FAMILY PLANNING SERVICES DURING THE FIRST WAVE OF COVID-19 IN FOUR FRANCOPHONE WEST AFRICAN COUNTRIES:

Continuity, Utilization, and Adaptation in AmplifyPF Intervention Districts

REPORT

AUGUST 2022

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Amplify Family Planning and Sexual Reproductive Health project (AmplifyPF) is a USAID-funded project, with a goal of mobilizing partners to expand access to and utilization of quality FP services in four selected West African countries (Burkina Faso, Côte d'Ivoire, Niger, and Togo) through an innovative approach consisting of synergizing all health resources available at the district level to form an Integrated Learning Network (ILN). AmplifyPF is led by Pathfinder International.

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Photo credit on cover page: A young women wearing a mask during the COVID-19 pandemic. World Bank/Ousmane Traore (MAKAVELI).

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List of Acronyms

AmplifyPF	Amplify Family Planning and Sexual Reproductive Health Project
CBD	Community-Based Distribution
CHWs	Community Health Workers
CHR	Centre Hospitalier Régional
CLA	Collaborating, Learning and Adapting
COOPI	Cooperazione Internazionale
COVID-19	Coronavirus Disease of 2019
CSO	Civil Society Organization
CYP	Couple-Years of Protection
DFP	Department of Family Planning
DHIS-2	District Health Information System 2
DQA	Data Quality Assurance
DMPA-SC	Depot medroxyprogesterone Acetate Sub-Cutaneous
FP	Family Planning
FPSD	Family Planning Special Days
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HIV/AIDS	Human Immunodeficient Virus/Acquired Immunodeficiency Syndrome
HP+	Health Policy Plus
ILN	Integrated Learning Network
IPC	Infection and Prevention Control
ISBC	Identification Systématique des Besoins des Clients en PF
IUD	Intra-Uterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PACFP	Post-Abortion Care Family Planning
PPE	Personal Protective Equipment
PPFP	Post-Partum Family Planning
PLWHIV	Person Living with HIV
RPA	Research and Program Advisor
RH/FP	Reproductive Health/Family Planning
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SOS JD	Youth and development NGO
STATD	Secretariat for Accelerating the Demographic Transition
STIs	Sexually Transmitted Diseases
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WABA	West Africa Breakthrough ACTION
WHO	World Health Organization

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Executive Summary

Background

Most West African countries reported their first COVID-19 cases within the first two weeks of March 2020. As governments in the region swiftly responded to the pandemic, the United States Agency for International Development-funded AmplifyPF project seized the opportunity to assess the influence of COVID-19 on family planning service delivery and use in 17 intervention districts across urban and peri-urban areas of the four project countries: Burkina Faso, Côte d'Ivoire, Niger, and Togo. Assessing the influence of crises on health services are often retrospective. In contrast, the present study was conducted in real-time to generate findings for prospective and practical use in sustaining provision of family planning services during health crises.

Methodology

This study combined qualitative and quantitative methods, allowing for more complete evidence towards understanding the phenomenon at hand. Qualitative data collection in all four countries took place in July and August 2020. To document adaptation measures taken to ensure continuity of family planning services and functionality of the project's Integrated Learning Network, AmplifyPF country teams conducted key informant interviews in the respective countries. The interviews were conducted by phone using semi-structured interview guides developed and administered in French and tailored to each type of national, regional, and district stakeholder:

- Ministry of Health representatives
- Health facility-level family planning service providers
- Representatives of community organizations and municipalities
- AmplifyPF country team members

The AmplifyPF team also conducted a desk review of relevant Ministry of Health protocols, directives, and documentation on the impact of COVID-19 on family planning services in the region. Finally, each country's AmplifyPF Adaptation Officer facilitated a virtual focus group discussion with their team. Two members of the AmplifyPF regional team independently reviewed the interview notes, summarizing and extracting meaningful statements by using textual and thematic analysis. Relevant statements were translated into English for this report.

The quantitative approach consisted of secondary analysis of family planning service statistics from the Network's health facilities captured monthly in the DHIS-2 in each of the four countries. The data span July 2018 to December 2020, and the analysis covered three themes:

- Family planning service use
- Health facility delivery and initiation of a modern contraceptive method in the immediate postpartum period
- Use of post-abortion care and initiation of a modern contraceptive method before discharge

This allowed the AmplifyPF regional team to examine trends in the 20 months preceding the COVID-19 pandemic (July 2018 to February 2020) and the first ten months of the COVID-19 pandemic (March 2020 to December 2020). Analysis consisted of plotting family planning service statistics for trend comparison and interpreting patterns of national governments' varied responses to COVID-19 disease prevalence. Supplementary analyses of the 2018, 2019, and 2020 calendar years were also performed to ascertain any effects of seasonality.

Findings

The findings of this study enhance the literature on the impact of major health crises on family planning service delivery and will help decision makers adjust ongoing pandemic mitigation measures, stabilize health services, and prepare for subsequent waves and future disease outbreaks. Across all four countries, MoH officials described national strategies that combined mass messaging about injection prevention and control with continued access to health services, including family planning. The study found that all four countries leveraged experience and infrastructure from their responses to Ebola, bird flu, and other outbreaks to respond quickly to the COVID-19 pandemic with campaigns to dispel misinformation, national and regional coordination of multisectoral collaboration, and local research into treatment and production of prevention and care materials.

Communication

Campaigns and messaging were delivered via mass media (including national and community radio programs and broadcasting spots in multiple languages), national and private television stations, online press, social networks, billboards, mobile operators, posters and leaflets at health facilities, and door-to-door awareness raising. These multi-level, multi-channel efforts helped overcome prominent barriers to health messaging, including social and cultural norms, religious beliefs, disbelief in COVID-19 and related failure to comply with prevention measures, as well as rumors about the unavailability of services and service providers.

Infection Prevention and Control

All four countries noted an initial shortage of personal protective equipment for health care providers and focused management of COVID-19 within the health system on reinforcement of five main infection prevention and control measures:

- Compulsory masking
- Systematic handwashing at key entry points
- Use of alcohol-based hand sanitizer
- Taking temperature of all who enter premises
- Physical distancing

Service Continuity

Family planning services were deemed essential in all four countries, allowing them to remain available during the initial lockdowns, with the following modifications:

- Temporary suspension of group health discussions, and, once reinstated, a combined focus on family planning and COVID-19
- Temporary suspension of family planning special days
- Reduction in service hours in Niger and Togo
- Temporary suspension of CHW home visits in Burkina Faso
- Relocation of services and redeployment of staff as needed
- Shifts in provider workload (some grew heavier with fewer staff, while others grew lighter with fewer clients seeking services)
- Reorganization of waiting rooms and consultation rooms for physical distancing, and isolation rooms for suspected cases
- Attempts at social distancing during service delivery, though challenging during clinical procedures
- Virtual appointment reminders and limited virtual service provision (e.g., in Togo, providers were trained on virtual DMPA-SC administration)

Demand

Stakeholders in all four countries observed a decrease in client attendance and follow-up and demand for family planning services at the onset of pandemic, though quantitative analysis found that the actual overall decrease in service provision was not statistically significant. The anecdotal decreases may have been linked to a notable decrease in demand-generation activities at the onset of the pandemic, as group dialogues were suspended and family planning messaging was overshadowed by COVID-19 messaging. In all countries, family planning providers discussed COVID-19 with clients and reinforced infection prevention and control measures during service delivery.

Method Choice

In Côte d'Ivoire and Togo, stakeholders observed an emerging preference for DMPA-SC self-injection and long-acting methods among clients. While quantitative analysis showed a significant decrease in couple-years protection across the countries during the initial period of pandemic, this did not significantly impact overall couple-years protection for 2020. There was no statistically significant impact of the COVID-19 on utilization of FP services and the pattern of utilization of immediate PPFP mirrored that of general FP use.

Recommendations

The study yielded several lessons for health systems to consider for future outbreaks:

- **Engaging adolescents and youth** in prevention efforts and mobilizing them to use essential sexual and reproductive health services, including family planning, during outbreaks, is critical to slowing the spread of disease and maintaining overall health and wellbeing
- **Use of long-acting contraceptive methods and self-care** options such as self-injection of subcutaneous DMPA is an effective way to reduce both client contact with health centers and contraceptive discontinuation during outbreaks or other emergencies

- **Health workers can serve as role models to promote infection-prevention measures** such as handwashing, disinfection of surfaces, and mask-wearing during and beyond outbreaks
- **Emergency preparedness –** including training, supplies and equipment, contingency planning, and resource allocation – is critical to health-system response and resilience
- **Community engagement** strategies, including community relays, mentors, mobile clinics, and community-based distribution of contraceptives, are highly effective in ensuring continuity of sexual and reproductive health and family planning services
- **Use of communication technologies** to offer remote health services and monitor activities is another high-impact strategy to maintaining health services during an outbreak

Conclusions

This study confirmed that the governments of the four countries took quick action to mitigate the effects of the unprecedented COVID-19 pandemic, thereby keeping the levels of disruptions to delivery and use of essential health services below those anticipated. While the countries did see a decrease in the number of family planning clients visiting facilities during COVID-19-related lockdowns in the first two months of the pandemic, health-system stakeholders diligently advocated for continuity of family planning service, which steered swift action by ministries of health, including timely public messaging and resource deployment to generate demand for essential health services. Moreover, analyses of indicators of interest by calendar year (2018, 2019, and 2020) suggests patterns did not change drastically as a result of the COVID-19 pandemic and in some cases saw increases in 2020, when compared to the two years prior. By mid-2020, the countries saw notable increases in the number of family planning clients served. Continuity of services was made possible because governments deemed family planning services essential, reorganized personnel where necessary, implemented COVID-19 prevention and treatment protocols nationwide, and collaborated with development partners. This study shows that maintaining continuity and use of family planning services during a pandemic is feasible when Ministries of Health act in collaboration with their partners to deliver an efficient, timely, and unified response that is accompanied by widespread, multi-channel supportive messaging.

Résumé exécutif

Contexte

La plupart des pays d'Afrique de l'Ouest ont signalé leurs premiers cas de COVID-19 au cours des deux premières semaines de mars 2020. Alors que les gouvernements de la région ont rapidement réagi à la pandémie, le projet AmplifyPF, financé par l'Agence américaine pour le développement international, a saisi l'opportunité d'évaluer l'influence du COVID-19 sur la prestation et l'utilisation des services de planification familiale dans 17 districts d'intervention à travers les zones urbaines et périurbaines des quatre pays du projet : Burkina Faso, Côte d'Ivoire, Niger et Togo. L'évaluation de l'influence des crises sur les services de santé est souvent rétrospective. Par contre, la présente étude a été menée en temps réel afin de générer des résultats pour une utilisation prospective et pratique dans le maintien de l'offre de services de planification familiale durant les crises sanitaires.

Méthodologie

Cette étude combine des méthodes qualitatives et quantitatives, ce qui permet d'obtenir des données plus complètes pour comprendre le phénomène en question. La collecte de données qualitatives dans les quatre pays a eu lieu en juillet et août 2020. Pour documenter les mesures d'adaptation prises pour assurer la continuité des services de planification familiale et la fonctionnalité du Réseau Intégré d'Apprentissage du projet, les équipes pays d'AmplifyPF ont mené des entretiens avec des informateurs clés dans les pays respectifs. Les entretiens ont été menés par téléphone à l'aide de guides d'entretien semi-structurés développés et administrés en français et adaptés à chaque type de partie prenante au niveau national, régional et district :

- Représentants du ministère de la santé
- Prestataires de services de planification familiale au niveau des établissements de santé
- Représentants d'organisations communautaires et de municipalités
- Membres des équipes pays d'AmplifyPF

L'équipe d'AmplifyPF a également procédé à une étude documentaire des protocoles, directives et documents pertinents du Ministère de la Santé concernant l'impact de COVID-19 sur les services de planification familiale dans la région. Enfin, l'Adaptation Officer de chaque équipe pays AmplifyPF a animé un groupe de discussion virtuel avec son équipe. Deux membres du bureau régionale d'AmplifyPF ont examiné de manière indépendante les notes d'entretien, résumant et extrayant les déclarations significatives en utilisant l'analyse textuelle et thématique. Les déclarations pertinentes ont été traduites en anglais pour ce rapport.

L'approche quantitative a consisté en une analyse secondaire des statistiques des services de planification familiale des établissements de santé du Réseau saisies mensuellement dans le DHIS-2 de chacun des quatre pays. Les données s'étendent de juillet 2018 à décembre 2020, et l'analyse porte sur trois thèmes :

- L'utilisation des services de planification familiale.

- Accouchement dans les établissements de santé et initiation d'une méthode contraceptive moderne dans la période du post-partum immédiat.
- Utilisation des soins après-avortement et initiation d'une méthode contraceptive moderne avant la sortie de l'hôpital.

Cela a permis au bureau régional AmplifyPF d'examiner les tendances des 20 mois précédant la pandémie de COVID-19 (juillet 2018 à février 2020) et des dix premiers mois de la pandémie de COVID-19 (mars 2020 à décembre 2020). L'analyse a consisté à tracer les statistiques des services de planification familiale pour comparer les tendances et à interpréter les modèles de réponses variées des gouvernements nationaux à la prévalence de la maladie COVID-19. Des analyses supplémentaires des années civiles 2018, 2019 et 2020 ont également été réalisées pour vérifier les effets éventuels de la saisonnalité.

Résultats

Les résultats de cette étude enrichissent la littérature sur l'impact des crises sanitaires majeures sur l'offre des services de planification familiale et aideront les décideurs à ajuster les mesures d'atténuation de la pandémie en cours, à stabiliser les services de santé et à se préparer aux vagues suivantes et aux futures épidémies. Dans les quatre pays, les représentants des ministères de la santé ont décrit des stratégies nationales qui combinent des messages de masse sur la prévention et le contrôle des injections avec un accès continu aux services de santé, notamment à la planification familiale. L'étude a révélé que les quatre pays ont tiré parti de l'expérience et de l'infrastructure acquises lors de leurs réponses à Ebola, à la grippe aviaire et à d'autres épidémies pour réagir rapidement à la pandémie de COVID-19 en menant des campagnes de désinformation, en assurant la coordination nationale et régionale de la collaboration multisectorielle et en menant des recherches locales sur le traitement et la production de matériel de prévention et de soins.

Communication

Les campagnes et les messages ont été diffusés par les médias de masse (y compris les programmes de radio nationaux et communautaires et les spots de diffusion en plusieurs langues), les chaînes de télévision nationales et privées, la presse en ligne, les réseaux sociaux, les panneaux d'affichage, les opérateurs de téléphonie mobile, les affiches et les dépliants dans les établissements de santé et la sensibilisation en porte-à-porte. Ces efforts multi-niveaux et multi-canaux ont permis de surmonter des obstacles importants aux messages de santé, notamment les normes sociales et culturelles, les croyances religieuses, l'incrédulité à l'égard du COVID-19 et le non-respect des mesures de prévention qui en découle, ainsi que les rumeurs sur l'indisponibilité des services et des prestataires.

Prévention et contrôle des infections

Les quatre pays ont constaté une pénurie initiale d'équipements de protection individuelle pour les prestataires de soins de santé et ont axé la gestion du COVID-19 au sein du système de santé sur le renforcement de cinq mesures principales de prévention et de contrôle des infections :

- Le masquage obligatoire
- Lavage systématique des mains aux principaux points d'entrée

- Utilisation du gel hydroalcoolique pour les mains
- Prise de température de toutes les personnes qui entrent dans les locaux
- Distanciation physique

Continuité des services

Les services de planification familiale ont été jugés essentiels dans les quatre pays, ce qui leur a permis de rester disponibles pendant les premières fermetures, avec les modifications suivantes :

- Suspension temporaire des discussions de groupe sur la santé et, une fois rétablies, accent mis sur la planification familiale et le COVID-19.
- Suspension temporaire des journées spéciales de planification familiale
- Réduction des heures de service au Niger et au Togo
- Suspension temporaire des visites à domicile des ASC au Burkina Faso.
- Déplacement des services et redéploiement du personnel selon les besoins.
- Modification de la charge de travail des prestataires (certains ont vu leur charge augmenter avec moins de personnel, tandis que d'autres ont vu leur charge diminuer avec moins de clients).
- Réorganisation des salles d'attente et des salles de consultation pour la distanciation physique, et des salles d'isolement pour les cas suspects.
- Tentatives de distanciation sociale pendant la prestation de services, bien que difficiles pendant les procédures cliniques.
- Rappels de rendez-vous virtuels et prestation de services virtuels limités (par exemple, au Togo, les prestataires ont été formés à l'administration virtuelle du DMPA-SC).

Demande

Les parties prenantes des quatre pays ont observé une diminution de la fréquentation et du suivi des clients ainsi que de la demande de services de planification familiale au début de la pandémie, bien que l'analyse quantitative ait révélé que la diminution globale réelle de l'offre de services n'était pas statistiquement significative. Les baisses anecdotiques peuvent être liées à une diminution notable des activités de génération de la demande au début de la pandémie, car les dialogues de groupe ont été suspendus et les messages sur la planification familiale ont été éclipsés par les messages sur le COVID-19. Dans tous les pays, les prestataires de services de planification familiale ont discuté du COVID-19 avec leurs clients et ont renforcé les mesures de prévention et de contrôle de l'infection pendant la prestation de services.

Choix de la méthode

En Côte d'Ivoire et au Togo, les parties prenantes ont observé une préférence émergente des clients pour l'auto-injection du DMPA-SC et les méthodes à longue durée. Bien que l'analyse quantitative ait montré une diminution significative de la protection des années-couple dans les pays pendant la période initiale de la pandémie, cela n'a pas eu d'impact significatif sur la protection globale des années-couple pour 2020. Le COVID-19 n'a pas eu d'impact statistiquement significatif sur

l'utilisation des services de PF et le schéma d'utilisation de la PPFP immédiate a reflété celui de l'utilisation générale de la PF.

