WISH2ACTION

Learning brief

Ensuring the continuity of government sexual and reproductive health/family planning services during the COVID-19 pandemic:

Experiences and lessons from the Women's Integrated Sexual Health (WISH2Action) programme

Key takeaways

The COVID-19 outbreak:

1. Provided new sexual and reproductive health/family planning (SRH/FP) policy opportunities, such as accelerating the introduction of self-care
2. Presented the opportunity to make SRH/FP systems more resilient and better prepared for a future pandemic
3. Led to stronger government stewardship of SRH/FP, including allocating more funding for contraceptive commodities

Introduction

Under the UK aid funded WISH2Action programme, Options Consultancy provides technical assistance to seven countries - two in South Asia (Bangladesh and Pakistan) and five in Sub-Saharan Africa (Malawi, Madagascar, Zambia, Tanzania, and Uganda) - to create an enabling environment for sexual and reproductive health/family planning (SRH/FP) services and increase national ownership. The programme's enabling environment work consists of four main work streams: 1) creating a favourable SRH/FP policy and planning environment; 2) improving public sector investment for SRH/FP; 3) strengthening national stewardship for quality improvement of SRH/FP services; and 4) establishing accountability systems to influence and track SRH/FP commitments and policies. Options' role became even more important since the COVID-19 outbreak shifted government priorities to managing the pandemic response, which subsequently led to the disruption in the delivery of essential health services and threatens to reverse the SRH/FP gains these countries have made to date.

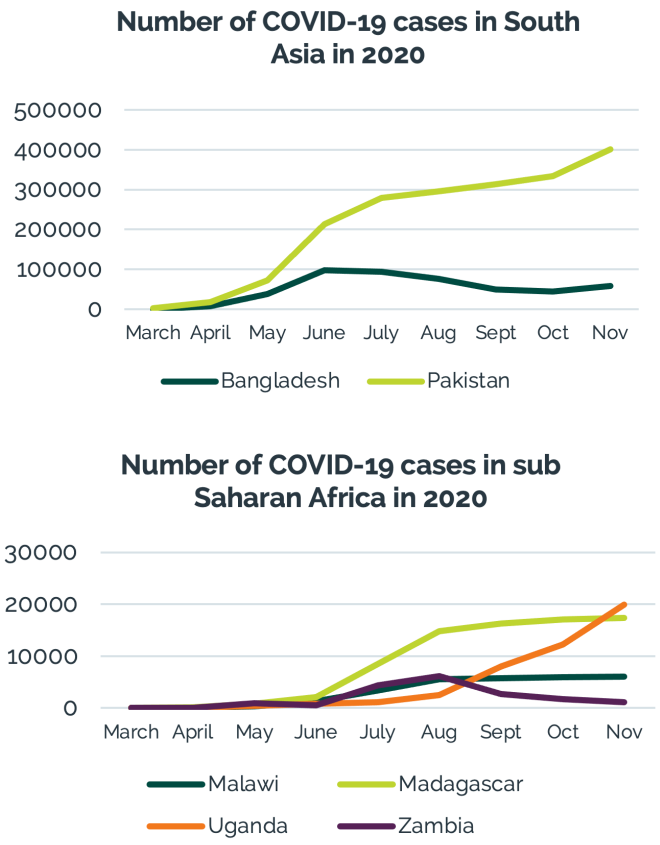
Options had been implementing the WISH2Action programme in these seven countries for 15 months, and had built a strong relationship with governments when COVID-19 struck. This learning brief outlines our experience in working with governments during the pandemic to ensure access to SRH/FP services remains a priority, and our efforts to keep the pre Covid-19 enabling environment work on track. It draws out wider lessons on the range of actions that can be taken at policy and systems level to protect SRH/FP services during a health emergency in different country contexts, taking into consideration the severity of their outbreaks as well as their socio-political environment and health systems preparedness.

