

The COVID-19 pandemic and healthcare systems in Africa: a scoping review of preparedness, impact and response

Gizachew A Tessema ^{1,2}, Yohannes Kinfu,^{3,4} Berihun Assefa Dachew,^{1,5} Azeb Gebresilassie Tesema ^{6,7}, Yibeltal Assefa ⁸, Kefyalew Addis Alene,^{1,9} Atsede Fantahun Aregay,^{10,11} Mohammed Biset Ayalew,^{12,13} Wolde Sellassie M Bezabhe,¹⁴ Ayele Geleto Bali,^{15,16} Abel Fekadu Dadi,^{5,17} Bereket Duko,^{1,18} Daniel Erku,^{19,20} Kahsu Gebrekidan,¹⁰ Kidane Tadesse Gebremariam,^{7,21} Lemlem Gebremedhin Gebremichael,^{22,23} Eyob Alemayehu Gebreyohannes,²⁴ Yalemzewod Assefa Gelaw,^{5,9,25} Hailay Abrha Gesesew,^{26,27} Getiye Dejenu Kibret,^{28,29} Cheru Tesema Leshargie,^{30,31} Maereg Wagnew Meazew ³², Alemayehu Mekonnen,^{33,34} Alemnesh H. Mirkuzie,^{35,36} Hassen Mohammed,^{37,38} Dejen Yemane Tekle,^{6,7} Fisaha Haile Tesfay^{7,39,40}

To cite: Tessema GA, Kinfu Y, Dachew BA, *et al.* The COVID-19 pandemic and healthcare systems in Africa: a scoping review of preparedness, impact and response. *BMJ Global Health* 2021;**6**:e007179. doi:10.1136/bmjgh-2021-007179

Handling editor Sanni Yaya

Received 12 August 2021
Accepted 19 November 2021



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For numbered affiliations see end of article.

Correspondence to

Dr Gizachew A Tessema;
gizachew.tessema@curtin.edu.au

ABSTRACT

Background The COVID-19 pandemic has overwhelmed health systems in both developed and developing nations alike. Africa has one of the weakest health systems globally, but there is limited evidence on how the region is prepared for, impacted by and responded to the pandemic.

Methods We conducted a scoping review of PubMed, Scopus, CINAHL to search peer-reviewed articles and Google, Google Scholar and preprint sites for grey literature. The scoping review captured studies on either preparedness or impacts or responses associated with COVID-19 or covering one or more of the three topics and guided by Arksey and O'Malley's methodological framework. The extracted information was documented following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension checklist for scoping reviews. Finally, the resulting data were thematically analysed.

Results Twenty-two eligible studies, of which 6 reported on health system preparedness, 19 described the impacts of COVID-19 on access to general and essential health services and 7 focused on responses taken by the healthcare systems were included. The main setbacks in health system preparation included lack of available health services needed for the pandemic, inadequate resources and equipment, and limited testing ability and surge capacity for COVID-19. Reduced flow of patients and missing scheduled appointments were among the most common impacts of the COVID-19 pandemic. Health system responses identified in this review included the availability of telephone consultations, re-purposing of available services and establishment of isolation centres, and provisions of COVID-19 guidelines in some settings.

Conclusions The health systems in Africa were inadequately prepared for the pandemic, and its impact was substantial. Responses were slow and did not match the magnitude of the problem. Interventions that will

Key questions

What is already known?

- ▶ COVID-19 affects people of all ages, however, older people, and those with underlying medical conditions are at greater risk of infection and mortality from the disease.
- ▶ Despite the slow progress of the COVID-19 pandemic in Africa, there is increasing concern about the impact as nearly all countries in the region have weak healthcare systems.

What are the new findings?

- ▶ Africa's health systems were not well prepared for the pandemic.
- ▶ The response was generally slow and disproportionate to the magnitude of the problem.
- ▶ The pandemic had sizeable adverse effects on access to and utilisation of essential services.

What do the new findings imply?

- ▶ Efforts should be directed toward building health system resilience through local, national and global engagement and improving healthcare financing.
- ▶ African countries should focus on a coordinated approach to build capacity for vaccine development, transport and roll-out of vaccination for healthcare professionals and high-risk individuals, including rural areas.
- ▶ High-quality time-trend analyses are needed to understand better the extent and nature of ongoing changes and responses of the African health systems to the pandemic.

improve and strengthen health system resilience and financing through local, national and global engagement should be prioritised.

INTRODUCTION

COVID-19, caused by a novel SARS-COV-2, continues to create havoc across the globe.^{1 2} COVID-19 affects people of all ages; however, older people; and those with underlying medical conditions are at greater risk of infection and mortality from the disease.² As of 26 October 2021, over 244 million people were infected by the virus, and the COVID-19 pandemic caused 4.95 million deaths globally. Africa alone registered an estimated 8.5 million COVID-19 infections and over 217 000 deaths.³ Despite the late start and slow progress of the COVID-19 pandemic in Africa, there is increasing concern about the impact of the pandemic as nearly all countries in the region have weak healthcare systems.⁴

Africa has limited health infrastructure and workforce, including a shortage of professionals trained in critical care and inadequate tertiary care facilities (specialised hospitals) equipped with intensive care units (ICUs).⁵ In urban areas of Africa, health facilities are overcrowded with patients due to staff shortages, while in rural areas, unreliable transport and poor roads infrastructure remain key bottlenecks for access to medical care.⁴

The World Health Organization (WHO) recommends regular hand washing, face masks, social distancing and covering the mouth and nose while coughing or sneezing to prevent transmission of the virus.^{6 7} However, these measures mainly depend on how individuals respond to advice.⁸ Furthermore, resource scarcity could further hamper compliance in regions like Africa, even when people are willing to abide by these rules. For the same reasons, African countries might also be unable to implement WHO's recommended quarantine strategies at airports and hospitals for suspected contact tracing of confirmed cases.⁹ The possibility of an outbreak of other infectious causes, including an Ebola outbreak, on top of COVID-19, may add further complexity to the already complex public health systems in the region.¹⁰

Cognisant of the multifaced effects of the pandemic and the need for better preparation, the Africa Centres for Disease Control and Prevention has established a task force in six main work streams: laboratory diagnosis; surveillance, including screening at points of entry and cross-border activities; infection prevention and controlling healthcare facilities; clinical treatment of people with severe COVID-19; risk communication; and supply chain management and stockpiles.^{11 12} Public health and social measures have also been implemented across Africa which included, but not limited to, shutting borders, introducing self-isolation of exposed persons and establishing of quarantine centres.⁵ However, adherence to prevention measures varied remarkably.¹³⁻¹⁵

The few available studies showed that while there was limited surge capacity to provide COVID-19 treatment, the pandemic also affected the general public's access to essential health services.^{16 17} While there were two scoping reviews to date, one investigated the impact of COVID-19 on maternal and perinatal health,¹⁸ and the other focused on access to sexual and reproductive health,¹⁹

both reviews were based on experience from western countries. It is worth reviewing the available evidence on the level of health system preparedness, impacts of and responses for COVID-19 in Africa, which is the aim of this scoping review.

METHODS

Study design

We conducted a scoping review since it allows us to capture the broad nature of the research question and range of health system preparedness measures, impacts of and responses implemented across Africa in different settings. We followed the methodological framework suggested by Arksey and O'Malley²⁰ and further refined by Levac *et al*²¹ which comprised of the following five steps: (a) identifying research questions, (b) identifying relevant studies, (c) selection of studies, (d) extraction and charting of data and (e) summarising and reporting results.

