



ReBUILD
FOR RESILIENCE

**Health system resilience during COVID-19:
understanding SRH service adaptation
in North Kivu**

Lara Ho, Maria Bertone & Wesam Mansour
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List of Acronyms

ANC	Antenatal Care
CSO	Civil Society Organization
DMPA-SC	Subcutaneous depot medroxyprogesterone acetate
DPS	Division Provinciale de la Santé
DRC	Democratic Republic of Congo
EPI	Expanded Program on Immunization
EVD	Ebola Virus Disease
FCDO	UK Foreign Commonwealth and Development Office
FP	Family Planning
GBV	Gender-Based Violence
IAWG	Inter-Agency Working Group
IDU	Intravenous drug users
(I)NGO	(International) Non-Governmental Organization
IPC	Infection Prevention and Control
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
LMIC	Low-to-Middle-Income Country
MISP Emergencies	Minimum Initial Service Package for Reproductive Health in Emergencies
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
MSP	Ministry of Public Health
PPE	Personal Protective Equipment
SGBV	Sexual and Gender-Based Violence

SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees

Executive Summary

Women and girls often face increased challenges to accessing healthcare during epidemics on top of pre-existing health disparities. There is emerging evidence that COVID-19 has had negative impacts on the health of women and girls in sub-Saharan Africa due to diverted funding, reduced services, negative socioeconomic impacts, and increased or new barriers to access. Although the Minimum Initial Service Package for Reproductive Health in Emergencies (MISP) was developed to ensure that women had access to reproductive health services during crises, implementation of it is dependent on governments and humanitarian actors prioritizing its roll out.

In the North Kivu province of the Democratic Republic of the Congo (DRC), the COVID-19 pandemic hit shortly after the end of an Ebola epidemic within a context of protracted insecurity following decades of conflict between armed non-state actors and the government. This study used mixed methods to examine the effects of the pandemic on sexual and reproductive health (SRH) services in North Kivu and how the health system did or did not adapt to ensure continued access and utilization of SRH services. We interviewed 13 respondents representing United Nations (UN) agencies, the Ministry of Public Health (MSP), international and national non-governmental organizations (I/NGO), and local civil society organizations (CSO) between December 2020 and February 2021.

We found there was limited prioritization of SRH in the response to COVID-19 despite negative impacts related to lockdowns and limits on numbers of people allowed at health centers at any given time. Although the government issued policies on how to adapt SRH services, these were developed centrally and did not provide much guidance on how to operationalize the policies in different contexts. As a result, healthcare providers and civil society actors developed their own ways to continue activities at local levels, not necessarily in a systematic way. In contrast with the recent Ebola response where there was a massive influx of donor funding, limited resources hampered implementation of adaptation measures to safely continue health activities. Despite the significant resources deployed for the Ebola response, there appears to have been limited longer-term strengthening of the health system to be able to adapt to the subsequent COVID-19 pandemic aside from increased capacity of healthcare providers to manage infection prevention and control measures. However, even this was hampered by a lack of personal protective equipment in facilities which did not receive external support.

Our findings stress the importance for donors to consider how resources can be leveraged to support sustained strengthening of the health system to be able to absorb and adapt to shocks even when new influxes of funding in the face of a crisis, such as a new outbreak, are limited.

Introduction

There is often collateral damage to health and health systems during epidemics, and women and girls frequently bear the brunt of the burden with reduced access to non-outbreak related services. In humanitarian settings, where health systems can be stretched thin in the delivery of care to populations already affected by violence, natural disaster, or political instability, the emergence of COVID-19 further threatens the delivery, quality, accessibility, and availability of vital care to communities in need. It has upended almost every aspect of public health programming (Riley et al., 2020). In low-to-middle-income countries (LMICs) and humanitarian settings, the access and use of SRH services among women and girls are limited even when available (Desrosiers et al, 2020). The emergence of COVID-19 has only exacerbated this poor access and has had disastrous consequences for many in the global South (HAI, 2021).

Past humanitarian crises have shown that reduced access to family planning, abortion, antenatal, HIV, gender-based violence (GBV), and mental healthcare services results in increased rates and sequelae from unintended pregnancies, unsafe abortions, sexually transmitted infections (STIs), pregnancy complications, miscarriage, post-traumatic stress disorder, depression, suicide, intimate partner violence, and maternal and infant mortality (Heidari et al., 2019; Hall et al., 2020). Additionally, systemic racism, discrimination, and stigma can further compound logistical barriers to accessing SRH care for women and marginalized groups (Hall et al., 2020). During the 2014 Ebola Virus Disease (EVD) outbreak in western and central Africa, SRH programming was given limited attention in the outbreak response, leading to sharp declines in the utilization of SRH services. In West Africa, excess maternal and neonatal deaths exceeded the number of deaths from Ebola. In eastern DRC, the EVD outbreak had an impact on the provision of and access to SRH services (Iyengar et al., 2015). In Sierra Leone, antenatal coverage dropped 20% during the epidemic, with declines also observed in the utilization of family planning and post-natal services (Sochas et al., 2017). Such drops in care contributed to an excess of 3,600 additional maternal, neonatal, and stillbirth deaths between 2014 to 2015; a number equivalent to Ebola-related deaths in Sierra Leone at the time. In Liberia, similar outcomes were observed as result of a profound drop in utilization of key SRH services during the epidemic, with recovery of service utilization taking months (Iyengar et al., 2015).

The current COVID-19 pandemic might have similar effects, with a stark impact on maternal and newborn mortality and morbidity. Consequences are expected to be particularly devastating for women's SRH given mobility restrictions, service disruptions and economic insecurity, which inhibit access to time-sensitive care. Adding to the existing challenges of fulfilling women's need for contraception, the pandemic may increase rates of unintended pregnancy and unsafe abortion. Women's fertility intentions and need for contraception may

also change due to unpredictable economic circumstances (Karp et al., 2021). While guidance and tools to adapt SRH protocols and programs to emergencies exist, often SRH services targeting women are dismissed as non-essential despite the risks of mortality and long-term morbidity when the services are not prioritized.

This study took place in North Kivu province in the DRC with the aim of understanding how SRH protocols and practices were or were not adapted to respond to the SRH needs of women and girls during the COVID-19 pandemic and exploring the challenges and barriers to effective SRH service adaptation. This study is part of a larger collection of work by the ReBUILD for Resilience research consortium, which focuses on resilience of the health system during shocks such as pandemics and is underpinned by a conceptual framework that is grounded in a broader view of health systems as complex adaptive systems.

Background

Impact of COVID-19 on SRH in Sub-Saharan Africa

While the direct impact of COVID-19 in Sub-Saharan Africa (SSA) so far is not as widespread as in other regions, the indirect costs are potentially greater. Public health measures to reduce infections have destabilized economies and weakened fragile healthcare systems. The COVID-19 pandemic has resulted in the redirection of funds and attention by governments, donors, and stakeholders towards COVID-19 containment efforts, thereby diverting focus from other important issues, including SRH (Ogunkola et al., 2021). As reported by the International Planned Parenthood Federation (IPPF), the closure of 447 mobile health clinics and community-based care centers in Africa due to the pandemic has led to women and girls being less able to access important healthcare services (IPPF, 2020; Ogunkola et al., 2021). In Kenya, many pregnant women have had abruptly reduced options for care as the health centers they normally access have shut down and healthcare providers have been assigned to the pandemic response (MSF, 2020; Eghtessadi et al., 2020; Kibira, 2020). Access for non-COVID-19 related health issues, including antenatal care services, has been impacted in Kenya, Tanzania, and Uganda, resulting in high maternal and neonatal mortality rates. This is largely due to the limited healthcare resources, restrictions in movement, a reduction in available healthcare services, and paucity of healthcare providers due to the COVID-19 response (Ogunkola et al., 2021). Health centers are being overstretched as a result of the response efforts, a limited supply of equipment due to the disrupted supply chain, and a shortage of skilled birth attendants as health workers need to respond to COVID-19. Health-related gender inequalities currently in existence will be exacerbated, translating to severe outcomes for women and girls (Ogunkola et al., 2021).

Clinic appointments are rare in low-income settings and people can wait long hours at crowded clinic waiting areas for antenatal care, contraceptive counselling, or other reproductive health services, which will increase risk of COVID-19 infection transmission. Shortages of essential medical supplies may be experienced due to disruption of the supply chain as a result of the closure of factories and restrictions on transport. Due to the disruption of the raw material supply chain in countries which produce medical goods, fears

of condom, progesterone and antibiotic shortages have also been raised and stock outs have been reported in some countries (Hussein, 2020). In a statement, IPPF warned that up to 9.5 million vulnerable women and girls risk losing access to contraception and safe abortion services in 2020 (Kibira, 2020). The closure of non-emergency services and transport restrictions implies that suddenly condoms, contraceptive pills and many SRH services have been deemed non-essential and have therefore become a luxury. Family planning, antenatal care and deliveries at health facilities are therefore not readily accessible (Kibira, 2020).

