Policy Brief

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

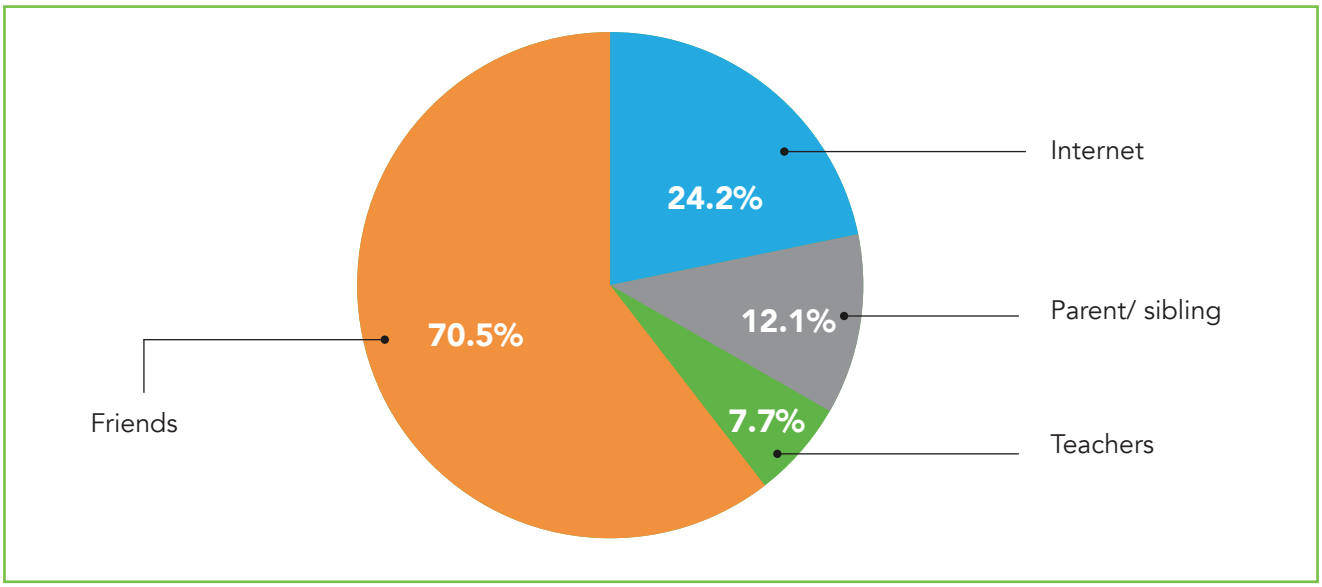
This policy brief summarizes evidence from a cross-sectional survey conducted in Uganda to document the impact of COVID-19 pandemic on sexual and reproductive health (SRH) services. Data were collected from 543 women and girls from across all regions of Uganda, as well as from health providers in 63 health facilities. Further, we conducted in-depth interviews with 41 women and girls, 85 healthcare providers, 3 policy makers, and 16 representatives from civil society organizations and non-governmental organizations. Findings highlight the impacts of COVID-19 pandemic on access to, availability and utilization of SRH services.

Key findings

Access to SRH information during COVID-19 pandemic

- Majority of respondents in Uganda sought SRH information from their friends/peers (70.5%) and from the internet (24.2%) during the pandemic.
- Friends form part of the social network that most people confide in. Similarly, online platforms increasingly play a critical role in facilitating access to SRH information and services over this period.

