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October 2013 | Issue Brief

# U.S. Humanitarian Assistance and Global Health Policy: Opportunities and Barriers for More Effective Coordination

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## OVERVIEW

U.S. support for global health and international humanitarian assistance efforts has grown over the last decade, but the mechanisms that staff, administer, and oversee each of these sectors have remained largely isolated and distinct from one another. While there are differences in the objectives and approaches of these two sectors, it is also true that their activities are integrally linked. Many times, the countries, communities and populations served by each are the same or closely overlap. In addition, there is a subset of countries where recurrent and chronic crises draw both significant U.S humanitarian and global health assistance year after year. As such, identifying opportunities for creating greater synergies and linkages between U.S. humanitarian and global health programs can help to improve longer-term health outcomes and increase the cost-effectiveness of U.S. investments.

While humanitarian actors have debated issues around linking the disaster response and longer-term development for decades, now may be an opportune moment for the U.S. to move the discussion forward and consider a more integrated, cooperative approach. Many donors and practitioners in the humanitarian sector are already focusing more on building "resilience" and reducing the risk of disasters through country-led plans, approaches that dovetail nicely with an increasing emphasis on country ownership and health systems strengthening by global health programs.

As a step toward understanding and addressing these issues, the Kaiser Family Foundation conducted an analysis of the policy and financing landscape at the intersection of these two sectors. The Foundation also convened a roundtable of experts in July 2013 for a policy discussion to explore the linkages between the U.S. humanitarian and global health sectors and responses, as well as to identify opportunities, challenges, and potential next steps for the U.S. government and others.

This summary document consists of two parts:

- **Part I** presents the key findings from the Kaiser Family Foundation review and analysis of the policy and financing landscape where humanitarian assistance and global health assistance meet, with an emphasis on the U.S.
- **Part II** summarizes the information shared and issues raised by participants during the July roundtable discussion, which focused on opportunities, challenges, and potential next steps for more effective coordination between humanitarian assistance and global health programs, for the U.S. government and others.

# PART I: POLICY AND FINANCING LANDSCAPE OF HUMANITARIAN AND GLOBAL HEALTH ASSISTANCE

As a step toward understanding the links between U.S. humanitarian assistance and global health programs, the Kaiser Family Foundation performed a review of the literature and an analysis of the policy and funding landscape where these two sectors overlap. These are summarized below.

## LINKS AND GEOGRAPHIC OVERLAP BETWEEN HUMANITARIAN AND GLOBAL HEALTH ASSISTANCE

U.S. support for global health and international humanitarian assistance efforts has grown over the last decade. The rise in global health assistance has been largely driven by the creation of new programs and initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Funding for humanitarian assistance has varied year-to-year depending on the nature of crises and responses required, but has generally increased over the same time period, and included a number of large-scale responses such as those following the Indian Ocean tsunami in 2004, the Haiti earthquake in 2010, and crises in the Sahel and the horn of Africa, among others.

Even as these two areas of activity – global health and humanitarian assistance – have grown, they remain largely isolated from one another. For the most part, the U.S. government staffs, administers, and oversees each of these sectors through mechanisms that are financially, legislatively, and organizationally distinct. One of the reasons for this separation is that the objectives of these two kinds of programs differ at their core: humanitarian assistance programs are designed to be flexible and quickly address the immediate emergency needs of persons at risk, while global health programs are focused on delivery of services over a longer-term, building sustainable health care systems, growing host country capacity, and contributing to overall development.

While recognizing that there may be important historical, political, and operational reasons for such a separation to exist, it is true that the two types of activities are also integrally linked. Protecting health is implicit in the very goal of humanitarian assistance.[1] Indeed, the stated mandate of the U.S. Office of Foreign Disaster Assistance (OFDA), the lead U.S. agency responsible for providing humanitarian assistance, is to "save lives, alleviate human suffering, and reduce the social and economic impact of humanitarian emergencies worldwide." In any large scale humanitarian response, initial emergency efforts will eventually need to transition to longer-term rehabilitation and reconstruction activities, often involving the (re)building of health systems.

In addition, U.S. humanitarian and global health assistance is often directed to the same countries and sometimes even the same communities. A Kaiser Family Foundation analysis of U.S. assistance, included as an Appendix attachment to this document, found that of the 54 countries that received disaster support from OFDA in FY 2011, 33 (almost two-thirds) also received global health support, including 17 of 21 African countries.[2] Also, 95% of the total amount of OFDA assistance in FY 2011 went to countries where at least one, but often several, global health programs were present. Of the 17 countries with complex emergencies that prompted an ODFA response that year, 13 had global health programs and in 10 of those 13, more than one global health program was present.

Further, there is a subset of countries where recurrent and chronic crises draw both significant U.S humanitarian and global health assistance year after year. The international community has put an estimated $57 billion in emergency assistance into the top 10 recipients of international humanitarian response aid between 2002-2011.[3] USAID alone directed approximately two-thirds of its humanitarian assistance funding over the last ten years to 10 countries.[4] Many of these, including Ethiopia, Kenya, Democratic Republic of the Congo, and Haiti, have been major recipients of U.S. global health assistance. A more thoughtful, coordinated approach between global health and humanitarian assistance could help reduce the occurrence or impact of future crises, making populations less vulnerable to recurrent shocks to health and well-being.

**Box 1. Selected Definitions of Key Terms**

***Complex Humanitarian Emergency***: "A humanitarian crisis in a country or region where there is a total or considerable breakdown of authority resulting from internal and/or external conflict requiring an international response."[5]

***Disaster Risk Reduction (DRR)***: "Reduc[ing] the damage caused by natural hazards like earthquakes, floods, droughts and cyclones, through an ethic of prevention."[6]

***Health System Strengthening***: "The process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges."[7]

***Prevention***: "The outright avoidance of adverse impacts of hazards and disasters…through action taken in advance."[8]

***Transition***: "The period between the immediate humanitarian response to a complex emergency and when long-term development processes are underway."[9]

***Recovery:*** "The immediate tasks of securing the [affected] area, housing victims, and establishing conditions under which households and businesses can begin the process of recovery"[10]; The restoration, and improvement where appropriate, of facilities, livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors."[11]

***Reconstruction***: "A set of activities aimed at achieving the medium- and long-term recovery of the components and structures that have been affected by a disaster or emergency."[12]

***Resilience***: "The ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth."[13]; "The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner"[14]

