Continuity of Essential Maternal, Newborn & Child Health Services during COVID-19

Perspectives from Clients & Frontline Health Workers in Kenya, Malawi and Mozambique

June – August 2021

A study commissioned by UNICEF and co-developed with Agha Kahn University – Kenya

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Overview

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This mixed-methods study was conducted to better understand how MNCH services were affected during the 2020-2021 period of the Covid-19 pandemic in three countries in Eastern and Southern Africa: Kenya, Malawi and Mozambique. Cross-country findings are presented.

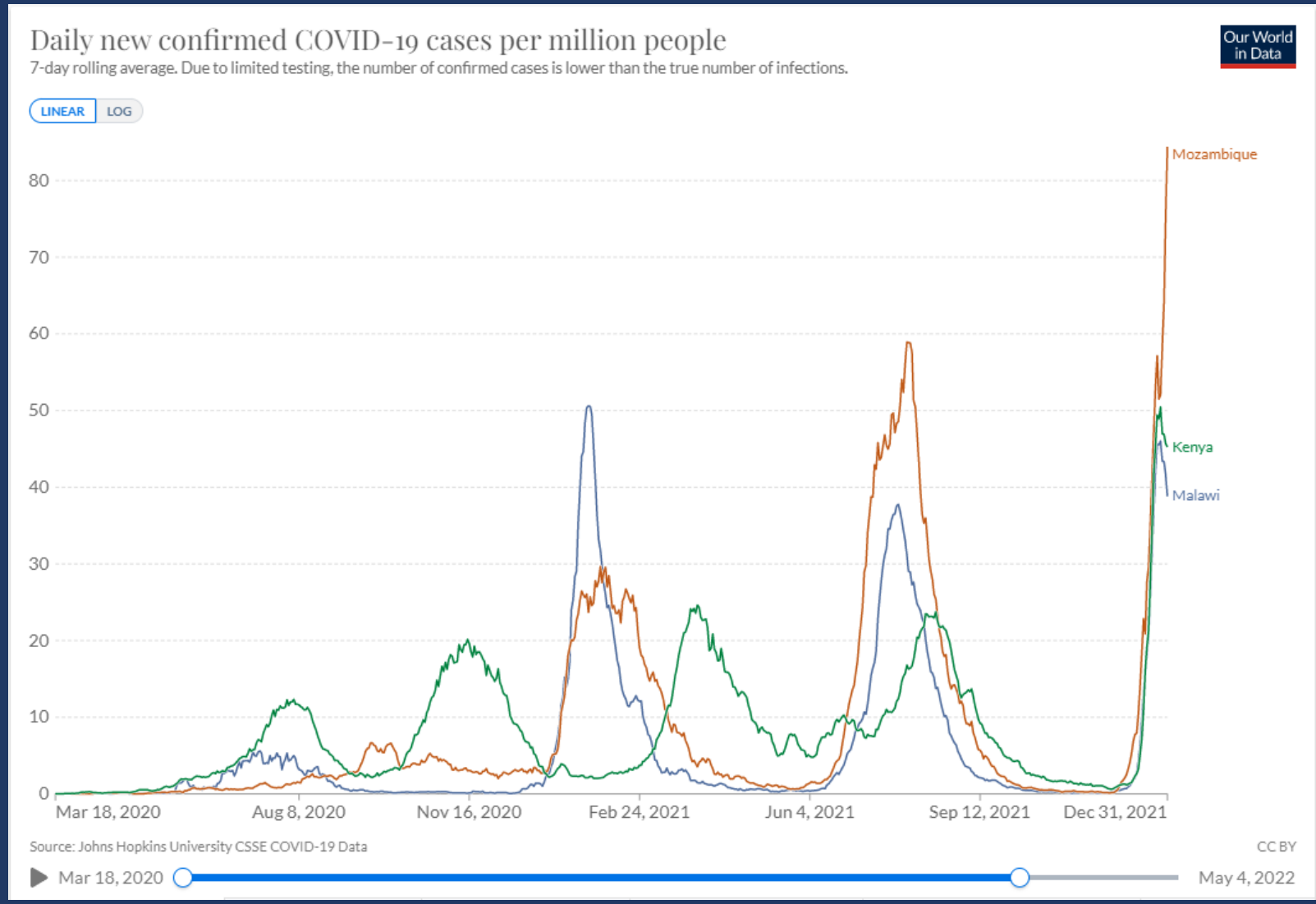
Background

Cumulative confirmed C-19 cases through Dec 2021:

- Kenya: 295,028 (5,366/mill)
- Malawi: 75,075 (3821/mill)
- Mozambique: 189,080 (5,879/mill)