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



Access to SRH services during the pandemic

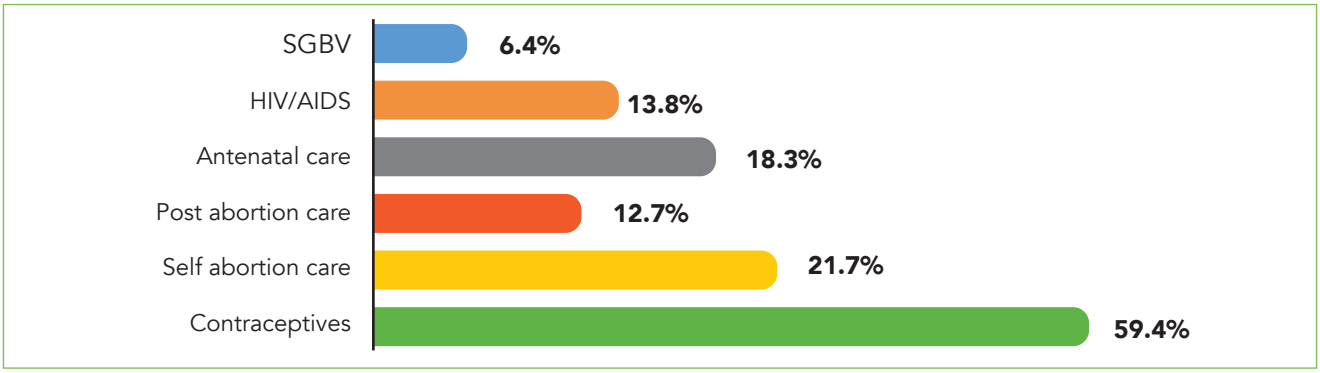
- Even before the pandemic, public and private health facilities faced stock-out challenges for SRH commodities, and this only worsened by the COVID-19 pandemic, thus limiting service access
- One-quarter of women and girls (24%), who needed contraceptives in Uganda, reported they could not access contraceptives at the health facility as at the time of the survey. Of those who received, 52.3% had short acting contraceptives while 44.4% received long acting reversible contraceptives.

- Health providers often 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

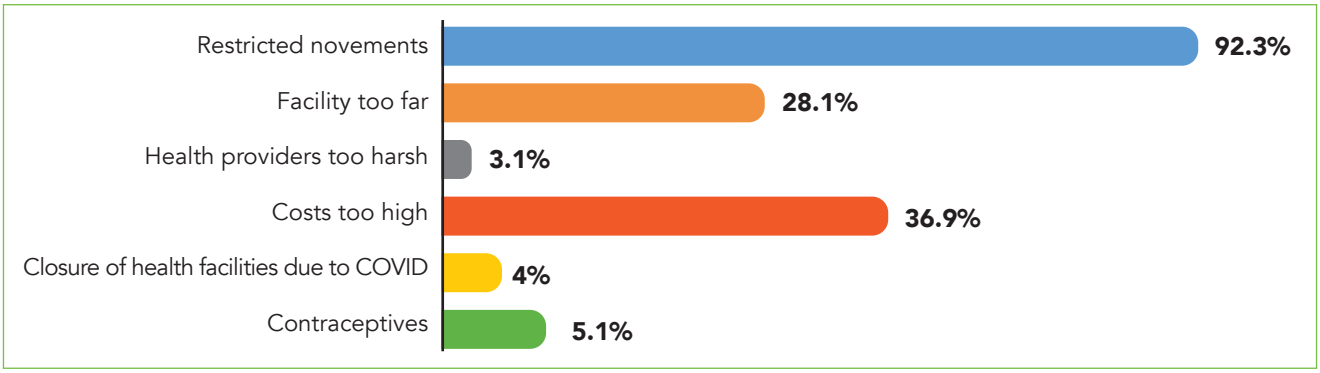
- Among women and girls who reported barriers, majority reported obstacles accessing contraceptives (59.4%), safe abortion care (21.7%) and antenatal care (18.3%).

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



- Most common barriers in Uganda, were restriction in movements (e.g., curfew/lockdowns) (92.3%), high care costs (36.9%) and long distance to facilities (28.1%).

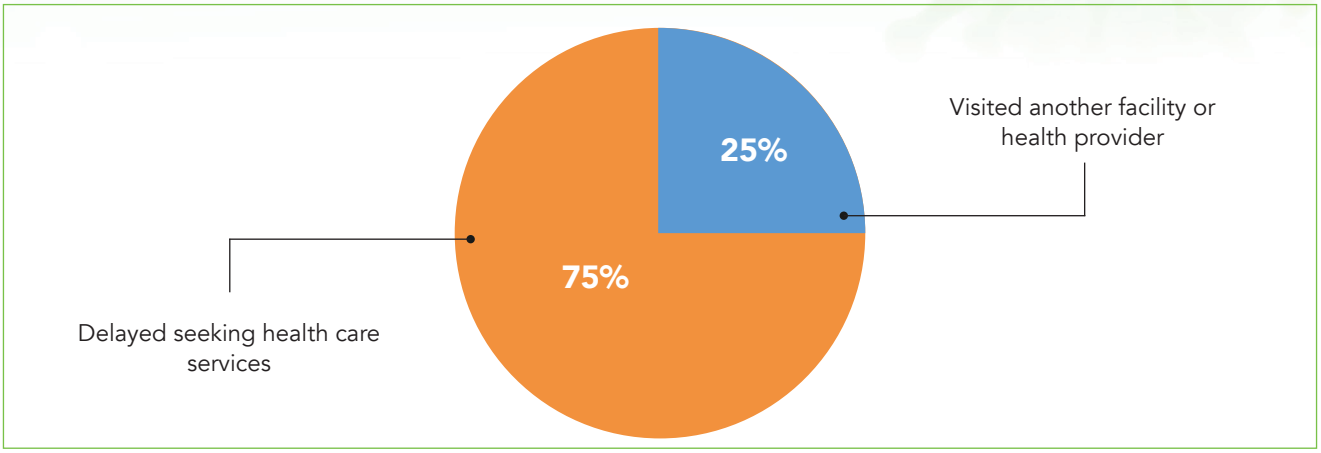
Figure 3: Barriers to seeking SRH services among women and girls