COVID-19 and disruption to SRH/FP services:
All seven countries had confirmed COVID-19 cases by April 2020. The outbreak was larger in South Asia than in Sub Saharan Africa, and Pakistan was the most heavily impacted country. Pakistan registered a total 908 cases per 100,000 population from March to November 2020. In the same period in Africa, Madagascar had the largest number of cases at 293/1000,000, compared to Zambia (101/100,000) and Malawi (156/100,000). Figure 1 displays the number of monthly COVID-19 cases in 6 countries by region. Tanzania reported a total of 509 cases of COVID-19 and 21 deaths in March and April 2020 to the World Health Organisation (WHO). But the country stopped reporting cases in June 2020 once the President denied the existence of the pandemic and declared the country free of COVID-19.

Governments across the seven countries were quick to introduce lockdown measures and to turn their attention to COVID-19 prevention, management, care and treatment. However, it took them time to distribute personal protection equipment (PPE) to facilities and implement track and test systems. While health facilities remained open in all countries except for Pakistan, SRH/FP provision was severely curtailed in the first few months of the pandemic as both health staff and clients were not able to reach facilities due to the enforced curfews and lack of public transportation, and fear of contracting the virus in health facilities. All this led to a drop-in uptake of SRH/FP services

in public facilities in all countries, during the first few months of the pandemic.

Figure 1: Number of COVID-19 cases in Sub Saharan Africa and South Asia



Source: Official COVID-19 data reported by the respective governments

Ensuring the continuity of SRH/FP services

Options' WISH2Action country teams reached out to governments at the start of the pandemic to offer technical assistance (TA) and stress the importance of maintaining SRH/FP services throughout the emergency. In almost all cases, this was done through virtual channels due to lockdown, using platforms such as SRH/FP Technical Working Groups (TWGs) and in some cases newly established COVID-19 Committees. At the same time, country teams continued their efforts to deliver against their originally planned work of creating an enabling environment for SRH/FP. This section outlines the activities that were undertaken, during the first six months of the pandemic, to ensure SRH/FP would be considered an essential service, as part of the four work streams.

1 Policy and planning

The Options teams shifted their attention towards alerting governments to the detrimental impact COVID-19 was having on SRH/FP services, and what measures to take to minimise the disruption. Two main activities were advocacy through policy briefs and the promotion of self-care.

Publishing policy briefs: Zambia, Madagascar, Uganda and Pakistan teams produced policy briefs to advocate to governments to declare SRH/FP services essential during the pandemic, and advise them how they could practically modify service delivery approaches to ensure uninterrupted provision. The briefs outlined context specific strategies to ensure the continuation of SRH/FP services during the health emergency and post recovery period, which included introducing robust infection control measures (IPC), placing greater emphasis on community-based care and self-care, ensuring commodity security and multi-month contraceptive dispensing, and reaching out to adolescents through social media and other virtual platforms.

Options disseminated the policy briefs to decision makers through a variety of channels, including in hard copy, and virtually to SRH/FP TWGs, National Health Taskforces, and Parliamentary Health Committee, among others. Additionally, in several countries, the advocacy messages were packaged by civil society accountability mechanisms and taken up by the media.

It is hard to measure and directly attribute the policy briefs' impact on government decisions and ultimately on the continuity of SRH/FP services. However, governments did introduce COVID-19 guidelines in Zambia, infection control guidelines and training in Pakistan, and DMPA-SC self-care in Madagascar after the briefs were published and disseminated. We can therefore conclude that the policy briefs, together with advocacy efforts other technical partners undertook, contributed to these decisions.

