ADVOCACY BRIEF

THE UHC THAT WE WANT AND NEED – BEFORE, DURING AND POST-PANDEMICS

APCASO
Strengthening community systems.
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BACKGROUND

The COVID-19 pandemic demonstrates and magnifies — and reminds the world — of the gaps in country health systems, as well as the vulnerabilities to the disproportionate impact of health emergencies of certain populations and communities brought about by social inequities, gender inequalities, and the inability to exercise one's human rights. Without deliberate mitigation, post-COVID-19 pandemic will see poor and marginalized communities pushed deeper into poverty and further into the margins. This advocacy brief, done in partnership between APCASO, UNFPA APRO and country partners convened an expert group from the region that formulated these policy recommendations in framing pandemic and post-pandemic responses that are community-centered, rights-affirmative, and gender-transformative. A virtual dialogue was conducted on 26th Nov. 2020 with relevant stakeholders to generate discussion and recommendations that are reflected in this advocacy brief.

INTRODUCTION

Globally, as of 13 January 2021, there have been over 90 million confirmed cases of COVID-19, including 1,954,336 deaths, reported to WHO.[1] However many countries in the region are still responding in an ad-hoc manner to the pandemic. The most frequently asked question in everybody's minds – could we have handled this pandemic better if our healthcare system was structured differently? While the question may sound rhetorical, the answer however is instrumental in ensuring we are better prepared for any such pandemics in the future.

As COVID-19 took on a fully fledged pandemic, governments around the world focused on "flattening the curve" and these efforts were critical to limit the direct health impacts of COVID-19 and to prevent already-stretched health systems from being completely overwhelmed. However at this juncture, it's time for us to join hands in addressing the more systemic issue – strengthening our health systems, ensuring universal health coverage while protecting other essential health services.

Perhaps a world where the core principles of right to health - equality, accountability, and participation were being realized would have been a world better prepared to respond to the immense health and societal demands of COVID-19. We need to work towards a health system that is well resourced, were equitable and of good quality, is universally accessible, one that would have sufficient numbers of health workers operating in environments safe for themselves and their patients and one where civil society and the public could monitor progress and hold their governments accountable.

We need a paradigm shift in reimagining our health systems—most current health systems are designed to treat the sick, not to keep people healthy—governments need to allocate more financing to primary health care, and in particular toward health promotion and disease prevention. Instead of waiting to spend money on treating the sick—which is more expensive—resources can be more efficiently used by keeping people healthy.

CHALLENGES AND OPPORTUNITIES TO THE UHC THAT WE WANT

The political salience of UHC is rooted in its attractive value proposition: to provide good quality health-care services to all citizens who need them without causing financial hardship.

UNIVERSAL HEALTH COVERAGE (UHC) aims 'to ensure that all people obtain the health services they need without suffering financial hardship when paying for them'. Key elements include: an effective health system geared toward priority health needs; the affordability of care; access to essential medicines and technologies, and well-trained and motivated health workers (WHO, 2014). The principle of UHC derives from the 1948 World Health Organization (WHO) constitution, which declared health a fundamental right (WHO, 1948), and from the Health for All agenda set out in the 1978 Alma-Alta Declaration (WHO, 2014).

In 2019, world leaders came together to step up their commitment to achieving health for all. The political declaration[2] unanimously endorsed by all countries at the UN High-Level Meeting on UHC included a promise to allocate resources to achieve "financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".

However one year on, COVID-19 is exposing uncomfortable truths about how UHC has sometimes been interpreted. UHC, by definition, includes access to the full spectrum of services including health promotion, prevention and treatment. All these, and health security, are included in tracking of UHC progress under SDG 3.8.1 (service coverage).[3] But in practice policy debates and subsequent implementation have largely focused on treatment, with less or no attention to promotion and prevention. Fundamentally, UHC is about equity. However, protecting the most vulnerable during the pandemic seems especially hard to do well. This makes it urgent to reappraise how to develop more equitable and resilient health systems, which ensure access to needed services with financial protection in both normal times and emergencies.[4]

