Maintaining the provision and use of services for maternal, newborn, child and adolescent health and older people during the COVID-19 pandemic

Lessons learned from 19 countries

A World Health Organization Initiative

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In memory of Dr Ramez Mahaini

Contents

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List of acronyms

ANC	antenatal care
ARI	acute respiratory infection
ART	antiretroviral treatment
CHW	community health worker
CMW	community midwife
DMPA	Depo Provera (depot-medroxyprogesterone acetate) (also DMPA-SC)
DPT	diphtheria-pertussis-tetanus [vaccine]
EHS	essential health services
EPI	expanded programme on immunization
FP	family planning
GBV	gender-based violence
HEW	health extension worker
HMIS	health management information system
IMCI	Integrated Management of Childhood Illness
IMT	incident management team
IPC	infection prevention and control
IUD	intrauterine device
LARC	long-acting reversible contraception
MCH	maternal and child health
MNCAAH	maternal, newborn, child and adolescent and ageing health
MUAC	mid-upper arm circumference
NDOH	National Department of Health
NGO	nongovernmental organization
NTF	National (COVID-19) Task Force
ORS	oral rehydration solution
PAHO	Pan American Health Organization
PHC	primary health care
PHSM	public health and social measure
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
PPE	personal protective equipment
RH	reproductive health

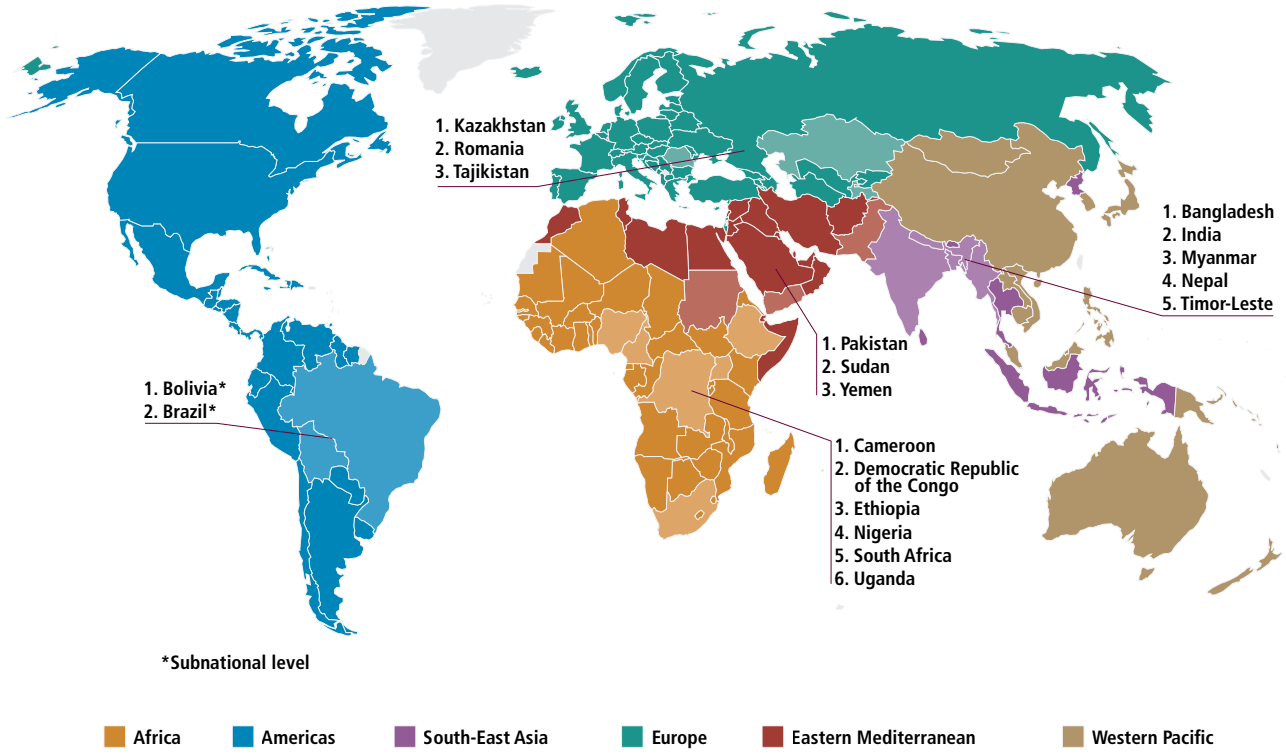
RMNCAAH	reproductive, maternal, newborn, child and adolescent health and ageing
RMNCAEH+N	reproductive, maternal, newborn, child, adolescent and elderly health and nutrition
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RMNCAYH	reproductive, maternal, newborn, child, adolescent and youth health
RMNCH	reproductive, maternal, newborn and child health
SAM	severe acute malnutrition
SRMNEA-Nut	Santé de la Reproduction, de la Mère, du Nouveau-né, de l'Enfant et Adolescent, et Nutrition
SOP	standard operating procedure
SRH	sexual and reproductive health
TSG	Technical Strategic Group
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

Since the start of the COVID-19 pandemic in early 2020, decision-makers in affected countries have acted quickly to address the immediate health effects of the pandemic and to put into place public health and social measures to slow or stop the spread of COVID-19. In order to preserve the gains made in maternal, newborn, child and adolescent health in the last decades and avoid negative impacts due to the pandemic, the global community quickly mobilized to advocate for protecting the health of these populations.

Since May 2020, the World Health Organization (WHO), through its headquarters, regional and country office teams, has supported 19 countries[a] in five WHO Regions (see **Figure 1**) to raise the profile of and commitment to maternal, newborn, child and adolescent health and ageing (MNCAAH)[b] through an Initiative on mitigating the indirect impacts of COVID-19 on MNCAAH services. The goal was to ensure that during the response to COVID-19, actions would be taken to mitigate indirect effects on MNCAAH due to disruptions to service provision and use.

Fig. A.1. Countries (n=19) and regions (n=5) involved in Phase I of the Initiative



a. In Brazil, the Initiative was implemented in two municipalities: São Luís (in the state of Maranhão) and Pelotas (in the state of Rio Grande do Sul). In the Plurinational State of Bolivia, it was implemented in the municipality of El Alto in La Paz Department.

b. The acronym MNCAAH is used throughout the report for ease of reference. However, we note that some countries also addressed nutrition interventions, many countries included family planning and sexual and reproductive health services. Therefore, in the individual country reports, some other acronyms are used.

This report covers Phase I of the Initiative, from May 2020 to February 2021. **Section A** of the report presents a synthesis of information across the 19 countries, including lessons learned. **Section B** includes more detailed individual country information, drawn directly from country Thematic Working Group (TWG) and national consultant reports, country health information management system (HMIS) data, research publications and surveys that describe the impact of COVID-19 on MNCAAH services.

Synthesis of findings and lessons learned from the Initiative

Governance mechanisms

A frequent theme from the 19 country reports was the difficulty of integrating health programmes into COVID-19 response committees and coordination mechanisms, thus delaying their inputs and efforts to sustain critical MNCAAH services. Similar lessons of enhanced communication and collaboration were also felt to be applicable within WHO.

A whole-of-government approach was widely deemed to be the key to ensuring a more effective response: decisions regarding public health and social measures to slow or stop the spread of the pandemic can benefit from being analysed in terms of the wider risks and benefits for other health and socioeconomic impacts; government leadership can ensure multisectoral and multi-partner coordination, including the private sector, for implementation of actions, for real-time data and for additional studies and surveys. Strengthened linkages and communication with subnational levels can ensure more timely information flow and coordinated actions.

Most countries established TWGs to address the needs of MNCAAH services, and policies and guidelines on relevant issues were developed early in the pandemic. In some countries, the functioning of these MNCAAH TWGs could have been boosted by considering gender, organization type and areas of expertise in membership.

Data and information for decision-making

Identifying key indicators and reviewing data on coverage of essential MNCAAH services was a key activity for all countries involved. However, six countries cited the quality and completeness of data among their challenges. Support was needed to ensure information could be received from subnational levels, and capacity-building and use of data for decision-making was recognized as a recurrent need.

HMISs were also disrupted by the pandemic. The flow of periodic reporting from health services to the HMIS, the processes to update and clean databases, and the production of non-COVID-19 reports were all affected. Strengthening HMISs and country capacity in analysis and interpretation of data and improving data quality and utilization, at both national and subnational levels, were identified as ongoing needs by all countries.

Maintaining essential services

- Countries recognized the importance of the continuation of essential services early on and tried to balance mitigation of COVID-19 infection measures with actions to maintain services. There were some areas of tension in striking the right balance, including: investing in hospital services for improved COVID-19 response over the delivery of primary health care (PHC);

- Designating some facilities exclusively for COVID-19 and suspending other services without proposing alternatives or communicating the closures impacted on essential service use;

- Re-purposing of health workers to COVID-19 and shortages of supplies added to problems in delivering essential MNCAAH services;

- Limiting transport made access to services for women and children difficult.

These observations led countries to conclude that a specific plan for maintaining MNCAAH essential services, specifically including the needs of adolescents and older people, was required in country preparedness and response plans.

Some service delivery adjustments, such as mobile units, were noted by some as unlikely to be continued after the pandemic. Improvements in infection prevention and control (IPC) measures in essential services put into place due to the COVID-19 pandemic were viewed positively.

There has been a substantial upsurge in digital health interventions, such as training and teleconsultations. While this increase is generally viewed positively, lessons were learned, such as the types of training and consultations that can be done well online, fatigue with virtual meetings and awareness that many areas within countries may have interrupted or no access to the internet.

The central importance of support for health workers, including their physical protection as well as their mental health needs and capacity to assume new tasks, was acknowledged as an important lesson learned by most countries.

Incentives for health workers received mixed reviews; some observed that the incentives may have caused distortions in the health system by providing them only for COVID-19 services.

Conclusion

This work reflects the lessons from the first phase of a WHO Initiative which will continue through February 2022. The world was not prepared for the pandemic when it hit, but the 19 countries reacted rapidly. While the initial concern was exclusively controlling COVID-19, countries realized almost immediately the need to look at essential services, including MNCAAH, and to respond to the indirect effects of the pandemic on them.

Actions to respond to COVID-19 required time to be thought through and occurred in systems that are often fragile and unresponsive. However, these systems showed important components of resilience within the context of lessons learned for improvements.

These findings provide valuable insight into measures adapted for health service continuity and share lessons learned from government voices. Documenting and disseminating these findings should help promote dialogue among decision-makers and implementing partners and encourage further identification of successful and scalable actions to protect the health of women, newborns, children, adolescents and older people and build resilient health systems.

Nepal
Photo credit: Ajay Maharjan

Section A

Description of the Initiative and country comparative summary

1. Introduction

Since the start of the COVID-19 pandemic in early 2020, decision-makers in affected countries have acted quickly to address the immediate health effects of the pandemic and to put into place public health and social measures (PHSMs) to slow or stop the spread of COVID-19. Analyses of previous outbreaks showed indirect impacts on access to and provision and utilization of routine preventive and curative health services with negative outcomes, especially for vulnerable populations *(1-4)*. In order to preserve the gains made in maternal, newborn, child and adolescent health in the last decades and avoid negative impacts due to the pandemic, the global community quickly mobilized to advocate for protecting the health of these populations *(5)*.

Since May 2020, the World Health Organization (WHO), through its headquarters, regional and country office teams, has supported 19 countries in five WHO Regions[a] to raise the profile of and commitment to maternal, newborn, child and adolescent health and older people (MNCAAH)[b] through Phase 1 of an Initiative on mitigating the indirect impacts of COVID-19 on MNCAAH services. The goal was to ensure that during the response to COVID-19, actions would be taken to mitigate indirect effects on MNCAAH due to disruptions to service provision and use. Regions and headquarters would share these lessons with other countries. **Figure A.1** shows the countries supported.

This report provides a synthesis of the different strategies taken by these countries to ensure the continuation of essential MNCAAH services, including governance mechanisms put into place, data and information available for decision-making and key actions taken by governments and implementing partners. Lessons learned by national Technical Working Groups (TWGs) (see **Box 1**) are summarized, and the methods to capture this information are detailed.

Box 1. The role of national Technical Working Groups

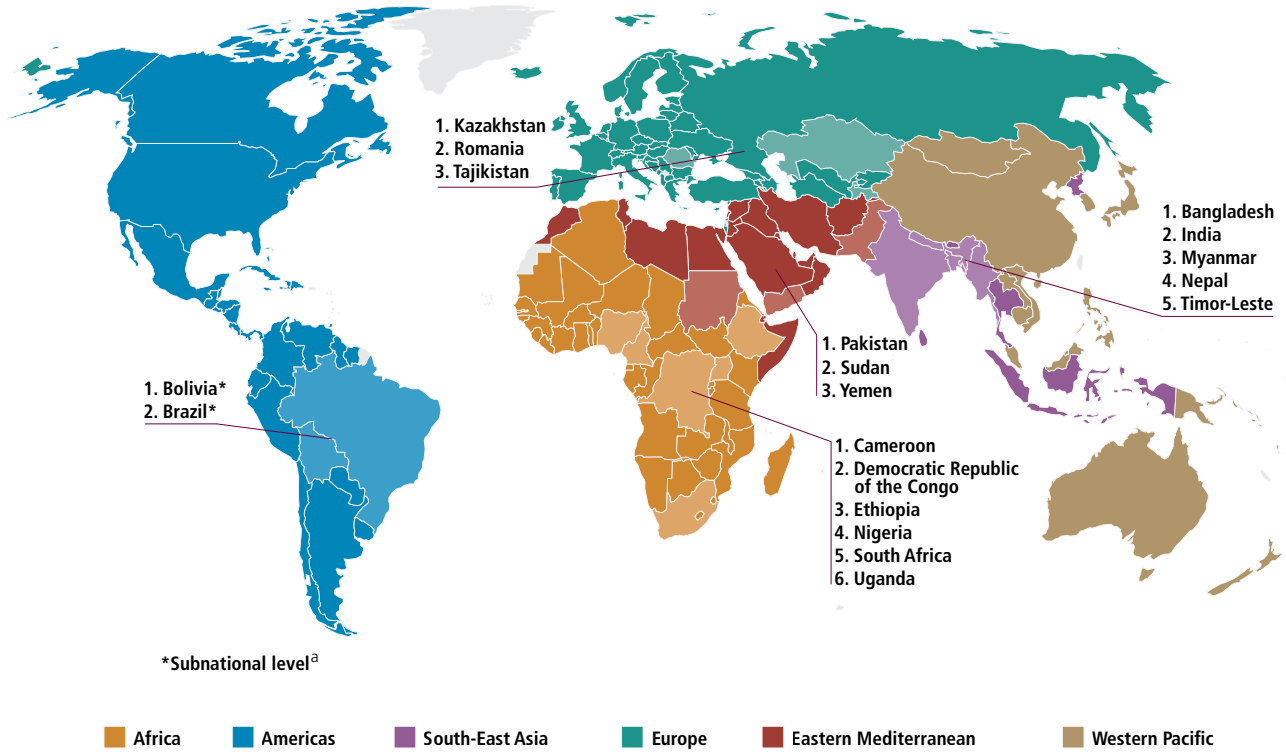
WHO promoted engagement with a national TWG on MNCAAH and COVID-19, composed of implementing partners and stakeholders, and working in close collaboration with national COVID-19 response structures. It was assumed that the TWGs would function to analyse the situation, prioritize issues requiring an immediate response, develop clear strategies responding to the context, define an essential set of interventions for each population group and recommend service delivery options to mitigate indirect effects of COVID-19.

a. One WHO Regional Office (Western Pacific) did not participate in Phase I.

b. The acronym MNCAAH is used throughout the report for ease of reference. However, we note that some countries also addressed nutrition interventions, many countries included family planning and sexual and reproductive health services, and others included services for adolescents and older people. Therefore, in the individual country reports, some other acronyms are used.

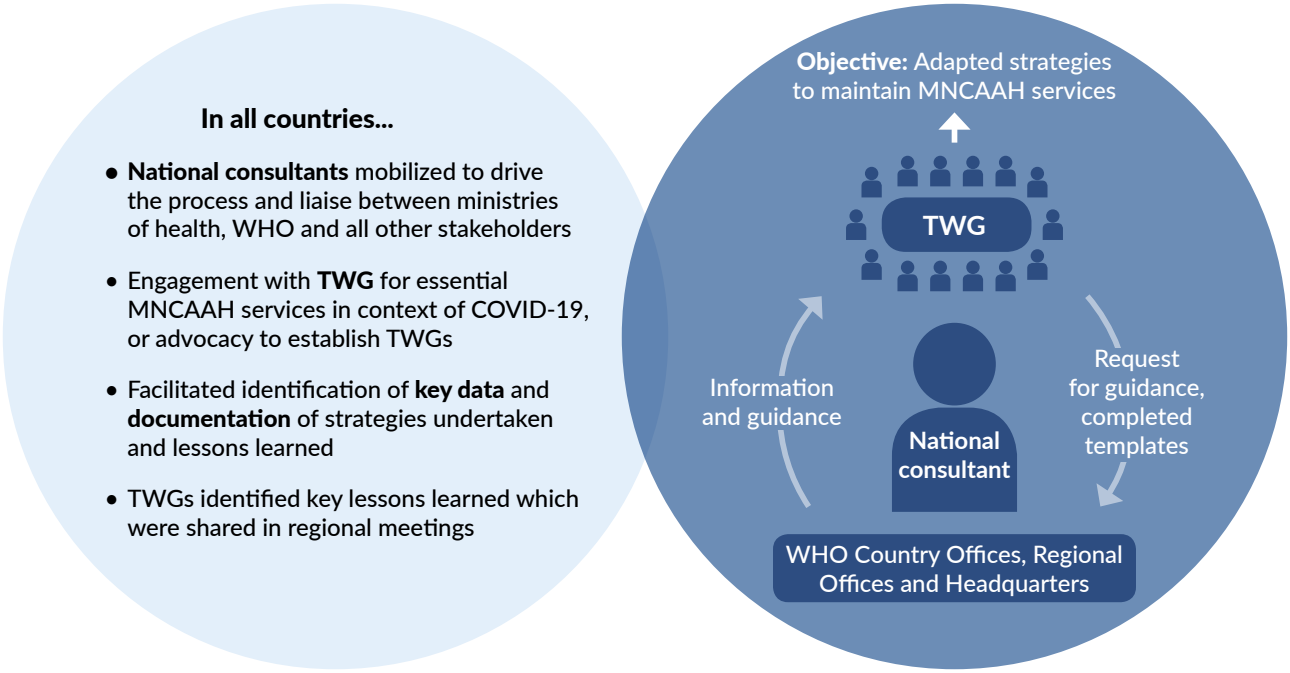
Section A presents a synthesis of information from the 19 countries. An overview of data on service use, governance mechanisms and actions to ensure the continuity of MNCAAH services is presented followed by a summary of lessons learned, as determined by each country's national TWG. **Section B** presents individual country information. These findings provide valuable insight into measures adapted for health service continuity and share lessons learned from government voices. Documenting and disseminating these findings have helped promote dialogue among decision-makers and implementing partners and encouraged further identification of successful and scalable actions to protect the health of women, newborns, children, adolescents and older people and build resilient health systems. This report should assist policy-makers, academics and global health experts interested in learning about actions countries took to mitigate the impacts of COVID-19 on MNCAAH services.

Fig. A.1. Countries (n=19) and regions (n=5) involved in Phase I of the Initiative



a. In Brazil, the Initiative was implemented in two municipalities: São Luís (in the state of Maranhão) and Pelotas (in the state of Rio Grande do Sul). In the Plurinational State of Bolivia, the Initiative was implemented in the municipality of El Alto in La Paz Department.

Fig. A.2. Information exchange between national consultants and MNCAAH TWGs



2. Methods

This report provides a snapshot of countries' responses to challenges that arose from March to December 2020 during the COVID-19 pandemic to ensure the continued provision and use of MNCAAH services. It also shows data on MNCAAH service utilization as reported by national health management information systems (HMISs). The report is based primarily on information collated by a consultant in each country, engaged by WHO and charged with working with the national MNCAAH TWG.

Each month the national consultants completed a template formatted to capture key information, including: the functioning and members of the TWG for MNCAAH; interventions put in place for each health area[a] categorized by key health systems as outlined by WHO *(6)*; and actions by key implementing partners to address the continued provision and use of MNCAAH services (see **Figure A.2**). In each report, the national consultant noted any changes to actions previously reported, i.e. discontinued, modified or added, and a regional team reviewed all reports received. A WHO headquarters team, including external consultants, compiled and organized the information received from the regional teams and national consultants and ensured that the national TWGs regularly received summaries. These summaries included activities and policies identified in a PATH database *(7)*; and additional activities and stakeholders' perspectives collected from literature reviews and social media sources. Regular meetings were held with the national TWGs to monitor progress and review current information.

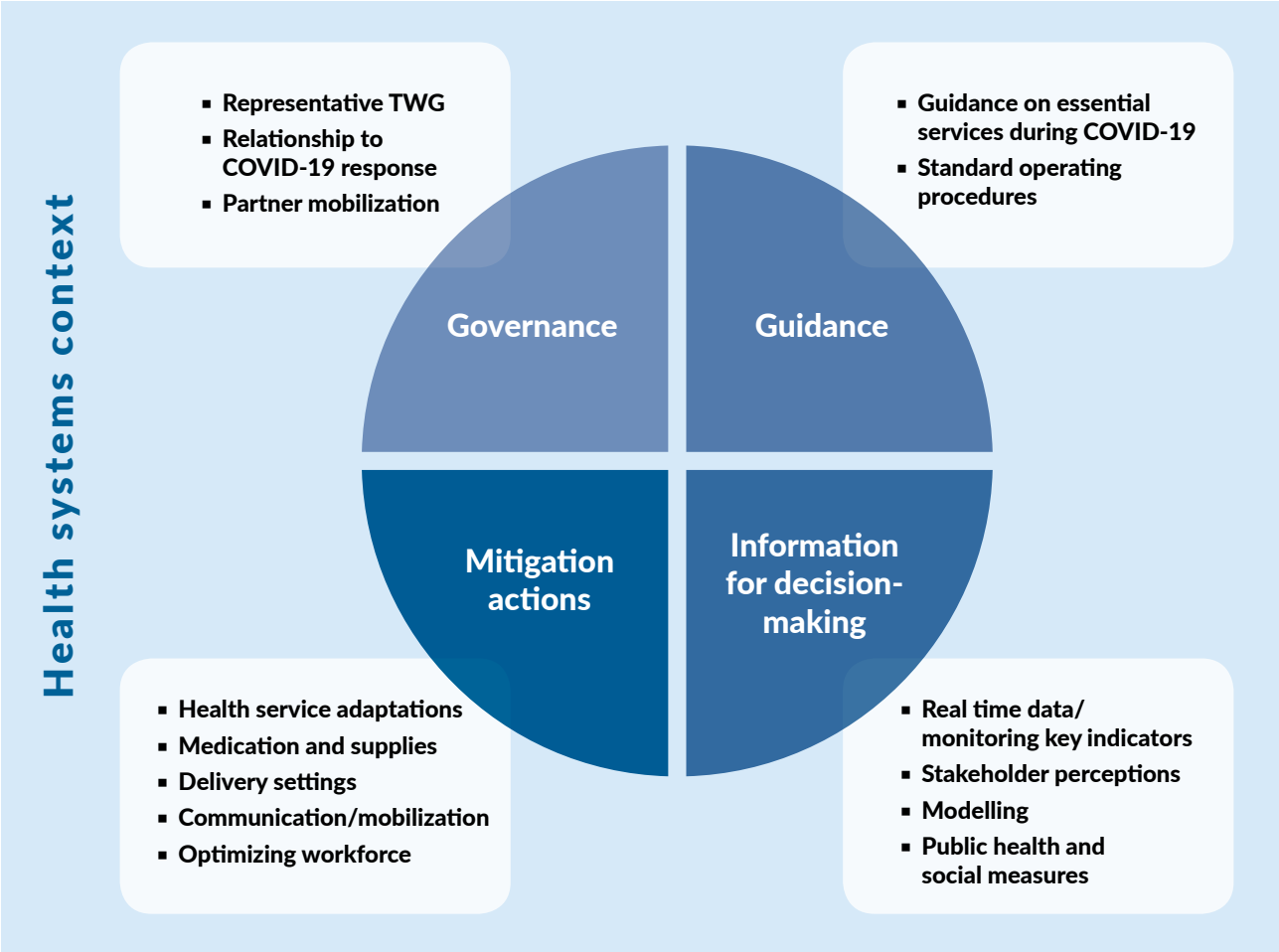
The operational framework to guide the Initiative proposed that a TWG would make decisions and take effective actions to maintain the provision and use of essential MNCAAH services provided that: it was composed of a set of actors representing diverse perspectives and with a balanced gender mix; it met regularly to review information on COVID-19; and it accessed real-time data on coverage of MNCAAH services and information on stakeholders' perceptions. In other words, to enable effective decision-making for maintaining the provision and use

a. Family planning, maternal, newborn, child, adolescent, older people, nutrition, etc.

of essential MNCAAH services, governments needed to bring together an array of reliable information (**Figure A.3**): data on COVID-19 infection rates; PHSMs put in place to reduce the spread of COVID-19; data on MNCAAH service utilization; documentation of actions taken to mitigate the effect on MNCAAH services; and feedback from key stakeholders, including population groups and health workers, on problems faced and mitigation actions taken.

In the following sections, a synthesis of select information from the 19 countries in the Initiative is presented on each of the different topic areas highlighted in **Figure A.3**. Each section also reflects a regional summary, where feasible. The individual country reports in **Section B** provide additional details. All information is not available for some countries; in the text the number of countries included is noted.

Fig. A.3. Operational framework for the Initiative



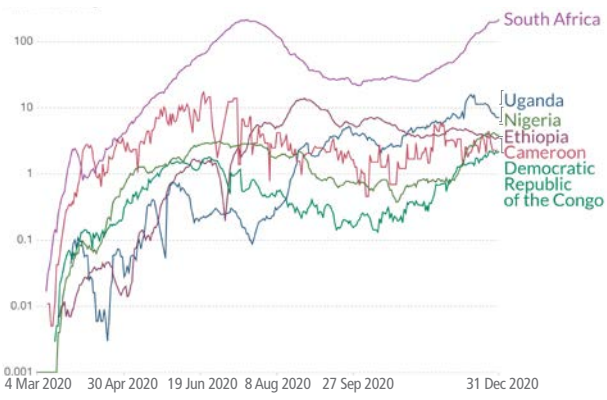
3. Synthesis and integration of country information

3.1 COVID-19 trends across countries in the Initiative

Figures A.4 – A.8 show COVID-19 case trends across countries in the Initiative from March to December 2020. These graphs illustrate the severity of the pandemic and its burden over time. As noted in the individual graphs, only confirmed cases are shown, with rolling seven-day averages. The numbers of actual cases per country are very likely to be higher, partly because countries vary in their testing capacity.

COVID-19 trends for countries in the African Region (**Figure A.4**) show a series of waves over time with varying levels of severity. The six countries in the region had the most diversity between countries among the five regions in COVID-19 case numbers and trends during the 10-month period. South Africa was one of the countries hardest hit by the pandemic. The graph shows steep spikes in cases there near the end of June and also in December 2020. The other countries in the region appeared to have low case numbers relative to their populations until June 2020, at which point COVID-19 cases began to fluctuate through subsequent waves. COVID-19 case numbers peaked at different points through the course of 2020, a pattern which was unique for the African Region.

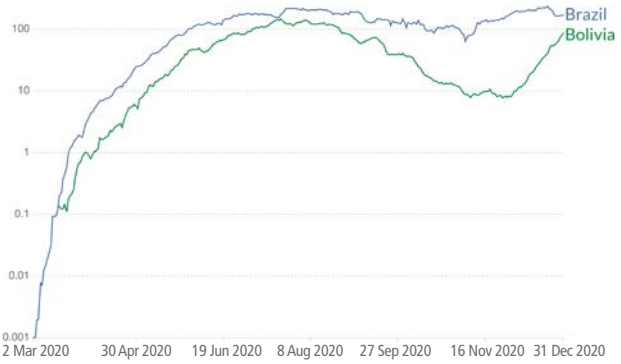
Fig. A.4. Daily new confirmed COVID-19 cases per million population in six countries in the African Region, March to December 2020 (rolling seven-day averages)* *(8,9)*



* Vertical axis shows COVID-19 cases on a logarithmic scale.

Examining the trends of COVID-19 cases for the two countries in the Region of the Americas in **Figure A.5**, the shape of the curve is similar, with simultaneous waves in August and December 2020. However, Brazil has been one of the most impacted countries of the 19 included in this report, along with being the largest in size. The Initiative was engaged at the subnational level in the Plurinational State of Bolivia and Brazil. Information about COVID-19 trends by municipality for these countries is available in the summaries in **Section B**.

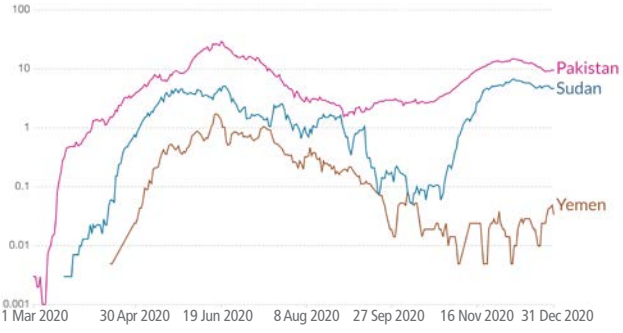
Fig. A.5. Daily new confirmed COVID-19 cases per million population in two countries in the Region of the Americas, March to December 2020 (rolling seven-day averages)* *(8,9)*



* Vertical axis shows COVID-19 cases on a logarithmic scale.

In **Figure A.6**, Pakistan, Sudan and Yemen show similar patterns in terms of the inflection points of COVID-19 trends. Pakistan has the consistently highest numbers, followed by Sudan, with Yemen the least affected. All countries in the Eastern Mediterranean Region appear to have reached their highest number of daily new confirmed cases per million around 20 June 2020.

Fig. A.6. Daily new confirmed COVID-19 cases per million population in three countries in the Eastern Mediterranean Region, March to December 2020 (rolling seven-day averages)* *(8,9)*



* Vertical axis shows COVID-19 cases on a logarithmic scale.

Pakistan and Sudan experienced another spike in cases at the same time in December; the spike was relatively less severe in Pakistan and more severe in Sudan compared to their previous first waves in June 2020.

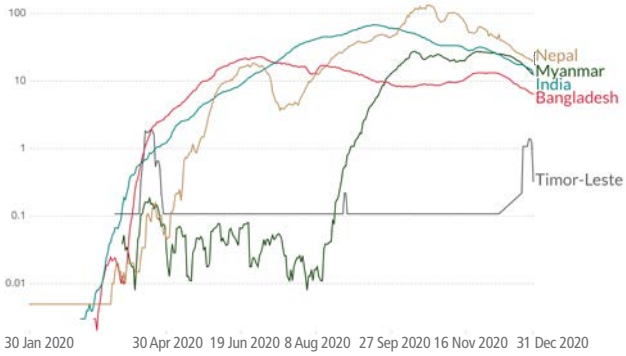
Romania, Kazakhstan and Tajikistan in the European Region have been differently affected by the COVID-19 pandemic, as shown in **Figure A.7**. Kazakhstan experienced an earlier spike toward the end of June 2020; Romania's numbers surpassed Kazakhstan in August and cases surged at the end of November 2020. Reported cases for Tajikistan have remained relatively low and stable within the region with a slight increase in May 2020.

Fig. A.7. Daily new confirmed COVID-19 cases per million population in three countries in the European Region, March to December 2020 (rolling seven-day averages)* *(8,9)*

* Vertical axis shows COVID-19 cases on a logarithmic scale.

Compared to the four other regions, countries in South-East Asia were impacted later in 2020 (**Figure A.8**). Bangladesh and Nepal experienced the earliest wave in the region in the middle of June 2020. After that, the number of confirmed cases in Bangladesh declined and remained relatively low for the rest of the year. India's COVID-19 cases peaked in the second half of September, while Myanmar experienced a spike in cases from August to September.
Among the South-East Asian countries, Nepal had the highest daily new confirmed cases, hitting its maximum in November with several spikes following as numbers began to decline at the end of the year. Throughout 2020, the small island country of Timor-Leste reported a low number of COVID-19 cases.

Fig. A.8. Daily new confirmed COVID-19 cases per million population in five countries in the South-East Asia Region, January to December 2020 (rolling seven-day averages)* *(8,9)*



* Vertical axis shows COVID-19 cases on a logarithmic scale.

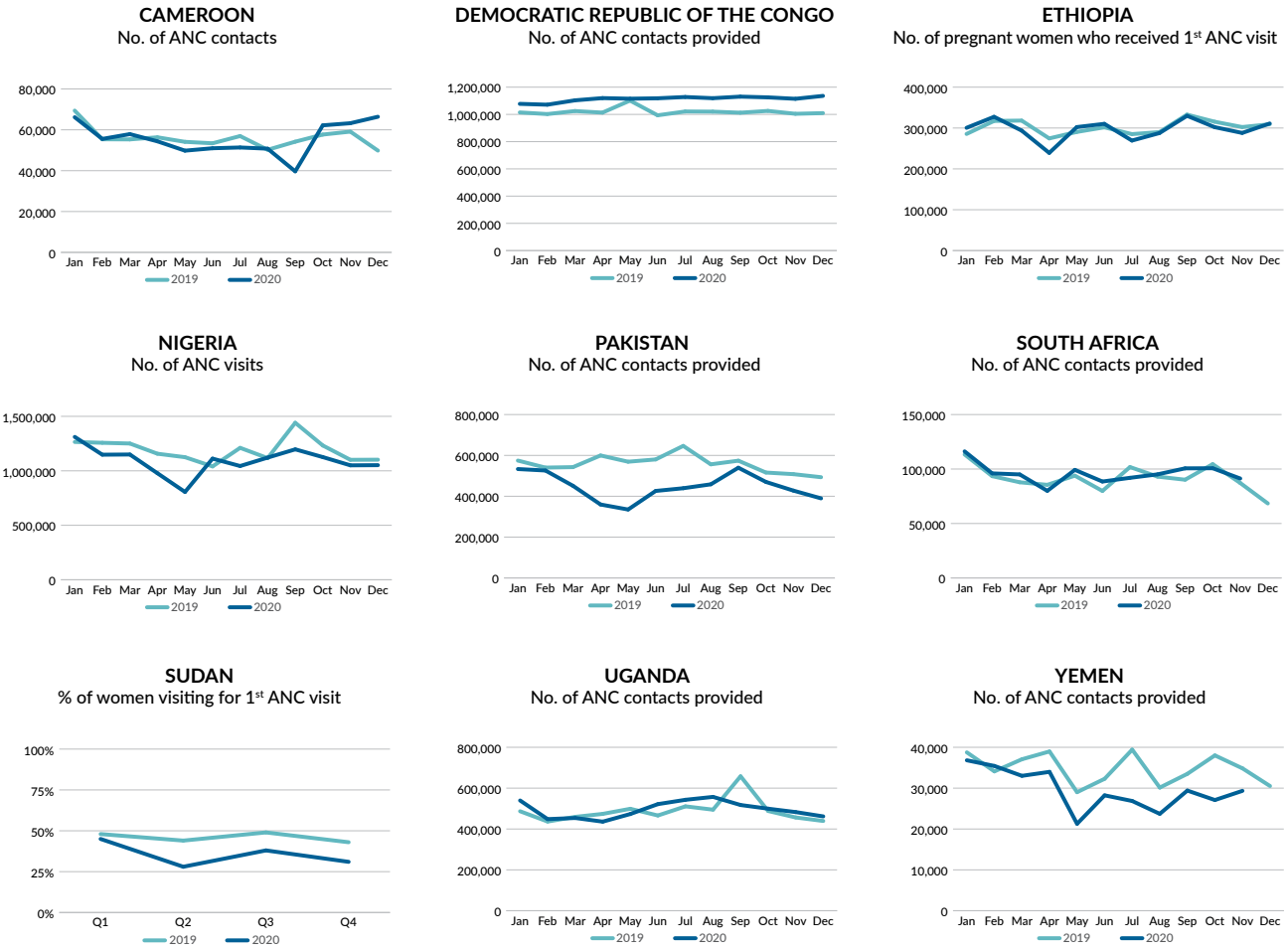
3.2 Service utilization

The WHO team and national consultants collaborated with ministries of health to identify and map indicators to monitor the effects of COVID-19 on essential services for reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N), as per recently released WHO guidance *(6)*. Some countries then integrated these key indicators into their HMISs and routine monitoring. These activities supported national TWGs in reviewing data regarding disruption of essential health services (EHS) and informed responsive decision-making. Examples of data and dashboards have been included for select indicators and countries for which information was available.

Antenatal care (ANC) contacts

In nine countries for which data were available, the numbers of reported ANC contacts provided through public sector facilities in 2020 varied (**Figure A.9**). In some countries, such as Ethiopia, there was minimal change between 2019 and 2020. During part of 2020, these numbers were higher than for corresponding months in 2019 in some places, such as the Democratic Republic of the Congo, South Africa and Uganda. In other countries, such as Nigeria and Pakistan, the number of ANC contacts in public facilities showed an initial decrease in comparison to 2019; however, these numbers increased over the course of 2020. In Sudan and Yemen, the numbers of ANC contacts in 2020 did not return to the 2019 level even towards the end of 2020.

Fig. A.9. ANC contacts in nine countries*

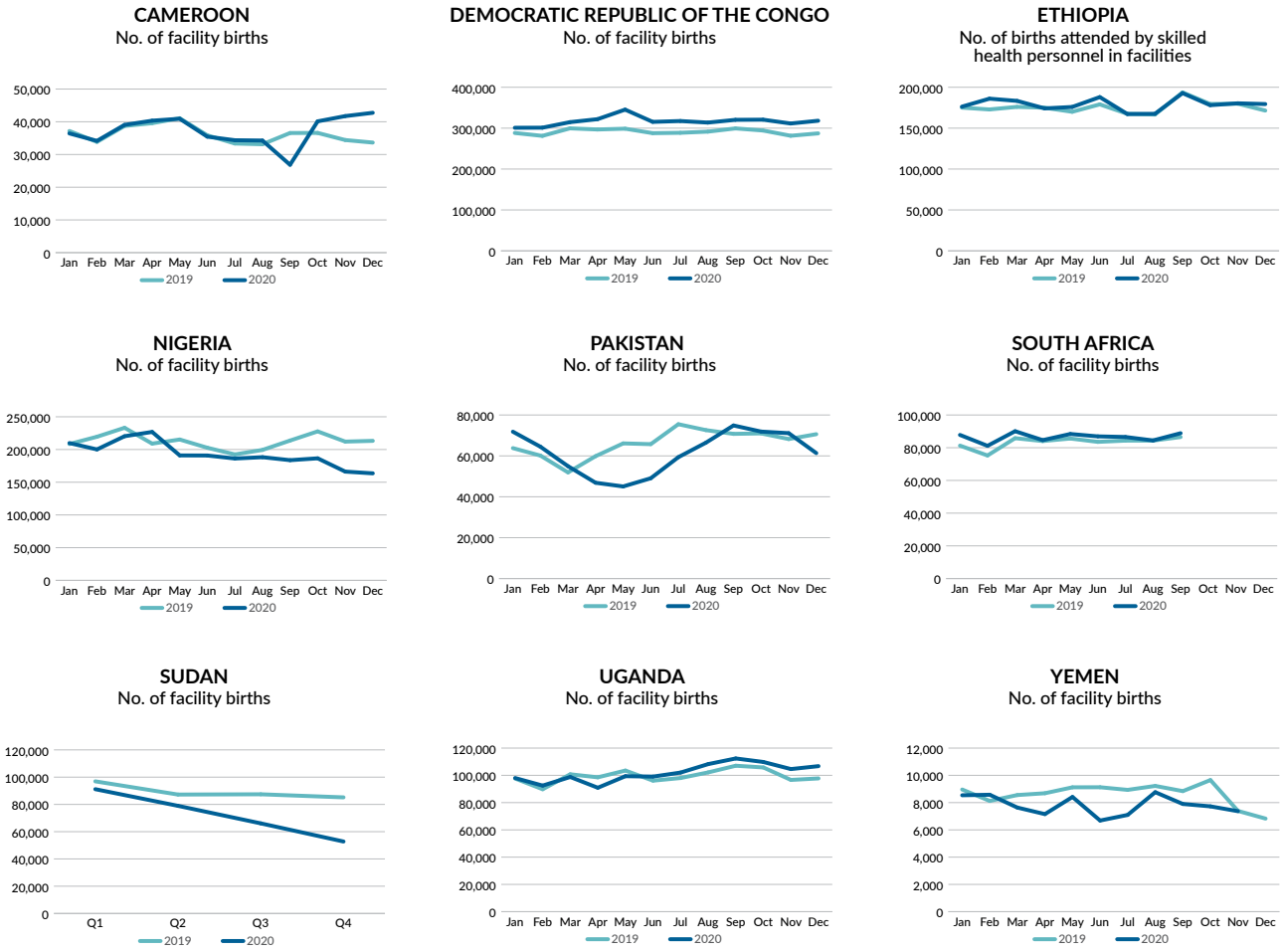


*Some countries did not provide information through December 2020.

