Innovation in the Face of COVID-19:

Optimising Teleconsultation to Assure Reproductive Health Consultations in Crisis Settings
Lessons from North West Syria

Charity Number: 1154881

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Background

From September to October of 2020, in response to the COVID-19 pandemic, Syria Relief (SR) pioneered a teleconsultation project for maternal health services in North West Syria (NWS). The project was one of the first of its kind in North West Syria. Despite lasting just two months, the project was successful beyond its expectations and led to other organisations adopting similar methods in their projects.

The update during the pandemic gave patients, particularly pregnant women, the option of a digital consultation. Teleconsultations do not remove the right to access in-person consultations, they allow women more choice.

Funded by Save the Children International (SCI) and in constant coordination with the reproductive health (RH) technical group, Syria Relief designed a method to provide in-person ANC and PNC consultations over the phone.

We now estimate that 2447 in-person visits were combined with 521 online consultations during October and November. Medical evidence shows the safety and effectiveness of teleconsultations. Continuing this practice after the pandemic will ensure that no patient, regardless of personal circumstances, health needs and safeguarding concerns will be forced to attend a clinic or hospital.

Recommendations

Funding for this service

The availability of maternal health services in NWS is insufficient. Funding for this area is crucial to ensure pregnant women maintain their right to health.

Monitor clients' perceptions

Clients' perception of the approach was important to be evaluated continuously because it was indispensable to ascertain whether services were effective. Clients had to trust in the services to cooperate optimally and inform us about potential danger signs, as well as to feel like they were in good hands. Because we regularly consulted them, we learned that the services were acceptable, and that clients felt cared for, but also that they did not always have internet available, which worried them. Future approaches should make sure to regularly check with clients whether they are experiencing any difficulties when working remotely. Additionally, misunderstanding of the initiative's purpose has influenced client's perception. When seen as an alternative to physical checks, it was not appreciated. However, when seen as a solution for service interruption, it was more acceptable.

Introduce awareness sessions on healthcare

Awareness sessions about potential danger signs can be very helpful to aid women in identifying indicative symptoms, activate them to proactively share signs with their midwife and make them feel more in charge as well as cared for. Service providers often found that women had problems describing their symptoms. Women lacked the words to describe what exactly they felt and were uncertain of whether it was worth mentioning.

By explaining the most dangerous signs to them clearly, and allowing them the time to ask questions, CHWs might empower women to make a basic evaluation of their health status and immediately contact a midwife when they suspect they might have a serious condition. Awareness sessions are ideally held in groups based on gestational age (WHO, 2016) and can be led by a CHW.

Introduction of patient file software

We strongly recommend putting in place a patient file software when using the telecommunications approach on a reasonably large scale. Alternatives like Excel files or paper records easily get cluttered. The telecommunications approach requires additional record keeping, such as the use of modality, and because of the higher risk of missing a diagnosis, it becomes particularly important to make a sound risk-assessment. Such record keeping is often not possible without good patient file software.

Introduction of a digital appointment booking system

We recommend using a digital appointment booking system, because the different modalities and frequent visits can make a manual or Excel-based system unworkable. Moreover, because patients do not show up to the clinic for digital consultations, it might be easier to forget a patient if the system is not optimally reliable.

This brief report describes how these services were planned and implemented, how they were received, what lessons we learned from them and what recommendations we can offer other service providers who are interested in the strategy.

Teleconsultation for Antenatal Care and Postnatal Care Contacts

Since 2016, the global standard for ANC visits is a minimum of 8 ANC visits, with an emphasis on the third trimester (WHO, 2016). The standard for PNC visits is 4 visits, at day 1 and 3, and in the second and sixth week (WHO, 2014). In humanitarian settings, neither is always feasible, and many women still deliver without having seen a healthcare professional during their pregnancy (Terkawi et al. 2020).

When the COVID-19 pandemic hit, access to maternal health services was further reduced globally, to protect both staff and the expecting mothers.

To guide this approach, the UNFPA published a technical guideline. This guideline suggests that tele-consultations can assist ANC and PNC. It recommends a schedule with 8 ANC contacts, 4 in-person and 4 online contact moments, and details what is expected in each visit.

The teleconsultations approach has been widely implemented and reviewed in high-income countries. However, little literature exists on the safety and efficacy of teleconsultation in humanitarian settings.

Health System Service Delivery and Current Governance in North West Syria

The availability of maternal health services in NWS is insufficient. After eleven years of war, healthcare services in Syria broke down as resources were re-allocated, medical staff fled and medical facilities were deliberately targeted. Currently, most of Syria is again under the control of the Syrian government in Damascus. The borders of the remaining areas in NWS are controlled by non-government actors, which puts strain on health service provision as well as on life conditions in the region as a whole. A new wave of displacement in 2019, which saw the movement of about one 1 million new internally displaced people into NWS, further strained the already scarce resources.

