“Building Resilience: Implementing Primary Care and Immunization Programs in the Covid-19 Context”

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FEATURING
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Good afternoon, and welcome to today's events on the links between immunization programs, primary health care services, and global health security in the COVID-19 context. My name is Katherine Bliss and I'm a Senior Fellow with the CSIS Global Health Policy Center. On behalf of the CSIS Commission on Strengthening America’s Health Security, it’s my pleasure to welcome you to the second in a series of discussions in which we’ll explore, on the one hand, how strong health systems can promote access to immunization services, including COVID-19 vaccines, and, on the other hand, how strong immunization programs can improve access to primary health care services as well. Now, the first meeting in this series was held back at the end of May. It featured Asaf Bitton from Ariadne Labs, Nikolaj Gilbert from PATH, and Kerry Pelzman from the U.S. Agency for International Development. They described new research documenting the relationships between immunizations and primary health care and outlined new organizational visions for work on immunizations and health systems coming out of PATH and USAID. Today we’ll go a bit further in assessing that dynamic relationship and hear from three experts on what it means to implement immunization and primary health care programs in the context of a global pandemic and with an eye toward the distribution of COVID-19 vaccines. Now, certainly the value of strong immunization systems and the relevance of resilient primary health care services to global health security have been reinforced over the course of the last 18 months, a time when health care personnel have been diverted from their routine duties to outbreak response and people have avoided going to clinics because of concerns about being infected with coronavirus. People have neglected routine diagnostic tests, prescription refills, therapeutic procedures, and follow-up appointments, often missing critical opportunities for prevention, health promotion, and condition monitoring. In places where health systems are weak, scaling up new COVID-19 testing, and treatment activities have proven to be especially challenging. But in locales where primary health care services were strong even before the pandemic, it has become clear that community-level health care assets can be a significant factor in quickly identifying cases, mitigating disease transmission, and linking those infected with available treatment, while ensuring continuity of care for preventative services and diagnosing new conditions. Indeed, one lesson that has been reinforced is that primary health care providers are trusted providers of vaccines and that the delivery of COVID-19 vaccines to adults, including healthy adults who may be less accustomed to visiting health facilities, offers an opportunity to reach people with a broader suite of primary health care services. Today I’m pleased to welcome John Borrazzo, who is Senior Health Specialist for Maternal Neonatal and Child Health at the Global Financing Facility Secretariat in Washington, D.C.; Hannah Ratcliffe, Assistant Director of Research on the Primary Health Care team at Ariadne Labs in Boston, Massachusetts; and Lora Shimp, who directs the Immunization Center, International at JSI in Washington, D.C. Over the course of the next 40
minutes or so, we’ll discuss how routine immunization programs have been affected over course of the pandemic, the factors that have enabled some health systems to demonstrate greater resilience than others, what it takes to support country-level health programs in recovering from backsliding or gaps in services, while also addressing the immunization and care needs of a new birth cohort, and the challenges and opportunities presented by the need to maintain routine immunizations for children, while initiating new programs for adults. And before we get started, I want to thank Michael Rendelman from the CSIS Global Health Policy Center for his support in putting together this event, and the CSIS AV team for their efforts in facilitating the livestream. And let me remind those of you in the audience that we are hoping to have time for questions from you, and you can submit those comments or questions for the speakers directly via the CSIS link or the link on the event page on the CSIS website. Please do so, and we’ll incorporate those later in the discussion. So, Lora Shimp, I want to start with you. Let me – I want to start by asking you to describe, you know, from the perspective of the countries that you’re working with, the impacts of the COVID-19 pandemic on routine immunization services. Now, last spring, in the spring of 2020, several surveys suggested that there was likely to be a big dip in immunization coverage globally, which had already plateaued over the previous several years. But then the World Health Organization, GAVI, and others released guidance to help countries stay or get back on track, and by late 2020, there were signs that some countries, at least, had been able to recover some lost ground, even as there was now a whole new cohort of babies and more children to be vaccinated. So, thinking about the countries where JSI is working, what do you see as the outlet for routine immunizations globally at this point, and what are you most concerned about over the next six to 12 months?

