Presentation to the MMI Seminar

With the Covid-19 pandemic: South Africa's health system torn between health security and universal access priorities

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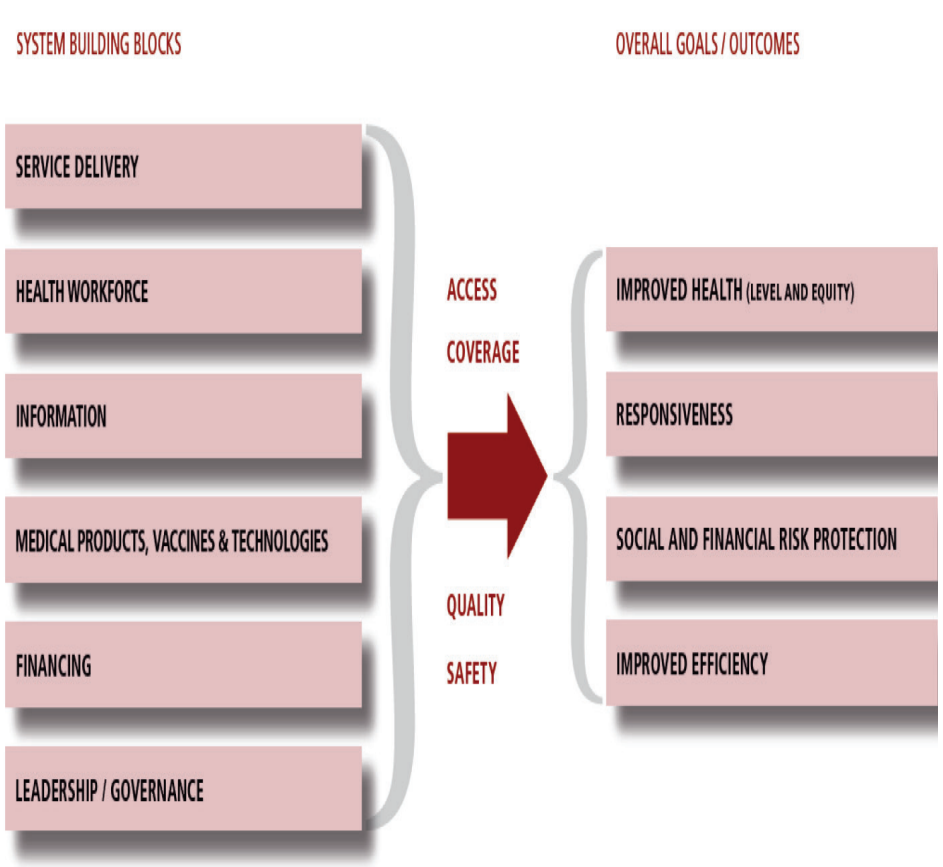
Introduction

- COVID-19 is the greatest global shock in decades.
- The pandemic has contributed to the current global economic crisis and has reversed growth in public spending on health and has set the advance toward UHC back many years
- COVID-19 pandemic has shown that health systems and economies in several countries are not strong enough to tackle a massive crisis.
- COVID-19 has highlighted the **value of emergency protection and coordinated efforts at multiple levels** put at the service of communities.
- Most countries are currently seized with managing Covid 19 through Prevention, preparedness, readiness, response and recovery which lie on a continuum
- As infections spread, a lack of universal health coverage has left billions of people, including many in rich countries, without reliable and affordable access to medical treatment.
- Attempting to save money by neglecting environmental protection, emergency preparedness, health systems, and social safety nets, has proven to be a false economy – and the bill is now being paid many times over.

GLOBAL HEALTH SECURITY THREATS

Synergy between strong Health Systems and the International Health Regulations-IHR Capacities



IHR STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING TOOL

- C1. Legislation and Financing
- C2. IHR Coordination and National IHR Focal Point Functions
- C3. Zoonotic events and the hUman–animal interface
- C4. Food safety
- C5. Laboratory
- C6. Surveillance
- C7. Human resources
- C8. National Health Emergency Framework
- C9. Health Service Provision
- C10. Risk Communication
- C11. Points of entry
  - Section 1. Information by type of points of entry
  - Section 2. Overall national profile of the implementation of core capacities at Points of Entry
- C12. Chemical events
- C13. Radiation emergencies

