**Data Abstraction Tool**

**FP, ANC, L&D and Immunization-specific analysis**

**COVID-19 RMNCH Policy Analysis**

**DRAFT 8/5/20**

*Instructions: Please fill **one** form in for every policy reviewed.*

Name of Country: Zimbabwe

Name of Policy: Continuity of RMNCAH-N Essential Services in the COVID-19 Pandemic Context

Date of Issuance: June 2020

Authority Issuing: Ministry of Health and Child Care (MOHCC)

Name of analyst(s) and date: Katie Williams 8/5/20, Absolom Mbinda 8/11/20

Comments on distribution of policy (format, media, levels): Paper draft

Any known mechanisms for enforcing policy (please describe): N/A

Overview: *This policy, finalized in June 2020, offers guidelines to ensure continuity and no interruption of provision of essential services while aiming to reduce the risk of infection for patients and providers. The introduction of the policy ends with a mandate that these guidelines "be used in conjunction with other statutory guidance developed and published in response to the COVID-19 pandemic" (Pg. 2) and will evolve as appropriate.*

Does this policy include (**BOLD** all that apply): **FP** **ANC** **Labor and Delivery/ Intrapartum** **Immunization** **Cross-cutting Health Services** **Cross-cutting Population/ Society**

**Section 1. Key Policy Factors for FP, ANC, L&D and Immunization_____**

**1a. Family Planning Service Provision**

*Overview: The policy starts by highlighting that, significant strides have been made and the country have surpassed it's 2020 modern contraceptive prevalence target and all these gains are under threat due to COVID-19. Provision of contraceptives is an essential service linked with reduction of unintended pregnancies, unintended births, induced abortions which may contribute to maternal, neonatal and child deaths. As FP services are offered all public sector health facilities, youth centers under the Zimbabwe National Family Planning Council (ZNFPC), and via ZNFPC community-based distributors, the network for services is wide (Pg. 35). FP services are to continue to be provided as an essential health service, with public facilities providing the full range of "facility-based" services. It also highlights that FP services are provided through a mix of static facilities (both public and private) and vibrant mobile outreach supported by 3 main partners (FHI360, PSI and PSZ). The partners work closely with district health executive.*

**Types of methods provided through public sector:**

*Full range of methods to be provided. Community-based workers are to try to work from home and provide condoms, informational material, and be orientated to FP service provision (Pg. 36). Fertility awareness methods (LAM, SDM) are to be expanded and patients are to be made aware of availability and acceptability (Pg. 36-37). Condoms (male and female) must be available at all outlets (Pg. 37). New acceptors are to be provided with method by providers; DMPA, LARCs, EC, are to be available at health facilities (Pg. 37). Partners are to enable facilities to bring oral contraceptives and information, education, and communication material to the community level (Pg. 37). Oral emergency contraception (EC) can be given by trained private pharmacist whilst oral EC and the Copper T should be provided at a health facility by a trained health service provider following proper counselling.*

**Outreach versus facility-based service provision (and timing of services):**

*Outreach has been temporarily suspended and those offering services via outreach are to liaise with provincial and district health executives to support public facilities (Pg. 36). However, target outreach is allowed on assessment for areas with "compelling FP need" as determined by MOHCC and ZNFPC (Pg. 36). Walk-in clients are encouraged to visit by appointment. This should be arranged via community health workers (pg36). Partners shall assist facilities with moving oral contraceptives and IEC material to the community level (pg37).*

**Recommendations on multi-month dispensing:**

*For patients already established on a contraceptive method such as oral pills, supply can cover 3 months (Pg. 37).*

**Method switching:**

*Removal services are to be provided when possible and counseling given to supplement when removal services are not possible (Pg. 37). The policy recommends appointments be made for patients with ne method desires and facilities will contact these individuals as appointments are available (Pg. 37). If removal of implants or intrauterine devices (IUDs) is not possible, women should be counselled and offered self-administered contraceptive methods (e.g. LAM), oral contraceptives, condoms or the SDM method, until removal services become available*

**Other:**

*Increase access to clear and consistent on FP & COVID-19 information through displaying of IEC material, social media, print and electronic media (pg 37)*

**1b. ANC Service Provision**

*Overview: The policy states that antenatal care (ANC) services should continue in order to minimize maternal and perinatal morbidity and mortality. Low -risk clients such as primi-gravida should be attended at primary level facilities while the high-level facilities attend to high risk-clients and those within their vicinity. No women should be turned away once she visits a facility regardless of their risk-*

*status. Generally, the policy outlines recommendations for the local clinics, district and mission hospitals, maternity waiting homes, and provincial and central hospitals. Routine services are to continue in alignment with ANC protocol, with contacts and toll-free lines provided to clients virtual consultations and referrals (Pg. 11). Patient flow at all levels of care is to follow a unilateral pattern with routes to triage and examinations delineated for those with and without COVID-19 symptoms (Pg. 13)*

