

Continuity of Essential Sexual and Reproductive Health Services During Covid-19 Pandemic in the Who African Region

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Abstract

Background: The COVID-19 pandemic has had a major impact on the capacity of health systems to continue the delivery of essential health services. While health systems around the world are being challenged by increasing demand for care of COVID-19 patients, it is critical to all other services including sexual reproductive health services. Countries are expected to ensure optimal balance between fighting the COVID-19 pandemic and maintenance of essential health services like sexual reproductive health. The purpose of this report was to assess and document continuity of sexual and reproductive health services with a focus on safe abortion, post abortion care and family planning services during the COVID -19 pandemic in selected countries of the World Health Organization Africa Region.

Methods: A descriptive survey using a simplified and user-friendly virtual web based rapid needs assessment through a questionnaire was filled in by key informants drawn from the ministries of health from 30 countries in July 2020. The questionnaires were filled in by the World Health Organization staff in charge of sexual reproductive health services in collaboration with their counterparts in the ministries of health and uploaded in excel data sheets and categorized in to thematic areas for analysis.

Results: Responses were received from 17 countries out of the 30 countries that received the questionnaires. Of the 17 countries, only 2 (12%) countries reported that sexual and reproductive health services are not integrated in the essential health services package. All the sexual reproductive health elements-family planning/contraception and comprehensive abortion care, including post abortion care are integrated in the essential health services package in 12 (80%) of the 15 countries that have sexual reproductive health integrated. Also,14(82%) countries reporting having ongoing awareness raising campaigns/communication messages about family planning, comprehensive abortion care and post abortion care during the COVID pandemic. 9(59%) of the countries reported reduction in the use of family planning services, 6(35%) indicated no changes in the use of family planning services with only 2(12%) countries providing no response.

Conclusion: The survey provides information on the weak health systems of the participating member states of the WHO Africa Region and the magnitude of disruptions of sexual reproductive health services in selected countries. Further, strategies adopted by countries to ensure continuity of sexual reproductive health services amidst COVID -19 like communications, Countries finally identified key areas that need to be supported in family planning/contraception, comprehensive abortion care and post abortion care during the COVID-19 pandemic.

Plain English Summary

The COVID-19 pandemic continues to revenge the world causing major impact on the capacity of health systems to continue the delivery of essential health services. While health systems around the world are being challenged by increasing demand for care of COVID-19 patients, it is critical to all other services including sexual reproductive health services. Countries are expected to ensure optimal balance between fighting the COVID-19 pandemic and maintenance of essential health services like sexual reproductive

health. We conducted a survey whose purpose was to assess and document continuity of sexual and reproductive health services with a focus on safe abortion, post abortion care and family planning services during the COVID – 19 pandemic in selected countries of the World Health Organization Africa Region. The results indicate that sexual and reproductive health services are not integrated in the essential health services package and that countries have ongoing awareness raising campaigns/communication messages about family planning, comprehensive abortion care and post abortion care during the COVID pandemic. Most countries have reported reduction in the use of family planning services. The survey provides information on the weak health systems of the participating member states of the WHO Africa Region and the magnitude of disruptions of sexual reproductive health services in selected countries

Introduction

The COVID – 19 pandemic has greatly put a strain on the health systems globally. The novel coronavirus (SARS-CoV-2) that causes COVID-19 was declared a global pandemic by the World Health Organization (WHO) on 11th March, 2020[1]. The strain of the outbreak on health systems has greatly impacted health services and collapsing others including sexual and reproductive health of individuals especially those living in low- and middle-income countries (LMICs) [2]. This is attributed to the challenges of responding to the outbreak directly while simultaneously maintaining essential health systems. Evidence shows that in any emergency or humanitarian crises, women and girls face multiple sexual and reproductive health challenges [3, 4, 5].

Approximately 95,043,934 positive cases of COVID – 19 have been confirmed globally with 2,032,786 deaths by mid-January, 2021[6, 7]. In Africa alone at the same period of time, a total of 3,196,365 infections of COVID-19 have been confirmed with 76,921 deaths recorded [8]. This has significantly disrupted essential health services with limited regular accessibility and availability of services including sexual reproductive health services (SRHS) such as family planning(FP)/contraception, comprehensive safe abortion care(CAC), post-abortion care(PAC), pre- and postnatal checks, HIV/AIDS and sexually transmitted infections, counselling, maternal and child health services [9, 10, 11]. Routine essential SRHS are being diverted and deprioritized with a potentially devastating impact on equity due to societal responses to the pandemic such as shifting resources to fight the pandemic, local or national lockdowns that force health services to shut down if they are not deemed essential, disruption or stock outs of supplies of medicines and FP commodities as well as the consequences of physical distancing, travel restrictions and economic slowdowns [12, 13, 14]. Other challenges include fear of patients contracting COVID-19 during visits to health facilities, closure of services as some health facilities have been converted to COVID-19 isolation centers, inadequate information on continued provision of essential SRHR services and heavy workloads on the existing health workers. This is compounded by limited capacity and investments to confront the challenges associated with containing the spread of COVID-19 and treating existing cases [15, 16].

Unmet needs for sexual and reproductive health services are greatest in low- and middle-income countries (LMICs). Two hundred and eighteen (218) million women and girls of reproductive age in these countries have an unmet need for modern contraception. Among women who want to avoid a pregnancy, unmet need is disproportionately high for adolescents aged 15–19 (43%), compared with that among all women aged 15–49 (24%). Annually, 127 million women in LMICs give birth, and many do not receive needed care. Fifty (50) million make fewer than four antenatal care visits, 31 million do not deliver in a health facility; 16 million do not receive the care they need following a major obstetric complication, 13 million have new-borns who do not receive needed care for complications thus lack of high-quality sexual and reproductive health care puts women at risk. A further 35 million have abortions in unsafe conditions, 299,000 die from causes related to pregnancy and childbirth, 133 million do not receive the treatment they need for chlamydia, gonorrhoea, syphilis and trichomoniasis [17]. The ravaging COVID-19 has exacerbated the existing bottlenecks for limited provision of SRHR for women in the poor resource settings of Africa [18].

