RMNCAH-N Services During COVID-19: A spotlight on Nigeria's policy responses to maintain and adapt essential health services

Key messages

- Nigeria's states have experienced varying levels of disruptions of reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services during the COVID-19 pandemic. Reasons for decreased access and utilization have changed over time, with a growing proportion of households stating they cannot afford to access needed services.
- Nigeria's Federal Ministry of Health has released policies and guidelines to maintain EHS. It is unclear the extent to which these recommendations are being implemented.
- These policies include a range of service delivery adaptations, many of which are evidence-based in non-COVID-19 contexts and offer promise for improved people-centered care. Limited written direction on how to implement these adaptations, particularly for telemedicine, task shifting, and appointment scheduling, call into question the feasibility and effectiveness of implementation during COVID-19.

Nigeria recorded its first case of COVID-19 in Lagos on February 27, 2020; as of January 26, 2021, there have been 121,566 confirmed cases reported. The pandemic is mainly concentrated in five states: Lagos (22,562 cases), Federal Capital Territory (6,385), Plateau (3,724), Oyo (3,693), and Rivers (2,916).[1] In response to the pandemic, Nigeria set up a Presidential Task Force, and the National Primary Health Care Development Agency also established a command center within its existing emergency operations center to determine guidelines for the health system. Unique to other national approaches analyzed, this leadership structure was responsible (alongside the Nigeria Centre for Disease Control) for fundraising and advocating with the federal government for necessary financial resources, as well as determining operational guidance for lower levels of the health system. Since March, the Federal Ministry of Health (FMOH) has also been engaged in the development of policy and guidelines to maintain essential health services (EHS).

Nigeria's national response to controlling the pandemic has been swift, with a two-phased lockdown that included school/university shutdowns, nationwide curfews, interstate lockdowns, and stay-at-home orders.[2] However, the introduction of lockdowns at the state level varied between each of the 37 subgovernments, depending on the severity of COVID-19 spread. Gradual reopening of the country took place beginning in May, in line with the World Health Organization (WHO) guidelines for easing of lockdowns.[3] However, no specific information for state-by-state reopening has been made available. In December 2020, the first case of a new COVID-19 variant was identified in Nigeria, though this brief does not capture any response to date.[4]

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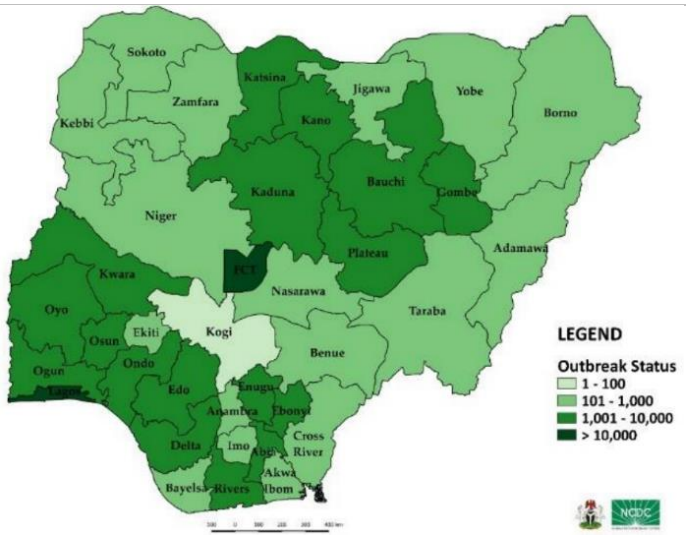
Figure 1. Distribution of cumulative COVID-19 cases as of January 3, 2021.



National COVID-19 response:

- Two-phased lockdowns including interstate restrictions and quarantine measures.
- Gradual reopening.

State COVID-19 response:

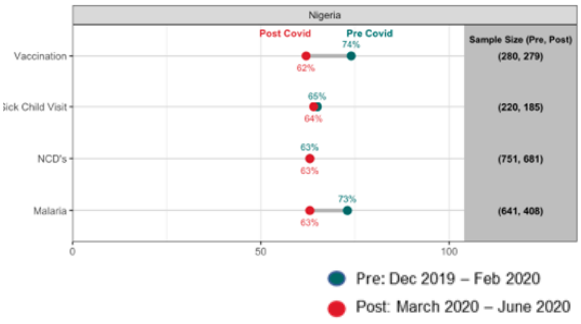
- 37 individual lockdown strategies including unique budgets, health service priorities, and service adaptation plans.
- Differentiated approach taking into consideration urban vs. rural areas.
- Limited guidance on ease of lockdown restrictions.

