Thinking and Working Politically on Health Systems Resilience:

Learning from the experience of Cameroon, Nepal and South Africa during COVID-19

Reflection Note

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Abbreviations and acronyms

COVID-19	SARS-Cov-2 (a coronavirus and its variants)
HIV	Human immunodeficiency virus

1. Introduction

The COVID-19 pandemic has tested the resilience of health systems across the world. The term resilience encapsulates the capacity of health systems to prepare for, respond to, cope with, recover from, and adapt to shocks such as a pandemic. These capacities have been critical to saving lives during COVID-19, and to enable health systems to maintain their routine functions during the pandemic. There are, however, many examples of health systems that have lacked resilience and been unable to adapt to pressure, thereby exposing their populations to increased, and even deadly, risks.

The resilience of health systems has been critically important to determining how well countries have fared during the COVID-19 pandemic. Long after the pandemic recedes, this issue will remain vital from a policy perspective to ensure adequate preparation for future pandemics and health crises. There is therefore a need to understand better what determines health systems' resilience and what policy actions can strengthen it in future. This note reflects on these questions, focusing particularly on the experience of three middle income countries that illustrate a range of experiences with COVID-19 and health systems response.

The key point is that governance and political economy factors are critical in shaping the resilience of health systems but are insufficiently understood or emphasised in policy-making and international cooperation. Governance and political economy factors act in concert with and in addition to the social, environmental, epidemiological, and other determinants that affect the burden of disease and the types and magnitude of shocks that challenge health systems. The ability of health systems to manage these shocks and remain resilient depends on how these systems are resourced, organised, managed and held to account, as well as the nature and reach of public communications through political messaging, traditional and social media. These critically important political economy, governance and communications factors are insufficiently appreciated and understood, particularly in specifying how particular factors operate in different country contexts.

Recognising the importance of the political economy dimensions of health systems resilience, the Thinking and Working Politically Community of Practice (TWP CoP) organised an online discussion on this topic on 17 February 2022.[1] This included a set of panel presentations highlighting the experiences of three countries – Cameroon, Nepal and South Africa.[2] These were selected because they illustrated different responses to COVID-19, making it useful to compare them in order to identify critical political economy factors that support or undermine resilience. This note summarises the main points arising from the discussion and highlights important policy issues. There are limitations to the analysis since this brief online discussion covered only three countries and the observations of a single, well-informed expert from each country. The findings should therefore be regarded as tentative and preliminary rather than being based on in-depth research. Although there are many areas of uncertainty and incomplete understanding, it is useful at this point to

[1] https://twpcommunity.org/thinking-politically-about-health-systems-resilience-in-the-context-of-covid-19

[2] The members of the panel were: Mahesh Sharma (Chair, Birat Nepal Medical Trust, Nepal), Professor Omer Njajou (Cameroon Country Co-ordinator for DAI-Tackling Deadly Diseases in Africa) and Dr Tumelo Assegaai (Senior Researcher, University of Cape Town). Dr Dell Saulnier (University of Lund and Karolinska Institute, Sweden) was the discussant. The panel was chaired by Gareth Williams (Director, The Policy Practice). Jeff Meckaskey, Dr Andrew McKenzie and Alina Rocha Menocal also kindly reviewed earlier drafts of the reflection note.

provide a rapid synthesis in order to take stock of emerging evidence, draw out potential implications for policy, and to identify questions for further research.

This note makes no overall judgement on which country's health system showed the most resilience, which would require further methodological development, evidence gathering and triangulation of data. It is nevertheless possible to observe some differences between countries in terms of the different aspects of resilience that were exhibited in different parts of the health system.

