"Learning from COVID-19: How to Ensure Resilient Health Service Delivery during Crisis in Africa."

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Regional Policy Position Paper

Introduction

"If the disruption (from COVID-19) to production of commodities and to services on the ground continues for another six months, we could have 500 000 additional AIDS related deaths; and we could have reversals of mother to child transmission of HIV back to where we were 10 years ago"

Winnie Byanyima, UNAIDS Executive Director

This Policy Position Paper aims at supporting policy and practice around building resilience of African health systems, during periods of crisis, shocks and new hazards. It supports policy-makers in planning effective and equitable health systems delivery during the recovery period post-crisis; with lessons drawn from the COVID-19 pandemic.

The Paper provides insight and direction for policy and governance decision makers Ministries (especially Ministries of Health and Ministers of Finance), and Parliamentary representatives. Civil society, development partners and media practitioners can utilise this paper in their advocacy and awareness raising actions.

State of Health Delivery During Crisis: Example of COVID-19

The first human cases of COVID-19 were first reported by officials in Wuhan City, China, in December 2019.[1] As of 6 September, 2020, the outbreak of the COVID-19 has spread to six continents, and approximately 26.7 million cases had been recorded and 876 thousand people had died after contracting the respiratory virus.[2] Africa and in turn Eastern and Southern Africa were not spared of the devastating effects of COVID-19. According to the WHO Africa Dashboard, as of 4 September, the region had recorded 1,275,906 cases and 30,446 deaths. Southern Africa had the greatest burden with 680,500, as compared to all the regions in Africa (Northern -239k; Western – 162.6k; Eastern -138.8k and Central – 54.9k).

1 WHO (2020) Addressing Human Rights as Key to the COVID -19 Response; August 2020
2 WHO Coronavirus (COVID-19) Dashboard at https://covid19.who.int/

The impact of COVID-19 has led to an increase in severity of other pandemics, especially with an increase in HIV related deaths being projected by UNAIDS. The impact was stated by **Winnie Byanyima, UNAIDS Executive Director,**

> *"If the disruption (from COVID-19) to production of commodities and to services on the ground continues for another six months, we could have 500 000 additional AIDS related deaths; and we could have reversals of mother to child transmission of HIV back to where we were 10 years ago"*

In addition, livelihoods are severely affected by the lockdown regulations in a region with high poverty levels and a large percentage of the population engaged in the informal economy.[3] Efforts to curb the impact of COVID-19 in Africa has also been also been adversely affected by poor access to safe water and sanitation facilities, and fragile health systems. Thus magnifying socio-economic exclusion already faced by vulnerable communities, especially women and girls. Ultimately, the magnitude of the impact will depend on the public's reaction within respective countries, the spread of the disease, and the policy response.[4]

Lessons Learnt in the COVID-19 Responses

Current efforts to reduce the spread and effect of COVID-19 comes with its lessons, so does the lack of adequate effort. These are some of the lessons learnt from the COVID-19 response.

LESSON 1 — There is need for strategic and adaptable leadership in response to a health crisis

Countries were strategic in their response to COVID-19: According to updates from International Monetary Fund (IMF), most countries in the Eastern and Southern Africa developed COVID-19 National Preparedness and Response Plans, which detail their plans towards prevention and reduction on impact of COVID-19.[5] This shows that countries are aware and have mechanisms to develop emergency response blueprints, which specifically sets an agenda. The blueprints, if adhered to, are vital in providing a strong platform for responding to a crisis. There is also evidence of UN agencies, donors and civil society organisations putting in place plans with a raft of interventions aimed at COVID-19. A multi-stakeholder response architecture is thus pivotal to a coordinated and multi-faced response to the pandemic.

Leadership needs to be adaptable in the face of a crisis: Adaptability is essential in the COVID-19 response, although this has underlying risks of prioritising the COVID-19 crisis in lieu of other health challenges and socio-economic needs. African governments reacted speedily to impose travel restrictions and closing borders to minimise COVID-19. Most African governments suspended international travel in mid-March, at the same time as most European countries. At the time, Europe had already suffered close to 1 751 deaths, while Africa had reported just six.[6] In addition to international and regional travel bans, public gatherings were banned and some reduced to a maximum of 50 people. Some countries impose overnight curfews to curb movement. Social distancing measures of a meter up to 2 meters are also in place, whilst schools have been closed, together with pubs and beer-halls and all non-essential businesses.[7] A number of Member States have adopted mandatory wearing of masks in public, in order to reduce transmission of the virus.[8] Resources aside, this shows leadership taking a stand and their citizens' health and wellbeing.