Promotion of self-care: Madagascar, Zambia, and Uganda recognised the potential for self-care (i.e. SRH/FP products that can be self-administered, such as the injectable contraceptive DMPA-SC and emergency contraception) as a way of circumventing the service delivery challenges that they face during the COVID-19 crisis. In Madagascar, Options and other partners had already laid much of the ground-work for introducing self-injection, including operational guidelines and regional level training, prior to the start of the pandemic. However, the programme had still not been officially launched and rolled out. Recognising that COVID-19 presented an opportunity to accelerate the national operationalization of self-injection, Options briefed the Madagascan Ministry of Health on the advantages of promoting DMPA-SC self-injection as part of their health emergency response. This led to the official launch of the DMPA-SC programme the following week on (28 May 2020) through a webinar with all 22 regional health directors present, and rollout of operational guidelines to service providers.

The policy change enabled women and girls to visit health facilities, receive training on self- administration by health workers and get their first injection at a health facility, and take home two further doses for self-administration. This means they will not have to return to the facility before nine months. The introduction of the self-injectable among the methods of choice during the pandemic has led to a significant rise in DMPA-SC uptake, from 3205 new users in May to 7536 new users in January 2021.

2 Health financing

In this work stream, country teams focused on preventing governments re-prioritising resources during the health emergency that would be detrimental to SRH/FP. At the same time, they continued to pursue their on-going work to

strengthen public investment and spend in SRH/FP through virtual platforms, and stressing this was even more important in the context of the pandemic.

Producing SRH/FP investment cases and undertaking budget advocacy: Bangladesh, Madagascar and Malawi published investment cases to advocate to governments on the importance of continuing funding for SRH/FP programmes during the COVID-19 crisis and recovery period. The investment briefs reinforced the message that a reduction in SRH/FP funding during the crisis would lead to a disruption in service provision, increased pressure on the health system, and additional maternal, newborn and child deaths. The briefs were disseminated to parliamentarians, ministries of finance, health directorates, regional and district councils and civil society, with some success.

For example, in Malawi, the country teams used the investment case to advocate to Members of Parliament for an increase of the annual FP commodity budget to ensure uninterrupted provision of family planning services. This resulted in a 14% increase in the commodity budget from $224,000 in the financial year 2019/20 to $254,500 in 2020/21.

In Zambia, Options had identified the low disbursement and use of allocated SRH/FP budget as the main financing challenge. Building on their budget monitoring and tracking work, the team made the case to the Parliamentary Committee for Health that the timely release and utilisation of SRH/FP funds was important during the COVID-19 crisis to prevent FP commodity stock outs. This led to parliamentarians querying the underspend with the Ministry of Finance, who in turn followed up with the Ministry of Health. This collective advocacy effort resulted in more timely disbursements being made to districts during the pandemic. By Quarter 3 of FY2020, 67% of the SRH/FP budget had been spent compared to only 41% during the same period in the previous year.

3 Quality improvement

As in the other work streams, the quality improvement (QI) work, which aimed at identifying and addressing gaps in SRH/FP service quality and monitoring results, was adjusted to respond to government needs during the COVID-19 pandemic, while the team also developed strategies to ensure a continued focus on WISH2Action's programme goals.

Developing a QI stewardship assessment tool: Options designed a tool to assess the level of disruption to QI stewardship work during the COVID-19 pandemic and help identify support needs of government to address QI for SRH/FP during the pandemic. The tool scores countries against several criteria, including disruption to government capacity to act as steward over SRH/FP, government prioritisation of SRH/FP during COVID-19, and level of disruption and adaptation to SRH/FP services. The assessment is repeated periodically to track progress being made, as well as identify new needs. Following the assessment, the Pakistan team helped the Population Welfare Department (PWD) rollout training in infection prevention and control (IPC) in 4 districts, and developed and disseminated COVID-19 related information education and communication (IEC) aides for health workers and service users. The PWD had closed all their facilities as soon as the pandemic arrived in the country due to lack of IPC measures and PPE, and as a result of the support provided by Options, they were able to reopen facilities in these districts by the end of July.

Building resilient QI systems: The Bangladesh team had been working with the Department of Family Planning to develop a digital monitoring system to track the quality of SRH/FP services when the pandemic struck. They seized the opportunity to incorporate new indicators related to COVID-19 infection and prevention control in this system that enabled tracking of health staff and client safety in health facilities, including hand washing, and social distancing. This has resulted in a more resilient SRH/FP QI system, and greater preparedness for a future COVID-19 or other outbreak.

