading to better alignment in targeted areas of the country between systems-strengthening interventions (implemented by UNICEF) and emergency response interventions (implemented by ICRC). In the Philippines, the team leveraged co-financing by a MDTF on integrating donor-financed health programs (supported by Australia). Activities aimed to identify supply side gaps and address service delivery issues and, in addition to being a stand-alone product, fed into the overall health systems assessment carried out by the WBG in the region. Furthermore, the DOH-ARMM has expressed their specific interest in using this information to improve their health system management and they have expressed interest in WBG's support on services of concern—immunization, nutrition and mental health.

Strengthening service delivery resilience

In participating countries strengthening service delivery resilience is a primary aim of the Program. The nature of the engagements and the settings entail that we will be measuring progress toward this objective largely through process and intermediary indicators. Overall, by devising tools that make reconstruction post-conflict or response post-pandemic more effective, by implementing processes that are likely to improve response to acute surges of trauma, and by informing how to improve the delivery of health services during conflict, this global ASA contributed to strengthening the resilience of health service delivery in FCV settings. For example, the review of the post Ebola health systems plans has already identified key building blocks that need to be focused on to strengthen the health system and improve resilience in the three Ebola affected countries. The SROI paper on the other hand will allow countries to build the evidence base to scale up their health workforce to improve service delivery resilience while also addressing how the initial interventions to strengthen resilience of the service delivery worked both in the short and long terms. In South Sudan, improved multi-donor coordination, particularly between humanitarian and development organizations as well as use of innovative technologies have strengthened the health sectors resilience to continue to provide care during conflict. In Palestine, an evidence-based intervention showed evidence of important improvements in health worker performance in emergency departments and in the quality of care for emergency patients, strengthening resilience to deal with surges in trauma. Strengthening of service delivery capacity in ARMM was measured through a census of all public primary care facilities in the 5 provinces of ARMM[30]. The survey tool also included a patient satisfaction survey to capture the quality aspects to a certain extent, as well as provincial deep dive to analyze some province-specific issues. In other settings, trainings, studies, and knowledge sharing has the potential to lead to new policies and strategies that will lead to improved service delivery resilience. In addition, the report was of particular importance at a time when the ARMM was transitioning to Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) following the signature of the Bangsamoro Organic Law, as the analysis provided an important baseline of the current status of health sector capacity to deliver key services which will help the new MOH-BARMM to make informed decisions when developing their own sector strategy and reorganizing the Ministry.

[30] Except facilities directly affected by the Marawi crisis ongoing during the time of data collection



Victoria Michael and three of her children: From left: Samuel (9), Joseph (8) and Godwin (6). , South Sudan.

Photo: © Arne Hoel / World Bank

The team faced challenges convincing the WBG to publish data in a politically sensitive environment, a challenge that was overcome.

Risks & Challenges

Throughout, the team took a relative approach to risk rating. For most of the implementation of the ASA, the Moderate categorization reflected that, given risks inherent to operating in FCV environments, the expected risk to achieving the PDO was moderate. The increase in the risk rating to Substantial during the Progress Review in May, 2018 reflected the disbursements to date, which at 50% were lower than the 80% targeted; the potential of receiving a negative response to the request extension of closing date by 12 months; and the persisting lack of progress in South Sudan, despite efforts. However, a 6-month extension was approved, South Sudan progressed despite difficulties, and the PDO was achieved.

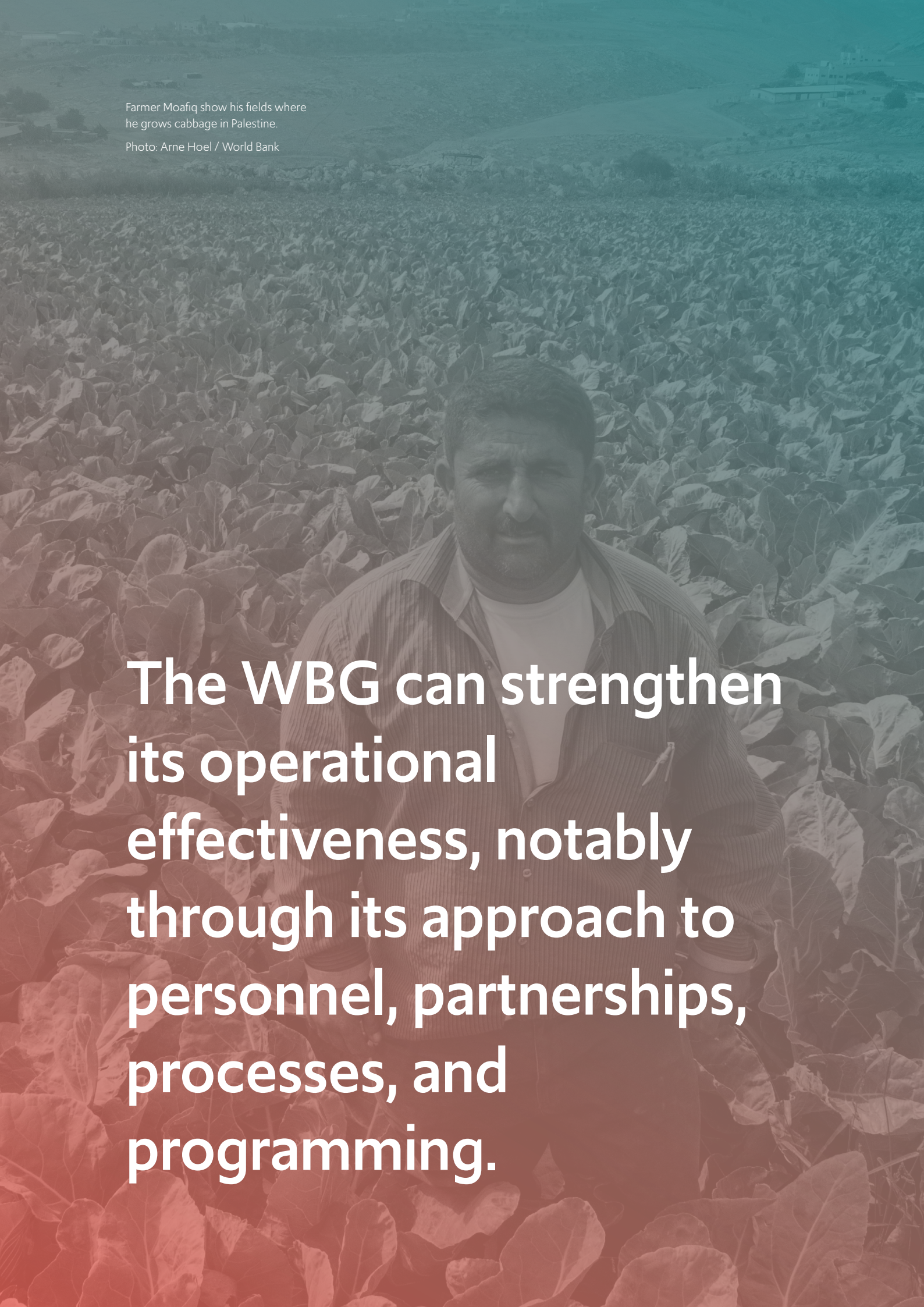
Summarizing risks and challenges faced as well as mitigation by component: **Component 1**,the ASA had buy-in, from key stakeholders including emergency department heads, and hospital directors. Initially the need to have in-depth coordination and communication among all stakeholders created delays, during which the team worked to align the design with concrete needs as expressed by decision-makers and physicians Ultimately, agreement was reached, and the initially agreed design was modified. Phase one of the ASA provided important insights on potential areas of strengthening emergency care provision in Palestine which were used as inputs for the second phase developed along with stakeholders and decision-makers at the MOH and to ensure that any recommendations made are brought into alignment with Ministry priorities and with the new WHO guidelines, the timeline of the original project was extended. **Component 2**, given the political situation, the World Bank was authorized to conduct analytical work at a distance (i.e. via satellite and social media analysis), but not authorized to have any "boots on the ground" in terms of detailed household surveys or lending operations. The health team was then advised to freeze all activities on Syria until an authorizing environment to undertake any more specific activities in-country materialized. Given the freeze, remaining $US 73,000 was transferred to support work relevant to the Program by the WBG FCV WG. The team faced challenges convincing the WBG to publish data in a politically sensitive environment, a challenge that was overcome. **Component 3**, increased insecurity and violence especially in the areas where the project implementation was planned reduced the capacity of the project to interact with affected counties and communities making it difficult to obtain useful information, which impacted negatively progress toward attaining original objectives and meant that objectives and approaches had to be modified, several times. Given slow disbursement and needs elsewhere in the Program, $US 50,000 from this component was transferred to component 5. Activities were reoriented to support new operation under preparation, which recently successfully passed Board. **Component 4**, the occurrence of sporadic

Victoria Michael (38) visits a clinic run by the Norwegian People's Aid. Victoria receives a bednet and her baby is vaccinated. South Sudan. Photo: © Arne Hoel / World Bank

encounters between the government and rebel troops initially threatened to affect the survey schedule, scope and timeline. To mitigate these risks, the team adjusted the survey coverage accordingly based on close coordination with the ARMM Department of Health (ARMM-DOH) and the ARMM regional government and other involved agencies (e.g., UNDSS) to adequately plan for the conduct of the survey, and with some delay, this was achieved. The change in the ARMM structure following the signing of the Organic Law for the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) into a Law (Bangsamoro Organic Law) abolished the ARMM and created the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM or simply the Bangsamoro Autonomous Region). While there was risk of losing ownership, the study has benefited from this transition in that it provided a credible data on the capacity of the primary health services in the region to help them make informed and evidence-based decisions in their health sector strategy, and to reorganize the sector to respond to the most important needs. This transition is ongoing, but the team has held multiple consultations with the incoming government which has been well received. A region-wide Health Sector Forum with the new government took place in June 2019 where the results of this study were

presented. **Component 5,** at concept no risks were identified for planned activities. For **Task 2**, support was requested for the EERP in connecting with necessary internal stakeholders which would help facilitate the data collection and consultations and keep the task on schedule with a tight timeline. Also, funding was found to be inadequate and a reallocation of US $50,000 to this task from Component 3 was implemented. After the contracting of the consultants, this Task was found to overlap with another ongoing World Bank study[31]. This prevented the consultants from conducting the full range of interviews that had been planned, particularly with government stakeholders, due to concerns by the World Bank about reputational risk. Thus, the interviews conducted were primarily with World Bank staff, thereby shifting the focus of the review to World Bank processes and partnerships.

