

## 6<sup>th</sup> ACT-A Facilitation Council

### Health Systems Connector – Dr Fifa Rahman

(4 minutes)

Thank you Chair.

Vaccines alone cannot take us out of this pandemic. It is clear that we have underinvested in health systems. Last month, we saw 1.3 million doses returned to COVAX from the DRC – owing to gaps in leadership, hesitancy, inaccurate assessments on vaccine readiness, and insufficient engagement of local communities. Other countries also are undergoing similar experiences due to the extreme infodemic. Numerous countries have underestimated surge needs – with the starkest example being India. At the last Facilitation Council, we heard the representative from India saying that it was completely self-sufficient on diagnostics – yet today there are massive shortages of diagnostics there. This should put all countries on alert.

We commend the WHO for developing the COVID-19 Essential Supplies Forecasting Tool (COVID-ESFT) to help guide countries to better estimate actual needs and urge countries to utilise this tool when applying for funding from all quarters, but especially under upcoming proposals for the Global Fund's C19RM mechanism. This can help ensure that sufficient PPE, pulse oximeters, and rapid diagnostic tests are budgeted for the entire implementation period.

Even where there is supply of COVID technologies, it's important that those technologies can be provided through services in a timely fashion by the right persons and in the right location, particularly with the rural poor. We hear that in Malawi, for example, rapid tests are not allowed at primary care – in contrast to what many Global North countries are doing. Rwanda on the other hand, has had much better uptake of rapid tests through CHAI projects. In a few weeks the WHO will release updated guidance on rapid tests, and we would encourage countries to build their funding proposals in anticipation of this.

Honourable Ministers, and notably Ministers from donor countries – successful uptake of health technologies depends on a robust health workforce. At least 17,000 healthcare workers have died due to COVID and if we continue to underinvest in healthcare staff, we will only prolong this pandemic further, and increase comorbidities from other diseases.

The ACT-A has unfortunately failed to leverage upon networks of community workers from the Ebola response. In preparation for this intervention we spoke to Dr Mosoka Fallah in Liberia who said that it was essential to build upon these gains to be able to continue to respond to COVID-19 while maintaining service delivery in routine health. Robert Kanwagi in DRC told us about demotivated and unpaid community health workers. Delivering an optimal COVID-19 response requires not just a public health approach, but a worker-justice and gender-justice approach, given that a majority of these workers are women. Community health workers can be crucial pieces of the puzzle to increase uptake of health technologies. Their value cannot be underestimated.

What happened in DRC cannot happen again. It cannot be denied that an element in this has been disintegrated leadership and inadequate engagement of local communities. We need to understand why COVAX's vaccine readiness tool failed to anticipate these barriers. We understand that now there is a system of 'red flags' that spot where slow uptake or product hesitancy exists, but there's a clear need to reengage domestic stakeholders – and in DRC this might involve meaningful engagement with trusted provincial leadership. We note also emerging data about vaccine non-acceptors in DRC and how they were more likely to cite cost and distance to vaccination facilities as reasons for not accepting the vaccine. Donors must ensure flexibility within their programs to provide travel reimbursements or to bring vaccines to them. There are ample examples in the West African Countries of Liberia, Sierra Leone and Guinea where vaccine hesitancy to the experimental Ebola vaccine during the 2014/2015 outbreak were successfully overcome. We need to quickly adapt those lessons.

There has been a massive focus on the ACT-A on financing of supply, but insufficient focus on financing of demand and the active engagement of citizens and communities. There needs to be investment in mass text messaging campaigns, ads in mass media, and community outreach to tackle vaccine hesitancy, to engage individuals on community-based testing, PPE, pulse oximeters, and other tools. Countries should ensure that they budget for these under the C19RM proposals.

Finally, there are enormous deficiencies in supply chain for PPE, oxygen, lab equipment, and other materials. The oxygen market, for example, is extremely concentrated, and there is an urgent need to explore catalytic interventions to change this. LMICs need domestically manufactured supplies – and we need to look into this.

We need to tackle the imbalance of funding in the ACT-A, and I appeal to donors to take these examples back to capital and urgently invest in Health Systems towards ending this pandemic.