

Impact of the COVID-19 Pandemic on Sexual and Reproductive Health Services in Burkina Faso, Ethiopia, Kenya, Malawi and Uganda



APRIL
2021

Table of contents

List of Tables	ii
List of Figures	ii
List of Acronyms	iii
Acknowledgements	iv
Background	1
Methods	3
Study design, population and setting	3
Sampling approach	3
Data collection	4
Data analysis	4
Ethical Approval	4
Main Findings	5
Characteristics of women and girls (patient-exit interviews)	5
Characteristics of health providers	6
Access to SRH information and services during COVID-19 pandemic	7
Barriers to SRH services	11
Availability of SRH services	15
Utilization of SRH services	20
Conclusions	22
Key Recommendations	23
References	24

List of tables

Table 1: Demographic characteristics of patients	5
Table 2: Demographic characteristics for Healthcare Providers	6
Table 3: Reasons why PAC and CAC services were not available at the time of the survey	19
Table 4: Services sought in previous and current visits to facilities	20

List of figures

Figure 1: Sources of SRH information for women and girls	7
Figure 2: Proportion of women and girls who accessed SRH services they needed	8
Figure 3: Proportion of women/girls who needed and obtained a contraceptive method	8
Figure 4: Contraceptive methods received by women and girls	10
Figure 5: Barriers to seeking SRH services among women and girls	11
Figure 6: Proportion of women and girls facing challenges accessing specific SRH services	13
Figure 7: Women and girls coping mechanisms for overcoming barriers to SRH services	14
Figure 8: Availability of SRH commodities and stock-outs	15
Figure 9: Measures by health facilities to address COVID-19 risks	16
Figure 10: Changes in SRH service delivery during the COVID-19 pandemic	17
Figure 11: Reasons why SGBV services were not available at the time of the survey	19

List of acronyms

AIDS	Acquire Immunodeficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal Care
APHRC	African Population and Health Research Center
ARVs	Antiretroviral drugs
CAC	Comprehensive Abortion Care
CCC	Comprehensive Care Center
COVID-19	Coronavirus disease 2019
CRR	Centre for Reproductive Rights
CSO	Civil Society Organization
FP	Family Planning
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IUCD	Intra-Uterine Contraceptive Device
KEMSA	Kenya Medical Supplies Authority
KII	Key Informant Interview
LGBT	Lesbian, Gay, Bisexual and Transgender
MCH	Maternal Child Health
MVA	Manual Vacuum Aspiration
NACOSTI	National Commission for Science, Technology and Innovation
NAYA	Network for Adolescent and Youth of Africa
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PPE	Personal Protective Equipment
PPG	Planned Parenthood Global
PSK	Population Service – Kenya
R4S	Research for Scalable Solutions
RHNC	Reproductive Health Network Kenya
SGBV	Sexual and Gender-Based Violence
SMS	Short Message Service
SOP	Standard Operating Procedure
SPA	Service Provision Assessment
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UHC	Universal Health Coverage
WHO	World Health Organization

Acknowledgements

The study reported here was led and carried out by a consortium of organizations: the African Population and Health Research Center (APHRC), Amref Health Africa, Centre for Reproductive Rights (CRR), Ipas Africa Alliance, Network for Adolescent and Youth of Africa (NAYA), Reproductive Health Network Kenya (RHNK) and Planned Parenthood Global (PPG).

We are grateful to Caroline Kabiru and Boniface Ushie (APHRC), Angela Akol and Suzanne Majani (Ipas), Evelyne Opondo and Martin Onyango (CRR), Victor Rasagu (NAYA), Achieng Akumu (PP Global), Nelly Munyasia (Reproductive Health Network Kenya) [RHNK], and Shiphrah Kuria (Amref Health Africa) for their efforts to initiate and coordinate this study. We also appreciate the in-country partners who supported data collection in Burkina Faso (BURCASO and Billis), Ethiopia, Kenya, Malawi and Uganda [Kyetume Community Based Health Care (KCBHC) and Flama]. We also thank all the women and girls, health care providers, representatives from civil society and non-governmental organizations, and policy makers who participated in the research and furnished the data used in the report. We also appreciate Esther Mutuku and Bonface Odianga for their roles in the data analysis and report writing.

This research was made possible by a generous grant (No. 12103) to APHRC by the Swedish International Development Cooperation Agency. Planned Parenthood Global provided financial support for data collection in Kenya, Uganda, and Burkina Faso. The Centre for Reproductive Rights provided financial support for coordination and data collection in Kenya. The Bill and Melinda Gates Foundation provided generous support to Amref Health Africa through the Building Research Capacity project.

Study Team

- Emmy Igonya (APHRC)
- Kenneth Juma (APHRC)
- Ruth Momanyi (PP Global)
- Graham Nyaberi (RHNK)
- Faith Mbehero (PP Global)
- Beverly Musili (CRR)
- Japheth Ogol (IPAS)
- Cynthia Odhiambo (NAYA KENYA)
- Winstoun Muga (APHRC)
- Dona Anyona (Amref health Africa)

Study Partners



Executive Summary

Since the first case of Coronavirus Disease 2019 (COVID-19) was reported in China in late 2019, the ensuing global pandemic has challenged human health and development and hampered the attainment of global, regional, and national health priorities and development goals. In sub-Saharan Africa (SSA), where health systems remain fragile, the COVID-19 pandemic brought unprecedented disruptions to healthcare delivery and utilization. The policies and actions of certain governments to control the pandemic further exacerbated existing inequalities, especially for the most vulnerable groups (e.g., young women, adolescents, and sexual and gender minorities). So far, limited data are available to assess the impacts of COVID-19 on sexual and reproductive health (SRH) services.

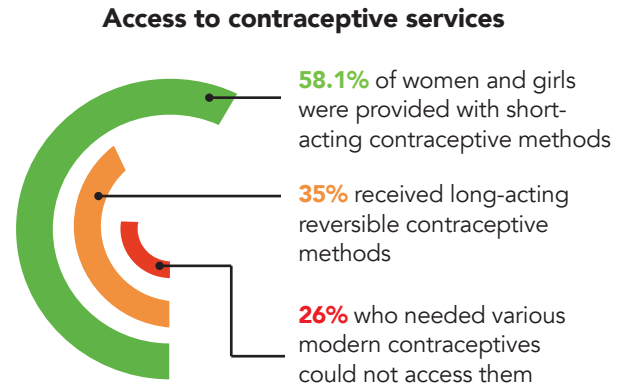
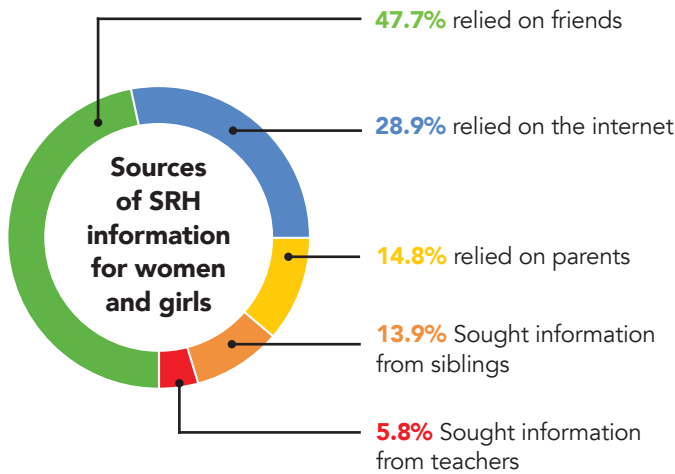
This report presents a comparative analysis of five SSA countries (Burkina Faso, Ethiopia, Kenya, Malawi, and Uganda), highlighting the overall impacts of the COVID-19 pandemic on the availability of, access to, and use of SRH services. We interviewed 3,473 women and girls, and 466 healthcare providers in Burkina Faso, Ethiopia, Kenya, and Uganda. In addition, we conducted in-depth interviews with 211 women and girls, 176 healthcare providers, 64 representatives from civil society organizations (CSOs) and non-governmental organizations (NGOs), and 13 policy makers (Ministry of Health officials) in the five countries (including Malawi).

Findings show that, during the Pandemic, women and girls had limited access to critical SRH services – contraceptive services, antenatal care, post-abortion care (PAC), and HIV/AIDS prevention and management. Government restrictions and lockdowns in response to the relentless spread of COVID-19 limited access to SRH services and disrupted other sectors, such as transport, health, trade, and security. Some health facilities were closed and some were converted to COVID-19 isolation and treatment centers. As a result, women and girls had to go to other, more distant health facilities. These clients reported that the longer distances, combined with a fear of contracting the virus, the elevated cost of healthcare, and the occasional negative attitudes of providers, impeded access to SRH services. Notably, those experiencing difficulties in accessing SRH services sometimes stopped visiting health facilities all together, delayed or postponed care seeking, or utilized non-facility-based care. Some women and girls decided to treat themselves with over-the-counter medications, while others sought alternative care sources (traditional healers and birth attendants).

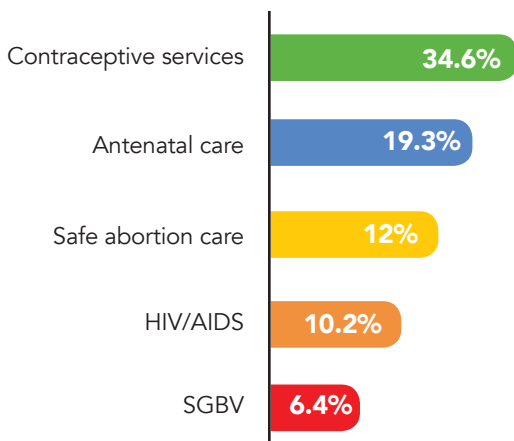
At the same time, health providers reported reduction in the availability of some SRH services, including contraceptives, antenatal care, comprehensive abortion care, and sexual and gender-based violence (SGBV) services. Unavailability of these services was due to shortages of supplies, an absence of trained healthcare personnel (many of whom were redeployed to COVID-19 units), the infection of healthcare providers, staff reductions, and the closure of health facilities. Consequently, providers reported a decline in the use of SRH services during the pandemic that corresponded with increased difficulty in accessing (or the unavailability of) SRH services and an overarching fear of contracting the virus when visiting the health facilities. However, several facilities implemented innovative strategies to ensure continuity of SRH services, including the use of telemedicine, self-care approaches, changes in timing for services, and altering referral patterns for care services.

The COVID-19 pandemic has had adverse effects on the availability of, access to, and utilization of critical SRH services across the five countries. These effects have led to, and continue to lead to, unmet needs for contraception, as well as limited access to and use of such services as antenatal care, PAC and HIV/AIDs, resulting in poor health outcomes. Therefore, the responses of governments to the pandemic must strike a delicate balance between mitigating the impacts of the virus and adopting multisectoral responses that are fit-for-purpose and address sexual and reproductive health needs, challenges and priorities.