Recommandations

L'étude a permis de dégager plusieurs leçons que les systèmes de santé devront prendre en compte lors de futures épidémies :

- Il est essentiel de **faire participer les adolescents et les jeunes** aux efforts de prévention et de les mobiliser pour qu'ils utilisent les services essentiels de santé sexuelle et reproductive, y compris la planification familiale, pendant les épidémies, afin de ralentir la propagation de la maladie et de préserver la santé et le bien-être général.
- **L'utilisation de méthodes contraceptives à longue durée d'action et d'options d'autosoins** telles que l'auto-injection de DMPA sous-cutané est un moyen efficace de réduire à la fois le contact des clients avec les centres de santé et l'interruption de la contraception pendant les épidémies ou autres urgences
- **Les agents de santé peuvent servir de modèles pour promouvoir les mesures de prévention des infections** telles que le lavage des mains, la désinfection des surfaces et le port du masque pendant et après les épidémies.
- **La préparation aux situations d'urgence** – y compris la formation, les fournitures et l'équipement, les plans d'urgence et l'affectation des ressources – est essentielle à la réponse et à la résilience du système de santé.
- Les **stratégies d'engagement communautaire**, notamment les relais communautaires, les mentors, les cliniques mobiles et la distribution communautaire de contraceptifs, sont très efficaces pour assurer la continuité des services de santé sexuelle et reproductive et de planification familiale.
- **L'utilisation des technologies de communication** pour offrir des services de santé à distance et surveiller les activités est une autre stratégie à haut impact pour maintenir les services de santé pendant une épidémie.

Conclusions

Cette étude a confirmé que les gouvernements des quatre pays ont pris des mesures rapides pour atténuer les effets de la pandémie sans précédent de COVID-19, en maintenant ainsi les niveaux de perturbation de l'offre et de l'utilisation des services de santé essentiels en deçà de ceux prévus. Bien que les pays aient constaté une diminution du nombre de clients de planification familiale se rendant dans les établissements pendant les périodes de fermeture liées au COVID-19 au cours des deux premiers mois de la pandémie, les parties prenantes du système de santé ont plaidé avec diligence en faveur de la continuité des services de planification familiale. Par ailleurs, les analyses des indicateurs d'intérêt par année civile (2018, 2019 et 2020) suggèrent que les tendances n'ont pas changé radicalement à la suite de la pandémie de COVID-19 et que, dans certains cas, elles ont augmenté en 2020, par rapport aux deux années précédentes. À la mi-2020, les pays ont enregistré des augmentations notables du nombre de clients des services de planification familiale. La continuité des services a été rendue possible parce que les gouvernements ont jugé les services de planification familiale essentiels, ont réorganisé le personnel lorsque cela était nécessaire, ont mis en œuvre les

protocoles de prévention et de traitement du COVID-19 à l'échelle nationale et ont collaboré avec les partenaires du développement. Cette étude montre que le maintien de la continuité et de l'utilisation des services de planification familiale pendant une pandémie est possible lorsque les ministères de la santé agissent en collaboration avec leurs partenaires pour fournir une réponse efficace, opportune et unifiée, accompagnée d'un message de soutien étendu et multicanal.

Background

By March 27th, 2020, the coronavirus disease 2019 (COVID-19) pandemic had spread to all continents and affected 177 countries (Dong et al., 2020). This unprecedented outbreak necessitated exceptional governmental responses as it presented the risk of disruption in routine activities, including the provision and use of essential health and nutrition services; this risk could potentially lead to increases in maternal, newborn and child morbidity and mortality rates that are preventable (WHO, 2020; UNFPA, 2020a).

In West Africa, the majority of countries reported their first COVID-19 cases within the first two weeks of March 2020. As governments in the region swiftly responded to the pandemic, USAID and the AmplifyPF[1] project saw the unique opportunity to assess the influence of COVID-19 on family planning (FP) service delivery during the pandemic in 17 intervention districts[2] across urban and peri-urban areas of the four project countries: Burkina Faso, Côte d'Ivoire, Niger, and Togo (Map 1).

Since 2018, the AmplifyPF project has implemented an innovative and catalytic FP service delivery model that synergizes all available health resources within a district level to form an Integrated Learning Network (ILN). Unlike previous studies assessing the influence of health crises that have been mostly retrospective, the AmplifyPF project interviewed ILN stakeholders in real time during the pandemic to document implementation and adaptation measures undertaken in response to the first wave of the outbreak (defined in this study as March 2020 to December 2020) and to ensure continuity of FP services and functionality of the ILN. It also conducted secondary analysis of service statistics from the ILNs' health facilities covering a period before (July 2018 to February 2020) and after the COVID-19 outbreak (March 2020 to December 2020).

This report presents findings from the qualitative interviews conducted in July and August 2020 with ILN stakeholders – Ministry of Health (MoH) officials at the national, regional and district levels; FP service providers at the facility level; representatives of community organizations and municipalities; and AmplifyPF country team members. The report presents its findings as themes and sub-themes that emerged from the multiple perspectives of these ILN stakeholders. The report also presents findings from the quantitative analysis of FP service statistics from AmplifyPF's intervention districts in each target country, as extracted from DHIS-2.

The findings contribute to the larger literature on the impact of major health crises or outbreaks on FP service delivery and inform decision-makers on how to adjust their ongoing mitigation measures and

[1]Amplify Family Planning and Reproductive Health project (AmplifyPF), a USAID-funded project led by Pathfinder International, has the goal of mobilizing partners to expand access to and utilization of quality FP services in the four selected West African countries (Burkina Faso, Côte d'Ivoire, Niger, and Togo) through an innovative and catalytic family planning service delivery approach consisting of synergizing all health resources available at the district level to form an Integrated Learning Network (ILN).

[2] At the time this study was conducted, AmplifyPF intervened in 17 health districts across the four project countries. Two additional ILNs were set up in Togo as of end of 2021 thus their data is excluded from this study.

prepare for subsequent waves or future outbreaks. These findings are also expected to guide reproductive health (RH)/FP projects and donors in their programmatic decisions through subsequent waves of the pandemic and into the stabilization phase.

Map 1. Map of the 17 districts selected to become Integrated Learning Networks (ILN) and AmplifyPF intervention sites

Objectives of the Assessment

The overall objective was to assess the influence of COVID-19 on continuity and utilization of FP services in the 17 health districts that operate as ILNs. There were four specific objectives:

1. To assess the trends in FP service delivery in public and private health facilities in the ILNs, before and during the COVID-19 pandemic
2. To document how decision-makers and health providers are adapting FP service delivery in the ILNs during the COVID-19 pandemic, as compared to before the pandemic
3. To document how RH/FP community organizations, municipalities, and the AmplifyPF project are adapting FP health messaging, FP resource mobilization, and FP activity implementation, respectively, in the ILNs during the COVID-19 pandemic
4. To assess the trends in FP service utilization in public and private health facilities in the ILNs, before and during the COVID-19 pandemic

Specific to FP service provision, the assessment aimed to understand implementation and adaptation experiences regarding:

a. FP services offered during the pandemic
b. FP service delivery modalities during the pandemic
c. Infection and prevention control measures and how they affected FP service delivery and client access
d. Availability of facility- and community-based health providers to offer FP services during the pandemic
e. Health campaigns and messaging and how they affected FP service utilization

Regarding the utilization of FP services, the specific objectives are:

a. Analyze the trends before and during the pandemic regarding:
    - The number of clients served, and new clients recruited by the health facilities
    - The method mix, to see if there is shift from short-acting to long-acting methods to avoid frequent contact with the facility
    - The number of women who delivered at the facility and the number discharged with an FP method (immediate post-partum family planning uptake)
    - The number of women who received post-abortion care (PAC) services and the number who received an FP method before leaving the facility (PACFP)
b. Investigate how the national response can be associated with the above-listed trends

Methodology

The study protocol and data collection tools were reviewed and approved by the Ethical Review Officer at Pathfinder International. The ERO determined that the proposed data collection did not constitute human subjects research and did not require IRB approval to proceed.

The study combined qualitative and quantitative approaches, as described in detail below.

The Qualitative Approach

Training of interviewers. AmplifyPF country team members served as interviewers for this study. Led by AmplifyPF's Research and Program Advisor (RPA), the regional team trained the team members on research ethics and data collection. The training involved a 3-hour session on key aspects of research ethics and data collection, including: informed and voluntary consent process, confidentiality of the information collected, field data storage, and maintenance of respondent privacy and comfort during the interview. Following a question-and-answer period, country team members engaged in role plays to practice interviewing the different stakeholder groups using the appropriate instrument. The RPA shared the approved version of the protocol and tools with the country teams, who in turn sent the tools to the identified stakeholders prior to the interview.

All key informants interviewed received an informed consent form ahead of the interview and provided verbal consent at the start of the call. Besides the name of the district, no personally identifiable information has been used in the report.

Data Collection.

Key Informant Interviews. In all four countries, AmplifyPF conducted key informant interviews (KIIs) using semi-structured interview guides tailored to each category of ILN stakeholder. The interview guides were developed and administered in French. AmplifyPF leveraged existing relationships with ILN stakeholders and identified 43 potential respondents using purposeful sampling, including MoH program heads and advisors at the national, regional and district levels, FP providers at the facility level, municipality staff, and community organization representatives. The criteria used to guide respondent selection included knowledge and proficiency in family planning delivery, information and level of involvement in ensuring the continuity of FP services during the outbreak. Respondents were informed about potential follow-up interviews within 6 months, so that any changes or further adaptations could be ascertained. However, no further interviews were needed within the 6 months after the first round of interviews

Focus Group Discussions. The Adaptation Officer or appointed staff member of each AmplifyPF country team facilitated a virtual focus group discussion (FGD) with their team members, while also contributing to the conversation. Up to two AmplifyPF regional team members joined each call to learn about the country team's real-time experiences with activity implementation in the unprecedented circumstances, but they did not contribute to the discussion. A total of 4 FGDs, one per country, were expected. With the exception of Togo, which had 3 members, the remaining three country teams included five members, thus adding up to 18 team members in all.

Both KIIs and FGDs were conducted between the end of July 2020 and the third week of August 2020. All interviews and group discussions were conducted in French.

Tools. The KII and FGD interview guides were pre-tested in Togo and modified after feedback from stakeholders. The country team members conducted interviews by phone and administered the semi-structured interview guides to ILN stakeholders. Interviews were not recorded, but the interviewer received permission to take written notes, which were later synthesized and shared with the AmplifyPF regional team for analysis and writing.

Desk review. The AmplifyPF regional team conducted a desk review of relevant MoH documents, such as service delivery protocols, COVID-19 directives, and situation reports. Studies addressing the impact of COVID-19 on RH/FP in the sub-region were also reviewed to provide contextual information.

Data Review and Analysis. Two members of the AmplifyPF regional team independently reviewed the interview notes, which they summarized and extracted meaningful statements using textual analysis. Issues or unclear notes were resolved by reaching out to the AmplifyPF country team member who had conducted the interview. A thematic analysis was done to identify themes and sub-themes. For the purposes of this report, relevant statements or quotations were translated into English.

This assessment study relied on the USAID Collaboration, Learning, and Adaptation (CLA) approach by building on existing data and information and on study findings to learn how ILNs adapted to remain functioning while in the face of a health crisis. Specifically, this report will be shared with all resource persons/stakeholders who had contributed to the study for follow-up discussion, interpretation of findings, identification of lessons learned, and scrutiny of adaptative practices that might need revising.

The Quantitative Approach

The methodology consisted of secondary analysis of FP service statistics produced by the health facilities in the catchment areas and captured monthly in the national DHIS-2 of the four countries.

Thematic Areas. The analysis covered three main themes:

a. Utilization of FP services
b. Delivery at health facility and initiated use of a modern contraceptive method during the immediate post-partum period (within 48 hours after childbirth)
c. Utilization of post-abortion care services and initiated use of a modern contraceptive method prior to discharge.

Time Period. The analysis covered a time period of 30 months, split into two periods as follows:

a. The 20 months preceding the COVID-19 pandemic outbreak in March 2020 (July 2018 – February 2020)
b. The 10 months from the onset of the COVID-19 outbreak (March 2020 – December 2020).

Study Sites/Sample. All 202 health facilities providing FP services and supported by AmplifyPF in the 17 ILNs were eligible to be included in the analysis. However, to avoid inconsistencies in data availability, we selected only those 122 facilities that had all 30 monthly reports entered in DHIS-2 for the study period of July 2018 to December 2020.

Matameye district in Niger was excluded from the analysis since it had been dropped from the AmplifyFP portfolio in mid-2020. The replacement district of Zinder Ville in Niger was included in the analysis. Additionally, all facilities represented in the four ILNs in Burkina Faso were excluded due to missing data in DHIS-2 for the months of June through October 2019, which had been occasioned by a health workers' strike.

Data. All data used in the quantitative analyses are health service statistics extracted from DHIS-2, the database used by MoH facilities for monthly reporting to the district and higher levels. The data extracted are as follows:

a. *Number of new FP clients* recruited at the facility. The MoHs define the new FP user as a client seeking a modern FP method and who never used one before. These data are disaggregated by method in Togo and Côte d'Ivoire, and by service delivery modality in Togo: routine, FP Special Days (FPSD), mobile services, and community-based distribution (CBD).
b. *Number of continuing FP users* served at the facility. A continuing FP user is a client who visits the facility for resupply, to change their method, or to resume FP utilization after an interruption. These data are disaggregated by method in Togo and Côte d'Ivoire, and by service delivery modality in Togo. Niger does not report the number of continuing users in DHIS-2.
c. *Quantities of contraceptives distributed to the clients* at the facility.
d. *Number of women who delivered at the facility*. This includes a few cases where the delivery occurred while the woman was on her way to the facility or at home but immediately transferred to the facility for proper management. A more accurate way to name these data would therefore be "Number of women whose deliveries are managed by the facility".
e. *Number of women discharged from the facility with an FP method after delivery*. FP utilization after delivery and before discharge is called immediate post-partum family planning (PPFP) uptake. Women are typically discharged 48 hours after giving birth except in cases of complications that necessitate a longer period of hospitalization.
f. *Number of women who received post-abortion care* (PAC Clients) at the facility.
g. *Number of PAC clients who received an FP method before leaving the facility*, also called post-abortion care family planning (PACFP) uptake.

Methods of Analysis:

The quantitative analysis is purely descriptive and consists of:

a. Computing simple indicators:
   - *Couple-Years of Protection (CYPs) per month*
   - *Number of clients who received an FP method per month (new + continuing users), also referred to in this report as "number of FP clients served"*
   - *Method mix among new clients*
   - *PPFP Uptake (Percentage of women discharged with an FP method after delivery)*
   - *PACFP Uptake (Percentage of PAC clients who received an FP method before leaving the facility)*

b. Plotting the trends in FP utilization using the above-mentioned data and indicators[3]
c. Paralleling the trends in the data and indicators with the national response

Note regarding the Number of FP clients served (New + Continuing). Since in Niger the number of continuing users is not reported in DHIS-2 platform, we estimate the number of clients served during the month at the facilities from the quantities of contraceptives distributed. For IUDs, injectables, implants, and the calendar-based method, we counted one client for each product distributed. For oral contraceptives, although the MoH rule is to offer 3 cycles of pills per client per visit, we could not estimate the number of clients by dividing the quantities by three. In fact, anecdotal reports suggest that during the COVID-19 pandemic some providers gave more than 3 cycles per client to limit the number of resupply visits to the facility to reduce the risk of transmission of the virus. Therefore, we analyzed the trends only in the number of clients who received methods other than pills, bearing in mind that this may not reflect the pattern if all clients served were included.

Limitations of the Study

Despite the richness provided by the present mixed methods study, its inherent nature also has some limitations. Although AmplifyPF intervenes in 17 districts[4], interviews were not conducted with ILN stakeholders from each of these districts. While representativeness is not the aim of qualitative research, gaining the perspectives of other stakeholders in the remaining ILNs could have provided even more enriching contextual information on adaptations undertaken in those ILNs. In addition, two-fifths of the facilities (80 out of 202, or 39.6%) needed to be dropped from our quantitative analysis due to incomplete data, reducing the intended sample.

COVID-19 Situation in the Four Target Countries

The COVID-19 pandemic has affected countries in Francophone West Africa to varying degrees. In each country, the first COVID-19 case was recorded during the month of March 2020 as follows: March 6 in Togo, March 9 in Burkina Faso, March 11 in Côte d'Ivoire, and March 19 in Niger. Table 1 sets the scene with COVID-19 statistics for the four AmplifyPF project countries and ILNs as of July 31, 2020, the month interviews began.

The respective Ministries of Health, alongside partners such as UNICEF and the World Health Organization, provided regular updates on the status of COVID-19 in their country along with the government's response for stopping the spread. In all four countries, regions around the capital city have seen the greatest amount of confirmed COVID-19 cases:

[3] Supplementary analysis of indicators of interest by calendar year (2018, 2019, 2020) were also conducted to ascertain any effect of seasonality. These analyses are presented in graphs in Appendix 1 through Appendix 14.

- In Burkina Faso, 84% of the total confirmed cases were located in the Central region, while the remaining 16% were detected in 8 of the 12 other regions of the country[5]
- In Niger, 74% of the total cases were found in and around Niamey, followed by 11% of cases in the Zinder Region, and 15% across the other 6 regions[6]
- In Togo, Grand Lomé has accounted for 56% of total confirmed cases, Central Region followed next at 17% and Kara Region at 11%[7]
- In Côte d'Ivoire, geographic mapping of detected cases was not undertaken during this period

Table 1. Selected COVID-19 Statistics from the Four Countries, as of July 31, 2020

Country	Date first COVID-19 case was diagnosed	Total confirmed* cases	Total deaths	Community transmission
Burkina Faso	March 9, 2020	1,117	53	0
Côte d'Ivoire	March 11, 2020	15,978	100	0
Niger	March 19, 2020	1,134	69	1
Togo	March 6, 2020	908	18	0
Total	**--**	**19,137**	**240**	**1**

Source: WHO, Coronavirus disease (COVID-19) Situation Report – 193, data as received by WHO from national authorities by 10:00 CEST, 31 July 2020.

Findings

Description of the Qualitative Sample

AmplifyPF collected qualitative data from a total of 25 individual resource persons across the four target countries on their implementation and adaptation experiences: 9 MOH officials, 7 FP providers, 5 municipality representatives, and 4 community organization representatives. Members of the four AmplifyPF country teams were also interviewed. Table 2 presents the number of persons interviewed in the study, while Table 3 to Table 6 provide a general description of the key informants interviewed. Table 7 describes the AmplifyPF country team members who participated in the focus group discussions.

