

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

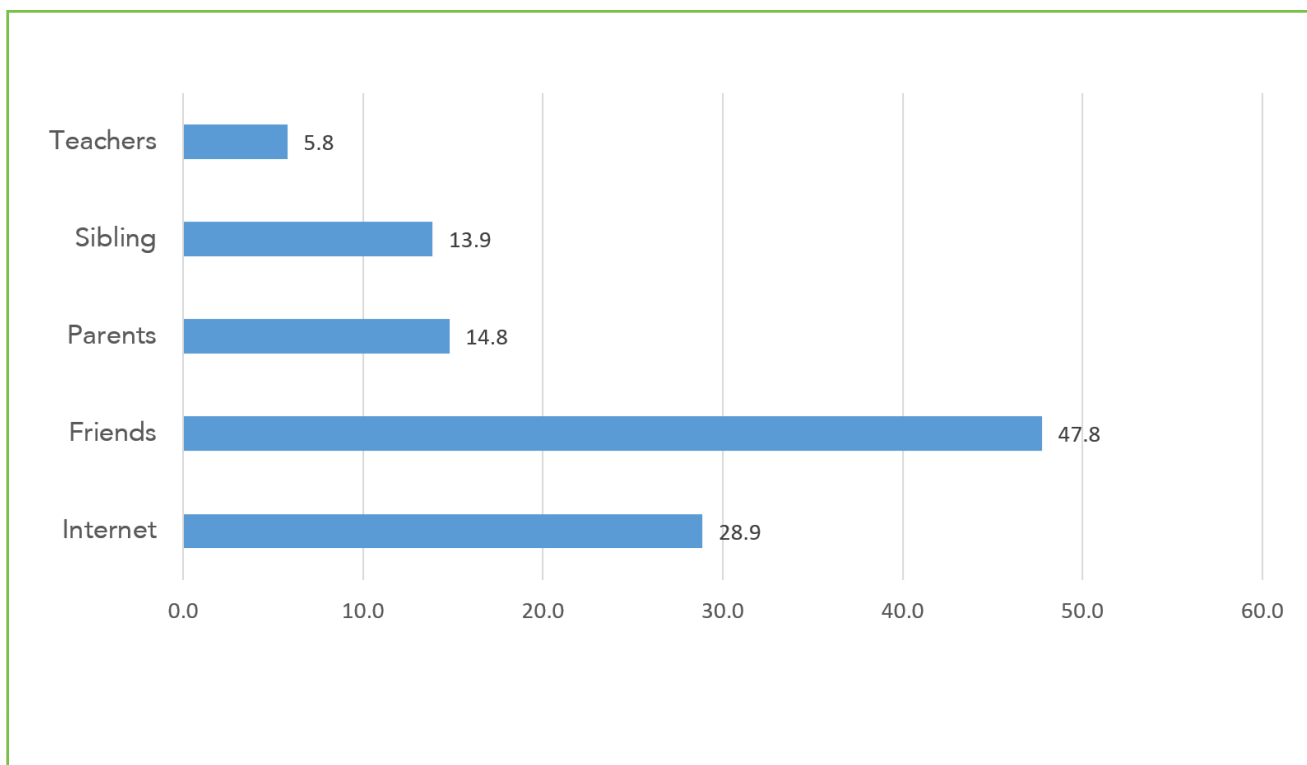
This policy brief summarizes evidence from a comparative analysis of five selected sub-Saharan Africa countries, highlighting the overall impacts of the COVID-19 pandemic on the availability of, access to, and use of SRH services. A total of 3,473 women and girls and 466 healthcare providers in Burkina Faso, Ethiopia, Kenya, and Uganda were interviewed. Further, we conducted in-depth interviews with 211 women and girls, 176 healthcare providers, 64 representatives from civil society organizations and non-governmental organizations, and 13 policy makers in the five countries (including Malawi).

Key findings

Access to SRH information during the Pandemic

- Most women and girls relied on friends (47.7%) and the internet (28.9%) for SRH information. Social media and telehealth platforms deliver information instantly and offer recipients the opportunity to interact with health providers anonymously and schedule appointments (Figure 1).

