Rebuilding Health and Education in Africa: Lessons from Spanish Flu and COVID-19

As the tempest of the pandemic rages, leaving carnage in its wake with healthcare sectors and national economies being the worst hit, there is no disputing that the world will never be the same again, a sentiment, echoed by many observers during these unsettling times. The pandemic and its scourge on humanity has made certain of that.

Right across the globe, there is a general all-pervasive air of uncertainty. Undoubtedly, everyone from all walks of life has been directly or indirectly affected by the COVID-19 pandemic and, as is the case with every devastating crisis, the already disconcerting disparity between the middle class and economically disadvantaged is set to be more glaring as the latter (with less access to resources, infrastructure and social services) grapple to cope with the situation. This crisis has revealed the inadequacies in African social infrastructure. Going forward, if we are to be prudent with a view to preparing for the next pandemic and make adequate provisions – history has shown us that there will most certainly be others – then it is incumbent on us to address these systemic issues.

With every major global crisis, there are shifts in received wisdoms and paradigms that had hitherto reigned supreme, that result in policy changes for the overall good of society. We have seen this to be the case after both world wars and, more pertinently, after the 1918 Spanish flu pandemic. Likewise, with the toll this current pandemic is taking on the global population and economy, one would not be wrong to equate it with other world-altering events.

Devastating as the Spanish flu was – the global death toll is estimated to have been between 50 million and 100 million – it acted as the much-needed catalyst for the Global North to revolutionize their health systems and change preconceived notions about healthcare. Being unprepared and susceptible to dire consequences of future pandemics was not something they wished to contend with. This determination led to the emergence of centralised health systems with the concept of universal access to healthcare elevated in public policy considerations.

A century on, centralised and extensive health coverage is the norm in the Global North, with governments spending significant portions of their budgets on free healthcare for all citizens. Russia was the first country to put a centralised public healthcare system in place after the Spanish flu, closely followed by countries in Western Europe. Eventually the idea spread across the developed world and came to be adopted as the standard. The US was the

exception as it opted for an insurance-based corporate sponsored health scheme.

Although the Spanish flu also affected Africa on a significant scale infecting up to 80 percent of the population with a 15 percent death toll, a corresponding health revolution was muted on the continent afterwards. Possibly this was because the nation states were in the hands of colonialists and their priorities in terms of administration were different compared to what we would expect if the wellbeing of the citizen was at the centre of public policy. That notwithstanding, this pandemic has revealed weaknesses not only in our health systems and economies but has likewise highlighted the gross inadequacies of our education sectors. On one level, these inadequacies have combined to dampen the efficacy of measures adopted to combat the pandemic, and on another, they have undermined our abilities to join the race to develop a vaccine or therapeutics to contain the virus as our global counterparts are doing. Sadly, this has proved to be a tall order as universities and research centres on the continent are inadequately resourced. This fact is borne out by the inability of African countries to undertake widespread testing, as most are struggling with expertise and equipment. Even the production of reagents necessary for testing for the presence of the novel coronavirus, have proved beyond us. To put it bluntly: We have university teaching hospitals, but we do not have enough labs.

Looking beyond our dilapidated health systems, the staggering levels of illiteracy across the continent are alarming. The poor who are, more often than not, illiterate will presumably be hardest hit by the pandemic because of the combination of a lack of comprehension of the disease, the inability to safely isolate due to their deplorable living conditions, and a lack of access to information and basic utilities such as water.

It is perhaps because of this that a good number of the population believe the pandemic to be untrue and an elaborately orchestrated lie to cause hardship on them, or see it as a test of their faith. As such they are more susceptible to make decisions or engage in activities that will exacerbate their exposure and vulnerability to the novel coronavirus. From popular media, we have seen vulnerable people taken advantage of by their faith leaders who peddle miracle cures for COVID-19, people trying on cloth masks in open markets- completely defeating their intended purpose, disregard for social distancing rules with crowds pushing and shoving to get into public buildings or access ATMs, rural and urban dwellers alike overcome by mirth at the thought of “a common cold” being a killer, and so on. Equally as disturbing perhaps is the demographic of the supposedly enlightened who espouse disturbing views and rehash far-fetched conspiracy theories relating to the pandemic. It would seem that our education, where present, is devoid of critical reasoning.

