



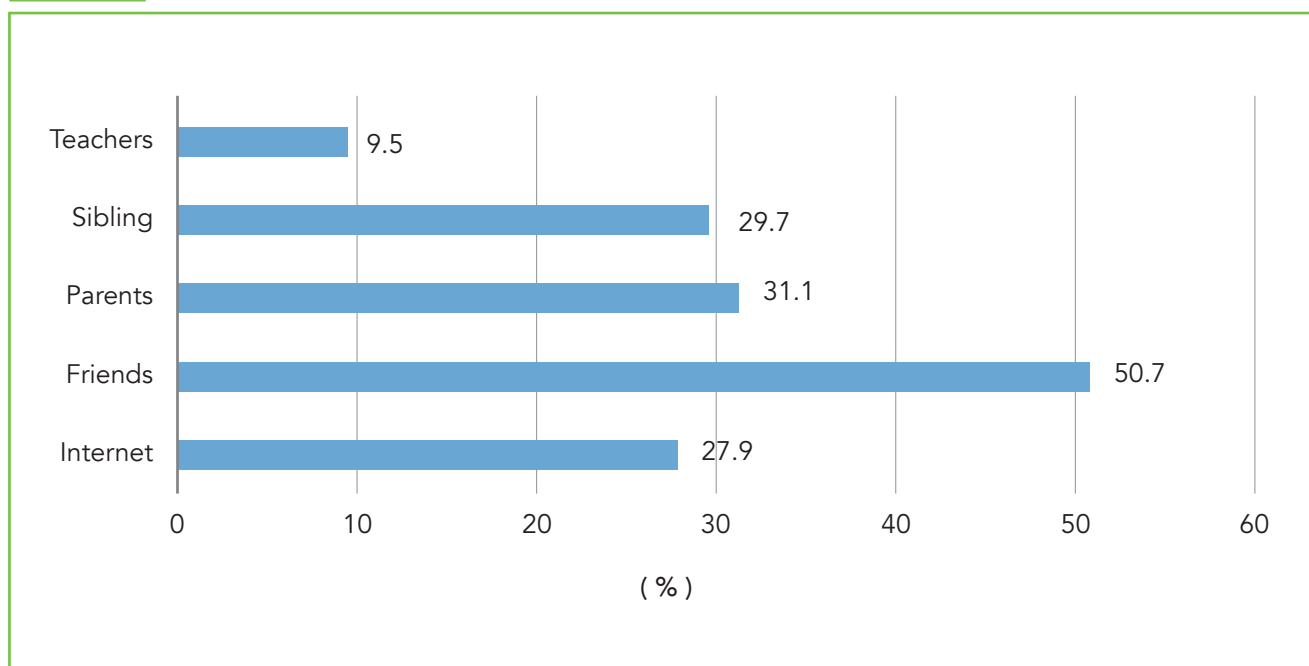
Impacts of COVID-19 Pandemic on Sexual and Reproductive Health Services in Burkina Faso

This brief summarizes evidence from a cross-sectional survey conducted in Burkina Faso to document the impact of COVID-19 pandemic on sexual and reproductive health (SRH) services. Data were collected from 1000 women and girls from across five regions, as well as from health providers in 80 health facilities. Further, we conducted in-depth interviews with 32 women and girls, 15 healthcare providers and seven representatives from civil society organizations and non-governmental organizations.

Access to SRH information during the pandemic

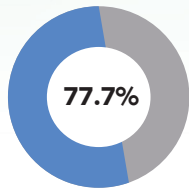
- Majority of respondents (women & girls) in Burkina Faso sought SRH information from their friends/peers (50.5%) and the parents (31.1%). About one-quarter of women and girls also reported getting information from their siblings (29.7%) and the internet (27.9%) (Figure 1).

Figure 1: Sources of SRH information for women and girls

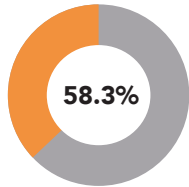


Access to SRH services during the pandemic

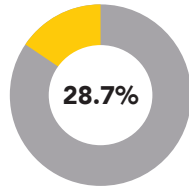
- Public and private health facilities faced stock-out challenges for SRH commodities, but this was worsened by the COVID-19 pandemic.