Policy Recommendations

1. Ministries of health need to ensure strengthened disease monitoring systems are put in place to enable real time reporting of infection patterns within the general population. This will strengthen relevance and effectiveness of response strategies through answering critical questions such as which demographic group are infections peaking, the geographical spread and concentration of infections and likely sources of spikes in infection. Critical decisions on resource allocation can be made in light of such evidence.

3UNFPA (April 2020) Eastern and Southern Region; Situational Report No1 – April 2020
4 World Bank (2020) Press Release: COVID-19 (Coronavirus) drives Sub-Saharan Africa towards first recession in 25 years
5 IMF (2020) Policy Responses to COVID-19
6 OECD (2020) Africa's Response to COVID-19: What roles for trade, manufacturing and intellectual property?
7 UNOCHA (2020) Southern and Eastern Africa COVID-19 Digest: Situation Report: Last Updated 20 August 2020 (Archived)
8 SADC (2020) SADC Response to COVID-19 Bulletin No. 3: Report on the COVID-19 Pandemic in the SADC region

2. In acknowledging that a multifaceted approach is required, which brings in both state and non-state actors of varying capacities, the national COVID-19 coordination committees should bring in civil society, academia and corporate business as members. This will maximize on pooling of resources and capabilities within each actor.
3. Regional Economic Communities (RECs) such as SADC should start the conversations now towards development of a harmonized Regional Recovery Road-map for "post crisis," which recognizes the impact of COVID-19 across various areas of human development.
4. The impact of COVID-19 is more than on health and touches critical human development aspects such as access to education and poverty eradication. At national level, membership of committees established to respond to the pandemic must go beyond health to also include other critical ministries responsible for social protection, finance, education, economic empowerment and gender. This allows for a holistic and relevant response package, with requisite policy adjustments.

LESSON 2 | **Sustainable Health Financing mechanisms need to be put in place. Although countries built a strong road map to the response, inadequacy of resources still posed a huge threat to achieving set targets**

Long term investments in public Health are important in responding to health crisis: Resources are an integral part of response to crisis, and part of getting ready for any response is having long term health financing options in place. Evidence shows that the response in Africa is crippled by lack of financial resources to deal with the pandemic. WHO reports that the top ten countries spend $5000 per person while the bottom ten spend less than $30, and recommends countries spend between 4 and 5% of GDP on healthcare, while Africa averages 1.5% of GDP on healthcare.[9] To compound this challenge, many African countries are already facing a myriad of debt challenges. This makes the response to the crisis even more difficult. Action Aid states that the system was broken well before COVID-19, and the potential persistence of COVID-19, and the threat of further super-viruses, and mean that there can be no short-term solution to resourcing for health.[10] UNAIDS Executive Director notes an example of Zambia, which is struggling to service its debts and this is compounded by the macro-economic impacts of COVID-19.

> *"Zambia had increased debt servicing by 760% and cut health budget by 30%. So there was already a trend with many countries in debt distress or about to get into debt distress. That is a big piece of the problem of financing health in those countries"* ***Winnie Byanyima, UNAIDS Executive Director***

The funding response to COVID-19 has compromised other critical health needs: As governments grapple with funding for COVID-19 response, resources are being moved from other critical health and economic needs. Malawi's COVID-19 response plan includes US$20 million (0.25 percent of GDP) in spending on health care, while Mozambique increased the budget allocation for health, from about MT 2 billion (or about 0.2 percent of GDP) to about MT 3.3 billion (0.3 percent of GDP). Zambia issued an 8-billion-kwacha bond (2.4 percent of GDP) to finance COVID-19 related expenses and Zimbabwe has put in funds to support COVID-19 mitigation and zontrol measures with a ZWL$1.8 billion disbursement. Although these budget adjustments provide relief for the COVID-19 response, they result in funding gaps for other health issues including HIV and SRH services. In Zimbabwe the case still remains the same;

> *"Domestically our largest source of resources has been the AIDS levy and we were already discussing on how we can leverage locally generated resources to ensure sustainability. The advent of COVID-19 has made it very difficult, we have had to reprioritize the domestic resources for HIV mainly to look at COVID-19 and HIV…"* ***Raymond Yekeye, National AIDS Council of Zimbabwe Operations Director speaking during IAC 2020***