**Recommendations on timing and number of visits:**

*The policy states that the established WHO schedule of 8 contact visits continue. Depending on the risk of cases, the visits could be held over telephone or at primary care facilities (Pg. 11). Frequency of visits is dependent on the facility level and can be reduced at the discretion of the doctor. Frequency of level 2 and level 3 facilities visits may be reduced at discretion of the doctor and patient referred to clinic or level 2 for routine care and clinic based virtual consultation with doctor at level 2 until 37 weeks, or in the event of additional complications. Visit number 3 (26 weeks) and number 5 (34 weeks) were recommended to be done through tele-medicine (pg 14). There is no indication of how these visits will be recorded. The policy includes a table (Table 1) that compares WHO recommended ANC contacts against "modified alternate modality of antenatal contact" (Pg. 14).*

**Recommendations on multi-month dispensing of ANC medicines:**

*The policy does not mention issues to do with multi-month dispensing of ANC supplements except for 1st dose of IPTp dose. Women who visit the facility at or before 12 weeks are given SP for malaria to take home and a date is written on when to take the medicine (pg 14). It also states that if on ART adequate supplies of ARVs should be taken without mentioning how many months are covered with the stock.*

**Other:**

**Midwives:** *Midwife to keep record and contacts for high-risk cases for follow up, including telephone numbers and village/ward. Daily checks to be conducted at the MWH, including screening for COVID-19. The women should not go to FCH (Family and Child Health), but the midwife should conduct the checks at the home (Pg12).*

**Facility-based remote consultation**: *The policy states that remote consultation with women at home is not recommended unless she shows signs or is in isolation due to COVID-19. Rather, women should visit proximal health facilities for ANC care and consultation can occur between healthcare workers and providers at higher level facilities (Pg. 14).*

**1c. Labor and Delivery Service Provision (Intrapartum Care)**

*Overview: Labor and delivery services require providers to wear PPE and follow other COVID-19 safety protocols, including screening for fever and separating suspected/COVID-positive patients, as well as psychosocial support provision (Pg. 15). An effective client flow should be established, and triaging should be done before admitting into labor and delivery room. The policy includes facility level-specific algorithms screening (Pg. 16-18). The policy includes algorithm for management of screened/suspected and screened/not suspected pregnant women at various levels (Pg. 23-25). All women to receive respectful maternity care.*

**Closure of maternity waiting homes:**

*The policy (literally) boldly states that women should not be turned away from maternity waiting homes (MWH) even if they arrive before the required final 3 weeks of pregnancy (Pg. 12). Routine visitors are not allowed. The policy forecasts that facilities may need to prepare additional rooms and rearrangement of lodgings to appropriate space expectant mothers; "beds should be at least 1m apart, well ventilated" (Pg. 12).*

**Support person during labor:**

*The policy states that a companion is discouraged (Pg. 18).*

**Other:**

**Postnatal care packages:** *women are to be provided with an "expected package of services" that outlines procedure at the community, primary, secondary and tertiary, and central levels (Pg. 26-28)*

**1d. Immunization Service Provision**

*Overview: Broadly, immunization services are to continue in public and private facilities; outreach services continue as well and if disrupted, are to resume as quickly as possible. To support this, community mobilization should increase at all levels and "activities to maintain trust, reduce barriers, involve communities, and activate intentions for vaccination should be intensified" (Pg. 32). The "ideal approach" would integrate immunization to growth monitoring and nutritional services (Pg. 34). The policy highlights that immunization visits and outreaches are opportunities to share COVID messages.*

**Outreach versus facility-based service provision:**

*Outreach efforts are to continue with guidance on the safe provision of immunization services at all points. Safe provision guidelines include avoiding crowded waiting rooms, displaying of visual alerts in clinics with COVID information, holding smaller (and more frequent) sessions, using outdoor space for sessions and identifying specific immunization sessions for high risk populations (Pg. 33).*

**Other:**

**Communication:** *The policy recommends integrating using mass media programs on safety of vaccinations, key messages into ongoing COVID programming, addressing misinformation and rumors about immunizations, and advocating for access to immunizations (Pg. 32).*

**Continuity of Care:** *The policy provides recommendations on continuity of services and safe provision of the same. Some of the recommendations and guidance are;*

- *Stepping up community mobilization for immunization at all levels to address the threats to access and demand for the services.*
- *Catch up vaccination should be planned implemented locally for all children who have been missed during intensive COVID 19 lockdown phases (Pg32).*
- *Bundling immunization activities with other essential preventive health services, as appropriate for age to limit the amount of time vaccines and their caregivers spend at health facilities*

