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of the Global Fund

What C19RM reveals about our impact on health systems

On my last assignment, a colleague from a Francophone African country, who has worked in the health system in his country for more than 30 years, and who has a managerial role in the Ministry of Health, welcomed me with these words: “All the millions invested in our country to improve the health system and the provision of care, and when it comes down to it, faced with the COVID-19 emergency, no health care facility is able to test quickly and provide quality care. What did we do with all that money? Has all this support provided us with something sustainable?”

This notion that the outcomes do not match the investment of health donors torments us all. We are not able to identify what is and isn’t true because we have never established indicators on cost-effectiveness or the level of funds per country, which should ultimately be sufficient to strengthen the system ‘forever’. Yet, we sense that certain indicators are not fully fledged, that maternal and neonatal mortality is still far too high in developing countries, that dying from malaria at a time when treatment is simple and accessible is unacceptable, and that access to water and hygiene, which is needed to achieve good health, should no longer be an issue, particularly in health care facilities that still do not have access to it.

The response to COVID-19 is a good barometer for measuring the impact of our actions, and how sustainable they are. Because as we respond to this relentless pandemic, the foundations laid by the response to infectious diseases should have helped us. Indeed, it follows the same logic: we need to monitor the disease, test to identify patients, isolate and treat them, and trace their contacts to avoid transmission. Test-isolate-treat, the three pillars of the response to infectious diseases.

Yet, to my surprise, in many African countries, despite this approach being well established by national programs responding to HIV and tuberculosis (TB), they have struggled to put it in place to respond to COVID. Even the concept of vulnerable populations or target groups, integral to the response to the three

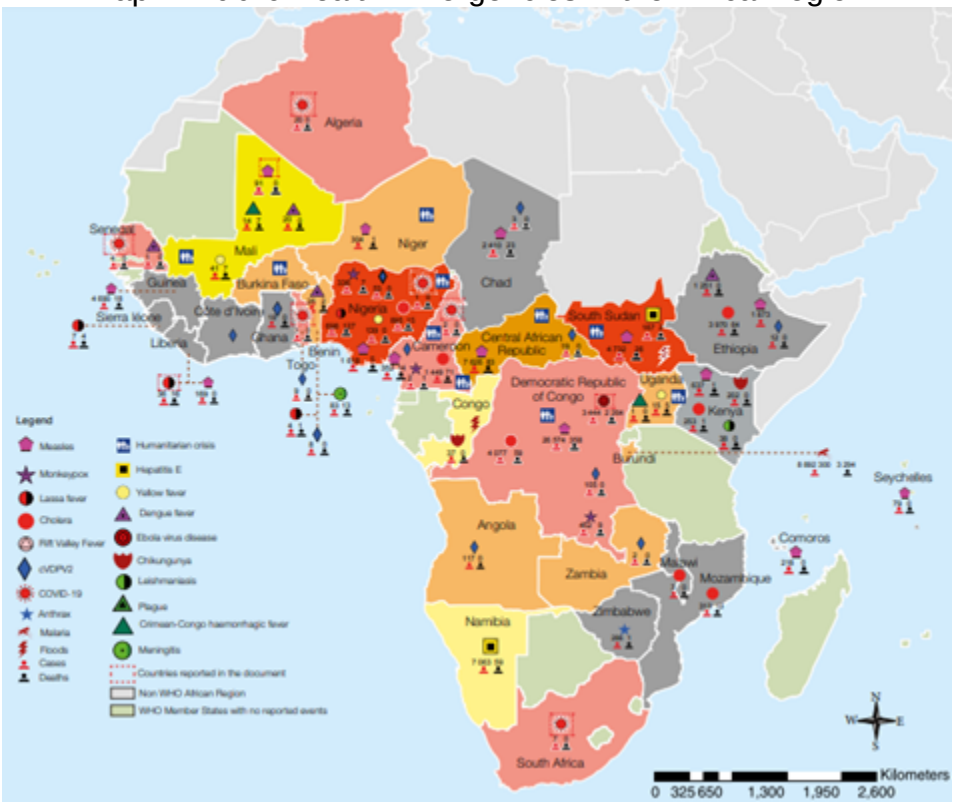
diseases, was not at the heart of the COVID-19 response, despite the fact that after just a few months of the pandemic, we learned that certain people were at higher risk of infection, and of developing more serious forms of the disease. It should therefore have been a priority to detect, protect and treat these groups.

Monitoring and testing

Let's talk about surveillance and testing: globally, every country was overwhelmed at the start of the pandemic, they lacked tests, commodities, manpower and, in low-income countries, skills. But after 18 months of pandemic, it is clear that testing strategies have not developed in many countries and are based on the passive testing of patients who come forward for testing. The generalized use of antigen tests, which are easy to use and are recommended for decentralizing testing to the community level, is difficult to achieve, particularly as ministries are reluctant to use community stakeholders to deliver them. This is despite the fact that civil society organizations (CSOs) have been providing HIV testing for years, and self-testing is now being rolled out with support from CSOs in most countries in the sub-region. This results in a poor understanding of how the virus is spreading and, thus, inadequate active case finding.