## An opportune moment?

Humanitarian actors have debated issues around linking the disaster response and longer-term development for decades,[15,16,17,18,19,20,21] often expressing concern that these two areas have been poorly coordinated and that disaster prevention and resilience activities in particular have been underfunded and insufficiently prioritized.[22,23,24,25,26,27,28,29] In the last few years the international humanitarian community appears to have embraced prevention and resilience concepts to a greater degree, as highlighted by the creation of the Hyogo Framework for Action,[30] a ten year plan initiated in 2005 and led by the United Nations that is designed to help build international support for disaster prevention and improve nations' resilience to disasters, and the creation of the Global Facility for Disaster Reduction and Recovery (GFDRR), a partnership for reducing vulnerability to natural hazards seeking to "mainstream disaster risk reduction (DRR)" in country development strategies that was established in 2006.[31] Most recently, ongoing discussions related to the post-2015 agenda – the set of global development goals and targets that will succeed the Millennium Development Goals – have included recognition of the importance of promoting resiliency and addressing risk. For example, one of the four key targets for ending poverty recommended in the Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda is "Build resilience and reduce deaths from natural disasters by X%."[32] In addition, the July 2013 UN Secretary General's report to the UN General Assembly on the development agenda beyond 2015 states that "building the resilience of and investing in those communities and nations most vulnerable to disaster risk…will require a greatly stepped up response" and will form a key component of sustainable development and poverty alleviation going forward.[33]

Still, while one of the key motivations for pursuing such prevention-based approaches is that they are likely to be more cost-effective, and improvements longer-lasting,[34] DRR comprised only about 4.7% of total bilateral humanitarian assistance in 2011[35] and the amount of assistance provided for disaster prevention and preparedness has remained roughly the same since the Hyogo Framework for Action was endorsed in 2005.[36] A recent review of DRR spending estimated that over the last 20 years, for every $9 spent by donors on disaster response globally, about $1 was spent on preventing and preparing for them.[37]

In the U.S. context, the U.S. Agency for International Development (USAID) recently provided a new emphasis on this issue with the release of its agency-wide Resilience Strategy in 2012, which directs the agency to adopt "resilience" and "disaster risk reduction" concepts across all of its programs, from humanitarian assistance to development.[38] The strategy outlines potential policy and programmatic approaches for resilience in USAID assistance, such as coordinated strategic planning and consideration of how to effectively "layer, integrate, and sequence" humanitarian and development programs. As it notes, efforts to build resilience to the health impact of disasters require expertise, support, and technical assistance that fall closely along the lines of the system strengthening that characterizes traditional global health work.[39]

In the global health and humanitarian assistance spheres alike, there has also been a growing emphasis on country ownership, transition, and program integration, creating policy openings for these two types of programs to work more closely together and to harmonize more effectively with recipient countries. Country ownership is a key principle the US Global Health Initiative (GHI), the effort to develop a comprehensive U.S. government strategy for global health that was initiated by the Obama administration in 2009,[40] and is an important component of the strategy outlined by the largest U.S. global health program, PEPFAR.[41,42] The

GHI's 2012 interagency paper on country ownership states: "USG's global efforts to foster country-owned and country-led health responses indicate a fundamental shift in our orientation towards achieving sustainable health outcomes concurrent with a recipient country's ability to support and achieve better health and security for its own people."[43] Similarly, humanitarian actors have also placed greater emphasis on "local ownership" as a way to improve outcomes and create conditions for sustainable response.[44,45]

Finally, in the current budget climate, the emphasis on cost-effectiveness that extends across all donors provides even greater incentive to consider whether programs are doing the best they can with limited resources. Given the amount of assistance provided for global health and humanitarian assistance programs by the U.S. government, the recurrent nature of crises in many countries, the geographic and programmatic overlap between them, and the cost-effectiveness of prevention-based approaches,[46] now may be an opportune time to consider better alignment, new synergies and, ultimately, a more effective way to proceed.

### An ongoing debate, a long-standing set of issues

Clearly, the issues and obstacles involved in coordinating these two areas are not new, and attempts at encouraging development programs and emergency responses to work more effectively and proactively together have been present as long as these activities have occurred. Those engaged in global health programs have long had to consider how best to continue their operations and deliver services at the onset of a crisis. Likewise, those involved in humanitarian assistance efforts have had to consider how to create systems and implement their activities in a way that can help prevent and reduce the impact of future crises while leaving a sustainable foundation for longer-term development to occur following an emergency situation.

That does not mean the issues have ready solutions or that such obstacles have been overcome, though, and given that disaster response and humanitarian needs are likely to continue in the foreseeable future and possibly increase over time,[47,48,49] and that global health programs will continue operate in many of the same areas, it is an opportune time to take stock of where and how these efforts overlap, and to identify opportunities for improving communication, interactions, and activities for more effective efforts on both sides.

## PART II: SUMMARY OF A ROUNDTABLE DISCUSSION: OPPORTUNITIES, CHALLENGES, AND NEXT STEPS FOR GLOBAL HEALTH AND HUMANITARIAN ASSISTANCE

In July 2013, the Kaiser Family Foundation hosted a roundtable expert discussion on the topic of U.S. humanitarian and global health assistance. Roundtable participants were asked to address three main issues:

- What are the key opportunities for creating greater synergies and linkages between U.S. humanitarian assistance and global health programs to improve long-term health outcomes?
- What are the key challenges to achieving more effective coordination between humanitarian assistance and global health programs?
- What are some of the next steps needed to move toward a more effective, better coordinated approach for humanitarian assistance and global health programs?

The sections below give an overview of information shared by participants on each of these three issues during the discussion; also see Box 2 (next page) for a summary of this information.

## Opportunities

There was a consensus among roundtable participants that **the current policy climate was more favorable than ever for forging greater linkages between U.S. humanitarian assistance and global health programs**. They brought up several reasons why there may be an important window of opportunity to act at this moment in time:

- Meeting participants stated that there was a growing understanding at relevant U.S. agencies and within the broader international community that approaches such as disaster prevention, resilience, and disaster risk reduction should have greater focus not only in humanitarian programs, but within development, including global health. Likewise, there is a realization among many important actors in this space that it is important to forge greater cooperation and build bridges between humanitarian assistance and development, so that both types of programs can be more effective in achieving their goals.
- There appears to be more willingness at the leadership level of relevant agencies, particularly in the U.S., to adopt a more coordinated approach between global health and humanitarian assistance programs, and greater recognition that prevention, resilience, and disaster risk reduction represent cost-effective approaches in a time of budget difficulties. Further, there is a growing belief that such cross-sector approaches could contribute to, and dovetail with, other important U.S. government policy priorities in this area such as country ownership and program integration.
- The ongoing set of discussions, recommendations, and reports related to the post-2015 agenda and its inclusion of the importance of building resilience, including as one of the four key targets recommended for ending poverty by the High Level Panel, may provide new policy space to adopt more ambitious approaches that pursue broader, joint objectives such as resilience and DRR. Leaders could build on these suggestions and make policy changes so that such concepts are incorporated not only into rhetoric, but also into practice within humanitarian and global health programs.
- According to meeting participants, there appears to be an environment of greater collaboration across the USG agencies responsible for humanitarian assistance and global health programs, as well as between the USG and other partners. Policy makers can learn from and build off of several recent, successful interagency efforts to address problems in a joint way. For example, joint teams from various agencies and from multiple sectors worked effectively together in addressing the large-scale humanitarian issues faced by populations in the Horn of Africa and in the Sahel over the last several years. During the 2011-2012 Horn of Africa response in particular, a broad set of humanitarian, food security, and global health personnel worked and implemented programs together.[50,51]

