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# African Governments Need a Post-Covid Plan to Protect Essential Health Services

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## Executive Summary

As the world slowly moves on from the Covid-19 pandemic, we must take stock of the damage the crisis has caused and heed the warning of early indicators. Unless African governments have a plan to rebuild and protect essential health services, they risk wiping out health and economic gains made over several decades. There have already been resurgences in diseases that African countries and the rest of the world have worked hard to reduce or eradicate. Some of these setbacks are linked to the disruption in essential health services caused by Covid-19. Examples include:

- In April 2022, the World Health Organisation (WHO) reported a 400 per cent increase in measles cases in Africa compared to the same period in 2021. In the first three months of this year, 20 African countries reported measles outbreaks – eight more than in the first three months of last year.
- For the first time in a decade, DTP3 vaccination rates, used as a proxy for overall vaccination coverage among children (with three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine per child constituting “vaccination”), dropped in Africa. Coverage now stands at its 2015 level.
- In May, Mozambique reported its first indigenous wild poliovirus case in nearly 30 years.
- For the first time in more than a decade, tuberculosis (TB) mortality has increased: the total number of deaths in 2020 returned to 2017 levels.
- For the first time in nearly two decades, malaria mortality and morbidity in Africa increased in 2020.
- A WHO preliminary analysis in 22 countries found that ten reported a rise in maternal deaths between February and July 2020 compared with the same period in 2019, with the highest increases reported in Comoros, Mali, Senegal and South Africa. Nine of the 22 countries reported a decline in births in health facilities and an increase in abortion complications.

The resurgence of preventable diseases and negative health outcomes is not unexpected. The Covid-19 pandemic and associated mitigation efforts have severely impacted the delivery of essential health services, including routine immunisations, diagnostics and treatments. Although these services were disrupted around the world, particularly in the early months of the pandemic response and during variant-driven waves, the consequences have been acutely felt in many African countries. Despite significant improvements in health outcomes in recent years and hard-won knowledge gleaned from battling other diseases, the unprecedented scale of the Covid crisis in Africa compounded problems facing already overstretched health systems.

The diversion of health workers and laboratory capacity towards the Covid-19 response, in combination with lockdowns and hesitancy to go out in public, left significant gaps in the continuity of essential non-Covid health care.

The re-emergence of diseases such as polio and measles is a canary in the coal mine. Not only have Covid-driven disruptions to essential health services intensified the current public-health situation, but they have also exposed how vulnerable these services are in the face of a crisis. Until essential services are adequately resourced, governments will be forced to continue prioritising one disease at the expense of others.

So, what are the implications of these resurgences to policymakers and leaders now? Are such resurgences an early indicator of a much bigger health crisis? If governments do not act now to rebuild the systems and resources damaged by the pandemic, we will continue to witness renewed damage as a result of preventable diseases in Africa and the rest of the world.

These resurgences would not only have dire consequences on health outcomes and life expectancy for people on the continent, but would also have a snowballing effect, exacerbating poverty and undoing the progress many countries have made in terms of economic development. The severity of the impact would not, of course, be the same across African countries; it is not the same within countries either. Disease resurgence hits some groups much harder than others. High-income households may be able to obtain treatments or vaccines when needed but low-income groups – including women and children – and people living in rural areas are likely to struggle. This is an unfortunate reminder that while Covid-19 spread across the world indiscriminately, the consequences and second-tier impacts of the pandemic are felt much more acutely by some members of society than others.

African governments need to have a post-Covid health plan that protects essential health services, safeguards them against future public-health emergencies and builds public-health systems back better. We recommend this post-Covid health plan focuses on the following:

1. Utilising the momentum of the Covid-19 response
2. Prioritising public-health spending
3. Expanding the health-care workforce
4. Developing regional manufacturing of health commodities
5. Accelerating the integration of digital-health technology

Strengthening essential health services will enable governments to be better prepared to respond to the next pandemic, as this improves the resiliency of health systems overall. With stronger health systems, governments will not have to choose between protecting the people from one health crisis or another. Many African governments are already making an effort to reduce the impact of interruptions and build

back better, and these recommendations only aim to complement existing efforts, depending on country context.