Identifying research questions

The following questions guided the scoping review: (1) How well prepared were the existing health systems in responding to adverse impacts of COVID-19 infection? (2) What were the implications or consequences associated with COVID-19 on the healthcare system in Africa? (3) How did the health system respond in maintaining pre-pandemic health service needs, including providing essential healthcare services?

To effectively answer these questions, we adopted the population, concept and context framework developed by the Joanna Briggs Institute,²² as described in [table 1](#).

Identifying relevant studies

GAT developed a comprehensive searching strategy and discussed with the research team, presented in online supplemental file 1. We searched peer-reviewed papers on PubMed, Scopus and CINAHL bibliographic databases for peer-reviewed articles. Since grey literature such as unpublished work, preprint articles and relevant government reports on COVID-19 have grown in number and significance, we also searched Google and Google Scholar and MedRxiv and Research Square websites. We considered studies that employed quantitative or qualitative methods and reported health systems more broadly or any essential health services. These studies reported the impact of COVID-19 on maternal and child health services, services for infectious diseases such as tuberculosis, malaria, HIV and antiretroviral treatment services, chronic care, cancer care, hypertension care and treatment, and mental health services. We included studies conducted between 1 December 2019 and 21 March 2021, at which time the comprehensive literature search was performed.

Study selection

We included any published, preprint or grey literature in English that explored a combination of the following

Table 1 Population concept context (PCC) framework for defining the eligibility of the studies for the primary research question

Criteria	Element(s)	Descriptions
P— Population	All people	All individuals accessing healthcare services.
	Health workforce	Healthcare workers such as physicians, nurses, midwives and paramedics working as frontline contact in the healthcare system.
C— Concept	Preparedness	The ability and readiness of the health system to avail material and human resources to provide general and essential services during the pandemic.
	Impact	The effects that COVID-19 has on the provision of uptake and access to health services.
	Response	The capacity of the health systems to mobilise the required resources and act quickly to address the adverse consequences of COVID-19 pandemic; deliver all the necessary health services to those in need and support the healthcare workers during the pandemic.
C—Context	General health services	Any health service sought by patients at any level—community health posts, health centres, hospitals—or provider—public or private—settings.
	Essential health services	Healthcare services comprising any of the following services: maternal and child health services such as antenatal care, facility delivery, postnatal care and immunisation services; infectious diseases such as malaria, HIV and chronic care including cancer treatment.
	African countries	Any country in continental Africa that reported on preparedness, impacts and responses of COVID-19 on general or essential health services and its health workforce.

three terms: ‘health system preparedness’, ‘the impact of’ and ‘responses for COVID-19 pandemic by the healthcare system’. Two investigators (GAT and FHT) searched and screened the studies by titles and abstracts and then reviewed the full texts of potential studies. Records were managed by EndNote X9.0 software. The reference lists of the included studies were screened for relevant studies. Any questions around study eligibility were resolved through consensus between the two investigators (GAT and FHT). However, we excluded articles that mainly focused on the clinical and biological conditions of the diseases without any contextual linkage into the health system or those investigating the perceived/anticipated health system impact of the COVID-19 pandemic. Editorials, commentaries and letters to the editor that did not involve primary data were also excluded.

Data charting process

Two reviewers (GAT and FHT) initially developed a pre-determined electronic data-charting form that the research team later discussed and agreed on. Five reviewers (GAT, BAD, AGT, KG, DE) extracted data from included studies. The data extraction form had the year of publication, country name, article title, journal, study design, study setting and population. It also captured the key findings reported in the three core areas of health systems (ie, preparedness, impact and response) and limitations acknowledged in each study.

Summarising and reporting the results

We used a thematic content analysis using narrative descriptions of the extracted data, and organised the results under three main domains: preparedness, impacts and responses. We reported the review following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines Extension for Scoping Review reporting standards (online supplemental file 2).²³

Patient and public involvement

The study did not involve patients or the general public. Their input was not sought in the systematic review design, interpretation of results, or drafting or editing this document.

Ethics statement

This study was a systematic review of publically available literature, and ethical approval was not required.

RESULTS

Description of studies

We retrieved 804 records from databases and an additional 37 documents from grey literature sources. After removing duplicates, 747 records remained for titles and abstracts screening, of which 83 articles were retrieved for full-text screening. We conducted the final review on 22 studies,^{16 24–44} of which 19 (86.4%) were quantitative (figure 1, table 2). A total of 61 papers were excluded for the following reasons: studies assessed clinical and biomedical aspects of COVID-19 (n=28); covered expert opinions or commentary that did not involve primary data (n=12); assessed perceived or anticipated impacts (n=13); were not focused on Africa (n=8).

Characteristics of the included studies

Table 2 summarises the key characteristics of the studies included in our review. Of the included studies, about three-quarters (72.7%) were published in 2020. Except for four studies^{24 31 38 42} that were multicountry, 18 came from 10 different countries: four were from Ethiopia,^{16 32 33 36} three each from Kenya,^{27 34 43} and Uganda.^{28 30 41} While 18 (81.8%) were original studies^{16 24 26–30 32–35 37 38 40 42–44} published either in peer-reviewed journals or available in preprint repositories, the remaining four studies^{25 31 36 39} were published as letters to editors or commentaries but