[5] Burkina Ministry of Health, 2020
[6] Niger Ministry of Public Health, 2020
[7] Togo Ministry of Public Health and Hygiene, 2020

Table 2. Number of ILN Stakeholders Interviewed within Each AmplifyPF Country

Country	Number of MOH Officials Interviewed	Number of FP Providers Interviewed	Number of Municipality Representatives Interviewed	Number of Community Representatives Interviewed	Number of AmplifyPF country team members that participated in FGDs
Burkina Faso	2	1	3	2	5
Côte d'Ivoire	3	2	2	0	5
Niger	2	2	0	1	5
Togo	2	2	0	1	3
Total	**9**	**7**	**5**	**4**	**18**

Table 1. Description of MOH Officials Interviewed

Country	Number of MOH Officials Interviewed	Role of MOH Officials	Number of Years in Role (Range)	Level of Operation	Departments/ Divisions Represented	Countries and Districts Represented
Burkina Faso	2	- Head of Department - Coordinator - Director (x2) - Division Chief - District Communications Officer - Head of Program - Head of Maternity - Technical Advisor	1 to 7 years	- National: 6 - District: 3	- Maternal and Child Health - Family Health - Family Planning - Demographic Transition Acceleration	- Boulmiougou - Do
Côte d'Ivoire	3					- Bouaké Nord-Ouest
Niger	2					- Niamey 1
Togo	2					- Agoè-Nyivé

Table 2. Description of Providers Interviewed and Affiliated Health Facilities, by Country

Country	Districts Covered	Type of Health Facilities	Number of FP Providers in Health Facility	Number of FP Providers	Number of Years of Experience	Current Role at Health Facility
Burkina Faso	Do	Health and Social Promotion Center	17	1	5	Head Nurse
Côte d'Ivoire	Bouaké Nord-Ouest	Urban Health Facility	13	1	4	Midwife
	Abobo Ouest	Community-based Urban Health Center	7	1	5	Head Maternity Nurse
Niger	Niamey 1	Integrated Health Center Type 2	2	1	14	FP Focal Person
		Integrated Health Center Type 2	1	1	1	FP Unit Head

Togo	D3 de Lomé	Social-Medical Center	2	1	10	Auxiliary midwife
		Social-Medical Center Type 2	4	1	5	FP Provider

Table 3. Description of Municipality and Representatives Interviewed, by Country

Country	Districts Covered	Level of Operation	Number of Municipality Representatives	Number of Months Mobilizing	Current role
Burkina Faso	Boulmiougou	Municipality	3	4	- Secretary General - Head of Department - Deputy Director - Councilor
Côte d'Ivoire	Daloa	Municipality	1	5	
	Port-Bouët-Vridi	Municipality	1	6	
Niger	No interviews conducted	- No interviews conducted	No interviews conducted	No interviews conducted	
Togo	No interviews conducted	- No interviews conducted	No interviews conducted	No interviews conducted	

Table 4. Description of Community Organizations and Representatives Interviewed, by Country

Country	Districts Covered	Number of Community Representatives Interviewed	Length of time Community Organization has been operational	Title or Role in Community Organization	Target Group(s)
Burkina Faso	Boulmiougou	1	20	Chairman of the Board of Directors	- Youth/adolescents - Children under 5 years - Pregnant women - Nursing mothers - Elderly - PLWHIV
	Boromo	1	19	Chairman	
Côte d'Ivoire	No interviews conducted	No interviews conducted	No interviews conducted	No interviews conducted	No interviews conducted
Niger	Niamey 1	1	3	Chairman of the Management committee	- Religious leaders - Traditional leaders - Heads of households
Togo	D3 de Lomé	1	27	Operations and Management Support	- Community

Table 5. Participation of AmplifyPF Country Team Members in respective Focus Group Discussions

Country	Country Program Manager	Adaptation Officer	High Impact Practice Officer	Scale-up Officer	Monitoring, Evaluation and Learning Officer
Burkina Faso	Yes	Yes	Yes	Yes	Yes

Côte d'Ivoire	Yes	Yes	Yes	Yes	Yes
Niger	Yes	Yes	Yes	Yes	Yes
Togo	Yes	Position did not exist at the time the study was conducted	Yes	Yes	Position did not exist at the time the study was conducted

Description of the Quantitative Sample

Only facilities which had all their monthly reports over the 30-month period (July 2018 to December 2020) in DHIS-2 were included in the analysis to allow for comparability of health service uptake trends. Based on this criterion, all facilities supported by AmplifyPF in Burkina Faso were excluded due to lack of complete information following a strike of the health workers between June 2019 and October 2019. In the remaining three countries (Côte d'Ivoire, Niger, and Togo), the majority of the supported facilities in the three countries were included in the analysis as shown in Table 8 below: 56% in Côte d'Ivoire, 55% in Niger and 79% in Togo. By district, the reporting rates varied from 31% in Zinder ville in Niger to 100% in the Ave district of Togo.

Table 6. Number of Facilities Included in the Analysis. by Country and District

Country/ District	Number of Facilities Supported by AmplifyPF	Number of Facilities Included in the Analysis	Percentage of Facilities Included in the Analysis
Côte d'Ivoire			
Yopougon Ouest-Songon	14	8	57%
Abobo Ouest	12	5	42%
Port-Bouët-Vridi	13	8	62%
Daloa	38	25	66%
Bouaké Nord-Ouest	12	4	33%
Total	**89**	**50**	56%
Niger			
DS Niamey 1	15	12	80%
DS Niamey 3	9	3	33%
DS Niamey 5	11	7	64%
DS Mirriah	20	12	60%
Zinder-Ville	16	5	31%
Total	**71**	**39**	**55%**
Togo			
D3 Lomé Commune	12	6	50%
Agoe-Nyive	12	9	75%
Ave	18	18	100%
Total	**42**	**33**	**79%**
Total for the 3 countries	**202**	**122**	**60%**

Using the qualitative and quantitative data, we explored eight main themes and present our findings in the sections that follow, namely: (1) Leveraging past experiences; (2) Managing COVID-19 within the health system; (3) Continued access to FP services in a new normal; (4) Client attendance of FP services; (5) Recruitment of new FP clients; (6) Method mix; (7) The Couple-Years of Protection (CYPs); (8) Client attendance of labor and delivery services; (9) Client attendance of PAC services; (10) Reshuffles and reductions; (11) Collaboration and communication for continuity; (12) Perceived effect of health messaging of FP service utilization; (13) Projected impact of COVID-19; and (14) Emerging aspects and lessons learned.

LEVERAGING PAST EXPERIENCES: *Findings from the Qualitative Analysis*

In all four countries, governments swiftly developed and implemented a COVID-19 response plan, which included the closing of land and air borders, schools, and places of worship within the first month of the outbreak. In Togo, a three-month state of emergency was instituted with a curfew in cities considered at high risk of COVID-19, while inter-city movement was limited. Furthermore, the Togolese government implemented measures in favor of vulnerable populations by absorbing the cost of electricity and water for each admissible household.

MoH representatives at the national level were asked whether the government's COVID-19 response was shaped by previous epidemics. Representatives unanimously agreed that they leveraged previous strategies and lessons learned in their response to COVID-19. Officials in Côte d'Ivoire affirmed that the MoH relied on the country's experience with managing the Ebola epidemic, beginning with an awareness-raising strategy of dispelling rumors about COVID-19 to the larger population. An MoH official qualified it is an 'intense' strategy that involved all public sectors and stakeholders. In the Bouaké Nord-Ouest district, a team that had been trained in emergency management of crises during the Ebola epidemic was called upon for the management of the COVID-19 pandemic.

In Togo, a national coordination unit was established to manage the pandemic with sub-units at the regional level and response teams in each district. In the prefecture of Avé, a committee for the fight against epidemics was reactivated and relied upon for their experiences with managing the response to diseases such as meningitis and hemorrhagic fevers (e.g., Ebola, Lassa). These response teams are responsible for ensuring the surveillance of suspected cases, taking samples from suspected cases and transporting them to the National Institute of Hygiene, where the COVID19 tests are carried out.

An ad hoc committee in Togo was also set up at the national university to bring together scientists and traditional herbalists to reflect on possible drugs as well as the production of local prevention and care materials, including alcohol-based sanitizing gel, masks, respirators, and drugs under trial. Furthermore, Togo established a unique system to reflect methodically on the pandemic and take informed steps, as described by an MoH official:

> *"In addition to this national coordination, in each sector, a think tank on the pandemic is being set up. At the level of the health sector, this think tank met every day for two months and then three times a week to take stock and propose the steps to be taken based on past experiences and what is being done in other countries."*
>
> *- MoH Official 1, Togo*

In Burkina Faso, while one health official stated that the MoH depended on past experiences of Ebola in other countries to improve their response to the COVID-19 outbreak, another official regarded the country's COVID-19 preparedness as a novel experience:

> *"The COVID-19 epidemic is a revolutionary pandemic in that it differs from the one usually encountered in Burkina. The experience of other epidemics has not been of much use. It was*

essentially a barrier for everyone...health, clients. Hygiene, hand washing. The whole system put in place was new."

- MoH Official 1, Burkina Faso

Officials in Niger confirmed that the MoH used its experiences from managing epidemics such as the avaian flu to craft its response to the COVID-19 pandemic. At the district level, the MoH established disease control teams stationed at the perimeters of the health district.

MANAGING COVID-19 WITHIN THE HEALTH SYSTEM: *Findings from the Qualitative Analysis*

In all four countries, MoH officials and FP providers explained that at the advent of the COVID-19 pandemic, health facilities reinforced staff adherence to existing infection and prevention control (IPC) practice standards and introduced five broad measures: compulsory wearing of masks, systematic hand-washing at key entry points, use of alcohol-based hand sanitizing gel, taking of temperature of all those who enter the premises, and social distancing in waiting areas and consultation rooms. Across the four countries, FP providers were instructed on COVID-19 health protocols and advised to closely follow them. In Côte d'Ivoire, some facilities set up a reception and sorting station managed by a health worker whose sole role was to ensure compliance with preventive measures. In addition to training on COVID-19 health protocols and the proper wearing of protective gear (head coverings, glasses or visors, gowns, booths and coveralls), providers in Togo also learned how to recognize COVID-19 symptoms and take steps in managing suspected cases.

Also, across the four countries, health facilities received COVID-19 related donations and supplies from a host of sources, including the district, municipality, associations, and development partners, such as Pathfinder International through AmplifyPF, and other international non-governmental organizations (NGOs). However, purchases of soap, alcohol-based sanitizing gel, and face masks were mostly borne by the health facilities themselves. In Côte d'Ivoire, some FP providers specifically requested personal protective equipment (PPEs), including helmets and adapted goggles, but donations and supplies were slow to come. Some providers had to secure their own protection gear, and that which was eventually received seemed inadequate:

"In the early days of the pandemic, providers procured the means to create barriers on their own. Then, the providers received a very insufficient supply of protective equipment (masks and hydroalcoholic gel) from the health facility management and the Ministry throughout the district."

- FP Provider, Côte d'Ivoire

An MoH official from Côte d'Ivoire explained the delay in supplies and confirmed the insufficiency at the facility levels:

"Infection prevention and control measures have evolved over time with adaptations. At the beginning of the pandemic there were no masks for health workers, [which were] then [later]

acquired as the pandemic progressed. However, this remains insufficient. At the beginning of the pandemic, the population did not have any means of protection (nose masks), then the state purchased them for free distribution to the population. And then there was local manufacturing at an affordable cost for the population."

- MoH Official, Côte d'Ivoire

FP providers in Burkina Faso, Côte d'Ivoire, and Togo clarified that the mode of delivery of FP services did not change during the pandemic. No new protocols related to safeguarding personnel from COVID-19 were received. What was reinforced were the COVID-19 control measures already instituted by their facilities. One FP provider in Togo explained how COVID-19 was integrated into compliance of infection prevention and control norms:

"COVID-19 did not really change the way providers complied with infection prevention in FP rooms because they continued to follow standard infection prevention precautionary measures, that is, pre- and post-procedure hand washing, disinfection of procedure areas, wearing gloves on both hands, gowns. Waste sorting is done normally. The change that has been noted is that each provider is provided with two masks per day, hydroalcoholic gel, use of the hand washing device; taking temperature at the entrance of the health facility… respect of the distance between providers themselves and between providers and clients."

- FP Provider, Togo

FP providers interviewed in Côte d'Ivoire and Togo reported that no FP provider had been infected in their health facility as at the time of the interview. In Niger, an MoH official confirmed that no COVID-19 cases were reported for Niamey 1 District at the time. In Togo, however, a district-level MoH official explained that while not many providers in the district had been infected, work schedules were being reorganized and staff were redeployed to ensure continuity with services.

Continued Access to FP Services in a New Normal: *Findings from the Qualitative Analysis*

Across all four countries, FP services – including FP counseling, provision of available methods, and related clinical procedures – were deemed essential health services, and they remained available during the initial shutdowns. However, steps taken to ensure continued delivery of FP services did vary within each country's MoH. For example, the Burkina Faso MoH did not issue a specific directive regarding access to FP services during the pandemic; rather, its Technical Secretariat for Accelerating the Demographic Transition (STATD) Division worked to establish free access to FP services.

In Niger, a COVID-19 committee was established to develop a preparedness and response plan, followed by an April 14, 2020 memo on the maintenance of antenatal care, post-natal care, and FP as essential services. The Niger MoH went further and developed a service continuity plan for RMNCH, mobilized actors on the issue of continuity of RH/FP services, and reorganized services accordingly, with enforcement of protective measures, redeployment of resources, and revised working hours. In

Togo, the Department of Maternal and Child Health developed and disseminated guidelines for all related health services, including those on COVID-19 prevention measures.

As essential services, all public health facilities remained open and all contraceptive methods and services (counseling, clinical procedures) that were offered pre-COVID continued to be offered throughout the pandemic. Even so, it was business unusual as FP providers had to offer their routine services while implementing COVID-19 health protocols for themselves and for clients.

MOH officials and FP providers detailed the ways in which activities changed or were adapted by being either suspended, stopped, or slowed down:

- ***Group Health Discussions***. In the four countries, all large gatherings, including group health discussions conducted at the facility-level, were suspended at the beginning of the pandemic in order to prevent the spread of infection. Over time, FP was integrated into COVID-19 group health discussions in Togo, while in Burkina Faso and Niger, it was the other way around, with COVID-19 being integrated as a topic into FP group health discussions. Over the course of the pandemic, some restrictions, such as lockdowns, were eased and activities of 50-200 people were allowed with COVID-19 protocols still maintained. One MoH official in Côte d'Ivoire explained that the restrictions evolved with the epidemiological situation and the consequences from government directives becoming better understood.
- ***FP Special Days***. FP Special Days occurred on a regular basis at health facilities but were suspended starting April 2020. FP Special Days resumed in May 2020 in Togo and in August 2020 in the remaining countries.
- ***Service Hours***. In two of the four countries, service hours were explicitly reduced by decree of the President. In Niger, service hours were reduced from 8 hours to 6 hours to decrease the risk of spread of the virus among providers. To ensure continuity, however, FP services were still available outside of working hours via an on-call FP provider with commodities on hand. In Togo, service hours were reduced from 9am to 4pm at the beginning of the pandemic when the curfew was imposed. In Burkina Faso, Côte d'Ivoire and Togo, outside of government-imposed restrictions, health facilities maintained regular service hours and service fees.
- ***Home Visits***. While in Burkina Faso, home visits by community health workers (CHWs) were suspended, although referrals and evacuations continued. CHW home visits continued in Côte d'Ivoire, Niger and Togo.
- ***Reorganization/Relocation of Services and Staff Redeployment***. None of the FP providers interviewed reported being deployed to other health units or health facilities as a result of the pandemic. In Niger, an MoH official stated that one thousand health workers were recruited as part of staff redeployment, while outreach and mobile outreach services were strengthened. There was little to no relocation/outsourcing of FP services during the pandemic across the four countries. In Togo, an MoH official further explained that a regional hospital was transformed into a national care center for COVID-19 patients and that most of the original providers at this hospital were transferred to other health facilities. The Togolese MoH official described how staff redeployment was conducted to ensure continuity of services:

"In the health facilities where there have been cases of providers infected with COVID-19, a reorganization of the work schedules for the rest of the staff of these health facilities has been carried out, the staff of the CHR Lomé Commune has also been redeployed in some of these health facilities. […]

"These strategies have ensured the availability of services and prevented discontinuation and loss-to-follow-up, reduced workload and the risk of infection, provided safe services, met the expectations and needs of the community, contributed to the reduction of morbidity and mortality of the population and also slowed down the collapse of the economy."

- MoH Official 2, Togo

The reorganization of services was not applicable to all parts of the country. An MoH official from the Bouake Nord-Ouest district, an unaffected by the pandemic at the time of the interviews explained:

"No reorganization was undertaken because we did not feel the impact of COVID-19 in our district."

- MoH Official, Côte d'Ivoire

In Niger, MoH undertook unannounced visits to health facilities to verify the presence of the service providers. Additionally, a quick client satisfaction survey was undertaken and an on-call system among health workers was established as part of the reorganization of schedules to ensure essential services.

In Togo, one district implemented a task-sharing strategy both for health providers and community health workers to maintain access to services, including subcutaneous injectable contraceptives:

"At the health facility level, there has been task-sharing, allowing other providers to offer FP services to clients. Also, the availability of services 24 hours a day allows clients to be served at all times. [...] Promotion of the introduction of self-injection at the DMPA-SC at the level of all districts. »

- MoH Official 2, Togo

- ***Provider Workload***. In Niger, one FP provider described the workload as having increased due to the closure of certain health centers. In Burkina Faso, FP providers expressed that the pandemic led to smaller sizes of staff teams and reduced work shift periods as well as decreased workloads, all due to fewer clients seeking health services. FP providers in Côte d'Ivoire reported no changes in the workflow despite the decrease in client attendance. Meanwhile in Togo, FP providers reported varied effects of the outbreak and application of protocols on their workload:

  "The load is heavier during COVID-19 because a lot of things are added to sensitize clients about FP and at the same time giving messages about the pandemic is a lot [to the work] load."

  - FP Provider 1, Togo

"The workload decreased during COVID because of the attendance rate; when attendance resumed in July, there was no change in the task, the schedule did not change but adapted to the ministry's schedule to the curfew…9 a.m. to 4 p.m. at the time of the health crisis."

- FP Provider 2, Togo

An MoH official in Burkina described what more could have been done for providers:

"We have not been reactive in order to propose adaptations. All messages focused on the availability of services and providers. We could do better. It came back that clients were refusing to attend because of COVID and that some providers were also no longer coming to the service. We lacked information for the health workers. They were overwhelmed and did not have enough information, and the proof is that the information was changing from day to day. We were not able to give clear guidance, and we stayed within general[ized messaging.]"