Lola Shimp:
Thanks, Katherine, and pleasure to be here with this group of panelists. And thanks to CSIS. In the spirit of primary health care and immunization and what we refer to as basic immunization or routine immunization and that sense of really trying reach children between zero to 11 months of age, from birth to 11 months, and then in the second year of life, we have seen some of the operational funding that’s often at the subnational levels; that’s where we see the hardest hit because they’re having to deviate resources, particularly human resources such as health workers, and some of the structural issues around getting services out to communities have been interrupted. They can’t have the same outreach that they had before in areas that have been under quarantine or other types of interruptions due to the COVID-19 pandemic. But also, what we’ve seen is stronger health systems have been able to bounce back better. So where there are countries that have a more robust health system, such as Tanzania, Ghana, areas that have been able to withstand interruptions in the past due to other outbreaks or other vaccine preventable diseases that they’ve grappled with over time, they’ve been able to maintain their system for the younger children, so the routine
services, the outreach, the mobile, and other types of normal processes that they would go through in the year and do some special application of initiatives like missed opportunities for vaccination or ability to do PIRI, periodic intensification of routine immunization, to be able to catch up infants because they have them basically registered in the system already. There’s a pretty mature system of being able to track children and get them into services through community mobilization, through regular routine services to underserved areas where they have a cyclical way of doing that. But where we’ve seen the biggest challenges are, for example, in second-year-of-life initiatives, like measles second dose, where it’s not part of the regular sort of 6, 10, 14-month, 9-month schedule in many countries, or for HPV vaccination, for example, where we’ve seen most significant interruptions, arguably, in several countries because of the need to work with schools, with school closures due to COVID-19 vaccination, or with just the newness of HPV vaccination and the life-course program, not having a contingency plan for being able to reach those adolescent girls or preadolescent girls who are the targets for the HPV vaccination, and therefore really trying to catch up on those systems, which is, in fact, not too late. Because HPV vaccination can be given even beyond that cohort age, they still can catch up those services over the course of the next year or two, but they’re going to have to look at the operational planning and the funding that’s going to be needed to basically reinvigorate those services or to be able to adapt the system now to reach those populations. And although the immunization programs, the essential program for immunization, EPI, that is functional in most countries, and reaching-every-district approaches that have really helped to look at planning, community engagement, data tracking, and use of resources effectively for review and updating the planning and procedures in countries, the challenge that we’ve seen is that those exist primarily for that young target age, so it’s, you know, infants not adults. And therefore, the big challenge, including what we’re seeing now with Immunization Agenda 2030, is really trying to utilize this COVID-19 vaccine opportunity to really intensively look at those adult platforms that are going to be needed to reach populations and then that life-course approach that takes us through that continuum, including for preadolescence and adolescence, as I mentioned for HPV, but now also being able to identify and really use a holistic approach to primarily health care to reach adult populations who haven’t traditionally been part of the immunization programs.

Ms. Bliss: Thank you. I mean, so it sounds like for the youngest children, if there were kind of routine opportunities for them to have checkups, then keeping up those vaccines, you know, has not been as challenging as, you know, when the timing falls in the gaps between some of those usual appointments.

Ms. Shimp: Right.
Ms. Bliss: Hannah Ratcliffe, let me turn to you. You know, primary health care services, as Lora has pointed out, are really an entry point for families and children into the health system and a way that they can access the preventative services, you know, particularly at the youngest ages but over the life course, you know, like immunizations and other preventive as well as diagnostic approaches. So when you think about the factors, you know, drawing on the research that you all have done at Ariadne Labs and with the Primary Health Care Performance Initiative and others, you know, when you think about the factors that have enabled some communities to weather the pandemic better than others, you know, not just in terms of maintaining immunizations but, you know, really maintaining linkages to the communities and providing the services that people need on an ongoing basis, how important have primary health care services been in responding to the outbreak, and where have you seen, from your research, some of the greatest successes?