Data also shows a reduction in HIV testing at first antenatal visits in at least 17 countries between January and June 2020, and a reduction in HIV treatment access among pregnant women in at least 15 countries (Goga et al., 2020). Treatment access had still not recovered in five countries (Botswana, South Africa, Sierra Leone, Togo, and Guatemala) by October 2020. Given that pregnant adolescents have poorer access to HIV-related care to prevent vertical HIV transmission than adults, these challenges have no doubt adversely affected the health of adolescent girls and young women. Strategies to ameliorate these impacts, especially in SSA, are urgently needed (Goga et al., 2020).

The gendered impact of COVID-19 is illustrated by an upsurge in violence against women and girls in Africa, specifically sexual and gender-based violence (SGBV) and unintended pregnancies (Ajayi & Ezegebe, 2020; de Paz et al., 2020; "The Impact", 2020). Women and girls under stringent lockdown rules have had limited access to social protection, threatening their SRH rights ("The Impact", 2020; UNHCR, 2020). Further, for young women in humanitarian and LMIC settings, comorbid mental health disorders can further compound the risks for poor SRH outcomes and respectively impact SRH service use. These risks are further heightened because they are more likely to develop mental health problems (e.g., depression, anxiety, psychological distress) and to experience sexual violence in comparison with men and boys (Desrosiers et al., 2020).

Adaptations to SRH services during the pandemic

With the recognition of reproductive health as a human right, the Inter-Agency Working Group (IAWG) on Reproductive Health drafted a list of minimum reproductive health interventions that would be put in place in the event of emergency. These interventions are now packaged as the Minimum Initial Services Package (MISP) and are targeted to prevent excess morbidity and mortality among women and girls (Lisam, 2014). The MISP objectives include prevention of HIV transmission, reducing the morbidity and mortality due to HIV and other STIs, planning for comprehensive SRH services and their accessibility, and the prevention and management of GBV (Lisam, 2014). Evaluations of SRH in emergencies, especially since development of the MISP, have demonstrated a greater awareness of the critical role of SRH services and their evaluations by humanitarian organizations, Ministries of Health (MOH), and field responders. A 2015 evaluation of MISP found donors gave increased attention to SRH in emergencies as seen through the leadership of their MOHs, UNHCR, and UNFPA and a higher level of funding for related activities and resources (Krause et al., 2015).

The COVID-19 pandemic has required SRH practitioners to be adaptive and innovative to meet population needs, particularly those of women and girls. Many health programs in LMICs and fragile settings have made several programmatic adaptations to respond and provide rights-based care (Khatun, 2020). For example, the IPPF's flagship women integrated SRH program has been implemented across 15 countries in Africa and Asia and has witnessed first-hand the need to adapt to a rapidly changing context to ensure and protect people's rights and access to services (Khatun, 2020).

Adaptive leadership has also been necessary during the COVID-19 pandemic as policymakers, practitioners, and researchers work to provide key SRH services to populations in humanitarian and fragile settings in a way that understands the needs and realities of communities and their contexts. In their guidance for adapting interventions to meet gender needs during the COVID-19 outbreak, Ramalingam et al. assert the need to identify which interventions, or combinations of such, are most effective and will have the best intended impact and how to ensure these interventions can be designed to adapt to change. In their guidance, they demonstrate that policymakers need to rapidly interpret different forms of evidence, determine exactly what they seek to achieve, define measures that will trigger adaptations to interventions, and most importantly bring communities into the decision-making process (Ramalingam et al., 2020).

During the pandemic, adaptations to SRH services in the global FCDO-funded WISH2Action program included adapting clinic services in line with the national guidelines on social distancing (in waiting areas, redesigning client flow, screening of clients as they came in), enhanced hand-washing provision, and increased IPC measures, including separate consultation rooms for suspected COVID-19 clients. Clinics were open but operated with reduced hours and staffing. As part of routine SRH counselling sessions, script guides were updated to include COVID-19 information and referral pathways. In responding to the increased risk of SGBV, refresher training was provided to service providers on screening, counselling, treatment, and provision of psychological first aid for SGBV survivors. Referral linkages were strengthened in countries in collaborations with other stakeholders (Khatun, 2020).

Reaching people at home and increasing self-care options is another approach that has used community-based distributors who were trained on inclusion of COVID-19 awareness messaging and provided with infection prevention and control (IPC) materials. The community-based distributors also provide pills and condoms as well as share information on referrals for long-acting reversible contraception. While mobile outreach services were on hold in some countries, outreach providers were deployed as door-to-door health visitors. The COVID-19 pandemic increased expansion of DMPA-SC as a contraceptive method in countries such as Madagascar, Malawi, and South Sudan, exploring opportunities for self-injection through launching pilots and inclusion of counselling for self-care in service provider training (Khatun, 2020).

Finally, support services have also been moved online as an approach to increase access. New technologies such as call center helplines providing tele-counselling and telemedicine services were either newly established (Sudan) or scaled up and promoted where they were previously in existence (Ethiopia, Madagascar, Tanzania Uganda, Zambia and Zimbabwe) to incorporate COVID-19 messaging and strengthen referral linkages. These helplines are toll-free to enable the poorest in society to access services and notable advances in mHealth have promoted their use in SRH service delivery (Khatun, 2020). mHealth has been used to train SRH healthcare workers in remote settings and provide them access to accurate and current clinical information which they could review at their convenience on their mobile devices. Previous research has demonstrated the effectiveness and feasibility of using mHealth to train frontline health workers in rural settings e.g., Nigeria. Patients have also been empowered by providing them with accurate and readily available information on SRH on their mobile devices (Otu et al., 2021).

A recent evidence summary by Ivankovich and colleagues (2020) categorized adaptations into 2 levels. First, the national policy adaptations that include: (1) development and dissemination of protocols for provision of RMNCH health care during the pandemic; (2) designation of MNCH/FP/RH health care as "essential" to promote continuity of care and allow for advocacy efforts during lockdown; (3) improved coordination, integration, and stakeholder/institutional alignment; and (4) use of data for rapid, dynamic policy decision-making e.g., immunization targeting, placement of staff and to influence lockdown policy. Second, the facility-level adaptations which include: (1) COVID-19 risk reduction through social distancing, provision of PPE, and promotion of IPC measures in health facilities, and improving the triage system; (2) healthcare worker-focused through recognition of and support for healthcare workers and more frequent communication for patient management and capacity building; (3) technological adaptations at the district and/or facility level through the use of mobile and web-based technologies for: triage and referral, requests for transportation to facilities, remote monitoring and follow up, hotlines providing information about care options and where to seek care, training, learning, and supervision, and commodity delivery (e.g., drones); and (4) community-based care and other community-focused strategies by: coordinating with local Community Emergency Transport Systems, combatting fears with community mobilization and advocacy efforts, tools for promoting home-based antenatal care by community health workers with COVID-19 precautions, and increasing outreach to prevent teenage pregnancy spikes seen in Ebola.

COVID-19 in the DRC

The first case of COVID-19 in the Democratic Republic of Congo (DRC) was identified on March 10, 2020, in Kinshasa (Nachega et al., 2020). Since then, the number of confirmed cases has been continuously increasing. By the end of September 2020, there had been 10,630 confirmed cases and 272 deaths recorded. Kinshasa is more highly affected than any other province with 8,138 confirmed cases, followed by North-Kivu, Kongo Central, and Haut Katanga. The DRC was expected to deal effectively with the pandemic by taking advantage of preventive lessons learned from its previous epidemics; however, the current indicators are worsening with a test positivity rate of 21% (Juma et al., 2020).

The DRC is one of the poorest countries in the world, where more than 70% of the people live in poverty (“The World Bank”, 2021). The country remains ill-equipped to address COVID-19 as there is a shortage of facilities to deal with the pandemic. Of 26 provinces, COVID-19 testing is only available in the towns of Kinshasa, Matadi, Lubumbashi, Goma, Kolwezi, and Mbandaka. The daily testing of only 900 individuals is very low compared with a population of more than 100 million (Juma et al., 2020).

After the first few cases, the government declared a state of emergency and set up a multi-sectoral national committee to devise strategies in response to the pandemic. Lockdown was first imposed in Kinshasa before it was country wide. Raising people’s awareness and enforcing restrictions on the borders were initiated (Nachega et al., 2020). International flights from COVID-19–infected countries were suspended and returning nationals were required to self-quarantine for 14-days (Whembolua and Tshiswaka, 2020). Schools and universities were closed, and mass gatherings of more than 20 individuals were prohibited (Whembolua and Tshiswaka, 2020). Wearing masks became compulsory in public areas (Juma et al., 2020).

