

COVID-19 and sexual and reproductive health in low- and middle-income countries

REVIEW OF IMPACTS AND DONOR RESPONSES

CONSULTATION 1

About Countdown 2030 Europe

Countdown 2030 Europe is a consortium of 15 non-governmental organizations in 12 European countries working to hold European donor governments and the European Union institutions to account for their policy and funding commitments on sexual and reproductive health and family planning.

Acknowledgments

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Views expressed in this report do not necessarily represent those of individual members of the Countdown 2030 Europe consortium.

Published in February 2022

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Executive summary

In the early stages of the COVID-19 pandemic, there were serious concerns and expectations that the ensuing health crisis would affect both the supply and the demand side of sexual and reproductive health services. As the scientific evidence on the impact of COVID-19 on sexual and reproductive health is fragmented, it is difficult to draw general conclusions on the actual impact of COVID-19 on sexual and reproductive health, as well as to define strategies to mitigate this impact. This report takes stock of the current evidence on the impact of the COVID-19 pandemic on different aspects of sexual and reproductive health in low- and middle-income countries (LMICs), including through a look at donor trends related to sexual and reproductive health.

A desk review on the impact of the COVID-19 pandemic on sexual and reproductive health was undertaken, based on scientific literature published in peer-reviewed international scientific journals, grey literature from reliable sources and case studies and country examples. The purpose of the desk review was to retrieve a limited number of key documents with strong evidence for each sexual and reproductive health sub-topic, rather than doing an exhaustive exploration of scientific literature through a systematic literature review. Only original research and reviews based on original research were included. Estimations, projections, opinion texts, commentaries, and advocacy texts were excluded.

Based on the available scientific evidence, the report concludes that COVID-19 has had a considerable impact on sexual and reproductive health:

- Substantial disruptions in sexual and reproductive health services were reported, with contraception and family planning services and sexual and gender-based violence services reportedly most affected.
- There is strong evidence on the impact of COVID-19 on maternal and neonatal health outcomes in LMICs, with significant increases in maternal deaths, stillbirths, and maternal depression.
- Studies point towards a decrease in the number of safe abortions in the early months of the COVID-19 pandemic. It is not clear whether this is due to a reduction in unplanned pregnancies, and whether this decrease is accompanied by an increase in unsafe abortions or telemedicine and over-the-counter services.
- COVID-19 had a major impact on schools. This impacts access to sexuality education, as access to school-based youth clubs on topics related to sexual and reproductive health was no longer possible. Several organizations sought alternatives to provide information to young people.
- Evidence points in the direction that COVID-19 had an – at least temporary – impact on access to HIV care, antiretroviral therapy, and testing services for HIV and other sexually transmitted infections.

Further, for several sexual and reproductive health topics, the evidence on the impact of COVID-19 was mixed:

- Several studies report a decrease in contraceptive use in the initial phases of the pandemic, after which it recovered to the pre-pandemic state in most countries. At the same time, there are studies that show an increase in the use of contraceptives.
- Regarding sexual and gender-based violence, some studies report an increase in violence compared to pre-pandemic violence, while others report a stability or even a decrease. One consistent factor across studies is that the level of intimate partner violence since COVID-19 – whether it increased, decreased, or stayed the same – is high.

This inconsistent evidence suggests underlying drivers and inequalities. In that regard, it is important to note that most studies report average change, which may in fact hide important impacts in subgroups of the population. This is reflected in the fact that hardly any disaggregated data is available on specific vulnerable groups, such as adolescents and young people, people living with a disability, or sexual and gender minorities.

There is a dearth of good quality original research on the impact of COVID-19 on sexual and reproductive health in LMICs. The available research is concentrated on a limited number of countries, resulting in large knowledge gaps for certain regions. Further, the quality of most studies was assessed as moderate, since many rely on online surveys using convenience sampling, often generating a bias in the sample towards younger and better educated participants.

Almost all European donor countries increased their Official Development Assistance (ODA) spending in 2020, reaching a record high, with the United Kingdom being a notable exception. The general focus on health systems strengthening can be recognized in sexual and reproductive health and rights priorities during COVID-19, with several countries prioritizing access to sexual and reproductive health services in resilient health systems. Also, gender-based violence prevention and response was prioritized by several countries. Overall, Countdown 2030 Europe countries contributed €1.447 billion in funding to access to sexual and reproductive healthcare and family planning in 2020, a substantial increase compared to 2019. Countdown 2030 Europe countries' funding for sexual and reproductive health and rights more widely – that is including funding for other core sexual and reproductive health and rights elements, such as HIV, prevention and integrated responses to sexual and gender-based violence, comprehensive sexuality education, safe abortion, work with lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ+) people, or broader human rights-based, gender-responsive and intersectional approaches – amounted to €2.614 billion in 2020.¹

In order to build back better and to learn for future pandemics, the following recommendations are made:

- To ensure the sustainability of sexual and reproductive health service provision and programme delivery in times of crises, strong and continuous governmental commitment to sexual and reproductive health and rights is essential. The literature review provided indications that women and girls who already had less access to sexual and reproductive health services in countries with weaker health systems are most affected by the health crisis. Sustainability of health service provision will require secure, continuous, and

long-term investment, funding, and support for sexual and reproductive health and rights. This includes investment in health systems – including infrastructure, skilled staff, and strong supply chains – to build and sustain resilient health systems that can adapt to crisis situations.

- The COVID-19 crisis generated a lot of creativity in terms of providing alternative ways of sexual and reproductive health service and information provision. Such initiatives include mobile abortion services, online comprehensive sexuality education, expanded outreach models and telemedicine. It is essential to invest in further exploration of the (cost-) effectiveness and acceptability of these alternative services, including in different settings. This will help to understand whether they can be more permanently put in place as (cost-)effective alternatives to (complement) traditional services. Further, learning from these alternatives allows the development of protocols for alternative models of service delivery in future health crises.
- Demand-side factors, such as fear of COVID-19 infections, were important barriers in access to sexual and reproductive health services during the pandemic. To reduce this barrier, communication campaigns should be undertaken in future pandemics, to emphasize the safe availability of sexual and reproductive health services.
- There is a need to invest in consistent monitoring of key indicators. Many independent small-scale efforts are being undertaken to map the impact of COVID-19 on sexual and reproductive health. However, forging alliances among key players in the global sexual and reproductive health field and advocating for funding to set up proper monitoring tools for key sexual and reproductive health indicators, would provide more reliable data for policy-makers, programmatic staff and healthcare organizations to base their decisions on. Further, the available evidence emphasizes the importance of disaggregating data to identify population subgroups that are at increased risk for poor sexual and reproductive health outcomes in crisis situations, and trajectories of impact.

¹ This figure includes the €1.447 billion in funding for sexual and reproductive healthcare and family planning mentioned above.

1. Introduction

In the early stages of the COVID-19 pandemic, there were serious concerns and expectations that it would affect both the supply and the demand side of sexual and reproductive health services. On the supply side, this impact could become visible through reduced capacity of health facilities, redeployment or dropout of health workers, and through supply chain disruptions. On the demand side, the impact could be caused by movement restrictions, loss of income, and concerns about COVID-19 transmission hindering people to seek healthcare (Global Financing Facility, 2020). Early evidence from a global pulse survey of the World Health Organization (WHO) indeed indicated considerable disruptions in reproductive health services, with family planning services (68% of countries included in the study reported at least partial disruptions) and antenatal care (56%) reported to be most interrupted (World Health Organization, 2020). This was hypothesized to potentially lead to numerous excess morbidity and mortality rates. For example, Robertson et al projected up to 113,000 excess maternal deaths and up to 2.3 million excess child deaths over a 12-month period in low- and middle-income countries (LMICs) (Robertson et al., 2020). Nevertheless, the scientific evidence on the impact of COVID-19 on sexual and reproductive health is fragmented, making it difficult to draw general conclusions and to define strategies to mitigate this impact.

Further to its impacts on the provision of and access to sexual and reproductive health services, the COVID-19 pandemic has also affected donors' priorities and channels for development funding, which may have lasting impacts on development cooperation well beyond the pandemic period. The COVID-19 health crisis also presents an opportunity for rethinking current methods of development cooperation and 'building back better'.

This report aims to take stock of the current evidence on the impact of the COVID-19 pandemic on different aspects of sexual and reproductive health and track donor trends related to sexual and reproductive health. It seeks to identify lessons learned from the current crisis and based on this, present recommendations on how to reduce this impact and to prepare better for future pandemics. The report is intended to support Countdown 2030 Europe partners' advocacy for maintained and increased donor funding for sexual and reproductive health in the context and aftermath of the COVID-19 pandemic.





2. Methodology

The report consists of two main parts: a review of the available evidence on the impact of COVID-19 on sexual and reproductive health and a mapping of priorities and trends in donor responses to the pandemic with regard to sexual and reproductive health.

2.1. The impact of the COVID-19 pandemic on sexual and reproductive health in LMICs

A desk review on the impact of the COVID-19 pandemic on sexual and reproductive health was undertaken. This part is built on three sources:

1. Scientific literature, published in peer reviewed international scientific journals
2. Grey literature
3. Case studies and country examples

The purpose of the desk review was to retrieve a limited number of key documents with strong evidence for each sexual and reproductive health sub-topic, rather than do an exhaustive exploration of scientific literature through a systematic literature review. The focus is not on the direct clinical outcomes due to COVID-19, but on the secondary effects of COVID-19 measures imposed to contain the spread of the virus on sexual and reproductive health.

1. Scientific literature: Targeted rapid searches per topic were done. The aim was not to be exhaustive and identify all available evidence. Rather, we aimed to retrieve a limited number of key documents with strong evidence for the impact of COVID-19 for the different sexual and reproductive health sub-domains, that either synthesize knowledge or that contain strong original research results on the topic. It is important to note that only original research and reviews based on original research were included. Estimations, projections, opinion texts, commentaries, and advocacy texts were excluded. The search was done in September 2021. On finalization of the report in December 2021, a few additional recent studies were added.

Two scientific databases (Web of Science and PubMed) were searched. These databases are complementary and jointly cover the vast majority of relevant journals. Further, Google Scholar was used to identify additional articles. The following search terms (in title) were used:

- COVID-19: (SARS-Cov-2 OR Corona* OR COVID*) AND
- Sexual and reproductive health topics:
 - Contraception: contracept* OR “family planning” OR “birth control” OR “pregnancy prevention”
 - Maternal and neonatal health: “maternal health” OR “neonatal health” OR “reproductive health”
 - Partner violence and gender-based violence: “partner violence” OR “gender-based violence” OR “sexual violence”
 - Female genital mutilation (FGM) and early marriage: “female genital mutilation” OR “female genital cutting” OR FGM OR FGC OR “early marriage” OR “forced marriage” OR “child marriage”
 - Abortion: “abortion” OR “pregnancy termination”
 - Sexuality education: “sexuality education” OR “sex education” OR “reproductive health education” OR “life skills education”
 - HIV/STI: HIV OR AIDS OR STI OR STD OR “sexually transmitted infection” OR “sexually transmitted disease”

In the description of the studies in the report, the strength of the evidence as well as the limitations of the study are included. This allows the reader to contextualize the findings. Studies that did not meet minimal quality research standards are not included.