## Covid-19's Impact on Essential Health Services in Africa

Essential health services (EHSs) are just that – services that are vital to maintaining a healthy society. Though every country defines them a little differently depending on needs and priorities, EHSs generally encompass routine immunisation, the diagnosis and treatment of communicable and non-communicable diseases, sexual and reproductive health, nutrition, and other forms of preventative health care and ongoing patient care. The delivery of these services is dependent on a robust health-care workforce, appropriate funding and physical infrastructure and successful community engagement.

EHSs support the reduction of morbidity and mortality through both prevention and response, for example by immunising the population against diseases such as yellow fever, or having a strong testing system to identify and treat illnesses early on. The adequate provision of EHSs to a population – ideally, universal access to affordable care – is key to a resilient health ecosystem. These services play a central role in enabling health systems to prevent localised outbreaks and keep health emergencies from snowballing.

Covid-19 is not the only crisis that has highlighted the need for governments to be able to manage multiple health priorities at the same time. During the 2014–2016 Ebola epidemic in West Africa, there was a diversion of resources and subsequent strain on health systems across Liberia, Guinea and Sierra Leone, where an 18 per cent reduction in service delivery was documented. The disruptions caused by the Ebola epidemic in the provision and utilisation of EHSs resulted in substantial increases in morbidity and mortality from malaria, for example.

When Covid-19 began to spread in early 2020, many African governments – much like governments the world over – were underprepared for the sheer enormity of the whole-of-government, whole-of-society response needed to manage the pandemic. In anticipation of and in response to waves of infections that threatened fragile health systems and were predicted to lead to an unparalleled rise in deaths, governments had to make tough decisions early on to divert already limited resources from EHSs towards the immediate crisis. While most services were eventually restored, the suspension of access – even for those services inaccessible for only a matter of weeks – has had far-reaching consequences.

### Health Care in Africa

Health systems in Africa were strained before the emergence of Covid-19. Around 25 per cent of the global burden of disease is in Africa, close to 94 per cent of all malaria deaths are in Africa, and the numbers of mother and child deaths are four times higher than in other regions. Yet Africa's share of

global health expenditure is less than 1 per cent. Put another way, the rest of the world spends ten times more per capita on health care than Africa. And less than 2 per cent of drugs consumed in Africa are manufactured locally. This means that health systems in many African countries are heavily dependent on multi- and bilateral aid, global supply chains and, as Covid-19 exposed, even international politics.

In addition, despite having the greatest burden of preventable disease, Africa has the lowest density of health workers worldwide. A recent WHO study finds that among 47 countries surveyed within Africa, the average country has just 1.55 health workers (defined as doctors, nurses and midwives) per 1000 people, well below the 4.45 benchmark density the WHO considers adequate for delivery of EHSs to the population. The severe health-worker shortage has been driven by numerous factors, including rapid population growth on the continent, insufficient training capacity, inadequate financing, international migration, weak governance of the health workforce, insufficient incentives and poor retention of personnel. The WHO projects that Africa's health-care-worker shortage will reach 6.1 million by 2030, up 45 per cent from the last projections made in 2013.

Health-care facilities are under-resourced. The continent averages less than one intensive-care unit (ICU) and one ventilator per 100,000 people. The limited capacity of Africa's health facilities is demonstrated by a global comparison of mortality rates among those most critically ill with Covid-19. Though the region has the lowest documented Covid-19 death rates per capita, deaths among those who are hospitalised with Covid-19 are significantly higher than the global average.

Health systems have also been disadvantaged by an overdependence on foreign manufacturing of much-needed medicines and related supplies. About 95 per cent of all medicines used in Africa are imported, while Africa accounts for only 3 per cent of all medicine production globally. African countries rely heavily on imports when it comes to medical supplies; for example, almost all surgical gloves on the continent are imported. Covid-19 exposed the vulnerability that an overdependence on imports of these critical goods causes for African health systems.

Despite incremental improvements in health care on the continent in the past few decades, significant challenges to the delivery of EHSs in Africa were widespread before the arrival of Covid-19.