Source: Nigeria Centre for Disease Control COVID-19 Situation Report.

RMNCAH-N service disruptions during the COVID-19 pandemic

Nigeria has seen significant disruptions to routine essential health services during the pandemic. A report from UNICEF noted Nigeria as one of ten countries that are at particular risk of increasing under-five mortality.[5] The biggest service disruptions are seen in maternal health, newborn care, vaccination, sick child care, family planning, and noncommunicable disease (NCD) treatment services, as seen in health management information system data from the government of Nigeria (Table 1). Ipsos surveys conducted in June corroborate this, with respondents noting vaccinations as the most disrupted. (Figure 2).[6]

Figure 2. Changes in utilization of health services in December 2019–February 2020 to March–June 2020.



Abbreviation: NCD, noncommunicable disease.

Methods note: Circles reflect the percentage of survey respondents who were able to access or utilize needed services during each period in question. Survey weights were used to address representativeness of the sample.

Source: Premise/Ipsos rapid phone surveys.

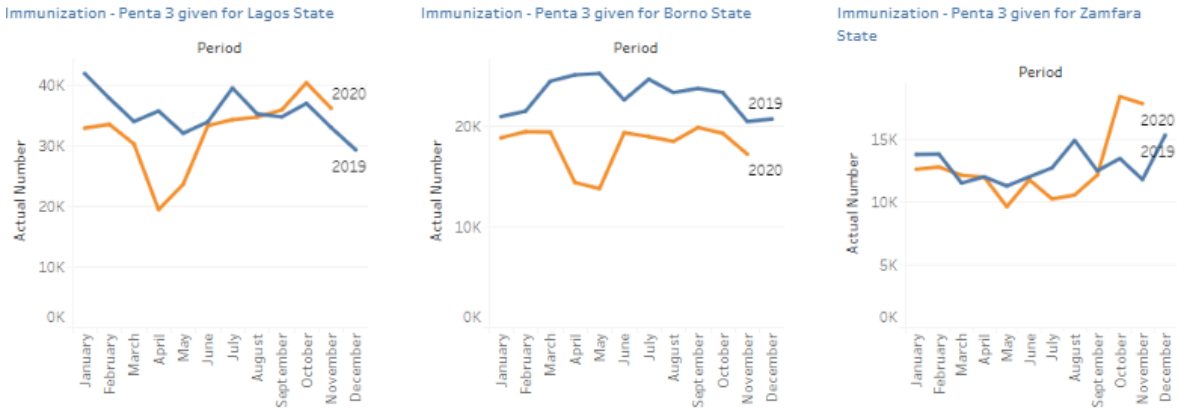
Table 1. Coverage changes reported in April 2020 compared to April 2019.

Service	Nigeria
Outpatient attendance	13% drop
Deliveries by skilled birth attendants	4% increase
Fully immunized < 1 year	16% drop
Penta3 given, national	14% drop
Antenatal total attendance	15% drop
Family planning clients counseled, national	2% drop
Postnatal visits total, national	10% drop

Source: Nigeria Department of Health Planning, Research & Statistics (DHPRS) Multi-Source Data Analytics and Triangulation Platform (MSDAT).

While there has been an overall drop in RMNCAH-N services since the onset of the pandemic, there is significant subnational variation, which reflects variable COVID-19 burden and other contextual factors. Looking at immunization, we see substantial subnational variation in coverage disruptions. Lagos State, an urban setting with a high concentration of COVID-19 cases, shows a steep disruption at the outset of the pandemic. Conversely, Zamfara State, a more rural area with limited COVID-19 cases, shows only a slight rupture in services. Borno State, at the heart of the northeastern conflict, has overall lower coverage in 2020 year-round. Like COVID-19 cases, disruptions have significant subnational variation, and further attention must be given to subnational context to understand policy implementation.

Figure 3. Monthly trends in immunization—Penta3 given for Lagos, Borno, and Zamfara.