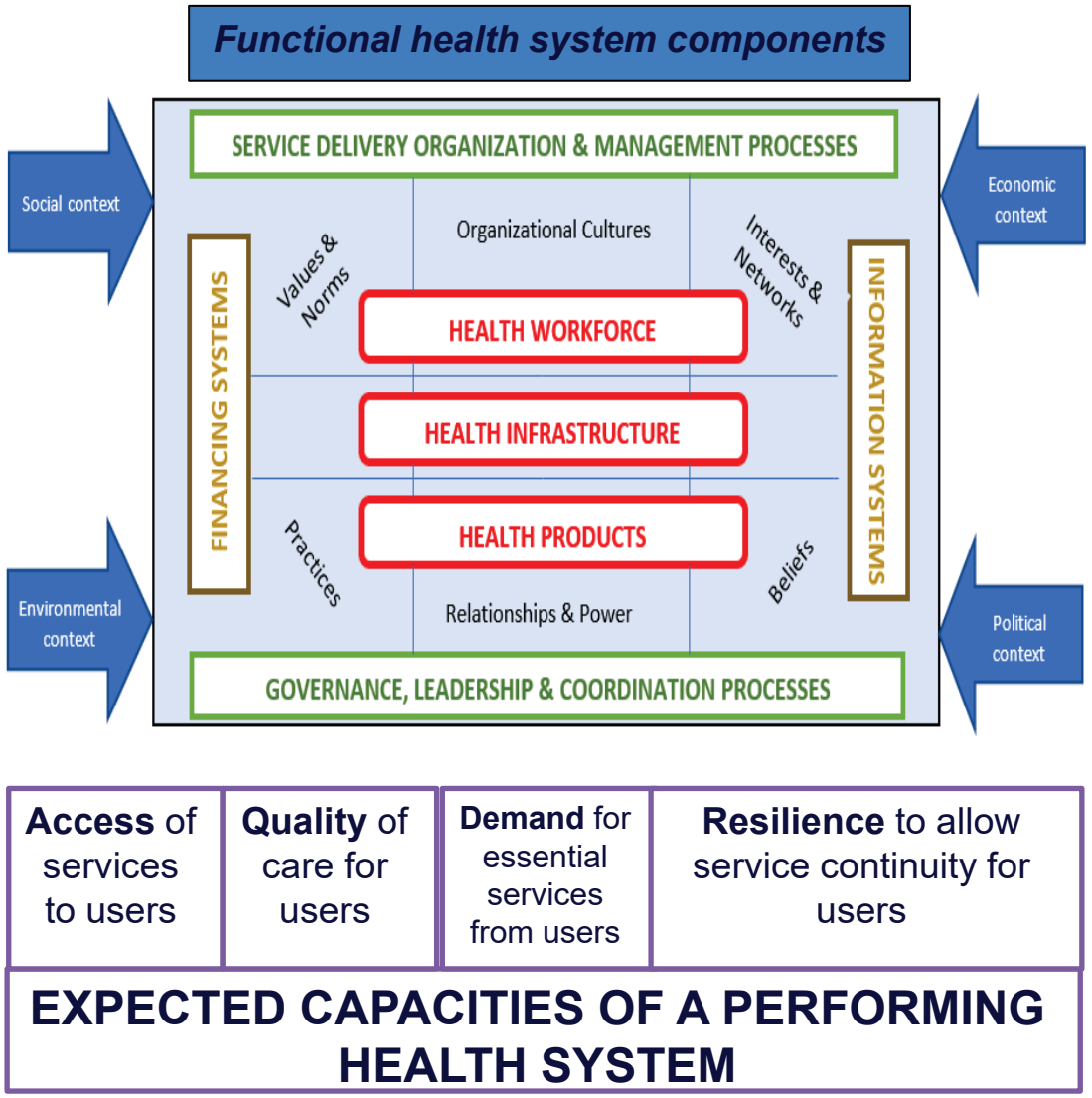
A WHO Tool is arranged according to the following core elements for Joint External Evaluation:

- Preventing and reducing the likelihood of outbreaks and other public health hazards and events defined by IHR (2005) is essential.
- Detecting threats early can save lives.
- Rapid and effective response requires multi-sectoral, national and international coordination and communication.

The Tool also includes a series of Technical Area Questions under each IHR Capacities. These questions are intended to guide the Joint External Evaluation Team's discussion and facilitate a deeper understanding of the country capacity as related to the indicators.

COVID-19 and Health Systems Performance

- COVID-19 is affecting all four interconnected system performance capacities
  - **Access capacity:** Ability to overcome barriers (physical, financial, socio-cultural)
  - **Quality capacity:** Ability to provide services as expected
  - **Demand capacity:** Ability to provide services expected by populations
  - **Resilience capacity:** Ability to sustain provision of essential services during shock events
    - **Resilience of health system:** Driven by the need to ensure continuity of essential services provision
    - Brings together the work of emergency preparedness and health systems – **health Security and UHC goals**



System resilience vital signs

1. AWARENESS CAPACITY
Knowledge of what can be done, and gaps-Good surveillance & information systems

2. DIVERSITY CAPACITY
Ability to provide / respond to wide range of services-essential package of services across the life course

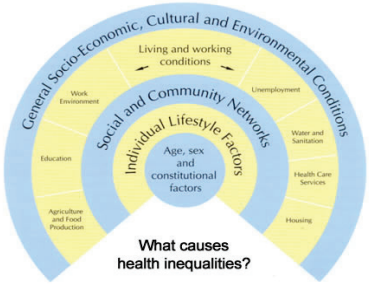
5. TRANSFORMATION CAPACITY
Ability to learn from shocks, and react better in future

IARs and AARs

RESILIENT SYSTEM

3. VERSATILITY CAPACITY
Ability to move resources to where they are most effective-Role of decentralization

4. MOBILIZATION CAPACITY
Local mandate to coordinate available resources for outbreak response



- Countries need good capacity in all these vital signs to build system resilience
- Countries are strong in some vital signs, and weak in others
  - **Diversity capacity** generally is strong (facilities provide wide range of services)
  - **Versatility capacity** is weak in highly centralized systems
  - **Awareness and transformation capacities** are generally weak, but can easily be strengthened

COVID-19 in South Africa: Daily Epidemiology and Surveillance

As of the 15th June 2021

- The majority of cases reported today were from **Gauteng** which accounted **64,4% (5 433)** of all new positive cases, followed by the **Western Cape** with 7,2% (609); the **North West** with 6,2% (523); the **Free State** with 5,5% (464); **KwaZulu-Natal** with 5,2% (442); **Eastern Cape** with 4,4% (370).
- Provinces with the lowest proportion of new cases today were **Mpumalanga** with 2,8%; **Northern Cape** with 2,5%; and **Limpopo** with 1,7%.
- The **Northern Cape** currently has the highest number of **active cases per 100 000 population** at 645,0**;** followed by the **Free State** at 322,2; **Gauteng at** 255,8; the **North West** at 232,5; and **Western Cape** at 105,9 active cases per 100 000 population.