2. What is health systems resilience?

Health systems resilience is a concept emerging in health system research, and is characterised by different terminology and definitions.[3] Based on a review of the literature, this note proposes the following broad definition:

> *Health systems resilience refers to the ability of the health system to prepare for, respond to, cope with, recover from, and adapt to shocks, while at the same time providing appropriate and equitably distributed health services required by the population for routine and emergency needs.*

This definition highlights five aspects of resilience that describe actions taken before, during and after the pandemic. The first, ***preparedness***, refers to measures taken *before the pandemic* to establish effective surveillance systems, develop emergency plans, train staff in crisis response, pre-purchase and pre-position essential materials and develop communications plans to combat misinformation. The second aspect, ***responsiveness***, is relevant *during the pandemic* and refers to the rapid deployment of funds, staff and materials, implementation of appropriate public health controls and accompanying social and economic policy measures backed by a robust communications plan. The third aspect, ***maintaining basic functions,*** highlights the ability of health systems to cope with additional pressures *during the pandemic*, including managing a greater number of patients, protecting health professionals from infection and excessive work-related stress, and maintaining a basic level of functioning for provision of routine health services. The fourth aspect, ***recovery***, refers to the adjustment of pandemic-related functions *as the pandemic slows* and depends on numerous factors including the vaccination programme, the strength of the routine health system and the flexibility with which human and financial resources can be redeployed. The final aspect, ***learning***, refers to the ability to assess how well the health system is functioning *before, during and after the pandemic* to identify what changes need to be made to strengthen resilience to future shocks.

These five aspects of resilience apply across the health system as a whole and its constituent parts. Using the six building blocks of health systems set out by the World Health Organization (WHO), Table 1 maps out key aspects of resilience at different stages of

[3] For a wide-ranging survey of the terminology of health systems resilience see Fridell, M., Edwin, S., von Schreeb, J. and Saulnier, D.D. (2019) Health Systems Resilience: What are we talking about? A scoping review mapping characteristics and keywords. *International Journal of Health Policy and Management*, 9(1), 6-16. https://dx.doi.org/10.15171/ijhpm.2019.71 See also Saulnier, D.D., Blanchet, K., Canila, C., et al. (2021) A health systems resilience research agenda: moving from concept to practice. *BMJ Global Health*, 6: e006779. https://gh.bmj.com/content/6/8/e006779

the pandemic and in relation to components of the health system.[4] Health systems resilience also depends on actions taken outside the health system, including economic and social policy measures to support the economy, and lower-income and vulnerable groups, in order to encourage adherence to public health restrictions.

Table 1. Examples of actions taken in the three countries during COVID-19 to support health system resilience

	The five aspects of health systems resilience				
The six building blocks of health systems	**1. Preparedness**	**2. Responsiveness**	**3. Maintaining basic functions**	**4. Recovery**	**5. Learning**
A. Service delivery	Prioritise health services that contribute to the prevention of infectious disease.	Rapid scale-up of disease treatment.	Prioritisation of health services (COVID and non-COVID) essential for saving lives.	Progressive return to routine health service provision. Scale-up of COVID-19 vaccination programme.	Identifying gaps in essential service provision during the pandemic and planning to avoid these in future
B. Health workforce	Strengthen skills in crisis management procedures. Training, simulation exercises and drills.	Rapid redeployment of health staff according to fast-changing needs. Additional recruitment where needed. Mobilisation of community health workers (CHWs).	Protecting the health workforce from disease (PPE) and excessive workload. Contingency planning to deal with staff shortages.	Staff redeployment from emergency to routine functions at an appropriate pace.	Learning lessons from experience of staff and skills shortages and investing in human resources to avoid these gaps in future.
C. Information	Effective disease surveillance systems and early warning systems in place. Develop communications plans to combat misinformation.	Use of surveillance data for rapid and appropriate decision-making on public health measures. Delivery of communications plans to combat misinformation.	Maintenance of surveillance systems including for non-COVID threats. Actively combating misinformation.	Maintenance of surveillance systems including for non-COVID threats.	After Action Review to assess the performance of disease surveillance and decision-making systems. Corrective measures where needed.
D. Medical products, vaccines and technologies	Pre-stock critical materials (e.g. PPE, oxygen). Systems for emergency procurement are in place and ready.	Rapid deployment of materials according to fast-changing needs. Additional procurement rapidly organised.	Careful stock management and replenishment. Avoidance of shortages.	Ensuring provision of materials required for routine health services.	Assessment of the performance of procurement systems during the pandemic, focusing on responsiveness and avoidance of corruption. Corrective measures where needed.