### **How Has Covid-19 Impacted Essential Health Services?**

The emergence of Covid-19 aggravated many of these underlying vulnerabilities in health systems across Africa. Actions taken to mitigate the pandemic, especially in the early stages of the crisis, impacted the delivery of EHSs such as diagnostics, treatments and routine childhood immunisations. The WHO and UNICEF have raised the alarm that years of progress in improving health outcomes on the continent have been undone. This not only affects the immediate health of communities but also leaves countries and the world more vulnerable to future health threats.

Through the Tony Blair Institute for Global Change (TBI)'s [Africa Vaccines Programme](#), we have tapped into on-the-ground experience from our advisors embedded in governments throughout Africa to gain insight into the challenges that African governments faced in responding to Covid-19 and how Covid-19 impacted EHSs in their countries.

Across the board, public health and safety measures that were used to mitigate Covid-19 transmission made it more difficult for the general public to access EHSs. This was driven both by direct policy measures that prohibited movement, such as lockdowns or the closure of public-transport services, and by citizens' personal choices to avoid going out in public for fear of infection. Furthermore, the redirection of the already limited pool of health-care workers from their regular essential service provision towards the Covid-19 response impacted services, especially routine childhood immunisations and diagnostic testing for diseases such as TB and human immunodeficiency virus (HIV). The diversion of laboratory resources towards testing for Covid-19 led to a reduction in diagnoses and the subsequent treatment of other communicable and non-communicable diseases.

### **Routine Immunisation**

In June 2020, a significant reduction in routine-immunisation campaigns was reported in 89 per cent of WHO African Region member states. According to a [2021 WHO global survey](#) of WHO member states undertaken to measure the continuity of EHSs during the pandemic, around 50 per cent of the member states surveyed reported service disruption for routine facility-based immunisation and routine-outreach immunisation services. Observations from TBI teams on the ground in Kenya, Burkina Faso and Ghana as well as findings from [continental surveys](#) of service interruptions largely validate this global survey.

In Kenya, the combination of redirected resources and restrictions on movement to control Covid-19 led to a reduction in vaccination rates for routine childhood immunisations.

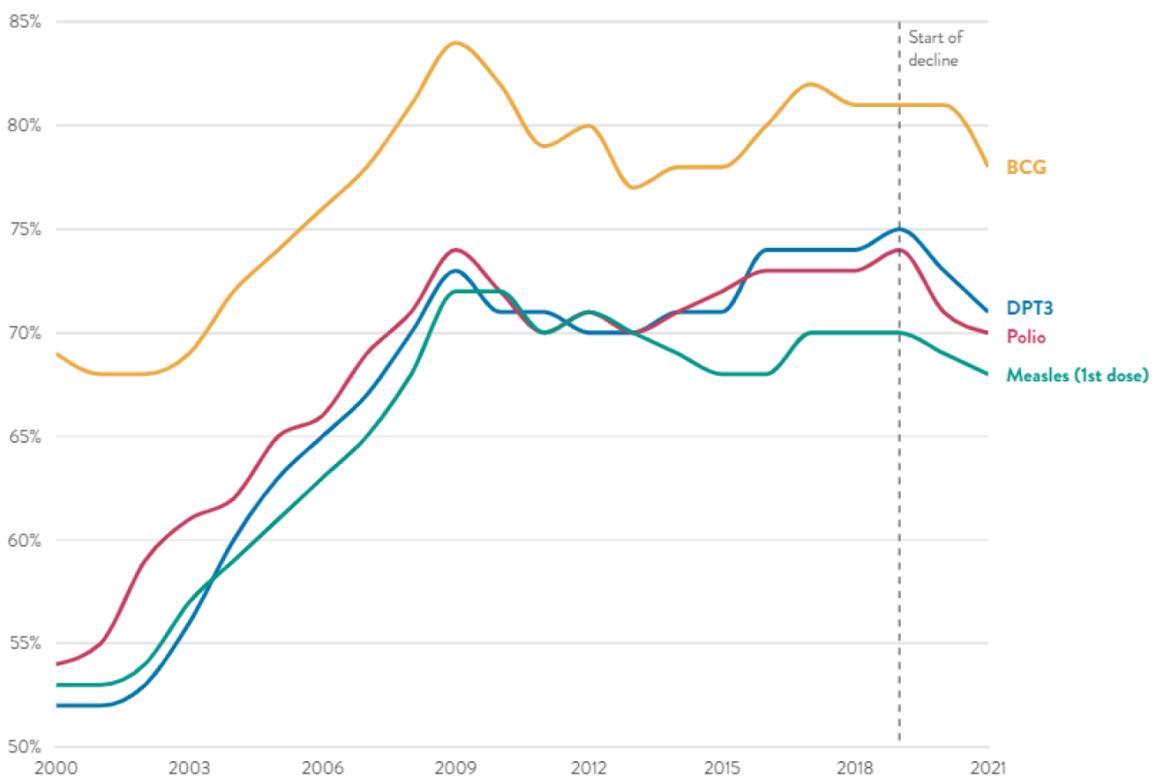
Similarly, in Ghana, a review of routine-immunisation uptake in 2019 through 2021 revealed that the pandemic has negatively impacted this service. National data from Ghana show that routine vaccines such as the Bacillus Calmette–Guérin (BCG) vaccine used to protect against TB had national coverage of 96 per cent in 2019, which dipped to 93 per cent in 2020 due to public-health restrictions, as well as diversion of health-care staff towards the Covid-19 response. Several routine vaccines such as those protecting against polio, hepatitis and rotavirus showed a similar downward trend according to [WHO data](#), although 2021 showed some improvement compared to 2020.