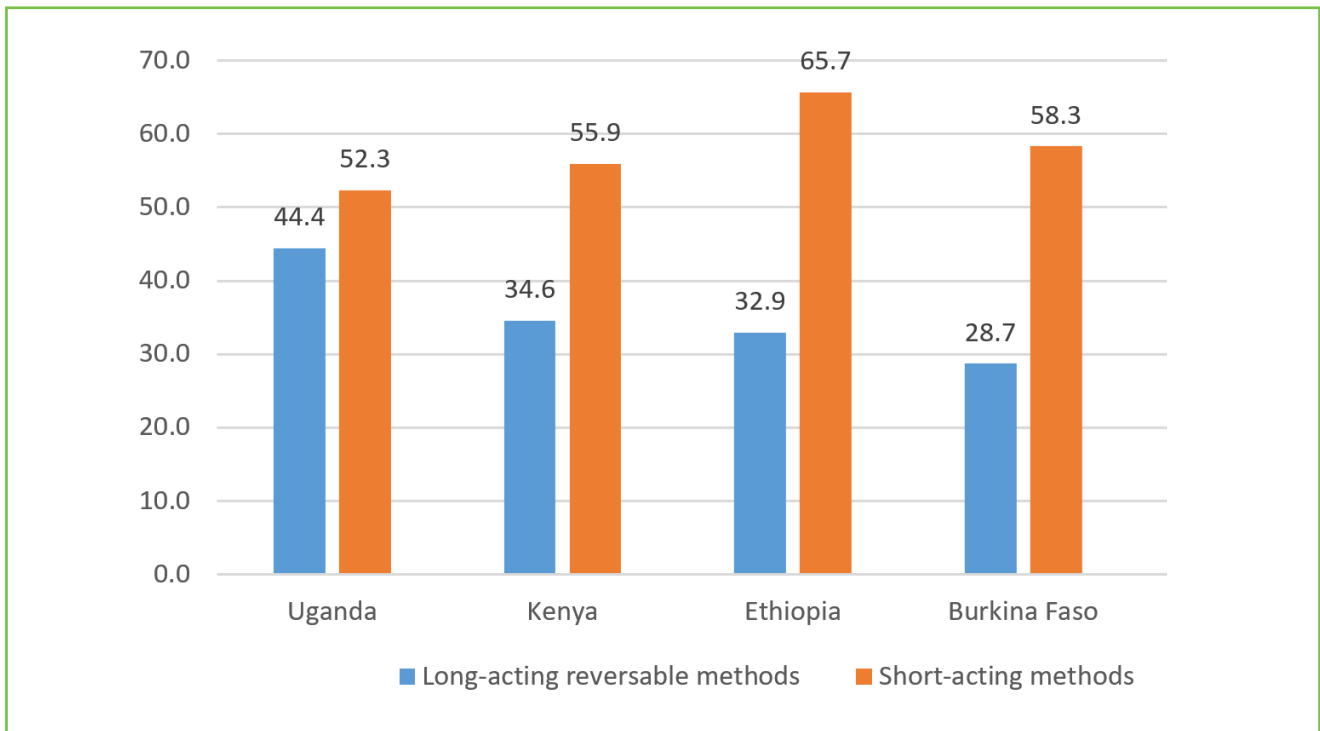
Figure 1: Percent of women/girls reporting various sources of SRH information during the pandemic



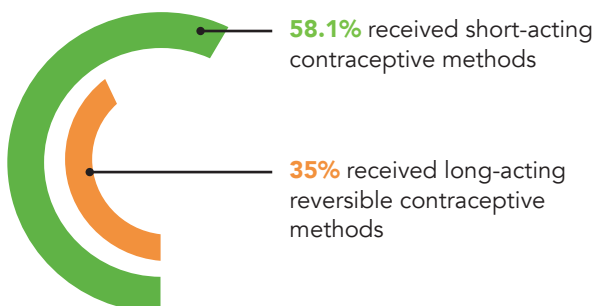
Access to SRH services during the pandemic

- Health facilities faced challenges restocking their FP commodities. While shortages of SRH commodities was not a new phenomenon, COVID-19 made it worse. This was largely linked to government “prioritization of COVID-19 over other health services”.
- While SRH services were available in some health facilities, challenges created by COVID-19 prevention requirements (mandatory facemasks and social distancing) reduced the number of clients allowed into health facilities.
- About 26% of women and girls who needed modern contraceptives could not access them. Among those that accessed contraceptives, 58.1% received short-acting contraceptive methods, compared to 35% who got long-acting reversible contraceptives (Figure 2).

