



Africa Development Bank Group

## Policies for Inclusive Health in Post COVID -19 Africa: Summary Outcomes of the African Development Institute (ADI) Global Community of Practice (G-CoP) e-Seminar, 22 and 23 June 2020.

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**INTRODUCTION:** Health is the prerequisite for life, economic productivity and every human experience. Health is local. Global agendas and global policies need to be domesticated and adapted to local conditions. Investing in health is investing in lives and economies. Africa needs to own its knowledge and its discoveries for the health and well-being of its citizens.

Yet many African countries have not fully prioritized investments in inclusive health and wellness in their development policies and programs over the years. Africa's health policies have mostly focused on “*consumptive*” rather than “*productive*” health – a colonial principle that prioritized “*health care*” as management of disease outcomes over “*the provision of public health services*” that prioritize inclusive health and wellness from conception to the end of life. Health pandemics have therefore continued to plague African countries disproportionately compared to other regions of the world. HIV/AIDS, coronary diseases, respiratory diseases, lassa fever, malaria, tuberculosis, etc., are longstanding pandemics in Africa. Put together, these ‘pandemics’ kill many more Africans daily than does COVID-19.

Delegates of the African Development Institute (ADI) Global Community of Practice (G-CoP) policy seminar held on 22 and 23 June 2019, called for a *Marshal Plan for an inclusive resilient health system in Africa*. There is need to build an

integrated system that strengthens human health and wellness, able to detect and interpret local warning signs and quickly mobilize internally to absorb the shocks, isolate threats, and transform itself to adapt to shocks; and organically innovates new ways to maintain its core functions today and tomorrow.

*An inclusive health system is shaped by interactions amongst several spheres of the human experience: the food system, water and sanitation, social environment, education systems, the physical environment and infrastructure, including the quality of the human habitat, health infrastructure, social infrastructure, and the environment, that inform the disease emergence, disease management and control system in a society*

The two-day e-policy seminar held on 22 and 23 June 2020 for delegates from the Western and Eastern hemispheres, respectively – brought together over 565 global experts and 69 panelists from 50 nationalities (Annex 1).

The African Development Institute (ADI) of the African Development Bank Group hosted the seminar in collaboration with the World Health

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Organization (WHO); The African Centre for Disease Control (CDC); The Bank Group's Health Department (AHHD) and Health Centre (CHMH); African Population and Health Research Center (APHRC); Murdoch University, Western Australia; Drexel University (School of Public Health) USA; City University of New York (School of Medicine) USA; University of Nigeria (Faculty of Health Science and Technology).

Key panelists included a Minister of Health from Western Australia, former Ministers of Health, Education and Finance from Africa, a Commissioner for Health, technical staff of Prime Minister's Offices, specialists from multilateral institutions such as Africa CDC, WHO, World Bank Group, University Vice-Chancellors, and heads of health policy research institutes, Teaching Hospitals, think tanks, professional associations, and private sector leaders.

### **The Background**

Human health is shaped by the human experience, the broader socio-economic, psychological, and environmental systems of interaction with the human genome and the human phenome. Empirical evidence suggests that differences in the human genome and the human phenome might explain the differences in the severity of the symptoms observed in COVID-19 patients. A resilient and inclusive health system goes beyond the end of the pipe approaches to treating disease conditions to reduce morbidity and mortality. It encompasses the full cycle of conditions that prevent disease emergence, contain disease occurrence, manage health and wellness, and reduce morbidities and mitigate mortalities from disease-causing agents throughout the life cycle. It was noted that such a system must be informed by institutions and governance systems that are *absorptive, adaptive, reflexive, and transformative*<sup>1</sup>.

The Experts at the G-CoP seminar called for a radical shift in Africa's health policy from one that focuses on medical outcomes, to one that focuses on the broader concept of inclusive health – ensuring quality health from conception to end of life, to all people and all the time.

*“Africa urgently needs a “Marshal Plan” on inclusive one-health policy in Africa. If we focus on what is, we are condemned to repeating what was. But if we focus on what is possible, we stand a chance of transcending what is. Africa must learn from its experiences and unlearn the received wisdom from its colonial history and build its one health system – one that is adapted to its contexts, cultures, and realities”.*

### **The State of Health and Wellness in Africa**

Africa has made progress in reducing premature mortality and prolonging life expectancy since the year 2000 but still lags other regions of the world in almost all indicators of health and wellness. Life expectancy increased by an average of 5 years per decade since the year 2000; Under-5 and maternal mortality rates have equally fallen by 54.2% and 40.7%, respectively<sup>2</sup>. Maternal Mortality Ratio (MMR) declined at an average 0.9% per annum from 542 to 421 per 100,000 live births between 1990 and 2015; and communicable diseases (malaria, measles, and HIV/AIDS) substantially declined since 1990.