One of the reasons for this relates to the very slow progress being made in community-based surveillance, despite it being crucial for alerting the health authorities in the event of an epidemic resurgence, which is highly likely in the African context. This is shown in the World Health Organization (WHO) map below:

Map 1: Public Health Emergencies in the Africa Region



Source: Weekly Bulletin from the WHO Health Emergencies Program, week of 2-8 March 2020

Despite the support programs in place, it is clear that surveillance, particularly in the community (where infections occur), is still lacking. This is linked in particular to a continued lack of structure in terms of community health and the role of community health workers (or community outreach workers), and to poor data feedback through a single system, which is gradually being put in place.

The majority of African countries had contingency plans but they lacked ownership within ministries, so in reality they were not really operational, and had a very theoretical vision based on the emergency response pillars. Despite the combined efforts of partners such as the Africa Centres for Disease Control (CDC), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and international non-government organisations responding to humanitarian emergencies, these plans required an operational review phase to translate them into test, trace, isolate and treat activities.

Treatment

The vast majority of COVID-19 cases have been mild and did not require any particular treatment except isolating at home. However, for patients who developed severe forms, the majority of whom had comorbidities (HIV, tuberculosis, sugar diabetes, hypertension), treatment, high-flow medical oxygen in particular, has proved to be a significant challenge. The situation has cast a harsh light on the lack of well-equipped facilities at the third level of the health pyramid where there are trained and paid medical personnel. It has also further widened the inequality gap in terms of access to care, because the cost of intensive care is so high in countries where social protection systems are non-existent or are in their infancy, that most patients either present late, or do not go to hospitals, particularly private ones. There have not been many studies looking at the financial barriers around the decision to go for a test or to access a health care facility, but we know that patients present late at health care facilities (in Mali, 69% of COVID patients arrive when they are already in respiratory distress and have lung damage). There are very large disparities in the cost of tests (ranging from free to tens of dollars) but they are not often free. When it comes to hospital care, it is the costs linked to non-COVID treatment that most patients cannot cover: tests for patients with comorbidities, treatment for these comorbidities, meals, and administrative costs, which can increase the bill to several thousand dollars ($5,200 in a Kinshasa hospital, for example, to cover all the costs related to 20 days in hospital).

Can the Global Fund become a player in strengthening the response to epidemic emergencies?

In this context, what role can the Global Fund play, as a mechanism that aspires to contribute, through its grants, to improving the preparedness of recipient countries for epidemic emergencies, as set out in its next strategy, which is currently being finalized?

As it stands, the Global Fund can only play a minor role in responding to epidemic emergencies. The process of developing C19RM grants has shown that the Global Fund has not developed the right tools for an emergency response, and it has virtually zero appetite for risk, which makes it impossible to respond to emergencies. In addition, the type of activities usually financed by the Global Fund do not adapt well to the urgency of saving lives: treatment for co-morbidities is not covered, malnutrition (an aggravating risk-factor for patients) is not covered, the procurement procedures for commodities and equipment supply are much too lengthy, and the implementers (the main beneficiaries) are generally not trained in emergency responses. Major changes would therefore need to be made internally so that the Global Fund's emergency response work is responsive and adapted to needs (and not needs adapted to their own procedures).

We therefore envisage a different role for the Global Fund: supporting ministries to structure their epidemic emergencies management response and integrate it into the health system. In many countries, there is a lack of preparedness. Epidemic emergencies management sits under the emergencies department, but they have few resources to train health staff to organize regular simulation exercises to check that health staff know how to use protective equipment, and that health care facilities know how to quickly establish triage and testing areas. They also need to understand the referral channels and the basic principles of hygiene in care settings. In certain countries elsewhere, the response to COVID-19 has been placed under the Prime Minister's Office or the Presidency, and institutions other than the

emergencies department have been made accountable, creating governance conflicts that have hampered the efficiency of the response. One of the current challenges is reintegrating epidemic management into the MOH.

The Global Fund could also support learning activities after each outbreak, so that countries are not starting from scratch with each new outbreak, that they can learn from mistakes and successes, and prepare a response to the most prevalent outbreaks as they appear on the map: cholera, Marburg, Ebola, measles, yellow fever… The Global Fund could support WHO, which seeks to formalize the concept of the Public Health Emergency Operations Center, a hub dedicated to coordinating all health emergency responses.

Finally, Global Fund grants must regularly help finance responses that build both the capacity to respond to the three diseases and also respond to epidemics in general. This support must form the basis of the response to any epidemic emergency in terms of surveillance, testing and referrals, from the community level to the most specialized levels of the health pyramid. Support for a ’minimum package’ that can ring the alarm bell and disseminate information on preventive measures, supplemented by other actions to save lives during epidemic resurgences (intensified testing, treatment and intensive care, widespread risk communication messaging) could be an option because it is through identifying improvements to the mechanisms deployed in ‘emergency’ mode, within ministries that respond to particular epidemics on a daily basis, that the three-pronged objectives of the new strategy (eliminating the three pandemics, strengthening health systems and improving epidemic emergency preparedness) will be effective.

*Christelle Boulanger has supported several Francophone countries to develop their C19RM submissions to the Global Fund.

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