Figure 2: Proportion of women/girls who needed and obtained contraceptives



Among those that accessed contraceptives

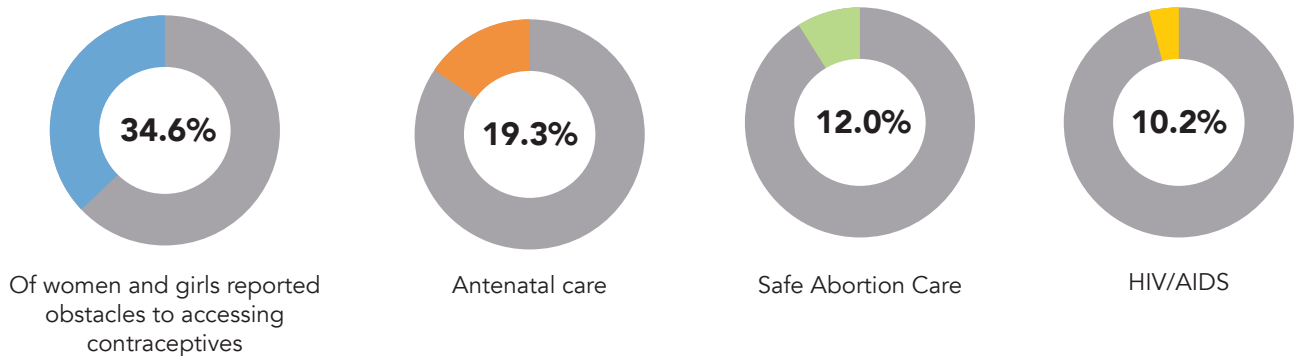


- The choice of contraceptives was largely influenced by health providers, who often advised women/girls to switch to contraceptive methods that suited the pandemic period.
- This practice was at times based on government COVID-19 prevention guidelines. Short-term methods not requiring physical interaction with providers were encouraged compared to methods that require close contact. Some women lamented that providers offered them birth control pills for extended periods beyond the usual duration to reduce the frequency of facility visits.