2. Grey literature on the impact of COVID-19 on sexual and reproductive health: Searches for high-level impact data were done in the following sources:

- The Demographic Health Survey (DHS): data were collected in 2020 and 2021 in several LMICs. However, either the data were not yet available, or were still being collected. While the DHS does report on a few COVID-19 related indicators, such as households with basic washing facilities or access to personal protective equipment, no information was available on sexual and reproductive health indicators at the time of this study. In time, the DHS will be an important source to track the immediate and long-term impact of COVID-19 on a number of important indicators, such as fertility rate, maternal and neonatal morbidity and mortality, contraceptive use, and intimate partner violence.
- Marie Stopes International (MSI) has undertaken research to map the impact of COVID-19 (mainly on abortion services) in India and South Africa, which was included in this report. The organization also made several projections and estimations which were not taken into account.
- UNFPA and UN Women: within the UN agencies, we focused on screening UNFPA and UN Women's websites and publications. Several projections and reports were found, which were not included in this review. However, these reports referred to interesting sources that were checked and, if relevant, included.
- Publications of several large international non-governmental organizations with a research focus working in the field of sexual and reproductive health and rights were screened, including Avenir Health, Population Council, Kinsey Institute, Reproductive Health Supplies Coalition and the Guttmacher Institute. Most resources were estimations, projections, and advocacy papers, but also several original studies were identified and included in the review.

3. Case studies and country examples from different regions were used to illustrate the above data. The cases were provided by the International Planned Parenthood Federation (IPPF). They were selected to best illustrate the findings from the literature review and high-level impact data.

2.2. Priorities and trends in donor responses to the pandemic

Three sources were used to assess the impact of COVID-19 on priorities and trends in donor responses.

1. Information was provided by Countdown 2030 Europe partners on priorities and trends in the responses of their governments to the COVID-19 pandemic in relation to sexual and reproductive health and rights. They provided responses to the following questions:

- When it comes to overall ODA policy commitments – what have been your government's priorities in the context of COVID-19?
- When it comes to preferred mechanisms/bodies for channelling ODA funding – what has been your government's overall response to COVID-19?
- What have been your government's sexual and reproductive health and rights ODA policy priorities (if any) in the context of COVID-19?
- If possible, please specify any funding commitments to sexual and reproductive health and rights in the context of COVID-19 (please include amount and sexual and reproductive health and rights area).
- Where possible, please provide any additional information on funding commitments to sexual and reproductive health and rights in the context of COVID-19.

2. Countdown 2030 Europe's 2020 donor tracking: Each year Countdown 2030 Europe publishes a trend analysis of European donor support to sexual and reproductive health and family planning. The analysis of the 2020 data was used in this report. For the methodology of donor tracking, see *European Donor Support to Sexual & Reproductive Health & Family Planning - With a spotlight on SRHR. Trends Analysis 2020-21* (Countdown 2030 Europe, 2022).

3. Additional information: If gaps were identified, additional information was searched on websites of organizations that track global, regional, or national donor aid, such as the Organisation for Economic Co-operation and Development (OECD) and Development Tracker.

3. The impact of the COVID-19 pandemic on sexual and reproductive health in LMICs

This section presents the results of the desk review on the impact of the COVID-19 pandemic on sexual and reproductive health. It combines evidence from scientific literature and reports from relevant international and non-governmental organizations. Country case studies are included as examples of good practices.

3.1. Main takeaway messages

COVID-19 has had a clear impact on sexual and reproductive health. The available evidence allows a number of conclusions to be drawn on the impact of COVID-19 on sexual and reproductive health, which differ depending on the topic:

- Substantial *disruptions in sexual and reproductive health services* were reported, with contraception and family planning services and sexual violence and gender-based violence services reportedly most affected.
- During the COVID-19 pandemic, many countries adopted national policies regarding *maintaining essential health services*. Only one-third of these policies prioritized maternal health services and roughly one in five policies explicitly mentioned sexual and reproductive health services.
- There is strong evidence on the impact of COVID-19 on *maternal and neonatal health outcomes* in LMICs, with significant increases in maternal deaths, stillbirths, and maternal depression.
- Studies point towards a decrease in the number of safe *abortions* in the early months of the COVID-19 pandemic. It is not clear whether this is due to a reduction in unplanned pregnancies, and whether this decrease is accompanied by an increase in unsafe abortions or telemedicine and over-the-counter services.

- Several studies report a decrease in *contraceptive use* in the initial phases of the pandemic, after which it recovered to the pre-pandemic state in most countries. The most cited reasons for reduced use of contraceptive methods were demand-side driven. At the same time, there are studies that show an increase in the use of contraceptives. The inconsistent evidence suggests underlying drivers and inequalities.
- The available evidence on the impact of COVID-19 on *sexual and gender-based violence* presents a mixed picture, with some studies reporting an increase in violence, while others report stability or a decrease. One consistent factor across studies is that the level of intimate partner violence since COVID-19 – whether it increased, decreased, or stayed the same – is high. Further, an increase in intimate partner violence during COVID-19 seems to be associated with the socioeconomic stability of the household.
- COVID-19 had a major impact on schools. This impacts access to *sexuality education*, as access to school-based youth clubs on sexual and reproductive health-related topics was no longer possible. Several organizations sought alternatives to provide information to young people.
- All evidence points to the direction that COVID-19 had an – at least temporary – impact on *access to HIV care, antiretroviral therapy, and testing services for HIV and other sexually transmitted infections*.

The impact is largest in LMICs. While this review focused on LMICs, some of the included studies and reviews compared the impact of COVID-19 in different countries or regions and found a more pronounced impact in countries where sexual and reproductive health services were already lacking or weak. This indicates that the COVID-19 pandemic has more severely impacted the sexual and reproductive health of women and girls who already suffer from lack of access to these services.

The numbers possibly hide differences in subgroups of the population. Further, for several sexual and reproductive health topics (in particular contraceptive use and sexual and gender-based violence), the evidence on the impact of COVID-19 was mixed, or no substantial changes were found. In that regard, it is important to note that most studies report average changes. Such average numbers may in fact hide important impacts in subgroups of the population (*'the flaw of averages'*). This is reflected in the fact that hardly any disaggregated data is available on specific vulnerable groups, such as adolescents and young people, people living with a disability, or sexual and gender minorities.

The level of evidence and knowledge gaps. There is a dearth of good quality original research on the impact of COVID-19 on sexual and reproductive health in LMICs. The available research is concentrated on a limited number of countries, resulting in large knowledge gaps for certain regions. In Africa, most research comes from Uganda, South Africa, Kenya, and Ethiopia. In Asia and the Pacific, most studies were done in India and Bangladesh. The Latin American and Caribbean region is largely a blind spot in internationally published English scientific literature. Further, the quality of most studies was assessed as moderate, since many rely on online surveys using convenience sampling. This is understandable, given the speed and limited resources with which many of these studies have been implemented. Yet, it does generate a bias in the sample towards younger and better educated participants.

3.2. Sexual and reproductive health services

Substantial disruptions in the sexual and reproductive health service offer were reported, with contraception and family planning services, antenatal care, and sexual violence and gender-based violence services most affected in the first months of the epidemic. There are large variations between countries and regions, with LMICs reporting more disruptions in sexual and reproductive health services. There are indications that sexual and reproductive health service delivery has been recovering throughout the pandemic, though at the time of the last study (early 2021), sexual and reproductive health service interruptions were still substantial in several regions. Next to insufficient staff availability, demand-side factors were commonly reported as the main barriers to access to sexual and reproductive health services. Further, during COVID-19, many countries adopted national policies regarding maintaining essential health services. Only one-third of these policies prioritized maternal health services and roughly one in five policies explicitly mentioned sexual and reproductive health services.

Disruptions in sexual and reproductive health services

The World Health Organization (WHO) implemented two surveys to understand the extent of disruptions to essential health services caused by the COVID-19 pandemic. The most recent one was done in the first quarter of 2021 (World Health Organization, 2021). The survey targeted government officials.



Respondents from 135 countries completed the survey,² which asked for information on disruption of essential health services, including for reproductive, maternal, newborn, child and adolescent health (RMNCAH), in the three months before the survey. The level of evidence of this study is assessed as moderate, as it is faced with substantial limitations, including self-reporting bias, a limited number of respondents, and national data collection (potentially hiding substantial subnational variation). Nevertheless, the data provide valuable insights into disruptions in essential health services and compared with the first pulse survey (March to June 2020), give an indication of the evolution in access to essential health services in different phases of the pandemic.

The results indicate that the type and extent of services affected by the COVID-19 pandemic varied across countries and regions:

- 94% of participating countries reported disruptions in at least one essential health service
- 34% of countries reported disruptions in over half of services
- 29% of countries reported disruptions in 25–49% of services
- 32% of countries reported disruptions in less than 25% of services

On average, disruptions were reported in over one-third of services (38%), with countries in the Americas region (49%) and the African region (44%) reporting most disruptions,

though this can also be linked to the lower response rates in other regions. Further, the report states that in high-income countries (HICs), service disruptions were most often the result of strategic suspensions or modifications. In LMICs disruptions were more often unplanned.

The survey shows that, on average, 35% of countries reported disruptions across RMNCAH and nutrition services. Disruptions in RMNCAH services were more commonly reported in countries in the Americas region (41%), the African region (40%) and the South-East Asian region (37%). The most frequently disrupted services were family planning and contraception services (44%), intimate partner violence and sexual violence prevention and response (39%), antenatal care (39%), and post-natal care (33%).

Across all essential health services, a mix of demand- and supply-side factors were reported to be responsible for the disruption. On the supply side, the following causes were most frequently reported:

- insufficient staff availability, for example due to deployment of staff to COVID-19 or other causes (66%)
- cancellation of elective care (i.e. care that is planned in advance as opposed to emergency treatment) (47%)
- changes in treatment policies for care-seeking behaviours (35%)
- insufficient personal protective equipment availability (26%)

Demand-side factors were among the most often mentioned causes, including:

- community fear and mistrust in seeking healthcare (57%)
- patients not presenting to outpatient care (i.e. care that does not require overnight hospitalization) (57%)
- perceptions that financial difficulties during the outbreak were affecting attendance (43%)
- perceptions that travel restrictions were hindering access to care (36%)

2 **African region:** Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo (Republic of the), Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, South Sudan, Togo, Uganda, Zambia // **Region of the Americas:** Argentina, Bahamas, Belize, Bermuda, Bolivia (Plurinational State of), Brazil, British Virgin Islands (United Kingdom of Great Britain and Northern Ireland), Cayman Islands, Chile, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Uruguay // **Eastern Mediterranean region:** Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Morocco, occupied Palestinian territory, including east Jerusalem, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen // **European region:** Albania, Armenia, Austria, Bulgaria, Croatia, Czechia, Denmark, Estonia, Finland, France, Georgia, Hungary, Italy, Kazakhstan, Latvia, Portugal, Republic of Moldova, Sweden, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland // **South-East Asian region:** Bangladesh, Bhutan, Democratic People's Republic of Korea, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor-Leste // **Western Pacific region:** Australia, Brunei Darussalam, China, Fiji, French Polynesia (France), Japan, Lao People's Democratic Republic, Malaysia, Papua New Guinea, Philippines, Republic of Korea, Solomon Islands, Vanuatu.