Province	Updated Cases Post Harmonisation	New Cases	% New Cases	Total Cumulative Cases	% Total Cases	Total Deaths	Case Fatality Rate	Total Recoveries	Recovery Rate	Active Cases	New Case Incidence per 100k Population
		15 June 2021	15 June 2021	15 June 2021	15 June 2021	15 June 2021		15 June 2021	15 June 2021	15 June 2021	
Eastern Cape	200147	370	4.4%	200,517	11.4%	11708	5.8%	187,030	93.3%	1,779	5.5
Free State	107433	464	5.5%	107,897	6.1%	4600	4.3%	93,860	87.0%	9,437	15.8
Gauteng	509053	5433	64.4%	514,486	29.2%	11793	2.3%	463,068	90.0%	39,625	35.1
KwaZulu-Natal	343636	442	5.2%	344,078	19.5%	10585	3.1%	326,867	95.0%	6,626	3.8
Limpopo	67589	143	1.7%	67,732	3.8%	2517	3.7%	63,632	93.9%	1,583	2.4
Mpumalanga	85933	237	2.8%	86,170	4.9%	1488	1.7%	82,470	95.7%	2,212	5.1
North West	82355	523	6.2%	82,878	4.7%	2148	2.6%	71,178	85.9%	9,552	12.7
Northern Cape	54895	215	2.5%	55,110	3.1%	1267	2.3%	45,504	82.6%	8,339	16.6
Western Cape	301589	609	7.2%	302,198	17.2%	11981	4.0%	282,796	93.6%	7,421	8.7
Unknown	0	0	0.0%	0	0.0%	0	0.0%	0	0	0	0.0
Total	**1,752,630**	**8,436**		**1,761,066**		**58,087**	**3.3%**	**1,616,405**	**91.8%**	**86,574**	**15.1**

South African Provincial Wave Comparison

As of the 12th June 2021

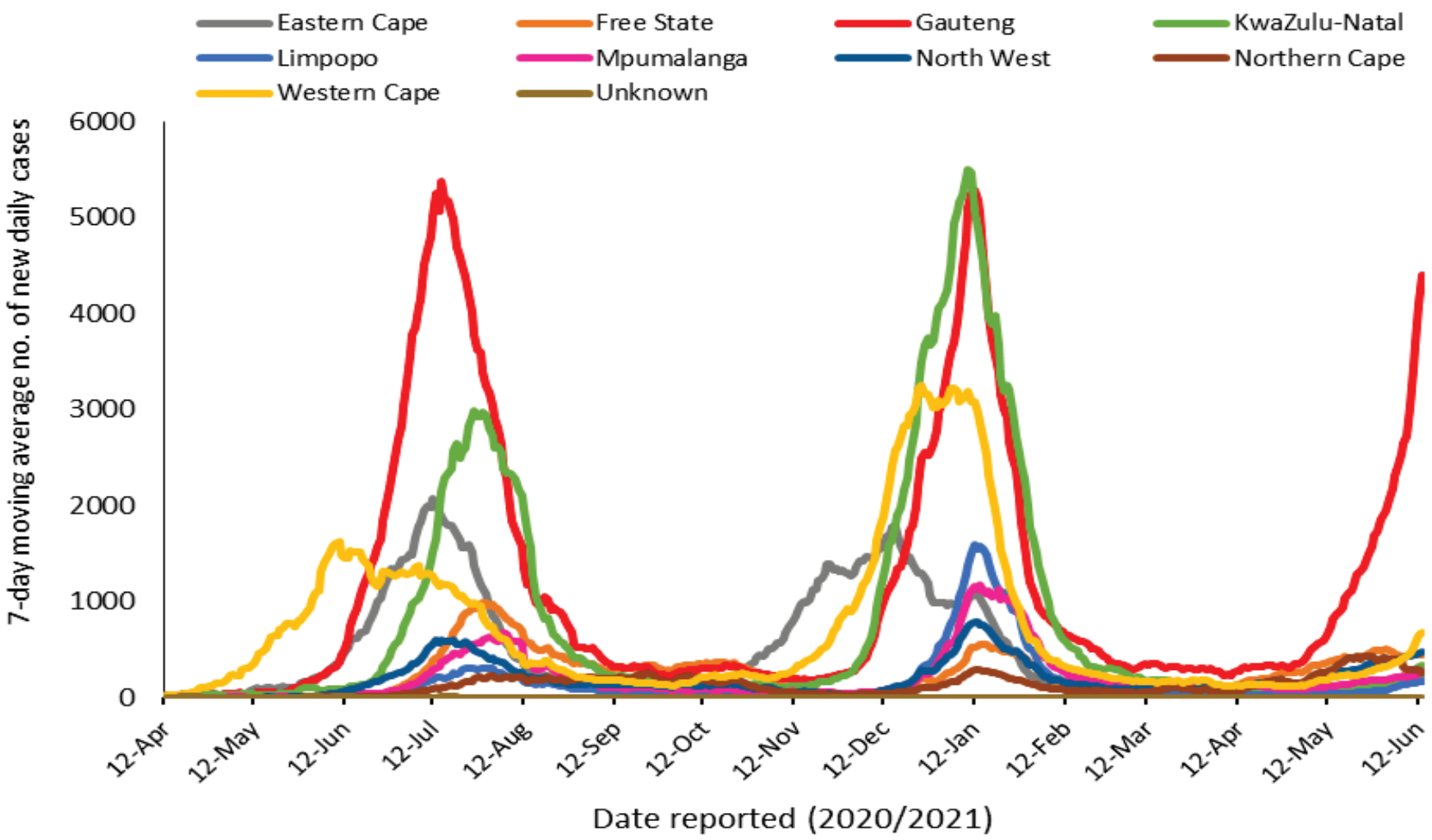
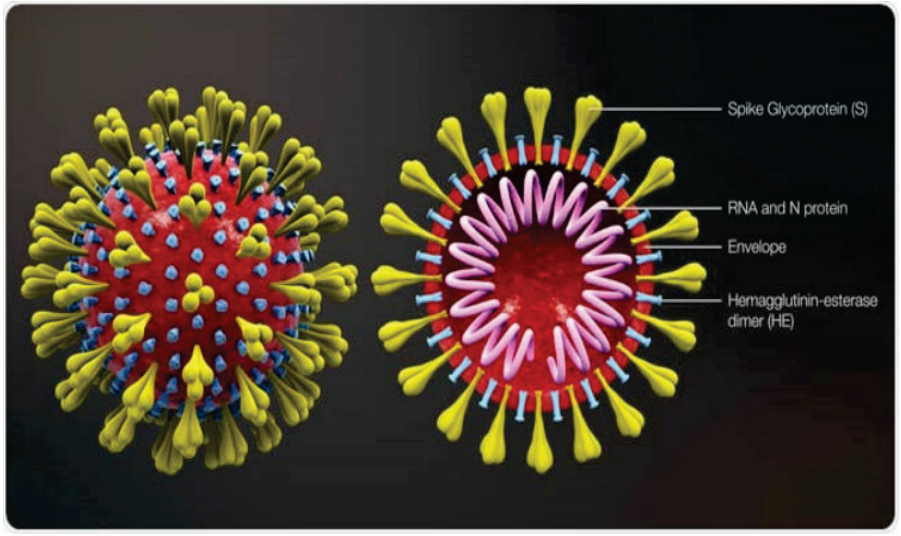