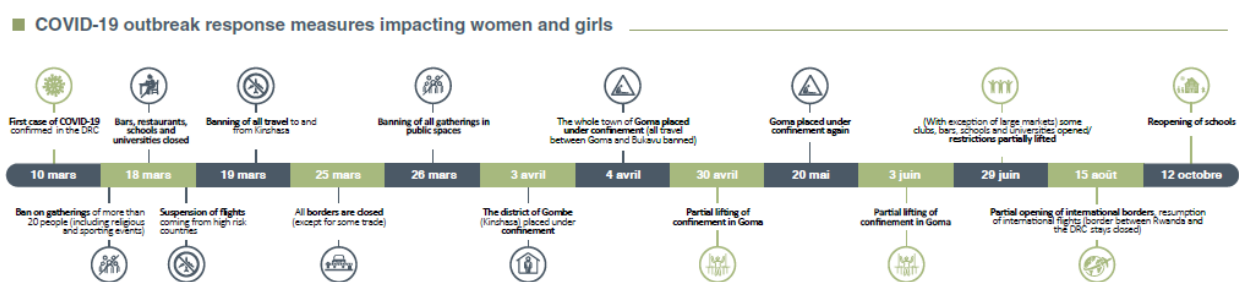


Figure 1. COVID-19 outbreak measures impacting women and girls. Source: (CASS, 2020)

Study Objectives

The overall aim of the study was to understand how SRH protocols and practices were or were not adapted to respond to the SRH needs of women and girls during the COVID-19 pandemic and identify the barriers to effective SRH service adaptation in North Kivu. We also reflected on what the SRH adaptations revealed in terms of the resilience capacity of the health system during the COVID-19 crisis. While research is emerging on the impact of COVID-19 in other settings, there has been limited analysis of the humanitarian context in eastern DRC. In addition, few analyses so far have used a policy analysis approach looking at the policy making processes around SRH response and adaptations.

Specific research questions were:

1. What is the impact of the COVID-19 pandemic on access to SRH services in North Kivu and on SRH needs for women and girls?
2. What are the guidelines and protocols for health service delivery and SRH service delivery that have been prepared to respond to the COVID-19 outbreak in DRC and North Kivu?

3. How are the guidelines implemented in practice to adapt SRH service delivery? How does this address or not address the SRH needs of women and girls?
4. What are the changes in SRH protocols and service provision practices at facility and community level? Who is deciding when, how, and where to implement those changes and who is responsible to implement them?

What are the elements that have supported and those that have hindered effective adaptation of SRH protocols and implementation of adapted SRH service delivery practices?

Methods

Study design and data sources

For this study, a largely retrospective (rapid) case study approach was used to gather information and views of stakeholders about how SRH policies, protocols and practices were adapted to respond to the COVID-19 pandemic. Data sources included a document review, key informant interviews, quantitative secondary data analysis, and knowledge embedded within the research team.

Ethical approvals to interview key informants were obtained from Queen Margaret University (reference REP 0230, granted on September 24, 2020) and the Liverpool School of Tropical Medicine in the UK (reference 20-083, granted on November 18, 2020), and *Université Catholique du Bukavu* in the DRC (reference UCB/CIES/02-10/2020, granted on October 28, 2020).

Data collection

Documents included in the review were found through a purposeful online search (general and specifically using the database of the *Cellule d'Analyse en Sciences Sociales (CASS)*¹), as well as shared by IRC staff in DRC and key informants. The document review included 17 documents and included existing laws, policies, and protocols for SRH in DRC and North Kivu; descriptions of COVID-19 adaptations; presentations from Health Cluster meetings; other reports and analyses of the effects of COVID-19 on SRH and on the health system in DRC; and reports on SRH and health systems of North Kivu before the COVID-19 epidemic. In addition, quantitative data from four health zones (Goma, Karisimbi, Beni, and Mweso) in North Kivu was extracted from DRC's DHIS2 database by the IRC for program purposes for the period between 2019 and 2020 and shared with the study team.

Key informants were purposefully identified from the five following groups: representatives of UN agencies, Ministry of Public Health (MSP) including province, zone and facility level, international non-governmental organizations (INGOs), national non-governmental

¹ <https://www.unicef.org/drcongo/cellule-analyse-sciences-sociales> & https://www.socialscienceinaction.org/search/?post_types=resources&_sft_country=democratic-republic-of-congo

organizations (NNGOs), and local civil society organizations (CSOs). A list of the representatives of main actor’s organizations in each of these categories was initially prepared by IRC staff in Goma with the aim of five per category. A total of 23 key informants were selected and contacted; interviews were successfully scheduled with 13 of those key informants, of whom only one was female (Table 1).

Table 1 Sample of key informants contacted and interviewed.

Category of key informant	Target number of informants	Number of informants interviewed
UN agencies	3	2
Ministry of Public Health (MSP)	5	3
INGOs	5	2
NNGOs	5	4
Local CSOs	5	2
Total	23	13

An information sheet and consent form in French were provided to the respondents at the time of scheduling interviews with instructions to notify the interviewer of any questions or to return the signed form if there were none. Informed consent was collected for all the interviewees and it specifically asked for consent to recording of interviews (providing the alternative option that only notes would be taken), to which all interviewees agreed. LH, MPB and CM conducted interviews with key informants in French remotely using WhatsApp or Microsoft Teams (LH, MPB) and in person (CM) between December 2020 and January 2021. Investigators used a semi-structured interview guide (Annex 1) to structure the interviews, which lasted about one hour and were recorded. Interviews were not transcribed or translated but detailed notes were taken during the interview, which were typed up in English and further expanded with interviewers’ notes immediately after the interview and by listening to recordings as necessary. Quotations used in the Findings section below were transcribed and translated by the authors based on the audio recordings. Consent documents were stored on password protected computers, while interview recordings and anonymous notes were stored in a secure Microsoft Teams channel.

Data analysis

Quantitative secondary data was reviewed for trends between 2019 and 2020 using Microsoft Excel to address whether the COVID-19 epidemic impacted the utilization of SRH services in North Kivu and on SRH health outcomes for women and girls. Data was also triangulated with reports and other information to compare trends in North Kivu with those at the national level and interpret those trends against the COVID-19 epidemic data and other key factors, such as changes in funding levels.

Interviews and documents were analyzed using thematic analysis (Braun and Clarke, 2012). A series of themes or codes was developed, closely building on the research questions and on

the elements of the resilience framework developed by the broader R4R research team, but also allowing space for revisions during analysis to accommodate emerging themes (Annex 2; R4R Consortium, 2020). Codes were applied to interviewer’s field notes and documents by LH, WM, and MPB using an Excel-based extraction matrix. The matrix with the coded text from documents and anonymous notes was shared by the team for joint analysis of the findings.

Findings from each source were carefully integrated and triangulated, and results of the data analysis, document review and interviews were written up jointly to allow for complementarity between data sources. Early findings were presented to a meeting of the Health Cluster SRH working group in Goma held via Zoom on April 6th, 2021, to allow for consultation and respondent validation.

Results/Findings

Impact of the COVID-19 epidemic on access to SRH services in North Kivu and on SRH needs for women and girls

“For services, we found a reduction in utilization because the population was fearful, it was the hospitals that had sick people who could infect them.” (male respondent, KI-MSP2)

Respondents reported a decrease in utilization of health services at the beginning of the pandemic. There were a variety of explanations as to why: rumors about the risk of being identified as having COVID-19 and subsequently forced into an isolation center made people fearful of seeking care; lockdown rules made it difficult for people to travel to facilities; limits on the number of people allowed to gather at facilities increased waiting times; some SRH services were regarded as non-essential and therefore access to facilities was refused; sensitization activities were reduced because of restrictions on gatherings; and economic constraints to paying user fees limited accessibility.

Utilization rates seemed to recover by the end of the summer of 2020 as community sensitization lessened fears of being quarantined or infected; people became used to the measures taken to reduce risk of infection such as checkpoints, mask requirements, and reduced size of gatherings; and providers adapted services. One respondent noted that community members saw COVID-19 as being imported, unlike EVD, and because COVID-19 was not as fatal and visible, it made it harder to sensitize the community to the dangers. Another stated:

“When COVID started, people were scared of everything. Because in our province, Ebola, it had been here more than a year. So people knew Ebola and had become accustomed to living with Ebola. So when COVID arrived, we presented it as a disease that you could get from someone when they breathed or spoke. So this may have been why utilization decreased... Now people have become used to living with COVID

and have developed resilience - and even for the 'mesures barrieres' more and more people neglect them." (male respondent, KI-UN2)

Quantitative utilization data from four health zones mostly reflects the qualitative findings with some initial decreases in the spring of 2020 that recovered later in the year. While some respondents not working in direct care did not think there were many changes in utilization, those working for NGOs or CSOs commented on decreases in utilization of some services, such as ANC, and increases in demand for others, such as family planning. Additional factors such as the end of free services when Ebola funding ceased at the end of July 2020 and insecurity in some health zones may have caused some of the fluctuations observed in Figures 2, 3 and 4.

