

THE EFFECTS OF COVID-19 ON SEXUAL AND REPRODUCTIVE HEALTH: A CASE STUDY OF SIX COUNTRIES

COVID-19 SITUATIONAL ANALYSIS PROJECT



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About this project

In July 2020, iMMAP launched the [Global COVID-19 Situation Analysis Project](#), funded by the Bureau of Humanitarian Assistance (BHA) of USAID. Implemented in Cox's Bazar, Bangladesh,1 Burkina Faso, Colombia, Democratic Republic of Congo, Nigeria, and Syria, this project has produced [monthly situation analysis](#) reports that provide humanitarian stakeholders with comprehensive information on the spread of COVID-19 and related humanitarian consequences. Data is identified from humanitarian sources and coded using the projects analytical framework, which is closely aligned with the JIAF framework. Data is stored in [DEEP](#) where it can be visualized, disaggregated and aggregated to respond to queries about humanitarian situations.

Based on Lessons Learned for the project, iMMAP commissioned a series of sector-specific lessons learned reports to assess data availability and quality, adaptations, challenges, opportunities that emerged in five humanitarian sectors: education, food security, livelihoods, protection, and water, sanitation and hygiene (WASH). Alongside this, seven thematic reports that focus on gaps in data were also commissioned.

The iMMAP Primary Data Collection exercises were contracted to RIWI and Premise under the supervision of iMMAP. Data collection was conducted remotely using digital data collection technologies that require a smart device and internet connection. All efforts were made to increase coverage of data collection, and weighting was applied, however the sample population may not be representative of the lowest socio-economic and marginalized groups

"This report is the result of a combination of primary and secondary data review exercises that cross-analyze a number of information sources. The views expressed herein do not necessarily reflect the views of USAID, the United States Government, the humanitarian clusters or any one of their individual sources."

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Abbreviations

| | |
|--------|--|
| ANC | Antenatal care |
| BAY | Borno, Adamawa and Yobe states (Nigeria) |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| CEFM | Child, early and forced marriage |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care |
| DRC | Democratic Republic of Congo |
| EmONC | Emergency Obstetric and Newborn Care |
| FGC | Female Genital Cutting / Female Genital Circumcision |
| FGM | Female Genital Mutilation |
| FP | Family planning |
| GBV | Gender-based violence |
| IUD | Intrauterine devices |
| LARC | Long-Acting Reversible Contraceptives |
| LMIC | Low and Lower-Middle Income Country |
| PNC | Postnatal care |
| PPE | Personal protective equipment |
| RMNH | Reproductive, Maternal and Neonatal Health |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| STI | Sexually Transmitted Infections |
| TBA | Traditional Birth Attendant |
| WRA | Women of Reproductive Age |

Glossary

| | |
|-------------------------------------|--|
| Antenatal care | Antenatal care (ANC) refers to the care provided by skilled healthcare professionals to pregnant women and girls in order to ensure optimal health conditions for both mother and baby during pregnancy and birth. ANC is also referred to as 'pre-natal care', 'pregnancy care' and 'maternity care'. The aim of ANC is to identify high risk pregnancies; to prevent and manage pregnancy-related or concurrent diseases; and to promote health education. ¹ |
| EmONC | EmONC stands for Emergency Obstetric and Newborn Care and refers to health facilities' capacity to perform functions and services relating to obstetric and newborn care. Basic EmONC (BEmONC) refers to health facilities' capacity to perform the following: administer antibiotics, uterotonic drugs, and anticonvulsants; manual removal of placenta; removal of retained products of conception; assisted vaginal delivery; and neonatal resuscitation. Comprehensive EmONC (CEmONC) refers to health facilities' capacity to deliver the above services, as well as surgery (specifically caesarean sections) and blood transfusions. ² |
| Family planning | Family planning (FP) allows people to attain their desired number of children, if any, and to determine the timing and spacing of pregnancies. Family planning is achieved through the use of modern contraceptive methods and treatment of infertility. Modern methods of contraception include hormonal contraceptives, intrauterine devices, emergency contraception, and condoms. ³ |
| Maternal and neonatal health | Maternal and neonatal health (MNH) refers to the health of women and babies during pregnancy, childbirth, and the postnatal period. ⁴ |
| Neonate/ newborn | The neonatal period is the first 28 days of a child's life. This is the most vulnerable time for a child during which they are at the highest risk of dying. The terms 'neonate' and 'newborn' are used interchangeably in this report to refer to infants less than 28 days old. |
| Nulliparous | Nulliparous is the medical term for a woman who has never given birth either by choice or for any other reason. This term also applies to women who has had a miscarriage, stillbirth, or elective abortion but has never given birth to a live baby. |
| Postnatal care | Postnatal care (PNC) is defined as the care given to both mother and newborn baby immediately after birth (within 24 hours) and for the first six weeks (42 days), with the aim of ensuring optimum health for the mother and newborn. While the term 'post-partum' refers to issues pertaining to the mother, and 'postnatal' refers to those concerning the baby, these terms are often used interchangeably. The WHO recommends the use of the term 'postnatal' to refer to all issues pertaining to both |

¹ WHO (2016) WHO recommendation on antenatal care for a positive pregnancy experience, <https://www.who.int/publications/i/item/9789241549912>, Accessed: 30 August 2021

² WHO (2009) Monitoring emergency obstetric care: a Handbook, http://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf;jsessionid=4D59AF15A45E823C1FA9850C79DD78F7?sequence=1, Accessed: 22 August 2021

³ WHO (2021) Contraception, https://www.who.int/health-topics/contraception#tab=tab_1, Accessed: 31 August 2021

⁴ WHO (2021) Maternal Health, https://www.who.int/health-topics/maternal-health#tab=tab_1, Accessed: 17 August 2021

| | |
|---------------------------------------|---|
| | mother and baby within the first six weeks; this is the definition adopted for this report. ⁵ |
| Sexual and reproductive health | Sexual and reproductive health (SRH) is defined as the ability of people to a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. SRH for women and girls requires that they have access to accurate information about family planning and sexually transmitted infection (STI) prevention, and to the safe, affordable, and acceptable contraceptive method of their choice. ⁶ |
| Skilled assisted delivery | Skilled assisted delivery refers to births delivered in a health-facilities, or deliveries assisted by a healthcare professional (midwife, nurse, doctor) in a non-healthcare setting (e.g. the home). This is often referred to as 'assisted delivery'. For the purpose of this report, the term 'skilled delivery' does not include births which are assisted by traditional birth attendants (TBAs) or other practitioners who are not formally trained. |

⁵ WHO (2015) Postnatal Care for Mothers and Newborns, <https://www.who.int/docs/default-source/mca-documents/nbh/brief-postnatal-care-for-mothers-and-newborns-highlights-from-the-who-2013-guidelines.pdf>, Accessed: 30 August 2021

⁶ UNFPA (2021) Sexual & reproductive health, <https://www.unfpa.org/sexual-reproductive-health>, Accessed: 22 August 2021

Executive Summary

Global responses to the COVID-19 pandemic are intersecting with pre-existing pervasive sexual and reproductive health inequities which disproportionately impact vulnerable populations. While COVID-19 has a severe, and in some cases, devastating impact on health systems around the world, studies show that people whose human rights are least protected – including refugees, displaced peoples, conflict-affected populations, indigenous peoples, and those living in low-income settings – are likely to experience unique difficulties in accessing quality sexual and reproductive healthcare during a crisis. Studies of previous health crises, notably the Ebola epidemic in West Africa and the Zika epidemic in South America also indicate that where health systems lack resilience the indirect mortality effects (including maternal and neonatal mortality) of a public health crisis can be as significant as the direct mortality effects. While there appear to be no direct clinical outcomes among pregnant women due to COVID-19, initial projections anticipated that COVID-19 would inevitably cause a disruption of health services, with resources and personnel diverted from SRH to the public health emergency. Disruption of global pharmaceutical and medical supply chains were also predicted, which would cause bottlenecks and reduced commodities (including contraceptives, antenatal supplements, and sterile medical equipment essential for deliveries). Experts also anticipated that COVID-19 would have an impact on health-seeking behaviours, with fears of contracting COVID-19 preventing women from accessing family planning, antenatal care, skilled birth assistance, and other essential reproductive, maternal, and newborn health (RMNH) services.

This report reviews data from six focal countries – Bangladesh, Burkina Faso, Colombia, Democratic Republic of Congo (DRC), Nigeria and Syria in order to assess the impact of COVID-19 on sexual and reproductive health. Overall, across the six focal countries the data available suggests that there has been a reduction in access to **family planning counselling** and to **contraception access and use** in some settings – although not all. Family planning has been significantly impacted in Bangladesh (down 50 per cent), as has contraceptive access and use (down 35 per cent). Contraceptive access and use has also been negatively impacted in Colombia due to supply chain disruptions and the DRC due to access barriers. However, contraceptive use has increased in Burkina Faso since the beginning of the pandemic – particularly among nulliparous women (up 39 per cent) – indicating a preference by women to delay a first pregnancy. School closures have contributed to increased rates of child, early and forced marriage (CEFM) and **adolescent pregnancy** – particularly in the DRC, the northeast of Nigeria, and Syria. Consequently, there has been a rise in demand for safe **abortion**, which does not appear to be met, particularly in the DRC.

Overall, there appears to be a critical reduction in availability and uptake of antenatal care (ANC) in most of the focal countries, however there is limited data available. There has been a 31 per cent decrease in ANC visits in Bangladesh, and in Colombia, border closures have had a serious impact on Venezuelan migrant and refugee women's access to ANC. **Skilled assisted delivery** rates were initially affected in Nigeria and Syria at the beginning of the pandemic, however both have since improved. In Syria, the percentage of births attended by a skilled health professional is now at 95 per cent, which is 4 points higher than it was before the pandemic. In Bangladesh, there was a two-thirds reduction in skilled assisted delivery across the country, and it does not appear that this has

fully recovered in 2021. **Maternal mortality** figures are available for some contexts; however, it is not always clear whether the rates reflect all deaths of pregnant women (including those who died from COVID-19), or only deaths caused by pregnancy complications. There has been a significant increase in maternal mortality in Colombia and the DRC, however rates appear to have improved in Burkina Faso compared with pre-pandemic figures.

COVID-19 has caused significant **barriers to health access**, as well as changes in people's health-seeking behaviour. Across the six focal countries, one of the dominant barriers to health access during the pandemic has been a diversion of health resources towards the pandemic, and away from SRH services. This has led to a lack of adequate health facilities, shortages of medical equipment including PPE, and an insufficient number of healthcare professionals to meet population needs. In Bangladesh, 19 percent of people felt COVID-19 had reduced their access to healthcare, while 15 percent of people in Colombia felt the same. In Syria, this figure increases to 45 per cent, suggesting that the ongoing conflict has caused very poor resilience of the health system. Shortages of healthcare workers have been particularly pronounced in Nigeria, Burkina Faso and Syria due to illness, burnout, and targeted attacks on health services. Other access barriers that existed prior to COVID-19 have been exacerbated by the pandemic, including travel distance, cost of healthcare and transport to healthcare facilities, and insecurity caused by conflict. The past 18 months have also seen changes in people's **health-seeking behaviour**; in many contexts people appear to be avoiding attending health facilities – even for essential care purposes -- due to fears of contracting COVID-19. Contraceptive access, ANC visits, safe abortions and skilled assisted deliveries are essential forms of healthcare, and reductions in women seeking out these services is incredibly concerning.

This report also explores the significant gaps in **availability of RMNH data** in the six focal countries. Comprehensive and quality data is essential for RMNH and SRH decision-making. Without information on gaps in services, barriers to access, and numbers of people affected, government health ministries and humanitarian health clusters cannot meaningfully respond to the health emergency with targeted strategies and resources. Where data is contradictory and conflicting, such as in Bangladesh and Nigeria, governments and Health Clusters are unable to assess the true scale of the need for response. In contexts where there is no data, this problem is magnified because it can render the issues completely invisible. For example, good data in Burkina Faso on contraceptive access disguises a lack of data on ANC coverage, which can lead to an assumption that ANC coverage must be good if it isn't reported. Similarly, in Syria where deaths from other causes are being reported, maternal deaths can be rendered invisible.

1. Introduction

On 11 March 2020, the World Health Organisation (WHO) declared the novel coronavirus (COVID-19) outbreak a global pandemic. COVID-19 cases have since been recorded in every country in the world with a global total of 209 million confirmed cases to date, and 4.4 million confirmed deaths directly caused by the virus.⁷ In addition to the direct impacts of the pandemic, COVID-19 is having a severe, and in some cases, devastating impact on health systems around the world. Studies show that people whose human rights are least protected – including refugees, displaced peoples, conflict-affect populations, Indigenous peoples, and those living in low-income settings – are likely to experience unique difficulties in accessing healthcare during a crisis. Women and girls in particular are affected by humanitarian crises, particularly health emergencies, due to their reliance on health services for sexual, reproductive, and maternal health.

In July 2020, iMMAP initiated the COVID-19 Situational Analysis project. The project collects data generated by humanitarian actors and other stakeholders towards strengthening the information flow to humanitarian actors to enable informed decision-making in response to the COVID-19 pandemic in six focal countries: Bangladesh, Burkina Faso, Colombia, Democratic Republic of Congo (DRC), Nigeria and Syria. The COVID-19 Situation Analysis project uses the DEEP⁸ platform to code, aggregate, analyse and extract information for the six focal countries. A repository of secondary data for each country is now available on DEEP. iMMAP has identified several key topics to form the basis for Global Thematic Reports. The focus of this research project is to deliver the Global Thematic Report on the topic of Reproductive, Maternal and Neonatal Health (RMNH).

Following an initial scoping study of available data, the following research questions were defined for this project:

In the six focal countries,

- 1) How has COVID-19 impacted family planning, including contraceptive access and use, adolescent pregnancy, fertility rates, need for and access to safe abortion, and SRH education?
- 2) What has been the impact of COVID-19 on antenatal care, skilled assisted delivery, maternal health, and maternal mortality?
- 3) How has COVID-19 impacted access to health facilities for the purpose of seeking RMNH and SRH services? How has COVID-19 impacted people's health seeking behaviours in these areas?
- 4) To what extent has COVID-19 had an impact on the availability of quality RMNH data for informed decision-making by humanitarian actors?

This report answers these questions across six 'country snapshots' which examine each focal country in turn. Within each snapshot, there is an overview of the pre-COVID-19 RMNH context in the country, an examination of the impact of COVID-19 on RMNH outcomes, and an exploration of

⁷ WHO (2021) WHO Coronavirus (COVID-19) Dashboard, <https://covid19.who.int/>, Accessed: 22 August 2021

⁸ The DEEP platform is available at: <https://beta.thedeep.io/>

barriers to health access and changes to health-seeking behaviour caused or influenced by the pandemic. The fourth question is addressed to in Section 4.7 which evaluates the availability of quality RMNH data for decision-making across all six focal countries, highlighting commonalities and differences, and exploring the potential reasons for these.

This report first outlines the methodology undertaken for this project, including the steps taken in data collection and coding, before a literature review in Section 3 establishes the global context against which the findings from the six focal countries are set. The literature review explores global SRH gaps that existed prior to the pandemic; lessons learned from Ebola in West Africa and Zika in Latin America on the impact of public health emergencies on SRH service delivery and health outcomes; and explores the available data on the global impact of COVID-19 on SRH to date. Section 4 captures the country snapshots and addresses the research questions.

2. Methodology

The methods undertaken for this research comprised three key stages: the literature review, collecting and coding data from the DEEP platform, and analysis of data. The steps and processes involved at each stage are discussed in this section.

2.1 Literature Review

The purpose of the literature review is to establish the global context of the impact of COVID-19 on reproductive, maternal, and newborn health (RMNH). This will give meaning to the data collected from and about the humanitarian contexts in the six focal countries and allow broad comparisons to be drawn between the impact of COVID-19 on RMNH availability, access, quality, and data availability in humanitarian and non-humanitarian settings. Furthermore, by examining previous significant health events, including the Ebola pandemic in West and Central Africa and the Zika epidemic in South America, we are able to compare and analyse their impacts on RMNH against COVID-19's impacts. Research was conducted using a wide range of peer-reviewed journals and publications (including The Lancet, BMJ etc.), repositories for UN data and reports (including ReliefWeb and HumanitarianResponse.info), and Google searches for NGO and INGO reports. This research broadly canvasses the following areas:

- SRH and MNCH context globally pre-pandemic
- SRH and MNCH context in the six focal countries pre-pandemic
- Impact of COVID-19 on RMNH, SRHR, family planning, GBV and FGM globally
- Impact of Ebola on RMNH in West and Central Africa
- Impact of Zika on RMNH in South America

2.2 Data collection and coding

For each country, a DEEP export search was conducted using the following filters:

- "Health" OR "Protection"
AND
- "Adult Female (18 to 59 years old)" OR "Youth Female (12-17 years old)" OR "Children Female <18 years old" OR "Infants/Toddlers (<5 years old)"

The decision to include documents and reports coded as 'Protection' was taken for two main reasons. Firstly, female genital mutilation (FGM) – which affects women and girls in two of the focal countries (Burkina Faso and Nigeria) – falls under the remit of the Protection Cluster. FGM is arguably both a Protection and Health issue, given it can have significant SRH implications for women and girls.⁹ The second reason was to scope for data on child, early and forced marriage (CEFM), which is also addressed by the Protection Cluster. While CEFM is not directly a health issue, it is known to be

⁹ UNFPA (2019), 5 ways female genital mutilation undermines the health of women and girls, <https://www.unfpa.org/news/5-ways-female-genital-mutilation-undermines-health-women-and-girls>

a significant determining factor for adolescent pregnancy.¹⁰ Girls affected by CEFM have often had limited access to SRH education and therefore poor knowledge about family planning (FP) and contraception. This can lead to planned and unplanned pregnancies, which can have serious health implications for young adolescent girls. Early pregnancies are linked with increased childbirth complications, maternal deaths, unsafe abortion, and malnutrition.¹¹ Therefore, CEFM was included in the scoping study as an important contextual factor influencing RMNH in the focal countries.

Once the DEEP report for each country was exported and downloaded, keyword searches were conducted to identify the relevant documents included within each export. The keywords and acronyms used for searches were:

| | | | |
|----------------|-----------------------------|-----------|--------------|
| abortion | contraception | FP | perinatal |
| adolescent | delivery | labour | postnatal |
| ANC | HIV | lactating | pregnant |
| antenatal | family planning | maternal | reproductive |
| BEmONC | female genital circumcision | midwife | sexual |
| birth | Female genital cutting | mortality | SRH |
| breastfeeding | Female genital mutilation | neonatal | STI |
| CEmONC | FGC | newborn | stillborn |
| child marriage | FGM | obstetric | |

Variants of the above terms were also included in the searches (e.g., ‘contraceptive’ and ‘contraception’). Searches were conducted in English for the Bangladesh, Nigeria, and Syria exports. Searches were conducted in English and Spanish for the Colombia export, and in English and French for the Burkina Faso and DRC exports. As a result of the keyword searches, 76 humanitarian reports and documents from DEEP were identified for inclusion in the data set, with the following breakdown:

Table 1: DEEP documents per focal country

| Focal Country | No. relevant reports/documents |
|----------------------|---------------------------------------|
| Bangladesh | 10 (English) |
| Burkina Faso | 22 (12 English, 10 French) |
| Colombia | 10 (7 Spanish, 3 English) |
| DRC | 16 (9 French, 5 English) |
| Nigeria | 11 (English) |
| Syria | 7 (English) |

The relevant French and Spanish documents (or relevant sections thereof) were translated into English using DEEPL, a free translation app. The details of relevant documents and reports captured in the above table can be found in [Annex 1](#).

All 76 documents were then uploaded into NVivo, a qualitative data analysis software programme, for coding and analysis. Documents were coded according to themes and sub-themes. Documents

¹⁰ Girls Not Brides (2021) Child marriage and health, <https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/>

¹¹ Girls Not Brides (2021) Adolescent pregnancy and child marriage, <https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/adolescent-pregnancy-and-child-marriage/>

that did not register the relevant codes were excluded from the dataset, taking the total documents to 42. The breakdown of the number of DEEP sources that registered relevant codes is presented in Section 4.7. The rationale for choosing these themes was based on the frequency of results during the keyword search of the DEEP exports. Terms that registered no keyword search results were excluded from coding (e.g., 'female genital circumcision'), and similar terms were grouped together under one theme (e.g., birth, delivery, labour). The themes and subthemes for coding were:

| | | |
|-------------------------|-----------------------------------|----------------------|
| antenatal care | Health facilities | Maternal |
| breastfeeding/lactating | - access | - maternal health |
| CEFM | - resourcing, supplies, personnel | - maternal mortality |
| - adolescent pregnancy | - Health seeking behaviour | - pregnancy |
| family planning | - BEmONC/CEmONC | reproductive health |
| - abortion | infant | sexual health |
| - contraception | - neonatal/newborn health | - STIs |
| - fertility | - neonatal mortality | - HIV |
| FGM | - stillborn | SRH |

2.3 Data Analysis

During the scoping study for this research, preliminary findings were analysed with two main considerations – quantitative (number of codes against each theme per country) and qualitative (quality, robustness, and richness of data at each code). In some cases, the themes with the greatest number of codes also pointed to the areas which had the most comprehensive research and data available to tell a story about the impact of COVID-19 on RMNH in the country. However, this was not always the case – for example, Nigeria registered a number of codes for FP, yet the majority of these were ‘weak positives’ – constituting a passing reference to the theme, rather than substantive commentary or figures. As a result of preliminary data analysis, dominant themes were identified for each focal country. These are provided below together with a summary analysis of the types and quality of information available.