## Box 2. Summary of Key Observations from Roundtable Discussion

### Opportunities

Participants regarded the current policy environment as more favorable than ever for forging greater linkages between U.S. humanitarian assistance and global health programs, and highlighted several opportunities available to forge more effective collaboration and coordination, including:

- Pushing forward country ownership and the adoption of country-led resilience approaches.
- Building on recent models and examples of coordination.
- Identifying and learning from the lessons of PEPFAR.
- Educating policymakers and working with Congress.
- Ensuring that women and youth are emphasized as a key entry point.
- Exploring the use of joint procurements and supply chains.
- Making a greater effort to incorporate academia and philanthropy.
- Educating and working with U.S. Ambassadors, particularly in countries with recurrent crises and significant U.S. investments in global health and humanitarian assistance programs.

### Challenges

Participants also recognized a number of significant challenges and some long-standing difficulties to achieving greater coordination and cooperation between U.S. global health and humanitarian assistance programs. Key barriers discussed included:

- A tendency to under-emphasize prevention, resilience, and disaster risk reduction.
- Programs not fully adapting to the changing circumstances and health needs of populations in crisis and at risk for crises.
- The unique and serious challenges to cooperative action presented by the countries with chronic humanitarian emergencies.
- Data to guide programs are often lacking.
- Humanitarian needs and country conditions vary greatly, requiring tailored responses.
- Health has not been a major component of resilience and disaster risk reduction efforts.
- Targeting of health facilities and health workers has become increasingly prevalent in conflict areas, increasing risks to coordinated planning and action.
- U.S. assistance mechanisms for global health and humanitarian response are siloed, creating barriers to joint work and leading to gaps in program coverage.

### Looking Forward: Potential Next Steps

Participants outlined a number of concrete steps that could be taken in the near future to facilitate more effective coordination and collaboration between these two sectors, which included:

- Develop a “typology” or “matrix” of countries receiving humanitarian and global health assistance.
- Develop a more robust mapping analysis of overlapping global health and humanitarian assistance efforts.
- Identify and track investments in resilience and disaster prevention, especially related to health.
- Develop cost-effectiveness models to assess and help communicate the value of prevention, resilience, and DRR approaches in helping achieve better health outcomes.
- Hold subsequent meetings with additional key stakeholder groups.

- USAID's Feed the Future Program has experience bridging the gap between short-term humanitarian assistance and longer-term development, providing emergency food aid as well as building sustainable platforms for food and nutrition programs. For example, Feed the Future has developed and implemented 5-year programs in a subset of countries to help them tackle both emergency and chronic nutrition needs.

The governments of affected countries and international actors are working more effectively together to develop country-led strategies and plans for addressing chronic cycles of crisis and poverty. For example, Kenya recently developed its first resilience plan addressing the geographic areas of chronic need in the country's north and east, and the government of Kenya has agreed to back the plan by providing 40% of the resources itself. The government of the Democratic Republic of the Congo requested and supported a scale-up of health programs in the chronically unstable east of the country, and has worked with partners to achieve this scale up to address nutrition and health care needs there in a way that builds the health system and resilience.

Participants highlighted a number of opportunities available to the U.S. government and others to forge more effective collaboration and coordination between U.S. humanitarian and global health assistance. Key opportunities discussed included:

- **Pushing forward the agenda of country ownership and the adoption of country-led resilience approaches**. Participants recommended that donors and international organizations provide greater support and assistance to countries for the development of their own plans. A key factor in supporting longer-term, broader societal resilience will be to have affected countries themselves shape and direct programs and set out priorities and strategies that are locally relevant. All partners involved in this process should be made aware of the importance of health as a component of broader resilience, and ensure the Ministries of Health in country be part of the conversation and planning efforts.
- **Building on recent models and examples of coordination**. The recent joint efforts in response to crises in the Sahel and the horn of Africa could serve as informative learning experiences and models to help mount future cross-cutting efforts, especially for U.S. government responses. Participants felt it would be helpful for leaders of U.S. government programs in both humanitarian assistance and global health to incorporate the principles and the guidance provided in the new USAID Resilience Strategy. In addition, Feed the Future's 5-year efforts could be used as a model or even platform off which future joint efforts to promote resilience, especially food and nutrition-related resilience, could be built. Such platforms, even when initial support has come from the global health/development side, can serve as important assets for emergencies and/or crisis situations.
- **Identifying and learning from the lessons of PEPFAR**. PEPFAR, the largest U.S. global health program as measured by funding, was created to be an emergency response to the crisis of HIV/AIDS. PEPFAR initially took a very humanitarian assistance-like approach emphasizing rapidity and flexibility in directing its support to where it was most needed most. More than ten years after the program began, it finds itself in a period of transition between an ongoing emergency response and contributing to sustainable, long-term and country-led responses to HIV/AIDS. In navigating this transition, the program has learned valuable lessons about bridging this divide that could be applied to other global health and humanitarian assistance programs. Such lessons could be catalogued and used to inform efforts to instill greater cooperation and coordination across global health and humanitarian assistance.

- **Educating policymakers and working with Congress** to better describe the important linkages between the humanitarian and global health and development sectors. While each of these areas is currently funded through separate earmarks and each has different requirements and authorities, increased awareness about their intersection may facilitate more flexible approaches going forward, to better support joint activities.
- **Ensuring that women and youth are emphasized** as a key entry point for addressing resilience in a comprehensive way. Reproductive health and gender-based violence concerns have long been important in the context of both humanitarian assistance and global health efforts. Focusing on these issues as an important intersection point, and working with women especially within these programs, can have large payoffs in terms of disaster response *and* longer-term development, and provide an important bridge between the two.
- **Exploring the use of joint procurements and supply chains** in areas where global health programs and chronic humanitarian needs overlap could potentially help with cost-effectiveness and achieving the greatest impact with both types of programs.
- **Making a greater effort to incorporate perspectives from and participation of academia and philanthropy** could help address areas where traditional actors have had weaknesses. Governments and other actors, particularly on the humanitarian side, spend much of their time and energy dealing with immediate needs, acute problems, and short-term objectives. Traditional actors may not have the time and flexibility to pursue cross-disciplinary and silo-spanning projects, or develop data tracking and analysis support for joint programming; philanthropy and academia could be utilized to a greater extent on these types of efforts. Academic researchers and philanthropists could provide another perspective and have a comparative advantage in being able to take risks, set up pilot projects, question standard practices, and "truth-test" standard beliefs.
- **Educating and working with U.S. Ambassadors**, particularly in the countries with recurrent crises and significant U.S. investments in global health and humanitarian assistance programs, could help create a more resilience-focused, cross-sector and interagency approach to U.S. assistance programs. Ambassadors serve as a key linchpin for both types of programs in each affected country, and could play a more prominent role in fostering a more effective, combined approach where applicable.