We can perhaps be forgiven for not having developed our health systems when the rest of the world did. In our current situation however, we can no longer claim ignorance of the sheer importance of having proper education systems alongside other social infrastructure in place. This pandemic should serve as a clarion call to improve on both healthcare and education infrastructure for posterity.

Therefore, as we plan for life after COVID-19, we must take the whole gamut of social infrastructure into consideration as central to our development and wellbeing in the future is having robust systems in place. Critical as they are, it is our contention that preparedness is more than just about adequate health systems. Increasing awareness amongst the populace of the impacts of pathogens, efficacies of measures to combat epidemics or pandemics, mean that education must be given necessary condition. Preparedness means an educated populace, only with education would our society be able to lift itself out of poverty and its attendant complexities and hardships, and be able to provide necessary healthcare and public health measures that are currently lacking.

While the world is focused on healthcare and the debate concentrates on life and sustaining livelihoods as different countries are emerging from their lock-downs, Africa must focus on building both its health and education sectors. Only such an approach will result in an enhanced state of wellness, improved standards of living, improved employment opportunities and economic independence on a sustainable basis.

Image by Pete Linforth from Pixabay

There's a healthy mind in a healthy body. Is the Nigerian body politic still healthy?

In the midst of the COVID-19 pandemic, the Federal Government has just announced that it is cutting the primary healthcare budget by 42% to ₦ 25.5 billion. As published by the International Centre for Investigative Reporting ICIR on Tuesday 2 June, "according to the revised document seen by Dataphyte, the Federal Ministry of Health had a downward cut of ₦15.17 billion." By contrast capital expenses not touched include ₦6 billion for OSSAP: Special Projects and ₦10billion for Office of the Senior Special Adviser to the President (OSSA)." The news has predictably been greeted by public outcry.

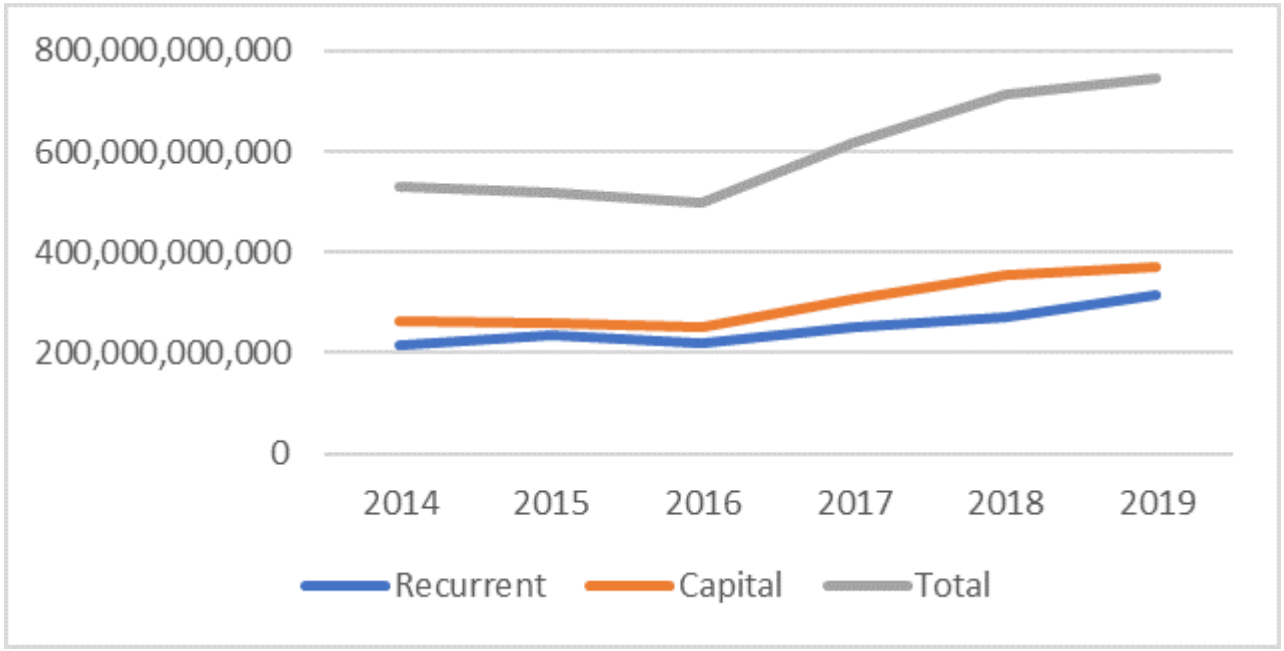
Research undertaken by TAPI shows that the alarm bells should have started ringing much earlier as the cut is just the most recent example of how national healthcare has been