Continuous provision of SRHR services is a predominant solution to supporting and improving women and girls health [19, 20]. Similarly, in the current pandemic and based on other previous pandemics, if the situation remains unsolved, especially on the already strained health systems will result to non-pandemic related additional maternal and neonatal mortalities, morbidities, still births, disabilities, increased adolescent pregnancies as well as other reproductive health crisis and emergencies with long term implications stretching to post-COVID-19[21].The need for preparedness, prioritization of SRHS and implementation of programmes and policies in addition to strengthening health systems provision during a pandemics and unlock opportunities for reducing mortalities and morbidities associated with lack or inadequate of SRHS [22]. Continuous tracking of access to essential services in such times should be balanced between the pandemic and the provision and sustenance of essential health services so that the changes on the patterns of service provision are reported and utilized to inform advocacy, prioritization, mobilization of resources and policy changes during emergencies and pandemic

Empowerment, capacity building, sustainable strategies and innovative interventions for timely provision and consistency of SRHS services via telemedicine, mobile clinics and use of motivated community health workers or volunteers (CHWs/CHVs) can be adopted to enhance and integrate accessibility and maintain positive health outcomes while submerged in the COVID19 pandemic to ensure that the tremendous achievements gained over time are not lost [23, 24]. The objective of this study was to assess continuity of essential SRHS during COVID-19 pandemic in selected countries of the WHO/AFRO region.

Methods

Study design

A descriptive cross-sectional survey was conducted to monitor the continuity of provision of sexual reproductive health services with a focus on family planning/contraception, comprehensive abortion care and post abortion care during COVID-19 pandemic as part of ensuring continuity of essential health

services to support reduction of maternal mortality and morbidity among the member states of the WHO Regional office for Africa.

Setting

The study was conducted in 17 purposively selected countries of the WHO Africa Region in June 2020. The countries included Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Democratic Republic of Congo, Ghana, Guinea, Madagascar, Mali, Nigeria, Rwanda, Senegal, South Africa, South Sudan, United Republic of Tanzania and Zimbabwe. The selection of countries was based on their involvement in ongoing initiatives investments for sexual reproductive health rights (SRHR)-SRHR initiative, FP accelerator project, Sweden grant for maintaining essential SRH during COVID-19 pandemic and the high burden of COVID-19. Other factors for inclusion included the country's context on provision of SRHS and the legal status on provision of family planning/contraception provision/ comprehensive abortion and post abortion care. The study focused on the continuity of essential sexual and reproductive health services with a focus on safe abortion, post-abortion care and family planning in the context of Covid-19 pandemic as part of ensuring continuity of essential health services (EHS) to support the reduction of maternal morbidity and mortality.

Sampling design, size and procedure

From a sampling frame of 47 member states of the WHO Regional Office for Africa, countries were invited to participate in a simplified user friendly virtual based rapid needs assessment (VBRNA). Of the 47 countries, 17 responded to the survey. The questionnaires purposively targeted WHO staff in charge of SRHS in collaboration with their counterparts in the Ministries of Health (MoH) in the selected countries.

Data collection and analysis

Using a questionnaire with a mixture of closed, multiple choices, drop down options and open ended questions, key information was collected. The questionnaire had eighteen questions related to SRHS integration into the national COVID -19 response continuity plan for essential health services, the specific services included in EHS package, self-care interventions and the specific measures taken to maintain the continuity of FP, CAC and PAC. Further questions on ongoing awareness and communications on FP, CAC and PAC, available, key messages, the target audience and the main channels used to convey the messages. A question asking respondents to state if there were any instances of service reduction in FP, CAC and PAC, the main challenges experienced and the expected support required for ensuring contraception, CAC and PAC with proposed suggestions on how to improve essential SRHS. Staff of WHO in charge of sexual and reproductive services in the selected countries in collaboration with their counterparts in the ministries of health filled in the questionnaires based on available information. The data collected from the virtual based Microsoft Excel data based questionnaires were grouped into

thematic areas, analysed and summarized into tables, graphs and described systematically based on the questionnaire.

Limitations

While the study had strengths, key informants provided responses based on available information through self-assessment risking the possibility of biasness and especially that the answers were not validated. The respondents' interpretation of the concepts could have been varied. Also, at the time of survey, countries were at various stages of the pandemic.

Results

Response rate

The survey targeted staff in charge of SRH for WHO Africa in 47 countries. A total of seventeen (17) countries participated in the web-based survey representing a response rate of 38% which was considered adequate for reporting.

Integration of FP/Contraceptive use

The countries were asked to report on integration of SRHS in the continuity plan for essential health services on the national COVID-19 response. Out of the 15 (88%) countries, 2((12%) countries reported not to have integrated SRH services on the national COVID-19 response and EHS continuity plan. Countries offered different packages of Essential Health Service (EHS), with only 12 countries offering full package of EHS that included FP/contraception and CAC, including PAC. Table 1 presents summary countries that have integrated FP, CAC, and PAC in their EHS package.

Table 1

Elements of SRH in essential Health Services package

Country	Family planning/contraception	Family planning/contraception(FP) and Post Abortion Care	Family planning/contraception(FP) and Post Abortion Care, Comprehensive abortion care)
Benin			YES
Burkina Faso			YES
Burundi			YES
Cameroon			YES
Central African Republic			YES
Democratic Republic of Congo			YES
Ghana			YES
Guinea		YES	
Madagascar		YES	
Mali			YES
Nigeria	YES		
Rwanda			YES
Senegal			YES
South Africa			YES
South Sudan			YES
United Republic of Tanzania			YES
Zimbabwe			YES

Ongoing awareness and communication messages on FP, CAC and PAC

The questionnaire had a question asking countries to respond to ongoing awareness campaigns or communication messages about during the COVID -19 pandemic. Of the countries that participated in the survey, 88.2% acknowledged that they had ongoing awareness campaigns and communication messages

about FP, CAC and PAC during COVID-19 pandemic. Majority (76%) of the countries had key messages that focused on where and how to access SRH services, and importance of services was reported as reported in Figure 1. Among the countries that had key messages, major target audiences were the entire community (64.7%), health care providers (52.9%), adolescent and youths 47.1%), and women groups/associations (41.2%) as shown in Figure 2. Figure 3, summarises the most commonly used communication channel. They included the radio (76.5%) and TV (70.6%). Other channels were banners text messages, web and social media and WhasApp all at 5.8%.

Utilization of Family planning services during COVID

Table 2 provides a summary of FP/contraception services and commodities in countries since the start of COVID-19 pandemic. From the survey findings, almost half, (59%) of the countries reported a reduction in the use of FP since the beginning of the pandemic. Among these countries 12 (71%) countries reported a reduction in uptake of Family Planning commodities while 8 (47%) countries reported stock out of Family Planning commodities with most countries reporting implants and IUDs as the major stock outs. Figure 4 presents comparison of number of FP clients seen during COVID-19 pandemic (January –May, 2020) before COVID-19 pandemic (January –May 2019). All the countries reported a decrease in uptake of FP commodities by clients except in Madagascar and United Republic of Tanzania

Table 2

FP/Contraception services and commodities During COVID-19 pandemic

Responses	Reduction in the use of family planning services n (%)	Reduction in uptake of family planning commodities n (%)	Stock out of family planning commodities n (%)
Yes	9 (59)	12 (71)	8 (47)
No	6 (35)	5 (29)	7 (41)
No response	2 (12)	0 (0)	2 (12)
Total	17	17	17

Figure 5 reports the proportion of countries that reported reduction in the uptake of FP commodities and stock outs. Implants and IUDs were reported to have the highest reduction in the uptake at 47.1% followed by injectables (41.2%) during the COVID-19 pandemic. On the other hand, commodities that were reported to have stock outs included injectables (23.5%) and implants (17.6%). IUDs, pills condoms and LAM were reported to have experience stock outs by 5.9% of the participating countries.