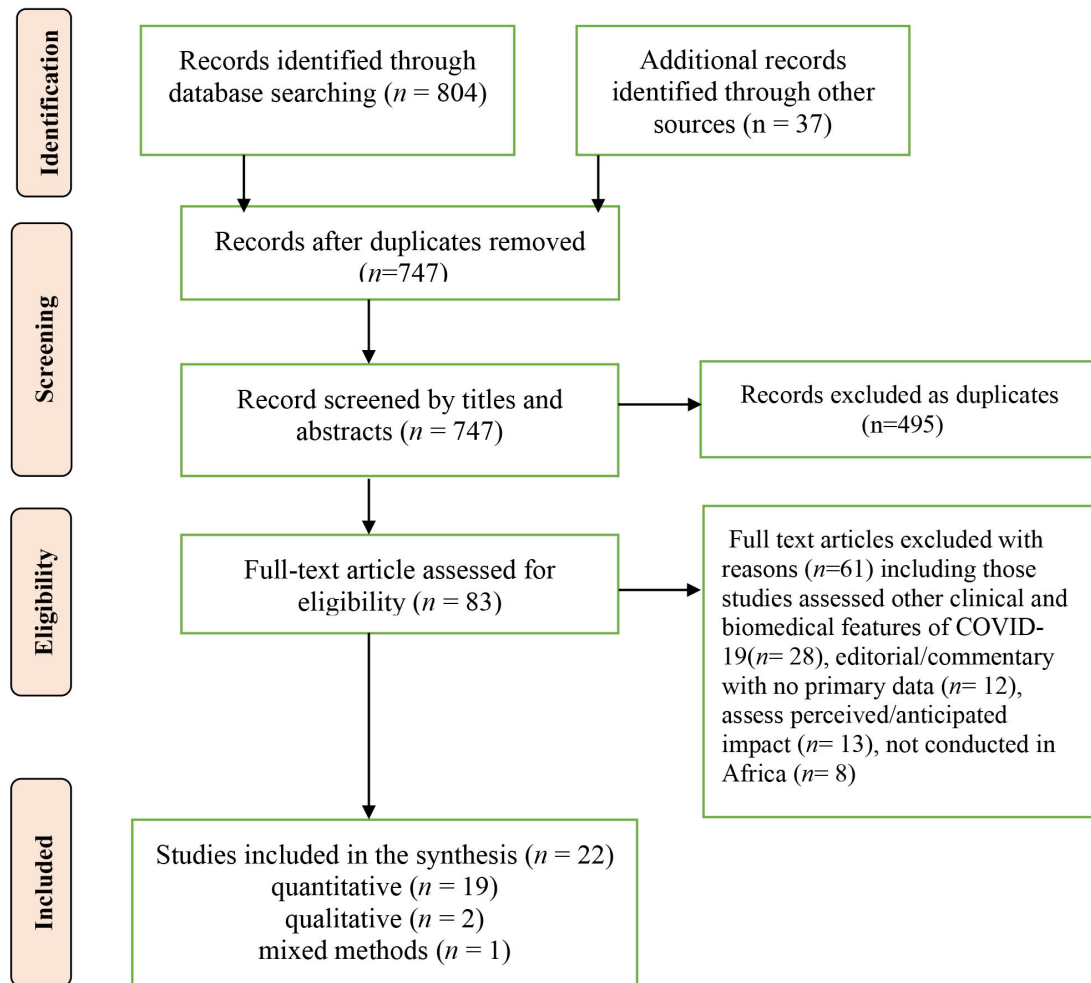


Figure 1 PRISMA-ScR flow diagram.

backed up by primary data. Of the included studies, 19 studies^{16 24 25 28–32 34–41 43–45} described the impacts of COVID-19 on accessing healthcare services, 7 studies^{24–28 33 38} reported health system responses to mitigate COVID-19 and 6 studies^{24 26 27 32 33 38} provided information on health system preparedness. Six studies^{24 26–28 34 38} focused on the general healthcare system. At the same time, four studies investigated specific health services components such as essential healthcare services, including specific healthcare delivery for maternal, child and sexual and reproductive health services.^{29 30 35 43} Additionally, three studies focused on infectious diseases such as tuberculosis^{36 37} and HIV.³⁹ Another three studies reported on healthcare services for cancer care,²⁵ mental health services⁴⁰ and integrated care for hypertension and HIV.⁴¹ Moreover, four studies^{31–33 42} assessed health workforce preparedness and workers' experiences during the pandemic. Details of the study characteristics are provided in online supplemental file 3.

Main themes from the included study

Health system preparedness

Six studies^{26 27 32 33 38 42} included under this theme demonstrated a low level of preparedness of Africa's health system to prevent, diagnose and manage the COVID-19

pandemic in the region (table 3, online supplemental file 4).

Resources to manage and guide COVID-19 were limited or not available

Three studies^{26 33 42} reported insufficient resources, including personal protective equipment (PPE) and clinical guidelines for healthcare providers during the pandemic. A Tanzanian study²⁶ showed low health facility readiness for COVID-19 prevention measures, with only two-thirds (64%) of urban and one-third of rural (32.9%) health facilities having functioning communication systems. A study from Ethiopia showed that half (50%) of the healthcare providers were not satisfied with the available medical equipment for COVID-19 treatment in their hospitals.³³ A global study that included African countries also reported that over half (53%) of healthcare workers working in maternal and neonatal health service provisions in low/middle-income countries did not receive updated guidelines for the management of COVID-19.⁴²

Healthcare workers preparedness

Two studies^{33 42} assessed the knowledge of healthcare workers on different aspects of COVID-19 and showed

Table 2 Summary of studies by study context and main focus in the healthcare system

Characteristics	Number (%)	Evidence
Publication year		
2020	16 (72.3)	Abdela <i>et al</i> , ¹⁶ Ahmed <i>et al</i> , ²⁴ Ammor <i>et al</i> , ²⁵ Bajaria <i>et al</i> , ²⁶ Barasa <i>et al</i> , ²⁷ Bell <i>et al</i> , ²⁸ Buonsenso <i>et al</i> , ²⁹ Gichuna <i>et al</i> , ³⁴ Mohammed <i>et al</i> , ³⁶ Odume <i>et al</i> , ³⁷ Sagaon-Teyssie <i>et al</i> , ⁴⁰ Jensen <i>et al</i> , ³⁵ Pierre <i>et al</i> , ³⁹ Semaan <i>et al</i> , ⁴² Shikuku <i>et al</i> , ⁴³ Siedner <i>et al</i> ⁴⁴
2021	6 (27.3)	Burt <i>et al</i> , ³⁰ Deressa <i>et al</i> , ³² Desalegn <i>et al</i> , ³³ Otitoloju <i>et al</i> , ³⁸ Schwartz <i>et al</i> , ⁴¹ Debes <i>et al</i> ³¹
Country of study		
Ethiopia	4 (18.2)	Abdela <i>et al</i> , ¹⁶ Deressa <i>et al</i> , ³² Desalegn <i>et al</i> , ³³ Mohammed <i>et al</i> ³⁶
Kenya	3 (13.6)	Barasa <i>et al</i> , ²⁷ Gichuna <i>et al</i> , ³⁴ Shikuku <i>et al</i> ⁴³
Nigeria	1 (4.5)	Odume <i>et al</i> ³⁷
Uganda	3 (13.6)	Bell <i>et al</i> , ²⁸ Burt <i>et al</i> , ³⁰ Schwartz <i>et al</i> ⁴¹
Rwanda	1 (4.5)	Pierre <i>et al</i> ³⁹
Tanzania	1 (4.5)	Bajaria and Abdul ²⁶
Mali	1 (4.5)	Sagaon-Teyssie <i>et al</i> ⁴⁰
Morocco	1 (4.5)	Ammor <i>et al</i> ²⁵
Sierra Leone	1 (4.5)	Buonsenso <i>et al</i> ²⁹
South Africa	2 (9.1)	Jensen and McKerrow, ³⁵ Siedner <i>et al</i> ⁴⁴
Multicountry*	4 (18.2)	Ahmed <i>et al</i> , ²⁴ Debes <i>et al</i> , ³¹ Otitoloju <i>et al</i> , ³⁸ Semaan <i>et al</i> ⁴²
Types of articles		
Original articles	18 (81.8)	Abdela <i>et al</i> , ¹⁶ Ahmed <i>et al</i> , ²⁴ Bajaria <i>et al</i> , ²⁶ Barasa <i>et al</i> , ²⁷ Bell <i>et al</i> , ²⁸ Buonsenso <i>et al</i> , ²⁹ Burt <i>et al</i> , ³⁰ Deressa <i>et al</i> , ³² Desalegn <i>et al</i> , ³³ Gichuna <i>et al</i> , ³⁴ Jensen <i>et al</i> , ³⁵ Odume <i>et al</i> , ³⁷ Otitoloju <i>et al</i> , ³⁸ Sagaon-Teyssie <i>et al</i> , ⁴⁰ Schwartz <i>et al</i> , ⁴¹ Semaan <i>et al</i> , ⁴² Shikuku <i>et al</i> , ⁴³ Siedner <i>et al</i> ⁴⁴
Commentary/letter to editor†	4 (18.2)	Pierre <i>et al</i> , ³⁹ Mohammed <i>et al</i> , ³⁶ Debes <i>et al</i> , ³¹ Ammor <i>et al</i> ²⁵
Study designs		
Quantitative	19 (86.4)	Abdela <i>et al</i> , ¹⁶ Ammor <i>et al</i> , ²⁵ Bajaria <i>et al</i> , ²⁶ Barasa <i>et al</i> , ²⁷ Bell <i>et al</i> , ²⁸ Buonsenso <i>et al</i> , ²⁹ Burt <i>et al</i> , ³⁰ Debes <i>et al</i> , ³¹ Deressa <i>et al</i> , ³² Desalegn <i>et al</i> , ³³ Jensen and McKerrow, ³⁵ Mohammed <i>et al</i> , ³⁶ Odume <i>et al</i> , ³⁷ Otitoloju <i>et al</i> , ³⁸ Pierre <i>et al</i> , ³⁹ Sagaon-Teyssie <i>et al</i> , ⁴⁰ Schwartz <i>et al</i> , ⁴¹ Shikuku <i>et al</i> , ⁴³ Siedner <i>et al</i> ⁴⁴
Qualitative	2 (9.1)	Ahmed <i>et al</i> , ²⁴ Gichuna <i>et al</i> ³⁴
Mixed methods research	1 (4.5)	Semaan <i>et al</i> ⁴²
Health services context		
General health services/health system	6 (27.3)	Ahmed <i>et al</i> , ²⁴ Gichuna <i>et al</i> , ³⁴ Abdul, ²⁶ Barasa <i>et al</i> , ²⁷ Bell <i>et al</i> , ²⁸ Otitoloju <i>et al</i> ³⁸
Essential healthcare service delivery	2 (9.1)	Abdela <i>et al</i> , ¹⁶ Siedner <i>et al</i> ⁴⁴
Maternal, child, sexual and reproductive health services	4 (18.2)	Burt <i>et al</i> , ³⁰ Jensen and McKerrow, ³⁵ Shikuku <i>et al</i> , ⁴³ Buonsenso <i>et al</i> ²⁹
Infectious diseases‡	3 (13.6)	Mohammed <i>et al</i> , ³⁶ Odume <i>et al</i> , ³⁷ Pierre <i>et al</i> ³⁹
Chronic care§	3 (13.6)	Ammor <i>et al</i> , ²⁵ Sagaon-Teyssie <i>et al</i> , ⁴⁰ Schwartz <i>et al</i> ⁴¹
Health workforce	4 (18.2)	Debes <i>et al</i> , ³¹ Desalegn <i>et al</i> , ³³ Semaan <i>et al</i> , ⁴² Deressa <i>et al</i> ³²
Main focus¶		
Preparedness	6 (22.7)	Ahmed <i>et al</i> , ²⁴ Bajaria and Abdul, ²⁶ Barasa <i>et al</i> , ²⁷ Desalegn <i>et al</i> , ³³ Deressa <i>et al</i> , ³² Otitoloju <i>et al</i> ³⁸
Impact	19 (86.4)	Abdela <i>et al</i> , ¹⁶ Ahmed <i>et al</i> , ²⁴ Ammor <i>et al</i> , ²⁵ Bell <i>et al</i> , ²⁸ Buonsenso <i>et al</i> , ²⁹ Burt <i>et al</i> , ³⁰ Debes <i>et al</i> , ³¹ Deressa <i>et al</i> , ³² Desalegn <i>et al</i> , ³⁴ Gichuna <i>et al</i> , ³⁴ Jensen and McKerrow, ³⁵ Mohammed <i>et al</i> , ³⁶ Odume <i>et al</i> , ³⁷ Otitoloju, <i>et al</i> , ³⁸ Pierre <i>et al</i> , ³⁹ Sagaon-Teyssie <i>et al</i> , ⁴⁰ Schwartz <i>et al</i> , ⁴¹ Shikuku <i>et al</i> , ⁴³ Siedner <i>et al</i> , ⁴⁴ Semaan <i>et al</i> ⁴²
Response	7 (31.8)	Ahmed, <i>et al</i> , ²⁴ Ammor <i>et al</i> , ²⁵ Barasa <i>et al</i> , ²⁷ Bell <i>et al</i> , ²⁸ Otitoloju, <i>et al</i> , ³⁸ Semaan <i>et al</i> ⁴²