Facility births

In nine countries, the changes in the number of births in public facilities in 2020 in comparison to 2019 reported through the HMIS varied (**Figure A.10**). Some countries, such as Cameroon, the Democratic Republic of the Congo, Ethiopia, South Africa and Uganda, reported little to no change in the number of facility births throughout 2020, with some even showing a slight increase in numbers compared to the corresponding months of 2019. Other countries, such as Pakistan and Yemen, reported decreases in the numbers of facility births during 2020 but showed a return to 2019 levels by the end of the year. In Nigeria and Sudan, these decreases had not returned to 2019 levels by the end of 2020.

Fig. A.10. Facility births in nine countries*



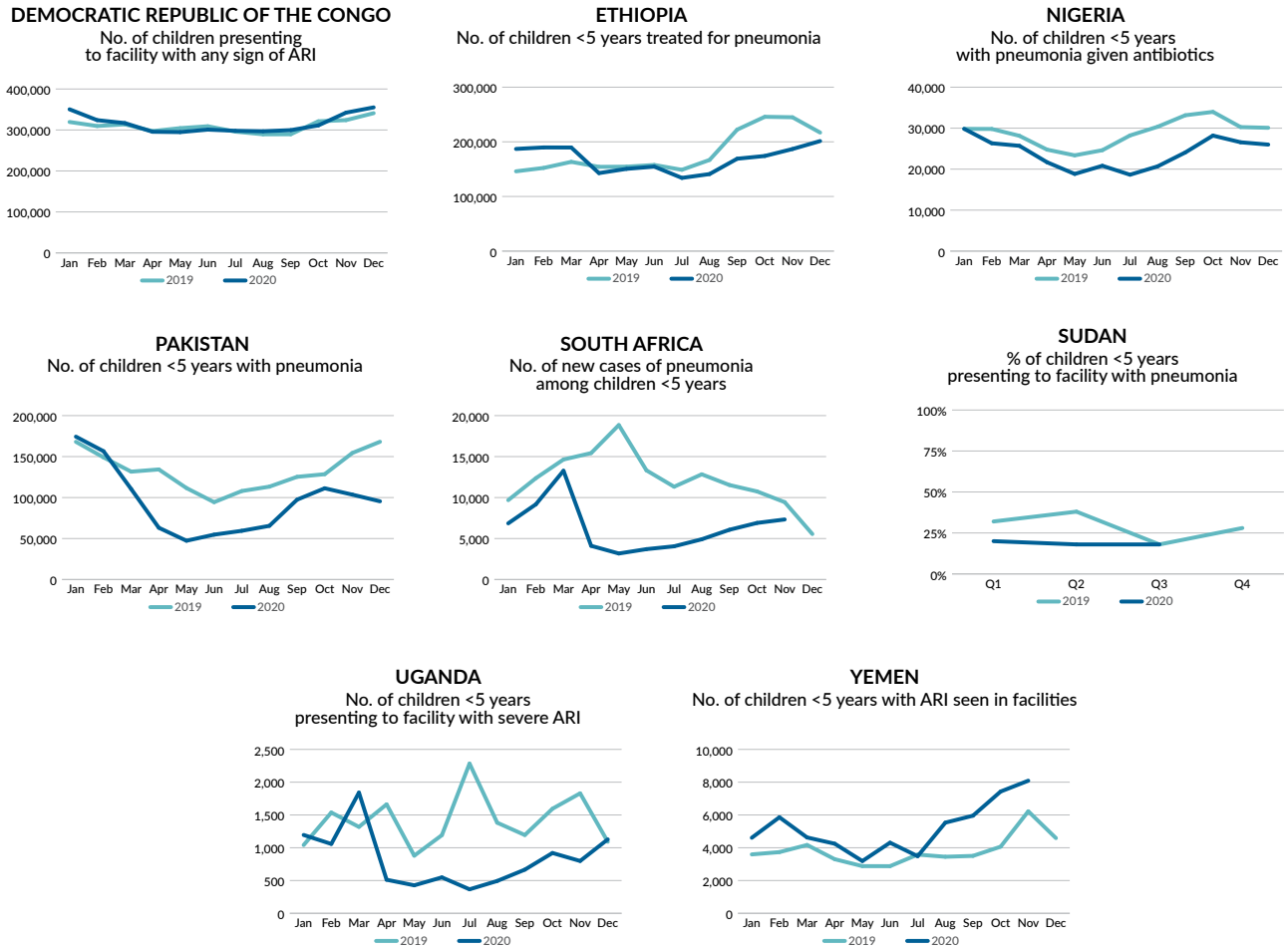
*Some countries did not provide information through December 2020.

Children less than 5 years of age seeking care for acute respiratory infections (ARIs)

The numbers of children less than 5 years of age reported to be seeking care for ARIs in public facilities varied across the eight countries providing data (**Figure A.11**). In the Democratic Republic of the Congo, there was minimal change, but in Yemen there was an increase in 2020. In the other countries, the numbers of children seeking care for ARIs decreased throughout 2020 and did not return to the 2019 levels by the end of the year.

Several limitations apply to these observations. Firstly, the data are presented as numeric counts with no information on HMIS reporting completeness and data quality. Similarly, it is unknown whether the same facilities reported each month. The data also represent services delivered through public sector facilities, limiting a full understanding of whether these services had been completely disrupted or whether they shifted to private sector facilities and/or home/community-based care. Finally, with respect to children seeking care for ARIs, it is unknown whether the reduction in facility visits was due to disruptions in service delivery due to COVID-19 or whether there was a reduction in illness due to mask-wearing, increased handwashing, and limited public interactions. More in-depth analysis of the data, such as limiting it to facilities that reported in all months and an assessment of data quality, is needed to more accurately understand changes to MNCAAH service utilization.

Fig. A.11. Care-seeking for ARI in eight countries*



*Some countries did not provide information through December 2020.

3.3 Governance mechanisms

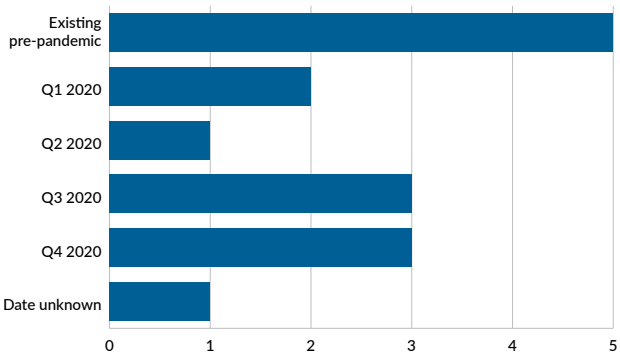
Established, reactivated or newly-formed MNCAAH TWGs played key roles in many countries' actions to mitigate the impacts of the COVID-19 pandemic on the continuity of MNCAAH services. **Box 1** and **Figure A.2** above describe the proposed role of the national TWGs. While some countries were able to refocus and/or operationalize existing MNCAAH TWGs before the first case of COVID-19 was declared within their borders, other countries did not establish them before the fourth quarter of 2020.

This section reviews various dimensions that reflect the functioning of the national TWGs in different countries.

Establishment of MNCAAH TWGs

Five countries had functioning MNCAAH TWGs before the pandemic, while 10 countries established them in response to COVID-19. The TWGs were operationalized at different points throughout 2020 (see **Figure A.12**) with one country's operational date unknown. Some country reports suggested that MNCAAH TWG restructuring was planned and in process before the pandemic. For these countries, not all TWG actions (i.e. restructuring and meetings) were necessarily in direct response to the pandemic but were rather a result of pre-planned administrative shifts.

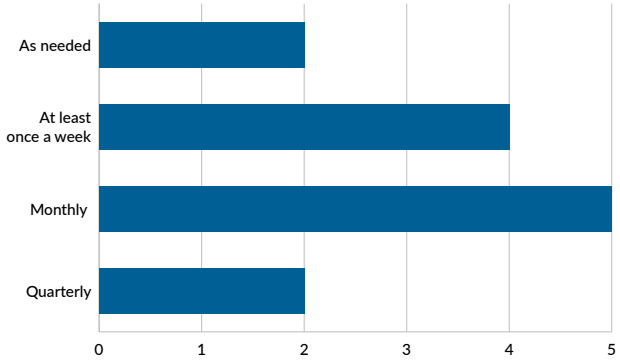
Fig. A.12. Date of operationalization of MNCAAH TWGs, by quarter (N=15)



Frequency of MNCAAH TWG meetings

Information on the planned frequency of TWG meetings was available for 13 countries. At inception, planned meeting frequency varied from 'as needed', which tended to be often, to weekly to quarterly (see **Figure A.13**). The frequency of meetings changed for some TWGs over time, often related to the progression of the COVID-19 caseload. TWG meetings were held both in person and virtually, depending on local COVID-19 rates of infection and PHSMs. Not all planned meetings took place due to TWG member illness, member unavailability or other disruptions.

Fig. A.13. Planned frequency of national MNCAAH TWG meetings (N=13)



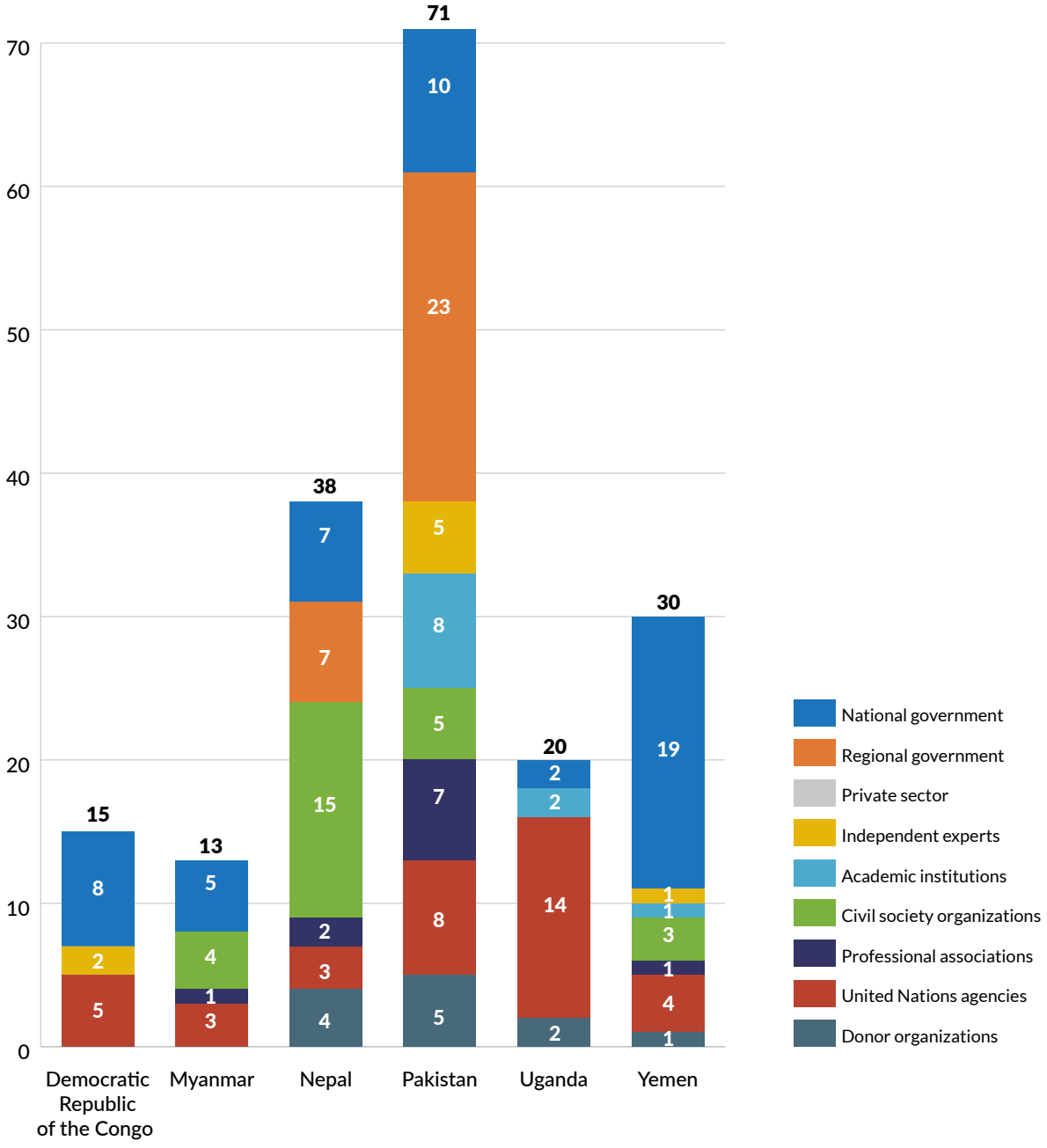
Representation in MNCAAH TWGs

Only six countries provided information on their TWG members by type of organization. **Figure A.14** shows the distribution of member affiliation.

The representation on TWGs varied between countries, although all had some diversity in representation. National government representatives, civil society organizations and United Nations agencies were represented on all TWGs. Apart from Nepal and Pakistan, the percentage of regional government representatives was relatively low compared to other members' affiliation. Academic institutions, professional associations and donors had low representation, in terms of both numbers and percentage, on all TWGs. The private sector was not reported to be represented on any of the TWGs.

Two countries provided information on gender distribution in their TWGs. The Democratic Republic of the Congo had 33.3% women (n=5), while Yemen had 43.3% (n=13); gender was not listed for 6.7% (n=2).

Fig. A.14. Representation by type of agency in MNCAAH TWGs (N=6)



3.4 Policy and guidance

The monthly templates completed by the national consultants included information on policy and guidance documents developed and actions taken to support continuity in provision and use of MNCAAH services. The WHO headquarters team collated this information and cross-checked it with information provided on the PATH COVID-19 EHS policy tracker *(7)*. Key actions taken by implementing partners, including stakeholders, private providers and non-government actors (e.g. nongovernmental, civil society and faith-based organizations and community groups) were also documented. **Table A.1** maps policies and guidance issued by MNCAAH area. **Tables A.2 – A.6** include actions taken by implementing partners.

Table A.1. Types of policy and guidance issued on maintaining the provision and use of essential MNCAAH services (N=19)

	FAMILY PLANNING	MATERNAL HEALTH	NEWBORN HEALTH	CHILD HEALTH	ADOLESCENT HEALTH
Bangladesh	■	■	■	■	
Bolivia (Plurinational State of)		■	■		
Brazil	■	■	■	■	
Cameroon	■	■	■	■	■
Democratic Republic of the Congo	■	■	■	■	■
Ethiopia	■	■	■	■	■
India	■	■	■	■	■
Kazakhstan					
Myanmar		■	■	■	
Nepal	■	■	■	■	■
Nigeria	■	■	■	■	■
Pakistan	■	■	■	■	
Romania					
South Africa	■	■	■	■	■
Sudan	■	■	■	■	
Tajikistan					
Timor-Leste	■	■	■	■	■
Uganda	■	■	■	■	■
Yemen	■	■		■	

Note: The coding of content indication reflects information from PATH COVID-19 EHS policy tracker *(7)* as well as information obtained from national consultants' monthly reports. Kazakhstan, Romania and Tajikistan listed guidance that could not be coded to any of these areas.

3.5 Information for decision-making

Monitoring MNCAAH service utilization

As the pandemic progressed, countries were overwhelmed by the severity and complexity of the response to the pandemic. The need for data to increase awareness of the disruptions to non-COVID-19 services resulted in the implementation of various "pulse" surveys, where often a representative of the Ministry of Health (key informant) was asked to share perceptions about the level and causes of disruptions of specific services. The WHO headquarters team collated the findings related to MNCAAH services from the surveys administered in each country and shared the same with the national consultants. Given limitations of such key informant surveys and the need for more timely data, the WHO team and national consultants collaborated with each Ministry of Health to analyse routine data from national HMIS. Each country team selected indicators to monitor based on what was already reported in their HMISs and its relevance to the context. The prioritized indicators were consistent with a larger list recommended in a WHO publication *(10)*. The country teams reviewed dashboards visualizing monthly changes in HMIS data on utilization of selected MNCAAH services in 2020 in comparison to the corresponding reporting periods of 2019 and previous years, if available. The results were presented to MNCAAH TWGs to support decision-making. Some countries engaged in the development of a risk-benefit model using the Lives Saved Tool (LiST) *(11)*, to project the potential impact of countries' responses to COVID-19 on essential service coverage. This modelling was often useful for advocating for actions to protect MNCAAH services.

Several issues linked to accessing, analysing and using routine data were common across countries engaged in the activities of the Initiative. In most cases these problems existed prior to the pandemic. They included data quality, limited ability to disaggregate data, lack of integration of community health and private sector data into the HMIS, challenges in access and limited understanding of how data were used for planning, prioritization and decision-making. HMISs were also disrupted by the pandemic. The flow of periodic reporting from health services was interrupted; the processes to update and clean databases were disrupted; and the production of non-COVID-19 reports was affected, among other issues. Strengthening HMISs and country capacity in analysis and interpretation of data and in improving data quality and utilization, at both national and subnational levels, were identified as ongoing needs by all countries.

Stakeholders' perspectives

Although considered important for decision-making, routine systems are not set up to appropriately capture utilization and experiences of health services. Universities in two of the countries in the Initiative (Brazil and Uganda) were commissioned to conduct studies to capture women's and health workers' perspectives on care. In Uganda, key informant interviews were conducted with seven technical experts, including officials from the Ministry of Health, the United States Agency for International Development and implementing partners, regarding strategies and innovations implemented to maintain the continuity of health services. Pakistan produced six different videos on stakeholders' perspectives, and WHO commissioned reports for nine countries of the results of a global survey of maternal and newborn health professionals *(12)* and their experiences during the pandemic. These reports were shared with the TWGs.

National stakeholders' meeting - December 2020
Photo credit: WCO Bangladesh

3.6 Actions taken to maintain the provision and use of essential MNCAAH services

The types of actions taken by countries to maintain continuity in the different health areas are captured in **Tables A.2a** and **A.2b**. The numbers reflect countries that have taken at least one action in a service area. The tables show that in general countries took more actions to maintain maternal, newborn, child and adolescent health and family planning (FP) services than for services for other population groups. There was a paucity of actions on services for older people.

Tables A.2a and **A.2b** also show that across the health areas the most frequently employed strategies to maintain services were telehealth and digital technology, community and mobile modalities for service delivery, and media and community activities for raising awareness of access to services and health advice. Information in **Tables A.2a**, **A.2b** and **A.3** were taken from national consultants' monthly reports.

Table A.2a. Number and type of actions to maintain the provision and use of essential MNCAAH services (N=17)*

		Family Planning	Maternal and Newborn	Children and Adolescents	Older People	Cross-cutting
Medications, equipment and supplies	Extension of prescriptions	**6**	**1**			**2**
	Monitoring, procurement and delivery (including logistics)	**8**	**1**	**1**		**2**
	Alternative contraceptive options	**10**				
Facilitating mobility	Mobility measures		**3**	**1**		**4**
Health service adaptations	Modifications to scheduling, frequency and service offerings		**7**	**2**		
	Restrictions on staff and patient numbers in group sessions and facilities		**3**			
	Extended hours, catch-up and special provision		**2**	**2**		
	Service integration measures	**2**	**3**	**1**		
	Modification of protocols		**5**	**1**		
Service delivery settings	Mobile + community provision/door-to-door	**7**	**8**	**7**	**1**	**4**
	Shift of services to lower-level facilities	**3**	**4**			**3**
Safe patient flow	IPC in facilities, PPE for health workers		**11**	**2**		**7**
	Triage screening and isolation		**6**			**5**

* Bangladesh, the Plurinational State of Bolivia, Cameroon, Democratic Republic of the Congo, Ethiopia, India, Myanmar, Nepal, Nigeria, Pakistan, Romania, South Africa, Sudan, Tajikistan, Timor-Leste, Uganda, Yemen

Table A.2b. Number and type of actions mentioned to maintain the provision and use of essential MNCAAH services (N=17)*

		Family Planning	Maternal and Newborn	Children and Adolescents	Older People	Cross-cutting
Telehealth and digital technology	Teleconsultations, hotlines/ social media platforms for counselling, advice and support	**8**	**8**	**8**	**2**	**5**
	Mobile apps/online platforms for training + health worker support/ information	**2**	**5**	**1**		**9**
Removing financial access barriers	Vouchers, free services/ supplies	**1**	**3**	**3**		
Optimizing workforce capacity	Recruitment and training		**3**	**2**		**6**
	Redistribution health workforce capacity, i.e. redeployment and task sharing					**3**
	Incentives					**5**
	Support (mental wellbeing, mobility)					**5**
Communication strategies (MNCAAH)	Broadcast, print and social media messaging	**3**		**2**	**1**	**8**
	Community outreach for awareness-raising (NGOs, volunteers, peers, CHWs)	**2**	**1**	**1**	**1**	**4**

* Bangladesh, the Plurinational State of Bolivia, Cameroon, Democratic Republic of the Congo, Ethiopia, India, Myanmar, Nepal, Nigeria, Pakistan, Romania, South Africa, Sudan, Tajikistan, Timor-Leste, Uganda, Yemen

Table A.3 summarizes the most common types of action that 17 countries took to maintain MNCAAH services. Telehealth and digital technology as a means of delivering services were adopted by almost all countries, along with ensuring IPC measures in facilities and providing health workers with personal protective equipment (PPE). These were closely followed by additional recruitment and training of health workers, communication strategies and a greater use of community health workers (CHWs) and mobile teams to deliver services.

As mentioned in **A.2 Methods**, from December to January the national TWGs responded to a number of reflective questions, including which actions they felt had been most important for maintaining continuity of MNCAAH services, and which actions they thought were likely to be continued or discontinued post-pandemic. These responses (**Tables A.4 – A.6**) give some indication of the perceived impact of the actions, pending the results of more structured evaluations.

Table A.3. Most common actions to maintain the provision and use of essential MNCAAH services (N=17)*

Area of mitigating action	Number of countries reporting action
Teleconsultations, hotlines/social media platforms for counselling, advice and support	15
IPC in facilities, PPE for health workers	15
Recruitment and training (including virtual) of health workers	14
Multi-media and community outreach for information	14
Mobile teams and community provision/door-to-door	13

* Bangladesh, the Plurinational State of Bolivia, Cameroon, Democratic Republic of the Congo, Ethiopia, India, Myanmar, Nepal, Nigeria, Pakistan, Romania, South Africa, Sudan, Tajikistan, Timor-Leste, Uganda, Yemen

Table A.4a. Actions deemed most important to maintain the provision and use of essential MNCAAH services (N=17)*

Top five actions cited as most important in maintaining service continuity
Digital health for delivery of services: teleconsultations, hotlines, mobile applications
Regular management and monitoring of data on continuity of EHS
Establishing and maintaining communication channels for health information and risk communication through social media and digital technology
Online training modules for new clinical protocols (e.g. obstetric, newborn care, nutrition)
Strengthening IPC in all services

* Bangladesh, the Plurinational State of Bolivia, Cameroon, Democratic Republic of the Congo, Ethiopia, India, Myanmar, Nepal, Nigeria, Pakistan, Romania, South Africa, Sudan, Tajikistan, Timor-Leste, Uganda, Yemen

Table A.4b. Actions deemed most important to maintain the provision and use of essential MNCAAH services (N=17)

Region	Africa						Americas	Eastern Mediterranean			Europe		South-East Asia				
Country	Cameroon	Democratic Republic of the Congo	Ethiopia	Nigeria	South Africa	Uganda	Bolivia	Pakistan	Sudan	Yemen	Romania	Tajikistan	Bangladesh	India	Myanmar	Nepal	Timor-Leste
Maintaining MNCAAH commodities	x							x	x	x			x				
Digital and social media channels for health information and risk communications	x		x	x			x	x	x				x				
Rescheduling appointment times (e.g. longer intervals)		x	x								x						
Taskshifting and retraining of health staff		x				x		x		x							
Digital health, e.g hotlines, mobile applications, teleconsultations		x	x	x	x		x	x	x	x	x	x	x		x	x	x
Online training modules for new clinical protocols		x		x	x					x		x		x	x		
Mobilize TWG with Ministry of Health leadership			x					x					x	x			
Strengthen IPC in all services			x	x		x		x	x								x
Regular management and monitoring of data			x	x	x				x				x	x	x	x	x

Table A.5. Actions deemed most likely to be continued after the pandemic (N=17)

Region	Africa						Americas	Eastern Mediterranean			Europe		South-East Asia				
Country	Cameroon	Democratic Republic of the Congo	Ethiopia	Nigeria	South Africa	Uganda	Bolivia	Pakistan	Sudan	Yemen	Romania	Tajikistan	Bangladesh	India	Myanmar	Nepal	Timor-Leste
Maintaining MNCAAH commodities	x								x								
Digital and social media channels for health information and risk communications	x						x										
Rescheduling appointment times (e.g. longer intervals)																	
Taskshifting and retraining of health staff																	
Digital health, e.g hotlines, mobile applications, teleconsultations		x	x	x	x			x	x	x	x		x		x	x	x
Online training modules for new clinical protocols		x								x				x	x		
Mobilize TWG with Ministry of Health leadership														x			
Strengthen IPC in all services			x														
Regular management and monitoring of data			x	x	x									x	x	x	
Governance, e.g integrating MNCAAH in COVID-19 response				x					x								

Table A.6. Actions deemed most likely to be discontinued after the pandemic (N=17)

Region	Africa						Americas	Eastern Mediterranean			Europe		South-East Asia				
Country	Cameroon	Democratic Republic of the Congo	Ethiopia	Nigeria	South Africa	Uganda	Bolivia	Pakistan	Sudan	Yemen	Romania	Tajikistan	Bangladesh	India	Myanmar	Nepal	Timor-Leste
Multisectoral governance and coordination of task force for maintaining EHS	x		x					x					x				
Reducing the number of facility visits and in-person health care contacts		x				x						x					
Development of specific thematic guidelines in context of COVID-19			x					x		x							
Screening of vulnerable populations for COVID-19 (i.e. children and pregnant women)			x														x
Community-based mobile clinics for the delivery of MNCAAH services						x				x					x		
Designated triage and isolation areas and COVID-19 facilities								x		x							x
Home visits became regular EHS strategy												x				x	
Monitoring dashboard of COVID-19 and routine MNCAAH service data													x				x
Virtual service delivery for ANC, PNC and FP				x												x	

From the actions reported, lack of access and lack of workforce capacity were addressed through alternative modalities, namely, through digital innovations and telehealth, and through increased delivery of services via mobile teams and CHWs.

CHWs also provided a valuable alternative channel for service delivery and outreach/ sensitization work. In countries where they were already widely used, their redeployment in test and trace efforts to contain the epidemic meant existing CHWs were less able than before to provide MNCAAH services. Additional recruitment and training of all health workers were actions taken by most countries, although some reported difficulties in recruitment and retention. These problems were due to previously existing workforce contexts which were frequently exacerbated by the demands that the pandemic placed on them.

Digital technology for the delivery of health services is one area that arguably could be said to have come into its own during the pandemic. In light of how highly most countries rated its importance, it would appear the pandemic served to accelerate the embrace of new technologies.

The synthesis questionnaire included a section on strategies that countries did not plan to continue after the pandemic, although they were thought to be important for emergency preparedness plans or in the face of another disruption to services. **Table A.6** includes the most frequently-cited discontinued strategies, although in terms of numbers countries were more likely to identify and report on strategies that were likely to be continued.

Four countries (Bangladesh, Cameroon, Ethiopia and Pakistan) reported on the intended discontinuation of high-level and multisectoral task forces and committees designed for a comprehensive mitigation response and ensuring the continuity of EHS. These countries cited the lack of need after the pandemic as a reason for discontinuing these coordination mechanisms. Another strategy adaptation was the development of guidelines for different health areas in the context of COVID-19, such as standard operating procedures (SOPs) for MNCAAH and training staff in Pakistan; criteria for diagnosing and treating malnutrition in Yemen; and screening practices, masking and physical distancing for service delivery in Ethiopia. Other strategies included those related to the prevention of COVID-19 infection in health care delivery settings: reducing the number of facility visits and in-person contacts; designated areas in facilities and separate facilities for triage and isolation of COVID-19 cases; community-based mobile clinics; home visits; and virtual appointments for MNCAAH services. Some of the stated reasons for discontinuing these listed actions were limitations due to sustainability and allocation of resources, while other strategies were designed as emergency responses during the pandemic and meant to be temporary.

3.7 Synthesis of lessons learned from countries

This synthesis is based on the reflections of the national MNCAAH TWGs from the 19 countries on the lessons learned in mitigating the effect of COVID-19 on MNCAAH service delivery and use. These key lessons were captured in the responses to the synthesis questionnaire and refined in most cases in the regional workshops (see **Section A.2 Methods**).

Governance mechanisms

A frequent theme from the 19 country reports was the difficulty of integrating health programmes into COVID-19 response committees and coordination mechanisms, thus delaying their inputs and efforts to sustain critical MNCAAH services. The need for a coordinated emergency response involving the incident management team (IMT), health systems departments, life-course and disease-specific programmes, as well as implementing partners, was felt to be critical. Similar lessons of enhanced communication and collaboration were also felt to be applicable within WHO (e.g. Health Emergencies Programme, Essential Health Services - Pillar 9 *(13)*, and specific health programme areas).

A whole-of-government approach was widely deemed to be the key to ensuring a more effective response, in several ways:

- The decisions regarding PHSMs to slow or stop the spread of the pandemic, e.g. lockdowns, transport barriers, budget, service and health worker reallocation and incentives for specific services - can benefit from being analysed in terms of the wider risks and benefits for other health and socioeconomic impacts.

- Government leadership can ensure multisectoral and multi-partner coordination, including the private sector, for implementation of actions, for real-time data and for additional studies and surveys. Such leadership can avoid wasting limited resources, duplication of efforts and gaps.

- Strengthened linkages and communication with subnational levels, including in decentralized forms of government, can ensure more timely information flow and coordinated actions.

Most countries established TWGs to address the needs of MNCAAH services, and policies and guidelines were developed early in the pandemic. In some countries, the functioning of these MNCAAH TWGs could have been boosted by expanding the range of perspectives participating, when considering stakeholder representation by gender, organization type and areas of expertise.

Guidelines on relevant issues were developed; however, there were often difficulties in ensuring their dissemination to all parts of the country.

Data and information for decision-making

Identifying key indicators and reviewing data on coverage of essential MNCAAH services was a key activity for all countries involved. However, many countries were cognizant of the limitations of not having real-time data for decision-making, with six countries citing the quality and completeness of data among their challenges. Support was needed to ensure information could be received from subnational levels, to overcome reporting problems. Capacity-building and use of data for decision-making was recognized as a recurrent need. Reporting from private facilities was not available.

Several issues linked to data were common across the countries in the Initiative, and in most cases existed prior to the pandemic. These included quality concerns, limited ability to disaggregate, lack of integration of community health and private sector data into the HMIS, challenges in access and limited understanding of how data are used for planning, prioritization and decision-making. HMISs were also disrupted by the pandemic. The flow of periodic reporting from health services to the HMIS, the processes to update and clean databases, and the production of non-COVID-19 reports were all affected. Strengthening HMISs and country capacity in analysis and interpretation of data and improving data quality and utilization, at both national and subnational levels, were identified as ongoing needs by all countries.

Maintaining essential services

Countries recognized the importance of the continuation of essential services early on and tried to balance mitigation of COVID-19 infection measures with actions to maintain services. There were some areas of tension in striking the right balance, including:

- Investing in hospital services for improved COVID-19 response over the delivery of primary health care (PHC) had implications for the provision of essential services.
- Designating some facilities exclusively for COVID-19 and suspending other services without proposing alternatives or communicating the closures impacted on essential service use.
- Re-purposing of health workers to COVID-19 and shortages of supplies, including PPE, for all health workers added to the problems in delivering essential MNCAAH services.
- Limiting transport made access to services for women and children more difficult than at other times.

These observations led countries to conclude that a specific plan for maintaining MNCAAH essential services was required in country preparedness and response plans. In the different resources reviewed, the specific needs of adolescent and ageing health were less explicitly addressed.

Countries reflected on specific service delivery adjustments and whether they could be sustained. One strategy, mobile units, was noted by some as unlikely to be continued after the pandemic. Improvements in IPC measures in essential services put into place due to the COVID-19 pandemic were viewed positively, and efforts will continue to maintain these.

There has been a substantial upsurge in digital health interventions to maintain communication with subnational decision-makers, health workers and service users and for other activities, such as training or teleconsultations. While this increase is generally viewed positively, there were several lessons to be learned for future implementation efforts, such as the types of training and consultations that can be done well online, fatigue with virtual meetings and awareness that many areas within countries may have interrupted or no access to the internet. Also, in some areas, the cost of using the internet may be prohibitive.

The central importance of support for health workers, including their physical protection as well as their mental health needs and capacity to assume new tasks, was acknowledged as an important lesson learned by most countries.

Incentives for health workers received mixed reviews, with some observations that these helped ensure commitment to providing services during COVID-19, while others that governments could not always deliver on the incentives promised, or that the incentives may have even caused distortions in the health system, i.e. providing them only for COVID-19 services.

4. Conclusion

The work presented above reflects the lessons from the first phase of a WHO Initiative which will continue through February 2022. The world was not prepared for the pandemic when it hit, but the 19 countries reacted rapidly and moved to ensure guidance was in place. While the initial concern was exclusively controlling COVID-19, countries realised almost immediately the need to look at essential services including MNCAAH, and to respond to the indirect effects of the pandemic on them.

Actions to respond to COVID-19 required time to be thought through and happened in systems that are often fragile and unresponsive. However, these systems showed important components of resilience within the context of lessons learned for improvements. Important lessons are summarized for how MNCAAH programmes and health systems can build back better to improve core functioning and ensure strengthened response and resilience to any future shock.

The next section of this report provides individual country information, organized by Region. The lessons learned are many and WHO remains committed to supporting countries for future events.

Section B

Introduction

As noted in **Section A**, this part of the report documents the impact of COVID-19 on MNCAAH (and in some cases, additional) services in the countries involved in the Initiative, as well as the responses of each government (sometimes with partners) to ensure the continuity of these essential services in the face of the disruption and challenges posed during the period March-December 2020.

Information contained in the report is drawn directly from country TWG and national consultant reports, country HMIS data, research publications and surveys that describe the impact of COVID-19 on MNCAAH services. More information is available for some countries due to specific circumstances, and slightly different indicators are shown in some cases.

With regards to country HMIS data, reporting completeness and data quality may be concerns. Therefore, interpretation of trends, especially for indicators reported in absolute numbers, is done with caution.

A few countries carried out risk-benefit modelling according to WHO, United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) guidance *(12)*, and the results are included in the individual reports.

Although included in the Initiative, the report for Kazakhstan is not presented here as only minimum information relevant to maintaining MNCAAH services was available.

Romania - Social life
Photo credit: Petru Cojocaru

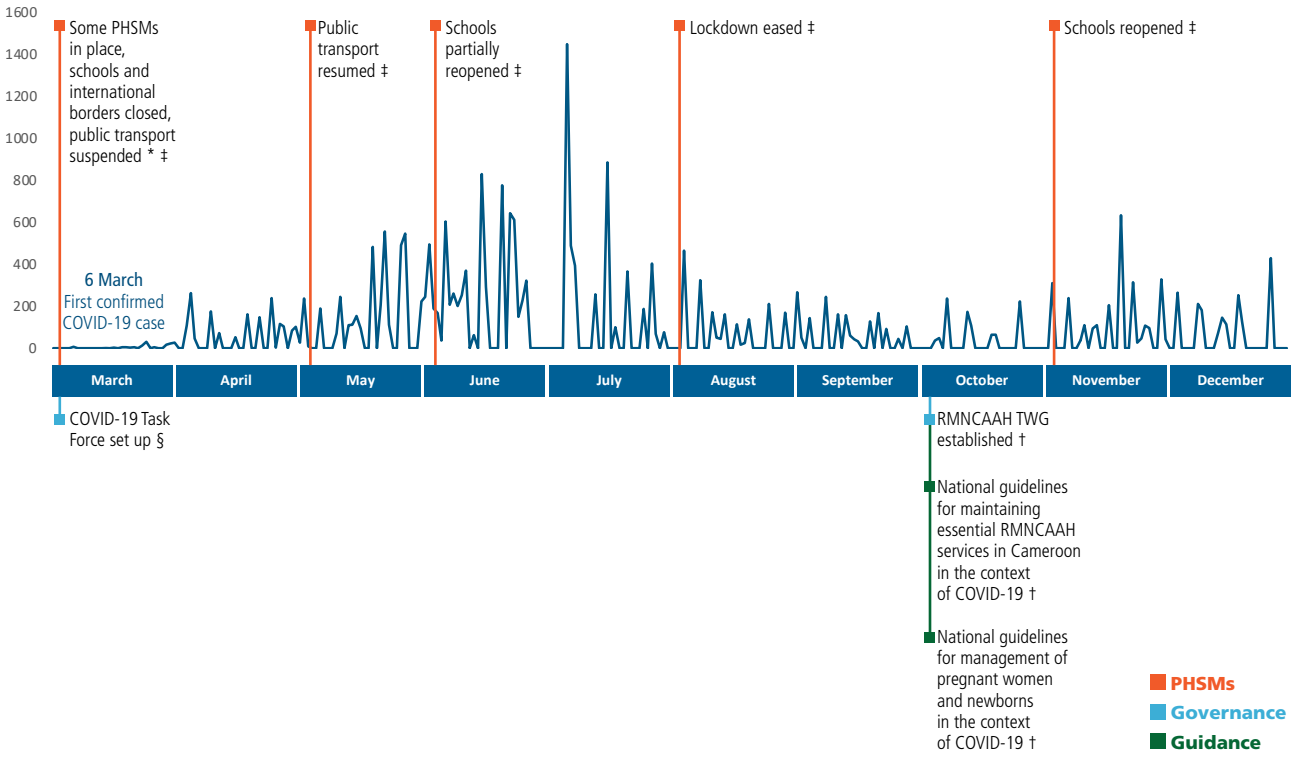
B.1 African Region

Country report - Cameroon

A. The COVID-19 context

The first confirmed case of COVID-19 in Cameroon was in March 2020, with peak numbers in July. The government response in terms of PHSMs and guidance in order to ensure the continuation of reproductive, maternal, newborn, child and adolescent health and ageing (RMNCAAH) services is shown in **Figure B.1.1**.