9 WHO (2003) Discussion Paper: How Much Should Countries Spend on Health?
10 Action Aid (2020) Financing Health Care in developing countries during the COVID-19 Crisis

To add to the effects of financial adjustments on other critical health needs, The Global Fund on AIDS, Tuberculosis and Malaria (GFATM) announced the re-programming of active grants to up to 5%, for both country and regional grants to COVID-19 Response. This shows that COVID-19 has taken over priority to HIV, TB and Malaria, thereby presenting a challenge in tackling the response of other critical health challenges. At individual level, absence of sustained health funding means populations resorts to private sector provided health services owing to gaps in public health services. This compromises the tenets of UHC on ensuring that the cost of using services does not place people in financial harm.

Without adequate financial resources; Infrastructure, equipment and workforce capacity remains inadequate: Lack of financial resources affects procurement of adequate equipment, building of infrastructure, and remuneration of workforce. However, with limited resources governments are making efforts in that regard. In Zimbabwe, the government targets increase of health staff by over 4 713 additional medical personnel (about 20 percent increase) to enhance effectiveness in dealing with COVID-19 despite the protracted labour action over remuneration. [11] During the virtual session, the Director of Public Health in the Zambian Ministry of Health stated that the country trained over 2000 additional workers to respond to COVID-19. In Malawi, the government's response plan includes hiring 2000 additional health care workers.[12] Despite these commendable efforts, majority of African States have weak healthcare systems, limited medical supplies and shortfall in medical personnel. Most countries lack adequate healthcare facilities and access even under normal circumstances. The number of hospitals per 10 000 people is 1.2 in Africa as compared 3.8 in OECD countries, WHO recommends 44.5 doctors per 10 thousand people; while Zambia has 12, Uganda 8, and Tanzania 2.[13] The WHO also emphasises that the predicted number of cases requiring hospitalisation would overwhelm available medical capacity in most of Africa.[14] The situation in Africa is worsened by the fact that the continent covers 94% of its pharmaceutical needs through imports, when the countries supporting pharmaceuticals imports to Africa are also fighting COVID-19, and this puts a strain on imports.[15] WHO has raised a flag on shortages on personal protective equipment, were such shortages are leaving doctors, nurses and other frontline workers dangerously ill-equipped to care for COVID-19 patients, due to limited access to supplies such as gloves, medical masks, respirators, goggles, face shields, gowns, and aprons.[16] There is still a gaping hole of infrastructure, equipment and capacity of health workforce in dealing with COVID-19 in the region. This raises the need for resourcing of health care systems and to ensure resilience during and post crisis.

Policy Recommendations

1. National Governments, through the relevant ministries of finance should facilitate emergency reviews of the national budget to increase public allocation for health services delivery.
2. National Governments must engage in review of tax architecture to allow for sustainable internal resources generation. This needs to be considered alongside tax exemptions for importation of critical health equipment, drugs and infrastructure.
3. Funding partners have an opportunity to review current and future funding arrangements to ensure mainstreaming of the COVID-19 response. This will cut across various thematic areas such as livelihoods, food security, citizen engagement, health and gender.
4. Major creditor countries and institutions such as the Paris Club and International Monitory Fund need to engage African debtor countries for the purpose of debt restructuring in light of the macro-economic impacts of COVID-19. It is critical that any debt restructuring acknowledges the current impact of the pandemic and gives "breathing space" for countries to invest in the crisis response. This may include "freezing" of interest payments or debt cancellation.
5. Private sector is a critical player and is urged to invest in the provision of critical health services to reduce the gaps in public health services delivery. Private sector led health services will serve to reduce the burden on public health facilities.

11 IMF (2020) Policy Responses to COVID-19
12 ibid
13 World Bank *(2020), Hospital beds (per 1,000 people)*
14 WHO (2020), New WHO estimates: Up to 190 000 people could die of COVID-19 in Africa if not controlled,
15 ITC (2020), *Tracking of COVID-19 Temporary Trade Measures*
16 WHO (2020) Press Release - Shortage of personal protective equipment endangering health workers worldwide – 3 March 2020

LESSON 3 **It is important to ensure an "equity lens", as no health crisis should lead to exclusion of other services and population groups**

