

Impact of COVID-19 Pandemic on Sexual and Reproductive Health Services in Kenya

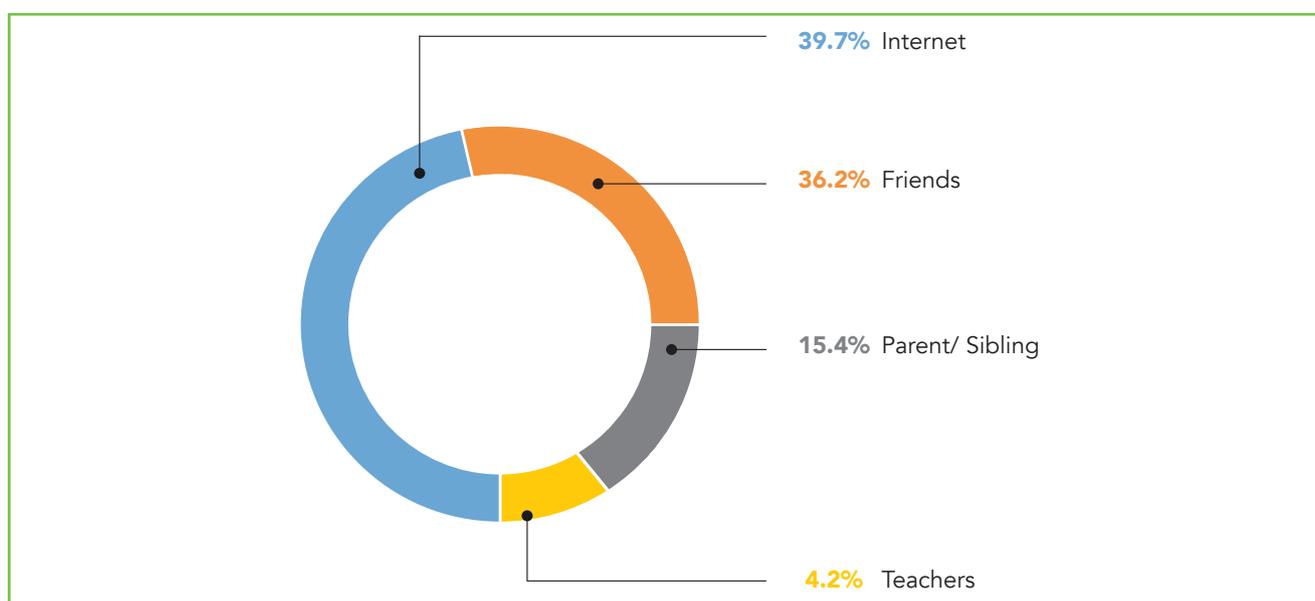
This brief summarizes evidence from a cross-sectional survey conducted in Kenya to document the impact of COVID-19 pandemic on sexual and reproductive health (SRH) services. Data were collected from 1816 women and girls from across 28 counties in Kenya, as well as from health providers in 223 health facilities. Further, we conducted in-depth interviews with 111 women and girls, 42 healthcare providers, six policy makers, and 19 representatives from civil society organizations and non-governmental organizations.

Key findings

Access to SRH information during COVID-19 pandemic

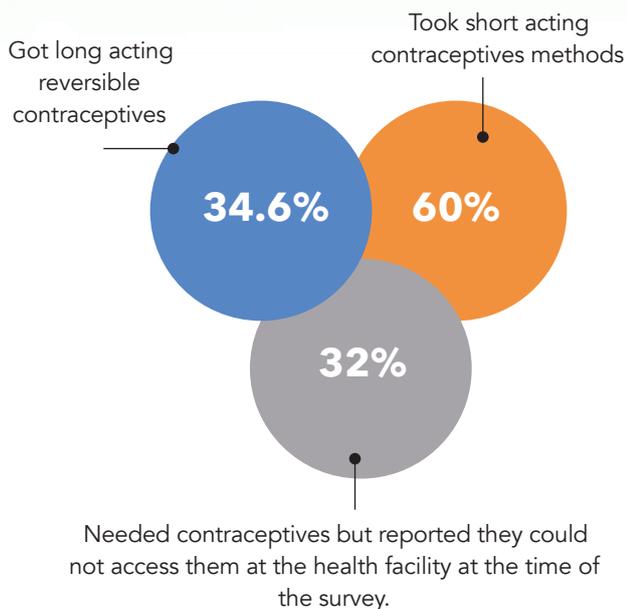
- Majority of respondents sought SRH information from the internet (40%) and from their friends/peers (36%) during the pandemic (Figure 1).