Fig. B.1.1. Reported COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place for continuing RMNCAAH services, 2020



Sources: * *(14)*; † National consultant reports; ‡ *(15)*; § *(16)*; *(17)*.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

In September 2020, a national TWG focused specifically on maintaining RMNCAAH services was established in response to the COVID-19 pandemic. In late October, the TWG received official recognition from the Ministry of Health, and the Secretary General of the Ministry of Health was appointed President. At this time the original TWG was expanded to include representatives from a range of national and regional government agencies, the private health sector, civil society organizations, professional associations, United Nations bodies and donor organizations. Both WHO and the Ministry of Health's IMT are key members of the TWG.

Meetings are scheduled virtually as need arises, and information is exchanged daily among members via email. Meeting agendas are agreed between the Ministry of Health and its partners.

C. Guidance for RMNCAAH services in response to COVID-19

The government developed guidance on various RMNCAAH-related issues over the course of 2020 (**Table B.1.1**). Some of the documents remained in draft form as of the date of this report.

Table B.1.1. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
National guidelines for maintaining essential RMNCAAH services in Cameroon in the context of COVID-19	Oct	
National guidelines for management of pregnant women and newborns in the context of COVID-19	June	
Draft national guidelines for psychosocial management of children and adolescents during the COVID-19 pandemic	In progress	
Draft guidelines for safe elderly care and ageing health in the context of COVID-19	In progress	
National guidelines for Expanded Programme on Immunization (EPI)	June	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

In response to COVID-19, the government of Cameroon took a variety of actions to protect the delivery and utilization of RMNCAAH services (**Table B.1.2**).

Table B.1.2. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	National carrier arrangement to ensure uninterrupted medicine supply chain	Cross-cutting
	Modification of frequency of vaccination clinics and outreach schedules from weekly to monthly	Immunization
Health services adaptations	Increased intervals between clinic visits	Maternal and newborn health Child and adolescent health
	Telehealth appointments for pregnant women	Maternal and newborn health
	Special and catch-up campaigns in certain areas for cholera, polio and measles vaccines	Immunization
Service delivery settings	Community-based ANC for asymptomatic/mild COVID-19-positive pregnant patients	Maternal and newborn health
	CHWs mandated to prescribe iron tablets to pregnant women unable to attend ANC and worm expellers to children	Maternal and newborn health Child and adolescent health
	Expansion of CHWs' role to include FP and vaccination counselling and to assist with adherence to public health programmes	FP Immunization
Safe patient workflow	PPE for health workers, and IPC in all health facilities	Cross-cutting
	Screening, triage and isolation for COVID-19 patients	Cross-cutting
	Spatial reorganization in labour and postpartum wards	Maternal and newborn health
Telehealth and digital technology	Teleconsultations for pregnant women unable to travel to health facilities, including for ANC and prescriptions	Maternal and newborn health
Removing financial barriers to access	Increased distribution of delivery vouchers and baby boxes to pregnant women in four regions to encourage delivery in public health facilities	Maternal and newborn health
Optimizing workforce capacity	Financial incentives for health workers	Cross-cutting
Communications strategies	Broadcast, print and social media campaigns to raise awareness of reopening of health facilities for routine services	Cross-cutting
	Community mobilization of youth groups to raise awareness of RMNCAAH service availability and changes	Cross-cutting
	Broadcast, social media and digital campaign against inter-personal violence and gender-based violence (GBV), and awareness-raising of child mental health and abuse	Maternal and newborn health GBV
	CHWs to reach out to older persons living at home	Older people

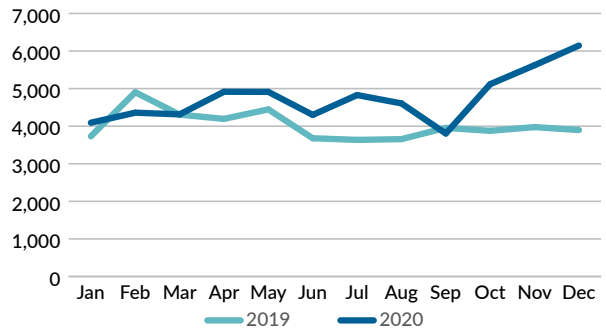
E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAAH indicators were compiled from the national HMIS. **Figures B.1.2 – B.1.6** show changes in utilization of health services based on this data. In general, it appears that health service utilization was not greatly impacted by COVID-19.

FP

- The reported number of women receiving modern contraceptives postpartum was higher in 2020 than in 2019 (**Figure B.1.2**).

Fig. B.1.2. Total number of women receiving modern contraceptives postpartum



Maternal and newborn health

- The reported number of ANC contacts was slightly lower in 2020 compared to the corresponding months of 2019 (**Figure B.1.3**). However, it returned to a similar level by the end of the year.

- The reported number of facility births in 2020 was similar to the corresponding months of 2019 (**Figure B.1.4**).

- The reported number of births by caesarean section increased steadily from March to July 2020 (**Figure B.1.5**).

Fig. B.1.3. Number of ANC contacts

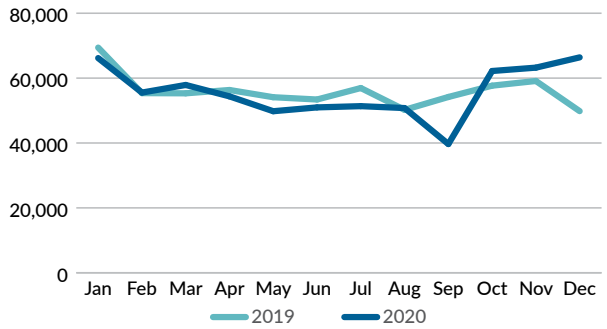


Fig. B.1.4. Number of facility births

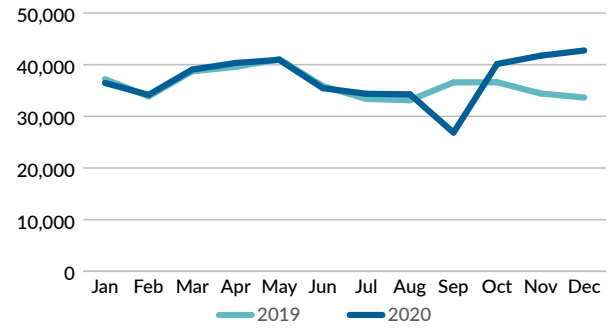
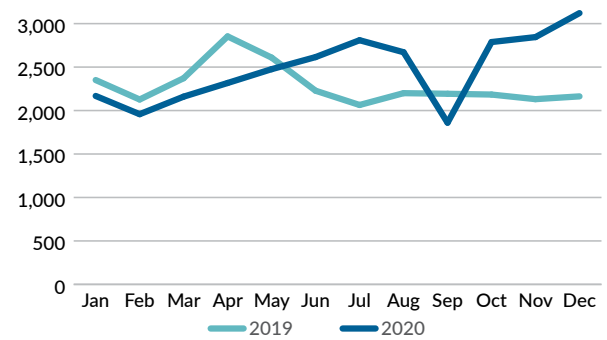


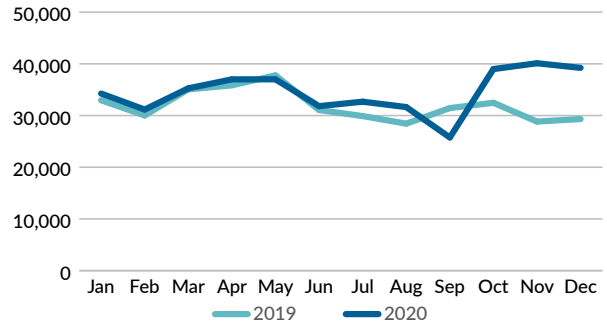
Fig. B.1.5. Number of caesarean births



Child health and nutrition

- The reported number of children less than 5 years of age receiving vitamin A supplementation was similar in 2020 compared to the corresponding months of 2019, with an increase towards the end of the year (**Figure B.1.6**).

Fig. B.1.6. Number of children < 5 receiving vitamin A supplementation



F. Lessons learned

- Designating tertiary health facilities to exclusively care for COVID-19 cases impacted the utilization of other services, as these facilities offer EHS to the entire population.

- Financial incentives promised to health care providers caring for COVID-19 patients were not always given, leading to frustration and demotivation in the health workforce.

- Early communications strategies were not well coordinated and were detrimental to health service use, especially those related to the management of COVID-19-related deaths. For example, the government initially prescribed that all bodies where COVID-19 was the cause of death should be decontaminated and stored in a special polythene bag. The transportation of these corpses to their villages or regions of origin for burial was strictly forbidden, and the bodies were buried immediately on the day of death. Later, the government softened the conditions of corpse management to allow up to three days in the presence of family members before burial, with strictly-prescribed barrier measures. Despite this slight shift in government policies, there was much frustration in the community concerning the treatment afforded COVID-19 deaths. As a result, the population was afraid of seeking care at health facilities for fear of dying there without the possibility of a dignified, culturally-appropriate burial.

On 26 October 2020, WHO Country Office for Cameroon donated a large consignment of PPE, water, sanitation and hygiene equipment, birthing beds and paediatric incubators to 13 maternity care facilities in the three regions most affected by COVID-19 in the country (Center, Littoral and West).

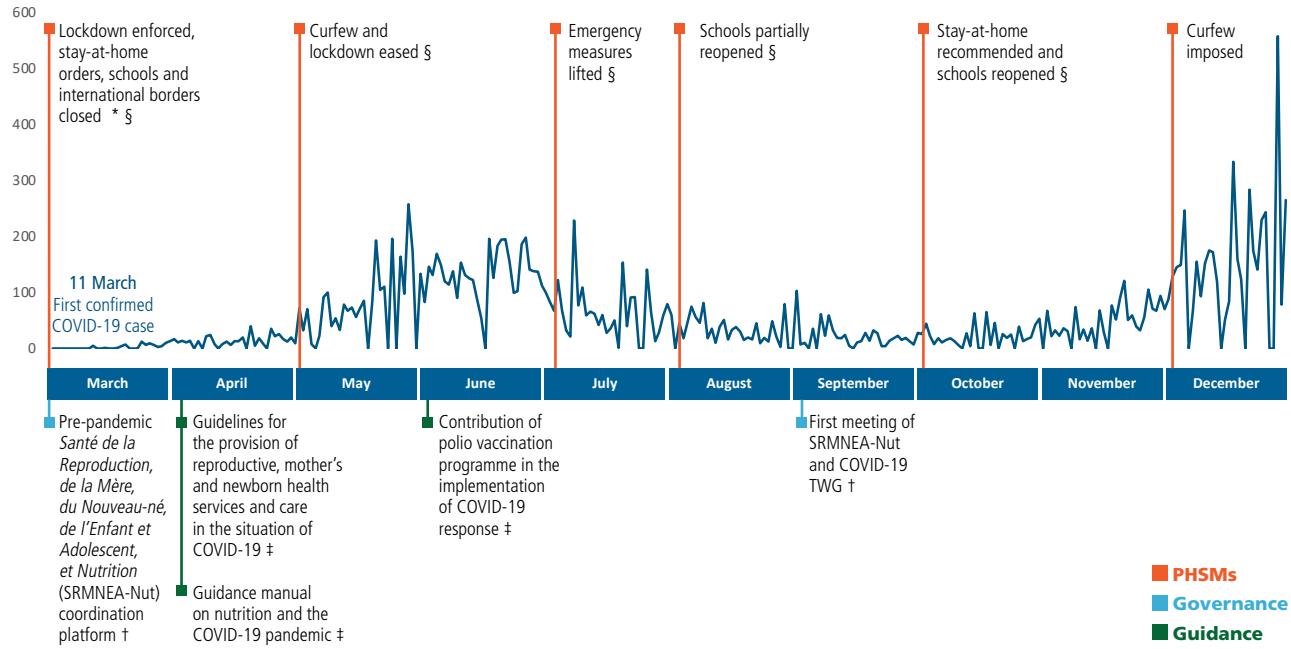
Photo credit: WHO Country Office for Cameroon COVID-19 Bulletin

Country report
Democratic Republic of the Congo

A. The COVID-19 context

The first confirmed case of COVID-19 appeared in the country in March 2020. The government instituted measures and issued guidance to control the pandemic according to the timeline in **Figure B.1.7**.

Fig. B.1.7. Reported COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services, 2020



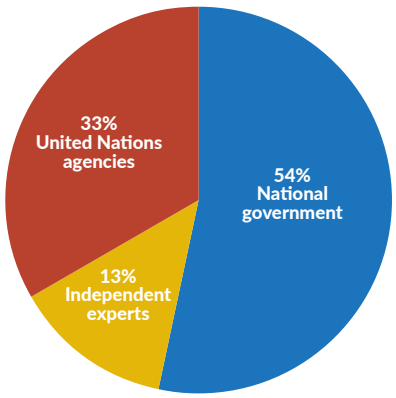
Sources: *(14)*; † National consultant reports; ‡ *(7)*; § *(15)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

A 15-member national TWG in the Democratic Republic of the Congo held its first meeting in September 2020. Most members are from national government directorates. **Figure B.1.8** shows the TWG membership by agency. The TWG was comprised of one third women (n=5) and two thirds men (n=10). At its inception the TWG planned to hold monthly meetings.

A member of the TWG, an expert from the Technical Secretariat of the Multisectoral Committee for the Fight Against COVID-19, acts as a bridge between the Multisectoral Committee and the national TWG. The TWG communicates twice a month with the Advisory Group of the Multisectoral Committee.

Fig. B.1.8. National TWG membership, by agency



C. Guidance for RMNCAAH services in response to COVID-19

Authorities issued guidance on a variety of RMNCAAH issues to help ensure that services and utilization were not greatly affected by the pandemic (**Table B.1.3**).

Table B.1.3. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Guidelines for the provision of reproductive, mother's and newborn health services and care in the situation of the COVID-19 pandemic in the Democratic Republic of the Congo	May	
Guidance manual on nutrition and the COVID-19 pandemic in the Democratic Republic of the Congo	April	
Contribution of polio programme in the implementation of the response against COVID-19 in the Democratic Republic of the Congo	June	
Briefings for health workers on self-injectable contraceptives	July-Aug	
SOPs on infection prevention in FP services	Oct	
Guidelines for mobile FP clinics	Aug	
Compendium of information for providers and people living with HIV on HIV and COVID-19	Sept-Oct	
Updated care and prevention plans for survivors of sexual violence	May	
Prevention of mother-to-child transmission of HIV (PMTCT) training manuals which take into account all aspects related to the fight against COVID-19 – update underway	In progress	
Updated COVID-19 and vaccination guidelines	May-June	
Standards and guidelines on the health of the elderly – under development	In progress	
Key national guidelines for care of COVID-19 patients covered by RMNCAAH services	**Month (2020)**	**Content**
Revision of protocol for addressing malnutrition in the context of COVID-19 and integration of the management of nutrition into the protocol for the management of COVID-19 patients	Oct	

FP Maternal health Newborn health Child health Adolescent health Ageing

D. Key actions to ensure continuity of RMNCAAH services

Table B.1.4 shows the various actions that the government and other bodies took to mitigate the effects of COVID-19 on relevant services.

Table B.1.4. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Extension of prescriptions for FP and HIV medication	FP HIV
	Promotion of self-care/auto-injected contraception (Depo Provera [DMPA-SC])	FP
	Necessary supplies for management of malnutrition distributed to COVID-19 health facilities	Nutrition
Health services adaptations	Group postnatal care (PNC) sessions reduced to 20 participants maximum, increase in number of sessions scheduled	Maternal and newborn health
	Number of medical staff during delivery reduced to a maximum of two	Maternal and newborn health
Service delivery settings	Reduced home visits to pregnant women and breastfeeding mothers, replaced by community mobilization	Maternal and newborn health
	Mobile and community vaccination campaigns	Immunization
Safe patient workflow	Provision of PPE in health facilities managing COVID-19 cases	Cross-cutting
	Spatial reorganization in labour and postpartum wards	Maternal and newborn health
	PPE and IPC measures at vaccination sites	Immunization
Telehealth and digital technology	Online training modules for obstetrics, neonatal emergency care and other RMNCAAH services	Cross-cutting Maternal and newborn health
	Use of WhatsApp for training provincial health officials in promoting breastfeeding during COVID-19	Maternal and newborn health
	Hotline for FP advice and prescription renewal	FP
Optimizing workforce capacity	Redeployment and accelerated retraining of nursing staff as midwives for uncomplicated births in two provinces	Maternal and newborn health
	Training for midwives, sexual and reproductive health (SRH) educators, nutrition trainers and providers on aspects of COVID-19	Maternal and newborn health Nutrition
Communications strategies	Media channels used in the community and in hospitals to raise awareness on breastfeeding	Maternal and newborn health
	Broadcast media programming on COVID-19 and SRH for adolescents and youth	Child and adolescent health

E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAAH indicators were compiled from the national HMIS. **Figures B.1.9 – B.1.18** show reported changes in utilization of health services in facilities.

Maternal and newborn health

- The reported numbers of ANC visits (**Figure B.1.9**) and births in facilities (**Figure B.1.10**) increased in 2020 compared to 2019.
- The percentages of births by caesarean section (**Figure B.1.11**) and of newborns receiving essential newborn care (**Figure B.1.12**) in 2020 were similar to 2019.
- The reported number of newborns admitted for inpatient care was higher in 2020 than in 2019 (**Figure B.1.13**).

Fig. B.1.9. Number of ANC visits/contacts provided

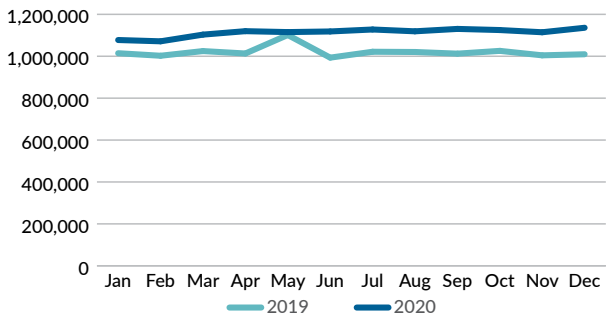


Fig. B.1.10. Number of facility births

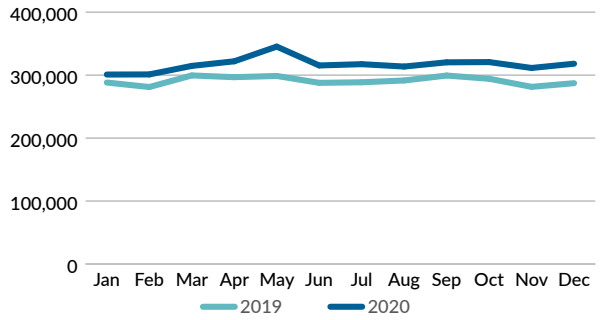


Fig. B.1.11. Percentage of caesarean births

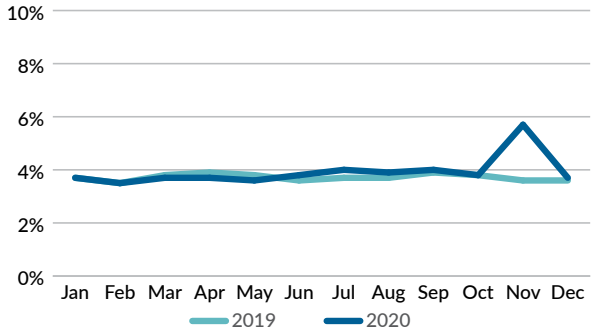


Fig. B.1.12. Percentage of newborns receiving essential newborn care

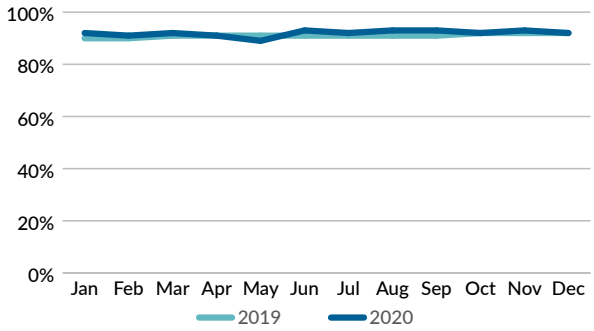
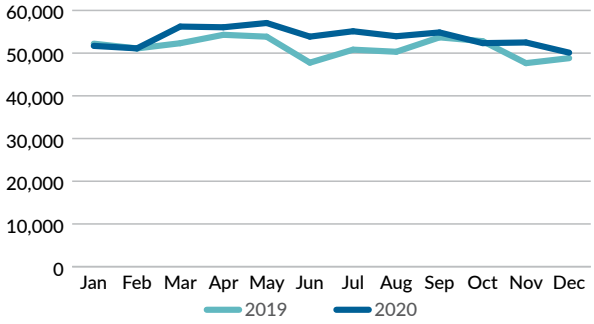


Fig. B.1.13. Number of newborns admitted for inpatient care



Child health and immunization

- The reported number of children less than 1 year of age receiving the third dose of diphtheria-tetanus-pertussis (DTP) vaccine was higher in 2020 compared to the corresponding months of 2019 (**Figure B.1.14**).
- The reported number of children less than 5 years of age presenting to facilities with ARIs in 2020 was similar to 2019 (**Figure B.1.15**).
- The reported number of children treated for diarrhoea with oral rehydration solution (ORS) was slightly higher in 2020 than the corresponding months of 2019 (**Figure B.1.16**).

Fig. B.1.14. Number of children < 1 year of age receiving 3rd dose of DPT vaccine

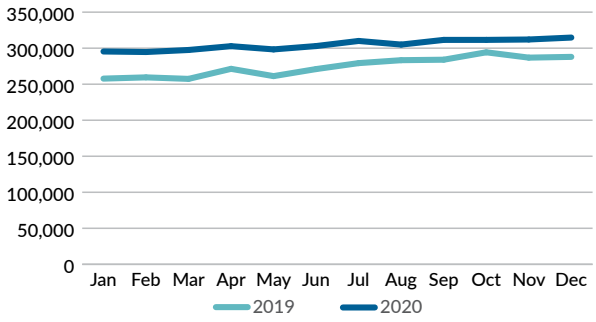


Fig. B.1.15. Number of children < 5 years of age presenting to facility with any sign of ARI

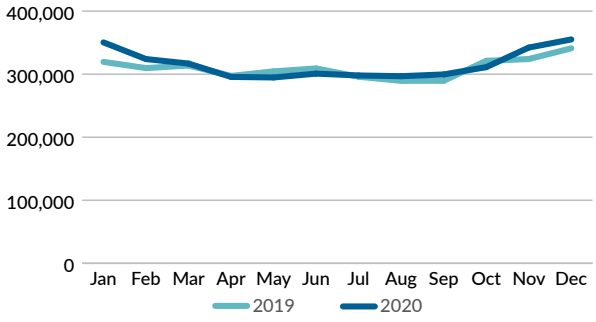
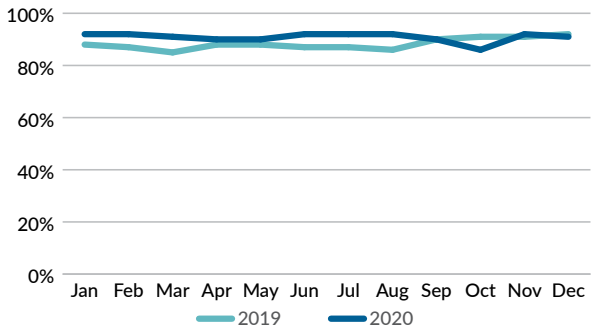


Fig. B.1.16. Percentage of children < 5 years of age with diarrhoea treated with ORS



SRH

- The reported number of clients who received injectable contraceptives was higher in 2020 compared to the corresponding months of 2019 (**Figure B.1.17**).
- The reported number of female survivors of sexual violence was higher in 2020 compared to the corresponding months of 2019 (**Figure B.1.18**).

Fig. B.1.17. Number of clients who accepted injectable contraceptives

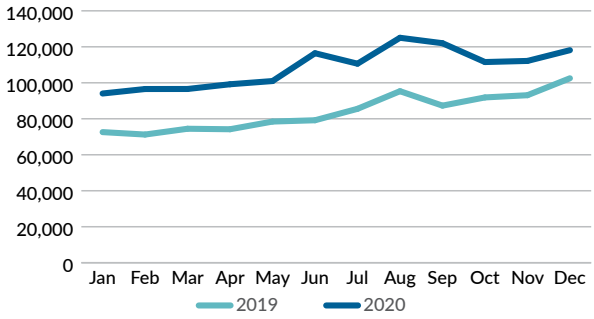
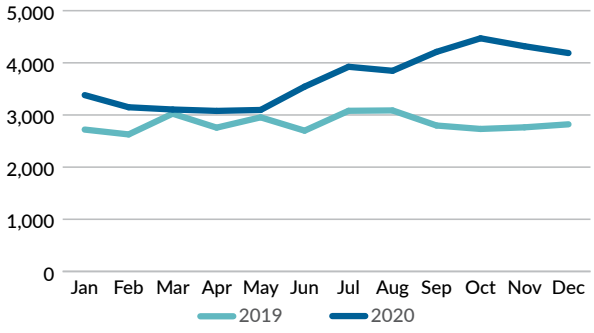


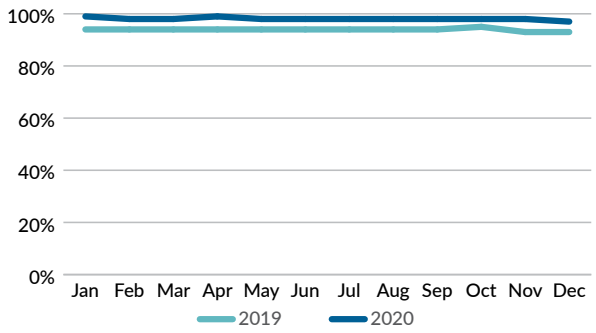
Fig. B.1.18. Number of new cases of female survivors of sexual violence



Reporting completeness

- HMIS reporting completeness was higher in 2020 than in 2019, which should be considered when interpreting changes in utilization of health services (**Figure B.1.19**).

Fig. B.1.19. Completeness of HMIS reporting (%)



F. Lessons learned

- Engaging mothers and other relatively simple approaches were adapted for nutrition and identifying cases of severe malnutrition in the community, enabling case management and avoiding additional administrative burden during the COVID-19 pandemic.
- The use of hotlines for FP, PMTCT and HIV helped to manage the workload of providers in health facilities.
- The SRMNEA-Nut platform was not effectively integrated into the Multisectoral Committee for the Response to the COVID-19 Pandemic, especially in early 2020.
- Delayed and lack of dissemination of COVID-19-adapted SRMNEA-Nut guidelines to lower-level health facilities led to incoherent/non-standardized responses, policies and protocols across facilities.
- Lack of PPE in the health facilities led some providers to avoid (for their own protection) certain medical procedures which would have been beneficial for patients, especially pregnant women or patients suspected of having COVID-19.
- The pandemic also increased awareness and practice of IPC measures, such as handwashing and disinfecting surfaces and equipment, by providers in health facilities.

Popularization of the WHO Initiative to executives and partners of the SRMNEA-Nut platform of the Ministry of Health of the Democratic Republic of the Congo.

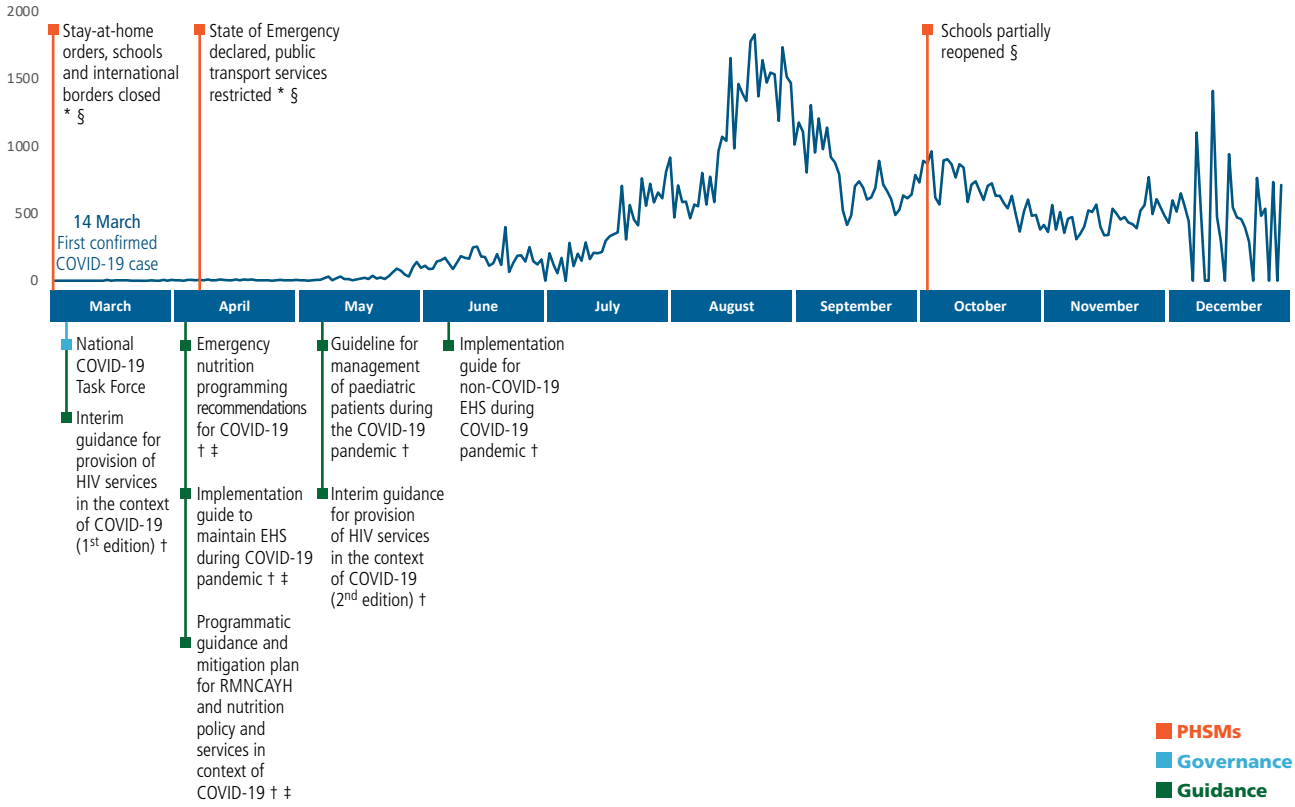
Photo credit: WHO Country Office for the Democratic Republic of the Congo

Country report - Ethiopia

A. The COVID-19 context

Ethiopia experienced its first cases of COVID-19 in March 2020, and put in place PHSMs and guidance to ensure the continued provision of reproductive, maternal, newborn, child, adolescent and youth health (RMNCAYH) services at that time, as seen in **Figure B.1.20**

Fig. B.1.20. Reported COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place for continuing RMNCAYH services, 2020



Sources: * *(14)*; † National consultant reports; ‡ *(7)*; § *(15)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAYH services during COVID-19

Continuity of EHS is a pillar of the Ethiopian National COVID-19 Task Force. This task force is an 11-member group of national-level government officials that meets weekly.

Table B.1.5 lists the national-level directorates and entities represented on the EHS Task Force.

RMNCAYH service needs is a standing item in the EHS Task Force agenda. The Vice Chair of the EHS Task Force is the Director of the MCH Directorate. There is a joint meeting of the EHS and National COVID-19 Task Forces every week chaired by the Minister of Health. This joint meeting includes the heads of the Regional Health Bureaus.

Various RMNCAYH TWGs exist under the MCH Directorate and focus on continuity of RMNCAAH essential services. These include the Safe Motherhood TWG, Child Health TWG and Adolescent Health TWG, among others, each chaired by the respective programme team leads. During the pandemic the TWGs have been developing guidelines on maintaining their respective services.

TWGs are not directly involved in the National COVID-19 Task Force. Directors of each directorate and agency communicate their concerns to the appropriate TWGs. The TWGs in turn flag issues to the Vice Chair of the EHS Task Force on a weekly basis.

Table B.1.5. EHS Task Force representation

Members represented on EHS Task Force	
State Minister	Maternal and Child Health (MCH) Directorate
Medical Service General Directorate	Disease Prevention and Control Directorate
Public Relations Directorate	Pharmaceuticals and Medical Equipment Directorate
National Blood Bank Service	Hygiene and Environmental Health Directorate
Ethiopian Pharmaceutical Supplies Agency	Ethiopia Public Health Institutes/Public Health Emergency Management Centre
Policy, Planning, Monitoring and Evaluation Directorate	

C. Guidance for RMNCAYH services in response to COVID-19

The types of key national guidelines and dates issued are shown in **Table B.1.6**.

Table B.1.6. Guidance issued for RMNCAYH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Emergency nutrition programming recommendations for COVID-19	April	
Implementation guide to maintain EHS during the COVID-19 pandemic	April	
Programmatic guidance and mitigation plan for reproductive, maternal, neonatal, child, adolescent and youth policy in the context of the COVID-19 epidemic	April	
Guideline for the management of paediatric patients during the COVID-19 pandemic	May	
Implementation guide for non-COVID-19 EHS in Ethiopia during the COVID-19 pandemic	June	
Technical guideline for reproductive, maternal, and newborn services during the COVID-19 pandemic in Ethiopia	In progress	
Draft RMNCAYH self-care interventions technical guideline	In progress	
Key national guidelines for care of COVID-19 patients covered by RMNCAYH services	**Month (2020)**	**Content**
Pregnant women screening and management algorithm for COVID-19 pandemic	April	
Labouring mother screening and management algorithm for COVID-19 pandemic	April	

D. Key actions to ensure continuity of RMNCAYH services

To ensure the continuity of relevant services, the government and partners took the mitigation actions shown in **Table B.1.7**.

Table B.1.7. Mitigating actions to ensure continuity of RMNCAYH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Ensured sufficient stock and distribution of RMNCAYH and nutrition commodities	Cross-cutting
	Promotion of long-acting reversible contraception (LARC)	FP
	Extension of prescriptions for HIV-affected children	HIV
Health services adaptations	Telehealth appointments for ANC and PNC patients	Maternal and newborn health
	Promotion of self-care for HIV using WHO-adapted self-care guidelines	HIV
	Synchronized mother and child appointments for HIV-exposed infants	HIV
	Reduced frequency of PMTCT appointments to every three months (a model known as 3MMD)	HIV
	Duration of EPI campaign extended	Immunization
	Reduced frequency of follow-ups for children with malnutrition, increase in ready-to-use food rations	Nutrition
Service delivery settings	Increased use of community health extension workers (HEWs) to deliver services in the community and door-to-door	Cross-cutting
	Measures to conduct births in open and well-ventilated areas	Maternal and newborn health
Safe patient workflow	IPC measures, PPE for health workers in facilities	Cross-cutting
	Triage, screening and isolation for pregnant women and children	Maternal and newborn health Child and adolescent health
	Spatial reorganization in labour and postpartum wards	Maternal and newborn health
	Birth companions limited to one person per patient	Maternal and newborn health
Telehealth and digital technology	Mobile learning platform (LEAP), interactive text messages and interactive voice response for training HEWs on RMNCAYH services during COVID-19	Cross-cutting
	Virtual technology for staff meetings, stakeholders and diaspora health professionals	Cross-cutting
	Mobile app for training HEWs to deliver PMTCT services	HIV
	Mobile phones and other virtual platforms for PMTCT counselling	HIV
Optimizing workforce capacity	Training health workers on COVID-19 protocols	Cross-cutting
Communications strategies	Public health broadcasts on protecting mental health during lockdown	Cross-cutting
	HEWs raise public awareness of FP and RMNCAYH service continuity	Maternal and newborn health Child and adolescent health FP

E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAAH indicators were compiled from the national HMIS. **Figures B.1.21 – B.1.29** show changes in utilization of health services in facilities.

FP

- The reported numbers of new (**Figure B.1.21**) and repeat (**Figure B.1.22**) clients who received injectable contraceptives was slightly higher in 2020 compared to the corresponding months of 2019.

Fig. B.1.21. Number of new clients who accepted injectable contraceptives

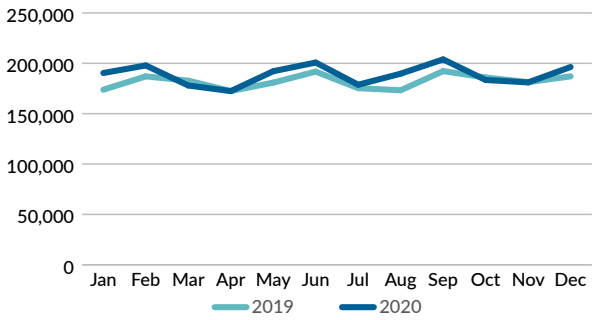
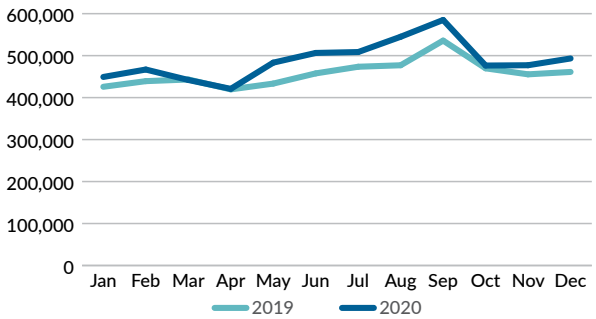


Fig. B.1.22. Number of repeat clients who accepted injectable contraceptives



Maternal and newborn health

- The reported number of pregnant women who had their first ANC visit was slightly lower in 2020 than throughout 2019 (**Figure B.1.23**).
- The reported number of births attended by skilled health personnel in health facilities in 2020 was similar to the number reported in 2019 (**Figure B.1.24**).
- The reported number of births by caesarean section increased in 2020 in comparison to the corresponding months of 2019 (**Figure B.1.25**).
- The reported number of women receiving PNC within the first 24 hours after birth was generally higher in 2020 than in 2019 (**Figure B.1.26**).

