

COVID-19 Pandemic, SRH and Health Systems in Africa

Dr Renay Weiner

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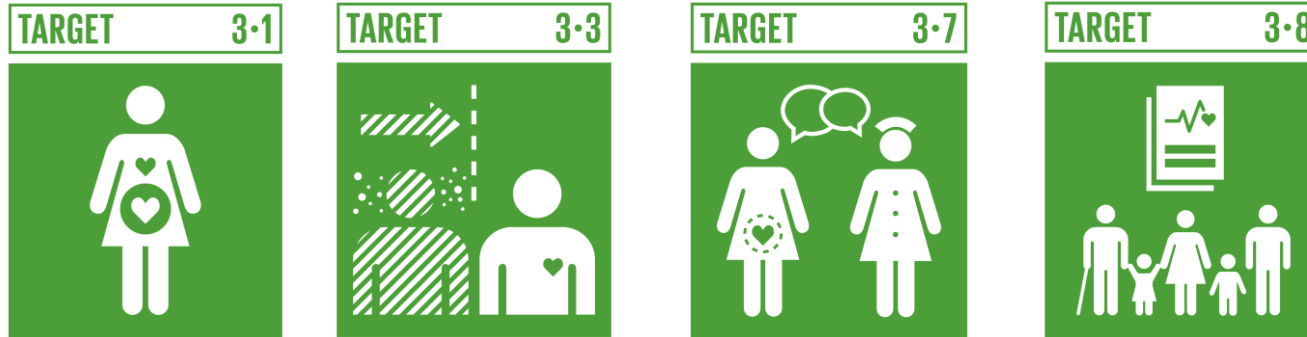


Presentation Outline

- Background
- Health systems and previous epidemics in Africa
- COVID-19, SRH and health systems
- Responses to limit the impact on SRH
- Conclusions

Background

SDG 3: good health and well-being



Maputo Plan of Action 2016 – 2030

Operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa beyond 2015.

ESA commitment (2013)

Ministries of health and education in 21 countries pledge to SRHR for youth

EUP health system drivers in ESA (Sit anal of EUP Drivers, UNESCO, 2018)

- Low modern contraceptive use and access 15-19 year olds
- Clinics often not youth friendly-judgemental attitudes of staff, long distances, opening hours during school

Access to high quality care limited—high MMR persist

- Lack of emergency transport for obstetric emergencies
- Long distances to health facilities for deliveries especially in rural areas
- Variations in the quality of ANC care provided e.g. diagnosis and referral of HT in pregnancy
- Supply chain weaknesses and stockouts

Background

COVID-19 in Africa:

- Variation in epidemiology across the continent
- Globally SA **6th** highest case numbers , Egypt **31st** , Morocco **46th** (www.worldometers.info)
- Early responses and lockdowns
- Outbreak response infrastructure/experience
- Relatively young population

But

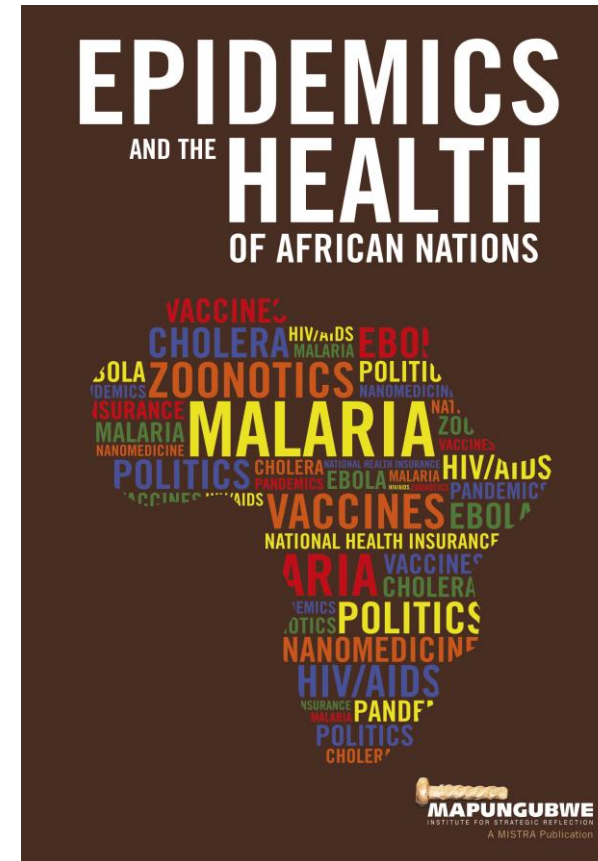
- Weak health systems: struggle to cope with additional case loads and/or critical care
- Co-morbidities (including undernutrition, HIV + emerging NCD)
- Threat of health systems being overwhelmed
- COVID-19 risk—greatest in urban/peri-urban areas; informal settlement residents less likely seek non-COVID-19 care (Stats SA, April 2020)