Figure 2. 7-day moving average number of new cases by province and date of reporting, 13 April 2020 to date, South Africa

Variants and Genomics

- Virus genome sequencing is playing a vital role in the efforts to tackle the COVID-19 pandemic.
- Sequencing enabled the world to rapidly identify SARS-CoV-2.
- Knowing the genome sequence allowed rapid development of diagnostic tests and other tools for the response
- In South Africa the coronavirus variant (501Y.V2 / B.1.351) uncovered by whole **genome sequencing**.
- Several genomic sequences from this lineage were submitted to the **Global Initiative on Sharing All Influenza Data (GISAID) sequence database**.



Governance Structures

NCCC and IMC on Vaccines → Overall Political Oversight and governance

Inter-ministerial Committee

MAC on Vaccines → Scientific guidance

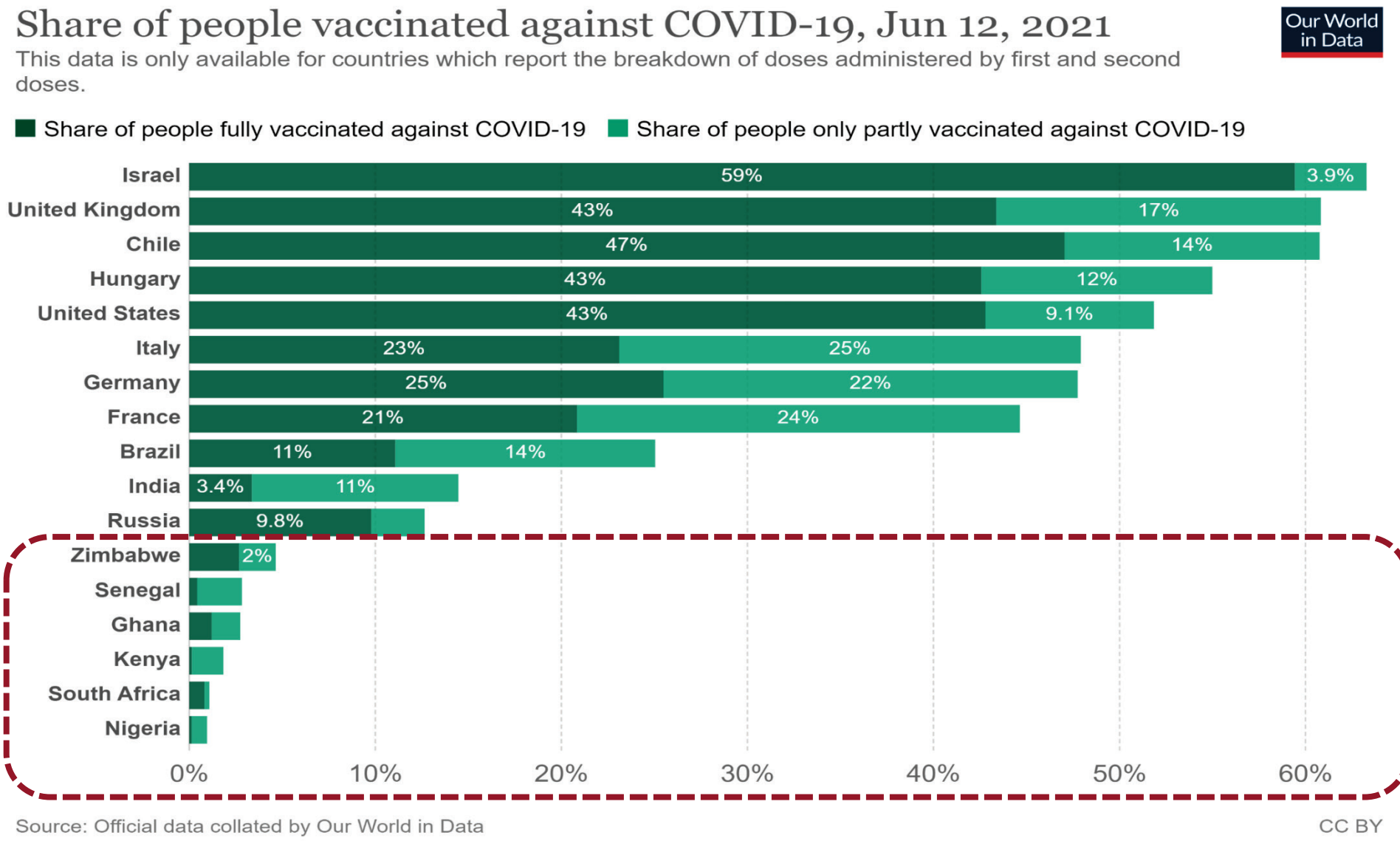
Ministerial Advisory Committee

MAC on Social and Behaviour Change → Social and Community mobilization