Fig. B.1.23. Number of pregnant women who received first ANC visit

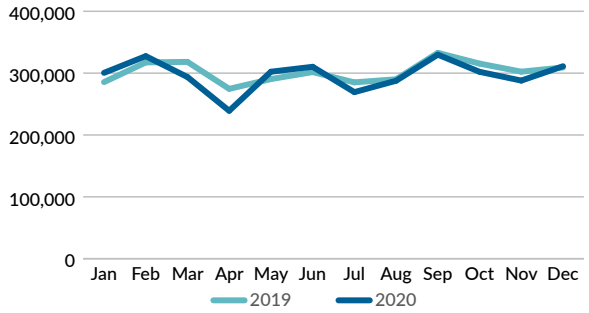


Fig. B.1.24. Number of births attended by skilled health personnel in health facilities

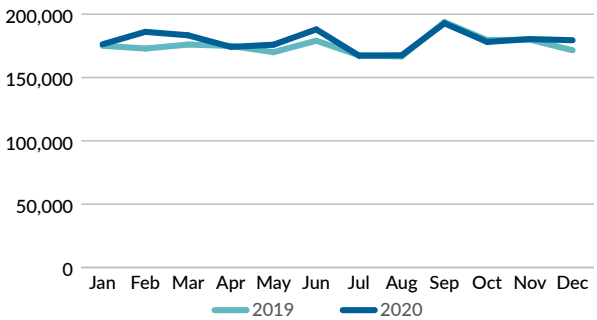


Fig. B.1.25. Number of caesarean births in health facilities

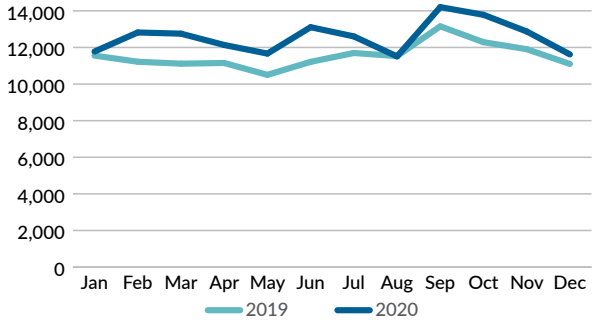


Fig. B.1.26. Number of women receiving PNC within first 24 hours of birth

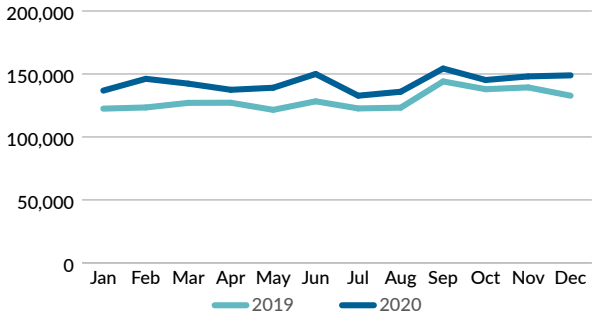


Fig. B.1.27. Number of children < 1 year of age receiving 3rd dose of pentavalent vaccine

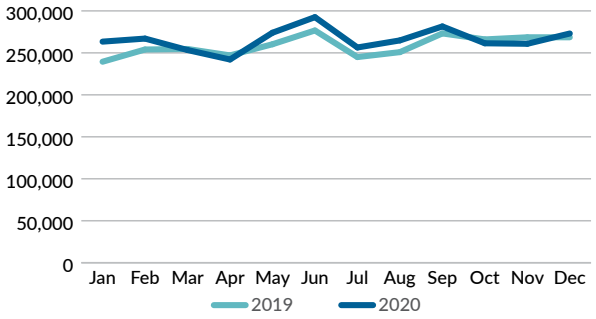
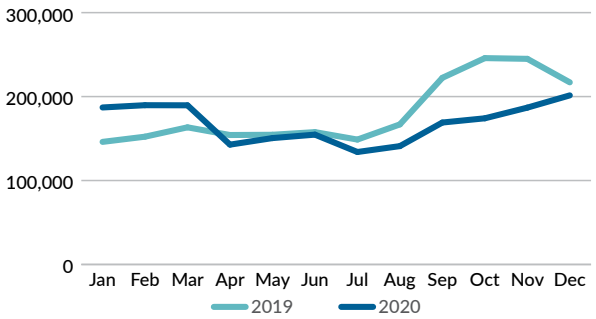


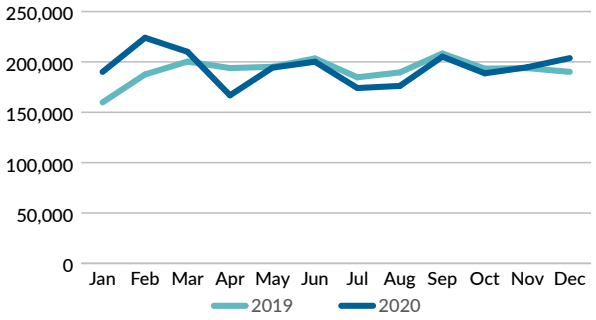
Fig. B.1.28. Number of children < 5 years of age treated for pneumonia



Child health and immunization

- The reported number of children less than 1 year of age receiving the third dose of pentavalent vaccine was slightly higher in 2020 in comparison to 2019 (**Figure B.1.27**).
- The reported number of children less than 5 years of age treated for pneumonia was lower from April to December 2020 than in the corresponding months of 2019 (**Figure B.1.28**).
- The reported number of children less than 5 years of age treated for diarrhoea with ORS and zinc was lower from April to November 2020 than in the corresponding months of 2019 (**Figure B.1.29**).

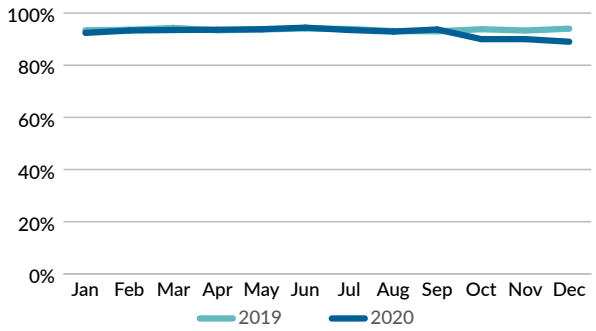
Fig. B.1.29. Number of children < 5 years of age treated for diarrhoea with ORS and zinc



Reporting completeness

- HMIS reporting completeness in 2020 was similar to 2019 for most months, with a slight decrease at the end of 2020 (**Figure B.1.30**).

Fig. B.1.30. Completeness of HMIS reporting (%)



F. Lessons learned

At the time of reporting, COVID-19 mitigation strategies were still being implemented and evaluated. In the early stages of implementation, however, there was concern that temperature screening was an insufficient COVID-19 mitigation measure. This was a perception for reasons such as dysfunctional thermal scanners, creating a false sense of reassurance/safety in the community and lack of training/capacity of those who screen and interpret temperature readings.

Elisabeth Ali, 25, provides skin-to-skin care to her low-birth-weight baby at a kangaroo mother care unit at Felege Hiwot Hospital in Bahir Dar, Ethiopia on 25 March 2021.

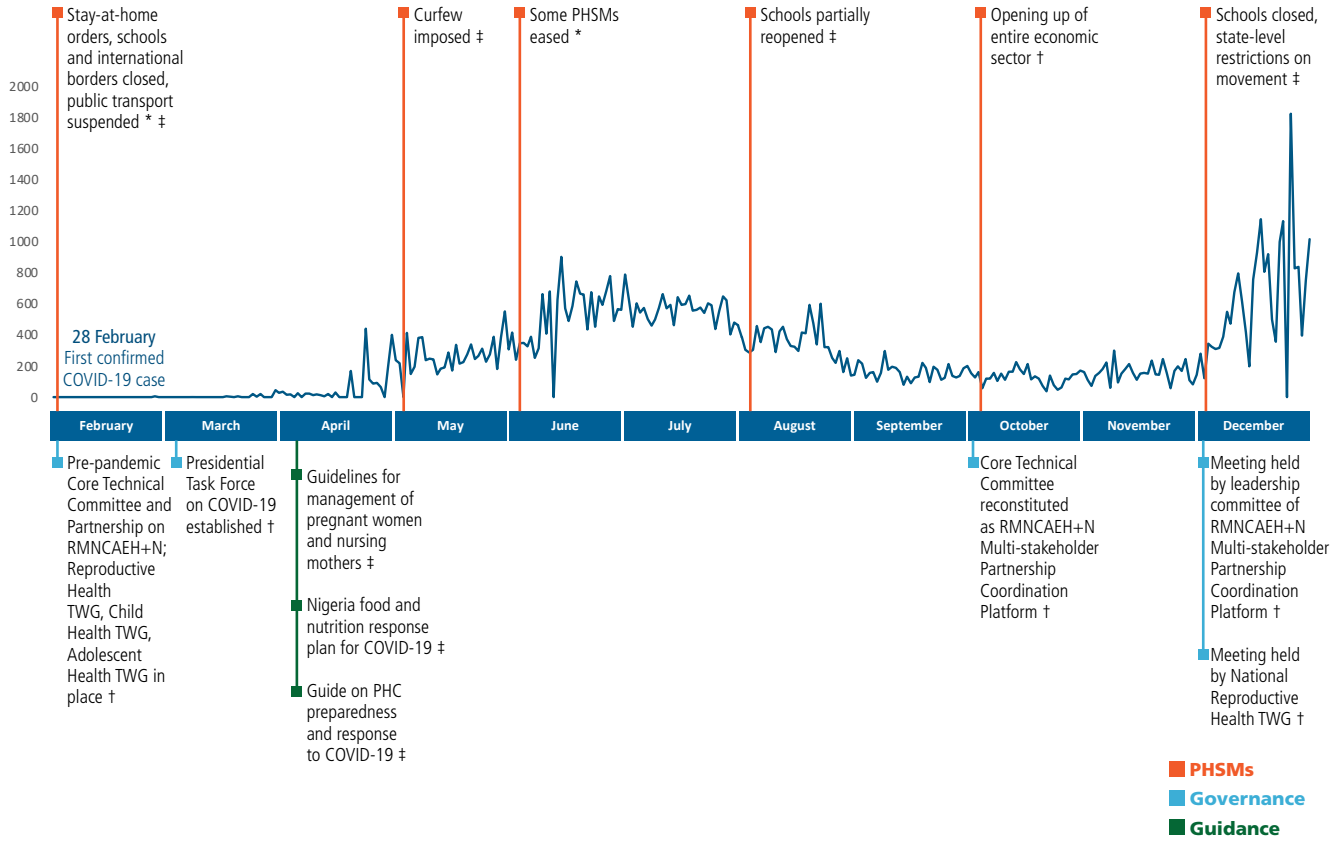
Photo credit: WHO / Blink Media - Hilina Abebe

Country report - Nigeria

A. The COVID-19 context

Nigeria reported its first case of COVID-19 at the end of February 2020. It implemented PHSMs and began developing coordination mechanisms and guidance for reproductive, maternal, newborn, child, adolescent and elderly health and nutrition (RMNCAEH+N) services from that time (see **Figure B.1.31**).

Fig. B.1.31. Reported COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place for continuing RMNCAEH+N services, 2020



Sources: * *(14)*; † National consultant reports; ‡ *(15)*.

B. National governance arrangements for decision-making on RMNCAEH+N services during COVID-19

A national RMNCAEH+N TWG with about 50 members was already established prior to the pandemic and had last met in March 2019.

During the initial lockdown, a core group of 18 leaders and experts from this TWG from the Department of Family Health and its partners in various RMNCAEH+N sectors drove processes. The group produced an initial draft of the RMNCAEH+N COVID-19 response plan, and the continuity of RMNCAEH+N services was their overall focus.

Coordinating bodies within different government agencies are responding to the COVID-19 pandemic. Relevant to the health sector are the:

- Presidential Task Force on COVID-19
- National COVID-19 IMT
- Expert Advisory Committee.

To ensure RMNCAEH+N interventions are integrated into national COVID-19 response plans, key actors sit on these coordinating bodies. For example, the chairperson of the RMNCAEH+N Multi-stakeholder Partnership Coordination Platform is also a member of the National COVID-19 IMT. The Expert Advisory Committee reports to the Chairperson of the Multi-stakeholder Partnership Coordination Platform and a member of the Presidential Task Force on COVID-19. The Director of Family Health, responsible for RMNCAEH+N nationally, is a member of the Expert Advisory Committee on COVID-19 which sits in the Ministry of Health. As of May 2020, all RMNCAEH+N focal persons at the state level were members of the COVID-19 state response team.

C. Guidance for RMNCAEH+N services in response to COVID-19

Nigeria has produced many guidelines related to maintaining essential services during the pandemic, as shown in **Table B.1.8**.

Table B.1.8. Guidance issued for RMNCAEH+N services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Nigeria food and nutrition response plan for the COVID-19 pandemic	April	
Guide on PHC preparedness and response for COVID-19	April	
Guidelines for pregnant women and nursing mothers	April	
Guidelines for management of pregnant women and nursing mothers	April	
RMNCAEH+N COVID-19 response continuity plan	April	
Nigeria self-care guidelines for sexual, reproductive and maternal health, 2020	In progress	
Draft guidelines for state procurement of FP commodities to standardize the subnational-level process for procurement	In progress	
Development of monitoring and evaluation framework for adolescent health and development	Nov	
Development of implementation plan for adolescent and youth health and development	Nov	
Development of operational guidance for continuity of essential services impacted by COVID-19. A practical guide for programme implementation and adaptation (developed with JHPIEGO)	Sept	
Return to field SOPs for community health interventions amid the COVID-19 pandemic in Nigeria (developed with the Malaria Consortium)	July	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAEH+N services

The actions taken to mitigate the effects of the COVID-19 pandemic on health services are described in **Table B.1.9**.

Table B.1.9. Mitigating actions to ensure continuity of RMNCAEH+N services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Extended prescriptions	FP
	"Last mile" distribution measures for FP commodities to ensure delivery of methods all the way to end users	FP
	FP dashboard developed to monitor and distribute adequate supplies of contraceptive commodities	FP
	Promotion of self-injecting contraception and LARC	FP
Transport for facilitating mobility	Waiver letters from Federal Ministry of Health to facilitate patient mobility to health facilities during lockdown	Cross-cutting
Health services adaptations	Health facility visits restricted to essential visits	Cross-cutting
	Scheduled appointments for women with suspected COVID-19	Maternal and newborn health
	Caregivers supported to self-diagnose and provide care for children at home	Child and adolescent health
	Scheduled appointments for immunization	Immunization
Service delivery settings	Task shifting/sharing using community HEWs to deliver certain RMNCAEH+N services	Cross-cutting
	Home visits by community health influencers, promoters and services programme to identify and treat abused children (in select states)	Child and adolescent health
Safe patient workflow	PPE for health workers, IPC in facilities	Cross-cutting
	Screening, triage and isolation of COVID-19-symptomatic patients	Cross-cutting
	Modifications for better ventilation in labour wards	Maternal and newborn health
	Masking of women in labour	Maternal and newborn health
Telehealth and digital technology	Online/virtual technology and text messages for meetings, training and reporting	Cross-cutting
	Text messaging to provide psychosocial support and mental wellness for families	Cross-cutting
	Social media, digital platforms and hotlines for advice and access to RMNCAEH+N services for pregnant women, mothers and girls	Maternal and newborn health Child and adolescent health
	Mobilization of commercial digital marketing platform (Konga) for home delivery of contraceptives to women, follow-up and referral (Society for Family Health-DIST Project, initially free)	FP

	MITIGATING ACTION	SERVICE AREA
Optimizing workforce capacity	Additional front-line health workers recruited and trained to provide RMNCAEH+N services	Cross-cutting
	Government incentive pay for health workers	Cross-cutting
	Palliative packages to support and motivate health care providers	Cross-cutting
	Training health workers on FP, social and behaviour change communication materials, Integrated Management of Childhood Illness (IMCI), IPC measures in facilities and GBV	FP GBV Nutrition Child and adolescent health
	Training of health workers, pharmacists, medicine vendors and community pharmacists on LARC, DMPA	FP
Communications strategies	Broadcast messages and awareness raising by nongovernmental organizations (NGOs)/community groups on accessing essential RMNCAEH+N services and immunization	Cross-cutting
	Religious/community leaders mobilized to facilitate community health interventions in some areas	Cross-cutting
	Youth peer networks provide health information through various media	Cross-cutting Child and adolescent health
	Outreach activity on FP services (select states)	FP
	Public messaging for families on maintaining nutritional status with home-grown foods	Nutrition

E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAEH+N indicators were compiled from the national HMIS. **Figures B.1.32 – B.1.39** show changes in utilization of health services in facilities reporting to the HMIS.

FP

- The reported number of oral contraceptives dispensed in 2020 was higher for most months of 2020 in comparison to the corresponding months of 2019 (**Figure B.1.32**).
- The reported number of injectable contraceptives dispensed in 2020 was higher for all months compared to the corresponding months of 2019, except for May (**Figure B.1.33**).

Fig. B.1.32. Oral contraceptive pills dispensed

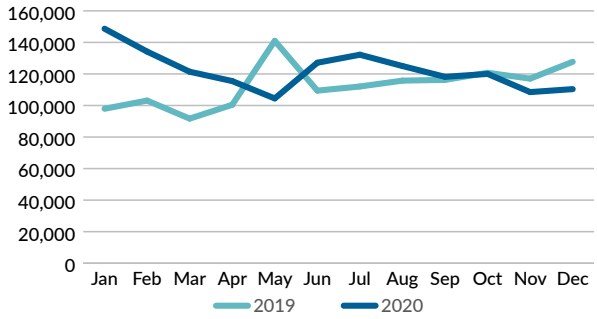
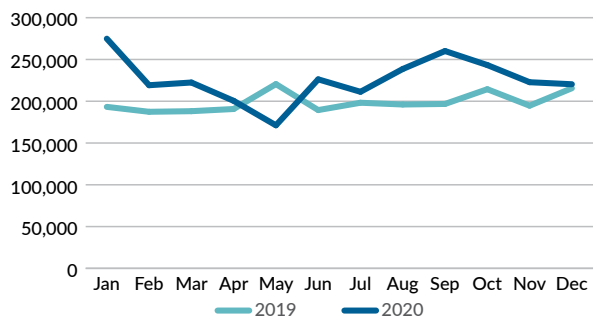


Fig. B.1.33. Injectable contraceptives dispensed



Maternal and newborn health

- The reported numbers of ANC visits and facility births were lower in 2020 in comparison to almost all of the corresponding months of 2019 (**Figures B.1.34 and B.1.35**).
- The percentage of births by caesarean section in 2020 was very similar to 2019 (**Figure B.1.36**).
- The percentage of women who received PNC within one day of birth was slightly lower in most months of 2020 than in the corresponding months of 2019 (**Figure B.1.37**).

Fig. B.1.34. Number of ANC visits

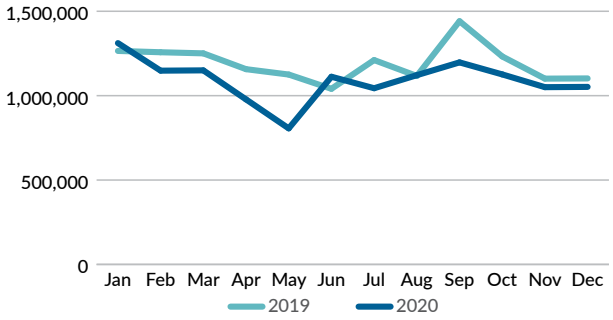


Fig. B.1.35. Number of facility births

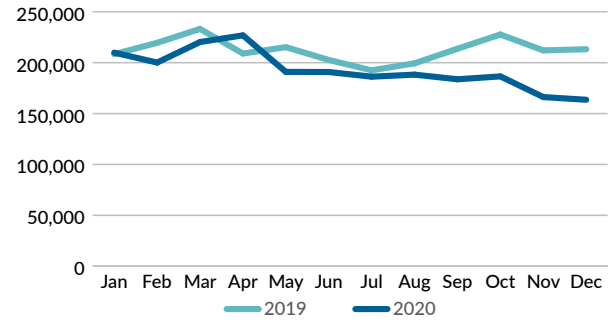


Fig. B.1.36. Percentage of caesarean births

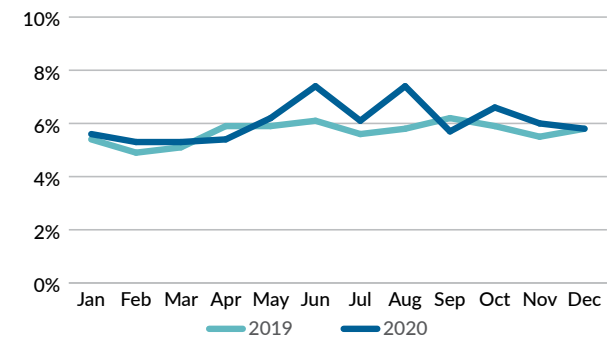
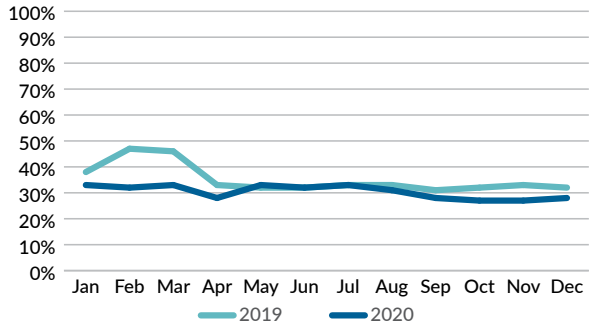


Fig. B.1.37. Percentage of women who received PNC within 1 day of birth



Child health and immunization

- The reported number of children less than 1 year of age receiving the third dose of pentavalent vaccine decreased in 2020 in comparison to the corresponding months of 2019. However, it returned to similar levels by the end of 2020 (**Figure B.1.38**).
- The reported number of children less than 5 years of age with pneumonia who were given antibiotics was lower throughout 2020 than in 2019 (**Figure B.1.39**).

Fig. B.1.38. Number of children < 1 year of age receiving 3rd dose of pentavalent vaccine

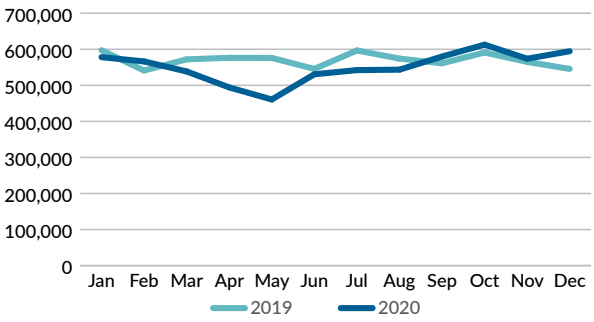
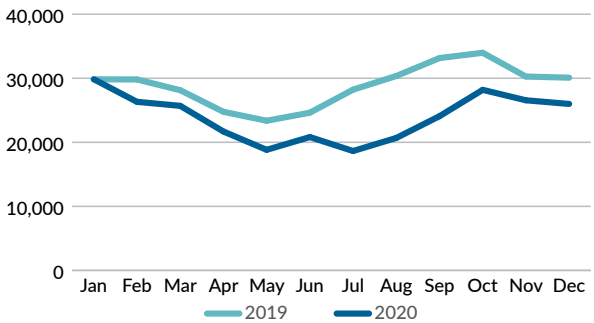


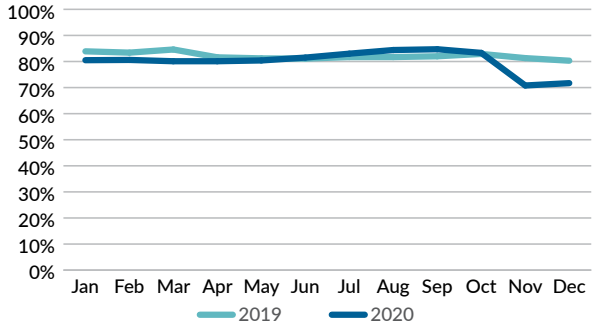
Fig. B.1.39. Number of children < 5 years of age with pneumonia given antibiotics



Reporting completeness

- HMIS reporting completeness was slightly lower in several months of 2020 than in 2019 (**Figure B.1.40**), which should be considered when interpreting changes in utilization of health services.

Fig. B.1.40. HMIS monthly summary reporting rate (%)



F. Modelling

WHO, UNICEF and UNFPA developed guidance on *Modelling the health impacts of disruptions to essential health services during COVID-19 (12).* The guide provides an overview and description of modelling methods. Used in Nigeria, the risk-benefit modelling demonstrated the benefits of maintaining essential RMNCAEH+N services compared to the risk of acquiring COVID-19 infection.

- **Number of lives lost due to the COVID-19 pandemic.** Approximately 17 622 lives were lost due to the disruption of EHS, including RMNCAEH+N services, during the height of the COVID-19 pandemic in April to July 2020. The majority of lives lost were children (17 174), amongst whom 4526 were newborns. Most child lives lost were a result of reduced provision of newborn care. An estimated 447 maternal lives were also lost as a result of the COVID-19 pandemic.

- **Number of lives saved due to increased coverage due to mitigation measures.** In 2021, 67 784 lives could be saved with an increase in coverage of RMNCAEH+N services triggered by the mitigation measures implemented. This includes 66 088 children's (of these, 15 041 neonatal) and 1696 maternal lives.

- **Numbers of lives lost due to excess risk of infection.** Results from this modelling exercise indicate that 589 lives could be lost due to excess COVID-19 infections acquired because of attendance at health facilities. These infections may be a result of interactions with health care providers or other attendants, or contacts made en route to the health facility.

- **Overall results.** The overall benefit-risk ratio from this exercise was found to be 113.4 which means that for every 113.4 lives saved due to increased RMNCAEH+N coverage, there was one related COVID-19 death. The highest benefit-risk ratios were for newborn care and FP (599.5 and 491.9 respectively).

G. Lessons learned

At the time of reporting, all COVID-19 mitigation strategies were still being implemented and evaluated. In the early stages of implementation, however, it was observed that virtual training was not effective for personnel with a low level of technological skills and experience. Virtual training also presented challenges in areas with poor internet access.

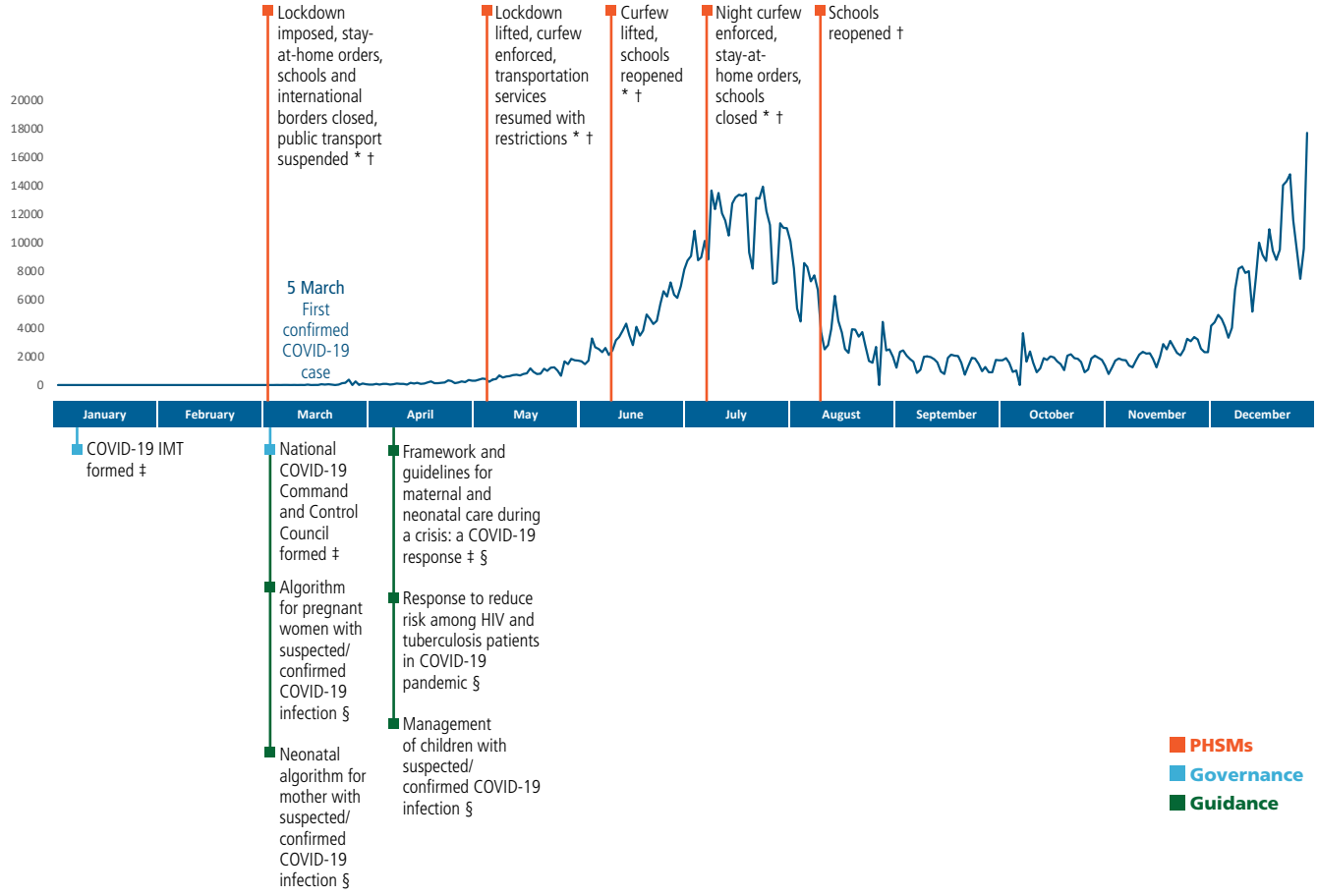
Photo credit: Eromosele Ogbeide, WCO Nigeria Communications Photographer

Country report - South Africa

A. The COVID-19 context

The first case of COVID-19 in South Africa occurred in March 2020 (see **Figure B.1.41**), while an IMT had been in place since January. PHSMs and guidance related to reproductive, maternal, newborn, child and adolescent health (RMNCAH) services during the pandemic were implemented over the course of the year.

Fig. B.1.41. Reported COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place for continuing RMNCAH services, 2020



Sources: * *(14)*; † *(15)*; ‡ National consultant reports; § *(7)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAH services during COVID-19

On 30 January 2020, more than one month before the first case of COVID-19 in the country was announced, the Ministry of Health established a COVID-19 IMT. A National COVID-19 Command and Control Council was also established by the national cabinet on 15 March 2020 for intergovernmental coordination and government-wide decision-making.

A high-level, multidisciplinary TWG was rapidly formed to guide and maintain the continuity of RMNCAH services. The TWG included members from academia, civil society, the Ministry of Health, clinicians, managers and policy-makers. The TWG was able to set policy and guidelines to ensure coherent implementation, including the creation of the *Framework and guidelines for maternal and neonatal care during a crisis: COVID-19 response (18)* in April 2020. The aim of this document was to facilitate communication and provide information for all levels of RMNCAH care in a crisis. The guidelines continue to be updated monthly and are a resource for both professionals and the public. The document also contains a checklist and dashboard which help groups and individuals ensure they complete the recommended tasks/actions.

The TWG also developed new COVID-19 algorithms for RMNCAH, including:

- pregnant women (ANC, COVID-19-positive women in labour, specific patient scenarios with management guidance);
- managing newborns (of well and unwell mothers);
- management of children with suspected/confirmed COVID-19;
- health services guidelines for provincial, district, facility and clinical managers, including a plan for data collection and PPE.

C. Guidance for RMNCAH services in response to COVID-19

Table B.1.10 shows the various guidelines that South Africa produced to help in maintaining essential RMNCAH services during the pandemic.

Table B.1.10. Guidance issued for RMNCAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Response to reduce risk among HIV and tuberculosis patients within the context of the COVID-19 pandemic: the South African response to COVID-19	April	
COVID-19 maternal and newborn care guidelines	April	
Key national guidelines for care of COVID-19 patients covered by RMNCAH services	**Month (2020)**	**Content**
Pregnant women COVID-19 algorithm	March	
Neonatal algorithm for mother with suspected/confirmed COVID-19 infection	March	
Management of children with suspected/confirmed COVID-19 infection	April	

D. Key actions to ensure continuity of RMNCAH services

South Africa took various actions to mitigate the effect of COVID-19 on relevant health services (**Table B.1.11**).

Table B.1.11. Mitigating actions to ensure continuity of RMNCAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Promotion of LARC, reinforced through public-private partnerships	FP
	Household delivery of antiretroviral treatment (ART) and community centre lockers for collecting ART	HIV
	Enhanced monitoring of vaccination supplies	Immunization
	Nutritional supplements procured and issued for longer periods, typically a month or more	Nutrition
Health services adaptations	Pregnant women referred for assessment by a midwife/doctor by 34 weeks gestation	Maternal and newborn health
	Catch-up immunization drives in all provinces	Immunization
	IMCI adapted to include immunization whenever a child presents to the clinic	Immunization
	Integration of mid-upper arm circumference (MUAC) screening with COVID-19 screening (select states)	Nutrition
	Follow-up visits reduced to 1 or 2 per month for children with uncomplicated severe or moderate wasting	Nutrition
	School nutrition programmes continued in face of school closures	Nutrition
	Strengthened linkages and referral to differentiated service delivery of recovered severe acute malnutrition (SAM) and active moderate acute malnutrition cases through social workers	Nutrition
Service delivery settings	CHWs conducting COVID-19 screening identify and refer pregnant teens as well as children who have missed immunization services	Maternal and newborn health Immunization
	Primary and community health centres provided greater access to ANC, FP, termination of pregnancy and immunization services	Maternal and newborn health FP Immunization
	Mobile units provided additional contraception and HIV services during lockdown	FP
	DREAMS programme for monitoring HIV indicators expanded for children less than 15 years (DREAMS is a multicounty flagship programme to address key factors that make girls and women particularly vulnerable to HIV)	HIV
	Reinforced community case finding, treatment initiation and medicine delivery for HIV-affected patients	HIV

	MITIGATING ACTION	SERVICE AREA
Safe patient workflow	IPC measures enforced in facilities and while conducting anthropometric measurements, PPE for staff and clients	Cross-cutting
	Spatial reorganization of beds in labour and postpartum wards	Maternal and newborn health
	Triage, screening and isolation algorithms for pregnant women, newborns and children with suspected/confirmed COVID-19	Maternal and newborn health Child and adolescent health
Telehealth and digital technology	MomConnect linked to HealthWorker Alert (part of HealthConnect mobile health services) to provide front-line staff with psychosocial support and updated service delivery information	Cross-cutting
	Training via virtual platform (Knowledge Hub SA) for SRH, IMCI, EPI and anthropometric measurement	Cross-cutting
	Virtual communications technology used by National Department of Health (NDOH) to support and provide technical guidance to provinces, partners and front-line workers	Cross-cutting
	MomConnect (NDOH mobile health programme for ANC and maternal health) platform linked to other services for early ANC booking, reminder messaging, facility status information and referral	Maternal and newborn health
	Teleconsultations for FP services through NGO platforms	FP
	Online sessions provided technical support for poor-performing districts/facilities in addressing children with acute malnutrition	Nutrition
	Virtual/teletraining and support for caregivers managing older people with dementia and other chronic mental health conditions	Older people
Optimizing workforce capacity	Recruitment of additional retired and contract staff, e.g. Cuban doctors	Cross-cutting
	Suspension of redeployment/rotation of staff in obstetric or newborn/neonatal facilities, wards or clinics to other wards/clinics	Maternal and newborn health
	Psychosocial support and information for staff through HealthConnect app/HealthWorker Alert	Maternal and newborn health
	Midwifery staff redeployed to facilities with greatest needs	Maternal and newborn health
Communication strategies	Broadcast and social media campaign for health messaging on breastfeeding and service continuity for immunization, child health and nutrition, SRH and ANC	Maternal and newborn health Child and adolescent health Immunization Nutrition

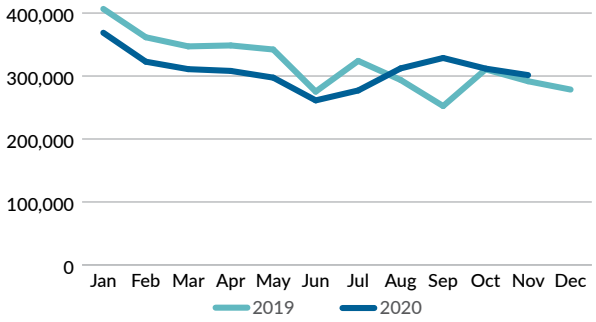
E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAH indicators were compiled from the national HMIS. **Figures B.1.42 – B.1.48** show changes in utilization of health services in facilities reporting to the HMIS. (Note that figures do not have data for December 2020.)

FP

- The reported number of clients who received oral contraceptives was lower in most of 2020 than in the corresponding months of 2019, but returned to similar levels by the end of 2020 (**Figure B.1.42**).

Figure B.1.42. Number of clients who accepted oral contraceptives



Maternal and newborn health

- The reported number of ANC contacts was slightly higher in 2020 in comparison to 2019 (**Figure B.1.43**).
- The percentage of facility births in 2020 was similar overall to that in 2019 (**Figure B.1.44**).
- The reported number of women receiving PNC six days after birth was higher in 2020 than in 2019 for January to March before the pandemic, but then lower than 2019 for most of the rest of 2020 (**Figure B.1.45**).

Fig. B.1.43. Number of ANC visits/contacts provided

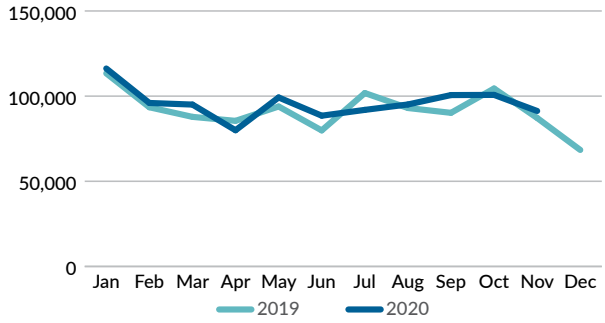


Fig. B.1.44. Percentage of births in health facilities

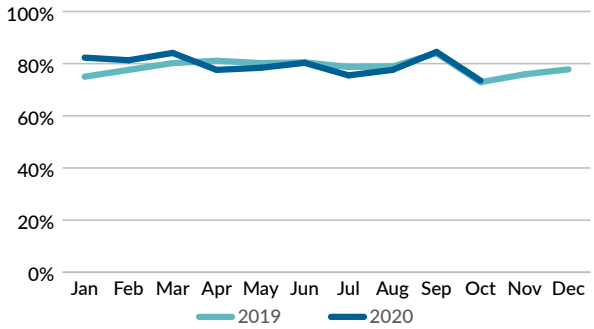
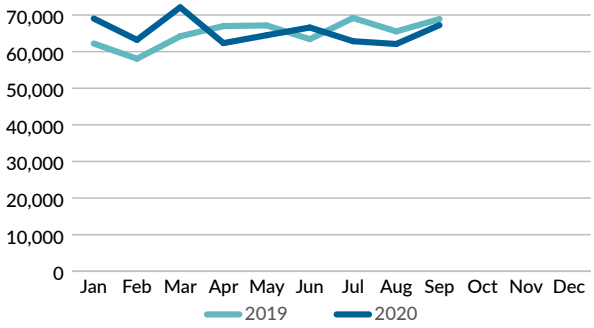


Fig. B.1.45. Number of women receiving PNC within 6 days after birth



Child health and immunization

- The reported number of children less than 1 year of age receiving the third dose of the hexavalent vaccine in April 2020 was lower than in 2019, but returned to similar numbers by June (**Figure B.1.46**).

- The reported number of children less than 5 years of age with new cases of pneumonia and diarrhoea with dehydration was much lower from April to September 2020 than the corresponding months of 2019, but began to increase by the end of 2020 (**Figures B.1.47** and **B.1.48**).

Fig. B.1.46. Number of children < 1 year of age receiving 3rd dose of hexavalent vaccine

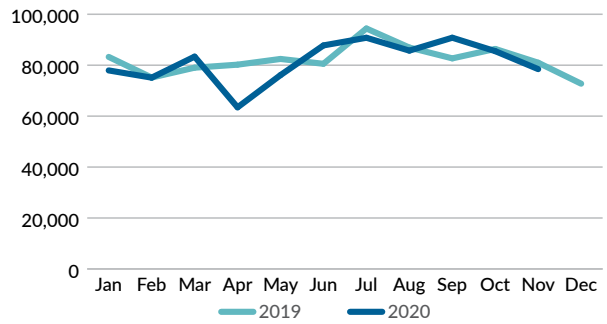


Fig. B.1.47. Number of new cases of pneumonia among children < 5 years of age

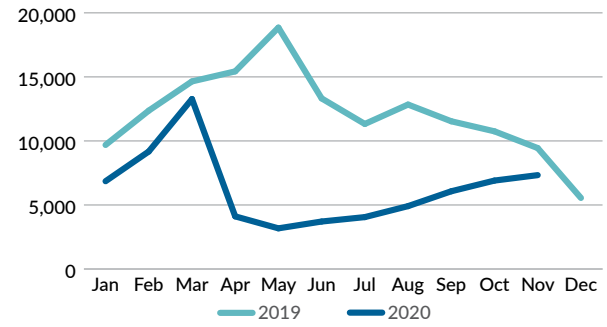
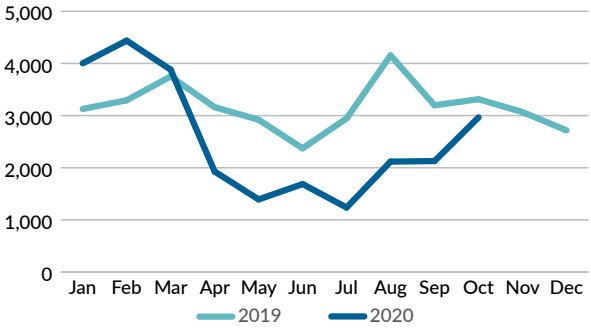


Fig. B.1.48. Number of new cases of diarrhoea with dehydration in children < 5 years of age



F. Lessons learned

- Leaving provinces/subnational level systems to develop their own strategies risks an incoherent response. Multiple and differing subnational strategies resulted in uncoordinated efforts not informed by current evidence from the NDOH. This may have resulted in facility closure, inadequate PPE and communication gaps.
- Provinces with strong clinical governance adapted better and provided higher-quality services than other provinces.
- Introducing resource-intensive strategies during a pandemic can be unsustainable. For example, mobile units for service provision were proposed and tried but were not sustainable due to lack of funding.