[31] Lessons Learned in Financing Rapid Response to Recent Epidemics in West and Central Africa – ASA (P168445)



Farmer Moafiq show his fields where he grows cabbage in Palestine.

Photo: Arne Hoel / World Bank

The WBG can strengthen its operational effectiveness, notably through its approach to personnel, partnerships, processes, and programming.

Lessons Learned

Some key lessons learned from Program components are potentially generalizable to other FCV settings. As input into the WBG FCV strategy under preparation, this section first outline lessons by the "4 Ps" challenges of delivery framework outlined in the Strategy concept note[32] to enhance operational effectiveness the Strategy to focus on how the WBG can strengthen its operational effectiveness in FCV, notably through its approach to ***personnel***, ***partnerships***, ***processes*** and ***programming***. It then looks at further lessons for WBG management and the SPF secretariat.

Lessons related to the "4 Ps"

Personnel:

- Given the unique and challenging FCV environment for operations planning, implementation and monitoring/evaluation, WBG team needs the right knowledge and skills to successfully manage Bank operations in FCV contexts.
- Preparation can be made faster, more efficient and more effective by assembling a diverse team involving people both at HQ and at the national level and with a combination of skills.
- "Readiness" in emergencies includes readiness to support staff by strengthening the WBG's debriefing and support for staff working in FCV contexts and under emergency conditions, including psycho-social support other organizations working in emergencies routinely provide.
- Through effective use of VC, email and telephone correspondence, task teams can link with key individuals (client, WB colleagues and partner agents) to obtain the needed information. This not only saves money for the HQ based team, but also allows the work to be informed by key sources on the ground.

[32] *https://consultations.worldbank.org/Data/hub/files/consultation-template/world-bank-group-strategy-fragility-conflict-and-violence/en/materials/conceptnote_06_041519.pdf*

- Recruitment of local firms/consultants embedded in the region and well versed in the political context can be crucial to maneuver through the political complexities.

- Publications and knowledge sharing events (e.g., operational clinics and seminars) were well perceived by HNP and other VPU/GPs staff to gain more fundamental knowledge and skills to interact with clients and partners in FCV contexts.

Partnerships:

- Operations in FCV contexts require strategic partnerships with various partners to leverage comparative advantages, including UN agencies.

- WBG teams need to better understand partners' different mandates, programming and processes to establish concrete operational partnerships. Prioritizing partnership with governments and building on pre-existing relationships; thinking about how governments within FCV settings may be given more ownership in implementation partnerships (e.g., in contracting with partners).

- Make use of available resources on the ground. Close collaboration with partner agents on the ground, as was well global partners who can provide much needed and complementary expertise can be crucial in these settings. Use of local networks can create buy in and help manage political economy. The close engagement of the community in this process can be critical.

- Program/Project design, where possible, should flow from demand from top level authorities and that from the outset there is clarity on objectives and outputs to increase probability of sustainable change.

- Creation of a Technical Working Group can enhance local ownership.

- Treating partners as partners (not simply contractors) and thinking about how to involve UN agencies earlier during consultation and preparation and design, in order to fully utilize their knowledge and resources.

- Identifying and addressing barriers to partnership early on so WBG teams understand how best to maximize partnerships so that partners and their local offices have a clear sense of their implementation relationships with government.

Processes:

Preparation can be made faster, more efficient and more effective by:

- Finding the best mechanisms to provide rapid funding, (e.g., restructured health projects in the affected countries, a PPA, and IDA CRW resources.
- Minimizing time at every step by deploying or innovating work strategies (e.g., establishing focal points; utilizing performance dashboards; leveraging regional time differences; conducting steps in parallel; holding pre-meetings; involving senior management in reaching out to partners).
- Strategically using existing policy and guidelines (e.g., identifying intersections within existing guidelines and processes; asking for policy exceptions where necessary).
- Taking a pragmatic and creative approach in order to act rapidly but also to ensure that guidelines are met at least to a minimum standard and putting in mitigation measures or post-measures.
- Giving sufficient mandates at all levels to task teams working in emergencies to avoid bureaucratic bottlenecks and facilitate work as a single team even when team members come from different units across the WB.

Transition from emergency to the recovery phase can be made more effective and efficient by:

- Keeping sight of the bigger picture: strengthening national and regional systems can be costly so it is important that conversations about transition from emergency start early;
- Recognizing that different stages bear different risks and require different approaches; consider building recovery phase support into an emergency response from the beginning with sufficient funding.

The WBG can be more ready for emergencies in FCV settings by:

- Making the WB's operational environment ready for emergencies by addressing both the technical and financial gaps at the country level that might be relevant to future outbreaks or events, as well as the issue of how to streamline and formalize procedures and partner agreements. A toolkit for task teams to draw upon may be worthwhile;
- Not neglecting institutional memory and ensuring that lessons learned from an emergency response have been captured early and comprehensively.

Programming:

- Investing in prevention by scoping the potential consequences of FCV and preemptively heading off future health emergencies (e.g., through investment in health and social protection systems and conflict mitigation) and by designing strategies that address the underlying drivers of fragility is key to prevention.

- Budgeting and workplan needs to be carefully worked out considering the evolving situation on the ground. Ongoing active conflict and persisting insecurity, in addition to geographical inaccessibility often can mean that costs may be underestimated.

- Implementation in FCV contexts require the teams to well prepare and manage 'unexpected' shocks and changing environment. This can make monitoring outputs/outcomes difficult. Use of disruptive technology (e.g., geo-enabling monitoring and supervision, geospatial analysis, social media analysis, etc.) have proven effective in providing reliable data. Where possible, process evaluations for new, innovative projects in real time, as events are unfolding, are recommended to minimize delays and recall bias in post-hoc evaluations.

Messages for Leadership

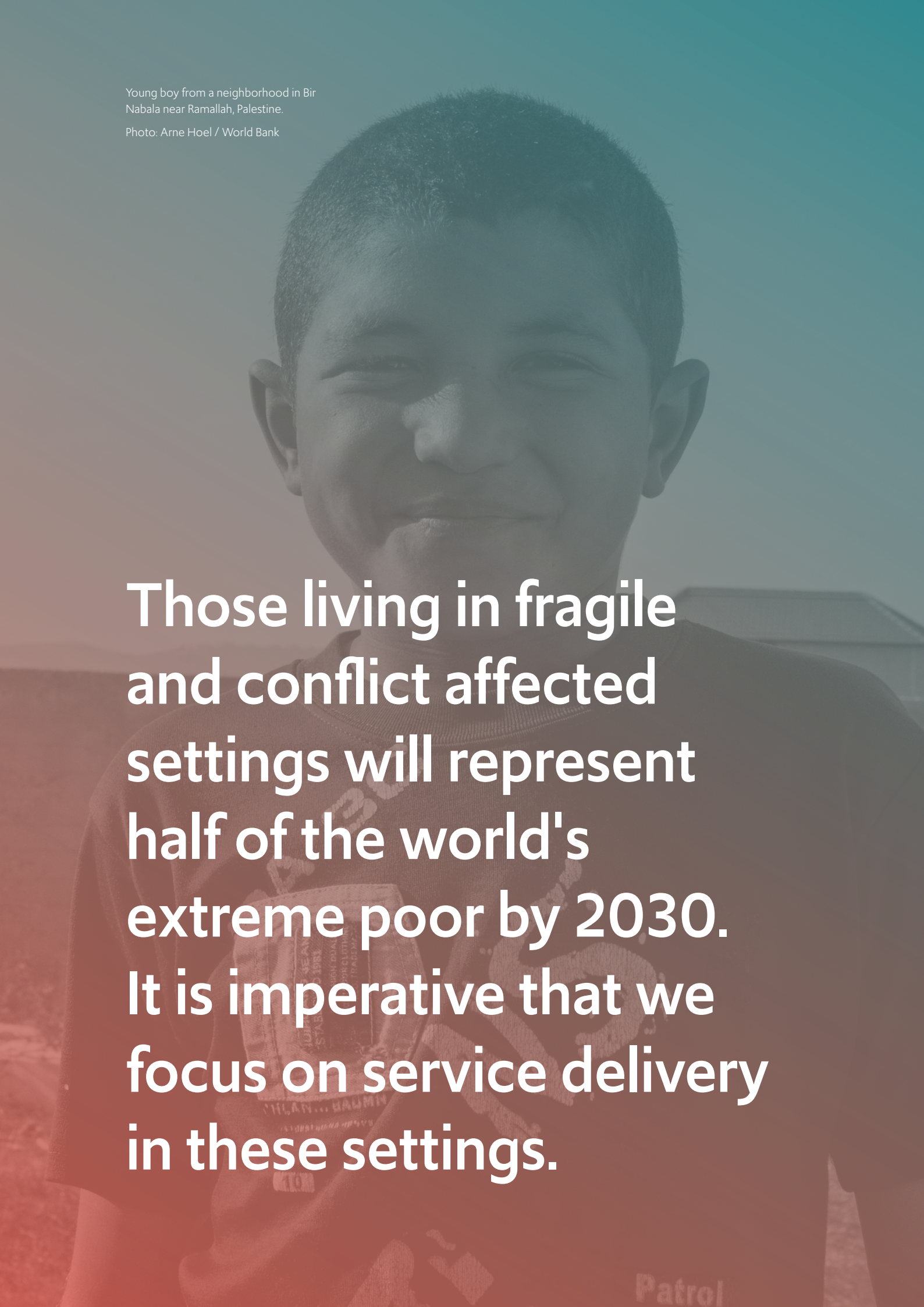
The ***Strengthening Health Service Delivery Resilience in FCV Settings Program*** Global PA ASA was successful in enhancing global knowledge, supporting innovative pilots with catalytic effects, and strengthening service delivery resilience in target countries/settings. Given the relatively small funding it received, it presented an excellent value-for money proposition in terms of achievements and outputs, particularly in its contributions to the global learning agenda, and highlighted potential catalytic impact of funds such as the SPF. Beyond key lessons learned cited, particularly related to a Team skills and building partnerships, with the client and partners, two additional factors contributed to this success:

Flexibility. Flexibility is critical to implement operations in FCV contexts. This Program benefitted from flexibility of funding, of modality, of time-frame, and of concept. Funding was fungible, with appropriate controls, within and across Program components, and to new opportunities that arose (e.g., to the WB FCV WG). Furthermore, while some grants provided through the WBG are tied to IDA/IBRD, the fact that this was not the case for SPF enabled for timely and focused engagement with the client Program countries (particularly where there may not currently be lending). The Programmatic Approach ASA allowed for yearly, and as needed reviews, for modification to components to flexibly adapt initial approaches to realities on the ground (South Sudan and the Philippines benefited particularly from this approach). The time frame was flexible, which was crucial in allowing for space needed to implement interventions in unpredictable and constantly variable FCV settings. While ASAs typically have a 1-year time frame, this ASA benefitted from a 3-year time frame, with an additional 6-month extension. Finally, the concept

Lucia Boki fetches water at a borehole the village of Bilinyang, near Juba, South Sudan.
Photo: © Arne Hoel / World Bank

and approach, particularly of senior leadership in the HNPGP were particularly flexible. That not meeting initial objectives was not a failure, but a learning opportunity was built into the Program design and leadership allowed that the approach to risk was relative and flexible and gave the Program latitude to experiment and adjust as needed. These flexibilities ensured that the team could adjust to the unforeseen and were not held hostage to bottlenecks.

