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Rapid policy development for essential RMNCAH services in sub-Saharan Africa: what happened during the COVID-19 pandemic and what needs to happen going forward?

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INTRODUCTION

In 2020, Africa had a lower incidence of COVID-19 infections and deaths per 100 000 population compared with many high-income counterparts.[1 2] Various reasons were hypothesised to contribute to this phenomenon, including political commitment, prompt contact tracing, demographic pyramid, genetics among others.[2 3] This story changed in mid-2021. Then, many countries that were thought to have 'successfully' suppressed COVID-19 infections were battling surging infections and deaths.

For example, in Uganda, between July 2020 and May 2021, there were only 362 COVID-19 related deaths officially recorded. This completely changed in June 2021 when there were over 1500 deaths in single month.[1] The deaths in 1 month were five-times more than those that occurred during the entire preceding pandemic period. We also saw similar trends during the months of May, June and July 2021 for countries like Zambia, Kenya, Rwanda and the Democratic Republic of Congo.[1]

In this article, we focus on the importance of country-led policy development to aid the continuity of essential reproductive, maternal, newborn, child and adolescent health (RMNCAH) services to mitigate the indirect effects of COVID-19 pandemic in countries in sub-Saharan Africa (SSA). We have focused on RMNCAH services because women, children and adolescents are a vulnerable population whose health has been negatively impacted by the pandemic, and thus the need to prioritise continuity of their healthcare services.[4]

Summary box

- The rapidity with which policies were issued by countries in sub-Saharan Africa to support reproductive, maternal, newborn, child and adolescent health (RMNCAH) services in the COVID-19 pandemic is a positive development that could represent a new era in local policy making, that is more aligned with the sustainable development goals policy of self-reliance.
- These rapidly developed policies have also included selected changes to essential health services that could potentially be beneficial to maintain postpandemic. These potentially beneficial policy improvements include multimonth dispensing of medications and family planning methods and self-care.
- Policies to support RMNCAH during the COVID-19 pandemic should be adapted as evidence, technology, context, available resources and the situation evolves.
- The need for evolving policy response requires countries to have capacity for rapid policy development, and a good coordinating mechanism by WHO and other technical partners so that country policies are informed by international recommendations and evidence.
- Two potential approaches to rapid policy making in these evolving pandemic situations include technical experts at country level preparing 'policy templates', and standing multidisciplinary and cross-sectoral teams tasked with mobilising rapid policy response.

CHANGING PARADIGMS IN COUNTRY POLICY DEVELOPMENT AND THE NEED FOR COORDINATION

In non-pandemic circumstances, policy making often followed a pattern in which WHO synthesised evidence and issued recommendations, which country programmes could then adapt or make specific to their own context. At the start of pandemic, the need for

policy guidance during the pandemic was so urgent that countries like Uganda, Kenya, Rwanda and Zimbabwe issued policies to protect essential health services either before or concurrently with WHO. The COVID-19 pandemic put into action the call for increasing country capacity and self-dependency for policy development, and an increased need for policies that fit local contexts and available resources.[5 6]

Furthermore, international travel restrictions interrupted the in-person provision of technical assistance to SSA countries by experts from WHO and the West. This may have had a net effect of decreasing country-level capacity for policy making. Further investigation of policy makers' experience in issuing rapid policies for RMNCAH should be explored. However, this may potentially be a 'good problem'—a step towards self-reliance and building sustainable, locally owned policy making resources. For instance, in Uganda, we saw an unprecedented 'whole' of government mobilisation, with significant collaboration with local academia. For instance, academia from Makerere University were appointed by government to chair Technical Advisory Groups, advise the Minister of Health (MoH), and were funded to conduct rapid data analysis or to collect and present data to the MoH to guide decisions on interventions to ensure continuity of emergency health services.[7] This country level policy leadership is in keeping with the spirit of the sustainable development goals, as countries take lead in developing and financing their health systems, based on their political, and hopefully local people's aspirations.