Health system and previous epidemics in Africa



Ebola outbreak in West Africa in 2014 - spread rapidly(Ageyeman et al 2020)

- High rates of non-Ebola deaths
- Weak health systems, insufficient trained personnel contributed to the scale of the outbreak, and epidemic contributed to further weakening of health system
- Need to invest in health systems strengthening recognized (lab, PH, clinical, communications)
- Nigeria – averted EVD—early response, co-ordination, communication etc



Health systems and previous epidemics in Africa

Indirect impacts of EVD in West Africa on health care utilisation (Ribacke et al,2016)

- Major impacts on RMNCH –consistent across three countries (Sierra Leone, Liberia, Guinea)
 - Decrease in Caesarian Section Rates e.g. SL: nationwide decrease in **20%**
 - Decrease in facility- based deliveries e.g. SL drop in **27-37%**; G: **74-81%** decline in most affected areas
 - Decrease in ANC and PNC visits
 - Outcome data—scarce—in SL maternal case fatality rate/IRR: 1,44 (**95%** CI:1.17-1.75); estimate of additional 3600 M,N,SB deaths in SL (Sochas L et al 2017)
- Demand driven decline important
- Sharp declines in FP uptake during and six months after Ebola epidemics:

COVID-19, SRH and health systems

Demand impacts

- Under-utilisation of SRH services
 - Fear of contracting COVID-19 at health services
 - Lack of transport especially during strict lockdowns
 - Lack of money for transport due to decreased incomes during lockdowns/restrictions

Supply impacts

- SRH/FP not always considered essential services
- Services closed e.g. workplace and/or tertiary education health services, sanitise if a COVID-19 case confirmed; closure of NGO mobile FP clinics (funding redirected, K4D 2020)
- Stock outs including FP, ART
- Resource (Staff and finance) reallocation away from SRH to COVID-19 screening and testing
- Decreased health workers due to COVID-19 infection

COVID-19, SRH and health systems



Evidence for demand and supply impacts limited

- rapid surveys
- routine health service data review
- mortality trends
- media reports

COVID-19, SRH and health systems

South Africa (Adelekan et al,2020)

Gauteng province: public health care facilities serve 15,2 million people

Clinical services data analysis: previous 2 years and 5 weeks following lockdown in SA

Data source: District Health Information System database

Findings:

Family Planning: reduction in uptake compared to previous 2 years April 2020

- **45%** reduction injectable contraception
- **48%** reduction subdermal implants
- **10%** reduction IUD
- OCP uptake similar to previous years

TOP: **17%** decline in 2nd trimester; **5%** decline overall; April 2020 compared to April 2019

South Africa: NIDS CRAM survey (National Income Dynamics Survey, MATCH and Corona Rapid Mobile Survey) Burger et al July 2020

- Explored unintended consequences of the COVID 19 response

Data sources

CRAM: NIDS panel survey – computer assisted telephone interviews with 7074 adults, national sample

MATCH: MomConnect mhealth platform: 3140 women responded via sms; Mothers and pregnant women were surveyed during the last week of June 2020



Findings (Burger et al,2020)

- **23%** of the CRAM survey sample reported that they could not access medication, contraceptives or condoms over the past 4 weeks; lack of access highest :
no medical aid, poorest, lowest education levels

