Health Systems & Response Connector: Key Lessons

The Health Systems and Response Connector (HSRC) is co-convened by The Global Fund, World Bank Group and WHO with UNICEF. The HSRC acts across the three vertical ACT-Accelerator pillars (vaccines, diagnostics, and therapeutics) with a primary goal to address health systems gaps during the COVID-19 pandemic. The HSRC works in partnership with international organizations and countries to enhance the uptake of COVID-19 tools, particularly by helping governments to identify needs and gaps, address identified bottlenecks, and closely monitor national progress against global targets. The Connector's mandate includes strengthening health systems and protecting healthcare workers through effective personal protective equipment (PPE).

There are 14 planned workstreams but only two functioning ones (in bold):

- Consolidated planning & financing
- Implementation monitoring & tracking
- Scale-up of vaccine delivery
- Scale-up of testing for surveillance
- **Scale-up of clinical care pathways**
- Health workforce
- **Risk Communication & Community Engagement**
- Health logistics
- Country adoption of policies & guidelines
- Essential health services
- Infection Prevention & Control
- Acute situations
- Fragile, Conflicted and Vulnerable settings

Civil society and community representatives have confirmed regular and sustained engagement on the 'Risk Communication & Community Engagement' workstream and the 'Scale-up of clinical care pathways' workstream. The operational status of the other workstreams is unclear as of July 2022.

Key accomplishments

Overall, civil society and community representatives do not think the pillar achieved its goals although they acknowledge the progress that was made given the delayed start of this pillar's activities, and the innate challenges with the cross-pillar and cross-agency nature of its work.

The HSRC's accomplishments in this period include:

- Establishing data platforms, such as the Global COVID-19 Access Tracker and the Partners Platform, which allowed real-time needs from the country level to be raised by governments and implementing partners.
- Developing a model of coordinated country support, including country coordination support teams that were implemented in priority countries.
- normatively pushing pillar agencies and governments to think beyond traditional response capacities to also consider impacts on basic health systems functions (particularly on bringing new attention to health workforce, essential health service disruptions, community engagement) -- this was too little, too late, but still represents a rather important shift when looking at traditional emergency response.

Key barriers and enablers

We emphasize that the HSRC was initiated too late and underfunded from the start. The funding gap and massive delay in prioritizing health systems across the COVID-19 response have been the biggest barriers. The ACT-Accelerator prioritized the siloed vertical pillars for far too long, in the absence of also supporting health systems and cross-cutting approaches from the beginning. Once initiated, the Connector continued to face challenges in garnering political will and adequate financial support. Not only did this delay addressing major health systems gaps that ultimately hampered response efforts, it also fundamentally shifted attention away from community needs in a pervasive way that continues to skew donor and programmatic priorities over 2 years later.

There are also continued barriers in integrating across pillars; the Connector's operating structure, especially how it coordinates with other pillars effectively, has remained unclear. Within its programming, the pillar included clear indicators for PPE, but few (often none) indicators on supporting the health workforce with adequate training, remuneration, decent working conditions and protection and care as well as recruiting additional workforce. Strong indicators and investments for community systems for health were also missing. Overall, the focus by other pillars largely stopped at supply of commodities. While this is critical - and an area that faced substantial challenges during the pandemic - once commodities are identified and supplied, there is an entire cascade of work for systems to meaningfully and sustainable deliver the commodities throughout the health system. These efforts require a comprehensive approach with a deliberate focus on equity, the rural poor, and community involvement and advocacy from the start. These limitations in scope are a barrier in achieving stronger health systems that can effectively deliver the COVID-19 response.

The governance challenges of the ACT-Accelerator at large were also seen with the HSRC with low to minimal involvement and engagement of civil society and communities. With one or two notable exceptions (e.g., the Risk Communication and Community Engagement workstream, HSRC Secretariat briefings), civil society engagement was limited to periodic briefings without a process for continuous and meaningful feedback. Social participation and access to information was challenging at the global and implementation levels. We are thus unclear about the progress made at the country level due to the lack of transparency. Civil society and communities have not been well-engaged consistently, which is a barrier for resource

absorption, the suitability and effectiveness of the pandemic response, and accountability at the implementation level. It is unclear how well the HSRC aligned with other health systems strengthening initiatives and investments by multilateral, bilateral, or domestic sources.