- MoH Official, Burkina Faso

- ***Space and Infrastructure***. In Burkina Faso, FP providers reported no change in the use of space and infrastructure due to COVID-19. In the three remaining countries, however, waiting areas and consultation rooms were reorganized to comply with the social distancing protocols. In these countries, additional adaptations were undertaken: in Côte d'Ivoire, some health facilities set up an isolation room for suspected cases. In Togo, there was daily disinfection of the premises by the sanitation service and designation of rooms at several health facilities for the isolation of suspected cases; in addition, hotels were requisitioned to accommodate isolation and proper surveillance of suspected cases for. In both Niger and Togo, FP providers stated that only one client was allowed into the consultation room at a time.
- ***Service Delivery***. For FP providers in Niger, social distancing guidelines were routinely put into practice when providing FP services to clients. For FP providers in other countries though, practicing social/physical distancing while providing service brought on its own set of challenges. In Togo, distancing was observed during counseling and during sensitization, but it was difficult to maintain proper distancing during clinical procedures and to ensure that masks were correctly worn by both the provider and the client. FP providers in Togo shared their perspectives:

  "Respecting distancing in counseling does not allow for good interpersonal communication."

  "Physical distancing at all levels of the customer circuit slows down the work, reducing the number of customers to be served per day. Physical distancing during counseling does not allow for good client-provider interaction. Physical distancing is respected during counseling but difficult during clinical procedures. Each time a client is served, the provider disinfects the work surfaces."

  "The work is rendered difficult especially [because of] the fear of being infected."

  - FP Provider1, Togo

"It should be noted that there has been a reduction in support to other centers for the provision of long-term methods."

- FP Provider 2, Togo

One FP provider in Burkina Faso acknowledged that the application and respect of the practice of social distancing by providers when offering FP services during COVID-19 was more or less enforced, but often with some degree of laxity. One FP provider in Côte d'Ivoire observed that several months after the onset of the pandemic, providers were not fully practicing social distancing when providing FP services and that providers were often seen not wearing masks and providing care to clients, who are also unprotected. Nevertheless, FP providers expressed a sentiment that some level of adherence to COVID-19 protocols for service delivery has become normalized:

"It's a habit that has become part of our reflexes."

- FP Provider, Côte d'Ivoire

"Several months after the start of the pandemic, providers learned to live with the pandemic with respect to physical distance in counseling, talking and standard precautions in clinical procedures."

- FP Provider, Togo

Besides the general preventive measures put in place at the facility level, FP providers took intentional actions to ensure a positive client experience, as summarized here by an FP provider in Burkina Faso:

"We wash our hands upon arrival in the morning in front of the clients, wearing a mask and using hydroalcoholic gel also in front of the client".

- FP Provider, Burkina Faso

In Burkina Faso and Togo, although telehealth was not officially put in place as a measure to ensure continued service delivery, some health facilities had established links with clients and were sending them reminder text messages. FP providers also recalled that some clients reached out to them by cell phone:

"...Continuing clients would call to reschedule their appointments or to manage side effects."

- FP Provider, Burkina Faso

In Togo, service delivery continued thanks to training of FP providers on DMPA-SC administration, done virtually:

"Orientation in Sayana Press administration [was] done online."

- FP Provider 2, Togo

Also common to the four countries, FP providers discussed COVID with clients during counseling and reiterated the necessity of respecting preventive measures. Only providers in Niger, however, informed clients about the availability of FP services at any time and outside of regular working hours.

CLIENT ATTENDANCE OF FP SERVICES: *Findings from the Qualitative Analysis*

Across all countries, FP providers observed a decrease in client attendance at the onset of the pandemic, as well as in use and demand of FP services. A FP provider in the Bouake Nord-Ouest district of Côte d'Ivoire, untouched by the pandemic at the time of the study, noted that fewer clients attended the health facilities at the onset of the pandemic compared to the pre-COVID period despite continued community mobilization efforts, out of fear of being infected at the health facility:

> *"We came to the center every day. Confinement did not concern us. It is the population who were afraid to come to the hospital because according to them COVID is in the hospital. But with the awareness they started to come."*
>
> *– FP Provider, Côte d'Ivoire*

FP providers in Côte d'Ivoire mentioned a noticeable loss to follow up of clients. In Niger, according to some FP providers, COVID did not have an impact on clients adhering to their follow-up appointments. In Togo, one FP provider explained that some clients missed their appointment due to travel, while others missed their appointment for fear of infection. Another FP provider in Togo noted that most of the clients came for their follow-up appointments, although there was a decrease in the attendance rate compared to that of the previous year.

In Burkina Faso, Côte d'Ivoire and Niger, FP providers reported no observed change in either demand by service type or method choice by those clients who attended the health facilities during COVID, as compared to pre-COVID. Meanwhile in Togo, FP providers noticed an increase in demand for long-acting methods by clients during the pandemic compared to pre-COVID, on one hand, and an increase in demand for DMPA-SC and self-injection, on the other:

> *"...service delivery for DMPA-SC started almost at the same time as COVID-19, as it took the place of Depo-Provera, and with the focus on self-injection, some clients started injecting themselves."*
>
> *- FP Provider, Togo*

Findings from the key informant interviews on FP service delivery presented above suggest that visits to health facilities fell in number due to challenges of practicing social/physical distancing while providing services and due to the population's fear of COVID-19 exposure. However, a quantitative analysis provides another perspective by analyzing the trends in the documented numbers of FP clients served and new FP clients recruited at those health facilities that have been supported by AmplifyPF in Côte d'Ivoire, Niger and Togo[8].

[8] As noted earlier, lack of complete client services data from Burkina Faso during the 30-month period of study disqualified usage of any such data from that country for this study.

CLIENT ATTENDANCE OF FP SERVICES: *Findings from Quantitative Analysis*

Between July 2018 and December 2020, the average number of clients served monthly across all Amplify-supported facilities in Côte d'Ivoire, Niger and Togo was 15,996. In the months prior to the COVID-19 outbreak, there was an overall average of 16,097 clients served. After the COVID-19 outbreak, it reached 15,795, a non-statistically significant decrease (p=0.54) and a finding similar to what had been found with changes in monthly averages of clients served in Côte d'Ivoire and Togo.

Figure 1. Monthly Trend of FP Users (New and Continuing) across the Health Districts Supported by AmplifyPF, by Period of Analysis (July 2018 - December 2020)

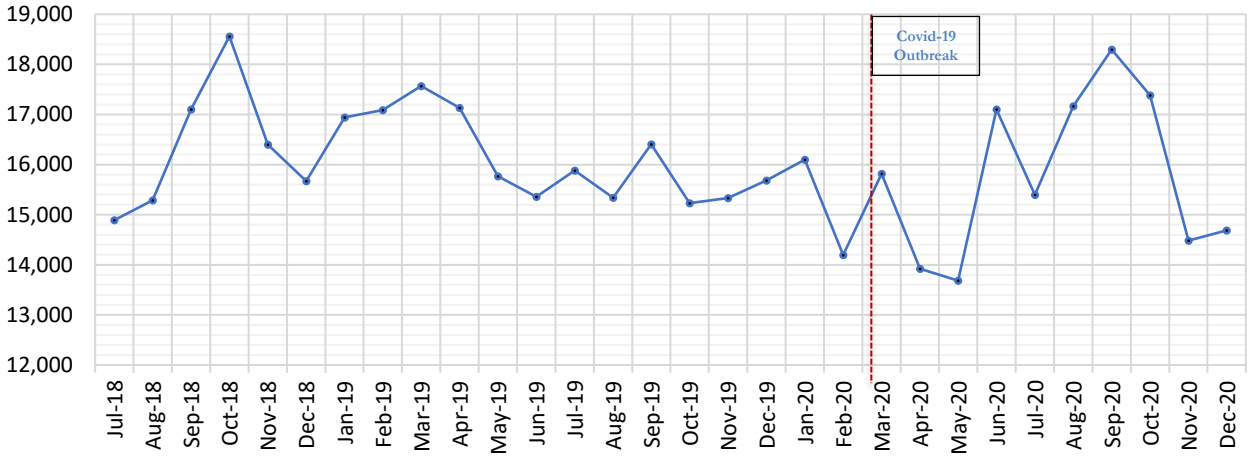


Table 7. Monthly Average of FP Users (New and Continuing) across Health Districts Supported by AmplifyPF, by Country, Region and Period of Analysis (January 2018 - December 2020)

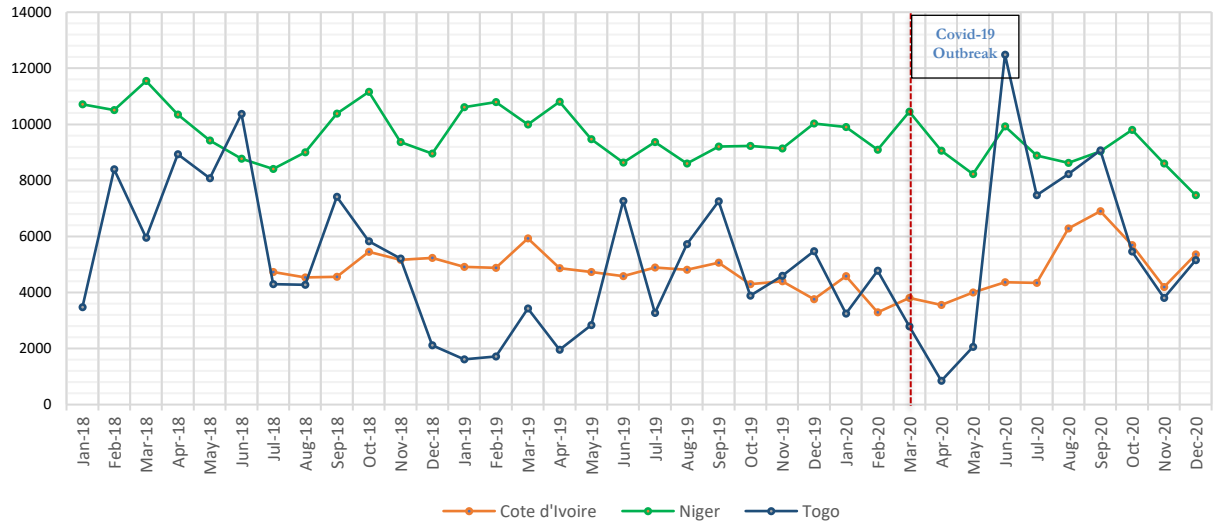
	Côte d'Ivoire			Niger			Togo			Region		
	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value
Before COVID-19	4,735	564	0.21	9,750	870	0.03*	1,850	306	0.11	16,097	1,048	0.59
During COVID-19	4,852	1,136		9,005	874		1,938	462		15,795	1,614	
All the period	4,774	783		9,543	923		1,874	351		15,996	1,245	

Table 9 shows that the effect of the COVID-19 outbreak on FP clients served was not the same in the three study countries. Specifically:

- In Côte d'Ivoire, the average number of clients served per month throughout the entire study period of July 2018 through December 2020 was 4,774. Before the COVID-19 epidemic, up through February 2020, this monthly average was slightly lower at 4,735, but increased to an average of 4,852 during the pandemic; this was not statistically significant, however (p=0.21).
- In Niger, the average number of clients served monthly throughout the entire study period was 9,543. Prior to the pandemic, it was 9,750 clients, but this average fell to 9,005 during the months of the COVID-19 outbreak, which was a statistically significant decrease (p=0.03).

- In Togo, the average number of clients served monthly throughout the entire study period was 1,874. It was 1,850 during the months prior to the pandemic compared to 1,938 during the outbreak, not a statistically significant increase (p=0.11).

Figure 2. Monthly Trend of FP Users in the Health Districts Supported by AmplifyPF, by Country and Period of Analysis (January 2018 - December 2020)



RECRUITMENT OF NEW FP CLIENTS: *Findings from the Qualitative Analysis*

For each of the four countries, qualitative findings revealed a noticeable decrease in the number of outreach activities to raise demand for FP services following the start of COVID-19. In Burkina Faso, FP providers noted a slowdown in demand creation. One FP provider in Togo described the onset of the pandemic as "abrupt" and resulting in the suspension of community mobilization, group health discussions, and use of community relays. In contrast, the MoH in Niger utilized community relays to continue FP demand creation. The MoH in Niger also turned to other high-impact practices, such as task-sharing, mentoring, and targeting youth/adolescent populations, while also seeking engagement for demand generation from all stakeholders, including implementing partners, civil society organizations (CSOs), and the private sector. According to FP providers in Niger, however, demand creation was dampened because FP messaging was overshadowed by COVID-19 related messaging. One FP provider explained:

> *"There is a clear difference in client recruitment. Client recruitment has dropped sharply compared to the period without COVID."*
>
> *- FP provider 1, Niger*

RECRUITMENT OF NEW FP CLIENTS: *Findings from the Quantitative Analysis*

Overall, between July 2018 and December 2020, the average number of new FP clients recruited at all Amplify-supported facilities was 4,285. We observed a significant drop in the number of new FP

clients recruited during the initial period of the pandemic (April 2020), see Table 10. The reduction in the number of new FP client recruitment was greater (+10%) than the reduction in average new clients recruited in April 2019 (17%). The effect of this reduction during the initial pandemic was not significant on the average number of clients recruited after the COVID-19 outbreak. The average number of FP clients recruited before the COVID-19 outbreak was 4,245, compared with an average of 4,366 clients recruited in the months before the COVID-19 outbreak. The increase in the average number of clients recruited during the two study periods was not significant (p=0.65).

Figure 3. Monthly Trend of New FP Clients Recruited across the Health Districts Supported by AmplifyPF, by Period of Analysis (July 2018 - December 2020)

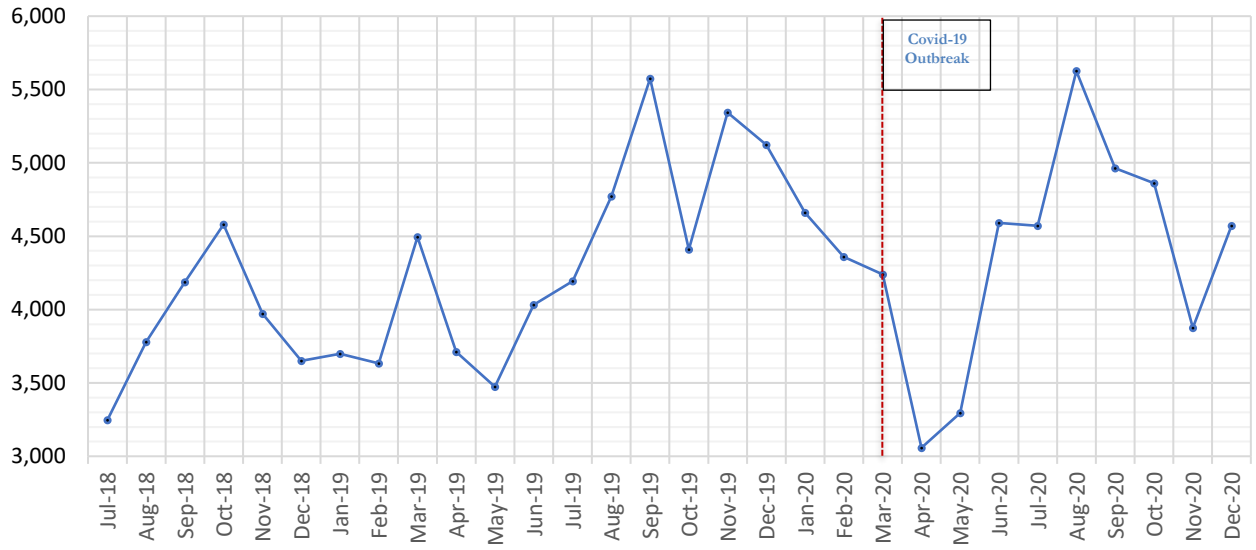


Table 8. Monthly Average of New FP Users Recruited across Health Districts Supported by AmplifyPF, by Country, Region and Period of Analysis (January 2018 - December 2020)

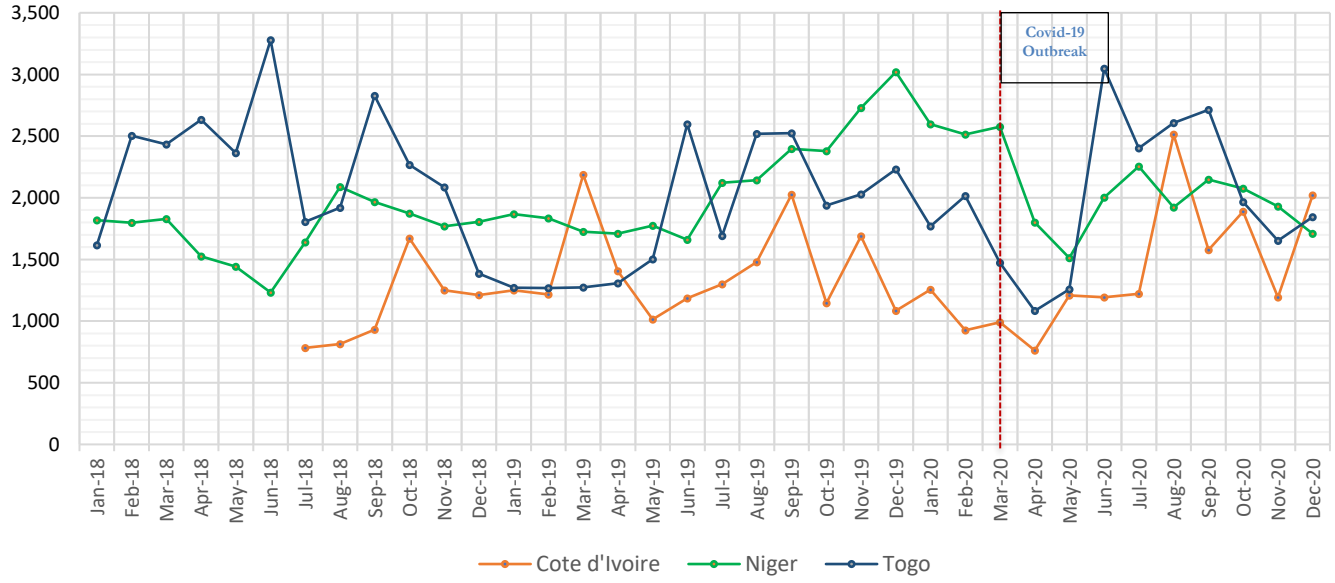
	Côte d'Ivoire			Niger			Togo			Region		
	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value
Before COVID-19	1,291	371	0.33	1,971	417	0.88	933	248	0.87	4,245	635	0.65
During COVID-19	1,457	537		1,993	297		917	303		4,366	777	
All the period	1,346	431		1,977	384		928	260		4,285	674	

The trend in the number of new FP clients recruited in the three countries varied, as detailed here and presented in Figure 4:

- In Côte d'Ivoire, the average number of newly recruited clients per month between July 2018 and December 2020 was 1,346. Before the arrival of COVID-19 (through February 2020), the average number of clients per month had been 1,291. This average rose to 1,457 during the subsequent period, despite COVID-19, although this difference was not statistically significant (p=0.33). There was an increase in the number of newly recruited FP clients during the months of the pandemic than there had been for these same months from the previous year, before the onset of COVID-19.