The concept of UHC and thus its measurement do not encompass the resilience of health systems to crisis and pandemic preparedness. Epidemics and disease outbreaks are not counted explicitly in any UHC measure—they are relegated to a separate silo of "preparedness". Yet, as we have seen in the COVID-19 pandemic, ensuring that all people have access to testing, treatment, rehabilitation and, when available, prevention through vaccination, are universally viewed as core functions of a successful health system. Any index of UHC that is fit for purpose thus must encompass the fuller goals of a health system, including its ability to avert deaths from outbreaks while maintaining high-quality health services for other conditions.[5]

These challenges notwithstanding, the crisis certainly offers possibilities for developing health systems, realizing UHC for all and for the opportunity to build back better.

An ODI research[6] exploring the experiences of 49 countries that have achieved or laid the groundwork for UHC highlights contributing factors. Three key points are especially worth noting and give us hope for the future. Firstly, 71% of these countries moved to the UHC following episodes of crisis. Fragile contexts can create political appetite for UHC and disrupt power bases that oppose it.

What follows times of crisis are times of reconstruction—and often a period of reflection. In these periods, the status quo is never tenable, opposition voices are weaker, and grand moves toward improving welfare, including steps toward universal health coverage, take place more easily. Given that COVID-19 is explicitly a health crisis, it seems particularly likely that it will prompt a rethink of what adequate health care looks like.

Secondly, a country's wealth matters far less than its politics when deciding to invest in universal health care. State capacity appears to be more important, alongside economic growth. This highlights the potential for all countries to build their health systems equitably and reinforces the primacy of politics. The expected post-crisis economic 'bounce-back' could provide increased fiscal pace for greater investments in health. Indeed, several

Health workers in protective gear monitor body temperature of people at a slum in Mumbai, India. Photo: Manoej Paateel/Shutterstock.

countries that have acted quickly to successfully contain COVID-19, such as South Korea and Taiwan, are significantly less wealthy than countries in Europe and North America who continue to struggle. Thirdly, although progress on healthcare is generally an iterative process, once countries have established UHC they tend not to go backwards: universal systems are robust, even when facing new shocks.

WHAT DID WE LEARN FROM PAST EXPERIENCES OR PANDEMICS?

As we document best practices and lessons learned from the ongoing pandemic, it is important to look back at past experiences – while the magnitude of past outbreaks may differ the learnings are nevertheless relevant. From past experiences, we have witnessed instances of what starts as a health emergency quickly spreads with far reaching consequences with the most impact felt by the most vulnerable, marginalized and underserved communities.

During the Ebola outbreak of 2014–2015 in West Africa, what began as a health crisis quickly escalated into a humanitarian, social, economic and security crisis. More people died from the interruption of social services and economic breakdown than from the virus itself. Researchers estimate that disruptions in health services and other factors such as mandatory curfews, border closures, and disruption of transportation routes made obtaining medical services or continuing drug therapy challenging during the outbreak, thus resulting in as many as 10,000 additional preventable deaths due to malaria, HIV/AIDS, and tuberculosis.[7]

Lessons from the Ebola outbreak showed the importance of a resilient health system to deal with such outbreaks. In the case of Ebola, researchers found several preconditions for health system resilience lacking. The first of these preconditions is recognition of the global nature of severe health crises and clarity about the roles of actors at all levels of the global health system. Although national governments are fundamentally responsible for their health systems, they need the capacity to mobilize the full range of local actors and to rapidly draw on external resources if necessary. The need for a global resilience network is both a moral imperative and a recognition of the fact that pathogens do not respect borders. Shocks to the health system of one country can reverberate across regions and the world. Health system resilience is thus a global public good and needs a collective response from the global community.[8]

In our region, several countries and states have prior experience of dealing with respiratory and zoonotic diseases such as SARS (2003), avian influenza H5N1 (2005), swine flu H1N1 (2009), MERS (2015) and the Nipah virus 50 (2015). These experiences seem to have been useful as countries such as Singapore, Taiwan, Hong-Kong, and South Korea appear to have led the way in being better prepared for COVID-19, with strong contract tracing and isolation measures.