Civil society and community representatives to the HSRC highlight the leadership of the HSRC Secretariat despite these many barriers. Qualified and experienced pillar colleagues enabled the Connector's progress.

The data dashboards enabled country actors to participate, and linked the knowledge stream on the needs of the COVID-19 response from the local to global levels but this was often faced with a lack of resources to address the issues and needs flagged from the countries due to the overall underfunding of the pillar. The needs were higher than the potential support. The HSRC Pillar were not aggressively visible as other pillars in mapping out the needs and costing the entire pillar needs besides PPE. This limited potential resources and support; this approach potentially gave the impression that the pillar needs were covered. There was a lack of a full assessment and costing of the needs and even where these were known, the Pillar was silent about it giving the impression to the world that the needs were only in COVAX, Therapeutics and Diagnostics Pillars as they were loud and clear with their gaps and needs.

Equally the pillar continues to remain not proactive and visible in the PPR conversations and so health systems and the very same issues such as health workforce are not a visible and top priority of the discussions and most likely it may end up being the pillar with the least viable transition plan due to the lack of political will and prioritisation. This risks a future PPR framework that will have the same challenges as ACT-A. Yet, a robust resilient HSS approach with strong community systems component is what will enable the rest of the delivery of effective PPR.

The Pillar did establish data platforms, such as the Global COVID-19 Access Tracker and the Partners Platform, which allowed real-time needs from the country level to be raised by governments and implementing partners and also developed a model of coordinated country support, including country coordination support teams that were implemented in priority countries The country support coordination team model developed by the HSRC aims to improve communications and coordination at the implementation level, and is an important model to support and scale-up.

Alignment between ACT-A partners' objectives and work plans to the needs in-country

Overall, the ACT-Accelerator's heavy focus on commodities resulted in the under-prioritization of health system needs in countries. This misalignment may have been a result of limited country-level input, feedback, and joint planning especially at the earlier stages of work. At least until early 2022, partners did not align with or fully understand in-country needs. It continues to be challenging to meaningfully incorporate civil society perspectives on country needs.

Key Recommendations

- **Health systems must be the foundation** for equitable access to HEPR countermeasures. A key lesson from the ACT-Accelerator is the need to invest in health systems, particularly key aspects required for response (e.g., health workforce, essential health services, community systems) that can deliver commodities when available.
- Any future mechanism for PPR must have an **inclusive and transparent governance structure**. This includes, as a priority, leadership and equal partnership of governments and civil society from low- and middle-income countries. Decision-making must include real engagement of civil society and communities, especially from the implementation level. The governance structure should safeguard itself from the undue influence of private sector agendas in favor of the principles of universal health coverage.
- There should be a **standing HSRC country coordination team** (based on ACT-A HSRC model) in all governments, country-owned and country-led, that are multi stakeholder and multi sector and involve diverse representation of international organizations and CSOs. These may be integrated with IHR focal points, but these focal points should be on standby and ready to support at all stages of HEPR, as well as prevention and recovery efforts.
- There should be **clear communication and coordination channels** for all stakeholders at the country level from the beginning stages of design to implementation. The HSRC country coordination task teams must be preserved and supported to be standing committees for preparedness, prevention, response, and recovery.
- Partners must also commit to **sustaining the progress made by the ACT-Accelerator**, regardless of the form or structure of future PPR mechanisms. Within the HSRC's scope, this includes continuing to scale-up and support the uptake of the data platforms as well as beginning (or re-starting) workstreams, such as the one focused on the health workforce.
- **Financial support** for civil society participation and community health systems strengthening is necessary for effective and equitable PPR.
- Need for a robust HSS gaps analysis and costing as well as comprehensive Health workforce costing

The ACT-Accelerator experience has provided another reminder that the status quo in global governance for health is unacceptable. We need a willingness to shift the power dynamics in the global health sphere to achieve equity both within and across countries.

While acknowledging the tremendous effort and coordination undertaken by the ACT-Accelerator, we note that the mandate for equitable access was largely missed by the global community, due to the interests of high-income countries and the private sector, and the limited opportunities for civil society and community input. At the same time, it has demonstrated the potential of global collaboration and solidarity to address health crises, and the possibilities for in-depth country-level multi stakeholder coordination that can be scaled up and replicated for a new global health architecture.