Nurse Nosipho Khanyile dons her PPE before entering the "Red Zone" at the special COVID-19 Field Hospital in Nasrec, Johannesburg.

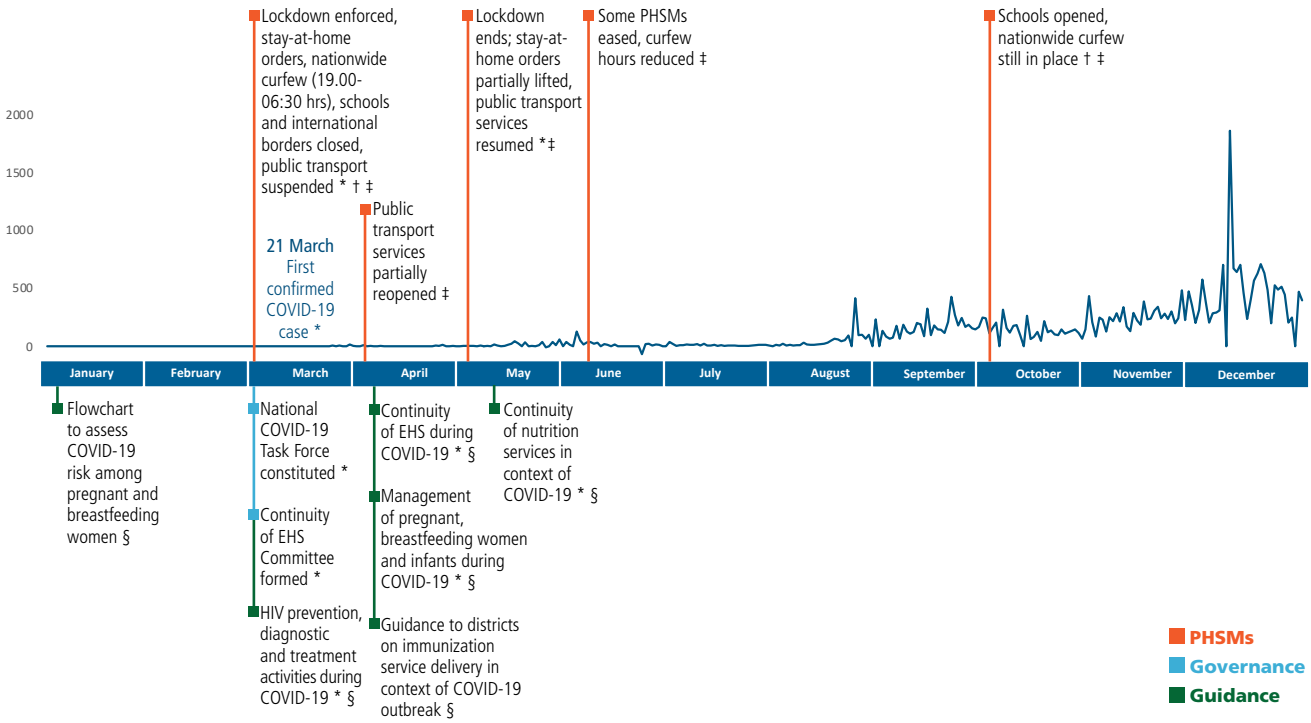
Photo credit: IMF Photo/James Oatway

Country report - Uganda

A. COVID-19 context

Uganda reported its first COVID-19 case in March 2020, numbers stayed low until August, and peaked in December (**Figure B.1.49**). PHSMs to control the effect of the pandemic were ongoing throughout the year.

Fig. B.1.49. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place for continuing RMNCAAH services

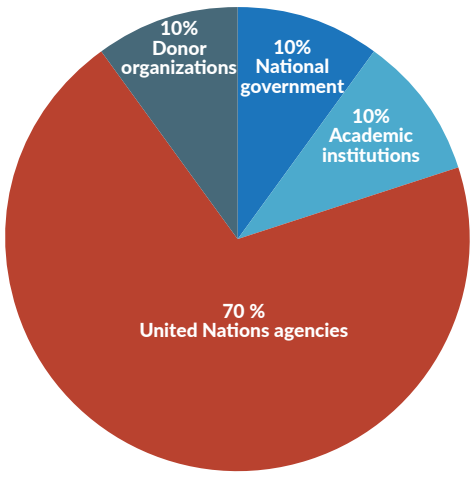


Sources: * National consultant reports;† *(14)*; ‡ *(15)*;§ *(7)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

A multisectoral National COVID-19 Task Force (NTF) was set up soon after the first lockdown measures were put into place and covers all EHS. The NTF meets twice a week. It has over 60 members, some of whom are also members of the National COVID-19 IMT. **Figure B.1.50** describes the distribution of NTF members by agency. A third-party report published in July 2020 stated that 22.5% of key response committee members were women, and that the most influential positions were held by men *(19)*.

Fig. B.1.50. Distribution of Uganda National TWG members, by agency



The NTF is organized around eight pillars, one of which is the Continuity of essential health services (CEHS). The CEHS committee prioritized certain EHS, including those related to RMNCAAH. Data from the national and district HMIS on RMNCAAH service delivery and utilization are presented to the Ministry of Health on a monthly basis.

Within the Ministry of Health, a number of TWGs were in existence before the pandemic, including ones for FP, safe motherhood, newborn and adolescent health. The pandemic response strengthened those TWGs. In December 2020, the Ministry of Health agreed to form a TWG for the ageing population's health as well. TWGs prioritized the continuity of RMNCAAH services during the pandemic.

District COVID-19 Task Forces are functional in each district with dedicated work plans and budgets for EHS; task forces meet on a weekly basis. Many districts also included MCH and HIV focal persons on their task forces. The District Task Forces supported the community COVID-19 Task Forces, particularly the Village Task Forces, to enforce adherence to Ministry of Health guidelines in the community.

C. National guidance for RMNCAAH services in response to COVID-19

Uganda has produced several guidance documents to help protect health services during the pandemic, as shown in **Table B.1.12**.

Table B.1.12. Guidance issued for RMNCAAH services*

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Flowchart to assess COVID-19 risk among pregnant and breastfeeding women	Jan	
COVID-19 IPC guidelines for HIV service delivery	March	
Guidance on continuity of EHS during the COVID-19 outbreak	April	
Guidance on care during pregnancy, childbirth and PNC in the context of COVID-19	April	
Guidance on continuation of immunization services during the COVID-19 outbreak	April	
COVID-19 IPC guidance for HIV and tuberculosis service delivery	April	
Guidance for a revised implementation of Integrated Community Case Management of Childhood Illnesses during the COVID-19 outbreak	April	
Guidance on continuity of nutrition services in the context of COVID-19	April	
Guidance for the integrated management of acute malnutrition in the context of COVID-19	April	
Guidance for SRH and rights: access to modern contraceptives in the context of COVID-19	April	
Guidelines on provision of SRH, HIV and GBV services in the context of COVID-19	April	
Interim guidelines for continuity of care and wellbeing of adolescents and young people during the COVID-19 outbreak	April	
Home-based care and continuity of EHS in the face of the COVID-19 pandemic	April	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

* All listed national guidelines were developed at the same time by the respective TWGs and integrated into one document, the *National continuity of essential health services guidelines* which were published and disseminated in April 2020.

D. Key actions to ensure continuity of RMNCAAH services

As well as developing the guidance described above, Uganda took several actions to mitigate the effect of the pandemic on the continuity of health services (**Table B.1.13**).

Table B.1.13. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Enhanced monitoring, procurement and redistribution of FP commodities to areas with stock-outs	FP
	Increased community-based condom dispensers	FP
	Extended prescriptions for FP and multi-month dispensing of antiretroviral drugs	FP
	Delivery of antiretroviral drugs through alternative community differentiated service delivery models	HIV
	Reinforced support for monitoring and procurement of RMNCAAH commodities	HIV
Transport for facilitating mobility	Phone details distributed to local community leaders for arranging emergency access to transport	Cross-cutting
	Transport voucher eligibility criteria widened (select areas)	Cross-cutting
	Car and motorcycle taxis (*boda boda*) for emergency transport for pregnant and postpartum mothers, newborns and children to health facilities	Maternal and newborn health Child and adolescent health
Health services adaptations	PNC integrated into EPI outreach	Maternal and newborn health
	Reduced patient numbers (2 or 3) for group ANC visits	Maternal and newborn health
	Early child violence detection tool developed for districts with high levels of reported GBV	Child and adolescent health GBV
	FP services integrated into other health services, including: postpartum, young child and ART clinics, and community ART delivery	FP
	GBV screening and referral integrated into immunization, ANC, PNC and outreach service delivery points	GBV
	Expanded immunization outreach and mobilization of additional delivery partners	Immunization

	MITIGATING ACTION	SERVICE AREA
Service delivery settings	Lower-level health facilities mandated to provide FP services	Cross-cutting
	Mobile clinics and door-to-door SRH and GBV services for women, adolescents and young people	Cross-cutting GBV
	Special child clinics for MCH and HIV services to reduce congestion	Maternal and newborn health Child and adolescent health HIV
	Community delivery of ANC and PNC services for women living with HIV	Maternal and newborn health HIV
	Community outreach activities for adolescents on SRH, HIV counselling and testing, ANC, contraception, condom distribution and human papilloma virus immunization	Child and adolescent health
	Direct delivery of condoms by motorbike taxis to Community Health Agents, pharmacies and users	FP
	Home-based HIV care for psychosocial support, ART adherence counselling, routine viral load monitoring	HIV
	Outdoor settings and door-to-door delivery of immunization services	Immunization
Safe patient workflow	IPC measures and PPE for health workers, FP users and group ANC participants	Cross-cutting
	Triage, screening and isolation to identify COVID-19 symptomatic patients at facilities	Cross-cutting
Telehealth and digital technology	Social media platforms, e.g. WhatsApp, used by youth peers to advocate for contraceptive use among adolescent girls and young women	Child and adolescent health
	Online training of FP providers by civil society organizations	FP
	Psychosocial and ART adherence counselling via phone and WhatsApp for adolescents and mothers, and text message appointment reminders	HIV
Optimizing workforce capacity	Transport for health workers organized where needed	Cross-cutting
	Improvisation of overnight lodging facilities for health workers in some districts	Cross-cutting
	Training of trainers in EHS	Cross-cutting
	Daily risk allowance for health workers	Cross-cutting
Communications strategies	Door-to-door and community outreach to encourage timely medical care-seeking among women, refugees	Cross-cutting
	Community outreach by peers and experts to provide FP information and counselling in some districts	Cross-cutting
	Regional broadcast channels to raise awareness on how to access FP services	FP

In addition to completing monthly information exchange forms to document mitigation actions, consultants affiliated to the Makerere University School of Public Health conducted key informant interviews with technical area experts focusing on strategies and innovations implemented to ensure the continuity of health services during the pandemic. The interviews were conducted in October and November 2020 and included a total of seven respondents from the Ministry of Health, United States Agency for International Development and implementing partners. Respondents provided information on specific measures taken to address FP, maternal, child, adolescent and ageing health and cross-cutting issues, along with their perspectives on strategies implemented to mitigate the indirect impact of COVID-19 on essential services. The full report, *Measures used to mitigate the indirect impacts of COVID-19 on maternal, newborn, child, and adolescent and ageing health (MNCAAH) services in Uganda: report of expert interviews*, is available from the WHO Country Office for Uganda.

E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAAH indicators were compiled from the national HMIS. **Figures B.1.51 – B.1.59** show changes in utilization of health services in facilities reporting to the HMIS.

FP

- The reported number of clients who received oral contraceptives decreased from March to June 2020, but recovered to numbers similar or higher than 2019 by July (**Figure B.1.51**).
- The reported number of clients who received injectable contraceptives increased in May 2020 and remained higher than in the corresponding months of 2019 for the rest of the year (**Figure B.1.52**).

Fig. B.1.51. Number of clients who accepted oral contraceptives

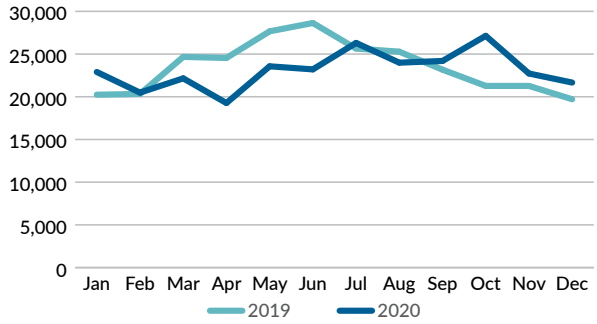
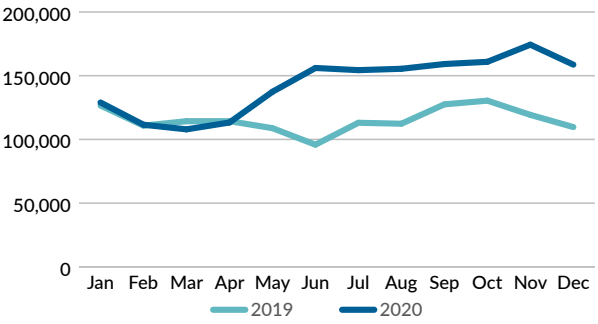


Fig. B.1.52. Number of clients who accepted injectable contraceptives



Maternal and newborn health

- The reported numbers of ANC contacts (**Figure B.1.53**) and facility births (**Figure B.1.54**) were similar in 2020 and 2019, and slightly higher in 2020 for the second half of the year.
- The percentage of births by caesarean section was similar in 2020 and 2019 (**Figure B.1.55**).
- The percentage of women receiving PNC was higher in 2020 than in 2019 (**Figure B.1.56**).

Fig. B.1.53. Number of ANC visits/contacts provided

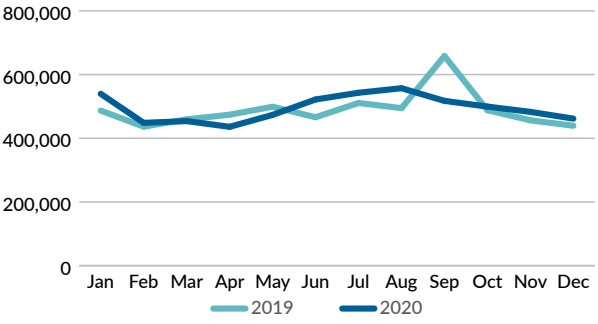


Fig. B.1.54. Number of facility births

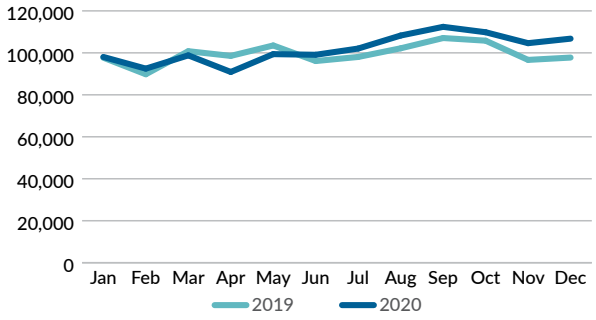


Fig. B.1.55. Percentage of caesarean births

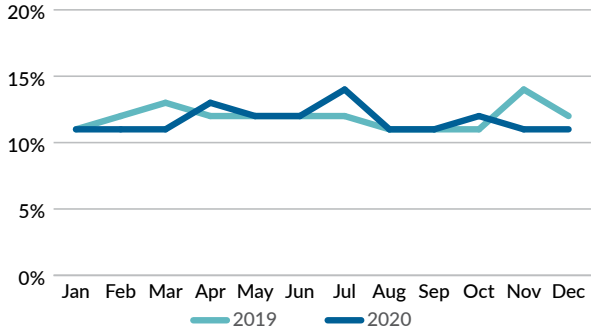
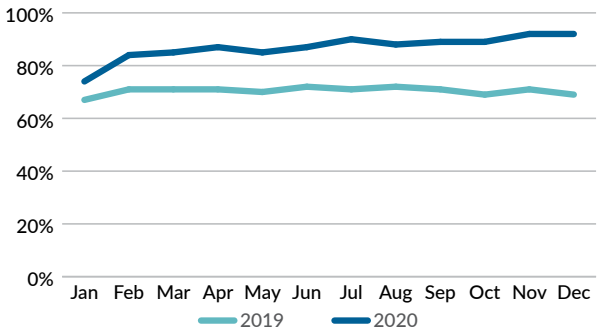


Fig. B.1.56. Percentage of women receiving PNC



Child health and immunization

- The reported number of children less than 1 year of age receiving the third dose of DPT vaccine was lower in 2020 than in 2019 (**Figure B.1.57**). The largest drop was in April 2020, but the numbers of children receiving the vaccine had increased somewhat by June.

- The reported number of children less than 5 years of age treated for diarrhoea was lower from January to August 2020 than the corresponding months of 2019, but increased again by the end of 2020 (**Figure B.1.58**).

- The reported number of consultations for children less than 5 years of age for any cause was lower from April to November 2020 compared to the corresponding months of 2019 (**Figure B.1.59**).

Fig. B.1.57. Number of children < 1 year of age receiving 3rd dose of DPT vaccine

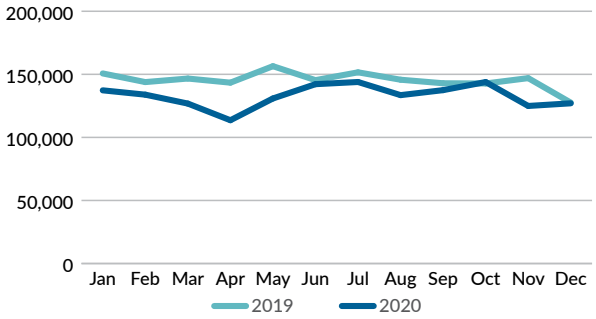


Fig. B.1.58. Number of children < 5 years of age diagnosed and treated for diarrhoea

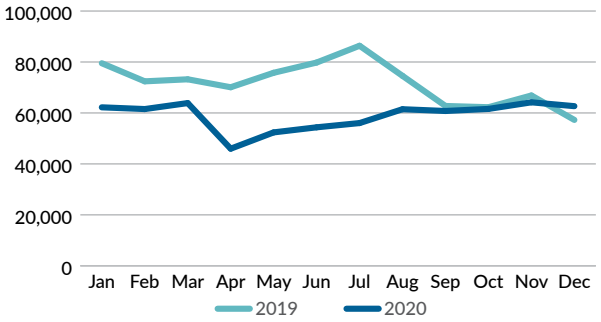
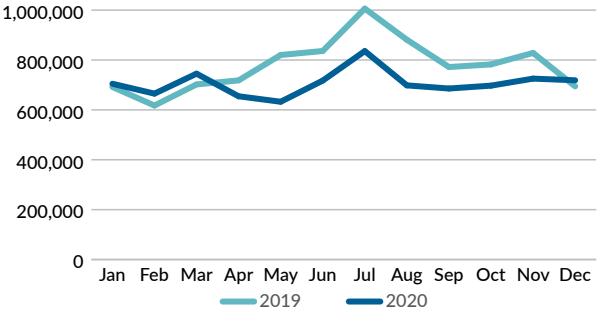


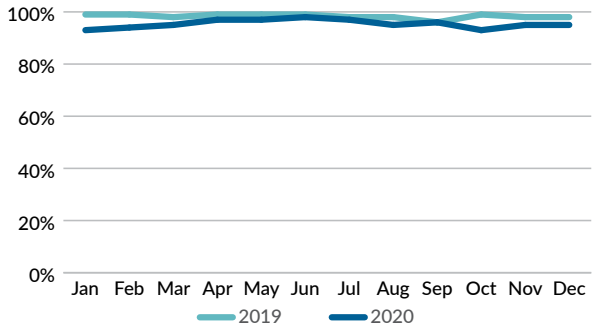
Fig. B.1.59. Number of consultations for children < 5 years of age for any cause



Reporting completeness

- HMIS reporting completeness decreased slightly in 2020 compared to 2019 (**Figure B.1.60**), which should be considered when interpreting changes in utilization of health services.

Fig. B.1.60. Completeness of HMIS reporting (%)



F. Lessons learned

- Lockdowns and limited transport made travel for women and children very difficult. In the future, an alternative means of transport should be available for these groups from the start of a pandemic response.

- CHWs should have been involved in earlier stages of the COVID-19 response. The delay meant community-level input into the planning and delivery of health services came late.

- Similarly, the failure to use bottom-up approaches in designing and rolling-out strategies meant community members were not involved from the beginning of the response. This hampered community buy-in to the interventions. Going forward, community members should be involved in the design and planning of mitigation strategies (i.e. transport).

Uganda: assisting refugees in times of COVID-19.
Photo credit: © European Union, 2021 (photographer: Mathias Eick)

B.2 Region of the Americas

Both countries in the Region of the Americas that participated in the Initiative did so at the subnational level – El Alto Municipality in the Plurinational State of Bolivia, and Pelotas and São Luís Municipalities in Brazil.

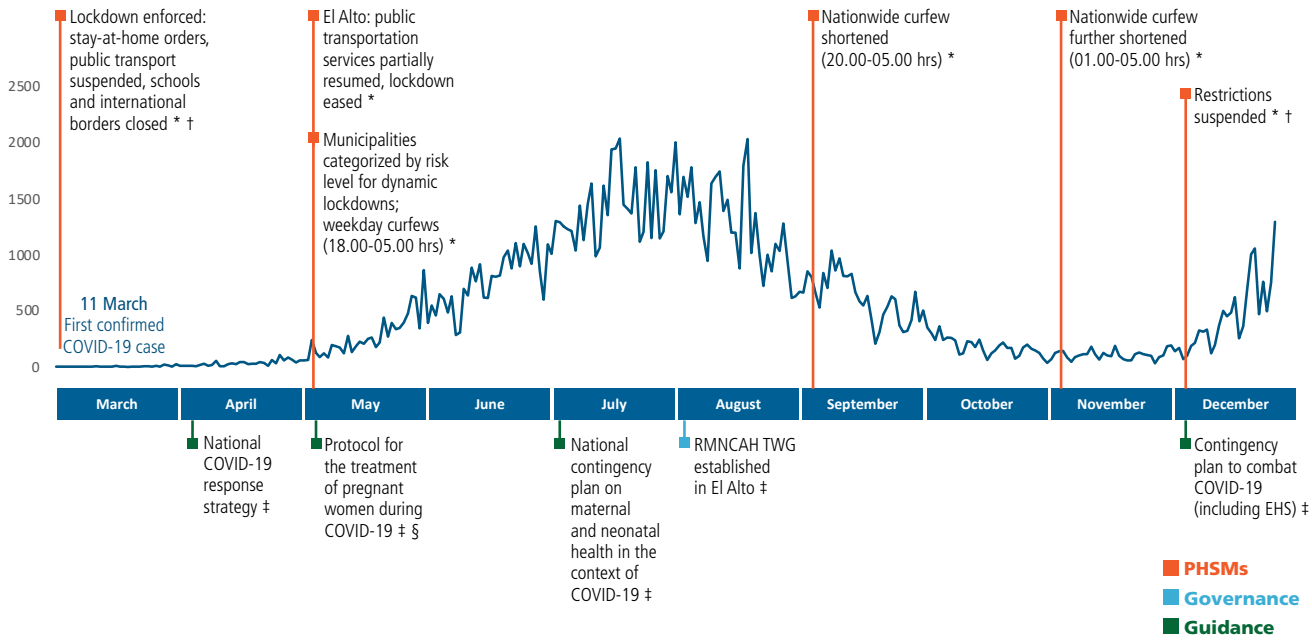
Country report
The Plurinational State of Bolivia

This report covers El Alto Municipality which is located in the Pedro Domingo Murillo Province in the La Paz Department. El Alto is organized in five networks of health services.

A. The COVID-19 context

The first confirmed COVID-19 case was reported in El Alto in March 2020, with cases increasing through July and August, then declining and rising again towards the end of the year (**Figure B.2.1**). Measures were put in place over this time to contain the pandemic.

Fig. B.2.1. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place for continuing RMNCAH services



Sources: * *(15)*; † *(14)*; ‡ National consultant reports; § *(7)*; First Case + Epi Curve: https://covid19.who.int/.

B. Governance arrangements for decision-making on RMNCAH services during COVID-19

In response to the pandemic, El Alto established a TWG for RMNCAH services. The 28 members represented national and regional governments, the private health sector, academia, civil society, professional associations and United Nations bodies.

Meetings were held when deemed necessary and according to staff availability. The TWG periodically used WhatsApp to communicate among members and take decisions.

TWG meeting agendas were agreed between the Pan American Health Organization (PAHO)/WHO team in coordination with the Ministry of Health focal point.

C. Guidance for RMNCAH services in response to COVID-19

El Alto Municipality did not produce its own guidance around COVID-19, but followed that produced at the national level (**Table B.2.1**).

Table B.2.1. Guidance issued for RMNCAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Protocol for treatment of pregnant women during COVID-19	May	
National contingency plan on maternal and neonatal health in the context of COVID-19	July	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAH services

El Alto benefitted from national actions to protect RMNCAH services, and also put in place local measures (**Table B.2.2**).

Table B.2.2. Mitigating actions to ensure continuity of RMNCAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	UNFPA provided contraceptives to guarantee a six-month supply	FP
	National and Departmental Secretary of Health, UNFPA and Marie Stopes assisted in the distribution of condoms and inserted implants	FP
	Distribution of condoms and contraceptive pills to first- and second-level health facilities	FP
	Social workers with Surveillance, Information and Referral Centres delivered ART at home to people who could not travel	HIV
Health services adaptations	RedBol12 (National Network of People Living with HIV and AIDS) and National Sexually Transmitted Infection/HIV/AIDS Programme coordinated to support Surveillance, Information and Referral Centres and provide ART for people living with HIV/AIDS	Cross-cutting
	Strengthening referral systems to higher-level public and private centres for complications and abortion services	Maternal and newborn health FP
	Integration of traditional medicine with home birth, in coordination with referral centre, to provide safe childbirth care in the event of service closures	Maternal and newborn health
	Scheduling of prenatal and postnatal visits to reduce the number of women in close contact at health facilities	Maternal and newborn health
Service delivery settings	Conversion of outpatient health centres into comprehensive health centres for essential non-COVID-19 routine services	Cross-cutting
	Training of human resources working at health facilities in El Alto on COVID-19 and biosafety	Cross-cutting
	Locating child vaccination tents next to health facilities or scheduling convenient hours for child health visits	Child and adolescent health Immunization
Safe patient workflow	Screening, triage and isolation procedures in all facilities, and referral to home care or COVID-19 "green" hospitals (hospitals identified for treatment of COVID-19 patients)	Cross-cutting
Telehealth and digital technology	Virtual care through telemedicine and WhatsApp	Cross-cutting
	Use of digital technology for orientation and training of health personnel, monitoring of population health problems, and health education for the general population	Cross-cutting
	Government-supported youth initiatives incorporating WhatsApp and call centres to provide health information and service referrals	Child and adolescent health
	Regional Health Secretariat and neighbourhood clinics distributed or delivered Nutribebe, food supplement for children, to homes	Child and adolescent health

	MITIGATING ACTION	SERVICE AREA
Removing financial barriers to access	Coordination with doctors to make appointments for mothers with children in public primary schools on the same day they receive payment vouchers to encourage attendance and use of health services	Maternal and newborn health Child and adolescent health
Communications strategies	"Si te cuidas ganas" [if you take care of yourself, you win] campaign by the Ministry of Health, UNFPA, and PAHO/WHO advocating for SRH services and prevention of violence against girls and adolescents	Child and adolescent health FP GBV

E. Lessons learned

- Health system interventions should consider integrated health networks over isolated facility interventions. Health authorities focused most interventions on organizing hospitals as referral centres and organizing the integrated health centres for provision of EHS. This shift required different levels of system strengthening, including training providers, providing PPE, hiring additional staff to replace departing staff, and defining a functional and timely referral network to improve response and problem resolution capacity.

- Coordination between the public, social security, private and other subsectors was important to avoid disruptions to essential services.

- Intersectoral work with entities outside of the health system - such as the police, the army, universities, NGOs and local community authorities (such as neighbourhood councils), neighbourhood zone coordinators, social and youth networks that actively participated in community brigades - increased population access to health guidance and information beyond COVID-19.

- An efficient epidemiological surveillance system allows for timely, evidence-based communication and efficient monitoring of the effects of the COVID-19 pandemic. Evidence-based communication and efficient follow-up identifies trends in key tracers and the need to implement strategies to mitigate effects on essential services. It also allows counteracting the effects of the '*infodemic*' on social networks.

- General health promotion and prevention strategies, such as incorporating handwashing as a healthy and necessary practice, should be prioritized always, not just during a pandemic.

- Lockdown measures have increased cases of domestic violence and malnutrition.

- Lockdown measures have allowed men to participate in household chores and child care, increasing perceptions of domestic work as shared tasks between women and men.

- Teamwork, solidarity and cooperation will facilitate the construction of a Single Health System for the implementation of national universal health insurance so that the population can exercise its right to quality and timely health services.

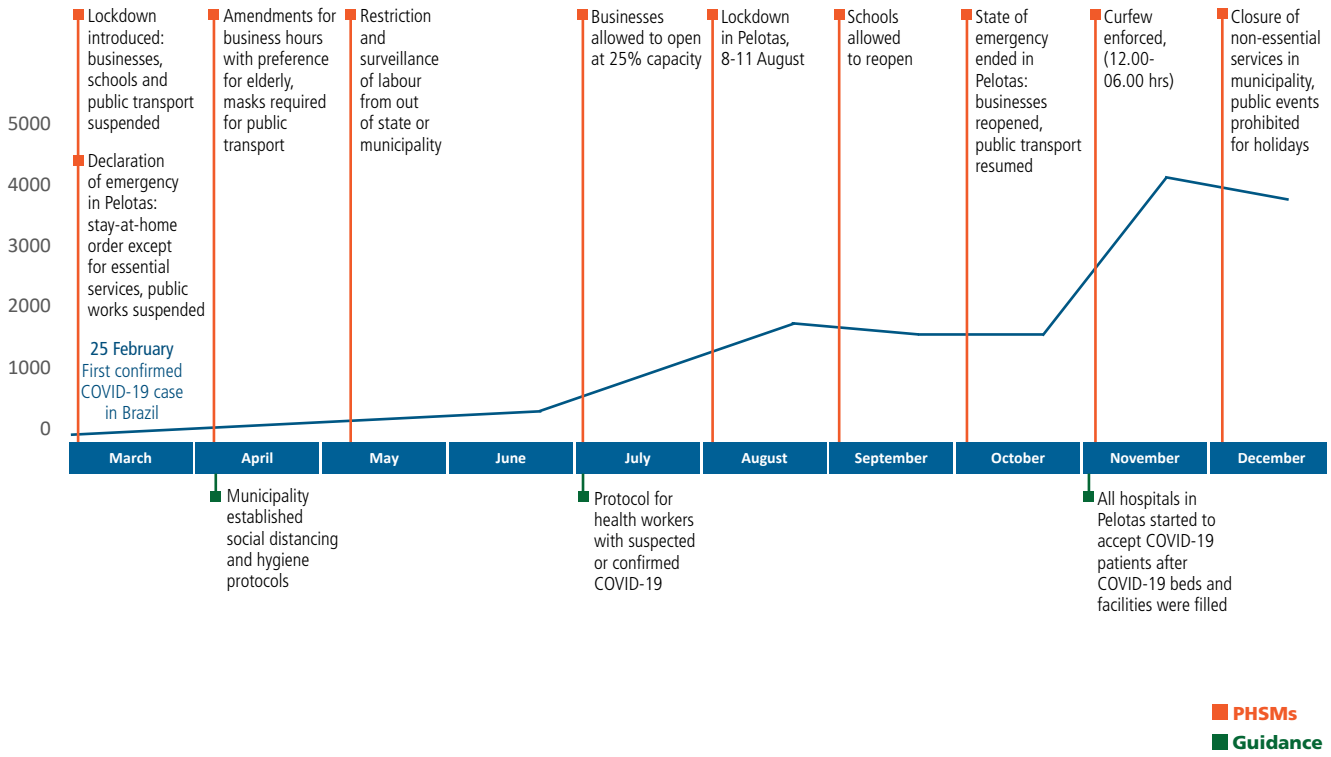
Country report
Brazil, Pelotas Municipality

This report covers Pelotas Municipality, located in the southern state of Rio Grande do Sul.

A. The COVID-19 context

Figure B.2.2 shows the number of COVID-19 cases in Pelotas Municipality, as well as the national and municipal-level measures put in place to contain the pandemic.

Fig. B.2.2. COVID-19 cases in Pelotas Municipality, and timeline of national and local COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services

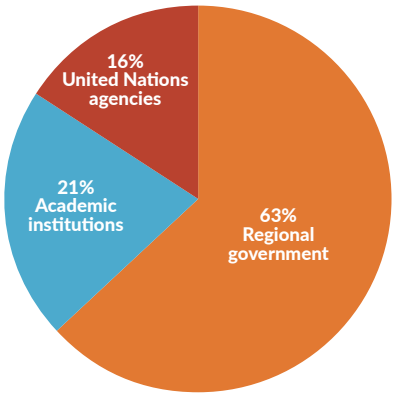


Sources: National consultant reports; Epi curve: the Ministry of Health, State Department of Health.

B. Local governance arrangements for decision-making on RMNCAAH services during COVID-19

The Municipality of Pelotas established a TWG for RMNCAAH services during the COVID-19 pandemic. At its inception, the TWG met virtually on a weekly basis. Meeting frequency was switched to bi-weekly in November 2020 and again back to weekly in December 2020. Additional meetings were scheduled as needed, as determined by TWG members. **Figure B.2.3** shows the distribution of members by agency affiliation.

Fig. B.2.3. TWG member distribution, by agency



About one third (31.6%) of TWG members were men, while about two thirds (68.4%) were women.

Two committees report to the TWG. The first committee focuses on hospital beds and emergency services. The second committee includes representatives from the municipal health department and the managers of the two local universities that provide training/medical education. This committee also addresses the organization of PHC.

The TWG interacts with the State Secretariat of Rio Grande do Sul (3rd Regional Health Coordination), Municipal Health Secretariat of Pelotas, the TWG of the state of Maranhão and other partners identified as important at each stage of work.

Each TWG agenda is agreed upon by all members during meetings or by WhatsApp group every 15 days. The agenda has included the data collection process, health indicators, analysis, improvements and advances.

C. Guidance for RMNCAAH services in response to COVID-19

The various guidelines related to maintaining RMNCAAH services during the pandemic are shown in **Table B.2.3**.

Table B.2.3. Guidance issued for RMNCAAH services

Key guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Decree No. 6.268 to provide preferential and special assistance to the elderly, hypertensive, diabetics, pregnant women and people with disabilities	April	
Municipal prenatal care protocol focusing on care in times of pandemic	Aug	
Clinical protocols with focus on nursing with the objective of expanding the scope of actions in primary care teams, as well as qualifying their actions in assistance for prenatal, peripartum and child care	Aug	
Development of practical guidelines for health care of the elderly during the pandemic	June	
Key guidelines for care of COVID-19 patients covered by RMNCAAH services	**Month (2020)**	**Content**
Guidelines for the prevention and control of infections by the new coronavirus (SARS-CoV-2) in long-term care institutions for the elderly, National Agency for Health/Ministry of Health	Aug	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Actions taken at municipal and national level to maintain RMNCAAH services are shown in **Table B.2.4**.

Table B.2.4. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Health service adaptations	Scheduling of ANC appointments farther apart, except for final stage of pregnancy	Maternal and newborn health
	Prioritization of high-risk prenatal care at obstetric clinics, with low-risk prenatal care assigned to basic health units	Maternal and newborn health
	Updated care protocol and training of PHC staff on care for pregnant women survivors of violence	Maternal and newborn health GBV
	Identification and monitoring of vulnerable older people at risk of functional or fragile decline, along with establishment of care plans for cases	Older people
	Implementation of Elderly Health Home Record Book to record personal, social and family data; health conditions; health behaviours and vulnerabilities; and guidance on self-care	Older people
Service delivery settings	First postpartum visit conducted as home visit by woman's health provider, including PNC and orientation on newborn care	Maternal and newborn health
	Contracting with universities to provide obstetric services, such as ultrasounds and echocardiograms, for pregnant women	Maternal and newborn health
	Paediatric services established within Emergency Care Unit with semi-intensive care beds for symptomatic COVID-19 patients	Child and adolescent health
	Vaccination teams dispatched to specialty centres and basic health units in urban and rural areas	Immunization
	Mobile unit for vaccination campaigns	Immunization
	CHWs engaged in outreach activities to provide advice to older people	Older people
Safe patient workflow	Separate treatment times and areas for COVID-19 and non-COVID-19 symptomatic patients, maternity hospital dedicated to pregnant women with suspected and confirmed cases of COVID-19 established	Cross-cutting Maternal and newborn health
	Paediatric ward health providers work longer scheduled shifts, i.e. 10-day shifts followed by 10 days off, to reduce infection risk	Child and adolescent health

	MITIGATING ACTION	SERVICE AREA
Telehealth and digital technology	Procurement and implementation of telemedicine consultations to increase user access and reduce in-person contact at health facilities	Cross-cutting
	Volunteer health workers offer teleconsultations over WhatsApp and Instagram about pregnancy and COVID-19	Maternal and newborn health
	Guidelines on health care for older people during the pandemic developed and disseminated, e.g. healthy eating, practice of leisure activities, physical exercise	Older people
Optimizing workforce capacity	Emergency recruitment of extra health workers	Cross-cutting
	Volunteer community group outreach via newsletters and social media to inform and advise target populations on SRH, COVID-19, general health services and mental health	Cross-cutting
	Relocation of specialists to primary health centres to expand access to care for pregnant women	Maternal and newborn health
	Letters sent by post to disseminate information on child health services, i.e. opening hours, service locations, vaccination guidelines, existing programmes	Child and adolescent health

E. Lessons learned

As much as possible, access to EHS should be maintained so that non-COVID-19-related health problems do not become exacerbated.

- Good coordination and redirection of the workforce to areas of need during the pandemic is necessary so that all workers, including those working from home, are being used effectively and contributing to the maintenance of EHS.

- The pandemic drew attention to, as well as exacerbated, an overall shortage of health professionals.