Community outreach worker distributing masks in Hanoi, Vietnam. Photo: SCDI.

VIET NAM reported its first case of COVID-19 in January 2020 but, over the following months with rapid targeted testing, contact tracing and successful containment, have managed to keep the number of infection and death much longer that the rest of its neighbors in the region. This could be attributed to Viet Nam having invested heavily in its health care system including public health.

Since 2000, for every 1.0 percent increase in GDP per capita, public spending on health has increased by 1.7%. This has translated to an almost three-fold increase of spending in constant US dollars, from $46.2 spent on health per capita in 2000 to $129.6 in 2017. A social health insurance scheme was introduced in Viet Nam in 1992 and between 2000 and 2017, coverage in the scheme increased from 13% to 87% of Viet Nam's population.[9]

It was the first country recognized by WHO to be SARS-free in 2003, following which it increased investments in public health infrastructure, including developing a national public health emergency operations center and a national public health surveillance system. Viet Nam's aggressive response to contain COVID-19 was also accompanied by a multimedia public communications effort, engendering trust in the government, measures that are crucial as they help to stem stigma and discrimination.[10]

While the number of cases increased dramatically during the first two weeks of August, the situation now appears largely under control. Viet Nam's investment in UHC, particularly in preventive measures, have helped to ensure that sufficient infrastructure and systems existed to support COVID-19 response.

WHERE ARE WE NOW – A SITUATIONAL ANALYSIS

REDEFINING VULNERABILITY

During global health crises, the most vulnerable and poorest groups are reported to be typically affected the most. Vulnerability in the time of COVID-19 is more than the risk of contracting the disease—it is a dynamic process that needs to be acknowledged and understood for us to effectively respond to and manage the ongoing pandemic. Someone who wasn't considered vulnerable before the pandemic may now find themselves in a vulnerable position while someone with pre-existing vulnerabilities may now find themselves feeling the effect of multiple ones. In order to become resilient, society needs to be aware of its own vulnerabilities and to constantly redefine it to avoid complacency.

Beyond the groups who are epidemiologically vulnerable to COVID-19 (eg, older people and individuals with comorbidities), there are people from diverse socioeconomic backgrounds who are vulnerable as they struggle to cope with the crisis in various ways—financially, mentally, or even physically.[11] The health risks and the economic impacts of the coronavirus are disproportionately affecting population groups with pre-existing vulnerabilities and socially excluded groups, as well as creating new poor and new vulnerabilities. Due to the nature of the pandemic, older persons, persons with some types of disabilities or pre-existing health issues such as HIV, TB or malaria are even more vulnerable due to their pre-existing health conditions and/or not having equal access to health-related information and preventative measures.

As over 60 percent of the Asia-Pacific population have limited access to any form of social protection, the vulnerabilities of those engaged in the informal sector are likely to be exacerbated. The economic impacts coupled with the lack of social protection such as cash transfers, universal health coverage and access to other basic services is putting already vulnerable and socially excluded groups at a double disadvantage: particularly women, daily wage workers, migrant workers, persons with disabilities and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) persons that are engaged in many of these economic activities.[12] Any discussion on how to deal with the pandemic need to involve equity and the social determinant of health including vulnerability—our response to the pandemic cannot succeed if it happens in a vacuum.

THE IMPORTANCE OF A RESILIENT AND SUSTAINABLE SYSTEM FOR HEALTH (RSSH)

Health systems throughout the world have demonstrated different levels of preparedness for an outbreak of this nature and magnitude. The current pandemic has tested their resilience – the ability and capacity of health systems to absorb, effectively respond and adapt to shocks and structural changes while maintaining and sustaining everyday operations.