Self-care interventions for SRH

Majority of the countries (76%) reported to have implemented self-care interventions for FP/contraception or safe abortion. The most common self-care interventions implemented in 47% of the countries during the COVID pandemic included self-provision of pills and subcutaneous depo medroxyprogesterone acetate (DMPA-SC) self-administration, followed by HIV self-testing (29%). Figure 6 summarises the self-care intervention that were reported to have been implemented.

Supply of SRH commodities for Comprehensive abortion care (CAC) and Safe abortion services during COVID 19

The trend in uptake of CAC amid COVID-19 did not experience any change in 11(61%) of the 17 countries. However, 3 (18.8%) of the countries reported a decrease, and only 1 (6%) reported an increase in CAC services during the period under review as shown in Table 3. Medical abortion drugs (misoprostol and mifepristone) were available in health facilities in 13 (76%) countries. In the 4 countries where the drugs were not available in health facilities, various reasons that contributed for non-availability include; abortion completely forbidden in the country, drugs not in health facilities but available in the pharmacies, controlled drugs which are not available for medical abortion, available but for induction of labor and for post-partum haemorrhage, and abortion drugs not included on the essential medicines list. Only Madagascar reported that designated health facilities for CAC/PAC are not currently operational and this was due to lack of trained healthcare workers.

Table 3

Trend in CAC/PAC during COVID-19 pandemic by country

Country	Increasing	Decreasing	No change
Benin			YES
Burkina Faso			YES
Burundi			YES
Cameroon			YES
Central African Republic			YES
Democratic Republic of Congo			YES
Ghana		YES	
Guinea		YES	
Madagascar	YES		
Mali			YES
Nigeria			YES
Rwanda			YES
Senegal			YES
South Africa	YES		
South Sudan			YES
United Republic of Tanzania			YES
Zimbabwe			YES

Key challenges to provision of FP/contraception and CAC/PAC services during COVID-19 pandemic

Figure 7 reports key challenges reported by countries for the provision of FP/Contraception and CAC/PAC services during COVID-19 pandemic. The key challenge identified in most countries (70.6%) was the fear of patients/clients to seek SRHS at designated health facilities that they might contract COVID-19. More than half (52.9%) of the countries reported that the population lacked information on the continuity of SRH services as essential health services.

A follow up question further asked the countries to state if they had any challenges in funding of FP/Contraception, CAC/PAC services. 61% of the countries reported that they experienced challenges in funding the services while 39% reported no challenges in funding. The SRHS largely depended on funding. They were also asked to state if their countries had any challenges on data collection and 16 (94%) countries reported on data challenges. Out of the 16 countries (31%) stated that lack of trained

health workers while (25 %) stated that heavy workloads contributed inadequate FP/Contraception and CAC/PAC services data collection. 19% reported that health care workers were re-purposed to support COVID-19 response resulting to weak data collection for SRHS.

Support needed by countries for FP/contraception and CAC/PAC services during COVID-19 pandemic

Countries were asked to identify and provide specific support they needed from WHO and her partners. Figure 8 summarizes the various support required by the participating countries in the survey during the COVID-19. Majority of the countries, 13 (72%) reported the need for emergency contraceptive supplies and PPEs, 10(56%) required financial support, resource mobilization and funding, 8(44%) reported the need for training, capacity building, and mentorship. While 6(33%) accounted for support supervision, technical support & information, communication on continuity of services & advocacy.

Out of the 17 countries that participated in the survey, United Republic of Tanzania expressed the highest need for support, followed by Benin, Burkina Faso, Cameroon and Nigeria. Proposals for the specific measures to maintaining continuity of FP/CAC varied from one country to another though others remained similar amid COVID-19. Nigeria, Benin and Guinea reported more measures compared to other countries.

Recommendations for improving continuity of care for FP, CAC, and PAC services

Several recommendations were presented for the improvement of continuity of care among the participating countries. The recommendation included strengthening training and supervision of healthcare providers, improving services provision at community level; advocating for funding; improving policy to allow engagement of various stakeholders in the provision of services; Alternative approaches to service delivery; Promotion of self-care interventions for SRH; Availability of FP products; Protection of Health worker; Sharing of country experiences; and Improving information and communication on essential SRH services for population

Discussion

This paper presents the results of the assessment of the continuity of SRHR provision during COVID-19 pandemic in some countries of the WHO Africa Region. SRHR is human rights whose support improves women and girls health [19, 20]. Similarly, in the current pandemic and based on other previous pandemics like Ebola, it was noted that if the SRHR remains unresolved; especially on the already strained health systems more non-pandemic related additional maternal and neonatal mortalities, morbidities, still births, disabilities are bound to increase. Moreover, adolescent pregnancies and other reproductive health

crises and emergencies with long term implications stretching to post-COVID-19[21] may occur reversing all the gains that have been realised over time.

SRHS integration and communication amid COVID 19

Majority of the countries in the WHO Africa Region had at least integrated SRH services in response of COVID-19. This is similar to other studies that reported the deficiencies health services delivery challenges and inadequate integration during the previous pandemics in different countries [25, 26,27, 28]. Despite the ongoing challenges in provision and accessibility, 76% of the WHO African countries have adopted ongoing awareness raising campaigns and communication messages on FP, CAC and PAC during the COVID pandemic. These messages are focused on where to access the services, how to access the services, and importance/usefulness of services. The major target audiences are the entire community, health care providers, adolescent and youths, and women groups/associations. Depending on the different countries context, different channels of communication including radio, TV, banners, web and social media and WhatsApp are used. This is consistent with studies that have affirmed the need to consistently, effectively and efficiently providing information in order to bridge the knowledge gap due to misinformation on SRHR services delivery [29, 30].

Utilization of Family planning services during COVID

Amid COVID-19, the utilization and health seeking of SRHR has been reported to be low during the COVID-19 pandemic with more than half, 9 (59%) reporting reduction in use of Family Planning since the beginning of the pandemic, 12 (71%) reported reduction in uptake of contraception and reported stock out of Family Planning commodities with most countries reporting implants and IUDs as the major commodities experiencing stock outs. Similar challenges have been reported by other researchers [31, 32]. Though this is variation from one country to another, this is also documented as evidence from other studies [30, 31,32, 33]. There is urgent need to continuously educate the public on health seeking behaviour even during the pandemic. In the previous and current pandemics, health systems have been constrained in provision of essential services as [30-34], and therefore revamping the health systems with contraception commodities during and after the pandemic is critical to continuity of SRHR services.