Burkina Faso recorded similar disruptions, with nearly 18,000 children deprived of overall childhood vaccination in just three months from March to June 2020 when public-health restrictions such as partial lockdowns were the most stringent. These numbers are especially relevant in light of a [risk-benefit analysis](#) conducted for Africa during the initial outbreak. The analysis indicated that for every excess

Covid-19 death acquired during routine-vaccination-clinic visits, 84 deaths in children could be prevented by sustaining routine childhood immunisation.

Disruptions to these routine-immunisation services have led to the worst backslide in global vaccination coverage in a generation. For the first time in a decade, DTP3 vaccination rates, used as a proxy for overall vaccination coverage among children, dropped in Africa. Coverage now stands where it was in 2015.

**Figure 1 – Immunisation coverage (1-year-olds), WHO African Region**



Source: [WHO](#)

Even before the pandemic, the WHO African Region lagged behind other regions of the world in access to vaccines. Approximately one in five African children do not receive all necessary vaccines. As a result, more than 30 million children under 5 still suffer from vaccine-preventable diseases (VPDs) every year in Africa. Of these, more than half a million children die from VPDs annually.

Disruptions to EHSs driven by the Covid-19 response have compounded several pre-existing challenges related to increasing routine childhood immunisation coverage, which had largely stalled on the continent since 2010. One such challenge is exponential population growth, which means just maintaining coverage rates requires vaccinating hundreds of thousands more children every year. Another challenge is that the remaining vaccine rollout required to reach population-wide coverage for

many non-Covid vaccines means reaching the most rural communities that often don't have regular access to health care.

## **Diagnosis and Treatment**

Scaling up Covid-19 testing required governments to divert resources – such as health-care workers – that would otherwise contribute to the diagnosis and subsequent treatment of diseases. This was notably evident in TB, HIV, hepatitis and malaria. [A survey conducted by Partnership for Evidence-Based Response to COVID-19 \(PERC\) in 2021](#) showed that the most common types of health services missed by respondents were general routine check-up and diagnostic services.

For the first time in more than a decade, [TB mortality has increased](#); the total number of deaths in 2020 returned to 2017 levels. Meanwhile, the number of newly detected cases in high-burden countries in Africa fell. Prior to Covid-19, there were consecutive years of increasing levels of detection of TB cases.

For the first time in nearly two decades, [malaria mortality and morbidity in Africa increased in 2020](#). At the same time, a year-on-year comparison of malaria testing in select countries across similar periods between 2019 and 2020 shows a 15 to 22 per cent drop. Most of the countries showed reductions in outpatient attendance and malaria testing.

Many of the services related to detecting and treating TB and malaria were severely disrupted for only the first few months following the onset of the pandemic. Yet even just a few months of disruption can have profound consequences for people and the health systems on which they rely.