Diversity. The five different entry points created resilience in the Program approach and greatly increased the value-for-money proposition. Arguably, 3–4x more results and impact were achieved than if the same funding had been invested in a single country, with a much-reduced risk. The smaller relative funding per Component necessitated that task teams be entrepreneurial and leverage other sources of funding to be able to produce high-quality analytical pieces. It also required teams to engage in strategic partnerships to similarly achieve objectives. This may be an important consideration for the SPF in its future funding strategies, that funding allocated across a purposive sample of FCV settings, united by a common objective may yield greater returns to investment.



Young boy from a neighborhood in Bir Nabala near Ramallah, Palestine.

Photo: Arne Hoel / World Bank

Those living in fragile and conflict affected settings will represent half of the world's extreme poor by 2030. It is imperative that we focus on service delivery in these settings.

Conclusions

Those living in fragile and conflict affected settings will represent half of the world's extreme poor by 2030. It is therefore imperative that we focus on service delivery in these settings. Improved service delivery in these settings not only can meet the basic needs of the target populations, but also have positive political consequences, often improving state- and peace- building and contributing to national solidarity. Working well in these setting is essential to contributing to the twin goals, to building human capital, and to attaining the SDGs. Strengthening the delivery of services in particular for the poor is absolutely critical to rebuilding the social contract and improving the legitimacy of the state in FCV countries with fragile health infrastructure and limited domestic resources for health.

The World Bank is committed to bridging the humanitarian-development divide, an effort essential to mitigating the impacts of current crises and reducing the probability of occurrence of future ones. And while the challenges to closing the strategic and institutional gaps between humanitarian and development organizations, securing flexible and long-term financing, and building the technical know-how to work in these settings are considerable, there is increasing commitment towards these goals, with positive and collaborative partnerships centered on innovative thinking that are allowing us to move beyond shock-driven responses towards addressing underlying vulnerabilities and engendering resilience.

Strengthening Health Service Delivery Resilience in FCV Settings Program Global PA ASA is an example of a development accelerator for results, contributing to the World Bank's efforts to engage in FCV settings by exploring various service modalities and highlighting what constitutes successful engagement in various aspects of service delivery in different FCV countries with varying degrees and fragility, conflict, and violence affecting their health systems. The Program had contributed to building a foundation of how to effectively engage in FCV contexts, through improving staff knowledge and skills on FCV and HNP and a network of operational humanitarian and development partners. This foundation would allow the future task to adopt lessons-learned from previous operations and help teams adopt new business models to maximize development impacts in FCV contexts.

Throughout, and despite varying challenges faced by participating countries, each context was able to develop a strategy for effective service delivery. Overall, the Program generated a large amount of global knowledge, strengthened local capacity and catalyzed new approaches and new engagements. Should further funding become available, the strategic positioning of the WBG and of HNPGP using this type of resource can bring further high-impact outputs in these settings.

Woman receives a health check-up. Agusan del Sur, Philippines. Social Welfare and Development Reform Program.

Photo: Dave Llorito / World Bank

Annexes

ANNEX 1
Program Component Case Studies

ANNEX 2
Fourth Global Symposium on Health Systems Research: Organized Session Abstract

ANNEX 3
Session for Human Development Learning Week: HNP Days

ANNEX 4
HNP FCV Working Group Achievements (FY 2018 - FY 2019)

ANNEX 5
Component Contribution to PDO and Specific Objectives

ANNEX 6
Component-specific

Program Component Case Studies

Strengthening Service Delivery Resilience in FCV Settings

Considering that those living in fragile and conflict affected settings will represent *40% of the world's extreme poor*[1] 33 by 2030, it is important to focus on service delivery in these settings. Proper service delivery in these settings not only has the ability to meet the basic needs of the target population, but it can have positive political consequences, often legitimizing residing governments and other important groups.

In an effort to explore various service modalities in fragile, conflict, and violence (FCV) affected settings, the World Bank conducted a series of pilots highlighting various aspects of service delivery. Different FCV countries were selected with varying degrees and fragility, conflict, and violence affecting their health systems.

Case: Philippines, Autonomous Region in Muslim Mindanao (ARMM)

Service readiness assessment—HOW can service readiness be assessed in situations affected by FCV?

The Autonomous Region in Muslim Mindanao (ARMM), the poorest administrative region in the Philippines, was created in 1989 with significant fiscal autonomy from the central government. The ARMM has had long-lasting and ongoing conflicts between the government and Muslim separatists. The ARMM faces a combination of political, geographical, and socioeconomic challenges, some of which are exacerbated by protracted fragility and insecurity from ongoing conflicts and violence. The 2000 census showed poor health outcomes in the ARMM, with

[1] http://documents.worldbank.org/curated/en/837881467996741019/Setting-the-agenda-for-IDA18-strategic-directions

a 15-year gap in life expectancy between the ARMM and the highest region (Region 1) in the Philippines. Further, the recent 2017 DHS shows poor health outcomes, specifically for children. It is estimated that one-third of all children nationwide are stunted, while over 45% of children in the ARMM are stunted.

The World Bank conducted a supply-side assessment covering almost all Rural Health Units (RHUs) (123 out of 130 in the ARMM, equivalent to Primary Health Care Centers). The survey built upon WHO's Service Availability and Readiness Assessment (SARA) framework, focusing on service readiness for primary health care (i.e., whether facilities were equipped with hard and soft infrastructure to provide services). The survey findings included the following bottlenecks for primary health care in the ARMM:

- Health facilities availability: the number of RHUs needs to increase by 50% to achieve a national target (one RHU per 20,000), with a significant increase in human resources for health; currently the system relies heavily on central level deployment programs of health personnel.

- Limited basic infrastructure at facilities: lack of running water and no access to power sources (e.g., 20% of facilities in Lanao del Sur Province); emergency transportation is a persisting issue, especially in remote island provinces.

- Weak supply chain: one-third of RHUs lack stocks of measles and pentavalent vaccines, while the oral polio vaccine was only available at fewer than 50% of RHUs.

- Among the specific services considered, capacity to deliver maternal and child health (MCH) services was strong across the region. This was possibly due to most of the in-kind support from the central level being directed to vertical programs such as MCH. However, capacity to deliver non-communicable disease (NCD) services was particularly weak.

Successess

- The assessment findings were discussed and shared through consultative workshops which involved the authorities of ARMM and local chief executives. Separate consultations also took place with the transition government. The assessment adds valuable data and makes suggestions on areas to be strengthened within the delivery of health services at the primary care level, as well as suggestions for the health sector related to better planning and resource mobilization.

- This document will provide very important baseline data to the authorities of the region, particularly at a time when the region is transitioning from the ARMM to the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM), and new health sector structures will be put in place.

Lessons Learned

The service readiness assessment is key to understanding constraints and health needs unique to FCV contexts and areas to strengthen on the supply side. The assessment in the ARMM highlights the following important lessons learned when assessing health service readiness in FCV settings:

- Use of local network for smooth implementation (i.e., managing local political economy).
- Quick assessment, but flexible implementation arrangement (i.e., rearranging implementation schedule and sites due to insecurity).
- A thorough consultative process to get buy-in from authorities, including the regional government and health authorities, as well as local chief executives.

Case: West Bank and Gaza (Palestine)

How can quality of key health services be strengthened in low-resource settings affected by FCV?

Palestine, with protracted fragility and ongoing conflicts, requires a resilient health system to provide necessary health care services to those affected in FCV contexts. Due to the limited mobility of those living in West Bank and Gaza and limited available resources, health service delivery faces unique challenges in meeting the demands of the population's health needs. This is especially so in emergency care, which is often the first entry point in providing necessary treatments and saving the lives of those in FCV settings. The task of strengthening emergency care in this setting was to be accomplished through the following: initial data collection to assess the quality and gaps in emergency care; the design and implementation of quality improvement interventions; and the analysis of post-intervention data to evaluate the intervention's impact.

The baseline data collection showed gaps in basic emergency care processes. For example, vital signs were often not recorded and triage was not performed. In addressing these gaps, the following challenges arose:

- Process and behavioral changes are needed to improve clinical practices and communications (provider–provider, provider–patients).
- Limited human resources—there is a need to design interventions that do not require additional time and human resources at emergency departments.

Production facility of Birzeit Pharmaceutical Company (BPC). Based in Ramallah, BPC is a leading manufacturer of generic medicines. With more than 300 products distributed among ten production lines and covering different therapeutic ranges.

BPC market is not limited to the Palestinian Territory, the company has a well established presence in different export markets – mainly Algeria and Eastern Europe. -- Alia T. Nasser Aldin is the HR manager at Birzeit Pharmaceutical Co. (Photo: Arne Hoel)

Successes

- The Ministry of Health's (MOH's) strong will to improve quality of emergency care.
- Thorough consultations and capacity building process with the MOH and hospital physicians and nurses at emergency departments.
- Quantitative and qualitative data on emergency care service delivery situations in West Bank and Gaza.