## Challenges

Despite a sense that there is a conducive policy environment and that a number of important opportunities are available to help achieve greater coordination and cooperation between global health and humanitarian assistance programs, participants also recognized a number of significant challenges and some long-standing difficulties, including:

- **An ongoing tendency to under-emphasize prevention, resilience and disaster risk reduction approaches.** Even though the humanitarian community has long appreciated the need to invest more in prevention and resilience, and there is new attention to its importance, it will be difficult to change the historical mindset and culture among some policymakers and practitioners that prioritizes response and treatment in lieu of supporting prevention and risk-reduction. Despite years of significant levels of international assistance, the community has not been able to help most chronically affected countries move out of a state of recurrent crisis, and insufficient emphasis on resilience and prevention may have

contributed to this. This lack of emphasis, it was noted, reflects a larger, societal emphasis on and expectation of using funds, especially humanitarian assistance funds, to save lives in the short-term and a general reluctance to spend funds on prevention or resilience.

- **The circumstances and health needs of populations in crises and at risk for crises have changed, and programs have not fully adapted**. Participants agreed that, for the most part, many humanitarian and global health actors have not fully taken into account the "new normal" of needs and gaps, and instead have often relied on outdated assumptions and approaches to the populations most at risk or in need. This hampers program effectiveness, and represents an ongoing challenge to forging effective cooperation between humanitarian and global health programs. For example, a major trend has been the growing urban character of disaster-affected populations, but responses and mindset remain more focused on rural areas. Those areas and populations will likely continue to need support but participants were concerned that going forward, programs will be underprepared for changing health needs in emergency and disaster environments. Urban environments present unique challenges and difficulties, and require different approaches than rural areas. Further, identifying and delivering services to urban populations tend to be more difficult and more expensive than other types of responses, and both types of programs should take this into account in order to be able to target resources at the greatest need.
- **Countries with chronic emergencies present unique and serious challenges to cooperative action**. Many states chronically affected by complex emergencies, some of which have been categorized as "fragile states",[52] present unique difficulties for both humanitarian assistance and global health programs and coordination between them. There are shared challenges from working in areas where governance is weak and security may be an issue. Participants felt global health and humanitarian programs have often had difficulties working together in such environments to build resilience and promote prevention, often because humanitarian actors were focused on the challenge of meeting immediate needs such that there is often little capacity for taking on partnerships or joint activities focused on the common goal of reducing longer-term risks.
- **Data to guide programs are often lacking**. Timely data on humanitarian and health needs, especially in post-disaster and complex emergency environments, are often unavailable, and data collection and analysis are typically not prioritized. An evidence base and an understanding of local needs are essential to targeting resources effectively, but such information is often lacking and health surveillance systems absent or limited. Even in countries where surveillance systems may be adequate, in the wake of a disaster these systems may become unavailable and hamper efforts to build a sustainable collaborative response. Another information need that often goes under-addressed is the measurement and evaluation of those programs which are actually integrated, such that their effectiveness can be assessed.
- **Humanitarian needs and country conditions can vary greatly, requiring tailored responses**. The marked variations in country circumstances can present a barrier to integrated global health and humanitarian assistance programs because such approaches must be tailored to each country's situation – no "cookie cutter" approach to building resilience would be very effective. Countries differ greatly in their level of development, demographics, geography, public health infrastructure, and other factors. In addition, different types of humanitarian situations require different kinds of responses. Therefore effective strategies must be matched to the health needs specific to each situation.

- **Health has not been a major component of resilience and disaster risk reduction efforts to date**. While exact financing amounts across sectors are difficult to identify, international support for resilience and DRR funding have historically tended to focus on issues other than health such as flood prevention and control (including support for large infrastructure projects like dams and flood barriers), early warning systems and land management.[53] Despite recognition that human health is heavily impacted by disasters and extreme weather events, and that climate change may lead to increased risk of such events, building resilience in the systems that support health has not been featured as a major component of humanitarian efforts to date.[54] In addition, health practitioners have often emphasized reactive responses to climate and disaster effects rather than preventive efforts.[55]
- **Targeting health facilities and health workers has become increasingly prevalent in conflict areas**. A growing trend of combatants targeting health facilities and health workers has created a significant challenge to addressing resilience and building health systems in many conflict-affected areas and raises the stakes for the importance of more coordinated planning and action between the humanitarian and global health sectors.[56,57,58]
- **U.S. assistance mechanisms for global health and humanitarian response are siloed, creating barriers to joint work and leading to gaps in program coverage**. U.S. funding for humanitarian assistance and global health programs are almost entirely isolated from one another, with each funding stream earmarked for specific uses. This means each set of activities is staffed and managed in isolation, with little institutional incentive to plan jointly or integrate activities. It also leads to a situation where neither funding mechanism is focused on or responsible for addressing the disaster prevention and resilience agenda, creating a "gap" in funding and responsibility where the two types of programs overlap. This presents an ongoing challenge for actors on both sides of this divide.

## Looking Ahead: Potential Next Steps

Participants outlined a number of concrete steps that could be taken in the near future to facilitate more effective coordination and collaboration between humanitarian and global health programs and to address the current analytical and programmatic gaps. Some of the key next steps identified include:

- **Develop a "typology" or "matrix" of countries receiving humanitarian and global health assistance**. Generating a typology of countries that receive both humanitarian and global health assistance would help identify categories of countries and situations, making it easier to understand the range of potential responses and opportunities to promote greater coordination and cooperation across program assets. With such a tool in hand, policymakers would likely find it easier to match resources with needs and illustrate paths forward. Some of the key variables to consider for inclusion in such a typology could be:
  - Degree of conflict/instability
  - Degree of development/income
  - Type of disasters experienced: complex humanitarian assistance vs. natural disaster, etc.
  - Geographic/demographic variables
  - Levels/types of US/foreign assistance
  - Health measures/indicators
  - Governance structures