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 4: **Coping mechanisms by women and girls dealing with barriers to accessing SRH services**



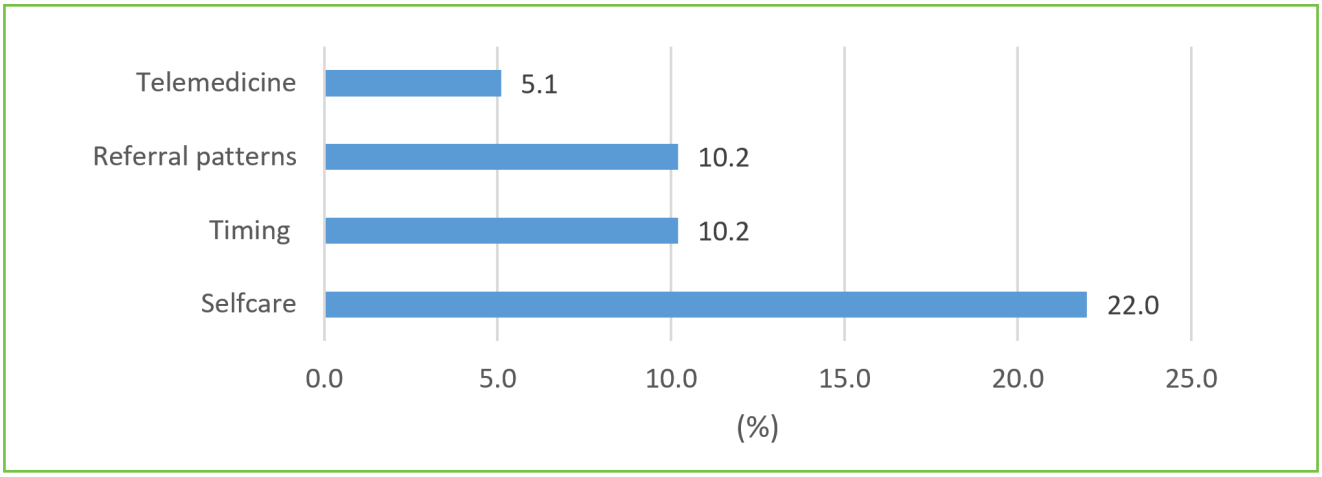
Availability of SRH Services

- About 19% of health facilities had stock outs of prepackaged combined mifepristone/ misoprostol at the time of survey, while about 47.6% had stocked out of the same in the last 3 months. About 85.6% indicated they experienced stocks of misoprostol alone in the last 3 months. Further, close to half of facilities (41.3%) and 38.1% lacked implants and IUCDs respectively in the last 3 months.
- 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.
- 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

- About 22% of health facilities introduced self-care to ensure continuity of SRH services. One-tenth of facilities (10.2%) adjusted service delivery timings (specific days and times for services) and altered referral patterns, while 5.1% of facilities implemented telemedicine.
- Virtually all facilities (100%) had disinfection points, 98.4% enforced sanitization, while 95.2% implemented social distancing measures. About 36.5% of facilities supplied providers with PPEs, and 60.3% had staff trained on COVID-19, 28.6% provided print media/posters information on COVID-19. Service delivery changes were aimed at limiting contact between providers and clients.

Figure 5: **Health facilities adjustments to ensure continuity of SRH services**



Utilization of SRH services

- 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 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.

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