*Studies involving one or more African counties as part of a global study.

†Included letters to editor's papers that was conducted based on a primary study.

‡Tuberculosis and HIV care services.

§Cancer, mental health, integrated care for hypertension and HIV.

¶More than one aspect was involved.

Table 3 Summary of key findings on preparedness, impact and response of healthcare system in included studies

Health system context	Evidence	Examples
Preparedness		
Resources to prevent COVID-19 were limited or not available	Bajaria and Abdul ²⁶	▶ Limited availability of some COVID-19 precaution products, such as medical masks, disinfectants, alcohol-based hand rub and access to running water, especially at publicly managed facilities and facilities in rural areas.
	Semaan <i>et al</i> ⁴²	▶ Less than half (47%) of respondents in LMICs received updated guidelines for care provision.
	Desalegn <i>et al</i> ³³	▶ Half (50%) of the healthcare workers were not satisfied with the medical equipment available for COVID-19 treatment in their hospitals. ▶ Most of the healthcare workers were not optimally prepared to prevent the COVID-19 outbreak.
Knowledge gaps by healthcare workers	Desalegn <i>et al</i> ³³	▶ Moderate knowledge about signs and symptoms, identification of persons at risk of developing the disease, case definition of COVID-19, appropriate tests offered to suspected cases and high-risk patients and preventive measures that help to minimise the risk of transmission.
	Semaan <i>et al</i> ⁴²	▶ Only 15% of healthcare workers reported that they clearly identified how to provide care for women with COVID-19.
Lack of training opportunities and resources	Semaan <i>et al</i> ⁴²	▶ One-third of respondents received training.
		▶ Half of the respondents in LMICs received updated guidelines for care provision.
		▶ Shortage of qualified staff, either because of symptoms, self-isolation after potential exposure or inability to reach their workplace, as a midwife in Uganda described: '(t)ransport to work is a big challenge due to lockdown; many staff live far away from the hospital. Staff who manage to come to work hurry to leave early to observe the curfew time of 7.00 p.m.'
Limited surge capacity and low testing ability	Barasa <i>et al</i> ²⁷	▶ Limited ICU bed surge capacity. ▶ When equipment were available, they were not functioning properly. ▶ While Kenya has 537 ICU beds, it only has 256 ventilators.
	Otitoloju <i>et al</i> ³⁸	▶ The testing capacity in African countries was very low. Most of the countries on the very low capacity need to scale up rapidly.
Limited or no available health services needed during the pandemic	Ahmed, <i>et al</i> ²⁴	▶ Mental health services and those addressing gender-based violence were perceived to be limited or unavailable.
Impact		
Reduced patient flow or limited access to health services	Abdela <i>et al</i> ¹⁶	▶ Reduced patient flow for accessing essential health services (maternal and child health and tuberculosis).
	Ahmed <i>et al</i> ²⁴	▶ Stakeholders perceive a reduction in access to all healthcare services in slums during COVID-19 lockdowns with services uptake was affected by an increased cost of healthcare, reduced household income, increased challenges in physically reaching healthcare facilities and exacerbated reluctance of residents to seek healthcare due to fear of infection and stigmatisation.
	Ammor <i>et al</i> ²⁵	▶ A significant decrease in patients' admissions during the lockdown period at the different units of oncologic centre.
	Bell <i>et al</i> ²⁸	▶ Reduction in the rate of detection of HIV and malaria and reduction of the provision of prophylaxis for tuberculosis prevention for patients with HIV. ▶ Reduction in facility deliveries in March 2020.
	Burt <i>et al</i> ³⁰	▶ Reduced attendance for antenatal care services, neonatal admission and prevention of mother to child transmission of HIV remarkably.
	Buonsenso <i>et al</i> ²⁹	▶ The under-five vaccination rate dropped by 50%–80% in 2020 compared with the previous year (p<0.0005).
	Gichuna <i>et al</i> ³⁴	▶ Limited access to receive sexual and reproductive healthcare services by female sex workers. ▶ Limited access to some reproductive health commodities. 'One of the main commodities we lack is family planning. During this time if we are not careful we will deliver a lot of 'corona babies'. There is a problem with Norplant and the family planning injectables are also not available for continuing women. This is not good for us. (Sex Worker, 40 years, Kasarani)'
	Jensen and McKerrow ³⁵	▶ Significant declines for clinic attendance (36%; p=0.001) and hospital admissions (50%; p=0.005) of children aged <5 years and a 47% increase in neonatal facility deaths were reported.