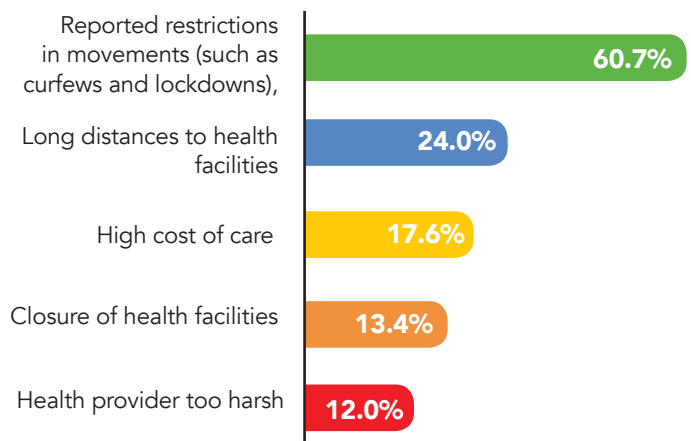
Impact of COVID-19 on Sexual and Reproductive Health Services



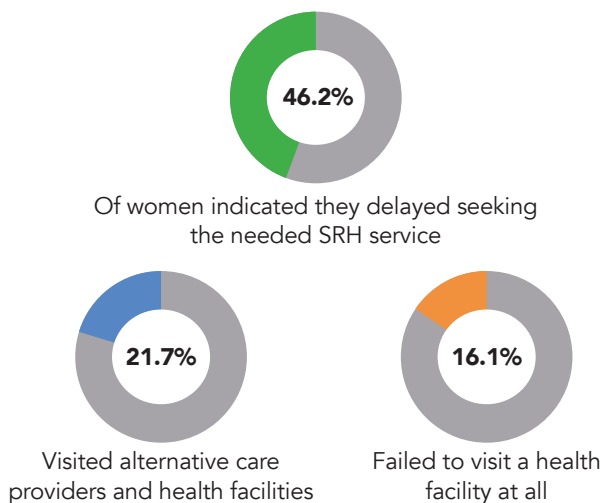
SRH services with barriers to access



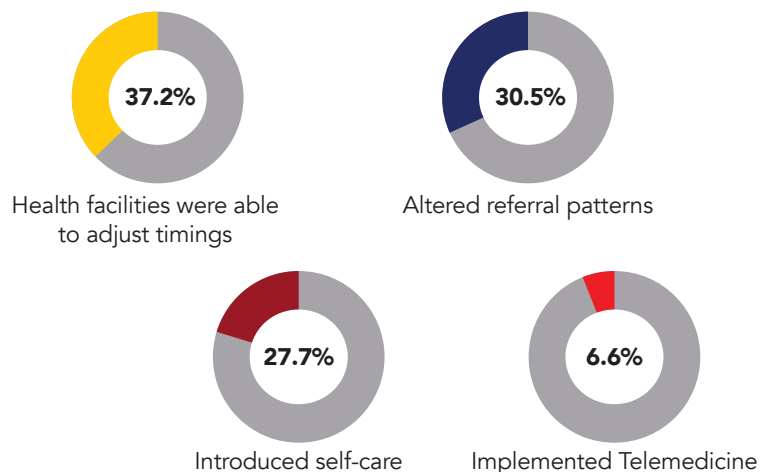
Barriers to seeking SRH services among women and girls



Coping mechanisms to the barriers accessing services



How health facilities adjusted operations to ensure continuity of SRH services





Background

Evidence shows that public health emergencies typically exert tremendous pressure, with severe consequences on SSA's fragile healthcare system (Tessema et al, 2021). The COVID-19 pandemic has only served to confirm this notion. Governments have focused on overcoming the COVID-19 challenge in the face of several competing needs and priorities in health and other sectors (Mbatha & Tendai, 2020; Hillier, Tom, Rithika & Larsen, 2020). Certain services have been deprioritized, while broad and sometimes non-specific interventions have been implemented, such as travel bans, lockdowns, and curfews among others (Haider et al, 2020). Similarly, SSA governments put forth national guidelines and policies for the continuity of essential health services and information, even though some failed to recognize or prioritize critical SRH services (World Health Organization, 2020; PAI, 2020). Some COVID-19 SRH guidelines proposed innovative interventions to circumvent pandemic barriers even though some of the suggested measures had not been widely tested, particularly in the context of limited resources, and this exacerbated inequality (Barach et al, 2020).

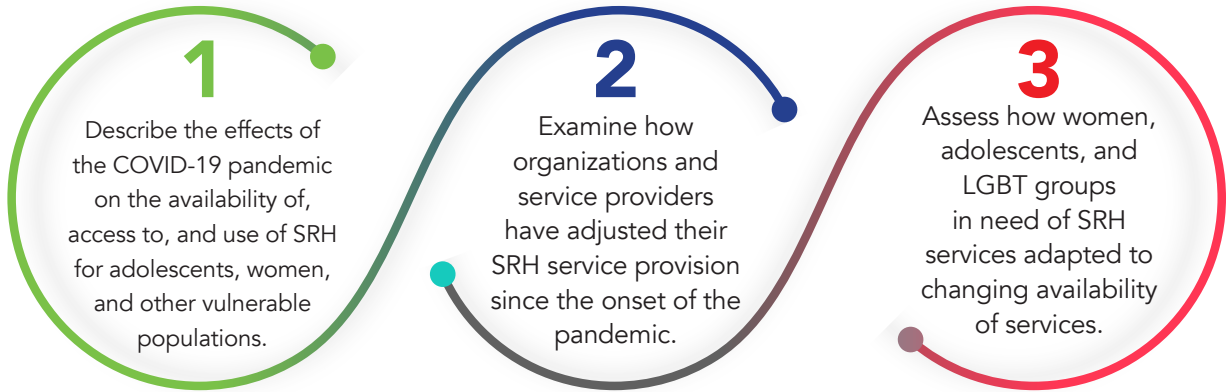
The COVID-19 mitigation measures and disruptions from the pandemic have diminished the availability of, access to, and utilization of SRH services (Mbatha & Tendai, 2020), as well as the quality of available services (Tang et al, 2020). Groups typically excluded from SRH services faced additional barriers during the pandemic (Plan International UK, 2020). Vulnerable individuals who had suboptimal access to health services even before the pandemic now faced the greatest risks of abuse, exclusion, and devastating health outcomes from both the pandemic and the response of governments to the emergency (Mbatha & Tendai, 2020; Tang et al, 2020; Plan International UK, 2020).

So far, large-scale data describing the effects of the pandemic on SRH services are lacking in SSA (Riley, Sully, Ahmed & Biddlecom, 2020). Existing research suggests linkages between public health emergencies and increased risks of sexual and gender-based violence, unintended pregnancies, unsafe abortions (Banke-Thomas & Yaya, 2021), and the exclusion of minority communities – for example, members of the lesbian, gay, bisexual and transgender (LGBT) community and people with disabilities (Ella, 2020). Existing estimates show that modest disruptions of SRH services create a huge unmet need for modern contraceptives, and result in unintended pregnancies, poor health outcomes, and the deaths of newborns, infants, and mothers; they also exacerbate chronic inequalities (Riley et al, 2020). In this report, we describe results from cross-sectional surveys conducted in five SSA countries to examine and document the overall impact of the COVID-19 pandemic on the access, availability, and utilization of SRH services. The findings are useful for informing and guiding response and mitigation strategies for the present and future pandemics in SSA, and for strengthening advocacy to establish resilient health systems.

While substantial variations exist among the five countries in terms of the timing and magnitude of the spread of Covid, at the time of this survey and reporting, all of them had reported large numbers of confirmed cases and Covid-related deaths. The numbers continue to change, and the widespread infections and case fatalities are constantly changing depending on the experience of the different waves of disease.

Objectives of the study

This multicountry survey aimed to document the overall impact of the pandemic on the availability of, access to, and utilization of SRH services for women and adolescent girls in Burkina Faso, Ethiopia, Kenya, Malawi, and Uganda. The specific objectives were to:





Methods

Study design, population and setting

Data for this study were collected using cross-sectional surveys in the five countries. In Burkina Faso, Ethiopia, Kenya and Uganda, we conducted mixed-methods surveys of women and girls seeking care in health facilities (both public and private); we also surveyed healthcare providers, and representatives of selected NGOs, CSOs and policy makers. In Malawi, only a qualitative survey was conducted with similar participants due to limited resources.

Sampling approach

Sampling of health facilities and health providers

Across the five countries, we drew health facilities from a master list of all public, private, NGO-owned, and faith-based health facilities that were functioning as of December 2019. In addition, we included health facilities that are owned, supported, or collaborating with the consortium member organizations. The current provision of a range of SRH services (e.g., family planning [FP] and contraceptives, antenatal care, safe abortion, post-partum care, newborn care, PAC, delivery services, HIV services, and care for SGBV survivors) was a condition for inclusion of such facilities. We used a stratified sampling approach to select health facilities within the study countries, paying attention to geographic and administrative units, as well as facility-level and ownership. Sample sizes per country reflected the minimum number of health facilities required for facility-level estimates of availability of, access to, and utilization of SRH services during the pandemic and to detect at least a 5% difference with sufficient power (0.8). We replaced closed or non-operational facilities in the sample with similar facilities from the universe. Within selected health facilities, we focused only on healthcare providers involved in SRH care. We interviewed one SRH provider per health facility, obtaining information on the facility's SRH service status and on their experience delivering SRH services during the pandemic.

Sampling of women and girls

We targeted women and girls seeking various SRH services in all selected health facilities across the study countries. We calculated the sample size we needed of this client group in each country to provide sufficient power for a stable estimation of the proportion of women and girls able to access and use SRH services while detecting a statistical difference compared to the pre-pandemic levels. Research assistants recruited women and girls at the end of their care at the facility, informing them about the study, obtaining their consent to participate, and then interviewing them. Interviews focused on their experiences seeking, receiving SRH care, and their perceptions of the services available.

The selection of representatives from CSOs, NGOs and policy makers was made from a comprehensive list of individuals operating at national and subnational levels in various sectors, including health, livelihoods, welfare, gender, security, and education, among others. Selection was based mainly on their ability to speak to the impacts of the COVID-19 pandemic.

Data collection

Quantitative interviews

We conducted face-to-face interviews with 466 healthcare providers and 3,473 women and girls using structured questionnaires. We adapted the provider questionnaire from the WHO service provision assessment (SPA) tool (Sheffel, Karp & Creanga, 2018), and the patient questionnaire from the Research for Scalable Solutions (R4S) project (Research for Scalable Solutions, 2020). The R4S instrument had modules of questions developed to document the effects of COVID-19 on FP access and use (World Health Organization, 2020). Trained research assistants conducted interviews within the facility premises but in private spaces, and in a language convenient to the participants.

Qualitative interviews

We conducted 211 in-depth interviews (IDIs) with women and girls, and 176 IDIs with healthcare providers across the five countries. Key informant interviews (KIIs) targeted 13 policy makers, including officials from ministries of health, and 64 representatives from CSOs and NGOs. In Ethiopia, we conducted six focus group discussions with women and young girls seeking SRH services. Trained qualitative interviewers used semi-structured qualitative guides to conduct the IDIs and KIIs. Female research assistants conducted the interviews with women and girls to make connecting and gaining trust with the participants easier. All interviews with health providers and with women and girls took place within health facilities. Interviews with policy makers and CSO/NGO representatives were done in mutually agreed locations. We also conducted some IDIs with LGBT people in Kenya. We recruited the LGBT people through CSOs providing services to them.

Data analysis

We analyzed quantitative data using Stata 15 (StataCorp LP, Texas, USA). Descriptive statistics, such as proportions and percentages, were used to summarize the data, and results are presented in tables and graphs. All qualitative interviews were recorded and uploaded to the researchers' password-protected computers. Professional verbatim transcriptions of the recordings were made (and translated into English when necessary). A coding framework was developed, and the data were coded using qualitative data assisted software – NVivo 10 (QSR International). We used a thematic analysis approach to summarize key findings in relation to the study objectives.

Ethical approval

The study protocol was reviewed and approved by national ethics and scientific review committees in each country. We obtained additional permits and approvals from national research commissions and from each participating health facility. All participants provided a written informed consent prior to involvement in the study.



