Impacts of COVID-19 Pandemic on Sexual and Reproductive Health Services in Ethiopia

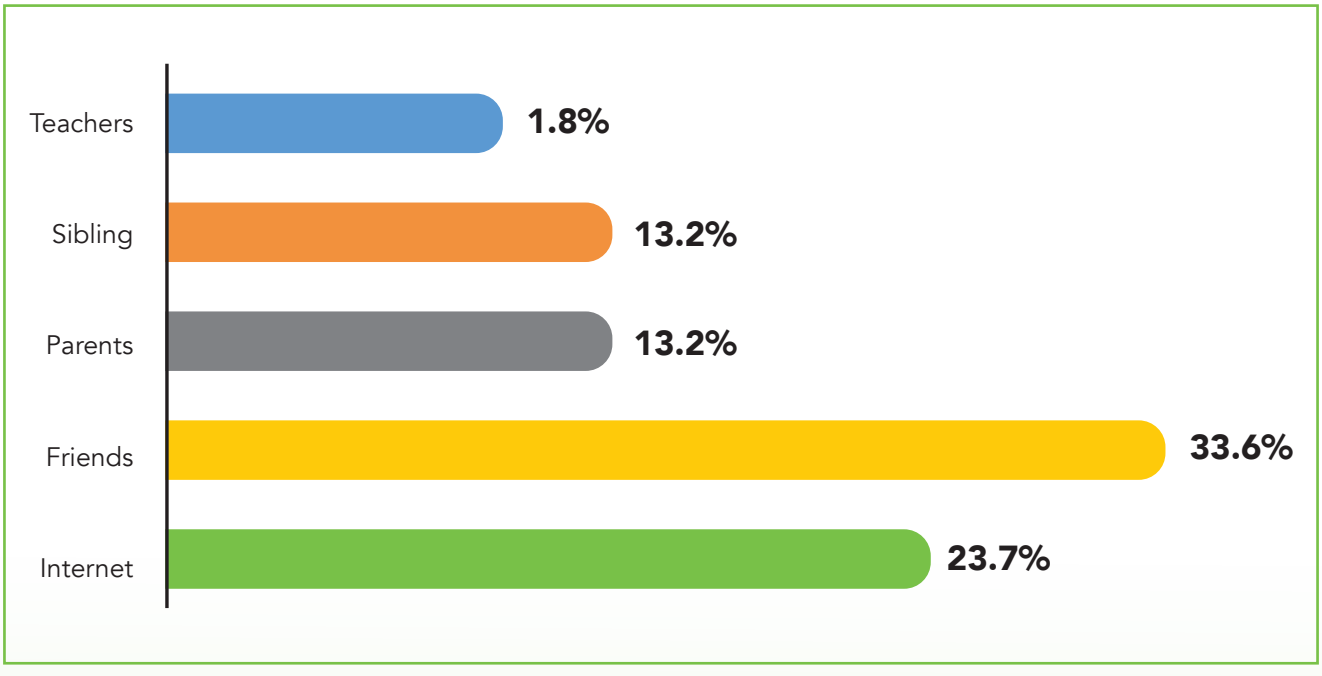
This policy brief summarizes evidence from a cross-sectional survey conducted in Ethiopia to document the impact of COVID-19 pandemic on sexual and reproductive health (SRH) services. Data were collected from 114 women and girls from across Ethiopia, as well as from health providers in 100 health facilities. Further, we conducted in-depth interviews with 21 women and girls, 21 healthcare providers, 4 policy makers, and 9 representatives from civil society organizations and non-governmental organizations. We also conducted six focused group discussions with clients attending health facilities. Findings highlight the impacts of COVID-19 pandemic on access to, availability and utilization of SRH services