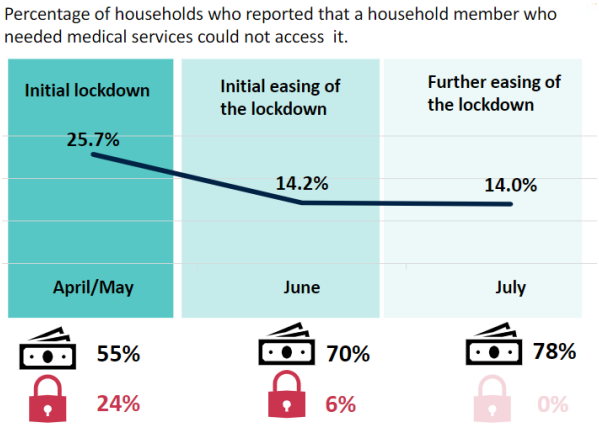
Source: Nigeria DHPRS MSDAT.

Reasons for RMNCAH-N service disruptions and other reasons for low utilization

Reasons for disruptions in Nigeria are driven by decreased patient demand and access due to lost income, movement restrictions, and concerns about COVID-19 transmission. A World Bank rapid panel survey of households found more than 25 percent of respondents who needed health services in April 2020 could not access them; this proportion decreased to 14.2 percent in June and 14.0 percent in July as lockdowns were eased. However, the proportion who could not access for financial reasons increased over this period. By July, 78 percent of respondents who could not access care cited financial barriers as being their main reason (Figure 4). An Ipsos survey between April and June found that among those who were unable to access services, 24 percent said it was due to lockdowns or stay-at-home mandates; 19 percent said it was due to mobility restrictions (such as reduced carrying capacity in public transport); and 22 percent said it was due to fear of getting COVID-19 (Table 2).[6]

Other contributing factors for low utilization of services include delivery limits, which have reduced service capacity and supply. Most secondary and tertiary public hospitals have shut down routine outpatient services, with most elective surgeries on hold.[7] In addition, fewer clinical supplies are available because they are being used to combat COVID-19. The pandemic has also exacerbated existing health services challenges including supply chain distribution and health care worker redeployment due to the ongoing conflict in Nigeria's northeast states: 27 percent of health facilities reported disruptions in supply resulting in shortages of face masks, vaccines, and oxytocin.[6]

Figure 4. Percentage of households who reported that a household member who needed medical services could not access it. April–July 2020.



Note: Among those who did not have access, most reported the primary reasons being financial constraints, as shown below the figure.

Source: Global Financing Facility.[6]

Table 2. Barriers to health care visits April–July 2020.

Among those who reported that someone in their household had delayed or skipped health care visits	
Could not afford care	26%
Worried about risk of COVID-19	22%
Mobility restrictions	19%
Most common self-reported reasons for missed visits	
Malaria	37%
General/routine checkup	22%
Vaccinations	7%

Source: Partnership for Evidence-Based Response to COVID-19 (PERC). Data obtained from Ipsos survey.

Nigeria's RMNCAH-N policies during the COVID-19 pandemic

Nigeria has developed several new policies to support its health system during pandemic response. We reviewed national policies that provided guidance on RMNCAH-N services during COVID-19, and which were available on the Federal Ministry of Health website, national government agency websites, or were provided by government stakeholders or partners. We reviewed four policies that were published in English between March to May 2020, and which took the form of one national strategy, two guidelines,[a] and one draft national strategy on maintaining reproductive, maternal, newborn, child, and adolescent health (RMNCAH-N) services. The following brief reports an analysis of the policy content, with the following aims:

- Describe the approach to maintaining RMNCAH-N services that Nigeria has taken during the COVID-19 pandemic and note how it aligns with global guidance.
- Identify innovative adaptations used to maintain essential health services that could be replicated elsewhere or used to accelerate primary health care (PHC) progress beyond the pandemic.