- **Develop a more robust mapping analysis/capability of overlapping global health and humanitarian assistance efforts**. For the purposes of the roundtable, KFF developed and distributed an initial analysis of the country-level overlap between U.S. global health and humanitarian assistance programs (these handouts are included as appendix attachments to this document). A more robust analysis of the geographic overlap between these two areas would be a helpful tool for informing policymakers and driving discussions as to where additional efforts at coordination and cooperation could be most effectively targeted. For example, a sub-national level analysis looking at regions within countries would be a natural and helpful extension of this initial analysis.
- **Identify and track investments in resilience and disaster prevention, especially related to health**. Despite the large amount of discussion around building resiliency, it is still not clear how much funding donors have directed toward resilience and DRR programs, or to which sectors and project types this funding is directed. It is worth a careful look at the extent to which governments of the world have funded and supported resiliency efforts, especially those efforts linked to health.
- **Develop cost-effectiveness models to assess and help communicate the value of prevention, resilience, and DRR in helping to achieve better health outcomes**. Given the lack of understanding of the importance of disaster risk reduction, resilience, and disaster prevention to protect and save lives and the well-being of populations at risk, it would be helpful to develop an econometric model or cost-effectiveness model that examined with some rigor the health benefits of spending on resilience/prevention efforts compared with response alone. Access to such an analysis would help to inform policymakers about the potential benefits of a more integrated, prevention and resilience-based approach.
- **Hold subsequent meetings with key stakeholder groups**. Participants agreed that convening subsequent meetings with particular stakeholders working in this space would be helpful. For example, while some implementers attended the roundtable, it would be helpful to bring together implementers from both global health and humanitarian programs to share their insights into some of the practical and day-to-day issues and challenges. This could help to craft a more comprehensive and effective approach to greater cooperation between these two fields. Other key stakeholder groups could include country and local representatives, and multilateral agency representatives.

## Conclusion

U.S. support for global health and humanitarian assistance has grown over time but the two sectors have remained largely isolated from one another despite sharing many objectives and often working in the same geographic regions, sometimes with the same communities. In fact, U.S. global health and humanitarian assistance programs provide large amounts of assistance year after year to countries that experience recurrent and chronic emergencies along with ongoing poor health conditions. For these and other reasons, it is important to examine the opportunities and barriers to these two sectors working together more effectively together to achieve mutual goals and better serve the communities and countries at greatest risk and with the greatest needs.

For a number of reasons it appears to be an opportune time now to pursue more communication and greater collaboration between humanitarian and global health programs, though with the recognition that important barriers and challenges remain. There are concrete steps that policymakers, implementers, and others can take

in order to realize the benefits of a more coordinated approach emphasizing resilience to health impacts of emergencies.

### *Additional Resources Referenced During Roundtable Discussion*

- State Department/USAID Committee report examining transition from emergency to sustained development following the Haiti earthquake: http://pdf.usaid.gov/pdf_docs/pdacr222.pdf.
- Population and climate change hot spots work of Population Action International (PAI), which highlight the links between high unmet need for FP and climate change-affected areas: http://www.populationaction.org/climatemap/.
- Interaction maps of local public health capacity and NGO activity. Initially designed with a focus on pandemic response capacity, but holds lessons and information for health in the context of disasters generally: http://www.interaction.org/work/ngoaidmap.
- Lessons learned from USAID funding for Population, Health, and Environment (PHE) programs http://www.ehproject.org/phe/phe.html.
- Resilience initiatives supported by AUSAID and World bank, managed by UNDP.
- Review of lessons from the recent UK/DfID review of humanitarian programs: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67579/HERR.pdf.

# APPENDIX: EXPLORATORY ANALYSIS OF U.S. GOVERNMENT OFDA AND GLOBAL HEALTH ASSISTANCE, FY2011

For this exploratory analysis, we examined amounts of country assistance provided through OFDA in response to disaster declarations in FY2011 compared to funding amounts for U.S. global health programs in the same year.

**Appendix Table 1** shows an alphabetical listing of countries received global health assistance, along with OFDA assistance for those countries in FY 2011. The type of disaster(s) declared and number of global health programs present in country is also provided.

**Appendix Table 2** breaks out global health assistance by country and by program, including funding provided through USAID Food for Peace.

**Appendix Boxes 1-3** give further details about OFDA and Global Health Assistance in three countries with recurrent/chronic humanitarian assistance needs: Democratic Republic of the Congo, Ethiopia, and Haiti.

Key takeaways:

- Of the 54 countries that received disaster response support from OFDA in FY 2011, 33 (almost two-thirds) also received global health support in the same period, including 17 of 21 African countries.
- 95% of the total amount of OFDA disaster response assistance to countries was provided to countries with global health programs.
- Complex emergencies:
  - GH programs are present in 13 of 17 (about 76%) countries that experienced complex emergencies prompting OFDA responses. In 10 of the 13 countries with overlap, more than one GH program was present.
  - 76% of the total amount OFDA assistance to countries with complex emergencies in FY2011 went to countries with global health programs.
- Floods:
  - GH programs existed in 12 of the 25 (almost half) countries that experienced floods that prompted an OFDA response
- Four countries are among the top ten recipients of both OFDA assistance and global health funding in FY 2011: Afghanistan, Ethiopia, Haiti, and Kenya.

Data sources: OFDA assistance, FY 2011: OFDA Annual Report for FY2011; Global health assistance, FY 2011: www.foreignassistance.gov. Funding represents enacted amounts.

# APPENDIX TABLE 1. COMPARISON OF OFDA AND GLOBAL HEALTH ASSISTANCE, FY 2011.

| Country | OFDA Assistance | Disaster Type(s) | Global Health Assistance | # of GH Programs |
|---|---|---|---|---|
| Afghanistan | 30,524,309 | Complex Emergency | 162,429,000 | 7 |
| Albania | 49,962 | Floods | 2,550,000 | 3 |
| Angola | | | 50,653,000 | 4 |
| Armenia | | | 6,372,000 | 5 |
| Azerbaijan | | | 4,605,000 | 4 |
| Bangladesh | | | 83,098,000 | 6 |
| Belarus | | | 250,000 | 1 |
| Belize | | | 20,000 | 1 |
| Benin | 1,239,544 | Floods | 28,197,000 | 4 |
| Bolivia | 50,000 | Floods | 16,367,000 | 3 |
| Botswana | | | 74,443,000 | 1 |
| Brazil | 235,705 | Floods | 6,290,000 | 2 |
| Burkina Faso | | | 11,270,000 | 2 |
| Burma | 300,000 | Cyclone | 2,100,000 | 1 |
| Burundi | | | 39,297,000 | 3 |
| Cambodia | | | 35,460,000 | 5 |
| Cameroon | | | 22,750,000 | 1 |
| Chad | 8,964,707 | Complex Emergency | 3,035,000 | 3 |
| China | | | 5,000,000 | 1 |
| Cote d'Ivoire | 7,960,877 | Complex Emergency | 93,305,000 | 1 |
| Democratic Republic of Congo | 33,511,114 | Complex Emergency | 136,654,000 | 7 |
| Djibouti | | | 2,200,000 | 3 |
| Dominican Republic | | | 18,293,000 | 3 |
| Egypt | | | 13,000,000 | 5 |
| El Salvador | | | 3,106,000 | 2 |
| Ethiopia | 35,115,115 | Complex Emergency, Drought | 412,337,000 | 7 |
| Georgia | | | 8,085,000 | 5 |
| Ghana | 50,000 | Floods | 75,113,000 | 7 |
| Guatemala | | | 34,484,000 | 4 |
| Guinea | | | 17,469,000 | 4 |
| Guyana | | | 13,525,000 | 1 |
| Haiti | 79,060,093 | Earthquake, Cholera Outbreak | 202,977,000 | 5 |
| Honduras | | | 11,988,000 | 3 |
| India | 136,347 | Floods | 89,299,000 | 6 |
| Indonesia | 2,370,100 | Volcano, Tsunami | 48,774,000 | 4 |
| Iraq | 23,800,903 | Complex Emergency | 31,706,000 | 2 |
| Jamaica | | | 1,500,000 | 1 |
| Jordan | | | 47,274,000 | 3 |
| Kazakhstan | | | 3,829,000 | 3 |
| Kenya | 26,697,979 | Drought, Pipeline Explosion | 580,405,000 | 7 |
| Kosovo | | | 814,000 | 1 |
| Kyrgyz Republic | | | 3,171,000 | 4 |