Table 2: Dominant themes per focal country

| Focal Country | Dominant themes | Summary analysis |
|---------------------|---|--|
| Bangladesh | Maternal health, labour/delivery, skilled assisted delivery, neonatal mortality, breastfeeding/lactating | Primarily focused on access to ANC and skilled delivery. Minimal quantitative data available, although some maternal mortality figures. Good deal of information about breastfeeding/lactating, however this is all in the context of Nutrition. Overall, poor availability of data. |
| Burkina Faso | CEFM, adolescent pregnancy, contraception access and FP, fertility rates, access to healthcare, health-seeking behaviour, FGM, HIV, Ebola | Good amount of qualitative and quantitative information was available for Burkina Faso, as well as some quantitative data. Qualitative data related to CEFM and adolescent pregnancy, access to healthcare and health-seeking behaviour, and FGM. Quantitative data related to access to contraceptives and to FP services and included a peer-reviewed journal article. |
| Colombia | Adolescent pregnancy, contraception access, unwanted pregnancy, and access to safe | Majority of information related to adolescent pregnancy, unwanted pregnancies, and access to safe abortion. |

| | | |
|----------------|---|--|
| | abortion, SRH education, access to health facilities for migrants, access to RMNH for migrants, maternal mortality, Zika | Qualitative data also available on migrants' access to healthcare facilities for antenatal care and skilled assisted delivery. |
| DRC | Adolescent pregnancy, unwanted pregnancy, and access to safe abortion contraception, CEFM, Health-seeking behaviour, access to health facilities, Ebola | Good data availability on adolescent pregnancy, contraceptive need and use, SRH education and safe abortion. Data also available on health-seeking behaviour and social stigma associated with COVID-19 infection. |
| Nigeria | Access to healthcare – including safe facilities, proximity, availability of healthcare workers, health-seeking behaviour, CEFM and reproductive choices, sexual health | Limited meaningful data availability for Nigeria – mostly summary-level with little detail and almost no quantitative information. |
| Syria | Access to healthcare – including safe facilities and availability of healthcare workers, contraception and FP, forced abortion | Limited quality information available for Syria. Majority of information available restricted to access to healthcare (not RMNH specific). Qualitative reports of forced abortion also featured. |

Figure 1: Number of focal countries registering RMNH theme

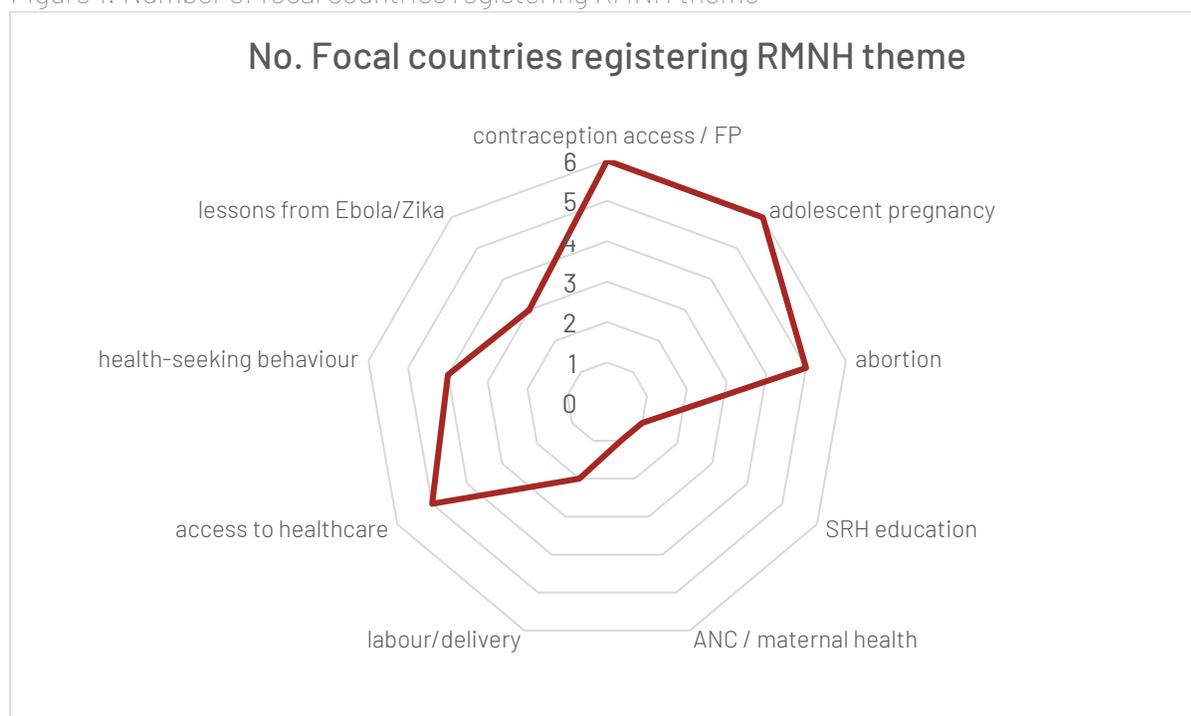


Figure 1 (above) illustrates the most frequently mentioned themes and sub-themes that were identified during scoping. Reflecting on the overlaps in the data and the potential stories that could be told from this research and following consultation and workshopping with iMMAP COVID-19 Situation Analysis Project team, the four research questions listed under Section 1 were identified for this project. The data for each focal country was contextualised against historical data available for each country in order to understand pre-COVID trends and draw conclusions as to the impact of the pandemic. Pre-pandemic data was drawn from peer-reviewed articles, and from humanitarian reports catalogued by ReliefWeb, HumanitarianResponse.info and other repositories. The DEEP

sources were also complemented by reports and data available on other platforms, including Health Cluster bulletins, Situation Analysis reports, and other updates; these were primarily sourced from ReliefWeb and HumanitarianResponse.info. **Figure 2** illustrates the breakdown of where data was sourced (DEEP versus other). Of the sources that were not located through the DEEP export of reports and documents, **Figure 3** illustrates the breakdown of where these were accessed from.

Figure 2: Breakdown of data by country, and by source (DEEP or non-DEEP)

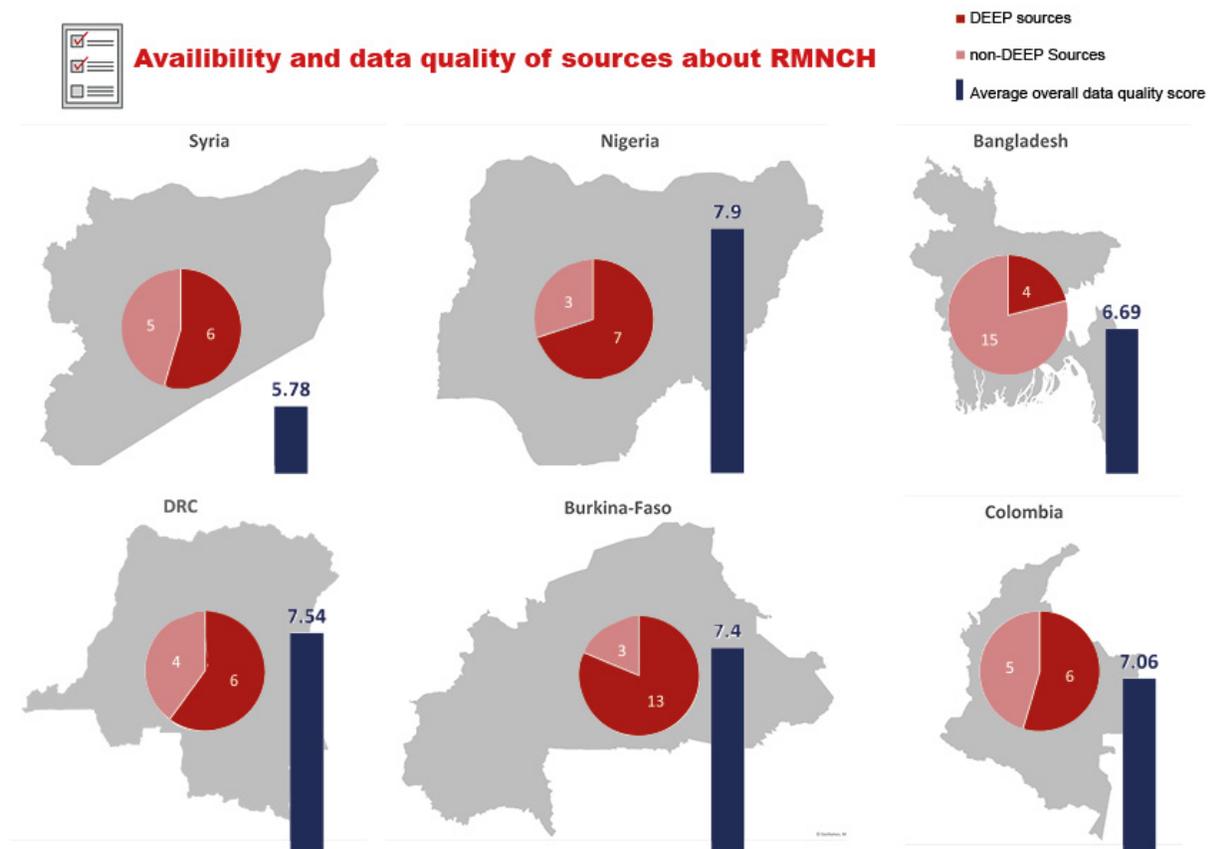
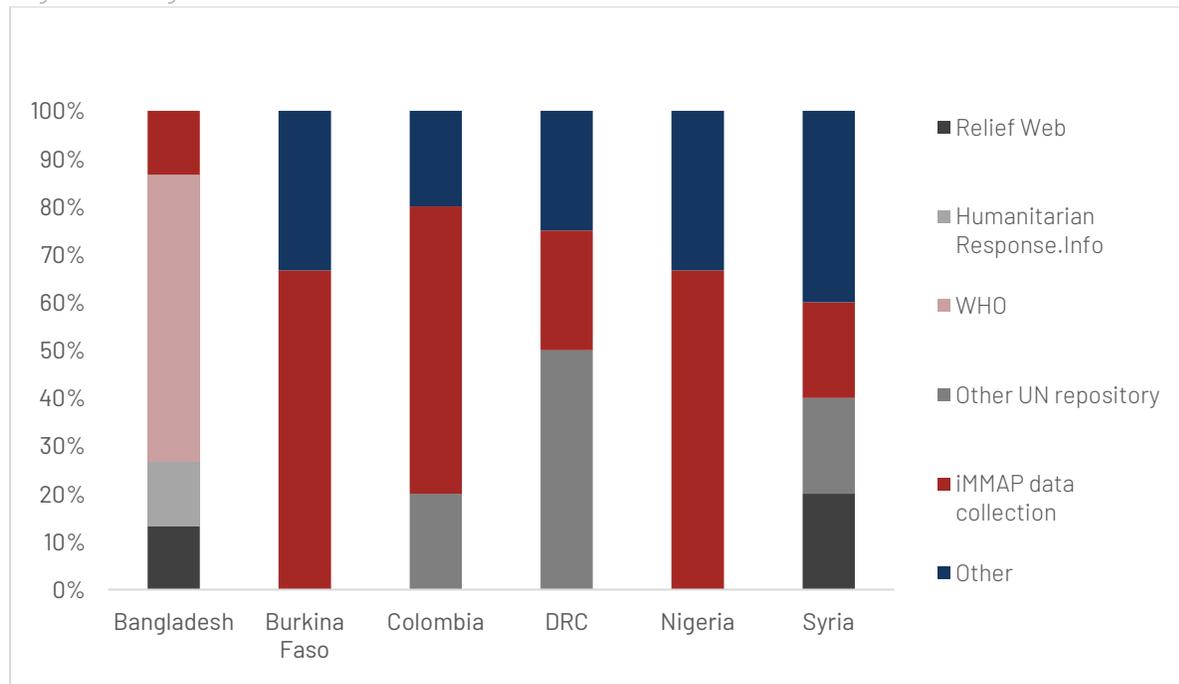


Figure 3: Origin of non-DEEP sources



3. Global context: COVID-19 and SRH

Global responses to the COVID-19 pandemic are intersecting with pre-existing pervasive sexual and reproductive health inequities which disproportionately impact vulnerable populations.¹² While COVID-19 is having a severe, and in some cases, devastating impact on health systems around the world, studies show that people whose human rights are least protected – including refugees, displaced peoples, conflict-affect populations, indigenous peoples, and those living in low-income settings – are likely to experience unique difficulties in accessing quality sexual and reproductive healthcare during a crisis.^{13 14 15} Studies of previous health crises, notably the Ebola epidemic in West Africa (2014-2016) and the Zika epidemic in South America (2015-2016), also indicate that where health systems lack resilience the indirect mortality effects (including maternal and neonatal mortality) of a public health crisis can be as significant as the direct mortality effects.^{16 17}

This section first establishes the global context of SRH prior to COVID-19 is established, before turning to an examination of the literature on SRH outcomes and lessons learned during the Ebola and Zika epidemics as potential indicators of how COVID-19 could impact the provision of SRH services in low resilience healthcare contexts. Finally, this section reviews the limited – although rapidly growing – body of literature available on the impacts of COVID-19 on SRH globally to date. This literature review aims to establish essential context against which the results of the analysis will be presented. While we cannot directly compare global pre-COVID-19 data with current information coming out of the humanitarian settings in the six focal countries, this information provides a broader background on the state of SRH globally to allow contextual understanding of the focal data. The context helps us to understand how progress in the areas of contraceptive access and safe abortion have been undermined, and what the potential SRH outcomes are for communities suffering from limited access to routine healthcare, antenatal care (ANC), postnatal care (PNC), FP, and reproductive health services, as well as safe abortion, skilled assisted delivery, and essential post-abortion and postpartum care.

3.1 Global SRH gaps pre-pandemic

Prior to the COVID-19 pandemic, there was a mixed picture of SRH globally. While evidence suggests that rates of unintended pregnancy have declined worldwide since 1990, with improved access to

¹² Stidham Hall, K., Samari, G., Garbers, A. et al (2020) Centring sexual and reproductive health and justice in the global COVID-19 response, *The Lancet*, 395, p.1175

¹³ Ibid

¹⁴ Kluge, H.H.P., Jakab, Z., Bartovic, J. et al. (2020) Refugee and migrant health in the COVID-19 response, *The Lancet*, 395, p.1238

¹⁵ Bateson, D.J., Lohr, P.A., Norman, W.V. et al (2020) The impact of COVID-19 on contraception and abortion care policy and practice: experiences from selected countries, *BMJ Sex Reprod Health*, 46, p. 241

¹⁶ Sochas L, Channon AA, Nam S. (2017) Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone, *Health Policy Plan*, 32:3, p. iii38

¹⁷ Roberton T, Carter ED, Chou VB, et al. (2020) Early estimates of the indirect effects of the coronavirus pandemic on maternal and child mortality in low- and middle-income countries, *Lancet Global Health*, 8(7), p.e901

and use of contraception likely contributing to these trends,¹⁸ the International Planned Parenthood Federation (IPPF) reports that the unmet need for contraception in 2019 was significant, estimating that 214 million women and girls were not using modern contraceptive methods despite wanting to avoid pregnancy.¹⁹ As a result of this, it is estimated that around 48 to 50 per cent of all pregnancies globally were unplanned.^{20 21} In 2019, only 55 per cent of sub-Saharan African women's need for contraception was met, leading to an unintended pregnancy rate of 91 per 1,000 women – the highest rate globally.²²

Unplanned pregnancies can have dire consequences for women, girls, and newborns. Consequences may include unsafe abortion, serious pregnancy complications, stillbirths, maternal mortality, and neonatal mortality.²³ In their study of safe abortion access in humanitarian contexts, McGinn and Casey found that nearly half of all abortions worldwide (of which there are approximately 56 million annually)²⁴ and 97 per cent of those in sub-Saharan Africa were unsafe.²⁵ Globally, almost all unsafe abortions occur in developing country contexts. The complications of unsafe abortion include haemorrhage, infection, sepsis, physical and psychological trauma, and maternal mortality.²⁶ The World Health Organisation estimates that between 5 and 13 per cent of maternal deaths can be attributed to unsafe abortion.²⁷

Approximately 140 million births take place globally every year, and the proportion attended by skilled health personnel has increased from 58 per cent to 81 per cent. This is credited to a greater number of births taking place in health facilities.²⁸ However, as of 2018, it is estimated that 830 mothers die daily from preventable causes, which equates to over 300,000 women per year. 94 per cent of all maternal deaths occur in low and lower middle-income countries (LMIC), and more than half occur in fragile and humanitarian settings.²⁹ In 2017, sub-Saharan Africa alone accounted for roughly two-thirds (196,000) of all maternal deaths.³⁰ Globally, there are significant gaps in ANC coverage. The WHO recommends a minimum of eight ANC visits to improve morbidity and mortality

¹⁸ Bearak, J., Popinchalk, A., Ganatra, B. et al (2020) Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, *Lancet Global Health*, 8, p.1152

¹⁹ IPPF (2020) Contraception and COVID-19: Disrupted supply and access, <https://www.ippf.org/blogs/contraception-and-covid-19-disrupted-supply-and-access>, Accessed: 7 August 2021

²⁰ Bearak et al, Unintended pregnancy and abortion, p.1154

²¹ Nanda, K., Lebetkin, E., Steiner, M.J. et al (2020) Contraception in the Era of COVID-19, *Global Health: Science and Practice*, 8:2, p. 166

²² Wood, S.N., Karp, C. and Olofinla, F. (2021) Need for and use of contraception by women before and during COVID-19 in four sub-Saharan African geographies: results from population-based national or regional cohort surveys, *Lancet Global Health*, 9, p. e794

²³ Nanda et al, Contraception in the Era of COVID-19, p. 166

²⁴ Wenham C., Arevalo A., Coast E., et al. (2019) Zika, abortion and health emergencies: a review of contemporary debates. *Global Health*, 15: 49, p. 3

²⁵ McGinn, T. and Casey, S.E. (2016) Why don't humanitarian organizations provide safe abortion services? *Conflict and Health*, 10:8, p.2

²⁶ WHO (2021) Abortion, https://www.who.int/health-topics/abortion#tab=tab_1, Accessed: 9 August 2021

²⁷ Ibid

²⁸ WHO (2021) Maternal Health, https://www.who.int/health-topics/maternal-health#tab=tab_1, Accessed: 17 August 2021

²⁹ Ibid

³⁰ WHO (2019) Maternal mortality, <https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality>, Accessed: 17 August 2021

outcomes, however only 64 per cent of women receive ANC consultations four or more times during their pregnancy.³¹

In humanitarian contexts pre-COVID-19, the situation was more dire still. Women and children account for a disproportionate morbidity burden among conflict affected populations, as they are heavily dependent on a functioning and responsive health system, and vulnerable to economic and societal disruption induced by conflict.³² A 1994 study found that beyond minimal ANC and delivery care, reproductive health services were rarely made available to refugees and internally displaced people (IDP).³³ While this has improved somewhat in the last 25 years – particularly in the areas of ANC, short-acting contraceptive methods, and HIV-prevention – studies have shown that there are still serious gaps in humanitarian SRH services, including post-abortion care, long-acting and permanent contraceptive methods, and HIV-treatment.³⁴ McGinn and Casey found that there is a greater risk of unsafe abortion in refugee and IDP camps due to limited access to safe abortion in humanitarian settings because of donor politics and NGO conservatism.³⁵ Studies have also documented more obstetric problems among refugees compared with local populations; refugee women experienced severe and more frequent illnesses and complications during pregnancy³⁶ which can be largely attributed to insufficient ANC, poor nutrition, and unsanitary and cramped conditions.

3.2 Lessons from Ebola and Zika

Previous public health emergencies have shown that epidemics cause serious and long-lasting impacts on sexual and reproductive health access and outcomes, with reduced access to family planning, contraception, safe abortion, post-abortion care, HIV-treatment, ANC, and postnatal care (PNC). Studies have also shown that during humanitarian crises, rates of unintended pregnancies, unsafe abortions, sexually transmitted infections (STIs), pregnancy and obstetric complications, miscarriage, stillbirth, and maternal and newborn mortality all increase.³⁷ The literature suggests that these outcomes can stem from three key causes: decreased availability of and access to quality SRH, changes in people’s health-seeking behaviour, and direct impacts of certain viruses on pregnancy outcomes.