Hannah Ratcliffe: Yeah, thanks so much, Katherine, and thanks to you and CSIS for the invitation to join you all today; it's a great panel. To jump right into your question, you know, I think as a start, in terms of factors that have enabled success, I really believe we can't overstated the importance of good governance and good leadership at all levels, and I think that can be kind of a squishy topic that gets thrown around casually, but COVID, if anything, has illustrated what good governance and strong leadership really look like by putting in sharp relief what happens when those things are not good and not strong. And that's not specific to primary health care but I think this has really been a moment where strong PHC leadership has made a difference in many places. And relatedly, you know, I think epidemics tend to highlight the importance of trust in that leadership as well as trust in the health system and individual trust of providers. We saw, for example, in West Africa during the Ebola outbreak the dire consequences of a lack of trust and I think we're seeing that again during COVID. And I think it's that trust element that's really at the core of why primary health care is so central to an effective response. When done well, as you've just been saying, you know, primary health care should be the first point of contact for the health system. For the majority of people, the majority of the time, strong primary health care provides continuous care over the life course, which allows for the formation of these long-term trusting relationships between people and their providers. And strong primary health care should be rooted in population health management, which means that primary health care providers know the people they serve and work proactively as teams to meet those needs, rather than reactively waiting for people to arrive in a clinic. And that requires deep, nuanced knowledge of the community. And I think that's similar to what Lora was talking about with, you know, very young children and vaccination schedules, but ideally, strong primary health care should be able to do that across the life course for everyone. And we've seen places where, you know, primary health care strengths, like these – you know, trust, long-term relationships, knowledge of the community, team-
based care – have been really key to the success not only of direct COVID response but also maintaining access to routine and essential services. And as you were just saying, you know, this piece is so critical. We're seeing more and more evidence that mortality due to disruptions in those routine services is going to be orders of magnitude higher than the mortality that's directly attributable to COVID. And so, you know, to answer your question about examples: You know, I think recognizing the fluctuation and success stories we've seen over the last 15 to 18 months and the – you know, the risk or folly of pegging any country as a complete success – one that I particularly like to highlight is Ghana, as a place where the COVID response has both been pretty effective and robust and that that's been due, in large part, to the strength of their primary health care system and Ghana's ability to leverage that. And so, as many of you know, I think Ghana has seen lower case and death rates than many of its neighbors and certainly compared to sub-Saharan Africa overall. And their COVID response has been fairly decentralized to the regional and the district and even, in some cases, the sub-district level. And the success of that decentralization approach has really hinged on them being able to leverage their community-based health planning and services, or CHPS, system, which is the basis of their primary health care. CHPS is rooted in community-based primary health care provided by teams of providers through proactive outreach in communities. And we've really heard from our colleagues there that these structures, along with really robust primary health care information systems, have been essential for all facets of their COVID response, from early and sustained risk communication, testing and contact tracing, building confidence in the health system to promote continued access to those routine services – not just access but use of – and now in building trust in vaccines and getting doses delivered and shots in arms. We've also documented through the Primary Health Care Performance Initiative several other examples that I won't dive into in as much detail, but I think places like Bhutan where they've been able to build on their longstanding and really trusting relationships with the system as well as a vast network of community health workers to vaccinate over 90 percent of their population in two weeks or less, as well as Chile and Israel, which have used empanelment systems and their really robust primary health care-oriented information systems to rapidly scale up their vaccination efforts.

Ms. Bliss:

Thank you. I mean, so let me turn to John Borrazzo. You know, John, Hannah has just, you know, really focused on the success of efforts or, you know, research showing that services very much rooted at the local and community level have been critical in responding both to this outbreak and maintaining services. You know, the Global Financing Facility works alongside the World Bank at the global level, really, you know, supporting a wide variety of countries', you know, national activities regarding maternal and child-health services, with immunization being an important service but certainly not the only one. So, I wanted to ask you to say a few words about what the Global
Financing Facility is doing to help countries assess the impacts of the pandemic on maternal and child health programs, you know, from the national down to the local level, and what issues are of greatest concern to you and your colleagues as another birth cohort enters the picture?