consistently deprived of resources.

Nigeria committed to Sustainable Development Goal 3 ostensibly to “ensure healthy lives and promote wellbeing for all at all ages” by 2030. Yet a look at the financing of the healthcare sector suggests that the commitment is vacuous and swiftly becoming a pipe dream. Back in 2001, the Federal Government in concert with other major African nations signed the famousAbuja Pledge to spend 15 percent of each annual budget on healthcare. Fast forward to today: Were the primary healthcare budget just announced to constitute all government healthcare spending, then it would mean the total Federal budget was only ₦170 billion! That is how far short of the mark spending has fallen.

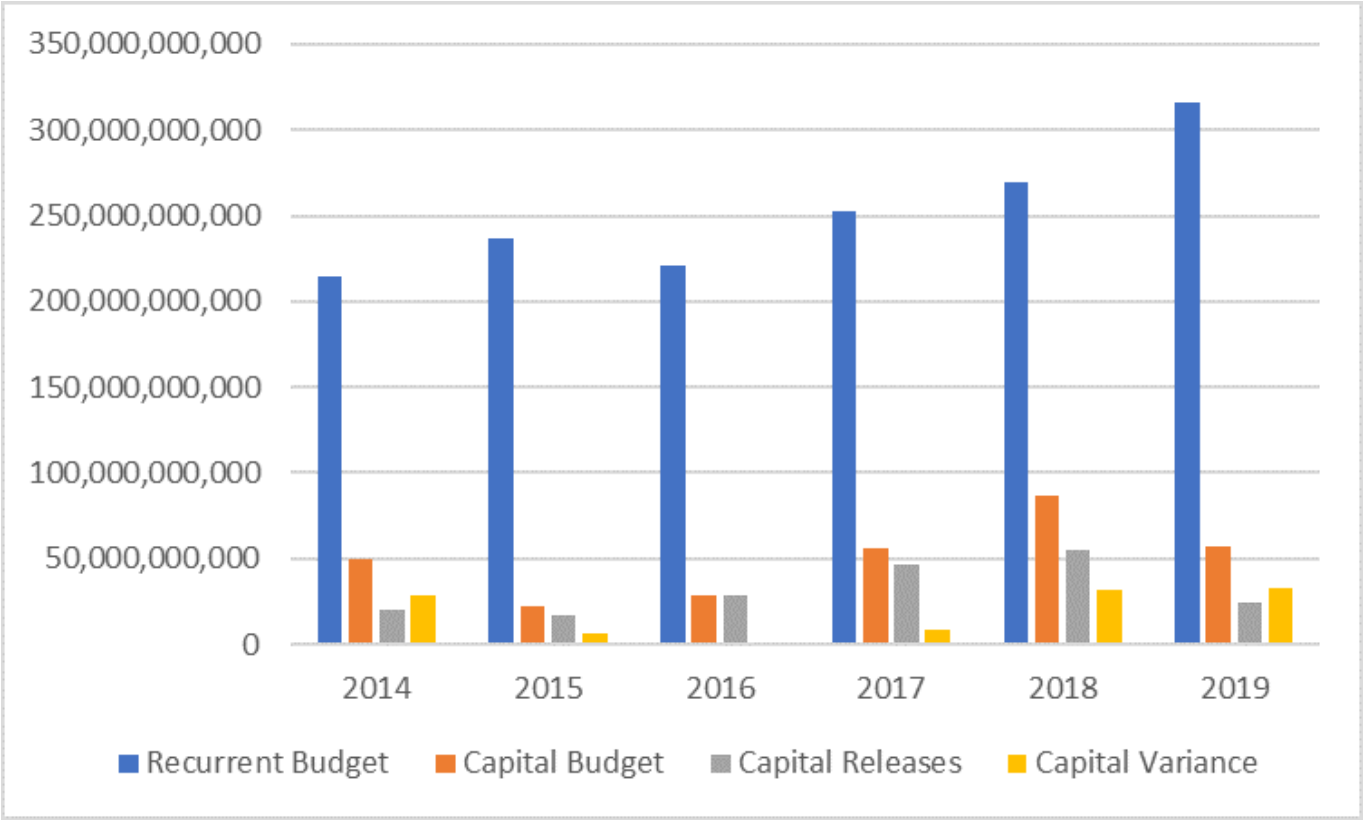
Facts are sometimes painful to accept, and one such fact is: The Federal Government has never since 2001 met its pledge. Paper, as the saying goes, is patient, and once the ink had dried on the pledge it evidently simply became another piece of paper in a drawer. A quick glance at other international benchmarks for the public healthcare financing such as ratios of expenditure to GDP or staffing levels, which are crucial for provision of primary healthcare, shows that the Nigerian picture is dire.