However, health services have not been equitable. The health of Africans, the health of black people and other races around the world presents a tale of multiple worlds. There is a 14-fold difference in under-five mortality between high income and low-income countries (most of which are in Africa)<sup>3</sup>; and access to all forms of health care is skewed against the poorest people<sup>4</sup> (most of whom are in Africa and/or are black people in other countries). Africa and the Middle East have high rates of deaths due to cardiovascular disease; Africa has the highest rate of death from tuberculosis; Africa and India have the highest rates of deaths from diarrheal diseases in 2017; and Africa has highest death rates from HIV/AIDS and Malaria, and lowest life expectancy in years than other regions<sup>5</sup>. The overall COVID-19 mortality rate for Black Americans is 2.4 times as

high as the rate for Whites and 2.2 times as high as the rate for Asians and Latinos<sup>6</sup>. Available evidence suggests that without transformative policies and investments, the third Sustainable Development Goal (SDG 3) on “*Ensuring healthy lives and promoting well-being for all at all ages*” is unlikely to be achieved in Africa. Without Africa, this SDG will not be achieved globally.

Yet, Africa’s health systems have not been prioritized over the decades. Early warning signs of increasing vulnerability of African citizens to disease prevalence and higher morbidity and mortality rates from pandemics such as COVID-19 appear to have been ignored by policymakers in Africa and globally prior to the COVID-19 pandemic:

- Africans have high rates of preventable mortality from non-communicable diseases (NCDs) and associated pre-conditions, including unhealthy diets, tobacco use, inadequate physical activity, and misuse of alcohol<sup>7</sup>.
- Sub-Saharan Africa is in the lowest decile in the mitigation of preventable deaths, with country scores as low as 19%<sup>8</sup>.
- 85% of all undiagnosed people with diabetes are estimated to live in Africa<sup>7</sup>.
- More than 218 million people in Sub-Saharan Africa are undernourished. The number grew by 44 million in the past 25 years. It could grow to 320 million by 2025<sup>1</sup>.
- Close to 40% of children under five years of age in Africa are undernourished<sup>9</sup>.

### **Health Expenditure in Africa**

Public expenditure on health in Sub-Saharan Africa is less than 5.2% of GDP<sup>10</sup> (about 50% of the global average and about one-third of the 15% agreed by African Member States in the Abuja Declaration). Africa is the only region where health expenditure is expected to decrease to 5.1% of GDP in 2030<sup>10</sup>. The total health financing gap in Africa is estimated to be about US\$66 billion per annum<sup>11</sup>. South Asia and Africa South of the Sahara together account for over 50% of the global disease burden and 37% of the world’s population, but only 2% of global health spending<sup>10</sup>.

With over 22% of total health expenditure in the form of Official Development Assistance (ODA), and some countries dependent on donor money as high as 50%<sup>12</sup>, the border closures and the protectionist policies that countries enacted to focus first on flattening the COVID-19 disease in their own countries, has created a perfect storm for African health systems. Most citizens in Sub-Saharan Africa pay for healthcare out of pocket and very high health expenditures have been documented as being rampant and a major cause of poverty<sup>13</sup>. A large proportion of African workers are in the informal sector and as such are left out of the private health insurance schemes that mainly focus on individuals in formal employment. In many African countries, health insurance coverage is as low as 5%. Government-supported programs are at a nascent stage and need to be supported to grow while limiting leakages in the service delivery supply chains.

### **Density of Health Workers in Africa**

Compared to the global average of 52.8 health professionals per 10,000, Africa has 23 health professions per 10,000 except for 10 of its 54 countries<sup>14</sup>. Thirteen (13) of the 47 countries for which data are available have less than five health professionals per 10,000 population<sup>14</sup>. The ratio of nursing and midwifery personnel-to-population is 11:10,000 in Africa, compared to the global average of 28: 10,000<sup>14</sup>. Africa has a shortage of 3.6 million health workers and 50% of the population has no access to modern health services.

### **Brain Drain in the Health Sector**

The flip side of the human capital challenge in Africa’s health sector is that the continent exports up to 70,000 skilled professionals (including medical professions) to other parts of the World annually<sup>15,16</sup>. The percentages of trained medical professionals emigrating annually from Africa ranges from 70% from Angola, 59% from Malawi, 57% from Zambia, 51% from Zimbabwe, and over 75% of all trained physicians from Mozambique<sup>11,17</sup>. It is estimated that each migrating African professional represents a loss of US\$184,000 to Africa<sup>18</sup>. Based on this statistic, we estimated that Africa might be losing up to US\$128 billion and US\$2.1 billion through the emigration of skilled

professionals and medical professionals annually, respectively. The US\$2.1 billion loss to Africa is other nations' gain with the financial benefits amounting to US\$2.7 billion to the United Kingdom, US\$846 million to the United States, US\$621 million to Australia and US\$384 million to Canada<sup>19</sup>.