Needed contraceptives but could not access them within health facilities.



Took short acting contraceptives methods.



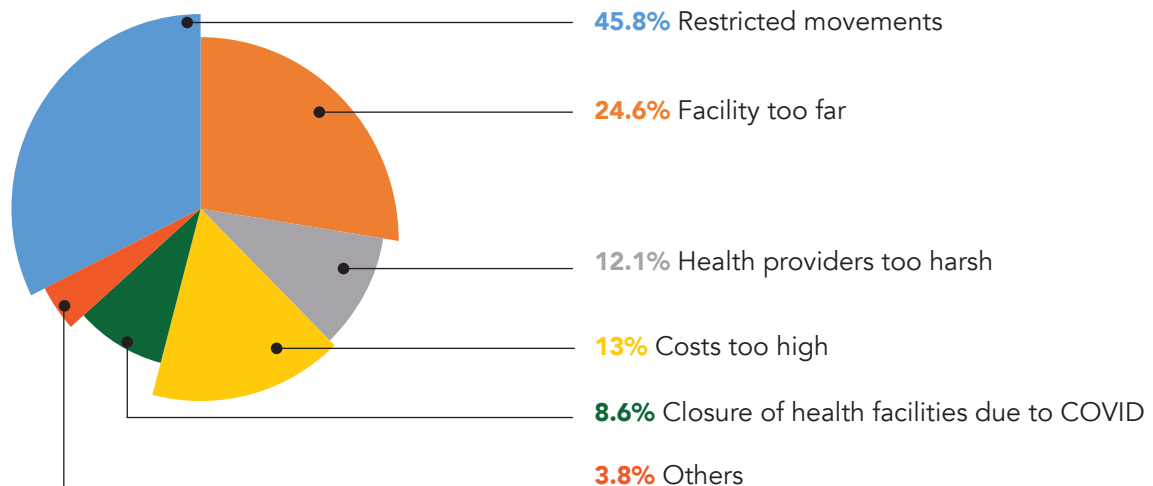
Took long-acting reversible contraceptives.

- 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. At times, contraceptives switch meant moving to less effective or no method at all.

Barriers to access of SRH services among women and girls

- Among women and girls who reported barriers to access, 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 (13.0%), and unfriendly health providers (12.1%) (Figure 2).
- Patients could not travel to health facilities due to lockdowns/curfews and a lack of public transportation. Sometimes, 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.

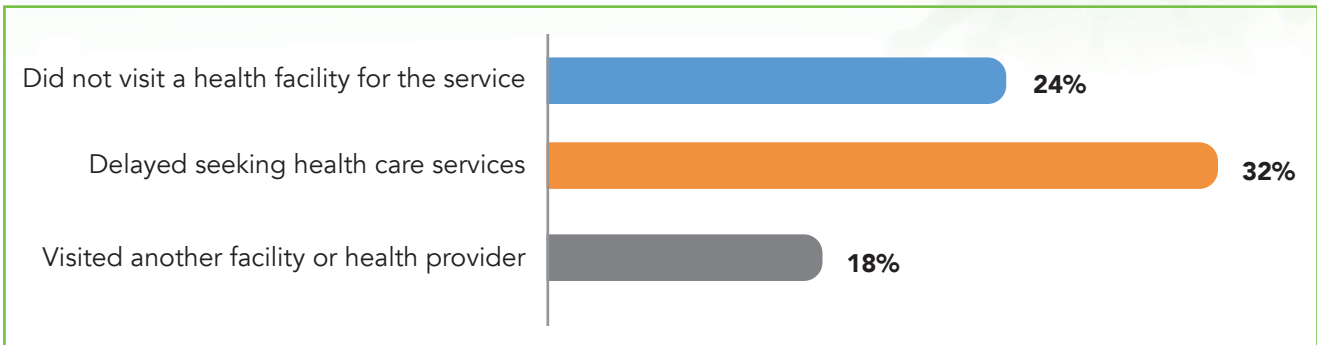
Figure 2: Percent of women who reported challenges accessing SRH services