REACHING VULNERABLE GROUPS

The initial findings of IPPF's COVID-19 impact survey (March 2020) for Nepal indicated that people living with disabilities (PwD) were neglected by basic government healthcare services. They faced discrimination and economic hardship in the pandemic.

The Family Planning Association of Nepal (FPAN) took the following actions to support this group:

- Clinical services and community sessions were continued by providing personal protective equipment to service providers and PwD peer educators.
- FPAN transformed its work through digital health interventions to conduct training with staff, PwD peer educators, and individuals in the community.
- Outreach expanded with peer educators mobilized for door-to-door services within safety measures. Hygiene kits were provided to PwDs with spinal injuries during the lockdown.
- Special awareness programmes specifically for PwD were run in partnership with national TV channels. Also, partnerships with a range of organizations supporting PwD were set up to ensure inclusive service reach.
- Expansion of helpline services to reduce unnecessary client visits and keep all services to vulnerable groups free. (IPPF, 2021f)

Compared to the first pulse survey (World Health Organization, 2020), the interruption of sexual and reproductive health services reduced over time, as it stood at 51% in Round 1. The comparison of the countries that participated in both survey rounds showed that the percentage of countries reporting disruptions decreased from:

- 67% to 45% for family planning and contraception services
- 56% to 40% for antenatal care
- 34% to 25% for facility-based births

Also, compared to the first survey, fewer countries reported disruptions related to patients not presenting and community fear and mistrust.

Endler et al aimed to provide a global overview of trends in access to sexual and reproductive health services during the COVID-19 pandemic. An online survey was sent out to clinicians, researchers, and organizations working in the field of sexual and reproductive health to assess access to sexual and reproductive health services and risk of sexual and reproductive health violations. The survey was completed by 51 people in 29 countries – Europe (11), North America (2), South America (4), Africa (4), Asia (6), and Australia/Oceania (2). It is prone to several limitations, most importantly self-selection bias of the respondents, as well as the small sample size and limited geographical representation. Nevertheless, in combination with other studies, it helps to identify trends in sexual and reproductive health service delivery (Endler et al., 2021).

According to the respondents, the most reported changes in sexual and reproductive health services were linked to family planning and contraception: 86% of respondents reported that access to contraceptive services was less or much less because of the COVID-19 pandemic. Corresponding figures for surgical and medical abortion were 62% and 46% respectively. Many respondents also reported a reduction in access to contraception (approx. 80%), emergency contraception (approx. 60%), and long-acting and reversible contraceptives (LARCs) (approx. 80%). No comparison was made between countries or regions.

The qualitative analysis of open responses in the survey from Endler et al indicated *“a consensus around the fact that political will to support the advancement of SRHR was often lacking, and that this will was fundamental to ensuring both continued access during the pandemic and, in a minority of cases, the solidification of gains made to SRHR during the crisis”*. The results suggest that *“the extent to which the pandemic has impacted SRHR may correlate inversely with the extent to which these services and rights were available before the pandemic. It is likely that countries that gave SRHR low prioritization before the pandemic continued to make SRHR a low priority during the pandemic. The COVID-19 pandemic has in that case most severely impacted the SRHR of women who already suffer from lack of access to these needs and rights.”* (Endler et al., 2021).

Disruptions in sexual and reproductive health supply chains

One of the anticipated ways that COVID-19 could impact sexual and reproductive health was through the disruption of supply chains (Global Financing Facility, 2020). The Reproductive Health Supplies Coalition (RHSC) did a study on the supply chains of sexual and reproductive health commodities, identifying disruptions in all aspects of the supply chain, with manufacturing, logistics, and systems being most affected. Despite these early disruptions, data from six countries showed that stockout rates were generally no higher during the acute crisis management period (March–May) or adaptive period (June–August) in 2020 than in periods preceding the pandemic. The report presents a number of explanations for this, including donor responsiveness to increased costs of sexual and reproductive health commodities, full pipelines for sexual and reproductive health products, short-term drops in demand, and human resilience and problem solving (Reproductive Health Supplies Coalition, 2021).

A study from IPPF among its Member Associations (MAs) in March, May, and November 2020, showed stockouts in 36% of MAs, including stockouts of contraceptives (29 MAs), HIV medicine (16 MAs) and safe abortion supplies (12 MAs). 59 MAs experienced delays transporting supplies within state borders and 19 MAs experienced commodities being delayed at customs. While many MAs reported improvements in their commodity supply chains since the start of the pandemic, in November 2020, 22 MAs in Europe and Africa were reporting commodity shortages for the first time, hinting at a long-term effect of COVID-19 on supply chain interruptions (IPPF, 2021a).



NOVEL APPROACHES TO SERVICE DELIVERY

In order to respond to difficulties in service delivery during the pandemic, many IPPF MAs replaced, duplicated or supplemented aspects of their original service model with technology enabled services:

- Telemedicine and digital modalities have been scaled up, with 29 MAs providing telemedicine for sexual and reproductive health services in 2021 (especially abortion, contraception and management of sexually transmitted infections).
- 67 MAs provided digital sexuality education and 20 MAs initiated digital sexual and reproductive health counselling and information sessions.
- The number of MAs providing home delivery of health commodities more than doubled (from 12 MAs in April to 26 in November 2020).
- MAs expanded sexual and gender-based violence support, including online and door-to-door care, additional referral partners, and financial assistance. For example, the MA in Bangladesh expanded telephone helplines across the country with trained sexual and gender-based violence care teams offering assistance to women reporting violence. Specialized door-to-door teams assess, counsel, and assist women and refer them to relevant support services. (IPPF, 2021a)

Service delivery by civil society

Marie Stopes International (MSI) assessed its service delivery during the initial months of the COVID-19 pandemic and reports having served 1.9 million fewer women with its programmes for January–June of 2020 than forecasted, based on numbers from previous years. Importantly, the reported impact varied hugely by country, with MSI's countries in Asia facing the greatest impact. The service delivery in India was most severely affected by lockdowns, resulting in 1.3 million fewer women served than forecasted, with 920,000 fewer safe abortion and post-abortion care services being delivered (Marie Stopes International, 2020).

IPPF mapped the impact of COVID-19 on its work through three rounds of online surveys that collected data from its MAs around the world (March, May, and November 2020). The five areas where the strongest impact on sexual and reproductive health and rights was reported are:

- loss of skilled workforce, e.g. 37 MAs released staff to support the national response to COVID-19
- decreased range of services, e.g. 88% of MAs reduced their service package, mostly in HIV and contraceptive service delivery
- reduced geographic coverage, e.g. 66% of MAs closed facilities and 5,633 service points were closed
- limited opportunities for advocacy, e.g. all MAs reported a decrease in advocacy-related meetings and community consultations

The service delivery reductions were reported to be largely restored by November 2020, with MAs reporting having resumed operations at 90% of the service delivery points that they had been forced to close in March 2020 (IPPF, 2021a).

Sexual and reproductive health in essential health services policies during COVID-19

During a health crisis, it is recommended that governments define the essential health services to be maintained. The WHO pulse survey reports that 87% of countries included in their study reported having defined the essential health services that must be maintained during the COVID-19 pandemic (about a 20% increase in 2021 compared to 2020). However, from this study, it is not clear whether these essential services also include sexual and reproductive health services (World Health Organization, 2021).

Global Health 5050 analysed the policy response to the COVID-19 crisis in terms of gender sensitivity in different policy domains, including essential health services. They found that fewer than one in eight countries mentioned gender in any of their policies on maintaining essential health services during the COVID-19 pandemic. Among the 47 policies reviewed across 29 countries, fewer than one out of ten (9%) accounted for gender. Gender-responsive commitments included prioritizing sexual and reproductive health during the pandemic. About one in three policies prioritized maternal health services and one in five policies focused on sexual and reproductive health services (Global Health 5050, 2021).

ADVOCATING FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING COVID-19

This lack of a gender- and sexual and reproductive health-responsive policy response can have important consequences. As the International Medical Advisory Panel of IPPF stated in its *Statement on COVID-19 and Sexual and Reproductive Health and Rights*, “a gender lens is critical in any intervention in response to the pandemic. The response must be gender responsive, while also acknowledging and recognizing the needs and rights of women and girls, and vulnerable people, including the elderly, adolescents and young people, people with disabilities, and refugees.” (IPPF, 2020).

Therefore, IPPF has been advocating for the inclusion of sexual and reproductive health and rights and a gender-responsive approach throughout the pandemic:

- MAs in 27 countries ensured the prioritization of sexual and reproductive health and rights in their country’s pandemic response as members of their national COVID-19 task force. Over 80% of MAs reported that sexual and reproductive health and rights were included in their government’s minimum essential health service package during the pandemic.
- Nine MAs helped develop and deliver national service delivery guidelines on sexual and reproductive health and rights in the pandemic.
- 54 MAs partnered with governments to support survivors of sexual and gender-based violence.
- 59 MAs advocated for continued access to sexual and reproductive healthcare for vulnerable groups. (IPPF, 2021a)

One example is the work done by the Family Planning Association of India (FPAI), together with other civil society organizations, to influence the government of India to include sexual and reproductive health in the list of essential services to maintain continuity of sexual and reproductive healthcare delivery. They advocated for time-bound sensitive services including services related to reproductive health (e.g. care during pregnancy and childbirth, medical and surgical abortion services) to be ensured at appropriate facility level, along with counselling for post-abortion care and provision of contraception (IPPF, 2021b).

3.3. Contraception

While there is no overall systematic review or meta-analysis studying the impact of COVID-19 on contraceptive use, several original research studies have been published on the topic, mostly from the initial period of the lockdown. The studies present a mixed picture. Several studies indicate that family planning services were disrupted and contraceptive use decreased in the initial phases of the pandemic, in particular for provider-dependent contraceptive methods, after which it recovered to the pre-pandemic state in most countries. The most reported reasons for reduced use of contraceptive methods were demand-side driven. At the same time, there are studies that show an increase in the use of contraceptives. Studies that present differences between population subgroups suggest a differentiated impact for specific subgroups, e.g. there is some evidence that women who have never given birth and people who have lost income are more likely to report reductions in contraceptive use. As the evidence is inconsistent, this suggests underlying drivers and inequalities. Studies that differentiate contraceptive methods seem to report a more negative impact on provider-dependent contraceptive uptake. Unknowns are the long-term impact of COVID-19 on contraceptive use (linked to fertility desire). Finally, even small disruptions – especially in short-term contraceptive methods – may have important consequences and may result in a substantial number of unplanned pregnancies.

A scoping review from Bolarinwa et al published in April 2021 (including articles up to October 2020) on the impact of COVID-19 on sexual and reproductive health, including family planning services, could not identify any study on the impact of COVID-19 on contraception in an LMIC (Bolarinwa et al., 2021). Fortunately, since then, several studies have published original data on the actual impact of COVID-19 on the use of contraceptives.