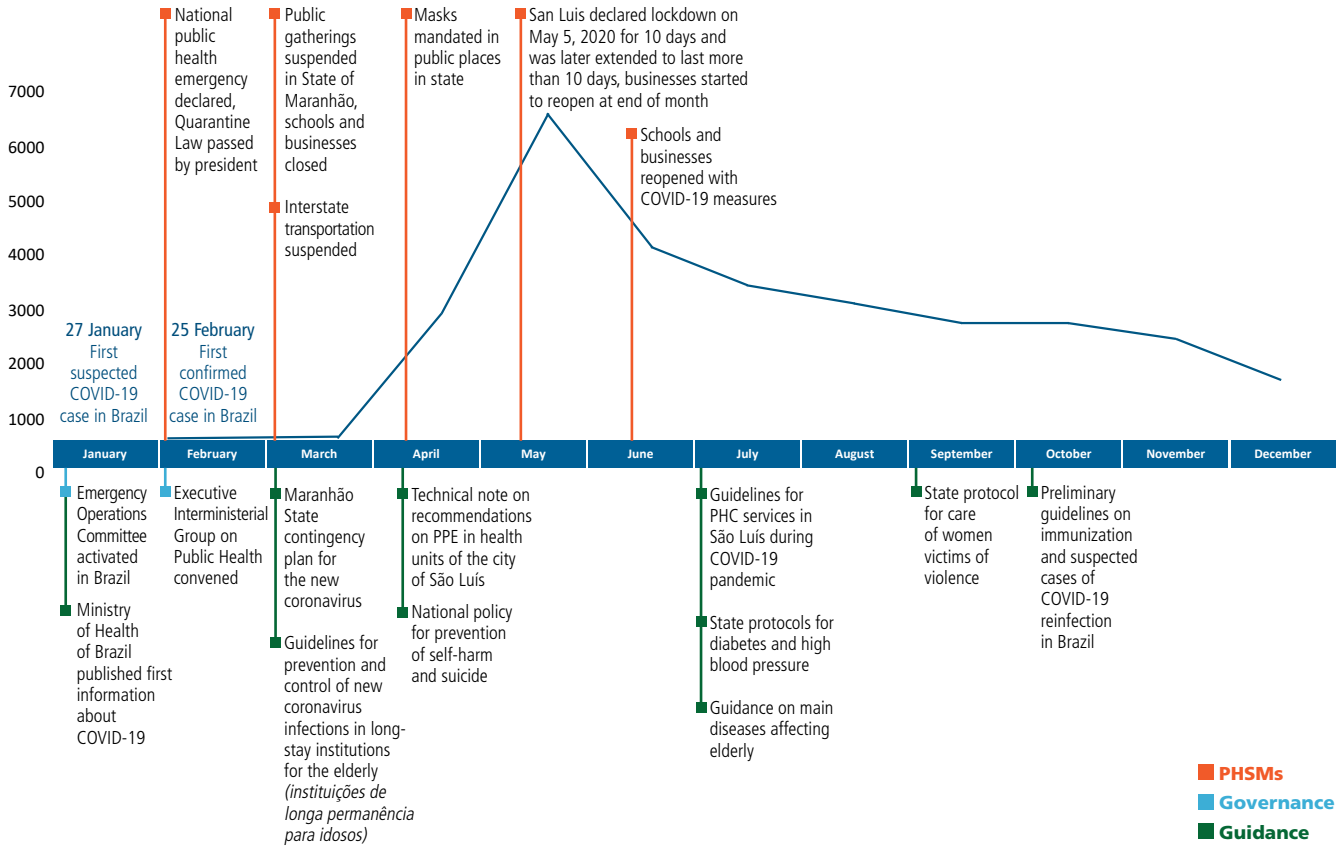
Country report
Brazil, São Luís Municipality

This report covers São Luís Municipality in the state of Maranhão.

A. The COVID-19 context

Figure B.2.4 shows the number of COVID-19 cases in São Luís Municipality, as well as the national and municipal measures put in place to contain the pandemic.

Fig. B.2.4. COVID-19 cases in São Luís Municipality, timeline of national and local COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services

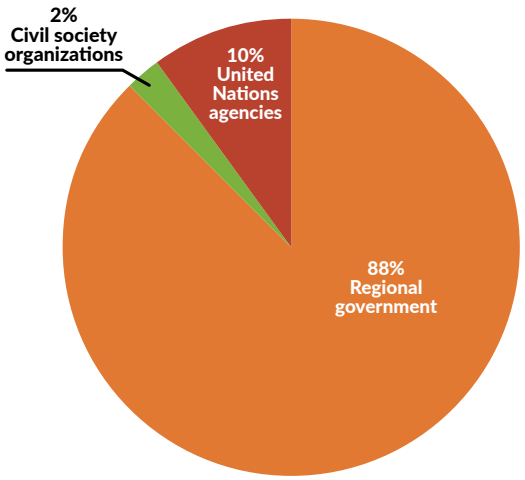


Sources: National consultant reports; Epi curve: Ministry of Health, State Department of Health.

B. Governance arrangements for decision-making on RMNCAAH services during COVID-19

The Municipality of São Luís established a TWG for RMNCAAH services during The COVID-19 pandemic. The TWG met every 15 days with additional meetings scheduled as needed/ determined by members. **Figure B.2.5** shows the distribution of TWG members by agency affiliation.

Fig. B.2.5. TWG member distribution, by agency



TWG meeting agendas were set by members to address issues raised at previous meetings and based on feedback from technicians on the impact of COVID-19. Maintaining RMNCAAH services, monitoring the needs of the population, and reviewing actions of the state and nongovernmental institutions were regular items on the agenda.

In São Luís, several members of the TWG are also members of the Crisis Office, the COVID-19 IMT established by the state government of Maranhão. The Coordinator of Women, Children and Adolescent Health assumed the role of Focal Point in the São Luís Municipal Health Secretariat.

The TWG in São Luís opted to hold specific meetings with technical staff responsible for different priority populations from the Municipal as well as State Secretariat. Initially, four such meetings were scheduled with teams in different technical areas of women's, children's, adolescent and elderly health, as well as the cross-cutting issues of violence and mental health. These meetings informed subsequent strategies to address the impact of the pandemic on RMNCAAH services.

C. Guidance for RMNCAAH services in response to COVID-19

Table B.2.5 shows guidance issued at national and local level on maintaining services during the pandemic.

Table B.2.5. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Reference for conducting ultrasound exams for the public: pregnant women from the São Luís Primary Care Network (Basic)	June	
Guidelines for the prevention and control of infections by the new corona virus (SARS-CoV-2) in long-term care institutions for the elderly, National Agency for Health/Ministry of Health	March	
Draft joint Technical Note SEMUS-SLZ/SES-MA on agreement for the insertion of intrauterine devices (IUDs) in the municipality of São Luís	Oct	
Guidelines directed to the Emergency Operations Centre for Coronavirus (COE COVID-19), to be adopted by the single health system to guide breastfeeding in the context of transmission of influenza syndrome	Dec	
LAW No. 11,285 establishes guidelines for the state programme Protection of women's life: combating COVID-19 and domestic violence	Aug	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Table B.2.6 shows the various types of actions the municipality, state and national level took to mitigate the effects of the pandemic on relevant health services.

Table B.2.6. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Condoms, lubricants and contraceptives distributed to vulnerable populations	FP
	Extended prescriptions for patients on long-term medication	Older people
Health services adaptations	Health outreach activities for vulnerable populations including homeless pregnant women, trafficked people and Venezuelan migrant women	Cross-cutting
	Establishment of collection point for maternal milk bank and breastfeeding support rooms for basic health units	Maternal and newborn health
	Establishment of the first mental health centre in Maranhão focused especially on children and youth (NASMCA)	Child and adolescent health
Service delivery settings	Routine vaccinations administered via open-air drive-in centres and at homes, schools and workplaces	Immunization
Safe patient workflow	Designated PHC facilities for COVID-19 symptomatic and non-COVID-19 patients and referral of pregnant women without COVID-19 to other primary care units for prenatal care and delivery	Cross-cutting Maternal and newborn health
	Designated wards in maternity hospitals for patients with suspected COVID-19	Maternal and newborn health
Telehealth and digital technology	Smartphone devices and WhatsApp application used for scheduling PNC at the maternity ward	Maternal and newborn health
	Counselling on pregnancy, labour and COVID-19 offered to pregnant women over Instagram by volunteers	Maternal and newborn health
	Partnership between legal prosecutors, digital influencers, and NGO to develop digital violence prevention campaigns for adolescent girls	Child and adolescent health GBV
	Virtual meetings and online lectures (government/ UNICEF) aimed at supporting adolescents and young people during the pandemic	Child and adolescent health
	Identification of technology available and methods to facilitate remote PHC teleconsultations with older people	Older people

	MITIGATING ACTION	SERVICE AREA
Removing financial barriers to access	Distribution of adolescent gynaecological consultation vouchers by NGO	Maternal and newborn health Child and adolescent health
Optimizing workforce capacity	Financial incentives for health workers providing care for COVID-19 patients during the three most intensive months	Cross-cutting
	Paid sick leave for health staff	Cross-cutting
	Emergency recruitment of extra health workers from Cuba	Cross-cutting
	Implemented training for notification of cases of violence through schools	Child and adolescent health
	Social media messaging to dispel myths and disseminate accurate information on IUDs	FP
Communications strategies	Volunteer and advocacy community groups provide information via newsletters and social media, e.g. about SRH, COVID-19 and general health services, and provide advice and mental health support	Cross-cutting FP

E. Lessons learned

- CHWs were not integrated into the pandemic response and could have been active agents in identification of cases and contact tracing, community health education campaigns regarding social distancing, quarantine, use of masks and handwashing. CHWs should be trained in pandemic containment with an emphasis on preventive work.

- Pandemic guidelines recommended walk-in appointments (no scheduling) for the first prenatal consultation and scheduled prenatal appointments thereafter (1 appointment/40 minutes). In practice this strategy did not work, and all consultations were walk-ins (without scheduling). In São Luís Municipality, prenatal care is mostly performed in PHC units, which are insufficient in number to meet demand. Thus, limited scheduling did not meet the needs of the population.

- The suspension of services without proposing an alternative for the care of users of these services had negative consequences for population health. For example, in São Luís elderly care was suspended at the Comprehensive Care Centre for the Elderly without a proposal for continuity of care for this population group.

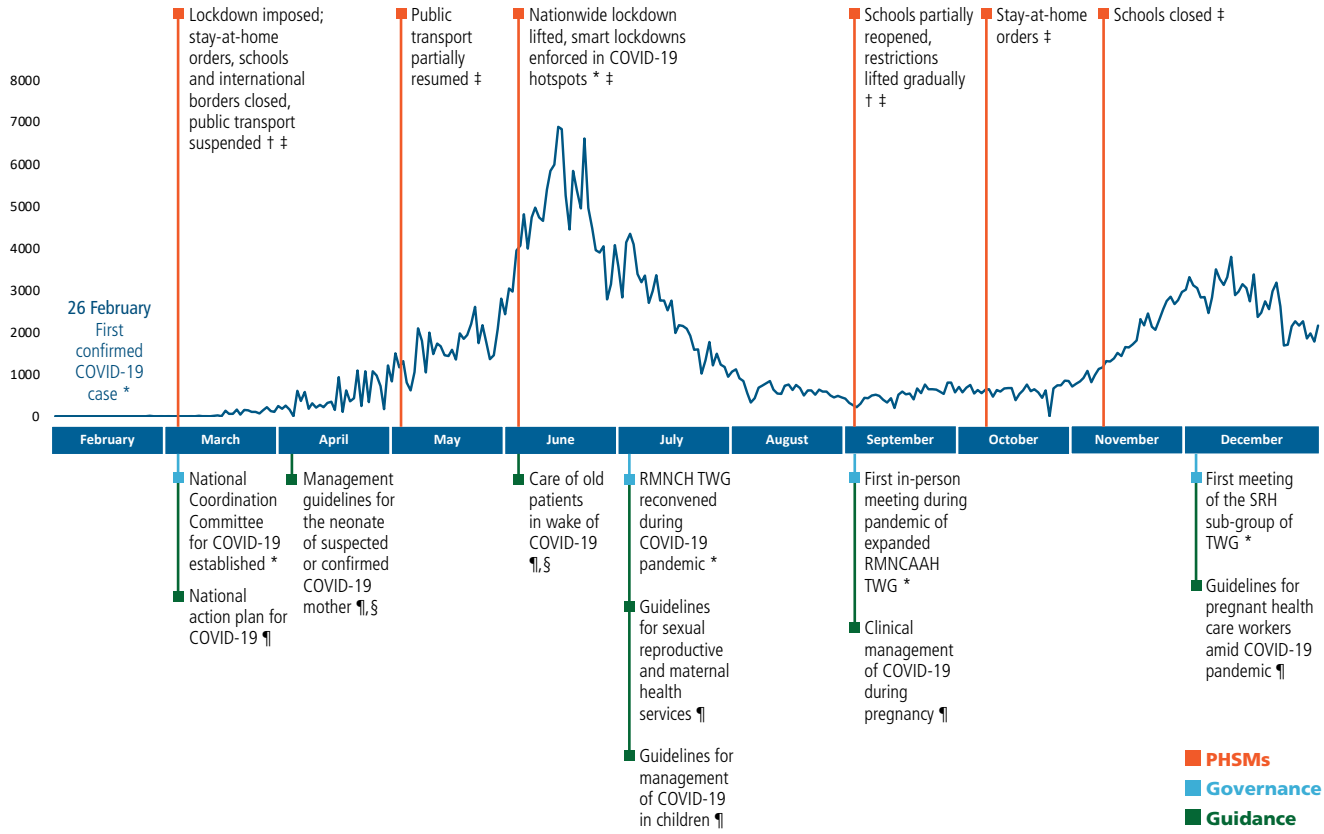
B.3 Eastern Mediterranean Region

Country report - Pakistan

A. The COVID-19 context

The first confirmed COVID-19 case in Pakistan was in February 2020, and measures to control it were put in place soon after (**Figure B.3.1**).

Fig. B.3.1. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * National consultant reports; † *(14)*; ‡ *(15)*; ¶ National Institute of Health, Pakistan; § *(7)*; First Case + Epi Curve: https://covid19.who.int/.

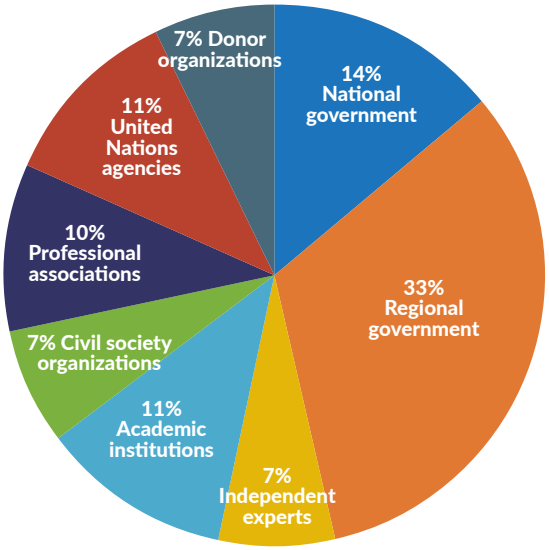
B. Governance arrangements at national level for decision-making on RMNCAAH services during COVID-19

Initial COVID-19 response committees were coordinated at the provincial level, in line with Pakistan's federal structure (*20*). However, as the pandemic worsened the National Security Committee launched a nationally-coordinated response and designated the National Disaster Management Agency as the lead. A number of response bodies and committees were subsequently formed.

Pakistan had an established TWG specifically for RMNCH services prior to the COVID-19 pandemic. In response to the pandemic, this TWG was reactivated in July 2020 and now takes a life-course approach (RMNCAAH) to its response by including older people as one of its target populations. In early November 2020, a sub-group of the TWG was formed for activities specifically related to SRH for both adolescent and adult populations with a focus on FP services.

The RMNCAAH TWG has 34 permanent members nominated in their Terms of Reference, though participation reaches around 80 attendees for meetings (see **Figure B.3.2** for sector representation). Attendees include individuals chosen by their organizations to be representatives. Member expertise is diverse and includes clinicians, public health professionals, academics, researchers, bilateral, multilateral and nongovernmental health programme specialists and administrators. An external analysis published in July 2020 (*19*) indicated that only 8% of Pakistan's key response committee members were women. Within the TWG for RMNCAAH about one half of the members are women.

Fig. B.3.2. Distribution of Pakistan TWG members, by sector



The TWG first met in July 2020 with quarterly meetings planned to follow and has planned to convene additional meetings as needed. As of January 2021, the TWG has met three times. Meeting agendas are guided by national priority issues set by the Ministry of National Health Services, Regulations and Coordination Department of Health and the TWG members themselves. The TWG has been working in coordination with the National Disaster Management Authority's National Command and Control Centre. The SRH sub-group met for the first time in early December 2020. Meetings are scheduled on a quarterly basis or more often as needed.

C. Guidance for RMNCAAH services in response to COVID-19

Pakistan produced various guidelines, policies and plans in response to the pandemic (**Table B.3.1**).

Table B.3.1. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Pakistan preparedness and response plan COVID-19	April	
Care of old patients in wake of COVID-19	June	
Sexual, reproductive and maternal health services during COVID-19	July	
Key national guidelines for care of COVID-19 patients covered by RMNCAAH services	**Month (2020)**	**Content**
Management guidelines for the neonate of suspected or confirmed COVID-19 mother	April	
Management of COVID-19 in children	July	
Clinical management of COVID-19 during pregnancy	Sept	

D. Key actions to ensure continuity of RMNCAAH services

A number of actions were carried out to protect RMNCAAH services (**Table B.3.2**).

Table B.3.2. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Reactivation of emergency logistics supply system	Cross-cutting
	Extension of prescriptions	Cross-cutting
	Promotion of LARC and barrier methods	FP
	Procurement and distribution of FP supplies	FP
Health services adaptations	Routine and non-serious cases declined and referred to digital platforms	Maternal and newborn health
	Immunization and growth monitoring frequency reduced	Newborn health Child and adolescent health Immunization
Service delivery settings	Outdoor community settings for immunization services	Child and adolescent health
	Delivery of contraceptives to homes, door-to-door medical abortion counselling and FP commodities	FP
	EPI services delivered by motorbikes and vans (some provinces)	Immunization
Safe patient workflow	Screening, triage and isolation facilities for pregnant women	Maternal and newborn health
	IPC in facilities and PPE for health workers	Child and adolescent health
Telehealth and digital technology	Helplines for domestic abuse and mental health support	Cross-cutting
	Mobile phone apps, WhatsApp for accessing RMNCAAH services, i.e. telehealth consultations for maternal and newborn care in cities	FP

	MITIGATING ACTION	SERVICE AREA
Optimizing workforce capacity	Training for health providers using distance learning/ e-courses	Cross-cutting
	Redeployment of personnel from departments with low patient load to RMNCAAH departments	Cross-cutting
	Mobilizing previously non-active female doctors for digital delivery of RMNCAAH services through private partnerships	Cross-cutting
Communications strategies	Public broadcast channels, social media (Instagram) and health partners relayed public messages on COVID-19 protection and SRH, safe motherhood, self-care for pregnant women, nutrition and GBV	Maternal and newborn health GBV Nutrition

E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAAH indicators were compiled from the national HMIS. **Figures B.3.3 – B.3.11** show changes in utilization of health services in facilities reporting through the HMIS.

FP

- The numbers of clients receiving oral (**Figure B.3.3**) and injectable (**Figure B.3.4**) contraceptives respectively were very similar for 2019 and 2020, with slight decreases in oral contraceptive distribution.

Fig. B.3.3. Number of clients who accepted oral contraceptives

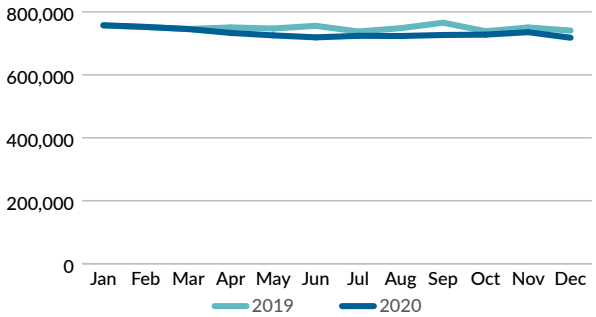
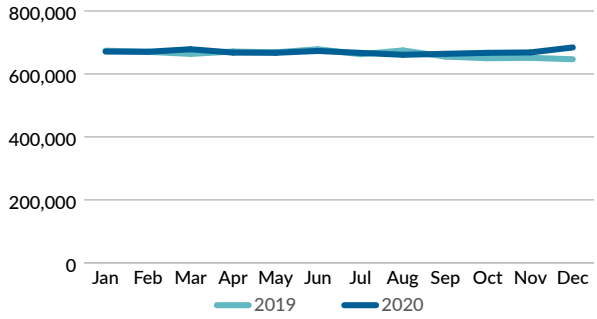


Fig. B.3.4. Number of clients who accepted injectable contraceptives



Maternal and newborn health

- The reported number of ANC contacts provided was lower in 2020 than in 2019 and had not returned to the same level by the end of 2020 (**Figure B.3.5**).
- The reported number of facility births was lower from March to August 2020 compared to the corresponding months in 2019, but returned to similar levels by the end of 2020 (**Figure B.3.6**).
- The reported number of caesarean births was lower from April 2020 to the end of the year compared to the corresponding months in 2019 (**Figure B.3.7**).
- The reported number of women and newborns receiving PNC was lower from April to August 2020 compared to the corresponding months in 2019, but returned to similar levels by the end of 2020 (**Figure B.3.8**).

Figure B.3.5. Number of ANC visits/contacts

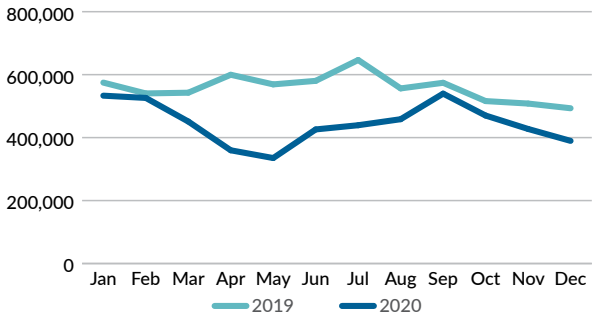


Fig. B.3.6. Number of facility births

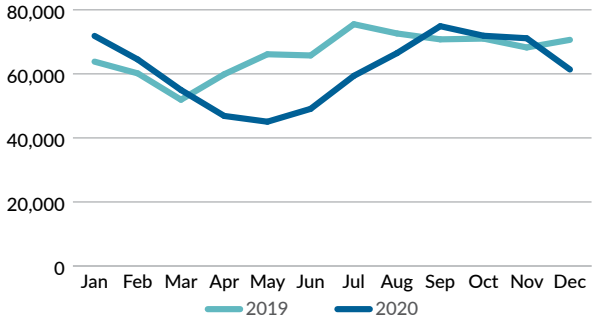


Fig. B.3.7. Number of caesarean births

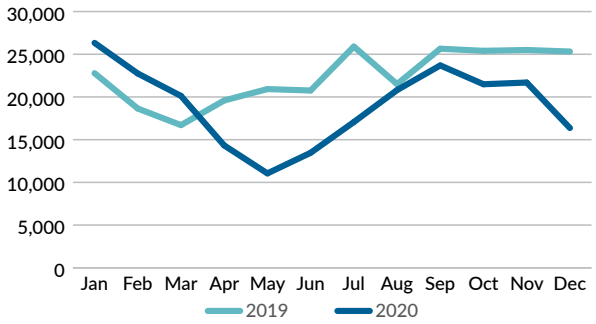
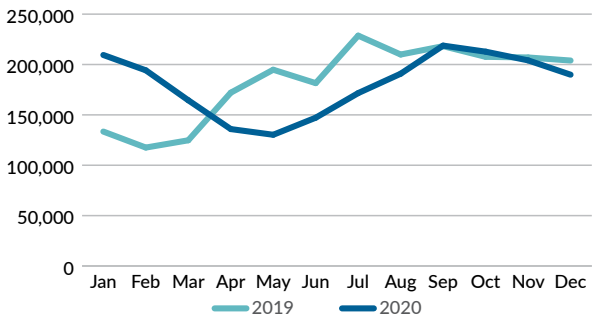


Fig. B.3.8. Number of women and newborns receiving PNC



Child health and immunization

- There was a drop in the reported number of children less than 1 year of age receiving the third dose of DPT or pentavalent vaccine in 2020 starting in March, with the lowest dip in the second quarter of the year (**Figure B.3.9**). However, the number of children receiving this vaccination returned to levels similar to 2019 by the end of the year.

- The number of children less than 5 years of age with ARIs (**Figure B.3.10**) and treated for diarrhoea (**Figure B.3.11**) in health facilities was lower in 2020 compared to 2019 and did not return to similar levels by the end of 2020.

Fig. B.3.9. Number of children < 1 year of age receiving 3rd dose of DPT or pentavalent vaccine

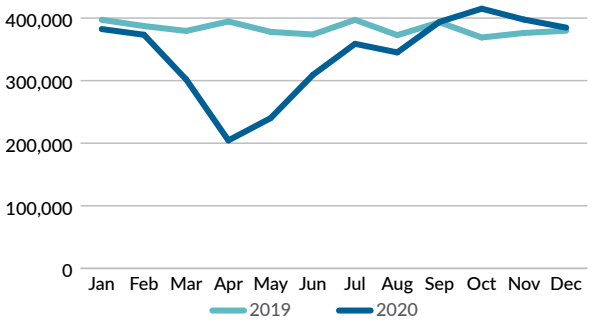


Fig. B.3.10. Number of children < 5 years of age with pneumonia

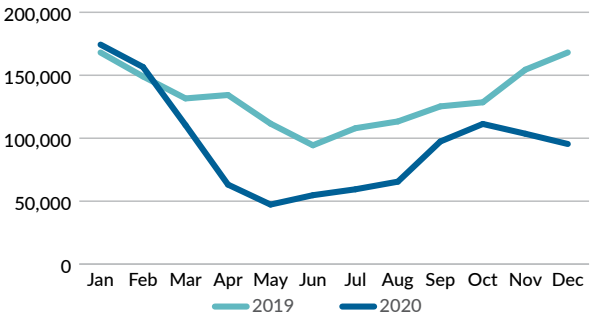
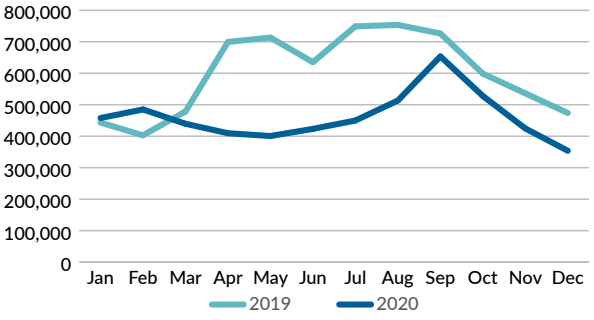


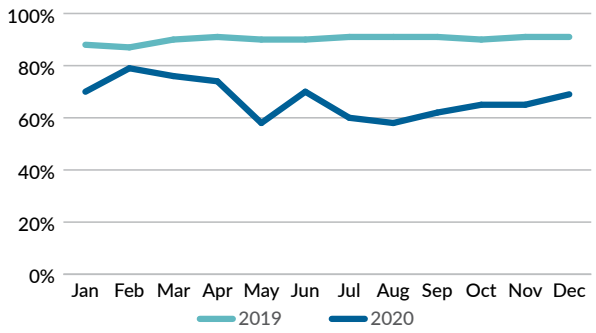
Fig. B.3.11. Number of children < 5 years of age treated for diarrhoea



Reporting completeness

- HMIS reporting completeness was much lower in 2020 than in 2019 (**Figure B.3.12**), which should be considered when interpreting changes in utilization of health services.

Figure B.3.12. Completeness of HMIS reporting (%)



F. Modelling

WHO, UNICEF and UNFPA developed guidance on *Modelling the health impacts of disruptions to essential health services during COVID-19 (12)*. The guide provides an overview and description of modelling methods. Used in Pakistan, the risk-benefit modelling demonstrated the benefits of maintaining essential RMNCAAH services compared to the risk of acquiring COVID-19 infection.

- **Number of lives lost due to the COVID-19 pandemic.** Because of disruption of service delivery, during the three months at the height of the pandemic in 2020 almost 48 062 child lives were lost (including 20 874 newborns) and an additional 440 maternal lives, for a total of 48 502.

- **Numbers of lives saved due to increased coverage due to mitigation measures.** With restored coverage levels of EHS due to mitigation measures implemented, 38 104 child lives could have been saved (including 18 020 newborns) plus 424 maternal lives for a total of 38 528 lives saved.

- **Numbers of lives lost due to excess risk of infection.** Results from this modelling exercise indicate that 1269 lives might have been lost due to added COVID-19 infections acquired because of contact with a health facility. These infections may be a result of interactions with health care providers or other attendants, or contacts made en route to the health facility.

- **Overall results.** The benefit-risk analysis indicates that while 1269 lives might have been lost due to added COVID-19 infections acquired due to contact with a health facility (as well as travel to and from a health facility) 92 466 lives may have been saved due to mitigation measures implemented to increase coverage and reduce transmission of COVID-19, resulting in an overall risk-benefit ratio of 72.9. The highest benefit-risk ratios were for breastfeeding, newborn care and childbirth care (1409.5, 466.6 and 52.4 respectively).

G. Lessons learned

- A multisectoral/whole-of-government response is required and more effective to tackle a pandemic or major health emergency.

- Duplication of activities and wastage of meagre resources can be avoided through an effective coordination mechanism; government should play a leadership role.

- Complete lockdown is not a preferred option to tackle an epidemic of long duration as it may have a very negative impact on the economy of the country, and especially on the poorest segments of society. Smart lockdown interventions, coupled with other mitigation measures, are a better option.

- Provision/continuation of EHS should be ensured in all health emergencies.

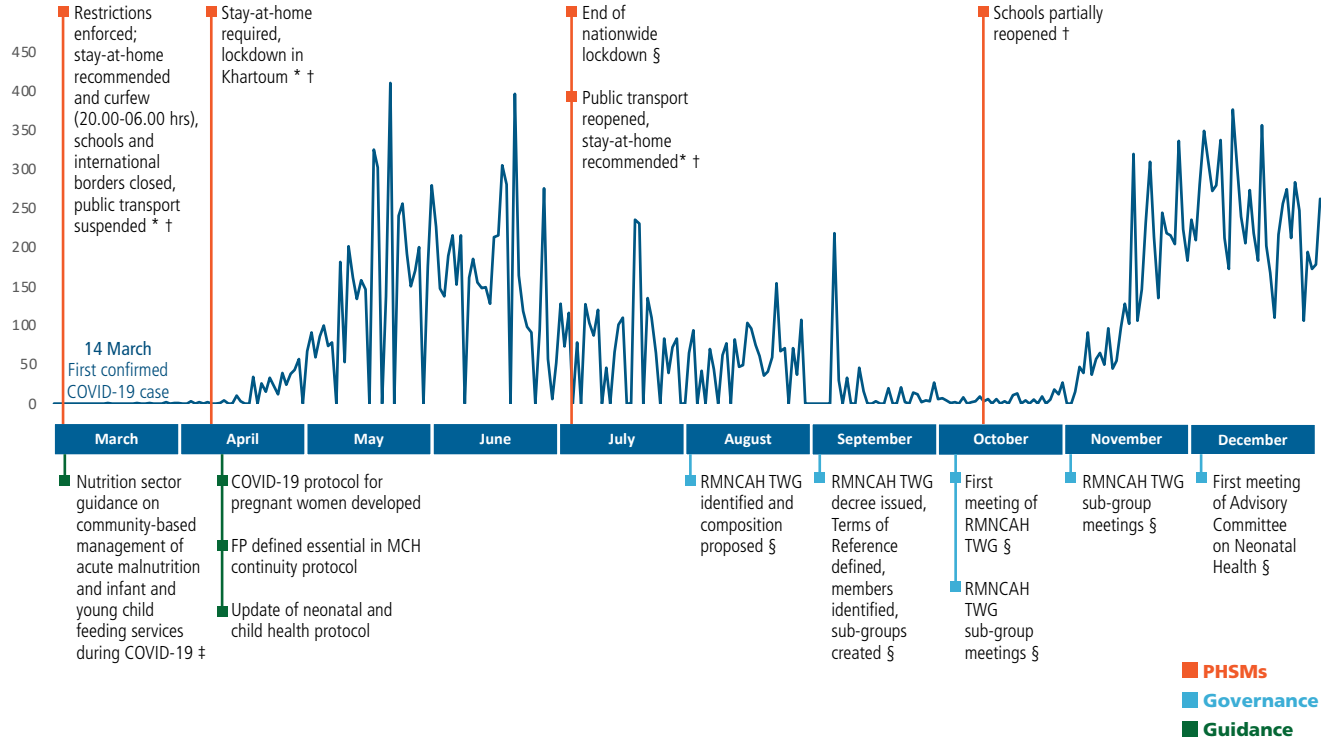
- Alternative contact methods, such as digital technologies, could be introduced for improving access to EHS.

Country report - Sudan

A. The COVID-19 context

The first confirmed COVID-19 case was reported in Sudan in March 2020, and various measures were implemented while guidance was introduced (**Figure B.3.13**).

Fig. B.3.13. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAH services



Sources: * *(14)*; † *(15)*; ‡ *(7)*; § National consultant reports; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAH services during COVID-19

The Sudan RMNCAH TWG was established in late September 2020, with the first meeting held on 6 October 2020. A total of 33 individuals were nominated to join the TWG with three sub-committees focusing on five work streams.

The TWG was scheduled to meet monthly; however, meetings in November and December 2020 were not possible. In November senior officials at the Ministry of Health were infected with COVID-19, and in December TWG members were occupied with the second wave of the pandemic. Sub-group meetings were held in October and November but not December. Meeting agendas were developed in conjunction with the MCH Directorate team.

C. Guidance for RMNCAH services in response to COVID-19

Several guidelines and policies were developed to support maintenance of RMNCAH services (**Table B.3.3**).

Table B.3.3. Guidance issued for RMNCAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Nutrition sector guidance on community management of acute malnutrition and infant and young child feeding services implementation during the coronavirus pandemic at community and facility levels	March	
MCH continuity of service guideline	March-April	
Guidelines for pregnancy and birth complications	March-April	
Clinical management of rape guidelines	March-April	
Key national guidelines for care of COVID-19 patients covered by RMNCAH services	**Month (2020)**	**Content**
COVID-19 protocol for pregnant women	April	
COVID-19 newborn and child health protocols	March-April	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAH services

Sudan took several actions with the aim of mitigating the effect of COVID-19 on RMNCAH services (**Table B.3.4**).

Table B.3.4. Mitigating actions to ensure continuity of RMNCAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Reinforcement and adaptation of supply chains, procurement and logistics arrangements	Cross-cutting
Transport for facilitating mobility	Local sentinel points for ambulatory services	Maternal and newborn health
Health services adaptations	Opening hours in PHC facilities in Khartoum State extended to 22:00 hours	Cross-cutting
	Prioritization of service delivery modalities during COVID-19, such as the focus of health workers on essential services provision	Cross-cutting
Safe patient workflow	Triage, screening and isolation centres for COVID-19-positive patients	Cross-cutting
	PPE for health workers in isolation centres, PHCs and nutrition centres	Cross-cutting
Telehealth and digital technology	Telemedicine, e-health and m-health hotlines established, i.e. hotline/call centre for FP and virtual consultations; WhatsApp used to send results, prescriptions	Cross-cutting
	Mobile phones distributed to community leaders in GBV prevention networks	GBV
Removing financial barriers to access	Ensure the provision of free drugs for children less than 5 years of age at hospitals and PHC facilities	Child and adolescent health
Optimizing workforce capacity	Redeployment and temporary recruitment of health workers	Cross-cutting
	Reinforced communications with health workers	Cross-cutting
	Incentives and staff retention efforts for health workers in select areas	Cross-cutting
	Training of staff from hospitals on updated paediatric and obstetric/gynaecological protocols, emergency obstetric and newborn care	Maternal and newborn health
Communications strategies	Various communication modalities with messaging aimed at improving care-seeking behaviour and knowledge and perceptions of the public about COVID-19	Cross-cutting
	Awareness-raising activities on FP, maternal, newborn and child services, GBV and nutrition services specifically targeting migrants and displaced persons	Maternal and newborn health FP GBV Nutrition
	Awareness-raising for FP service availability through national broadcasting channels and community volunteer efforts	FP

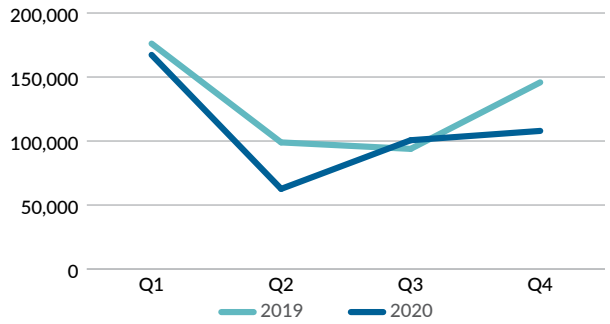
E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAH indicators were compiled from the national HMIS. **Figures B.3.14 – B.3.21** show changes in utilization of health services in facilities as reported through the HMIS. (Note that data are by quarters, not months, and not available for fourth quarter 2020 for some indicators.)

FP

- The reported number of women receiving any one of five types of contraception in 2020 was lower in Q1, Q2 and Q4 than in corresponding periods of 2019 (**Figure B.3.14**).

Fig. B.3.14. Number of women who received FP services with 5 types of contraceptive methods



Maternal and newborn health

- Fewer pregnant women visited health facilities for ANC in all quarters of 2020 in comparison to the corresponding reporting periods in 2019 (**Figure B.3.15**).

- The number of births in facilities was lower in 2020 than in 2019 and decreased from Q1 to Q4 (**Figure B.3.16**). Reported numbers of births at home were also lower in Q2-Q3 of 2020 than in corresponding periods of 2019 but returned to similar numbers in Q4 2020 (**Figure B.3.17**).

- The reported number of women attending for their second PNC visit was lower in Q2-Q4 2020 in comparison to corresponding periods of 2019, with a notable decrease in Q2 (**Figure B.3.18**).

Fig. B.3.15. Percentage of women visiting for 1st ANC contact

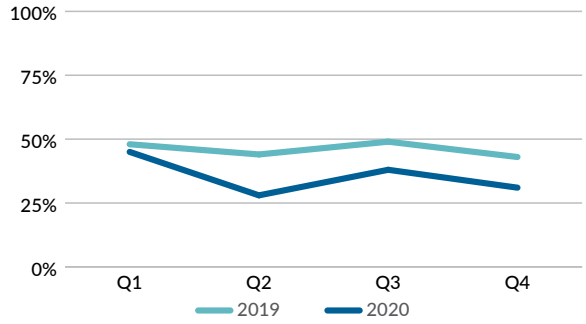


Fig. B.3.16. Number of facility births

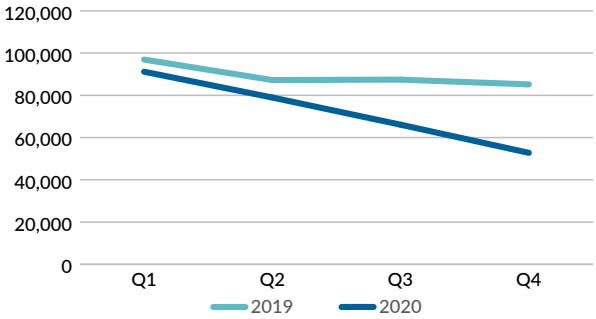


Fig. B.3.17. Number of births at home

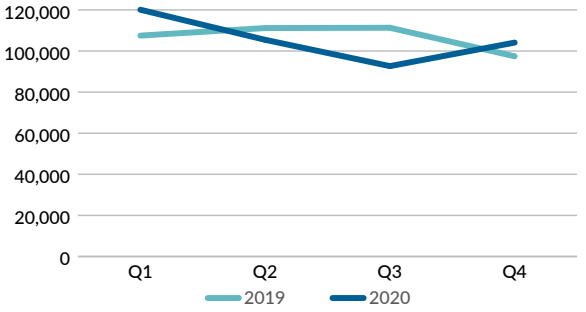
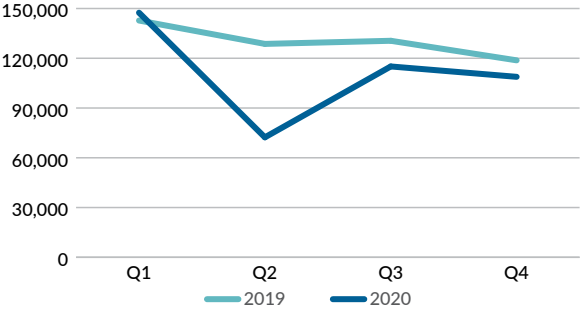


Fig. B.3.18. Number of women who attended a 2nd PNC visit



Child health and immunization

- Coverage for children less than 1 year of age for the third dose of pentavalent vaccine was slightly lower in 2020 in comparison to 2019 (**Figure B.3.19**).