Coping mechanisms to address barriers to accessing SRH

- 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 by women and girls dealing with barriers to accessing SRH services



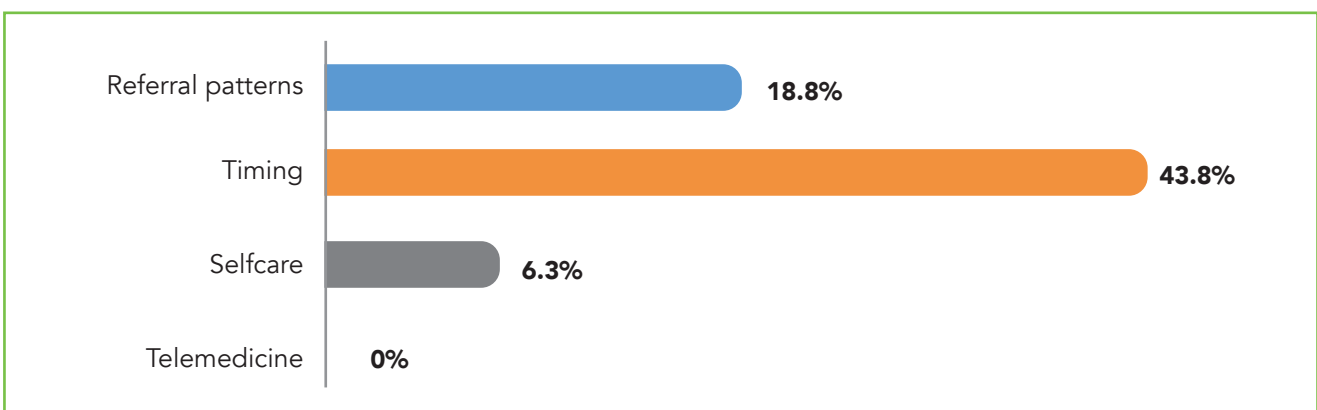
Availability of SRH Services

- Virtually all surveyed health facilities in Burkina Faso had at least one stocked MA medication at the time of data collection. About 71% of health facilities had either misoprostol or mifepristone alone, while only 11.3% had prepackaged combined mifepristone and misoprostol. About 28.6% reported they lacked mifepristone alone whereas 8.8% and 2.5% lacked implants and IUCDs respectively.
- 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 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 43.8% of health facilities in Burkina Faso adjusted service delivery timings (specific days and times for services) to ensure continuity of SRH services. About 18.8% of facilities altered referral patterns and 6.3% introduced self-care, and surprisingly, none had implemented telemedicine (Figure 4).
- About 96% of the facilities enforced social distancing, 95% had disinfection points, while 87.5% implemented sanitization. About 73.8% of health facilities had staff trained on COVID, 97% had providers supplied with PPEs. Majority of these changes in service delivery 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. 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 were 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.
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. The government 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 community health outreach and interventions to enhance access to health information and services.
5. Government should ensure sustainable and resilient supply chain management systems for SRH commodities for public and private health facilities.
6. Health facilities should institutionalize inclusive, continuous, consistent, and client-friendly training and sensitization of health providers in delivery of SRH services during pandemics.
7. 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.
8. Sexual and reproductive health funders and partners need to increase funding and support for SRH services, targeting resilience of supply chains and services during the crisis.

Authors

Emmy Igonya, Kenneth Juma, Beverly Musili, Japheth Ogol, Ruth Momanyi, Cynthia Odhiambo, Graham Nyaberi, Faith Mbehero, Dona Anyona

Acknowledgement

This research was made possible by a generous grant (No. 12103) to APHRC by the Swedish International Development Cooperation Agency. PP Global provided financial support for data collection in Kenya, Uganda, and Burkina Faso. The CRR 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.

See full report: APHRC, Amref Health Africa, CRR, Ipas Africa Alliance, NAYA, RHNK, PPG, 2021. Impacts of the COVID-19 Pandemic on Sexual and Reproductive Health Services in Burkina Faso, Ethiopia, Kenya, Malawi and Uganda. APHRC, Nairobi, Kenya