The 'International Sexual and Reproductive Health survey in times of COVID-19' (I-SHARE) was a global cross-sectional study among the general population in 30 countries from all continents. The evidence is considered to be moderate, because of the sampling method (online survey) and study design (cross-sectional study). Overall, the study found that COVID-19 measures impeded access to condoms for 8.7% of the respondents and contraceptives for 7.5% of respondents. Fertility intentions were also affected, with 10.4% (n=1,101)

of female respondents reporting they postponed their fertility desire, in particular in sub-Saharan Africa (28%) (Erausquin, 2021).

In sub-Saharan Africa, there is one overall study from the WHO regional office for Africa and country-level studies from Burkina Faso, Kenya, DRC, Nigeria, Mozambique, and South Africa that include four rounds of rapid assessment on continuity of essential sexual and reproductive health services including family planning, mostly using data from Health Information Systems (HMIS/DHIS2). The evidence is considered to be moderate, since little information could be found on the methodology of the study. The findings show a decline in family planning counselling in the early months of 2020, followed by a recovery starting in May 2020 (World Health Organization African Region, 2021).

A study by Wood et al analysed population-level data from Burkina Faso, Kenya, DRC (Kinshasa) and Nigeria (Lagos). Using the established and functional Performance Monitoring for Action (PMA) platform, telephone interviews were conducted and this information was compared with baseline interviews done immediately before the pandemic (between November 2019 and February 2020). The analyses were restricted to 7,245 women in union (married or living with a partner, as if married) who participated in both data collection moments. The quality of this study is assessed as high, with the only important limitation being that the data collection methods differed in the two rounds (face-to-face vs telephone).

The study paints a mixed picture:

- Contraceptive use among women in need increased significantly in rural Burkina Faso (30.7% to 48.1%) and in rural Kenya (71.6% to 78.9%).
- The rise in contraceptive use in the first months of the COVID-19 pandemic followed a period of stagnation and decline in Kenya and rural Burkina Faso. Conversely, in Kinshasa and Lagos, contraceptive use stabilized during the COVID-19 pandemic after years of substantial increases.
- The proportion of women in need of contraception only significantly increased in Lagos (from 74.5% to 80.3%), and specifically for women with higher education and those who experienced partial income loss due to COVID-19.
- At the same time, across all geographies there was an increase in the need for contraception among women. (Wood et al., 2021).

A sub-analysis in Kenya and Burkina Faso using the same data found that the majority of participating women did not change their contraceptive status during COVID-19 (68.6% in Burkina Faso and 81.6% in Kenya). Those who did change their contraceptive status were more likely to adopt a method (25.4% and 13.1% respectively) than to discontinue (6.0% and 5.3% respectively). Most women who switched contraceptives were using methods as or more effective than their pre-pandemic contraception. Even though nearly two-thirds of women reported difficulties accessing health services, the vast majority (87%) reported being successful in accessing care.

Among contraceptive non-users, 3.8% and 14.4% of women in Burkina Faso and Kenya respectively reported COVID-related reasons for non-use. Fear of infection at health facilities was the most frequently given reason, associated with 1.9% and 9.5% of non-use in Burkina Faso and Kenya respectively (Karp et al., 2021).

Leight et al studied the short-term effects of COVID-19 on contraceptive access and use in Mozambique. Administrative data on use of contraceptive health services by women referred via an ongoing community health promoters programme in two large urban and peri-urban areas of Mozambique were compared before, during and after the state of emergency in Mozambique. The study built on an ongoing programme in which community health promoters provide door-to-door referrals to public health facilities. The evidence of this article is assessed as high, since it uses monitoring data that allow comparison of the situation pre-COVID-19 and since COVID-19 (Leight, Hensly, Chissano, & Ali, 2021).

The results demonstrate a modest short-term drop in both service provision and use in the initial phase of the epidemic, followed by a relatively rapid rebound. The authors conclude that the accessibility of reproductive health services was not dramatically reduced during the first two months of the pandemic-related emergency. At the same time, the short-term decrease in the contraceptive receipt rate could have meaningful implications, as the majority of women participating in the study receiving contraceptives were using short-term methods (76% of women used injections or oral contraceptives) (Leight et al., 2021).

Important to note is that the study included some evidence that the decline in contraceptive referrals and receipts was not uniform for all women. The probability of contraceptive referral increased for women who were not current users of contraception post-emergency, and the probability of contraceptive receipt increased for women who reported access to phones. Two important side-notes need to be made. Firstly, the state of emergency in Mozambique was not as stringent as those imposed in several other settings. Secondly, promoters in the programme were incentivized to encourage women to visit clinics for contraceptive services, and thus may have continued to provide such encouragement and support during the state of emergency (Leight et al., 2021).

EXPANDING SELF-CARE OPTIONS

In Madagascar, Fianakaviana Sambatra led an agile response to the pandemic impact and strengthened the remote delivery of family planning commodities through outreach and mobile clinics to reach the most vulnerable populations.

Further, they enhanced access and information by working with women peer champions who pass on information within their communities and act as community-based distributors providing commodities and self-injectables to women (IPPF, 2021d).

Adelekan et al describe the effect of the COVID-19 pandemic on family planning and termination of pregnancy services use immediately following the lockdown in Gauteng Province in South Africa, by analysing the administrative data on clinical services use from the district health information system database during the previous two years, including five weeks following the enforcement of the lockdown in South Africa (1 April 2018–30 April 2020). The evidence of this article is assessed as high, since it uses monitoring data that allow comparison of the situation pre-COVID-19 and since COVID-19 (Adelekan et al., 2021).

The uptake of provider-dependent contraceptive methods showed a decline from April 2018 to April 2020, with a particular decline noticed before the lockdown period in February 2020. The uptake of injectables reduced by 45% compared to the previous two years. On the contrary, the uptake of oral contraceptive pills had been increasing over the past two years, with a 30% increase in the use of this contraceptive method in April 2020 compared to the same period in 2018 and 2019 (Adelekan et al., 2021).

The authors hypothesize that this switching to less effective contraceptive methods may be an indication of either limited access to other choices, supply challenges, and/or limited information provision on the spectrum of contraceptive options (Adelekan et al., 2021).

The only study on access to contraceptive services among adolescent girls comes from Uganda, where data from two private service providers were used to compare services use from March to November/December 2019 with the same period in 2020. The data show a temporary dip in service visits during April 2020. This was followed by a return to previous levels and even an increase in family planning visits among adolescent girls during the remainder of 2020 (Makumbi et al., 2021).

This seems to contrast with the study done by Fawe on teenage pregnancies in Uganda. This study was based on adolescent pregnancy data from the health information management system and school records, a cross-sectional survey among a sample of over 3,000 randomly selected school-going girls and young women, and a similar number of boys and young men. The study reports an increase in first antenatal care visits among girls and young women aged 10–14 years between March 2020 and June 2020: from 80,655 in March 2020 to 98,810 in June 2020 (Forum for African Women Educationalists (FAWE) Uganda Chapter, 2021).

Only two studies could be identified from the East Asia and Pacific region, and one from the Middle East and North Africa region.

In Bangladesh, Hossain et al examined trends for distribution and use of short-acting and long-acting contraception, using publicly available service statistics from before, during, and after the lockdowns:

- Short-acting methods: distribution of pills and condoms declined somewhat prior to the lockdown, followed by a marked decline in April 2020, coinciding with the beginning of the lockdown. Injectable contraception use also declined at the beginning of the lockdown. Between June and July 2020, all three methods were recovering.
- Long-acting and reversible contraceptives (LARCs), along with permanent methods, were all disrupted in April 2020, at the beginning of lockdowns. Implants were particularly affected. From May to July 2020 there was a positive trend in LARCs provision.
- Comparing monthly statistics for 2020 to the same month in 2019, all family planning methods but the pill showed decreases of 30% to 100% in April 2020, indicating disruptions immediately after the lockdown started. Trends improved in May and June, indicating recovery towards pre-lockdown levels. According to the authors, COVID-19 related disruptions may be related to restricted mobility of clients due to lockdown, and disruptions in contraceptive supplies, combined with insufficient qualified personnel to distribute family planning methods (Hossain, 2020).

Marie Stopes International (MSI) issued a study in July–August 2020 among 1,000 women per country in India and South Africa. It reported that almost a third of women in India (31%) and a quarter of women in South Africa (26%) who were seeking a contraceptive service or product were unable to leave home to attend the service due to fear of COVID-19 infection (Marie Stopes International, 2020).

In Jordan, Aolymat et al used a cross-sectional survey among 200 women to assess changes in contraceptive use before, during, and after the total curfew. The survey was distributed through social media channels, making it subject to self-selection bias. Further, it is a cross-sectional survey in which respondents were asked about their past behaviour regarding contraception, making the study subject to recall bias. The survey found that:

- Contraception use during lockdown significantly decreased (59.5% vs. 65.5%). After the lockdown, 61.5% reported using contraception.
- Before the lockdown, none of the women reported that there was a lack of medical care for contraception-related complications. However, during the lockdown, 11 women were unable to obtain medical care to manage their complications linked with contraception use, and eight

women were unable to obtain reproductive health services to treat contraception-related complications after the lockdown.

- During the lockdown, eight of the participants needed to replace their IUD and seven of them were not able to renew their IUD. The women were given a list of potential reasons for the inability to renew their contraceptive injections or IUD during and after the lockdown. The most commonly mentioned reasons were demand-side driven, such as fear of acquiring COVID-19 or lack of child care (Aolymat, 2021).

A little over one year into the pandemic, UNFPA and Avenir Health projected the potential impact of the short reduced access to family planning services and reduced contraceptive use. These projections are updates from the initial April 2020 projections, based on the newly available evidence. An estimated 12 million women [ranging from 4 million to 23 million] may have been temporarily unable to access family planning services because of the COVID-19 pandemic. As a result of these disruptions, as many as 1.4 million unintended pregnancies [ranging from 500,000 to 2.7 million] may have occurred before women were able to resume use of family planning services (UNFPA, 2021).



3.4. Maternal and neonatal health

There are limited studies on the impact of COVID-19 on the use of maternal and neonatal health services. However, they indicate that use of these services has decreased, and there are indications that the COVID-19 pandemic hindered the provision of respectful maternal services by healthcare workers. There is strong evidence from a meta-analysis on the impact of COVID-19 on maternal and neonatal health outcomes in LMICs, which demonstrates increased maternal deaths, stillbirth, and maternal depression. A large-scale hospital study from India further reported a decrease in hospital birth and an increase in admission from septic abortion.