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



Access to SRH services during the pandemic

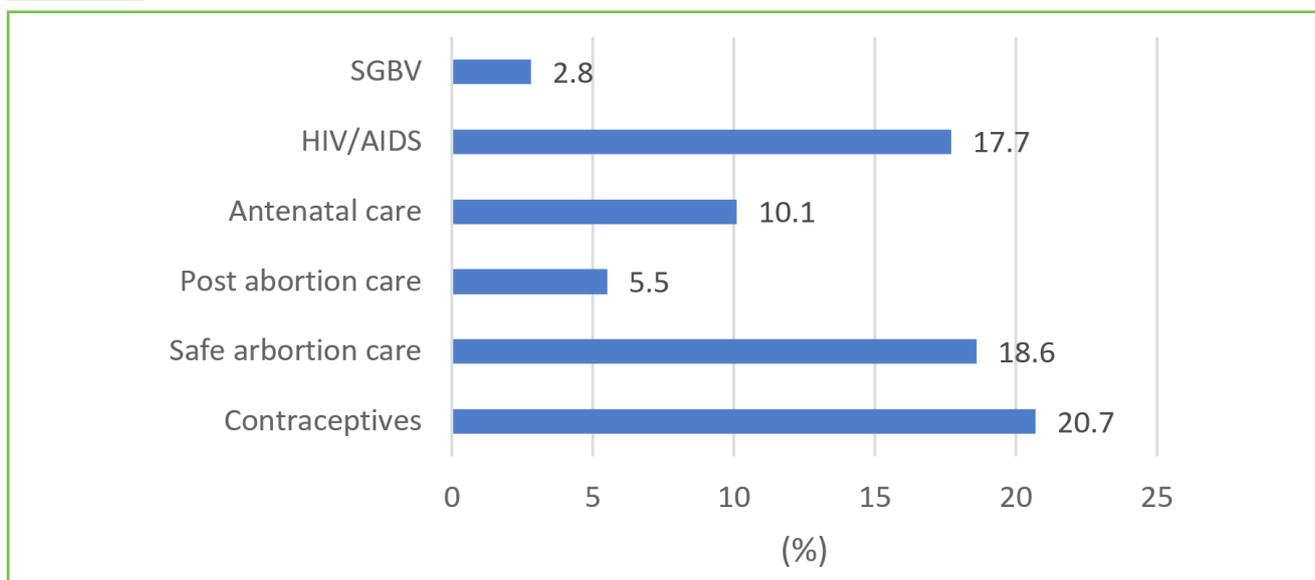
- Health providers influenced the choice of contraceptives by advising women to switch to “pandemic-friendly” contraceptive methods, sometimes based on government COVID-19 prevention guidelines. Switching of contraceptives sometimes meant moving to a less effective or no method at all, that could result in contraceptive failures and/or unintended pregnancies.



Barriers to SRH services

- Among women and girls who reported barriers, majority reported obstacles accessing contraceptives (20.7%), safe abortion care (18.6%), and HIV/AIDS services (17.7%) (Figure 2).
- The most commonly cited barriers were restriction in movements (e.g., curfew/lockdowns) (57.5%), long distance to facilities (21.3%), high cost of care (19.6%), and unfriendly health providers (5.7%) (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 clinics. 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, passed on the cost to their clients.