4 Accountability

Madagascar, Zambia, Uganda, Malawi, and Bangladesh country teams, who had been helping to strengthen civil society accountability mechanisms for SRH/FP, pivoted their attention towards holding government to account for the continuation of SRH/FP services during the pandemic. By working in a complimentary manner with the other WISH2Action work streams, especially policy and planning and health financing, the accountability work was able to deliver synergistic impact. Actions undertaken by the civil society accountability mechanism included: generating information on the impact COVID-19 was having on SRH/FP service delivery and uptake by women and girls; packaging the evidence into compelling formats (including advocacy messages contained in the investment and policy briefs); and using it to advocate to key decision makers to continue providing SRH/FP information, counselling and services. Advocacy messages were targeted at decision makers within central government and at sub national levels, using a range of platforms, such as parliamentary committees, budget committees, SRH/FP technical working groups, district forums, and one to one meetings. Several of the accountability structures (Uganda, Madagascar, and Zambia) worked with the print and digital media to draw attention to the impact COVID-19 was having on SRH/FP services, as a way to build pressure on government to act. They were supported and encouraged to publish human interest stories, highlighting the impact the neglect of SRH/FP services was having on vulnerable groups, such as adolescents and the disabled.

Advocating to regional and district officials to ensure the continued provision of SRH/FP services: In Uganda, the lead civil society organisations under the sub national accountability mechanism in Bugiri and Kaliro districts conducted a rapid assessment to gather evidence on the impact of the pandemic on SRH/FP service access, which they shared with the District Task Force on COVID-19. Our advocacy work in Uganda led to an easing of restrictions that had limited the provision of community outreach FP services. In Madagascar, Options' supported its civil society accountability partner COMARESS, who operates in all of the country's 22 regions, to develop regional advocacy strategies. In the Vatovavy Fitovinany region, the COMARESS affiliate met with its regional RH/FP manager and presented information from this assessment on SRH/FP uptake. Following the meeting, the regional manager sensitised health workers on the importance of continuing to provide quality FP services and ensure the availability of

FP commodities. He also went on a local radio programme to urge the public to continue to visit health facilities and informed them it was safe to do so.

Programme contribution to mitigating the disruption of COVID-19 on SRH/FP service uptake

Due to the lack of preparedness for the health emergency, including securing infection control in health facilities quickly and not considering SRH/FP an essential component of the emergency response, all the countries, except Tanzania, experienced a decline in SRH/FP uptake (as indicated by modern contraceptive prevalence rate (mCPR), number of new FP users, FP discontinuation, and number of injectable users), when compared to FP uptake in the previous year. Most countries experienced the biggest fall/negative impact during March to May 2020, followed by a gradual improvement from June/July onwards. As of November 2020, the majority had reached or almost reached pre COVID-19 performance levels, with the exception of Pakistan. Tanzania is an outlier in that there is no discernible impact of COVID-19 on FP uptake.

Although data is not yet available to demonstrate the direct impact of Options' work on countries' FP performance, we can conclude that our interventions, together with those by other technical partners, contributed to minimising the SRH/FP services disruptions caused by the pandemic. For example, work undertaken in Pakistan's QI pathway on supporting infection prevention control (IPC) training as well as printing and sharing of communication materials, through virtual platforms, directly led to the reopening of health facilities in July. Similarly, in Zambia, advocacy undertaken through the policy and planning, health financing, and accountability work streams led to stronger COVID-19 safety measures in health facilities, SRH/FP service adaptations (such as self-care), and the timelier release of the FP commodities budget, which, in turn, helped reverse the negative impact that COVID-19 had on SRH/FP services.