Similarly, we posit that perhaps policy response in the wake of the COVID-19 pandemic has fomented SSA's ability to rapidly produce policy guidelines, under emergency situation, to support continuation of RMNCAH services. Countries need to embrace this challenge, pandemic or no pandemic. However, in doing so, they still need to coordinate policy development with WHO to ensure alignment, but also to reduce the risk of creation of too different policies between countries in regions with great cross-border mobility. This could be achieved by working very closely with WHO country offices.

Country policies to sustain RMNCAH services in Uganda, Kenya, Mozambique and Zimbabwe note potentially positive changes to policy which may extend beyond the pandemic, such as multimonth dispensing of family planning methods. Other innovations for RMNCAH services continuity have included self-care in which individuals, families and communities manage parts of their healthcare.[8]

The international community should be partners, enablers and facilitators in supporting country-level policy makers to issue sound and rapid policy guidelines. In order for these efforts to succeed, there is need for continued and expanded collaboration between WHO, government policy makers and local academics. For instance, WHO could help to build the capacity of local technical experts in policy analysis, who then work with the MoH in policy development. Such local led efforts in policy making will require prioritised funding from national government and partners for local experts, including technical experts, civil society and academia, to have standing capacity and involvement in policy making.

Whether country policies are issued before WHO recommendations or afterwards, we note a substantial need for increased efficiency and quality in coordination of the policy making processes in countries. In many low-income and middle-income countries, there is so much fragmentation that actors are not well coordinated, resulting in uncoordinated policy making or implementation. For example, in Uganda, in the early stages of the pandemic, it was not uncommon to find different partners in the same district or hospital trying to create capacity on Standard Operating Procedures for continuity of essential health services.[9]

DATA, INNOVATION AND POLICY FOR RMNCAH DURING COVID-19

As governments develop or adopt policies, they need to ensure that the policies (and the subsequent investment) balance the pandemic control with the need to mitigate the collateral damage of the pandemic. Some early reports indicated increases in maternal, neonatal and child deaths.[10 11] The policies also need to be informed by local data so that they are realistic in the geographical and social context.

Many countries suspended programmes whose activities could potentially increase the risk of additional spread of the virus. Notable programmes disruptions included immunisation outreaches, Community Health Worker home visits, provision of antenatal care and nutrition assessment, and family planning or even adolescent sexual educational programmes. Some countries like Uganda chose to suspend the presence of birth companions during birth because birth companions potentially increase the risk of infection to mothers and health workers. However, this is also against the WHO quality-of-care standards that call for birth companionship.[12] We find that such decisions have far reaching impact and should only be made after thorough consideration of their consequences. In this case, the absence of birth companions means that mothers do not receive emotional, psychological, physical support from trusted community members. The SSA context of having limited healthcare staff make companions an absolute essential at birth. Moreover, there is evidence to show that social support for labouring mothers leads to less operative births, shorter labour, reduced occurrence of maternal blues, and better baby outcomes.[13]

As countries develop new policy responses to COVID-19, there is a need for innovations in RMNCAH service delivery. Such innovations need to focus on the most vulnerable, on promoting health equity, and building resilient health systems. Promising innovations include self-care services, increased use of telemedicine, multimonth dispensing Family Planning methods and

Antenatal Care medications and supplements, and Differentiated Service Delivery (DSD) model commonly used in HIV/AIDS. The DSD model aims to deliver care that is tailored to the needs of the clients, but at the same time reducing the burden to the health system.[14] For instance, unlike the traditional model of HIV care, where clients pick their antiretroviral drugs from facility, in DSD model, stable clients may have their drugs delivered at their homes. This reduces facility visits for stable clients at same time allows the health facilities to focus on only those with complications.

