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LEARNING NOTE:

# Public Health Emergency Management (PHEM) Workstream

**Prepared for the BRE-TA Learning Event held on 8 December 2023**

## 01 Introduction

The Building Resilience in Ethiopia – Technical Assistance Programme (BRE-TA) worked with the Ethiopian Public Health Institute (EPHI) and the Ministry of Health (MoH) from October 2019 to the end of December 2023. The focus of the Public Health Emergency Management (PHEM) workstream was **to support EPHI to build the resilience of the health system in preparing for and responding to shocks.**[1] In so doing, it contributed towards the BRE-TA programme's overall objective, that the Government of Ethiopia will **'lead and deliver an effective, more self-financed and accountable response to climate and humanitarian shocks'.**

1. Oxford Policy Management (2019) 'BRE-TA Inception Report'.

## The six main areas of technical assistance (TA) provided by the PHEM workstream form the structure of this learning note:

Regionalisation of the national PHEM strategic plan.

Emergency nutrition.

PHEM leadership.

Risk communication and community engagement.

Risk-informed emergency preparedness and response planning.

Generating evidence for action: COVID-19.

**Together, these areas of TA contributed to the three building blocks of the workstream's theory of change: PHEM system design, region- and woreda-level PHEM structures and processes, and financing PHEM.**

# 02 Workstream approach

An important early step for the PHEM workstream was a systematic mapping and prioritisation exercise to ensure the alignment of BRE-TA support with government priorities and minimise the risk of duplicating activities. This involved desk reviews, key informant interviews, focus group discussions, and consultative meetings with a wide range of stakeholders. From a list of priorities agreed by stakeholders, the workstream drew up a shortlist for consideration by the MoH, EPHI, and BRE-TA's donors. Each step of this inclusive and consultative process was critical to the progress that was subsequently made.

### PHEM workstream: Summary of overall lessons learnt

**Local ownership:** from its inception, BRE-TA worked hard to ensure the government was in the lead. Activities were identified and requested by government counterparts and overseen by a Technical Working Group, led by EPHI's Deputy Director General.

**Adding value:** the participation of experts from government and non-government stakeholders helped ensure activities were appropriately harmonised and coordinated, and that BRE-TA's 'value addition' was clear.

**Results-oriented:** the workstream's theory of change clearly described the pathways to change, with the indicators for tracking progress (outputs and outcomes) providing a roadmap towards the desired results.

**Accountability:** close engagement of government counterparts at all stages encouraged a sense of shared accountability between the government and BRE-TA.

# 03 Summary of lessons learnt by major activity

## 3.1 Regionalisation of the national PHEM strategic plan

1. **Ownership, consultation, and contextualisation.** Following BRE-TA support to prepare the national PHEM strategy and presentation of it by government to the national PHEM forum, several Regional Health Bureaus and Regional Public Health Institutes (PHIs) requested support from EPHI and BRE-TA to help them adapt the national PHEM strategy to their regions. The support subsequently provided included professional and technical expertise and oversight from EPHI to help prepare the regional PHEM strategies and then publicly validate these strategies and plans with stakeholders.

   Workshops to prepare and validate the regional strategies and implementation plans explicitly involved stakeholders from the health and non-health sectors of government and development partners to ensure a whole-of-society and whole-of-government approach (a guiding principle of health emergency-focused disaster risk management (DRM)). Feedback from these workshops led to revisions to the regional PHEM strategies and accompanying operational plans. This was an iterative process, led by the principal regional actors, and drew on technical expertise from BRE-TA, EPHI, and wider stakeholders.

   There were two important by-products of this approach:
   - It forged **collective ownership of the regional PHEM strategic plans,** making it easier to mobilise resources for their implementation (Sidama was particularly successful).
   - **As a result of the approach, custodianship of the regional PHEM plans now belongs wholly to the regional administrations** and Regional Health Bureaus, and not to any national-level institution.

2. **The importance of Regional PHIs as early adopters and reform champions.** Regional PHIs' mandate is to improve regional capacity to detect, prevent, and respond to public health emergencies. Significantly, they brought this institutional capacity to bear in leading the process of adapting the national strategy to regions. With their technical appreciation of the need to contextualise PHEM systems, the Regional PHIs emerged as natural and ready partners, and were useful entry points for rolling out reforms. The intensive and inclusive engagement

process they led covered the ground comprehensively, from reference to, and alignment with, the national PHEM strategy to considering other relevant national and regional frameworks, such as the International Health Regulations 2005, the Health Sector Transformation Plan (HSTP II), and the National Health Security Plan.