Lessons Learned

- Quality improvement can be obtained with minimal resource investment. For example, the use of open-source materials such as the WHO Emergency Care Checklist.
- Optimal use of available international and local technical expertise, especially of local experts with a great network with relevant stakeholders.
- Manage the political economy through extensive consultations with all stakeholders.

Case: Syria

How does disruptive technology help in understanding the cost of functionality and service readiness of health facilities in a conflict setting?

As an active conflict setting where it is difficult to extract data on the ground, Syria was chosen because of the unique nature of its conflict in that health facilities are not only damaged, but targeted. This component sought to develop innovative tools that could be used across sectors in various countries experiencing conflict, triangulating both "known" and "unknown" data to calculate estimates.

Successes

- An updated remote damage and needs assessment (DNA) was completed based on the triangulation[2] of various modes of disruptive technology.
- The satellite and social media analysis performed contributed to the *economic and social impact assessment (ESIA)*[3] of the cost of war in Syria which found that by the end of 2016, GDP losses were estimated at $US 226 billion.
- A two-day conference was organized highlighting human resources for health in light of the Syrian crisis. The workshop brought together governments, donors, and academics working in the region, and included the former President of Portugal, Jorge Sampaio. As a result, innovative solutions for rebuilding Syria's human capital were explored through the training of doctors using an app-based software.

Lessons Learned

This study has shown that with the use of technology, it is possible to assess service readiness in inaccessible fragile and conflict areas. However, to replicate these findings in other FCV settings, there are suggestions and recommendations that should be considered:

- Ensure that the technology used is appropriate for the target problem. For example, the satellite imagery used here was effective in identifying airstrike damage. It may not be as effective in identifying street-level damage or displaced persons living in the community.

[2] Data gaps were filled using technologies including satellite imagery and social media, in addition to third-party reports.

[3] https://www.worldbank.org/en/country/syria/publication/the-toll-of-war-the-economic-and-social-consequences-of-the-conflict-in-syria

- It is important to note that one source of remote technology, particularly in FCV settings, may only tell part of the story. Using multiple technologies to verify information will ensure that data are reliable and accurate.

Case: South Sudan

What models of alternative implementation arrangements for supporting health service delivery in FCV settings can be designed when traditional approaches don't work?

Due to South Sudan's protracted crisis, its health system has long been dependent on external support to deliver basic health services. Based on experiences in the former states of Upper Nile and Jonglei, the World Bank sought to explore several issues, including the following:

1. Factors that have impeded gains in improving access to health care, with a particular focus on project implementation arrangements.

2. How nontraditional and non-state actors can potentially be mobilized to both address emergency health needs of the population and contribute to system strengthening and resilience.

Challenges

- The Coordination and Service Delivery Organization (CSDO) model introduced by the Health Rapid Results Project (HRRP) was designed before the December 2013 crisis to respond to the context of endemic violence. However, limited access, infrastructure, and population mobility, in addition to the upsurge in violence, has led to an increased need for lifesaving health services in a context where insecurity and instability have generated additional challenges to providing support.

- While HRRP has contributed positively to providing health services in the two former states, results from the project show that coverage remained ineffective due to: (i) upsurge in instability and violence, reducing the CSDO's ability to provide services; (ii) inability to monitor and verify results in opposition-held territory and insecure locations; (iii) perceived (and probable) non-neutrality in service delivery support across areas held by the government and opposition forces; and (iv) limited oversight and ability of the government to provide satisfactory justification/evidence of supplies, drugs, and services arriving at their intended destination.

Launched in October 2016, the drone delivery project made Rwanda the first country in the world to use the drone technology at the service of saving lives. With the help of these drones, patients no longer have to wait for blood for hours to get to remote clinics and hospitals. They can now receive blood transfusions in minutes.

Currently, the program is focusing almost exclusively on blood deliveries. However, the project aims to expand the deliveries of vaccines and essential medicines for the treatment of diseases such as HIV/AIDS, malaria and tuberculosis.

Photo: Sarah Farhat / World Bank

Lessons Learned

- It was concluded that for future Bank engagement in South Sudan's health sector, a different mix of approaches would be needed to support health services for inaccessible areas affected by conflict or held by the opposition. UNICEF and the International Committee of the Red Cross (ICRC) were identified as uniquely placed in accessing the people who needed immediate assistance. Selecting both agencies will bring together diverse resources from both the development and humanitarian service delivery segments. It will also leverage their comparative advantages to ensure that services are delivered to target populations in a neutral, flexible, and rapid manner, with a particular focus on at-risk and vulnerable populations. The importance of leveraging these actors and providing an immediate flow of funds is necessary for sustaining the existing momentum and scaling up ongoing activities while avoiding interruption to service delivery supported by HRRP.

- The newly designed implementation arrangements will help in ensuring continuity in the provision of essential health services in a coordinated manner. This will guarantee coverage of different population groups who often shift their location in an environment where conflict and uncertainty remain underlying factors.

- The monitoring and evaluation arrangements for the new approach focus on accountability for results in the delivery of health services. In addition to the internal monitoring and reporting mechanisms of UNICEF and ICRC, the new arrangements will deploy an independent monitoring system to assess project implementation and impact in accessible areas where security and confidentiality issues are less of a concern. To strengthen monitoring activities in the project zones, the project will harness disruptive technologies for FCV contexts in collaboration with the Geo-enabling for Monitoring and Supervision (GEMS) initiative (P167344).

- Monitoring arrangements for inaccessible areas will triangulate data from various sources to produce a robust monitoring and reporting platform that tracks results achieved in health facilities supported by the operation. These will include both corroboration of 'hard' inputs (i.e., that health care facilities do exist and that medical supplies have been provided for their functioning), and corroboration of 'soft' inputs (i.e., that health care facilities have been benefitting from ICRC staff's expertise and support).

Case: Ebola-affected countries (Liberia, Sierra Leone, Guinea): Health for human resources

What is the efficient Human Resources for Health (HRH) plan in response to crisis/conflict responses?

As Ebola has repeatedly affected the West Africa region, it has become increasingly important to distill knowledge and lessons from past experiences to inform future responses. To address this need, the World Bank sought to analyze the post-Ebola health workforce. Three different products have been developed as a result:

- A *study published by the World Bank*[4] concluded that the scale-up of the workforce will require an increase in the health budgets. It was also found that in order to increase value-for-money, better geographical distribution of the workforce is necessary in addition to a scale-up in the mix of cadres.

[4] https://human-resources-health.biomedcentral.com/track/pdf/10.1186/s12960-019-0351-y

Gibriel Kabba, a swabber for the ministry of health, prepares to enter a house with protective clothing, after a new born child recently died. The ministry of health in Sierra Leone is working together with NGO's to contact trace every death, no matter the reason, in Freetown, Sierra Leone on March 3, 2016.

Photo © Dominic Chavez/World Bank

- The Bank authored a book, *Strengthening post- Ebola health systems: from response to resilience in Guinea, Liberia, and Sierra Leone*.[5] The book highlights the challenges to the health systems and the need to develop sustainable systems in Ebola-affected countries. The primary recommendations for these post-Ebola countries are as follows:
  - Move toward Universal Health Coverage for all populations.
  - Performance-based financing is necessary in these settings.
  - Harmonize the planning and budgeting processes in addition to adding results-based financing.
  - Guinea should increase its health budget in comparison to its counterparts.

[5] http://documents.worldbank.org/curated/en/707921513841518782/pdf/Strengthening-Post-Ebola-Health-Systems-From-Response-to-Resilience-in-Guinea-Liberia-and-Sierra-Leone.pdf

- The final product, still in progress, is a toolkit which will conduct a Social Return on Investment (SROI) analysis of health professional education in post-Ebola affected countries. This framework will seek to reduce perceived inequalities and can be used in forecasting the value of specific interventions.

Case: Ebola-affected countries (Liberia, Sierra Leone, Guinea): World Bank responses to conflict

How can the World Bank respond better to crises/conflicts?

In addition to analyzing the health systems of Ebola- affected countries, the World Bank engaged in a self-evaluation process where it assessed its own response in an effort to extract lessons for future pandemic responses. To embark on this, the World Bank conducted a series of in-depth interviews to gauge the effectiveness of its response, the challenges that arose, and the lessons learned. Although the study has limited input from national-level stakeholders, the interviews successfully answer the following questions:

- What was the result of the Ebola Emergency Response Project (EERP) and the restructured WB health responses, and how did they contribute to the containment of the Ebola Virus Disease (EVD) outbreak?

- How were different phases of the EERP prepared, why were operations prepared the way they were, and what challenges and facilitating factors were encountered?

- How were activities developed in the three countries, how relevant were they, and how were they adjusted along the way?

- How did different types of partnerships work with respect to the effectiveness, goals and objectives, ownership, efficiency, speed, and accountability during the implementation of activities?

- How did EERP transition from emergency response to recovery?

Challenges

- The World Bank had two different teams performing interviews on the same topic. This prevented the team from conducting the full range of desired interviews. It was necessary for the teams to collaborate and share information so that they would not overlap and duplicate efforts.

- Additionally, once the interviews began, another challenge arose surrounding the interviewee's recall. Since the start of the interviews was so far from the Ebola outbreak, it was difficult in some cases for interviewees to remember the specific details.

Lessons Learned

- There is a need to begin studies like these immediately following an outbreak in order to receive accurate accounts form interviewees. Earlier interviews performed in 2014 proved to be useful in gathering some of the data needed for this component.

- Before beginning a study like this, it is important to do a clear review of other Advisory Services and Analytics (ASAs) going on in the same region and to assure that any overlapping studies can be identified as soon as possible, so that complementarity is assured.

Conclusion

Despite the varying challenges faced by countries in fragility, conflict, and violence, each country context was able to develop a strategy for effective service delivery. Flexibility emerged as a common factor throughout each of the case studies as each team needed to adapt to changing conditions while considering alternative methods for service delivery. It is also important to note that careful coordination with stakeholders is essential for the successful implementation of service delivery in such difficult settings.