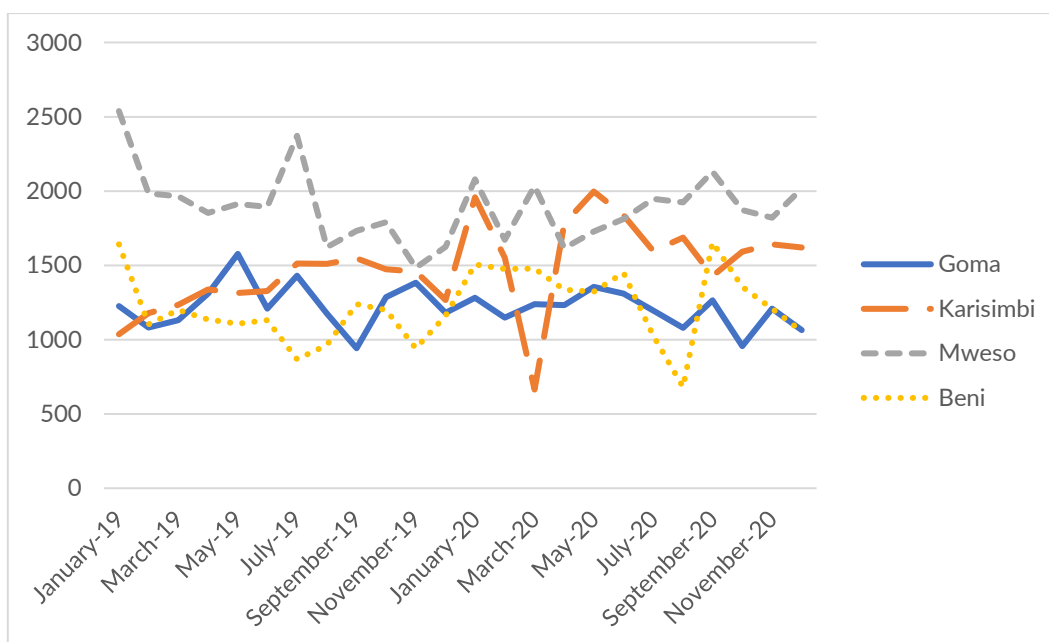


Figure 2.. ANC1 Visits in selected North Kivu Health Zones

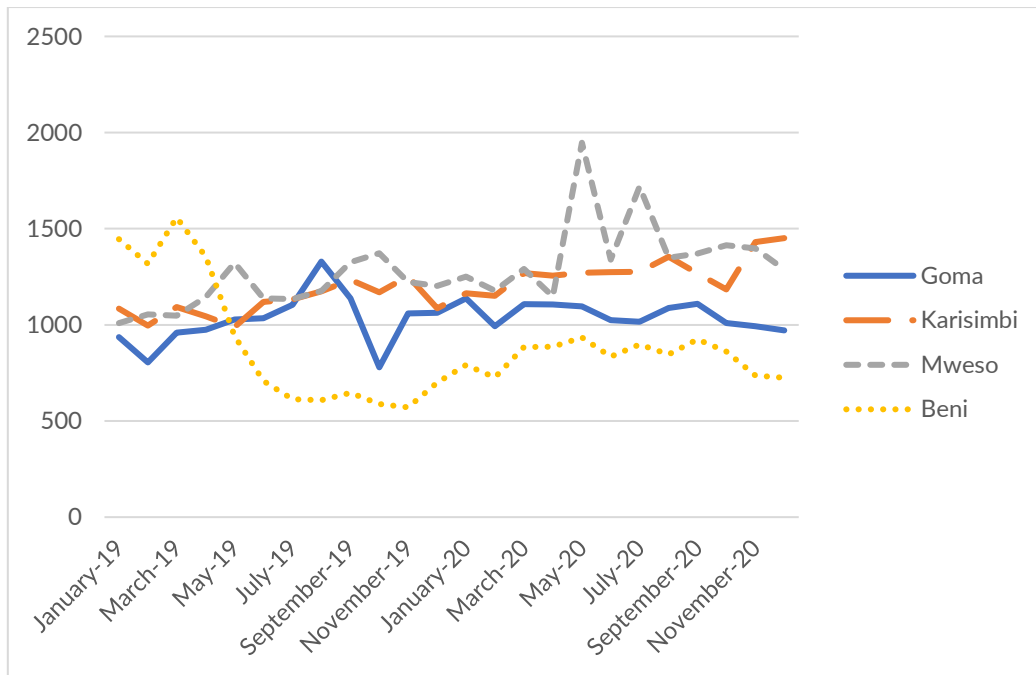


Figure 3. Birth with skilled attendance in North Kivu Health Zones

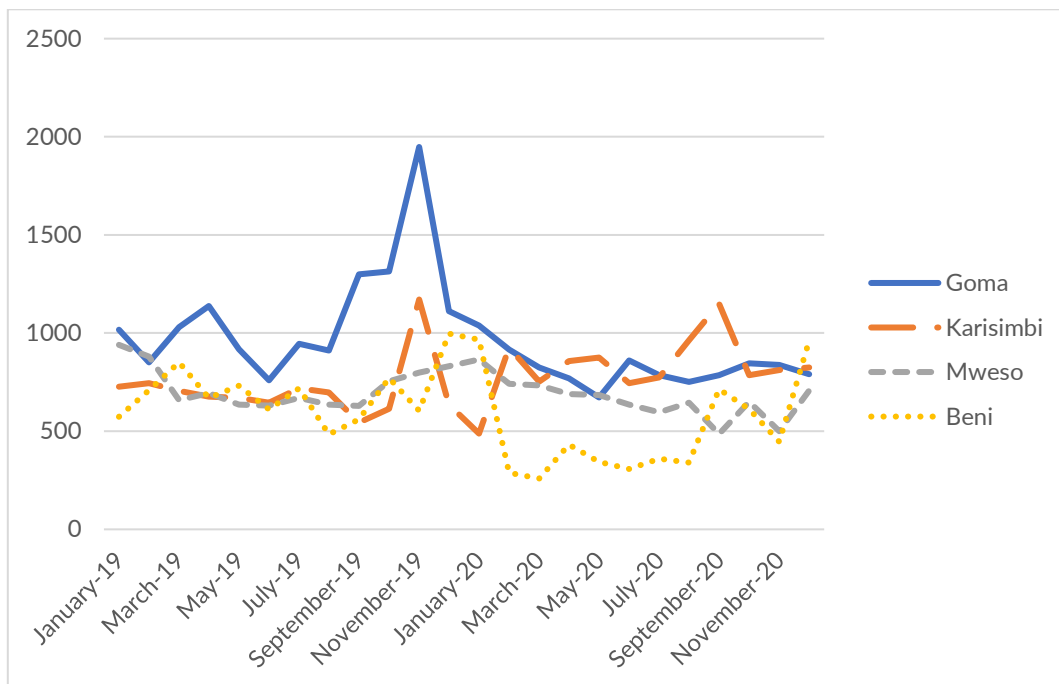


Figure 4. New Family Planning Users in selected North Health Zones

The pandemic has had an impact on everyone, but respondents noted that vulnerable populations may have been hit particularly hard, such as those with disabilities. For instance, wearing of masks made it impossible for deaf people to read lips. Populations without safety nets, such as internally displaced persons and street children, were particularly at risk because of loss of livelihoods. User fees were not reduced or removed as they had been

during the Ebola outbreak so for those who lost income, financial barriers may have prevented them from seeking care, although some MoH staff noted that indigent patients were often exempt from fees before and during the pandemic. Respondents suggested that some changes in utilization of SRH services may have reflected needs triggered by the pandemic; the lockdowns reduced movements and constrained economic activities, creating financial hardship for many families. Respondents reported increases in women seeking family planning and abortion care later in the pandemic, which they attributed to women deciding that it was not financially prudent to have more children and to increases in unintended pregnancies resulting from increased transactional sex for survival and increased sexual activity among adolescents who were out of school. This also led to increased STIs according to some respondents. Unfortunately, the urgent need to respond to COVID-19 early on resulted in funds earmarked for family planning at the provincial level to be diverted to the COVID-19 response.

These reflections are similar to those found by the Social Sciences Analytics Cell (CASS) and its partners in their mixed methods data from DRC, which present a dynamic where pre-existing disparities between men and women in terms of health, social protection and economic status are being exacerbated by the outbreak and its response (CASS, 2020).

COVID-19 policy response, guidelines, and protocols

As the reach of the pandemic became clear around the world and in the DRC, the government put together guidance to plan a response to COVID-19. Initially, the *Secretariat Technique COVID-19* (which was created under the Presidency) drafted a « *Plan de préparation et de riposte contre l'épidémie au COVID-19 en République Démocratique du Congo* » (“Plan de préparation”, 2020). The Plan included key principles such as intra- and inter-sectoral collaboration and coordination and the integration of the COVID-19 response to the health system and health system structures. In addition, in April the existing “Plan for Humanitarian Response 2020” was updated with a new “Plan for Humanitarian Response to COVID-19” which aligned onto the general COVID-19 response strategy and defined actions and needs from a multi-sectoral perspective, going beyond the health sector (“Plan de préparation”, 2020; “Plan de réponse”, 2020)

Most of the focus in those initial phases had been on the “barrier measures”, which are the IPC measures implemented in clinical settings, including: use of masks, hand washing, social distancing (for example, by creating new, larger waiting rooms at the facility level), taking temperatures, triage of patients, and isolation for suspected cases. These measures built on and, in a sense, reactivated the measures that had been in place during the EVD epidemic and were still largely being followed. For this reason, there was a clear sense that the response to the COVID-19 epidemic followed on and was almost indistinguishable in terms of response protocols and strategies to that of EVD for many respondents.