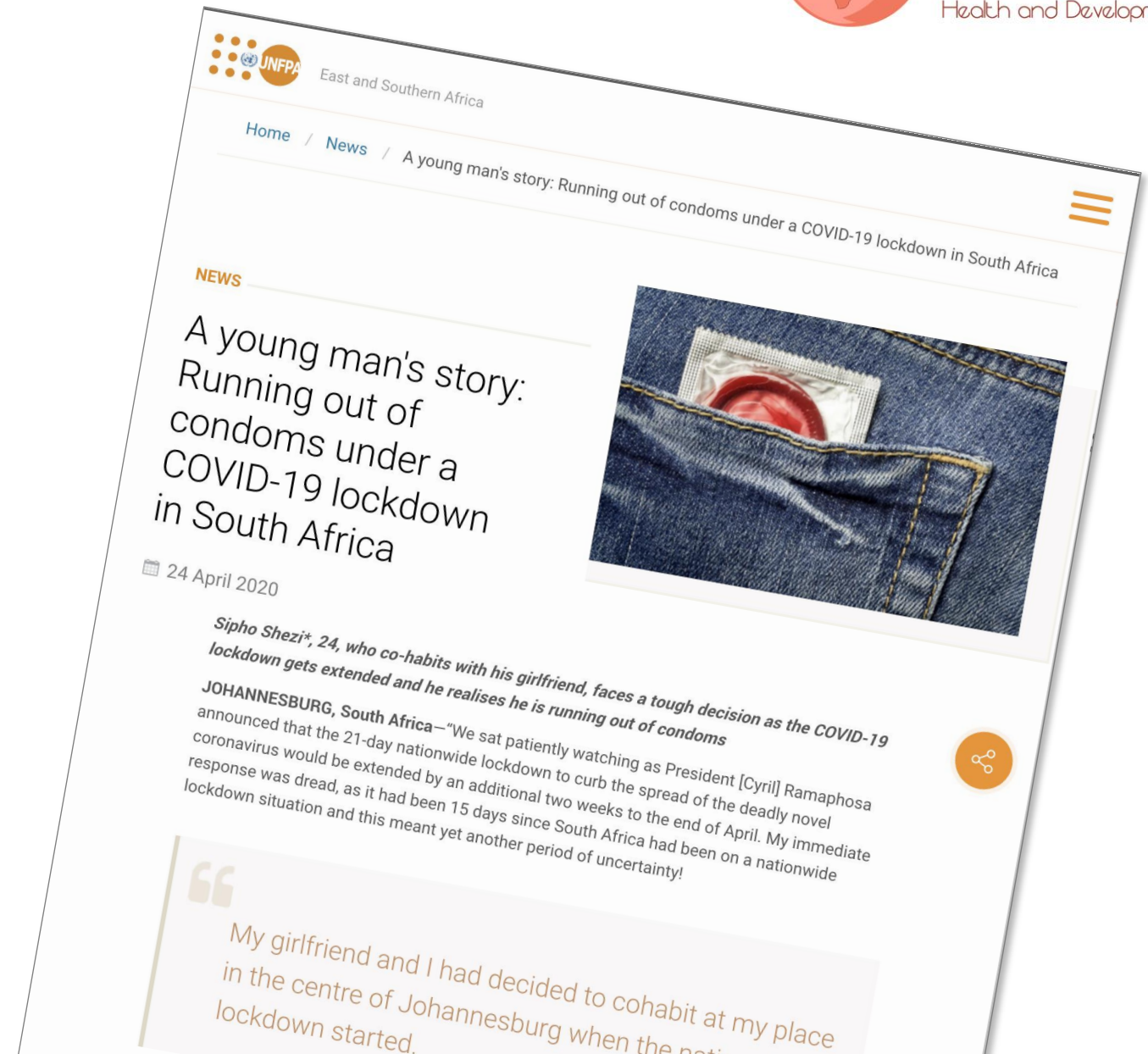
Pregnant mothers

- **Sixteen percent** had not been to ANC in preceding 2 months : **44%** in 3rd trimester afraid of getting virus
- **One quarter** of moms with babies 8 -16 weeks had not been to the clinic in 2 months, providing evidence of missed six week follow-up (FP). **39%** claimed it was due to fear of contracting COVID-19; **32%** said no need
- **11%** of mothers living with HIV ran out of ARTs: **40%** were afraid of going to the clinic while **21%** said clinic had run out, **21%** said transport problems

COVID-19, SRH and health systems

Media reports (Mbatha T, 2020)