National Vaccine coordinating Committee → National Coordination

Joint Working Group with Partners → Day to day granular planning **(Business, Labour, Civil Society)**

COVID-19 Global Vaccination Coverage (to date)

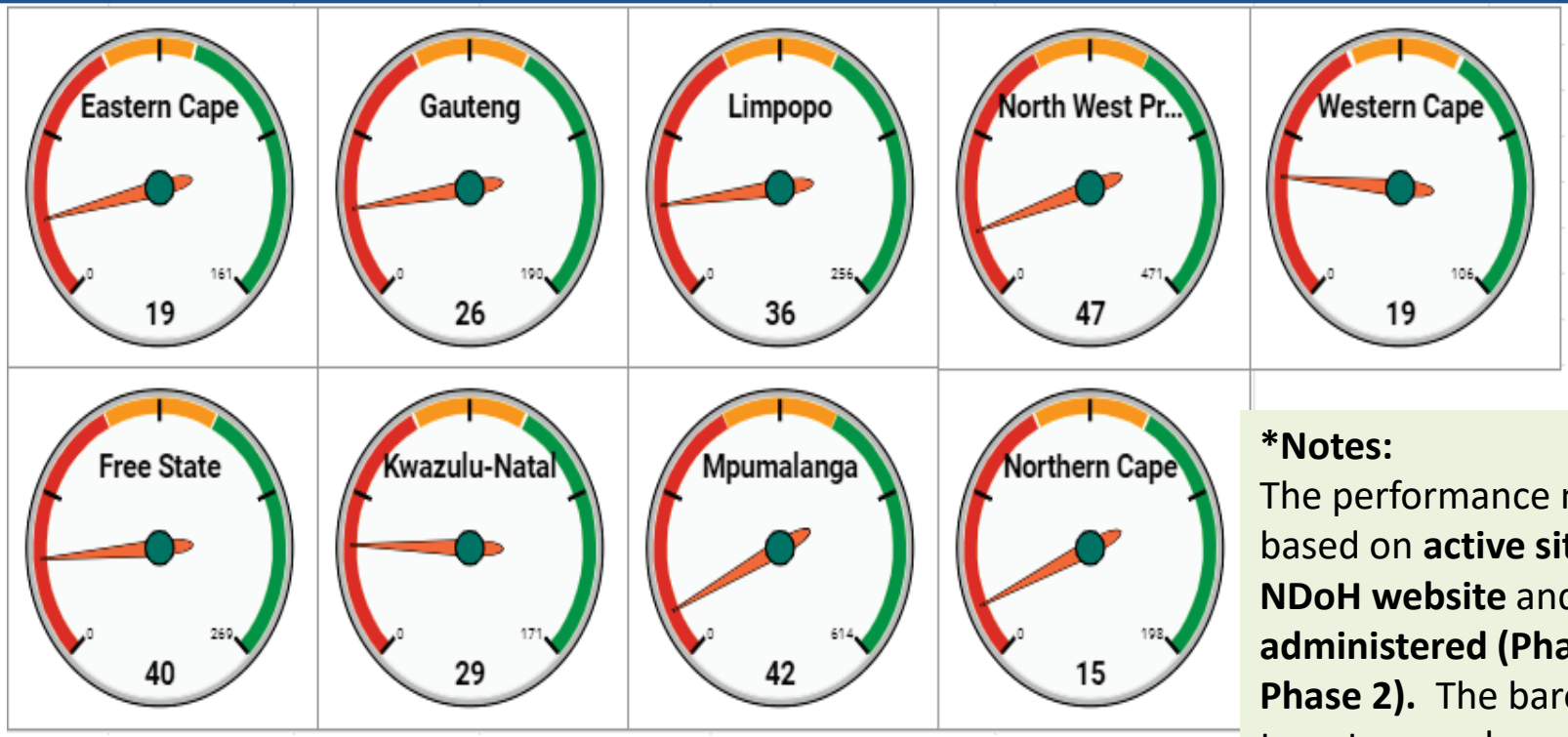


Last Updated: 13 June 2021

* **Note:** South Africa's data last updated in May 2021

Vaccination Rollout: Performance (Last updated: 13 June)

Provincial Vaccination Sites Current Performance vs Targets (daily dose administration per site)



https://dataobservatory.csir.co.za

***Notes:**
The performance monitor is based on **active sites as per NDoH website** and **doses already administered (Phase 1 and Phase 2).** The barometer and targets may change as new sites are introduced and/or existing sites become inactive

- **Urban - Rural posture**
- **Mpumalanga and Northern Cape** are lagging behind on current average doses per day per site when comparing against estimated target doses per day per active sites.