3. **Leveraging existing coordination platforms.** Two coordination platforms, the national PHEM forum and the PHEM workstream Technical Working Group (which met quarterly), provided opportunities to review progress and consider and celebrate innovative approaches to adapting and implementing the PHEM strategy. Lessons from regional adaptations were shared with other regions at the national PHEM forum. The final versions of the regional PHEM strategic plans were approved by the national PHEM forum and disseminated by either the Regional Health Bureaus or the Regional PHIs. The national PHEM forum will remain critically important after BRE-TA's end in March 2024. Its membership includes Regional Health Bureaus, Regional PHIs, EPHI, and MoH, and the regionalisation of the PHEM strategy remains a regular agenda item.

4. **An appetite for improving PHEM systems.** Perhaps one of the key findings of this initiative was the appetite in government for improving DRM-linked health systems, and the openness to establishing a national and decentralised approach to PHEM. This willingness was apparent among the political and technical stakeholders who played an active part throughout the reform process, at a very challenging time for the country's health systems (due to disease outbreaks, including the COVID-19 pandemic, and drought and internal conflicts that led to major internal displacement across the country).

**Notwithstanding the progress, there are three important issues on which further work is needed:**

**Resource limitations:**
there are significant technical but also and more critically budgetary gaps at national and regional levels that make implementation of regional strategies and plans challenging.

**Regional differences:**
the capacity across regions varies widely. While some regions have strong Regional Health Bureaus and Regional PHIs, in other regions these bodies are still being planned or are at a developmental stage. Core institutional capacity will need to be strengthened before work can take place on refining strategic frameworks.

**Decentralisation does not end at the regional level:**
a comprehensive national health system requires effective capacity throughout the nodal points of delivery at every level, from the national to the regional levels, and further down to zones and woredas. In that respect, much work remains to be done to adapt and implement PHEM strategic plans to lower administrative levels.

## 3.2 Strengthening PHEM leadership

Leadership is key to an effective health system. However, health crises pose huge challenges as they require even more robust and dynamic leadership to ensure an emergency is effectively managed and responded to. Cognisant of this, the MoH and EPHI identified PHEM leadership as their top priority, out of nine DRM pillars. This is consistent with research that shows that leadership is an important pillar in a resilient system of emergency response.[2]

**The PHEM workstream accomplished several tasks in this area and learnt that the following are important:**

1. **Leadership buy-in and ownership.** Sound TA is essential but not sufficient for a successful outcome. A counterpart that is not consulted at the appraisal and needs assessment stage will not have a sense of ownership and buy-in to the changes. The PHEM workstream's process of preparing the PHEM leadership training programme engaged key stakeholders at every step that was relevant to their likely roles in capacity building and helping produce quality materials.
2. **Strong working relationships and rapport.** This was evident from the early stages of inception and design, where ideas were generated and acted on jointly by BRE-TA and partners in government.
3. **Creativity, innovation, detailed scanning of the changing context, and learning from emerging challenges.** PHEM leadership received a lot of attention because of the multiple emergencies which required systematic and growing PHEM competencies. Often, implementing one activity opened up opportunities and demand for the next PHEM system strengthening activity.
4. **Communication, persuasion, teamwork, and collaboration.** Activities were carried out in a logical order, which was helped by continuous communication. There were regular Technical Working Group meetings to check-in on progress, complemented by follow-ups with the Deputy Director General and other Directors, as well as validation workshops with other stakeholders to enrich and publicly endorse policies, strategies etc.

2. BRE-TA contributed extensively to a report titled 'How can we strengthen partnership and coordination for health system emergency preparedness and response? Findings from a synthesis of experience across countries facing shocks': https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08859-6

5. **Sharing experience.** The process of planning how to develop PHEM leadership training materials required the involvement of partners with substantial experience of leadership in public health emergencies (in this instance, the Asian Disaster Preparedness Centre).