The first set of statistics evaluating Nigerian government healthcare expenditure is the absolute figures for federal budget allocations, whereby we distinguish between recurrent costs and capital costs. The Ministry of Health budgets over the last six years are captured in the graph below



In absolute terms the budgeted figures thus increased, whereby the rise has not been nearly

as significant for capital spending as it has been in recurrent expenditure. However, the figures gloss over reality. Actual budget releases for capital expenditure were nowhere near as high. (For simplicity's sake, we have excluded allocations to National Primary Health Care Development Agency and National Health Insurance Scheme because they together formed a negligible ratio of the whole of less than ten percent.)



If we assume a 100% performance for recurrent expenditures as actual recurrent releases always trail the budget, and focus on the 2014-2019 time series, we see that only in 2016 was the budget volume released anything near the figure actually budgeted.

If we aggregate the numbers, a total ₦191.65 billion was released for capital expenditure over the six years, or on average ₦31.94 billion p.a. for an average population of some 175 million (starting at 161.5 million in 2014 and rising to 190 million in 2019). Put differently, annual per capita capital expenditure for the period was a mere ₦ 182.49.

When population growth and inflation are factored in, a better of idea of the *real* budget figure emerge. The National Bureau of Statistics (NBS) database gives average year-on-year inflation rates for the years 2014 to 2019 inclusive, as 8.0%, 9.0%, 15.62%, 16.55%, 12.15% and11.39%, respectively. The difference between the Ministry of Health budgets for 2014 and 2019 is therefore 40.9% in nominal terms. Discounting for average inflation of 11.39% in

2019 implies that government expenditure for health over the period dropped by 0.4% in real terms. Let us further assume population growth of 3% per annum., population growth over the 2014-2019 period of 15.9%.Health expenditure per capita in real terms thus amounted to ₦ 1,407, down from ₦ 1,638 in 2014. In other words, government health expenditure per capita fell between 2014 and 2019 by 14.1%! Moreover, this fall does not even factor in the significant change in the Naira-Dollar exchange rate during the same period… (it fell from ₦ 164 to ₦ 305). Since many of the drugs and medical equipment have to be procured abroad, the value of the health expenditure dropped 47%,

To shed some light on the benchmarks and the pledges, attention is turned to FGN health expenditure in relation to GDP and FGN Revenue over the same period. The story that emerges is bleak: The last five years have not seen growth in healthcare spending, they have seen a decrease. Meaning that the system lags ever further behind the targets.