Self-care interventions for SRH

Most of the countries implemented self-care interventions for FP/contraception or safe abortion. The most common self-care interventions implemented in during the COVID-19 pandemic were mainly self-provision of pills and DMPA-SC self-administration by clients. In pandemics and emergencies, it is important that services that can be provided through self-care are allowed to enhance uptake and continuity. Such approaches are expected to ease accessibility and convenience to respond to the SRHR needs for women and girls [25, 26] continuously.

Supply of SRH commodities for Comprehensive abortion care (CAC)-(Safe abortion, legal and post-abortion care) services during COVID 19

The survey results indicate that 11(61%) of the participating countries reported on the trend of CAC that has not largely changed amidst COVID-19. 3 (18.8%) reported a decrease and only 1 (6%) reported an increase in CAC services from the beginning of the pandemic. On availability of medical abortion drugs (misoprostol and mifepristone), it was reported that they were available in 13 (76%) countries and were lacking in 4 countries due to reasons including: abortion completely forbidden in the country, drugs not in health facilities but available in the pharmacies, controlled drugs which are not available for medical abortion, available but for induction of labour and for post-partum haemorrhage, and abortion drugs not included on the essential medicines lists of those countries. Similar finding has also been reported by studies conducted on health systems during this COVID-19 pandemic [32, 35].

Key challenges on SRHR during COVID- 19 pandemic

Fear of contracting COVID-19 and lack of information on the continuity of SRH services were the key challenges to accessing SRH services among the populations in the various countries. This therefore highlights the need for continuously providing information on SRHR during pandemics as well as integration of these messages while responding to the pandemic [36, 37]. Funding deficiencies for SRHR in provision and acquiring of contraception and FP commodities as well as providing SRHR services for large scale populations was reported to be another challenge hindering continuity of SRH services during COVID-19 pandemic. Lack of trained health care workers and heavy workload respectively were reported as the major challenges facing data collection for FP/Contraception and CAC/PAC services. Also, shortage of healthcare workers being re-purposed to support COVID-19 response resulted to more challenges of SRHS data collection [36-38].

During COVID- 19 pandemic there is need for support in the WHO African countries for FP/contraception and CAC/PAC services. The needed support include provision of emergency contraceptive supplies and PPEs, financial support, resource mobilization and funding, training, capacity building, mentorship, support supervision and Technical support & Information, Communication on continuity of services & Advocacy[38, 39, 40].

Recommendations for improving continuity of care for FP, CAC, and PAC services

In order to enhance continuity of SRHR, there is need to strengthen training and supervision of healthcare providers, improve services provision at community level; advocate for funding; improve policy to allow engagement of various stakeholders in the provision of services including private sector; identify

alternative approaches to service delivery; promote self-care interventions for SRH; avail FP products; protect of HCWs; share country specific experiences; and improve information and communication on essential SRH services for population. These recommendations, if implemented will go a long way in improving continuity of service provision of SRH.

Conclusions

In this paper we explored the continuity of SRH services during COVID-19 pandemic. As experienced from previous pandemics, this study documented the status of service provision in the countries that participated in the survey. Continuity of SRH services is important during this COVID-19 pandemic, since any laxity may destroy the many gains achieved in SRHS indicators over a period of time. The survey provides information on the weak health systems of the member states of the WHO Regional office for Africa and the magnitude of SRHR disruptions. Further, strategies adopted by countries to ensure continuity of SRH services amidst COVID -19 are highlighted. Countries finally identified key areas that need to be supported in family planning/contraception, comprehensive abortion care and post abortion care during the COVID-19 pandemic.

Abbreviations

CAC Comprehensive Abortion Care

EHS Essential Health Services

FP Family Planning

IUD Intra Uterine Device

PAC Post Abortion Care

PPE Personal Protective Equipment

SRHR Sexual and Reproductive Health and Rights

VBRNA Virtual based rapid needs assessment

Declarations

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Ethics approval

Ethics approval was not required for this study since no personal information was collected during data collection.

Consent to participate

Participating countries were informed about the study and no personal information was collected during the member states of WHO.

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Availability of data and materials

Data and materials will be availed on reasonable request from WHO Regional Office for Africa (WHO/AFRO)

Competing interests

All the authors declare no competing interests.

Author's contribution

LO, TN and CA conceptualized the idea of the study. LO, HF, AM, PO, GO and GC developed the study design and data collection plans. LO, NK, AS, AA and GO collected and analyzed the data. LO, TN, CA and OGCK drafted the manuscript. All authors provided critical input on an earlier version of the manuscript and read and approved the final manuscript.