Main Findings

Characteristics of women and girls (patient-exit interviews)

Table 1 summarizes the characteristics of patients (women/girls) and shows that 3,473 women and girls participated in the quantitative study. Over half (55.3%) were 20-29 years old, with only 6% older than 40 years. Across the countries, 35.8% of the patients had completed secondary education; only 11.0% had no formal education. A majority of the patients (60.7%) were married, but the sample also included a sizeable proportion of women and girls who had never been married (33.9%).

Table 1: Demographic characteristics of patients

		Burkina Faso (N=1000)	Ethiopia (N=114)	Kenya (N=1816)	Uganda (N=543)	Overall (N=3473)
		n (%)				
Age group (Years)	19 and younger	104 (10.4)	1 (0.9)	187 (10.3)	109 (20.1)	401 (11.5)
	20-29	535 (53.5)	69 (60.5)	1009 (55.6)	307 (56.5)	1920 (55.3)
	30-39	297 (29.7)	43 (37.7)	474 (26.1)	117 (21.5)	931 (26.8)
	40 and older	64 (6.4)	1 (0.9)	132 (7.3)	10 (1.8)	207 (6.0)
	Didn't respond	-	-	14 (0.8)	-	14 (0.4)
Education	Primary school	226 (22.6)	28 (24.6)	489 (26.9)	164 (30.2)	907 (26.1)
	Secondary school	321 (32.1)	32 (28.1)	687 (37.8)	202 (37.3)	1242 (35.8)
	University/College	91 (9.1)	40 (35.1)	500 (27.5)	78 (14.4)	709 (20.4)
	No formal education	285 (28.5)	12 (10.5)	54 (3.0)	32 (5.9)	383 (11.0)
	Others	-	-	69 (3.8)	-	69 (2.0)
	Didn't respond	77 (7.7)	2 (1.8)	17 (0.9)	67 (12.3)	163 (4.7)
Marital status	Never married	261 (26.1)	24 (21.1)	650 (35.8)	241 (44.4)	1176 (33.9)
	Married	714 (71.4)	81 (71.1)	1049 (57.8)	264 (48.6)	2108 (60.7)
	Divorced/Separated	12 (1.2)	7 (6.1)	71 (3.9)	31 (5.7)	121 (3.5)
	Widowed	13 (1.3)	1 (0.9)	43 (2.4)	7 (1.3)	64 (1.8)
	Didn't respond	-	1 (0.9)	3 (0.2)	-	4 (0.1)

Characteristics of health providers

Overall, 466 healthcare providers participated in the quantitative study. Most of these providers were in primary-level facilities (81.5%); 42.9% of them were females, and 43.6% were 30 years old or younger. About 85% were registered nurses/midwives, clinical officers, or doctors/specialists (Table 2).

Table 2: Demographic characteristics for Healthcare Providers

Characteristics of healthcare providers		Ethiopia (N=100)	Uganda (N=63)	Kenya (N=223)	Burkina Faso (N=80)	Overall (466)
		n (%)				
Facility level	Primary	86 (86.0)	56 (88.9)	182 (81.6)	56 (70.0)	380 (81.5)
	Secondary	8 (8.0)	5 (7.9)	41 (18.4)	5 (6.3)	59 (12.7)
	Tertiary	4 (4.0)	-	-	-	4 (0.9)
	Didn't respond	2 (2.0)	2 (3.2)	-	19 (23.8)	23 (4.9)
Sex	Male	46 (46.0)	27 (42.9)	55 (24.7)	27 (33.8)	155 (33.3)
	Female	54 (54.0)	36 (57.1)	74 (33.2)	36 (45.0)	200 (42.9)
	Didn't respond	-	-	94 (42.2)	17 (21.3)	111 (23.8)
Age	20-30	78 (78.0)	38 (60.3)	49 (22.0)	38 (47.5)	203 (43.6)
	31-40	18 (18.0)	18 (28.6)	63 (28.3)	18 (22.5)	117 (25.1)
	41-50	3 (3.0)	3 (4.8)	45 (20.2)	3 (3.8)	54 (11.6)
	51-60	1 (1.0)	4 (6.3)	60 (26.9)	4 (5.0)	69 (14.8)
	Didn't respond	-	-	6 (2.7)	17 (21.3)	23 (4.9)
Professional cadre	Doctor/Specialist*	3 (3.0)	2 (3.2)	2 (0.9)	-	7 (1.5)
	Clinical officers	-	36 (57.1)	50 (22.4)	13 (16.3)	99 (21.2)
	Nurses/midwives	80 (80.0)	11 (17.5)	151 (67.7)	48 (60.0)	290 (62.2)
	Pharmacist/Lab tech	2 (2.0)	2 (3.2)	2 (0.9)	7 (8.8)	13 (2.8)
	Others**	-	-	5 (2.2)	10 (12.5)	15 (3.2)
	Didn't respond	-	-	-	-	-

*Includes Anesthetist; **Health officers, environmental science, administrative staff

Access to SRH information and services during the pandemic

As detailed in the sections below, there were varying degrees of changes to how women and girls accessed SRH information and services throughout the pandemic period.

Access to SRH information

Most of the respondents relied on friends (47.7%) and the internet (28.9%) for SRH information during the pandemic. Relatively few of them (<10%) sought SRH information from their teachers, which could be the result of disruptions in teacher-student interactions due to school closures. Summary results are shown in Figure 1.

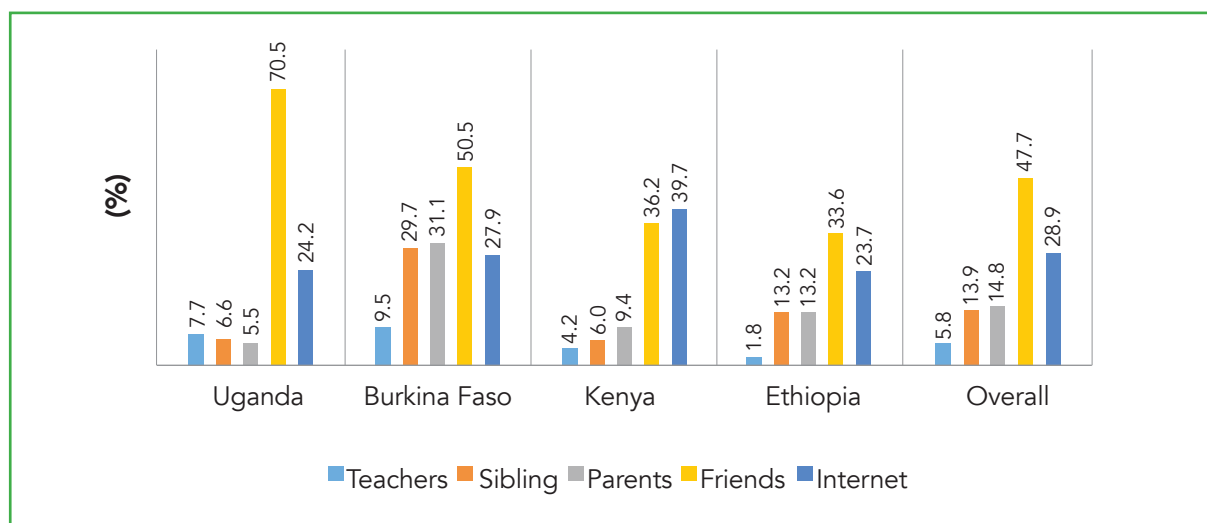


Figure 1: Sources of SRH information for women and girls

Social media and tele-health platforms can deliver information instantly and offer recipients the opportunity to interact with health providers, pose follow-up questions, and schedule appointments anonymously. Participants in the qualitative interviews explained ways in which SRH information was disseminated to various groups and highlighted how online platforms were instrumental in addressing SRH information gaps during the pandemic. As noted below, CSOs in Kenya utilized various channels (e.g., phones, social media, and audiovisual materials) to routinely transmit SRH information during the pandemic:

[...] So we leveraged on technology where we produced short films, dramatized videos with SRHR [sexual and reproductive health and rights] messaging, and then we disseminated these videos using our youth networks [...] and our social media platforms – Facebook, Instagram, Twitter, and our website. We also did weekly social media blitz or Twitter blitz where we would discuss a particular topic that is SRHR related. We also communicated through a bulk SMS where we shared SRHR messaging with adolescents and young people. (LGBT CSOs, Kenya)

The IDIs revealed extensive involvement of community health volunteers in Kenya and Ethiopia who shared SRH information in the community on such topics as SGBV, menstrual hygiene, and safe delivery and motherhood services. Key informants in Malawi noted that CSOs and NGOs leveraged community-based initiatives (local outreach activities, for example) to address the challenge of unwanted pregnancies:

When accessing the services, it's one person at a time, and we are observing social distancing. We have many cases; people are aborting. [...] Yes, we have seen them, and we have been encouraging that if you are a youth, it is better to go to the hospital and seek contraceptive methods to avoid unwanted pregnancy. (CSO, Malawi)

In Burkina Faso, participants mentioned health providers and radio stations as key sources of SRH and COVID-19 information:

If the people there are talking on the radio, we will listen, and that is good for all those who do not come [to health facilities]. It is not all the women who come to the hospital to take the family planning there, the ones who are at home will also follow [on the radio]. (Client, Burkina Faso)

Access to SRH services

Figure 2 shows that 91% of women and girls across the four countries received the various SRH services they sought at the health facilities they visited, with minor variations across countries.

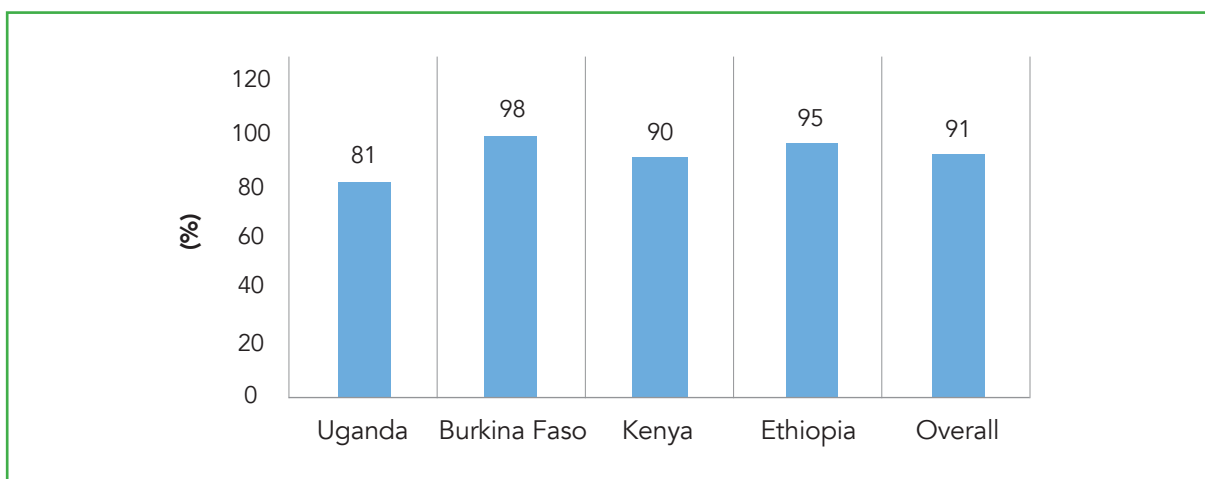


Figure 2: Proportion of women and girls who accessed the SRH services they needed from the facilities they visited

Regarding access to contraceptives, more than one-fourth of the women and girls (26%) who needed various modern contraceptives could not access them. The highest proportion of women with no access to contraceptives was in Burkina Faso (47%), and the lowest (2%) was reported in Ethiopia (Figure 3).