| Country | OFDA Assistance | Disaster Type(s) | Global Health Assistance | # of GH Programs |
|---|---|---|---|---|
| Laos | | | 1,000,000 | 1 |
| Lebanon | | | 17,395,000 | 1 |
| Lesotho | | | 33,050,000 | 1 |
| Liberia | 3,980,088 | Complex Emergency | 48,954,000 | 7 |
| Madagascar | 2,500,051 | Locust Outbreak, Cyclone | 59,896,000 | 6 |
| Malawi | | | 120,661,000 | 6 |
| Mali | | | 62,125,000 | 6 |
| Mauritania | | | 2,326,000 | 2 |
| Mexico | 29,244 | Wildfires | 3,455,000 | 2 |
| Mozambique | | | 337,311,000 | 7 |
| Namibia | 594,950 | Floods | 103,068,000 | 2 |
| Nepal | | | 32,645,000 | 4 |
| Nicaragua | | | 6,788,000 | 3 |
| Niger | 13,658,943 | Food Insecurity | 4,708,000 | 2 |
| Nigeria | | | 575,218,000 | 6 |
| Pakistan | 114,900,799 | Complex Emergency, Floods | 95,582,000 | 3 |
| Papua New Guinea | | | 5,000,000 | 1 |
| Peru | | | 9,173,000 | 4 |
| Philippines | 200,000 | Floods | 33,687,000 | 5 |
| Russia | | | 17,744,000 | 4 |
| Rwanda | | | 152,487,000 | 6 |
| Senegal | | | 57,388,000 | 7 |
| Sierra Leone | | | 6,454,000 | 2 |
| Somalia | 46,620,155 | Complex Emergency | 1,547,000 | 1 |
| South Africa | 50,000 | Floods | 550,788,000 | 3 |
| South Sudan | 94,359,859 | Complex Emergency | 52,884,000 | 7 |
| Sudan | 100,922,160 | Complex Emergency | 3,000,000 | 1 |
| Swaziland | | | 59,600,000 | 1 |
| Tajikistan | | | 8,791,000 | 5 |
| Tanzania | 50,000 | Munitions Explosion | 429,976,000 | 7 |
| Thailand | 125,000 | Floods | 1,500,000 | 1 |
| Timor-Leste | | | 1,996,000 | 2 |
| Turkmenistan | | | 1,407,000 | 2 |
| Uganda | 50,000 | Floods | 393,935,000 | 7 |
| Ukraine | | | 29,023,000 | 5 |
| Uzbekistan | | | 3,036,000 | 1 |
| Vietnam | | | 81,978,000 | 1 |
| West Bank and Gaza | | | 53,800,000 | 3 |
| Yemen | 14,974,584 | Complex Emergency | 9,482,000 | 3 |
| Zambia | | | 342,309,000 | 7 |
| Zimbabwe | 13,023,009 | Complex Emergency | 76,789,000 | 5 |
| Total | 656,105,597 | | 6,291,450,000 | |

# APPENDIX TABLE 2. GLOBAL HEALTH ASSISTANCE BY COUNTRY AND SECTOR, FY 2011.

| Country | HIV | TB | Malaria | MCH | FP/RH | Nutrition | Other | Water | Food For Peace (FFP) | Global Health Total (minus FFP) |
|---|---|---|---|---|---|---|---|---|---|---|
| Afghanistan | 250,000 | 8,000,000 | - | 111,455,000 | 23,933,000 | 2,500,000 | 11,291,000 | 5,000,000 | 1,877,000 | 160,552,000 |
| Albania | - | - | - | 1,320,000 | 530,000 | - | 700,000 | - | - | 2,550,000 |
| Angola | 14,700,000 | - | 30,614,000 | 1,347,000 | 3,992,000 | - | - | - | - | 50,653,000 |
| Armenia | - | 399,000 | - | 2,020,000 | 790,000 | - | 2,163,000 | 1,000,000 | - | 6,372,000 |
| Azerbaijan | - | 499,000 | - | 1,581,000 | 980,000 | - | 1,545,000 | - | - | 4,605,000 |
| Bangladesh | 2,700,000 | 9,980,000 | - | 20,958,000 | 23,154,000 | 22,376,000 | - | 3,930,000 | 21,615,000 | 61,483,000 |
| Belarus | - | 250,000 | - | - | - | - | - | - | - | 250,000 |
| Belize | 20,000 | - | - | - | - | - | - | - | - | 20,000 |
| Benin | 2,000,000 | - | 18,313,000 | 4,890,000 | 2,994,000 | - | - | - | - | 28,197,000 |
| Bolivia | - | 1,297,000 | - | 5,988,000 | 9,082,000 | - | - | - | - | 16,367,000 |
| Botswana | 74,443,000 | - | - | - | - | - | - | - | - | 74,443,000 |
| Brazil | 1,300,000 | 4,990,000 | - | - | - | - | - | - | - | 6,290,000 |
| Burkina Faso | - | - | 5,988,000 | - | - | 5,282,000 | - | - | 5,282,000 | 5,988,000 |
| Burma | 2,100,000 | - | - | - | - | - | - | - | - | 2,100,000 |
| Burundi | 18,500,000 | - | 5,988,000 | 14,809,000 | - | - | - | - | 12,753,000 | 26,544,000 |
| Cambodia | 15,500,000 | 4,990,000 | - | 8,982,000 | 4,990,000 | 998,000 | - | - | - | 35,460,000 |
| Cameroon | 22,750,000 | - | - | - | - | - | - | - | - | 22,750,000 |
| Chad | - | - | - | 910,000 | - | 850,000 | - | 1,275,000 | 3,035,000 | - |
| China | 5,000,000 | - | - | - | - | - | - | - | - | 5,000,000 |
| Cote d'Ivoire | 93,305,000 | - | - | - | - | - | - | - | - | 93,305,000 |
| Democratic Republic of Congo | 48,835,000 | 9,980,000 | 34,930,000 | 17,858,000 | 14,471,000 | 3,788,000 | - | 6,792,000 | 5,973,000 | 130,681,000 |
| Djibouti | 1,800,000 | 250,000 | - | 150,000 | - | - | - | - | - | 2,200,000 |
| Dominican Republic | 15,000,000 | 1,297,000 | - | 1,996,000 | - | - | - | - | - | 18,293,000 |
| Egypt | - | - | - | 2,950,000 | 2,950,000 | 500,000 | 1,600,000 | 5,000,000 | - | 13,000,000 |
| El Salvador | 1,110,000 | - | - | 1,996,000 | - | - | - | - | - | 3,106,000 |