John Borrazzo: Well, thanks, Katherine, for the question, and thanks also for organizing this interesting discussion and thanks for inviting me. And thanks to all of you out there who have taken the time to participate today. When we say, what is the GFF doing, I think I want to open with a couple of comments about what is the GFF, since that might not be clear to everyone participating. You know, before the COVID-19 pandemic, we had been really – there had been a lot of momentum with years of significant improvements in the health status for women, children, and adolescents, and this was, you know, driven over time by a concerted effort from governments, nongovernmental organizations, the World Bank, global health partners including U.N. agencies and bilateral donors, and most recently, over the – since it started in 2015, the Global Financing Facility for Women, Children and Adolescents. And we use the short term all the time, GFF. These gains included improved access to family planning, antenatal care, skilled attendants at birth, childhood immunizations, access to safe drinking water and sanitation, better child nutrition. As you said, there’s a whole range of things that go into essentially these improved outcomes, and immunization is an important piece of it but it’s not the only thing to focus on. Certainly, when we looked at the progress that was being made, it was uneven; there were countries – there were some regions that were doing better than others. There are some countries within regions that are doing better than others. I mean, we’ve seen what we’ve all seen. You know, the data that comes out of sub-Saharan Africa where sub-Saharan Africa as a region has done less well over time than South and Southeast Asia, but even within sub-Saharan Africa, there are countries that have done well and countries that have done less well. And then the other important thing to remember is the issue of equity and that, even within countries that are doing reasonably well, there are still populations and geographies where there are still challenges. And I think it’s important that we keep that in mind. But at least progress was, in general, consistent and it was moving in one direction, only getting better, even if slower than desired in many places. So, the GFF was established to try to really accelerate those changes and to really focus on those countries and those places within countries on those populations within countries that really required a step change in their access and utilization of essential, life-changing services for women, children, and adolescents. And these are critical for, you know, building the – in the long-term development strategy of building human capital and achieving health security. So, the GFF currently supports 36 countries with some of the highest burdens for maternal and child mortality and morbidity, as well as the largest financial gaps in ensuring sustainable financing to support those services. This GFF financing is linked to World Bank financing to create this combination for empowering countries to
invest in the key systems reforms, including sustainable financing, for the health services that are most critical for women, children, and adolescents. And we use the term and I use the term partnership for – GFF partnership quite deliberately because it’s not just about funding but it’s about the way the donors, the U.N. agencies, the banks, civil society, private sector all come together, each leveraging their comparative advantages to deliver this anticipated step change in an outcome. So coming back, then, to your concrete question: This GFF model has, you know, really tried to deliver on these results by significant leveraging of financing, and that’s across the board in terms of not just focused on a particular subset, although the outcomes are the things that get measured, but really focusing on this from an assistance perspective, which makes it very amenable to the kinds of discussion I think we’re having today and the support for primary health care writ large. In terms of the issue of specifically looking at what have the impacts been on this broader range of services, the GFF has been supporting countries in two ways about – on these potential impacts. So, first, we’ve been working with countries on secondary analysis of routine data that is already collected, oftentimes from the DHIS2 systems that have been rolled out, these platforms that have been expanded in many countries, and trying to tease those apart a little more and using modeling techniques to look at projected use of services versus the actual use and to see which services seem to have been most disrupted over the – on a year-to-year comparison or a seasonal comparison. And some of the insights that have been gained from that are important, but they do lag real time, typically by about two months. So, we are also working with countries to roll out closer-to-real-time data-gathering systems that rely on phone surveys directly to health facilities and to use that information to better understand what they are seeing on the ground, slightly closer to real time. And there’s some insights that have come from that. One is that in the early days, immunization was one of the services that seemed to be disrupted most quickly, but that largely seemed to be a function of access. Remember that many countries early on – and this is happening less now, for better or for worse, with lockdowns that really restricted access to facilities; those lockdowns affected not only the ability of those who give care to seek services but also those who are on the human resources and the human resources for health to be able to get to the place where they would render services. The second insight is that those services seem – like immunization, that were really impacted, also seem to recover most quickly. The third insight was that there were both supply- and demand-side impacts. I mentioned that example, one of those examples already, but the supply-side impacts on the human resources were also most pronounced in the places where there was the most transmission of the coronavirus, which is what you might expect. I mean, the reality is that the health workforce was also impacted. And so, the ability of the health workforce to actually deliver services was also a function of where in a country the community transmission was most substantial. And then, finally, the – some things were affected less. For example, antenatal care
seemed to take a pretty big impact, but things that seemed to be viewed as most critical for those who are trying to – in places where skilled birth attendants, for example, is well established, facility delivery still seemed to be maintained. But the ability to actually seek antenatal care, which is a critical service to ensure the safety of even skilled delivery – sorry, facility delivery, was actually restricted. And then the other piece of it, on the supply side, is that it wasn’t always clear that the facility delivery, when it was – was actually still with the same standard and the same quality of care as would normally be expected given all of the human resource constraints. So, it’s hard to make a general – make general statements about what’s been going on, but we do know that the situation is dynamic, which is why the critical – it’s very critical to continue to have these monitoring systems in place and to have analysis underway so that countries themselves can figure out what their responses need to be and how to adapt to new situations as they arise. Over. Thank you.

Ms. Bliss: John, thank you for really, you know, laying out the analytical work that you all are doing and some of the information that is developing, you know, as more data is gathered. Hannah, I want to turn back to you for a second. John really emphasized the importance of the, you know, the impact of the pandemic on health workers and, you know, resources for health, the availability of people to deliver their services, and even just, you know, access. You know, in your remarks you mentioned the importance of the primary health care services as really a way of developing trust within communities; you know, providers are rooted right there at the community, they know people, they’re working with them that they’re serving. And so, you know, I want to – I guess I want to ask – you know, at this point, the majority of COVID-19 vaccine doses have been distributed through high-income countries with COVAX, you know, the vaccine pillar, the Access to COVID Tools Accelerator. Distributions, you know, are currently limited, at least in part, due to export controls and supply issues. So as countries are preparing for the distribution of COVID-19 vaccines, what role do primary health care providers play in supporting, you know, demand for vaccines in promoting confidence in vaccines? You know, how important are they, you know, in terms of their own confidence in vaccines? You know, we had an event last week where, you know, we heard I think in Nigeria, you know, there were – there have been challenges; you know, even when vaccines are offered to health care providers, you know, they’ve been reluctant, in some cases, to address that. We’ve certainly seen that in the United States here as well. You know, and how do you see – if you could say a little bit more about how you see immunization programs really offering an opportunity, especially, I guess, for adults, to link people to primary care and to other kinds of services they might need?