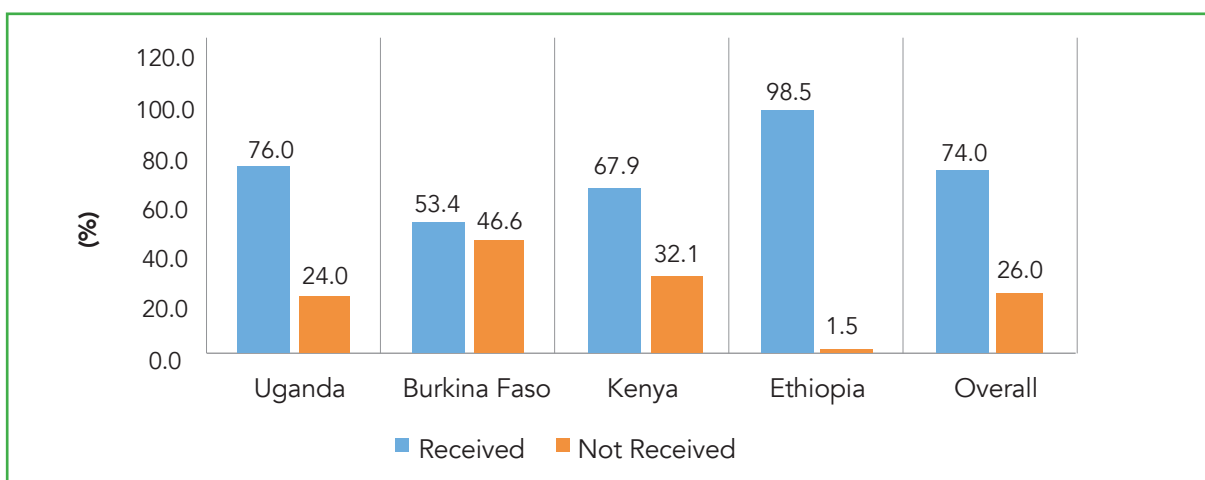


Figure 3: Proportion of women/girls who needed and obtained modern contraceptives

Qualitative interviews revealed reasons why some women and girls in Burkina Faso, Ethiopia, Kenya, Malawi, and Uganda could not access SRH services, especially contraceptives, at the height of the pandemic. For example, in Uganda, state actors acknowledged that COVID-19 severely disrupted SRH services and the government provided only limited support during the initial phases of the pandemic. Organizations and partners at the local level had to stand in and provide guidance to the communities.

In Kenya, some health providers in private facilities faced challenges in restocking various FP commodities. In Ethiopia and Burkina Faso, CSO actors remarked that whereas the shortage of SRH commodities in public healthcare facilities was not a new phenomenon, COVID-19 made it worse. As such, women and girls lamented that the acute shortage of contraceptives (e.g., Depo Provera injectable) in public health facilities forced them to seek services in private facilities at a higher cost. At the same time, shortages of condoms and gels increased the risks of HIV and sexually transmitted infections (STIs). Participants blamed these stock outs on the lockdown and closure of manufacturing and transport services, particularly during the first wave of the pandemic:

With the COVID-19 pandemic, it was difficult to shift [move] drugs and supplies from one place to other due to travel restrictions. [...] Transportation costs doubled during COVID-19 (CSO/NGO participant, Ethiopia)

There were times when contraceptives were no longer available. We were out of stock, because COVID had blocked everything. It was difficult to get a condom or any other means of contraception. Therefore, that increased the risk towards infections (STIs, HIV) (NGO/CSO, Burkina Faso)

Similarly, shortages of SRH commodities in Kenya were prevalent in public and private facilities. A CSO participant linked the stock out to government “prioritization of COVID-19 over other health services”. Some facilities were forced to source SRH supplies from private entities at an inflated cost, and in turn passed the cost on to clients. Providers acknowledged that most of their usual clients could not afford the inflated prices, but they felt they had no option since “the cost of providing service had gone high, and the revenue has gone down”, and they had to charge higher fees to stay afloat. The quote below illustrates this theme succinctly:

[...] We used to buy a tin of paracetamol at KES 300. Right now, it is KES 700 and above. [...] A packet of masks we used to buy at three Kenya shillings [...]. Right now.... we can get them at KES 400 to 450. Once COVID set in, the pack used to be KES 1500. And it is just fifty pieces. [...] So do you tell me that those charges you will add to the patient and the patient cannot even cater to the minimum? Do you think you are making a profit? (Health provider, private facility, Kenya)

The COVID-19 pandemic has had unavoidable economic impacts that have limited access to and/or the utilization of SRH services. A client in Uganda reported that “services became quite expensive compared to before the pandemic”, and women in Ethiopia and Kenya indicated they could not afford to pay both for transport to distant health facilities and the cost of healthcare services. They therefore chose not to visit health facilities for care, or just returned home after being told they had to pay for services:

People lost employment...and then the country's economy at that particular time everything was bad. People did not have money. So actually, I think I met someone who once told me that instead of getting treatment, I only have money to buy food. I am sick, yes. I cannot be treated because I do not have money. The few coins that I have...to buy food for my family and I continue being sick. (Health provider, Ethiopia)

[...] Yes there was a time I went back home. I had only 200 Kenyan shillings, and I was sick, they told me to go and buy drugs. Upon asking how much the drugs were, they told me 5000 shillings, so it was hard, I just went back home. (SRH client, Kenya)

In Ethiopia, Malawi, and Burkina Faso, SRH services remained available in some health facilities, but challenges created by COVID-19 prevention requirements (such as mandatory facemasks and social distancing) resulted in a reduced number of clients being allowed into health facilities, a practice that inhibited access to SRH services:

Okay, it is not efficient enough to the doctors' side because they were afraid of people who would go to the hospital without masks, so they [health providers] would send you back. That was a barrier to us who needed healthcare. (SRH client, Malawi).

[...] When you go to the hospital for care and, the providers kept insisting that they could only attend to a small number of people and send the rest back and ask them to come another day. Moreover, when you come back another day, you find that the kind of care you need is not available. (SRH client, Malawi)

When someone tells you that it's been a week and I haven't been able to take the medication because last time, when I came to the door, I was chased away...the price here for bibs (masks?) was 500 francs...it was a difficult situation... (NGOs/CSOs, Burkina Faso)

At the same time, women and girls in Burkina Faso reported being turned away from health facilities because of limits placed on the number of SRH clients that could be seen on any given day:

When I arrived here at 6am, they said everyday they only take 20 people, and you have to be among the 20, so you have to leave home at 4am or 5am. I arrived and found so many people already here, and you are tired. They [health providers] told me that I have to go back home and return tomorrow. (SRH client, Burkina Faso)

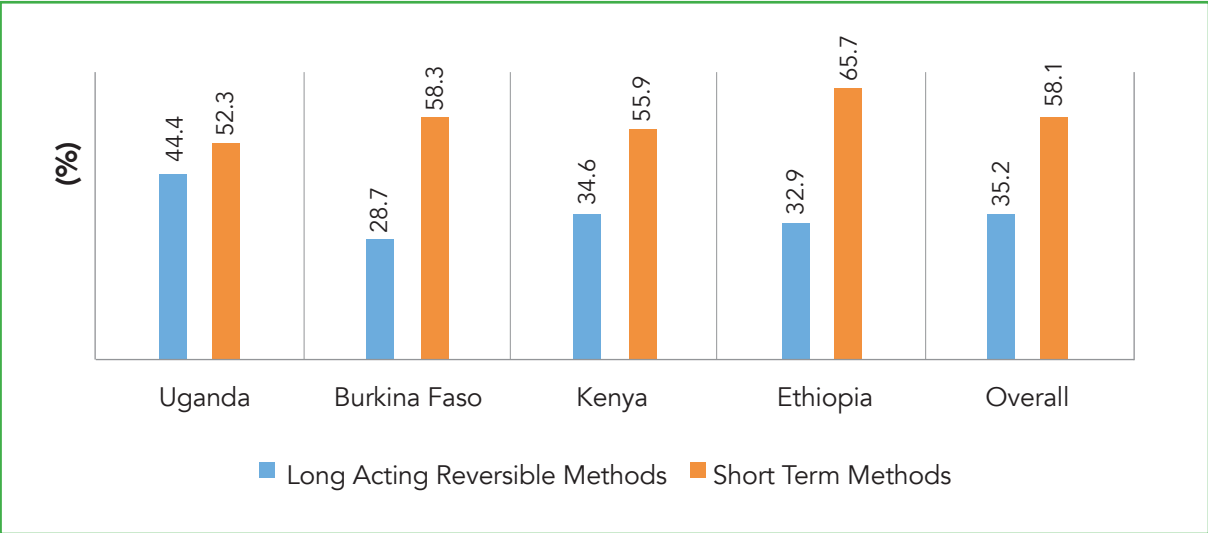


Figure 4: Contraceptive methods received by women and girls

Types of contraceptives women could access

A majority of respondents (58.1%) were provided with short acting contraceptive methods, while only one-third (35%) received long-acting reversible contraceptive methods (Figure 4).

Women in our survey reported that their choice of contraceptives was influenced mainly by healthcare providers, who often advised them to switch to contraceptive methods that suited the COVID-19 pandemic period. This practice in some cases was based on government COVID-19 prevention measures articulated

in policies and guidelines. Short-term methods that do not require physical interaction between providers and clients were encouraged instead of intra-uterine contraceptive devices (IUCDs) and implants that require close contact and invasive procedures during insertion. This raises the question of whether the rights of women, especially around contraceptive choices, were subjugated in the process of dealing with the virus. Furthermore, inconsistent or discontinued use of short-term contraceptive methods can result in unintended pregnancies. Women noted that providers offered them birth control pills for extended periods beyond the usual duration to reduce the frequency of visits to the facility. As described below, some clients seeking IUCDs and implants were unhappy with suggestions by health providers to switch to short-term methods, especially in cases where their partners or parents were unaware that they use FP:

[...] somebody had a long-term family planning method. Now her time had come for a removal. [...] So this client was told that 'no, those procedures of removing we are not doing them now [...] until COVID 19 goes down [...] because you also want to protect against unwanted pregnancy, so clients would be advised to take another method, maybe pills, we can give them that [...]. They always feel like they are not handled well' when they [dont get what they need]. (Health care provider, Kenya)

The efforts to prevent or reduce risks of COVID-19 intersected negatively with the contraceptive preferences of women, which created a dilemma for health providers in deciding what to prioritize. The impact was that women could easily fail to take up a contraceptive method, despite their need, or discontinue use out of fear that their partners may find out they are avoiding pregnancy.

Barriers to SRH services

The COVID-19 response measures implemented by governments were cited as major barriers to accessing and utilizing SRH services. Close to two-thirds of the women and girls we interviewed (Figure 5) reported that restricted movement due to lockdowns and curfews was the main barrier to accessing SRH services; participants in Uganda and Kenya reported this most frequently. The impacts of these restrictions were compounded by limits placed on the number of people who could use public transport at any one in time. The longer distances to health facilities, the high costs of services (including such indirect costs as transportation), and the closure of facilities were reported as significant barriers.