**1e. Other**

**Psychosocial support:** *For suspected COVID-19 patients, psychosocial support is to be provided (Pg. 14), largely to reduce anxiety and fear and explain change of care management. It is mentioned at multiple points throughout the policy.*

**Breastfeeding:** *The policy states that there is no evidence suggesting that SARS-COV2 is transmitted through breastmilk. The summarized version in this policy promotes hand hygiene and mother wearing a mask; and in cases that the mother cannot be with the baby it is recommended that the mother express milk and a care giver feed this to the baby, with appropriate breastmilk substitutes used when needed (Pg29).*

**Section 2. Key Policy Factors: Cross Cutting Health Service Provision_____**

**2a. PPE:**

*PPE is to be provided and used by providers for all patient interactions, but regular face masks are to be used with patients who are not suspected of COVID-19 symptoms and swapped for N95/FF@ respirators (plus overshoes) for suspected COVID-19 cases (Pg. 13-14).*

**2b. Establishing designated COVID-19 health facilities:**

*Not mentioned although there are indications of isolation wings/centres at district, provincial or central level which can be utilized (Annex 1).*

**2c. Human Resources for Health (including absenteeism, compensation, work station or shifts, other HRH-related)**

*For technical working group virtual meetings or trainings, the guidelines suggest that support may be needed for WIFI, data bundles, or airtime (Pg. 11).*

**2d. Screening of patients:**

*Algorithms for screening clients based on the facility level are provided. This policy encourages facilities to set-up unilateral traffic flow at the facility and screening to be done at the entrance to the facility and at every consultation point for RMNCH services.*

*Screening should be conducted for symptoms prior to entering L&D room, every twelve hours after, every consultation point and for potential exposure to someone with COVID.*

**2e. Testing health care providers or clients for COVID-19:**

*The policy states that those identified as being following the "green route" or those not suspected of COVID-19 symptoms are to be rescreened every 12 hours for potential exposure (Pg. 19).*

**2f. Telehealth/Telemedicine**

*Toll-free lines are to be linked to hospitals to support ANC referrals (Pg. 11). The policy also includes a section on "facility-based remote consultation" where women visit the nearest health facility and consult with providers at higher level facilities (Pg. 14). Generally, telemedicine is most heavily emphasized at the facility or District/Mission hospital level (Pg. 14). Mobile technology should be used to disseminate key*

*information about available FP/SRH services, including directories of service delivery points and contacts (Pg. 37).*

**2g. Other cross-cutting health service provision (please describe):**

**Meetings & trainings:** *the policy recommends virtual meetings for clinical mentorship, maternal and perinatal deaths surveillance and response committee meetings, general trainings, and technical working group meetings (Pg.10-11). Trainings are recommended to follow a blended approach with both in-person and interactive virtual sessions, with safety protocol followed for in-person interactions (Pg. 11).*

**Triage**: *triage spaces should be set up near entrances to the facility and ideally in open spaces outdoors or well-ventilated, sparsely furnished rooms (Pg. 13). The policy suggests determining the wind direction and setting up the seating arrangements so that air flow moves away from clients and providers (Pg. 13).*

**Section 3. Key Policy Factors: Cross Cutting Population / Society_____**

**3a. Curfews and/or restrictions on movement:** *N/A*

**3b. Face masks:**

*The policy states that if pregnant women show up without facial coverings, masks are to be provided and women are not to be turned away (Pg. 13). Mothers with positive/suspected COVID-19 are to wear N95s during labor and all contact with the baby until declared COVID-free (Pg. 20).*

**3c. Other (please describe):**

**Community engagement:** *the policy encourages communities to establish their own healthcare worker-guided health center committees for the care of pregnant women who face complications at home (Pg. 11). In addition, for information, education, and communication, the policy recommends collaboration with entities able to reach out such as grocery shops and security companies in order to reach clients (Pg. 37). Communities are encouraged to come up with their own specific communication channels via the health center committees, guided by the healthcare workers, should a complication arise while the woman is at home (Pg 11).*

**Young people provisions:** *the policy includes a section dedicated to framing the COVID-19 response to young people, including engaging with schools, availability of minimum health service delivery package (psychosocial support, ART, contraceptives, condoms), linkages between young people and community-based health workers, leveraging social media and mobile communication channels and youth-specific help lines, and conducting client satisfaction surveys with age-disaggregated data (Pg. 42). The policy includes specific messaging (quotations) for young people (Pg. 43-44).*

*The policy states that young people face diverse challenges. They also face anxiety and stress related to COVID-19. It states that the need for continuity of services including mental health and counselling is important (Pg40). The policy highlights that Youth friendly services (YFS) are services that are accessible, acceptable, and appropriate for young people. It goes on to describe the 9 standards on YFS provision and a COVID-19 response with young people – for young people focusing on what health providers, development partners, civil society organizations, youth networks need to do.*