Ms. Ratcliffe: Yeah, thanks, Katherine. You know, I think primary health care certainly has a really vital role to play in preparing for and then delivering COVID
vaccines. As you just touched on in getting back to my earlier points, you know, as a first point of contact with health systems and the source of these trusting relationships, primary health care providers are just hugely important messengers for building vaccine demand, and, you know, that’s because they have the ability or the access to understand the reasons behind local vaccine hesitancy, to know their population and how to effectively communicate with that population to overcome the particular vaccine hesitancy reasons that are relevant there. And, you know, through our research with PHCPI we’ve seen this work in action in countries all over the world, from Rwanda to Thailand to Afghanistan, the ability to really use those locally rooted community health workers or primary health care workforce to build that demand, whether it’s for COVID or, you know, for other vaccines as well. I think when it comes time for, you know, vaccine delivery and in planning for that, as well, primary health care workers are, I think, in many cases well equipped to themselves safely and efficiently distribute vaccines through their existing supply chains, through their proactive population outreach mechanisms, you know, community outreach care provision. And in terms of the planning, you know, primary health care, as you were just talking about, John – ideally, primary health care is really the source of this rich information about their own population’s health needs and community needs and preferences, which are critical to making sure that the right number of doses get to the right places and that distribution is planned and conducted in ways that really meet people where they are. And I think, you know, whether those means of distribution end up being through community outreach or at primary care facilities or VMS vaccination sites – all of which we’ve seen, you know, more of in the high-income world, which has had better access to vaccines – the primary health care workforce, as that trusted messenger, I think can really play a role, regardless of where the vaccines are actually, you know – where the shots are actually being given. To the second part of your question, and I think this is perhaps, you know, the most important thing, is the distribution of COVID vaccines I think is a really incredible opportunity to strengthen primary health care. And at a time when we’re seeing just, you know, billions and billions of dollars going out the door and into the health sector and really sustained focus on the health sector, I think that we as a global community have an obligation to find ways to use those funds that not only immediately address the COVID pandemic but contribute to long-term sustainable improvements in primary health care. And as we’ve been talking about, there’s really huge urgency around this. We know that, at baseline, primary health care is the foundation of a strong and resilient health system but is all too often underfunded and under-resourced and unable to meet its potential. And as we’ve been talking about today, we also know that COVID has caused huge disruptions to routine- and essential-service delivery and has been really massively detrimental towards progress on the STGs kind of across the board. And so, in the coming months and years, primary health care systems around the world are going to be trying to get back to business as usual and
serve as that real foundation of the health system. They're going to be key to ongoing vaccination efforts. They'll be essential to preventing the next pandemic. And they're also going to be facing the huge extra pressure that's coming from delayed or missed care that's inevitably increased disease burden in the communities that they serve. And so, all of those factors together really make strengthening primary health care systems now absolutely essential. So how do we do that? (Laughs.) I think there's a few ways and a few opportunities that COVID's offering. The first is to really capitalize on the opportunity that vaccination efforts provide to interact with people who might not otherwise come in contact with the health care system, and that's what Lora was speaking about, you know, people who are not infants, who are not children under five, who are not women of reproductive age, who are now coming into contact with the health care system for these vaccination efforts, and to use that vaccination window, whether that's while people are waiting in line after they've been given a shot and are being monitored for their adverse reactions, to build trust in the system, to empanel individuals to a primary care provider who can ensure their continuous and coordinated care, and scheduling, you know, just an annual checkup or a follow-up visit for a health condition. And that might sound complicated, but I think, at its heart, it's about having real, human interactions with members of their community who are part of the health system, getting signed up with the usual point of care who's going to be responsible for your care in the years to come, and scheduling that next visit so that there's a plan and that vaccination visit isn't just a one-off. The second opportunity I think that we've been touching on today is the opportunity to strengthen surveillance and information systems that support primary health care. And, you know, there's major efforts, as John was just talking about, and, you know, in many other arenas, to develop or build on information systems to track vaccine rollout, and I think we have the opportunity now to ensure that those systems and those improvements are integrated into and interoperable with routine health information systems and routine primary care systems so that those routine systems themselves are strengthened and not, you know, be putting effort into new and parallel systems. I think an example of this is the creation in many places of unique IDs to track vaccination status and the massive returns that that could have for strengthening longitudinal health records, for strengthening primary health care's ability to know the population they serve and track their needs over time, and really wanting to make sure that efforts that go into the development of something like an individual ID are strengthening the underlying system and interoperable with that underlying system. We've also seen, I think, you know, a lot of tremendous innovation around telehealth and those services have, really, the opportunity to be game changers in promoting access but, if done poorly, I think also run the risk of becoming, you know, either another vertical one-off program or exacerbating inequities in access, if they're not being designed with local needs and realities in mind. And I think the final opportunity that we've just
been talking a little bit around, as well, is sustaining investments in the health workforce, and that might look like permanently hiring and employing new members of the workforce who’ve been on to support contact tracing and vaccination, using contact with the health workforce as they themselves get vaccinated to develop health workforce management information systems that can be really instrumental to better planning for and allocating workforce in the future, and then, finally, elevating as a global priority the issue of workforce well-being and burnout that I think COVID has so tragically shed a light on. And so, none of these things, I think, are rocket science but they do take intention and they take resources and I think this is really our golden moment of opportunity to make those investments now for the longer-term strengthening.