Most countries were able to resume their pre-COVID work two to three months into the pandemic (mostly continuing to do this through virtual platforms), when government had more bandwidth to engage with technical partners. In some cases, COVID-19 actually served to strengthen the case for their enabling environment work. In Malawi, for example, our advocacy work during the pandemic played a role in increasing the FP commodities budget.

Overview of key lessons

- **Options country teams were well placed to help the government to mitigate the impact of COVID-19 on SRH/FP services:** The strong relationships that had already been built with governments (including with Ministries of Health, Ministries of Family Welfare/ Population Welfare) and parliamentarians meant that Options country teams were able to quickly pivot their advocacy and technical support towards COVID-19 mitigation.

- **The political economy is the most important factor determining the ability to influence policies and practices both during and outside a health emergency:** The accountability work in Pakistan was severely constrained both before and after the arrival of the pandemic, due to the political and security environment not allowing space for civil society to hold government to account. In contrast, Zambia and Madagascar have strong civil societies, and they were able to leverage it effectively to hold government to account and minimise the disruption to SRH/FP services. In Tanzania, the President's denial of the pandemic meant the Options team was not able to implement any activities to limit disruption to SRH/ FP.

- **Civil society accountability mechanisms played a critical role in mitigating the disruption to SRH/FP services:** Countries that had developed a strong accountability mechanism were able to leverage it to target advocacy messages generated by the policy and planning and health financing work streams and to influence government decision makers at national and sub national levels. They were also able to successfully harness the media to hold government to account for the continuation of SRH/FP.

- **COVID-19 served to strengthen the case for more enabling SRH/FP policies:** Several country teams saw the pandemic as an opportunity to strengthen their case for enabling SRH/FP policies, which they had started before the pandemic, especially in their health financing and policy and planning work. Both the Zambia and Malawi country teams generated evidence on FP commodities stock outs in health facilities to advocate for an increase and better utilisation of the commodities budget. In Madagascar, the COVID-19 outbreak hastened the launch of self-care, such as the self-administration of DMPA-SC.

- **SRH/FP systems are more resilient and better prepared for future health emergencies:** The IPC guidelines, standard operating procedures (SOPs), new tools, and manuals that Options helped develop or modify are ready for use in a future health emergency. In Bangladesh, the team added health emergency indicators to the digital quality of care dashboard and the digital financial management system, strengthening preparedness of both digital systems. The modified guidelines, new tools, and more resilient systems will enable governments to respond more quickly to any future major infectious disease outbreak, which will reduce SRH/FP service disruption.

The annex contains more detailed information for each country on: the severity of the COVID-19 outbreak; the main COVID-19 intervention implemented and result achieved; FP service uptake during the COVID-19 outbreak compared with the same period the previous year; and the key takeaway lesson.

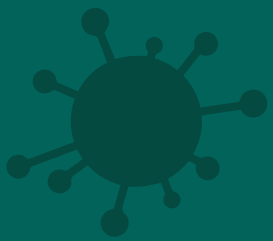
Zambia

1. COVID-19 outbreak

(March to November 2020)

Fatality rate:
1.7%

Number of cases :
101/100,000 population



Zambia: Number of COVID-19 cases

Source: Government of Zambia

2. COVID-19 intervention and result

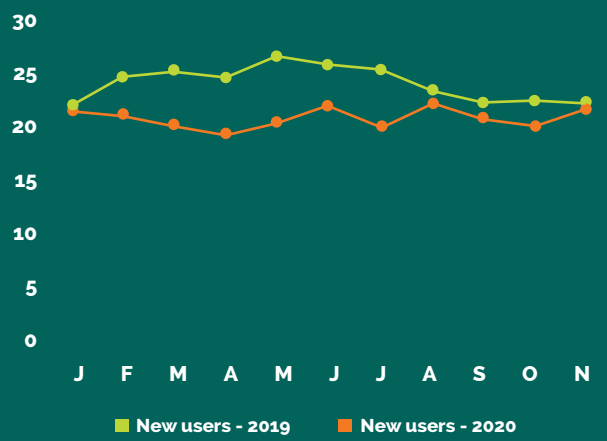
Options advocated to the Parliamentary Committee for Health on the importance of timely release and better utilisation of the allocated family planning (FP) commodities budget to avoid FP contraceptive stock outs, especially during the health emergency.