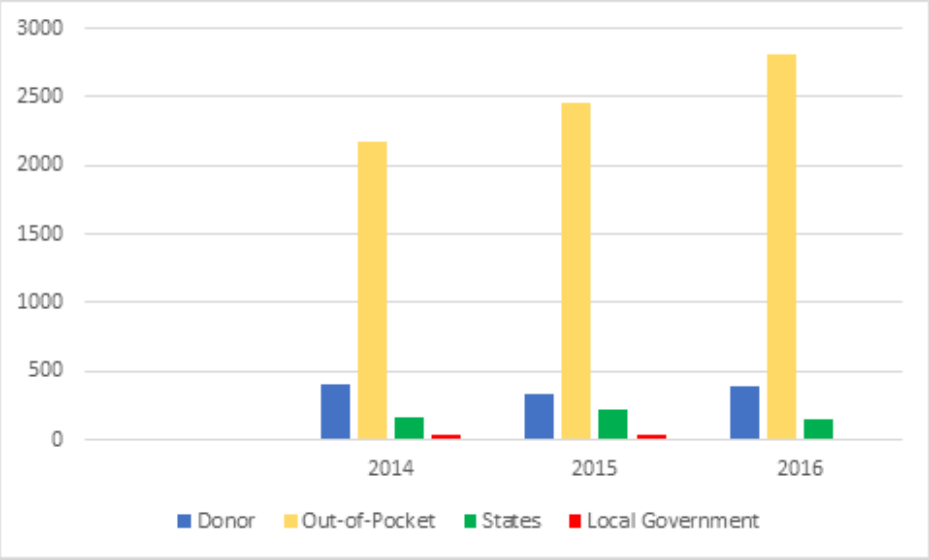
	FGN Revenue	GDP	Health / FGN Rev	Health / GDP
2014	3,731.00	48,066.29	7.6%	0.6%
2015	3,452.35	95,843.16	7.9%	0.3%
2016	3,855.74	102,921.72	7.0%	0.3%
2017	5,084.40	107,958.33	6.6%	0.3%
2018	7,165.87	113,088.88	6.2%	0.4%
2019	6,967.00	139,811.509	6.7%	0.3%

The figures fall far short of the benchmarks discussed above of the Abuja Pledge of 15% or the 4-5% of GDP recommended by WHO to achieve universal health coverage.

Turning attention from financing to staffing levels does not yield grounds for optimism. The WHO reports and other peer-reviewed studies reveal that the growth rate in staff per 10,000 members of the populace has flatlined since 2004. In absolute terms, the number of doctors, midwives or nurses in Nigeria are grossly inadequate to provide primary healthcare at the level WHO recommends. For this to be achieved, staffing levels must grow at an annual growth of 7.5%.

Another expression of the fact that government healthcare expenditure has actually dropped in the 2015-2019 period with dire consequences is in regards to infant, under-5 and maternal mortality compared to many of its peers. This is one of the areas investigated in the TAPI research – Nigeria is compared to Ethiopia, Indonesia, Kenya and South Africa. When attention is turned to death rates attributed to malaria and tuberculosis, the picture that emerges is the same. With government's avowed determination to create jobs, it stands to reason that addressing incidence of malaria estimated at 57 million cases of malaria per annum would positively impact productivity.

Equally worrying, healthcare in Nigeria today is mainly something accessible only to those who can privately afford it as an out-of-pocket (OOP) expense. A glance at the figures for the period covered in this study from 2014-2016 reveals the following:



OOP expenditure compared to combined spending by the states and local government authorities (S&LGAs) for 2015 show that total S&LGA expenditure came to a mere 10.43% of OOP. In 2016, the comparable figure was only 6.51%, and the relationship was clearly skewed even further toward OOP healthcare spending. If we include the Ministry of Health budget alongside the S&LGA outlays, then total public-sector expenditure for 2015 and 2016 still mounted to only 21.03% and 15.4% of the respective OOP expenses.