"The protection system for Ebola is the same system we use for COVID except maybe for the addition of masks which we didn't use for Ebola, but we use for COVID" (male respondent, KI-MSP2)

However, many noted important differences in the policy guidelines provided. In contrast to what had happened with EVD, there was no official policy to reduce user fees, which in the DRC are charged to patients for almost all services with few exceptions. In the context of the lockdown and the loss of livelihoods for many, continuing to charge user fees would have created barriers to access services for many girls and women.

Beyond clinical guidelines, public health measures such as social distancing, limits to the number of people able to gather, and 'lockdown' measures, including closure of schools and other activities and businesses, were implemented, which also impacted how SRH services were provided and their accessibility.

In terms of SRH, a document entitled « *Directives pour l'offre des services et de soins en Santé de la reproduction, de la mère et du nouveau-né en situation de la pandémie au COVID-19 en République Démocratique du Congo* » was prepared in April 2020 by the National Programme for Reproductive Health (*Programme National de Sante de la Reproduction, PNSR*) of the MSP (MSP, 2020), followed by the *Directives SRMNEA-NUT [Santé de la Reproduction de la Mère, du Nouveau-né, de l'Enfant et des Adolescents y compris la Nutrition] dans le contexte du COVID-19 en République Démocratique du Congo* in May 2020 (MSP, 2020). These documents recognize the importance of prioritizing SRH and the possible negative consequences of the COVID-19 pandemic on women and girls, in particular: increased home and unassisted deliveries; maternal, neonatal and infant mortality; GBV; and unplanned pregnancies due to limited access to contraceptives.

The practical guidelines for SRH services proposed focusing on IPC measures such as triage and screening of patients, isolation of suspected cases, handwashing and PPE, social distancing within the facility. For consultation services, it is suggested to specify the appointment time to patients rather than ask them to wait, use telephone communication where possible, and reduce group counselling to 5 people maximum. In areas with high COVID-19 prevalence, the document suggests avoiding all group counselling and increasing strict adherence to IPC measures. The guidelines include a recommendation to systematically screen all key populations for COVID-19, including sex workers, men who have sex with men (MSM), intravenous drug users (IDU), transgender people, prisoners, elderly, displaced, children, adolescents and youth in disrupted families, and people with disabilities; however, no information is provided on procedures to ensure this is implemented in practice. Similarly, while promotion of self-care is mentioned, there is little information on what that means in practice and how it should be implemented.

Overall, it was noted that the guidance focused mostly on IPC measures to reduce infections in health workers and patients and on adaptations to provider behavior in clinical settings, both for curative as well as preventative or counselling services. There is little reflection on how services can better respond to the needs of women and girls and to emerging needs as well as new challenges that the COVID-19 pandemic has created in terms of accessibility of

services. For example, while the document focuses almost exclusively on infection prevention for patients at health clinics, there is less attention to the possibility that patients would be isolating at home due to public health measures or personal decisions and not accessing services or facilities in-person. No specific measures or adaptations to service delivery patterns are envisioned to respond to this specific challenge. In the words of the respondents:

"Some measures were decided by the government, but these measures were not really supported. In the sense that there was not a plan to support [providers] with guidance around those measures. So, at health center level, there are not really things that were done differently, to adapt to COVID." (male respondent, KI-NNGO3)

Based on the document review, it is unclear how the response to COVID-19 intends to manage the prioritization of key SRH services, in terms of which services are considered critical and which are not, as this is not explicitly stated.

Regarding processes and agencies involved, the planning of the COVID-19 response seemed to mirror those created for the EVD response. Indeed, the Technical Secretariat attached to the Presidency at the national level in Kinshasa, which had dealt with the EVD response and was still functioning when the COVID-19 pandemic started, was tasked with the COVID-19 response so that the responses would be coordinated between the two epidemics. The Technical Secretariat put together a response plan with the support of international agencies and building on international evidence and guidelines, while the MSP and its departments developed service-specific guidelines ("Plan de preparation", 2020). Respondents stressed that it was the government and the MSP at the national level which were in charge of decision-making and drafting policies and guidelines, which were then communicated to the provinces and from there to the zonal and facility levels. It appears that in North Kivu, the provincial health authority (DPS) remained almost a "paper pusher", tasked with sharing the documentation and guidelines from the government at the national level to the partners in charge of implementation, but without real ownership of the response and dependent on partners for financial support to facilities. As one respondent mentioned,

"What is less developed is [DPS's] ownership of the COVID response. Development partners are really leading it, there is no funding or equipment available from the government, they are totally relying on the development partners" (male respondent, KI-UN2).

Communities and civil society, whose role had been stressed and built on during the response to the EVD epidemic, did not seem to play an active and critical role for the planning of the COVID-19 response (Ntumba et al., 2019). During interviews, there was a general sense that decision-making happened in a very top-down manner, perhaps even more so than during the EVD epidemic since the health crisis was now affecting the entire country and not only the eastern regions.

"These decisions [on COVID-19 response and protocols for service delivery] were not made through meetings to discuss them. We participated [in] briefings and training" (male respondent, KI-MSP2).

Respondents also shared their frustration at the difficulties of coordination between different actors at the provincial level. On the one hand, while meetings of the Health Cluster and the SRH sub-working group continued to be carried out monthly, there were technical difficulties since meetings had to be held remotely, online, and many participants struggled with internet connectivity. In September 2020, a fire destroyed the IT equipment of the DPS and made their participation even more challenging if not impossible on many occasions. On the other hand, many respondents also noted a lack of funding, technical expertise, and overall momentum among agencies and stakeholders which created challenges for effective coordination. Each partner was effectively tasked with implementing the COVID-19 guidelines in the facilities and communities that they were supporting, but there was a sense of lack of coordination due to the limited and varied funding (with some partners able to access higher levels of funding than others) so that implementation was patchy and not standardized. In the following section, we review the implementation processes and the challenges related to those.

Another challenge and frustration that respondents mentioned concerns the prioritization of SRH in the COVID-19 response. One mentioned,

"SRH should be considered as a priority but unfortunately that has not been always the case. Often SRH is forgotten during the crises, it is put on the side. For example, we manage to create a budget line within the province budget dedicated to family planning, which had funds on it. In March we asked for funding from that budget line, but COVID came and became a priority so that it was not possible to purchase contraceptives using that line. (...) We tried to make the case for it, but it was not accepted. What became a priority other preventative measures, the pandemic became the priority" (male respondent, KI-MSP1).

Adaptations to SRH services in practice and challenges in the response

Implementation of Adaptations

In terms of implementation, many respondents noted that there was both limited guidance provided for SRH service delivery, as described above, and no concerted effort to support adaptations to SRH services. As one respondent said:

"The effort of the decision makers was not there after putting in place policy." (male respondent, KI-CSO2).

Many noted that most of the IPC measures included in the COVID-19 response were already in place as part of EVD prevention, with the addition of masks and social distancing. The EVD epidemic had increased awareness and attention to IPC measures and changed the practices of providers and clients. Consequently, measures such as triage (for which dedicated spaces had been built), temperature taking, handwashing, etc., were already known and, in some cases, practiced with infrastructure and supplies available for them. However, many noted that diminishing support and funding to keep IPC measures in place (discussed further below), coupled with a perception that COVID-19 is less threatening compared to EVD, had led to the abandonment of many IPC practices over time.

The new “barrier measures” introduced with COVID-19 included distancing and masking which were disseminated out to the provincial levels, but without much detail on how to operationalize them or how to adapt services to ensure continued access. As a result, health zones and the organizations supporting them came up with their own *ad hoc* strategies to ensure continued access to SRH services.

A number of practical adaptations to SRH services that were happening somewhat haphazardly at facility and community levels were mentioned in interviews. These included, providing several months of oral contraceptives so that women would not have to come back as often to replenish their supply, increasing the number of sensitization sessions in the community to inform people of how to continue to seek services safely and protect themselves from COVID-19, scheduling appointments by phone to avoid waiting times, and extending health facility hours to reduce crowding. In some facilities, ANC, and Expanded Program on Immunization (EPI) days were spread out across the week into more sessions to reduce the number of people gathering because of the public health restrictions. Respondents reported that some women did not like the increased wait times that resulted and that some pregnant women felt that wearing masks was very uncomfortable.

The need to increase the number of sessions for ANC and other group services or to extend hours was a strain on providers who had to work longer hours. If a provider contracted COVID-19, this required the facility to be closed for disinfection, which reduced access to services for the catchment population.