Data on basic health indicators is scarcely available. There are no comprehensive numbers on the maternal mortality rate, proportion of women attending 4 or more ANC visits, PNC access and prevalence of low birthweight among new-borns (Akik et al. 2020). (Terkawi et al. 2020) reported that as many as 39% of the 730 women who delivered in their centre in the study period did not receive any ANC consultations.

Because health staff need to be registered, their numbers are well-documented and known to be extremely low. For example, there are 185 gynaecologists available for about 4.6 million people, which is about 4/100.000 (HeRAMs Q4 2021). All medical and most camp services are delivered by humanitarian actors, and these are struggling to meet the basic demands, like water, food and shelter. Stable electricity and internet supplies are not always available in camps.

The teleconsultations approach was launched in two RH clinics in Sarmada and Armanaz, in Idlib province. The maternal health programme was run by six midwives, three in each of the two clinics. Midwives were also supported by an outreach worker to facilitate E-awareness sessions visits for pregnant and lactating women.

Establishing Teleconsultations During the Pandemic

The initiative for transitioning into a partially digital maternal health approach resulted in a continuous discussion between SR and SCI on how to assure service continuation. After various rounds of internal discussion about the desired approach, the idea was presented to donors. SCI approved and supported the implementation for the duration of the project, which lasted from October to November 2020.

Because of the urgency caused by the spreading pandemic, the design and implementation needed to be finished as quickly as possible. A UNFPA guideline for digital ANC and PNC consultations was available and was adapted to suit the circumstances. To validate our approach, the developed protocol - which detailed which questions had to be asked at each online consultation, and what the criteria for referral were - was reviewed and approved by technical team from the SRH technical group.

Data would be collected using a novel data-collection modality, Kobo. We collected the personal and medical details of the involved patients. The Kobo was selected as it facilitates a more accurate data collection process by counting on automated and multiple-choice questions which reduced human errors.

In the final approach, we combined 2447 in-person visits with 521 online contacts during October and November. All six midwives and the two outreach workers were involved. Each morning, they first completed their in-person consultations. After that, they started the online follow-up sessions based on the follow-up schedule. Consent to complete the consultation over the phone was obtained at the beginning of the call. During the call, the midwife would go through all the listed questions, which covered risk factors, emotional state, COVID-19 symptoms and awareness messages.

The Positive Impact of Teleconsultations on Safety During the Pandemic

In the 2 months we operated the teleconsultations, we made approximately 521 phone calls, 384 for PNC and 137 for ANC visits. Some of these substituted face-to-face visits, others were in addition to the usual 4 visits. Because the ANC visits are spread out over the duration of the pregnancy and the registration method was not always consistent, our data cannot be used to show whether ANC consultations were more frequent or more regular during this period of time.

However, for the PNCs, we saw a clear trend that the number of women who received 4 PNC contacts per month increased during the implementation of this approach. Figure 2 shows how teleconsultation approach allowed more women to be reached despite the COVID-19 restrictions. It shows the number of women who received a total of 4 PNC contacts per month and demonstrates a peak in the months where the telecommunications approach was implemented.

Figure 2 compares physical and online modalities in October and November. 39% of PNC contacts were done remotely which facilitated the improvement of the ANC4/PNC4 indicators.

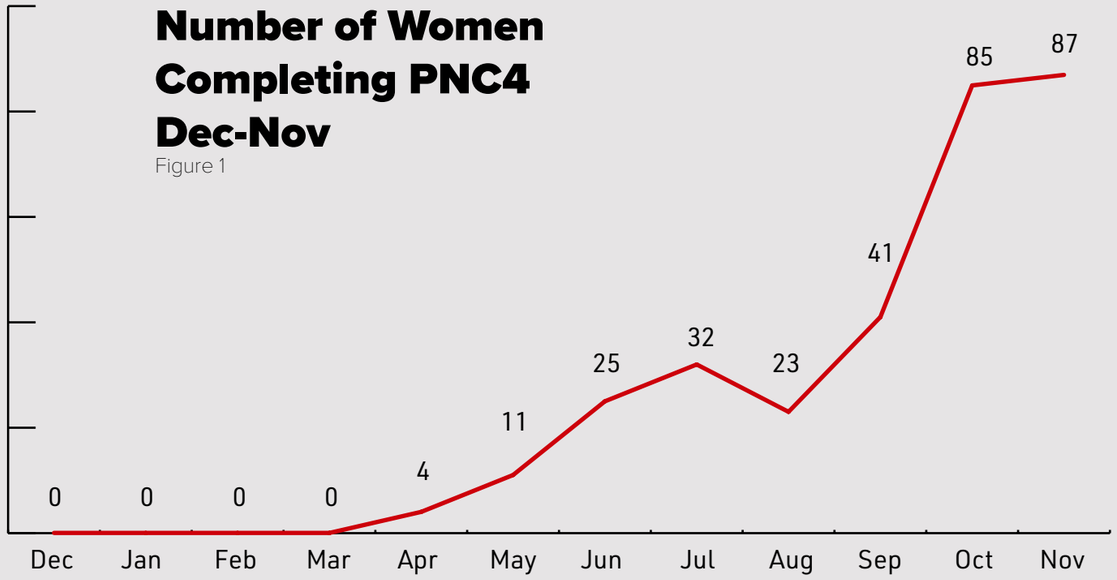
Figure 3 represents number of women who received 4 PNC contacts to those received only one by month. It shows a clear peak during the months of teleconsultation through which more women were reached by phones. This facilitated the increase presented.