This phenomenon is also referred to as “*brain drain*” from the supply side and “*highly skilled migrants*” from the demand side. Most African emigrants (also referred to as *African Diaspora*) cite better infrastructure and policy incentives as the pull factors that drive them to the more developed nations. However, recent surveys suggest that over 60% of the African Diaspora are keen to return to Africa and the rest are keen to contribute to African development from their duty stations in the Diaspora, if there is a reliable platform to facilitate and securitize their re-engagement.

It is estimated that Africa spends about US\$4 billion annually on the salaries of over 100,000 foreign experts.<sup>18,20</sup> In effect, Africa is subsidizing the skilled workforce out of Africa and paying for international experts to fill the skills gaps created by the African emigrants. The G-CoP experts noted that the demographic structure of Africa – notably its youthful population – could be strategically harnessed to facilitate continued export of human capital to support development elsewhere. In a globalized world, this could be beneficial to both sides, but strategic policies for re-engaging the

*Africa should explore policy options to build and retain its health work force within the shores of Africa; reverse the brain drain through strategic incentives for African Diaspora to return to Africa and encourage brain circulation between Africa and the rest of the World. Strategic incentives for the African Diaspora to re-engage in African development from their duty stations outside Africa is urgently needed in post-COVID-19 Africa.*

African Diaspora in African development is required.

There is need to review the WHO's code of practice on international recruitment of health care workers, adopted in 2010, to tackle problems caused by demand-led drivers of brain drain from developing to more developed nations at the detriment of the former. The current code of practice is a moral guide rather than an enforceable legal instrument.

Africa is also largely missing in the medical tourism industry currently estimated at US\$100 billion with a projected growth rate of 15% to 25% in destinations that have implemented best practices<sup>21,22</sup>. Many African elites and public officials spend billions of dollars in patronizing hospitals outside the shores of Africa annually<sup>4</sup>.

### **Africa's Footprint in the Pharmaceutical Industry**

The G-CoP experts also noted that Africa is not pulling its weight in harnessing its rich biodiversity in vaccine discoveries and the development of pharmaceutical products. Africa's share of the global pharmaceutical industry, which is estimated to be worth US\$1.57 trillion by 2023, is only 2.96%<sup>23</sup>. While Africa contributes nearly 25% of the world trade in biodiversity, the continent is largely missing in the race for vaccine and drug discovery for several disease conditions that plague the continent<sup>24</sup>.

In addition, while over 90% of citizens in some African countries and over 80% of the emerging world's population rely on traditional medicine<sup>25</sup>, ethnomedicine (also referred to as traditional medicine) is regarded with disdain in most African countries. Yet the ratio of traditional healers to the population in Africa is 1:500 compared to the ratio of Medical Doctors to population is 1:40,000<sup>25</sup>. African medical curriculum is designed to meet Western standards to the detriment of African traditional practices, which might be equally potent.

<sup>4</sup> Exact estimate of the cost of medical tourism to African economies was not available at the time of drafting this summary outcome of the seminar,



African countries have only 375 pharmaceutical companies for the population of about 1.3 billion people, while China and India, with a population of 1.4 billion people each have over 7,000 and about 10,500 pharmaceutical companies, respectively<sup>26</sup>.

At the time of the emergence of COVID-19 pandemic in Africa in March 2020, there were fewer than 2,000 functional ventilators in 41 African countries, while the total number of available intensive care unit beds in 43 countries on the continent is less than 5,000<sup>27</sup>. There is urgent need for Africa to enact policies and strategies to harness its wealth in biodiversity rich in medicinal plants, roots, herbs and other microbes to accurate vaccine and drug discovery locally.

### Health Impacts of COVID-19 in Africa

The health impacts of COVID-19 around the world in terms of confirmed rates of infection, morbidities and mortalities as well as geographical spread have been unprecedented (Box 1). Beyond the widely reported mortalities and morbidities, emerging evidence suggests that the impacts of COVID-19 might be triggering and/or amplifying other chronic disease conditions such as diabetes, cardiovascular diseases, blood clotting and affecting liver function in patients. It remains unclear how the disease curves will evolve and/or if the COVID-19 virus would mutate into other strains of the coronavirus. And more importantly, the reported cases are based on the levels and accuracy of testing in communities. There is a relatively high number of asymptomatic carriers of the COVID-19 virus who may be spreading it in communities unwittingly. These asymptomatic spreaders can only be identified and quarantined if there is widespread community testing capacity in countries. In addition, some of the available test-kits result in up to 15% false negatives. This can further exacerbate the community spread of COVID-19.

*We can expect a “V”, “U”, extended “U”, a “W” or multiple “W” shaped recovery in African countries depending on public policy options implemented by countries, until the vaccine for COVID-19 virus or a therapeutic cure becomes universally available<sup>1</sup>*

It was noted that most of the health pandemics caused by zoonotic diseases such as COVID-19 have resulted from anthropogenic incursions into natural habitats climate change, trade in wildlife; biodiversity loss, food insecurity; massive social inequalities that are driving the poor to the banks of survival; and a development model that benefits the few at the detriment of the masses. Until these sources of disequilibria in the outcomes of the current development paradigm are decisively addressed, more pandemics are yet to come<sup>1</sup>.