Earlier release of the FP commodities budget and higher fund utilization (67% of the budget was utilised in quarter 3, 2020 compared to 41% the previous year).

3. FP uptake

FP uptake dropped in March and April 2020, followed by a gradual increase in the following months, reaching pre-COVID-19 levels by November.

Zambia: new FP users in 2019 and 2020



Source: DHIS2

4. Key lesson

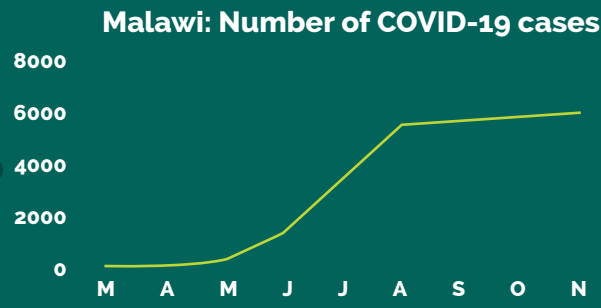
The pandemic strengthened the case for more timely release of the FP commodities budget, and for greater utilisation of the allotted funds.

Malawi

1. COVID-19 outbreak
(March to November 2020)

Fatality rate:
2.91%

Number of cases:
156/100,000 population



Source: Government of Malawi

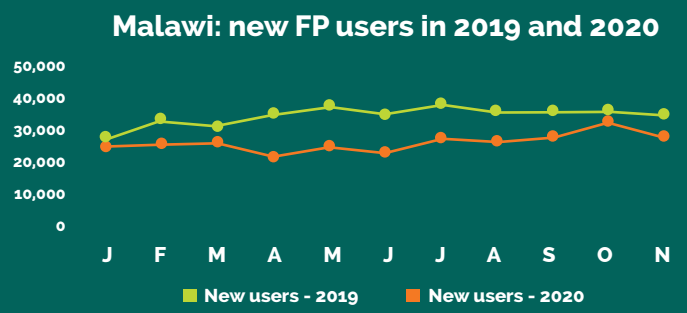
2. COVID-19 intervention and result

Options advocated to parliamentarians, for an increase to the FP commodity budget during the national assembly budget hearing, making the case that it was even more important to prevent stock outs during the pandemic.

The FP commodity budget increased by 14% from $224,000 to $254,000 for the financial year 2021.

3. FP uptake

FP uptake dropped significantly during April to June 2020 (compared to the same period in 2019), and then slowly rose to pre-COVID-19 levels by October.



Source: DHIS2

4. Key lesson

The pandemic opened an opportunity for increasing the FP budget.

Madagascar

1. COVID-19 outbreak
(March to November 2020)

Fatality rate:
1.3%

Number of cases :
293/100,000 population

Madagascar: Number of COVID-19 cases

Source: Government of Madagascar

2. COVID-19 intervention and result

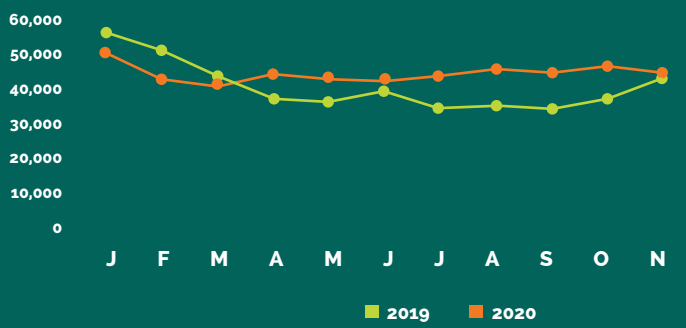
Options advocated for the immediate launch of self-administration of the injectable contraceptive DMPA-SC as a way of increasing access to FP during the COVID-19 pandemic.