Health systems are resilient if they protect human life and produce good health outcomes for all during a crisis and in its aftermath.[13] A health system that is resilient can deliver everyday benefits and positive health outcomes. This double benefit—improved performance in both bad times and good—is what has been called "the resilience dividend". Building resilience is thus context-dependent and iterative, needing advance assessments of system capacities and weaknesses, investments in vulnerable components of the system before a crisis, reinforcements during the emergency, and review of performance after a crisis.[14]

A resilient health system is also one that is highly adaptable whether in normal times or in times of extreme crisis. During crises much like what we are facing today, a resilient health system will reduce the loss of life and mitigate adverse health consequences by providing effective care for emergency and routine health needs. It also has the potential to minimize social and economic disruption that characterize pandemics and other large-scale health crises by engaging people as partners in containment efforts, reducing fear, and hastening resumption of normal activity. Therefore the adaptability of a health system not only allows for it to function differently, but also function better in times of crisis and provide the right climate to bounce back stronger.

Resilient health systems function on the core principles of being aware, integrated, diverse, self-regulating, and adaptive. These features do not arise in a vacuum: they require a foundation of strong local and national leadership, a committed health workforce, sufficient infrastructure, and global support.[15] The need for global

People crossing the road wear masks to prevent respiratory tract infections. Photo: Chang Lee/ Shutterstock.

TAIWAN has been hailed as a success story in dealing with COVID-19. Despite it's close proximity to the source of the pandemic and its high population density, it experienced a substantially lower case rate of 20.7 per million compared to other countries in the region. The Taiwanese government's response to COVID-19 has been characterized by speed, vigilance and political decisiveness. Researchers have noted that Taiwan's responsiveness to pandemic diseases and similar threats is embedded in its national institutions through the establishment of a dedicated CDC in 1990 to combat the threat of communicable diseases and a National Health Command Centre (NHCC) in 2004 following the SARS epidemic.

It's pandemic response was largely mapped out through extensive planning as a result of SARS and was developed in such a way that it could be adapted to new pathogens. It's well-developed pandemic approach, with extensive contact tracing through both manual and digital approaches, and access to travel histories, meant that potential cases could be identified and isolated relatively quickly. Leveraging on lessons learned from SARS, the government built a robust health system that was well-equipped and well-prepared to handle the COVID-19 outbreak. The experience may also explain the high degree of public adherence to guidance on social distancing and mask wearing. This strong "societal defense mechanism" benefits from a sense that the public is a partner of the government in the fight against COVID-19. Therefore while Taiwan's policy decision making process since January 2020 is a commendable feature of its response, the roots of its success in implementing those decisions were in the making for years and shaped by lessons from the past.

solidarity and action in addressing the pandemic is especially worth emphasizing as resilience is not self-sufficiency. Another core principle to build a resilient health system is that it should be diverse. Health systems that have the capacity to address a broad range of health challenges rather than a targeted few are more stable and capable of detecting disturbances when they arise. This approach is most feasible where UHC is in place, which is why UHC is seen as an essential resilience measure. It promotes broad-based provision of health services, and protects vulnerable families from financial hardship and helps to ensure health-seeking behavior. This can foster relationships that make individuals more likely to seek timely care, which in a situation such as COVID-19 can be the difference between life and death, and an opportunity to contain the pandemic.

PRIMARY HEALTH CARE – THE CORNERSTONE OF ACHIEVING UHC

In 2018, WHO's member nations collectively affirmed in the landmark Astana declaration[16] that PHC "is the most inclusive, effective, and efficient approach to enhance people's physical and mental health, as well as social well-being" and "a cornerstone of a sustainable health system for universal health coverage. In 2019, WHO estimated that investing an additional $200 billion a year in PHC could save 60 million lives by 2030.

A medical worker administering a swab test on a potentially infected elderly man. Photo: aslysun/Shutterstock.

JAPAN has been credited with containing the pandemic relatively well and one contributing factor is its universal healthcare system where all 126 million Japanese have equal access to advanced medical care.+ Japan introduced the National Health Insurance (NHI) system in 1961. The NHI ensures that all citizens are provided with essential healthcare, regardless of preexisting conditions or economic status; free access and a no-gatekeeping system, meaning patients are free to choose any hospital nationwide; and high-level care at low cost since the system is maintained with the use of public money.[23]

Japan's COVID-19 response was driven by a unique model of regionalized public health delivery, featuring local public health centers (PHCs), hokenjo in Japanese. If a patient feels unwell or suspects exposure to COVID-19, their initial point of contact is to contact a local call center, which is either housed within or in close communication with a PHC. With more than 460 centers scattered across Japan's prefectures and some serving millions of regional residents, the PHC is a nearly century-old stakeholder in Japan's public health infrastructure borne from the 1937 Public Health Center Act.