## 3.3 Risk-informed emergency preparedness and response planning

Effective risk management significantly reduces the impacts of disasters. Emergency risk management for health draws on the disciplines of risk management, disaster management, and health systems. It emphasises the identification and active management of risks, prior to an emergency occurring, in order to prevent and reduce the potential consequences for health. It also acknowledges how disasters and public health emergencies have unequal effects. Gender relations and inequities and other social dimensions and power divisions create different needs and vulnerabilities, such that people are affected to different degrees and in different ways by shocks such as drought, disease outbreaks, and conflict.[3]

BRE-TA's inception and prioritisation phase identified risk-informed emergency preparedness and response planning as one of the top areas BRE-TA could support. The process used came to be called **Vulnerability Risk Assessment and Mapping and Emergency Preparedness and Response Planning (VRAM-EPRP).** It marked a change from past practice, where, while EPRP was not new to Ethiopia (it was one of the few countries to have conducted VRAM at the national and sub-national level before 2021), the planning dimension (EPRP) had not previously relied on an initial assessment of vulnerability and risk.

**Lessons learnt:**

1. **Adaptability to context.** VRAM-EPRPs were conducted in most of the highly vulnerable woredas that were initially selected, even amidst the COVID-19 response and conflict. This was possible because of flexibility and adaptability in approach and tremendous support from government as it was a top priority. Delivery was decentralised to the sub-national level, with focal persons and facilitators taking a central role in scheduling and conducting the exercises. The development of the EPRP in 29 war-affected woredas happened within a week through a hybrid approach, with national and sub-national facilitators conducting simultaneous exercises at different sites at the same time. Other regions will be able to cover woredas in a shorter time if the resources and commitment are there to do so.

2. **Local capacity building.** The process provided an opportunity to build capacity at the sub-national level. The participants and facilitators who were trained will be rostered in EPHI's pool of facilitators and are potential resource people who can lead similar exercises in other woredas.

3. **Leadership buy-in.** The commitment and dedication of EPHI and the MoH throughout the process was indispensable

3. See the report 'Unveiling new perspectives in public health emergency management: integrating gender equality and social inclusion in vulnerability risk mapping and emergency planning': www.rebuildconsortium.com/public-health-emergency-management/

to its success – particularly since it coincided with the COVID-19 pandemic. BRE-TA's support to the VRAM-EPRP process was incorporated in national/sub-national annual plans and monitored as a key performance indicator in review meetings and national PHEM forums. This happened because of the active engagement of the leadership at each step of the process.

4. **Regional ownership.** Implementation was only possible because of capacity building in the regions and support from the centre. Some regions, such as Addis Ababa, Amhara[4], and Oromia, conducted risk-informed planning with very limited technical and financial support from the centre. A matched funding approach offered by EPHI means they will financially support the costs of preparing risk assessments and planning processes in two woredas for every one woreda supported by a region. This initiative significantly helps to enhance ownership and sustainability; and to support this transition, the central team from EPHI will train and mentor more regional facilitators in all regions.

5. **Co-creating VRAM-EPRP Guidelines to ensure consistent scale-up of the approach and consistency in the training.** The guidance helps ensure that the training is applied in a uniform and standardised manner across all regions of the country, thereby contributing to the sustainability of risk-informed planning.[5]

6. **Using monitoring platforms.** The quarterly national PHEM forum, hosted by regions on a rotating basis, brings together the MoH, EPHI, Regional Health Bureaus, and Regional PHIs to monitor performance, identify challenges, and agree on actions that are relevant to public health and nutrition emergencies. The PHEM forum also nurtures and cultivates flagship initiatives, including VRAM-EPRP, sub-regional Public Health Emergency Operation Centres, and PHEM at health facilities. VRAM-EPRP has been a standing agenda item at the forum since 2021. To ensure sustainability through the co-financing of VRAM-EPRP-related costs, in December 2022 the PHEM forum agreed that the regions would take a more proactive role in subsequent roll-outs and would be supported in this through the matched funding approach.

7. **Sustainability.** Several factors are likely to contribute to the sustainability of the VRAM-EPRP initiative, including its integration in the PHEM framework and annual operational plans, the guidelines for scaling up VRAM-EPRP, the trained facilitators, and the experience of those involved.

