

# Understanding the interruption of essential health services by COVID 19 to guide recovery

Programme brief: Based on cross regional analysis of COVID-19 impact on health services

10 October 2020

**Context and Need:** With more than two hundred days into the COVID-19 pandemic, and over one million deaths, the challenges in access and availability of data to monitor essential health services have been evident. Complementing the socioeconomic impact survey, Health programme in UNICEF Programme Division, in collaboration with 43 country offices and all regional offices, made a comparative analysis of the coverage of essential health services during the period April to June in 2019 and the corresponding period in 2020. The set of tracer indicators selected were antenatal care, institutional delivery, cesarean section, care of sick newborn, post-natal care, immunization (Penta/DPT3), pneumonia and diarrhoea treatment.

**Macrotrends to Guide Country Actions:** There are clear macrotrends emerging from this analysis. Taking them into consideration will be critical for countries as they plan their journey of recovery.

1. The degree of disruption varies considerably amongst countries and regions. Countries in South Asia and Latin America region have been affected much more as compared to those in Sub-Saharan Africa.
2. The services delivered through different service delivery platforms have been impacted differently. This will have implications while planning strategies to address the interruption.
  - ◆ Immunization services were hit early and hard but are the first to recover with clear signs of a V-shaped recovery being seen in most countries. Still, nearly 3.8 million fewer children got Penta-3 immunization in Q2 of 2020.
  - ◆ In contrast, the impact on facility based care seems sustained with a much slower recovery. For example, institutional delivery, cesarean sections, care of sick newborn and children. Emergency interventions are time sensitive and 'catch up' is not possible if missed.
3. There appears to be a clear correlation between the COVID case load, mitigation measures, and system response to COVID on utilization of health services. In general countries with higher COVID caseloads have seen more severe disruption of services. However, this is only one of the triggers, with system response to COVID, like lockdowns, government policies on suspension of services, closure or repurposing of health facilities, reduced demand by communities due to fear and misinformation being the other defining factors.
4. In each country, it will be critical to look at sub-national data, as national averages can mask the inequities in disruption. It will be vital to see impact in provinces/counties/states and districts with high COVID case load, sustained lockdowns and urban population. There is a need for further analysis to look at rural–urban differentiation including urban slums, and impact on gender and marginalized groups in terms of service utilization.
5. Models to determine secondary impact should consider differential impact across countries and different service delivery platforms. The duration and severity of interruption is not uniformly applicable across all countries or on different services within a country. Within the same country, one service might be disrupted for a much longer duration than another, as seen for institutional delivery in comparison with immunization services.
6. It will be critical to also look at data from the private sector, as in many countries the private sector is an important provider. Limited data available for the private sector shows significant impact on private sector utilization as well, especially on inpatient care.
7. Decline in coverage is not yet translating into a corresponding increase in reporting of home deliveries, still births, maternal, child deaths, except for a few countries. This points to the limitations of HMIS data and possible time lag in capturing mortality. Country teams should also validate this with health facility records (labor room, newborn care units and pediatric wards), Maternal and Perinatal Death Surveillance (MPDSR) and civil vital registration data to better understand the true impact of reduction in coverage on mortality.

## Programme Implications and Suggested Country

**Actions:** As substantial quantitative and qualitative data from a wide range of countries is now available, it is time to use the knowledge gained so far to support countries to plan their journey of recovery and take steps to mitigate similar disruptions during subsequent waves of Pandemic.

1. Monitoring disruption and recovery pattern of essential health services will be a priority for the remainder of 2020 and most of 2021. Country teams should work closely with government and partners to put in place a government led mechanism to monitor disruption of services and track recovery on a real time basis. This needs to be complemented by pursuing budgetary allocations and policy actions made to expedite recovery.
2. Identify and Address “Drivers of Disruption” at national and subnational level. These may vary for each country and within a country. The key drivers listed below may work in isolation or often act in tandem.
  - ◆ COVID case load, intensity of lockdowns, mitigation measures, system response.
  - ◆ Repurposing of health facilities and shut down of peripheral health facilities.
  - ◆ Interruption of supplies, essential drugs and commodities.
  - ◆ Inadequate infection prevention and control measures creating apprehension among both the health providers and community, impacting utilization and quality of services.
  - ◆ Anxiety, fear and misinformation in community affecting demand.
3. Use “Differential Approach for Different Service Delivery Platforms”. As the duration and causes of disruption of outreach and facility based services differ, we need to adopt a differential approach while planning recovery.
  - ◆ The utilization of any service depends on the availability of the service and related supplies along with access to service and demand in the community. Disruption of any of these

can impact utilization. The strategy should be guided by the principle underlying factor responsible for reduced utilization.

- ◆ For outreach services like immunization, resumption of services and overcoming the supply side bottlenecks will be the dominant determinant initially, as efforts to address demand side barriers are undertaken simultaneously.
  - ◆ For facility based care, addressing demand side barriers to allay apprehensions and misinformation and restoring confidence in community will be the major driving factors, while efforts to improve access, sustain services and supplies are made in tandem.
  - ◆ Communication and infection prevention and control efforts will be key to restoring trust and confidence both in community and amongst health care providers. This will have an impact on both demand and quality.
4. Advocate and support building “Resilient, Responsive, Reliable and Realtime Data Systems” with transparency in data sharing at its core. The hesitancy of data sharing by countries, compounded further by disruptions/delays in data entry has brought to forefront the fragility of data systems.
    - ◆ UNICEF can play a role in supporting health management information system to generate reliable real time information, address gaps in digitalization, data analysis including developing country dashboards, and ensuring its use to guide national and subnational actions.
    - ◆ Digital health initiatives like U-Report and telephonic surveys can be used to get quick feedback from the community and health workers.
    - ◆ Countries should develop a mechanism to also report on utilization data from telehealth services and private sector.
    - ◆ Data strengthening should be a part of the overall effort of health system strengthening complementing efforts of the government.

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### For More Information Contact:

Gagan Gupta, [ggupta@unicef.org](mailto:ggupta@unicef.org)

Lu Wei Pearson, [lpearson@unicef.org](mailto:lpearson@unicef.org)