Maternal and neonatal health services

Studies from Semaan et al and Asefa et al take a health workers' perspective. Semaan et al collected data from 712 maternal and newborn health professionals globally through an online survey (March–April 2020) and revealed that many maternal and newborn healthcare providers worldwide did not receive training on COVID-19 from their health facility. Further, over half (53%) of respondents from LMICs did not feel knowledgeable in how to care for a COVID-19 maternity patient. Facility-level responses to COVID-19 (signage, screening, testing, and isolation rooms) were more common in HICs than LMICs (Semaan et al., 2020). Also, Asefa et al collected data through a global online survey among 1,248 maternal and newborn health workers, of whom 1,127 (90.3%) participants from 71 countries responded to the question on respectful care. Among these, 17% reported that their ability to provide respectful care during the COVID-19 pandemic was somewhat lower or substantially lower than before the pandemic. This was highest in respondents from HICs (24%), followed by those from LICs (21%), and MICs (14%). Lower ability to provide respectful care was also higher among midwives (24%) compared to obstetricians and gynaecologists (15%), and nurses (10%). Responses from 120 respondents from 33 countries to an open-ended question on respectful maternity care – 52% from HICs, 37% from MICs and 12% from LICs – were analysed and six central themes were identified that demonstrate a negative impact of the COVID-19 pandemic on the provision of respectful maternity care:

- less family involvement
- reduced emotional and physical support for women
- compromised standards of care
- increased exposure to medically unjustified caesarean section
- staff overwhelmed by rapidly changing guidelines and enhanced infection prevention measures
- health workers' fear of getting infected and measures taken to minimize COVID-19 transmission (Asefa et al., 2021)

The level of evidence of both studies is assessed as moderate, because of the sampling design and self-selection bias, and a small number of respondents from LMICs.

Kassie et al studied the use of maternal and neonatal health services in five governmental health facilities in Southern Ethiopia and found a significant decrease in service use for overall antenatal care (27.4%), health facility birth (23.5%), post-natal care (29.1%), family planning visits (15.9%), and newborn immunization service use (28.5%) from March–June 2019 to March–June 2020. On the contrary, even though not significant, abortion care service use increased by 8.5% during the same period. The level of evidence of this study is assessed as good, as it reports on actual hospital data (Kassie, Wale, & Yismaw, 2021).

Oluoch-Aridi et al studied the perspective of women and interviewed, in the months from May–June 2020, 71 women from informal settlements in Kenya who had received services for childbirth from hospitals in the region in the six weeks prior to the study. 40% of women reported reduced access due to fear of contracting COVID-19. Respondents also reported deprioritization of health services, economic constraints, and psychosocial effects due to the lockdown. At the same time, they perceived improvements in quality of care due to short waiting times, hygiene measures, and responsive health personnel. However, this was only reported for the outpatient services and not inpatient services. The evidence level of this study is assessed as moderate because of the small sample (Oluoch-Aridi et al., 2020).

A study by Goyal et al in a tertiary hospital centre in India compared the number of admissions, deliveries, high-risk women, and referrals pre-COVID-19 to during COVID-19. The study reports a reduction of 45.1% in institutional deliveries, a 7.2% increase in high-risk pregnancy, and 2.5-fold rise in admission to the intensive care unit of pregnant women during the pandemic. One-third of women had inadequate antenatal visits. The most reported reasons for delayed health seeking were lockdown and fear of contracting infection. The level of evidence of this study is assessed as good because of the use of hospital data (Goyal et al., 2021).



Maternal and neonatal health outcomes

Chmielewska et al published a systematic review and meta-analysis in June 2021 which summarizes the evidence on the impact of COVID-19 on maternal and perinatal outcomes that had been published up to January 2021. The review included studies from around the globe. As this is a meta-analysis, the level of evidence is assessed as strong.

The study concludes that the COVID-19 pandemic has significantly worsened global maternal and foetal outcomes, more specifically resulting in an increase in maternal deaths, stillbirth, ruptured ectopic pregnancies, and maternal depression. An important note is that there was considerable disparity between high-resource and low-resource settings (Chmielewska et al., 2021):

- Two studies on maternal mortality (from India and Mexico including a total of 1,237,018 pregnancies during and 2,224,859 before the pandemic) were included in the meta-analysis and showed a significant increase in maternal death during the pandemic.
- Regarding stillbirths, 12 studies were included in the meta-analysis, of which four were in LMICs (Botswana, India (2) and Nepal). There was a significant increase in the rate of stillbirths. Additionally, the subgroup analysis for studies in LMICs reached statistical significance.
- When subdivided according to country income status, there was a statistically significant increase in mean postpartum depression scores in LMICs compared to pre-COVID-19. Of the 11 studies reporting on maternal mental health, seven reported a statistically significant increase in postnatal depression, maternal anxiety, or both.

- There was a significant decrease in preterm birth in specific subgroups. Preterm birth was reported in 18 articles with conflicting findings. Several large studies reported a local decrease in preterm birth, mostly in western European countries. One large study reported an increase in preterm birth in Nepal. Pooled analysis showed no overall effect for preterm birth before 37 weeks' gestation.
- On the basis of 11 studies, there was no significant change in the rate of spontaneous vaginal delivery during versus before the pandemic. 17 studies showed no significant change in caesarean section rate with consistent findings when subdivided into HICs and LMICs. Additionally, based on seven studies, rates of instrumental delivery did not differ during versus before the pandemic. However, the only LMIC study included in the meta-analysis (Nepal) reported a significant increase in induction of labour.

Chmielewska et al hypothesized a few reasons for their findings. One proposed explanation for the increase in adverse pregnancy outcomes is that such outcomes could be linked to reduced access to care, as is reported earlier in this section. In HICs, much of routine care was rapidly restructured and delivered remotely using diverse models, including telephone or video-based appointments. In LMICs, where remote consultations are less feasible, people might simply miss out on preventive antenatal care. The authors conclude that: *"The findings suggest that the increased rate of adverse outcomes might be driven mainly by the inefficiency of health-care systems and their inability to cope with the pandemic, rather than by the stringency of pandemic mitigation measures."* (Chmielewska et al., 2021)

A recent large-scale study from India did find a correlation between the stringency of the COVID-19 measures and maternal and neonatal health. Nair et al used hospital-based data on nine severe maternal complications and death in 15 hospitals across five states in India covering a total of 202,986 hospital births (Dec 2018–May 2021). A significant decrease in hospital births was observed during the pandemic period. The incidence of severe complications in the pandemic period was not significantly different from the pre-pandemic period, but hospital admissions from septic abortion were 56% higher (Nair & MaatHRI writing group, 2021).

3.5. Sexual and gender-based violence

The impact of COVID-19 on sexual and gender-based violence is one of the more researched sexual and reproductive health and rights topics. The available evidence presents a mixed picture, with some studies reporting an increase in violence, while others report stability or a decrease. One consistent factor across studies is that levels of intimate partner violence since COVID-19 – whether they increased, decreased, or stayed the same – remain high. Further, an increase in intimate partner violence during COVID-19 seems to be linked to the socioeconomic stability of the household (with women living in poorer households or where the men lost their job being more at risk of intimate partner violence). Proxy indicators – such as calls to helplines and reports from community health workers – indicate an increase in violence. Key problems in the studies on intimate partner violence are the different measures used to measure intimate partner violence, making it hard to compare numbers across studies, and the lack of reliable pre-COVID-19 prevalence data.

We could not identify a strong systematic review or meta-analysis on the topic of sexual and gender-based violence. Other gaps in knowledge are:

- All studies focused on partner violence, leaving an evidence gap on the impact of COVID-19 on other types of sexual and gender-based violence.
- While there are numerous publications and commentaries and plenty of anecdotal evidence on the potential impact of COVID-19 on female genital mutilation and early marriage, we could not identify original research providing reliable evidence in the form of incidence or prevalence data on this topic.

RESPONDING TO GENDERED VIOLENCE IN A PANDEMIC

In response to the COVID-19 crisis, both the Family Planning Associations of Malawi (FPAM) and Bangladesh (FPAB) intensified their sexual and reproductive health programmes to care for women victims of partner violence.

FPAM integrated mobile and static clinics to reach people living in remote areas. They increased the number of teams per district and their frequency. Team units were enhanced by increasing the number of trained health workers to provide integrated care for sexual and reproductive health, HIV and sexual and gender-based violence. Further, the sexual and gender-based violence care services were strengthened using community structures with health workers like Community Reproductive Health Promoters (CRHP), Health Surveillance Assistants (HSA), Community Based Distributor Agents, and Youth Community Based Distribution Agents (CBDA) providing sexual and gender-based violence support, including counselling and contraceptive methods. Finally, social behaviour change communication through mass media and social media was used to provide sexual and reproductive health information to all target populations (IPPF, 2021e).

FPAB took a different approach and installed a hotline service. Medical officers and counsellors from 21 FPAB branches provided specialized assistance for sexual and gender-based violence issues for women and girls during the pandemic. The hotline services were enabled by an effective and user-friendly e-platform to report sexual and gender-based violence and trigger the emergency support system (IPPF, 2021c).

In the next paragraphs, we present (mostly cross-sectional) country-level studies that mainly focus on partner violence. Most studies came from North Africa and the Middle East, with limited studies in sub-Saharan Africa, Asia and the Pacific, and Latin America and the Caribbean.

Studies that report an increase in partner violence:

- A cross-sectional study from Sediri et al among 751 Tunisian women using convenience sampling found a significant increase of domestic violence during the lockdown (from 4.4% to 14.8%). Psychological abuse was by far the most frequent type of violence followed by economic and physical violence. Women who had experienced abuse before the lockdown were at an increased risk of violence during lockdown. Violence during lockdown was associated with, among others, higher scores of depression, anxiety, and stress. The level of evidence is estimated as moderate because of self-selection and recall bias (Sediri et al., 2020).
- El-Nimr et al disseminated an online survey in different countries (Saudi Arabia, United Arab Emirates, Kuwait, Qatar, Oman, Yemen, Palestine, Iraq, Jordan, Syria, Egypt, Libya, Sudan, and Morocco) to which 490 women responded. Half of women reported that they were ever exposed to intimate partner violence, with psychological violence and verbal violence ranking highest. Further, the respondents reported that exposure to any type of intimate partner violence (from 39.6% to 46.9%) and exposure to psychological (from 20.4% to 26.5%), physical (from 6.9% to 13.1%), and sexual violence (from 9% to 13.5%) significantly increased during the lockdown compared to before the lockdown. Living in an African country was associated with a two times higher risk of exposure to intimate partner violence, while sufficient family income and the respondent's husband keeping his job during lockdown reduced the likelihood of exposure by nearly half. The level of evidence is estimated as moderate because of self-selection and recall bias (El-Nimr, Mamdouh, Ramadan, El Saeh, & Shata, 2021).

Studies that show a decrease in partner violence:

- The study of Abujilban et al in Jordan collected data from pregnant women through a cross-sectional online survey. Based on a non-representative sample of 215 pregnant women, the study found that a substantial number of women was exposed to different types of intimate partner violence before and during the lockdown period. The most prevalent form, both before and during the lockdown period, was control and humiliation (from 65.1% to 50.2%) and the least prevalent was sexual violence (from 15.2% to 11.2%). The scores on WHO's domestic violence questionnaire screening tool were significantly lower scores for all types of violence during the COVID-19 lockdown compared to before the lockdown. However, the proportion of pregnant women experiencing intimate partner violence during lockdown is high and warrants attention. The authors develop several hypotheses related to this reduction in violence. Firstly, the sample was biased towards better educated women with higher socioeconomic status who have not experienced loss of income due to COVID-19. Also, times of emergency might lead to seeking safety in their spouses, as well as to new interests that draw attention away from intimate partner violence. Further, earlier studies have found a reduction in intimate partner violence during pregnancy, so the reduction may be linked to the progression of the pregnancy status. The level of evidence is estimated as moderate because of self-selection and recall bias (Abujilban, Mrayan, Hamaideh, Obeisat, & Damra, 2021).
- In Nigeria, Ojeahere et al performed a cross-sectional online study among 474 people. The sample was biased towards respondents with higher education and higher socioeconomic status. Overall prevalence of intimate partner violence ranged from 7.2% to 13.5%. The results indicate a reduction in partner violence during the early stages of the COVID-19 confinement period. The level of evidence is estimated as moderate because of self-selection and recall bias (Ojeahere, Kumswa, Adiukwu, Plang, & Taiwo, 2021).

