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AHOP **POLICY BRIEFS**

Essential health care service disruption due to COVID-19:

Lessons for sustainability in Nigeria

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Key messages

Disruption was due to supply and demand factors: significant disruption to Nigerian essential health care services (EHS) during the COVID-19 pandemic was caused primarily by fear and stigma associated with the disease and physical barriers to service access on the demand side, and shortages of health goods and workforce constraints on the supply side.

Innovative service and goods delivery helped sustainability: mobile diagnostic units, telemedicine services, dedicated COVID-19 clinics, multi-month drug dispensing, and home delivery of medications helped mitigate EHS disruption. Embedding these practices into regular EHS provision could build health system resilience in the longer term.

Increased investment in health is essential: increased government attention on health systems during the pandemic resulted in essential investment in the health workforce and health infrastructure. Maintaining and increasing investment in infrastructure and logistics for sustainable service delivery is crucial for future system strengthening.

Leveraging collaboration helped sustain service provision: fostering multisectoral approaches and partnerships at the community level, across government silos, and between public and private sector actors proved successful in supporting the continuity of EHS provision. Adopting such approaches more extensively could bring systemwide benefits.

Executive summary

The COVID-19 pandemic revealed how strained the Nigerian health system is and how easily its essential health care services (EHS) can be disrupted. It underscored the importance of developing a sustainable approach to maintaining EHS provision during health shocks.

The mitigation strategies employed to combat COVID-19 disruption drew on Nigeria's substantial experience in combating epidemics, such as HIV/AIDS, Ebola, and severe acute respiratory syndrome (SARS). Identifying and reflecting on where disruption occurred and how it was managed offers insights to inform future health system planning.

Cause

EHS were disrupted by a range of supply side and demand side factors. On the supply side was a lack of resources, essential medicines, and health workers due to illness; a shortage of personal protective equipment (PPE); and an absence of incentives for high-risk frontline health work. On the demand side were fear and stigma associated with COVID-19 and transport restrictions that prevented patients from accessing the services that were available.

Impact

Nigeria's already overstretched health system experienced disruption to key services, including routine immunization, family planning, antenatal and neonatal care, tuberculosis (TB), HIV/AIDS, and malaria. From 2019 to 2020 the initiation of TB treatment went down by 72%, planned mosquito net distribution by 75%, and the provision of maternal care services by 6%, while child mortality rose by about 18% and maternal mortality by 9%, all attributed to the lack of EHS (Global Fund, 2020; Ahmed et al., 2020). The pandemic set back the pre-pandemic gains made in addressing the unmet need for family planning services and disrupted well-established and effective immunization provision.

Response

Nigeria adopted a proactive approach to health service provision in response to the pandemic by taking services to patients via telemedicine consultations, using community health apps, delivering drugs to patients' homes, and deploying mobile immunization units. Service provision was responsive and adaptable, with maternity services prioritized, dedicated COVID-19 clinics established, and multi-month drug dispensing introduced to help manage chronic diseases. Nevertheless, the late release and inadequacy of the guidelines around the delivery of EHS hampered response efforts.

Conclusions

The impact of COVID-19 on Nigeria's health system revealed gaps in EHS, but it also highlighted innovations that could be scaled up to support longer term improvement in health system performance. Investment in the training and capacity building of over 7000 primary health care (PHC) workers and community health workers (CHWs) proved critical, as did investment in health infrastructure and equipment, from test kits and ventilators to ambulances and diagnostic laboratories. Workforce and infrastructure strengthening supported both the pandemic response and the continuity of access to EHS.

Service delivery innovations that brought services to communities in need were crucial to sustaining EHS access. These innovations built on Nigeria's past pandemic experience, allowing the rapid leveraging of community networks established during the Ebola and Lassa fever outbreaks. Increased government investment in health during the pandemic sustained EHS in the short term and built system resilience for the longer term. The government's facilitation of the Coalition Against COVID-19 (CACOVID) and other public-private partnerships was instrumental in the upgrading of infrastructure and equipment.

Policy implications

Evidence suggests that adopting policies that strengthen the whole society and health system may facilitate the continuity of EHS service delivery. Areas of focus might include:

Investing in health workers: reviewing and strengthening the training and support measures for health workers could help maintain and expand a healthy, motivated, well-compensated, professionally trained, and well-equipped workforce to continue to deliver EHS during and beyond health emergencies.

Balancing pandemic containment and health service access: avoiding blanket lockdowns and coordinating pandemic containment measures with strategies to enable continued access to EHS could help prevent deterrents to health care usage and support the sustainability of services.

Cultivating community engagement: investing resources in community engagement and deploying CHWs to support both public health communication efforts and EHS delivery have proved demonstrably effective.

Building public trust: proactive investment in public health communication efforts to build trust and confidence in the health response to pandemics has been shown to encourage continued use of services and adherence to containment measures.

Responsive service delivery: sustaining and embedding innovations in responsive, flexible service delivery through mobile clinics, integrated community vaccination and testing programmes, and telemedicine could help sustain EHS and build system resilience.

Addressing health supplies' constraints: supply chain disruption and limited access to health commodities had a significant impact on the sustainability of EHS provision. Providing support to cover transportation, power, equipment, and communication costs where they impact health service delivery may mitigate disruptions to accessibility. Formalizing innovations in drug provision, such as multi-month drug dispensing or home delivery approaches, could contribute to building supply chain resilience.

Prioritizing health funding: increased government investment in health during the COVID-19 pandemic was essential to EHS continuity. Diversifying budgetary allocation across the various tiers of government would reduce reliance on the federal government. Improving the adequacy and targeting of existing human, finance, and infrastructural health resources could also support continuity of EHS access.

Fostering multisectoral approaches and partnerships: multisectoral approaches, working across government silos, and uniting diverse actors across sectors, proved crucial in the COVID-19 pandemic response. Leveraging engagement with non-state actors and private sector stakeholders – such as CACOVID – in both service provision and the design of innovative funding mechanisms, offers the potential to reduce out of pocket expenditure (OOPE) and increase service sustainability in the short and long term.

About AHOP

The African Health Observatory - Platform on Health Systems and Policies (AHOP) is a regional partnership that promotes evidence-informed policy-making. AHOP is hosted by the WHO Regional Office for Africa (WHO AFRO) through the integrated African Health Observatory. National Centres include Addis Ababa University, Ethiopia; KEMRI Wellcome Trust, Kenya; the Health Policy Research Group, University of Nigeria; the University of Rwanda; and Institut Pasteur de Dakar, Senegal. AHOP draws on support from the European Observatory on Health Systems and Policies (EURO-OBS), the London School of Economics and Political Science (LSE), and the Bill & Melinda Gates Foundation (BMGF).

AHOP policy briefs

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