Continued

Table 3 Continued

Health system context	Evidence	Examples
	Mohammed <i>et al</i> ³⁶	▶ The pandemic has reduced TB care significantly including diagnosis, care and treatment.
	Odume <i>et al</i> ³⁷	▶ TB clinic attendance, presumptive TB identification, TB cases detection and treatment initiation significantly decreased since the onset of the COVID-19 (p<0.001).
	Siedner <i>et al</i> ⁴⁴	▶ There was a >50% reduction in child healthcare visits at the start of the level five lockdown from 11.9 to 4.7 visits/day (7.1 visits/clinic/day, 95% CI=8.9 to 5.3), both for children aged <1 year and 1–5 years.
Missed appointment for chronic care services	Pierre <i>et al</i> ³⁹	▶ Less than half (48%) patients with HIV attended scheduled antiretroviral treatment collection clinic appointments.
	Gichuna <i>et al</i> ³⁴	▶ Female sex worker reported a missed appointment due to COVID-19 restrictions to travel: 'I have missed my appointments to the clinic at BHESP (Bar Hostess Empowerment and Support Program). I was supposed to go collect my ARVs but now with the lockdown, how will I go to collect them? I cannot visit the public health facility because of stigma and discrimination. (Sex worker, 21 years, Jogoo Road)'
	Schwartz <i>et al</i> ⁴¹	▶ Compared with the pre-lockdown period (0.4%–5.2%), the percentage of missed appointments during lockdown for HIV and hypertension care ranged from 16.2% to 21.5%.
Re-orientation of services deter essential services provision	Mohammed <i>et al</i> ³⁶	▶ Human and material resources for tuberculosis have been shifted to COVID-19. ▶ Some health facilities that have been providing tuberculosis care and treatment services have been committed as COVID-19 isolation and treatment centres.
	Gichuna <i>et al</i> ³⁴	▶ It was observed disruption of supply for reproductive health commodities due to the focus on COVID-19 had led to a neglect of routine reproductive healthcare services especially in the public health centres. 'For now, when you visit the public health facility, we cannot be given contraception, priority has been given to responding and attending to emergency cases. (Sex workers, 20 years, Jogoo Road)'
Not all services were affected	Abdela <i>et al</i> ¹⁶	▶ Attendance for health facility delivery services was stable during the pandemic).
	Siedner <i>et al</i> ⁴⁴	▶ There was no drop-in clinic visitation in adults at the start of the Level 5 lockdown, or related to HIV care.
	Schwartz <i>et al</i> ⁴¹	▶ During the lockdown, 49%–66% of those who missed appointments for HIV care sought care at other health facilities but not for hypertension due to its limited integration.
	Shikuku <i>et al</i> ⁴³	▶ No differences in monthly mean (±SD) attendance between March and June 2019 vs 2020 for antenatal care, hospital births, family planning attendance, post-abortion care and pentavalent 1 immunisation.
	Burt <i>et al</i> ³⁰	▶ Immediate postnatal care, and contraceptive provision remained stable during the pandemic.
Impact on healthcare providers		
Perceived stigma	Debes <i>et al</i> ³¹	▶ Over half (56%) of health professionals reported safety concerns related to stigma from being healthcare workers.
Experienced mental health illness	Sagaon-Teyssie <i>et al</i> ⁴⁰	▶ 72%, 73% and 77% of participants (community healthcare providers) reported depression, anxiety and insomnia symptoms, respectively.
	Semaan <i>et al</i> ⁴²	▶ Healthcare workers providing essential services to women and newborns during this pandemic experience increased stress and anxiety levels. An obstetrician from Mozambique described, 'My stress level is immeasurable. Every time a pregnant woman with flu-like symptoms (visits the health facility), I feel almost completely lost. I need to be equally protected and I don't feel any protection from whoever (is responsible for protecting me)'
	Deressa <i>et al</i> ³²	▶ About 38% of respondents were perceived as somewhat worried and a half (50%) were apprehensive due to the potential risk of becoming infected with COVID-19 by their clinical role in the hospital setting. ▶ About two-thirds (65%) were extremely worried about the potential risk of infection to their family and loved ones.
Response		
Provision of guidelines	Otitolaju <i>et al</i> ³⁸	▶ Countries adopted the WHO protocols, personal hygiene, economic palliatives and social distancing measures.
	Semaan <i>et al</i> ⁴²	▶ Lack of national guidelines to facilitate the provision of health services for pregnant women. An obstetrician/gynaecologist from Uganda expressed: 'I am worried that no national guidelines (are) rolled out yet regarding care for pregnant women and newborns.'

Continued

Table 3 Continued

Health system context	Evidence	Examples
Tailored healthcare services and consultation	Ahmed <i>et al</i> ²⁴	<ul style="list-style-type: none"> ▶ Mobile consultation using phones at the time of pandemic lockdowns. A Kenyan health manager expressed: 'We have given out telephone numbers for the rapid response team to help with COVID-related cases. We also have a health facility telephone numbers for patients to call and talk to a health worker for non-communicable conditions that need monitoring. That way we can continue providing other services besides COVID-19 and ensure continuity of services.' ▶ Increased patronage of locally available services.
Re-purposing available health services	Ammor <i>et al</i> ²⁵	<ul style="list-style-type: none"> ▶ Allocating a special clinical unit to manage suspected COVID-19 cases. ▶ Adapted schedules to suit healthcare workers and treatment administration.
Implementing COVID-19 prevention methods to avoid COVID-19 transmission inside the facility	Ammor <i>et al</i> ²⁵	<ul style="list-style-type: none"> ▶ Surgical masks were provided for non-suspected patients. ▶ Suspected patients with COVID-19 were isolated in a dedicated area, and later referred to COVID-19 facilities for further examinations.

ARV, antiretroviral drugs; CI, confidence interval; HIV, human immunodeficiency virus; ICU, intensive care unit; LMICs, low and middle-income countries; WHO, World Health Organization.

mixed findings. The study from Ethiopia showed that healthcare workers generally had moderate knowledge on detection and management of COVID-19.³³ Another study showed limited understanding of case definition, identification of high-risk patients, tests appropriate to identify suspected cases and lack of adequate preventive measures to minimise transmission.⁴² In this study, only 15% of the participants perceived that they had complete knowledge to provide maternity care to patients with COVID-19.⁴² The same study also reported on the lack of training opportunities for staff and shortage of qualified staff as some experienced staff were not on their role partly due to self-isolation because of contact with patients with COVID-19 infection.⁴²

Limited surge capacity and low testing ability

A study in Kenya²⁷ showed that health facilities had limited surge capacity due to a lack of ICU beds and ventilators. Even when these equipment were available, there were also concerns about the lack of accompanying equipment or managing the equipment properly. Studies also noted resource gaps, particularly the incompatibility between infection rates and the infrastructure available to provide COVID-19 testing, given the size of the population in the region. For example, Otitolaju *et al*³⁸ reported that while few countries such as Mauritius, Ghana, South Africa, Botswana, Tunisia and Cape Verde had a medium to higher ability to carry out COVID-19 testing, the capacity in most African countries was low compared with their population size.