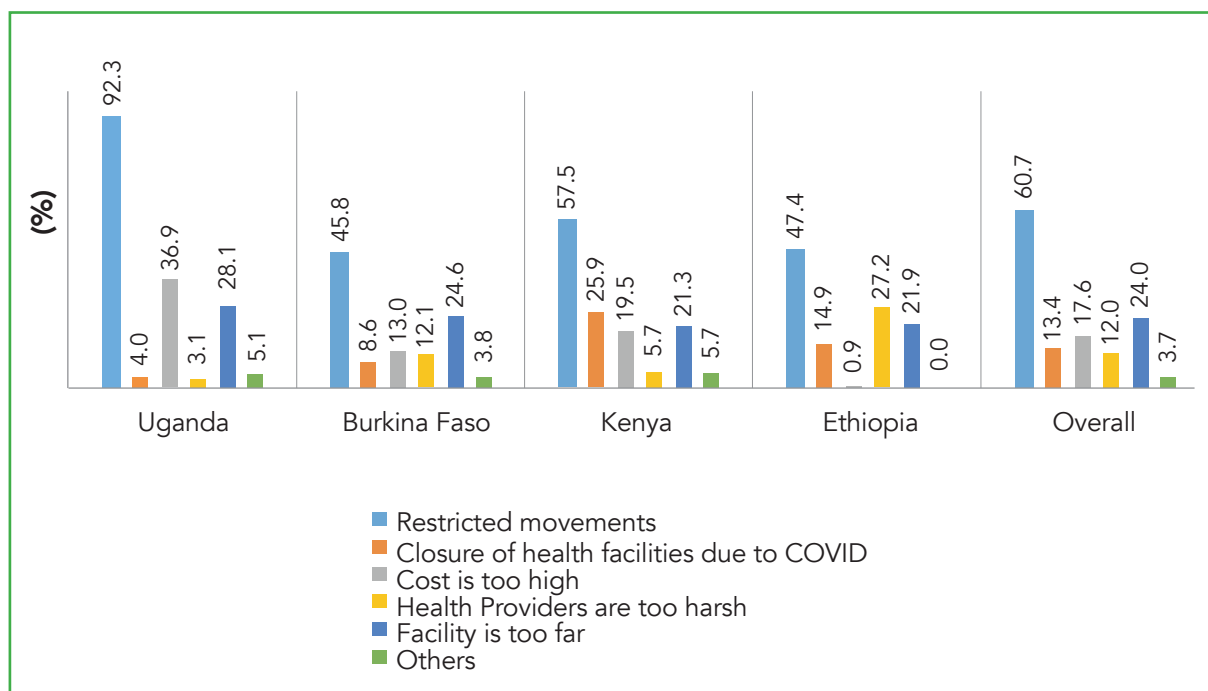


Figure 5: Barriers to seeking SRH services among women and girls

While the majority of healthcare facilities remained open across all five countries, access to SRH and FP services was severely curtailed in the first few months of the pandemic. Healthcare providers as well as their clients could not travel to facilities due to the enforced lockdowns and curfews and a lack of public transportation; fear of contracting the virus at health facilities was also a factor. A study participant in Ethiopia reported that many clients were discouraged from traveling to healthcare facilities when the government began enforcing COVID-19 prevention measures:

[...] To maintain [social] distance, vehicles were pushed to use one-third of the seats. Due to transport shortages at the time and geographic barriers due to distance, many clients were also not able to access health facilities. (CSO/NGO, Ethiopia)

Even when women and girls were able to travel, the negative attitudes of some care providers (their beliefs and practices) kept some girls from visiting health facilities.

When services were suspended at their usual facilities, clients were redirected to other locations. These were mainly clinics and private hospitals that were further away, requiring the use of public transportation or private vehicles to get there. This meant higher costs, as well as delays due to overcrowding. In Burkina Faso and Uganda, SRH clients complained about long waiting times and spending an entire day at the health facility due to long lines, which resulted in the loss of daily work and wages:

[...] I was to go to the health facility and come back quickly [to work], but I took too long waiting there that day. I did not go to work [...]. If I do not go to work, I don't get paid for that day. So they [at the health facility] made me not get paid for that day I didn't go to work...I didn't feel good, I was not happy. (SRH client, Uganda)

Okay, I was served, but not in time. The wait-time is too long [...] I would say that my satisfaction was not complete... Women are punctual...not everyone has the time to come and spend the day. (SRH client, Burkina Faso)

Many women reported the intersection of such barriers as a lack of money or income, coupled with the increased cost of seeking services (including transport charges). For example, a Kenyan client who wanted an IUD coil removed found that the cost had doubled:

So I came here and they have told me that it is [KES] 1,500 (approx. \$15). I told them I have [KES] 600 (approx. \$6). They told me to go and look for the rest... they had told me to remove that coil. [...] It had affected me and needed it removed. The money we just looked for it. My husband does not work, he just does casual work and I do casual work, and with COVID, it is difficult to get a job, and the children need food, and they need school fees. (SRH client, Kenya)

Clients in Uganda reflected on how the curfews and lockdowns restricted movements and prevented or delayed them from accessing services. As noted by one post-abortion client, her pregnancy (the current one) was unwanted, and had come about because she abandoned FP at the onset of the pandemic:

Because of lockdown, I had to abandon using FP, which is why I am pregnant right now; otherwise, it was not my choice. (SRH client, Uganda)

A client who needed SGBV services explained how it was difficult for her to get to the health facility at night because of curfews:

I was beaten at midnight, and I was brought to the hospital at 3AM. [...] the motorbike [drivers] were saying that there was a curfew...There are soldiers on the road, and they do not like people walking at night. (SRH client, Kenya)

In some cases, curfews and lockdowns led to harassment of women and girls going to the hospital at night for obstetric emergencies, as noted by this healthcare provider in Kenya:

Yes, police were harassing. Initially when they started police were harassing people completely, even pregnant women. When they get them when they are in labor coming to the hospital, they tell them 'Show us your tummy, so that we can know if you are pregnant – really pregnant.' Such embarrassments. (Healthcare provider, Kenya)

Similarly, in Burkina Faso, a patient bore the pain overnight and avoided trying to get to a health facility because of fear of the police and security agents enforcing nighttime curfews:

Well... this had an impact on my health because of the fact that there was curfew of everything. When I felt unwell, I could not go out because as soon as you go out, it is quite a problem. So often, we have to stay at home, bear the pain, and that can make our problem worse than we ever imagined. (SRH client, Burkina Faso)

Figure 6 shows that a substantial portion of women and girls (34.6%) reported obstacles to accessing contraceptives. The highest number of those experiencing such challenges were in Uganda (59.4%) and the lowest was in Burkina Faso (19.8%). The smaller number in Burkina Faso was attributed to the national rollout there of free FP services.

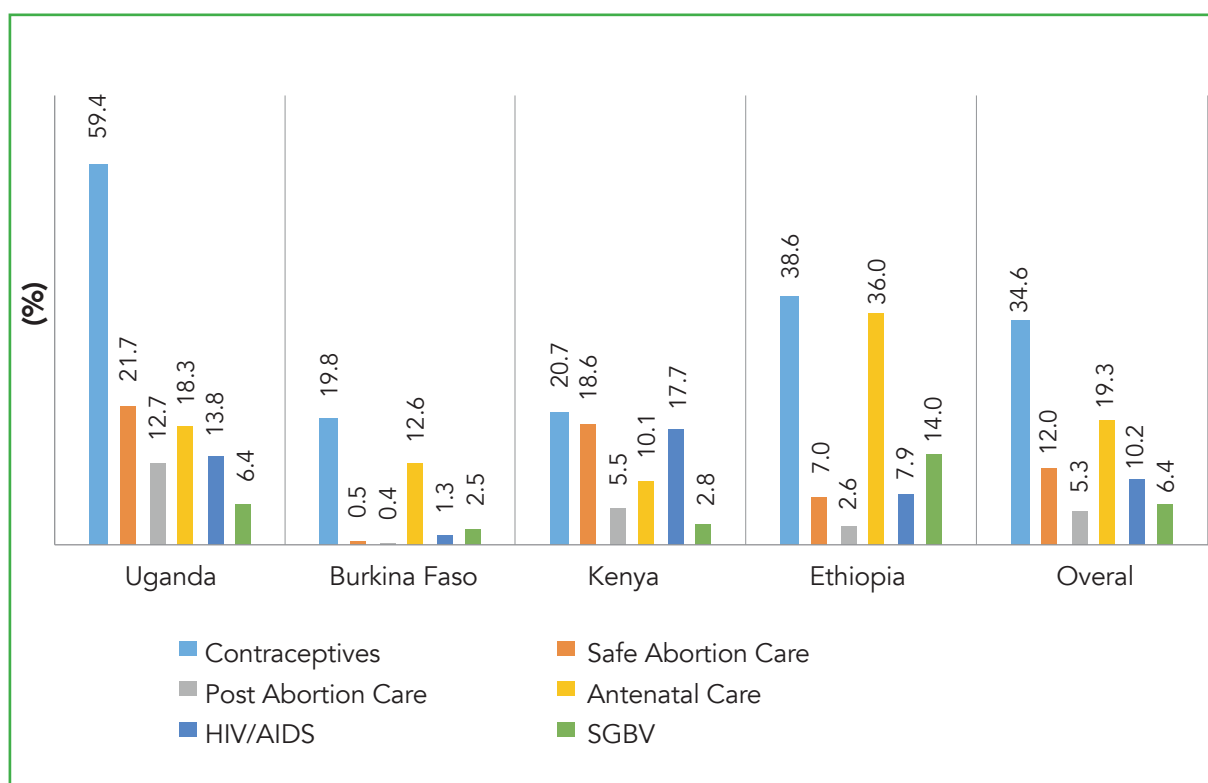


Figure 6: Proportion of women and girls facing challenges accessing specific SRH services

Interviews with healthcare providers and women and girls revealed additional social challenges that limited the autonomy of women. For example, female interviewees noted that confining their parents or male partners at home compromised women’s and girls’ autonomy. They often found it difficult to get to health facilities because they would have to explain to their parents or partners where they were going and why, which infringed on their privacy and agency.

Coping mechanisms for dealing with barriers to accessing services

Figure 7 shows the coping mechanisms adopted by women and girls to overcome the barriers in accessing SRH services. Overall, nearly half (46.2%) of the women and girls interviewed noted that they delayed seeking needed SRH services. Uganda had the highest proportion (63.6%) of women and girls who delayed seeking such services, followed by Ethiopia (51%), Kenya (38.5%) and Burkina Faso (31.8%). About a fifth (21.7%) of the women and girls we talked to visited alternative care providers and health facilities that they did not normally frequent, while another fifth (21.5%) opted out of visiting a health facility at all.