This shows that the Nigerian populace is directly paying for healthcare. Evidence suggests this has been the case since 2006. Since then, out-of-pocket spending has increased by almost 20% over the period reviewed, government spending fell by close to 7.5%. For a large section of the population such payments amount to "catastrophic health spending", meaning they constitute more than 10% of the household's possible spending. The household then

faces a catastrophic decision: Choose between healthcare or other necessities in life.

Note also thatless than 5% of those eligible are signed up to the NHIS. TAPI research shows that many rural communities are starved of primary healthcare facilities, as the health centres are located in main towns in the relevant ward or LGA. The situation is compounded by the fact that as the World Bank has outlined, the cash primary healthcare centres have at their disposal tends to stem from “user fees” (even for services that the 2014 National Health Act says should be free).

As one of Nigeria’s main lenders the World Bank offers a sobering assessment of Federal Government health financing:

“Low government health spending over the last two decades has limited the expansion of highly cost-effective interventions, stunting health outcomes and exposing large shares of the population to catastrophic health expenditures.Nigeria spends less on health than nearly every country in the world. … Funding for primary health care is especially affected as the bulk of spending occurs at the central level and is focused on tertiary and secondary hospitals.

Coverage of promotive, preventive, and primary health care interventions is low with the universal health service coverage index – defined as the average coverage of tracer interventions for essential universal health coverage – at just 39 percent.”

Primary health centres receive little to no operating budget.Primary health centres are meant to receive cash and in-kind support through the various fund flow arrangements … However, the 2016 National Health Facility Survey (NHFS) confirmed that on average providers received salaries with a two-to-three-month delay and only a third of facilities received any form of cash grants to meet their operational costs.” (World Bank 2018)

And now the Federal Government of Nigeria has further cut the primary healthcare budget. When what it should be doing is massively increasing it if it is to provide primary healthcare to all the country’s citizens as per SDG 3. Before the cuts were announced, Nigeria was already spending well over three times its healthcare expenditure on debt servicing. We can therefore only assume a general lack of political will to achieve SDG 3 is the cause of the malaise.

The conclusion can only be that government has not dared prioritize healthcare over other sectors and that unless it does the situation will not change and funding will continue to fall. Alternatively, government must look for alternative sources of financing. To say that there is already a state of emergency in the Nigerian healthcare sector as regards financing is to understate the magnitude of the problem. Capital and operating expenditures need to be radically increased (infrastructure, drugs and medicines, human resources). The original commitment to 15% of budget as stated in the Abuja Pledge would be a minimum starting point in light of the number of years of 'negative' investment in healthcare when compared to population growth. To paraphrase the old chestnut: If there were political will then there would be a way.

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Early Lessons COVID-19 has Taught Us

Seven months ago, the world seemed a steady place. Christmas holidays upon us. President Trump was ramping up for his re-election bid. Boris Johnson had just won a thumping majority. Brazil's agro-industry was receiving massive government support. The Federal Government of Nigeria was gearing up to borrow US$30 billion for massive infrastructure projects: mainly railways, a smattering of main roads, a huge dam, (but no hospitals) blithely turning a blind eye to the already fast-falling oil price and the ever-contracting market for black gold. Suddenly, news started to seep out of Wuhan, and China, that premier destination of Nigerian wholesale traders of consumer electronics who then fly home with Emirates, Ethiopian, Qatar, or Turkish, seemed less alluring. Four months later flights from the US, UK and mainland Europe started to seem like a way of importing possible death rather than goods.

At the same time as it has reaped death on a large scale, COVID-19 has also ravaged economies. Just as it sent US unemployment figures through the roof, so it sent the price of oil – so key to Nigerian government revenues – from fast fall into free fall, and then straight through the floor. Gone are the days of borrowing US$ 30 billion – as the Senate approved – Abuja has now scaled back its loan requests by a factor of 10 and is being granted a loan in order to survive – promising the IMF to behave, much as it had to back in IBB's day. The IMF insisted "The focus should remain on medium-term macroeconomic stability, with revenue-based fiscal consolidation essential to keep Nigeria's debt sustainable and create fiscal space for priority spending. Implementation of the reform priorities under the Economic Recovery

and Growth Plan, particularly on power and governance."