- In Niger, between July 2018 and December 2020, a monthly average of newly recruited clients was 1,977, a slight increase from the 1,971 average before the onset of COVID-19. However, as was true for Côte d'Ivoire, the average number of newly recruited clients increased during the pandemic to 1,993, but again not to a significant degree of difference (p=0.88). Also, during the initial period of the pandemic (April 2020 and May 2020), the reduction in newly recruited clients between March and May was greater than the average reduction in newly recruited clients for the same months from the previous year (41% vs. 9%).
- In Togo, the monthly average of newly recruited clients between July 2018 and December 2020 was 928, which did not much vary from the monthly averages before COVID-19 (933) or since its onset (917) and which difference was not statistically significant (p=0.87). However, as with Côte d'Ivoire, a similar pattern whereby the average number of clients newly recruited per month actually rose after the first two months of COVID's onset is noted.
- Collectively, the monthly average of newly recruited clients was 4,245 before COVID-19, which rose to a not statistically significant degree to 4,366 after outbreak of the pandemic; the overall average from July 2018 through December 2020 was 4,285.

Figure 4. Monthly Trend of New FP Users Recruited in the Health Districts Supported by AmplifyPF, by Country and Period of Analysis (January 2018 - December 2020)



METHOD MIX: *Findings from the Qualitative Analysis*

Opting for a longer acting method may be a strategy clients take to avoid frequent visits to the facilities to reduce the risk of exposure to the virus. When asked about emerging themes and lessons learned during the COVID-19 pandemic, some key informants noted a shift to longer methods and DMPA-SC by FP clients.

FP providers in Côte d'Ivoire mentioned the use of long-acting methods and DMPA SC (self-injection) as a way to avoid frequent contact with the health center and also decrease contraceptive discontinuation. In Togo, an MoH official highlighted the emergence of the subcutaneous injectable:

> *"It is the choice of DMPA-SC (self-injection) that emerges. The challenge is the mastery of the technique by the clients, the respect of visit appointments and the strategy to have a traceability of the quantities served to the clients in order to take them into account in the planning and avoid possible stock shortages."*
>
> *- MoH official, Togo*

FP providers in Côte d'Ivoire and Togo observed variance in contraceptive use and method choice as emergent aspects:

> *"Yes, cases of discontinuation are emerging. But they come back to continue or change their method."*
>
> *- FP Provider, Côte d'Ivoire*

> *"Long-acting methods are more likely to be chosen by clients during COVID 19."*
>
> *- FP Provider, Togo*

METHOD MIX: *Findings from the Quantitative Analysis*

The quantitative analysis explored the issue of preference of long-acting method by examining the method mix among newly-recruited clients in Côte d'Ivoire and Togo. New clients are not disaggregated by FP method in Niger, so this country was excluded from analysis.

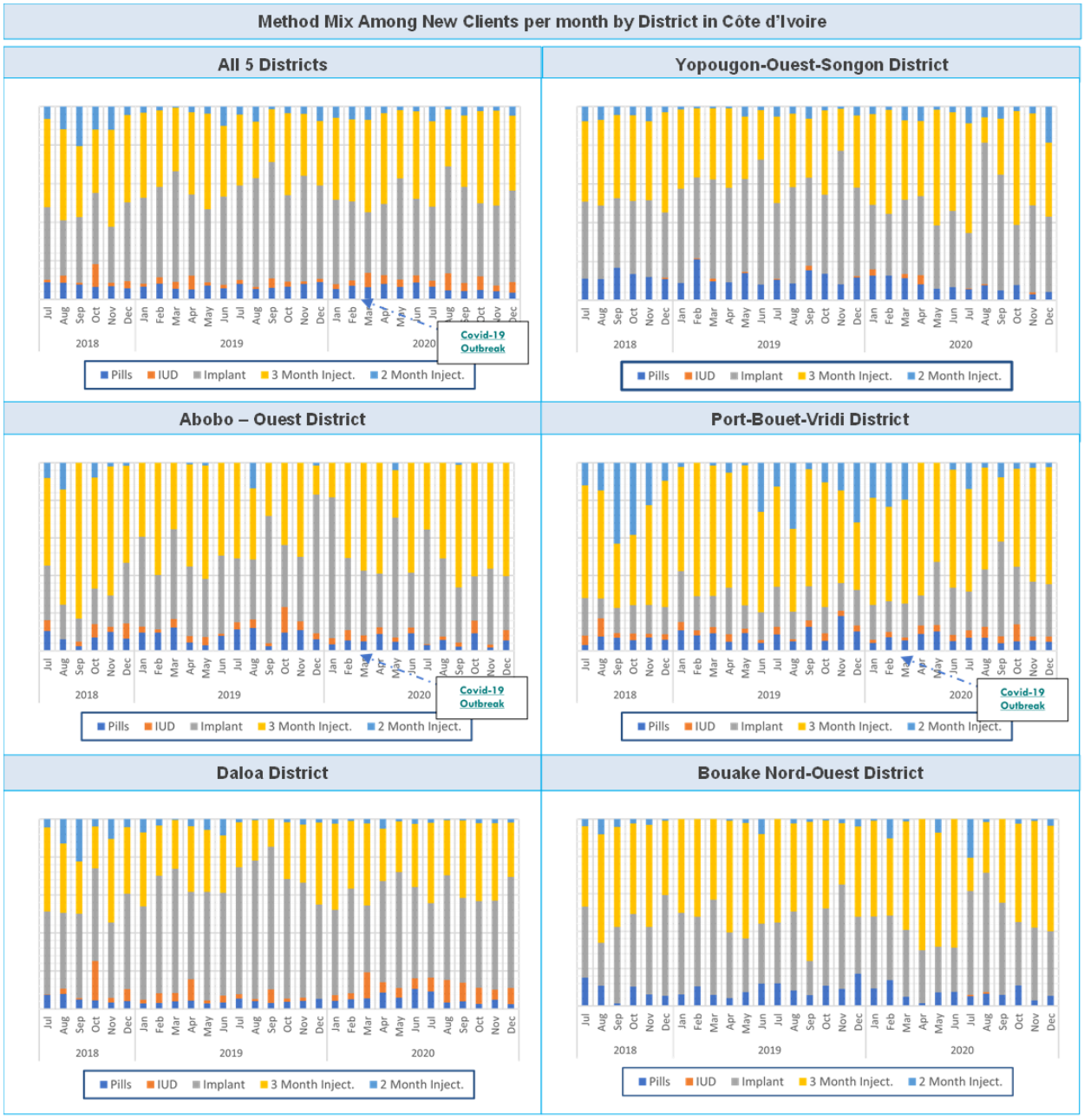
Method Mix in Côte d'Ivoire

In Côte d'Ivoire, the percentage of clients using implants increased in April 2020, just one month after the outbreak, as well as in August and September 2020, but at levels already reached before COVID-19 (see Figure 5). In contrast, the 2-month injectable became less popular in the favor of the 3-month injectable, but this trend had started well before the COVID-19 pandemic.

As with the other indicators, the trends in method mix vary across the districts. A shift towards longer-acting methods (implants, IUDs) seems to have started from May 2020 in Yopougon-Ouest-Songon district and from April 2020 in Port-Bouet-Vridi district; meanwhile, there seems to have been less of

this trend in Daloa district and some attrition among women using longer-acting methods in Abobo-Ouest district. This variation suggests the need for further investigation.

Figure 5. Trends in Method Mix among New Clients per Month by District in Côte d'Ivoire, by Period of Analysis (July 2018 - December 2020)

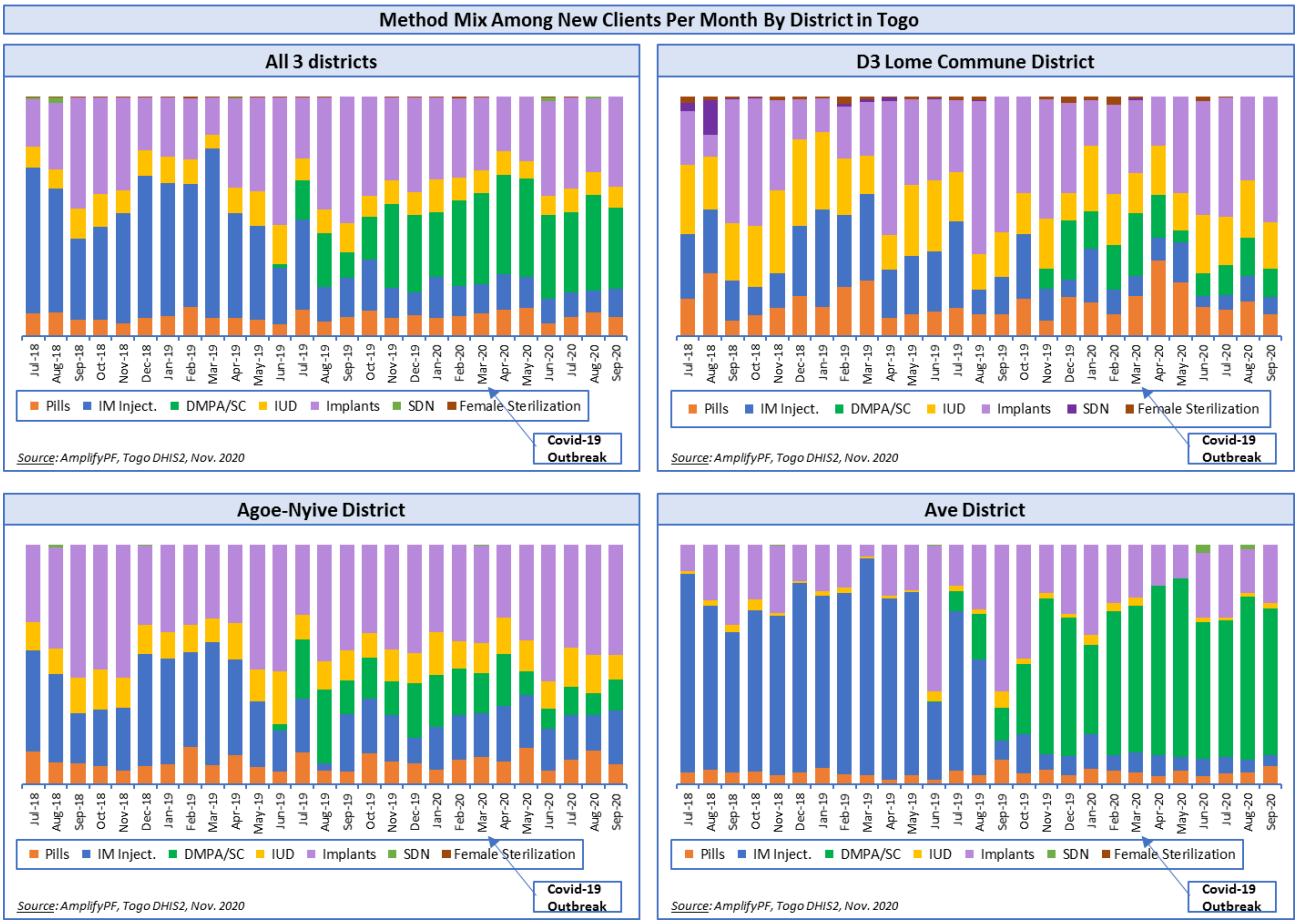


Method Mix in Togo

In Togo, from July 2018 to June 2019, the trends in method mix show a large proportion of clients using intra-muscular injectables and implants (see Figure 6). Since the introduction of DMPA-SC into the method mix in July 2019, the proportion of clients using the version that is injected subcutaneously (SC) has continued to increase, overtaking the version that is injected intramuscularly (IM), and in some months, implants as well. The steady increase of clients using DMPA-SC since March 2020, at the onset of the COVID-19 outbreak is presented in Figure 6.

The increasing preference for the DMPA-SC is more noticeable in Ave (the only district outside the capital city). In the capital city districts of D3 Lome Commune and Agoe-Nyive, the two long-acting methods – Implants and IUD – remain popular, as no major change in their use was observed following the outbreak of the pandemic.

Figure 6. Trends in Method Mix among New Clients per Month by District in Togo, by Period of Analysis (July 2018 - December 2020)



COUPLE-YEARS OF PROTECTION (CYPS): *Findings from the Quantitative Analysis*

Overall, between July 2018 and December 2020, the average monthly CYP value across all Amplify-supported districts was 12,317 (Figure 7). We observed a significant decrease in CYP during the initial period of the pandemic (April 2020), which was slightly higher (+12%) than the reduction in CYP in April 2019 (10%). The effect of this reduction during the initial pandemic was not significant to the overall average CYP since the COVID-19 outbreak (through December 2020). The mean CYP value before the COVID-19 outbreak was 12,147, as compared to the mean CYP value of 12,656 in the months since the COVID-19 outbreak. The difference in the increase between these periods was not significant (p=0.60).

Figure 6. Monthly Trend of CYP Value in the Health Districts Supported by AmplifyPF, by Period of Analysis (July 2018 - December 2020)

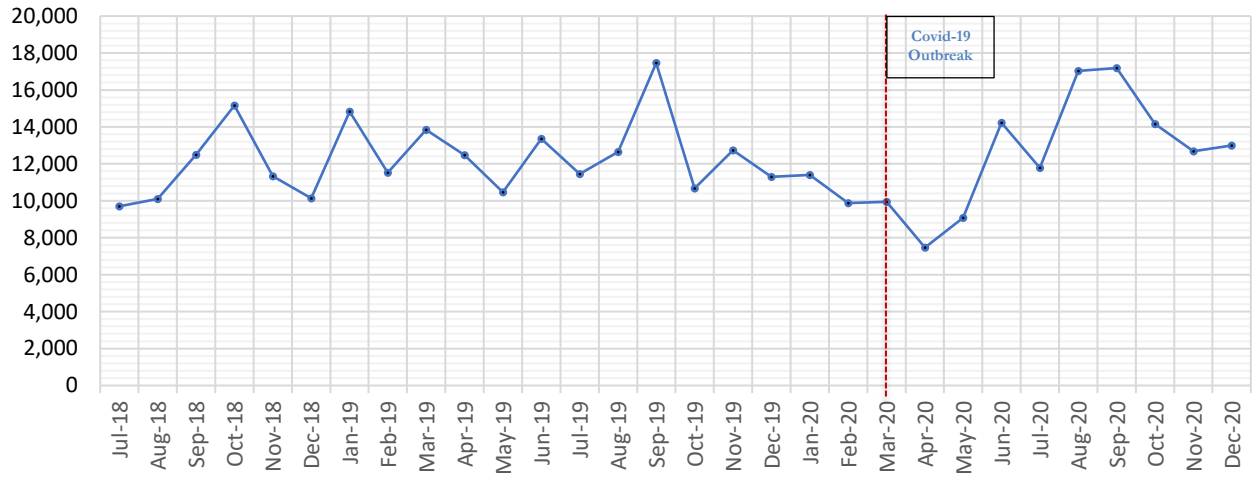


Table 9. Monthly Average of CYP Value across Health Districts Supported by AmplifyPF, by Country, Region and Period of Analysis (January 2018 - December 2020)

	Côte d'Ivoire			Niger			Togo			Region		
	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value
Before COVID-19	4,858	1,340	0.66	4,989	902	0.94	2,183	823	0.27	12,147	2,010	0.60
During COVID-19	5,142	2,161		4,961	1,288		2,553	1,040		12,656	3,201	
All the period	4,952	1,626		4,981	1,004		2,286	889		12,317	2,426	

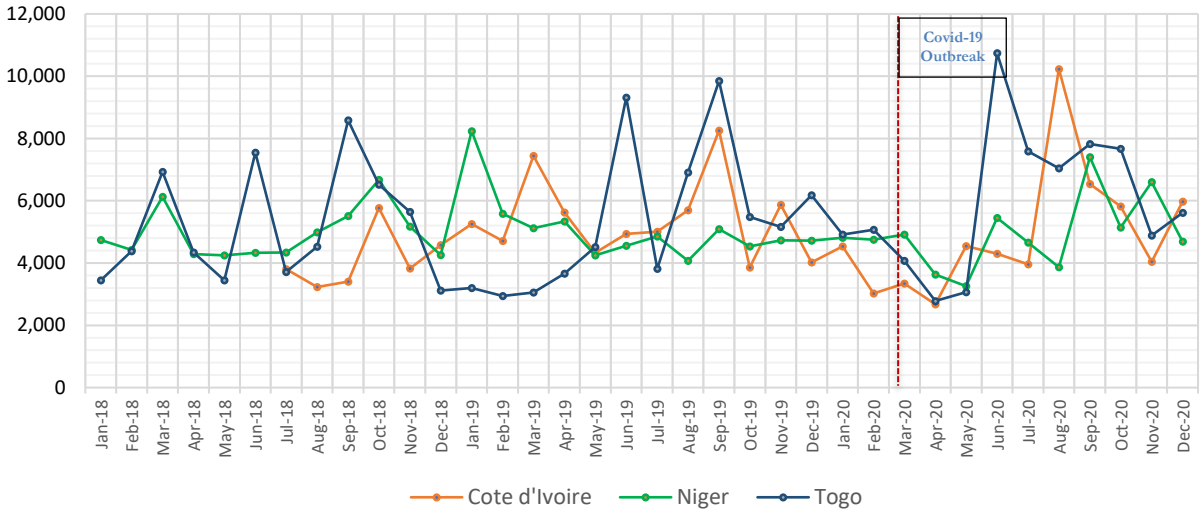
Among the three countries, the trend of calculated CYP values, as based on FP methods provided, is presented in Figure 8:

- In Côte d'Ivoire, the average monthly CYP value between July 2018 and December 2020 was 4,952. The mean CYP value per month after the COVID-19 outbreak (from March 2020) was 5,142, which was higher than it had been before the outbreak at 4,858, although the difference was not statistically significant (p=0.66). The lowest CYP value occurred in the initial period

of the pandemic, while the overall trend since then has been one of increase, despite some erratic changes from month to month.

- In Niger, between January 2018 and December 2020, the monthly mean CYP value was 4,981. The average CYP value before COVID-19 was 4,989, which was slightly higher than the CYP value of 4,961 after the COVID-19 onset, although this was not a statistically significant difference (p=0.94). Looking at the monthly CYP trend in Niger, we observed a decrease in the initial period of the pandemic (April 2020 and May 2020) and with the lowest CYP value recorded in May 2020. The reduction in the monthly value recorded between March and May 2020 was greater than the reduction in the average CYP value recorded during the same months from the previous year (26% vs. 13%), but the overall trend since the onset of COVID-19 has best one of modest growth to approximate levels of CYP values that had been attained before the pandemic.
- In Togo, the monthly mean CYP value was 889 between January 2018 and December 2020, with an average CYP value of 823 before COVID-19 and 1,040 since disease onset; this difference is not statistically significant (p=0.27). The drop in monthly average CYP value during the early month of the pandemic was offset by a dramatic rebound observed in May 2020.