Lack of condom access

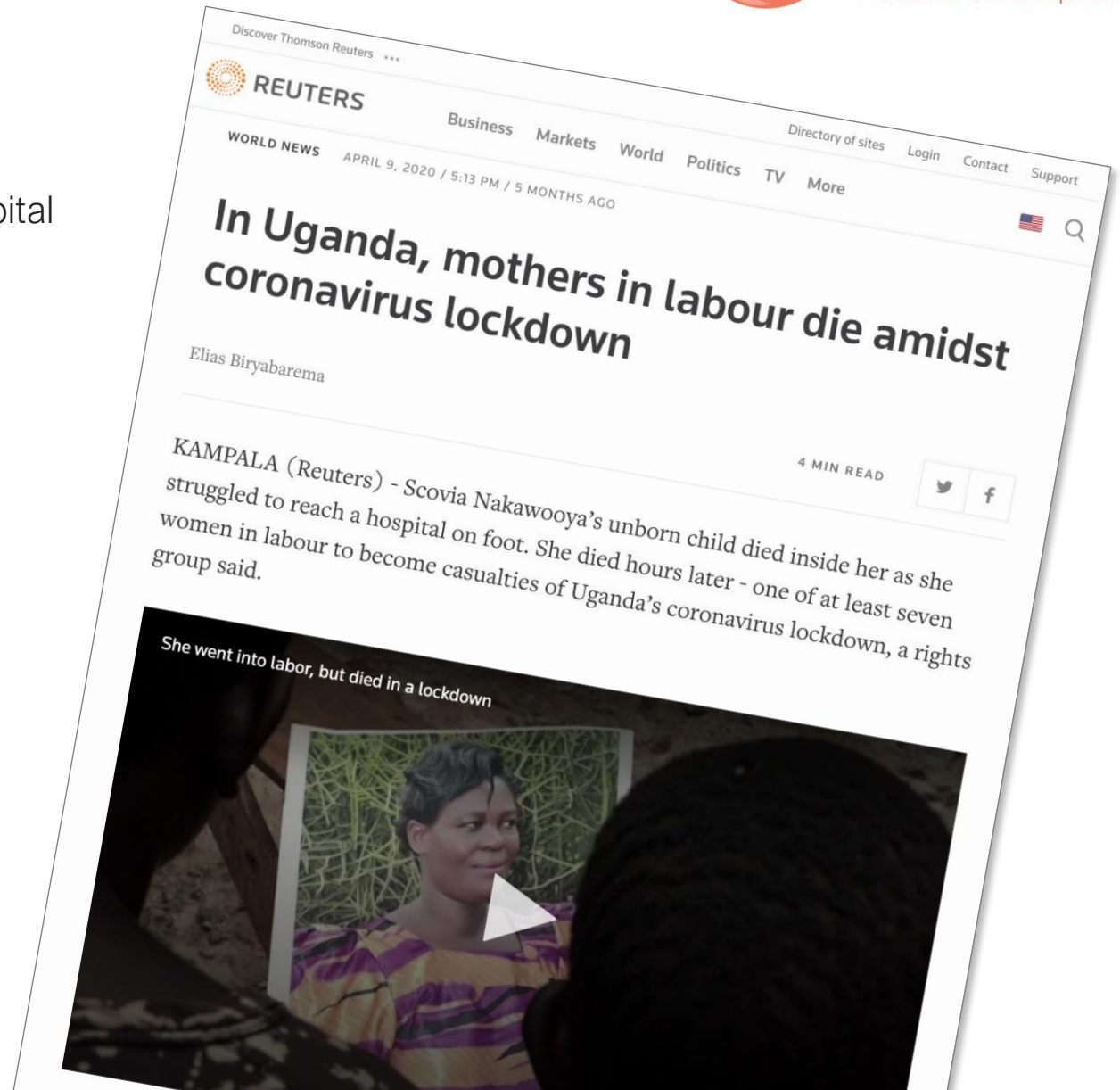


COVID-19, SRH and health systems

Lack of transport

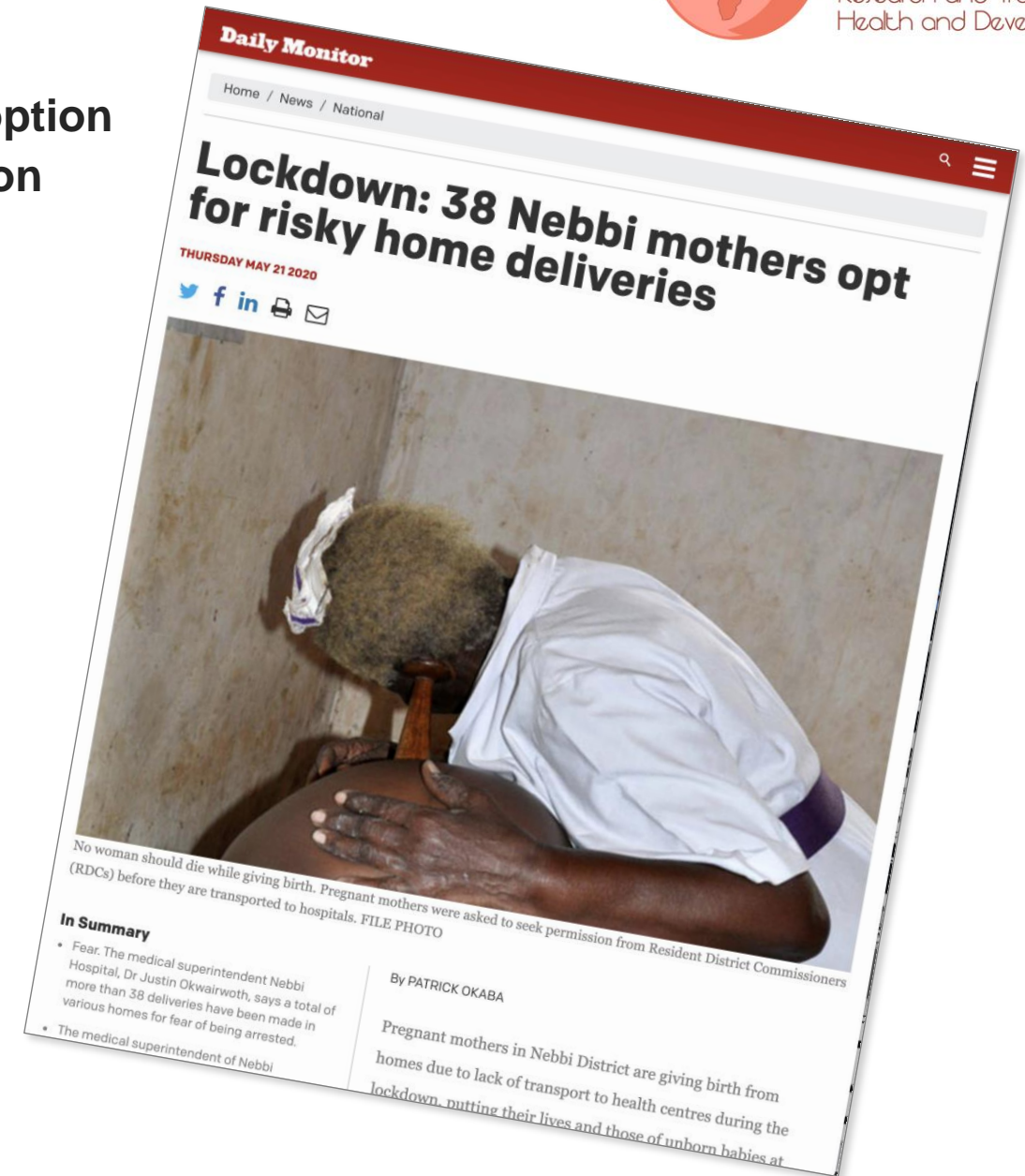
Media reports (Mbatha T, 2020)

Lack of transport for pregnant women to the nearest hospital



COVID-19, SRH and health systems

Many women choosing home births as the only option available to them due to very limited transportation services and/or fear of infection



Responses to limit the impact of COVID-19 on SRH

Health services

General

- Ensure continuity of SRH care—limit disruptions due to stock outs
- CHW expand services offered
- Telemedicine/digital health
- Youth Friendly Services

Contraception

- Promote LARC and multi month dispensing for OC;
- Community dispensing

Maternal health

- Consider separate facilities for ANC and PNC
- Quality ANC and referrals
- Strengthen emergency transport systems EOC

Social and Behaviour Change Communication

- Develop communication that addresses fears of service utilisation
- Demand maintenance—public awareness that SRH essential service and importance of uninterrupted use
- Communication channels: mobile phones e.g. MomConnect; helplines; community radio ; online webinars, social media
- Support existing multi-country SRH campaigns e.g. LetsTalk EUP, My Choice Our Choice



Policy

- Ensure that SRH are essential services during lockdowns/restricted movements
- Review SRH policies and laws which contribute to MM and create barriers for youth access to SRH

Conclusion

1. COVID-19 undermining SRH access including maternal care—fear of transmission important demand factor

2. Ensuring continuity of SRH and maternal care during and after COVID-19, requires

- ❖ **Strengthening demand** – strong communication efforts to emphasise importance of FP, maternity care continuity, and allaying fears; ensuring transport available
- ❖ **Strengthening supply** – planning for adequate supply chains, personnel, financing, HCW wellbeing, and decentralized care e.g. home based/CHW for contraception, community dispensing; emergency transport for pregnant women

3. Opportunities for long term SRH health systems strengthening

4. Strengthening policies that promote access to quality SRHR e.g

- contraceptive access including for adolescents
- relaxation of abortion legislation

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