- Fewer children less than 5 years of age came to health facilities with pneumonia (**Figure B.3.20**) and diarrhoea (**Figure B.3.21**) in 2020 than in 2019.

Fig. B.3.19. Percentage of children <1 year of age with 3rd dose of pentavalent vaccine

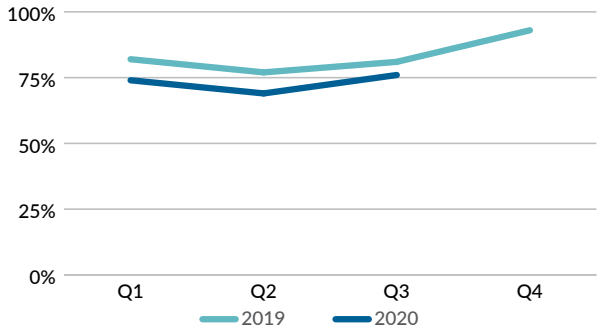


Fig. B.3.20. Percentage of children < 5 years of age presenting to facility with pneumonia

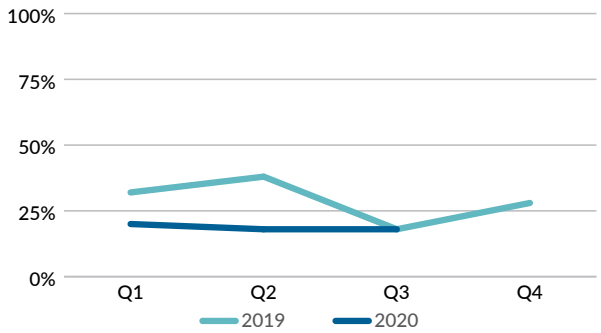
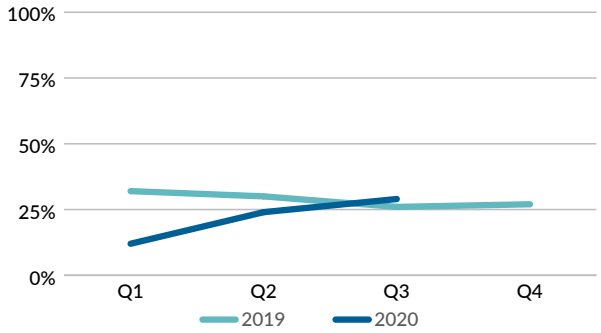


Fig. B.3.21. Percentage of children < 5 years of age presenting to facility with diarrhoea



F. Modelling

WHO, UNICEF and UNFPA developed guidance on *Modelling the health impacts of disruptions to essential health services during COVID-19 (12).* The guide provides an overview and description of modelling methods. The risk-benefit modelling demonstrated the benefits of maintaining essential RMNCAH services compared to the risk of acquiring COVID-19 infection.

- **Number of lives lost due to the COVID-19 pandemic.** This risk-benefit analysis indicates that approximately 931 lives were lost due to the disruption of EHS, including RMNCAH services, during the height of the COVID-19 pandemic (April through September 2020). The majority of lives lost were newborns and children (900), and most were a result of reduced provision of newborn care. It was estimated that 31 maternal lives were also lost as a result of the pandemic.

- **Numbers of lives saved due to increased coverage due to mitigation measures.** This risk-benefit analysis showed that 2407 lives could be saved in 2021 with an increase in coverage of RMNCAH services triggered by the mitigation measures implemented. This number includes 2320 newborn and children's lives and 87 maternal lives.

- **Numbers of lives lost due to excess risk of infection.** Results from this modelling exercise indicate that 101 lives could be lost due to excess COVID-19 infections acquired because of attendance at health facilities. These infections could be a result of interactions with health care providers or other attendants, or contacts made en route to the health facility.

- **Overall results.** The overall benefit-risk ratio from this study was 23.8, which means that for every 23.8 lives gained due to increased RMNCAH coverage, there was one related COVID-19 death. The highest benefit-risk ratios were for newborn (210.3) and childbirth care (67.4).

G. Lessons learned

- The centralization of COVID-19 investigations in the early phases of the pandemic caused delays in case confirmation, thus delaying provision of services and treatment for those testing positive for the virus.
- While prioritizing resource distribution to hospitals over PHC facilities may have improved the response to COVID-19, this strategy had a negative effect on the availability of PHC services to the population at large.
- Incentive systems for health workers to sustain service provision were not uniformly implemented across facilities/geographic areas. In areas where incentives were not implemented or sustained, there was a decline in service availability/use.
- The use of external teams of health workers to cover patient triage in health facilities was disruptive to service provision. Using alternative available units already working within the facility may have been preferable and avoided disruptions.
- Protective measures which advised seniors (over 55 years) to stay at home had an adverse effect on the availability of senior health workers, including specialists and CHWs/community midwives (CMWs), who generally fall into this age category.
- The HMIS is affected during emergencies, as indicated by the reduced reporting rate and completion. The country should consider reviewing and strengthening existing monitoring mechanisms to ensure they are more resilient.
- Telemedicine, e-health and m-health, and hotlines have the potential to both increase accessibility and reduce costs and out-of-pocket expenditure on health. Ageing health should be included.

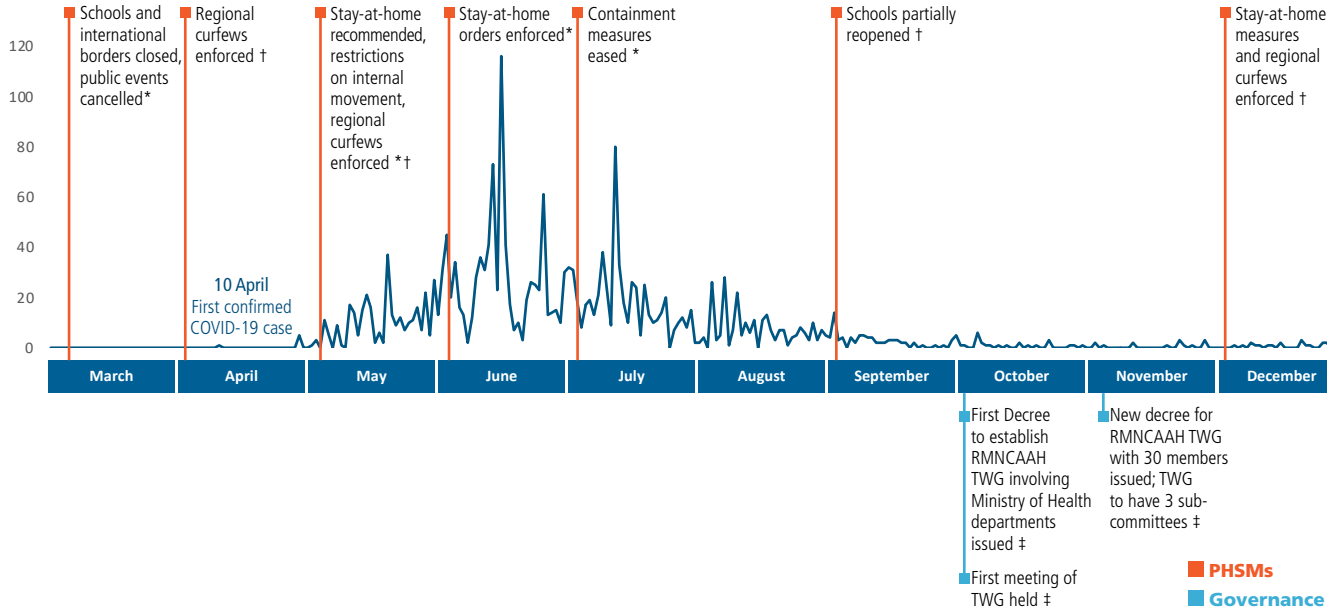
Photo credit: WHO/@whosudan

Country report - Yemen

A. The COVID-19 context

The first confirmed COVID-19 case in Yemen was in April 2020. The number of cases peaked in June and declined in the last months of the year (**Figure B.3.22**).

Fig. B.3.22. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * *(14)*; † *(15)*; ‡ National consultant reports; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

In October 2020, a national RMNCAAH TWG was established to focus on mitigating the impacts of COVID-19 on the relevant populations. The first meeting was held at the end of October 2020.

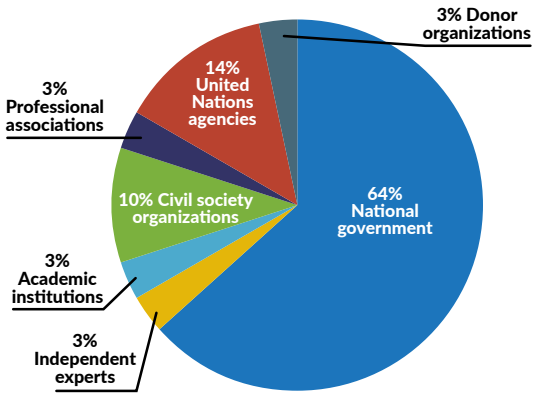
The TWG has 30 members (see **Figure B.3.23** for members by agency). Of the members, 40% were women (the gender was unknown for 10%). Three sub-committees work on the five priority workstreams established by the TWG:

- Policy dialogue and implementation
- Information sharing and support
- Monitoring

When the TWG was first convened, agenda items included identifying priority EHS for RMNCAAH population groups. This planning was for the acute phase of the pandemic as well as a possible future outbreak/crisis.

The TWG meets monthly while sub-committees meet as often as required.

Fig. B.3.23. TWG membership distribution, by agency



C. Guidance for RMNCAAH services in response to COVID-19

Guidance issued by Yemen to help maintain services in the face of the pandemic is shown in **Table B.3.5.**

Table B.3.5. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
National guide for reproductive health service providers during the COVID-19 pandemic	June	
Revised version of Referral guideline for safe motherhood	Aug	
Amendment of nutrition guidelines for treatment of cases of malnutrition in ways that limit the spread of COVID-19 infection	May	

D. Key actions to ensure continuity of RMNCAAH services

Yemen took a number of actions to mitigate the effect of the pandemic on RMNCAAH services (**Table B.3.6**).

Table B.3.6. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Construction and rental of additional warehouses for storing additional supplies	Cross-cutting
	Additional supplies of medical commodities (FP, reproductive health kits, clean birth kits, medicines for treating rape and post-abortion care)	Maternal and newborn health FP
	Introduction of a new self-injected contraceptive method (Sayan)	FP
Health services adaptations	Clarification and reinforcement of referral process for maternal and newborn emergency cases	Maternal and newborn health
	Kangaroo mother care practice established at community level	Maternal and newborn health
	Two additional immunization campaigns	Immunization
	Nutrition programme facility and mobile team follow-up visits reduced from weekly to monthly	Nutrition
	MUAC measurement established as sole criteria in assessing nutritional status and basis of entry criteria to outpatient therapeutic/supplementary feeding programmes	Nutrition
	Modification of entry and follow-up criteria to outpatient therapeutic/supplementary feeding programmes for pregnant and lactating mothers with moderate acute malnutrition	Nutrition

	MITIGATING ACTION	SERVICE AREA
Service delivery settings	Increase in services and referrals provided by CMWs at community level across geographical areas, i.e. FP and ANC services, home birth, basic emergency obstetric care and community newborn care	Maternal and newborn health FP
	Enhanced mobile services for FP, ANC and nutrition, particularly in camps for internally displaced people	Maternal and newborn health FP Nutrition
	Mobile units conducting examinations for physical and mental health among children in wake of school closures	Child and adolescent health
Safe patient workflow	IPC measures during service delivery and distribution of PPE for health workers	Cross-cutting
	Screening, triage and referral to isolation centres in 13 governorates, including one isolation centre for emergency obstetric care	Cross-cutting
Telehealth and digital technology	Hotline services for FP, ANC and support for women and girls at risk of/experiencing violence (e.g. WhatsApp for medical consultations including obstetrics/gynaecology)	Maternal and newborn health FP GBV
	Training of CMWs in emergency obstetric care enhanced to include more FP and ANC services	Maternal and newborn health FP
	Training of medical staff and postgraduate students in IMCI	Child and adolescent health
	Hotline service for older people on general health, COVID-19 prevention and chronic diseases	Older people
Optimizing workforce capacity	Health workers retained with incentives to prevent health system collapse due to reduction in donor support	Cross-cutting
	Training on IPC protocols and measures for health workers and community health volunteers	Cross-cutting
	Provision of psychosocial support in the community for CMWs	FP
Communications strategies	Radio programmes for raising awareness of women's rights and GBV issues	GBV

E. Monitoring of service utilization

Data from 2019 and 2020 for key RMNCAAH indicators were compiled from the national HMIS. **Figures B.3.24 – B.3.33** show changes in utilization of health services in facilities reporting to the HMIS. (Note that data for December 2020 are not available.)

FP

- The reported number of clients who received oral contraceptives was higher in 2020 for most months in comparison to the corresponding months of 2019 (**Figure B.3.24**).
- The reported number of clients who received injectable contraceptives was lower in 2020 compared to 2019 from May 2020 onward, but returned to similar levels by the end of the year (**Figure B.3.25**).

Fig. B.3.24. Number of clients who accepted oral contraceptives

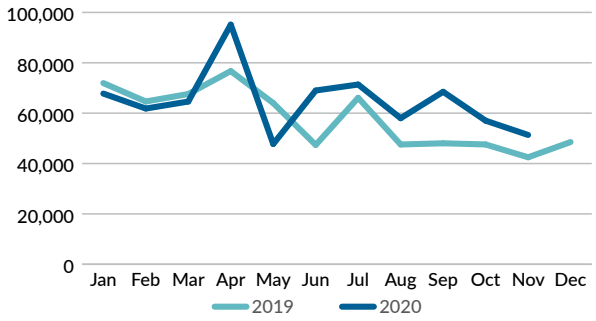
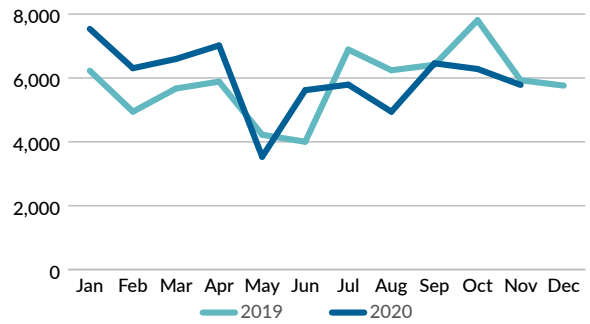


Fig. B.3.25. Number of clients who accepted injectable contraceptives



Maternal and newborn health

- The reported number of ANC contacts was lower in 2020 than in the corresponding months of 2019, and had not returned to similar levels by the end of the year (**Figure B.3.26**).
- The reported number of births in facilities was lower in 2020 than in most corresponding months of 2019, but was returning to similar levels by the end of the year (**Figure B.3.27**).
- The percentage of births by caesarean section in 2020 was slightly higher than in the corresponding months of 2019 (**Figure B.3.28**).
- The reported number of newborns admitted for inpatient care was lower for most months of 2020 than the corresponding months of 2019 (**Figure B.3.29**).

Fig. B.3.26. Number of ANC visits/contacts

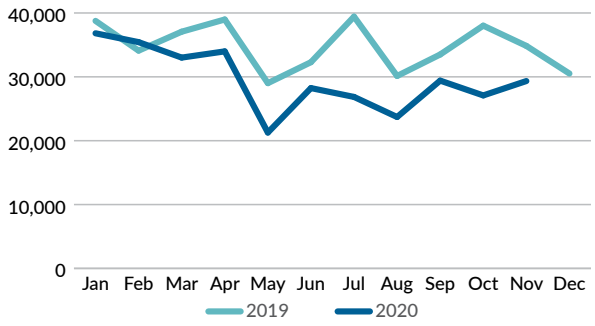


Fig. B.3.27. Number of facility births

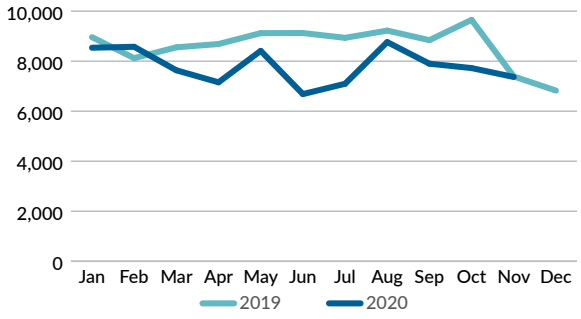


Fig. B.3.28. Percentage of caesarean births

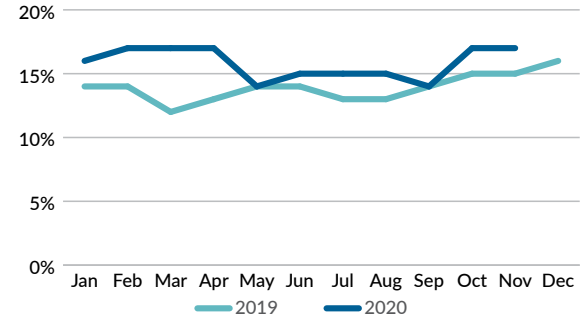
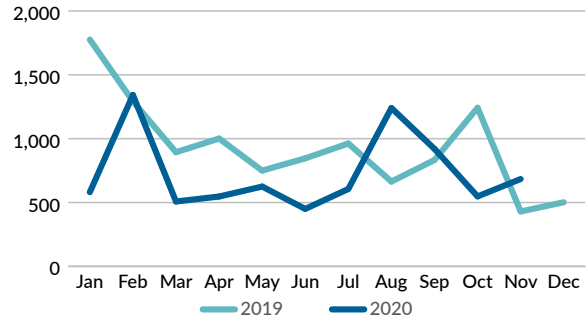


Fig. B.3.29. Number of newborns admitted for inpatient care



Child health and immunization

- The reported number of children less than 1 year of age receiving the third dose of pentavalent vaccine was higher in 2020 than in 2019 (**Figure B.3.30**).
- The reported numbers of children less than 5 years of age seen for ARIs (**Figure B.3.31**) and treated for diarrhoea (**Figure B.3.32**) in facilities were higher in 2020 than in the corresponding months of 2019.
- The reported number of children 6 – 59 months of age admitted for SAM was lower in 2020 than in the corresponding months of 2019 (**Figure B.3.33**).

Fig. B.3.30. Number of children < 1 year of age receiving 3rd dose of pentavalent vaccine

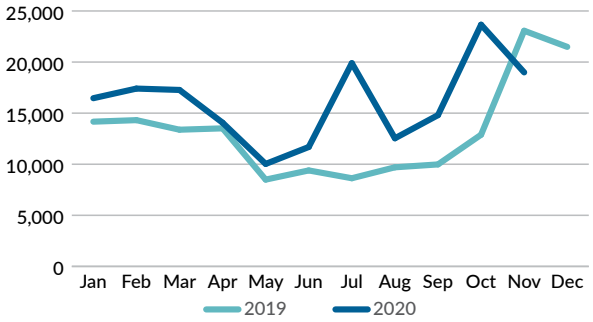


Fig. B.3.31. Number of children < 5 years of age with ARIs seen in health facilities

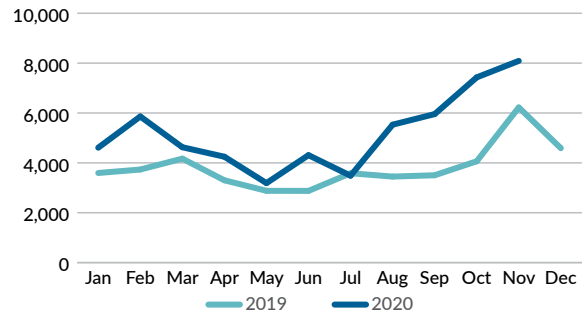


Fig. B.3.32. Number of children < 5 years of age treated for diarrhoea in health facilities

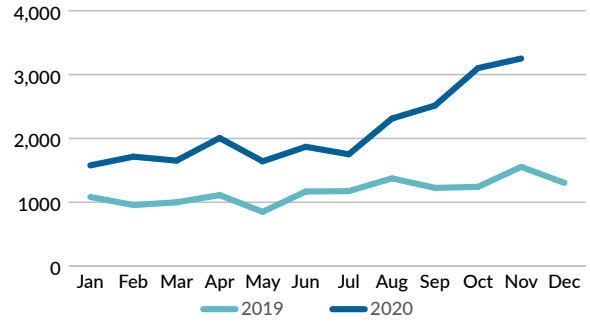
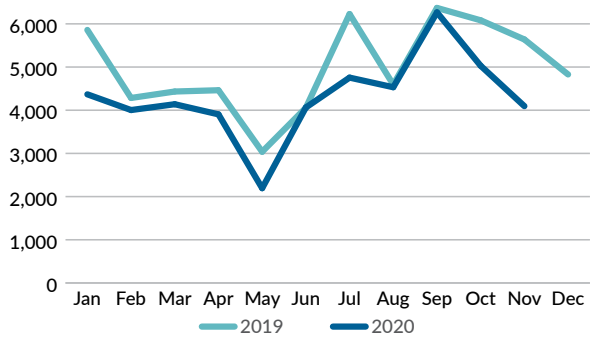


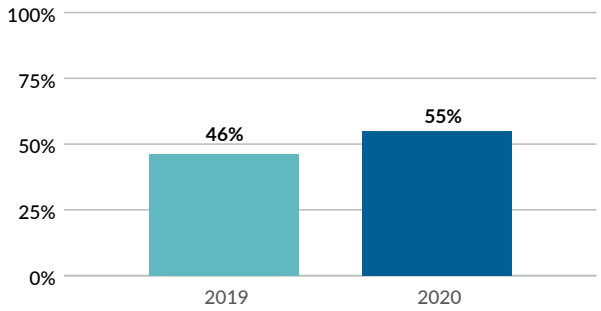
Fig. B.3.33. Number of children 6 - 59 months of age admitted as SAM cases with wasting and bilateral pitting oedema



Reporting completeness

- HMIS reporting completeness was higher in 2020 than in 2019 (**Figure B.3.34**) according to annual figures.

Fig. B.3.34. Completeness of HMIS reporting (%)



F. Lessons learned

- Poor emergency preparedness, ineffective implementation of comprehensive contingency plans and shortage of most medical commodities at facility level led to chaos and disruption of service delivery at the beginning of the pandemic.
- Training courses were not well planned to effectively confront the pandemic and meet the needs of the target group.
- Distribution of PPE was not proportional to the magnitude of services provided by the facility or the population density.
- EHS during a crisis should be approached using multiple methods, strategically distributing medical commodities and strengthening community-based services. Crisis responses should not completely rely on partner organizations and donors.
- Modifications to diagnosis and treatment criteria for nutritional status excluded weight and height/length measurements and solely relied on MUAC measurement. These modifications reduced physical contact during anthropometric measurements and were meant to prevent overcrowding in service delivery settings and reduce risk of infection transmission. Basing nutritional assessment on MUAC in accordance with Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey analysis resulted in diagnosing more children with SAM and moderate acute malnutrition and changes in entry criteria for outpatient therapeutic programmes/supplementary feeding programmes.
- The Ministry of Public Health and Population is in need of technical and financial support. In particular, the capacity to respond to pandemics, outbreaks and disasters needs to be improved.

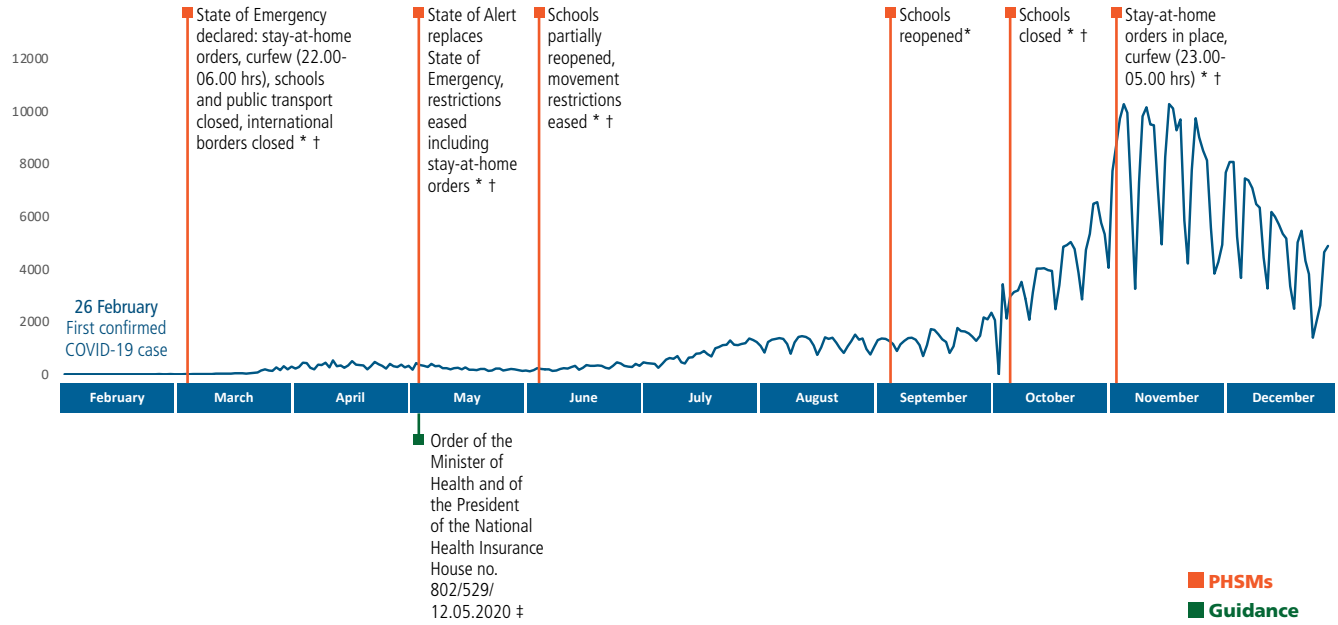
B.4 European Region

Country report - Romania

A. The COVID-19 context

After the appearance of the first confirmed COVID-19 case in February 2020, cases rose very slowly until a peak in November followed by the start of a decline (**Figure B.4.1**). However, the numbers fluctuated greatly in the last quarter of the year.

Fig. B.4.1. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * *(15)*; † *(14)*; ‡ National consultant reports; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

The Romanian Ministry of Health established a commission specifically for COVID-19 epidemiology and management with representation from government, health services and research organizations. This commission oversees the country's response to COVID-19.

As of October 2020, RMNCAAH services were not included on the commission's agenda, and no separate committees were established.

Special commissions at the level of the Ministry of Health did advise the larger commission on specific patient groups (e.g. children) and produced guidelines and protocols to minimize the impact of COVID-19 on these groups.

C. Guidance for RMNCAAH services in response to COVID-19

National guidance was produced to help maintain health services during the pandemic (**Table B.4.1**).

Table B.4.1. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Decree no. 195/2020 for ensuring access to medical services in safe conditions for doctors and patients ■ Waiving of social insurance confirmation procedures and co-payment arrangements ■ Permitted changes to prescriptions	March	
Order of the Minister of Health and of the President of the National Health Insurance House no. 802/529 ■ Enables use of remote service provision in certain service areas	May	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Table B.4.2 shows the key actions the country took to mitigate the effect of the pandemic on health services.

Table B.4.2. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Telehealth and digital technology	Telemedicine and teletherapy for mental health services	Cross-cutting
	Medical prescriptions sent by email or text message	Cross-cutting
	Phone consultations for chronic conditions	Cross-cutting Child and adolescent health Older people
Removing financial barriers to access	Suspension of national social health insurance card requirement to receive services	Cross-cutting
Optimizing workforce capacity	Providers supported by private sponsorships during lockdown	Cross-cutting
Communications strategies	Ministry of Health issued press release to encourage parents to schedule vaccination visits for children	Immunization

E. Lessons learned

- Suspension of outpatient care during lockdowns can place great pressure on the health system.
- Health service providers have taken the initiative to adapt individually and adopt best practices.

Romania - Vaccine marathon

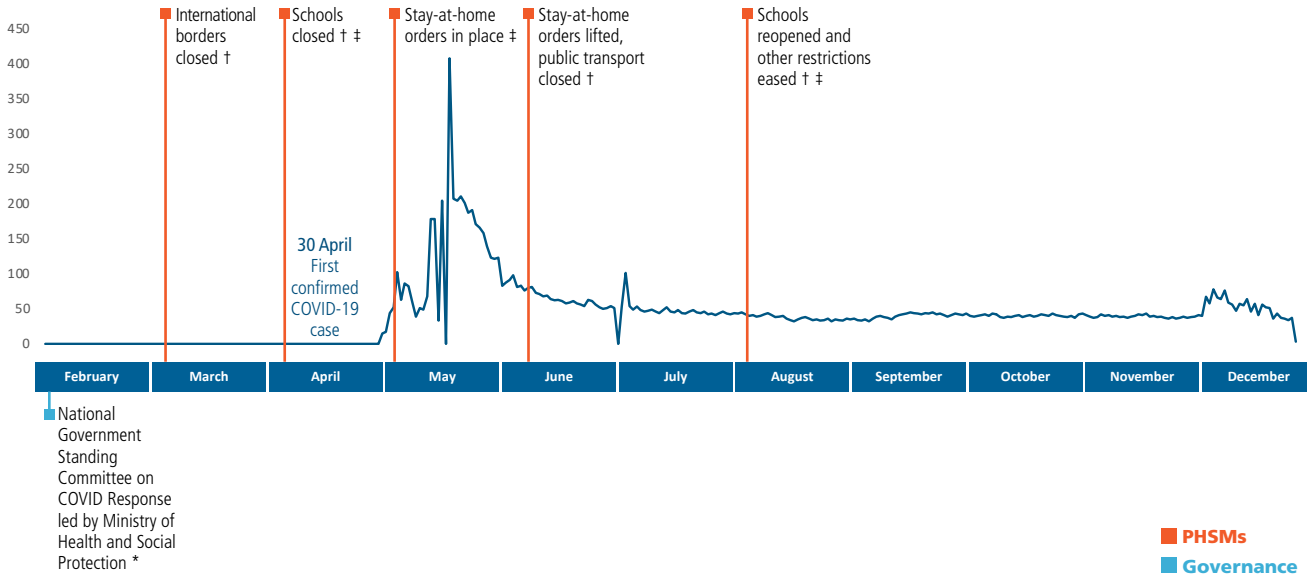
Photo credit: Petru Cojocaru

Country report - Tajikistan

A. The COVID-19 context

Tajikistan did not have any COVID-19 cases until the end of April 2020, but some measures were already in place to protect health services. The number of reported cases peaked in May, and gradually returned to low levels for the rest of the year (**Figure B.4.2**).

Fig. B.4.2. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * National consultant reports; † *(15)*; ‡ *(14)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

The Tajikistani Ministry of Health and Social Protection established a working group specifically for the response and prevention of COVID-19 with representation from the government, hospitals and laboratories. In 2020, RMNCAAH services were not on the working group's permanent agenda, but issues specific to RMNCAAH were periodically discussed. During a working group meeting in late 2020, the Deputy Minister for Maternal, Newborn and Child Health services called for the prioritization of RMNCAAH services and care. No separate committees or working groups for these services during COVID-19 have been established.

C. Guidance for RMNCAAH services in response to COVID-19

Tajikistan issued guidance on maintaining health services, but not specifically for RMNCAAH (**Table B.4.3**).

Table B.4.3. Guidance issued for RMNCAAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Order of President of Republic of Tajikistan on salaries for medical workers during COVID-19	May	
Draft "Strategic plan for the response and prevention of COVID-19 infectious disease in the Republic of Tajikistan"	In progress	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Tajikistan took several actions to mitigate the effect of the pandemic on its health services (**Table B.4.4**).

Table B.4.4. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	UNFPA provided contraceptives to prevent supply shortages	FP
Transport for facilitating mobility	Improved coordination between PHC, ambulances and hospitals	Cross-cutting
Health services adaptations	Night shifts introduced in PHC facilities	Cross-cutting
	Ministry of Health and Social Protection ensured regular home visits for early detection of COVID-19, registration of pregnancies, and provision of ANC and other services	Maternal and newborn health
	ANC visits to a health facility reduced to a maximum of four during pregnancy, with health workers conducting home visits	Maternal and newborn health
Service delivery settings	Home visits for patients with chronic conditions	Cross-cutting
	People living with HIV visited at home for management of ART side effects	HIV
Safe patient workflow	IPC standards implemented and health facility staff trained in IPC procedures	Cross-cutting
Telehealth and digital technology	Phone consultations	Cross-cutting
Optimizing workforce capacity	Recruitment of new nurses due to staff retirement or resignation during pandemic	Cross-cutting
	Specialized doctors joined PHC providers to ensure coverage of home visits	Cross-cutting
	Hospital and outpatient health workers provided with food incentives	Cross-cutting

E. Lessons learned

- The Ministry of Health and Social Protection should prioritize a supportive environment for accurate data reporting and evidence-based decision-making. This requires capacity-building (e.g. in data collection, decision-making) and transforming a punitive culture around data reporting challenges into a supportive environment for accurate reporting.

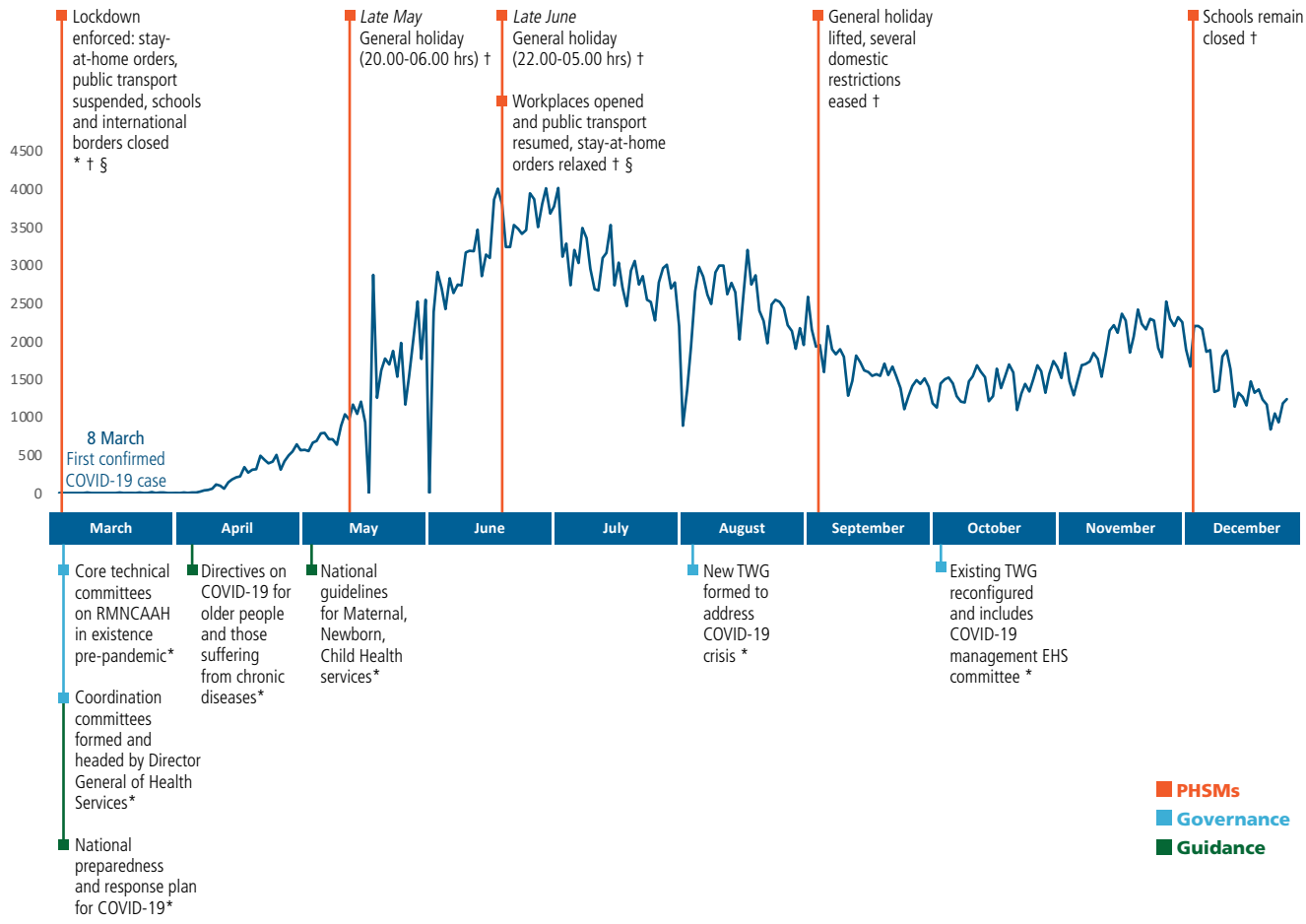
B.5 South-East Asia Region

Country report - Bangladesh

A. The COVID-19 context

The first reported COVID-19 case in Bangladesh was reported in March 2020. The number increased to a peak at the end of June/beginning of July and declined somewhat for the rest of the year (**Figure B.5.1**). Restrictive measures and relevant policies began to be put in place from March.

Fig. B.5.1. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * National consultant reports; † *(15)*; § *(14)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

In March 2020, the *Bangladesh preparedness and response plan* was developed to prevent and control the spread of COVID-19, mitigate pandemic-related impacts on EHS and the economy, and reduce pandemic-related morbidity and mortality. A national body dedicated to the continuity of EHS was maintained from the initial preparedness and response plan formation throughout subsequent structural reorganizations of the COVID-19 response.

A Core Technical Committee and Partnership on RMNCAAH, including country-level thematic working groups, was in place before the pandemic. In October 2020, a new national TWG to coordinate pandemic response was formed with six subcommittees. The Committee for Essential and Routine Health Care Services was tasked with maintaining continuity, including for RMNCAAH services, immunization programmes, nutritional services, PPE provision for providers and health service continuity at subnational levels. At inception, committee members included individuals from the Ministry of Health and Family Welfare, a national maternal health association and United Nations agencies such as UNICEF, UNFPA and WHO. The committee met virtually each month.

C. Guidance for RMNCAAH services in response to COVID-19

Table B.5.1 shows the guidance put in place to ensure EHS during the pandemic.

Table B.5.1. Guidance for RMNCAAH services issued

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
COVID-19 Pandemic: stakeholders' recommendations on strengthening contraceptives, menstrual regulation and post-abortion care	April	
Government directives on COVID-19 pandemic: how to help older people and those suffering from chronic diseases	April	
National guideline for providing essential maternal, newborn and child health services in the context of COVID-19 (Version 1.2)	May	
SOPs for pregnant women and family (Obstetric and Gynaecological Society of Bangladesh) in the COVID-19 pandemic	April	
Government order on clinical contraception, long-action and permanent methods	April	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Key actions were taken by the government to mitigate the effects of the pandemic on health services (**Table B.5.2**).