Studies with undetermined direction:

- In Bangladesh, Hamadani et al randomly sampled women from a cohort of families previously enrolled in a community randomised controlled trial. 2,174 women living with their husbands responded to the questions on intimate partner violence during the lockdown. Emotional violence included insults, which was reported by 19.9% (of those, 68.4% said it had increased since the lockdown measures); humiliation, which was reported by 8.9% (of those, 66% reported an increase); and intimidation, which was reported by 13.5% (of those, 68.7% reported an increase). Physical violence (e.g. being slapped or having something thrown at them) was reported by 6.5% (of those, 56% reported an increase). Sexual violence was less common and reported by 3.0% (of those, 50.8% reported an increase). The level of evidence of this study is assessed as moderate. The measures in this study are validated and the sampling strategy is reliable. However, since there are no comparison data from before the lockdown measures, and questions on decrease/increase of intimate partner violence were only asked to respondents who reported experiencing violence since the lockdown (and not to those who reported not having experienced violence during lockdown), it is not possible to reliably determine whether intimate partner violence actually increased or decreased since the lockdown (Hamadani et al., 2020).
- In Ethiopia, Tadesse et al randomly selected 589 married or cohabiting women to participate in a community-based cross-sectional study. Of them, 22.4% experienced at least one form of intimate partner violence: 11.0%, 20.0%, and 13.8% of respondents experienced physical, psychological, and sexual intimate partner violence respectively. After adjusting for covariates, being illiterate, having an illiterate husband, having a substance using husband, and reporting a community tolerant attitude to violence were predictors of intimate partner violence. While the study did not assess changes in intimate partner violence before and during the lockdown measures, they report that prevalence of intimate partner violence among married women in this study was comparable to the national pre-COVID figure. The level of evidence is estimated as moderate because of the lack of baseline data from the study population (Tadesse, Tarekegn, Wagaw, Muluneh, & Kassa, 2020).



- Several other studies measured levels of intimate partner violence during COVID-19 without comparing it to pre-COVID-19 levels. This indicates that intimate partner violence is prevalent in this period but does not allow conclusions to be drawn on whether COVID-19 changed intimate partner violence levels. For example, in Turkey, Akalin et al reported 35% of intimate partner violence among a cross-sectional sample of 1,036 women who were either married or had an intimate partner (physical (10.1%), sexual (4.0%), psychological (32.2%) or economic (11.5%)). Exposure to intimate partner violence during the pandemic was significantly associated with being married, having children, being unemployed, having poor marital/relationship satisfaction, reporting an increased workload in the household, and the negative effect of quarantine on mood (Akalin & Ayhan, 2021). In Ethiopia, Teshome et al reported levels of violence among a sample of 464 pregnant women: 33 (7.1%) reported intimate partner violence during pregnancy, and among those 24 (72.7%) reported emotional violence, 16 (48.5%) reported sexual violence, and 10 (30.3%) reported physical violence (Teshome et al., 2021).

Other perspectives:

- In Peru, Aguero et al studied calls to the helpline for violence against women in the initial phases of stay-at-home policies (starting mid-March) and found a 48% increase in calls since the pandemic, with effects increasing over time. The results were not driven by any particular demographic group or background characteristics. The level of evidence is estimated as moderate. While calls to helplines are a proxy indicator, it is not clear from the article what these calls were about and if they represent an actual increase in violence (Aguero et al., 2021).
- The Population Council measured the impact of COVID-19 on violence through phone interviews with community health workers in Kenya (1,385), Bangladesh (370) and Haiti (260). In total, 56%, 32% and 12% of community health workers perceived an increase in domestic violence (both against intimate partners and children) in their communities during COVID-19 in Kenya, Bangladesh and Haiti respectively. Asked about key reasons for this increase, several factors were identified, mainly increased stress/tension due to loss of employment/income (> 80%) and children being at home/misbehaving (> 50%) (Gotttert et al., 2021).



3.6. Sexuality education and access to sexual and reproductive health information

Only one study was identified that includes the impact of COVID-19 on access to sexuality education in Southern Africa, and states that sexuality education was not included in online learning. Further, the major impact of COVID-19 on schools is well documented. As of September 2021, schools were still fully closed in 13 countries, all of them LMICs, and partially closed in many more, without good alternatives such as online education. Subsequently, access to school-based youth clubs on topics related to sexual and reproductive health is impacted. Internet and social media were an important and appreciated source for sexual and reproductive health information during COVID-19 and the pandemic has intensified the development and implementation of digital comprehensive sexuality education. Nevertheless, access to online sources is not possible for a substantial proportion of young people in LMICs.

A survey by MIET Africa involving a small sample of young people in Southern Africa (82) indicated that while most respondents (78%) said they received sexuality education in school before the lockdowns, teachers were not scheduling these classes in online learning. The same study presents interesting information based on focus group discussions with 240 young people (15–24 years) in Lesotho, Malawi, Madagascar, Zambia, and Zimbabwe. The young people said they had gained greater appreciation of digital sexuality education, because of the privacy and anonymity, the diversity of information, and the fact that it is not filtered by teachers' beliefs on morality and sexuality (MIET Africa, 2021).

A report published by Rutgers, the Dutch Countdown 2030 Europe partner, presents the results of a mixed methods study in six LMICs (Ghana, Indonesia, Kenya, Nepal, Uganda, and Zimbabwe). In total 2,693 young people (15–30 years) participated in the online survey (October–December 2020) and four to six online focus group discussions per country were organized (August–November 2020). While there is a substantial risk of bias in this study – in particular because of the required access to computers or mobile devices, the distribution channels of the survey, and the lack of baseline data – it provides interesting insights into the impact of COVID-19 on young people's lives (Both, Castle, & Hensen, 2021).

Respondents were asked about whether they needed/wanted information on specific topics related to sexual and reproductive health, and whether they had received sufficient information during the COVID-19 crisis. In all countries, over 40% of young people reported needing/wanting information on at least four of the surveyed sexual and reproductive health topics. Over half needed/wanted information on sex and COVID-19 (and 57% (Kenya) or fewer young people considered that they had received sufficient information on this topic); between 45% (Ghana) and 71% (Kenya) needed/wanted information on gender-based violence; and over 30% needed/wanted information on sexual pleasure and sexually transmitted infections. The report concludes that there is a gap regarding the provision of information on topics related to sexual and reproductive health to young people during the pandemic, though it is unclear if this need has changed compared to pre-COVID-19.

The qualitative part of the study found that by far the most used source of sexual and reproductive health and rights information for young people during the pandemic has been the internet and social media: WhatsApp discussion groups, Facebook and Twitter were commonly used in many settings to request and acquire information about specific sexual and reproductive health issues and services, though this may be the result of participant recruitment bias (online). Other sources of sexual and reproductive health and rights information accessed by young people during the COVID-19 crisis included health facilities and churches. Others reported seeking information from the radio and TV. However, the cost as well as the non-interactive nature of TV and radio programmes was frustrating to many young people. In certain countries, such as Kenya and Zimbabwe, telephone hotlines with assigned counsellors, which have continued to run during the pandemic, were seen as very useful sources of information about sexual and reproductive health and rights and services.

Further, the impact of COVID-19 on school closures has been well documented. School closures have been substantial and uneven across countries – as of September 2021, in LMICs schools had remained closed for an average of 115 days. Fewer than a third of LMICs reported that all students had returned to in-person schooling, heightening their risk of learning loss and dropout (UNESCO, 2021). In August 2021, UNESCO reported that over 112 million learners were still affected by COVID-19, which corresponds to 6.4% of total enrolled learners. There were still 13 countrywide school closures, all in LMICs.

According to Rutgers' report, one of the biggest impacts of school closures and/or lockdown, across all settings, has been that girls could not access sanitary products or information about menstrual hygiene. Further, the report shows that in Nepal, students indicated that they had not received any comprehensive sexuality education since they had started learning online, and in Zimbabwe, sexual and reproductive health clubs that met in school were no longer accessible (Both et al., 2021).

At the same time, the COVID-19 pandemic intensified the development and implementation of digital comprehensive sexuality education, and can be seen as not only a challenge, but also an opportunity to explore and leverage online spaces and digital tools in the context of comprehensive sexuality education (UNESCO, 2020). Rutgers reports that some non-governmental organizations (NGOs) have carried out their sensitization sessions and held their meetings on Zoom instead of in person. However, the cost of having a computer or smartphone and of an internet connection has prevented some young people from taking part (Both et al., 2021).

ALTERNATIVES TO IN-SCHOOL FACE-TO-FACE COMPREHENSIVE SEXUALITY EDUCATION

In Mali, the Malian Association for the Protection and Promotion of the Family (AMPPF) quickly converted its face-to-face sexuality education model to hold online sessions on digital platforms such as WhatsApp and Facebook. Awareness campaigns were conducted using radio and social media to complement the online sessions. AMPPF worked with the youth action movement (YAM) members and trained community-based peer educators as youth champions who facilitated digital sexuality education through WhatsApp groups and worked through the modules with youth groups to ensure that discussions supported the learning sessions and to answer all questions. The digital sexuality education content has enabled AMPPF to work with the largest group of young people they have ever served; in 2020 160,288 young people were reached through online services (IPPF, 2021h).

In Togo, the Association Togolaise pour le Bien-Etre Familial (ATBEF) provided youth-friendly services through its mobile app 'Infos Ado Jeunes'. To overcome challenges in accessing healthcare facilities during COVID-19, ATBEF adapted this app by adding a toll-free teleconsultation service that young clients can use to access abortion consultations and pre- and post-abortion counselling. The app has enabled young clients to continue to access care when they face challenges travelling to clinics (IPPF, 2021g).



3.7. Abortion

Hospital data from Ethiopia and South Africa, and population data from India, point towards a decrease in the number of safe abortions in the early months of the COVID-19 pandemic. It is not clear whether this is due to a reduction in unplanned pregnancies, and whether this decrease is accompanied by an increase in unsafe abortions or telemedicine and over-the-counter services.