Lack of essential services needed during the pandemic

Despite the anticipated increase in demand for some health services, such as mental health, following a pandemic, including COVID-19, the review identified no concomitant expansion in health services to address mental health issues or gender-based violence in some countries.²⁴

Impact of COVID-19 on health services utilisation

The included studies reported a range of impacts associated with the emergence of the COVID-19 pandemic in one or more African countries (table 3, online supplemental file 4).

Reduced patient flow or limited access to health services

Over half of the studies^{16 24 25 28–30 34–37 44} showed significant reductions in inpatient hospital admissions and access to essential and general health services. The COVID-19-related lockdown restrictions has impacted all healthcare services,²⁴ including HIV care, treatment for malaria and tuberculosis, and maternal and child health services.^{25 35} A study from Ethiopia reported a decline in service utilisation as high as 98% for family planning services and up to 50% for antenatal care attendance compared with pre-pandemic trends.¹⁶ In addition, three studies^{16 36 37} have observed substantial declines in diagnosis and management of tuberculosis services. As a study from Ethiopia revealed, part of the decline was attributed to the re-orientation of health services as some healthcare facilities have been re-purposed to serve for COVID-19 care services.³⁶ Similarly, in Kenya, routine reproductive healthcare services were neglected due to priorities accorded to COVID-19-related services, especially in the public health centres.³⁴ A female sex worker expressed her concern as: 'For now, when you visit the public health facility, we cannot be given contraception; priority has been given to responding and attending to emergency cases. (Sex workers, 20 years, Jogoo Road)' (p. 1436)³⁴ In South Africa, there was a 36%–50% reduction in the rate of child healthcare visits^{35 44} and a 50% decline in hospitalisations for child health services.³⁵ Other essential health services with a reduced patient flow included prevention of mother to child transmission of HIV,³⁰ malaria diagnosis and treatment services,²⁸ sexual and reproductive healthcare services for some segments of the population such as female sex workers,³⁴ and patient admissions for

oncologic services.²⁵ Moreover, under-five vaccination rates in the region have declined significantly, by up to 50%–80%, in the post-pandemic period as compared with the year immediately before the pandemic.²⁹

Missed appointments for chronic care services

Three studies reported that COVID-19 impacted certain health services in chronic care follow-up clinics as patients could not attend routine appointments for follow-up and refilling drugs.^{34 39 41} A study in Rwanda showed that over half of patients with HIV with scheduled appointments were not visiting antiretroviral treatment collection clinics during COVID-19 lockdown, with patients from outside Kigali and patients with advanced HIV status (WHO stages 3 and 4) were impacted more than their counterparts.³⁹ Similarly, a Kenyan study showed that female sex workers could not attend their appointments due to the pandemic, as expressed by a female sex worker: ‘I have missed my appointments to the clinic at BHESP [Bar Hostess Empowerment and Support Program]. I was supposed to go and collect my ARVs, but now, how will I collect them with the lockdown? I cannot visit the public health facility because of stigma and discrimination. (Sex worker, 21 years, Jogoo Road)’ (p.1434).³⁴

Access to some health services in some settings was stable

Five studies^{16 30 41 43 44} reported that COVID-19 did not hamper health services provisions or affect the number of patients attending health services during the pandemic. For example, a Kenyan study comparing the monthly rate of antenatal care, hospital skilled births, family planning, post-abortion care and immunisation services during the 4 months before (March–June 2019) and after the COVID-19 pandemic (July–September 2019) showed no difference. Similarly, a study conducted in Uganda showed that, unlike other essential health services, immediate postnatal care and contraceptive provision remained stable during the pandemic.³⁰ A study in Ethiopia showed that while family planning services were severely affected by the pandemic, the effects were minimal for institutional delivery services.¹⁶ Similarly, a study from Uganda showed that despite COVID-19-related national lockdown, HIV services were still available in the country during the early phase of the pandemic, though this was not the case for hypertension services, reflecting the lag in integrated service delivery for chronic conditions.⁴¹

Impact of COVID-19 on healthcare workers

Four studies^{31 32 40 42} showed that healthcare workers had experienced mental health issues due to stressful working conditions and perceived fear of acquiring COVID-19 infection. For example, a study conducted in Mali involving community healthcare workers showed that about three-quarters (72%–77%) of the participants reported having at least one of the three symptoms of mental illness, including depression, anxiety and insomnia.⁴⁰ Similarly, an obstetrician from Mozambique who participated in a global study described their

circumstances as follows: ‘My stress level is immeasurable. Every time a pregnant woman with flu-like symptoms (visits the health facility), I feel almost completely lost. I need to be equally protected, and I don’t feel any protection from whoever (is responsible for protecting me)’ (p. 6).⁴² While about 38%–50% of healthcare workers reported somewhat to extremely worried for themselves being at risk of COVID-19 infections. Nearly two-thirds (65%) were extremely worried that they could potentially risk their families and loved ones for COVID-19 as they continued to be in hospital settings for clinical duty.³² Similarly, a survey of healthcare providers from 13 African countries demonstrated an increase in daily depression for stigmatisation in their community.³¹

Health system responses

Three studies^{24 25 38} reported on responses taken by the healthcare system to prevent the negative consequences of the COVID-19 pandemic and maintain existing health services provision. [Table 3](#) summarises the findings from these studies, while the details are provided in online supplemental file 4.

Provision of guidelines

The results related to guidelines provisions and adoptions are mixed. A preliminary evaluation of COVID-19 outcomes throughout African countries showed that almost all countries adopted the WHO protocol and guidance. Most countries established compulsory isolation and treatment centres for treating COVID-19 positive patients, mainly with hydroxychloroquine, chloroquine and chloroquine–azithromycin combination.³⁸ However, interviews with healthcare workers from Uganda demonstrated a lack of national guidelines to facilitate the provision of health services for pregnant women. ‘I am worried that no national guidelines (are) rolled out yet regarding care for pregnant women and newborns’, an obstetrician/gynaecologist had remarked. (p. 4)⁴²

Establish a channel for consultation

A multicountry study that examined response mechanisms during the early phase of the pandemic²⁴ had demonstrated the use of telephone consultation to mitigate the challenges of physically accessing health facilities by patients. A healthcare worker in Kenya attested that: ‘We have given out telephone numbers for the rapid response team to help with COVID-related cases. We also have a health facility telephone number for patients to call and talk to a health worker for non-communicable conditions that need monitoring. That way, we can continue providing other services besides COVID-19 and ensure continuity of services’ (p. 13).²⁴

Re-purposing of available services and establishing a dedicated isolation centre

One study reported that existing health services had been re-arranged to suit healthcare workers capability and treatment administration. The re-purposing of existing services involved, among others, providing health services

for COVID-19 suspected cases through dedicated clinical units, establishing isolation centres and providing protective masks.²⁵

DISCUSSION

Our scoping review provided comprehensive information on Africa's health system preparedness, impact and responses to the pandemic. While Africa's weak health-care system is already well recognised, our findings identified three core preparedness-related bottlenecks. These included the lack of resources and equipment, limited testing ability and inadequate surge capacity to deal with COVID-19. Our results identified several impacts attributed to the pandemic, including reduced service utilisation rates and missing scheduled appointments by chronic care patients. Despite the negative consequences, some response measures such as availing telephone consultations, re-purposing of services and facilities and establishing isolation centres and provisions of guidelines were in place as response mechanisms. However, in some settings, some services remained unaffected.