Example of indicators to monitor the continuity of essential health services

Service availability	Service capacity
• Outpatient utilization • Inpatient utilization • DPT-3 (pentavalent) coverage • ANC coverage • Deliveries Supervised by a health worker • Access to TB and HIV Care	• Changes in HRH numbers (new / leaving staff by cadres) • Changes in major infrastructure (new / retired) • Changes in supplies availability- Stockouts of key health commodities

- Indicators should be kept minimal to avoid duplicating the routine DHIS system that is capturing all data trends
- Selected indicators are ONLY to assist identify if there is a sudden drop / increase beyond what is expected. Where this is noted, the country team coordinating continuity of essential services is notified, and further action is taken
- Plan to include mortality monitoring indicators **(All cause & Tracer Disease, Event and Condition Specific)**
- System should be designed to exist beyond COVID-19-**Laying the basis for health system monitoring and IDSR**

Summary of Impact of COVID-19 on Service Delivery in South Africa

- Decline in the number of clients accessing testing, prevention and treatment services at facilities leading to decline in case-finding, ART initiation , TROA and treatment adherence

- Medical Male Circumcision, as an elective surgery for HIV Prevention, was suspended from April-June and resumed on the 1st of July 2020 under a COVID-19 risk-adjusted strategy.

- Deployment of staff in facilities to prioritise COVID-19 activities led to limited support to HIV and TB programs

- Disruptions in service delivery due to temporary clinic closures and staff isolations because of staff members testing positive for COVID-19

- The COVID-19 pandemic required the reprioritisation of human and financial resources to save lives

- According to a HIV and risk of COVID-19 death study in the Western Cape, HIV was associated with a doubling of COVID-19 mortality risk.

Total HIV Tests Done

Province	Quarter-on-Quarter Change				
	Outputs (SELECTION)		Between (Apr to Jun 2019 and Apr to Jun 2020)		
	Apr to Jun 2019	Apr to Jun 2020	Deviation	Growth	Progress (QoQ Change)
Eastern Cape	495 514	346 863	-148 651	*Negative*	-30%
Free State	181 605	128 768	-52 837	*Negative*	-29%
Gauteng	1 170 412	206 724	-963 688	*Negative*	-82%
KwaZulu-Natal	1 049 094	776 363	-272 731	*Negative*	-26%
Limpopo	385 497	237 442	-148 055	*Negative*	-38%
Mpumalanga	391 313	278 876	-112 437	*Negative*	-29%
Northern Cape	71 454	45 626	-25 828	*Negative*	-36%
North West	286 027	243 164	-42 863	*Negative*	-15%
Western Cape	436 141	164 738	-271 403	*Negative*	-62%
National	**4 467 057**	**2 428 564**	**-2 038 493**	*Negative*	**-46%**

HIV positive new eligible client initiated on TPT

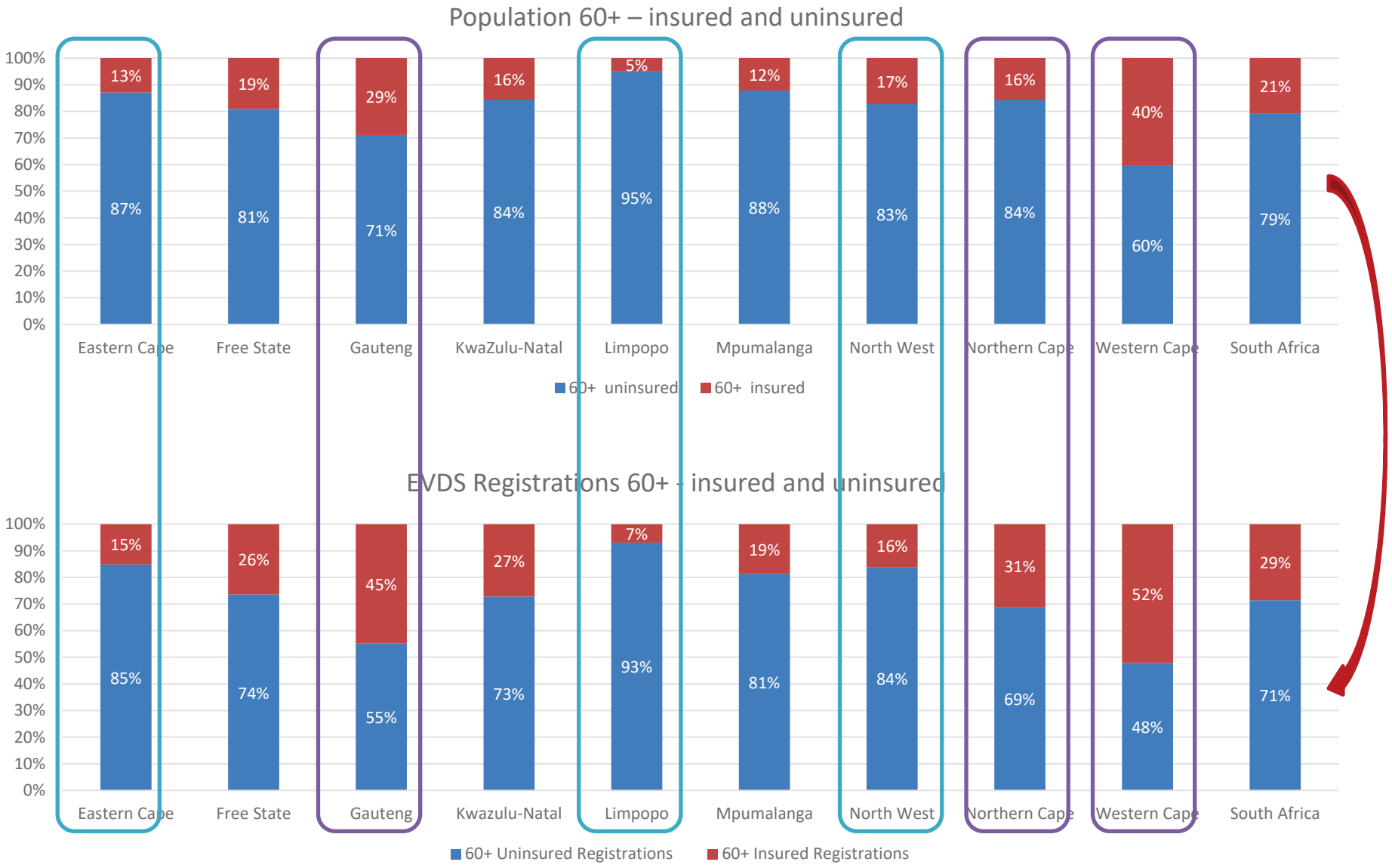
Province	Quarter-on-Quarter Change				
	Outputs (SELECTION)		Between (Apr to Jun 2019 and Apr to Jun 2020)		
	Apr to Jun 2019	Apr to Jun 2020	Deviation	Growth	Progress (QoQ Change)
Eastern Cape	14 530	8 789	-5 741	Negative	-40%
Free State	6 510	3 179	-3 331	Negative	-51%
Gauteng	32 780	20 701	-12 079	Negative	-37%
KwaZulu-Natal	35 558	21 033	-14 525	Negative	-41%
Limpopo	6 432	4 403	-2 029	Negative	-32%
Mpumalanga	14 690	10 054	-4 636	Negative	-32%
Northern Cape	988	639	-349	Negative	-35%
North West	8 022	4 621	-3 401	Negative	-42%
Western Cape	7 472	4 065	-3 407	Negative	-46%
National	**126 962**	**77 484**	**-49 478**	Negative	**-39%**