## **Maternal, Newborn and Child Health**

More data are needed to understand the extent of Covid-19's impact on women and children across Africa, although preliminary numbers demonstrate a reduction in the use of essential reproductive, maternal and neonatal health services. For example, in [Nigeria in June 2020](#) the number of women seeking medical care during pregnancy fell by 16 per cent, and in Liberia the number of women who attended all recommended clinic visits during pregnancy dropped by 18 per cent. Meanwhile, in parts of Ethiopia in 2020, there was a reported decline of up to 25 per cent in the use of family-planning services and a decrease of 20 per cent for antenatal-care attendance compared with pre-pandemic trends, according to UNICEF analysis shared with TBI teams.

These drops in access to essential health-care services can be linked to deteriorating health outcomes, including an increase in maternal deaths. [A WHO preliminary analysis in 22 countries](#) found ten countries reported a rise in maternal deaths, with the highest increases reported in Comoros, Mali, Senegal and South Africa between February and July 2020 compared with the same period in 2019.

Nine of the 22 countries reported a decline in births in health facilities and an increase in abortion complications.

A UN report estimates 68.1 million people among the urban population were at risk of acute food insecurity in sub-Saharan Africa in 2020. This was largely due to the closure of informal markets, loss of income and price surges due to Covid-19 containment measures. With already weakened health systems less able to respond to the specific health concerns that accompany food insecurity, especially for people living in extreme poverty, a vicious cycle of responding to one crisis after another is inevitable, and this is not sustainable.

The response of African countries to Covid-19 and the related impact on the administration of other health services is not unique. However, this scenario is especially concerning to African countries because the long-term indirect damage done to health systems by Covid-19 may outweigh the pandemic's direct impact.

### **Resurgence of Diseases: A Canary in the Coal Mine?**

In addition to losing hard-won gains made against endemic diseases such as malaria, TB and HIV, the continent is experiencing a resurgence of VPD cases. Though there are various factors potentially driving these outbreaks, such as internal conflict and climate change and related humanitarian crises, disruptions to EHSs during the pandemic may also be key to understanding the unexpected resurgence of diseases such as polio.

Both wild-polio and vaccine-derived-polio outbreaks have been emerging across the continent. Africa was declared free of indigenous wild polio in August 2020. Then wild poliovirus was identified in Malawi in November 2021, flagging a major setback in the progress made. Malawi has experienced a 5 per cent decline in polio-vaccine coverage of 1-year-olds compared to 2019 data, suggesting that even a minor decline in vaccination rates can have dire consequences for disease resurgence. Soon after, Mozambique, which has recorded a record decrease of annual polio-vaccine coverage of 15 per cent in 2020, declared its first polio outbreak in 30 years. While these outbreaks have not reached the level of national or continental emergencies, they speak to the bigger concern that any level of interruption in immunisation and outreach efforts has dire consequences. So far only these two countries have identified wild polio, but vaccine-derived polio remains widespread across the continent and can only be curbed by mass vaccination.

The decrease in routine immunisation has also potentially resulted in the resurgence of diseases like measles. The WHO reported that 15 African countries had delayed their measles-immunisation drives in 2020 in order to respond to the pandemic. In April 2021, eight of those countries still had not restarted their campaigns, increasing the risk of a major measles outbreak. In the first three months of 2022, 20

African countries reported measles outbreaks – eight more than in the first three months of last year. In fact, the region saw a 400 per cent increase in measles cases in the first quarter of 2022 compared to first quarter of 2021. Because measles is highly contagious, it spreads quickly as soon as immunisation levels fall. These growing outbreaks may be the canary in the coal mine: an early indicator of other disease outbreaks still to come.

Another resurgence to monitor is cholera. There is an active cholera outbreak in eight countries in Africa. Nigeria saw its biggest outbreak in a decade in 2021 due to contaminated water caused by extensive flooding. Although cholera is predictable and preventable, if left untreated it can kill within hours. The disease is more prevalent in impoverished areas due to inadequate education, poor hygiene, and limited access to clean water and health care. To make matters worse, in October the WHO announced the temporary suspension of its two-dose strategy for cholera vaccines, replacing it with a one-dose regimen due to strained global supply.