At the community level, group activities (i.e., youth clubs) were reduced because of the restrictions on large gatherings, although NGOs supporting these activities reported increasing the frequency of smaller sessions and focusing on sensitizing the community on COVID-19 in addition to routine health services. Encouraging community members to continue seeking care for SRH services while respecting the “barrier measures” as an increase in home births was observed. Radios were used as a method to reach people without having to worry about distancing or masking. However, curfews limited when activities could take place.

Factors Affecting Adaptation

It was clear from the interviews, that the adaptations remained mostly ad hoc and were not uniformly implemented. In addition, the extent to which policy changes were understood and adhered to varied in the opinions of respondents. Overall, there was a sense that facilities which did not have external support for training and supervision were less likely to have put in place the new protocols and to consistently follow guidance. As one respondent said:

"It's a continuous process, when an organization [an NGO] comes to support a facility, they come with a package of support and with that package of course a protocol and they start explaining to us and with training, that with the package this is now the protocol, and then we start implementing according to these protocols" (male respondent, KI-MSP2)

Another source of variation mentioned was the financial support to facilities or community-level organizations due to differences in funding partners: partners with priorities other than SRH, partners with lower funding levels, or lack of external financial support. In addition to limiting the delivery of training and supervision, the lack of funding impacted the availability of supplies for both the COVID-19 response and to ensure SRH services could continue to be delivered for free. In a world of limited funds, the lack of COVID-19 funding may have resulted in funding being diverted from SRH because it was necessary to ensure PPE to deliver SRH services. The lack of additional funding combined with increased workloads led to some demotivation of healthcare workers.

"There is a difference in the inputs [e.g. materials, equipment, consumables, etc.] given to different facilities, depending on who is the partner supporting them. Some partners are not responsive, and it takes time before a stockout is addressed, while others visit facilities regularly and there are no stockouts. Secondly, there is also a difference in motivation [top-up payments] provided to health workers. If motivation [payment] is low, providers work, but you can see the difference between facilities (...). And each partner comes with their indicators and objectives" (male respondent, KI-NNGO1)

Most actors remarked that the low amount of funding available to ensure continued access to SRH services and COVID-19 safe service delivery was particularly stark in comparison to the amount of funding available for EVD response. Similarly, the logistical and technical support as well as the capacity for coordination and standardization of practices was limited during the COVID-19 response when compared to the EVD response. The EVD response had mobilized actors with high levels of funds and technical expertise with the capacity for contact tracing, surveillance, communication, sensitization, and defining emerging best-practices and supporting their roll-out almost in real time.

"During [COVID-19] the coordination is weak in comparison to Ebola. There is no standardization at facility level – while during EVD there was an effort of

standardization so that all facilities had the same support, followed the same protocols and that a package of services was available and offered in all the facilities supported. During COVID, I do not see that effort anymore. Everyone knows the barrier measures (IPC) to be adopted, but each partner is left to do what they can" (male respondent, KI-UN2)

Stockouts of IPC/PPE materials as well as SRH commodities were a consequence of the lower financial support. Providers often mentioned that they depend on partners for their supplies and experience enormous challenges in keeping up with service delivery once partners diminish or withdraw their support. Stockouts of SRH commodities also meant forced changes in terms of practices and service accessibility. For example, family planning methods being unavailable or only available for a fee, when they were previously offered free of charge.

"We don't have a partner for family planning. People were used to getting [FP] methods for free, but when we have a stockout, we start to give prescriptions for a method. Then, the person goes to buy a method and then comes back to a health facility with it, and what happens is that the health worker will ask for something [i.e. a payment] for the service. So that is the fear we start to have, we still have some supplies that [INGO] gave us, but by the end of March we will have stockouts" (male respondent, KI-MSP2)

Additional challenges to the adaptation of SRH services and practices came from the longstanding issues related to conflict and instability in some areas of North Kivu. Those areas are not within government control and access remains insecure, so supervision, training, and supplies reach there with many difficulties. Insecurity has an impact on the response, but also on the needs of women and girls in the affected areas, which are often higher due to violence and GBV.

On the positive side, in terms of factors that supported SRH service adaptation, it emerged from many interviews that the experience with EVD had prepared providers and the health cluster coordination for COVID-19 in many ways. As noted above, many IPC measures were already in place and protocols were able to be adapted. Health workers, as well as patients and clients, were well aware of IPC measures and understood their importance.

"With Ebola the health system became multisectoral - everyone was involved, communities, government and health actors. There was not a lot of resistance [during COVID], because we had lived through Ebola. So, we understood how to deal with it. There were some changes in tasks, and health workers were well equipped to combat the disease based on Ebola experience" (male respondent, KI-CSO2).

Despite the EVD experience being helpful in maintaining IPC, it did not necessarily seem to have strengthened the system. In particular, the stark difference between the responses to the two epidemics, with EVD better funded, better coordinated and evidence-based, while COVID lacked funding and had top-down policies with fragmented implementation of measures, left some of the respondents with a sense of a missed opportunity for health system strengthening. The end of the EVD epidemic had been a moment of hope for a better long-term health system, but this was crushed by COVID-19 and the response to it which highlighted the usual problems of the health system in North Kivu.

“The general consideration that we made is that the health system remains extremely fragile. In principle, the health system was supposed to take advantage of the Ebola epidemic for its strengthening. And indeed, there has been some capacity strengthening [during Ebola]. However, when the new COVID crisis arrived and people [NGOs/partners] left, we had the impression that the system is again fragile. So, it was a wrong impression that the system could have been strengthened. Quite the opposite! (male respondent, KI-UN2)

Study Limitations

This study had several limitations. The COVID-19 pandemic prevented travel to the study site, so interviews had to be conducted remotely for the most part and without video due to low internet bandwidth. The remote nature meant it could be hard to track down respondents and schedule the interviews, particularly over the holiday period when many work activities slow down or cease in the DRC. In addition, competing crises such as a new Ebola outbreak and attacks on civilians made it difficult to reach all key informants. This led to a low response rate, particularly from key informants belonging to categories that are community-based and often have less ease in accessing good internet services, such as local CSOs. Similarly, presentation of preliminary analysis to the health cluster SRH sub-working group had to be done remotely during a Zoom meeting, which did not facilitate easy discussion.

Discussion

The access and use of SRH services among women and girls in LMICs and humanitarian settings is limited, even when services are available (Desrosiers et al., 2020). In SSA, the access to SRH services is generally poor and the emergence of COVID-19 has further exacerbated this limited access (HAI, 2021). The COVID-19 pandemic has resulted into redirection of funds and attention by governments, donors, and stakeholders towards COVID-19 containment efforts, thereby diverting focus from other important issues including SRH. This has led to women and girls being less able to access important healthcare services, while at the same time their SRH needs are likely to have increased (Ogunkola et al., 2021).

Although respondents from North Kivu reported a decrease in utilization of health services at the beginning of the pandemic because people were afraid of being isolated if they tested COVID-19 positive and of the risk of being quarantined (and separated from their children), difficult access due to lockdown and travel restrictions to health facilities, and inability to pay user fees, utilization rates recovered by the end of the summer of 2020 after successful community sensitization and once people became familiar with restrictions and safety measures. This is in line with the findings of the CASS report. On the one hand, there was an increase in the use of FP services by women after an initial reduction because of fear of pregnancy due to the cost of raising a child and because of an increase in sexual activity among adolescents, but there was a decrease in ANC visits which were not always considered urgent, especially by women who had already given birth (CASS, 2020).

On the other hand, there was also an increase in unintended pregnancies resulting from increased transactional sex for survival and increased sexual activity among adolescents who were out of school which led to increased STIs, as reported by respondents. Additionally, data showed an increase in the number of women and adolescents seeking abortion care who, without another option, were forced to seek clandestine abortions. Increased incidence of SGBV was also observed nationally and in North Kivu and Goma specifically (CASS, 2020). This is in accordance with Karp's claim that the pandemic may increase rates of unintended pregnancy and unsafe abortion, while women's fertility intentions and need for contraception may also change due to unpredictable economic circumstances (Karp et al., 2021).

Many health programs in LMICs and fragile settings have made several SRH adaptations to respond to women and girls needs during the COVID-19 pandemic. An IPPF program which has been implemented across 15 countries in Africa and Asia recommended adapting clinic services in line with the national guidelines on social distancing and IPC measures (Khatun, 2020). Similarly, in the DRC, the country had put together guidance to plan a response to COVID-19 which primarily included key principles such as intra- and intersectoral collaboration and coordination to develop the general COVID-19 response strategy. Learning from the previous EVD outbreak, the focus was on IPC measures and its implementation in clinical settings to limit the spread of the infections, with the addition of masks. This guidance was largely top-down however, with limited detail on operationalization of how to ensure continued access to services and no concerted effort to support adaptations to SRH services. Some measures that were implemented in other countries, such as community distribution of FP, increased support for self-care, and mHealth solutions do not seem to have been used in this context (Khatun, 2020). This may have been because of lack of financial resources, human resources, technological infrastructure, as well as policy barriers to task shifting. Communities and civil society whose role had been stressed and built on during the response to the EVD epidemic, did not seem to play an active and critical role for the planning of the COVID-19 response, which was organized by the government, although they mobilized to sensitize community members about COVID-19 anyway.