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Figures

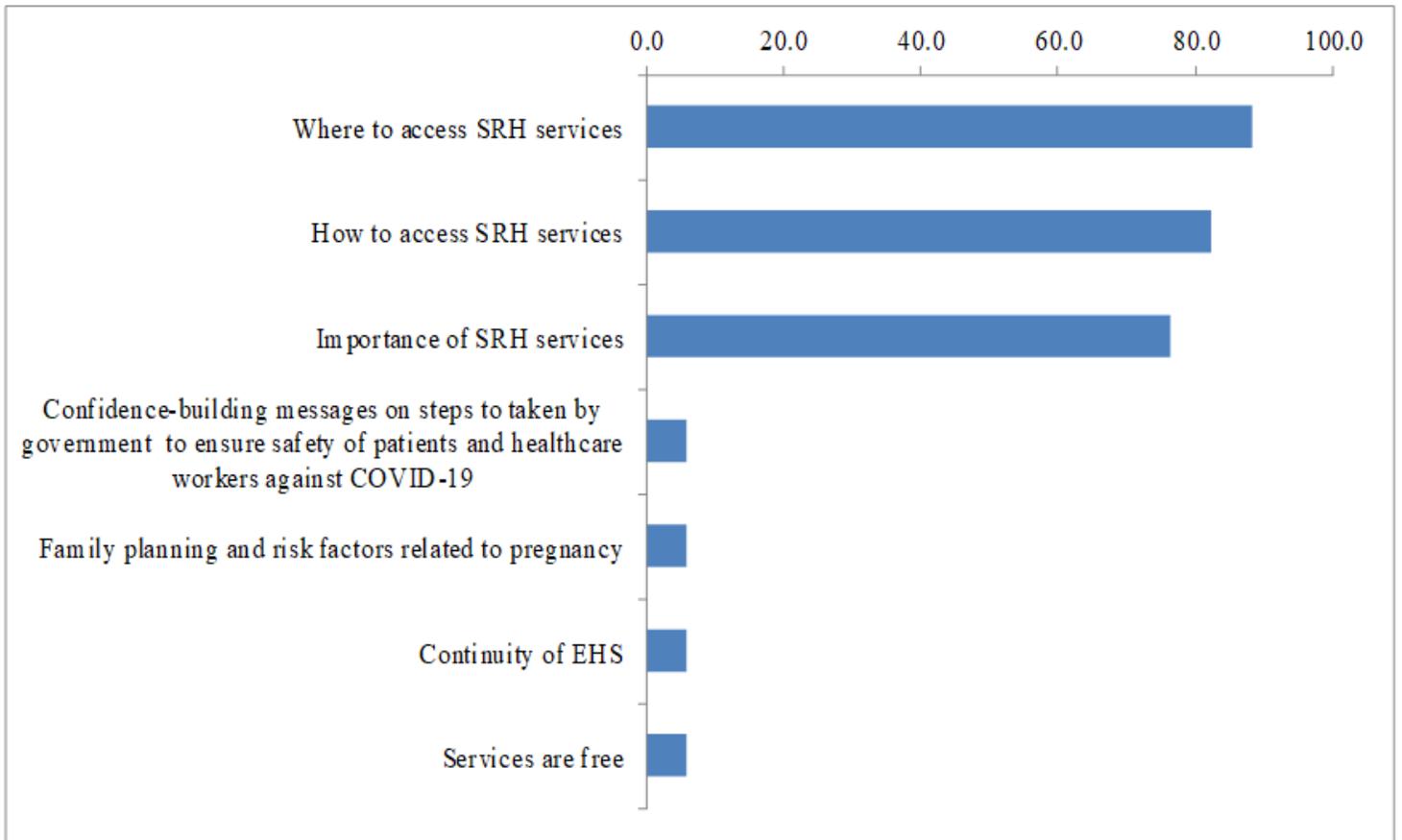


Figure 1

Key messages on FP, CAC and PAC during the COVID-19 Pandemic in countries

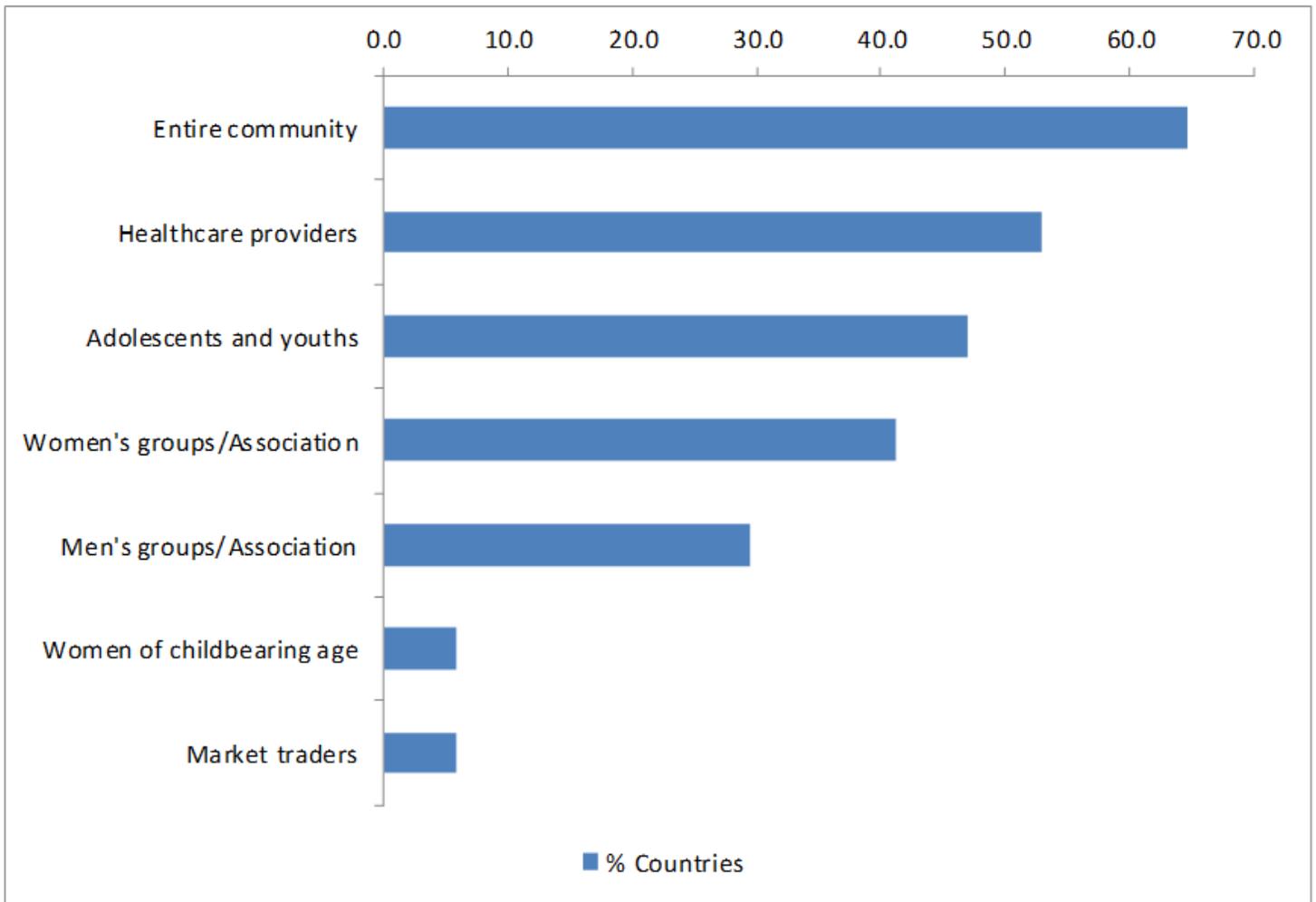


Figure 2

Major target audiences with the key messages on FP, CAC, PAC during COVID-19 pandemic