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

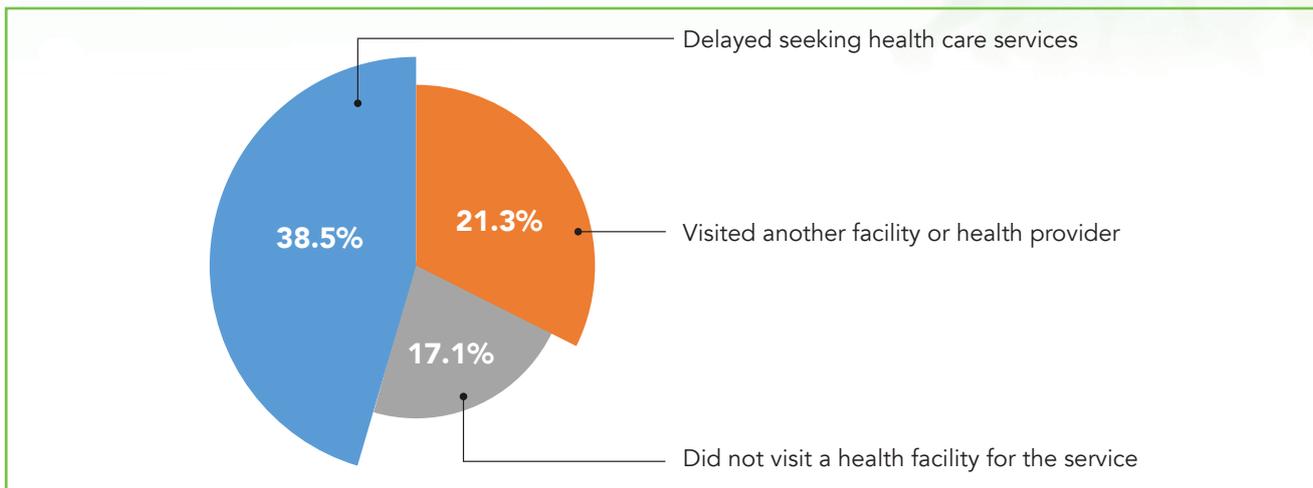


- COVID-19 confined parents and male partners at home, and women and girls often found it difficult to get to health facilities since they would have to explain to their parents/partners where they were going and why. This threatened their autonomy and privacy.

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 (Figure 3).
- Occasionally, women seeking delivery or antenatal services but faced curfews or had fears of contracting the Virus 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



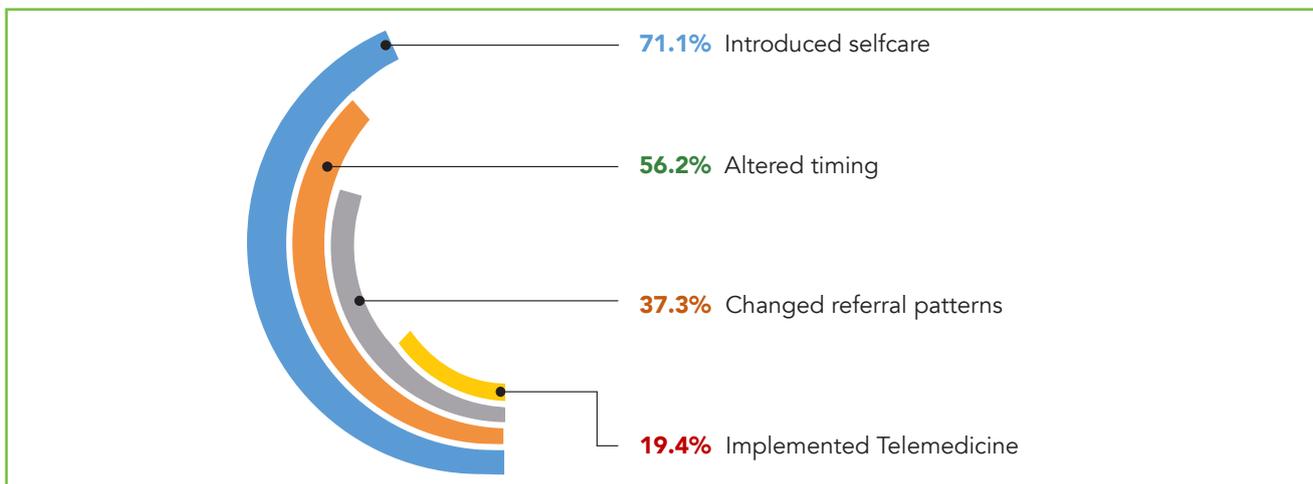
Availability of SRH Services

- Over 71% of health facilities reported Stock-out of prepackaged combined Mifepristone/ Misoprostol in the last 3 months. About 59% reported they lacked either Mifepristone or Misoprostol (alone) whereas 19% and 6% lacked implants and IUCDs respectively.
- Shortages of FP commodities was partly driven by the Pandemic. Lockdowns were implemented soon after COVID set in, however, it took time for the 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 brought on by COVID, and the ensuing barriers to access of SRH services, health facilities implemented several measures to ensure continuity of health services:
 - About 71.1% of health facilities in Kenya implemented self-care approaches to service delivery to ensure continuity of SRH services, while about 51.1% adjusted timings (specific days and times for services). One-third of facilities (37.3%) altered referral patterns and about one-fifth (19.4% implemented telemedicine (Figure 4).
 - About 96% of the facilities enforced sanitization, while 87% had disinfection points. About 77% of facilities had providers supplied with PPEs, and 66% had staff trained on COVID-19. 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. 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 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, 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. The Ministry of Health and Kenya as a whole ought to 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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