The target audiences of the policies were health program managers, clinicians, and health care workers. The policies were adapted from global guidance, specifically WHO guidance,[8] and existing Nigerian policies and guidelines. The most comprehensive policy, *Preparedness and Response to Coronavirus Disease 2019 (COVID-19) at Primary Healthcare and Community Level*,[9] addressed a wide range of EHS, including RMNCAH-N services, and the other policies focused on subthemes within RMNCAH-N services. The PHC preparedness strategy also included detailed scenario planning for state and local health leaders, as much of the operationalization of policy on maintaining EHS is conducted through the State Primary Health Care Boards. All the policies we reviewed were developed by the FMOH and the

a. Systematically developed evidence-based statements that assist providers, recipients, and other stakeholders to make informed decisions about appropriate health interventions. Health interventions are defined broadly to include not only clinical procedures but also public health actions.

National Primary Health Care Development Agency. As the COVID-19 situation evolves, the policies noted that they would be updated as time goes on. To date, no updated policies are available.

Maintenance of RMNCAH-N services

The policies we reviewed recognized the importance of continuing what are defined as essential services for RMNCAH-N, while underscoring the need to follow infection prevention and control (IPC) protocol. The policies suggest that most services should continue; overall, Nigeria's guidance aligns with the global guidance that WHO has issued on maintaining essential health services during the COVID-19 pandemic. Below is a table outlining what Nigeria's policies advise in each RMNCAH-N subtheme area.

Table 3. Summary of RMNCAH-N services during COVID-19.

Health area	Program activity	Recommendation and status of services
Maternal and newborn care	Antenatal care	*Adaptation of services:* ANC clinic hours should be extended on a location-by-location basis, with appointment scheduling and patient intake reconfigured to allow for physical distancing. Group ANC visits are recommended to be discontinued during the pandemic. There is limited mention of modifying the ANC visit schedule.
	Labor and delivery	*Adaptation of services:* Safe delivery kits are distributed to pregnant women during ANC visits, regardless of birth plan, to ensure supply availability at time of delivery. Policies suggested utilizing telehealth, task shifting, and task sharing for labor support. *Maintenance of services with IPC:* Specific facilities were identified as referral hospitals for neonatal and obstetric emergencies. Caesarean sections can proceed, but elective caesarean sections should be delayed if a pregnant woman has COVID-19 symptoms.
	Postnatal care	*Adaptation of services:* Health facilities are to replace subsequent contacts in no-risk cases with telecounseling and home visits (where possible) by trained CHEWs.
	Breastfeeding	*Maintenance of services with IPC:* Kangaroo mother care, early initiation of breastfeeding, and other interventions in early newborn care are encouraged to continue. Breastfeeding mothers who have COVID-19 should wear a mask when caring for newborn and practice good hygiene.
Child health	Sick child acute visits	*Adaptations of services:* Community-based management of acute malnutrition (CMAM) in children should continue, with clinics remaining open and community outreach continuing. The policy directed that CMAM clinics should extend their hours and utilize SMS tools to book appointments and track patients.