## 3.4 Emergency nutrition

Inadequate access to food is a key driver of food insecurity and frequent humanitarian emergencies. In Ethiopia, the high prevalence of malnutrition among children under five, an indicator of the wider nutritional status of a community, has made emergency nutrition

4. The region initiated the cascading of EPRP but BRE-TA provided both technical and logistics support.
5. Other donors are now required by EPHI to use this approach and the VRAM-EPRP Guideline. See https://oia.osu.edu/news/workshop-prepares-ethiopian-communities-to-respond-to-public-health-emergencies/, where it is noted that 'The Woreda (District) level risk informed planning practice is one of the milestones achieved by the Public Health Emergency (PHEM) system in Ethiopia. Launched in March 2021, it has proven to be a game changer and is considered one of the government's innovative flagship programs'.

management a priority for the government, and thus the PHEM workstream. The national PHEM Strategic Plan identifies nutritional emergencies as one of its three pillars, and its implementation plan includes several activities to build a resilient nutrition management system.

The first step for the PHEM workstream was to understand the emergency nutrition landscape more deeply and then to prioritise specific areas where BRE-TA could add value to the activities of the government and its partners. Through an inclusive process this ultimately led to development of a new curriculum on emergency nutrition that was accredited by the University of Gondar. This led to it being integrated into 15 departments of nutrition in public universities, with 74 trainers certified to roll it out and 23 emergency nutrition response teams trained on the new modules so far.

**Lessons learnt:**

1. **An inclusive process of preparing a scoping study** helped engage a wide range of nutrition partners, and ultimately the development of an integrated and shared workplan.

2. **Mentorship of facilitators** and trainers is critical to ensuring quality training. Faculty from the departments of nutrition of 15 public universities were trained and then engaged to train regional facilitators, who were also then mentored. These 15 universities all went on to adopt the emergency nutrition training modules. This ensures the requirement of competency-based training system which spans from training needs assessment to mentorship.

3. **Demand-driven training**, and the evidence-based design of training programmes and training materials, was really appreciated by counterparts and built a strong sense of ownership.

4. **Institutionalisation of the training programme** is critical for system strengthening in a sustainable way. The pre-service aspect of the training is institutionalised in the university curricula while the pre-service aspect is institutionalised in EPHI, as the anchor institution, to coordinate the training.

5. **Building a critical mass of training of trainers** is crucial for building a sustainable emergency nutrition training system. Core staff from EPHI, MoH, and the Ethiopia Disaster Risk Management Commission (EDRMC), and regional health and DRM bureaus from all regions, were trained so they can cascade the training down to the zone and woreda levels.

6. **Preparation of useful training materials** was an essential component of the emergency nutrition capacity building system strengthening. The modularised competency-based emergency nutrition training manual, which was prepared based on the identified needs, was handed over to both the universities and regional health and DRM bureaus and EPHI for use in future endeavours after pre-testing and validation.

7. **Testing competency and certification** is critical for competency-based learning. Training involved strict pre-test and post-test examinations based on the learning outcomes, which served to improve attendance of the trainees in all the modules (certification required complete attendance, as well as an average post-test score above 75%). All of the participants appreciated this and said it was useful.

8. **Integrating emergency nutrition intervention planning** is critical to create synergy and avoid duplication of effort. The integrated plan developed with BRE-TA for government counterparts (EPHI, MoH, and EDRMC) and partners (UNICEF and the World Food Programme) helped them work jointly, by pooling resources. For example, 'SMART' training was conducted in collaboration with EDRMC, MoH, and BRE-TA, as was the roll-out of the emergency nutrition training conducted in collaboration with EPHI.

## 3.5 Risk communication and community engagement

Risk communication and community engagement (RCCE) is an integral part of managing any epidemic or pandemic, humanitarian crisis, or disaster response. Effective communication allows those who are most at risk to understand and adopt protective behaviours, and helps authorities and experts understand and address people's needs and concerns so that the advice they provide is relevant, trusted, and acceptable.[6] The MoH and EPHI identified RCCE as an important DRM pillar. The experience of the COVID-19 response underscored the well-known – but now more urgent – need to improve the effectiveness of health messaging. In response, the PHEM workstream embedded a technical adviser in EPHI to provide COVID-19 information and communication advice, alongside a senior socio-behavioural communication adviser who developed RCCE-focused activities that were then implemented by MoH, EPHI, and regional partners.