Countries are therefore called upon to adopt the non-pharmaceutical measures recommended by the World Health Organization – notably personal hygiene, frequent handwashing, social distancing and wearing of masks while in public to prevent the spread of COVID-19 and other communicable diseases. These basic personal hygiene practices are needed not only for containing COVID-19 but also for mitigating other communicable diseases that affect citizens of Africa.

### Impact Transmission Channels of COVID-19

COVID-19 is a supranational pandemic. It has impacted several spheres of human health and wellness through several channels:

- **Demand shock:** lockdowns and loss of incomes reduce household incomes and affect demand for Medicare.
- **Supply shock:** contraction in local production and export ban limit medical supply.
- **Induced price shock:** Artificial buying, hoarding and protectionist policies increase prices of medical equipment and pharmaceuticals during a pandemic. The contraction in production, stranded assets and incurred debt may lead to sustained price hikes in the medium term.
- **Fiscal balance constraints:** Constrained budget balances in countries, limited and plummeting internal revenue and foreign exchange earnings and instability in the value of domestic currencies caused by easing of monetary and fiscal policies elsewhere will further limit the capacity of countries to expand health sector budgets. Available health budgets reallocated to COVID-19 could lead to budget deficits for other sectors, including primary health care,

water and sanitation, food and other medical needs of vulnerable populations.

- **Lack of coordination among relevant Ministries and Governments Agencies:** This could lead to the risk of further budget constraints in critical sectors as resources are relocated to importation of testing equipment and personal protective equipment (PPEs), leaving key sectors at risk.
- **Prevailing conditions:** The impact of COVID-19 is exacerbated by existing health, demographic and social conditions of patients. Population density, lack of access to basic primary health services, food, water and sanitation, etc., exacerbate the impacts of COVID-19 in Africa.

### COVID-19 Lockdowns are Not Equal

During the COVID-19 lockdowns, hunger pandemic, domestic violence, and social insecurity may exacerbate health challenges in many African communities. Already, it is estimated that about 135 million Africans are experiencing critical food insecurity. By the end of 2020, upwards of 265 million people could be on the brink of starvation globally, almost double the current rate of crisis-level food insecurity<sup>28</sup>. Children under five years who survive the hunger pandemic may suffer stunting and reduced brain development – a condition that could limit their capacity for life.

In 2018, the proportion of under-5 children who were not growing well (stunted, wasted, or overweight) was over 40% in sub-Saharan Africa compared to just under 15% in developed countries<sup>9</sup>. More African children and young people are surviving, but far too few are thriving. Malnutrition is both a result and a significant cause of poverty and deprivation in Africa. The causes of malnutrition also include poor access to essential health services and to clean water and adequate sanitation, which can lead to illnesses that impact the intake and absorption of nutrients. The number of undernourished people in Africa grew by 44 million in the past 25 years.

One severely impacted country is the Democratic Republic of Congo, where over 15 million people are experiencing acute food insecurity. DRC's eastern region is at risk of Ebola re-emergence. In

Eastern Africa, a new generation of locusts has descended on croplands, wiping out vital food supplies for millions of people. Weather conditions could exacerbate the growing swarm of trillions of locusts into countries that are not normally accustomed to dealing with the pest. This could continue to cause significant problems in the region in 2020.

The confluence of factors will drive rural-urban migration and social conflicts and confrontations at the community, state, national and regional scales. This could drive further protectionism as individuals, states and countries implement measures to protect themselves. The majority of African households already spend more than 40% of disposable income on food<sup>29</sup>.

*Continued COVID-19 lock-down could become a silent war on the poor without guns if the necessary social safety net measures are not urgently put in place to ensure food and medical supplies to the vulnerable households. This could kill more than COVID-19 in Africa<sup>1</sup>.*

About 4.5 billion people (60% of the world) do not have access to safely managed sanitation; 15% of the world still practice open defecation and 40% of the world does not have access to basic handwashing facilities. About 400 million Africans lack access to safe water and nearly 800 million do not have access to basic handwashing facilities. Unsafe sanitation is responsible for 775,000 deaths annually<sup>30</sup>.

Yet, water, sanitation and personal hygiene are the first lines of defense against COVID-19. Air pollution remains one of the greatest environmental threats to human health. In 2018, 97% of cities in low- and middle-income countries with more than 100,000 inhabitants did not meet WHO air quality guidelines<sup>31</sup>. It is estimated that over 500,000 Africans (mostly women and children) die annually from indoor air pollution-related illnesses. COVID-19 lockdown policies must account for these

underlying pre-conditions that are mainly responsible for how households can cope with lockdowns and implement personal hygiene and social distancing measures.

Policies must be informed by localized scientific evidence on the prevalence of the COVID-19 virus based on widespread community testing, epidemiological models of potential spread based on the demographic factors and underlying socio-economic factors relevant to the spread of COVID-19, as well as the resilience capacity of the populations.