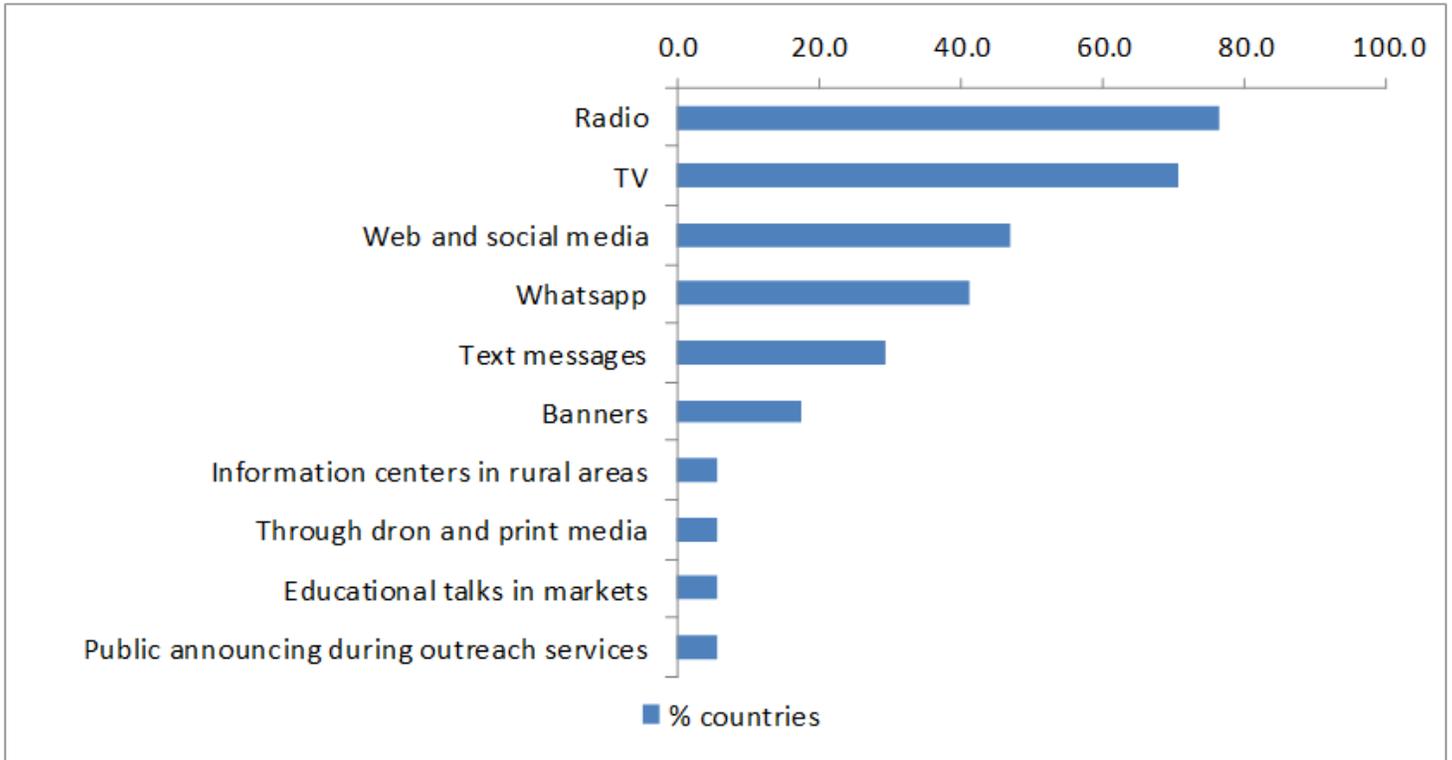


Figure 3

Communication channels for ongoing awareness raising campaigns/communication messages about FP, CAC and PAC during the COVID pandemic

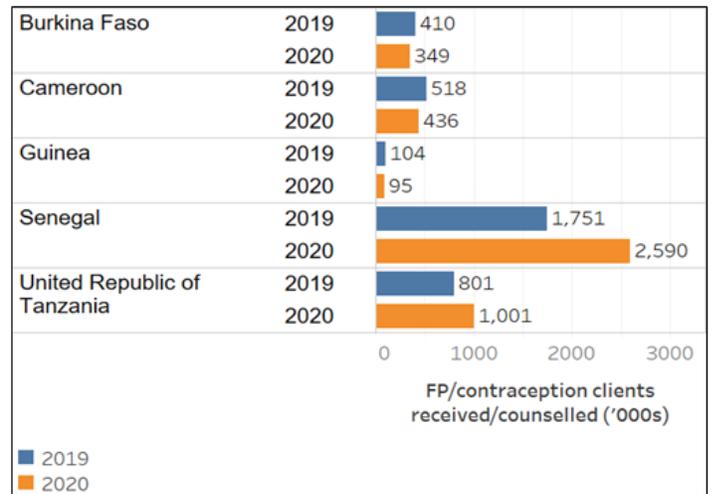
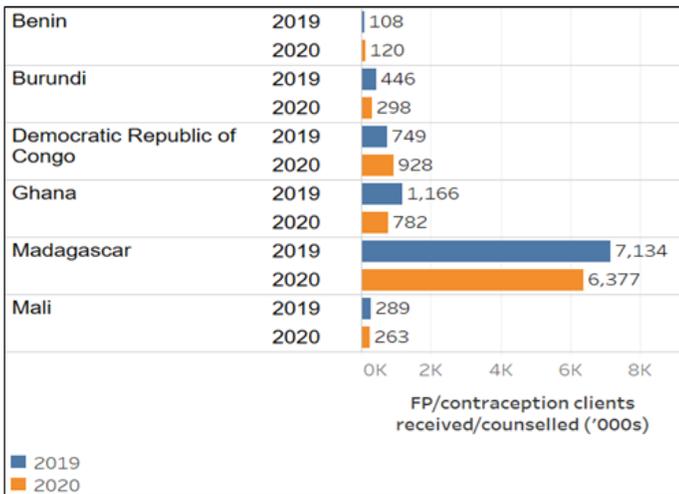


Figure 4

4a: FP/contraception clients received/counselled by country from January to April 2019 and 2020 4b: FP/contraception clients received/counselled by country from January to May 2019 and 2020