HIV, SRH and other service provisions "*legging behind*" due to prioritisation of COVID-19: COVID-19 has taken space as the 'only" essential service at the expense of other services. Access to essential health services, such as sexual and reproductive health, especially for girls and women being affected by the increased restrictions on mobility, social exclusions within communities and by the economic challenges that households are facing.[17] Also, HIV and AIDS programming has lost momentum due to greater priority on COVID-19 response, besides targets to end AIDS by 2023.[18] Evidence is emerging of service declines for antenatal care, PMTCT, ARV initiation, refills, adherence support, HIV testing and HIV prevention.[19] Within the region, there is however, an effort by UN agencies and civil society to ensure that HIV and SRH remain as essential health services during and post COVID crisis. UNFPA, WHO, UNICEF, UNAIDS and NGO partners advocated for sexual and reproductive health (SRH) and gender-based violence (GBV) services, to be maintained on the list of essential health services, and developed a contextualized guidance note on the continuity of essential maternal and new-born health services for countries. It's also imperative to ensure that national responses do not exclude populations whose vulnerability has been worsened by COVID-19.[20]

Health service provision to vulnerable population in the COVID-19 era can be enhanced by effective use of technology: Technology has proved a useful and necessary tool to help ensure that local and regional governments on the frontline of the emergency continue to provide essential public services during the COVID-19 crisis.[21] Local and regional governments on the frontline of the COVID-19 crisis have resorted to digital technologies to monitor, anticipate and influence the spread of the disease. In Lesotho, UNICEF is supporting efforts to triangulate programme information, scorecard data and weekly community worker reports to ensure that both access to and quality of HIV services are maintained and to catch early declines for prompt remedial action.[22] Use of technology is meant to also reduce inequalities and lower risk of spreading the virus and also increase access to public services during and after the COVID-19 crisis. Technology is expensive and even less accessible in the rural and remote areas. Closing the digital divide also means ensuring technology is non-discriminatory and accessible to all people in the community; including internet access, devices, and information.

Focusing on community engagement, and reducing social exclusion, is important as countries face complex challenges: As evidenced in Tanzania, the Ministry of Health is improving the coordination of the implementation of different community support models including peer-to-peer systems, mother support groups focusing on provision of mental health and psychosocial considerations for pregnant and breastfeeding mothers living with HIV. Mother support groups and peer educators were oriented to focus on ART adherence and general continuation of essential health services in the context of COVID-19.[23] Ensuring all population groups are reached with services needs robust community engagement. Communities are resilient and will always find solutions, so working with them to determine how to continue supporting the services that are needed, while keeping everyone safe.[24] The dual nature of community engagement as a function and a process can play a significant role in health systems and can improve the quality of health services at the same time as contributing to integrated and coherent health programming.[25] Community engagement can be fruitful when community leaders, community structures/committees and the community members themselves are part of the response. Structures for community engagement need to be mainstreamed and supported as part of routine health care delivery. Such structures will serve a dual purpose of raising up community perspective on the emergency health response and also cascade interventions in the community through established cadres.

17 UNFPA (2020) COVID-19 Gender-lens WHO.COVID-19 and violence against women
18 UNICEF (2020) HIV COVID-19 Compendium – July 2020
19 UNICEF's HIV Programming in the Context of COVID-19: Sustaining the gains and reimagining the future for children, adolescents and women Compendium of innovative approaches in Eastern and Southern Africa, July 2020
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23 UNICEF (2020) HIV COVID !9 Compendium
24 Oxfam; (2020) Community Engagement During COVID-19: A guide for community facing staff;
25 WHO (2020) Service Delivery Safety Areas and Community Engagement

Policy Recommendations

1. Civil Society should support the national response through conducting community level information dissemination campaigns, which are aligned to the WHO and national COVID-19 response guidelines. Such campaigns should also focus on increasing usability of information i.e. translating it into local languages or mediums suitable for persons living with disability i.e. Braille and sign language.
2. Civil Society, through already running development projects, can support referrals of communities to essential health service points.
3. Governments through the ministries of Health should conduct mapping and integration of existing community structures and mechanisms within the COVID-19 response. Such structures are critical for early detection of the virus and referrals. Equally, they can play a critical role in information dissemination and monitoring of community adherence to virus prevention efforts in line with WHO guidelines.
4. Academic institutions and private sector technological firms can support the national response through providing innovative solutions for real-time technologies that aide information dissemination, tracking, provision of services and strategic information management of data with efforts to it accessible and affordable to all populations.
5. Community radio, Television and Newspapers have a mandate to avail critical information focused on COVID-19 response and operational facilities where people can access other essential health services. This ought to be considered as part of corporate social responsibility.

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