There is no one size fits all policy option. Decisionmakers need to engage with local experts and influencers (Scientists, Community Leaders, Faith leaders, and Civil Society) to articulate clear policy messages, define incentives, norms or behaviors, and rules for managing defiance. Policies to contain COVID-19 is non-pharmaceutical and behavioral at this stage.

*Health outcomes do not trickle down. Countries must move from a focus on flattening the COVID-19 disease curve to more comprehensive measures to flatten the primary healthcare needs of citizens. There must not be another return to business as usual. We cannot contain the COVID-19 pandemic and/or avert a next pandemic with the same logic and systems that got us to this point. Incrementalism does not work in the health sector. Bolder action for health in Africa is urgently required now. Africa needs to unlearn to learn transformative ways of addressing the health challenge in Africa in an African way. To build a resilient health system post-COVID-19, Africa needs to refocus its policies on inclusive public health services not on managing disease*

#### **Box 1: Health Impacts of COVID-19 as at 22 June 2020**

- 8,736,664 COVID-19 confirmed cases globally: 49% in the Americas, 26% in Europe; 21% in Asia.
- Over 4.0 million tests conducted in Africa: South Africa (32%), Morocco (13%), Ghana (7.0%), Ethiopia (5%) and Egypt (4%).
- Confirmed cases (295,406); Recovered cases (142,261); Mortalities (7,852); Active cases (145,293).
- South Africa, Egypt, Nigeria, Ghana, Algeria, and Cameroon account for 68% of cases reported in Africa.
- Five countries with the least number of cases are Lesotho, Seychelles, Gambia, Namibia, and Botswana
- As of June 20, 2020, a total of 7,852 deaths were reported in Africa, of which 42.3% are in North Africa, 24.9% in Southern Africa, 13.7% in West Africa, 11.5% in East Africa and 7.6% in Central Africa.
- The case fatality rate (CFR) stands at 2.7% for Africa in the review period, compared to 5.3% globally.

*Source: African Development Bank, Statistics*

## INCLUSIVE HEALTH POLICY OPTIONS FOR POST COVID-19 AFRICA

The experts proffered actionable policy options (Box 2) to flatten the COVID-19 disease curve; rebuild an inclusive and resilient health system for Africa; and improve the health and wellness for the people of Africa. Detailed analysis of the short-term, medium and long-term policies including their potency, implementation challenges, and possible solutions will be provided in the Matrix of Policy Options (MPO) and Summary for Policymakers (SPM) that are currently under preparation<sup>5</sup>.

### BOX 2: Policy Options

- Countries should enforce the non-pharmaceutical measures including personal hygiene, handwashing, hand sanitizing and use of masks in public places depending on the severity of COVID-19 in communities.
- Countries to provide social safety nets and essential services for primary health care (access to quality water and sanitation, food, and basic sanitary services) for vulnerable households.
- Countries to scale up testing, contact tracing, isolation and quarantining COVID-19 positive patients, social distancing, restricted movement, and border protection to minimize spread of the virus.
- Proactive knowledge and capacity sharing within the region and globally to better understand the epidemiology of the virus and impacts of measures being implemented.
- Establish public policy and regulatory frameworks to enhance the digitization of health care; operationalization of telemedicine, mobile clinics, and innovative /mobile outpatient services in Africa – address licensing, patient confidentiality and data protection, digital infrastructure and ICT access, and public participation.
- Development Banks and Financial Institutions should prioritize investments in domestic capacity for production of medical equipment and pharmaceuticals including vaccine and drug discovery.
- Finance Ministers to implement prudential macro-economic policies to ensure adequate budget provision for public health services in countries and fiscal stimulus to support the most vulnerable citizens.
- Countries to enact Vaccine and Drug Discovery Policy that encourages the public and private sectors to leverage Africa's rich biodiversity for the development of pharmaceuticals for the benefit of Africans and the humanity in general. There should be inward policies to produce vaccines and drugs locally.
- African Development Bank Group and the African Union Commission and WHO should initiate a Marshall Plan on Inclusive Health embedded in African realities for Africa. This should be ratified through a Continental Health Summit of Heads of States and Governments, Leaders of the Private Sector, the Accademia, and Civil Society.
- Establish African Phenome and Genome Centre – for disease profiling, research, and development and enhanced precision public health care services in Africa.

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<sup>5</sup> The list of policy options reflected in this summary benefited from the contributions of the Panelists and Delegates who submitted think-pieces to the seminar (Annex 2).