³¹ Profamilia (2020) Desigualdades en salud de la población migrante y refugiada Venezolana en Colombia, <https://www.profamilia.org.co/wp-content/uploads/2020/04/Desigualdades-en-salud-de-la-poblacion-migrante-y-refugiada-venezolana-en-Colombia-Como-manejar-la-respuesta-local-dentro-de-la-emergencia-humanitaria.pdf>, Accessed: 16 August 21, p.55

³² DeJong, J., Ghattas, H., Bashour, H. et al (2017) Reproductive, maternal, neonatal and child health in conflict: a case study on Syria using Countdown indicators, *BMJ Global Health*, 2, p.1

³³ McGinn T. (2000) Reproductive health of war-affected populations: what do we know? *International Family Planning Perspectives*, 26

³⁴ McGinn et al, Why don't humanitarian organizations provide safe abortion services?, p.2

³⁵ Ibid

³⁶ McGinn, Reproductive health of war-affected populations

³⁷ Stidham Hall et al, Centring sexual and reproductive health and justice, p.1176

The Ebola virus epidemic in West Africa resulted in 11,300 direct deaths across Guinea, Liberia and Sierra Leone between December 2013 and January 2016.³⁸ There were, however, further deaths as an indirect result of the epidemic. Studies indicate that the epidemic caused decreased utilization of health services by around 50 per cent, which is linked to an excess 2,800 deaths from malaria, HIV/AIDs and tuberculosis, as well as a collective estimated total of 3,600–4,900 maternal, neonatal and stillbirth deaths during the first year of the epidemic.³⁹ Access to SRH services was impacted by a number of factors as these resources were diverted to the emergency response. Health-facilities were converted to Ebola-dedicated quarantine and treatment facilities, and healthcare staff were stretched beyond capacity to deliver ANC, facility delivery, PNC and especially contraceptive counselling and FP. Health workers may also have lacked appropriate personal protective equipment (PPE) to provide an adequate range of health services, and frontline health workers (who were predominantly women) were at higher risk of infection – leading to human resource shortages when healthcare workers were ill or quarantining.^{40 41} The Zika virus epidemic demonstrated that in times of crises, health resources are concentrated towards the emergency, which lead to a reduction in resources allocated to sexual and reproductive health and to preventative SRH education programmes.⁴²

Health-seeking behaviour is also impacted by epidemics. A number of studies indicate that there was a marked reduction in people seeking health treatment during the Ebola outbreak due to fear of contracting Ebola at the health facilities, distrust of the health system, and rumours about the source of the disease.⁴³ During Ebola, maternal mortality increased by an estimated 75 per cent as resources were diverted to the outbreak response and because fear of contracting Ebola deterred women from attending ANC appointments and giving birth in hospitals; the number of women giving birth in health facilities during Ebola dropped by approximately 30 per cent.⁴⁴ Health-seeking behaviour is often gendered, with women’s access to healthcare facilities often determined by their husbands, or male heads of households. During the Zika virus outbreak, studies show that women did not have autonomy over their sexual and reproductive health, with husbands denying permission for them to access health facilities. This was further compounded by women’s insufficient independent financial resources which would allow them to travel to healthcare facilities.⁴⁵ However, this was not the case universally, as findings from the early stages of the Zika epidemic in Brazil show that many women were able to access contraceptives for the first time or switch to a more effective form.⁴⁶ Other social determinants of health outcomes were affected during the Ebola epidemic. School closures deprive girls of a protective environment, which can lead to increased risk of sexual violence, sexual exploitation, CEFM and adolescent pregnancy. School closures can

³⁸ Sochas et al, Counting indirect crisis-related deaths, p. iii33

³⁹ Ibid

⁴⁰ Hussein, J. (2020) COVID-19: What implications for sexual and reproductive health and rights globally?, *Sexual and Reproductive Health Matters*, 28:1, p. 2

⁴¹ Wenham, C., Smith, J., Morgan, R. (2020) COVID-19: the gendered impacts of the outbreak, *The Lancet*, 395, p. 847

⁴² CEPAL (2020) Los riesgos de la pandemia de COVID-19, p.2

⁴³ Roberton et al, Early estimates of the indirect effects of the coronavirus pandemic, p. 902

⁴⁴ Plan International (2020) COVID-19 and Child Marriage in West and Central Africa, Dakar: Senegal, p.4

⁴⁵ Wenham et al, COVID-19: the gendered impacts of the outbreak, p. 847

⁴⁶ Karp et al, Contraceptive dynamics during COVID-19 in sub-Saharan Africa, p.7

also deprive girls of essential SRH education. In Sierra Leone, school closures during the Ebola outbreak contributed to a doubling of cases of adolescent pregnancy to 14,000.⁴⁷

A further impact on healthcare access was that pregnant women and newborns were reportedly denied care as providers were concerned about contracting Ebola from those with unknown Ebola status.⁴⁸ Overall, studies estimate that during Ebola, ANC decreased by 22 percentage points, family planning coverage decreased by 6 percentage points, facility delivery decreased by 8 percentage points, and PNC decreased by 13 percentage points.⁴⁹ Poor access to FP services during Ebola is estimated to have resulted in 1.2 million unplanned pregnancies.⁵⁰ Finally, previous public health emergencies have also demonstrated that viruses can have direct impacts on SRH. Zika, Middle East Respiratory Syndrome (MERS), and Severe Acute Respiratory Syndrome (SARS) are all known to cause adverse pregnancy outcomes including miscarriage, prematurity, foetal growth restriction, birth defects, and maternal and neonatal mortality.^{51 52}

The impacts of past public health crises provide us with potential indicators of what the effects of the COVID-19 pandemic on SRH could include. In terms of long-term impacts, the results are mixed – some studies indicate that post-Ebola SRH access returned to pre-epidemic levels within 6 months, while others suggest that ANC visits and facility deliveries took significantly longer to recover – particularly in Guinea which had the least resilient healthcare system.⁵³ With COVID-19, we can project a similar disparity in recovery times, with high and middle income contexts likely bouncing back quicker, and LMICs and humanitarian contexts suffering from poor SRH access long after the pandemic passes. However, studies show it is not all bad news. Hussein argues that epidemics have the capacity to shape broader discourse about SRH and the gendered impacts of health crises. In Latin America, the Zika epidemic sparked an important debate on the need to extend abortion laws to protect women’s rights to safe abortion.⁵⁴ Currently discussion about the impact of COVID-19 on SRH has the potential to shape future action on resilience and access in humanitarian contexts.

3.3 Global impact of COVID-19 on SRH

At the time of writing, there have been over 222 million confirmed cases of COVID-19, and 4.5 million deaths.⁵⁵ As early as March 2020, UN bodies, INGOs, and SRH experts have been advising of the specific gendered threats that the pandemic presents to women and girls globally, and especially to

⁴⁷ Plan International, COVID-19 and Child Marriage in West and Central Africa, p.3

⁴⁸ Sochas et al, Counting indirect crisis-related deaths, p. iii33

⁴⁹ Robertson et al, Early estimates of the indirect effects of the coronavirus pandemic, p. 902

⁵⁰ Burkina24 (2021) Gestion du COVI-19 au Burkina Faso: Investir dans la planification familiale, <https://www.burkina24.com/2021/01/06/gestion-du-covid-19-au-burkina-faso-investir-dans-la-planification-familiale/>, Accessed 15 August 2021

⁵¹ Hussein, COVID-19: What implications for sexual and reproductive health and rights globally?, p. 2

⁵² WHO (2021) Zika virus, <https://www.who.int/news-room/fact-sheets/detail/zika-virus>, Accessed: 9 August 2021

⁵³ Riley, T., Sully, E., Ahmed, Z. et al (2020) Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries, *International Perspectives on Sexual and Reproductive Health*, 46, p. 73

⁵⁴ Hussein, J. (2020) COVID-19: What implications for sexual and reproductive health and rights globally?, p. 2

⁵⁵ WHO (2021) WHO Coronavirus (COVID-19) Dashboard, <https://covid19.who.int/>, Accessed: 10 September 2021

those in low-income, humanitarian, and conflict contexts. In April 2020, UNFPA reported that the pandemic had already critically undermined progress made towards achieving the Sustainable Development Goals (SDGs) that relate to FP, and ending gender-based violence, FGM, and CEFM.⁵⁶ This sub-section will examine evidence and data available on the impact of COVID-19 on SRH globally to date and will explore causal factors that have been observed in various settings. This information will provide a crucial context against which data and findings from the six focal countries will be set.

Significantly, there appear to be no direct clinical outcomes among pregnant women due to COVID-19. While pregnant women are at risk of contradicting COVID-19, and morbidity and mortality of mothers have increased by virtue of the global infection and mortality rates, clinic outcomes are similar to non-pregnant adults.⁵⁷ There is limited data available to date, however, and more studies are needed in order to confirm the initial reports. While there does not appear to be significant clinical outcomes for neonates based on their mother's COVID-19 status, one study has identified intrauterine vertical transmission of COVID-19 from mother to child. This occurred in 3 cases out of a study of 33 neonates born to mothers in China who had contracted COVID-19 in their third trimester.⁵⁸ This study should be replicated with a greater sample size across a variety of contexts – and should also examine the impact on transmission during the first and second trimesters, as viral infections during pregnancy are typically most severe during the first 20 weeks of gestation.⁵⁹

Initial projections anticipated that COVID-19 would inevitably cause a disruption of health services, with resources and personnel diverted from SRH to the public health emergency.⁶⁰ ⁶¹ It was anticipated that the pandemic would cause a restructuring of health systems in many contexts and could result in the closure of 'peripheral' health facilities, or the re-purposing of these to be used exclusively for COVID-19 quarantine and care. A lack of healthcare workers available for SRH services was also projected due to personnel being diverted to COVID-19 activities, or due to illness, death, quarantine, or burnout. Disruption of global pharmaceutical and medical supply chains were also predicted, which would cause bottlenecks and reduced commodities (including contraceptives, antenatal supplements, and sterile medical equipment essential for deliveries). This would inevitably impact countries with low buying power (low income, conflict-affected etc.) the most.⁶² According to UNFPA, as many as 47 million women around the world may have experienced restricted access to modern contraceptives in the first half of 2020; this could result in up to 7 million unplanned pregnancies.⁶³ Experts also anticipated that COVID-19 would have an impact on health-seeking behaviours. Hussein explains that pre-pandemic, clinic appointments in LMICs were

⁵⁶ UNFPA (2020) Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage Interim Technical Note, https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf, Accessed: 7 August 2021, p. 1

⁵⁷ Stidham Hall et al, Centring sexual and reproductive health and justice, p.1176

⁵⁸ Zeng, L. Xia S, Yuan W, et al. (2020) Neonatal early-onset infection with SARS-CoV-2 in 33 neonates born to mothers with COVID-19 in Wuhan, China, *JAMA Pediatrics*, 174:7

⁵⁹ Stidham Hall et al, Centring sexual and reproductive health and justice, p.1176

⁶⁰ Pfitzer, A., Lathrop, E., Bodenheimer, A. et al (2020) Opportunities and Challenges of Delivering Postabortion Care and Postpartum Family Planning During the COVID-19 Pandemic, *Global Health: Science and Practice*, 8:3, p. 335

⁶¹ Stidham Hall et al, Centring sexual and reproductive health and justice, p.1176

⁶² Robertson et al, Early estimates of the indirect effects of the coronavirus pandemic, p. e902-904

⁶³ Plan International, COVID-19 and Child Marriage in West and Central Africa, p. 4

already rare, with people waiting hours in crowded clinics to access care.⁶⁴ Fears about contracting COVID-19 at health facilities are causing women to refrain from visiting health facilities, while home isolation and movement restrictions are also deterring women from accessing SRH services under the belief that family planning and ANC visits are not essential. Telehealth services have been recommended by experts.⁶⁵ However, there are extreme barriers to access in low resilience and humanitarian contexts.

Projections also indicated that COVID-19 would cause an increase in risk-factors that cause women and girls to require greater access to SRH services. In April 2020, UNFPA projected that a year of lockdown and deferred CEFM programming would lead to an estimated 7.4 million child marriages that would otherwise have been prevented between 2020 and 2030, as well as an additional 5.6 million child marriages likely to take place between 2020 and 2030.⁶⁶ CEFM is known to be a significant determining factor for adolescent pregnancy.⁶⁷ Girls affected by CEFM have often had limited access to SRH education and therefore poor knowledge about (FP) and contraception. This can lead to planned and unplanned pregnancies, which can have serious health implications for young adolescent girls. Early pregnancies are linked with increased childbirth complications, maternal deaths, unsafe abortion, and malnutrition.⁶⁸ Other risk-factors include stay-at-home orders (sometimes referred to as lockdowns, home isolation or other similar terms) which have increased reports of intimate partner violence.⁶⁹ Without access to contraception, intimate partner violence (specifically rape – although, of course intimate partner violence and gender-based violence encompass a broad range of acts) can lead to unplanned pregnancy and thus a requirement for safe abortion, ANC, and skilled assisted delivery. UNFPA projected that for every 3 months that lockdowns continued, there would be an additional 15 million additional cases of gender-based violence (GBV).⁷⁰ Finally, UNFPA predicted that COVID-19 would have a significant impact on progress towards ending FGM, anticipating that due to disruptions in prevention programming 2 million FGM cases would occur over the next decade that would have otherwise been averted.⁷¹ FGM can have serious SRH implications for women and girls, including prolonged and obstructed labour.⁷²

Impact of COVID-19 on family planning, contraception, unplanned pregnancy, and unsafe abortions.

Globally, COVID-19 is having a severe impact on access to family planning and contraception. In many contexts, including sub-Saharan Africa and humanitarian settings, there were pre-existing

⁶⁴ Hussein, COVID-19: What implications for sexual and reproductive health and rights globally?, p. 1

⁶⁵ Nanda et al, Contraception in the Era of COVID-19

⁶⁶ UNFPA, Impact of the COVID-19 Pandemic, p. 5

⁶⁷ Girls Not Brides (2021) Child marriage and health, <https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/> Accessed: 9 August 2021

⁶⁸ Girls Not Brides (2021) Adolescent pregnancy and child marriage, <https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/adolescent-pregnancy-and-child-marriage/> Accessed: 9 August 2021

⁶⁹ Bateson et al, The impact of COVID-19 on contraception and abortion care policy and practice, p. 241

⁷⁰ UNFPA, Impact of the COVID-19 Pandemic, p. 2

⁷¹ Ibid

⁷² UNFPA (2019) 5 ways female genital mutilation undermines the health of women and girls, <https://www.unfpa.org/news/5-ways-female-genital-mutilation-undermines-health-women-and-girls>, Accessed: 9 August 2021

challenges in meeting women's contraceptive needs. Lockdown measures have caused major disruptions to contraception supply chains. IPPF reports that large manufacturers of contraceptives in Asia have been forced to halt production or operate at reduced capacity – with the world's largest condom producer, Malaysia's Karex Bhd which makes one in every five condoms globally, forced to suspend production in March 2020 which caused a significant global backlog in the supply chain.⁷³ In April 2020, IPPF also reported that production of intrauterine devices (IUDs) in India, which is a major global producer of the commodities, had come to a standstill.⁷⁴ Border closures and other restrictions have further disrupted the supply chain,⁷⁵ with shortages in many of the lowest-income countries.⁷⁶ Adding to this, the pandemic has influenced many women's fertility intentions and need for contraception due to unpredictable economic circumstances. This has increased demand for contraceptives globally.⁷⁷

Prior to the pandemic, 77 per cent of contraceptive needs were met globally. Projections indicate that this rate could drop to 71 per cent of needs met, with 60 million fewer contraceptive users due to COVID-19. Modelling projects that this may result in 15 million additional unintended pregnancies, leading to 28,000 additional maternal deaths.^{78 79} UNFPA estimates that an additional 47 million women in 114 LMICs experienced an unmet need for contraception in the first six months of the pandemic.⁸⁰ This estimate closely aligns with those of Pfitzer et al (additional 50 million women with unmet need for contraception)⁸¹ and Riley et al (additional 49 million women).⁸² In Latin America and the Caribbean, UNFPA projects that COVID-19 could represent a 5-year setback in the reduction of the adolescent fertility rate.⁸³ In addition to an unmet need for contraceptives, the diversion of resources to the pandemic, together with quarantine measures and mobility restrictions is causing a disruption in broader FP needs – including counselling on timing and spacing of births;^{84 85} the WHO currently recommends a 24-month interval between live birth until subsequent pregnancy.⁸⁶ An increase in unplanned pregnancies causes an increased demand for abortions, however restrictions on access to health facilities and skilled practitioners may lead to an increase in unsafe abortion.⁸⁷ Studies suggest that abortion is being considered a nonessential service in a number of countries, meaning that an estimated 10 per cent of women who would normally have access to safe abortion instead resorted to an unsafe method – leading to approximately 3.3 million additional unsafe

73 IPPF (2020) Contraception and COVID-19: Disrupted supply and access, <https://www.ippf.org/blogs/contraception-and-covid-19-disrupted-supply-and-access>, Accessed: 7 August 2021

74 Ibid

75 Ibid

76 UNFPA, Impact of the COVID-19 Pandemic, p. 1

77 Karp et al, Contraceptive dynamics during COVID-19 in sub-Saharan Africa, p.2

78 Wood et al, Need for and use of contraception by women before and during COVID-19, p. e793

79 Riley et al, Estimates of the Potential Impact of the COVID-19 Pandemic, p.75

80 UNFPA, Impact of the COVID-19 Pandemic p. 1

81 Pfitzer et al, Opportunities and Challenges of Delivering Postabortion Care, p. 340

82 Riley et al, Estimates of the Potential Impact of the COVID-19 Pandemic, p.75

83 CEPAL, Los riesgos de la pandemia de COVID-19, p.4

84 Ibid

85 Jhpiego (2020) COVID-19 Response: Country Knowledge Exchange Series – Continuity of Maternal, Newborn, and Child Health, Family Planning, and Reproductive Health Care in the Time of COVID-19, USAID, p. 45

86 Pfitzer et al, Opportunities and Challenges of Delivering Postabortion Care, p. 335

87 Bateson et al, The impact of COVID-19 on contraception and abortion care policy and practice, p. 242

abortions in LMICs within a year.⁸⁸ This 10 per cent shift to unsafe abortion is estimated to cause 1,000 additional maternal deaths during 2020.⁸⁹

Impact of COVID-19 on antenatal care, skilled assisted delivery, and maternal and neonatal mortality

Evidence suggests that routine and emergency maternal health services may be the hardest hit by COVID-19 as resources are diverted to addressing the pandemic.⁹⁰ The impact of this is being acutely felt across the world. Antenatal care, skilled assisted delivery, and life-saving procedures such as caesarean sections cannot be delayed or substituted with telehealth. Studies indicate that a 10 per cent decline in pregnancy and newborn care could equate to more than 1.7 million additional women experiencing major obstetric complications within a year,^{91 92} and 2.6 million additional newborns experiencing health complications.⁹³ Studies on the impact of COVID-19 on maternal and newborn mortality offer different results, suggesting that the data is not yet conclusive in this area. One study indicates that COVID-19-based disruptions will cause an additional 28,000 maternal deaths and additional 168,000 newborn deaths within a year.⁹⁴ However, another study suggested a rate of 56,700 additional maternal deaths and 115,700 infant deaths within a six-month period.⁹⁵ More research is needed in this area to clarify this data.

Maternal healthcare requires in-person access to health facilities and healthcare professionals. This puts pregnant women at increased risk of contracting COVID-19 because of their regular and prolonged contact with clinical settings where exposure to infection is higher with greater viral loads – particularly in LMIC experiencing PPE shortages.⁹⁶ Women who have to spend additional time recovering in hospital wards following delivery complications or caesarean sections are further at risk due to prolonged exposure.⁹⁷ Exposure to COVID-19 has obvious health implications for women however the extent of the risk is disputed. Some studies suggest that the risk of a severe case of COVID-19 during pregnancy is no greater than in nonpregnant women,⁹⁸ while studies from Latin America have drawn connections with increased risks of severe COVID-19 and maternal mortality.⁹⁹ Unfortunately, there is little data available on the risk of COVID-19 to pregnancy. Early data indicates that COVID-19 can cause foetal distress, pre-term delivery, and intrauterine virus transmission.^{100 101} Across Latin America and the Caribbean, studies show that there has been a decrease in SRH coverage, evidenced by a reduction in the number of ANC visits and health facility deliveries. Among

⁸⁸ Riley et al, Estimates of the Potential Impact of the COVID-19 Pandemic, p.74

⁸⁹ Ibid, p.75

⁹⁰ Hussein, COVID-19: What implications for sexual and reproductive health and rights globally?, p. 1

⁹¹ Riley et al, Estimates of the Potential Impact of the COVID-19 Pandemic, p.75

⁹² Pfitzer et al, Opportunities and Challenges of Delivering Postabortion Care, p.340

⁹³ Ibid

⁹⁴ Riley et al, Estimates of the Potential Impact of the COVID-19 Pandemic, p.75

⁹⁵ Robertson et al, Early estimates of the indirect effects of the coronavirus pandemic, p. e906

⁹⁶ Hussein, COVID-19: What implications for sexual and reproductive health and rights globally?, p. 1

⁹⁷ Ibid

⁹⁸ Stidham Hall et al, Centring sexual and reproductive health and justice, p. 1176

⁹⁹ CEPAL, Los riesgos de la pandemia, p.5

¹⁰⁰ Hussein, COVID-19: What implications for sexual and reproductive health and rights globally?, p. 1

¹⁰¹ Stidham Hall et al, Centring sexual and reproductive health and justice, p. 1176

the reasons for this are pregnant women's fear of attending health facilities for fear of contracting COVID, as well as a redeployment of healthcare personnel and resources away from SRH services towards addressing the pandemic.¹⁰²

It is against this backdrop that the data analysis from the six focal countries is presented in Section 4. Overall, it can be seen that prior to the COVID-19 pandemic, SRH access and outcomes in LMICs and humanitarian contexts were poorer than global averages. Recent improvements in access and outcomes threaten to be undermined by the pandemic, with data from the Ebola and Zika epidemics providing illustrative examples of how SRH services may be deprioritised while resources are dedicated to the emergency response. At the global level, impacts are already being seen – with a reduction in contraception access and use and an increase in unplanned pregnancies, and thus an increase in demand for safe abortion, ANC, and skilled assisted delivery.