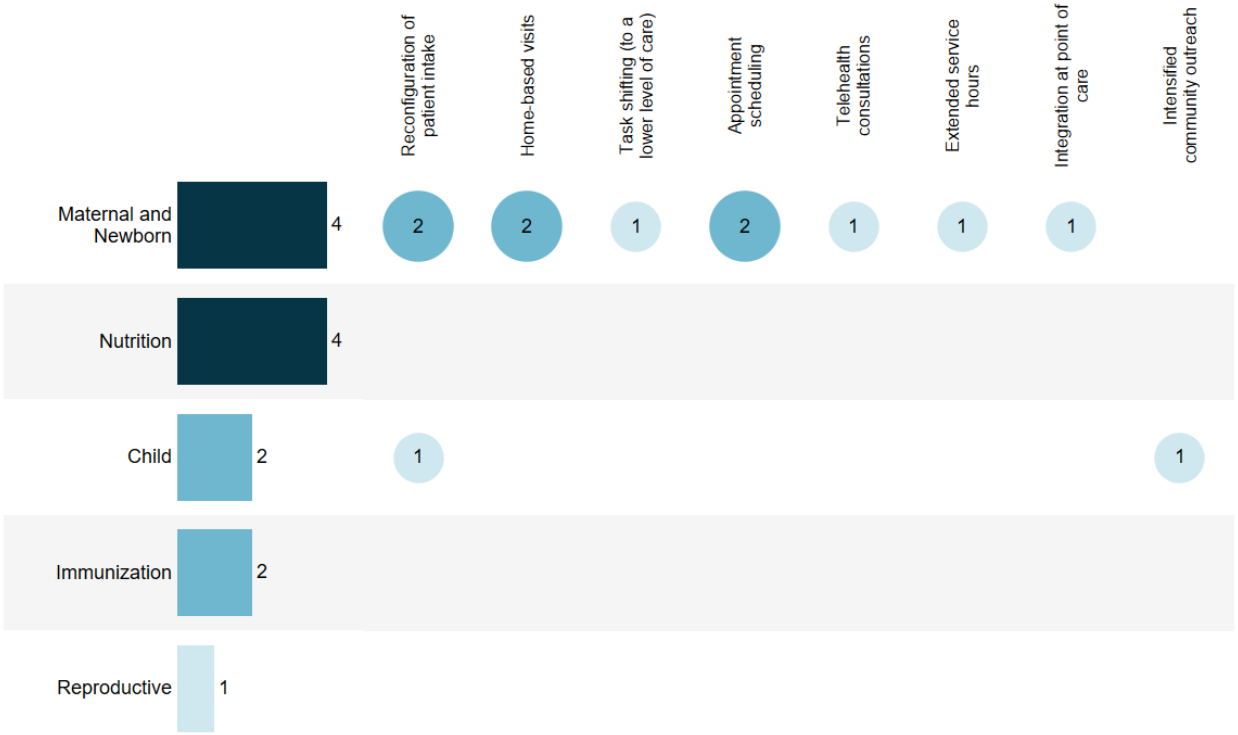
Health area	Program activity	Recommendation and status of services
	Immunizations of children and adolescents	*Adaptations of services:* Immunization focal points should map all public and private health facilities and ensure public awareness of where immunization services are available. Adding immunization services to hospital visits at the point of care is also encouraged to reduce points of contact with the health system. Health worker redistribution is encouraged, with task sharing (no details given on which tasks), rapid training, and reassignment as options available to immunization focal officers.
Reproductive health	Family planning contraception, abortion, sexual health	*Maintenance of services with IPC:* Designate units with enhanced IPC provisions, triage, and isolation areas for COVID-19 cases to sustain provision of safe and quality services for reproductive and sexual health care. Available policies did not include specific family planning services guidance.
Immunizations	Routine immunizations	*Adaptations of services:* Assess and monitor ongoing routine immunization services to identify and respond to gaps. This includes identification of potential low-coverage areas and reallocation of immunization teams to support catch-up activities in those areas. *Maintenance of services with IPC:* Newborn immunizations should proceed as usual.
	Vaccination campaigns	*Adaptations of services:* Immunization catch-up activities should be planned at the earliest opportunity to avoid immunity gaps. Priority for staffing and planning given to locations where outbreaks are likely. *Suspension of services:* Mobile and community outreach immunization programs are directed to halt operations in high-burden COVID-19 locations, with new temporary fixed posts being used only in the instance of a localized outbreak of a vaccine-preventable disease.
	Vaccine supply	*Maintenance of services with IPC:* Emphasized the need for continuing security of the vaccine supply chain.

Abbreviations: ANC, antenatal care; CHEWs, community health extension workers; CMAM, community-based management of acute malnutrition; IPC, infection prevention and control.

Adaptations and innovative solutions

In order to balance the need to maintain essential health services with the urgent prevention and management of COVID-19, global guidance recommends certain adaptations to how services have been routinely conducted. However, each country is experiencing the pandemic differently, and Nigeria, like many countries, has tailored its approach to meet its needs and priorities. Figure 5 details the policies mentioned across health areas; below is further description of select adaptations from Nigeria's policies. It is worth noting that while the national strategy document provides an overarching view of the adaptations recommended, there is limited operational guidance or detail on how to translate these policies into practice, a key limitation that is discussed in further detail below.

Figure 5. Policies reviewed in the RMNCAH-N area.



Data note: Each bar represents the number of documents recommending maintenance of or adaptation of services in each health area. Each bubble represents the number of documents that mention the use of a specific adaptation.

Source: PATH COVID-19 EHS Policy Tracker.