Cumulative confirmed C-19 deaths through Dec 2021:

- Kenya: 5,378
- Malawi: 2,364
- Mozambique: 2,006

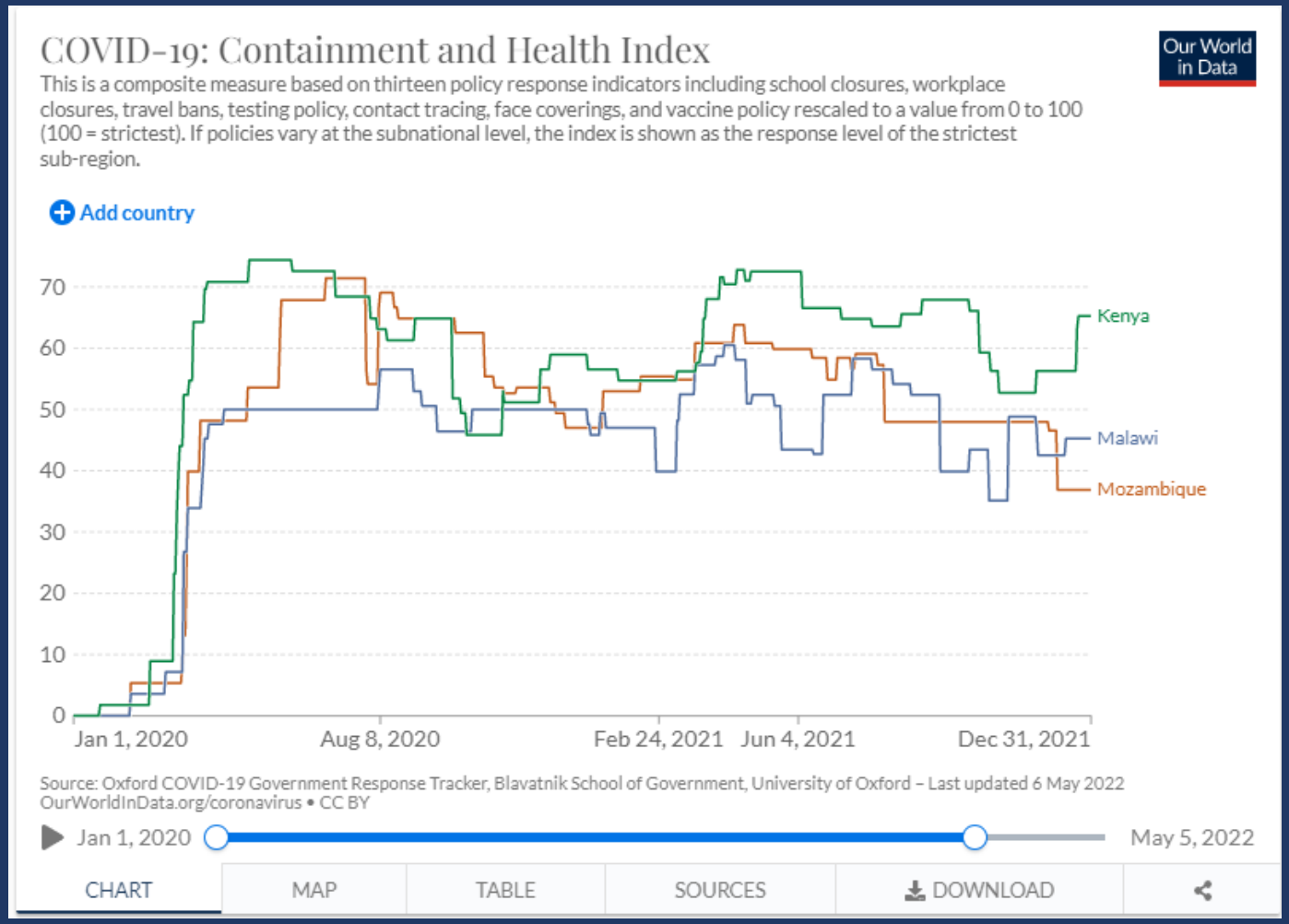


Source: chart: Our World in Data.
Data: Johns Hopkins University Center for Systems Science & Engineering

Background

Study countries employed fairly strict C-19 containment measures, particularly early on.

During the interview period (June-Aug 2021), all countries had stay-at-home measures in place for non-essential workers and schools were mostly closed in Kenya and Mozambique.