[4] World Health Organization (2007) *Everyone's Business – Strengthening Health Systems to Improve Health Outcomes*: WHO's Framework for Action. Geneva: WHO. https://apps.who.int/iris/handle/10665/43918

E. Financing	Systems for emergency mobilisation of funds are in place and ready.	Rapid deployment of additional funds using emergency and routine procedures as needed.	Monitoring of financial requirements, Replenishment of funds as required.	Appropriate timing for ending use of emergency funding procedures.	Assessment of the performance of public financial management systems during the pandemic, focusing on responsiveness and avoidance of corruption. Corrective measures where needed.
F. Leadership and governance	Political leaders are fully committed to disease prevention and preparedness. Public health organisations responsible for pandemic preparedness and response strengthened. Mechanisms for multisectoral coordination in place.	Political leaders take rapid, appropriate and evidence-based decisions. They avoid delay, are willing to take unpopular measures and communicate well with the public. Mechanisms for multisectoral coordination and emergency management are fully supported.	Political leaders maintain commitment to pandemic response. Government messages are well communicated. Public trusts government health messages and is responsive.	Appropriate decision-making on removal of emergency measures driven by scientific advice rather than political expediency.	Performance of government in managing the pandemic assessed during and after the pandemic. Changes to policy, procedures and organisational structures based on evidence and implemented at an appropriate pace.

3. How resilient were health systems in the three countries?

Health systems performed markedly differently in the three countries during the COVID-19 pandemic. These differences are explained in part by the timing and severity of the infection waves. Most importantly, however, they reflect differences in governance and political economy factors shaping resilience.

At the start of the pandemic, Cameroon experienced a less severe COVID-19 shock than the other two countries, with relatively low case numbers; but a more severe second wave in early 2021 placed the health system under stress. The slow start to the pandemic allowed Cameroon more time to prepare and learn from the experiences of other countries with earlier waves of the pandemic. The overall *preparedness* of the health system, including disease surveillance and the readiness of response plans, was already relatively strong. There were, however, some weaknesses in the *responsiveness* of the health system. Substantial additional resources for the COVID-19 response were mobilised, but rather slowly. Cameroon was also slow to adopt some public health measures (e.g. travel restrictions), and there were no accompanying measures to offset the social and economic costs of lockdowns. Public Health Emergency Operation Centres had already been established during the Ebola crisis in 2014–15 and were quickly reactivated during the COVID-19 pandemic. Cameroon also experienced some challenges *maintaining basic functions* during the pandemic, as indicated by the large number of frontline health workers who became infected and the neglect of other health priorities, including HIV and tuberculosis and routine vaccinations.

Nepal experienced a large COVID-19 shock with a particularly severe second wave in May 2021. This was made worse by the lack of *preparedness* and initially uncoordinated *response*. While preparedness plans existed on paper, they had not been properly tested or adapted to the new institutional context in Nepal following the decentralisation reforms and 2015 constitutional change to a federal system of government. Despite initial confusion and lack of coordination, emergency response teams and a COVID-19 Command Centre were rapidly established. Additional funding was quickly mobilised, but slow procurement of oxygen and personal protective equipment (PPE) and the delayed recruitment of extra health workers led to severe difficulties in *coping with* the influx of patients, particularly during the second wave. The lack of available COVID-19 tests also undermined the effectiveness of response. *Recovery* from the pandemic has been relatively rapid thanks to a swift vaccination programme and corrective measures to address previous shortages. There are some indications that Nepal has learned lessons from the COVID-19 experience leading to a recognition that health infrastructure and laboratory services should be upgraded to manage COVID-19 and in preparation for future shocks.