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For more information on other HNP topics, go to www.worldbank.org/health

Fourth Global Symposium on Health Systems Research: Organized Session Abstract

Title: Strengthening Health Sector Resilience in Fragile, Conflict and Violence Settings

Session type: Panel

Thematic area: Enhancing health system resilience: absorbing shocks and sustaining gains in every setting

Field-building dimension: Cutting-edge research or Innovative research approaches and measures

The session organizer's contact details

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Contributors' details: the session chair/moderator as well as a maximum of four/five named additional contributors, who will play active roles in the session; whether lead author is from low- and middle-income countries

Chair: Dr Emre Özaltın, The World Bank
Contributors: HE Dr Kadil Sinolinding, Secretary of Health, Autonomous Region in Muslim Mindanao (ARMM) Philippines; Susan Ayen Chagai, Ministry of Health, South Sudan; Dr Aakanksha Pande, The World Bank; Dr Ziad Obermeyer, Harvard University.

A short (50 word) overview of the organized session that will appear in the Symposium programme

This session on strengthening the resilience of health service delivery in fragile, conflict, and violence settings explores new approaches to strengthen the humanitarian-development nexus. Methods and results from 4 innovative and catalytic pilots from the occupied Palestinian territories, Syria, the Autonomous Region in Muslim Mindanao, and South Sudan are presented.

A 400-word (maximum) summary of the session content, including: purpose/objective, technical content, target audience, and significance for the selected thematic area and/or field-building dimension; learning objectives

Purpose/objective: To discuss novel approaches to strengthening service delivery in Fragility, Conflict and Violence (FCV) settings. Country-owned and -led health systems building activities, at different phases of conflict and in different settings, are explored as drivers of transition out of fragility.

Technical content: For FCV countries, service delivery in the health sector is a challenge, with a potential double burden from acute surges in trauma and supply disruptions. We discuss four contributions to sectoral monitoring and needs assessment as input into specific interventions and policies towards health sector resilience strengthening in these settings:

1. **Tools to build up a nascent health sector in active conflict settings:** focuses on the outcomes of a results based financing (RBF) program in South Sudan with innovative methods for monitoring and validation in areas of unrest and recurrently flaring conflict.

2. **New operational tools to conduct service delivery constraints assessments in active conflict settings:** methods and results of a tool mapping service availability to need on a publicly available web platform and aiming to identify under-served areas critical investment gaps in the Autonomous Region in Muslim Mindanao, Philippines

3. **Rebuilding health systems: Estimating the cost of conflict:** damage to a health system is measured using satellite imagery triangulated with social media analytics and third party reports, using novel statistical methods, with data from Syria and Gaza.

4. **Innovative approaches to improve emergency care in fragile settings:** the results of an impact evaluation of an intervention to assess and improve outcomes in emergency departments is presented, covering hospitals in Gaza and the West Bank.

Target audience: The target audience are academics, development professionals, civil society and government officials interested in the growing body of evidence bridging the humanitarian-development divide and in strengthening health systems work in FCV settings.

Thematic significance: This topic focuses on enhancing health system resilience is a particular setting. The panel focuses on enhancing learning to strengthen health systems in FCV settings by testing innovative new approaches and operational FCV tools with the potential to catalyze larger-scale interventions.

Learning objectives: The Panel aims to generate a discussion on how to strengthen the humanitarian development nexus. Should systems strengthening and sustainability be integrated from the onset? What is the value of the concrete tools and guidelines presented on implementing relief, rehabilitation and development, and are they generalizable to other settings? How do health systems contribute to stability, peace, and state-building in fragile settings?

A 400-word (maximum) summary of the planned session process, including: short description of any presentations or inputs, the moderation or management approach of the session, the role of contributors—both those named in the abstract and any others with planned roles, and a rough breakdown as to how the 90 minutes will be used

The discussant/moderator will introduce the session objectives, outline, and introduce the presenters. He will provide a background of the overarching thematic focus of the session and the key learning objectives for the audience's consideration (5 minutes). Each presenter will then introduce and present their specific topics, each also outlining the presentation-specific suggestions for discussion. HE Dr Kadil Sinolinding, Secretary of Health, Autonomous Region in Muslim Mindanao (ARMM) Philippines will be the first presenter and he will present the needs assessment work from the Philippines; Susan Ayen Chagai from the Ministry of Health, South Sudan will be second and she will present the RBF and monitoring work from South Sudan; Dr Aakanksha Pande from The World Bank will be next and she will present the methods for estimating cost of conflict; and, finally, Dr Ziad Obermeyer from Harvard University will present the results of the impact evaluation to improve emergency care in the occupied Palestinian territories (12 minutes each: 10 minutes presentation; 2 minutes questions of clarification). Next the discussant will summarize presentations, with a focus on tying them back to the session theme and highlighting key emerging questions for the audience's consideration (5 minutes). The discussant will then moderate a discussion with the audience and presenters on the themes, topics and questions presented (30 minutes).

Session for Human Development Learning Week: HNP Days

Date: Wednesday, May 10, 2017
Time: 11:00 am – 12:30 pm
Location: Room 3

Session champion: Emre Ozaltin (GHN13), Aaka Pande (GHN05), Noel Chisaka (GHN07), Roberto Rosadio (GHN02), Christopher Herbst (GHN05), Tomo Morimoto (GHN02)

Session moderator: Emre Ozaltin (GHN13)

Session title: Working on the humanitarian-development nexus: Innovative approaches to measuring and delivering Health in Fragility, Conflict, and Violence

Speakers: Emre Özaltın (GHN13), Aaka Pande (GHN05), Noel Chisaka (GHN07), Roberto Rosadio (GHN02), Christopher Herbst (GHN05), Tomo Morimoto (GHN02)

Description: This session aims to discuss FCV related issues in health services delivery through sharing experiences from the Global Programmatic Approach ASA: Strengthening Health Service Delivery Resilience in FCV Settings (P157931), a series of innovative and catalytic pilots, aiming to strengthen health service delivery resilience in participating countries and to contribute to knowledge base at the Bank and globally. It aims to:

1. Share technical details of 5 service delivery resilience pilots, in diverse FCV settings, in an engaging and interactive format;
2. Address questions on how to strengthen the humanitarian-development nexus;
3. Share and discuss operational experience and knowledge on engaging in the health sector in FCV settings.

Hyperlinks to background material:
http://wbdocs.worldbank.org/wbdocs/viewer/docViewer/index1.jsp?objectId=090224b0845f27c9&standalone=true&respositoryId=WBDocs

Overview

There is a growing recognition that working fragile, conflict, and violence (FCV) settings is a strategic imperative for the Bank, reflected in our recent commitments to what has been termed 'bridging the humanitarian-development divide' and in the recent large increases in funding to these settings under IDA 18.

FCV countries have over half of MNCH mortality; a third of the HIV, TB & malaria burden; are critically important for displacement and mental health; and will soon be home to half of the world's poor. If we are to make meaningful progress towards the twin goals, and towards all of the SDGs, we have to do the work of development effectively in these setting.

However, there are large knowledge gaps in operationalizing this approach: how do we best bring the Bank's resources and comparative advantages to bear in diverse FCV settings in meaningful and sustainable ways?

This session aims to discuss these questions by sharing the experience under the Global Programmatic Approach ASA: Strengthening Health Service Delivery Resilience in FCV Settings (P157931), a series of innovative and catalytic pilots, aiming to strengthen health service delivery resilience in participating countries and to contribute to knowledge base at the Bank and globally.

This topic fits under the FCV cross-cutting area. The work presented will cover the Service Delivery, Population and Development; Decision Science; and Healthy Societies GSGs, with focus on results based financing; vulnerability and resilience; and big data for decision making.

Objectives

The objectives of the session are threefold:

1. To share the technical details of five service delivery resilience pilots, in diverse FCV settings, in an engaging and interactive format;

2. To address questions on how to strengthen the humanitarian-development nexus. Should systems strengthening and sustainability be integrated from the onset? What is the value of the pilots presented to implementing relief, rehabilitation and development, and are they generalizable to other settings? How do health systems contribute to stability, peace, and state-building in fragile settings?; and

3. To share and discuss operational experience and knowledge on engaging in the health sector in FCV settings. How do we assess risk? How do we evaluate projects? Does this work have implications for a broader FCV strategy? How do we leverage our comparative advantages in these settings?

Outline of Session

The session is divided into 3 parts:

Introduction (5 minutes): The discussant/moderator will introduce the session objectives, outline, and introduce the presenters. He will provide a background of the overarching thematic focus of the session and the key learning objectives.

Presentations (35 minutes): 5 *Pecha Kucha** presentations will be made, one for each of the 5 projects under the global ASA:

1. Approaches to improve emergency care under fragility & conflict; in Palestine

2. Approaches to build up the health sector in active conflict; in S Sudan

3. Tools to assess the cost of conflict on the health sector; in Syria

4. HSS in post-pandemic settings; in Liberia, Guinea, and Sierra Leone

5. Addressing service delivery constraints in active conflict; in ARMM Philippines

**Pecha Kucha* is a presentation format where 20 images are shown for 20 seconds each. The images advance automatically and presenters talk along to the images. Further details can be found here: *http://www.pechakucha.org/*.

Interactive Panel (45 minutes): The 5-person panel will be posed 3 questions on operational issues related to working in FCV settings by the moderator. Questions will focus on tying in the operational experience gained through the Global ASA with broader themes and issues related to HNP and the World Bank's engagement in FCV settings. An interactive session will follow where session attendees will share their own experience and ask questions of the panel.

Main Messages

There are three main messages of the session:

1. Beyond humanitarian relief, systems building, in health specifically, is critical in active and post-conflict settings, to prepare for rebuilding post-conflict and for state- and peace-building efforts.

2. As we significantly ramp up our engagement in FCV countries, the World Bank (and HNP GP) needs to quickly ramp up our technical and operational knowledge base on how to effectively work in these settings.

Nowhere is the Bank's new rhetoric on risk-taking put to the test more than in FCV settings. Risk ratings for projects should to be relative, based on context. Similarly, project evaluations should reflect inherent uncertainty in expected outcomes. Overall, staff need to be incentivized to take on these challenging projects.

Questions to discuss and think about

1. What are the World Banks's comparative advantages in working in FCV settings?

2. How should the World Bank engage with other agencies, particularly humanitarian agencies, in coordinating work in FCV settings?

3. How should we be assessing project risk in FCV settings?

4. How do we evaluate projects in FCV settings? What is our tolerance for failure? How can we incentivize TTLs to take on inherently risky projects?

5. What is the role of HNP and HD in the Bank's FCV agenda and how do we engage and leverage the broader FCV community in our work?