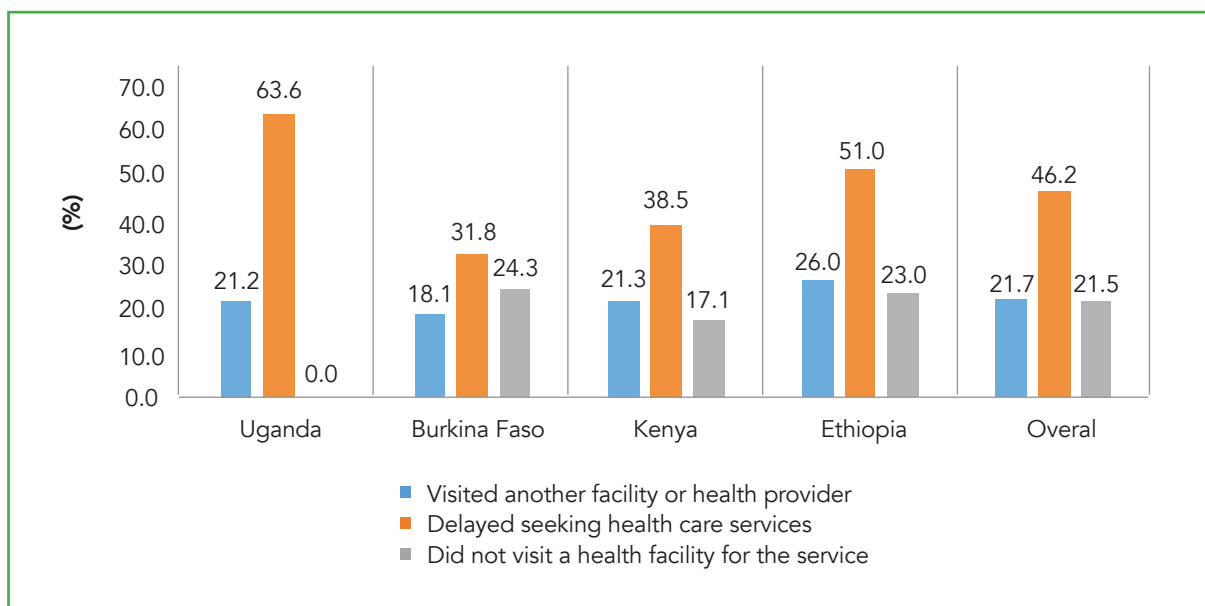


Figure 7: Women and girls coping mechanisms for overcoming access barriers to SRH services

Qualitative data revealed that some clients did not seek any services and instead stayed home. For instance, an SRH client in Ethiopia who went to a healthcare facility for an abortion shared how she decided not to seek contraceptives while there because she feared contracting COVID-19. The result: another unwanted pregnancy. Similarly, some pregnant women chose to not visit antenatal clinics. As narrated by providers in Burkina Faso, many HIV positive women and girls resorted to staying home and not going for treatment or drugs:

COVID-19 had a huge impact on maternal health and HIV/AIDS. For HIV/AIDS patients, they have appointments all the time in the health services and at one time, we had reduced intercity transport. There are many who come from far away. When transport was reduced, there are many who could not come to be treated. Also on maternal health, COVID also had an impact due to the transport issue and the fact that there were many hassles like mandatory wearing [of] masks, taking temperatures, handwashing, which some clients viewed as an inconvenience and opted not to come to health service points. (Health provider, Burkina Faso)

A few women and girls in Kenya opted to seek services, mainly commodities from the pharmacies, despite the prohibitive costs:

I went to the hospital [...] I was given a pair of tablets [...] I was told to buy from a chemist [pharmacy]. I went to a chemist [pharmacy] I was told one drug is KES 40 another one KES 30, another one is for KES 120. I told them to give me half because they were telling me all of them would amount to KES 360. I told them to give me all the drugs I had been prescribed for KES 250, and now they are finished [...] (SRH client, Kenya)

Women and girls in need of delivery or antenatal services found it difficult to access such services during curfew hours. There were also reports of clients fearing health facilities, which were seen as epicenters of COVID-19 infection, and this led to many women self-medicating by using over-the-counter medication and/or telemedicine, while others sought services from traditional birth attendants or had home deliveries.

Availability of SRH services

The availability of SRH supplies and commodities is key to providing SRH services. More than a quarter of the health facilities in Burkina Faso (26.3%) reported a lack of medical abortion medications at the time of the survey (Figure 8). Similarly, large numbers of healthcare facilities in Uganda (48%), Kenya (72%), Burkina Faso (23%) and Ethiopia (20%), reported stock outs of prepackaged combined mifepristone/misoprostol three months before the survey. About 41% of the health facilities in Uganda, 19% in Kenya, 6% in Ethiopia, and 9% in Burkina Faso experienced stock outs of implants during the last three months.

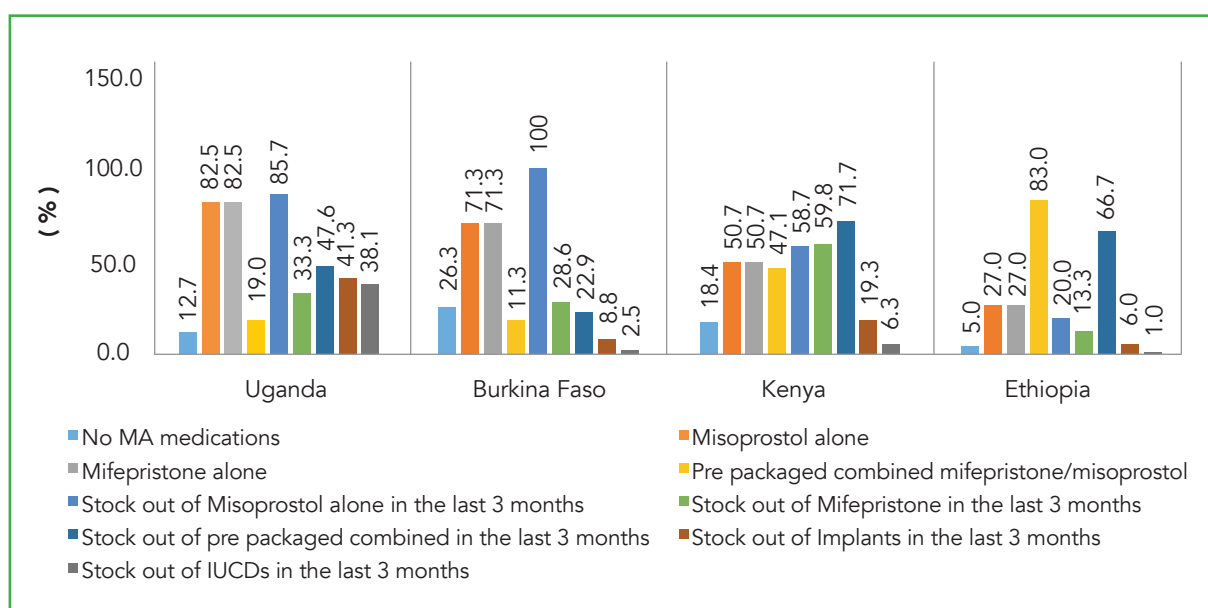


Figure 8: Status of SRH commodities and the occurrence of stock outs during COVID-19

Qualitative data indicate that, while some were available, there were severe disruptions of SRH services across the various phases of the Pandemic. There was a consensus among healthcare providers, policy makers and CSOs that the pervasive shortage of FP commodities was linked to the pandemic and varied in severity at different moments of the outbreak. Lockdowns were implemented almost immediately after index cases were identified. However, it took time for governments to address the resulting shock this had on the flow of commodities and supplies and the disruption of services, particularly during the first wave of the pandemic:

[...] Of course, the prioritizing of COVID-19 over other health services affected the delivery of the commodities to our institutions where KEMSA [the Kenya Medical Supplies Authority] was seen to be focusing on COVID-19 commodities more than reproductive health commodities, which meant that women and girls lack access to those services. [...] We had no stock, and pharmacies were closed. (CSO representative, Kenya).

Stock outs were reported on contraceptive methods like emergency contraception, condoms, oral contraception, injectable, implants, and IUCDs. (Health provider, Malawi)

In Uganda, healthcare providers reported staff reductions of more than 30% when COVID-19 began because of the reassignment of staff to different facilities and because of COVID-19 infections among staff. While we could not confirm this figure, it was consistent with a common trend across most countries. Similarly, health providers in Kenya and Uganda said they stopped community outreach programs, including group discussions on SRH and HIV, and reduced daily antenatal and postnatal attendance; they did, however, establish additional clinic days to address congestion.

Continuity of SRH services during COVID 19

Different countries adopted various strategies to ensure continuity of services during the pandemic. National guidelines and policies informed most approaches, including provider training on handling COVID-19 and the provision of personal protective equipment (PPE) and sanitizers, among others. Figure 9 shows that Burkina Faso and Ethiopia had the highest percentage of health facilities with staff trained in handling COVID-19 patients, 74% and 75%, respectively. At the time of the survey, Ethiopia had the highest number of facilities supplied with PPE (84%), followed by Kenya (77%). Virtually all facilities enforced sanitization and social distancing measures. Limiting the number of patients allowed to visit facilities was a practice imposed more frequently in Kenya (64%) and Uganda (54%) than in the other countries.

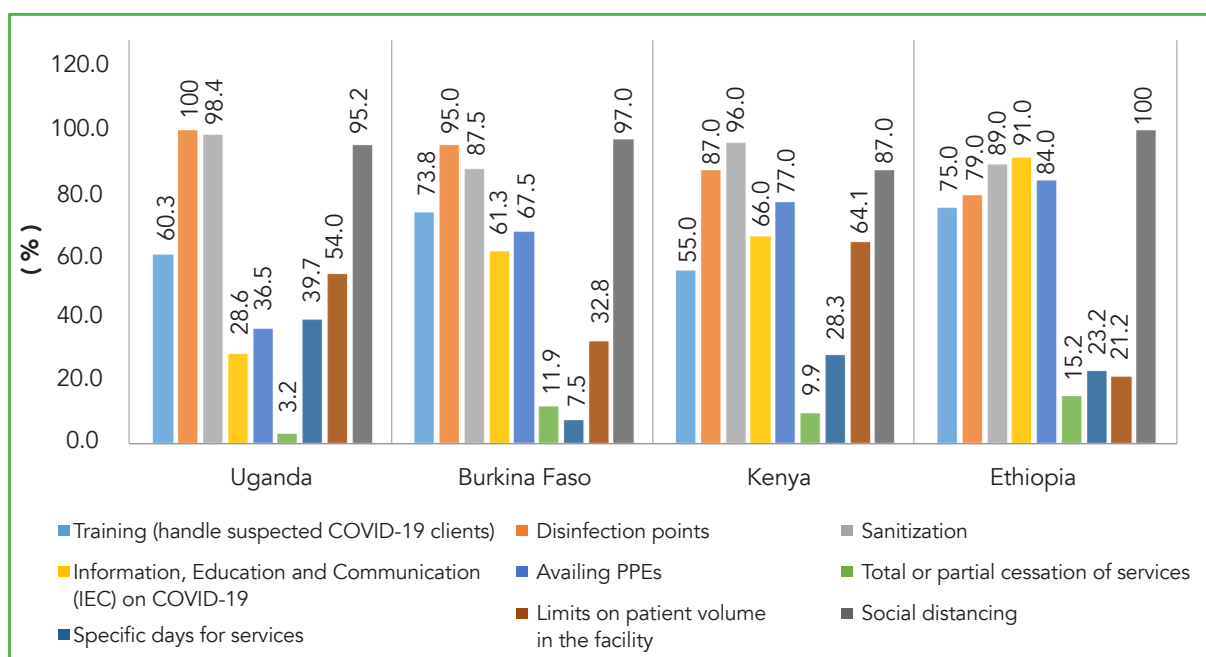


Figure 9: Measures taken by health facilities to address COVID-19 risks

In Uganda, the government made repeated public announcements to emphasize that health facilities were open and that normal services were still available at the facilities despite the pandemic. There were also supervisory visits by Ministry of Health officials to ensure that the health workers needed to provide these services were in place in all the facilities.