Findings

Access to SRH information during COVID-19 pandemic

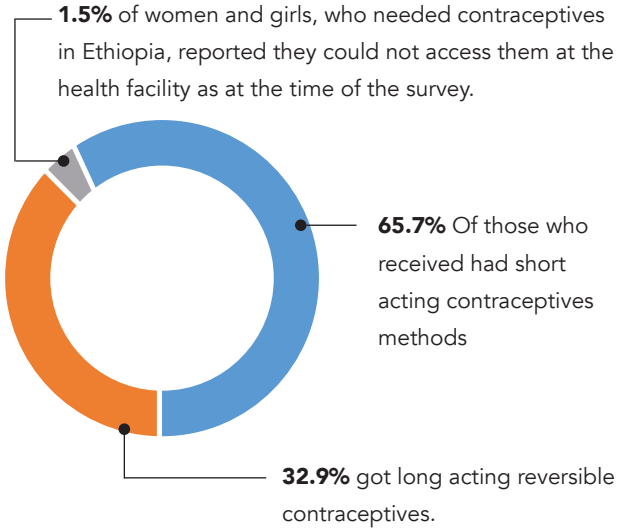
- Majority of respondents sought SRH information from their friends/peers (33.6%) and from the internet (23.7%) during the pandemic.
- Online platforms are crucial in facilitating access to SRH information and services during the pandemic, accelerating the transition toward self-care and telemedicine especially for SRH services.
- Web-based and phone-messaging platforms deliver information instantly and offer an opportunity for anonymous interaction with providers to ask follow-up questions and set up appointments.

Figure 1: Percent of women/girls reporting various sources of SRH information during the pandemic



Access to SRH services during the pandemic

- Even before the pandemic, public and private health facilities faced stock-out challenges for SRH commodities, and this only worsened by the COVID-19 pandemic, resulting in limited access to services

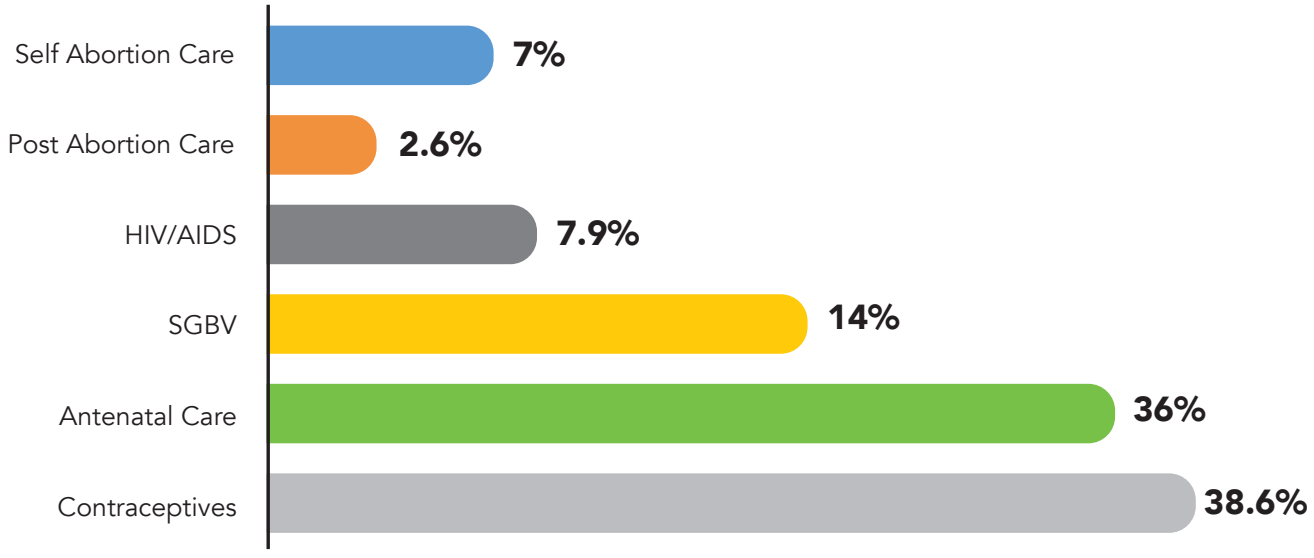


- Health providers influenced the choice of contraceptives. Providers frequently advised women to switch to pandemic-friendly contraceptive methods, sometimes based on government COVID-19 prevention guidelines. Short-term methods not requiring physical interaction with providers were preferred, even though they made women to visit health facilities regularly.
- Switching of contraceptives at times meant moving to a less effective or no method at all, that could result in contraceptive failures and/or unintended pregnancies

Barriers to SRH services

- Among women and girls who reported barriers, majority reported obstacles accessing contraceptives (19.8%) and antenatal care (12.6%).
- Most common barriers were restriction in movements (e.g., curfew/lockdowns) (45.8%), long distance to facilities (24.6%), high care cost (13%), and unfriendly health providers (12.1%).
- Patients could not travel to health facilities due to lockdowns/curfews and a lack of public transportation. Fear of contracting the virus prevented patients from visiting. Stock outs of SRH commodities forced some patients to seek services in private facilities at higher costs. Facilities that sought SRH supplies from private entities at inflated costs, in turn passed on the cost to their clients.