6. Is a Bank- (or HD-) wide FCV strategy emerging? What would this look like?

Reading and resources

http://www.huffingtonpost.ca/development-unplugged/humanitarian-development-divide_b_12849410.html

http://unsdsn.org/wp-content/uploads/2016/05/WHS-background-paper.pdf

http://documents.worldbank.org/curated/en/652991468196733026/pdf/106182-BR-IDA18-Fragility-Conflict-and-Violence-PUBLIC-IDA-R2016-0140.pdf

http://reliefweb.int/sites/reliefweb.int/files/resources/HDQ1185.pdf

http://www.sciencedirect.com/science/article/pii/S0277953609006339

http://blogs.worldbank.org/health/bridging-humanitarian-development-divide-health-sector

HNP FCV Working Group Achievements (FY 2018 – FY 2019)

Health, Nutrition and Population Fragile, Conflict and Violence Working Group (HNP FCV WG) is a resource group to provide catalytic support to TTLs and teams working in FCV-affected settings whose activities were partially funded through the ***Strengthening Health Service Delivery Resilience in FCV Settings*** Global PA ASA. The aim is to enable HNP teams to deliver quality health inputs for clients affected by FCV. The HNP FCV WG provides tailored support on "operations", "knowledge", and to "convene" with regard to HNP issues and FCV. The activities fall into six main areas:

Activities				About
Operations	1	Who to ask	SWAT team	60 cross-sectoral experts with specific experience in FCV settings are ready to provide quick support
	2	What to do	HNP FCV Knowledge Brief and Operational Clinics	Concise, hyperlinked operational briefs provide the latest evidence, guidelines, and interventions in response to HNP challenges in FCV settings
	3	How to do	Tailored support to teams	Conducting stakeholder assessments, diagnostics of FCV settings, developing/implementing products best fitting unique needs of each project
Knowledge	4	Fill the gaps	Analytical work	Global analytical work to better understand the unique health needs of forcibly displaced populations
	5	Does it work	Impact evaluation	Impact evaluations of WBG projects addressing the needs of forcibly displaced populations to provide key achievements and essential lessons-learned for future operations
Convening	6	Knowledge sharing/ Partnership	Seminars, trainings, internal/external partnership	Operational training, seminars, and high-level dialogue, to raise awareness about health development in FCV settings

The HNP FCV WG has made extensive contributions for operational support, knowledge/learning and convening agendas with internal and external audiences.

Publications

HNP FCV Knowledge Brief series address five key questions on specific HNP issues in conjunction with FCV contexts. Six publications were delivered, with a total of 795 abstract views (as of April 9, 2019). Three more publications (Health Financing, External Partnership, and Health System Resilience) are in draft and will be published during Q4 of FY19.

1. *Mental Health and Psychosocial Support in Fragile, Conflict, and Violence Situations: Five Key Questions to be Answered*[1]: This brief highlight best practices in designing, implementing and evaluating a project, including a mental health and psychosocial support (MHPSS) component.

2. *Gender Based Violence in Fragile, Conflict, and Violence Situations: Five Key Questions to be Answered*[2]: This brief highlight best practices in addressing gender-based violence (GBV) in FCV situations. It also provides an overview of the World Bank's current engagement on GBV in fragile settings and internal resources available to TTLs.

3. *Non-Communicable Diseases in Fragile, Conflict, and Violence Situations: Five Key Questions to be Answered*[3]: This brief addresses the need for investment, as well as best practices in designing, implementing, and evaluating a project that includes an NCD focus or component within FCV settings.

4. *Using Technology in Fragile, Conflict, and Violence Situations: Five Key Questions to be Answered*[4]: This brief offers basic guidance on how to approach a new frontier and use of disruptive technology in FCV health projects.

5. *Health Service Delivery in Fragile, Conflict, and Violence Situations*[5]: This brief answers five questions related to FCV situations and service delivery. In FCV settings, successful service delivery depends on extensive situational analysis (for example, political economy, forms of violence, rent-seeking behavior/motivations), close monitoring, flexibility, and rapid response mechanism against shocks or threats.

[1] https://openknowledge.worldbank.org/handle/10986/30387

[2] https://openknowledge.worldbank.org/handle/10986/30592

[3] https://openknowledge.worldbank.org/handle/10986/30591

[4] http://documents.worldbank.org/curated/en/218081537875825707/Using-Technology-in-Fragile-Conflict-and-Violence-FCV-Situations-Five-key-questions-to-be-answered

[5] https://openknowledge.worldbank.org/handle/10986/30497

6. *Pandemic Preparedness and Response in Fragile, Conflict, and Violence Situations*[6]: This brief addresses the urgent need for prevention, detection, and response to outbreaks in FCV situations. Pandemic preparedness and response contribute to universal health security, protecting all people from threats to their health.

Blogs

1. *Financing Health Services for Refugee Populations*[7]: How to Pay the Bill: This blog post discussed non-traditional, short-term, and camp-based service delivery and financing models to deliver necessary health services for refugee populations. Posted on June 20, 2018.

2. *Why investing in health is critical for addressing gender-based violence in fragile settings*[8]: This blog post sheds the light on the importance of addressing GBV issues in FCV settings, areas to be strengthened and key points for GBV-related interventions. Posted on December 17, 2018.

Learning Events – Operational Clinics

A total of 12 operational clinics (chaired by Ernest Massiah, HNP MNA Practice Manager) were delivered on a range of HNP and FCV topics. About 315 participants (Bank staff and external participants) joined discussions during the clinics.

1. ***Mental Health and Psychosocial Support in FCV situations*** (January 29, 2018): Experienced TTLs in FCV situations shared operational experiences to implement mental health and psychosocial support activities in World Bank operations. The panelists included Rene Antonio Leon Solano (Sr. Social Protection Specialist); Preeti Kudesia (Sr. Health Specialist); Ghulam Sayed (Sr. Health Specialist); Nadwa Rafeh (Sr. Economist); and Patricio V. Marquez (Lead Public Health Specialist).

2. ***Gender-Based Violence in FCV contexts***: (February 26, 2018): The clinic with internal and external experts focused on how to design, implement and evaluate operations addressing GBV issues in FCV situations. Panelists were Sameera Maziad Al Tuwaijiri (Lead Health Specialist); Verena Phipps-Ebeler (Se. Social Development Specialist); and Elizabeth Blackney (Panzi Foundation).

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[6] https://openknowledge.worldbank.org/handle/10986/31442

[7] http://blogs.worldbank.org/health/financing-health-services-refugee-populations-how-pay-bill

[8] https://blogs.worldbank.org/health/why-investing-health-critical-addressing-gender-based-violence-fragile-settings

3. ***Non-communicable diseases (NCDs) in FCV contexts*** (March 29, 2018): Experts discussed views on how to raise awareness to address rising public health concern of NCDs in FCV situations. The clinic was chaired by Patrick Oswe (Lead Health Specialist) and included panelist of Shiyong Wang (Sr. Health Specialist); Nadwa Rafeh (Sr. Economist); and Sylvia Kehlenbrink (Sr. Fellow at Harvard Humanitarian Initiative).

4. ***Using Technology in Health Projects in FCV Contexts*** (May 17, 2018): The clinic invited two external experts to highlight ways to utilize disruptive technology in planning, data collection, project implementation and monitoring and evaluation. The experts included Mark Polyak (Sr. Vice President, Ipsos) and Wally Okpych (Director for Advisory Forensic Technology Practice, PwC).

5. ***How to Deliver Services in FCV Situations*** (June 13, 2018): Experienced TTLs, along with an external expert, discussed options to identify key points to design effective and resilient service delivery model in FCV situations. The experts included Mickey Chopra (Lead Health Specialist); Noel Chisaka (Sr. Health Specialist); Hadia Samaha (Sr. Operations Officer); and Jacob Hughes (Sr. Technical Director, Management Sciences for Health).

6. ***Technology as Solutions in FCV contexts: Addressing Real Questions from TTLs*** (July 12, 2018): Based on TTLs' real life questions on how to use disruptive technology into HNP operations, technology experts provided feasible solutions. The experts included Mark Polyak (Senior Vice President, Ipsos); Sarah Elizabeth Antos (Data Scientist, Geospatial Operations Support Team); and Annabelle Vinois (Consultant, Geo-Enabling initiative for Monitoring Supervision, FCV).

7. ***Pandemic Preparedness and Response in FCV Situations*** (September 19, 2018): Experts discussed key achievements and areas to strengthen when addressing pandemic preparedness and response. The experts include Hadia Samaha (Senior Operations Officer, HNP AFR); Leisel Talley (Nutritional Epidemiologist, US-CDC); Sara Hersey (Senior Health Advisor, HNP GE); and Mickey Chopra (Global Lead, Service Delivery GSG).

8. ***Health Financing in FCV Situations*** (November 14, 2018): The clinic focused on topics, including implementation of results-based financing and performance-based contracting in FCV settings, financing modality for refugees and host communities, and innovative financing instruments for FCV contexts. Experts in this clinic included Fernando Montenegro Torres (Senior Health Economist, HNP MNA); Sayed Ghulam (Senior Health Specialist, HNP SAR); Christine Lao Pena (Senior Human Development Economist, HNP AFR); and Hafeez Ladha (Director for Innovative Finance, Financing Alliance for Health).

9. ***Disruptive Technology in the Pacific*** (November 26, 2018): HNP Pacific team requested an operational clinic to discuss feasible options to utilize disruptive technology in HNP operations in the Pacific. The expert (Mark Polyak, Senior Vice President, Ipsos) presented several disruptive technology options suited for the Pacific contexts (i.e. off-line communications, telemedicine, patient monitoring in remote islands).

10. ***Working with Humanitarian Partner in Conflict-affected Situations*** (December 12, 2018): This clinic provided an opportunity for HNP TTLs working in conflict-affected settings (DRC, Somalia, Yemen, Libya and West Bank and Gaza) to discuss the Bank's role in Humanitarian-Development-Peace Nexus. The external guests (Jason Millis and Reshma Adatia from Médecins Sans Frontières) shared their views on the Bank's advantage and disadvantages for the Bank's assistance in conflict-affected settings.

11. ***Innovative External Non-Donor Health Financing in FCV Situations*** (February 14, 2019): A health financing expert showcased innovative financing structures and instruments to re-risk private sector investment in FCV situations. Hafeez Ladha (Former Director of Innovative Finance, Financing Alliance for Health) presented examples of financing modalities and instruments used in Africa.