Task shifting to lower levels of care, task sharing between providers, and home-based visits

A cornerstone of Nigeria's maintenance of essential health services is to recommend task shifting and task sharing. In theory, this strategy acts to alleviate the burden on facilities focused on COVID-19 care by diverting patients to other facilities, but it also emphasizes increased access to high-quality care by sharing responsibilities across multiple cadres of health providers with adequate skills. In Nigeria, shortages of skilled providers within all cadres have historically posed challenges for implementing successful task-shifting policies. Task shifting and sharing was discussed in the COVID-19 context primarily for maternal care, with guidance recommending that postnatal care for low-risk women who underwent normal delivery and are well should be conducted through home visits by community health workers (or virtual visits), unless expressly advised. The national strategy recommends that low-risk or no-risk women and newborns should not be seen at tertiary-level health facilities unless necessary, and that they would be cared for by community-level health workers. Trained community health workers may also conduct home visits for postnatal care within the first week after childbirth using IPC. Community health extension workers (CHEWs) are to focus specifically on reducing risk of vulnerable groups, such as women with complicated pregnancies or deliveries, by encouraging them to seek care at delivery and postnatal care. CHEWs may provide education, facilitate transportation, or deliver drugs for these vulnerable groups.

Directing women to different levels of care based on their risk may reduce the risk of transmission of COVID-19 in facilities. The question is whether there are specific guidelines on how to determine the

different risk profiles and care needs, and whether other health systems factors, including human resource availability, allow the effective implementation of this policy. In addition, the effectiveness of the referral process is unclear considering communication and transportation services may be limited in rural regions of Nigeria.

Questions to consider when evaluating the effectiveness of task shifting and task sharing:

- How have guidelines for risk triage and patient diversion been communicated to providers and patients?
- Whether and how has health worker reallocation been done in real time to allow for continuity of care? What have been the unintended consequences?
- How have community health workers been trained for new responsibilities? Are they receiving adequate supportive supervision?

Telemedicine and digital health

The policies recommended that telemedicine and digital tools are to be encouraged for maternal and newborn care to reduce the risk of COVID-19 exposure. Nigeria recommends that telemedicine be used throughout pregnancy, antenatal care (ANC) visits, and postnatal checkups as a mechanism to reduce the number of in-person visits. Remote counseling was also encouraged to provide an educational component that typically occurs at the point of care. However, guidance provided on how to conduct these telehealth visits—and with which patients—was limited and at times variable. Unique to other countries in sub-Saharan Africa was the use of telehealth for visitors during labor and delivery: the policy recommends utilizing teleconference mechanisms (Zoom, FaceTime, and Skype) to include labor support persons who are not allowed to attend in person (and for family members). It is not clear if this recommendation extends beyond RMNCAH-N. However, there are applications across the health care sector.

A key gap here is again implementation guidance on how telehealth recommendations should be operationalized. A recent survey of maternal health providers during COVID-19 found that providers were particularly concerned over the feasibility, acceptability, and equity of telemedicine for maternal health services. These concerns included the loss of nonverbal feedback, distrust among patients, technological barriers, and lack of technological literacy among providers and patients.[10] While there are approximately 170 million mobile subscriptions in Nigeria, only 10 to 20 percent of these are for smartphones, presenting a key equity challenge in telehealth access.[11] There are also concerns about health providers having the tools they need to provide telehealth care, such as mobile credits, which are costly and susceptible to corruption.

Questions to consider when evaluating the effectiveness of telemedicine:

- To what extent to do people have access to phones or internet to receive care through telemedicine? What are the implications for equitable access to care?
- How does the quality and acceptability of care change when delivered via telemedicine?

Appointment scheduling

The use of digitized patient scheduling is an innovation that can improve patient flow at health facilities, reduce congestion and crowding, and improve the ease of follow-up. Nigeria recommends utilizing SMS-based scheduling tools to schedule appointments, but also for record keeping (critical for immunization follow-up). The guidance recommended appointment scheduling for ANC visits and encouraged health providers to use pre-appointments for patients who are likely to delay or skip care, have a high-risk pregnancy, or are suspected to have COVID-19. Appointment scheduling has also been encouraged for community-based management of acute malnutrition (CMAM) clinics, with appointments being used to track patients through the course of their treatment.

Appointment scheduling goes beyond RMNCAH-N services and is recommended for all essential services that health facilities have the capacity to provide. However, operational guidance is again limited, with limited information on the platforms that should be used for scheduling appointments with clients. It is unclear how health facilities should schedule appointments if they do not already have access to digital patient services, are located in rural areas with unreliable electricity, or are unable to reach patients through telecommunication.