Ms. Bliss: So, John, let me come back to you for a second. Hannah has really laid out, you know, a set of opportunities, really, to improve information gathering, to develop follow-on programs, to undertake additional training for the health workforce, you know, all to really better link immunizations and people’s access with preventive and follow-on care. Of course, all of this costs money to do and to do well. Last October, the World Bank approved a multibillion-dollar fund to make loans to countries to support COVID-19 vaccine purchase and distribution – I guess in particular but part of that. As of June 18th, I think some $3.6 billion of that had been allocated to 36 – more than 30 countries, anyway – to support vaccine rollout. Many are also counting on distributions from COVAX and, more recently, the G-7 countries have promised to donate hundreds of millions of vaccine doses to lower- and lower-middle-income countries as well. So, you know, I just wanted to ask you to talk a little bit about, you know, the role that the global financing facility is playing in supporting countries as they plan, you know, as they gather that information, think about, plan, and purchase vaccines and prepare for vaccine delivery, and what you see as the opportunities for better linking COVID-19 vaccine delivery and, in particular, access to maternal and child health services.

Mr. Borrazzo: Yeah, thanks, Katherine. You know, I think Hannah started out really well with this topic because I think that it’s clear from what you were saying, Hannah, that the – this is not – COVID-19 does not have to be a one-off effort, that the systems issues that surround COVID-19 have a common platform with essentially the systems that underlay primary health care. While sometimes the population targets may be different, the touchpoints in the system will be the same, and we have to fully exploit that. So, investing in those systems is an investment in the health of women, children, and adolescents, and if we do this right, we’re going to get a more equitable recovery. We know that these systems, that these wraparound systems issues – there’s many dimensions to this. For example, we ensure that – ensuring that caregivers can feel that they can safely seek out these routine PHC services, such as immunization, that provides a touchpoint with the
health system to both – immediately build demand for COVID-19 vaccination but also to deliver it when the vaccines become more widespread and available. Communications can be integrated. Communications to promote COVID-19 immunization can be integrated with the communications to promote essential services access and maintenance, and vice versa. And I think these are the kinds of partnerships and integration we’ve got to continue to look for. The GFF itself is an implementing partner out of the COVID ACT-A Accelerator and it’s focused on delivering on the health systems connector. And this is designed to roll out some of the COVID-19 systems tools with the co-financing from the World Bank and working in close collaboration with the COVAX and other partners. But these systems are going to be critical for maintaining essential MCH services. For example, the GFF supports countries to strengthen supply chains that secure the access to essential medicines for maternal and child health, as well as some of the COVID-19 tools, and this increase in the – increasing the capacity of the community health workforce, scaling up digital health interventions that are really – have gotten a big shot in the arm, no pun intended, from – as a consequence of the attention being given to, what can we do differently? What are the some of the innovations that we haven’t fully exploited? You know, clearly, the economic impact is another place where interaction with social protection programs can also play a role. That’s a bigger systems issue. It’s another system. I mean, one of the impacts of the pandemic has been that the poorest people, the most vulnerable people don’t have access to income. The GFF supports projects that also help countries to build their capabilities, infrastructure, and financing to be able to respond to and be prepared for future pandemics. And that’s also part of this big topic that we’re – that this forum is part of, which is global health security. Finally, there are some – there are – you know, this is being translated as rapidly as we can into immediate-country demand. So, in Mozambique and Rwanda, through COVID-19 essential services grants, we’ve been supporting the distribution of essential health drugs and some of the COVID-19 tools to rural areas, as well as training community health workers in rolling out the COVID-19 vaccine campaign, while at the same time promoting demand for and access to essential health services. Other examples include conducting outreach activities and catch-up campaigns, providing nutrition commodities, reducing the bottlenecks faced by patients and by health care providers by organizing transport systems to ensure safe and timely access to services, including immunization, and integration of essential-services demand, promotion, and vaccination campaigns. So, we’re trying to roll this all into a big push for – and increase donations and financing to help maintain essential health services and to strengthen health systems to respond to future pandemics. So, the GFF has launched this year a resource mobilization campaign that’s being governments of Senegal and Canada, as well as the World Bank, trying to raise $1.2 billion for these purposes by the end of 2021. So, thanks for the question and I’ll stop there.
Ms. Bliss: So, Lora, let me turn to you now. You know, both Hannah and John have really emphasized, you know, the importance of data, information, training, you know, the potential of digital health and telehealth and some of the innovations that we’ve really seen implemented in different ways globally, you know, throughout this pandemic. You know, I want to come back to something that you emphasized, something that has gone throughout the conversation, you know, which is really that most of the routine immunization programs are focused on children. You know, you did talk about some of the lessons from the Ebola vaccination campaigns and others that have been focused on adults, but, you know, at least for now, COVID-19 vaccines are for adults, with many countries really prioritizing delivery to health workers and the elderly, you know, before they reach general populations. So, you know, I wanted to ask you to just say a little bit more about what you’re seeing as countries are, you know, really trying to not shift completely away from children to adults but, you know, expand to include immunization services for adults and, you know, if there are ways to use – better use existing services for adults, such as HIV services or services for noncommunicable diseases, you know, diabetes, cardiovascular disease and others. What will it take to, you know, really ensure coordination among those sectors?