When COVID-19 hit Japan's shores, these PHCs took the helm of the pandemic response at the regional level—single-handedly managing patient triaging, cluster surveillance, contact tracing, and COVID-19 testing, with an overarching aim of testing and isolating the most high-risk cases. Under the guidance of PHC personnel, patients deemed to require a medical exam were directed to dedicated, undisclosed COVID-19 clinics, and those with a positive test were funneled into a select fleet of designated hospitals for a government-mandated hospitalization for isolation, regardless of symptom severity.+ However it has to be noted that Japan's regionalized public health system has faced severe strains as the country went through a new surge of cases recently. Many are of the opinion that Japan must not become complacent after its relative successes and seize this critical opportunity to learn from the first several months of the pandemic, continually strengthening its approach to absorb and tackle potential new waves of infections as the country eventually reopens.

Primary health care (PHC), Is a health system's first line of defense.

PHC is the most basic package of essential health services and products needed to prevent disease, promote health, and manage illness. It typically covers about 80 percent of a person's health needs during their lifetime and extends far beyond just managing illness to include disease prevention (e.g., immunization) and health promotion (e.g., education) as well.

As such, it is only logical that any discussion on effectively addressing and responding to this pandemic touches on the critical role of PHC. Studies[17] have indicated that some 80% of COVID-19 cases are mild and the majority of moderate cases seek PHC services as the entry point for getting medical care. Most people with COVID-19 develop mild or uncomplicated illness that can be managed at the primary care level and hence PHC plays a significant role in gatekeeping and clinical responses: differentiating patients with respiratory symptoms from those with COVID-19, making an early diagnosis, helping vulnerable people cope with their anxiety about the virus, and reducing the demand for hospital services.[18]

The crisis is clearly not just a health issue, but rather is closely intertwined with political, social and economic issues, which require a set of measures that go beyond immediate contention of the virus transmission chain.

In an increasingly complex and unpredictable world, the challenge arises of planning what social model and health system should be strived for in order to protect lives, especially those of the most vulnerable.[19] It remains the most cost-effective way to address comprehensive health needs close to people's homes and communities.[20]

A research by Overseas Development Institute (ODI)[21] exploring the experiences of 49 countries that have achieved or laid the groundwork for UHC shows that among the countries studied, around 60% incorporated and strengthened PHC within their strategy to achieve UHC. That means that regardless of whether the strategy involved setting a free benefits package to all, reducing user fees for some or mandating health insurance for instance, the strategy had a PHC focus. While most of these countries did so only at a later stage in the process of rolling out coverage, around a third put PHC at the core of the strategy during both early and later phases, including India, Japan, Malaysia and Sri Lanka, from our region.

THE IMPACT OF COVID-19 ON HIV, TB AND MALARIA

Health systems now face the dual challenge of responding to the COVID-19 outbreak while maintaining continuity of essential services to address other ongoing epidemics. The right to health means that no one disease should be fought at the expense of the other- it is easy to forget this in the midst of the ongoing emergency response to COVID-19.

While we aim to contain the pandemic, we cannot afford to ignore people's broader health needs – this includes HIV/AIDS, TB, and malaria services. Doing so will cause a deadly ripple effect, leaving millions more vulnerable to preventable and treatable illness while we face the danger of losing the hard-earned gains of the three diseases to the fight against COVID-19.

A research conducted in April 2020[25] quantified the extent to which such disruptions in services for HIV, TB and malaria in high burden low-and middle-income countries could lead to additional loss of life. In high burden settings, HIV, TB and malaria related deaths over 5 years may be increased by up to 10%, 20% and 36%, respectively, compared to if there were no COVID-19 epidemic. It is estimated that the greatest impact on HIV to be from interruption to ART, which may occur during a period of high or extremely high health system demand. For people living with HIV on antiretrovirals, interruption to treatment poses a triple threat: increased mortality; increased transmission due to less viral suppression among those already on treatment; and treatment interruption potentially contributing to a rise in drug-resistant virus.