Nevertheless, as is often the case in the DRC, zonal and facility level staff developed their own adaptations, such as: setting specific appointments to patients to reduce the waiting time, using telephone communication, and reducing group counselling to 5 people maximum.

These adaptations could overcome the reported problems of rare clinic appointments in low-income settings and long waiting times for hours at crowded clinic waiting areas for ANC, contraceptive counselling, or other RH services, which will increase risk of infection transmission (Hussein, 2020).

Although IPC measures were already known due to EVD prevention, diminishing support and funding to keep them in place, coupled with a perception of COVID-19 as less threatening compared to EVD, had led to the abandonment over time of many IPC practices. This forced the health zones and organizations supporting them to come up with their own ad hoc strategies to adapt services to ensure continued access to SRH services. For example, providing several months of oral contraceptives so that women would not have to come back as often to replenish their supply, increasing the number of sensitization sessions in the community to inform people of how to continue to seek services safely and to protect themselves from COVID-19, scheduling appointments by phone to avoid waiting times, and extending health facility hours to reduce crowding.

EVD, however, was the comparison for nearly all respondents when talking about COVID-19. The stark difference in funds available was reported by most respondents, but there was also less coordination, technical support, capacity for innovation, learning culture, and multi-sectoral collaboration. The lack of external support for training and supervision meant that facilities were less likely to have implemented the new protocols and consistently followed guidance, particularly if they did not have external NGO partner support. The lack of funding has also impacted the availability of supplies both for COVID-19 response which resulted in stockouts, both for IPC/PPE materials as well as SRH commodities, and this in turn threatened the ability of SRH services to continue to be delivered for free. The logistical and technical support and the capacity for coordination and standardization of practices was also limited during the COVID-19 response compared to the EVD response. Likewise, in other SSA countries, accessing SRH services including ANC services, has been impacted in Kenya, Tanzania and Uganda with consistently high maternal and neonatal mortality rates due to limited healthcare resources, restrictions in movement, and a shortage of healthcare workers due to the COVID-19 response (Ogunkola et al., 2021). Shortage of funding has also limited the coordination and the overall momentum among agencies and stakeholders, and this ineffective coordination has led to non-standardized and patchy implementation of the COVID-19 guidelines in the facilities and communities they supported.

Several respondents expressed frustration that the unsystematic and weak response demonstrated how the EVD response had not strengthened the health system as it was still dependent on external funding and support. This reflects the continued gaps in support from the central government to provincial and zonal health teams and the continued challenges in reinforcing bottom up strengthening approaches in a context of limited resources all around, volatility of external support, and continued fragility.

However, on the positive side, the experience with EVD had prepared providers and the health cluster coordination for COVID-19 in many ways since many IPC measures were

already in place and protocols were able to be adapted. Health workers, as well as patients and clients were well-aware of IPC measures and understood their importance. As described above, healthcare providers and communities demonstrated resilience in doing what they could to safely distance and continue services with the resources they had.

Conclusions

The prior EVD epidemic (a second one erupted during the data collection) had been an opportunity for health system strengthening that in the end was not sustained through the COVID-19 pandemic. This had consequences for access to SRH services, as the limited resources available for responding to the pandemic resulted in deprioritization of SRH services despite increased need. Respondents advised that continued funding was needed to support SRH services in the wake of what they had observed. Future donors should consider how resources can be leveraged to support sustained strengthening of the system to be able to absorb and adapt to shocks even when new influxes of funding in the face of a crisis such as a new outbreak are limited.

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Annexes

Annex 1: Interview Guides in French and English

Guide d'entretien

Notez les détails des participants avant l'entretien :

1. ID de l'entretien	
2. Date de l'entretien	
3. Genre	Homme <input type="checkbox"/> Femme <input type="checkbox"/>
4. Titre de l'interviewé	
5. Institution/Organisation/ Département	
6. Niveau nationale, provincial ou zonal	

Confirmez que la fiche d'information a été lue et comprise, posez d'autres questions - vérifiez que le formulaire de consentement a été signé - vérifiez / demandez le consentement pour l'enregistrement de l'entretien.

N'oubliez pas d'adapter et de personnaliser les questions en fonction des antécédents de l'informateur clé, de son expérience et de ses connaissances potentielles.

1. Pouvez-vous me dire quel est votre **rôle professionnel actuel** ? Quel est votre rôle / vos tâches **par rapport à la prestation de services de SSR** en particulier ? Depuis combien de temps travaillez-vous dans ce poste ?
2. Pouvez-vous me dire quel est votre **rôle professionnel actuel** ? Quel est votre rôle / vos tâches **par rapport** combien de temps travaillez-vous dans ce poste ?

[Rechercher le type de rôle / d'affiliation - voir les options ci-dessous :

- responsable des politiques au ministère de la Santé et / ou dans d'autres institutions compétentes
- directeur de la santé au niveau provincial ou zonal
- personnel d'une ONG nationale et internationale
- personnel de l'agence des Nations Unies
- bailleur de fonds travaillant au niveau des pays
- représentant d'un prestataire de soins de santé privé et privé à but non lucratif / confessionnel
- représentant d'une organisation de la société civile ou d'une organisation communautaire
- autre]

- De votre point de vue, pourriez-vous décrire *brèvement* la **réponse du système de santé à l'épidémie de COVID-19** ? De votre point de vue, pourriez-vous décrire *brèvement* la **réponse du système de santé à l'épidémie de COVID-19** ?
- Nous entendons par ça, quels ont été les principaux changements dans le fonctionnement du système de santé pendant l'épidémie de COVID-19 ? Y a-t-il eu des changements dans les services offerts à la population, dans la manière dont les patients accèdent aux services et comment les services sont financés ? Y a-t-il eu des changements dans le déploiement et les tâches des agents de santé ? Qu'est-ce qui a changé en termes de disponibilité et d'approvisionnement en médicaments essentiels ?

[Cela est une question pour comprendre les adaptations de la SSR dans le contexte général, pas besoin de trop de détails]

- Pour cette étude, nous souhaitons nous concentrer en particulier sur les services de SSR et la fourniture du DMU. Quels ont été les **changements dans les services de SSR** depuis le début de l'épidémie de COVID-19 ?

SSR et la fourniture du DMU. Quels ont été les **changements dans les services** depuis le début de l'épidémie de COVID-19 ?

- **Qu'est-ce qui** a changé en termes de politiques et de protocoles en place ? *[Demander également les modalités de financement et les modifications apportées à celles-ci]*
- **Quand** ces changements ont-ils été apportés ?
- Est-ce que les changements ont été révisés plusieurs fois dans le temps ? Si oui, veuillez décrire quand / comment.

L'utilisation d'une chronologie (timeline) peut aider à mieux se souvenir et à obtenir plus de détails. Si l'interview est sur Zoom / Skype et que la connexion est bonne, vous pouvez partager l'écran et utiliser Google Jamboards. Par téléphone / WhatsApp, un document / chronologie peut être partagé à l'avance pour que le répondant puisse commenter. Sinon, vous pouvez également utiliser une chronologie pour prendre des notes de la réponse, si cela vous aide.

1. Quel a été le **processus** qui a conduit au(x) changement(s) des politiques et protocoles ?
 Quel a été le **processus** qui a conduit au(x) changement(s) des politiques et protocoles ?
- Est-ce que des **réunions conjointes** ont été organisées ? Est-ce que ces réunions étaient gérées/organisées par des comités de coordination existants ou des nouveaux ont été créés ?
 - **Qui** a participé à ces réunions ? *[Si possible, renseignez-vous sur leurs « caractéristiques », y compris le sexe et le titre / diplôme / formation des participants]*. Est-ce que la composition des participants est différente de celle des réunions précédentes à la COVID-19, menées pour réviser les protocoles de SSR ? Si c'est le cas, comment la composition a-t-elle changé ?
 - Quelles **preuves / évidence** (par exemple, données locales ou directives internationales) ou **informations** (par exemple, provenant de patients et de communautés) étaient disponibles au cours de ces réunions ? Comment été utilisée cette information lors du processus décisionnel ?

1. 1. Quelle était la **justification et les raisons** qui ont été discutées pour soutenir et justifier les adaptations (ou le manque d'adaptation) ?
 - Quel est votre point de vue sur ce raisonnement ?
 - Auriez-vous fait les choses différemment ? Si oui, à quel égard ?

1. Comment ont été les adaptations aux protocoles SSR mises en œuvre dans la pratique ?
 - Quels sont les principaux goulots d'étranglement et défis ?
 - Quelle est l'opinion des prestataires / agents de santé au sujet de la mise en œuvre ?
 - Comment les perspectives des agents des sante ont influencée la mise en œuvre ?