South Africa experienced a large COVID-19 shock with four severe waves that contributed to excess mortality estimated at over 300,000.[5] Despite this, health systems have shown considerable resilience, in particular in terms of *preparedness* and *responsiveness*. South Africa has effective disease surveillance mechanisms in place, as indicated by the early detection and genetic sequencing of the Beta and Omicron variants. Pre-existing pandemic response plans were rapidly mobilised, including the activation of an Emergency Operations Centre comprising the National Institute for Communicable Diseases and the National Health Laboratory System. A key indicator of responsiveness was the rapid and large-scale mobilisation of additional funding to combat the pandemic, estimated at around 6% of gross domestic product (GDP).[6] Public health controls were imposed rapidly, with lockdown conditions differentiated according to local conditions. Overall, the health system coped reasonably well with the pandemic and took measures to protect services and staff. There appeared to be some strain earlier on in the pandemic, including oxygen shortages in Eastern Cape province, but there are indications of the rapid *recovery* of the health system that have been supported by reasonably fast progress in the vaccination campaign.

4. What explains the variation in resilience between the three countries?

The online workshop discussed a wide range of political economy and governance factors that supported or undermined health systems resilience. Presenters and the discussant emphasised the following as the most significant:

Committed and well-informed political leadership. In all three countries, a crucial factor in strengthening resilience was the commitment of political leadership to support the ability of the health system to respond effectively to the pandemic – elected politicians and public

[5] https://www.samrc.ac.za/reports/report-weekly-deaths-south-africa

[6] McKenzie, A., Assegai, T. and Schneider, H. (2021) Primary Health Care and COVID-19 in South Africa, Study for the Alliance for Health Systems Research.

officials demonstrated understanding of the seriousness of the crisis and the importance of responding rapidly. In Cameroon, however, this commitment took some time to emerge, possibly due to the slower arrival of the pandemic. All countries established structures to direct and coordinate the COVID-19 response that were under political control and so could connect decision-making at the political level to operational action.[7] The discussion also highlighted the importance of connecting political leadership to objective scientific advice in order to take timely and sound decisions. The case of South Africa was particularly positive in this regard because political leaders were closely connected to scientific advice from the public health institutes, as well as listening to social leaders, which helped establish a balance between public health and socioeconomic interests. The factors contributing to or undermining political commitment and connection to sound sources of advice need further research and explanation.

Establishing and maintaining trust. Across the three countries, speakers emphasised the importance of trust among political leaders, health system administrators, health workers and the population at large. Lack of trust weakens public compliance with COVID-19 control measures, which undermines the effectiveness of the COVID-19 response and places health systems under greater stress. This was a critical challenge in Cameroon, where low public trust was regarded as being linked to the government's poor communication of public health measures, suspicions about the mismanagement of public funds, and broader inter-regional political tensions. There is a concern that low trust in government has undermined public acceptance of the COVID-19 vaccine, which has extended to a general loss of public confidence in the wider routine vaccination programme. In Nepal, it was considered that national political leaders had worked hard to build trust through frequent public communications but had still struggled to establish the credibility and acceptance of public health restrictions.

Overall, the discussion highlighted the complexity of the issue of trust and the incomplete understanding of the processes by which governments earn and maintain this. These processes may be different in the emergency situation of a pandemic compared to normal times. There are also open questions as to whether trust in the health system during COVID-19 depends on perceptions of overall government performance, or more specifically in terms of actions taken in response to the emergency. The webinar discussion also highlighted the importance of the role of social media in health communication and deliberate misinformation, and their impact on building or destroying trust in the three countries. All of these issues are recognised as being critically important but are not well understood and require further research.

Centralisation vs decentralisation. The discussion did not produce clear answers on the question of whether centralised or decentralised health systems have proven more resilient during COVID-19. In general terms the experience from the three countries indicates that a centralised response can be essential for mobilising resources and ensuring a rapid, coordinated and coherent response, but that the decentralisation of some aspects of the governance of health systems is important to ensure that the response is properly adapted to local conditions, resources reach frontline facilities, and

[7] In Cameroon this was the Presidential Taskforce on COVID-19. In Nepal this was the Central High Level Covid Crisis Management Committee under the Office of the Prime Minister and Council of Ministers. In South Africa this was the National Coronavirus Command Council chaired by the President.

groups and actors operating at the local level are effectively mobilised. Finding the appropriate balance between a centralised and decentralised response can be difficult because each brings different challenges and there is often competition for power and resources between central and local governments.