**Lessons learnt:**

1. **Dedicated RCCE TAs** embedded at national and regional levels played an important role. Having qualified professionals in these positions allowed for more targeted and efficient implementation of RCCE strategies.

2. **Stakeholder integration and coordination.** The Technical Working Group facilitated collaboration between diverse organisations and entities, and harnessed their collective expertise, ensuring a unified, effective, and comprehensive approach.

3. **Advocacy for RCCE** with key health officials and stakeholders is essential in order to secure the budget allocations at national and regional levels that will guarantee the quality and sustainability of RCCE activities, both during emergencies and in non-emergency periods.

6. World Health Organization (2017) 'Communicating risk in public health emergencies', Geneva.

4. **Clear RCCE guidelines and standard operating procedures** help to streamline efforts, ensure consistent communication strategies, and enhance the efficiency of response by providing a structured framework for implementation.

5. **Multi-sectoral training** for a diverse range of stakeholders, including media professionals, PHEM officers, religious leaders, and social and behaviour change experts, empowered them with the necessary RCCE skills and knowledge. It also ensured that there is now a range of people who are equipped to contribute to communication efforts in times of crisis.

**A notable achievement of the RCCE initiative was the greater emphasis given to it by EPHI - RCCE is now prioritised as a key pillar of the incident management system and a new RCCE Directorate has been established. Despite this, three issues illustrate the need for continued support:**

***Consistent allocation of resources for RCCE during both emergency and non-emergency periods*** is a challenge that requires careful planning and recognition of the critical role these activities play in public health and safety.

***Regional differences in RCCE systems and structures*** create difficulties for reporting and service delivery. These challenges are particularly pronounced at sub-regional levels (in zones and woredas).

***There is a lack of dedicated expertise at regional level,*** where individuals often fulfil dual roles, simultaneously handling RCCE responsibilities alongside other PHEM tasks.

## 3.6 Generating evidence for action: COVID-19

The COVID-19 pandemic was unprecedented in its scale and persistence, and in its initial phase, Ethiopia faced major disruption to the continuity of essential health services. The World Health Organization recommended that member states assess their capacities and response efforts and adapt these as evidence and lessons emerged. To that end, it produced a guideline for countries seeking to conduct Intra-Action Reviews which in consultation with, and with the approval of, government counterparts and donors, BRE-TA provided support to, as it aligned clearly to PHEM system-building.

A key finding from the COVID-19 Intra-Action Reviews was that a wide range of partners were mobilised to respond to the pandemic: for example, the higher education sector was among those directly involved. However, the level and process of this engagement were not well documented. To explore this, in consultation with EPHI and with the approval of the Directorate for Research and Community Engagement in the Ministry of Education, BRE-TA conducted a review on the role of higher education institutions (HEIs) in the COVID-19 response.

**Nine public and private HEIs were enrolled in the study, which revealed the following:**

1. HEIs played an important role in the pandemic response, of particular note was the rapid expansion of laboratory testing services.
2. HEIs carried out comprehensive public health interventions for their students, staff, and surrounding communities.
3. HEIs were considered as useful resources and responsible stakeholders in PHEM, but their engagement was not sustainable given the pace and scale of the pandemic.
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These findings revealed the **untapped potential of HEIs to mitigate the impact of emergencies on both their campus community and the population in their catchment area,** and underscored the need for a more innovative approach to engaging them formally in the PHEM system.

Thus, a **strategy for the sustainable engagement of HEIs in the broader aspects of PHEM system strengthening was prepared, validated, and approved by the Ministry of Education, the MoH, and EPHI.** The final version of the engagement strategy was shared with Regional Health Bureaus/ Regional PHIs and with universities. So far, Jimma University in Oromia Region and Amhara Public Health Institute have adapted and contextualised the framework to their respective regions.

**Lessons learnt:**

1. **Disasters associated with infectious diseases may generate new evidence** that informs both the adaptation of response in the short term and improvements in PHEM systems over the long term.
2. **Closer collaboration between the education and health sectors benefits both.** For example, it improves the capacity of the health system to deliver services, improves the quality of training of health professionals enrolled at the respective HEIs, and safeguards HEIs' communities.
3. **Recognising the role of all partners and stakeholders**, and engaging them throughout, promotes trust and sustainable partnerships.

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