12. ***Improving Health Service Delivery in Active Conflict Settings*** (April 16, 2019): HNP Cameroon team requested to have a deep-dive with HNP FCV WG to learn more about operational experiences to improve service delivery in active conflict settings. HNP FCV WG shared operational experiences from Yemen, Libya, South Sudan, and Mali.

Learning Events – Others

HNP FCV WG hosted or joined following public events to convene with partners as well as share knowledge on HNP and FCV. The events attracted more than 280 people in audience and included:

1. ***Fragility Forum 2018***: Health Care for All in FCV Contexts – Paying and Providing Health Care for Refugees and Host Populations (March 6, 2018)

2. **3rd Annual Health Financing Forum**: Providing Health Care to Refugee Populations – How to Pay the Bill (April 19, 2018)

3. **Reproductive Health and Rights in Humanitarian Settings**: Building Evidence into Actions (May 30, 2018)

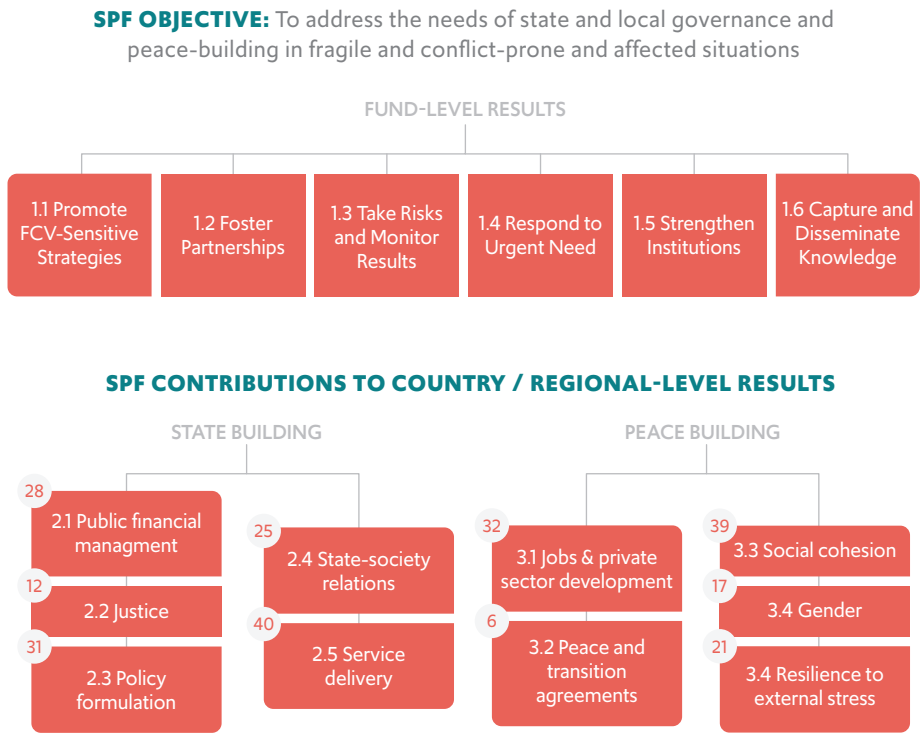
4. **CORE Group Global Health Practitioner Conference**: Prioritizing the Investment and Financing for the Humanitarian-Development Nexus (June 6, 2018)

Component Contribution to PDO and SPF Objectives

The Program components are aligned with the PDO and with SPF Objectives (SPF objectives are illustrated in **figure 1**).

Component 1 supports the **PDO** by supporting a catalytic pilot to improve emergency care in select hospitals in Palestine by designing and implementing continuous quality improvement interventions. The activity kept in mind that this could be scaled up within the Palestinian territories and be replicated to other FCV settings. It is linked to the **SPF overall objective** of supporting

Figure 1. SPF Objectives



Note: The circled numbers above indicate the number of SPF grants that contribute to each objective. One SPF project can contribute to multiple results.

Source: SPF Pilot Monitoring Dashboard 2014

measures to improve governance and institutional performance in countries emerging from, or at risk of sliding into, crisis and arrears. It is furthermore linked to SPF **fund-level results** to promote FCV sensitive strategies; **state-building results** to improve PFM in the health sector improving service delivery through improving emergency department outcomes; and **peace-building results** by strengthening resilience to external stress.

Component 2 linked to the **PDO** by developing cutting edge tools to estimate the cost of the conflict in Syria and then broadly disseminate these tools and findings. It is linked to the **SPF overall objective** to support the reconstruction and development of countries prone to, in, or emerging from conflict by estimating the cost of the damage to the health sector in Syria which will directly be used to rebuild Syria when the conflict ends. It furthermore links to **fund-level results** to take risks and monitor results by measuring the impact of the conflict over a period of time and so monitors the situation and produces results; and to **state-building results** of service delivery by helping better understand the service delivery situation in Syria and areas to target during rebuilding.

Component 3 contributes to the **PDO** by improving knowledge and understanding of operations in FCV countries. It will further support **SPF overall objective** to support the reconstruction and development of countries prone to, in, or emerging from conflict by contributing to understanding of operational issues and how these can be effectively implemented in these settings. It furthermore contributes to **fund-level results** to promote FCV sensitive strategies as well as to take risks and monitor results; to **state-building results** of service delivery in health in FCV settings; and to **peace-building results** of contributing to build resilience under stress.

Component 4 is strongly linked to the **PDO** of strengthening service delivery resilience as the results of the health facility survey in ARMM will enable the ARMM regional government to identify supply side gaps and address service delivery issues. It is linked to the **SPF overall objective** to support measures to improve governance and institutional performance in countries emerging from, or at risk of sliding into, crisis and arrears as, with the information on supply side issues in health service delivery gathered from the survey, the ARMM DOH will be in a better position to make decisions and adjustments to improve health care delivery in the entire region. The survey data will be included in the ARMM Regional Government's plans to develop an Open Data platform wherein the survey results will be made publicly available. This will enable NGOs/CSOs and other interested parties to have a dialogue with the ARMM Regional Government with regard the published data. It is furthermore linked with **fund-level results** to promote FCV sensitive strategies by providing the ARMM DOH with the necessary tool to evaluate the status of its health care delivery system that it could replicate whenever there will be a future need; and with **state-building results** of PFM as the proper allocation of resources based on the survey data will undoubtedly contribute, though indirectly, to the overall public financial management of the health sector in particular and the regional government in general and service delivery, as the component will provide an impact on the management by the ARMM regional government of its

health care delivery system. Utilizing the survey information, it will be able to make proper decisions based on objective information with the end in view of improving universal health coverage in the region.

Component 5, both activities of this component contribute to the **PDO**: Activity (1) by analyzing and providing guidance towards post Ebola health systems strengthening (both with regards to the health workforce and systems strengthening more widely); as well as developing new methodology guide to calculate the social return of investing into health workforce education; Activity (2) by generating key lessons learned on how to tackle pandemic response situations, in particular in fragile countries, drawing on the lessons from the WBG's engagement in the Ebola response effort Both activities will generate critical evidence that will be of use to other countries. They linked to the **SPF overall objective** to support reconstruction of countries prone to or emerging from "conflict", in this case from a pandemic conflict such as Ebola. Activity 1 in terms of justifying the need for frontline health worker scale up and wider systems strengthening, and Activity 2 in terms of critical lessons from responding to such a pandemic. They are furthermore linked with **fund-level results** to promote FCV sensitive strategies by generating critical information and evidence that can help promote FCV sensitive strategies; Activity 1 on the scale up of health professionals, and Activity 2 regarding the organizational response to a major pandemic and to take risks and monitor results: Activity 1, to identify the post Ebola scale up needs and strategies for the workforce (and the health system more widely), and to develop a methods paper on SROI of health professional education in fragile countries. And Activity 2 on the key lessons learned from the experience in responding to the Ebola crisis, documenting the response and results achieved. They are indirectly linked to **state-building results** of strengthening public financial management, documenting effective and efficient strategies with which the scale up the health workforce (activity 1) and respond to a pandemic situation (activity 2) and with service delivery, as Activity 1 will provide guidance on how to scale up the health workers, as well as how to help justify investment into particular health professional education systems, all of which is designed to ultimately strengthen health service delivery by producing a fit for purpose health workforce in fragile countries. Activity 2 examined how to assist on maintaining health service delivery at the height of pandemics.

Component-specific Results

Component 1 objectives were achieved. The authorities asked the team to identify interventions that could be implemented with existing resources and could be continuously carried out after the project closure. Specifically, the interventions included Training of Trainers for strengthening triage functions at emergency departments. This allowed sustainable continuous educational environment, in which trainers could train other medical staff in a cascade process. As a result of interventions, there was a significant increase in taking of vital signs with the greatest improvement in pulse and oxygen saturation (some improved over 100% compared to baseline data). 36% increase from the baseline data on ECG performed for patients aged 50 and older presenting with a chief complaint of either chest or abdominal pain. These achievements show a major improvement on the quality of care for emergency patients in Palestine.

Sequenced activities & results:

- The Principal Investigators (Department of Emergency, Yale University) and implementing agency (Juzoor for Health and Social Development) hired.
- The draft evaluation instruments and study methods developed and piloted in 2 hospitals in the west bank (Beit Jala & MOH Qalqilya). Pilot data collected and analyzed.
- Instruments & methods revised based on pilot analysis.
- Baseline Emergency department data collected on 3278 patient visits in 11 sampled hospitals in the West Bank and Gaza (Alia; PMC; PEDS PMC; Rafidia; Yatta; Qalqilia; Beit Jala; Qalqilia UNRWA; Al-Shifa; Nasr Pediatric; and Nasser Medical Complex). The sampling was designed to simulate a theoretical week of emergency care at sampled facilities.
- Baseline results showed limited triage functions performed by medical staff (i.e., insufficient use and records of vital signs to stratify acuity and critically ill).
- Primary interventions identified, including training in WHO/ICRC Triage for Emergency Care and WHO Emergency Medical and Emergency Trauma Care Checklists and technical consultations on reorganization of patient flow and monitoring of quality indicators.