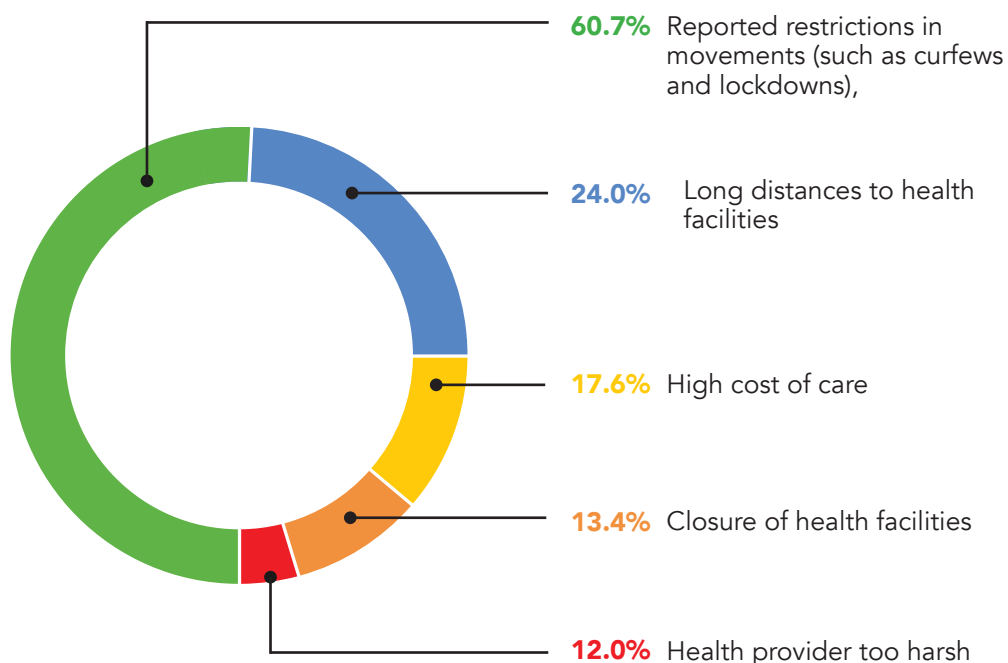
Barriers to SRH services

- Women and girls complained about stockouts of SRH commodities (family planning products), forcing them to seek services in private facilities at higher costs. Health facilities also sought SRH supplies from private entities at an inflated cost, and in turn passed the cost on to clients.

Proportion of women and girls facing challenges accessing specific SRH services

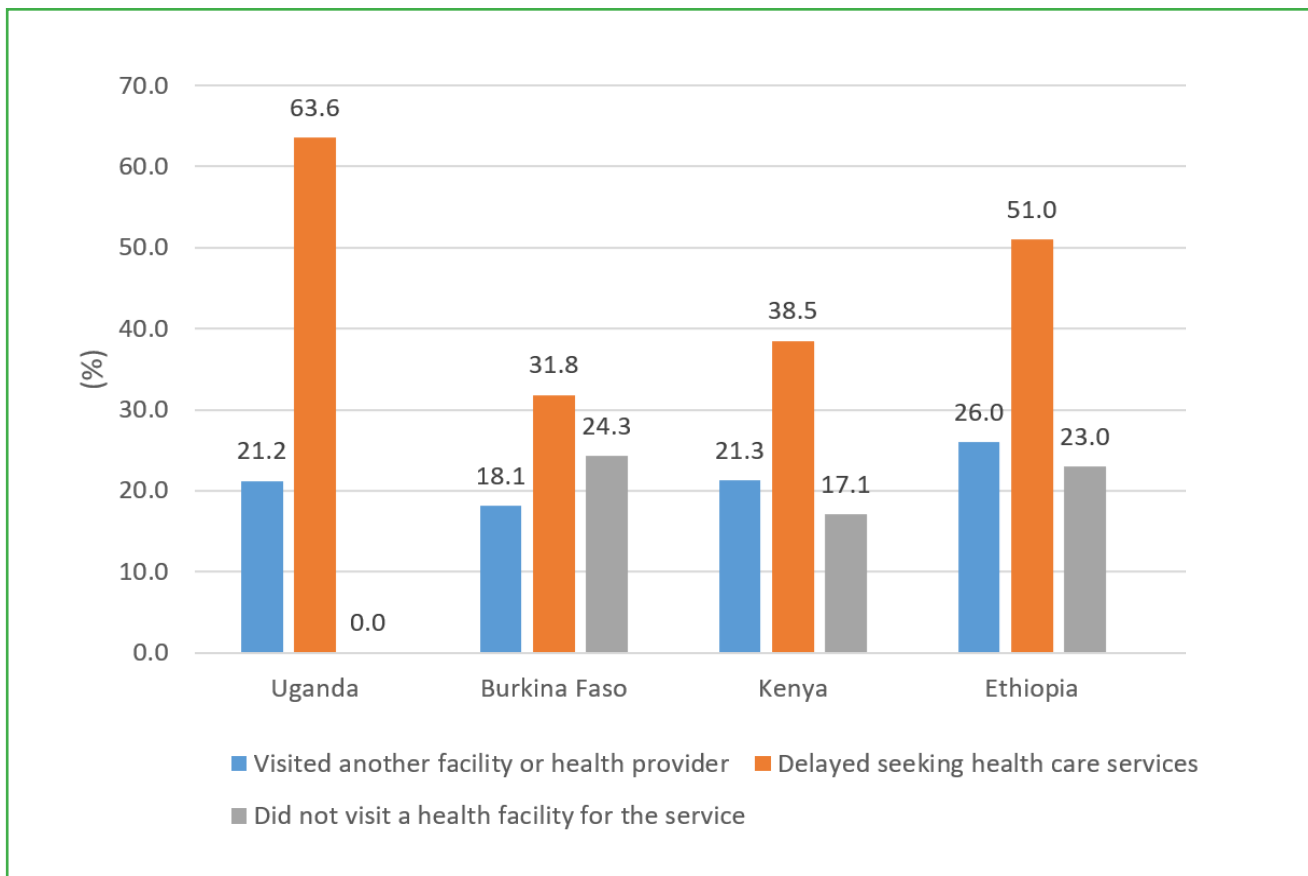


- When services were unavailable in usual health facilities, participants were redirected to other facilities mainly private hospitals that were further away, requiring transport and incurring higher costs and delays in care as reported by women in Burkina Faso and Uganda.
- COVID confined parents and male partners at home, and women and girls 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 autonomy, privacy and agency.