For TB, the greatest impact is estimated to be from reductions in timely diagnosis and treatment of new cases, which may result from a long period of COVID-19 suppression interventions. A rapid assessment was conducted by the Stop TB Partnership of the impact the pandemic and related measures had on TB in 20 high burden countries that represent 54% of the global TB burden. Similarly, the Global Coalition of TB Activists (GCTA) did a worldwide survey through their network of members collecting answers from TB civil society and communities from 16 countries. The results of both these assessments indicate that the measures taken for the COVID-19 pandemic produce significant disruptions in the TB programmes and response with massive impact on communities and people affected by TB, and especially among the most vulnerable who are struggling to get their treatment, care and other types of support.[26]

For malaria, the greatest impact could come from reduced prevention activities including interruption of planned net campaigns, through all phases of the COVID-19 epidemic. According to WHO estimates,[27] COVID-19 could result in an additional 382,000 malaria deaths in 2020 alone. In some countries mosquito net distribution campaigns have been delayed. Case management has been affected in some places by constraints on the movement and availability of health workers, while some countries face potential stock-outs of essential anti-malaria medicines. Too often people who feel sick are not seeking treatment, frightened of contracting COVID-19 at a health facility.

Therefore in high burden settings, the impact of each type of disruption could be significant and lead to a loss of life-years over five years that is of the same order of magnitude as the direct impact from COVID-19 in places with a high burden of malaria and large HIV/TB epidemics. In the short-term, maintaining the most critical services – treatment for HIV and TB (new and current enrollees to treatment) and resuming vector control for malaria as soon as possible – is a major priority and is likely to be one of the key ways in which the overall impact of the COVID-19 epidemic can be reduced. A major focus in the longer-term is likely to be improving the resilience of the health system to cope with shocks such as pandemics and the changes necessary may be far-reaching.

WHAT NEEDS TO BE DONE

RECOMMENDATIONS

The ongoing pandemic is an opportunity to 'build back better' as international communities, advocates and governments are calling for the need to move towards a new normal built on the pillars of resilient and inclusive development. We need to combine effective health interventions with social protection measures that are inclusive for the most vulnerable populations in any adequate policy response. Key recommendations are as below:

1. COVID-19 has exposed and widened systemic inequities that go beyond health and needs to be addressed urgently. We need governments to create stronger social and financial safety nets for all, especially for poor and vulnerable communities that were struggling even before the pandemic and are being hit hardest by its health and economic impacts. These 'safety nets' need to cover the full ambit of health (including mental health) in order to achieve a complete state of physical, mental and emotional well-being. This is the opportunity to demonstrate the universality of UHC where nobody should be left behind in accessing vital health services. As access to health services should be determined by need and financed according to ability to pay, more attention should be paid to achieving UHC equitably, prioritizing the needs of the most vulnerable. This requires governments to commit the maximum available resources towards meeting the minimum core obligations under the right to health including access to essential medicines and the equitable distribution of all health facilities, goods and services.

Village health workers teaching proper mask use in the community, Phnom Penh, Cambodia. Photo: KHANA.

2. In order to leave no one behind, everyone needs to be counted. The availability of disaggregated data on vulnerable population groups is key to achieving this. Therefore governments and multilateral donors need to earmark investments to strengthen data, health information and monitoring systems at country levels. During emergency response, it is very easy to forget the importance of data collection, storage and analysis but evidence-based decisions can only be made with the existence of accurate, timely, complete, disaggregated and secure data. Any effort to identify and support communities most left behind requires active participation from these communities in the collection, analysis, interpretation and use of data. Capacity strengthening and building partnerships with communities is needed to

effectively address existing inequities by improving health information systems to be most reflective of ground realities.