Figure 7. Monthly Trend by Country of CYP Value in the Health Districts Supported by AmplifyPF, by Country and Period of Analysis (January 2018 - December 2020)



CLIENT ATTENDANCE OF LABOR AND DELIVERY SERVICES: *Findings from the Quantitative Analysis*

The COVID-19 pandemic may not only have affected attendance of FP services, but also other maternal and child health services. In this analysis, we investigated if a decrease occurred in the number of women who had given birth at a health facility, as well as a decrease in the number among these women who had accepted a FP method before their discharge (immediate post-partum FP uptake). Only two countries, Niger and Togo, have been documenting these data in DHIS-2.

Figure 9 depicts a pattern of births at health facilities increasing somewhat regularly between January and September 2018 before a tapering off during the last few months of that calendar year. Trends in facility births during 2020 mirrored those observed during 2018 and 2019 and, as such, COVID-19 did not seem to have had much effect in women electing to deliver at health facilities. The average monthly number of facility births during the overall study period of January 2018 through December 2020 was 2838. The average monthly number of facility births prior to the COVID-19 outbreak was 2789 and 2964 since the pandemic's onset; this increase, however, was not statistically significant (p=0.1190), see Table 12.

Figure 8. Monthly Trend of Monthly Facility-Based Births in the Health Districts Supported by AmplifyPF, by Period of Analysis (January 2018 - December 2020)

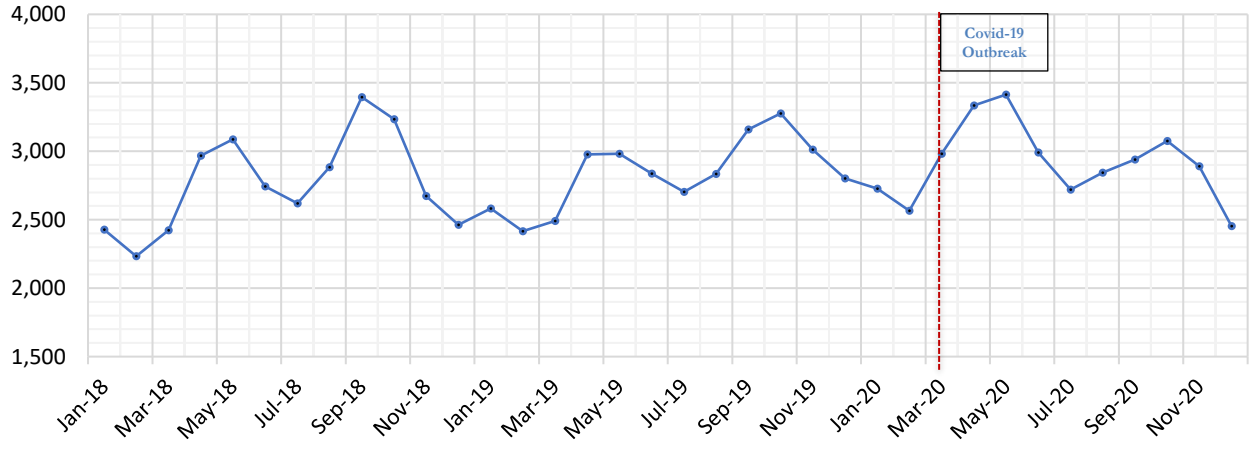


Figure 9. Monthly Trend of Monthly Facility-Based Births in Health Districts Supported by Amplify PF in Niger and Togo, by Period of Analysis (January 2018 - December 2020)

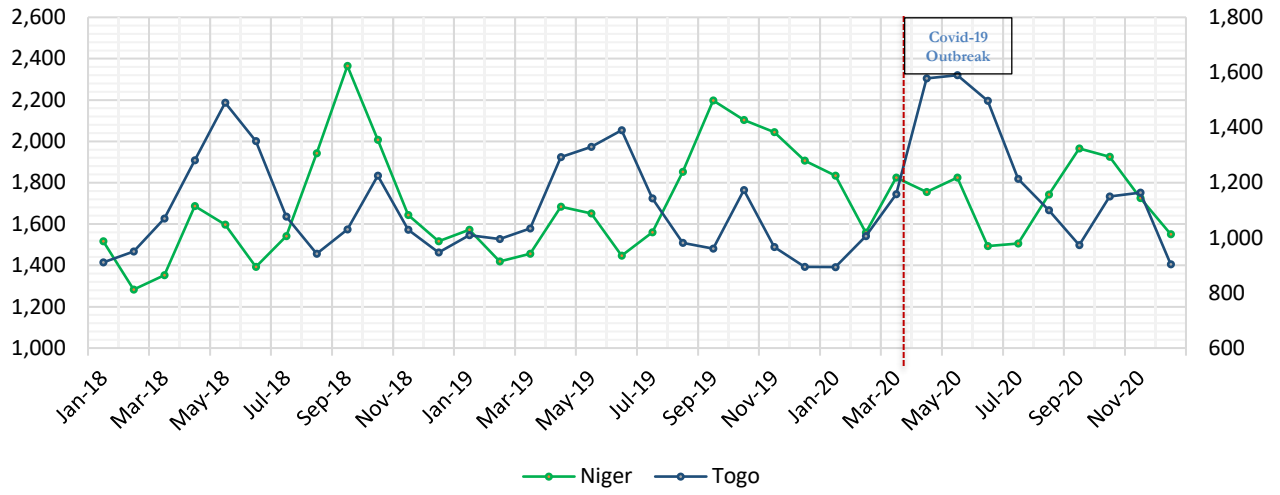


Table 10. Monthly Average of Facility-Based Births across Health Districts Supported by AmplifyPF, by Country, Region and Period of Analysis (January 2018 - December 2020)

	Niger			Togo			Region		
	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value
Before COVID-19	1,697	280	0.72	1,092	171	0.06	2,789	300	0,1190
During COVID-19	1,731	167		1,233	242		2,964	278	
All the period	1,707	252		1,131	200		2,838	301	

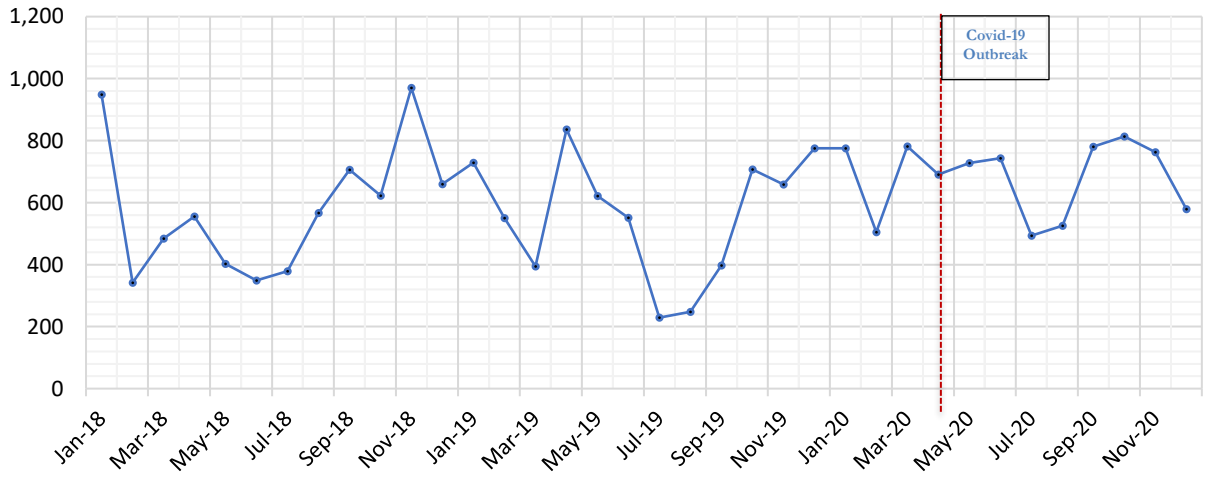
The trends with the facility-based births in Niger and Togo are similar in terms of the overall trend just (see Figure 10). Specifically:

- In Niger, there was a monthly average of 1707 facility births recorded during the study period of January 2018 through December 2020. Prior to the COVID pandemic, the average monthly number of facility births was 1697, with a minor increase to 1731 recorded during the pandemic period, which difference was not statistically significant (p=0.72). The yearly pattern of facility-based deliveries recorded monthly that increase from January to September before trailing downwards does suggest a seasonal cycle.
- In Togo: An average monthly number of 1,131 facility births was recorded for the entire study period of January 2018 through December 2020, although this average was lower, at 1092 prior to the COVID-19 outbreak and higher since the pandemic at 1131; this difference was not statistically significant (p=0.056). There also appeared to be an annual seasonal effect with facility-based births, with monthly numbers rising from January through May/June before trending downwards thereafter; this trend continued even during the initial months of the COVID-19 pandemic.

CLIENT ATTENDANCE OF LABOR AND DELIVERY SERVICES: NUMBER OF POST-PARTUM CLIENTS RECEIVING FP METHOD WITHIN 48 HOURS OF CHILDBIRTH: *Findings from the Quantitative Analysis*

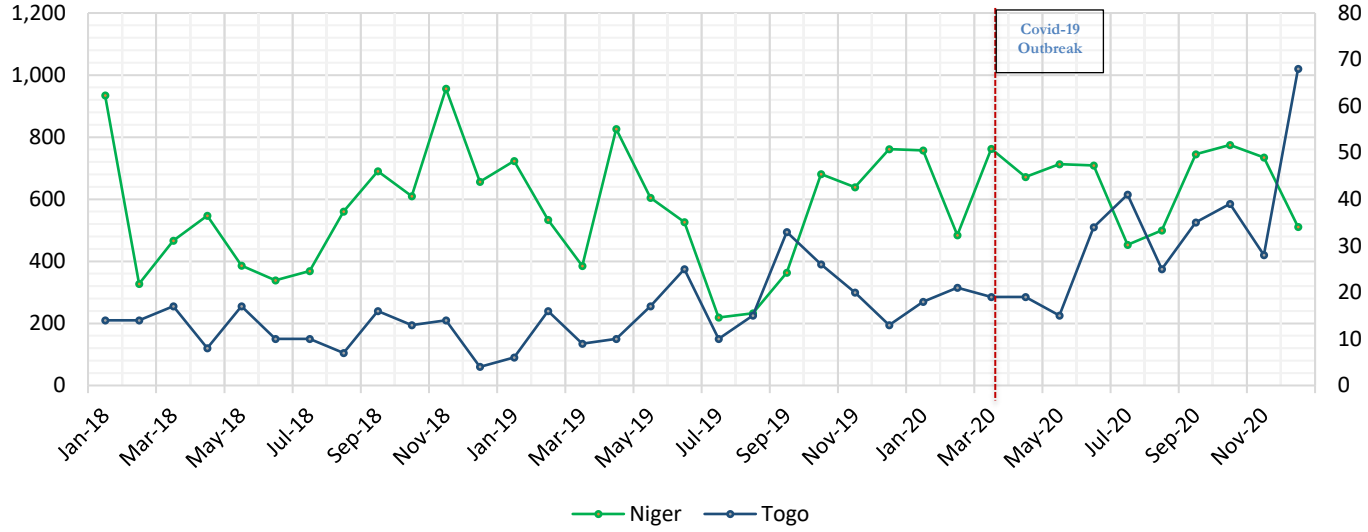
There are less obvious parallels between the graphs presented in Figure 9 and Figure 11, that is, the monthly average number of facility-base births recorded for Togo and Niger and the monthly average number of those same women who, having undergone childbirth, opted for a family planning method within 48 hours of delivery. What is more apparent, however, is that the COVID-19 pandemic seemed to have not have significantly reduced the opportunities for post-partum women to select a FP method while at the facility where they had delivered.

Figure 10. Monthly Trend of PPFP Clients in the Health Districts Supported by AmplifyPF, by Period of Analysis (January 2018 - December 2020)



Data on women who had accepted a FP method before their discharge from the facility was recorded in DHIS-2 by Togo and Niger, but not by Côte d'Ivoire during the study period of January 2018 through December 2020. As such, a cross-country comparison is limited to the first two countries. In Togo, the trend line across the first 30 months was relatively flat, but it angled significantly upwards since the onset of COVID-19. For Niger, monthly averages fluctuated more significantly throughout the entire study period, while it seemed to be sloping mostly downward since the pandemic.

Figure 11. Monthly Trend by Country of PPFP Clients in the Health Districts Supported by AmplifyPF in Niger and Togo, by Period of Analysis (January 2018 - December 2020)



Regarding the number of PPFP clients, Table 13 reveals a non-significant increase in Niger (p=0.16) in contrast with a significant increase in Togo (p <0.0001).

Table 11. Monthly Average of PPFP Clients in Niger and Togo, by Period of Analysis (January 2018 - December 2020)

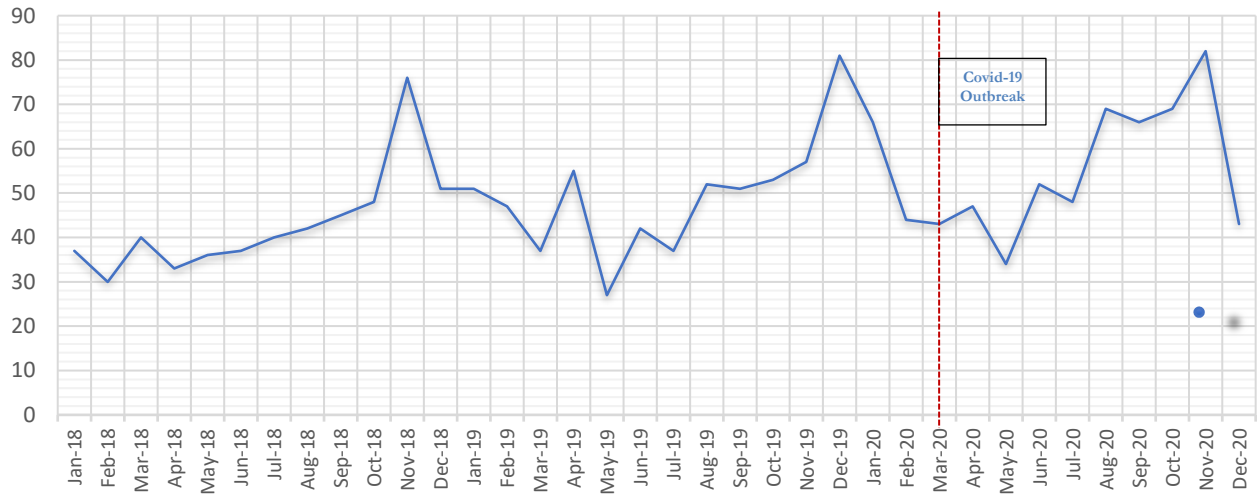
	Niger			Togo			Region		
	Mean	Std Dev	p-value	Mean	Std Dev	p-value	Mean	Std Dev	p-value
Before COVID-19	561	200	0.1622	15	7	<0.001*	576	200	0.1004
During COVID-19	658	121		32	15		690	115	
All the period	588	185		20	12		607	186	

CLIENT ATTENDANCE OF PAC SERVICES IN TOGO[9]: *Findings from the Quantitative Analysis*

Number of Women who Received Post-Abortion Care (PAC) Services in Togo

Figure 12 shows the trends in the average number of women in Togo who received post-abortion care. The trends across the three years show general fluctuations throughout the year, with an apparent rise in the number of women during the later months of each year (September through November), before a plummeting decrease in between November and December of 2018 and 2020. In late 2019, the decrease begins in December and spans two months.

Figure 12. Monthly Trend Women in Togo who Received PAC Services in the Health Districts Supported by AmplifyPF, by Period of Analysis (January 2018 - December 2020)

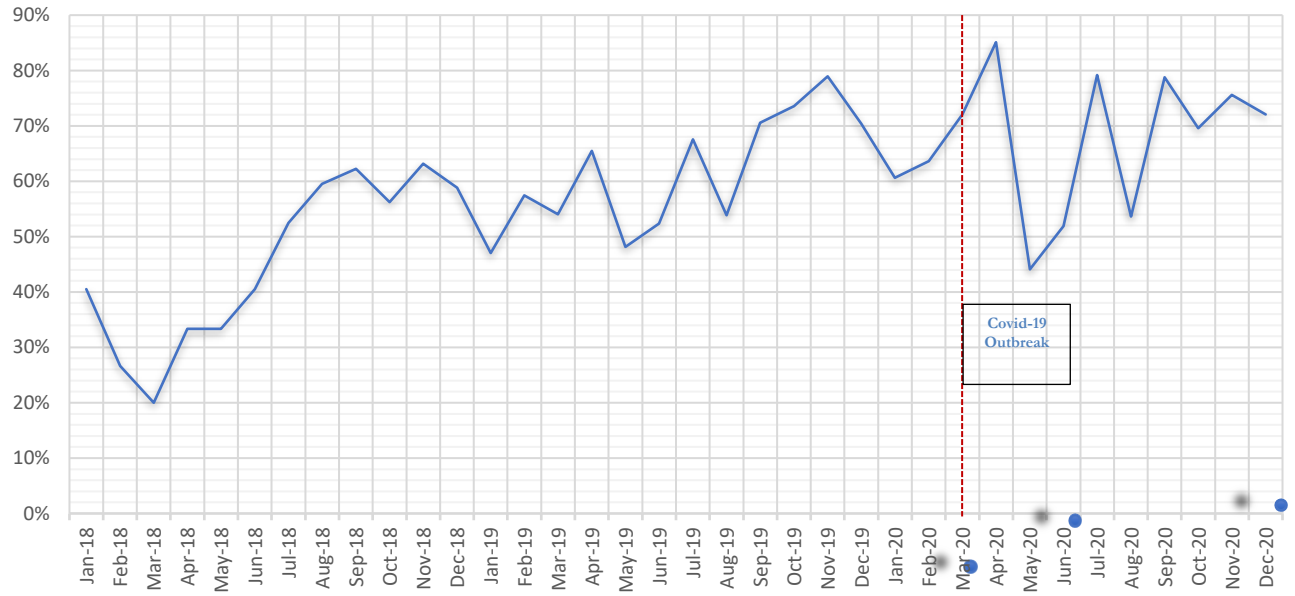


Percentage of PAC Clients who Leave the Facility with an FP Method in Togo

Figure 13 captures the trend in the percentage of women in Togo who had received an FP method during post-abortion care. In each of the three years, the trend lines generally slope upwards with each succeeding month, indicating sustained interest among women to begin an FP method subsequent to receiving PAC.