In September 2022 Uganda declared an Ebola outbreak caused by the Sudan ebolavirus species. The outbreak is still considered containable and is not yet a regional emergency. However, the fatality rate of the Ebola virus and the lack of an approved vaccine for the strain mean it is essential to remain vigilant and prevent the virus from spreading further. Modelling by the Ugandan Ministry of Health estimates that 250 people will die by January in the spiralling epidemic, rising to 499 by the spring. Already we are witnessing history repeating itself, with the country experiencing shortages of personal protective equipment and the health-care workers needed to manage the crisis and deal with other EHSs simultaneously. The case in Uganda can serve as a bellwether for how able vulnerable health systems, already weakened by Covid-19, are to respond to concurrent health crises. It is a test of what lessons we have learned from the Covid-19 pandemic and how prepared we are to face the next pandemic.

Both reductions in routine childhood immunisations and weakened non-Covid disease-surveillance mechanisms during the pandemic may be to blame for the rising number of newly reported health emergencies.

And there is a high possibility that this is only the tip of the iceberg. More outbreaks may well be on the horizon as countries continue to feel the knock-on effects of the disruptions to EHSs that occurred during the height of the pandemic. The task at hand now is considering how to ensure that countries do not find themselves in the same position during (and after) the next health emergency.

## How Can Countries Safeguard and Strengthen Essential Health Services?

The Covid-19 pandemic has led to a backslide in years of progress in improving health outcomes in Africa and to the resurgence of diseases once thought to be under control. Indeed, this may only be the beginning of the knock-on effects of the pandemic on other health indicators. The extent of EHS disruption points to the reality that many health systems in Africa are not currently prepared to withstand the next health crisis without sacrificing or compromising their existing services.

To safeguard EHSs against future public-health emergencies, African governments need a post-Covid health plan. This plan will need to protect EHSs and, in doing so, strengthen the delivery of those services overall. This post-Covid health plan should seek to:

1. Utilise the momentum of the Covid-19 crisis response
2. Prioritise public-health spending
3. Expand the health-care workforce
4. Develop regional manufacturing of health commodities
5. Accelerate the integration of digital-health technology

### Utilise the Momentum of the Covid-19 Crisis Response

Governments must utilise the momentum of the Covid-19 crisis and the resources mobilised to fight it to bolster EHSs for the long run. Countries can take advantage of increased financing triggered by Covid-19 to invest in their health systems. We call this the “pandemic dividend”.

Since the start of the pandemic, multilateral expenditure on health has increased significantly. For example, there has been \$39 billion in new financing for Africa provided by the World Bank, \$1.5 billion from the Mastercard Foundation and €116 million (approximately \$114 million) from the European Union. These arrangements have also been accompanied by global contributions through the Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response, which has allocated \$1.3 billion towards pandemic preparedness.

Although much of this investment is going towards Covid-19 vaccine procurement, funds are also being allocated to improve elements of vaccine-delivery systems such as cold-chain storage and infrastructure, as well as to the overall strengthening of health systems and services, including digital-health-technology platforms and workforce development. This represents an opportunity to make headway in closing the

continent's wide health-financing gap. These investments can and should bolster underlying EHSs, especially as they relate to routine immunisations.

The pandemic dividend has huge potential. However, to take advantage of this opportunity, governments must have the political will to recognise the benefits of the dividend and make use of existing momentum. Continuing to make health a top priority requires high-level government commitment.

### **Prioritise Public-Health Spending**

Due to the pandemic, there is currently a large pool from which health financing can be drawn, but governments must simultaneously plan for adequate long-term funding of their public-health systems.

The pandemic has underscored that overall government investment in public health in Africa is still far below the level required. While high-income countries spend \$4,000 per capita on health, African countries spend just \$8 to \$129. This gap is attributed to comparatively lower GDPs and competing budget priorities. However, even when countries have undergone economic growth, there have not been significant complementary increases in health spending. For example, between 2001 and 2015, 48 African countries showed an increase in budget allocation for health infrastructure, yet government spending on health relative to overall spending decreased in 21 of those countries. This figure shows there is space to increase health spending, especially for reinforcing essential services.