Figure 2: **Percentage of women who reported challenges accessing SRH services**

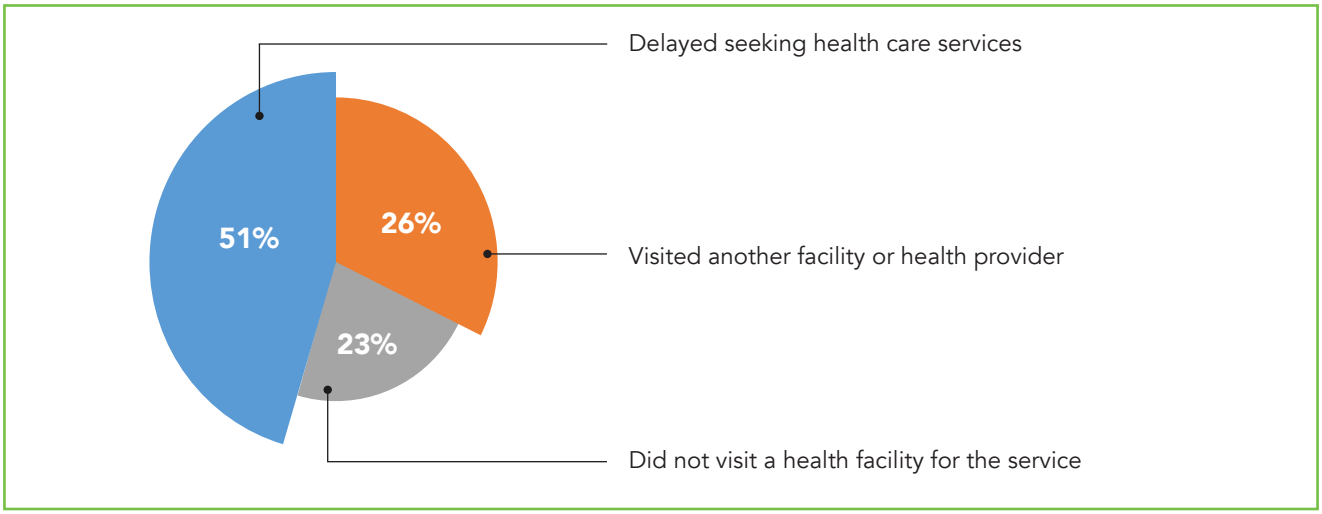


- COVID confined parents and male partners at home, and women and girls often found it difficult to get to health facilities since they would have to explain to their parents/partners where they were going and why. This threatened their autonomy and privacy.

Coping mechanisms for dealing with barriers to accessing services

- Women and girls responded to the barriers to accessing SRH services, by delayed seeking of needed SRH services, others visited alternative care providers (pharmacies, traditional healers/birth attendants) while others failed to visit health facilities all together.
- Occasionally, women seeking delivery or antenatal services, but faced curfews or had COVID fears at health facilities resorted to self-medicating using over-the-counter medication and/or telemedicine, while others sought services from traditional birth attendants or had home deliveries.