Coping mechanisms for dealing with barriers to accessing services

Figure 3: Coping mechanisms for overcoming access barriers to SRH services



- As noted in Ethiopia, women and girls who sought abortions in health facilities, shared how they decided not to seek contraceptives because of fear of COVID, and this resulted in unwanted pregnancies. In Burkina Faso, providers narrated how several HIV positive patients resorted to staying home and not go for drugs.
- In some cases, participants in Kenya reported seeking alternative services from pharmacies,

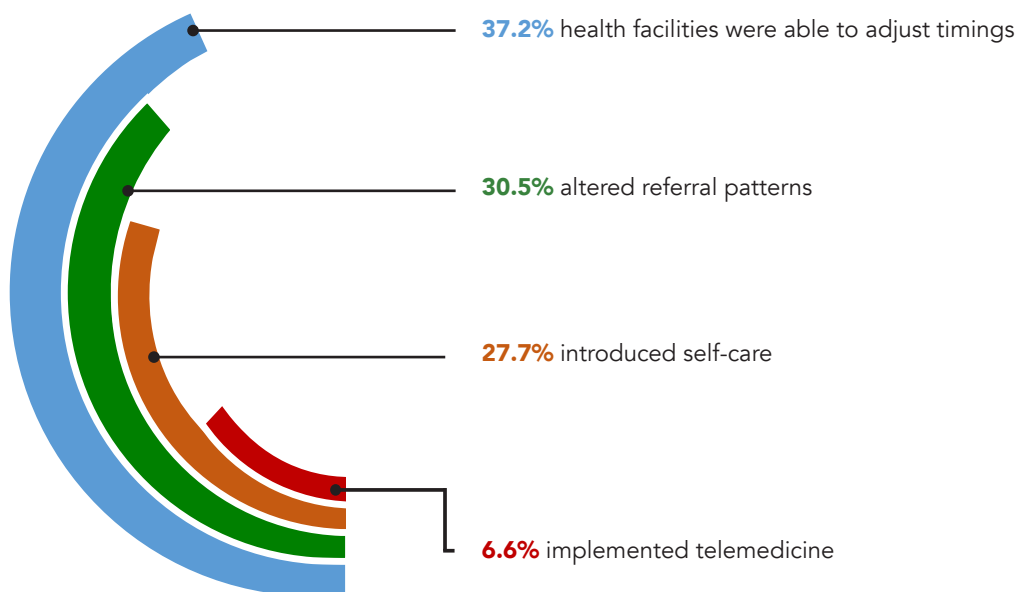
despite the prohibitive costs. Women in need of services (including delivery or antenatal), but were restricted by curfews or feared health facilities because of COVID resorted to self-medicating using over-the-counter medication and/or telemedicine, while others sought services from traditional birth attendants or had home deliveries. (Figure 3)

Availability of 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. 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.
- Healthcare providers, policy makers and CSO representatives noted that shortages of FP commodities was partly pandemic driven. 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.
- Health providers in Kenya and Uganda stated they stopped community outreach programs targeting discussions on SRH and HIV, and reduced daily antenatal and postnatal attendance

Continuity of SRH services during the pandemic

Health facilities adjustments to ensure continuity of SRH services



- Ethiopia (75%) and Burkina Faso (74%) had the highest proportion of health facilities with staff trained on COVID-19. Ethiopia had the highest number of facilities supplied with PPE (84%), then Kenya (77%). All facilities enforced sanitization and social distancing measures. Majority of these changes in service delivery were to reduce or limit contact between providers and clients.