The case of South Africa seems to provide an example of a well-balanced system with strong central political direction coupled with sufficient local autonomy to enable considerable adaptation of public health measures and pandemic response depending on epidemiological conditions in each province. This also enabled the effective mobilisation of around 30,000 Community Health Workers (CHWs), including focused training and mass screening of communities in high-risk areas in the early days of the pandemic.

In Cameroon, central government initially took a highly directive approach to pandemic response, which arguably missed opportunities to mobilise civil society organisations (CSOs) and CHWs. Since then, there has been a more balanced approach that has enabled more decentralised decision-making.

In Nepal, the challenges of switching from a unitary to a federal system of government over the past five years clearly contributed to the organisational problems experienced in the initial pandemic response. This appears to be a consequence of the disruption caused by transition processes in larger governance and delivery systems rather than an indication that decentralised arrangements are unsuited to pandemic response, but the hypothesis will need to be tested further over a period of time. While provincial, local and municipal governments were given the mandate and resources to respond to the pandemic, they lacked experience and guidance, and often operated in an ad hoc way without using evidence. Many local governments had also deprioritised health spending in favour of more politically visible economic development and infrastructure projects. However, the experience of the pandemic appears to have refocused the attention of local political leadership on the importance of providing health services at the local level.

Using existing plans and mechanisms. There were important differences between the three countries in the extent to which existing plans and mechanisms for pandemic response were used or by-passed. In South Africa the pandemic response largely followed existing plans and worked through established organisational structures. This was regarded as having made a critical contribution to the effectiveness of the response and the overall resilience of the health system. In Cameroon, however, there was less use of existing plans and structures, as shown by the lack of reference to pre-existing mechanisms for capacity building and coordination, including the National Action Plan for Health Security and National One Health Platform. In Nepal, plans and structures for pandemic response had been established, but had not been adequately tested following the change to a federal system of government. Furthermore, existing processes for the procurement of materials and recruitment of additional health staff appeared to be too slow and unsuited to emergency conditions. Overall, the experience from the three countries shows the value of adhering to pre-existing plans and mechanisms where these are well developed, locally adapted and tested. It also shows, however, that in practice well-laid plans often do not withstand the pressures of an emergency and the tendency of political leaders to override them and take direct control during a crisis.

Engaging non-state actors. The discussion generated several examples of the critical role provided by non-state actors in pandemic response. In South Africa, Public–Private Partnerships (PPPs) enabled the government to leverage private companies to increase laboratory capacity, which substantially reduced testing turnaround times. In Cameroon, CSOs have been playing an increasingly important role in communicating public health messages and overcoming vaccine hesitancy.

Role of international support. The three countries provided several examples highlighting the shortcomings of international assistance in supporting the pandemic response and health systems resilience. Most notably, the slow international response to the severe crisis and oxygen shortage that occurred in Nepal during the second COVID-19 wave was regarded as a major disappointment. Subsequently large-scale international support did arrive but was poorly coordinated and not fully matched to actual needs. In Cameroon, international donors were also perceived as having been slow to provide an appropriate package of support, in particular on vaccines, but there is now a stronger focus on systems strengthening and overcoming vaccine hesitancy.

5. What are the policy implications emerging from this comparative country experience?

This brief exploration of health systems resilience in three countries has highlighted the importance of health systems governance and political economy issues. Governance matters at least as much as the technical aspects of health systems resilience. However, the governance of health systems is often neglected as a priority for policy and investment, and instead the focus of public spending and international support has been on strengthening infrastructure and equipment.

The discussion highlighted several priorities for strengthening the governance of health systems to improve resilience to COVID-19 and future pandemics:

Use the present political moment to draw attention to the importance of health systems resilience. Domestic actors and international donors need to focus advocacy on building the commitment of political leaders towards the health systems resilience agenda. Before the memory of the pandemic fades, there is an opportunity to focus political attention on strengthening health systems to withstand future health crises. The pandemic has also revealed broader social problems that have undermined health systems resilience, in particular the socioeconomic inequalities that have prevented lower-income groups from obtaining access to health care and adhering to public health control measures. This recognition may create an opportunity to focus political attention on health and socioeconomic inequalities. For example, the implementation of universal health coverage (UHC) (National Health Insurance) in South Africa has gained more momentum from lessons learned during the pandemic.