Fast forward to now. The Coronavirus has shown populist leaders to be ineptly disposed to handling a highly complex crisis. Or rather in some cases, the leaders showed themselves to be staggeringly foolhardy. Be it the maverick praise by Trump for self-injecting disinfectant, or an ignorant attitude toward testing and locking down London, or even Bolsonaro commenting "So what?" when being asked what he thought of the pandemic's death toll in Brazil. Indeed, Trump ignored early warnings and thus by the time the White House swung into action, the virus was fast spreading. Johnson felt initially that it sufficed to simply recommend that the 'vulnerable' stay at home and No. 10 placed its faith in 'herd immunity'. When it became clear that the death toll of such would be extremely high, he switched strategy in mid-stream. In Brazil, when confronted by the facts of a spreading virus, Bolsonaro simply sacked his health minister as the harbinger of bad news.

Indeed, it is fair to say that the virus has savaged single-slogan political solutions – be it "Make America Great Again and Drain the Swamp", "Get Brexit Done" or "Let's Make Brazil Great". Such populist appeals to the people (along with the claim that they are being hoodwinked by an 'elite'), do not deter virus spread. Nor, for that matter, does our own homegrown, broom-waving "Sweep out Corruption". After all, populism is all about pandering to the people's purported will, rather than imposing constraints on them, which is what the pandemic calls on governments to do. Pakistan's PM Imran Khan openly said the matter of lockdowns was so very complex as it entailed a dilemma of striking an intricate balance between locking down and stopping the poor among the people from starving to death.

Let's look at the planning behind those simple solutions to the crisis a little more closely as this may cast some light on what went wrong in the crisis response centres of Washington, Westminster, and Brasilia, as opposed to Berlin, Madrid or Paris. The United States, the United Kingdom, and sadly Nigeria share key policy weaknesses: They are all guilty of testing too little and too late. And then failing to introduce widespread tracing and quarantining in time. To be fair, the US and the UK have an advantage and thus even less excuse: They have far greater health infrastructure in place. The Nigerian healthcare system has been neglected for years, so retrospective action is to upgrade hospitals is at best to gloss things over (again, the SDG recommendation is 15%, the reality in Nigeria 4.5%). In this regard, for Nigeria, with its dwindling resources, the rush to buy ventilators/ICU beds was a race to the bottom, in that the baseline was max. 0.6 beds per million inhabitants as compared to a figure of 1 per 10,000 in the main EU Member States. To be equally fair: Nigeria had an advantage it wasted: If it had closed its airports at an early date, or at the very least introduced testing

(and not thermometer guns) at the entry points, it would have been in a better position to control the spread.

Regardless in such a situation you must mass test, isolate; mass test, isolate, and ensure people maintain personal hygiene methods. On the testing front: In Germany as many as 400,000 people are being tested a day (the actual capacity is 800,000 a day), in Nigeria the total number tested is 17,500, with 2,500 of that number testing positive (1 in 7). In the US, 7.1m have been tested with 1.15m positive (roughly 1 in 7), in the UK 1.2m with 187k positive (1 in 6.4). What of Europe's "front-line" states. Italy has tested 2.1million 210k were positive or a 1-in-10 ratio), Spain 1.93million (217k were positive meaning 1-in-9) – and in Germany 2.5million have been tested with 165k positive (1 in 15).

Put bluntly, Europe has been very strong on testing and has, despite the awful number of deaths, kept the number of persons testing positive for Coronavirus down in percentage terms. That is the product of careful, methodical planning to ensure best use of resources under tough conditions. In Germany's strongly federal system, coordination between the states has been an absolute priority to make sure everyone was on the same page, even if state policies differ. Remember, all three countries in mainland Europe imposed stark lockdowns as quickly as they could in line with existing plans for pandemics (for the record: Trump had disbanded the US agency responsible for drawing up such plans) and are only now starting to think of easing the regulations.