[9] Togo is the only project country to report PACFP data in its DHIS-2.

Figure 13. Monthly Trend of Percentage of Women in Togo who Received an FP Method during PAC in the Health Districts Supported by AmplifyPF, by Period of Analysis (January 2018 - December 2020)



RESHUFFLES AND REDUCTIONS: DATA MONITORING AND REALLOCATION OF FINANCIAL RESOURCES
Findings from the Qualitative Analysis

Reporting FP Service Statistics and Monitoring

According to MoH officials in Côte d'Ivoire, reporting FP service statistics maintained its usual circuit and periodicity, but analysis and reconciliation changed from quarterly to monthly. Furthermore, the National MCH Program intensified its monitoring activities through calls and visits to health facilities.

In Niger, each health facility data manager continued to collect and enter the health facility's data into DHIS-2. Once transmitted to the central level, MoH analyzed the DHIS-2 data and conducted monitoring via video, telephone, or WhatsApp calls. Where necessary, due to limited internet connectivity, face-to-face monitoring visits were conducted, with COVID-19 prevention measures enforced.

Similarly, Togo MoH analyzed DHIS-2 FP service data that had been entered by at the health facilities. When necessary, MoH followed up with on-site visits for verification. While districts continued holding their monthly monitoring meetings, any activity that could be carried out virtually was done via videoconferencing. Togolese FP providers also continued to enter data for the national health information system and logistics management. MoH officials in two countries gave concrete examples of how FP service statistics were used to make decisions during the pandemic: in Niger, the Niamey region used the data to successfully reorganize services and staff deployment to ensure continuity of service provision. In Togo, data revealed a commodity bottleneck for Sayana Press, which was quickly resolved to ensure continuity of service provision.

Reallocation of Financial Resources

There was no reallocation of financial resources in Niger to fund pandemic control measures. In Burkina Faso and Côte d'Ivoire, an MoH official stated that funding from certain partners had been reallocated to purchase protective equipment and products for health facility providers of MCH and FP services. Specific to budgeting, however, the MoH of Burkina Faso reduced its budget for providing free FP services, although purchases for contraceptives were not affected:

> *"There has been a budget adjustment, but we can't be more specific. The portion for the purchase of contraceptives has not been affected. But as far as the management of the free program is concerned, there has been a reduction. With the COVID, the budgetary regulation has reduced the management of the program. Regulation is the technical term they gave to the reduction of the budget allocated to the management of the FP free program."*
>
> *- MOH Official, Burkina Faso*

In Togo, MoH Officials reported no reallocation of state resources in relation to FP and that the state budget line for the purchase of FP products was maintained. Any budgetary adjustments made did not affect the health sector.

RESHUFFLES AND REDUCTIONS: CHANGES TO AMPLIFYPF COMMUNITY- AND FACILITY-BASED ACTIVITIES: *Findings from the Qualitative Analysis*

It was also business unusual for other ILN stakeholders as the COVID-19 outbreak was particularly disruptive. Across the four countries, regularly scheduled activities were suspended. The work schedule was organized into shifts, and large gatherings, such as municipal council meetings, were suspended or limited to a very small number of people. Moreover, community organizations were unable to engage with community members as a result of the confinement/lockdown restrictions. Representatives described how the pandemic led to the suspension or reprogramming of activities, reduced funding, and almost all in-person meetings being canceled. Organizations in Burkina Faso had to lay-off staff due to canceled or postponed activities:

> *"The COVID-19 outbreak has had a profound effect on [organization]'s activities. At the staff level, the center has been reduced to the strict minimum necessary for operation, with only a counselor and a health worker."*
>
> *– Community organization representative 2, Burkina Faso*

> *"Maintaining our animators with the suspension of the project, we had to find a compensation measure to retain human resources. This will allow us to have the same skills when resuming."*
>
> *– Community organization representative 1, Burkina Faso*

Resource Mobilization for FP

Mobilizing resources for FP is an essential component of the ILN model. The 17 ILNs cover 21 urban municipalities, 24 rural municipalities and 14 communes. The AmplifyPF project has supported these municipalities and communes through capacity enhancement on resource mobilization and mapping of potential resources within the catchment area, particularly in the private sector. For municipalities, operational capacity and functionality were curtailed from both a human and financial resources perspective as a result of the COVID-19 pandemic. ILN described their various situations:

> *"Before and during COVID-19, the city hall did not mobilize resources for FP. It was after the training in resource mobilization provided by the AmplifyPF project that the City Hall began to take an interest in resource mobilization for FP issues. Unfortunately, COVID-19 came and the town hall was unable to carry out activities in this regard."*
>
> *– Municipality representative, Burkina Faso*

> *"We took the time to identify partners from whom we could mobilize resources. The meetings were conducted by phone call to continue the resource mobilization meetings. All meeting dates were reviewed."*
>
> *– Municipality representative, Côte d'Ivoire*

> *"After the training of the members of the municipalities in resource mobilization in June 2020, a mapping of the partners was done and steps are underway to organize meetings of the partners and to mobilize funds for FP (construction of a type 1 peripheral health care unit)."*
>
> *– Municipality representative, Togo*

Most municipalities were not prepared with the necessary funding for the COVID-19 precautionary measures, even though some reported receiving support in cash and in kind from benevolent individuals and private companies. Regularly scheduled activities were either suspended or re-programmed to focus on the COVID-19 response.

> *"COVID- 19 required additional resources. We were not prepared for this, but we were able to cope thanks to the chain of solidarity that was born from it. We will take advantage of this to review our way of functioning. We are going to invite the partners to take part in the meetings of the city council so that they are informed about the projects of the city council. From now on, the state has transferred everything to the town halls (construction of health centers, construction and equipment of drinking water supply schools etc...) We will sensitize people to be key partners of the town hall."*
>
> *- Municipality representative, Côte d'Ivoire*

Despite the disruptions, some municipality representatives saw new opportunities for FP-specific mobilization:

> *"There are several partners within this community that can support resource mobilization for FP as was the case for COVID-19."*
>
> *- Municipality representative, Togo*

> *"The advent of this health crisis that is COVID-19 has allowed us to draw innumerable lessons, first of all this crisis should lead politicians to mobilize resources in order to work the health sector to avoid the effervescence of hospitals, the crisis also calls for solidarity in various areas including resource mobilization."*
>
> *- Municipality representative, Togo*

> *"COVID-19 turned everything upside down, disrupted what we put in place. Companies were approached for COVID. We're going to use that for what we want to do. In general, when companies are approached about health, they respond positively. We're counting on that to mobilize resources."*
>
> *– Community organization representative 1, Côte d'Ivoire*

Reduction in Revenue

Municipalities across the four countries reported record losses in revenue all the while having to institute COVID-19 health protocols for staff and visitors. With establishments closed during the first months of the pandemic, there was no tax/revenue collection from vendors such as eateries. In Togo, a municipality focal point illustrated the gravity of the shortfall:

> *"Prior to COVID-19 our average revenue from collection fees in the markets was an average of 800,000 FCFA[10] per month. During the pandemic our revenues were 300-400,000 FCFA per month. More than 50% shortfall."*
>
> *– Municipality representative, Togo*

[10] 1 US Dollar = 550 FCFA

COLLABORATION AND COMMUNICATION FOR CONTINUITY: *Findings from the Qualitative Analysis*

Combined Health Messaging

Across all four countries, MoH officials described a national strategy that combined mass messaging about infection prevention and control measures with continued access to health services, including RH/FP. This strategy has continued over the course of the pandemic, although it was most intense at the onset. In the four countries, health campaigns and messaging are carried out through mass media, including national and community radio programs and broadcasting spots in multiple languages, national and private television stations, online press, social networks, billboards, mobile operators, posters, and leaflets at health facilities as well as through door-to-door awareness raising.

MoH Working with Other Partners

In Burkina Faso, the Department of Communication and Department of Promotion of Health Education worked with a communication agency to develop FP messages that were sent by SMS to the larger population. Another set of health messages was developed in partnership with West Africa Breakthrough ACTION (WABA).

At the district level, MoH officials reported collaborating with an NGO and a local association to raise awareness on the accessibility of FP services during the pandemic in marketplaces within the municipality of Ouagadougou. Specifically, MoH Burkina Faso contracted SOS JD (a youth and development NGO) to carry out the campaign on the continuity of RH/FP services on national and municipal radio stations reaching a total of 22 markets in the catchment area.

The Burkinabe MoH Technical Secretariat for Accelerating the Demographic Transition (STATD) Division obtained funding with the help of PP Global, an NGO, to acquire protective equipment. Also in Burkina Faso, health information was also communicated through town criers known as "griots," community health workers (CHWs) and through posters. CHWs went door-to-door to raise awareness, with support from Médecin du Monde. According to one of the Burkinabe MoH officials, it was in the interest of MoH to collaborate with and benefit from the experience of partners such as NGO ALIMA which managed the height of the Ebola and had extensive experience in the health system.

Burkina Faso MoH also received financial support from partners, such as WHO and UNFPA. Furthermore, Health Policy Plus (HP+) provided training of local experts across the country and supported the COVID-19 Committee with training. Months into the pandemic, some of these health messages have been adapted to a certain degree. While one Burkinabe MoH official stated that all messages have stayed the same over time, another MoH official clarified that there had been a segmentation of the message for certain target audiences, including women, religious and traditional leaders.

In Togo, MoH collaborated with development partners and projects, such as WHO, UNFPA, AmplifyPF, WABA, Jhpiego and GIZ. MoH Togo also sought out media and CSO to produce and

disseminate radio and televisions spots in several languages. Similar to Burkina Faso, in certain prefectures, COVID-19 prevention messages were disseminated in public spaces, such as marketplaces. Specifically, community sensitization was carried out using vehicles with loudspeakers for two consecutive weeks at the beginning of the pandemic, with messages tailored to COVID-19 protection measures as well as continued use of RH/FP services despite the pandemic. While the vehicles with loudspeakers had stopped circulating as of early August 2020, community relays continue to diffuse information, and public service messages are still broadcast on radio. An MoH official stated that the district's collaboration with community organizations and other NGOs made it possible to take into account and take ownership of infection control measures and rapid control of the infection.

Ivorian MoH officials reported receiving technical and financial support from various partners (public sector, private sector, municipalities, development partners) to implement the country's COVID-19 response plan as well as disseminate awareness messages. Coordination with partners was facilitated by a platform for exchange and coordination between the MoH and partners that existed prior to the pandemic. Specifically, MoH worked with partners like WABA and AmplifyPF on radio spots.

MoH officials reported success in mobilizing all sectors for sensitization and material support to populations. Specifically, the government's good collaboration with NGOs and CSO made it possible to raise awareness among health providers (giving providers the information to handle COVID-19 infection cases) and populations (explaining safety measures) and to reassure both groups. Moreover, this collaboration enabled all sectors to adhere to the messages and actions of the government for infection prevention and control. According to one FP provider in Côte d'Ivoire, communication to the community was also done by griots, as well as by community leaders and religious leaders.

In Niger, MoH signed an agreement with the COOPI, an NGO, for community awareness-raising using community relays. MoH also mobilized development partners and private sector to be part of the COVID-19 management committee. MoH officials in Niger reported success in collaborating with partners by obtaining their commitment to infection prevention and control. It also reported success at the community level by engaging the District Health Committees and the District Management Committees. Health communication was also done by using trained female community relays who diffused information on COVID-19 and encouraged the community, especially women and youth/adolescents, to go to the health facilities to seek services, including FP and child immunizations. Health officials also made media appearances to reinforce the messaging; a national hotline was even created. In addition to prioritizing messaging on use of FP services and compliance with preventive measures, MoH officials in Niger also mentioned developing messages targeted for young people on promoting their use of health services. There were also messages created to reduce stigmatization of the uptake of RH services and of those who became infected by COVID-19.

Additional Collaborations

Municipalities and community organizations also played a critical role in encouraging the community to continue seeking FP services. In Côte d'Ivoire, one municipality worked closely with doctors from a medical school in the local area to organized weekly health talks on FP, STIs, HIV/AIDS, alcoholism, and drug addiction, targeted for young people in the catchment area. The municipality also coordinated a free condom distribution campaign that was organized by the AmplifyPF during which 64 young people were identified to each distribute 720 condoms to the larger population:

> *"During the period of confinement, we organized programs on RH/FP on the communal radio. We participated in the condom distribution campaign organized by Pathfinder through AmplifyPF. We did this because the students were at home and we felt that the risk of contracting unwanted pregnancies was high."*
>
> *- Municipality representative, Côte d'Ivoire*

The same municipality also provided the space, chairs, and tarpaulins for community dialogues that it scheduled; it also partnered with WABA to organize health facility site walkthroughs.

Technical Assistance from the AmplifyPF

The AmplifyPF project provided direct technical assistance to respective MoHs at various levels. During the focus group discussions, AmplifyPF country teams reflected on specific activities that they had undertaken to support the MoH in ensuring continuity and use of FP services.

National Level

Having recognized that at the beginning of the pandemic, health workers had stopped offering basic healthcare services, including FP, for fear of being infected with COVID-19, the AmplifyPF/Niger country team advocated for developing a memo on FP service continuity. This memo was released in April 2020 and directed at health officers are all levels. During this period, the AmplifyPF/Niger team also supported the Department of Family Planning (DFP) to develop a service continuity plan and provided technical support and IT equipment to facilitate virtual meetings, including the first roundtable between the DFP and partners on the monitoring the FP continuity plan. The country team also used the meeting as an opportunity to distribute commitment sheets for resource mobilization in Niamey 1 District.

Likewise, the AmplifyPF/Burkina Faso noted the lack of a normative document to guide healthcare providers on how to handle pandemics, such as COVID-19, and the need to make available guidance manuals related to coordinated response to pandemics. The team provided technical assistance to the MoH to implement its FP service continuity initiatives. The assistance was in the form of revising the reference manual for DMPA-SC self-injection at private pharmacies and developing a guide for continuity of health services.

The AmplifyPF/Togo team recalled the initiative it took to organize a meeting via Microsoft Teams which brought together implementing partners (IP) and the Directorate of Mother and Child Health on April 22, 2020 to discuss mitigating plans across board. This pivotal discussion held among IPs

led to the organization of a series of virtual meetings in which AmplifyPF was well represented, namely: the Togo IP Community Health sub-group (April 30, 2020), the quarterly meeting of the Technical Group on Product Safety and Scaling Up of Good Practices in Health, and the quarterly meeting of the Technical Group on Product Safety and the Scaling up of Good Health Practices (June 24, 2020). Furthermore, AmplifyPF/Togo participated in the daily "Fight Against COVID19" coordination and management, meetings led by the MoH (national and regional).

Regional Level

At the regional level, AmplifyPF/Niger liaised with MoH in Niamey and Zinder to provide technical support for organizing virtual meetings to identify FP service continuity strategies in these intervention regions.

District Level

At the district level, AmplifyPF/Niger also organized virtual meetings for the ILN Technical Support Committee in each district. These committees are headed by the District Director for Health Services. Specifically, the country team provided technical support to install the Microsoft Teams software for committee members to facilitate discussions and decision-making on strategies for continued FP services. The team described the strategies as follows:

- Doubling healthcare workers at the service delivery points to reduce wait times for clients
- Using community relays to follow up on appointments with FP clients
- Creating WhatsApp groups with public and private health centers in order to share information on the continuity of services
- Creating a WhatsApp group for monitoring messages on the COVID-19 that had been developed by WABA for the ILNs

AmplifyPF/Burkina Faso maintained regular contact with the District Directors for Health Services via telephone, email, and WhatsApp to keep abreast with the continuity of services in health facilities as well as the difficulties encountered over the course of the pandemic. Additionally, WABA conducted field visits to follow-up on these needs and difficulties and relayed information to the AmplifyPF about the availability of FP services and compliance with COVID-19 measures in the ILNs. The team also worked remotely with the District Directors for Health Services and RH Managers of Boulmiougou, Do and Dafra districts to plan FP Special Days that were slated for resumption in August 2020.

Health Facility Level

Once the lockdown restrictions were lifted, the AmplifyPF/Niger provided technical and financial assistance, including the donation of infection prevention materials and organization of sessions with selected private health centers in order to brief them on:

- DMPA-SC and the ISBC approach
- RH/FP monitoring activities that were being organized for selected health posts in Niamey
- plans for assessing on-site the quality of data reported by healthcare workers
- financial support for the remote monitoring of ISBC activities in Mirriah and Matameye Health Districts

AmplifyPF/Burkina Faso successfully trained, coached and monitored health facility managers in Do and Dafra Districts who had not begun implementing the ISBC approach before the lockdown.

Leveraging Technology

AmplifyPF country teams capitalized on various technologies to create, enhance, and solidify relationships with multiple ILN stakeholders. AmplifyPF country teams used the telephone to reach health providers and monitor the implementation of the ISBC approach as well as gauge access to contraceptive methods. Country teams made use of WhatsApp platforms to keep up-to-date with MoH activities and communicate with officials at various levels. The AmplifyPF/Burkina Faso team continues to monitor the ISBC intervention through discussions with Facility Managers via WhatsApp.

AmplifyPF's Contribution to Health Campaigns and Messaging

All four AmplifyPF country teams provided support to WABA in their development of reproductive health- and COVID-19-related messaging. Specifically, in Niger, these messages were accessible via the Airtel 325 Hotline. To promote the use of FP services during the pandemic, messages were disseminated in Burkina Faso through radio spots across two radio stations per ILN, amounting to 8 radio stations. AmplifyPF/Burkina Faso also worked with STATD to develop communication supports on FP and COVID-19, as well as free FP services.

Facilitators and Challenges to Collaboration and Coordination

For Burkina Faso MoH, the coordination of the COVID-19 response was centralized. As the pandemic became manageable, each department developed messages in collaboration with partners, first on COVID, and then on service utilization. However, insufficient funding made it impossible to cover all markets. A notable challenge was that some private sector companies sent messages without coordination with MoH.

For Ivorian MoH officials, one aspect that facilitated collaboration was the fact that development partners were already implementing projects in districts. Likewise, MoH officials at the Department of Maternal and Child Health in Togo agreed that the existence of a group of development partners that were already in regular contact prior to the advent of the pandemic was a facilitating factor. Videoconferences also allowed for efficient exchanges among partners.