Table B.5.2. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Ensured supply and distribution of antibiotics for childhood illness, EPI vaccines, oxytocin and magnesium sulphate for management of labour, and iron and folic acid for mothers	Cross-cutting
	Iron and folic acid to pregnant and lactating mothers supplied for longer duration	Maternal and newborn health
	Increased distribution of short-acting FP methods	FP
	Extended prescriptions for FP	FP
	Promotion of self-injection contraceptive methods	FP
	Promotion of long-acting contraceptive methods	FP
Health services adaptations	Face-to-face ANC consultations limited to four with clients prioritized by stage of pregnancy (earliest first) and teleconsultation for others	Maternal and newborn health
	First PNC consultation at facility for clients who had hospital birth, and teleconsultations thereafter until the 6-week face-to-face consultation (except in case of complications)	Maternal and newborn health
	Presence of labour companion encouraged	Maternal and newborn health
	Promotion of midwifery-led care at facilities	Maternal and newborn health
	Promotion of early breastfeeding and skin-to-skin contact	Maternal and newborn health
Service delivery settings	Home visits to individuals by community-based health workers limited. Priority given to high-risk pregnant women, mothers, newborns with complications and low-birth-weight babies	Maternal and newborn health
	Distribution of contraception by Community Health Care Providers at community clinics	FP
Safe patient workflow	IPC and PPE for maternity care facilities	Maternal and newborn health
	Screening triage and isolation for women at facilities	Maternal and newborn health
	Use of mask in labour room mandated	Maternal and newborn health
	Long-acting and permanent methods service providers orientated through virtual technology	FP

	MITIGATING ACTION	SERVICE AREA
Telehealth and digital technology	24/7 telecounselling services via government call centres	Cross-cutting
	Digital platforms (WhatsApp, Viber), hotlines and telemedicine and support services on maternal, child, reproductive and adolescent health provided (some 24/7)	Maternal and newborn health Child and adolescent health
	Teleconsultancy for ANC provided by Obstetric and Gynaecological Society of Bangladesh at tertiary and community levels	Maternal and newborn health
	Virtual orientation on maternal, newborn and child health guidelines for providers platform	Maternal and newborn health Child and adolescent health
	Use of mobile messages for ANC, PNC and essential newborn care services	Maternal and newborn health
	Virtual platform for training staff on revised IMCI protocols	Nutrition
Optimizing workforce capacity	Recruitment of additional doctors, nurses and midwives	Cross-cutting
Communications strategies	Community and volunteer groups engaged to help distribute health care information to families	Cross-cutting
	Community radio messages for raising awareness on maternal, child, reproductive and adolescent health and FP services	Maternal and newborn health Child and adolescent health FP
	Social and behavioural change communication materials (print/audio/visual) developed and disseminated at various levels	Maternal and newborn health

E. Lessons learned

- Online training replaced some hands-on, clinical training for health workers (i.e. IPC, normal vaginal birth, resuscitation). Limited and interrupted internet service in some rural areas proved challenging for delivery of virtual training.
- The conversion of existing health facilities to COVID-19 treatment facilities led to disruptions of essential RMNCAAH services in these facilities' catchment areas.
- Some private health facilities limited their services at the early stage of the pandemic. The strain of COVID-19 on health facilities and workers required coordination among different partners and sectors.

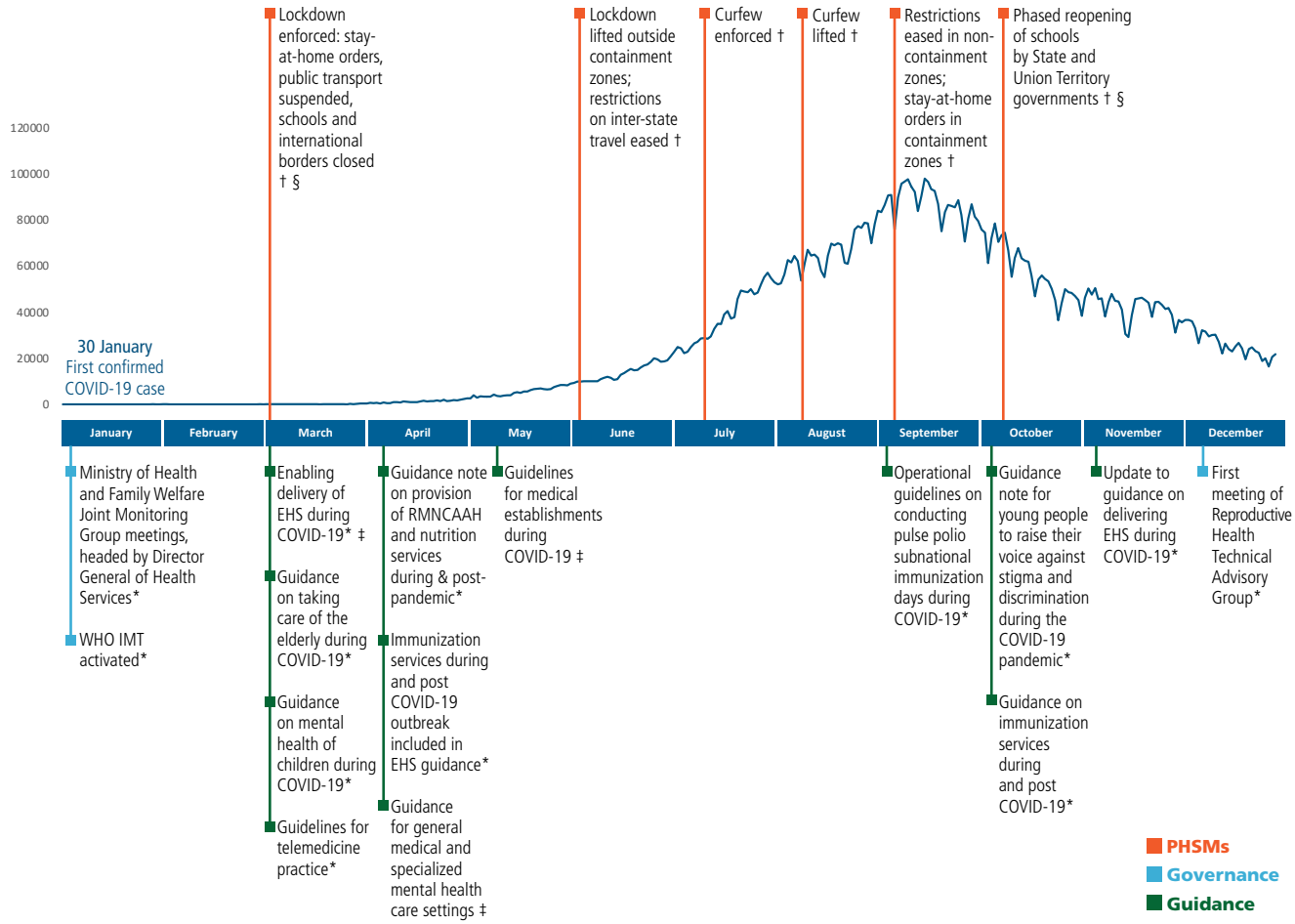
National stakeholders' meeting - December 2020
Photo credit: WCO Bangladesh

Country report - India

A. The COVID-19 context

The first confirmed COVID-19 case in India was on 30 January 2020. The outbreak subsequently led to very high numbers of cases, peaking in September. Various restrictive measures and guidance were put in place in response (**Figure B.5.2**).

Fig. B.5.2. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * National consultant reports; † *(15)*; ‡ *(7)*; § *(14)*; First Case + Epi Curve: https://covid19.who.int/.

B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

The Reproductive Health Advisory Group met for the first time in December 2020.

C. Guidance for RMNCAAH services in response to COVID-19

Table B.5.3 shows key guidelines that were issued by India as the pandemic evolved.

Table B.5.3. Guidance for RMNCAAH services issued

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Enabling delivery of EHS during the COVID-19 outbreak	March	
Guidelines for telemedicine practice	March	
Guidance document for taking care of the elderly during COVID-19	March	
Guidance document on taking care of mental health of children during COVID-19	March	
Guidance for general medical and specialized mental health care settings	April	
Guidance note on provision of RMNCAAH and nutrition services during and post COVID-19 pandemic	April	
Immunization services during and post COVID-19	May	
Guidance note for immunization services during and post COVID-19 situation	May	
Guidelines for medical establishments during COVID-19	May	
Operational guidelines on conducting pulse polio subnational immunization days during COVID-19	Sept	
Guidance note for young people to raise their voice against stigma and discrimination during the COVID-19 pandemic	Oct	

D. Key actions to ensure continuity of RMNCAAH services

Several actions were taken at the local, state and national levels to ensure that services continued during the pandemic (**Table B.5.4**).

Table B.5.4. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Promotion of Centchroman (postcoital contraceptive) usage throughout the country	FP
	Condom boxes placed in post offices in Assam State	FP
	FP commodities delivered by post in Orissa State	FP
Health services adaptations	Extra days to provide ANC and immunization services by front-line health workers in Chhindwara District, Madhya Pradesh State	Maternal and newborn health Immunization
	Dedicated ANC outpatient department and iron and folate acid and calcium counters at ANC registration set up in Jharkhand State (Ranchi/Ramgarh/Khunti)	Maternal and newborn health

	MITIGATING ACTION	SERVICE AREA
Service delivery settings	RMNCAAH primary care services available from previously non-functional health facilities (sub-health centre from Village Hiroli, Dantewada, Chhattisgarh State)	Cross-cutting
	House-to-house visits conducted by ASHA or health workers/COVID warriors for COVID-19 purposes utilized to enquire about services for women and children and provide linkages to required services	Cross-cutting
	Primary health centres offer safe MCH services, i.e. birth for pregnant women without complications (Block Tilda Neora, Raipur, Chhattisgarh State, Health and Wellness Centres)	Maternal and newborn health Child and adolescent health
	Standard Operation Procedures for screening, triage and isolation for suspected maternal and newborn COVID-19 cases developed by All India Institutes of Medical Sciences disseminated across all facilities	Maternal and newborn health
	FP services available at health and wellness centres	FP
Safe patient workflow	PPE for health workers conducting deliveries in Jharkhand State (Ranchi/Ramgarh/Khunti)	Cross-cutting
	Labour room spatial arrangements to reduce COVID-19 risk in shared spaces in Danapur, Bihar State	Maternal and newborn health
	Pre-birth waiting rooms created to ensure timely service provision; 19 in Sukma and 5 in Dantewada, Chattisgarh State	Maternal and newborn health
	Separate wing and entrance for all ANC services and dedicated staff in Chhindwara, Sub-district Hospital Sausar in Madhya Pradesh State	Maternal and newborn health
Telehealth and digital technology	Telemedicine digital platform E-Sanjeevani for caregivers, medical professionals and those seeking health services	Cross-cutting
	Department of Personnel and Training launched a learning platform (https://www.pradhanmantriyojana.co.in/igot-online-training-portal-covid/) for all frontline workers for training and to provide updates on coping with the pandemic	Cross-cutting
	Telemedicine training and webinar series on providing safe RMNCAAH care during COVID-19	Maternal and newborn health Child and adolescent health
	WONDER App: dedicated mobile-based application developed in Darbhanga, Bihar for tracking high-risk pregnancies and providing referral and ambulance service	Maternal and newborn health
	Online training for national adolescent counsellors on essential services and on COVID-19 (including services, referral and reinforcing COVID-19 appropriate behaviour)	Child and adolescent health
	Mobile app for informing adolescents and peer educators on SRH, nutrition, mental health and COVID-19 in Uttar Pradesh State	Child and adolescent health FP Nutrition
	Screening of clients for Antara Programme (Depo Provera contraceptive injection) at sub-health centres and outreach via teleconsultations in Rajasthan State	FP
	National helpline for FP counselling and referral set up	FP

	MITIGATING ACTION	SERVICE AREA
Optimizing workforce capacity	Additional nursing staff redeployed from other facilities in Chhattisgarh State	Cross-cutting
	Private doctors delivering emergency ANC and childbirth services in Chhindwara, Madhya Pradesh State	Maternal and newborn health
	Online training of 11 500+ paramedical staff along with obstetric and gynaecological association on continuation of RMNCAH services	FP
Communications strategies	Women's self-help groups engaged in community sensitization on COVID-19	Maternal and newborn health
	Youth outreach engagement and peer-networking undertaken by youth leaders through the YP Foundation	Child and adolescent health

E. Lessons learned

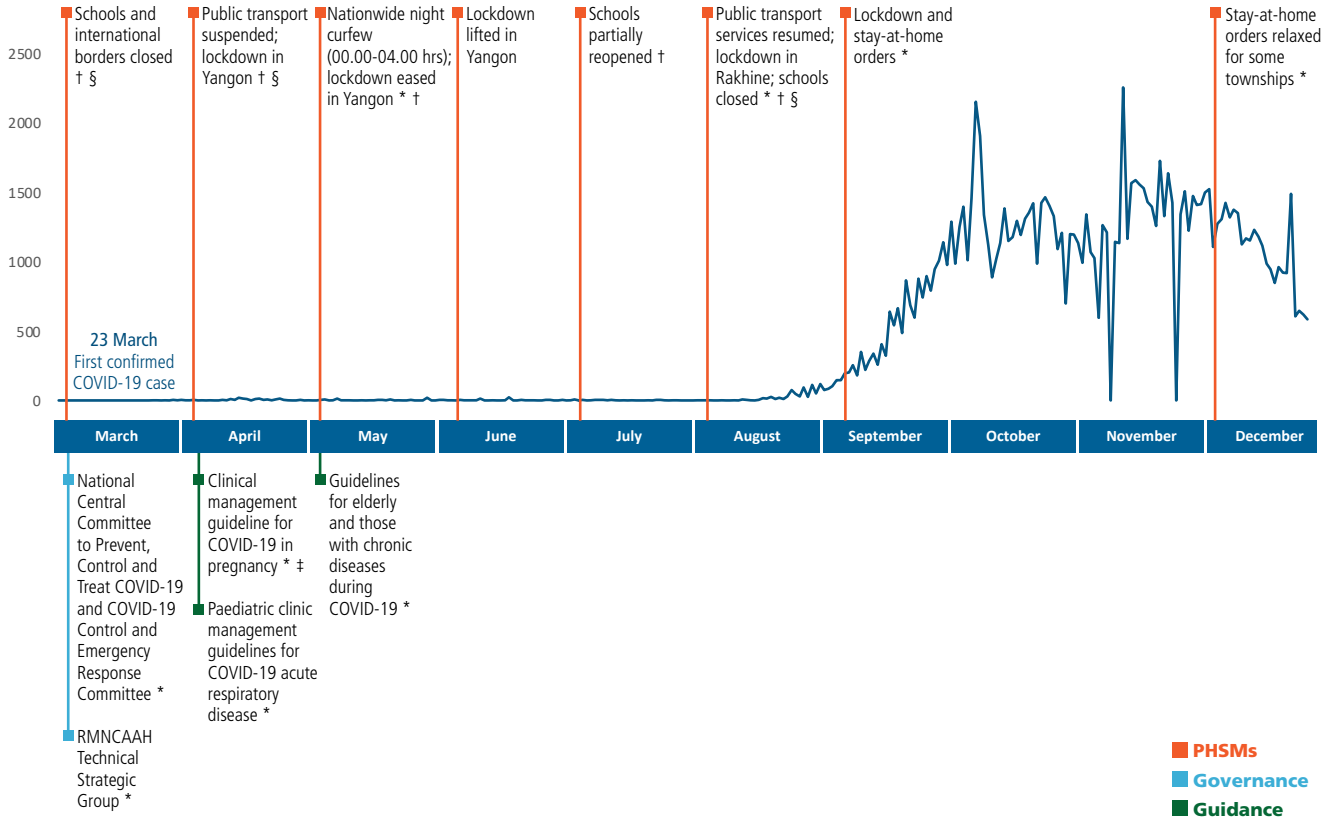
- 'Whole of government-whole of society'- cross-sectoral government approach and strong government leadership have been key for ensuring an effective pandemic response.
- Timely issuance of simple, clear and specific guidelines from the national level and their dissemination across the country with a focus on 'no denial of services' ensured the availability of RMNCAAH services and mitigated impact on maternal and newborn health.
- RMNCAAH drugs and commodities needed for continuing RMNCAAH services were treated as essential commodities, particularly contraceptives in urban settings. Essential medicines such as iron-folic acid, calcium, ORS, zinc, and contraceptives, were delivered to homes through police and other non-health sector mechanisms, another example of cross-sectoral collaboration during the pandemic.
- Focussing on integrated service delivery through strengthening of PHC facilities, particularly health and wellness centres, was key in maintaining essential RMNCAAH services.
- Flexible COVID-19 testing ensured that pregnant women received the care they needed. At the start of the national lockdown, India had interim policy directives for triage and treatment of pregnant women with flexible testing requirements. This was supplemented with clear clinical guidelines for PPE and IPC to protect health workers from possible COVID-19 infection. This sort of agile policy ensured the delivery of services while respecting COVID-19 protocols.
- Regarding digital health, innovations leveraging digital technology emerged like recording and monitoring high-risk pregnancies through web-based applications. Nonetheless other uses of digital technology, such as online consultations, have resulted in visible fatigue. Adopting new and innovative ways to engage participants will be important to maintain momentum.

Country report - Myanmar

A. The COVID-19 context

The first confirmed COVID-19 case in the country was reported in March 2020. The numbers increased from September and stayed at the same level (with much variability) until the end of the year (**Figure B.5.3**). The government of Myanmar enacted various measures to contain the pandemic and issued guidelines.

Fig. B.5.3. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * National consultant reports; † *(15)*; ‡ *(7)*; § *(14)*; First Case + Epi Curve: https://covid19.who.int/.

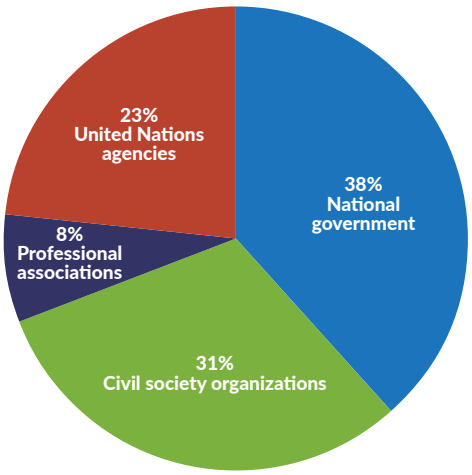
B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

The RMNCAAH Technical Strategic Group (TSG) has been functioning in Myanmar since before the COVID-19 pandemic. The TSG is under the Myanmar Health Sector Coordination Committee chaired by the Union Minister of Health and Sports. The TSG is composed of both a Core Group and Extended Groups. **Figure B.5.4** shows the RMNCAAH TSG Core Group member distribution by agency.

Four TWGs report to the RMNCAAH TSG, including ones on reproductive health, FP, child health and youth and adolescent health. The TSG and TWGs meet every quarter; the meeting agenda is set on an as-needed basis by members.

During the pandemic, mitigation of the COVID-19 impact on RMNCAAH is an additional role of the TSG and TWGs. However, in 2020 the linkage between the TSG and COVID-19 Response Committee was not well recognized.

Fig. B.5.4. RMNCAAH TSG Core Group member distribution, by agency



C. Guidance for RMNCAAH services in response to COVID-19

Several national guidelines to mitigate the impact of COVID-19 on RMNCAAH services were developed from May 2020 (**Table B.5.5**).

Table B.5.5. Guidance for RMNCAAH services issued

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Guideline for elderly and those with underlying chronic diseases during COVID-19	May	Ageing
SOPs on resumption of immunization services during and after COVID-19 outbreak	May	Child health
Key national guidelines for care of COVID-19 patients covered by RMNCAAH services	**Month (2020)**	**Content**
Clinical management guideline for COVID-19 in pregnancy	April	Maternal health, Newborn health
Paediatric clinical management guidelines for COVID-19 acute respiratory infection	April	Child health

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Various actions took place to mitigate the effect of the pandemic on RMNCAAH services (**Table B.5.6**).

Table B.5.6. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	Pre-scheduled appointments for outpatient services	Cross-cutting
	Pre-scheduled appointments with hospital-based paediatricians	Child and adolescent health
	Additional supplies of self-injecting contraceptive -DMPA-SC- to prevent stock outs	FP
	Pre-scheduled appointments for immunization and extension of vaccination days	Immunization
Health services adaptations	ANC services, PMTCT testing, weighing, immunization, iron supplements provided for pregnant women in quarantine centres	Maternal and newborn health
Safe patient workflow	PPE for health workers and midwives in health centres, and IPC in hospital facilities	Cross-cutting
	App platforms (Viber, Facebook Messenger) set up among health department officials to liaise on quarantine care	Cross-cutting
	General practitioner and paediatric teleconsultations for children in some hospitals	Child and adolescent health
	Free teleconsultations and information on FP and sexual health provided by NGO partner	FP
Telehealth and digital technology	Cash transfer to pregnant women and children less than 2 years using the *Ngwe Byte* app	Cross-cutting
	Government help line for emergency calls, including for GBV	Cross-cutting GBV
	Teleconsultations and hotline for older people's health and psychological support	Older people
Removing financial barriers to access	Health services provided free of charge at quarantine facilities supported by business donors	Cross-cutting
	App (*Ngwe Byte*) provides one-off payment of Kyats 30 000 (US$ 20) to families	Cross-cutting
Optimizing workforce capacity	Volunteer training in health services and psychosocial support for pregnant mothers, newborns, children, older people and survivors of GBV conducted via online platform/video conferencing	Maternal and newborn health Child and adolescent health GBV Older people

	MITIGATING ACTION	SERVICE AREA
Communications strategies	Ministry of Health and Sports website provided messages on menstrual hygiene, self-care and nutrition and hosted frequently-asked questions for pregnant and lactating mothers and newborns/ infants	Maternal and newborn health
	Nutrition promotion activities carried out in townships and camps for internally displaced people	Nutrition

E. Lessons learned

- **Health workforce management**. Early in the pandemic, midwives were tasked with COVID-19 preventive measures at the expense of routine RMNCAAH services, including immunization for children and pregnant mothers. Although routine services resumed later, service disruption could be avoided in future by tasking disease outbreak prevention to other health cadres, such as public health supervisors or volunteers.

- **Governance**. Myanmar responded to the COVID-19 pandemic with a coordinated effort among the concerned ministries and departments under the oversight of the then State Counsellor, as the Chair of the National Level Central Committee for Prevention, Control and Treatment of COVID-19. Several other committees were also formed to actualize timely and effective response actions. The RMNCAAH focal points should be included in the working committees' plans so comprehensive responses consider the needs of vulnerable populations, including mothers, children, adolescents and older people.

- **SOPs for RMNCAAH**. SOPs to continue RMNCAAH services during the pandemic should be developed to ensure consistent and uniform service implementation nationally and anticipate disease transmission in the future.

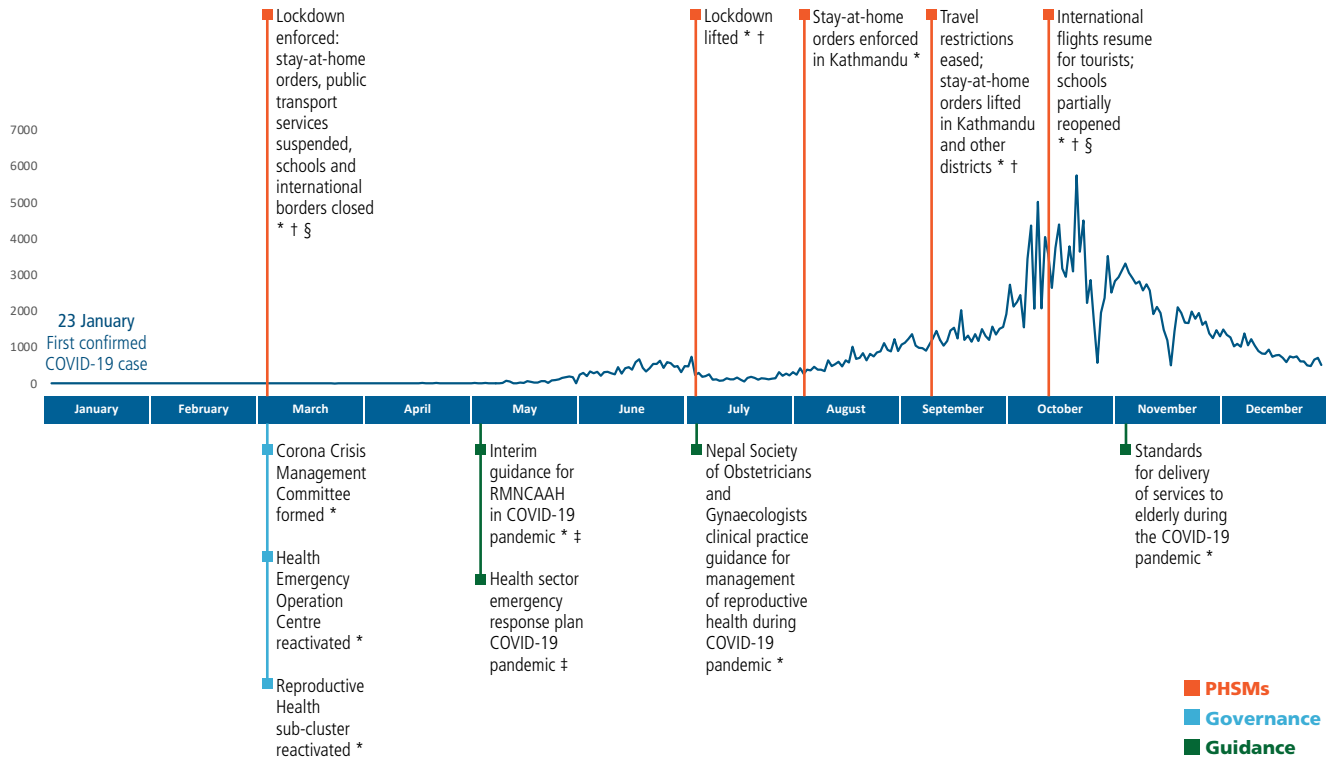
- **Real-time monitoring of RMNCAAH services**. In Myanmar, the electronic District HMIS, DHIS-2, has been functioning across the country, and the coverage of the electronic logistic management information system has reached one third of the country. During the pandemic, some delays occurred in monthly reporting through these electronic platforms. To ensure real-time monitoring of RMNCAAH services and, therefore, evidence-based responses, necessary support should be provided to health staff as well as officials from state, regional and central levels.

Country report - Nepal

A. The COVID-19 context

Figure B.5.5 shows the course of the pandemic in Nepal in 2020, with the first case confirmed in January and the numbers peaking in October before declining towards the end of the year. Restrictions and guidance were put in place from March.

Fig. B.5.5. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAAH services



Sources: * National consultant reports; †*(15)*; ‡ *(7)*; § *(14)*; First Case + Epi Curve: https://covid19.who.int/.

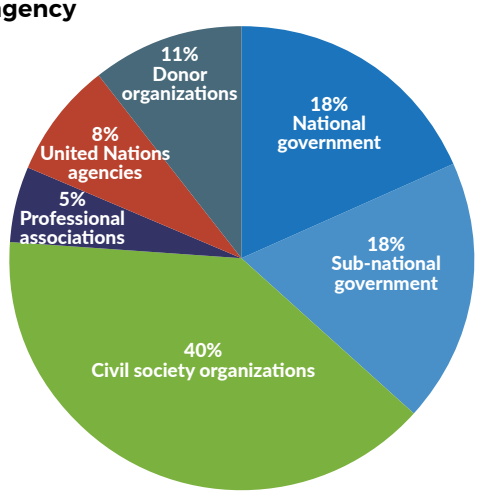
B. National governance arrangements for decision-making on RMNCAAH services during COVID-19

In March 2020, the Corona Crisis Management Committee was formed to address the pandemic on a national level. The Health Cluster, originally formed in response to an earthquake in 2015, was reactivated, as was the Reproductive Health (RH) Sub-cluster, to address RMNCAAH service continuity. The RH Sub-cluster was chaired by the Director of the Family Welfare Division and co-chaired by the Deputy Country Representative of UNFPA. As a member of the Health Cluster and Incident Command System, the RH Sub-cluster chair shared information and progress on RMNCAAH with national COVID-19 response teams.

Figure B.5.6 shows the RH Sub-cluster membership distribution by agency. The Sub-cluster was organized into a Core Group and Sub-groups to focus on specific areas of RMNCAAH including MCH, FP, safe abortion, child health and immunization. In the early days of lockdown measures when routine health service information was not readily available, Sub-cluster members coordinated directly with health facilities to obtain information on RMNCAAH service availability, usage and challenges.

The RH Sub-cluster developed guidance to maintain continuity of specific RMNCAAH services in relevant health facilities. The *Interim guidelines for RMNCAH services in the COVID-19 pandemic* were discussed in the RH Sub-cluster and approved by the Ministry of Health and Population on 21 May 2020. The guidelines were disseminated through government and partner networks. Health service providers were given virtual orientations on the guidance as it was released.

Fig. B.5.6. RH Sub-cluster member distribution, by agency



From March to November 2020 when Nepal was experiencing the first wave of COVID-19, the RH Sub-cluster met weekly. From November 2020 meetings were held biweekly. Meeting agendas were set by the Family Welfare Division in coordination with all members. Member organizations could also propose agenda items for discussion during meetings.

C. Guidance for RMNCAAH services in response to COVID-19

The key guidance issued during the pandemic is shown in **Table B.5.7**.

Table B.5.7. Guidance for RMNCAAH services issued

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
Interim guidance on continuing RMNCH services during COVID-19 pandemic	May	
Health sector emergency response plan COVID-19 pandemic	May	
Nepal Society of Obstetricians and Gynaecologists clinical practice guidance for management of RH during COVID-19 pandemic	July	
Standards for delivery of services to elderly during the COVID-19 pandemic	Nov	
Preparedness and response plan COVID-19: Protection Cluster Nepal	April	

FP | Maternal health | Newborn health | Child health | Adolescent health | Ageing

D. Key actions to ensure continuity of RMNCAAH services

Table B.5.8 contains the main actions undertaken in Nepal to ensure that RMNCAAH services continued.

Table B.5.8. Mitigating actions to ensure continuity of RMNCAAH services

	MITIGATING ACTION	SERVICE AREA
Medications, equipment and supplies	FP forecast adjusted to anticipate surge in migrant returnees	FP
	Procurement and "last-mile" distribution of FP commodities, especially short-term options, to ensure delivery of methods all the way to end users	FP
	Pills and condoms for 3 months distributed to clients	FP
	Increased supply of FP commodities in partnership with private entities and NGOs	FP
	FP commodities (e.g. pills and condoms) made available upon exit from quarantine centres	FP
Transport for facilitating mobility	Transport arranged and free ambulance services	Cross-cutting
Health services adaptations	Routine ANC provided by all health posts/PHC centres/hospitals	Maternal and newborn health
	Misoprostol and chlorhexidine provided to women in eighth month of pregnancy if unable to come to health facility for childbirth	Maternal and newborn health
	Iron and folic acid for lactating mothers	Maternal and newborn health
	Integration of FP services into immunization programme	FP
Service delivery settings	Community psychosocial counsellors mobilized in seven provinces to provide services for women, girls and lesbians, gays, bisexuals, transsexuals, intersexuals, and support people in quarantine	Cross-cutting
	Outreach programmes for routine child health services such as vitamin A and immunization (i.e. measles and rubella campaign)	Child and adolescent health
Safe patient workflow	PPE for health workers, and IPC in facilities	Cross-cutting
Telehealth and digital technology	Virtual communication of interim RMNCH guidance to health facilities	Cross-cutting
	Online portal for providing mental health and psychological support to health care providers	Cross-cutting
	Postpartum mothers and newborns followed up by phone on Days 1, 3, 7 and 28 postpartum, and home visits conducted if necessary	Maternal and newborn health
	Helpline and teleconsultations for FP, ANC, PNC and other maternal and child health-related services	Maternal and newborn health Child and adolescent health
	Safe Delivery App developed by Maternity Foundation adopted (COVID-19 and IPC modules) and used for training of trainers	Maternal and newborn health
	Help lines operationalized for reporting gender-based and/or domestic violence and the provision of psychosocial counselling	Maternal and newborn health
	Online counselling for adolescents regarding adolescent sexual and reproductive health	Child and adolescent health FP

	MITIGATING ACTION	SERVICE AREA
Removing financial barriers to access	Free iron tablets (3-month supply) for pregnant women	Maternal and newborn health
	Free local health check-ups for maternal and reproductive health	Maternal and newborn health
	Distribution of Kisori (dignity) kit at quarantine for menstrual health management	Maternal and newborn health Child and adolescent health
	Hygiene products provided for young people with disabilities through peer educators	Child and adolescent health
Communications strategies	RMNCAAH information in local catchment area provided via public media	Cross-cutting
	Mobile text messages for SRH awareness	FP

E. Lessons learned

- Preparedness to respond to disasters and pandemics should be an ongoing priority.
- Proper budgeting is needed to facilitate an effective response.
- Poor internet connections hindered efforts and is key to an effective pandemic response.
- Alternate service delivery modalities need to be adopted/promoted.
- Alternative approaches/tools are needed for capacity-building.
- Partnership with private entities (i.e. providing transport, health services) is a key factor in effective response efforts.

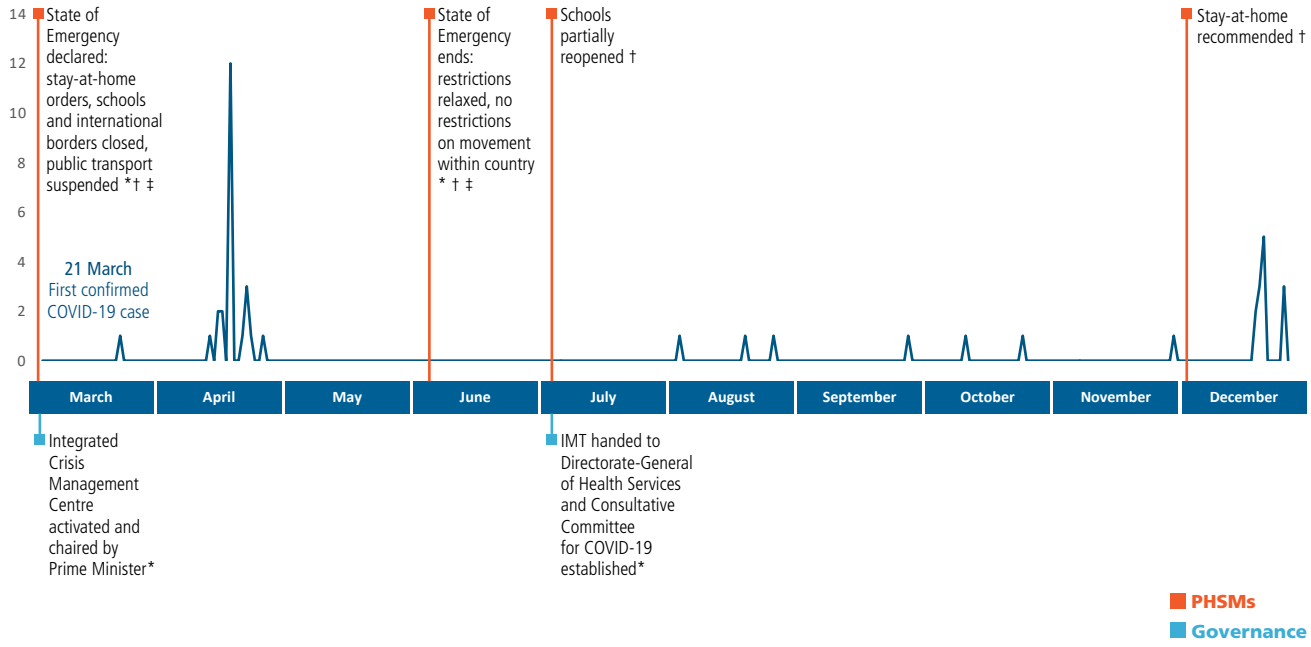
Photo credit: Ajay Maharjan

Country report - Timor-Leste

A. The COVID-19 context

Timor-Leste had its first confirmed case of COVID-19 in March 2020. Reported cases peaked in April and rose again at the end of the year (**Figure B.5.7**). Various measures were put in place to contain the pandemic.

Fig. B.5.7. COVID-19 cases, timeline of national COVID-19 PHSMs and policies put in place to ensure the continuation of RMNCAH services



Sources: * National consultant reports; † *(15)*; ‡ *(14)*.

B. National governance arrangements for decision-making on RMNCAH services during COVID-19

The existing MCH TWG was reactivated to mitigate the direct and indirect impacts of the pandemic on RMNCAH services. The TWG's aim is to develop and establish mitigation strategies in coordination with all health sector donors, development partners and United Nations agencies. As of December 2020, the inclusion of professional association representation on the RMNCAH TWG was being considered. The TWG meets monthly and is chaired by the head of the Department of MCH in the Ministry of Health. The chair routinely updates the COVID-19 Council Committee on the TWG's activities. TWG members represent government department heads and programme officers, United Nations agencies and international and local NGOs. A different TWG focuses on the ageing population, as elderly health is managed by the Non-communicable Diseases Department at the Ministry of Health.

C. Guidance for RMNCAH services in response to COVID-19

Timor-Leste issued various guidelines and policies to ensure the maintenance of RMNCAH services during the pandemic (**Table B.5.9**).

Table B.5.9. Guidance issued for RMNCAH services

Key national guidelines for managing and adapting essential services during COVID-19	Month (2020)	Content
National operational guidelines for maintaining routine essential reproductive, maternal and child health, immunization and nutrition services during the COVID-19 pandemic in Timor-Leste, including ANC, PNC, labour and childbirth, registration and review	May	
Key national guidelines for care of COVID-19 patients covered by RMNCAH services	**Month (2020)**	**Content**
Clinical protocols and guidelines for ANC for women with COVID-19 in Timor-Leste	May	
Clinical protocols and guidelines for intrapartum and immediate postpartum care for women with COVID-19 in Timor-Leste	May	

D. Key actions to ensure continuity of RMNCAH services

The government of Timor-Leste and various partners took a variety of actions to protect RMNCAH services from the impact of COVID-19 (**Table B.5.10**).

Table B.5.10. Mitigating actions to ensure continuity of RMNCAH services

	MITIGATING ACTION	SERVICE AREA
Transport for facilitating mobility	Community transport to health facilities for mothers and infants (select municipalities)	Cross-cutting Maternal and newborn health
Health services adaptations	Pre-scheduled appointments for pregnant women at Marie Stopes Timor-Leste	Maternal and newborn health
	Catch-up service provision through comprehensive outreach activities	FP
	Catch-up immunization for children less than 5 and school-aged immunization in community and public schools	Immunization
Service delivery settings	Outreach activities in response to identified low coverage of some services, i.e. counselling, implant and intrauterine device insertion, and distribution of other FP methods	FP
	Modified Integrated Medical Outreach Programme providing immunization and contraceptive access and general health care for mothers and young children in rural and remote areas	FP Immunization

	MITIGATING ACTION	SERVICE AREA
Safe patient workflow	IPC measures in facilities	Cross-cutting
	Screening, triage and isolation with separated maternity ward in centre for pregnant women with COVID-19	Maternal and newborn health
Telehealth and digital technology	Teleconsultations for FP advice by NGO partner	FP
	National youth hotline (*Liña Foin-Sa'e*) to provide information on RH to young people	FP
Removing financial barriers to access	Training for health professionals on ANC, intrapartum and postpartum care for mothers with COVID-19	Maternal and newborn health
	Free FP services in response to COVID-19 crisis (one clinic of Marie Stopes Timor-Leste in Dili)	FP
Communications strategies	Dissemination of video messages on children's rights, health care, child protection and COVID-19 for children	Child and adolescent health
	Dissemination of GBV guidelines for health workers (13 municipalities)	GBV
	Social impact workshop via social media on communication strategy for addressing GBV	GBV

E. Lessons learned

- Decision-making with incomplete data was challenging.
- Lack of coordination between supporting partners results in overlapping/duplicated coverage, over-emphasis on one programme/service/population/geographic group and a lack of support for other needs, populations and/or geographic areas.
- Adequate planning is needed before each activity is undertaken.

Distribution of the Dignity Kit to mothers along with FP services; comprehensive counselling in one of the community health centres in Timor-Leste.

Photo credit: WHO RMNCAH team

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