- (i) i) Selon vous, quelles sont les conséquences de l'adaptations des services/protocoles SSR en termes de l'état de santé des femmes et filles ?
 - Y a-t-il eu des changements en termes d'accès aux services de SSR, y compris l'accès financier ?
 - Est-ce que certains groupes sociaux, régionaux ou autres (ethniques, handicapés, déplacés, vulnérables) ont été inclus ou exclus ?
 - Comment les femmes et filles ont fait face et géré ces changements ? Quels comportements ont-elles adoptés pour s'adapter aux changements ? [Par exemple, éviter les centres de santé et chercher des soins ailleurs, ou d'avantage des grossesses parce que la contraception n'est pas disponible, etc.].

2. Quels défis persiste pour les femmes dans le domaine de SSR à cause de COVID-19 ?
 - i. Comment le système sanitaire et différents acteurs ont répondu aux ces défis ?
 - ii. Qu'est-ce qui reste à faire ?

3. Comment pensez-vous que le contexte et l'histoire récente du Nord-Kivu ont influencé la réponse de la SSR à la pandémie de COVID-19 ? Par exemple,
 - Y-a-t 'il des leçons tirées de l'épidémie de EVD ?
 - Comment la fragilité contextuelle / crise prolongée / (conflit actif dans certains cas) a-t-elle influencé la réponse SSR au COVID-19 ? [*Demander d'avantage des explications sur le rôle des acteurs / donateurs humanitaires et externes, sur les points de vue locaux et internationaux sur la SSR/VBG dans un contexte de crise et en particulier dans les Kivus, etc.*]
 - Comment les valeurs / croyances des différents acteurs ont-elles façonné les points de vue sur la SSR et les adaptations de protocole ? [*Enquête sur le rôle des organisations catholiques, des ONG internationales et de la société civile, le cas échéant.*]

1. Avez-vous des conclusions ou des recommandations à formuler ?
- Quels sont, selon vous, les principaux défis ou opportunités rencontrés pour garantir un accès continu aux services de santé sexuelle et reproductive, et fournir des recommandations potentielles ?

FIN DE L'ENTRETIEN

Remerciez les participants pour leur temps.

Partager des informations et des contacts pour un engagement à plus long terme et la diffusion des résultats.

Note details of participants before interview:

1. Interviewee ID	
2. Date of Interview	
3. Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
4. Title of interviewee	
5. Institution / Organization / Department	
6. Central, Province or Zone	

Confirm that information sheet has been read and understood, ask for any further questions – check that consent form has been signed – check/ask for consent for recording the interview.

Remember to adapt and tailor questions according to background of the key informant, their experience and potential knowledge.

1. Could you please tell me what is your **current professional role**? What is your role/tasks **in relation to SRH service provision** specifically? How long have you been working in this position?

[Probe for type of role/affiliation – see options below:

- policy-maker at the Ministry of Health and/or other relevant institutions
- health manager at provincial or zonal level
- staff at national and international NGO
- staff at UN agency
- donor working at country level
- representative of a private and private non-for-profit healthcare provider
- representative of a civil society organisation or a community based organisation
- other]

2. From your perspective, could you *briefly* describe the **health system response to the COVID-19 epidemic**?

- By this we mean, what were the main changes to how the health systems work during the COVID-19 outbreak? Were there changes in the services available to the population, in how patients access services and how they pay for them (or not)? Were there changes in the deployment and task of health workers? What changed in terms of availability of essential drugs and supply?

[this is a question to set the SRH adaptations against the general context, no need for too many details]

3. For this study, we want to focus in particular on SRH services and the provision of the MISP. What were the **changes in SRH services** since the start of the COVID-19 epidemic?
 - **What** has changed in terms of policies and protocols in place? *[also probe for funding arrangements and changes to those]*
 - **When** were these changes made?
 - Were these changes reviewed at different points in time? If yes, please describe when/how.

Using a timeline might help better recalling and eliciting more details. If the interview is one on Zoom/Skype and the connection good, you can share the screen and use Google Jamboards. Via phone/WhatsApp, a document/timeline can be shared in advance for the respondent to comment on. Otherwise, you can also use a timeline to take notes of the response, if that helps.

4. What was the **process** that led to the change(s) in policies and protocols?
 - Were **joint meetings** organized? Was that done via existing coordination committees or new/*ad hoc* ones were created?
 - **Who** participated to these meetings? *[if possible, ask about their 'characteristics', including gender and title/degree/training]. Is this different from previous changes to SRH protocols? If so, how?*
 - What were their respective positions/views on the changes needed or not? Was there general agreement or some differing/conflicting perspectives? *[probe for the reasons of their views/actors' agendas, including potential 'winners'/'losers' from changes, for example in terms of funding, rent seeking/patronage networks]*
 - **Why** did some views prevail over others? How did different groups influence the decision-making process? *[probe for issues around power and influence here, including official funding or unofficial payments/corruption]*
 - What **evidence** (e.g., local data or international guidance) or **information** (for example, from patients and communities) was available during those meetings? How was it used during the decision-making process?
5. What was the **rationale and reasons** that were discussed to support and justify the adaptations (or lack of adaptation)?
 - What is your perspective and view on this rationale?
 - Would have you done things differently? If so, in what respect?
6. How were the SRH adaptations implemented in practice?
 - Which are the main bottlenecks and challenges?
 - What are the views of health providers/health workers on them?
 - How did these views influence implementation?
7. What do you think are the consequences of the implementation of the SRH adaptations in terms of health outcomes for women and girls?
 - Were there any changes in terms of access to SRH services, including financial access?

- Are particular social, regional or specific groups (ethnic, disabled, displaced, vulnerable) included or excluded?
 - How women and girls have coped? What measures/behaviors are they taking to adapt to the changes? [For example, avoiding health facilities or seeking care elsewhere, or having more pregnancies because contraception is not available, increased access to safe abortion self-care pilot].
8. How do you think the context and recent history of North Kivu influenced the SRH response to the COVID-19 pandemic? For example,
- Were there any lessons learned from the EVD epidemic?
 - How did the contextual fragility/protracted crisis/ (active conflict in some cases) influence the SRH response to COVID-19? [probe for role of humanitarian and external actors/donors, local and international views of SRH/GBV in crisis context and specifically in the Kivus, etc.]
 - How did the values/beliefs of different actor's shape views around SRH and protocol adaptations? [*probe for role of Catholic organizations, INGOs and civil society, if relevant*].
9. Do you have any concluding thoughts or recommendations to make?
- What do you think are the main challenges or opportunities being faced with regards to ensuring continued access to sexual and reproductive health services, and provide potential recommendations?

END OF INTERVIEW

Thank participant for their time.

Share information and contacts for longer-term engagement and dissemination of results.

Annex 2: Coding Framework

Main theme	Sub-theme	Comments
Changes in access to/utilization of SRH services	Changes in utilization of SRH services <i>due to COVID-19</i>	Include any information, including anecdotal on changes in utilization rates that might be related to COVID-19
	Changes on access to/utilization of SRH services <i>due to other causes</i>	Include any information, including anecdotal on changes in utilization rates that might be related to other causes.
	Health seeking behavior	Include information on any changes to health seeking behavior of patients/users that might influence utilization rate
Impact of COVID-19 on SRH needs	--	Include any information, including anecdotal on changes in SRH needs for women and girls that might be related to COVID-19
COVID-19 guidelines and protocols	COVID-19 guidelines and protocols (SRH and beyond)	Include any reference to protocols/guidelines as designed/envisaged and description of measures included in those and the targets of those measures
	Actors involved in designing COVID-19 guidelines	Include actors at national and provincial level involved in designing COVID-19 protocols.
	(planning) processes for designing COVID-19 guidelines	Include description of processes and coordination forums/meetings/groups where COVID-19 protocols were designed/agreed on. Also include role evidence/information on utilization and needs in shaping guidelines.
Implementation and adaptations to SRH services	Changes in SRH service delivery at facility level	Include both changes that are due to public health/IPC measures (social distancing, hand washing, triage) and those which are a response of facilities to those changes (e.g., extending opening times, scheduling appointments, etc.).
	Changes in SRH service delivery at community level	As above
	Differences between actors/facilities in terms of SRH adaptation and implementation	
	Actors involved in implementing changes	Who decided on those changes? How? Who is responsible of decision making? How were changes

		communicated (unless decided at delivery level)?
	(planning) processes for defining SRH adaptations	Include description of processes and coordination forums/meetings/groups where SRH-specific adaptation and implementation issues were discussed (vs. focus on design in code above). Also include role evidence/information on utilization and needs in shaping adaptations decisions.
Role of different elements in implementation of SRH adaptation and service delivery	Funding / lack of funding	Can be challenges/ bottlenecks or elements supporting adaptation (and resilience)
	Availability of materials / inputs	
	Level of prioritization of SRH during COVID-19 response	
	Coordination / fragmentation	
	Learning processes	
	Technical knowledge and evidence	
	EVD epidemic	
	Beliefs and views of communities	
	Health workers (including skills/capacity, motivation and beliefs/views)	
Consequences of lockdown and other public health measures		
Other elements		
Assessment of response	Effectiveness of SRH changes to address needs	Considerations/perceptions/views of the respondent on how SRH service needs are met through those adaptations, or conversely on gaps in SRH service delivery



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