Endler et al sent out an anonymous online survey to clinicians, researchers, and organizations working in the field of sexual and reproductive health to assess access to sexual and reproductive health and rights services and risk of sexual and reproductive health and rights violations (Endler et al., 2021). The survey was completed by 51 people representing 29 countries – Europe (11), North America (2), South America (4), Africa (4), Asia (6), and Australia/Oceania (2). It is prone to several limitations, most importantly self-selection bias of the respondents, as well as the small sample size and limited geographical representation. The study reports that among countries with mildly restrictive abortion policies, 11 (69%) had implemented changes to facilitate access to abortion in response to the pandemic. No country where abortion was severely restricted before the pandemic had instituted any change toward facilitating access during the pandemic. Policy changes made to mitigate the threat of reduced access included the implementation of telemedicine consultation for abortion or contraceptives, a decrease in the number of required visits for medical abortion, and intake at home. Concerning abortion services, the survey asked respondents about the perceived most common reasons that women were not seeking abortion services. Most reported reasons were fear of COVID-19 infection, lack of transport, closure of clinics, and fear of leaving the house because of lockdown restrictions (Endler et al., 2021).

Marie Stopes International issued a study in July–August 2020 among 1,000 women per country in India and South Africa and reported that almost a third of respondents in India seeking an abortion said that the clinic in their area was closed. Further, a third (30%) also reported that the waiting time for an appointment was one to two weeks and 9% reported a waiting time of more than five weeks (Marie Stopes International, 2020).

A study by Belay et al compared deliveries, safe abortion, and post-abortion/delivery numbers in a tertiary facility in Ethiopia between the periods of March–May in 2019 and 2020. The authors reported a reduction in both safe abortion care by 16.4% (from 323 to 270) and in post-abortion care by 20.3% (from 507 to 404). Further, post-abortion family planning and post-partum family planning reduced by 40.5% and 66.7% respectively (Belay et al., 2020).

Adelekan et al described the effect of the COVID-19 pandemic on family planning and termination of pregnancy services use immediately following the lockdown in Gauteng Province in South Africa. They analysed administrative data on clinical services use during the previous two years, including the five weeks following the enforcement of the lockdown in South Africa, from the district health information system database. The evidence of this article is assessed as high, since it uses monitoring data that allow comparison of the situation pre-COVID-19 and since COVID-19. A total of 1,507 abortions were provided in health facilities in Gauteng in April 2020, out of which 1,254 (83%) were conducted in the first trimester of pregnancy, or a 5% decline compared to April 2019. Despite this decrease, there was a 2% increase in the number of abortions performed in the first trimester. Second trimester abortions performed in April 2020 compared to the same period in the previous year showed a 17% overall decline (Adelekan et al., 2021).

3.8. HIV

There were several studies from African countries (mainly South Africa and Uganda) that studied the impact of COVID-19 on testing and treatment for HIV and other sexually transmitted infections. Those studies all point in the direction that COVID-19 had an – at least temporary – impact on accessing HIV care and antiretroviral therapy, as well as testing services for HIV and other sexually transmitted infections.

Davey et al found that during the lockdown in South Africa, missed PrEP visits among pregnant women increased significantly to 63% at the one-month visit and 55% at the three-month visit (Davey et al., 2020). Also in South Africa, Jarolimova et al studied the primary concerns regarding antiretroviral therapy pick-up. These were COVID-19 infection risk (n=91, 33%), transportation availability (n=63, 22%), and safety (n=58, 21%). 20 (7%) of 278 participants had recently delayed picking up their antiretroviral therapy due to COVID-19 (Jarolimova et al., 2021). Siedner et al found a significant increase in HIV visits immediately after the lockdown in South Africa (Siedner et al., 2020). Pierre et al found that in Rwanda less than half (48%) of patients had attended a scheduled visit at an antiretroviral therapy collection clinic (Pierre, Uwineza, & Dzinamarira, 2020).

In Uganda, Linnemayr et al performed a study among people living with HIV, reporting that most participants (76%) agreed that COVID-19 impacts their ability to come to the clinic and slightly more than half (54%) agreed that coming to the clinic increased their chances of getting COVID-19. COVID-19 also impacted stress levels among people living with HIV in Uganda (Linnemayr et al., 2021). In a qualitative study, West et al found that mental stress during COVID-19 was compounded by worry about antiretroviral therapy access, distress over inadvertent disclosure of HIV status, fear that coronavirus infection would have more severe outcomes for immunocompromised individuals, and exacerbated poverty and economic stress (West et al., 2021).

Similar findings are reported by Ponticiello et al regarding HIV testing services in Uganda. A qualitative study among 20 people participating in voluntary HIV testing found that COVID-19 has negatively impacted engagement with HIV testing resources in two important ways: COVID-19 restrictions prevented participants from accessing HIV testing services and COVID-19 related stigma discourages the use of healthcare facilities where HIV testing services are located (Ponticiello et al., 2020). There are also signs that HIV testing programmes have been ceased for periods of time, also impacting access to these services (Silharova, Holubcik, Krcmery, & Suvada, 2021).



4. Donor responses

In May 2020, representatives of 59 countries issued a joint press statement titled ‘Protecting Sexual and Reproductive Health and Rights and Promoting Gender-responsiveness in the COVID-19 crisis’. In this statement, the signatory parties, among whom are governmental representatives of all Countdown 2030 Europe countries³, emphasize that, *“Sexual and reproductive health needs, including psychosocial support services, and protection from gender-based violence, must be prioritized to ensure continuity. We must also assume responsibility for social protection and ensure adolescent health, rights and wellbeing during schools close-down. [...] Funding sexual and reproductive health and rights should remain a priority to avoid a rise in maternal and newborn mortality, increased unmet need for contraception, and an increased number of unsafe abortions and sexually transmitted infections.”* (Representatives of 59 countries, 2020).

³ Belgium, Denmark, European Union institutions, Finland, France (not included in this analysis), Germany, Ireland, Netherlands, Norway, Spain (not included in this analysis), Sweden, Switzerland (not included in this analysis), United Kingdom (based on publicly available information).

In the following paragraphs, the Official Development Assistance (ODA) response to the COVID-19 pandemic is presented. In doing so, an assessment is made of changes in donors’ priorities and channels for development funding, which may potentially have a lasting impact on development cooperation well beyond the pandemic period. Key takeaway messages are:

- In terms of policy priority setting, the focus of most countries has been on supporting the direct response to the COVID-19 crisis and on health systems strengthening.
- Almost all donor countries increased their ODA spending in 2020, with the United Kingdom being a notable exception.
- Also, related to ODA for sexual and reproductive health and family planning, all Countdown 2030 Europe countries but one – the United Kingdom – sustained or increased their contributions.
- The general focus on health systems strengthening can be recognized in sexual and reproductive health and rights priorities during COVID-19, with several countries prioritizing access to sexual and reproductive health services in resilient health systems. Additionally, gender-based violence prevention and response was prioritized by several countries.
- In terms of funding mechanisms, multilateral funding was preferred by most countries, with several countries providing more core support to multilateral bodies to allow for a flexible response to the crisis. Further, several new funding mechanisms emerged, mainly related to vaccine equity.



4.1. Overall ODA response to COVID-19

Priorities in the context of COVID-19

Following the onset of the COVID-19 pandemic, most governments adjusted their ODA priorities, to include support to the direct response to COVID-19 in partner countries. This included prioritizing research into vaccines, diagnostic tests, operational research, and research in public health (e.g. Belgium, European Union institutions, Norway) and access to vaccines (e.g. Denmark, European Union institutions, Germany, Ireland, Netherlands, Norway, Sweden, United Kingdom). Further, several donors prioritized socioeconomic mitigation and social protection (e.g. Belgium, European Union institutions, Germany, Sweden, United Kingdom), protective equipment, prevention, testing, treatment, and sanitation (e.g. European Union institutions, Netherlands, Norway), pandemic preparedness and response (e.g. European Union institutions, Ireland), and inclusive, fair and green recovery (e.g. Netherlands, Sweden).

A second common ODA priority in the context of COVID-19 is health systems strengthening (e.g. Belgium, European Union institutions, Germany, Ireland, Netherlands, Sweden).

Other topics prioritized by countries in their ODA response to COVID-19, as per the input of Countdown 2030 Europe partners, have included:

- Nutrition and food security (e.g. Germany, European Union institutions, Ireland, Netherlands, Norway)
- Humanitarian aid (e.g. Belgium, Ireland)
- Water, sanitation and hygiene (e.g. European Union institutions, Netherlands)
- Coordination between donors (e.g. Belgium, European Union institutions, Sweden) and strengthening of international cooperation (e.g. Germany)
- Girls' education (e.g. Ireland, United Kingdom)
- Climate change mitigation (e.g. Ireland, United Kingdom)
- Implementation of human rights (e.g. Finland) and support to human right defenders (e.g. Denmark)
- Good governance (e.g. Ireland), conflict prevention and peace building (e.g. Sweden), stabilization of fragile regions affected by displacement (e.g. Germany), and support to civil society organizations (e.g. Denmark)
- Basic services for the most vulnerable (e.g. Denmark)
- Eradication of extreme poverty and reduction of inequalities (e.g. Finland)
- Responsible production of goods and services and future-proof trade (e.g. Netherlands)



Preferred funding mechanisms for channelling ODA funding

According to the OECD, from 2019 to 2020, increases in all funding mechanisms were noted: OECD Development Assistance Committee (DAC) members' bilateral projects and programmes increased by 8% (with budget support increasing by 131%), multilateral channels increased by 9% (with contributions to organizations other than the United Nations, the World Bank and regional development banks increasing by 68%), and humanitarian aid increased by 6% (OECD, 2021a).

In April 2020, OECD DAC members issued a statement that recognized ODA as *"an important means of supporting national responses to the COVID-19 crisis"* and said that they would *"strive to protect ODA budgets"* (OECD-DAC, 2020). The OECD reported that ODA from its members rose *"to an all-time high of USD 161.2 billion in 2020, up 3.5% in real terms from 2019, boosted by additional spending mobilised to help developing countries grappling with the COVID-19 crisis"* (OECD, 2021b).

For the DAC countries that are also part of the Countdown 2030 Europe consortium, the OECD reports the following changes in ODA in real terms in 2020 as compared to 2019 (ODA growth rate comparing 2019 and 2020): Belgium +2.8%, Denmark +0.5%, Finland +8.1%, France +10.9%, Germany +13.7%, Ireland -4.1%, Netherlands -2.8%, Norway +8.4%, Spain -1.8%, Sweden +17.1%, Switzerland +8.8%, United Kingdom -10.0% (OECD, 2021a). For the European Union institutions, the OECD reports an increase of 25.4% in ODA in real terms from 2019 to 2020 (OECD, 2021c).

Based on the data provided by Countdown 2030 Europe partners regarding preferred funding mechanisms in the ODA response to COVID-19, one trend emerges. Donors seem to emphasize the importance of flexibility in funding. This becomes visible in mainly two ways:

- Allowing flexibility in already committed funding, e.g. Belgium allowed partners in its bilateral cooperation to reallocate existing funding to the COVID-19 response.
- Providing core funding to multilateral agencies, e.g. Denmark supported UNFPA with DKK51 million for unmarked COVID-19 related responses.

Finally, new initiatives directly linked to COVID-19 are being funded, such as the Access to COVID-19 Tools (ACT) Accelerator, COVAX and the COVID-19 vaccine work from Gavi, the Vaccine Alliance and the Coalition for Epidemic Preparedness Innovations (CEPI).