### [...] Policy Options

- Support Youth and Women Innovation Incubation Program to harness and commercialize social innovations (e-health, M-health, and other applications) being developed by African youths and women.
- Strengthen and reform African health policy research institutions to focus on Africa-led solutions on inclusive health in Africa. This should include the strengthening of science and technological capacity of the African Centers for Disease Control (CDC), regional public health Institutes, National health policy research institutions, Faculties of Medicine, Pharmacy, Biomedical Sciences and related subjects, and policy think tanks.
- Establish policies to build and retain health professionals in Africa, reverse brain drain, and encourage brain circulation among the African Diaspora.
- Mobilize African Health and Finance Ministers to participate in World Health Assemblies to drive African agendas at the global scale.
- Invest in Big-Data systems to support medical and epidemiological research that can inform early warning systems and rapid responses to disease detection, management, and control.
- Refocus attention on community, national and sub-regional health policies. Health is local. Global policies do not work.
- Countries are encouraged to domesticate and scale up investments in the African Development Bank Group's Hi-5 Strategies as a broad framework for building inclusive and resilience health systems in Africa.
- Focus on Universal Health Care (UHC) policies to ensure that no one is left behind.
- Re-think investments in health care infrastructure to focus on efficiencies, flexibility, adaptive capacity, and collaboration (through referrals) rather than number of physical infrastructures built. Invest in inclusive public health system rather than disease specific infrastructure.
- Invest in transparency and accountability systems in the health sector – to reduce leakages and corruption.
- Enact policies for public-private sector partnerships (PPPs) in the health sector
- Global cooperation is required as an obligation to our shared humanity, planetary security, and our common future. If COVID-19 is anywhere, COVID-19 is everywhere.
- Further research on appropriate health technology, digital health, ethno-medicine, data environment and retroactive learning from earlier pandemics in Africa and elsewhere, and how other countries have addressed COVID-19 is required.
- Inclusive Health Insurance Policy Required across countries is required
- Invest in basic public education and reform curriculum to address African realities.
- Invest in policies for behavioral change
- **Response policies should be guided by science not politics**

## POLICY TIMING, DESIGN, AND IMPLEMENTATION

Whichever policy options are chosen, countries should pay attention to the policy design, sequencing, relevance to local conditions, and the timing of implementation.

Poorly designed recovery policy is likely to be ineffective in delivering desired economic outcomes regardless of theoretical potential. Countries are advised to avoid “copy-pasting” policies designed for other contexts such as the “lockdown” policy. Policymakers should proactively engage local experts and scientists to help them identify the appropriateness of policies in their local conditions. Furthermore, policymakers should map out the potential multiplier effects and co-benefits on other sectors of the economy at the policy design stage. It was noted that a lack of capacity for policy implementation is also an ongoing concern on the continent. Policy design should include clear indicators of accountability and strategies for monitoring progress to maximize impact. National contexts and priorities differ and so should the policies targeted at addressing them.

The G-CoP experts noted that policy timing, timeliness and flexibility in implementation will be important characteristics for achieving the desired outcomes. In the context of COVID-19, there are many known unknowns and unknown unknowns. It is yet unclear how long the pandemic will last and whether there will be recurrence after the first cycle. With the current nationalistic approaches to the prevention and containment measures, it is very likely that hotspots of the virus may remain in less developed countries, especially in Africa, for much longer. These could become future epicenters for another global spread of the virus. In addition, it remains unclear whether the estimated recession will be deeper than projected with possible default cascades.

The discussion on the shape of the recovery of the economies remains unclear. It is yet to be seen whether economies will take the “V”, “U”, prolonged “U” or even a “W”, multiple “W” or “L”

shaped recovery path. Without a coordinated global action, the recovery path may likely be a multiple “W”, if there are multiple waves in the future.

*COVID-19 is a supra-national health pandemic. It requires a supranational and coordinated global response. If there is COVID-19 anywhere in the world, there is COVID-19 everywhere in the world.*

While extreme urgency was required in introducing prevention and containment policies that were sometimes inappropriate for local conditions, successful policies for the recovery and rebuilding phase will be defined by the appropriateness of the specific policies adopted to specific social, political, environmental, and financial contexts of actors.

Equity considerations demand that recovery policies should not pass on significant liabilities across nations and/or to future generations. Intergenerational inequities will be exacerbated within and among countries, if policy responses to pandemics such as COVID-19 focus on re-booting unlimited consumption and/or rebuilding national economies only. The COVID-19 lockdown and social distancing policies have exposed the significant inequities in the current economic system, which focuses on maximizing current consumption to maximize GDP growth without much recourse to the distribution effects of policies and externalities of social and natural capital, and the overall welfare of the current and future generation. The G-CoP experts encouraged African governments not just to focus on rebuilding the health system but to build inclusive health systems – one that focuses on sufficiency, efficiency, adaptive capacity, inclusiveness, and equity.

COVID-19 has renewed the appreciation of basic hygiene and public healthcare services. This should be maintained even after the COVID-19 pandemic.