¹⁰² CEPAL, *Los riesgos de la pandemia*, p.5

4. Analysis

Following a scoping study which reviewed available data from the six focal countries (see [Methodology](#) section), the following common issues were identified for discussion: family planning, access to and use of modern contraceptives, safe abortion, antenatal care, skilled assisted delivery, access to healthcare facilities, access to health resources (personnel and materials), and health-seeking behaviour. This section first provides an overview of the impacts of COVID-19 on RMNH outcomes, access to health, and changes in health-seeking behaviour across all six countries. Following this are the six country snapshots which examine the available data from each context. Each snapshot first provides pre-pandemic context before exploring the impacts of COVID-19. Finally, [Section 4.7](#) provides commentary on the availability of quality and reliable RMNH data for decision-making across the six focal countries, and highlights gaps and their implications for health outcomes.

Overall, across the six focal countries the data available suggests that there has been a reduction in access to family planning counselling and to contraception access and use in some settings – although not all. While the pandemic can be seen to cause an increase in demand for contraceptives, with economic instability causing women to want to delay first and subsequent pregnancies, in most contexts it appears that this demand is not being met. In a number of settings an unmet need for contraceptives, together with school closures and CEFM, is contributing to an increase in adolescent pregnancies. With an increase in unplanned pregnancies comes an increase in demand for safe abortion, which overstretched health services are unable to provide. As a result, data indicates that unsafe abortion rates may have increased in some settings. However, there has not been a reduction in need for and use of contraceptives in all contexts. Data from Burkina Faso, the DRC and Nigeria do not support the anticipated deleterious effect of COVID-19 on women’s access to the use of contraception in the earliest stages of the pandemic. Instead, the COVID-19 pandemic is associated with marginal increases in women’s need for and use of contraceptives in sub-Saharan.¹⁰³ However, country-level data appears to mask distinct patterns by sociodemographic groups – particularly nulliparous women. This will be explored in more detail in the country snapshots.

There is limited data available about access to ANC in the six focal countries since the beginning of the pandemic. Overall, there appears to be a critical reduction in availability and uptake of ANC in most of the focal countries, however the information available doesn’t disaggregate based on number of ANC visits or demographics. Similarly, there is not a great deal of data available on skilled assisted deliveries during the pandemic. While the rates of women giving birth in facilities and/or with the attendance of a skilled healthcare worker seem to certainly have reduced, the evidence currently available is typically anecdotal rather than quantitative, necessitating further dedicated data collection in this area. Maternal mortality figures are available for some contexts; however, it is not always clear whether the rates reflect all deaths of pregnant women (including those who died from COVID-19), or only deaths caused by pregnancy complications.

¹⁰³ Wood et al, Need for and use of contraception by women before and during COVID-19, p. e797

COVID-19 has caused significant barriers to health access, as well as changes in people's health-seeking behaviour. Across the six focal countries, one of the dominant barriers to health access during the pandemic has been a diversion of health resources towards the COVID-19 response, and away from SRH services. This has led to a lack of adequate health facilities, shortages of medical equipment including PPE, and an insufficient number of healthcare professionals to meet population needs. Other access barriers that existed prior to COVID-19 have been exacerbated by the pandemic, including travel distance, cost of healthcare and transport to healthcare facilities, and insecurity caused by conflict. The past 18 months have also seen changes in people's health-seeking behaviour; in many contexts people appear to be avoiding attending health facilities – even for essential care purposes – due to fears of contracting COVID-19. Contraceptive access, ANC visits, safe abortions and skilled assisted deliveries are essential forms of healthcare, and reductions in women seeking out these services is incredibly concerning.

In order to discuss health 'access', this term must first be defined. Access to health care is conceptualised in terms of the opportunity to seek and obtain health services. Penchansky and Thomas define five dimensions of access to health care: availability, accessibility, accommodation, affordability, and acceptability.¹⁰⁴ Availability refers to the supply of health workers, facilities, and services. In humanitarian contexts, availability can be curtailed or disrupted by the destruction or closure of health facilities, supply chain disruption, and a lack of qualified health personnel (due to attacks, kidnapping, insecurity, burn out or other). Accessibility refers to the distance that must be travelled to reach a health facility (considering travel time, modes of transportation typically available, and cost). During COVID-19, accessibility has been impacted due to lockdowns, movement restations, road closures, and checkpoints. Accommodation refers to the perception of appropriateness of the health facility (hours of operation etc.); in some contexts, where COVID-19 has caused a deficit of staff facilities have had to reduce their opening hours. Affordability refers to the cost of services and patients' ability to pay for these; in situations where households have lost income due to COVID-19 this has made healthcare unaffordable. Acceptability refers to any personal characteristics of the patient or health provider that may influence health-seeking behaviour (sex, ethnicity, religion, migratory status etc.).¹⁰⁵ This framework will be used in order to evaluate the impact that COVID-19 has had on SRH access in the six focal countries.

The main barriers to accessing healthcare identified in this report include lack of available SRH services in the area due to facilities being dedicated to the pandemic response or closed; insufficient healthcare workers due to COVID-19 infection and death, insecurity, and re-deployment to pandemic response; and disrupted supply chains for essential medicine and medical equipment. A number of countries have introduced movement restrictions as a result of COVID-19, including stay-at-home orders, lockdowns, and limitations on the distance from home that people are allowed to travel for essential purposes. Movement restrictions, stay-at-home orders, and border closures have had a serious impact on SRH access. Pre-existing barriers that have been exacerbated by the pandemic include long travel distances to health facilities and the cost of travel; pre-COVID, the

¹⁰⁴ Penchansky, R. and Thomas, J.W. (1981) The Concept of Access: Definition and relationship to Consumer Satisfaction, *Medical Care*, 19:2, p.128

¹⁰⁵ *Ibid*, p.128-9

World Bank estimated that, globally, maternal mortality rates would decrease by about 9 (from 56 per 100,000 at present) if the average travel time to the nearest healthcare facility were to decrease by even 20 minutes. Presumably the inverse of this would also be true – where travel time to facilities increase, maternal mortality rates would increase.

Other barriers that have been exacerbated by the pandemic include the cost of medical care during a period of economic precarity and lost income, and conflict and insecurity. While insecurity is not new in these contexts, nor caused by COVID-19, the access barriers caused by conflict and by the pandemic are intersecting in these settings, compounding vulnerabilities, and limiting healthcare coverage. The intersection of these crises means that women seeking SRH care may be unable to attend their nearest clinic because it has been converted into a COVID-dedicated facility and are unable to travel to a clinic in the next town over because roadblocks and attacks make the journey too dangerous. The double-impact of attacks and COVID-19 infections means that when women reach health facilities, there may be an insufficient amount of healthcare workers to provide comprehensive care.

4.1 Bangladesh

Pre-pandemic SRH context

Pre-pandemic, healthcare coverage at the country-level in Bangladesh was poor, with only 5.4 physicians and 3.4 nurses per 10,000 people.¹⁰⁶ Neonatal mortality accounted for 60 per cent of under-five mortality, and the country was not on track to reach the target of 75 per cent overall contraceptive use by 2022.¹⁰⁷ However, there have been some positive SRH developments at country-level – progress which is at risk of being undermined due to the pandemic. The proportion of women aged 15–49 that received ANC increased from 68 per cent in 2011 to an impressive 92 per cent in 2018.¹⁰⁸ Women receiving over four ANC consultations per pregnancy also increased from 31 per cent in 2014 to 47 per cent over the same time period.¹⁰⁹ Improved access to FP services and social protection services had also helped to reduce the national fertility rate from 3.0 in 2004 to 2.3 in 2017.¹¹⁰ In Cox’s Bazar, a 2019 report found that of the approximately 900,000 Rohingya refugees in the region, 30 per cent were women of reproductive age. Among pregnant women, 70 per cent were reportedly enrolled in an ANC programme – however a troubling 82 per cent of births in the last year had taken place at home rather than a health facility.¹¹¹ The location of births appeared to have a gendered dimension, with 53 per cent of households reporting that the primary decision maker on the location of delivery was the husband of the pregnant women. Reportedly, only 13 per cent of

¹⁰⁶ United Nations in Bangladesh (2020) Immediate Socio-economic Response Plan (ISERP), Dhaka: United Nations, 31 August 2020, p.22

¹⁰⁷ Ibid, p.23-24

¹⁰⁸ Ibid, p.22

¹⁰⁹ United Nations in Bangladesh (2020) Immediate Socio-economic Response Plan (ISERP), p.23

¹¹⁰ Ibid, p.25

¹¹¹ ISCG (2019) Joint Multi-Sector Needs Assessment – Bangladesh, Rohingya Refugees, August – September 2019, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/bgd_jmsna_refugee_fact_sheet_december_2019.pdf, Accessed: 22 August 2021, p10

pregnant women reportedly had the autonomy to be the primary decision-maker.¹¹² Access to healthcare also appeared to be impeded by high costs, with 53 per cent of households reporting that they had gone into debt in 2019 in order to pay for health expenditures,¹¹³ while 11 per cent had treated their illnesses and conditions at home rather than sought help at a clinic due to lack of money.¹¹⁴ The most common challenges for adolescents seeking healthcare in Cox's Bazar were long distances to facilities (33 per cent) and high cost of services (18 per cent).¹¹⁵

Impact of COVID-19 on RMNH outcomes

Evidence suggests that there has been a 50 per cent decline in utilisation of **FP** and **adolescent reproductive health services** in Bangladesh since the beginning of the pandemic.¹¹⁶ Between January and May 2020, use of the oral contraceptive pill dropped by over 35 per cent and condom use dropped by around 43 per cent.¹¹⁷ This is a worrying indicator due to the implications for unplanned pregnancies, timing and spacing of births, safe abortion needs, antenatal care needs and assisted delivery needs. When looking specifically at Cox's Bazar, a total of 64,143 women were using modern methods of **contraception** (including long-acting reversible contraceptives) as of August 2020,¹¹⁸ out of an approximate total of 258,000 women of reproductive age (WRA).¹¹⁹ This is roughly 25 per cent of women. Unfortunately, we do not have a clear pre-pandemic picture of contraceptive use in order to make a meaningful comparison, nor do we have data on the number of women who wished to be using contraceptives but did not have access.

The pandemic has had a severe impact on provision of **antenatal care**. United Nations Bangladesh reported in August 2020 that there had been a country-wide 31 per cent decrease in antenatal care visits by expectant mothers.¹²⁰ Prior to the pandemic, ANC coverage was reported at 92 per cent,¹²¹ making this decrease a significant disruption after many years of consistent progress in this area. Fortunately, this appears to be recovering in 2021, with January 2021 ANC and PNC service provision between 70 – 80 per cent of that provided in January 2020.¹²² Specific to the humanitarian context in Bangladesh, UNCHR reported in August 2020 that among Rohingya refugees in Cox's Bazar camps there had been a reduced uptake of antenatal care services;¹²³ four months later UNCHR reported that access to appropriate maternal and neonatal health care was still limited at various levels.¹²⁴

¹¹² Ibid

¹¹³ ISCG (2019) Joint Multi-Sector Needs Assessment – Cox's Bazar, Bangladesh, September 2019, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/bgd_report_2019_jmsna_host_community_december_2019_to_share_v3.pdf, Accessed: 22 August 2021, p18

¹¹⁴ Ibid

¹¹⁵ iMMAP (2021) COVID-19 Impact on Children: COVID-19 Situation Analysis – Bangladesh, May 2021, p.19

¹¹⁶ United Nations in Bangladesh, Immediate Socio-economic Response Plan (ISERP), p.22

¹¹⁷ Ibid, p.24

¹¹⁸ WHO Bangladesh (2020) Rohingya Crisis Situation Report #18, Week 32: 03-09 August, https://www.who.int/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/sitreps-2020/who-cox-s-bazar-sitrep-18.pdf?sfvrsn=7c9ddaf9_4%27 Accessed: 15 August 2021, p.6

¹¹⁹ Toulemonde, T. (2020) COVID-19 Outbreak: Cox's Bazar Rapid Gender Analysis, May 2020, ISCG Gender Hub, p.6

¹²⁰ United Nations in Bangladesh, Immediate Socio-economic Response Plan (ISERP), p. 22

¹²¹ Ibid

¹²² iMMAP (2021) COVID-19 Situation Analysis – Bangladesh, March 2021, p.28

¹²³ UNHCR (2020) Rohingya Refugee Response – Bangladesh, Factsheet – Public Health, 31 August 2020, p.1

¹²⁴ Ibid

Skilled assisted delivery rates in Bangladesh since the pandemic do not appear to be straightforward. At country-level, there was an extreme decline in facility deliveries at the beginning of 2020, with 78,259 facility deliveries in January 2020 down to 25,995 in May 2020.¹²⁵ This is a two-thirds reduction (67 per cent) in skilled assisted delivery across the country, suggesting that tens of thousands of women gave birth in May 2020 (and likely the surrounding months) outside of healthcare facilities and without the assistance of a midwife, doctor, or trained professional. It is unknown whether the situation has improved in 2021. In Cox's Bazar, rates of facility deliveries are contested. In June 2020, the WHO reported that 53.2 per cent of deliveries took place in a health facility,¹²⁶ however MedGlobal reports that this figure is closer to 90 per cent.¹²⁷ It is worth noting that these figures come from different organisations; their methodologies and sample population groups may have varied, leading to these drastically different figures. Overall, these data indicate a trend away from facility delivery since the beginning of the pandemic. According to the UNHCR Rohingya Refugee Response Dashboard December 2020, a cumulative total of 3,310 deliveries occurred in health facilities in 2020 – however the report does not provide percentage data to allow for direct comparison with the 2019 figure.¹²⁸ The only months for which there were directly comparable data on health facility deliveries were April 2020 and April 2021. UNHCR found that in April 2020, 972 births were attended by a skilled health worker.¹²⁹ In April 2021, over a year into the pandemic, 1,140 births were attended.¹³⁰ While it would be helpful to have April 2019 figures to tell a more comprehensive story, as well as percentages against total births, these two figures indicate that initial barriers to assisted delivery at the beginning of the pandemic (whether they were health sector capacity or health-seeking behaviour) lessened throughout 2020.

In the Cox's Bazar camps in Bangladesh, WHO reports that there have been 74 probable **maternal deaths** in 2021 to date, 19 of which occurred in facilities and were referred for review by Maternal and Perinatal Mortality Surveillance Response (MPMSR).¹³¹ Unfortunately, maternal mortality figures were not recorded in the WHO's Situation Reports for 2020 or 2019 to allow for comparisons.

Impact of COVID-19 on access to health and health-seeking behaviour

Data indicates that many countries with already underperforming health systems have been severely impacted by COVID-19; inadequate funding and resourcing left many countries ill-prepared

¹²⁵ United Nations in Bangladesh, Immediate Socio-economic Response Plan (ISERP), p. 24

¹²⁶ WHO Bangladesh (2020) Rohingya Crisis Situation Report #18, Week 32: 03-09 August, https://www.who.int/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/sitreps-2020/who-cox-s-bazar-sitrep-18.pdf?sfvrsn=7c9ddaf9_4%27 Accessed: 15 August 2021, p.6

¹²⁷ Ackerman, E. (2021) Maternal health in Cox's Bazar: The impact of mother's clubs, ReliefWeb, <https://reliefweb.int/report/bangladesh/maternal-health-cox-s-bazar-impact-mother-s-clubs>, Accessed: 22 August 2021

¹²⁸ UNHCR (2020) Rohingya Refugee Response – Bangladesh, Factsheet – Public Health, 31 December 2020, p.2

¹²⁹ UNHCR (2020) Rohingya Refugee Response – Bangladesh, Factsheet – Public Health, 30 April 2020, <https://reliefweb.int/sites/reliefweb.int/files/resources/77105.pdf>, Accessed 15 August 2021, p.2

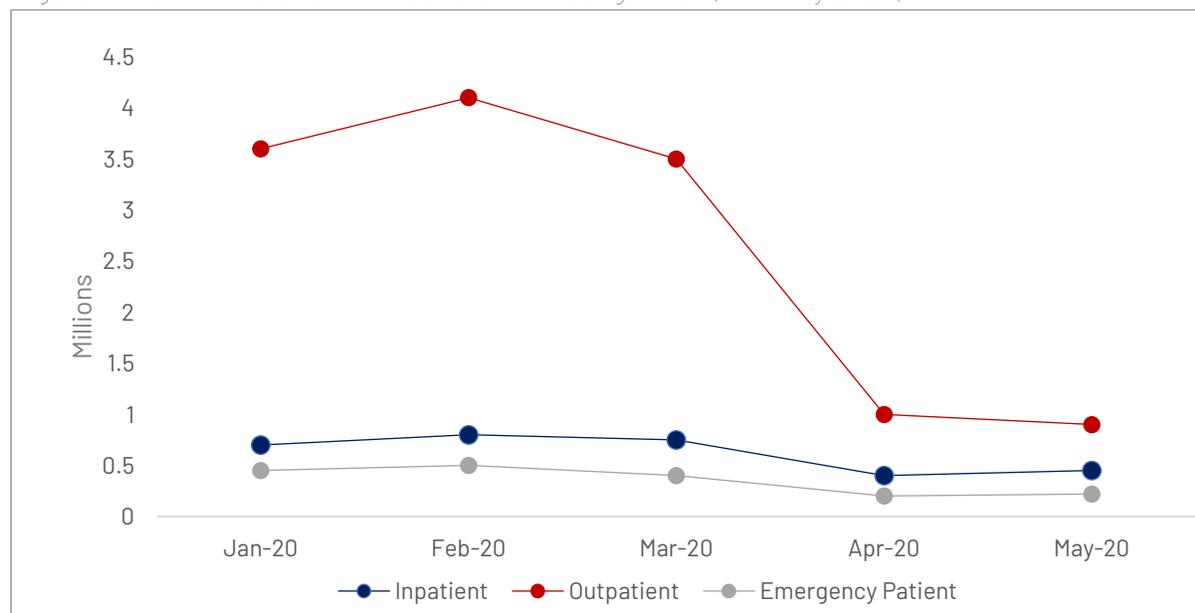
¹³⁰ UNHCR (2021) Rohingya Refugee Response – Bangladesh, Factsheet – Public Health, 30 April 2021, <https://reliefweb.int/sites/reliefweb.int/files/resources/Thematic%20Factsheet%20Template%20-%20Health%20v4.pdf>, Accessed 15 August 2021, p.2

¹³¹ WHO Bangladesh (2020) Rohingya Crisis Situation report #15, Weeks 29-30: 19 July – 1 August 2021, https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/2021/who-cox-s-bazar-situation-report-15.pdf?sfvrsn=f1b3bf3d_9, Accessed 15 August 21, p.7

for the pandemic. Prior to the pandemic, the health system in Bangladesh had poor resilience, with only 5.4 physicians and 3.4 nurses per 10,000 people. This capacity has been strained further due to shortened office hours, the redirection of front-line health workers, and the high incidence of COVID-19 among health workers.¹³² As a result, 19.3 per cent of people felt that COVID-19 had reduced the availability of health and nutrition services.¹³³ Adolescents, who have a particular need for SRH access due to high fertility rates, saw access to health services drop by 70 per cent between March and August 2020.¹³⁴

Travel distance and cost of transportation to health facilities is a significant barrier to access in Bangladesh. COVID-19 has exacerbated these issues, with closures and conversions of SRH facilities into COVID-dedicated clinics meaning that people’s closest facilities may be even further away.¹³⁵ This can increase travel costs in a time of economic precarity caused by COVID-19 when many have lost income. 17.41 per cent of people would not seek healthcare even if they suspected that they had COVID-19 due to costs, and due to their nearest facility being too far away.¹³⁶

Figure 4: Rate of health service utilisation in Bangladesh (Jan-May 2020)



Source: United Nations in Bangladesh (2020) *Immediate Socio-economic Response Plan (ISERP)*, Dhaka: United Nations, 31 August 2020

Health-seeking behaviour in Bangladesh has also been impacted by the pandemic. **Figure 4** (above) from the United Nations in Bangladesh demonstrates the significant decline in health service utilization in the first months of the pandemic. The country reported that in the first three months of the pandemic, the total number of healthcare consultations in health facilities dropped by over 50 per cent.¹³⁷ There was a 31 per cent decrease in antenatal care visits, as well as a 33 per cent drop

¹³² United Nations in Bangladesh, *Immediate Socio-economic Response Plan (ISERP)*, p. 24

¹³³ iMMAP data collection 2021

¹³⁴ United Nations in Bangladesh, *Immediate Socio-economic Response Plan (ISERP)*, p. 25

¹³⁵ iMMAP data collection 2021

¹³⁶ *Ibid*

¹³⁷ iMMAP, *COVID-19 Impact on Children*, p.19

in patients seeking FP counselling.¹³⁸ Between 2019 and 2020, there was an 86 per cent decline in testing rates for HIV¹³⁹ which, coupled together with the access and supply chain disruptions, may have serious implications for HIV spread and mortality in the country. Reduction in health-seeking behaviour is attributed to fear of contracting COVID-19, mistrust of authorities, and misinformation;¹⁴⁰ however thankfully consultations have since recovered somewhat.