4.2 Sexual and reproductive health and rights ODA in the context of COVID-19

Sexual and reproductive health and rights ODA topics in the context of COVID-19

As per Countdown 2030 Europe partners' input, a handful of donors explicitly prioritized sexual and reproductive health and rights in their response to COVID-19. Denmark and Ireland include sexual and reproductive health and rights and gender-based violence prevention and response in their ODA response to COVID-19, Belgium and Ireland focus on gender equality, and Sweden on equitable and gender-equal healthcare. A further example of donor focus on sexual and reproductive health and rights in COVID-19 response is the joint statement on 'Protecting Sexual and Reproductive Health and Rights and Promoting Gender-responsiveness in the COVID-19 crisis' (Representatives of 59 countries, 2020).

In their sexual and reproductive health and rights ODA work for 2020, Countdown 2030 Europe countries set the following priorities:

- Many donors' investments in sexual and reproductive health and rights in 2020 were directly related to the six building blocks of health systems strengthening and included access to sexual and reproductive health services in general (e.g. Belgium, Denmark, Germany, Netherlands, Sweden, United Kingdom) and to contraception (e.g. Denmark, Ireland, Netherlands, Sweden), safe abortion (e.g. Denmark, Sweden), and resilient health systems including sexual and reproductive health (e.g. Sweden) in particular.
- Sexual and reproductive health and rights acute needs in humanitarian settings, specifically ensuring access to sexual and reproductive healthcare and family planning and preventing and responding to sexual and gender-based violence (e.g. Denmark, Finland, Netherlands, Norway, Spain, Sweden)
- Gender-based violence prevention and response (e.g. Belgium, Denmark, European Union institutions, Sweden, United Kingdom)
- Access to sexual and reproductive health information (e.g. Netherlands) and to comprehensive sexuality education (e.g. Ireland)
- Prevention of early, child and forced marriage (e.g. Denmark, Ireland)
- Countering female genital mutilation and harmful practices (e.g. European Union institutions)
- Gender equality (e.g. Belgium, Ireland) and a gender-transformative perspective (e.g. Norway)
- Prevention of teenage pregnancies (e.g. Ireland)
- Engaging women and young people in decision-making (e.g. Belgium)
- Ensuring equal access to health (e.g. Sweden), emphasizing women's, girls', adolescents' and children's needs (e.g. Sweden), and promoting women's full and equal enjoyment of sexual and reproductive health and rights (e.g. Norway)
- Improving reproductive, maternal, newborn, and child health (e.g. European Union institutions)
- Supporting change of social norms, including for LGBTIQ+ groups (e.g. European Union institutions)
- Protecting civil society and human rights defenders, including women's rights defenders (e.g. Belgium)

Funding commitments to sexual and reproductive health and rights in the context of COVID-19

Based on tracking data of Countdown 2030 Europe, this section presents high-level trends in ODA funding for access to sexual and reproductive healthcare and family planning (SRH/FP) (Countdown 2030 Europe, 2022). Overall, the COVID-19 pandemic did not hamper European donors' efforts to advance SRH/FP.

Between 2019–2020, funding to SRH/FP through *all streams* (excluding government-to-government cooperation) increased by 10%. Overall, Countdown 2030 Europe countries contributed €1.278 billion in funding to SRH/FP in 2020, an additional €110.5 million compared to the previous year. This difference is even higher when factoring in government-to-government cooperation. If this channel is also taken into consideration, European donors contributed a total of €1.447 billion to SRH/FP, an even more substantial increase. In 2020, 11 donors increased their overall contributions to SRH/FP, one sustained its funding and one – the United Kingdom – reported a decrease.

Adding funding for other core sexual and reproductive health and rights elements, such as HIV, prevention and integrated responses to sexual and gender-based violence, comprehensive sexuality education, safe abortion, work with lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ+) people, or broader human rights-based, gender-responsive and intersectional approaches, the total ODA spending for sexual and reproductive health and rights by European donors amounted to €2.614 billion. This represents 3% of total ODA disbursed by European donors in 2020.

In terms of European donors' contributions to sexual and reproductive health and rights through the multilateral system, European governments disbursed €1.865 billion in 2020. This is equivalent to 71% of total spending on sexual and reproductive health and rights.

Looking at funding for UNFPA, the combined figure of European donor countries' SRH/FP funding in 2020 amounts to €582 million, which is 14% less than in 2019. European funding for UNFPA Supplies amounted to €43 million, which represented a decrease of 75% compared to 2019, mainly due to reduced support from the United Kingdom. To be noted, however, is that the United Kingdom had two grants running concurrently in 2019, to cover a new phase of the programme, leading to a peak of this country's contributions that year. Further to this, the European Union institutions did not contribute to the UNFPA Supplies programme in 2020, as disbursements under its multiannual pledge came to an end in 2019. In 2020, Denmark was the largest European contributor to UNFPA Supplies, with €15 million provided, followed by €12.5 million from the Netherlands.

In terms of a ranking for 2020, the United Kingdom, despite major reductions in its support compared to 2019, remains the largest contributor to SRH/FP and sexual and reproductive health and rights. The Netherlands is the second biggest contributor to SRH/FP, while Germany has spent the second most for sexual and reproductive health and rights. European donors allocate between 0.3% – 5.3% of their individual ODA to SRH/FP and between 0.5% – 6.6% to sexual and reproductive health and rights. In both cases, the Netherlands emerges as the donor that allocates the biggest share of its ODA to both areas, followed by Denmark.



5. Recommendations

The review of scientific literature indicates that COVID-19 has had an important impact on sexual and reproductive health. Especially in the early months of the COVID-19 health crisis, access to sexual and reproductive health services was reduced, resulting in worse maternal health outcomes, less access to contraceptives for specific subgroups (e.g. women who have never given birth), fewer safe abortions and less access to services for HIV and other sexually transmitted infections. Even though it is not clear from the data reviewed for this report whether overall gender-based violence rates increased or decreased since COVID-19, consistent high levels of gender-based violence are reported during COVID-19. Finally, due to school closures, young people have no longer had access to sexual and reproductive health clubs – and other support structures – in school. Alternatives to providing sexual and reproductive health and rights information to young people were established through community outreach and online education, though the latter is not accessible for many young people. Most European donors have stepped up and expressed the importance of supporting sexual and reproductive health and rights as well as a gender-sensitive response during COVID-19 and have increased ODA, including for sexual and reproductive health and rights. However, this did not prevent several sexual and reproductive health indicators from worsening. To build back better and to learn for future pandemics, we recommend the following:

Continuous strong commitment to sexual and reproductive health and rights. To ensure the sustainability of sexual and reproductive health service provision and programme delivery, continuous strong commitment to sexual and reproductive health and rights is essential. The literature review provided indications that women and girls who already had less access to sexual and reproductive health services in countries with weaker health systems are most affected by the health crisis. Sustainability of health service provision will require secure, continuous, and long-term investment, funding, and support for sexual and reproductive health and rights. It will also require prioritization of sexual and reproductive health and rights at a policy level, including through the inclusion of sexual and reproductive health services in essential services lists, for example.

Build strong health systems. Linked to the above, continuous investment in strong health systems – including infrastructure, skilled staff, and strong supply chains – is required to build and sustain resilient health systems that can adapt to crisis situations.

Learn from new approaches. The COVID-19 crisis generated a lot of creativity in terms of providing alternative ways of providing sexual and reproductive health services and information. Such initiatives include mobile abortion services, online comprehensive sexuality education, expanded outreach models, and telemedicine. It is essential to invest in further exploration of the (cost-)effectiveness and acceptability of these alternative services, including in different settings. This will help to understand whether they can be more permanently put in place as (cost-)effective alternatives to (complement) traditional services. Further, learning from these alternatives allows the development of protocols for alternative models of service delivery in future health crises.

Sensitization campaigns. Many studies found that access to sexual and reproductive health services was also substantially reduced because of demand-side factors – mainly women being afraid of contracting COVID-19 during visits to health services. To reduce this barrier, communication campaigns should be undertaken in future pandemics to emphasize the safe availability of sexual and reproductive health services.

Evidence and monitoring. There is a need for investing in consistent monitoring of key indicators. Many independent small-scale efforts are being undertaken to map the impact of COVID-19 on sexual and reproductive health. However, forging alliances among key players in the global sexual and reproductive health field and advocating for funding to set up proper monitoring tools for key sexual and reproductive health indicators would provide more reliable data for policy-makers, programme staff, and healthcare organizations to base their decisions on. Further, the available evidence emphasizes the importance of disaggregating data to identify population subgroups that are at increased risk of poor sexual and reproductive health outcomes in crisis situations, and trajectories of impact.

Key abbreviations

FP	Family planning
HICs	High-income countries
LARCs	Long-acting and reversible contraceptives
LMICs	Low- and middle-income countries
MA s	Member Associations
ODA	Official Development Assistance
PwD	People living with disabilities
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SRH(R)	Sexual and reproductive health (and rights)
WHO	World Health Organization

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Appendix 1

Recommendations to address the impact of COVID-19 on sexual and reproductive health identified in literature

Several publications and guidelines were found that present guidance on how to address the impact of COVID-19 on sexual and reproductive health:

Maintaining essential services:

- WHO has published an operational guidance document on 'Maintaining essential health services: operational guidance for the COVID-19 context': <https://apps.who.int/iris/handle/10665/332240>
- UNFPA has published a technical brief on responding to the sexual and reproductive health needs of adolescents in the context of the COVID-19 crisis: https://www.unfpa.org/sites/default/files/resource-pdf/Not_on_Pause.pdf

Delivering family planning services:

- Selected strategies for improving contraception access during the COVID-19 pandemic: <https://contraceptionmedicine.biomedcentral.com/articles/10.1186/s40834-020-00114-9>
- Recommendations Related to Integrating Postabortion and Postpartum Family Planning for Diverse Categories of Women: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7541126/>
- Ways in which particular High Impact Practices may serve as useful references to global family planning stakeholders as they respond to the impact of COVID-19: <https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1881210>
- A behaviour change model from persuasive design – the Fogg Behavior Model – to make timely adjustments to contraceptive social marketing programmes during the course of the COVID-19 lockdown: <https://gatesopenresearch.org/articles/4-141>

Comprehensive sexuality education:

- Global monitoring on school status: <http://covid19.uis.unesco.org/gpe-map/> and <https://en.unesco.org/covid19/educationresponse#schoolclosures>
- Practical information on out-of-school comprehensive sexuality education: <https://www.unfpa.org/resources/adapting-comprehensive-sexuality-education-programming-during-covid-19-pandemic> https://www.unfpa.org/sites/default/files/resource-pdf/Learning_Beyond_the_Classroom.pdf

Sexual and gender-based violence:

- Suggested strategies for prevention, screening, treatment of survivors and management of perpetrators: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7365082/>
- The Role of Service Providers, Technology, and Mass Media When Home Isn't Safe for Intimate Partner Violence Victims: Best Practices and Recommendations in the Era of COVID-19 and Beyond: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7447204/>
- COVID-19 and violence against women: What the health sector/system can do: <https://www.who.int/reproductivehealth/publications/vaw-covid-19/en/>

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