Yet recent shocks to the global economy – Covid-19, the war in Ukraine, the related food crisis and rising inflation – have put health funding at risk. Increasing US interest rates will make it more difficult for governments to pay off debt, adding pressure to public budgets. As governments confront tough choices, they must look beyond the short term. Maximising health spending and investments in EHSs now will lead to better health outcomes that, in the medium and long term, will ease pressure on those systems and ultimately increase economic productivity.

Global spending on essential TB services decreased from \$6 billion in 2019 to \$5.4 billion in 2021. The UK has cut its health-aid pledge to the Global Fund to fight HIV/AIDS, TB and malaria by almost a third. This is not a good sign in terms of where the priorities of global leaders lie when it comes to health. Global leaders need to maintain their support for global and regional partnerships, such as the Global Fund, that already have systems in place for financing local initiatives to fight health threats such as HIV/AIDS, TB and malaria.

In the face of more limited fiscal space, optimising the use of existing funds and resources will be key. This will require strengthening mechanisms for the monitoring and evaluation of current health spending, enhancing transparency, and improving the use of data to reduce waste and fill critical gaps. Continued partnership and coordination with bilateral and multilateral aid institutions will also be essential in the near term.

## Expand the Health-Care Workforce

Possibly the biggest challenge to the continent's ability to deliver EHSs, whether in times of crisis or not, is the skilled health-worker gap. For example, by the Africa Centres for Disease Control and Prevention (Africa CDC)'s measure, the continent needs to more than triple its current pool of epidemiologists to cope with existing and emerging disease threats.

Expanding the pool of skilled workers will require adequate training as well as reasonable incentives. Deferred salaries, for example, have plagued the region's ability to retain a large, high-quality health workforce. Recently, delayed payments – the result of limited resources – to some health workers involved in mass Covid-19 vaccination exercises have led to demoralised teams and made it more difficult to gain worker commitment to future campaigns. Prioritising payment disbursements is vital to maintaining a motivated and invested workforce that can deliver quality health care to the population.

At the 35th African Union (AU) summit in early 2022, members endorsed the establishment of the AU Health Workforce Task Team. This team is responsible for evaluating health-workforce needs and setting targets to meet those needs. This is a promising start to a regional approach to combatting the health-care-worker challenge.

A regional approach could also be used to quickly upskill workers. Given the varying degrees of workforce size and capacity across countries when it comes to the provision of EHSs, there may be an opportunity to leverage capabilities in countries with more robust EHSs to train and build capacity in countries with higher need. Institutional bodies at the regional level, such as the West African Health Organization, or the continental level, such as the Africa CDC, could support the facilitation of this exchange.

The health workers upskilled as part of the mass Covid-19 vaccination campaigns can also be utilised as a reservist force in the future to address gaps in routine services. For example, in Nigeria the polio contact-tracing workforce was used for the Ebola outbreak, while Botswana utilised community-health platforms that had been strengthened through investments from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

Along similar lines, task shifting is a vital tool for maintaining essential services in the face of external pressures, such as limited available resources or a public-health emergency. Task shifting is the redistribution of certain tasks from highly qualified health workers to workers with fewer qualifications and training to make more efficient use of human resources. This approach proved highly effective in Uganda as the country balanced its Covid-19 pandemic response with the maintenance of essential health care. Antenatal and postnatal care and treatment for malaria were transferred to community health workers while non-medical staff, such as security guards, were trained to conduct temperature screenings.

Increasing both health-care-workforce capacity and size needs to be a priority for African governments, regional institutions and global partners.

### **Develop Regional Manufacturing of Health Commodities**

To protect its EHSs, the continent must invest in building up regional manufacturing of key vaccines, medicines and medical supplies. The pandemic exposed just how dependent African health systems are on global supply chains, with resulting challenges ranging from PPE procurement to mass inequities in access to Covid-19 vaccines to shortages of syringes to administer them. Any disruption to supply could mean life or death for a child waiting for a vaccination, or an HIV patient waiting for a drug. African governments and global partners need to back initiatives that can facilitate production on the continent such as the [Partnerships for African Vaccine Manufacturing](#) and the Africa Medical Supplies Platform. There needs to be an increase in the domestic supply of medical commodities and equipment if African countries are to have resilient EHSs.