Questions to consider when evaluating the effectiveness of appointment scheduling:

- What infrastructure exists to connect patients to providers to schedule appointments? Do providers have access to the tools they need to reach patients?
- How does tracking patients through appointment scheduling integrate with existing methods of patient tracking and outreach?
- To what degree is community engagement being used to sensitize patients to new service models?

Extension of clinic hours

Extending clinic hours has also been broadly recommended within policies, though without specifics. Largely, this adaptation applies to all EHS on the condition that it is endorsed by community leaders and that there is a mechanism in place to inform patients of extended hours. Maternal and ANC and child health visits did receive specific attention, with ANC clinic hours recommended to be extended on a location-by-location basis. CMAM clinics were encouraged to extend clinic hours to improve access for those who may not be able to attend during normal hours. Again, specific guidance on how to execute this adaptation was not provided.

Recouping lost progress

As part of planning for a post-pandemic world, many countries have issued guidance that will form the foundation of a strategy to make up for lost gains in coverage. As one example, Nigeria's policies recommend that immunization catch-up activities should be planned at the earliest opportunity to avoid immunity gaps. Priority for staffing and planning are to be given to locations where outbreaks are likely. Gavi's latest reports note that Nigeria plans to use additional mobile outreach to help achieve this objective. However, additional clarification is needed on where resources will come from to support such activities, and further guidance is needed on how sites are to be identified and reached.

Moving forward: Questions for consideration

The policies underscore the importance of continuing RMNCAH-N services while ensuring the safety of patients and health care providers within the context of COVID-19. However, there is limited operational guidance on how to implement these recommendations at the state and health facility levels. Similarly, policies do not address key health systems building blocks that enable these adaptations, such as adequate financing, stock, and human resources. States have varying degrees of infrastructure, resources, and commitment to the implementation of national guidance, which may pose challenges in operationalization of policy recommendations to maintain essential health services. These policies are largely silent on private health care providers, which make up 33 percent of all facilities in Nigeria but account for up to 60 percent of visits.[12] Anecdotal reports during COVID-19 suggests that even more patients are seeking care in private facilities due to perceived higher quality and safety of services, and thus reduced risk of contracting COVID-19.

To date, there is no evidence on how widely these adaptations are being implemented, but these factors—as well as the variability in the severity of COVID-19 disruptions and individualized lockdown measures—likely translate to subnational variation in how policies on maintaining EHS are adopted and implemented across Nigeria. It is critical to further explore how national policies have been translated down to the state, local government authority, ward, and facility levels, considering:

- To what extent are the national policies adopted and used in all of the states?
- How have these policies been disseminated to the health facility/clinic level?
- Which adaptations have been implemented as recommended by the national policy? How widely and where have they been implemented?
- What management practices (such as supportive supervision, onsite mentoring, or e-mentoring) exist to support states and facilities in implementing policies?

In addition to the limited documentation on how policies have been disseminated and implemented at the state and lower levels, there is limited evidence on which adaptations are the most feasible, acceptable, and effective for health workers and patients. Further examination and study of these adaptations are required to understand which adaptations are being implemented and have the greatest impact; potential research questions are noted following each adaptation.

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Annex: Policies reviewed

Policy document title	Publication date	Hyperlink (if available)
Preparedness and Response to Coronavirus Disease 2019 (COVID-19) at Primary Healthcare and Community Level	2020	https://reliefweb.int/sites/reliefweb.int/files/resources/guide_on_phc_preparedness_and_response-covid-19.pdf
Guidelines for Pregnant Women and Nursing Mothers	2020	https://covid19.ncdc.gov.ng/media/files/GuidelinesforPregnantWomen_dUJKoC9.pdf
Guidelines for the Management of Pregnant Women and Nursing Mothers	2020	https://reliefweb.int/sites/reliefweb.int/files/resources/guidelinesformgtofpregnantwomen.pdf
Nigeria Food and Nutrition Response Plan for COVID-19 Pandemic	April 2020	https://reliefweb.int/sites/reliefweb.int/files/resources/Nigeria%20food%20and%20nutrition%20response%20plan%20for%20COVID-19%20pandemic%2C%20April%202020.pdf