Qualitative data revealed fragmentation in the training of health providers. Priority was given to providers working in public health facilities, while some in private sector and CSO facilities were neither trained nor supplied with usable formats of the policies and guidelines established by the government. Several factors influenced whether there was continuity in the provision of services, and these centered on the safety both of clients and of health providers. Strategies implemented to ensure safety included the use of PPE, checking the temperature of clients on arrival, careful handwashing, wearing masks and using well-ventilated rooms, improving social distancing by spacing out seats for clients, and booking fewer clients for

scheduled clinic visits such as in MCH, FP, and Comprehensive Care Center (CCC) units. Nevertheless, the operations of health providers were impeded in both Uganda and Kenya, due to difficulties in accessing standard COVID-19 equipment and procedures; adequate PPE and essential sanitizers were either simply not available or were costly to obtain. While governments focused on supplying SOP equipment to public health facilities, some participants decried delays or unavailability that resulted in a lack of services:

[...] There is a time we were having a meeting with Mombasa County health promotion officer, some health providers, even the Chief Public health Officer, [where it was raised that lack of PPE's materials discouraged some of the doctors and nurses to go to hospital because they had not been provided with enough PPE materials]. So even, I remember some of them coming or sending us emails just requesting if we could support some of the health providers with such materials. (CSO representative, Kenya)

Some private health facilities reported receiving different supplies, commodities and information during the pandemic from their NGO allies, including PPE (masks, gloves, sanitizers, and soap), FP commodities, and training and updates on COVID-19. In Kenya, supportive NGOs included Reproductive Health Network (RHNK), Tunza, Population Services-Kenya (PSK), and Marie Stopes Kenya:

[...] If it was not for Tunza and PSK, I would have closed during COVID-19 because sanitizer was very expensive at KES 500 or 600 a half litre, and half litre was only for a day [...] that is why we have sustained services up to this time, so whatever money we made we paid staff. (NGO representative, Kenya)

Private health facilities that did not receive material or financial support had to pass their increased costs on to clients, which in turn drove the rising cost of health services. However, these facilities reported that, while the government provided them with little support, the government relied on their COVID-19 data. As one private health provider lamented:

[...] [We were discouraged because we were preparing the data reports, and once the government received them, we were only receiving gloves]. However, the staff in public health facilities are given gowns and PPEs [yet] we are providing the same services, but we are not recognized. However, we are told that because we charge for our services and have money, we should buy PPEs for ourselves. (Health provider, Kenya)

In Kenya, 71% of the health facilities promoted the use of self-care by patients whose healthcare needs could be addressed away from the facility; far fewer facilities in the other three countries encouraged this

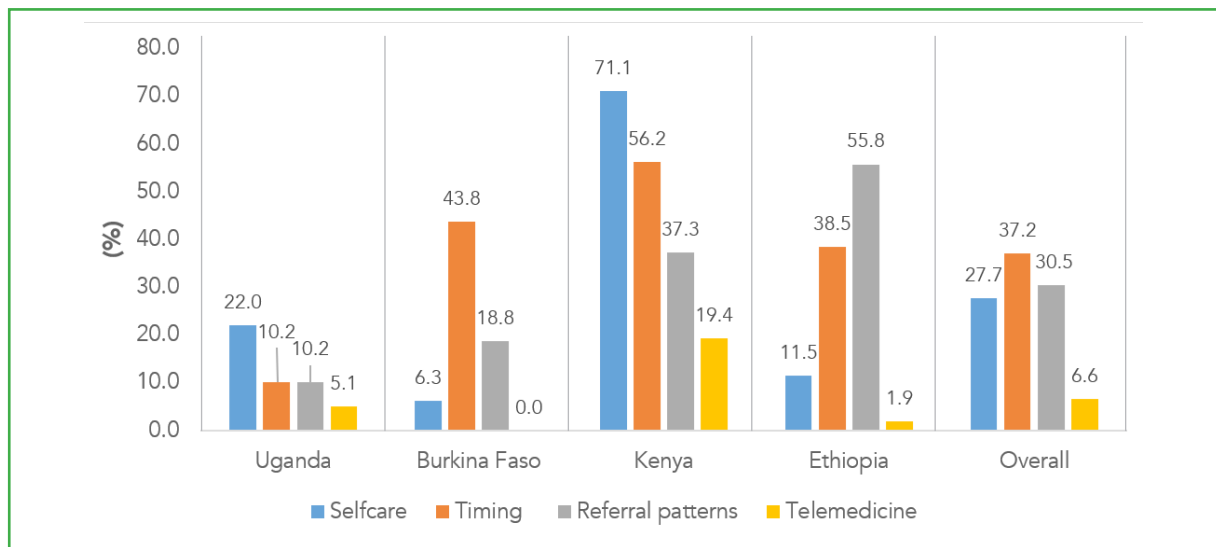


Figure 10: Changes in SRH service delivery during the COVID-19 pandemic

approach (Figure 10). There were changes in all four countries as to how long one can stay in a facility, or on which days clients can seek services. Other changes included alterations in referral patterns and the use of telemedicine. However, no health provider reported the use of telemedicine in Burkina Faso.

Qualitative data showed that health providers talked about some changes made in service delivery, mainly to reduce or limit the contact between providers and clients, as a preventive measure against COVID 19. Services affected were those that required close contact between clients and health providers and were not an emergency, such as insertion or removal of IUCDs – delaying the removal of the long-term expired FP method by up to 6 months. Other ways included implementing social distancing and extending clients' return dates.

Even though some reported using it before the pandemic, telemedicine was reported as one of the changes in service delivery (perhaps because this was the first time it was included in the government guidelines):

What has changed is we have consultations on the phone [...] we are consulting on the phone, and we give prescriptions on phones, where people are far away from pharmacies, we tell them if you get to the pharmacy let me talk to the pharmacist, I see what drugs we can give you, and it works very well. (Health provider, Kenya)

[...] If a person comes with incomplete abortion, we will do an MVA [manual vacuum aspiration], a procedure to evacuate what is remaining in the uterus. However, if you suspect this person has COVID-19, and feel that the time you will be with that patient will expose yourself (sic) to COVID-19, you decide to give medication to complete that procedure rather than do a procedure. So you give medicine to go and complete the abortion at home, rather than do an MVA [...] we are saying, you limit the contact time between you and the patient, especially those you suspect to be COVID 19. (Health provider, Kenya)

The choice to deny services was closely linked to policies and guidelines related to COVID-19, or to the fear of being infected. In some cases, clients were denied services even when they were available. Health providers reported actively influencing patient decision making by offering them options. For instance, in the case of PAC, health providers gave clients the medications needed to complete the abortion at home:

[...] Comprehensive services means the client can have the choice they want. With COVID-19, sometimes, it could limit the choice, like post-abortion care, if you suspect that the clients could be COVID-19 positive, rather than give the patient their choice; you give the medicine for completeness rather than do a procedure because you fear to be infected. Therefore, that affected the provision of services. [...] you could feel the procedure takes some time. If you suspect the person to be COVID-19 positive and exposing yourself, to limit the time with the client you change [...] and give the medication. (Health provider, Kenya)

Reasons why some services were not available

Virtually all health providers in Burkina Faso reported that they did not offer PAC services. This was due to a lack of commodities (stockouts) and the absence of trained healthcare staff. In the same breath, some said they did not offer CAC services due to the lack of commodities, the occurrence of COVID-19 in the facility, and an absence of patients. In Uganda, a large majority of healthcare providers reported not offering PAC (83%) and CAC (74%) services because of commodity stock outs; only a few reported the lack of trained staff and PPE as their reasons for not making these services available (Table 3). In Kenya, commodity stock outs were the main reason health providers stopped offering PAC and CAC services in some of their facilities. It was only in Ethiopia that the main reason given for not offering PAC and CAC services was the lack of trained staff and absence of patients needing the service.

Table 3: Reasons why PAC and CAC services were not available at the time of the survey*

SRH Services	Country	Stock outs	No trained health workers	Lack of PPE	Movement Restriction	COVID 19 in facility	No patients
PAC	Uganda	83.3%	8.3%	16.7%	16.7%		
	Burkina Faso	100.0%	100.0%				
	Kenya	45.5%	27.3%	18.2%		9.1%	27.3%
	Ethiopia		33.3%	33.3%			
CAC	Uganda	73.7%	15.8%	10.5%	15.8%		5.3%
	Burkina Faso	27.8%				5.6%	11.1%
	Kenya	81.8%	27.3%		9.1%		18.2%
	Ethiopia		33.3%				50.0%

*Multiple responses were allowed

A lack of trained health providers in Ethiopia, Burkina Faso and Uganda was the main reason given for not providing the healthcare services needed to cope with sexual and gender-based violence (Figure 11). The most frequent reason given in Kenya for the lack of these services was the absence of patients who needed them, though the lack of trained staff remained a significant factor. Other reasons cited by providers in our survey included a dearth of necessary commodities, the lack of PPE, restrictions on movements (lockdowns and curfews), and facility closures because of COVID-19. In all countries, our findings indicate a huge capacity gap in the skills of healthcare workers to handle SGBV cases.

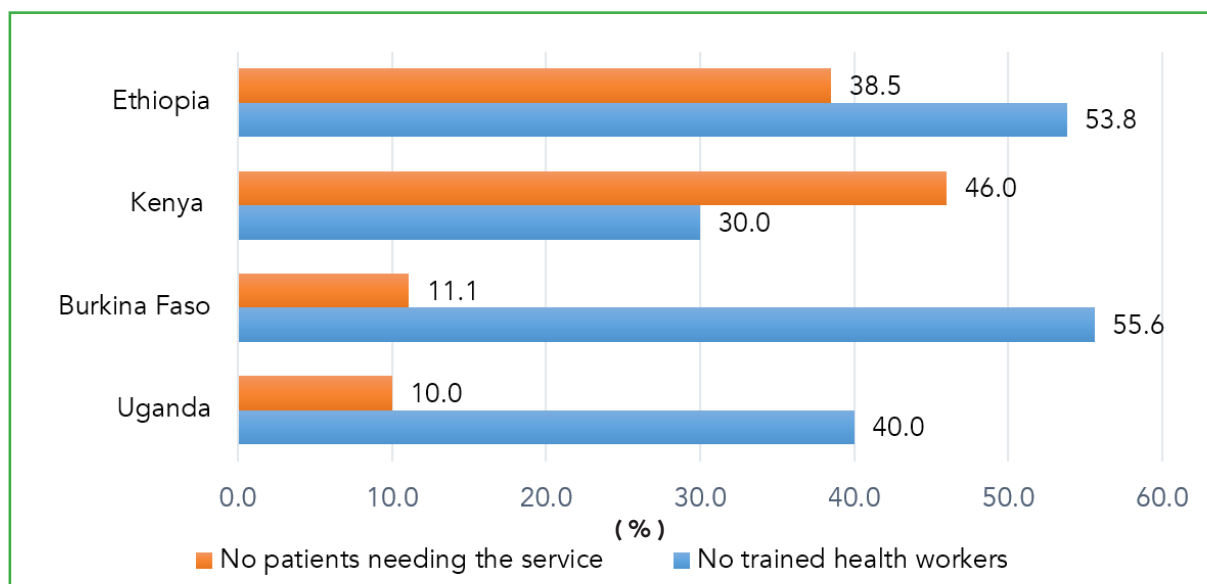


Figure 11: Reasons why SGBV services were not available at the time of the survey

Utilization of SRH services

Uptake of SRH Services by clients before and during the pandemic

Overall, there was a general decline in the uptake of services, as shown in Table 4. Contraceptives were the most sought-after service (45.9%) across the four countries, followed by antenatal care (40.4%); at 3.1%, PAC services were the least sought after. Nearly half of all women and girls participating in our survey came to the facility seeking contraceptives (40%) and antenatal care (26%).