Key Questions

How has Covid-19 affected:

- Willingness and ability to access essential MNCH services
- Experiences of care
- MNCH service readiness during the pandemic

Methods

Data:

- Qualitative: focus group discussions, key informant interviews, in-depth interviews
- Quantitative: Pre-post C-19 analysis of routine service statistics
- Review of policies and guidelines issued during C-19

Setting:

- 1 urban and 1 rural setting in each country

Respondents:

- Pregnant and breastfeeding women (15-19, 20+, living with HIV/AIDS)
- Parents of children under five (15-19, 20+, women & men)
- Front line health workers (facility-based, community-based)
- Sub-national health managers

Findings

Society wide COVID-19 mitigation measures aimed to promote physical distancing stymied essential health care utilization through contradictory messaging, punitive/inflexible enforcement, increasing costs associated with health seeking and loss of livelihoods/income, which further exacerbated access challenges

- Confusing “stay-at-home” messaging
- Curfews and lockdowns enforced without sensitivity to health seeking promoted fear
- Restrictions on passenger volume in transport vehicles > increased cost
- Loss of income led to greater sensitivity to cost barriers

Findings

Pre-existing health system capacity gaps limited health system resilience and directly affected client confidence & care seeking

- The public was initially fearful of contracting C-19 in health facilities and from community health workers due to **limitations in infection prevention and control (IPC) and personal protective equipment (PPE)** and perhaps lack of trust in the system
- **Health worker shortages** exacerbated due to sickness/death, reassignment & additional responsibilities, led to some gaps in service availability but more notably significant strain on health workers (long working hours, stress and demoralization), which inhibits quality of care, client confidence and further reduces the health workforce.
- **Uneven ability** of the health system **to clearly and credibly communicate with the public and its own workforce** caused confusion, especially early on
- **Ambulance shortages** for referrals were further strained (Mozambique, Kenya)

Findings

C-19 mitigation measures implemented by the health system aimed to protect health workers by reducing client volume/congestion, with less consideration of their impact on client health seeking & access

- Limitation on client volume & opening hours > clients turned away & discouraged
- Face mask requirements to enter facilities were unaffordable for some > suppression of demand
- Restrictions on birth companions & other companions for the sick > fear & isolation, less supportive care, less negotiation power > lower quality of care
- Closure of maternity waiting homes > more difficulty access to delivery services
- Reduction in community health worker circulation > reduced access to care
- Move from typical health service schedule to quarterly visits (ANC, HIV, child growth monitoring) > some danger signs missed
- Suspension of peer support groups > less client support

Findings

Vulnerable populations were particularly impacted

- Increased health seeking costs (transport, masks, multiple trips) particularly affected the **poor**, including **adolescents**
- Suspension of community health services for months (Mozambique), greatly affected access to services for the **rural poor.**
- Suspension of teen clubs/peer support groups, limited information and psychosocial support for **vulnerable pregnant adolescents and people living with HIV**
- **Newly diagnosed people living with HIV/AIDS** were less able to adhere to treatment due to more limited support from the health system (fewer visits, less counselling and limited peer groups) (Mozambique)

Findings

Existing community health workers/volunteers (CHW/Vs) were used to raise awareness of C-19 and communicate changes, but CHW/Vs could have been better utilized to bolster health system resilience earlier on

- Mixed experience on using CHW/Vs as an arm of the response in the region, from active training and provision of masks (Kenya) to shutting down community health services for months (Mozambique)
- When trained & equipped with masks etc, they could reduce population misconceptions about C-19, fear of being tested and help the community navigate society-wide mitigation measures so they were not barriers to care.

Findings

Over time adaptations helped better balance C-19 risk mitigation and the need to maintain access to essential services

- Changes in communication messages reduced fear & encouraged continuity of health services
- Hotlines/ motorcycles arranged transportation for pregnant women (Kenya)
- Re-organization of facilities improved infection prevention & control
- Development of facility appointment systems reduced waiting time (Mozambique)
- Longer facility hours improved access
- Longer time between appointments & release of larger quantities of treatment drugs (HIV) made health seeking more manageable

Findings

While service statistics suggest a dip in health service utilization early on, the picture is mixed thereafter. Nonetheless, health workers and clients perceived:

- Lower uptake and higher loss-to-follow-up for MNCH services, particularly in before C-19 became more normalized
- Increased use of informal health services (TBAs for home births, traditional healers) and private health services
- Increase in complications and negative health outcomes (complicated births, adolescent pregnancies)

Implications

- The burden of regular causes of maternal & child morbidity & mortality in ESAR, far outweigh the direct burden of COVID-19.
- In health emergencies, it is critical that policy measures & messaging maintain essential services, mitigate fear and reduce additional costs to health seeking for the population.
- Addressing long-standing health system constraints, particularly infection prevention & control readiness and health worker shortages is critical to continued health system function/resilience and client confidence during emergencies
- Community health systems should be invested in as a major arm of emergency response, but need to be well equipped, trained and supported to play this role.

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