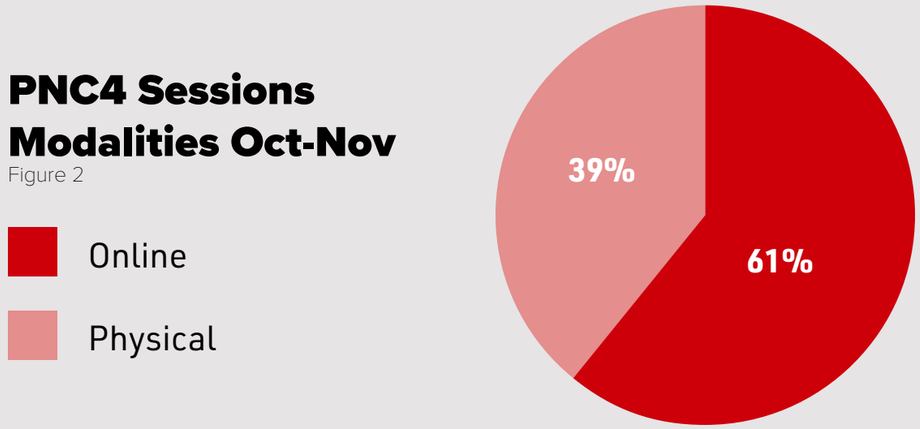
Initially, staff as well as beneficiaries were reserved about the approach. Midwives had not used the phones for consultations before and expressed that they were not comfortable using the technology. Midwives were also worried that patients would not accept the approach and would insist on being seen in person.

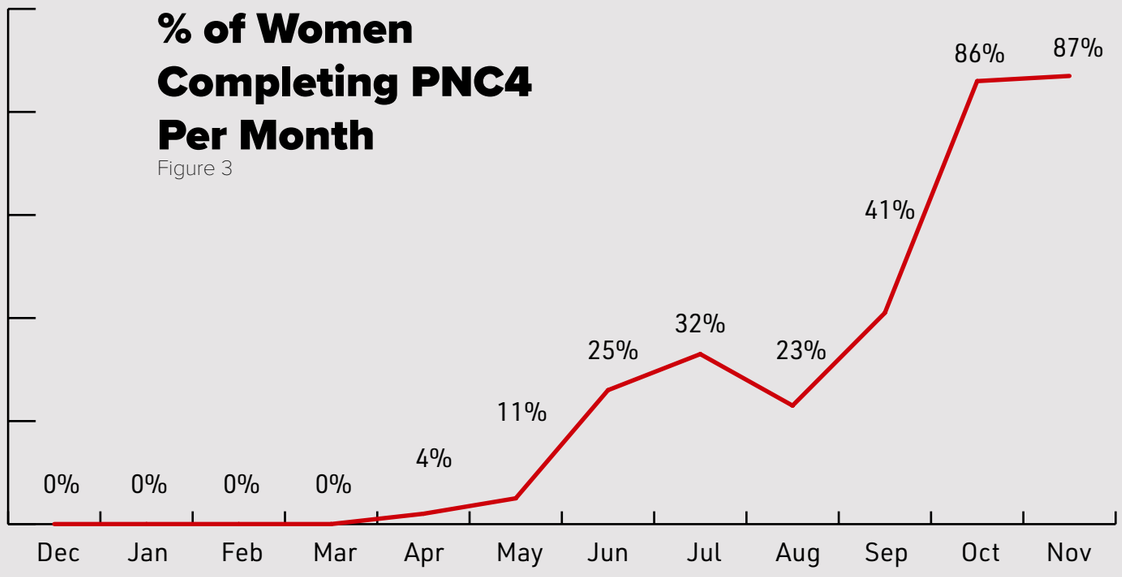
However, the point of this initiative was not to select one modality from a list of available ones, it was rather an operational necessity caused by access restrictions brought by COVID-19. Teleconsultation aimed to supplement physical consultation not to substitute it. It has offered a communication channel between service providers and clients when physical visits were not available.

As time went by, CHWs were involved to fill out the Kobo questionnaires and data-entry. This allowed midwives to focus on the medical assessment. Over time, midwives started to see positive reactions from patients who liked the approach, often because it offered them improved access to service providers. They also expressed that the individual calls gave them a sense of personal attention and being cared for. Yet, there were also clients who could not see the value of the remote consultations and insisted on coming to the centre for physical examination.

In retrospect, more women received 4 PNC sessions, and likely also 4 ANC visits. While the approach had shortcomings, it was clear that the benefits of service continuation and improved access in addition to avoiding viral infection and excessive stress on the medical system outweighed the risks.







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