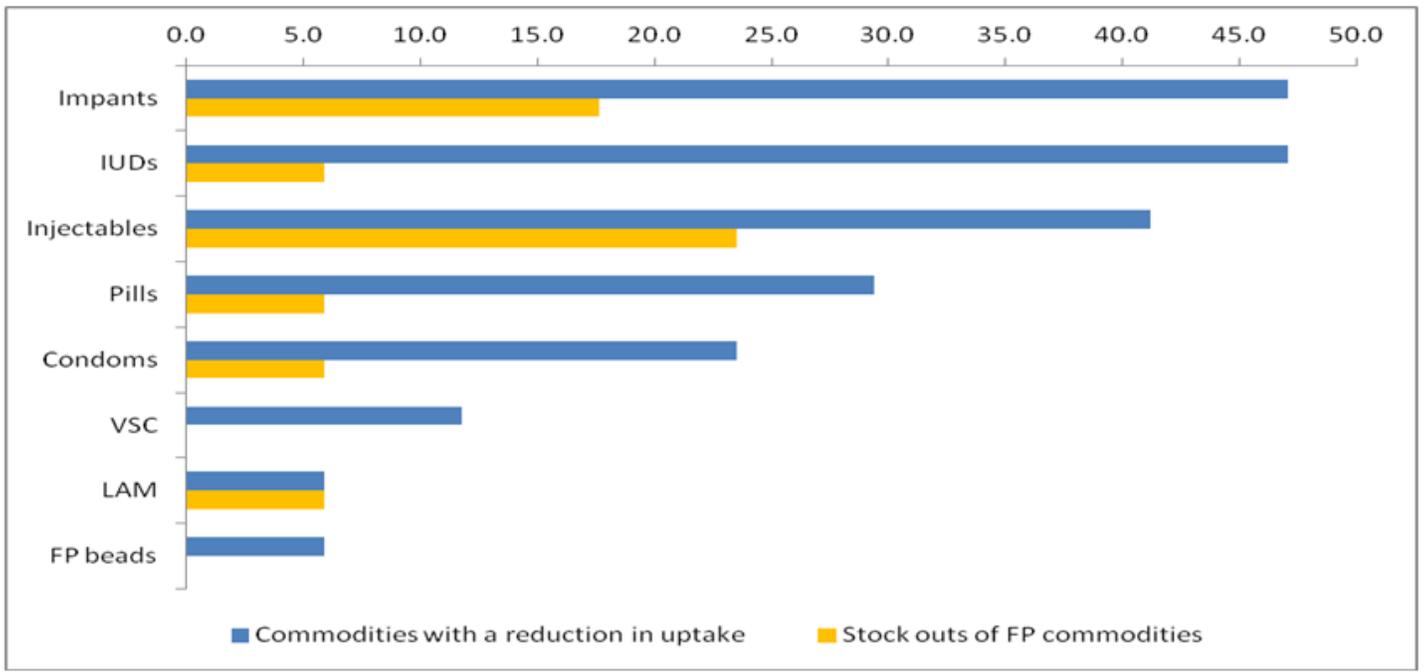


Figure 5

Proportion of Countries reduction in uptake of FP commodities and stockouts

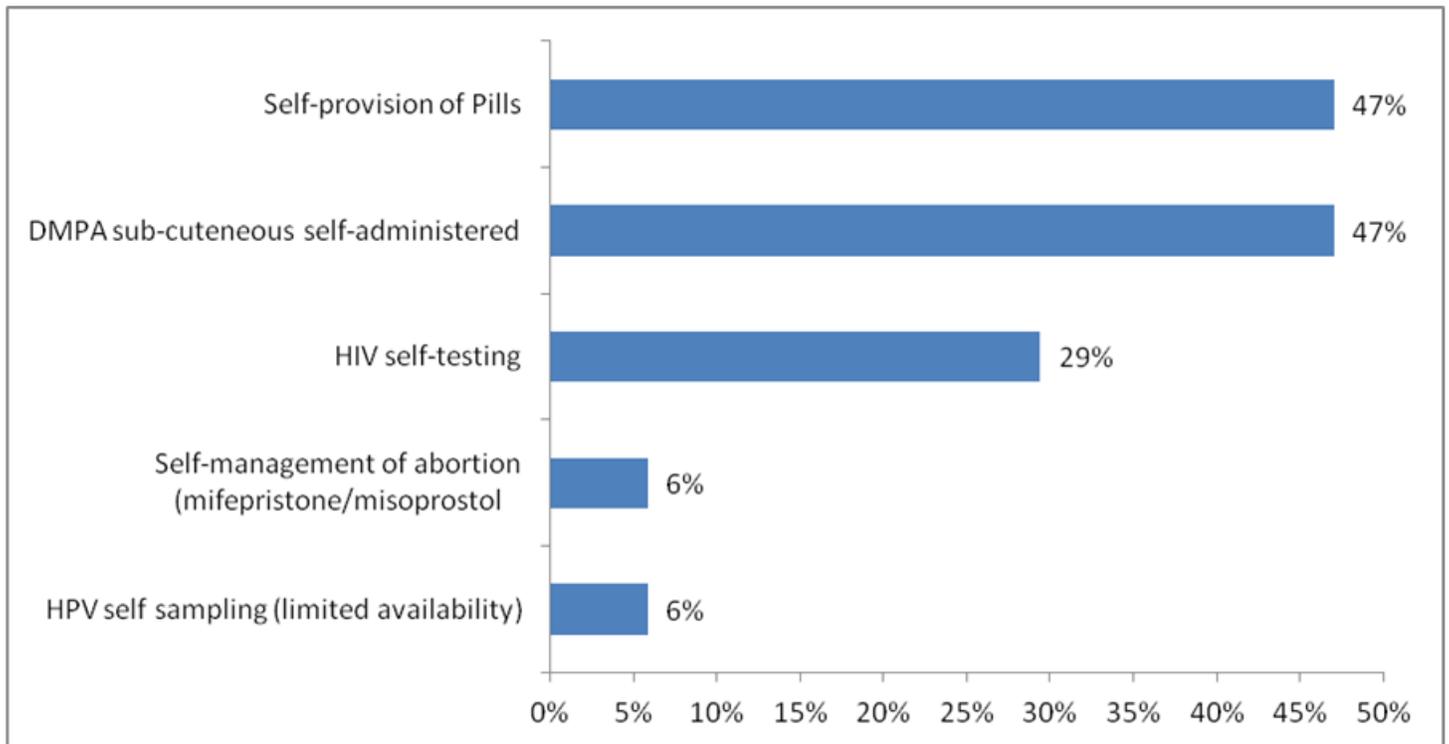


Figure 6

Self-care interventions for FP/contraception and safe abortion