Ms. Shimp: Yeah, thanks. And I think Hannah and John both nicely contextualized some of the important areas around better use of data, particularly at local levels, at input levels. You know, we’ve done work around improving the use of vaccination cards, for example, and look at all the pictures you’re seeing now with people with their COVID-19 vaccination cards. Well, we’ve struggled to have child vaccination cards and unique identifiers for individual children for a long time. Now we’re with adult populations where immunization programs aren’t accustomed to finding these individuals, so they need to partner with HIV and other comorbidity groups that are working with adult populations, with noncommunicable diseases, infectious disease, and others who are accustomed to reaching out to elderly populations or to a different group of people than what we see, as Hannah mentioned, with mothers or women of child-bearing age or caregivers of young children. I would say that – we need a paradigm shift in two ways: one, there has to be alignment on partnerships for preventive health and prioritization of preventative health. Much is done around curative services or health insurance-type mechanisms but not a lot on the basic services that are supposed to be integrated at the facility and outreach levels. For example, in India, you have village health and nutrition days that have been there for decades, of which immunization is part of nutrition services and other types of services where they’ve built a cadre of Anganwadi workers and ASHAs and ANMs who reach those populations, and we’ve seen this in the work that we’ve done in states like Uttar Pradesh and Jharkhand, where they’ve really developed that system over time. The second paradigm shift is that we have to actually fund civil society and community groups to help us from both the input level, human-
centered design, getting their inputs first, you know, while we’re designing, not as an afterthought. Engaging the health facility governing councils in Tanzania, for example, was critical to having more transparency around how the expenditures of local resources were being allocated for immunization, along with other preventive health services. If you don’t engage those communities as part of your planning and monitoring processes, then you’re always going to have difficulty, particularly when you get to these challenges around confidence and trust and reaching out to populations who aren’t your usual, you know, part of your usual services. And that’s where India and other countries I think have done a good job of really trying to look at the partnerships that are needed, you know, everything from the national-level NTAGI, the advisory group of experts that helps, you know, look at immunization policy, but then also to the FAQs and the hotlines and other ways that they’re trying to reach out to populations. It’s very unfortunate: India was really moving forward in their vaccination and then, with the new strains of the virus and, of course, just the size of the population, when you have to get to different states and decentralize systems. If you don’t have these partnership and coordination mechanisms at every level of the system, both global in terms of how funds are being allocated, national in terms of how federal resources are utilized and distributed in an equitable way, but then also, really, that local and community resourcing that’s there in kind or in financial ways where you can really link that with a broader sector of partners that can help you reach adult populations, when we know that individually our programs can’t do that. And I think that’s, to John’s point with Global Fund, with the collaboration that we’re seeing with GAVI and Global Fund, the commitments across donors that have come with COVAX, but also in the spirit of immunization of IA 2030 and really trying to look at life course and coverage and equity, really trying to bring more partners around the table in ways that some funders, like USAID, Gates Foundation, they have been better about sort of looking horizontally at health systems, less vertically. And I think that’s something that we really have to aspire to do with the adult platform now is really look at, what are the different preventive services we can bring together and how do we resource those most effectively with trying to find different populations, starting with health workers and how we build their confidence and make them better communicators, along with, then, the populations and the many that we’ve vaccinated already who can be good advocates and spokespeople for our programs but who maybe we haven’t tapped as resources as proactively as we could?