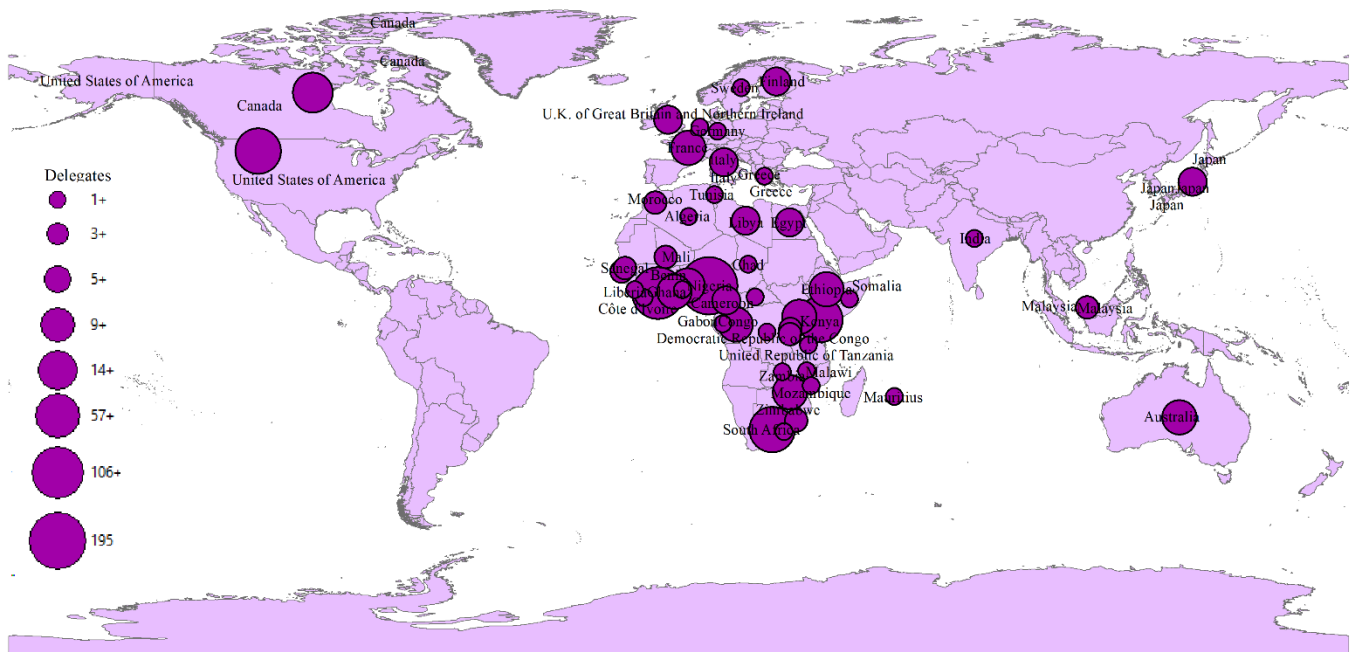
Contact: African Development Institute, Global  
Community of Practice,  
e-mail: [ADIGCOP@AFDB.ORG](mailto:ADIGCOP@AFDB.ORG)