Impact on Universal Health Coverage Goals

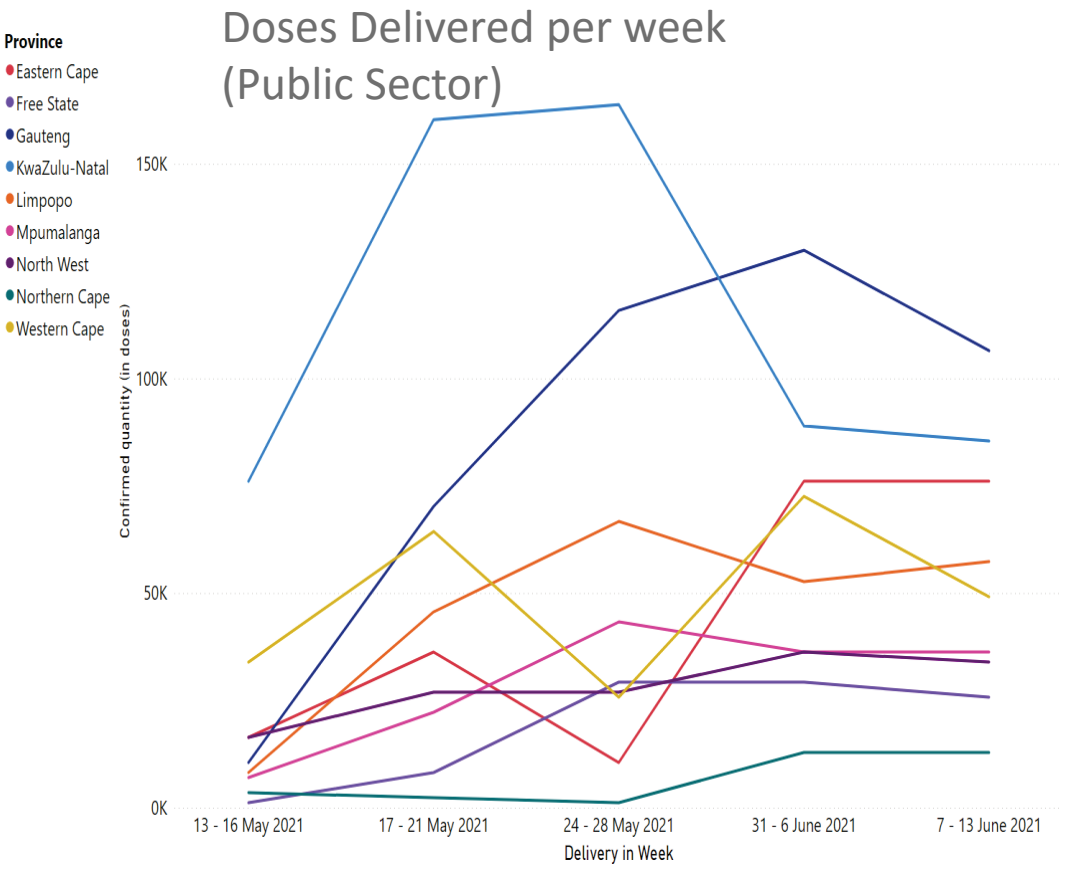
- Access to quality and affordable health services through Universal Health Coverage (UHC) has been affected by the Covid-19 pandemic
- Equitable health fnancing is central to the universal health coverage (UHC) debate in South Africa.
- Covid-19 has revealed limited and underfunded health services, inadequate and ineffective equipment, few and often unprotected health workers and a generally fragile healthcare system.
- COVID-19 has brought into focus the need for health care reforms that promote access to affordable care through the National Health Insurance.
- The pandemic has delayed the parliamentary process to enact the legislation by 1 year
- COVID-19 has brought many of the initiatives to bridge the divide between those who have and those who don't.
  - The principles of Solidarity, equity and commitment to the common good have been applied to the management of the pandemic and vaccination