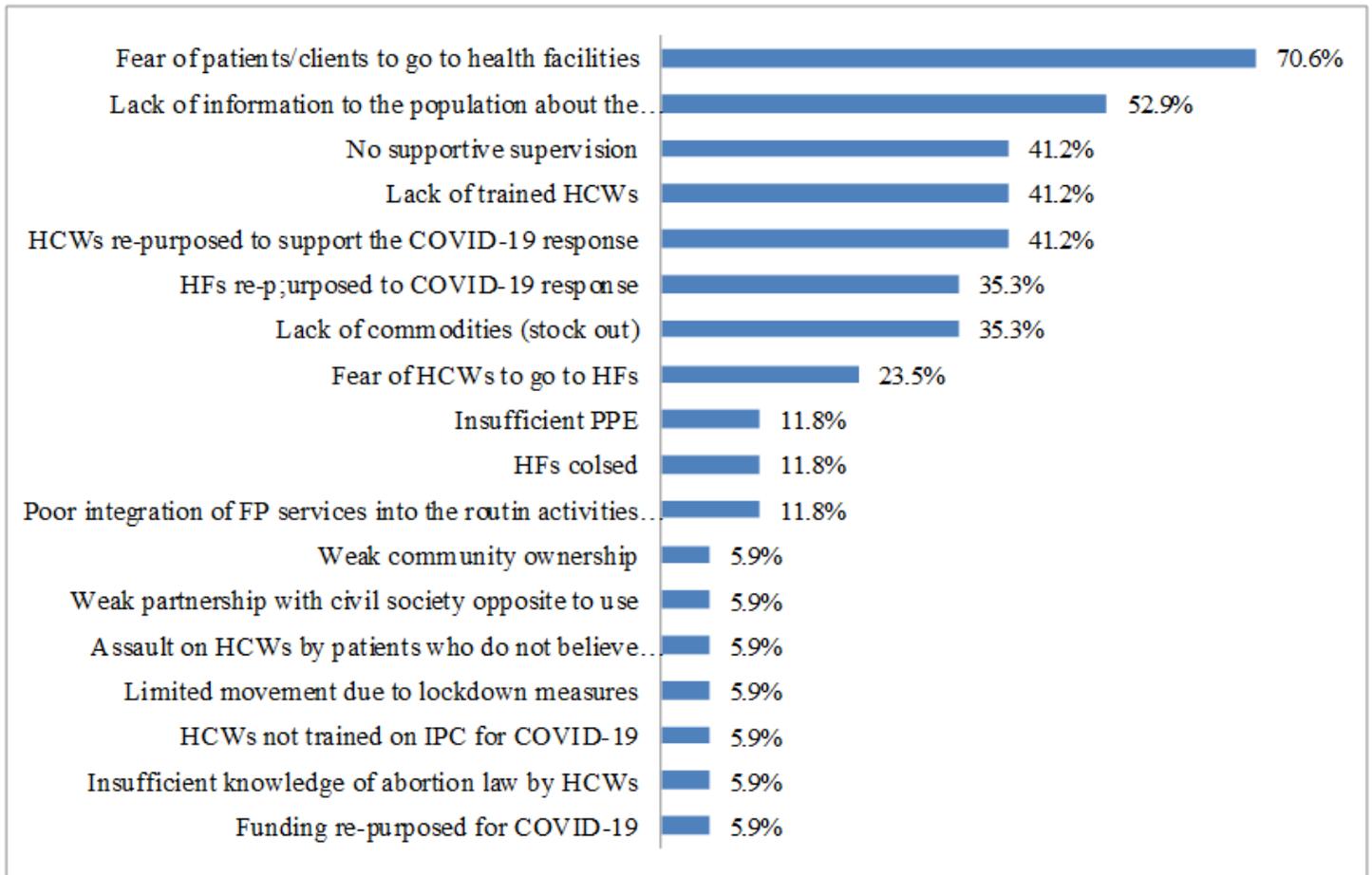


Figure 7

Key challenges to FP & CAC/PAC services during COVID-19 pandemic

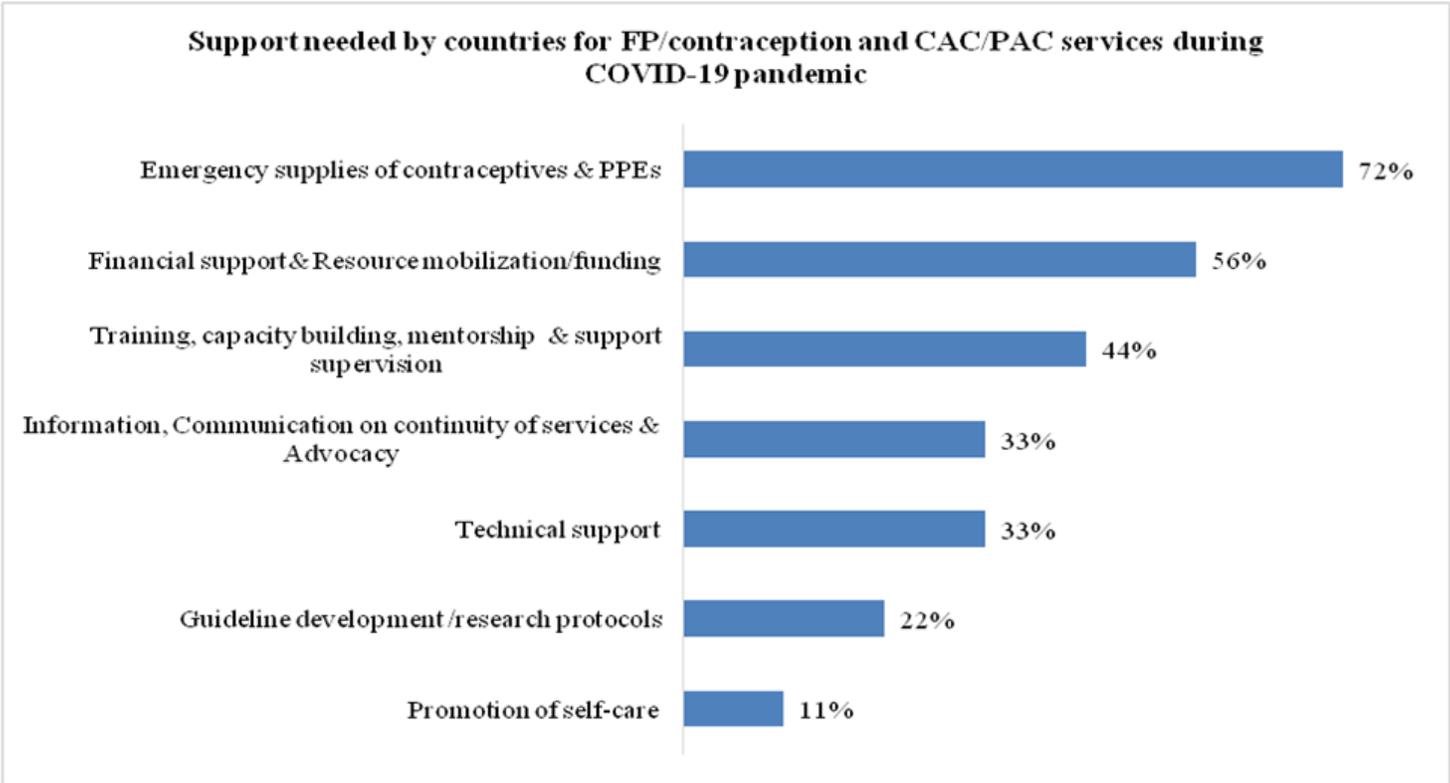


Figure 8

Support needed by countries for FP/contraception and CAC/PAC services during COVID-19 pandemic.