CONCLUSION

Capacity for local policy making is important, and fortunately it seems to be improving across countries in SSA, as has been shown from the experience during the COVID-19. For reasons already highlighted, the COVID-19 context has challenged countries to lead their own policy making, for reasons already highlighted. Since the COVID-19 pandemic effects observe no boundaries, countries must learn to develop and implement multisectoral policies as well as engage a broad scope of stakeholders. Future health policies, including those related to pandemics, need to be people centred as the services disruption mean that innovations in which people can increasingly take care of their own health are needed. A critical source of learning already exists in the work of tuberculosis and HIV/AIDS prevention, care and treatment. The DSD model, which has been widely used in HIV care, presents lessons on how to reorganise service delivery to suit the clinical needs of diverse populations even amidst difficult times of pandemic or political instability.[15] Since coming to crowded health facilities puts people at risk of acquiring COVID-19 or takes away badly needed time and resources from already constrained health workers, services can be organised in such a way that non-critical care is provided at home, for example, through self-care or in the community through outreaches. We also do think that the developed policies must continuously be reviewed to suit the changing context, evidence and availability of resources and technologies. Finally, it is important that the world and countries must learn and be 'policy ready' for future pandemics. One such mechanism may be the creation of standing boards of experts and civil society which develop 'policy templates' or be quickly deployed to create policy when needed. Policy templates may take the form of drafted scenario-based model policies that are ready to be quickly adapted when need arises. The policy templates, though not prescriptive, should highlight key aspects that need to be considered when formulating and/or implementing policies. Alternatively, countries in SSA should establish standing committees that are multidisciplinary and cross-society teams that can mobilise rapid policy response when needed.

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REFERENCES

1 Roser M, Ritchie H, Ortiz-Ospina E. Coronavirus pandemic (COVID-19). Our world data, 2020
2 Nachega JB, Atteh R, Ihekweazu C, *et al*. Contact tracing and the COVID-19 response in Africa: best practices, key challenges, and lessons learned from Nigeria, Rwanda, South Africa, and Uganda. *Am J Trop Med Hyg*;104:1179–87.
3 Wamai RG, Hirsch JL, Van Damme W, *et al*. What could explain the lower COVID-19 burden in Africa despite considerable circulation of the SARS-CoV-2 virus? *Int J Environ Res Public Health* 2021;18. doi:10.3390/ijerph18168638. [Epub ahead of print: 16 08 2021].
4 Chattu VK, Yaya S. Emerging infectious diseases and outbreaks: implications for women's reproductive health and rights in resource-poor settings. *Reprod Health* 2020;17:43.
5 Alam N, Mamun M, Dema P. Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH): Key Global Public Health Agenda in SDG Era. In: Leal Filho W, Wall T, Azul AM, *et al*, eds. *Good Health and Well-Being [Internet]*. Cham: Springer International Publishing, 2020: 583–93.
6 Waiswa P. Institutionalization of projects into districts in low- and middle-income countries needs stewardship, autonomy, and resources. *Glob Health Sci Pract* 2020;8:144–6.
7 Agaba J. Professors on the frontline – Using science to fight COVID-19. University World News [Internet]. Available: https://www.universityworldnews.com/post.php?story=20200422164808428
8 World Health Organisation (WHO). *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights*. Geneva: World Health Organization, 2019.
9 et alMargini F, Pattnaik A, Jordanwood T. Case Study: The Initial COVID-19 Response in Uganda. [Internet], 2020. Available: https://thinkwell.global/wp-content/uploads/2020/09/Uganda-COVID-19-Case-Study-_18-Sept-20201.pdf
10 PATH. Essential health services during and after COVID-19: responses across six countries 2020.
11 UNICEF, Health MUS of P, Insight DD, Health UM of. Monitoring the impact of COVID-19 on immunization and nutrition service delivery and utilization in Uganda 2020.
12 WHO. Standards for improving quality of maternal and newborn care in health facilities, 2016. Available: http://www.who.int/iris/handle/10665/249155
13 Bohren MA, Hofmeyr GJ, Sakala C, *et al*. Continuous support for women during childbirth. *Cochrane Database Syst Rev* 2017;2017.
14 World Health Organisation (WHO). Nigeria's early adoption of Differentiated Services Delivery model buffers effect of COVID-19 pandemic among People Living with HIV [Internet]. Available: https://www.afro.who.int/news/nigerias-early-adoption-differentiated-services-delivery-model-buffers-effect-covid-19 [Accessed 25 Apr 2021].
15 Ssonko C, Gonzalez L, Mesic A, *et al*. Delivering HIV care in challenging operating environments: the MSF experience towards differentiated models of care for settings with multiple basic health care needs. *J Int AIDS Soc* 2017;20:21654.