Figure 3: Coping mechanisms for dealing with barriers to accessing services



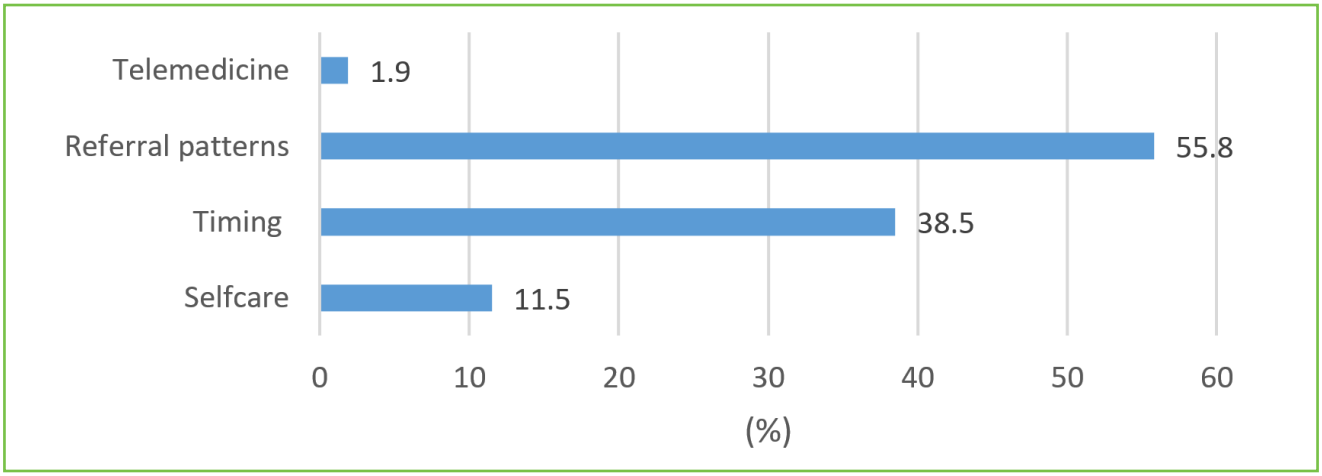
Availability of SRH Services

- Eighty-three percent of health facilities reported they had stocks of prepackaged combined mifepristone/misoprostol in the last 3 months. However, asking about the last three months, about 66.7% of facilities reported they lacked prepackaged combined mifepristone/misoprostol. Very few facilities (6% and 1%) lacked implants and IUCDs respectively over the last three months.
- Shortages of FP commodities was partly driven by the pandemic. Lockdowns were implemented instantly after COVID set in; 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.
- For most SRH services, the key reason for unavailability was the absence of SRH commodities (stock outs), lack of trained healthcare staff and occurrence of COVID-19 in the facility.

Continuity of SRH services during the pandemic

- Despite the challenges imposed by COVID, and the ensuing barriers to access of SRH services, health facilities implemented several measures to ensure continuity of health services.
- About 55% of health facilities altered referral patterns, while 38.5% adjusted service delivery timings (specific days and times for services) to ensure continuity of SRH services. One-tenth of facilities introduced self-care, while 1.9% implemented telemedicine.
- Virtually all facilities (100%) implemented social distancing measures. About 91% provided print media/posters information on COVID-19, 89% enforced sanitization, while 79% had disinfection points. About 84% of facilities had supplied providers with PPEs, and 75% had staff trained on COVID-19. Majority of service delivery changes were to reduce or limit contact between providers and clients.

Figure 4: Health facilities adjustments to ensure continuity of SRH services



Utilization of SRH services

- There was a general decline in the uptake/utilization of services during the COVID-19 Pandemic period, reflective of challenges in both the demand and supply of SRH services. As such, data comparing current and previous visits to health facilities for SRH services indicates that fewer women sought SRH services, except for post abortion care (PAC) and comprehensive abortion care (CAC).
- Fear of contracting COVID-19, testing positive for the virus, and fear of isolation or quarantine if confirmed positive was reported as responsible for the decline in use of services. Harsh or negative attitudes by health providers was also cited, especially among those seeking services regarded as non-essential.

Key Recommendations

1. Responding to public health emergencies may require drastic control measures, but the responses adopted need to be balanced against other public health needs and priorities, such as SRH.
2. Use a multisectoral approach when developing and implementing government policies and guidelines in response to pandemics through a collective action strategy that ensures the preservation of SRH services, and integrate continuous reviews.
3. All countries should invest in telemedicine and self-care approaches including strengthening capacities of providers and establishing the necessary frameworks and eliminating structural barriers to expanding access to SRH services.
4. Strengthen and utilize community health outreach and interventions to enhance access to health information and services, including use of community health workers and community-based distributors of FP commodities
5. Governments to ensure sustainable and resilient supply chain management systems for SRH commodities for public and private health facilities, and also support private facilities (with SRH supplies and commodities) since they serve a significant proportion of the population
6. 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.
7. 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.
8. 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.