The Government of Madagascar launched DMPA-SC self-injection through virtual platforms the following week and rolled out operational guidelines. This led to a steady rise in new users of DMPA-SC following the launch.

3. Discontinuation of FP

FP discontinuation rates were higher during the pandemic, and only dropped to pre-COVID-19 levels in November.

Madagascar: Dicontinuation of FP in 2019 and 2020



Source: DHIS2

4. Key lesson

COVID-19 has resulted in higher rates of FP discontinuation. This is likely due to difficulties faced in accessing services during the pandemic. DMPA-SC self-injection will help address these access barriers.

Uganda

1. COVID-19 outbreak

(March to November 2020)

Fatality rate:
0.91%

Number of cases :
105/100,000 population

Uganda: Number of COVID-19 cases

Source: Government of Uganda

2. COVID-19 intervention and result

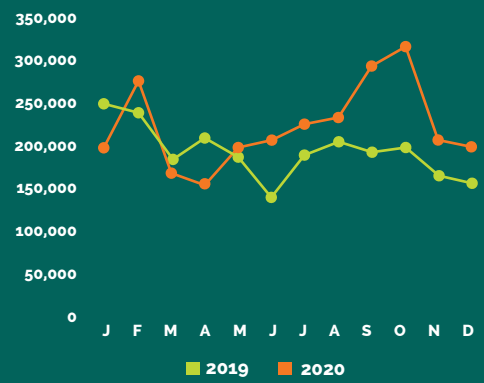
The civil society organisation working under the accountability mechanism in Bugiri and Kaliro districts conducted a rapid assessment to understand the negative impact COVID-19 on sexual and reproductive health (SRH)/FP service access and shared the findings with the COVID-19 District Task Force.

This led to an easing of restrictions on the provision of community outreach FP services.

3. FP uptake

The number of injectable users dropped in the first two months of the pandemic, and then rose in subsequent months, exceeding the number of users in 2019.

Uganda: Number of injectable users in 2019 and 2020



Source: Track 20 (FP2020)

4. Key lesson

It is important to focus advocacy at sub national levels, using locally generated data on the impact of COVID-19 on FP access.

Tanzania

1. COVID-19 outbreak

(March to April 2020)

Total cases in March and April:
509

Fatality rate:
4.1%

2. COVID-19 intervention and result

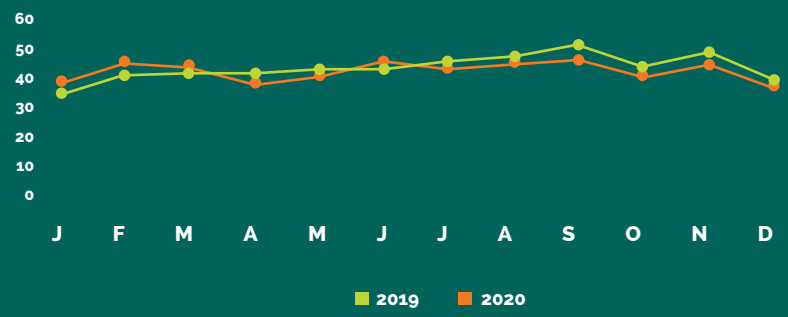
Prepared a set of COVID-19 related frequently asked questions (FAQs) that were intended to be including in the government's COVID-19 guidelines.

The guidelines were not released as the government reported no new cases of COVID-19 by June.

3. FP uptake

Contraceptive prevalence rates remained the same in 2019 and 2020 indicating that COVID-19 did not have a detrimental impact on SRH/FP services.

Tanzania: Modern contraception prevalence rate in 2019 and 2020



Source: DHIS2

4. Key lesson

The political economy of a country is the most important factor influencing the scope to improve the enabling environment for SRH/FP, both during and outside of a pandemic.