## References

- <sup>1</sup> Kevin Chika Urama. 2020. Building Resilient Health Systems: Policies for Inclusive Health in Post-COVID-19 Africa: ADI G-COP Presentation. African Development Institute (ADI) June 2020
- <sup>2</sup> World Health Organisation, 2018. State of health in the African Region <https://www.afro.who.int/publications/state-health-who-african-region>
- <sup>3</sup> WHO. Under-five mortality. 2018. [https://www.who.int/gho/child\\_health/mortality/mortality\\_under\\_five\\_text/en/](https://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/)
- <sup>4</sup> Barros AJD, Wehrmeister FC, Ferreira LZ, Vidaletti LP, Hosseinpour AR, Victora CG. Are the poorest poor being left behind? Estimating global inequalities in reproductive, maternal, newborn and child health. *BMJ Glob Health*. 2020;5(1):e002229. Published 2020 Jan 26. doi:10.1136/bmjgh-2019-002229
- <sup>5</sup> IHME, Global Burden of Disease (GBD); OurWorldInDdata.org
- <sup>6</sup> Laurencin, C. T., Ph, D., & McClinton, A. (2020). THE COVID-19 PANDEMIC: A Call to Action to Identify and Address Racial and Ethnic Disparities. *Journal of Racial and Ethnic Health Disparities*, 1–13. <https://doi.org/10.1007/s40615-020-00756-0>
- <sup>7</sup> World Health Organization (WHO) (2015). Global status report on noncommunicable diseases 2014. Geneva: World Health Organization
- <sup>8</sup> Fullman, N., Yearwood, J., Abay, S. M., Abbafati, C., Abd-Allah, F., Abdela, J., Abdelalim, A., Abebe, Z., Abebo, T. A., Aboyans, V., Abraha, H. N., Abreu, D. M. X., Abu-Raddad, L. J., Adane, A. A., Adedoyin, R. A., Adetokunboh, O., Adhikari, T. B., Afarideh, M., Afshin, A., ... Lozano, R. (2018). Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: A systematic analysis from the Global Burden of Disease Study 2016. *The Lancet*, 391(10136), 2236–2271. [https://doi.org/10.1016/S0140-6736\(18\)30994-2](https://doi.org/10.1016/S0140-6736(18)30994-2)
- <sup>9</sup> UNICEF. (2019). The State of the World's Children 2019. Yemane and Dennis Yuen. Lisa Rogers from WHO for providing original data used in Children, Food and Nutrition: Growing well this report. in a changing world
- <sup>10</sup> Global Burden of Disease Health Financing Collaborator Network. (2019). Past, present, and future of global health financing : a review of development assistance , government , out-of-pocket , and other private spending on health for 195 countries, 1995-2050. *Lancet*, April 25, 28. [https://doi.org/10.1016/S0140-6736\(19\)30841-4](https://doi.org/10.1016/S0140-6736(19)30841-4)
- <sup>11</sup> UNCEA. (2019). *Healthcare and Economic growth In Africa*.
- <sup>12</sup> Public Financing for Health in Africa: from Abuja to the SDGs. <https://apps.who.int/iris/bitstream/handle/10665/249527/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf?sequence=1>
- <sup>13</sup> Wagstaff A, Flores G, Hsu J, et al. Progress on catastrophic health spending in 133 countries: a retrospective observational study. *Lancet Glob Health*. 2018;6(2):e169-e179. doi:10.1016/S2214-109X(17)30429-1
- <sup>14</sup> For more details, visit <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS>
- <sup>15</sup> Kigotho, W. (2018). African Union devises 10-year plan to stem brain drain. University World News The Global Window on Higher Education
- <sup>16</sup> Pang, T., Ann, M., & Haines, A. (2002). Brain drain and health professionals A global problem needs global solutions. *BMJ*, 324, 499–500.
- <sup>17</sup> AU Capacity Development Plan Framework
- <sup>18</sup> Oyowe, A. (1996). Brain drain: Colossal loss of investment for developing countries. *The Courier ACP-EU*, 159, 59-60.
- <sup>19</sup> Laurencin, C. T., Ph, D., & McClinton, A. (2020). THE COVID-19 PANDEMIC : A Call to Action to Identify and Address Racial and Ethnic Disparities. *Journal of Racial and Ethnic Health Disparities*, 1–13. <https://doi.org/10.1007/s40615-020-00756-0>
- <sup>20</sup> Seepe, S. (2001, March 30). The brain drain will continue unabated. *Mail and Guardian*
- <sup>21</sup> Fetscherina, M., & Stephano, R.-M. (2016). The medical tourism index: Scale development and validation. *Tourism Management*, 52, 539–556. <https://doi.org/10.1016/j.tourman.2015.08.010>
- <sup>22</sup> Izadi, M., Saadat, S. H., Ayoubian, A., Hashemidehaghi, Z., Karbasi, M. R., & Jalali, A. R. (2013). Health Tourism in Iran ; Identifying Obstacles for Development of This Industry. *International Journal of Travel Medicine & Global Health*, 1(2), 89–94.
- <sup>23</sup> NAVADHI Market Research. (2019). *Global Pharmaceuticals Industry Analysis and Trends 2023*. Global Pharmaceuticals Industry Analysis and Trends 2023. <https://www.navadhi.com/publications/global-pharmaceuticals-industry-analysis-and-trends-2023>

- <sup>24</sup> REGULATORY STATUS OF TRADITIONAL MEDICINES IN AFRICA REGION Sharma Sharad\*, Patel Manish, Bhuch Mayank, Chatterjee Mitul, Shrivastava Sanjay. International Journal of Research in Ayurveda & Pharmacy, 2(1), Jan-Feb 2011 103-110
- <sup>25</sup> WHO global report on traditional and complementary medicine 2019. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO
- <sup>26</sup> Conway, M., Holt, T., Sabow, A., & Sun, I. (2019). Should sub-Saharan Africa make its own drugs? A comprehensive analysis of the business, economic, and public-health impact finds the potential for local production of pharmaceuticals to be a mixed bag. PUBLIC SECTOR PRACTICE, January, 9.
- <sup>27</sup> World Health Organisation, 2020. COVID-19 pandemic expands reach in Africa, <https://www.afro.who.int/news/covid-19-pandemic-expands-reach-africa>
- <sup>28</sup> <https://www.visualcapitalist.com/covid-19-global-food-insecurity/> (accessed 15 May 2020).
- <sup>29</sup> <https://ourworldindata.org/grapher/share-of-consumer-expenditure-spent-on-food-vs-gdp-per-capita>
- <sup>30</sup> Hannah Ritchie (2019) - "Sanitation". Published online at OurWorldInData.org. Retrieved from: 'https://ourworldindata.org/sanitation' [Online Resource]
- <sup>31</sup> <https://www.who.int/airpollution/data/cities/en/>

## Annex 1: Global Distribution of Delegates for the Seminar



## **Annex 2: List of the Panelists, the Delegates who submitted think-pieces to the Seminar**

**Dr. Matshidiso Rebecca Moeti**  
WHO Regional Director for Africa  
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**Brazzaville, Republic of Congo**

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Honorable Commissioner for Health,  
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