| Country | HIV | TB | Malaria | MCH | FP/RH | Nutrition | Other | Water | Food For Peace (FFP) | Global Health Total (minus FFP) |
|---|---|---|---|---|---|---|---|---|---|---|
| Ethiopia | 289,089,000 | 9,980,000 | 40,918,000 | 20,956,000 | 27,943,000 | 18,351,000 | - | 5,100,000 | 11,666,000 | 400,671,000 |
| Georgia | 850,000 | 920,000 | - | 3,495,000 | 1,520,000 | - | 1,300,000 | - | - | 8,085,000 |
| Ghana | 14,500,000 | 856,000 | 29,840,000 | 7,984,000 | 12,974,000 | 5,389,000 | - | 3,570,000 | - | 75,113,000 |
| Guatemala | 2,000,000 | - | - | 5,988,000 | 6,587,000 | 19,909,000 | - | - | 16,416,000 | 18,068,000 |
| Guinea | 2,000,000 | - | 9,980,000 | 2,495,000 | 2,994,000 | - | - | - | - | 17,469,000 |
| Guyana | 13,525,000 | - | - | - | - | - | - | - | - | 13,525,000 |
| Haiti | 156,240,000 | 1,996,000 | - | 17,074,000 | 8,982,000 | 18,685,000 | - | - | 19,791,000 | 183,186,000 |
| Honduras | 6,000,000 | - | - | 2,495,000 | 3,493,000 | - | - | - | - | 11,988,000 |
| India | 30,000,000 | 13,972,000 | - | 20,874,000 | 22,954,000 | 499,000 | - | 1,000,000 | 914,000 | 88,385,000 |
| Indonesia | 13,000,000 | 13,972,000 | - | 15,469,000 | - | - | - | 6,333,000 | - | 48,774,000 |
| Iraq | - | - | - | 17,756,000 | - | - | 13,950,000 | - | - | 31,706,000 |
| Jamaica | 1,500,000 | - | - | - | - | - | - | - | - | 1,500,000 |
| Jordan | - | - | - | 10,000,000 | 17,274,000 | - | - | 20,000,000 | - | 47,274,000 |
| Kazakhstan | - | 3,097,000 | - | 400,000 | 332,000 | - | - | - | - | 3,829,000 |
| Kenya | 498,760,000 | 4,192,000 | 36,427,000 | 7,980,000 | 23,752,000 | 2,994,000 | - | 6,300,000 | - | 580,405,000 |
| Kosovo | - | - | - | - | - | - | - | 814,000 | - | 814,000 |
| Kyrgyz Republic | - | 1,748,000 | - | 648,000 | 175,000 | - | 600,000 | - | - | 3,171,000 |
| Laos | 1,000,000 | - | - | - | - | - | - | - | - | 1,000,000 |
| Lebanon | - | - | - | - | - | - | - | 17,395,000 | - | 17,395,000 |
| Lesotho | 33,050,000 | - | - | - | - | - | - | - | - | 33,050,000 |
| Liberia | 5,500,000 | 399,000 | 13,273,000 | 10,080,000 | 6,986,000 | 3,620,000 | - | 9,096,000 | 6,814,000 | 42,140,000 |
| Madagascar | 2,000,000 | - | 28,742,000 | 9,623,000 | 13,972,000 | 3,122,000 | - | 2,437,000 | 5,249,000 | 54,647,000 |
| Malawi | 61,948,000 | 1,397,000 | 26,447,000 | 10,018,000 | 11,677,000 | 9,174,000 | - | - | 6,218,000 | 114,443,000 |
| Mali | 4,500,000 | - | 26,946,000 | 14,507,000 | 9,980,000 | 4,192,000 | - | 2,000,000 | 4,028,000 | 58,097,000 |
| Mauritania | - | - | - | 919,000 | - | 1,407,000 | - | - | 2,326,000 | - |
| Mexico | 2,200,000 | 1,255,000 | - | - | - | - | - | - | - | 3,455,000 |
| Mozambique | 261,953,000 | 4,990,000 | 29,241,000 | 11,976,000 | 11,477,000 | 15,214,000 | - | 2,460,000 | 10,224,000 | 327,087,000 |
| Namibia | 101,122,000 | 1,946,000 | - | - | - | - | - | - | - | 103,068,000 |
| Nepal | 5,000,000 | - | - | 10,479,000 | 10,978,000 | 6,188,000 | - | - | - | 32,645,000 |
| Nicaragua | 1,897,000 | - | - | 2,196,000 | 2,695,000 | - | - | - | - | 6,788,000 |