Unfortunately, we only have country-level information available and very little disaggregated information on the situation in Cox's Bazaar. However, it is reported that considerable work has been done by the Health Cluster to address SRH access needs in Cox's Bazaar. These have related to the provision of PPE, ensuring separate areas in health facilities for COVID-19 positive patients and non-positive patients receiving SRH care, and steps towards ensuring 24-hour CEmONC access in the camps.¹⁴¹ As of November 2020, there were 56 SRH-specific facilities in Cox's Bazar.¹⁴²

4.2 Burkina Faso

Pre-pandemic SRH context

The fertility rate in Burkina Faso is high – estimated at 5.1 children per woman. This is attributed to poor access to modern contraceptives and early marriage. In 2018, approximately 44 per cent of women and girls had been married before the age of 18.¹⁴³ CEFM in Burkina Faso, as in many other settings, is linked with early pregnancies and greater numbers of children compared with those who marry later.¹⁴⁴ As a result, Burkina Faso has one of the highest population growth rates in the world.¹⁴⁵ Pre-pandemic, two-thirds of Burkinabe women were not using any form of modern contraception; 18 per cent used a long-acting method, and 15 per cent relied on short-acting methods.¹⁴⁶ Rates of contraceptive use also appeared to be on the decline, from 34.3 per cent in 2014 to 24.9 per cent in 2018.¹⁴⁷ High rates of female genital mutation (FGM) in Burkina Faso also present increased risks of obstetric complications, obstructed labour, and maternal and newborn mortality. The FGM prevalence in Burkina Faso is 75.8 per cent as of 2018, a small decrease from 76.6 per cent in 2003.¹⁴⁸

Prior to the pandemic, Burkina Faso had a weak health care system, ranked 145th of 195 countries in the 2019 Global Health Security Index. With only 15 ICU beds for a population of 20 million, the country

¹³⁸ United Nations in Bangladesh, Immediate Socio-economic Response Plan (ISERP), p. 22

¹³⁹ Ibid

¹⁴⁰ iMMAP, COVID-19 Impact on Children, p.19

¹⁴¹ Office of the UN Resident Coordinator in Bangladesh (2020) Humanitarian Coordination and Collaboration in Bangladesh, Dhaka: United Nations Bangladesh, p.43

¹⁴² WHO Bangladesh (2020) Rohingya Crisis Situation report #17, Week 31: 27 July – 2 August 2020, https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/sitreps-2020/who-cox-s-bazar-sitrep-17.pdf?sfvrsn=d4b1dadb_2, Accessed 15 August 2021

¹⁴³ African Development Bank Group, Burkina Faso Country Gender Profile, p.31

¹⁴⁴ Girls Not Brides (2021) Adolescent pregnancy and child marriage, <https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/adolescent-pregnancy-and-child-marriage/> Accessed: 9 August 2021

¹⁴⁵ African Development Bank Group, Burkina Faso Country Gender Profile, p.30

¹⁴⁶ Karp, C., Wood, S.N., Guiella, G. et al (2021) Contraceptive dynamics during COVID-19 in sub-Saharan Africa: longitudinal evidence from Burkina Faso and Kenya, *BMJ Sex Reprod Health*, 0:1-9, p.3

¹⁴⁷ INSD, Tableau de bord de la gouvernance, p.79

¹⁴⁸ 28 Too Many (2021) Burkina Faso, <https://www.28toomany.org/country/burkina-faso/>, Accessed 15 August 21

was poorly prepared for a pandemic.¹⁴⁹ Despite this, the country had seen recent encouraging improvements in maternal and reproductive health. In 2018, the country recorded a maternal mortality rate of 117 deaths per 100,000 births – well below the 2015 rate of 371 deaths per 100,000.¹⁵⁰ This is attributed to increased access to skilled assisted delivery – with 83.9 per cent of births attended by a healthcare professional in 2017, and 83.1 per cent in 2018.¹⁵¹ However, this figure dropped to 79 per cent in 2019 which is less encouraging.¹⁵² Under five child mortality rates have also reduced by more than half, from 168 per 1,000 live births in 2003 to 81 per 1,000 in 2018.¹⁵³ ANC coverage for at least four visits remains inadequate in Burkina Faso, at 47 per cent; this is among the poorest level in sub-Saharan Africa.¹⁵⁴ However, this is an improvement on 2010, during which ANC coverage was recorded at 34 per cent.¹⁵⁵

Insecurity causes significant barriers to healthcare access in Burkina Faso. In late 2019, 68 health centres were closed due to insecurity, affecting over 800,000 people.¹⁵⁶ Security issues also affect mobility, and thus women’s ability to physically reach the remaining functional healthcare services – with impediments including roadblocks, attacks on public transport, and attacks on transport infrastructure. Healthcare facilities were also the target of attacks, with 27 per cent of basic health facilities and 41 per cent of comprehensive facilities experiencing a violent event within a 2km radius. This means over 1.3 million people were no longer able to feel safe accessing health facilities, even if they were physically able to do so.¹⁵⁷ As a result of access barriers, over 11 per cent of women of reproductive age reported having never received medical care.¹⁵⁸

Impact of COVID-19 on RMNH outcomes

In Burkina Faso, most women at risk of unintended pregnancy (68.6 per cent) did not change **contraceptive use** status between late 2019 and July 2020. 26.9 per cent of women in Burkina Faso remained contraceptive users during COVID-19 (down from 30.7 per cent pre-COVID), while 41.7 per cent remained non-users. Therefore, more women adopted contraception (25.4 per cent) than discontinued (6 per cent) during COVID. About 10 per cent shifted to more effective methods, while around 5 per cent shifted to less effective methods.¹⁵⁹ However, there is a different picture among nulliparous women in Burkina Faso. There was a 38.9 per cent increase in the need for contraception among women in rural Burkina Faso, and much greater proportions of women in urban centres have

¹⁴⁹ African Union (2020) The Impact of the COVID-19 Outbreak on Governance, Peace and Security in the Sahel, Addis Ababa: African Union Commission, p.16

¹⁵⁰ African Development Bank Group (2020) Burkina Faso Country Gender Profile, Ouagadougou: ADBG Burkina Faso Country Office, p.13

¹⁵¹ Ibid, p.30

¹⁵² INSD (2020) Tableau de bord de la gouvernance édition 2020, p.79

¹⁵³ World Bank Group (2021) Roads to Schools and Healthcare Facilities: Identifying Accessibility Gaps in Burkina Faso, Washington D.C: World Bank, p.13

¹⁵⁴ World Bank Group (2021) Connectivity for Human Capital: Realising the Right to Education and Healthcare through Improved Public Transport in African Cities, Washington D.C: World Bank, p.31

¹⁵⁵ Countdown to 2030 (2019) Burkina Faso, <http://countdown2030.org/pdf/Burkina-Faso-CD2030-2019.pdf>, Accessed: 18 August 2021

¹⁵⁶ World Bank Group, Roads to Schools and Healthcare Facilities, p.32

¹⁵⁷ Ibid, p.34

¹⁵⁸ Ibid, p. 40

¹⁵⁹ Karp et al, Contraceptive dynamics during COVID-19 in sub-Saharan Africa, p.3

also been using contraception during COVID-19.¹⁶⁰ This may indicate a preference by women to delay a first pregnancy.

Burkinabe women who were very concerned about COVID-19 were less likely to adopt a method (presumably to avoid visiting health facilities), however in cases where women experienced partial income loss or heightened food insecurity due to COVID-19, they were more likely to adopt contraception and less likely to discontinue.¹⁶¹ However, only 3.8 per cent of non-contraceptive users in Burkina Faso identified COVID-19 related reasons for non-use,¹⁶² suggesting there may be more significant barriers at play, such as cost. Nearly two-thirds of Burkinabe women reported difficulties accessing health services in order to seek contraceptives, however the vast majority (87 per cent) were eventually successful in accessing care.¹⁶³ This seems to conflict with other data, however. Two of the major providers of FP counselling and health services, Burkina Faso Association for Family Welfare (ABBEF) and Marie Stopes International (MSI), both reported a significant decrease (50 per cent and 30 per cent respectively) in clients accessing reproductive counselling and health services.¹⁶⁴

The **maternal mortality** rate in Burkina Faso has improved since the pre-pandemic period. While the country recorded a maternal mortality rate of 117 per 100,000 births in 2018,¹⁶⁵ this had dropped to 56 per 100,000 in 2021 indicating that COVID-19 has not had an adverse impact on maternal mortality.¹⁶⁶ However this improved country average masks disparities across the regions; some areas remain as high at 88 per 100,000.¹⁶⁷ **Infant mortality** is 51 per 1,000 live births, while child mortality (under 5) is 81 per 1,000. In response to an unusually high number of institutional maternal deaths reported during the period late April – early May 2020 in comparison with data from the same period in 2019 (numbers not specified), a maternal death review was conducted by the Ministry of Health with the support of the WHO. The review found that the deaths were caused by haemorrhage, severe infections, postoperative complications and eclampsia. The report also found there was a significant reduction in **skilled delivery assistance**, and of deliveries in health facilities.¹⁶⁸ At the community level, the review found inadequate monitoring of pregnancies, a high number of home deliveries, and the refusal of evacuation to health facilities by some attendants due to insecurity or high cost of community transport. At health facilities, the review found stock-outs of essential drugs, a lack of qualified personnel, no resuscitation or intensive care services, and permanent unavailability of blood products.¹⁶⁹

¹⁶⁰ Wood et al, Need for and use of contraception by women before and during COVID-19, p. e793

¹⁶¹ Karp, et al, Contraceptive dynamics during COVID-19 in sub-Saharan Africa, p.5

¹⁶² Ibid, p.1

¹⁶³ Ibid, p.7

¹⁶⁴ Lefaso.net (2020) Impact du Covid-19 sur les jeunes filles et les femmes: La pandémie a exacerbé les violences basées sur le genre, selon une étude de l'IPBF, IPBF, 5 October 2020, <http://lefaso.net/spip.php?article99753>, Accessed: 15 August 2021

¹⁶⁵ African Development Bank Group, Burkina Faso Country Gender Profile, p.13

¹⁶⁶ World Bank Group, Roads to Schools and Healthcare Facilities, p.5

¹⁶⁷ Première Urgence Internationale (2020) Rapport de Mission Exploratoire: Boucle du Mouhoun, p.15

¹⁶⁸ WHO (2020) Burkina Faso: Review of Maternal Deaths and the Continuity of Essential Reproductive, Maternal, and Child Health Services in the Context of Covid-19 and the Humanitarian Crisis in the Sahel, All Africa, 1 October 2020, <https://allafrica.com/stories/202010020073.html>, Accessed: 15 August 2021

¹⁶⁹ Ibid

Impact of COVID-19 on access to health and health-seeking behaviour

Long distances and travel time to the nearest health facility is a significant access barrier in **Burkina Faso**.¹⁷⁰ The pre-COVID average travel time to the closest healthcare facility across Burkina Faso exceeded two hours.¹⁷¹ However, nearly 12 million Burkinabes (of a total population of approximately 20 million) live in areas where the nearest medical centre cannot be reached within four hours of driving.¹⁷² Driving is a luxury that few can afford however, with 70 per cent of women of reproductive age in the rural regions reporting using a bike or walking to reach their nearest health facility.¹⁷³ Only one quarter of the population is able to access any form of health facility within one hour – assuming access to a motorized vehicle.¹⁷⁴ Since the beginning of the pandemic, evidence also suggests that there is a serious lack of qualified healthcare workers to meet population health needs. OCHA has reported a significant desertion of health workers in rural and regional areas, as well as a critical lack of essential medicines and medical equipment to serve the population’s health needs.¹⁷⁵ OCHA reports that in place of healthcare professionals, traditional village birth attendants are being called upon to assist with deliveries in rural areas.¹⁷⁶

Insecurity was also a cause of further access restrictions in Burkina Faso throughout 2020. In late 2019, 68 health centres were closed due to insecurity, affecting over 800,000 people.¹⁷⁷ By June 2020 the Burkina Faso Ministry of Health reported that 108 health facilities were closed by June 2020, and a further 189 were operating at minimal capacity – meaning around 1.3 million people are deprived of access to primary healthcare.¹⁷⁸ By the end of 2020 this number had reduced to 95 closures and 1.2 million people affected,¹⁷⁹ and by March 2021 only 75 facilities remained closed with 820,000 people impacted¹⁸⁰ – close to the 2019 figures. However, these figures disguise nuances in the quality of health services available. Although more facilities are now open compared with mid-2020, there has been an increase in the number of health facilities operating at minimal capacity and unable to provide comprehensive care.¹⁸¹ Overall, between April 2020 and April 2021, iMMAP estimates that there was a 42 per cent decrease in the number of operational health facilities.¹⁸² A number of ambulances have also been damaged or destroyed in attacks – with 7 rendered unusable in 2019, and 7 ambulances plus 18 motorbike ambulances pulled out of commission in 2020.¹⁸³

¹⁷⁰ OCHA (2020) Burkina Faso: Aperçu des besoins humanitaires 2021, p.58

¹⁷¹ World Bank Group, Roads to Schools and Healthcare Facilities, p.5

¹⁷² Ibid, p.6

¹⁷³ Ibid, p.7

¹⁷⁴ Ibid, p.24

¹⁷⁵ OCHA (2020) Burkina Faso: Aperçu des besoins humanitaires 2021, p.58

¹⁷⁶ Ibid, p.59

¹⁷⁷ World Bank Group, Roads to Schools and Healthcare Facilities, p.32

¹⁷⁸ Burkina Faso Ministère De La Santé (2020) Paquets de services essentiels de santé de qualité dans les zones à sécurité précaire prenant en compte les violences basées sur le genre, Septembre 2020, p.7

¹⁷⁹ World Bank Group, Roads to Schools and Healthcare Facilities, p.32

¹⁸⁰ iMMAP (2021) COVID-19 Analyse de Situation – Burkina Faso, Mars 2021, p.29

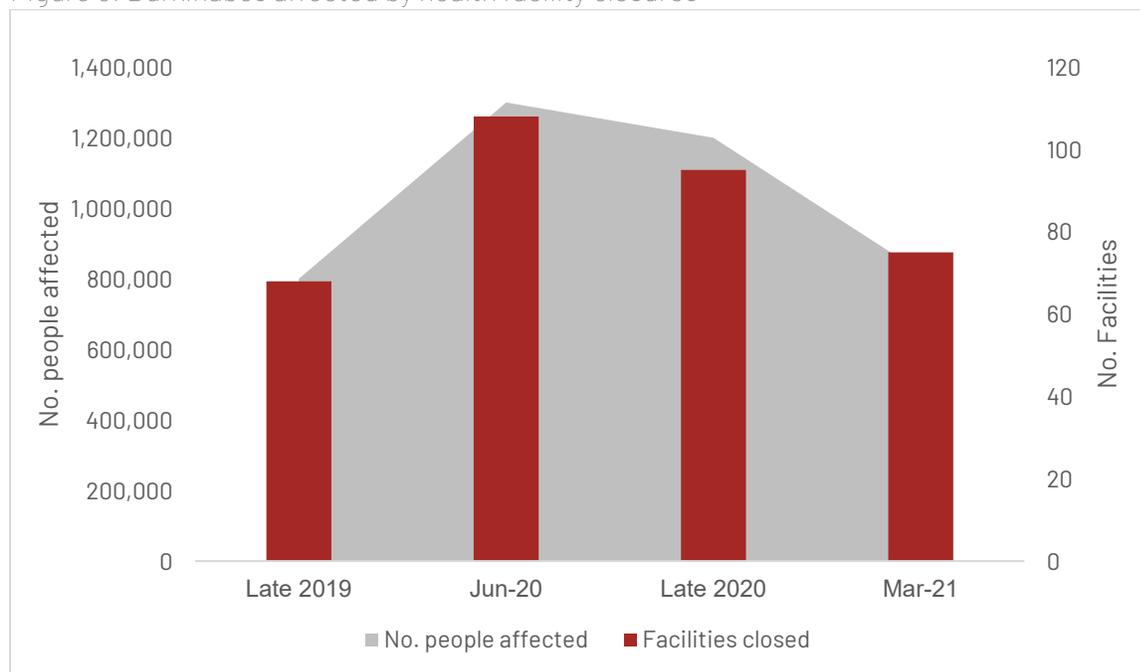
¹⁸¹ Ibid, p.31

¹⁸² iMMAP (2021) COVID-19 Analyse de Situation – Burkina Faso, Mai 2021, p.37

¹⁸³ Burkina Faso Ministère De La Santé, Paquets de services essentiels de santé de qualité, p.7

Intimidation, abduction and murder of health workers, and theft of medicines also have impacted access to healthcare in Burkina Faso.¹⁸⁴

Figure 5: Burkinabes affected by health facility closures¹⁸⁵



Sources: World Bank Group (2021), Burkina Faso Ministry of Health (2020), iMMAP (2021)

In Burkina Faso, a major determinant of women’s health-seeking behaviour is the husband’s permission to attend a health centre.¹⁸⁶ However, unlike in other contexts, COVID-19 does not appear to be having an impact on permission for women to seek healthcare. Data collected in December 2020 found that of those who were not seeking medical treatment as often as they would like to, 0 respondents listed safety concerns related to COVID-19 exposure as among the main deterrents. The main reasons instead were cost (74.6 per cent) and distance to facilities (27.1 per cent).¹⁸⁷ A separate survey in June 2020 found that one in five respondents reported distance to health facilities are the most important constraint in accessing healthcare – however it does not appear that this study included COVID-19 as a potential constraint.¹⁸⁸ However IPBF conducted a study with a sample of 455 girls and women, and found that a number of COVID restrictions including curfews and stay at home orders was impacting health-seeking behaviour, as well as a fear of contracting the disease at health facilities – especially given the considerably increased waiting times.¹⁸⁹

¹⁸⁴ iMMAP, COVID-19 Analyse de Situation – Burkina Faso, p.37

¹⁸⁵ The terms ‘late 2019’ and ‘late 2020’ are taken from the World Bank Group report, Roads to Schools and Healthcare Facilities, p. 32. Unfortunately, the specific months were not provided and the report does not define what it means by ‘late’.