Table 4: Services sought in previous and current visits to facilities*

	Burkina Faso		Ethiopia		Kenya		Uganda		Overall	
	P	C	P	C	P	C	P	C	P	C
	%									
Contraceptives	48.3	38.3	43.9	41.2	32.6	16.1	58.7	65.0	45.9	40.2
ANC	52.9	37.8	46.5	31.6	29.4	19.2	32.8	16.3	40.4	26.2
MCH	33.6	10.2	22.8	13.2	5.2	3.6	22.0	10.3	20.9	9.3
Cervical Cancer	5.7	2.0	4.4	2.6	28.4	20.2	14.9	5.1	13.4	7.5
HIV/AIDS	14.6	2.6	16.7	5.3	10.4	9.7	38.7	29.7	20.1	11.8
CAC	0.8	0.3	4.4	10.5	5.7	6.9	7.2	8.1	4.5	6.5
PAC services	2.0	0.6	1.8	9.6	0.3	0.3	8.3	3.5	3.1	3.5

P: previous; C: current;
 ANC: antenatal care, MCH: maternal and child health care, CAC: comprehensive abortion care, PAC: post abortion care . *Multiple responses were allowed

In general, policy makers, healthcare providers, and NGO and CSO representatives indicated that during the pandemic, the demand for SRH services declined. The first wave of the pandemic left the use of these services at their lowest levels, and while utilization of some of them picked up over time, the overall demand for SRH services remained lower than before the pandemic:

[...] PAC services [...] went down completely but for the last one week I have seen an increase of young girls [...] between the age of 14 and 17 coming with their parents, alone or with their boyfriends and I relate it to this long break the children had when all the schools [and colleges] were closed and [the activities] they were indulging in. (Health provider, Ethiopia)

Survey participants in Burkina Faso and Kenya attributed the decrease in utilization of SRH services to fear of contracting COVID-19, fear of testing positive for the virus, and fear of isolation or quarantine if confirmed positive. Other reasons given include self-medication, such as with over-the-counter or herbal medicines, a lack of income, the loss of employment, an inability to pay for services, and government pandemic prevention measures (social distancing, stay-at-home or lockdown orders, and curfews.

There was fear, we were suspicious, we didn't even want to go to health facilities or even go out for fear of contracting the disease. There was fear, fear of everything... In addition, there was fear that health facilities have many people. Some people respect the prevention measures, so, because the majority do not follow the barrier measures, you are afraid to go to the health facility... Yes, especially over there is a lot, everyone comes, everyone comes in. (SRH client, Burkina Faso)

[Majority] of people lost employment. The pandemic negatively affected the Country's economy [...] People did not have money. [...] I met someone who told me that [...] 'I'm sick, yes. The few coins that I have [I use] to buy food for my family and I continue being sick'. (Policy maker, Kenya)

Last year, clients feared coming to the facility. Work [in health facilities] came to a standstill for some time. Because people were being told 'stay home, if you are not that sick, don't come to the facility and do not mingle with people...'. Therefore, people stayed home for some time. They [came when someone] was very sick... Because they had heard the doctors are also dying, nurses are also dying and you will intermingle with them...you are also going to affect the family members. (Health provider, Kenya)

In Kenya, Malawi, and Uganda, clients reported that health providers treated them harshly and had negative attitudes towards patients who were seeking health services regarded as non-essential. This attitude by health providers was likely the result of their efforts to reinforce government COVID-19 prevention measures:

[...] The health care providers reinforced the government's message asking those who visited health facilities, 'what are you coming to do here if you know that you are not that sick? Why can't you stay home? What are you searching for?'. (Health provider, Kenya)

To deal with the 'negative attitudes' of health providers in Malawi for instance; there were deliberate efforts to ensure the continuity of youth-friendly services. Similarly, in Burkina Faso, awareness campaigns were ramped up to address the fears of women avoiding the hospitals:

At the beginning of the pandemic, infant consultations and vaccinations and prenatal visits went down. Mothers did not bring their babies for vaccinations due to the same fear. Awareness campaigns were done to let them know that in reality, by adopting barrier methods (wearing masks, hand washing, social distancing), their children could come and benefit from vaccination services and without actually contracting COVID-19. (Health provider, Burkina Faso)

However, while there was a decrease in the use of most SRH services, healthcare providers and CSO/NGO representatives reported an increase in SGBV cases, and a corresponding increase in requests for SGBV-related health services:

[...] I remember there was a day I was in the facility [...] and a woman came and had been beaten on the face [and her] face was swollen. When asked she said 'my husband came home and started asking me what I was doing in the house that there was no food' [...] She was beaten and then she came to the facility. So [...] there have been several of such kind of cases though prior to COVID-19, there were no such big numbers of those kind of cases within that area. As such, we have seen an increase in sexual and gender-based violence. (Health provider, Kenya)



Conclusion

Our research findings provide important insights into the implications of COVID-19 on the availability of, access to, and utilization of SRH services and information among women and girls.

Overall, COVID-19 continues to have adverse effects on various day-to-day aspects of life, including economic, educational, health, and transport. Governments of the five countries covered in our study have aggressively implemented strategies and measures to mitigate against COVID-19 infection. It should be stated that these measures effectively limited exposure to COVID-19; however, they caused broad disruptions to livelihoods and increased the vulnerability of the weakest. The pandemic also caused severe disruptions in SRH services that translated to negative experiences and outcomes for women and girls. In some cases, governments, through their Ministries of Health, developed useful policies, guidelines, and regulations that enable healthcare providers to continue delivering SRH services, including community health services. The governments in our study countries also invested in training healthcare providers on infection prevention procedures for COVID-19, and provided much-needed PPE.

In responding to the COVID-19 pandemic and other health crises, governments must strike a delicate balance between mitigating the impact of the health crisis while ensuring the continuity of essential health services. They should adopt multi-sectoral measures that are fit-for-purpose, and at the same time take the steps necessary to sustain services required to meet SRH needs, challenges, and priorities.

Key Recommendations

1

Responding to public health emergencies, especially those of high risk to humans may require drastic control measures, but the responses adopted need to be balanced against other public health needs and priorities, such as SRH.

2

A multisectoral approach should be used when developing and implementing government policies and guidelines in response to pandemics and other health crises through a collective action strategy that ensures the preservation of SRH services. The policies and guidelines that result need to be continuously reviewed in order to respond effectively to evolving needs, trends, challenges, and developments.

3

There is need for all countries to invest in telemedicine approaches to ensure access to SRH services for all. These include enhancing the capacities of providers in telemedicine and establishing the necessary frameworks and eliminating structural barriers to expanding access to SRH services that are in line with universal health coverage (UHC) goals.

4

There is a compelling need for Ministries of Health to develop self-care guidelines, and while doing so remove regulatory barriers to self-care to ensure a smooth rollout in all countries.

5

There is a need to strengthen and utilize community health outreach and interventions to enhance access to health information and services. This should include the use of community health workers and community-based distributors of FP commodities to address the challenges created by stock outs.

6

Governments should ensure sustainable and resilient supply chain management systems for SRH commodities for public and private health facilities. Governments should support private facilities (with SRH supplies and commodities) since they serve a significant proportion of the population and are able to reach disadvantaged sub-populations.

7

Governments should adopt a holistic response and recovery strategy that considers the impacts in different socioeconomic sectors at various stages of the pandemic.

8

Health facilities should institutionalize inclusive, continuous, consistent, and client-friendly training and sensitization of health care providers in the delivery of SRH services, even during pandemics.

9

To ensure the continuity of services, healthcare providers need to be protected, both from the pandemic (through the provision of essential PPE) and from broad social and economic fears, as well as the psychological stress that comes from operating in such crisis contexts.

10

Sexual and reproductive health funders and partners need to increase funding and support for SRH services, while improving the resilience of supply chains and services during the crisis.

11

Vulnerable populations, such as pregnant women and those facing SGBV, should be treated as essential populations needing critical services. They should be provided with identification that allows them to access services when needed and facilitates their mobility to health facilities. In addition, health facilities should be equipped with toll-free phones for easier access to services.



References

Ameyaw, E.K., Ahinkorah, B.O., Seidu, A-A. & Njue, C. 2021. Impact of COVID-19 on maternal healthcare in Africa and the way forward. Arch Public Heal [Internet]. 79(1):223. Retrieved from: <https://doi.org/10.1186/s13690-021-00746-6>

Banke-Thomas, A. & Yaya, S. 2021. Looking ahead in the COVID-19 pandemic: emerging lessons learned for sexual and reproductive health services in low- and middle-income countries. Reprod Health [Internet]. 18(1):248. Retrieved from: <https://doi.org/10.1186/s12978-021-01307-4>

Barach, P., Fisher, S.D., Adams, M.J., Burstein, G.R., Brophy, P.D. & Kuo, D.Z., et al. 2020. Disruption of healthcare: Will the COVID pandemic worsen non-COVID outcomes and disease outbreaks? Prog Pediatr Cardiol [Internet]. 59:101254. Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/32837144>

Church, K., Gassner, J. & Elliott, M. 2020. Reproductive health under COVID-19 – challenges of responding in a global crisis. Sex Reprod Heal Matters [Internet]. 28(1):1773163. Retrieved from: <https://doi.org/10.1080/26410397.2020.1773163>

Ella, S.D. 2020. Kenya and Covid: Pandemic Response Risks Excluding Minority Groups. Reinventing Peace [Internet]. Retrieved from: <https://sites.tufts.edu/reinventingpeace/2020/05/28/kenya-and-covid-pandemic-response-risks-excluding-minority-groups/>

Haider, N., Osman, A.Y., Gadzekpo, A., Akipede, G.O., Asogun, D. & Ansumana, R., et al. 2020. Lockdown measures in response to COVID-19 in nine sub-Saharan African countries. BMJ Glob Heal [Internet]. 5(10):e003319. Retrieved from: <http://gh.bmj.com/content/5/10/e003319.abstract>

Hillier, D., Tom, N-L., Rithika, N. & Larsen, C. 2020. Initial COVID-19 responses in Bangladesh, Kenya, Pakistan, Sierra Leone and Uganda: Documentation and learning from March to May 2020 [Internet]. London, England. Retrieved from: <https://reliefweb.int/sites/reliefweb.int/files/resources/COVID-19-Synthesis-report-Exec-Sum-Final.pdf>

Mbatha, T. & Tendai, M. 2020. COVID-19: What the lockdown means for sexual and reproductive health services [Internet]. Spotlight. p. 1-5. Retrieved from: <https://www.spotlightnsp.co.za/2020/04/22/covid-19-what-the-lockdown-means-for-sexual-and-reproductive-health-services/>

PAI. 2020. Optimizing the World Health Organization COVID-19 Interim Guidance. Washington DC.

Plan International UK. 2020. Implications of the COVID-19 Crisis on Girls and Young Women. London, England.

Research for Scalable Solutions. 2020. Documenting the Effects of COVID-19 on Family Planning Access and Use with Standardized Questions [Internet]. Durham, NC. Retrieved from: <https://www.fhi360.org/sites/default/files/media/documents/r4s-covid-19-family-planning.pdf>

Riley, T., Sully, E., Ahmed, Z., & Biddlecom, A. 2020. Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries. *Int Perspect Sex Reprod Health*. 46:73.

Sheffel, A., Karp, C. & Creanga, A.A. 2018. Use of Service Provision Assessments and Service Availability and Readiness Assessments for monitoring quality of maternal and newborn health services in low-income and middle-income countries. *BMJ Glob Heal* [Internet]. 3(6):e001011-e001011. Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/30555726>

Tang, K., Gaoshan, J., Ahonsi, B., Ali, M., Bonet, M. & Broutet, N., et al. 2020. Sexual and reproductive health (SRH): a key issue in the emergency response to the coronavirus disease (COVID- 19) outbreak. *Reprod Health* [Internet]. 17(1):59. Retrieved from: <https://doi.org/10.1186/s12978-020-0900-9>

Tessema, G.A., Kinfu, Y., Dachew, B.A., Tesema, A.G., Assefa, Y. & Alene, K.A., et al. 2021. The COVID-19 pandemic and healthcare systems in Africa: a scoping review of preparedness, impact and response. *BMJ Glob Heal* [Internet]. 6(12):e007179. Retrieved from: <http://gh.bmj.com/content/6/12/e007179.abstract>

World Health Organization. 2020. Maintaining essential health services: operational guidance for the COVID-19 context [Internet]. Geneva, Switzerland. Retrieved from: https://www.who.int/publications/i/item/WHO-2019-nCoV-essential_health_services-2020.2