| Country | HIV | TB | Malaria | MCH | FP/RH | Nutrition | Other | Water | Food For Peace (FFP) | Global Health Total (minus FFP) |
|---|---|---|---|---|---|---|---|---|---|---|
| Niger | - | - | - | 2,353,000 | - | 2,355,000 | - | - | 4,708,000 | - |
| Nigeria | 471,227,000 | 9,980,000 | 43,588,000 | 22,954,000 | 25,449,000 | - | - | 2,020,000 | - | 575,218,000 |
| Pakistan | - | - | - | 46,209,000 | 39,623,000 | - | 9,750,000 | - | - | 95,582,000 |
| Papua New Guinea | 5,000,000 | - | - | - | - | - | - | - | - | 5,000,000 |
| Peru | 1,290,000 | 598,000 | - | 3,393,000 | 3,892,000 | - | - | - | - | 9,173,000 |
| Philippines | 1,000,000 | 9,980,000 | - | 2,994,000 | 18,463,000 | - | - | 1,250,000 | - | 33,687,000 |
| Russia | 4,800,000 | 9,792,000 | - | 300,000 | 2,852,000 | - | - | - | - | 17,744,000 |
| Rwanda | 109,072,000 | - | 18,962,000 | 8,982,000 | 11,976,000 | 2,495,000 | - | 1,000,000 | - | 152,487,000 |
| Senegal | 4,535,000 | 848,000 | 24,451,000 | 6,487,000 | 12,475,000 | 3,992,000 | - | 4,600,000 | - | 57,388,000 |
| Sierra Leone | 500,000 | - | - | 5,954,000 | - | - | - | - | 5,954,000 | 500,000 |
| Somalia | - | - | - | 1,547,000 | - | - | - | - | - | 1,547,000 |
| South Africa | 535,319,000 | 13,972,000 | - | - | 1,497,000 | - | - | - | - | 550,788,000 |
| South Sudan | 14,046,000 | 1,397,000 | 4,491,000 | 18,966,000 | 6,986,000 | 998,000 | - | 6,000,000 | - | 52,884,000 |
| Sudan | - | - | - | - | - | - | - | 3,000,000 | - | 3,000,000 |
| Swaziland | 59,600,000 | - | - | - | - | - | - | - | - | 59,600,000 |
| Tajikistan | - | 2,488,000 | - | 1,954,000 | 905,000 | - | 1,633,000 | 1,811,000 | - | 8,791,000 |
| Tanzania | 336,254,000 | 3,992,000 | 46,906,000 | 8,982,000 | 22,655,000 | 6,687,000 | - | 4,500,000 | - | 429,976,000 |
| Thailand | 1,500,000 | - | - | - | - | - | - | - | - | 1,500,000 |
| Timor-Leste | - | - | - | 998,000 | 998,000 | - | - | - | - | 1,996,000 |
| Turkmenistan | - | 1,250,000 | - | - | 157,000 | - | - | - | - | 1,407,000 |
| Uganda | 309,084,000 | 4,291,000 | 34,930,000 | 8,483,000 | 20,958,000 | 14,189,000 | - | 2,000,000 | 7,502,000 | 386,433,000 |
| Ukraine | 21,878,000 | 4,008,000 | - | 580,000 | 2,108,000 | - | 449,000 | - | - | 29,023,000 |
| Uzbekistan | - | 3,036,000 | - | - | - | - | - | - | - | 3,036,000 |
| Vietnam | 81,978,000 | - | - | - | - | - | - | - | - | 81,978,000 |
| West Bank and Gaza | - | - | - | 9,400,000 | - | - | 4,400,000 | 40,000,000 | - | 53,800,000 |
| Yemen | - | - | - | 5,489,000 | 3,493,000 | - | - | 500,000 | - | 9,482,000 |
| Zambia | 283,661,000 | 3,293,000 | 23,952,000 | 9,481,000 | 12,974,000 | 4,348,000 | - | 4,600,000 | 1,254,000 | 341,055,000 |
| Zimbabwe | 55,830,000 | 3,992,000 | 11,977,000 | 2,994,000 | 1,996,000 | - | - | - | - | 76,789,000 |
| **Total** | **4,123,521,000** | **175,569,000** | **546,904,000** | **571,122,000** | **474,068,000** | **180,102,000** | **49,381,000** | **170,783,000** | **153,599,000** | **6,137,851,000** |

## Appendix Box 1. Democratic Republic of Congo Country Snapshot

**OFDA Response and Assistance Amounts, FY2011**

- $33.5m responding to a Complex Emergency (re-declared)
  - >$9 million of this was directed to health interventions
  - $7.4 million for economic recovery and market systems (ERMS)
  - $6.2 million for emergency relief supplies (blankets, plastic sheeting, etc.)
  - Multiple USG agencies involved in response, including for food assistance, logistics, and refugees.

**Global Health Programs and Assistance Amounts, FY2011*:**

- $136.7m in global health assistance provided, for seven global health programs in the country:
  - HIV: $ 48,835,000
  - TB: $ 9,980,000
  - Malaria: $ 34,930,000
  - MCH: $ 17,858,000
  - FP/RH: $ 14,471,000
  - Nutrition: $ 3,788,000
  - Water: $ 6,792,000

*Note: these amounts by program include Food for Peace funding, which totaled $5,973,000 in FY2011

## Appendix Box 2. Ethiopia Country Snapshot

**OFDA Response and Assistance Amounts, FY2011**

- $35.1m responding to a Complex Emergency and Drought
  - Failed rains, poor harvest, water shortage impacted incomes, food availability, livestock farming and other areas
  - Conflict-affected refugees, acute malnutrition increased
  - Significant levels of food assistance provided to drought-affected Ethiopians and refugees from Somalia
  - Multiple USG agencies involved in response, including for food assistance, logistics, and refugees, along with health, water, sanitation, and other programs.

**Global Health Programs and Assistance Amounts, FY2011*:**

- $412.3m in global health assistance provided, for seven global health programs in the country:
  - HIV: $ 289,089,000
  - TB: $ 9,980,000
  - Malaria: $ 40,918,000
  - MCH: $ 20,956,000
  - FP/RH: $ 27,943,000
  - Nutrition: $ 18,351,000
  - Water: $ 5,100,000

*Note: these amounts by program include Food for Peace funding, which totaled $11,666,000 in FY2011

| Appendix Box 3. Haiti Country Snapshot |
|---|
| **OFDA Response and Assistance Amounts, FY2011**<br>• $79.1m responding to an Earthquake (re-declared) and Cholera Outbreak<br>▪ Continuing humanitarian assistance needs from the January 2010 earthquake.<br>▪ Shelter, rubble removal, food assistance, work opportunities.<br>▪ >$40 million provided for cholera prevention, $7 million for WASH. |
| **Global Health Programs and Assistance Amounts, FY2011*:**<br>• $203m in global health assistance provided, for five global health programs in the country:<br>▪ HIV: $ 156,240,000<br>▪ TB: $ 1,996,000<br>▪ MCH: $ 17,074,000<br>▪ FP/RH: $ 8,982,000<br>▪ Nutrition: $ 18,685,000<br>*Note: these amounts by program include Food for Peace funding, which totaled $19,791,000 in FY2011 |

# ENDNOTES

[1] OECD definition of Humanitarian Assistance:

"1.17 Within the overall definition of official development assistance (ODA), humanitarian aid is assistance designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of emergencies. To be classified as humanitarian, aid should be consistent with the humanitarian principles of humanity, impartiality, neutrality and independence.

1.18 Humanitarian aid includes: disaster prevention and preparedness; the provision of shelter, food, water and sanitation, health services and other items of assistance for the benefit of affected people and to facilitate the return to normal lives and livelihoods; measures to promote and protect the safety, welfare and dignity of civilians and those no longer taking part in hostilities and rehabilitation, reconstruction and transition assistance while the emergency situation persists. Activities to protect the security of persons or property through the use or display of force are excluded. Includes aid to refugees in developing countries, but not to those in donor countries of which: Relief food aid (code 062)

1.19 Relief food aid comprises supplies of food, and associated costs, provided for humanitarian relief purposes."

[2] Data from the OFDA Annual Report for FY 2011 (http://www.usaid.gov/what-we-do/working-crises-and-conflict/crisis-response/resources/fy-2011-annual-report) and Kaiser Family Foundation's "major U.S. Global Health and Related Initiatives by Country table (http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7881_majorglobalhealthinitiativesbycountry.pdf.

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