¹⁸⁶ African Development Bank Group, Burkina Faso Country Gender Profile, p.30

¹⁸⁷ World Bank Group, Roads to Schools and Healthcare Facilities, p.39

¹⁸⁸ World Bank Group, Connectivity for Human Capital, p.51

¹⁸⁹ Lefaso.net, Impact du Covid-19 sur les jeunes filles et les femmes

4.3 Colombia

Pre-pandemic SRH context

In pre-pandemic Colombia, there were positive trends in contraceptive use among the general population; around 2 million people had good access to contraceptive services,¹⁹⁰ and only 7 per cent of unmarried women of reproductive age had an unmet need for contraception.¹⁹¹ Despite these positive figures, adolescent pregnancy was a major public health issue prior to the pandemic, at a rate of around 60 per 1,000 live births. The majority of these were unwanted pregnancies. In particular, pregnancies among girls under the age of 15 tend to be the result of abuse and sexual violence.¹⁹² There is a significant migrant and refugee population in Colombia; at the end of 2019 there were 1.6 million Venezuelan migrants and refugees in Colombia, and a further 3.4 million people regularly crossing the border to access basic services.¹⁹³ By the end of 2020, there were an estimated 1.8 million migrants and refugees in Colombia; among female migrants and refugees, 67 per cent were of reproductive age.¹⁹⁴ Refugees and migrant women are exposed to greater risks of sexual and gender-based violence, early pregnancies (defined as occurring between 10 and 14 years of age), unwanted pregnancies, a lack of access to safe abortions leading to unsafe abortion methods, and extreme maternal morbidity.¹⁹⁵ In 2020, Profamilia reported that only 2 out of 10 migrants and refugees have ever attended health services in Colombia.¹⁹⁶ This access appears to be gendered, as a 2019 IOM study indicated that 41 per cent of migrant and refugee women reported having no access to healthcare.¹⁹⁷ In 2019, only 9.3 per cent of refugee and migrant women received some form of contraceptive assistance.¹⁹⁸ However, this is double the number who received contraceptive care in 2018.¹⁹⁹ In a 2019 survey, 35 per cent of those seeking contraceptive services could not gain access.²⁰⁰

Across the total population, only 31.6 per cent of women had received the WHO-recommended 8 or more ANC consultations, and 3.8 per cent of women did not receive any ANC.²⁰¹ Prohibitive costs and other access barriers including discrimination may explain why these figures were so low pre-pandemic.²⁰² Skilled assisted delivery rates are high, on the other hand, with 97 per cent of women delivering in health facilities.²⁰³ However, among the migrant and refugee population, there was an 80 per cent increase in the use of ANC services between 2018 and 2019, as well as an increase in the

¹⁹⁰ Profamilia, *Desigualdades en salud de la población migrante y refugiada Venezolana en Colombia*, p. 51

¹⁹¹ *Ibid*

¹⁹² CEPAL (2020) *Los riesgos de la pandemia de COVID-19 para el ejercicio de los derechos sexuales y reproductivos de las mujeres*, p.2-3

¹⁹³ WFP (2020) *WFP Colombia Situation Report*, December 2019, Reliefweb, <https://reliefweb.int/report/colombia/wfp-colombia-situation-report-december-2019>, Accessed: 17 August 2021

¹⁹⁴ Profamilia, *Desigualdades en salud de la población migrante y refugiada Venezolana en Colombia*, p.10

¹⁹⁵ GIFMM and R4V (2020) *GIFMM Colombia Evaluación Conjunta de Necesidades ante Covid-19*, Bogota p.38

¹⁹⁶ Profamilia, *Desigualdades en salud de la población migrante y refugiada Venezolana en Colombia*, p.10

¹⁹⁷ IOM (2020) *Acceso a Servicios de Salud da la Mujeres Migrantes y Refugiadas de Venezuela*, p.1

¹⁹⁸ Profamilia, *Desigualdades en salud de la población migrante y refugiada Venezolana en Colombia*, p.50

¹⁹⁹ *Ibid*, p.51

²⁰⁰ GIFMM and R4V, *GIFMM Colombia Evaluación Conjunta de Necesidades ante Covid-19*, p.39

²⁰¹ Profamilia, *Desigualdades en salud de la población migrante y refugiada Venezolana en Colombia*, p.56

²⁰² iMAPP (2021) *COVID-19 Análisis de Situación – Colombia*, Marzo 2021, p.30

²⁰³ iMAPP data collection

number of births attended by a healthcare practitioner.²⁰⁴ Despite this positive increase, in 2019 a survey of the refugee and migrant population found that of those who required gynaecological care in the last 30 days, 58 per cent could not access the service. Colombia has one of the most progressive abortion laws in the region, with abortion permitted when the pregnancy threatens the woman's health (physical and/or mental); when the pregnancy is a result of rape, incest, or artificial insemination without consent; and when foetal malformations incompatible with life are diagnosed. The law does not specify a gestational deadline, and later term abortions can be sought where carrying the pregnancy to term may cause severe anguish or impact on mental health.²⁰⁵ Despite this there are still significant barriers to access – particularly for migrant and refugee women – and a significant number of unsafe abortions continue to occur. iMMAP estimates that if all contraceptive, maternal and newborn, and safe abortion care needs were met in Colombia, then unintended pregnancies would drop by 63 per cent, maternal deaths would decrease by 65 per cent, and newborn deaths would fall by 69 per cent.²⁰⁶

Impact of COVID-19 on RMNH outcomes

In Colombia, evidence suggests that the pandemic is restricting access to **contraceptives**. This appears to be for three main reasons: supply chain disruptions meaning pharmacies cannot maintain sufficient stock to service the population; discontinuity of use due to fears of contracting COVID-19 in healthcare settings; and a reduction in household incomes meaning women have less money to buy contraceptives.^{207 208} The pandemic threatens to undermine improvements in access to contraceptives among Venezuelan migrant and refugee populations in Colombia. Between 2018 and 2019, the use of contraceptive services by the Venezuelan refugee and migrant populations increased by 96 per cent.²⁰⁹ In many countries, one of the greatest SRH risks posed by the pandemic is an increase in **adolescent pregnancy**. In Colombia, research indicates that the pandemic is causing barriers to women and girls' access to contraceptive methods and **FP counselling**. UNFPA projects that adolescents could face 20 per cent more barriers to accessing contraception, which may lead to a 6 to 11 percentage point increase in the adolescent fertility rate as a result of COVID-19.²¹⁰ Stay-at-home orders, school closures, and quarantines have also exposed adolescent girls to situations of sexual coercion and assault, which may lead to an increase in unwanted pregnancies. School closures have also restricted girls' access to essential SRH education programmes.²¹¹ A 2021 study by Plan International found that 8 per cent of Venezuelan adolescent girls living in Colombia have experienced early pregnancy (between 10-14 years), and a further 19 per cent had experienced pregnancy between 14-19 years of age.²¹²

²⁰⁴ Ibid, p.58

²⁰⁵ Wenham C, Arevalo A, Coast E, et al. (2019) Zika, abortion and health emergencies: a review of contemporary debates. *Global Health*, 15:49, p.2

²⁰⁶ iMMAP data collection 2021

²⁰⁷ CEPAL, Los riesgos de la pandemia de COVID-19, p.6

²⁰⁸ OCHA Colombia (2020) Plan de Respuesta COVID-19: Colombia, Bogota: OCHA, p.10

²⁰⁹ GIFMM and R4V, GIFMM Colombia Evaluación Conjunta de Necesidades ante Covid-19, p.39

²¹⁰ CEPAL, Los riesgos de la pandemia de COVID-19, p.4

²¹¹ Ibid

²¹² Plan International Américas (2021) Niñas Venezolanas: Voces de la Migración, Estudio en Colombia, Ecuador y Perú, p.8

Antenatal care rates have been seriously impacted by pandemic. Border closures due to COVID-19 have had a serious impact on Venezuelan women's access to ANC. Typically, seeking maternal healthcare was a leading reason for low-income women migrating from Venezuela to Colombia. While many would migrate permanently, others living in border regions would cross the border for healthcare access before returning back home – and would do this multiple times during a pregnancy. Border closures force pregnant women to use unofficial routes controlled by armed groups, which expose them to sexual violence and human trafficking.²¹³ There has been a marked increase in **maternal mortality** in Colombia since the beginning of the pandemic. iMMAP reported that in the period April 2020 to April 2021 there was a 23 per cent increase in maternal deaths.²¹⁴ This figure is disputed, however. Preliminary data from the Ministry of Health suggests that in the first half of 2021 there were 265 maternal deaths, compared to a 4-year average of 156.5 (2016-2019). This represents a 69 per cent increase in maternal mortality, with COVID-19 infection directly accounting for 30 per cent of the increase.²¹⁵ It is unclear why the 23 per cent and 69 per cent figures diverge so dramatically; one possible explanation is that the 23 per cent figure did not include deaths caused directly by COVID-19. COVID-19 also threatens to exacerbate maternal mortality disparities in Colombia. While the 2018 national maternal mortality rate was 45.3 per 100,000 live births, among indigenous women the rate was 188.7/100,000, and among women of African descent the figure was 65.5/100,000.²¹⁶ The pandemic also threatens to derail progress in reducing the maternal mortality rate – which was expected to reduce to 32 per 100,000 by 2030, and to 70 per 100,000 in remote and rural settings.²¹⁷ The weakening of public health surveillance systems, including antenatal care, are believed to cause this increased risk.²¹⁸

Impact of COVID-19 on access to health and health-seeking behaviour

In Colombia, 15.29 per cent of people reported that COVID-19 had caused a reduced availability of health services in their area.²¹⁹ One of the reasons for this is that hospitals and primary care centres have had to prioritise resources towards addressing the pandemic.²²⁰ Resources have been diverted from antenatal care, obstetric emergencies, contraception and FP counselling, and SRH services (as well as other essential health services) towards the pandemic response.²²¹ The health system in Colombia is stretched trying to meet the excess demand caused by the pandemic, as well as a reduction of available healthcare staff as a result of being affected by COVID-19. There have also been a number of staff resignations due to unsafe situations that put their safety and security at risk – including physical violence.²²² Burnout among health professionals is compounding this problem.²²³ As a result, 59.38 per cent of people reported an increase in waiting times when trying

²¹³ Caribe Afirmativo (2021) Situación de deprechos humanos de personas con necesidad de protección internacional provenientes de Venezuela en Colombia, p.29

²¹⁴ iMMAP (2021) COVID-19 Análisis de Situación – Colombia, Abril 2021, p.33

²¹⁵ iMMAP data collection 2021

²¹⁶ CEPAL (2020) Los riesgos de la pandemia de COVID-19, p.5

²¹⁷ OCHA Colombia (2020) Plan de Respuesta COVID-19: Colombia, Bogota: OCHA, p. 35

²¹⁸ Ibid, p.10

²¹⁹ Ibid

²²⁰ CEPAL (2020) Los riesgos de la pandemia de COVID-19, p.1

²²¹ OCHA Colombia, Plan de Respuesta COVID-19: Colombia, p.47

²²² Ibid, p.10

²²³ Ibid, p.47

to access local health care services.²²⁴ A lack of availability of PPE for health care teams in **Colombia** also causes service disruptions, particularly in remote areas. Traditional doctors and midwives in indigenous and Afro-Colombian communities are poorly supplied with PPE and other essential materials for SRH services.²²⁵

iMMAP data collection indicates that stay at home guidance and restrictions on movement continue to have an impact in Colombia.²²⁶ Relatedly, border closures during the pandemic have had a critical impact on access to SRH services for Venezuelan migrants and refugees who are now unable to access health services in Colombia.²²⁷ For Venezuelan women and girls already in Colombia, there are still significant obstacles to access services including antenatal care and safe abortion. Only 22 per cent of Venezuelan migrants and refugees of working age are affiliated with the social security health scheme; those who are not affiliated with the scheme are charged for health services and these costs can be prohibitive.²²⁸ 55 per cent of migrants and refugees reported not having enough money to pay for health services.²²⁹ However, with the health care system stretched beyond capacity, it has been reported that health care providers have increasingly been making access conditional on the presentation of residency documents. This excludes women and girls who have irregular migratory status or who do not have the correct documentation – even if they have the means to pay.²³⁰ iMMAP reports that 61 per cent of Venezuelan migrant and refugee women have not received care then they have been ill, which is a worrying indicator for RMNH outcomes.²³¹ Despite the fact that mobility restrictions have eased, nearly 50 per cent of the surveyed population reported that they have stopped attending any health services since the beginning of the pandemic.²³² This may be explained by the access barriers for migrants and refugees, particularly costs and lack of documentation, however there may be other factors at play influencing health-seeking behaviour that are not reflected in the available data.

4.4 DRC

Pre-pandemic context

In 2019, the DRC had one of the weakest health systems in the world, ranked at 161 out of 195 countries.²³³ The country also ranked the poorest in the world among those with similar-sized populations. Pre-pandemic, Congolese women had very poor access to health services, with a ratio of 0.5 nurses and midwives per 1,000 patients.²³⁴ There was also poor emergency obstetric and newborn care (EmONC) coverage in the DRC pre-pandemic. In a 2017 survey of 42 public facilities designated to provide EmONC, only three facilities met the CEmONC criteria (including one hospital),

²²⁴ iMMAP data collection 2021

²²⁵ OCHA Colombia, Plan de Respuesta COVID-19: Colombia, p.47

²²⁶ iMMAP data collection 2021

²²⁷ Caribe Afirmativo, Situación de deprechos humanos de personas con necesidad de protección internacional, p.29

²²⁸ iMMAP (2021) COVID-19 Análisis de Situación – Colombia, Marzo 2021, p.30

²²⁹ iMMAP, COVID-19 Análisis de Situación – Colombia, Abril 2021, p.33

²³⁰ Caribe Afirmativo, Situación de deprechos humanos de personas con necesidad de protección internacional, p.29

²³¹ iMMAP, COVID-19 Análisis de Situación – Colombia, Marzo 2021, p.30

²³² iMMAP (2021) COVID-19 Análisis de Situación – Colombia, Mayo 2021, p.36

²³³ GHS Index (2019) 2019 Global Health Security Index, <https://www.ghsindex.org/>, Accessed: 22 August 2021

²³⁴ UNICEF (2016) Maternal and Newborn Health Disparities: Democratic Republic of the Congo, p. 2

and none of the local health centres qualified as BEmONC. As a result, the number of EmONC facilities per 500,000 population was only 1.5.²³⁵ Poor health coverage is more likely to impact women in rural areas, with only 42 of those in rural areas accessing at least four ANC visits (compared with 61 per cent in urban centres). While 94 per cent of births were attended by a skilled health professional in urban centres, over 25 per cent of births in rural areas were unattended.²³⁶ The DRC has a fertility rate of 6 children per woman, with approximately 8,800 babies born every day. The adolescent birth rate was 135 per 1,000 women, with over one in four women and girls giving birth to their first child before the age of 18.²³⁷ The maternal mortality ratio was 693 per 100,000 live births in 2015, while stillbirth rates were 27 per 1,000 (or 240 every day), and neonatal mortality was 30 per 1,000. These are among the worst mortality rates in the world. A third of neonatal deaths were caused by prematurity, while 28.6 per cent were caused by birth asphyxia and trauma, and 16 per cent were caused by sepsis.²³⁸

Impact of COVID-19 on RMNH outcomes

In Kinshasa city, there has been a mild reduction in **contraceptive** coverage; contraceptive use has stabilised during the COVID-19 pandemic after years of substantial increases.²³⁹ There was a 2.7 per cent increase in need for contraceptives in Kinshasa, and a 0.2 per cent increase in use. Economic downturns and concerns are typically associated with changes in fertility intentions, however changes in contraceptive use were not associated with COVID-19 related income loss in Kinshasa, despite 67 per cent of women reporting complete loss of income.²⁴⁰ The picture among nulliparous women in Kinshasa differs however, where we see a 28.8 per cent increase in need but a 25.2 per cent *reduction* in use.²⁴¹ The increase in need suggests that there may be a greater level of sexual activity among nulliparous women than in previous years, and/or a greater number of women wishing to delay first pregnancies. The reduction in use of contraceptives among nulliparous women despite an increased need warrants further exploration; there may be particular barriers to access among nulliparous women, for example, closures of youth-friendly services, or fear among unmarried adolescents of being seen at a family planning clinic and being shamed by others in the community for not practicing pre-marital abstinence.²⁴² Unfortunately we do not have data for other cities, or for rural areas to allow for comparison.

School closures in the DRC between March – October 2020 and again January – February 2021 have had a significant impact on the SRH of adolescent girls. An increase in **adolescent pregnancies** has been reported by health workers and teachers in communities.²⁴³ In a study by Save the Children, 72

235 Mizerero, S.A., Wilunda, C., Musumari, P.M. et al (2021) The status of emergency obstetric and newborn care in post-conflict eastern DRC: a facility-level cross-sectional study, *Conflict and Health*, 15:61

236 UNICEF, *Maternal and Newborn Health Disparities*, p.5

237 *Ibid*, p.3

238 *Ibid* p.3-4

239 Wood et al, *Need for and use of contraception by women before and during COVID-19*, p. e797

240 *Ibid*, p. e799

241 *Ibid* p. e798

242 CASS (2021) *Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo*, DRC: UNICEF, p.6

243 CASS (2021) *Fermeture des Écoles en Lien avec la COVID-19 en RDC: Impacts sur la Santé, Protection et Éducation des Enfants et Adolescents*, DRC: UNICEF, p.4

per cent of respondents reported an increase in teenage pregnancies in their neighbourhoods since COVID-19-related school closures.²⁴⁴ This finding is supported by data from Marie Stopes International which reported an increase in the number of pregnant women and girls coming to their clinics for consultations.²⁴⁵ Patient registry data from Kinshasa shows a sharp increase in the number of deliveries by adolescents in early 2021, in comparison to both January 2020 and January 2015,²⁴⁶ while data from North Kivu shows a 74 per cent increase in the number of adolescent girls visiting health facilities for the first time for FP services between March and October 2020. This supports the belief among health staff that there was an increased in sexual activity brought on by school closures.²⁴⁷ Research in Goma and Masisi in December 2020 found that increasing number of adolescent girls were engaging in transactional sex, increasing their risk of pregnancy, **HIV/STI transmission**, and sexual violence and abuse.²⁴⁸

Qualitative data collected from health professionals and communities in Kinshasa and Goma in DRC indicate an increase rate of unsafe **abortion** due to lack of available safe options. Some respondents speculated that health workers were performing clandestine abortions to supplement their income, which had decreased since the beginning of COVID. It is difficult to assess the impact of COVID-19 on abortion rates given abortion is illegal in the DRC, and thus was already poorly documented, however MSI mobile clinics reported in October that more women and adolescents were accessing post-abortion care services than earlier in the year indicating that abortion rates may have increased.²⁴⁹ Finally, UNICEF has reported that there were early indications of an increase in **maternal mortality** in 200 compared to 2019, however figures were not provided.²⁵⁰

Impact of COVID-19 on access to health and health-seeking behaviour

Travel is a significant barrier to access in South Kivu. In September 2020, only 32 per cent of people were able to reach their nearest functional health facility in less than 45 minutes, while 52 per cent had to travel between 45 minutes and 2 hours.²⁵¹ Further access barriers included a lack of means to pay for care, lack of adequate supply of medicines, and a lack of medical equipment necessary for care.²⁵² Travel costs were cited as barriers to access across DRC.²⁵³ Stay-at-home orders have also been a barrier to access in DRC. In March–April 2020, health services in Kinshasa recorded a 90 per cent reduction in new visits by women.²⁵⁴ This correlates with the beginning of the three-month stay-at-home period, suggestion that the main reason for reduced demand for healthcare was restriction of movement which prevented people from travelling to health facilities. Although in most countries, healthcare has been defined as an essential reason for which people were allowed to leave home and travel beyond the stated limits, it appears in the DRC that women’s health needs

²⁴⁴ Ibid, p.8

²⁴⁵ Ibid

²⁴⁶ Ibid

²⁴⁷ CASS, Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo, p.6

²⁴⁸ CASS, Fermeture des Écoles en Lien avec la COVID-19 en RDC, p.4

²⁴⁹ CASS, Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo, p.7

²⁵⁰ UNICEF (2021) Democratic Republic of the Congo: Humanitarian Situation Report No.2, February 2021, p.5

²⁵¹ REACH (2020) Suivi de la situation humanitaire: Province du Sud-Kivu, République du Congo (RDC), p.3

²⁵² Ibid, p.4

²⁵³ CASS, Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo, p.5

²⁵⁴ Ibid, p.4

were not understood as such. Although these access rates have improved over time, by October the monthly rate of new visits was still 50 per cent lower than pre-pandemic.²⁵⁵ Insecurity continues to impede access to healthcare in many parts of the country. In 2020 there were a number of attacks on health facilities, however the exact number is contested. OCHA reports that there were 29 attacks on health facilities in eastern and western provinces,²⁵⁶ while iMMAP reports that 79 health centres were looted, destroyed, or occupied in Ituri (an eastern province) alone.²⁵⁷ It may be that these reports have used different definitions of 'attack' in their reporting, which have influenced the figures.