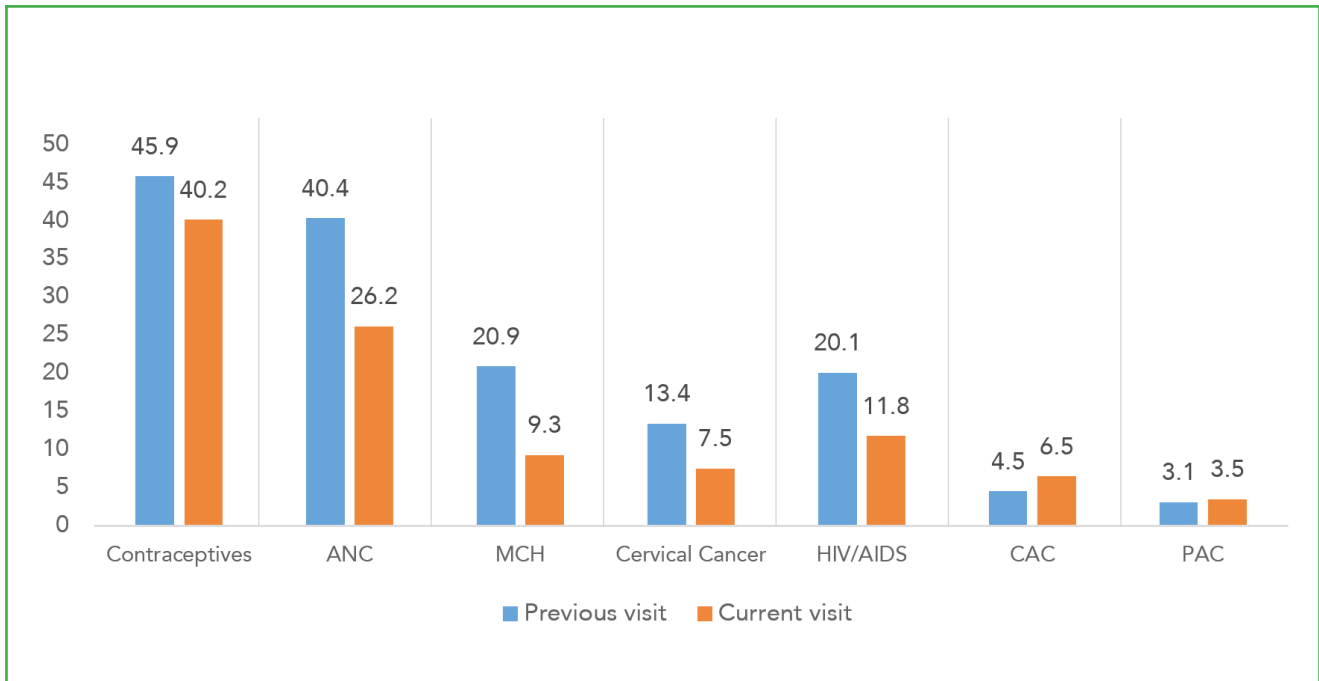
Reasons why some services were not available

- 1** Absence of SRH commodities (stockouts), lack of trained healthcare staff and occurrence of COVID-19 in the facility was associated with the lack of services including comprehensive abortion care (CAC), post-abortion care (PAC).
- 2** Absence of trained health providers in Ethiopia, Burkina Faso and Uganda was the main reason given for not providing services needed to cope with sexual and gender-based violence.

Utilization of SRH services

- During the survey, 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.
- Comparing current and previous hospital visits, there was a general decline in the uptake of all SRH services except for CAC and PAC, where there was a slight increase in uptake (Figure 4).

Figure 4: Comparing health facility visits before and during the pandemic



- Fear of contracting COVID, testing positive for the virus, and fear of isolation or quarantine if confirmed positive was linked to the decrease in use of SRH services. Other reasons included self-medication, inability to pay for services, and government pandemic prevention measures.
- Harsh and negative attitudes by health providers in Kenya, Malawi, and Uganda was cited as a deterrence to patients, especially those seeking services regarded non-essential. This attitude by providers was linked to efforts meant to reinforce government COVID-19 prevention measures.

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 of 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 crises.

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Source:

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Study Partners