Be it for Covid-19 vaccines or future vaccines in the pipeline, governments, regional organisations and global-health organisations – such as the WHO; the Coalition for Epidemic Preparedness Innovations (CEPI); Gavi, the Vaccines Alliance; and the Global Fund to Fight AIDS, Tuberculosis and Malaria – should ensure that the exchange of information and procurement policies is optimised so that a regionally distributed manufacturing network is well-coordinated and achieves its objectives of resilience, equity and efficiency.

### **Accelerate the Integration of Digital-Health Technology**

Adoption of digital-health technology underpins nearly all aspects of safeguarding EHSs and overall health-system strengthening. The digitalisation of health-management platforms will revolutionise the relationship that patients and service providers have with the health-care system. Digitalised health systems can enhance access to services and increase the speed at which patients can receive test results and treatment plans and get answers to questions. For providers, digitalising health-management systems will improve efficiencies in information collection and dissemination and equip policymakers with data for better decision-making.

In line with the pandemic dividend, Covid-19 has accelerated the adoption of health-technology systems and prompted rapid collection and integration of key population information. Until recently, many African countries did not capture disaggregated data on health groups or have systems in place to digitally record data. For example, in Senegal, TBI facilitated the adoption of the [Oracle Health Management System](#) vaccine registry for Covid-19, which has enabled the government to identify vulnerable populations as priorities and ultimately implement a more effective national vaccination

strategy. Innovations like this should be utilised to strengthen routine-immunisation tracking and other essential services.

Digital-health technology platforms will allow governments to have full visibility of informative data and to monitor the status of essential services. Having real-time access to this information will help ministries to more proactively identify and seek to resolve drops in vaccination rates, or reductions in the numbers of patients seeking basic care and preventative services.

The enhanced use of data for the Covid-19 response could be used as a catalyst to improve the use of sub-national data to drive childhood-immunisation coverage, especially to identify children who have received zero doses. In addition, the pandemic has created new partnerships in the innovation space that could be harnessed for EHSs, such as the integration of disease-surveillance systems with digital-health records or disease-monitoring software.

Many African countries, including the Gambia and Uganda, have adopted technologies such as vaccine-recording systems and health-registration systems to provide accurate and real-time data that help to inform vaccination strategies and reach priority groups. In order to be sustainable and forward looking, health strategies need to have data and technology at their heart.

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## Conclusion

There is much work to be done to rectify the losses in essential health-service delivery that the pandemic has caused. The continent is facing new public-health threats as a result of gaps in vaccinations, missed diagnoses and skipped treatments. Decades of advancements in health have been put at risk. African countries cannot afford to sacrifice the building blocks of their health systems to fight another pandemic. They must safeguard and strengthen EHSs – not only to ensure progress continues in improving health outcomes for their populations but, in doing so, to enhance their resilience to future public-health emergencies.

Governments should seize the opportunity presented by the pandemic to reinforce their EHSs. African countries should be thinking about how to maximise the usefulness of every health investment stemming from Covid-19 financing and support. If correctly applied, the pandemic dividend has significant implications for overall health-system strengthening.

Governments will need to secure more sustainable solutions for long-term public-health funding. This will require a larger commitment of domestic resources. These funds are critical to countries' ability to expand the health-care workforce and accelerate the integration of digital-health technology – both of which are key to safeguarding EHSs against future threats. Ultimately, the region must develop local capacity for manufacturing of essential medical commodities in order to build truly resilient health systems.

The redirection of resources normally used for EHSs, such as health workers, diagnostic tools, financing and supplies, was a necessary action for many governments during the height of the pandemic as they balanced suppressing the transmission of Covid under limited operational bandwidth with the usual health-care demands of their countries. However, the consequences of these disruptions are considerable, and we may only be seeing the tip of the iceberg in terms of knock-on effects. To avoid having to make the same trade-off in the future, governments must develop a post-Covid health plan that prioritises and protects EHSs for the future.



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