A fear of quarantine, particularly among women, has had a serious impact on health-seeking behaviour in the DRC,²⁵⁸ with many fearing being misdiagnosed as a COVID-19 case and/or being forcibly quarantined indefinitely.²⁵⁹ Data from Goma suggests that women had limited understanding of what tests for COVID-19 involved, or what would happen if someone was recorded as a positive case, which increased fears about medical visits.²⁶⁰ These fears were not unfounded; 28 per cent of COVID-19 cases were found to have visited a health facility in the 14 days prior to testing positive, making this a leading transmission site in the country.²⁶¹ However, these fears have appeared to lessen since the beginning of the pandemic. While there was initially a reduced utilisation rate of women seeking access to FP counselling and contraceptives, by November 2020 this had increased due to fears of the financial implications of unwanted pregnancy. However, while it appeared that antenatal care visits continued to be viewed as essential healthcare in March 2020 and therefore saw unchanged utilisation rates, by November 2020 there was an observed reduction in antenatal care visits, with informants noting that these were no longer seen as essential.²⁶² This was particularly the case among women who had previously given birth; they indicated that they would prefer to receive support from their female relatives or other women in the community, and did not feel that antenatal care visits would teach them anything new. Most health facilities had suspended their group maternal and child health ANC sessions, which many women said had been their main reason for participation.²⁶³

4.5 Nigeria

Pre-pandemic context

Worldwide, approximately 830 mothers die daily from preventable causes related to pregnancy and childbirth. Of these deaths, 145 (17 per cent) occur in Nigeria alone – making it the second largest contributor to global maternal mortality. Nigeria also has the second-highest newborn death rate in the world, at approximately 6,700 every day.²⁶⁴ Only 36 percent of births occur in a health facility in

²⁵⁵ Ibid, p.5

²⁵⁶ OCHA (2020) Aperçu des besoins humanitaires: République Démocratique du Congo, Décembre 2020

²⁵⁷ iMMAP, COVID-19 Analyse de Situation –RDC, Mars 2021, p.34

²⁵⁸ UNICEF DRC (2020) COVID-19 Situation Report #16: 23 September 2020 – 21 October 2020, Kinshasa: UNICEF, p.6

²⁵⁹ CASS, Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo, p.5

²⁶⁰ Ibid

²⁶¹ OCHA, Aperçu des besoins humanitaires: République Démocratique du Congo

²⁶² CASS, Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo, p.2

²⁶³ Ibid, p.7

²⁶⁴ iMMAP (2021) COVID-19 Situation Analysis – Nigeria, May 2021, p.24

Nigeria, and only 38 percent of deliveries are attended by a skilled health worker. In 2019 a study indicated that only 51 per cent of women received four ANC consultations.²⁶⁵ Although Nigeria has an FGM prevalence rate of 18.4 per cent,²⁶⁶ affecting 20 million women and girls, prevalence is concentrated in the south of the country. In the northeast, 3 percent of women and girls have undergone the practice.²⁶⁷ Approximately 1.9 million people under the age of 64 live with HIV/AIDS in Nigeria.²⁶⁸

The conflict in north-eastern Nigeria has been associated with numerous adverse health outcomes, particularly for women and girls. Boko Haram concentrate their activities in Borno, Adamawa and Yobe (BAY states),²⁶⁹ which have a collective population of over 13.4 million people. Boko Haram activities, attacks on health facilities, and insecurity have been associated with higher rates of child mortality and reduced access to maternal healthcare – in addition to psychological trauma, malnutrition, lower vaccination rates, poor treatment of HIV/AIDS and many other worsened health outcomes.²⁷⁰ Less than 60 per cent of health facilities in the BAY state are fully functional, while a quarter are either completely destroyed or non-functional.²⁷¹ Health access is further reduced due to shortages in health personnel, a lack of adequate medicine and supplies, and looting of essential health resources. People living in IDP camps are at heightened risk of poor health outcomes due to overcrowding, unsanitary conditions, and lack of access to healthcare.²⁷² Midwives and other health professionals working in BAY states and in IDP camps have been abducted and executed by Boko Haram.²⁷³ Boko Haram activity has contributed to a 13 per cent reduction in ANC visits, a 38 per cent reduction in deliveries taking place in health facilities, and a 26 per cent drop in births attended by a skilled health worker.²⁷⁴

Impact of COVID-19 on RMNH outcomes

In Lagos there has been a 5.81 per cent increase in need for **contraceptives**, and a non-significant decrease (0.95 per cent) in use.²⁷⁵ The greatest unmet need was for women under 25 years, where the need for contraceptives increased by 23.58 per cent yet use decreased by 24.35 per cent.²⁷⁶ Similar to DRC, more research is needed in this area to identify the specific barriers to contraceptive access among nulliparous women. In northeast Nigeria there are an estimated 2 million women of reproductive age, of whom only 306,000 use modern contraceptives (a further 244,000 are currently

²⁶⁵ Chukwuma, A. and Ekhatör-Mobayode, U.E. (2019) Armed conflict and maternal health care utilization: Evidence from the Boko Haram Insurgency in Nigeria, *Social Science & Medicine*, 226, p.104

²⁶⁶ 28 Too Many (2021) Nigeria, <https://www.28toomany.org/country/nigeria/>, Accessed: 16 August 21

²⁶⁷ Kimiri, P. (2020) CARE Rapid Gender Analysis: Northeast Nigeria – Borno, Abuja: CARE International, p.15

²⁶⁸ iMMAP, COVID-19 Situation Analysis – Nigeria, May 2021, p.24

²⁶⁹ EASO (2021) Nigeria Security situation: Country of Origin Information Report, p.121

²⁷⁰ UNDP (2020) Assessing the Impact of Conflict on Development in North-East Nigeria, Abuja: United National Development Programme, p.24

²⁷¹ Ibid

²⁷² Ibid

²⁷³ Busari, S. and Adebayo, B. (2018) Second aid worker held by Boko Haram executed as negotiation deadline expires, CNN, <https://edition.cnn.com/2018/10/16/africa/second-nigerian-aid-worker-killed-intl/index.html>, Accessed: 17 August 2018

²⁷⁴ Chukwuma et al, Armed conflict and maternal health care utilization, p.110

²⁷⁵ CASS, Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo, p. e798

²⁷⁶ Ibid, p. e799

pregnant).²⁷⁷ It estimated that FP can reduce maternal mortality rate by 25 per cent and it also contributes to both neonatal and under-fives survival rates. This means that by addressing the unmet need for FP, over 830 lives could be saved per year, in addition to those saved by access to safe delivery.²⁷⁸

In the BAY states of Nigeria, FP is traditionally controlled by male heads of households. Since the beginning of the pandemic, there appears to be more empowerment of older women (aged 30 and over) when it comes family planning, where they report to have decision making power by themselves or in partnership with their husbands, while younger wives (20-30) report having to comply with what their husbands say in matters family planning.²⁷⁹ It is unclear why older women have managed to gain greater reproductive autonomy since the pandemic. In Yobe, dire economic circumstances exacerbated by the pandemic have also driven people to engage in negative coping mechanisms; 4 per cent have engaged in transactional or survival sex, and 3 per cent have resorted to CEFM.²⁸⁰ With negative coping mechanisms such as these come risks of exposure to **HIV/STIs**, **adolescent pregnancy**, and unwanted pregnancies. A rise in unwanted pregnancies leads to a rise in demand for **abortion**. Strains on healthcare services means that around the world many are unable to access safe abortion and are thus resorting to unsafe methods.

Unlike data from other countries, in the BAY states research suggests that **ANC** consultations were not significantly affected at the beginning of the pandemic. However, while other contexts appear to have stabilised and improved in 2021, ANC in the BAY states seems to have deteriorated in the second year of the pandemic. In December 2019, UNICEF recorded 17,193 ANC visits.²⁸¹ This reduced to just under 16,000 per month for the first months of the pandemic²⁸² before rising slightly to around 16,400 per month during mid-2020.²⁸³ Inexplicably, ANC visits spiked to 21,177 in October 2020,²⁸⁴ before dropping down and stabilising to just over 12,000 per month in 2021.²⁸⁵ October's figure could reflect a temporary increase in access to ANC appointments, a built up need for ANC (if facilities were closed in the months prior), seasonality of pregnancy in the region, or other factors. Unfortunately, this is not made clear in the data. This trend is illustrated in **Figure 6**. Unfortunately,

²⁷⁷ OCHA, Humanitarian Response Plan: Nigeria, p.80

²⁷⁸ Ibid

²⁷⁹ Kimiri, CARE Rapid Gender Analysis: Northeast Nigeria – Borno, p.9

²⁸⁰ OCHA (2021) Yobe Multi-Sector Needs Assessment: Geidam and Kanama Displacement, 11 June 2021, p.23

²⁸¹ Health Sector Nigeria (2019) Northeast Nigeria Humanitarian Response: December 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/health_sector_bulletin_december_2019.pdf, Accessed: 18 August 2021, p.10

²⁸² Health Sector Nigeria (2020) Northeast Nigeria Humanitarian Response: COVID-19 Response, April 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/health_sector_bulletin4_april_2020.pdf, Accessed: 18 August 2021, p.10

²⁸³ Health Sector Nigeria (2020) Northeast Nigeria Humanitarian Response: COVID-19 Response, August 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/health_sector_bulletin_august_2020_ne_nigeria.pdf, Accessed: 18 August 2021, p.10

²⁸⁴ Health Sector Nigeria (2020) Northeast Nigeria Humanitarian Response: COVID-19 Response, October 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/health_sector_bulletin_october_2020_0.pdf, Accessed: 18 August 2021, p.10

²⁸⁵ Health Sector Nigeria (2020) Northeast Nigeria Humanitarian Response: COVID-19 Response, June 2021, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/health_sector_bulletin_june_2021.pdf, Accessed: 18 August 2021, p.12

we do not have these figures as a percentage of all pregnant women in the region in order to determine what these figures mean in terms of coverage.

Figure 6: Monthly ANC visits in the BAY states, Nigeria

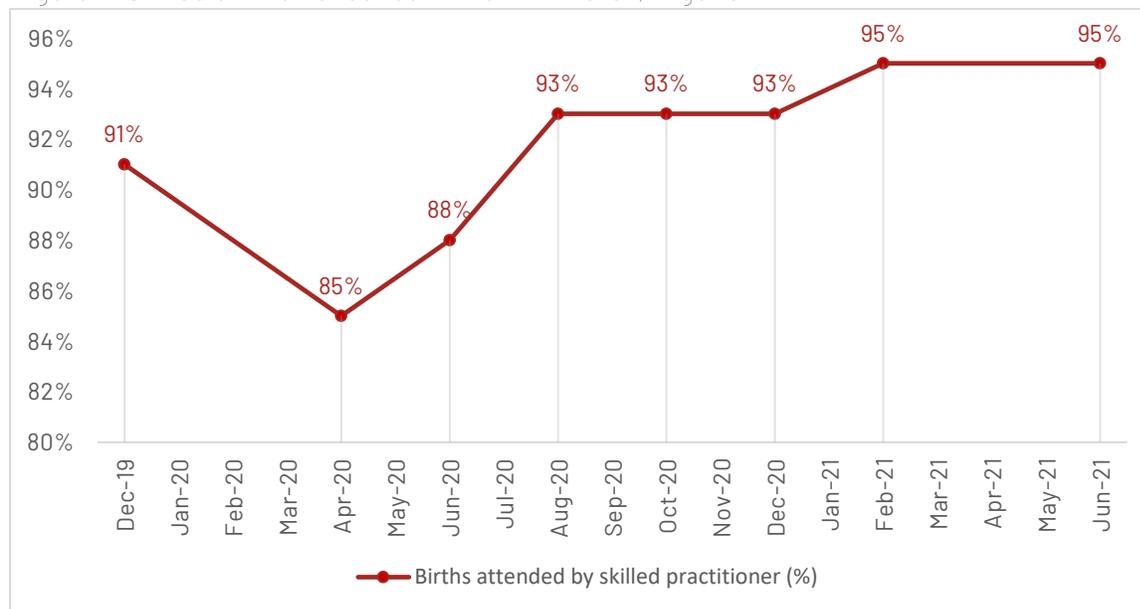


Source:

Heath Sector Nigeria reports 2019 - 2021

In the BAY states it appears that skilled delivery assistance was impacted in the initial months of the pandemic, dropping from 91 per cent in December 2019 to 85 per cent in April. However, these rates began steadily recovering almost immediately, suggesting that initial issues relating to health access and health-seeking behaviour were quickly addressed. The percentage of births attended by a skilled health professional is now 95 per cent, 4 percentage points higher than it was before the pandemic, suggesting that this area of health services has made a strong recovery. These rates are charted in **Figure 7** below.

Figure 7: Skilled birth attendance in the BAY states, Nigeria



Source:

Heath Sector Nigeria reports 2019 - 2021

Impact of COVID-19 on access to health and health-seeking behaviour

In June 2020, 66 per cent of people in Yobe reported that no one in their family had been able to access health services in the past two weeks despite having a medical condition that required attention.²⁸⁶ The primary barriers to SRH access in Nigeria are COVID-19 mobility restrictions;²⁸⁷ lockdowns and curfews,²⁸⁸ and insecurity. In the BAY states, attacks on health facilities and infrastructure have further reduced the number of health clinics that offer SRH services. Figures from March 2021 indicate that only 58.1 per cent of health facilities in the BAY states are fully functional, with 11.4 per cent partially functioning.²⁸⁹ Likely previous years, Borno is the most affected state,²⁹⁰ with 582 security incidents in 2020, up from 216 in 2019. There have been frequent attacks on highways, including the Kano-Maiduguri highway which is the 'only remaining safe route' connecting Borno state with Damaturu, the capital of Yobe capital. This threatens to cut off Borno from the rest of Nigeria. Illegal roadblocks set up by Non-State Armed Groups (NSAGs) particularly target humanitarian aid deliveries – which has had a devastating impact on supply chains during the pandemic.^{291 292} In Adamawa, ACLED reported 49 security incidents in 2020, with a number of health centres attacked and looted.²⁹³ Across the BAY states, in the first quarter of 2021, six facilities were targeted for attack, and medical supplies and equipment have also been looted. In June 2021 only 58.1 per cent of health facilities were fully functioning. 10.2 per cent were non-functioning, and 12.4 were fully damaged.²⁹⁴ As a result, there has been significant disruption to access and availability of health services. Health care workers have been abducted for the benefit of NSAGs, and many who witnessed these attacks have been traumatised and have since left their posts.²⁹⁵

Similar to Burkina Faso, in northeast Nigeria a major determinant of women's health-seeking behaviour is the husband's permission to attend a health centre.²⁹⁶ In the BAY states, many women are restricted by *purdah*, or female seclusion, meaning that they need not only permission from but also accompaniment by a male relative in order to be in public. Access to SRH has also been negatively affected by COVID-19, with fear of the virus causing male permission to decline. It has been reported that husbands have insisted upon the use of traditional birth attendants or neighbouring women for childbirth assistance, in place of seeking formal healthcare. *Purdah* has also impacted women's access to care even when they manage to reach facilities. In the BAY states, it is preferred that women be attended to by female medical staff. A critical shortage of all health staff, often a female nurse or doctor is unavailable, meaning that women's health needs are deprioritized.²⁹⁷

²⁸⁶ OCHA, Yobe Multi-Sector Needs Assessment: Geidam and Kanama Displacement, p.18

²⁸⁷ Kimiri, CARE Rapid Gender Analysis: Northeast Nigeria – Borno, p.1

²⁸⁸ *Ibid*, p.9

²⁸⁹ iMMAP (2021) COVID-19 Situation Analysis – Nigeria, March 2021, p.22

²⁹⁰ EASO (2021) Nigeria Security situation: Country of Origin Information Report, p.122

²⁹¹ *Ibid*, p.129-30

²⁹² *Ibid*, p.115

²⁹³ *Ibid*, p.114

²⁹⁴ Health Sector Nigeria, Northeast Nigeria Humanitarian Response: COVID-19 Response June 2021, p.1

²⁹⁵ *Ibid*, p. 4

²⁹⁶ Kimiri, CARE Rapid Gender Analysis: Northeast Nigeria – Borno, p.2

²⁹⁷ *Ibid*, p.9

4.6 Syria

Pre-pandemic context

Due to a decade of conflict, the Syrian health system was not capable of dealing with the pre-pandemic health needs of the population, let alone prepared to address COVID-19. In December 2019, about 50 per cent of the 113 hospitals across the country were considered partially functional or non-functional. A further 33 per cent of centres were damaged.²⁹⁸ In the northeast, only 9 per cent of public healthcare facilities were functioning in April 2020.²⁹⁹ Health workers, facilities and ambulances have been the targets of direct and repeated attacks since the beginning of the conflict, with the first documented execution of a doctor by pro-government forces occurring in March 2011.³⁰⁰ 782 health workers were killed between March 2011 and September 2016, and in 2016 alone there were 289 attacks on medical facilities, ambulances and Syrian Arab Red Crescent bases.³⁰¹ As a result of deliberate targeting, more than 70 per cent of the healthcare workforce has left the country since the beginning of the conflict.³⁰² In the northwest, there are only 1.4 healthcare workers for every 10,000 people, compared with the world average of 16:10,000. A Syrian Center for Policy Research study in 2016 found that 31 per cent of people across Syria lived in areas where health workers are insufficient, while 27 per cent lived in areas without any health workers at all.³⁰³ While global maternal mortality rates declined by 38 per cent between 2000 and 2017, in Syria it is estimated that maternal mortality has increased by around 40 per cent since the beginning of the conflict. The risk is highest among adolescent girls under the age of 15, who suffer the highest rates of pregnancy complications and mortality.³⁰⁴ A 2019 study found that only 25 per cent of Syrian women were receiving skilled medical assistance when giving birth.³⁰⁵

Impact of COVID-19 on RMNH outcomes

In Syria, adolescent girls continue to be perceived as an economic and a social burden on the family, best relieved through forced early marriage. OCHA have received increasing reports of families giving pre-pubescent girls **hormonal medication** to speed up puberty so that they can marry and bear children.³⁰⁶ It is believed that this is a result of the desperate economic situation and the stresses/impact of COVID-19.³⁰⁷ Prolonged school closures due to COVID-19 have also increased the risk of early marriage.³⁰⁸ OCHA reports that there has been an increase in **forced abortions** in

²⁹⁸ iMMAP (2021) COVID-19 Situation Analysis – Syria, March 2021, p. 18

²⁹⁹ Ibid

³⁰⁰ Fouad, F.M., Sparrow, A., Tarakji, A. et al (2017) Health workers and the weaponization of health care in Syria: a preliminary inquiry for The Lancet-American University of Beirut Commission on Syria, *The Lancet*, 390, p.2517

³⁰¹ Ibid, p.2518

³⁰² iMMAP, COVID-19 Situation Analysis – Syria, March 2021, p. 21

³⁰³ Fouad et al, Health workers and the weaponization of health care in Syria, p.2517

³⁰⁴ Human Appeal (2020) Risking Death to Give Birth: The consequences of conflict on the health needs of women and girls in Syria, <https://reliefweb.int/sites/reliefweb.int/files/resources/syria-report-website.pdf>, Accessed: 22 August 2018

³⁰⁵ Ibid

³⁰⁶ UNFPA (2020) Overview of Gender-based Violence in Syria Advocacy Brief 2021, UNFPA Regional Syria Response Hub, p.2

³⁰⁷ OCHA (2020) Syrian Arab Republic: Recent Developments in Northwest Syria, Situation Report No.18 – 25 July 2020, p.1

³⁰⁸ UNFPA, Overview of Gender-based Violence in Syria Advocacy Brief 2021, p.2

northwest Syria;³⁰⁹ we can assume that where abortions are performed without consent, they are unlikely to be performed in health facilities or under the supervision of health professionals. However, there is also positive data coming out of Syria – with **skilled assisted delivery** for 95 per cent of births in the Tel Samen IDP, and 87 per cent of pregnant women able to access **antenatal care**. Unfortunately, there is a disparity across IDP camps, with the nearby Twahina camp reporting an 88 per cent facility delivery rate, and 59 per cent access to antenatal care.³¹⁰ This disparity is interesting. Not only is Tel Samen an informal camp, but it also has a greater population size and higher percentage of women of reproductive age compared with the formal Twahina camp. The key variable appears to be the number of healthcare facilities: there is only one in Twahina, while Tel Samen has two.³¹¹

Impact of COVID-19 on access to health and health-seeking behaviour

Reproductive health facilities in **Syria** were equally ill-prepared for the COVID-19 outbreak. The prevention measures against COVID-19 greatly reduced daily patient visits and access to health facilities was greatly hampered. In July 2020, UNFPA reported that the main contributing factors included suspension or lack of health services, the long distances required to reach the health facilities, the scarcity of transportation, and fear of being infected with COVID-19 when accessing health facilities.³¹² The already minimal healthcare workforce has been further reduced since the beginning of the pandemic due to high rates of COVID-19 infections among health workers. Data collected over a year later indicated that this picture has not greatly improved; increased wait times, a lack of doctors, and no available appointments were all cited as the main impacts on health services.³¹³ As a result, 45 per cent of people in Syria reported a lack of healthcare access in December 2020.³¹⁴ However data collection in Syria in August 2021 seems to indicate that this has improved slightly, with only 38.75 per cent reporting reduced access.³¹⁵

As with the DRC, Burkina Faso, Bangladesh, travel costs were cited as barriers to SRH access to Syria.³¹⁶ In March 2021, 86 per cent of those who required healthcare in the informal IDP camp Tel Samen in Syria faced barriers accessing medical care. The leading barriers were cost of health services (reported by 93 per cent of informants) and cost of transportation to health facilities (80 per cent).³¹⁷ In the Twahina camp, 96 per cent of people reported barriers to health access.³¹⁸ iMMAP data collection from July–August 2021 indicates that stay at home guidance and restrictions on movement continue to have an impact in Syria.³¹⁹ Continued conflict and insecurity in Syria is also exacerbating barriers to health access. According to a December 2020 survey, close to 60 per cent

³⁰⁹ OCHA, Syrian Arab Republic: Recent Developments in Northwest Syria, Situation Report No.18 – 25 July 2020, p.1

³¹⁰ REACH (2021) Camp Profile: Twahina Ar-Raqqa governorate, March 2021, p.2

³¹¹ REACH (2021) Camp Profile: Tel Samen, Ar-Raqqa governorate, March 2021, p.2

³¹² UNFPA Syria (2020) COVID-19 Humanitarian Response Flash Update #6, p.2

³¹³ iMMAP data collection 2021

³¹⁴ UNFPA (2021) The protection situation during COVID-19 in Syria, Protection and Community Services Sector Inside Syria, 1st February 2021, p.11

³¹⁵ iMMAP data collection 2021

³¹⁶ UNFPA Syria, COVID-19 Humanitarian Response Flash Update #6, p.2

³¹⁷ REACH (2021) Camp Profile: Tel Samen, Ar-Raqqa governorate, March 2021, p.2

³¹⁸ REACH (2021) Camp Profile: Twahina Ar-Raqqa governorate, March 2021, p.2

³¹⁹ iMMAP data collection 2021

of people in the northwest had been directly impacted by an attack on a healthcare facility or health worker, and around 25 per cent of people reported being unable to receive medical treatment due to an attack on a health facility.³²⁰ In July 2020 alone, both a primary healthcare facility and a medical supplies warehouse were attacked.³²¹

It is estimated that more than half a million women inside **Syria** and in host communities throughout the region are pregnant. However, in many places, pregnant women are refraining from visiting health facilities due to movement restrictions or fears about exposure to the virus.³²² Social acceptance and fear of stigmatisation are also influencing health-seeking behaviour. As a result of this, a significant number of patients with COVID-19 symptoms go to health facilities late, decreasing their chance of survival. This is causing a high rate of fatalities in health facilities, which strengthens people's reluctance to seek treatment for their health needs due to fear of infection and death. Fear and profound distrust of state institutions in Government-held areas is also causing people to refrain from seeking healthcare.³²³ Attacks on health facilities is also a deterrent; approximately a third of people in the northwest had directly witnessed or experienced an attack on a health facility and as result there are high rates of anxiety and fear around seeking healthcare.³²⁴

4.7 Availability of RMNH data for decision-making across six countries

As noted in many points throughout this report, there are significant gaps in the data on the impact of COVID-19 on RMNH and SRH. Comprehensive and quality data is essential for RMNH and SRH decision-making. Without information on gaps in services, barriers to access, and numbers of people affected, government health ministries and humanitarian Health Clusters cannot meaningfully respond to the health emergency with targeted strategies and resources. The main sources of information gaps are where the data is inconsistent or contradicts one another, and where there is simply no reporting on SRH at all. The types of data gaps will be explored in this section, as well as a discussion of the reasons behind these.