- 52 medical staff from 13 hospitals trained as trainers and 91 medical staff trained in cascade training.
- 33 coaching visits conducted in 17 hospitals to provide technical guidance on triage functions.
- End line data collected through direct and health information system case observation and focus group discussion
- Final reports completed.

Component 1 output reports have been published and are being widely disseminated in country and across the WBG.

Component 2 objectives were achieved before time and under budget, by leveraging other trust funds, Global Practices, and partnerships. A set of activities were implemented to better understand the impact of conflict in the health sector, specifically with respect to the conflict in Syria, which was partially funded by this grant.

1. **Updates to remote based assessment of damages to health sector in Syria (DNA):** Have completed an updated assessment of the damages to the health sector in Syria for the Spring Meetings (specifically presented at Mashreq Day, 2016). Analysis showed a considerable increase in damage/destruction to physical infrastructure since December 2015. Updates were subsequently undertaken in December 2016 and March 2017. March 2017 Damage and Needs Assessment (DNA) of the impact of the war in Syria in key cities was made public for the first time. Multi sectoral collaboration led by GPSURR SIRIA project (TTL Raja Arshad).

2. **Impact of Syrian crisis on health system through updated analyses.** In 2017, MENA region published a detailed economic and social impact assessment (ESIA) of the cost of war in Syria. The report generated significant coverage in the mainstream global media as well as MENA regional media. The health team authored detailed chapters for both reports using the satellite and social media analysis methodology.

3. **Exploring ways to use "Big data" for health:** Worked with the Big Data team in LLI and the Delivery and Decision Sciences Global Solutions Group in the HNP GP to design and deliver a tailored workshop on how "big data" can be harnessed to assesses the health impact of conflicts similar to the conflict in Syria. Generated several leads of groups to potentially collaborate with to increase the scope of work (Contacts: Trevor Munroe, LLI and Rocio Schmunis, GHNDR)

4. **Qualitative assessments of health sector in Syria:** To better understand the impact of the Syrian conflict on the health sector a first of its kind mission was undertaken to Jordan and Lebanon to meet with humanitarian and development partners who provide services in Syria. The mission includes the MENA practice manager, Ernest Massiah, and members of the MENA Chief Economist Office and Syria CMU (July 2016). The rich discussions helped confirm the results of the remote based assessments and provided granular detail on the scale of the disruption to the health sector as well as helped generate potential entry points for engagement. This was used to inform a high-level two-day MENA VP retreat on potential role of WBG in conflict states which included the MENA Chief Economists Office and Practice Managers of most Global Practices.

5. **Organized global workshop on human resources for health in light of the Syrian crisis.** A two-day conference was held in partnership with OECD on March 2017 on rebuilding the human capital of Syria. This was the first-of-its-kind workshop bringing together MENA and ECA health leaders (governments, donors, academics) who are at the front lines grappling with the impact of the Syrian refugee crisis on their local health systems. The workshop was opened by the ex-President of Portugal, Jorge Sampaio, who chairs an NGO which trains Syrian medical students and included sharing of experiences of how different countries had integrated Syrian refugee health workers into their health systems to allow for the increase in health demands to be met. As part of the preparation for this workshop, a background paper was commissioned looking at the distribution of health workers in Syria and among Syrian refugee populations which was undertaken by Cambridge University and supported through the SPF grant[1].

6. **Explored innovative solutions to rebuild human capital in Syria.** Given that it takes five years to train a doctor, novel means to train and preserve human capital in Syria despite the war were explored and shared with SPF and the CMU. These included very preliminary conversations with a consortium of academics at Yale and Harvard University on using an app based software to train health workers in parts of Syria and discussions with a global NGO on training Syrian health workers in refugee hosting countries in MENA/OECD. However, the team was advised to not take the conversations further until the WBG had a suitable authorizing environment for Syria and so all activities were suspended.

7. Due to a lack of an authorizing environment, the team was advised in 2017 to "freeze all activities" on Syria until WBG decides to actively engage in country. At the Progress Review in June 2018, the team was approved to reallocate remaining funds ($US 73,000) to use for knowledge creation and convening on HNP and FCV through the HNP FCV WG. By

[1] *http://cmimarseille.org/highlights/strengthening-human-resources-health-integration-refugees-host-community-health-systems*

leveraging additional funding from Middle East and North Africa Multi-donor Trust Fund (MENA MDTF)[2] the component first conducted and jointly published case studies for each of the five Program components (See **Annex 1**). Leveraging this funding, the HNP FCV WG further published six publications and two blogs as well as convened 16 events, including 12 operational clinics on HNP and FCV (See **Annex 4**).

Component 3, the uncertainty on the ground meant that initial objectives were revised several times. Final objectives were: (1) exploring which factors have impeded gains in improving access to health care, with a particular focus on project implementation arrangements; (2) exploring how can Results-Based Financing be tailored to the specific context of South Sudan to address the factors affecting service delivery; and (3) exploring how non-traditional and non-state actors can potentially be mobilized to address both emergency health needs of the population and contribute to system strengthening and resilience.

Factors affecting access and coverage of health services: Monthly missions to South Sudan were conducted throughout 2018 to ensure the team was as present as possible in the country to discuss with government, donors, and implementing partners on factors that have contributed to the attenuated results of the HRRP project. Key factors that led to limited coverage of health services in the states of Upper Nile and Jonglei where the project was implemented include:

i. Upsurge in instability and violence, reducing the Coordination and Service Deliver Organization's (CSDO) ability to provide services; (ii) inability to monitor and verify results in opposition-held territory and insecure locations; (iii) perceived (and probable) non-neutrality in service delivery support across areas held by the government and opposition forces; and (iv) limited oversight and ability of the government to provide satisfactory justification/evidence of supplies, drugs and services arriving at their intended destination.

ii. Implementation by the Ministry of Health has also contributed to attenuated project outcomes due to several constrains: (i) continual payment delays to the CSDO due to the MOH providing incomplete documentation and justification for payment; (ii) passive contract management and insufficient oversight by the MOH, including lack of clarity on the extent to which services are supported in conflict-affected and opposition-held areas; and (iii) challenges related to fiduciary compliance that have grown over time.

[2] *http://www.worldbank.org/en/programs/middle-east-and-north-africa-multi-donor-trust-fund#2*

16 January 2019 - Beni, Democratic Republic of Congo.
Health workers put their gloves on before checking patients at the hospital.
Photo: World Bank / Vincent Tremeau

Exploring Results-Based Financing in South Sudan: Despite initial interest, after several discussions in-country and an opportunity to send a delegation to an in-depth training course on RBF, the senior leadership of the Ministry of Health expressed little interest in exploring the development of an RBF pilot in the country. As such government officials did not attend the RBF training course, which was a precursor to ensuring that the feasibility study and pilot design be developed with strong ownership by the MOH. As such activities related to RBF were not pursued further.

Working with non-traditional actors and exploring alternative implementation arrangements for health service delivery: Missions also allowed for the team to identify potential non-governmental partner agencies to support service delivery under the new operation under preparation (Provision of Essential Health Services Project, P168926).

- It was concluded that for future WBG engagement in South Sudan's health sector, a different mix of approaches would be needed to support health services to the extent necessary in inaccessible areas affected by conflict or held by the opposition. UNICEF and ICRC were identified as uniquely placed in accessing the people who need immediate assistance within the territory of South Sudan and to implement the project.

- A weeklong deep dive within ICRC's South Sudan country delegation was conducted in August 2018, which helped the WBG and ICRC understand better each organization's mission goals, their operations, and how they can work together to address the acute health needs in the country.

- Once the key design elements for activities to be implemented by ICRC were identified and agreed upon by the WBG and ICRC, a mission to ICRC headquarters in Geneva was conducted in October 2018 (consisting of experts from OPCS, LEGAM, Governance, HNP, GSURR, etc.) to iron out the alternative implementation arrangements to be applied by the new approach and implications for the WBG and ICRC. Topics covered operational policies, legal aspects, fiduciary arrangements, social and environmental safeguards, and technical design elements.

Component 4, Task 1, despite the initial slow start, the survey firm was recruited in March 2017, tools developed based on WHO's Service Availability and Readiness Assessment (SARA) framework as well as national level supply side capacity assessment that took place in 2016, data collected between July-October 2017 and the analysis completed in March 2018. The team has conducted consultative workshops with relevant key stakeholders based on the preliminary findings and the final report is currently being drafted. The team expects completion of the report by May 2018 and dissemination by June 2018. The activity is being closely supported by the ARMM-DOH Secretary of Health and his team. **Task 2** leveraged funding from other sources[3] and folded activities under the ongoing Health Financing Systems Assessment (HFSA), which aimed to conduct a comprehensive assessment of the health financing systems in ARMM. The study reviews funds flows and sustainability of financing in the ARMM region and examines supply side capacity and demand side constraints (through a small-scale household survey) in order to identify the bottlenecks and opportunities for more efficient health service delivery. In this context the current capacity of private sectors in the region will is also assessed. While the ARMM Supply side readiness assessment is an independent deliverable, it will also be an integral part of the overall HFSA, to provide a comprehensive assessment on supply side readiness to deliver efficiently the services. The final report has been completed and is currently being disseminated to the client and internally.

[3] Australia-funded regional MDTF on Integrating donor-financed health programs.

Component 5 objective, understanding the impact of health system strengthening efforts in improving HSDR in post-pandemic countries (Liberia, Sierra Leone and Guinea), has been achieved. **Task 1** has been achieved. Sub-activity 1(a), the review and assessment of the Post Ebola Strengthening plans in Liberia, Sierra Leone and Guinea has been completed. The findings of the review have been published in the WBG's Chief Economist Series "Strengthen Post Ebola Health Systems: From Response to Resilience in Guinea, Sierra Leone and Liberia". With a specific focus on the workforce, findings were additionally published in the journal *Human Resources for Health*[4]. Sub activity 1(b) which is the methods note on how to carry out SROI studies related to investing in health worker education has also been completed and is in the process of being published as an HNP discussion paper, given its purpose of providing a framework of guidance to efforts intending to carry out a social return on investments analysis in such areas as health professional education. **Task 2** has been achieved and the report of key lessons learned from the Ebola response effort has been produced.

[4] McPake et al, 2019. Never again? Challenges in transforming the health workforce landscape in post-Ebola West Africa. Human Resources for Health 17:19. *https://doi.org/10.1186/s12960-019-0351-y*