COVID-19 pandemic has challenged local, national, regional and global capacities to prepare and respond.⁴⁶ Recent pandemics, such as COVID-19 and others like the HIV epidemic of the early 1990s and the Ebola outbreak in the mid-2010s, have presented significant challenges to the African health systems.^{47 48} Several countries have learnt valuable lessons from these crises and developed coping mechanisms to combat these diseases.⁴⁹ Various experts have speculated the potential impact of the COVID-19 pandemic in the African health systems early in the pandemic and alerted resource-limited countries to make the utmost preparation to lessen the impact of the pandemic.⁵⁰⁻⁵² Also, lessons from outside the region were essential for controlling the spread of COVID-19. For example, during the early phase of the outbreak, some countries such as China quickly deployed human resources and expanded infrastructure, including constructing two new hospitals and re-designated wards in existing hospitals to isolate and treat patients immediately,⁵³ although the applicability of such aggressive measures remains a moot point in resource-limited countries. These being the case, the late introduction of COVID-19 into the African continent has offered an opportunity for the region to develop testing and treatment capabilities strategies.⁵⁴ This was evident from the number of countries that could undertake laboratory tests increased from only 2 (South Africa and Senegal) in January 2020 to 33 in a few months following the advent of the pandemic in the region.⁵⁵ Some countries achieved this by re-purposing existing research laboratories, diagnostic tools and reagents previously used for other infectious diseases.^{56 57} However, disruption in the supply chain of highly needed resources such as PPE and increased global demand^{58 59} meant vast shortages of such equipment in many countries globally, including African countries.⁶⁰ It was not surprising that

our review showed the lack of resources and equipment and limited know-how and surge capacity for COVID-19 in these countries. Several countries reported inadequate supply of PPE equipment and essential medicines.⁶¹ Moreover, the challenges became even more apparent when some African countries such as Kenya embarked on mass testing,⁶² despite shortages of test kits.⁶³ In part, this problem was exacerbated by travel restrictions⁵⁹ that hindered international trade, particularly the ability to purchase new equipment or transport donated materials.

Our review showed that the pandemic impacted essential and general health services, leading to reduced flow of patients, missed scheduled appointments and lower hospital admission rates. These findings were consistent with a recent time-series study in China that reported a significant decline in inpatient and outpatient visits.⁶⁴ Apart from essential healthcare services, healthcare services dedicated to non-communicable diseases were also impacted, partly due to priorities accorded to acute cases and to the COVID-19 pandemic. This was observed in a study from Morocco that reported a significant decline in cancer patients admission in the early phases of the lockdown.²⁵ The study result was consistent with a report from the WHO indicating a considerable degree of healthcare services disruption for non-communicable diseases in the early phases of the pandemic in more than three-quarters of countries globally.⁶⁵ Similarly, although not directly comparable as most studies in the reviews came from high-income settings, two reviews showed adverse effects of COVID-19 on hospital visits, hospitalisations, diagnostics, and maternal and child health services.^{19 66} Furthermore, the current study showed that the pandemic had also affected the mental health status of healthcare workers due to fear of infection and work-related stress. The findings from Africa were consistent with those from Thailand, which revealed that the COVID-19 pandemic led to uncertainty, anxiety, fear and stigmatisation among healthcare workers.⁶⁷ However, our review noted that not all health services were affected as demonstrated from studies conducted from Ethiopia and Uganda.^{16 30} While this could partly be explained due to that some of the studies included in our review conducted in earlier phases of the pandemic, it may also reflect the attention provided to preserve the provision of essential health services in some settings, which needs further research.

Our study has also indicated some variations on the impact of COVID-19 between geographic locations, vulnerable populations and countries. For example, our findings from a Tanzanian study²⁶ indicated that there were disparities in the level of health facility readiness for COVID-19 prevention measures as urban facilities were two times better than their rural counterparts in terms of available functioning communication systems.

Implication for policy and future research

The African health systems will continue to be confronted by emerging global and local events, including conflict, a

potential new infectious disease, climate change and the increasing burden of non-communicable diseases. On another side, countries with a fragile health system are likely to be overwhelmed by the complexity of case identification, the need to establish and maintain communication strategies, and the challenges of safely caring for a surge of critically ill patients.⁶⁸ Ultimately, the focus in the region should be on creating a resilient health system, a system that responds for all health challenges, times and people.⁶⁹ Well-established and resilient health system allows countries to prepare and respond appropriately to health system shocks and disturbances following unprecedented community health risks, including pandemics.⁴⁶ However, establishing a resilient health system will not be without challenges, partly due to limited resources, including insufficient health financing and shortage of skilled health workforce. While COVID-19 remains a biomedical challenge, an approach focused on disease control alone will be insufficient to contain the pandemic.⁷⁰ Lesson from past epidemics and major health challenges in the region remind us of the need to protect, support and empower the frontline healthcare workers, particularly the community health workforce, which remains the backbone of Africa's health system.⁷¹

With the advent of COVID-19 vaccines, vaccination roll-out can serve as one pillar of the health systems response globally and in Africa.⁷² Just in less than a year, we observed several success stories in vaccination coverage, mainly in high-income countries, including a coverage rate of over 85% in Portugal and the UAE.⁷³ In countries like Portugal, such success led to getting away with lockdowns or wearing masks outdoors.⁷⁴ Unfortunately, many countries in Africa are still at the bottom lane of the queue for vaccination access except Seychelles, which achieved a vaccination roll-out of over 75% of its population.⁷³ The COVAX initiative, a multilateral coalition led by GAVI, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations, and the WHO, was established to facilitate life-saving COVID-19 vaccines to low-income countries.⁷⁵ However, despite the pledges to allocate sufficient doses for 47 countries in Africa to vaccinate at least 20% of their population, the progress remains limited.⁷⁶ Thus far, in Africa, only 5% of its population has received access to COVID-19 vaccines, which poorly compares with over 55% vaccination coverages in Australia and Europe,⁷³ reflecting the continued disparities in equitable access to healthcare.

Unless vaccination access to the African countries is accelerated, the adverse impacts of COVID-19 identified in this review are likely to be further exacerbated as waves of existing and newly emerging variants of the COVID-19 hit the region.^{77 78} Therefore, African countries should focus on a coordinated approach to build capacity for vaccine development, transport and roll-out of vaccination for healthcare professionals and high-risk individuals, including rural areas. Even if these challenges are addressed through inter-African initiatives and cooperation with development partners, administering

Box 1 Implications for policy and research

Implications for health system policy

- ▶ Preparedness: Strengthen testing capacity and health emergency information system to ensure timely detection and response to new variants of COVID-19 and—as the pandemic matures and vaccine uptake increases—further integrate COVID-19 cases as part of a common notifiable disease.
- ▶ Impact: Moving toward a resilient health system responsive to emerging health threats and incorporating home care as part of the future pandemic impact response strategy.
- ▶ Response: Building human and infrastructure capacity and health financing mechanisms to ensure a sustainable supply and delivery of vaccines to eligible persons.