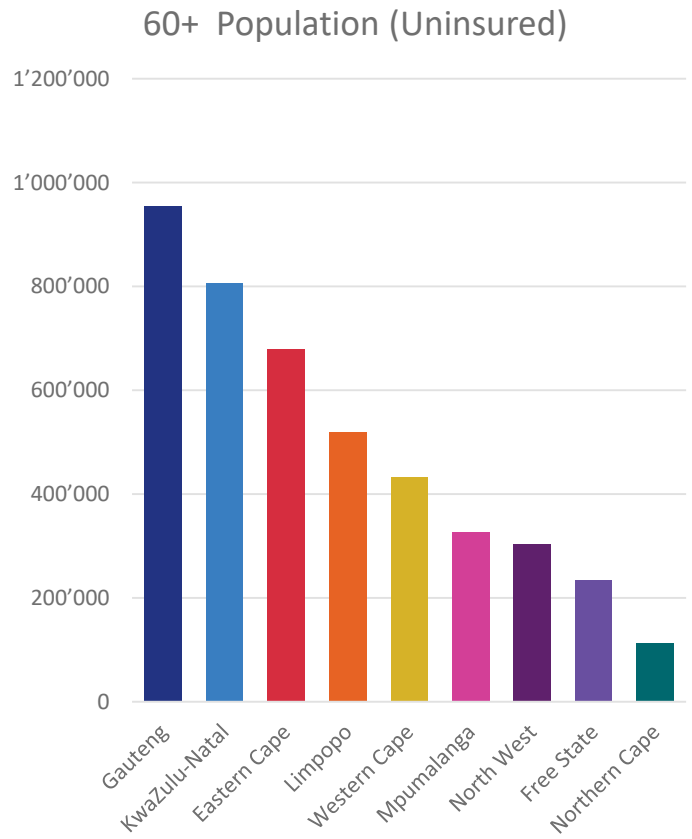
Population Coverage of >60 yrs : Insured versus Uninsured Population

Electronic Data Vaccination System (EVDS) Registrations



Vaccine Doses Delivered per week – Geographic Equity Considerations





Summing Up

In the absence of proven therapeutic remedies or vaccine, we MUST successfully suppress virus transmission through:

1. Robust testing, isolation and care for all cases of COVID-19, including those with mild disease.

2. Identification and quarantine of all contacts.

3. Practicing hand hygiene with water and soap or alcohol based sanitizers, respiratory etiquette, use of masks and adherence to strict infection prevention and control measures in health care settings.

4. Balancing PHSMs based on context while monitoring for resurgence of cases

5. Ensuring Continuity of Essential Services

6. The bold commitments towards UHC made by governments must be upheld.

"The COVID-19 pandemic has changed the lives of individuals, communities and societies across the world-we need to adjust to a "New Normal" while we mitigate the Non direct COVID-19 pandemic effects"

Governance, Leadership and Coordination Processes

- **There is a need to establish international and domestic capacities to respond to potential public health emergencies of international concern such as Covid-19.**
  - These capacities should include efforts to strengthen national and subnational health systems and to coordinate mobilization of domestic and international funding through multi-sectoral action plans and collaboration including coordination and communication, among the relevant entities.
  - Multi-sectoral collaboration should take into account global health risks that can be as a result of such factors as infections transmitted via goods, food, water or animals, as well as chemical, radio-nuclear and environmental events.

- **At a national level, there needs to be National policies, plans and legislation**
  - This will contribute to improvements to governance for multisectoral implementation through whole-of-government and whole-of-society approaches.
  - This will include the development of national policies and action plans for health emergency preparedness that will focus on the relevant roles, responsibilities, deliverables and timelines of the different role-players and will require political and financial commitments to develop and maintain these policies with costed action plans with identified technical and financial partners.

- **Governments must urgently increase their investments in scientific research, undertaking comprehensive and coordinated health system strengthening through improvement of infrastructure and equipment, upgrading of** human resources, and procurement and supply of medicines and health technologies, and proactively seek partnerships at the continental and global levels to expand access to key services and interventions.

Conclusion

- The COVID-19 health crisis calls for urgent actions to reinforce the whole global health architecture to ensure the "well-being of people and the planet", as well as Health Care systems at national levels, through a process of transformative resilience, which also builds in equity from the start

- There is an urgent need to strengthen the overall health security capacities of countries to meet immediate demands and to improve responses to future threats beyond COVID-19.

- Implementing rapid UHC reforms where they are needed the most will create pathways for actions that will not only help to address health inequities made worse by the pandemic, but also support the development of stronger and more resilient health systems able to provide timely responses to emergencies, also provides the best protection against any future outbreaks becoming epidemics and achieve progress towards Universal Health Coverage.

- Countries need to adopt fiscal policy approaches of increasing public spending during even during this period of economic downturn.
  - They must finance pandemic response and increase the capacity of their health systems to manage the outbreak as well as secure COVID-19 vaccines.

- Investments and expenditures for COVID-19 should therefore lead to longer-term, wider benefits, in line with national needs for sustainable capacities.

- Requires **re-thinking and reinforcement of the concept of global health security based on principles of solidarity and sustainability through rights-based, people-centred and gender-inclusive approaches**

Acknowledgements

1. Dr Ambrose Talisuna, Programme Manager, WHO/EPR programme, WHO Regional Office for Africa

2. Data Observatory Policy Centre, CSIR,

https://dataobservatory.csir.co.za/