Ms. Bliss: Well, thank you. We’re almost out of time. We’ve received a number of interesting questions. I want to just give each of you a moment just, you know, really to offer your final reflections, really, on what you expect to see over the next 12 to 18 months. You know, will we see, you know, even more emphasis on this relationship between immunizations and primary health care? We’ve had, you know, a question about a fund for, you know, a global
fund for pandemic preparedness, if you can, you know, take that on. Do you see that, you know, supporting health system resilience? And also, you know, what’s the extent to which testing, and diagnostics can really also form an element of the tools of primary health care for pandemic preparedness and mitigation as well? So, Hannah, let me start with you, just your final quick reflections on these issues and what you expect to see.

Ms. Ratcliffe: Sure. Thanks, Katherine. I think I might defer on predicting what I think the next 12 months will bring – (laughs) – just because I think the last year has showed us that that’s not necessarily a fruitful effort, or at least I’m not very good at predicting. But I think, you know, my summation of this and, really, you know, I think Lora’s final comments are a great way to end this in terms of a call for these paradigm shifts. And I really – maybe just to build on that briefly, you know, I think we as a global community at Astana two-and-a-half years ago and, again, you know, we continue to acknowledge that primary health care is our way of knowing the people we serve, of building trust, and of ensuring equitable provision of care, and I think epidemics, whether that’s COVID or Ebola or, you know, any other – you pick your favorite – continually show that we’re just not doing this well, and I think now is really our moment. And I hope in the next 12 months we use this moment to really put our dollars behind this commitment to PHC and put those dollars to cross-cutting, system wraparounds, things that John was talking about, and really achieve meaningful change and sustainable change over time.

Ms. Bliss: John, final thoughts and reflections on where some of this work may be headed.

Mr. Borrazzo: Yeah, thank you. I would probably also want to amplify and agree with Hannah that the most predictable thing we know about the COVID-19 pandemic is that it’s unpredictable. But even with that, I think one thing we can predict – I would predict – is that we face a risk of increasing inequity, and we have to be very cognizant of that and be working to ensure that that’s not the direction we go. The second point is, I think that we will see increasing emphasis on systems resilience and that we’ll be looking for the ways in which the kinds of money that’s being mobilized will be mobilized to support systems investments as opposed to vertical investments, at least I hope that’s the direction that we go. And then the third point, aligned to that, is that we have to measure outcomes. I mean, it’s not – we – I think we invest in systems, but we measure outcomes that relate directly to things that we care about, and then we strive to use the data systems that we’ve been developing and are evolving to better understand how those outcomes relate to those systems issues in which we’re investing. And I think that’s – hopefully that’s the way we’ll be increasingly using our funding over the next year. Thanks.
Ms. Bliss: Thank you. Lora, any final reflections on these linkages and what you see over the next period, particularly around routine immunizations and opportunities for COVID-19 vaccines?

Ms. Shimp: Yeah, thanks. And I agree with John around the measurement and outcomes. And I would also argue that we should also be paying a lot of attention and resourcing to the processes, because a lot of times we jump to impact or we jump to results when we haven’t really done due diligence to the steps it takes to really grow the system and be able to have a functional health system in these contexts, particularly for resiliency and really also building the capacity and competencies and trust and support for our health workers. We know from survey after survey that they are a reliable source of information. They have been so stressed and overworked during this pandemic; they’ve seen their own colleagues either, you know, be – succumb to COVID-19 or be taken into other areas of work. And I think we really need to emphasize their skills and competencies in preventive health, have them have confidence to be able to be good intermediaries, while also being able to make sure they have the updated skills and technology and access to resources that we have. My last trip before the pandemic, a year ago March, was Kinshasa, and there’s an assumption in DR Congo that everybody has a smartphone. Well, I was in two facilities where the majority of health workers did not have smartphones. They had the old Nokia phones. So, you know, if we’re going to incorporate technology, then we have to have fit-for-purpose technology that really does help also empower the people who are at our front line. So, I think for us it’s a matter of – there’s a lot of opportunity with the COVID-19 vaccination and, of course, the routine systems continue to be built on, but we really do need to leverage these new opportunities for partnership and coordination, such as under IA 2030 and some of the collaborative efforts. And I think a pandemic preparedness group would be good for contingency planning because we know that this is going to be with us for a while, so we need to resource it appropriately. Thanks, Katherine.

Ms. Bliss: John Borrazzo, Hannah Ratcliffe, Lora Shimp, thank you for taking the time to share your perspective and expertise on the links between immunizations, primary health care, and health security, and what we can expect when we do a better job of linking the two together, both in terms of routine services for adults and children but also in the context of the delivery of COVID-19 vaccines. And thank you also to those of you in the audience for joining today. If you are interested in additional content on these and other issues related to COVID-19, please check out our newest podcast, “Pandemic Planet,” which can be accessed through the CSIS website or other podcast platforms. Thank you all very much.