3. PHC is an important catalyst in reducing health inequities and must be strengthened and structured as one of the main health sector responses for crisis preparedness. There is an urgent need for civil society and community-led organisations to advocate and demonstrate the need for and cost-effectiveness of country investments in PHC. While most countries in the region are instinctively moving all current resources towards more ICU beds, PPE and ventilators, in the long term, investments should be channeled towards a strong PHC systems as the most sustainable way to fight this pandemic, any other future pandemics and towards ultimately achieving UHC.

4. Leaving no one behind entails addressing root causes of health inequities and vulnerabilities. As such, health investments and approaches need to include efforts to address human rights and gender issues. Governments, multilateral donors, and partners must invest and encourage community and civil society participation through empowerment and mobilization to ensure equitable response to COVID-19. This requires communities and civil societies to safeguard its role and give voice to the communities most likely to be left behind in a public emergency response. Efforts are needed to ensure that capacities are built to hold governments accountable and the creation of monitoring mechanisms for engaging effectively especially in a time where barriers like authoritarian policies, lockdowns, constraints on movements and closure of existing civic spaces makes it more challenging. Partnering with communities strengthens trust in the health care system, provides a mechanism for accountability, and increases chances that health care services are sustainable and ultimately acceptable and appropriate to the needs of community members.

5. Evidence shows that the ongoing pandemic is gendered: it affects women and men differently as it exacerbates already existing gender inequalities in our societies. Recognizing this complex relationship between a health crisis and gender is an important step towards creating equitable policies and responses. Therefore preparedness, response and recovery efforts need to have a gendered lens to ensure the unique needs of women are addressed and their roles in responding to the crises leveraged, whether as frontline healthcare and social workers, caregivers at home, or as mobilizers in their communities. As we attempt to build back better, we need to ensure our health systems meet the needs and realities of all. In order to do that, policy makers and programme managers must examine gender-based differences in health expenditures, disease detection and response, emergency preparedness, research and development and the health workforce and respond accordingly.

A Bangladeshi woman lines up to buy food during the COVID-19 situation. Photo: graphicsresource/Shutterstock.

6. Most countries where health systems already face enormous demands to handle the pandemic with significant capacity and resources crunch find themselves in a dilemma with the need for continued delivery of other essential health services like HIV, TB and malaria. In the short term, programme managers must maintain the most critical services, specifically treatment for HIV and tuberculosis and provision of both LLINs and prophylactic treatment for malaria a priority to reduce the knock-on impact of COVID-19 that can potentially undo significant progress made over the past two decades. For the longer term, improving the resilience of the health system to cope with shock events such as pandemics, and the changes necessary would be crucial to avoid a similar predicament.

7. Crisis situations are fertile grounds to change and build back better, however in the frenzy of responding to an immediate need, opportunities to document, research and analyze the ongoing situation is usually not prioritized. It is important that we harness lessons from the past, current and existing (HIV, TB and malaria) pandemics to better manage future health shocks. Decision makers will require better data and evidence, well-adapted modelling tools, and nuanced guidance in collaboration with the scientific community and civil society to make better informed decisions. More effort needs to go into conducting research, modelling, analysis and documentation to assess the direct and indirect impacts of COVID-19 across the health sector and evaluate the effectiveness of adaptive strategies. This will also be imperative to build the evidence base for efforts in any future epidemics and longer-term health system capacity building.

8. Pandemics do not occur with geopolitical boundaries and so resilience and preparedness requires thoughtful interconnectedness and global solidarity. Our advocacy needs to capitalize on the influence of global policies and movements toward universal health coverage for all. As advocates and practitioners, we need to push for a stronger integration between existing health and development agendas – we need to find the synergy to utilize mechanisms such Universal Health Coverage, the Global Health Security Agenda, and the Sustainable Development Goals—to create an urgency and to lend fresh impetus to the need to invest more and better in building a sustainable, resilient, and inclusive health systems.

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FEBRUARY 2021

PUBLISHED BY

APCASO
Strengthening community systems. Advancing human rights.

WITH FUNDING SUPPORT FROM

UNFPA Asia & Pacific

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Reviewers : RD Marte, Jeffry Acaba, and Jennifer Ho

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