A failure to report against consistent indicators makes it very difficult to use data to measure trends over time, analyse correlations, and speculate about causation. In **Bangladesh**, although the WHO produces weekly or bi-weekly Reports on the Cox's Bazar camps, a review of 2018, 2019, 2020 and 2021 reports reveals that the reports inconsistently report on indicators and fail to put data in sufficient context to make the information meaningful. For example, the Rohingya Crisis Situation Report #15, covering 19 July – 1st August 2021, reports 5 new probable maternal deaths for a

³²⁰ iMMAP, COVID-19 Situation Analysis – Syria, March 2021, p. 23

³²¹ OCHA (2020) Syrian Arab Republic: Recent Developments in Northwest Syria, Situation Report No.18 – 25 July 2020, p.2

³²² Mlambo-Ngcuka, P. and Kanemu, N. (2020) Op-ed: Put women at the centre of Syria crisis response, Reliefweb, 2 July 2020, <https://reliefweb.int/report/syrian-arab-republic/op-ed-put-women-centre-syria-crisis-response>, Accessed 17 August 2021

³²³ iMMAP (2021) COVID-19 Situation Analysis – Syria, March 2021, p.7

³²⁴ Ibid, p.23

cumulative total of 74 probably maternal deaths in 2021, 19 of which were reported by facilities.³²⁵ This information is not presented in context of how many births took place in the month or year in total, how many took place in facilities, or how many were attended by a skilled practitioner. For roughly the same reporting period in 2020 (Situation Report #16 covering 20th to 26th July 2020, and Situation Report #17 covering 27th July to 2nd August 2020), no update is provided on maternal deaths (for either the reporting period or the year to date) or on live births.^{326 327} The 2019 report from the same period reports on stillbirths that occurred during the reporting period (but not year to date), but this is not set against the total number of live births for context.³²⁸ In 2018, again no RMNH data was reported.³²⁹

UNHCR data is similarly inconsistent. For example, UNCHR reported that 558 deliveries were conducted by a skilled attendant in health facilities in July and August 2020, for a cumulative total of 1,963 facility deliveries to date that year.³³⁰ The report for the same period in 2019 also captures facility births (reporting period and cumulative),³³¹ but the 2018 and 2021 reports do not.^{332 333} Thus, we are only able to tell a story about the change between 2019 and 2020; this is helpful towards understanding the impact of COVID-19, it does not paint a picture of broader trends. Furthermore, while the UNCHR data about facility births may provide helpful context for the WHO data about maternal mortality, it is difficult to ascertain whether these reports speak to one another. It is unclear whether the same population group is reported on, or whether the data is validated and cross-checked by the Health Cluster. Inconsistent reporting against indicators makes it very difficult to understand the 2021 maternal deaths; we cannot use previous reports to understand whether this is an increase or decrease since the beginning of the pandemic, and indeed cannot examine other potential correlations or causations.

A similar issue is apparent in **Nigeria**. The Health Sector (joint partnership between the Government of Nigeria and the WHO) releases a monthly Bulletins reporting on the situation in the BAY states;

³²⁵ WHO (2021) Rohingya Crisis Situation Report #15, Weeks 29-30, 19 July - 1 August 2021, https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/2021/who-cox-s-bazar-situation-report-15.pdf?sfvrsn=f1b3bf3d_9, Accessed: 21 August 2021

³²⁶ WHO (2020) Emergency: Rohingya Crisis Situation Report #16, Week 30, 20-26 July 2020, https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/sitreps-2020/who-cox-s-bazar-sitrep-16.pdf?sfvrsn=98ec8d21_2, Accessed: 21 August 2021

³²⁷ WHO (2020) Emergency: Rohingya Crisis Situation Report #17, Week 31 27 July - 2 August 2020, https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/sitreps-2020/who-cox-s-bazar-sitrep-17.pdf?sfvrsn=d4b1dad2_2, Accessed 21 August 2021

³²⁸ WHO (2019) Emergency: Rohingya Crisis Bi-weekly Situation Report #15 Weeks 29-30, 14-27 July, https://www.who.int/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/2019/bi-weekly-situation-report-15---1-august-2019.pdf?sfvrsn=f94fade0_2 Accessed: 21 August 2021

³²⁹ WHO (2018) Emergency type: Rohingya Refugee Crisis Weekly Situation Report #37, 25-31 July 2018, https://www.who.int/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/2018/weekly-sitrep37-cxbban.pdf?sfvrsn=86a02512_2, Accessed: 21 August 2021

³³⁰ UNCHR (2020) Rohingya Refugee Response - Bangladesh Factsheet - Public Health, 31 August 2020

³³¹ UNHCR (2019) Rohingya Refugee Response - Bangladesh Factsheet - Public Health, 21 July 2019, <https://reliefweb.int/sites/reliefweb.int/files/resources/71418.pdf>, Accessed: 21 August 2021

³³² UNCHR (2018) Bangladesh Refugee Emergency Response Factsheet - Health, August 2018, <https://reliefweb.int/sites/reliefweb.int/files/resources/65839.pdf>, Accessed: 21 August 2021

³³³ UNHCR (2021) Rohingya Refugee Response - Bangladesh, Population Factsheet, 30 June 2021 <https://data2.unhcr.org/en/documents/details/87998>, Accessed: 21 August 2021

these reports provide an overview of activities for all health organisations operating in the region. Unfortunately, this data does not appear to be cumulatively tallied and validated by WHO to control for double counting. As an example, the July 2021 Bulletin includes reports from 25 organisations operating in the region, however the type of information reported varies from organisation to organisation. Regarding ANC, the following information was reported:

- UNFPA reports that 748 women attended ANC consultations in reporting period,
- PUI reports 3,843 consultations (number of women not specified),
- FSACI reports that 324 women visited health facilities for at least four visits (presumably over a longer interval than the one-month reporting period),
- UNICEF reported 15,093 visits,
- ALIMA disaggregated their data into local government areas, reporting on total ANC visits as well as number of first visits,
- and Action Against Hunger reported that 12,188 women received ANC services.³³⁴

From this reporting, we do not glean a clear overall picture of the number of women receiving ANC care or the number of ANC consultations that they had between them. Some organisations are reporting on the number of ANC consultations, while others are reporting on the number of women who received an ANC. Therefore, if a woman for some reason received more than one ANC consultation in the reporting period, this would be captured differently by each organisation. We also have no way of knowing if there is double-counting involved – that is, whether a woman has sought ANC care from more than one facility and has thus been counted multiple times. This snapshot of the July report reflects the reporting style of the other reports in this series. While we are able to compare individual organisations' numbers against each other for each month (for example, UNICEF reported 15,093 visits in July 2021, which we can compare against the 17,795 visits in July 2020,³³⁵ and 25,849 visits in July 2019³³⁶) which is helpful, we are only seeing one fraction of the broader picture, and we do not know what percentage UNICEF visits account for out of all ANC care provided in the northeast each year, and whether that percentage has fluctuated over time. It may well be that UNICEF's presence in the region has contracted over time, and that the fall in numbers is not related to COVID-19 but instead to patients seeking care at other facilities.

Arguably, inconsistent, and 'messy' data is more helpful than no data, which is unfortunately the case in **Syria**. Among the reports exported from DEEP, there was almost no data on SRH in **Syria**. Where mentions were made of health services and access, these tended to be in relation to the general population, rather than women and girls' specific health needs. Information also tended to be qualitative, with almost no quantitative data available. While qualitative data, especially anecdotes

³³⁴ Health Sector Nigeria (2021) Northeast Nigeria Humanitarian Response, COVID-19 Response, July 2021, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/health_sector_bulletin_july_2021.pdf, Accessed: 21 August 2021

³³⁵ Health Sector Nigeria (2020) Northeast Nigeria Humanitarian Response, COVID-19 Response, July 2020, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/health_sector_bulletin_july2020_ne_nigeria.pdf, Accessed: 21 August 2021.

³³⁶ Health Sector Nigeria (2021) Health Sector Bulletin: Northeast Nigeria Humanitarian Response, July 2019, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/health_sector_bulletin_july_19_ne_nigeria.pdf, Accessed: 21 August 2021

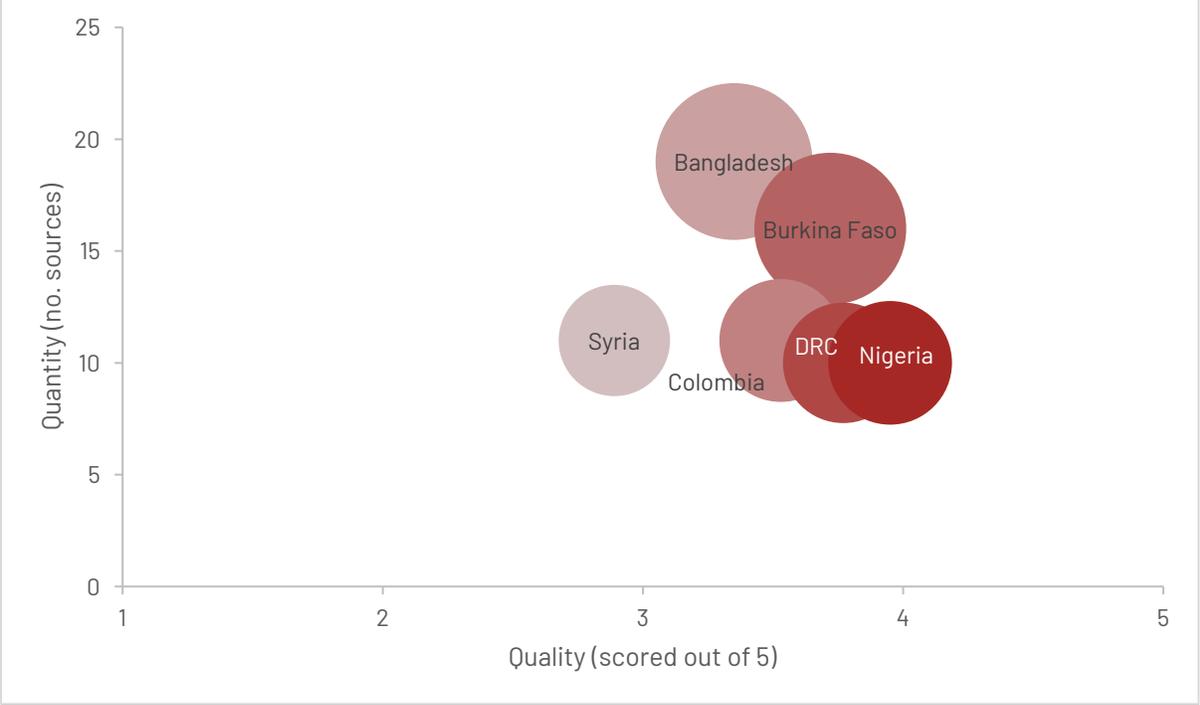
and reports from health workers and patients about perceived access and availability of health services, are extremely helpful in understanding the context, complementing this with quantitative data often helps to establish trends and draw comparisons. Essentially no data was available on FP consultations and contraceptive access in Syria; it is unclear whether these services are not provided or if they are simply not reported on for logistical or political reasons. An area of inquiry that warrants further research is the claim that there has been an increase forcing the premature start to puberty in order to enable CEFM for young girls. More information is needed as to how puberty is being sped up (for example, whether hormonal treatments are being used), how many girls are affected, demographic information on the girls affected (e.g., locations, household income) and what the projections are for fertility rates and adolescent pregnancies over the coming years. Another area of recommended further research is on the accounts of increased forced abortion in Syria; more information as to where and how these abortions are being procured, demographic factors, as well as the morbidity and mortality rates associated with these (if relevant), would allow for targeted health sector response.

In **Colombia**, much of the information available is similarly qualitative. While we do have quantitative information on contraceptive access and uptake, as well as information on fertility rates and adolescent pregnancy, since the beginning of the pandemic there appears to be no reliable data on ANC visits, skilled assisted delivery, or maternal mortality rates. The most amount of information we gain from reports in this area is accounts that border closures are affecting Venezuelan women's access to SRH services. There is not enough information available to understand how many women are affected, and whether there have already been negative health outcomes as a result. Information out of Colombia is also presented in formats that make it difficult to assess the full picture. OCHA produces regular reports, however these are either specific to individual towns or local government areas within Colombia or are region-wide reports encompassing the situation in Colombia, Peru, and Brazil. This makes it a difficult jigsaw to piece together composite parts in order to establish country-level information.

There is a similar situation in the **DRC**, where information is recorded by OCHA according to region (or 'hub'). Not all hub reports capture the same information or report against the same indicators, making it difficult to piece together a country-level view. As seen in this report, information presented about the DRC is often specified as being in reference to a particular city or region, because country-wide information is not available. Overall, data availability in **Burkina Faso** is good, with the only significant gap being information on ANC coverage both pre- and during the pandemic. This in itself is interesting, given that there is information available on contraceptive use and family planning, fertility rates, maternal mortality, and health access. It is unclear why humanitarian agencies do not seem to be reporting on ANC coverage in the country – this is a gap that warrants further research.

Figure 8 (below) provides an illustration of the quantity (number of sources) and quality (scored 1-5) of data available for each focal country. Quality of data was measured on the number of mentions of RMNH and SRH themes, the relevance and timeliness of data, the level of qualitative and quantitative data provided, the trustworthiness of the source, and the ability to put this data into context or make meaningful comparisons.

Figure 8: Quality and quantity of RMNH data available for decision-making



5. Conclusion

Globally, the COVID-19 pandemic has a severe impact on health systems' ability to meet population needs. This has been particularly the case in low resilience settings, including LMICs and humanitarian contexts where the health sector was ill-prepared and resourced to respond to a pandemic. Previous events have demonstrated that women and girls are disproportionately affected by health emergencies given their unique health needs, the propensity for SRH services to be re-allocated towards emergency-response, and due to gender inequities that create additional barriers for women and girls seeking access to healthcare. Early data from the COVID-19 pandemic suggests that this pattern is continuing, and that the gains made globally towards increasing contraceptive access, safe abortion, ANC coverage and skilled assisted deliveries are being undermined, causing troubling spikes in adolescent pregnancy, unsafe abortions, and maternal and neonatal mortality. Data from the six focal countries demonstrates that SRH has been dramatically affected. In a number of countries, the need for contraceptives has increased during the pandemic, particularly among nulliparous women. Early data indicates that this is causing an increase in unwanted pregnancies, particularly among adolescent girls, who have become vulnerable to CEFM and sexual assault while schools have been closed. An increase in unplanned pregnancies coupled together with a repurposing of SRH facilities to the pandemic response increases the risk of unsafe abortions; data from the DRC in particular demonstrates that the rate of unsafe abortions is increasing. ANC coverage and skilled assisted delivery rates also appear to be impacted across most of the focal countries.

Barriers to health access have increased since the beginning of the pandemic. These include a lack of SRH availability due to clinic closures and repurposing towards the pandemic response, as well as a lack of skilled healthcare workers due to COVID-19 illness, burnout, and conflict. Supply chains have been disrupted due to lockdowns and border closures, and the cost of healthcare has become prohibitive for many families experiencing partial or total income loss due to the pandemic. In Nigeria in particular, the impacts of the conflict in the BAY states and the pandemic have intersected to create complex and compounding access barriers that significantly impact the health of women and girls. Health-seeking behaviour has been likewise impacted, with perceptions that family planning and contraceptive services do not constitute 'essential' healthcare, as well as fear of contracting COVID-19 in medical settings. Equally as significant as the data that this report presents is the data that is missing. From surveying academic studies and humanitarian reports on SRH access, availability, and outcomes since the pandemic, we can observe significant gaps in information. The availability of quality data is essential for decision-making; data is used to inform health budget allocations and humanitarian responses. Where data is contradictory and conflicting, such as in Bangladesh and Nigeria, governments and Health Clusters are unable to assess the true scale of the need for response. In contexts where there is no data (either against a particular area of SRH, or across the board), this problem is magnified because it can render the issues completely invisible. For example, good data in Burkina Faso on contraceptive access disguises a lack of data on ANC coverage, which can lead to an assumption that ANC coverage must be good if it isn't reported. Similarly, in Syria where deaths from other causes are being reported, maternal deaths can be rendered invisible.

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Annex 1: List of DEEP sources

A total of 76 humanitarian reports and documents were identified during the DEEP exportation of data related to RMNH. 42 of these were relevant and were cited in this report. Below is a breakdown of the reports and documents identified during the DEEP export. Other reports and documents listed under 'References' were sources via academic journals, ReliefWeb, HumanitarianResponse.info, and UN and INGO websites.

| Focal Country | No. relevant docs | Source details |
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| Bangladesh | 4 | Office of the UN Resident Coordinator in Bangladesh (2020) <i>Humanitarian Coordination and Collaboration in Bangladesh</i> , Dhaka: United Nations Bangladesh |
| | | UNHCR (2020) <i>Rohingya Refugee Response - Bangladesh, Factsheet - Public Health</i> , 31 August 2020 |
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| | | Karp, C., Wood, S.N., Guiella, G. et al (2021) <i>Contraceptive dynamics during COVID-19 in sub-Saharan Africa: longitudinal evidence from Burkina Faso and Kenya</i> , <i>BMJ Sex Reprod Health</i> , 0:1-9 |

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| | | <p>Lefaso.net (2020) Impact du Covid-19 sur les jeunes filles et les femmes: La pandémie a exacerbé les violences basées sur le genre, selon une étude de l'IPBF, IPBF, 5 October 2020, http://lefaso.net/spip.php?article99753, Accessed: 15 August 2021</p> |
| | | <p>Plan International (2020) <i>COVID-19 and Child Marriage in West and Central Africa</i>, Dakar: Senegal</p> |
| | | <p>Première Urgence Internationale (2020) <i>Rapport de Mission Exploratoire: Boucle du Mouhoun</i></p> |
| | | <p>OCHA (2020) <i>Burkina Faso: Aperçu des besoins humanitaires 2021</i></p> |
| | | <p>WHO (2020) Burkina Faso: Review of Maternal Deaths and the Continuity of Essential Reproductive, Maternal, and Child Health Services in the Context of Covid-19 and the Humanitarian Crisis in the Sahel, <i>All Africa</i>, 1 October 2020, https://allafrica.com/stories/202010020073.html</p> |
| | | <p>World Bank Group (2021) <i>Roads to Schools and Healthcare Facilities: Identifying Accessibility Gaps in Burkina Faso</i>, Washington D.C: World Bank</p> |
| Colombia | 6 | <p>Caribe Afirmativo (2021) <i>Situación de derechos humanos de personas con necesidad de protección internacional provenientes de Venezuela en Colombia</i></p> |
| | | <p>CEPAL (2020) <i>Los riesgos de la pandemia de COVID-19 para el ejercicio de los derechos sexuales y reproductivos de las mujeres</i></p> |
| | | <p>GIFMM and R4V (2020) <i>GIFMM Colombia Evaluación Conjunta de Necesidades ante Covid-19</i>, Bogota</p> |
| | | <p>IOM (2020) <i>Acceso a Servicios de Salud de las Mujeres Migrantes y Refugiadas de Venezuela</i></p> |
| | | <p>OCHA Colombia (2020) <i>Plan de Respuesta COVID-19: Colombia</i>, Bogota: OCHA</p> |
| | | <p>Plan International Américas (2021) <i>Niñas Venezolanas: Voces de la Migración, Estudio en Colombia, Ecuador y Perú</i></p> |
| DRC | 6 | <p>CASS (2021) <i>Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo</i>, DRC: UNICEF</p> |
| | | <p>CASS (2021) <i>Fermeture des Écoles en Lien avec la COVID-19 en RDC: Impacts sur la Santé, Protection et Éducation des Enfants et Adolescents</i>, DRC: UNICEF</p> |
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| | | <p>REACH (2020) <i>Suivi de la situation humanitaire: Province du Sud-Kivu, République du Congo (RDC)</i></p> |

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The outbreak of disease caused by the virus known as Severe Acute Respiratory Syndrome (SARS-CoV-2) or COVID-19 started in China in December 2019. The virus quickly spread across the world, with the WHO Director-General declaring it as a pandemic on March 11th, 2020.

The virus' impact has been felt most acutely by countries facing humanitarian crises due to conflict and natural disasters. As humanitarian access to vulnerable communities has been restricted to basic movements only, monitoring and assessments have been interrupted.

To overcome these constraints and provide the wider humanitarian community with timely and comprehensive information on the spread of the COVID-19 pandemic, iMMAP initiated the COVID-19 Situational Analysis project with the support of the USAID Bureau of Humanitarian Assistance (USAID BHA), aiming to provide timely solutions to the growing global needs for assessment and analysis among humanitarian stakeholders.



BETTER DATA | BETTER DECISIONS | BETTER OUTCOMES

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