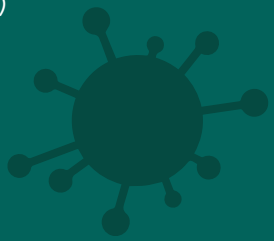
Pakistan

1. COVID-19 outbreak

(March to November 2020)

Fatality rate:
2.04%

Number of cases :
908/100,000 population



Pakistan: Number of COVID-19 cases

Source: Government of Pakistan

2. COVID-19 intervention and result

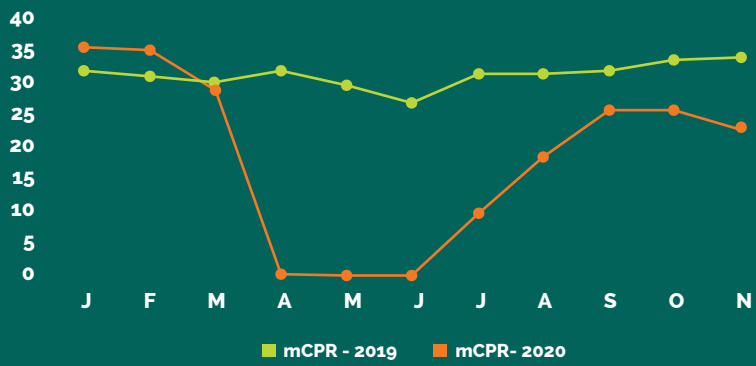
The Government of Punjab province had closed all facilities run by the Population Welfare Department (PWD) due to concerns about COVID-19 infection control. Options supported training in infection prevention control to staff in four districts.

Health facilities were reopened, and SRH/FP services were resumed in these districts following the training.

3. FP uptake

Contraceptive uptake dropped close to zero when the facilities operated by the Population Welfare Department were closed. It picked up once the staff had been trained in infection control and the facilities reopened.

Pakistan: Modern contraceptive prevalance rate in 2019 and 2020



Source: Contraceptive Logistics Management Information System (cLMIS)

4. Key lesson

Strengthening infection prevention control in health facilities should be the highest priority following an infectious disease outbreak to ensure continuation of services.

Bangladesh

1. COVID-19 outbreak

(March to November 2020)

Fatality rate:
1.43%

Number of cases :
283/100,000 population

Bangladesh: Number of COVID-19 cases

Source: Government of Bangladesh

2. COVID-19 intervention and result

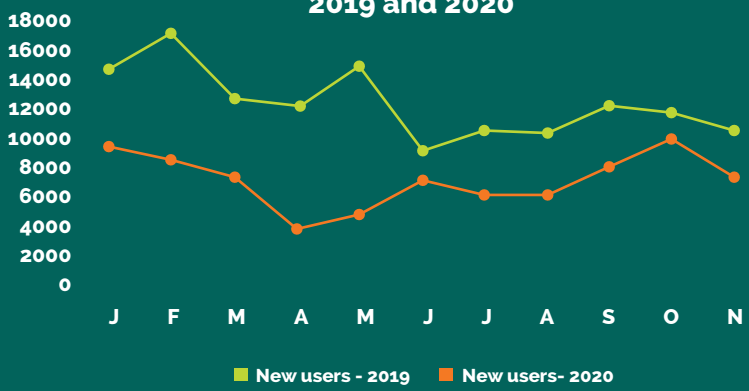
Options developed a digital quality improvement dashboard and incorporated a new indicator on infection prevention and control.

This has contributed to greater health system resilience and preparedness for a future infectious disease outbreak.

3. FP uptake

Family planning uptake was seriously impacted in the first few months of the COVID-19 outbreak. From September onwards, FP utilisation has gradually increased, and has almost reached pre-COVID-19 levels.

Bangladesh: New FP users in 2019 and 2020



Source: DHIS2

4. Key lesson

Mainstreaming resilience and preparedness into on going health systems strengthening work is important.