Support political and societal leaders to build trust and credibility. The resilience of a health system depends on public trust in political and social leaders, health professionals and the health system in general to perform in an effective, transparent and accountable manner, and to provide acceptable, appropriate and timely services of all kinds. During pandemics,

this is particularly important if citizens are asked to adhere to public health messages to stop the spread of disease. This trust is difficult to gain and can be rapidly lost through (real or perceived) politicisation of decision-making and/or poor communication. There is scope for international actors to support mechanisms to build trust and credibility, in particular institutional arrangements that connect political leaders to sound scientific advice, improved communications and transparency in health systems management, action to combat misinformation, as well as civil society participation in monitoring and evaluation of health systems' performance.

Be realistic about the strengths and weaknesses of international assistance. A key lesson from the experience of the three countries is that international assistance was slow to arrive and could not be relied on to alleviate the impact of the pandemic. This was partly because donor countries' health systems and economies were under considerable pressure and often proved less resilient than expected. Low-income and lower-middle-income countries therefore had to rely on their own resources and abilities. While the failings of international cooperation during the pandemic need to be examined and corrected, it is clear that international assistance can play an important role in strengthening health systems between crises to build resilience over time. These efforts need to be systemic, cohesive, and should avoid fragmenting health systems.

Strengthen preparedness, planning and response mechanisms and ensure that these are used during crisis. The use of previously established mechanisms and plans for pandemic response can make a critical contribution to health systems resilience. It is essential to invest in developing and testing these mechanisms, to adapt them based on learning about their performance under pressure, and to ensure that they are used in practice rather than pushed aside by political leaders anxious to demonstrate that they are taking control during a crisis.

Empower local-level decision making in health systems management, while ensuring strong central coordination. There is no simple answer to whether centralised or decentralised health systems have proven more resilient during the pandemic. A pragmatic approach is required, recognising the constraints of existing political systems and considering which functions are best centralised or decentralised on a case-by-case basis. There is a need for both centralised frameworks for policy, oversight, resource allocation and system-wide procurement, as well as decentralised mechanisms for service delivery. There will often be a good case for pushing against the common tendency of governments to over-centralise any crisis response and to encourage the decentralisation of selective functions where local-level decision-making can better respond to local needs and engage local actors. This applies in particular to mobilising communities, CHWs and community-based organisations in sharing information, communicating about the health crisis, and promoting acceptance of the vaccines.

Address specific weaknesses in public financial management and procurement processes that held back the pandemic response. Greater attention needs to be given to developing emergency procedures for financial management and procurement that can mobilise funds and equipment rapidly while maintaining some safeguards against corruption and diversion of funds. In practice, most countries (irrespective of their economic status) have struggled

to find the right balance, suggesting that further research and analysis is badly needed to discover what works best in different contexts.

Support health systems to learn and adapt. While learning and adaptation are essential in order to strengthen resilience to future crises, these processes will not occur automatically. They will need to be actively promoted to enable honest and dispassionate debate about what does and does not work, to confront interests that are vested in the status quo, and to promote adaptation based on evidence and consensus rather than political expedience or knee-jerk reactions. Learning and adaptation need to be promoted and valued as a continuous process that is conducted during pandemics (learning and adapting to the different conditions of each wave) and between pandemics as part of a long-term process of systems strengthening and building resilience.

Support further international research on health systems resilience. This note has highlighted how health systems resilience is influenced by governance and political economy processes but has only scratched the surface in analysing how these operate in different contexts. The three-country comparison has described *what* aspects of resilience have been present or absent but has not been able to explain fully *why* these patterns have developed in particular countries. There is a need to learn more about the causal processes, in particular how resilience is connected to trust and credibility, questions of centralisation and decentralisation, intersectoral linkages, collaboration between the public and private sectors, and the role of community-level actors. Far more can be learned from more in-depth and comparative studies of country-level experiences. Above all, this needs to be researched and analysed through a 'thinking and working politically' lens that recognises that resilience is created or destroyed by political processes and how these shape incentives, behaviour and interactions within the health system.