Not so Nigeria. Here the policy initially seemed to be 'wait-and-see'. And when the response came it was not based on a prior plan, but a copycat of the lockdown Modi had ordained in India. (causing a massive migration from urban areas to the villages and thus potentially spreading the disease very thoroughly). What did not go well in India was perhaps doomed to fail in Nigeria. Indeed, busy wrestling with a fiscal meltdown the government seems to have wilfully overlooked the fact that over 30% of the population are day-wage earners in the informal sector – and, therefore, if you 'lock them down' you condemn them to starvation. In other words, here advance planning should have involved not raising donations for new ICU beds but organizing a widespread system of getting food to people – and making certain there was fresh water everywhere so people could 'wash their hands'.

Abuja's strategy is also surprising because it flies in the face of the experiences we can assume the administration has garnered from both the IDP camps and the extensive social investment programmes; after all, the one field most definitely entails emergency/crisis management, while the other has hinged on the distribution of palliatives. Alternatively, we

could conjecture that lockdown coordination has been so poor precisely because it was based on those experiences, and that precisely those programmes must therefore be deemed to have largely failed.

Be that as it may, in one thing there has been policy consistency: The incoherence of the initial lockdown has been matched by the incoherence in lifting it again although numbers of persons testing positive is starting to increase fast. Once again, a simple “open on Monday” may be sweet to the ears of those left starving by the earlier “We are closing on Thursday”, but it doesn’t help you plan and implement marketplace layouts that ensure social distancing, educate the populace on the right temperature at which to wash masks, etc. Allowing two people on the backseat of a taxi and one person in the front passenger seat may lower possible contact numbers, but few are the VW Golfs or Toyota Corollas where you can maintain a minimum of 1.5 metres between the front and the back. Likewise, reopening buildings with shared a/c systems is tantamount to encouraging the virus to buzz around…

What could have been done or should be done, even if some of the horses have long since bolted? The virus has illuminated the power of individual will and autonomy and its effect on health security. People have been asked to self-check, report their symptoms, self-quarantine, self-isolate in their homes, and self-connect themselves to public health authorities. This they have tried to do – in Nigeria, too. If the authorities cannot test, then home-testing must become the new norm, and indeed home self-testing, enabled in an affordable manner rather than as something only a very slender proportion of the population can afford. At the same time, government must effectively educate, explaining what the protocols must be, starting with how to wash masks properly, which test kits should be used, and which rejected, etc. And government should be ramping up pharmaceutical production capacity to enable it to produce the 10-minute test kits the Senegalese and British are busy developing together.

Nigerians, let’s also us remember, are telco natives and tech-savvy. What do we all have smartphones for in a time of crisis? No, not for sending texts or instant messaging but likewise to report test results. Here, the mobile phone companies of this world can do far more than simply donate to hospitals. They can surely be involved in creating the special hotlines for free text-messaging. And then the phenomenon of citizens having to wait, in places for over a week, for government to ring them back, will become a thing of the past. Iceland has paved the way here, with Mrs Jakobsdóttir, the country’s Prime Minister, stating a few days ago: “We have introduced a tracing app, but use of it is voluntary. And the app we have provided is under the strict supervision of the Institution for Personal Privacy. In back-

tracing infections, we have found out where the infected persons have been infected in 93 percent of the cases.”

It is time to allow data to deliver mass-testing, to allow and enable individuals to exercise their autonomy to self-test, in an technology-driven, inter-connected manner with the public health authorities elected and appointed to serve them. To put it bluntly, to implement a lockdown that is ineffective because of a lack of data and leaves more deaths through starvation than would have been caused by COVID-19 is to put a population through trials and tribulations to no avail.

Lessons to be learned: Plan before you act. Plan on the basis of data and analysis. The more data we have, the safer we can be. The more we test, the more we can trace and isolate. The virus has not gone away simply because the lockdown has been eased. Here, data is the soap that helps stop the spread of the virus. Remember, never before have citizens stayed in their homes, waiting for contact from the government, be it testing or education. Yet we all have bank verification numbers that could be used to trace, isolate… and save lives.