In Brief

mConsulting

May 2020

This research is part of the **mConsulting study**, which explored mobile consulting in communities with minimal healthcare access in remote, rural areas in Pakistan and Tanzania; and urban slums in Bangladesh, Kenya and Nigeria.

The project was led by Prof Frances Griffiths of Warwick Medical School, UK, in collaboration with:
African Population Health Research Centre, Kenya
Aga Khan University, Pakistan; Independent University, Bangladesh
Ibadan University, Nigeria
St. Francis University College of Health and Allied Sciences, Tanzania,
King's College London, UK.

Research in each study site was guided by a **Project Advisory Group** of local experts, including community leaders, health workers, mobile and digital technology providers.

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COVID-19 has forced unprecedented changes to human behaviour, including in how and where we seek healthcare. Digital technology is in the spotlight as people seek new ways to connect and to support overburdened health systems. Many are turning to mobile phones and digital devices to consult with health workers - not only about COVID but for other health needs too. But is mConsulting a viable option in low-resource settings?

Mobile Consulting is when patients consult with healthcare workers about a health issue using some form of digital communication, e.g. mobile phone, tablet.

Box 1: Key recommendations

1. Governance, guidance and training are needed to enable confident mConsulting by health workers using their own phones for consultations.
2. Integration with existing services, awareness raising and governance are needed for mConsulting platforms to enhance healthcare provision
3. Local health workers acting as intermediaries for community members may enable community members to gain confidence in the use of mConsulting platforms.
4. Advocacy for health system strengthening and strategies to promote behavioural change will enhance mConsulting.

In this brief, we present key recommendations and findings from our scoping study of mConsulting in communities with minimal healthcare access in Bangladesh, Pakistan, Tanzania, Nigeria and Kenya.

Methods: Between April 2019 and March 2020, we analysed national policies and identified existing mConsulting services in each country. In two remote rural areas and five urban slum settings, we held interviews and ran workshops, reaching over 230 community residents, 50 local health workers and 30 local and national decision-makers about their use, experiences and perceptions of mConsulting. Data were qualitatively analysed for key themes within and across sites. We also analysed secondary data from a household survey undertaken in the five urban study sites by the NIHR Global Health Research Unit on Improving Health in Slums.

Box 2: Key findings

Nationally in each country

1. mConsulting is being provided as an alternative and in addition to face-to-face services by:
   a. Health workers accustomed to providing face-to-face healthcare; and
   b. mConsulting platforms operated by commercial companies with either their own provision for in-person contact where needed (examination, tests, treatments) or through links to existing face-to-face services.
2. mConsulting fits into existing health and ICT/digital policies in each country and it can add to health system resilience.
3. Specific mConsulting protocols and guidelines are needed.

For communities in remote rural areas and urban slums

4. While more men than women own mobile phones, almost all households have access to basic phones for phone calls and text messages but limited access to the internet.
5. Unreliable electricity and poor network coverage are obstacles to connectivity in rural areas.
6. Health workers are using their phones for mConsulting without being aware of what it is or how it should be done.
7. Community members are consulting with their usual health workers by phone. They are largely unaware of other mConsulting platforms.
8. Community members and health workers are concerned about privacy and quality but see benefit in anonymity for some health conditions e.g. HIV and STIs.
9. mConsulting is affordable if it is of high quality and so leads to appropriate management of the health problem. It saves on travel costs and waiting times, especially in emergencies and for conditions requiring ongoing, chronic care.

Conclusion: During a pandemic, a clear benefit of mConsulting is that it reduces travel, avoids congested waiting rooms and cuts out face-to-face interactions, thereby protecting frontline health workers, patients and vulnerable groups. For those with mobile devices and airtime or internet access, this enables advice-seeking and supports continuity in healthcare across a range of conditions. COVID-19 has forced a rapid acceleration in mConsulting. However, it is not a new form of clinical communication. In the past few years, digital technology has been promoted for strengthening health systems, delivering universal health coverage and providing quality health services, particularly for communities with minimal access to healthcare. Our study suggests that mConsulting is an option for improving access to quality healthcare for under-resourced communities living in remote rural areas and urban slums. In the five countries studied, services are already available- nationally through mConsulting platforms and at community-level with individual health workers using their phones. Regulatory frameworks are broadly in place and there is general willingness amongst decision-makers, health workers and community members to use mConsulting provided such services are trustworthy and of high quality. With COVID-19, there is global urgency to scale-up mConsulting.

Yet mConsulting is only one component of the care pathway. Wider system strengthening is needed to bolster referral and specialist services, equip laboratories, build supply-chains and ensure a resourced, trained and confident workforce in order to fully realise the continuity of care and responsiveness that mConsulting services can offer.

Thank you to all study participants.

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