Implications for future research

- ▶ Systematic analysis of the impact of COVID-19 on:
- ▶ Specific health services (eg, surgical services).
- ▶ The role of the private health sector in ensuring public health security and emergency response.
- ▶ Health workers performance, with the latter being supported by qualitative studies.

the new vaccines in each country could likely pose enormous logistical challenges for the region. For example, assuming a vaccination rate of 80% to achieve herd immunity for COVID-19, Africa will need to administer about a billion doses, which at the very least means doubling the region's vaccination capacity from its current level. Therefore, each African country will also have to develop the human resource need and infrastructural capabilities to vaccinate its population when the vaccines become available as desired. As the task is horrendous, countries must also intensify public awareness creation through active community engagement to reduce the burden of infection, debunk misinformation toward COVID-19 vaccination and improve Africa's health system ability to respond well with its limited capacity. Countries in the region also need to take the current challenge as an opportunity to develop a more resilient health system capacity through multilevel governance arrangements that coordinate local, national, regional and global actions.⁷⁹ A well-established and resilient health system allows countries to prepare and respond appropriately to health system shocks and disturbances following unprecedented community health risks, including pandemics.⁴⁶ Eventually, this will enable the health systems to minimise current COVID-19-related morbidity and mortality, maintain essential healthcare services, provide support for healthcare workers and effectively respond to subsequent waves of COVID-19 pandemic (see summary for implications for policy and research in [box 1](#)).

Strengths and limitations

Although two systematic reviews were conducted before the current study, the studies were mainly from high-income countries.^{18 19} Ours is the first study to provide an Africa focused comprehensive assessment of preparedness, impacts and responses to COVID-19 in the region.

The integration of quantitative and qualitative studies is another strength of this review, which allowed to improve the volume of evidence and get multiple dimensions of the effects of the pandemic on Africa's health systems. However, the findings should not necessarily be taken as reflective of the views and perspectives in the African health systems in their entirety as we have only included two mixed-method studies and one qualitative study. Given that scoping reviews, by their nature, are focused on mapping rather than on appraising the quality of the available evidence,⁸⁰ we have not performed quality appraisal in this review. In addition, we may have missed out on relevant studies published in other languages as the reviews in our paper were limited to those written in English. Despite the rigorous searching strategies that have been implemented in three broader bibliographic databases, our study might still have potentially missed out studies that could have been identified through other databases. Most of the included studies were based on data in the early stages of the pandemic. They may not be fully generalisable to or reflective of the ever-changing situation in terms of the newly emerging variants of COVID-19 on a one side and the development of COVID-19 infection on the other side. We have not also explored the private health sector, particularly how it is affected by and its responses and role in fighting the pandemic. This remains a limitation as the private sector has a significant role in service delivery and can be a powerful partner if mobilised and provided the necessary government support.

CONCLUSIONS

The health systems in Africa were inadequately prepared for the pandemic, and its impact on other health services was substantial. The response to the pandemic was generally slow and did not correspond to the magnitude of the problem. Interventions that will improve and strengthen health system resilience through local, national and global engagement and improving healthcare financing should be given priority. High-quality time-trend analyses are needed to understand better the extent and nature of ongoing changes and responses of the African health systems to the pandemic.

Author affiliations

¹Curtin School of Population Health, Curtin University, Perth, Western Australia, Australia

²School of Public Health, University of Adelaide, Adelaide, South Australia, Australia

³University of Canberra, Canberra, Australian Capital Territory, Australia

⁴College of Medicine, Qatar University, Doha, Qatar

⁵Department of Epidemiology and Biostatistics, Institute of Public Health, University of Gondar, Gondar, Ethiopia

⁶The George Institute for Global Health, University of New South Wales, Sydney, New South Wales, Australia

⁷School of Public Health, Mekelle University, Mekelle, Ethiopia

⁸School of Public Health, The University of Queensland, Brisbane, Queensland, Australia

⁹Telethon Kids Institute, Perth, Western Australia, Australia

¹⁰Monash University, Clayton, Victoria, Australia

¹¹School of Nursing, Mekelle University, Mekelle, Ethiopia

¹²Department of Pharmacy, University of New England, Armidale, New South Wales, Australia

¹³Department of Clinical Pharmacy, University of Gondar, Gondar, Ethiopia

¹⁴Faculty of Health, University of Tasmania, Hobart, Tasmania, Australia

¹⁵Research Centre for Generational Health and Ageing, University of Newcastle, Newcastle, New South Wales, Australia

¹⁶School of Public Health, College of Health and Medical Sciences, Haramaya University, Harar, Ethiopia

¹⁷Menzies Health Research Institute, Charles Darwin University, Darwin, Northern Territory, Australia

¹⁸School of Public Health, College of Medicine and Health Sciences, Hawassa University, Hawassa, Ethiopia

¹⁹Centre for Applied Health Economics, School of Medicine, Griffith University, Brisbane, Queensland, Australia

²⁰Menzies Health Institute Queensland, Griffith University, Brisbane, Queensland, Australia

²¹Lifelong Health, South Australia Health and Medical Research Institute, Adelaide, South Australia, Australia

²²College of Nursing and Health Sciences, Flinders University, Adelaide, South Australia, Australia

²³Department of Pharmacology, School of Pharmacy, College of Health Sciences, Mekelle University, Mekelle, Ethiopia

²⁴Division of Pharmacy, School of Allied Health, The University of Western Australia, Perth, Western Australia, Australia

²⁵Population Child Health Research Group, School of Women's and Child Health, University of New South Wales, Sydney, New South Wales, Australia

²⁶Public Health, College of Medicine and Public Health, Flinders University, Adelaide, South Australia, Australia

²⁷Department of Epidemiology, School of Health Sciences, Mekelle University, Mekelle, Ethiopia

²⁸Public Health, Debre Markos University, Debre Markos, Ethiopia

²⁹Faculty of Health, University of Technology Sydney, Sydney, New South Wales, Australia

³⁰College of Health Sciences, Debre Markos University, Debre Markos, Ethiopia

³¹School of Public Health, University of Technology Sydney, Sydney, New South Wales, Australia

³²Maternal and Child Health, Federal Ministry of Health, Addis Ababa, Ethiopia

³³Centre for Quality and Patient Safety Research, School of Nursing and Midwifery, Institute for Health Transformation, Deakin University, Burwood, VIC, Australia

³⁴Department of Medicine, School of Clinical Sciences, Monash University, Clayton, VIC, Australia

³⁵Ethiopian Public Health Institute, Addis Ababa, Ethiopia

³⁶Institute for Health Metrics and Evaluation, University of Washington, Seattle, Washington, USA

³⁷Vaccinology and Immunology Research Trials Unit, Women's and Children's Health Network, Adelaide, South Australia, Australia

³⁸Robinson Research Institute, Adelaide Medical School, University of Adelaide, Adelaide, South Australia, Australia

³⁹Deakin University, Institute of Health Transformation, Melbourne, Victoria, Australia

⁴⁰Southgate Institute for Health, Society and Equity, Flinders University, Adelaide, South Australia, Australia

Twitter Gizachew A Tessema @Giz_Tessema, Azeb Gebresilassie Tesema @Azebdeji, Getiye Dejenu Kibret @GetiyeKibret and Cheru Tesema Leshargie @Chertb19

Contributors GAT, YK, AGT, YA, AA, WMB, KG and FTH contributed to the concept, design and scope of this review. GAT, BAD, AGT, DE, KTG contributed to data extraction. GAT conducted data synthesis and wrote the first draft of the manuscript. All authors critically reviewed, edited and approved the final manuscript. GAT is the guarantor.

Funding GAT was supported with funding from the Australia National Health and Medical Research Council (NHMRC) Investigator Grant #1195716.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

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ORCID iDs

Gizachew A Tessema <http://orcid.org/0000-0002-4784-8151>

Azeb Gebresilassie Tesema <http://orcid.org/0000-0003-0618-4499>

Yibeltal Assefa <http://orcid.org/0000-0003-2393-1492>

Maereg Wagnew Meazew <http://orcid.org/0000-0001-7254-7468>

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