Despite the successes, Ministries of Health encountered challenges encountered in collaborating with partners to plan, design and execute adaptations. One MoH Official in Burkina Faso expounded on differences in approaches by the government compared to what associations and partners were proposing:

> *"The way the associations and partners saw the response, the country could not go in that direction. The first aspect is that the health system has not been sufficiently strengthened. We created a parallel structure…that was a political decision. In doing so, the response got off to a timid start. We did not have the resources to achieve the ideal that the development partners wanted. For example, we did not have the resources to acquire the masks and to respect their standards of use."*
>
> *- MoH Official, Burkina Faso*

AmplifyPF/Niger described a number of challenges related to logistics. Some health facilities were not able to make available at least three months' worth of contraceptives due to lack of storage space. The team was unable to have the desired maximum number of participants for virtual trainings with MoH staff since many did not have an email address and/or a smartphone on which the Microsoft Teams application could be installed. Quality or altogether lack of internet connectivity was another challenge.

AmplifyPF/Burkina Faso contended with competing interests faced by resource persons on the ground whose pandemic response work afforded them less time to attend virtual trainings. Internet access was also an issue.

PERCEIVED EFFECT OF HEALTH MESSAGING OF FP SERVICE UTILIZATION: *Findings from the Qualitative Analysis*

The content and intensity of the communication over time has varied within and across countries. In Burkina Faso, a FP provider reiterated that there'd been no change in the messages given that the disease is still relevant. Within Côte d'Ivoire, the FP provider in Abidjan explained that the frequency of information on COVID has been reduced in the capital city, while in Bouaké, the FP provider reported that the frequency of messaging remained the same, with emphasis on reassuring the community and reporting on the lack of positive cases in the area.

For one FP provider in Burkina Faso, health campaigns and radio spots allowed the population to have information on the disease and to appease the pervasive fear. Providers in Côte d'Ivoire, Niger and Togo credited an improvement in client use of FP services over the course of the pandemic as a result of this direct communication to the community.

> *"Yes, the messages we gave were successful because that's when they started coming to the hospital a little bit."*
>
> *- FP Provider, Côte d'Ivoire*

> *"These messages have borne fruit especially the spots that linked containment with the benefits of FP. Clients kept coming and also most of them chose the long-acting methods."*
>
> *- FP Provider 1, Togo*

"Confiance Totale" Campaign

Some MoH officials were aware of the "Confiance Totale" campaign implemented by the WABA project. An official from Burkina Faso summarized it as follows:

> *"The campaign was done by WABA. It invites the population to trust health services and to trust contraceptive methods. It will help health services attendance."*
>
> *- MoH Official, Burkina Faso*

MoH officials in Niger and Togo who knew about the "Confiance Totale" campaign all concurred that it would gradually improve client attendance and the use of FP services as well as increase knowledge on the availability of services and behavior change for use of FP services.

Stay at Home, yet Seek Health Services?

The strategy to combine health messaging about COVID-19 prevention and access to health services meant that, on one hand, clients were being asked to stay at home to prevent the spread of infection and, on the other hand, to physically seek services at health facilities while complying with COVID-19 health protocols. One MoH official explained that in Côte d'Ivoire, health messaging was progressive and provided a concrete example of the combined messaging from a health campaign:

> *"At the beginning of the pandemic, the [MOH] message was one of recognizing the signs to get tested and the protocols to be followed by the population to avoid being infected or infecting neighbors. Then the continuity messages from other services during the pandemic to tell the population to attend the health facilities because other services are available all the while respecting the prevention measures in place."*

> *"An example of "Confiance Totale" campaign message: "Confinement, yes, but protect yourself from unwanted pregnancy" or "Protect yourself from COVID, [also] but protect yourself from unwanted pregnancy and STI/HIV".*
>
> *- MoH Official, Côte d'Ivoire*

FP providers were also asked about how they reconciled these two types of messages in their work. For FP providers in Burkina Faso and Côte d'Ivoire, there was no contradiction in messaging because FP providers had a good understanding of the objectives of the messaging. For FP providers in Niger and Togo, the reconciliation of messaging was more challenging:

> *"Conciliation was slightly difficult at the beginning. Clients were reluctant [to access health services] for fear of infection. But the clients gradually understood as the nuance was explained."*
>
> *- FP Provider, Niger*

> *"From one perspective, there is a conflict in the message delivered by the FP provider asking the client to keep her appointments and at the same time to respect the confinement that forbids outings. Yes, confinement, but there is always the risk of unprotected sex/pregnancy in a couple's life and basic human needs…going to the market or respecting her follow-up visit, etc., hence the importance of making useful outings such as going to the hospital."*
>
> *- FP Provider 2, Togo*

Barriers to Accepting Health Messaging

MoH officials in Niger and Togo listed ignorance, social and cultural norms, as well as religious beliefs (divine retribution) as barriers to accepting health messaging. For MoH officials in Burkina Faso and Niger, barriers included many people not believing in COVID-19 and thus do not complying with the preventive measures. One Burkinabe MoH official further noted that there were rumors

surrounding the unavailability of service providers. Other contributors to these barriers in Burkina Faso included inaccurate messaging by authorities at the beginning of the pandemic:

> *"The first messages sent were not accurate. The authorities were not frank, which created uneasiness. In the beginning there was very bad communication. This led to a public apology from the Minister to the press for having been misled by her collaborators."*
>
> *- MoH official, Burkina Faso*

The AmplifyPF/Burkina Faso team members equally noted the generally low responsiveness at the level of the MOH to reassure providers and populations, which affected the quality of services offered and attendance by populations.

(PROJECTED) IMPACT OF COVID-19: *Findings from the Qualitative Analysis*

MoH officials were asked to discuss the impact of COVID-19 on service delivery and FP use over the course of the pandemic. On one hand, some MoH officials in Burkina Faso, Niger and Togo noticed a decline in client attendance, new FP users, and uptake of long-term methods:

> *"The figures in the reports showed that clients were attending fewer and fewer health facilities, so there was a decline in attendance rates [...] Over the period, there was a decline in the demand for long-term methods."*
>
> *- MoH Official 1, Burkina Faso*

> *"A decrease in the use of services, especially in Niamey due to fear of being infected, stigmatization. [...] Restriction in service delivery in relation to measures taken on service schedules."*
>
> *- MoH Official, Niger*

On the other hand, other MoH officials described an inconsequential impact of COVID-19 on service delivery and use over the course of the pandemic and, in some instances, an increase in new FP users:

> *"At the beginning of the pandemic, even outside of FP services, there was a sense that services were underutilized. It was the same with RH services. But when we compare the data for Q2 2019 to those for Q2 2020, we see more or less the same trend, so there is not really much change. It is recognized that at the beginning, in terms of attendance, the effect on service use was real. For example, I noticed in the mornings that the parking lot of the CMA in Pissy, the Hub maternity hospital of the ILN in Boulmiougou, was empty. But now attendance is picking up again. The impact was at the very beginning of the pandemic. [...] In any case, it cannot be said that there has been a large-scale negative impact."*
>
> *- MoH Official 2, Burkina Faso*

> *"We were able to see from the FP data for the past 5 months, [when] compared to the same months in 2019, that for the time being COVID has not had a negative effect on the supply and utilization of FP services."*
>
> *- MoH Official 1, Côte d'Ivoire*

"Analyses of routine statistical data show us that service provision in general has decreased but not in FP. The data from January to June 2020 are not significantly negative compared to 2019 for the FP service offer in Côte d'Ivoire."

- MoH Official 2, Côte d'Ivoire

"... but in the other regions there is no problem, and as evidenced by the comparison in terms of overall numbers, there has been an increase in the recruitment of new FP users."

- MoH Official, Niger

"At the beginning of the pandemic there was a general decline in attendance, but analysis of routine MCH and FP data did not show a significant difference between the period January to March 2019 on the one hand and 2020 on the other. However, the absence of data in mobile strategy and FP Open Days activities did not make it possible to achieve the objectives set for semester 1 of 2020. We had thought of a negative impact but with the rapid resumption of innovative FP Special Days and FP Open Days activities, FP indicators have not suffered too much."

- MoH Official 2, Togo

At the same time, some MoH Officials also detailed the impact COVID-19 has had on other domains. According to one MoH Official in Burkina Faso, service delivery was sub-optimal as a result of some providers no longer coming to work. In Togo, one MoH official noticed a limited choice in FP methods as a result of lack of financial means to procure commodities.

Asked about the expected impact of COVID-19 on service delivery and FP use in the three months following the interview (August to October 2020), expectations also differed within and across countries. Some MoH officials in all four countries expected a resumption of normal activities with COVID-19 health protocols enforced, leading to an increase in client attendance and use of FP services and, as a result, better health service indicators. One MoH official from Côte d'Ivoire emphasized that this expected positive impact was barring a second wave of COVID-19 infections. Meanwhile, another MoH official in Niger and one in Togo expected reductions in several front in general.

"Reduction in attendance and use of FP services, especially oral and injectable contraceptives. We believe long-term acting methods will increase."

- MoH Official 2, Niger

"In our district, we are at risk of having a decrease in FP users."

- MoH Official 1, Togo

Even though MoH officials in Burkina Faso did not expect any negative impact of FP commodities or service provision itself, there was an expected negative impact on the management of the free FP services program, since that the reimbursement component would decrease, the cost-of-service provision could increase in order to maintain what providers and health facilities had received at the same level as in the past.

In Côte d'Ivoire, MoH officials observed that their Ministry's messages on the continuity of services and the assurance given to the populations for the delivery of FP services were the principal reasons why the country had not seen a negative impact on FP in general.

ILN stakeholders reflected on COVID-related measures that were intended or wished for and to provide reasons why these measures had not been attained and/implemented. While the nature of these measures varied, the reasons for not implementing mainly centered on lack of financial resources (see Appendix 15).

EMERGING ASPECTS AND LESSONS LEARNED: *Findings from the Qualitative Analysis*

Respondents were asked about emerging aspects with regards to the impact of COVID-19 on the continuity of FP services and raised the following:

Resumption of Activities. MoH officials referred to the gradual return to routine activities f ollowing the lifting on strict limitations prescribed at the onset of the pandemic.

Prioritizing Youth and Adolescents. In two countries, MoH officials observed an emerging issue related to youth and adolescents not being prioritized:

"The issue of youth and adolescents has not been sufficiently addressed. Strong actions towards young people must be undertaken. […] Spots aimed at young people and adolescents are useful."

- MoH official, Burkina Faso

"Challenges in terms of involving adolescents and youth in the fight against the spread of COVID-19 infection, and particularly in mobilizing them to attend RH services."

- MOH Official, Niger

Prioritizing Long-Acting and Self-Administered FP Methods. FP providers in Côte d'Ivoire mentioned the use of long-acting methods and DMPA SC self-injection as a way to avoid frequent contact with the health center and also decrease contraceptive discontinuation. Likewise, a Togolese MoH official highlighted the subcutaneous injectable as an emerging aspect:

"It is the choice of DMPA-SC (self-injection) that emerges. The challenge is the mastery of the technique by the clients, the respect of visit appointments, and the strategy to have a traceability of the quantities served to the clients in order to take them into account in the planning and avoid possible stock shortages."

- MoH official, Togo

FP providers in Côte d'Ivoire and Togo observed variance in contraceptive use and method choice as emergent aspects:

"Yes, cases of discontinuation are emerging. But they come back to continue or change their method."

- FP Provider, Côte d'Ivoire

"Long-acting methods are more likely to be chosen by clients during COVID 19."

- FP Provider, Togo

Increased Hygiene. FP providers reported a noticeable improvement in hygiene as a result of frequent washing of hands and disinfection of surfaces. A Burkinabe MoH official made a similar observation, while a Togolose MoH official remarked on the role of health providers :

"Implicitly, diseases with dirty hands have systematically decreased when looking at the Ministry of Health database."

- MoH Official, Burkina Faso

"Every health worker served as a role model in respecting barrier measures and encouraged those around them to wear a mask and to respect barrier measures."

- MoH Official, Togo

Respondents were also asked to reflect on lessons learned five months into the pandemic and made the following observations:

Lacking Health Systems. In Burkina Faso, while one MoH official considered the country's management of the pandemic a lesson for other countries, their counterpart highlighted a weak healthcare system affecting service delivery:

"Our health care system is weakly resilient. Especially for service delivery, we health workers were not prepared, so delivery took a hit. We didn't go to the health centers, we were afraid, we didn't know how to welcome clients."

- MoH Official, Burkina Faso

Equally, in Côte d'Ivoire, one of the MoH officials also commented on an ill-equipped health system that saw improvements as a result of adaptations:

"At the beginning of the pandemic the health system was not 'equipped' for the fight but, with the adaptation of the different measures and the total involvement of all sectors, the health system has improved in the fight against the pandemic."

- MoH Official, Côte d'Ivoire

Some municipality representatives also highlighted the unpreparedness of the health system:

"In general, the lesson that the mayor's office learned from this pandemic is that the health system was not ready to manage a pandemic like COVID-19. The Ministry of Health needs to review the health system and prepare for the management of such a crisis. The same is true for city councils. What can the city hall do to help raise public awareness, etc.?

– Municipality representative, Burkina Faso

COVID-19 is No Longer an Obstacle. MoH officials in Niger and Togo both expressed that the progression of the pandemic was not an obstacle for clients to seek out FP services, once prevention measures are observed by all health facilities. Despite COVID-19, clients continue to come to the health facility for their methods in compliance with preventive measures, as evinced by successes of FP Special Days organized in Togo in the midst of the pandemic.

FP providers in Niger and Togo similarly expressed that the control of any epidemic or pandemic is essential for good continuity in the implementation of FP activities and that compliance with barrier measures allows the continuity of FP services without risk of infection because people have learned to live with the disease. For one FP provider in Togo, learning to live with COVID was the principal lesson over the course of the pandemic:

"We understood now that we have to live with COVID 19 at the beginning we had little stress but now for us to move forward we have to respect the prevention measures recommended by the WHO and the government and continue normally with the activities...Living with COVID to make everything work."

- FP Provider, Togo

Strengthened Technology and Community Engagement. In the four countries, MoH officials and FP providers reported learning that strengthening community interventions (sensitizing community relays on COVID-19, supporting mentors and mobile clinics using community relays, community-based distribution, CHWs offering FP methods to help maintain the continuity of FP services) is a high-impact strategy to ensure the continuity of RH/FP services. Also, offering services remotely using communication technologies (social networks, telephone) is also a great opportunity.

Discordant Management. In Burkina Faso and Niger, MoH officials and FP providers alike remarked about how the discord in the management of the pandemic at its onset had negative consequences, including denial of even the existence of the virus by a segment of the population. Moreover, a lack of material and financial support for health facilities or management committees and no financial incentives for health workers exacerbate the situation.

A New Way of Doing Business. AmplifyPF country team members unanimously noted the central role of information and communication technologies (ICTs), specifically the internet, to get results and help meet project targets in the absence of physical monitoring activities. Several activities once thought to necessitate physical presence could be conducted virtually, as long as the internet connection is stable and the bandwidth sufficient. Digitalization will likely lead to cost and time savings. AmplifyPF country teams wished to promote the use of ICTs for this new way of doing business.

Discussion and Conclusion

The AmplifyPF project leveraged its relationships with stakeholders in selected health districts across Burkina Faso, Côte d'Ivoire, Niger, and Togo, where it is implementing the ILN model to conduct key informant interviews about measures undertaken to ensure continuity of FP services during the pandemic. These stakeholders include MoH officials at the national, regional and district levels; FP service providers; representatives of community organizations and municipalities; and AmplifyPF country team members.

Although findings presented in this report are limited to the experiences of these ILN stakeholders interviewed, they provide several insights on implementation and adaptation measures undertaken in response to the COVID-19 outbreak four months into its onset, so that continuity of FP services and functionality of ILNs would be ensured. Generally speaking, previous studies assessing the influence of health crises have been mostly retrospective, that is, months or years after a given outbreak. This AmplifyPF-led study, however, combined qualitative and quantitative approaches to investigate in real time the impact of the COVID-19 crisis on the continuity of FP services at the start of the pandemic and from the perspective of multiple stakeholders at various levels of operation across four countries.

Globally, the COVID-19 pandemic presented the risk of disruption in the provision and use of essential health and nutrition services, which would potentially lead to preventable maternal, newborn and child morbidity and mortality (WHO, 2020; UNFPA, 2020a). Findings from this assessment study confirm that, in the four countries, governments took quick actions to mitigate the effects of the unprecedented COVID-19 outbreak, which arrived at its shores by mid-March 2020. Unlike suggested in the literature, in these four countries the risk of disruption in service delivery and use of essential health services was not as great as anticipated. The first two months after the outbreak coincided with the lockdown/confinement period and trends show a decrease in the number of FP clients attending the facilities: -22% in Togo, -18% in Niger, and -2% in Côte d'Ivoire. Nevertheless, these decreases cannot be fully attributed to the COVID-19 outbreak.

Faced with the tangible risk of reduction in attendance and disruption of services, the MoH partners fervently advocated for continuity of FP services, steering the MoH to take prompt action in public messaging and resource deployment. Echoing these efforts, the MoH swiftly reacted by fully resuming activities to generate demand for health services; such activities were taken up, in an intensified way, as early as May/June 2020 in Togo. The effect of the actions taken by translated into noted trends in the increase of FP service uptake, with Togo providing an exceptional case example. Indeed, there were noticeable increases in the number of clients served during the resumption period in mid-2020, with rates of increases of 76% in Togo, 23% in Niger, and 19% in Côte d'Ivoire. Additionally, there was no observed impact of the COVID-19 on utilization of delivery services and the pattern of utilization of immediate PPFP mirrored that of general FP use. Supplementary analysis by the calendar years (2018, 2019, and 2020) of the indicators of interest to this study (Appendix 1 to Appendix 14) disaggregated at the district level across the project countries, suggest that the onset of the pandemic

did not interfere with seasonal cycles. Indeed, in certain instances, that 2020 calendar year saw increases following the lockdown/confinement period of March to April 2020. Results from these supplementary analyses point to seasonal effects regarding facility-based births, with monthly numbers rising from January through May/June of each year, including the year of the onset of the pandemic. There may, however, be other confounding factors behind these trends that were not captured by our study.

In the four countries, continuity of services was made possible first by deeming health services essential, by reorganizing personnel where necessary, by implementing COVID-19 health protocols nationwide, and by collaborating with development partners to achieve service continuity.

A principal takeaway from this study is that it is feasible to ensure continuity and use of FP services while simultaneously fighting an unprecedented pandemic. Efficiency and timeliness are key: the MoH needs to act in collaboration with its partners to deliver a unified response that is promptly carried out with widespread, supportive messaging through various public media as well as community channels.

Further studies are needed to assess how the resumption of services impacted the course of the pandemic.

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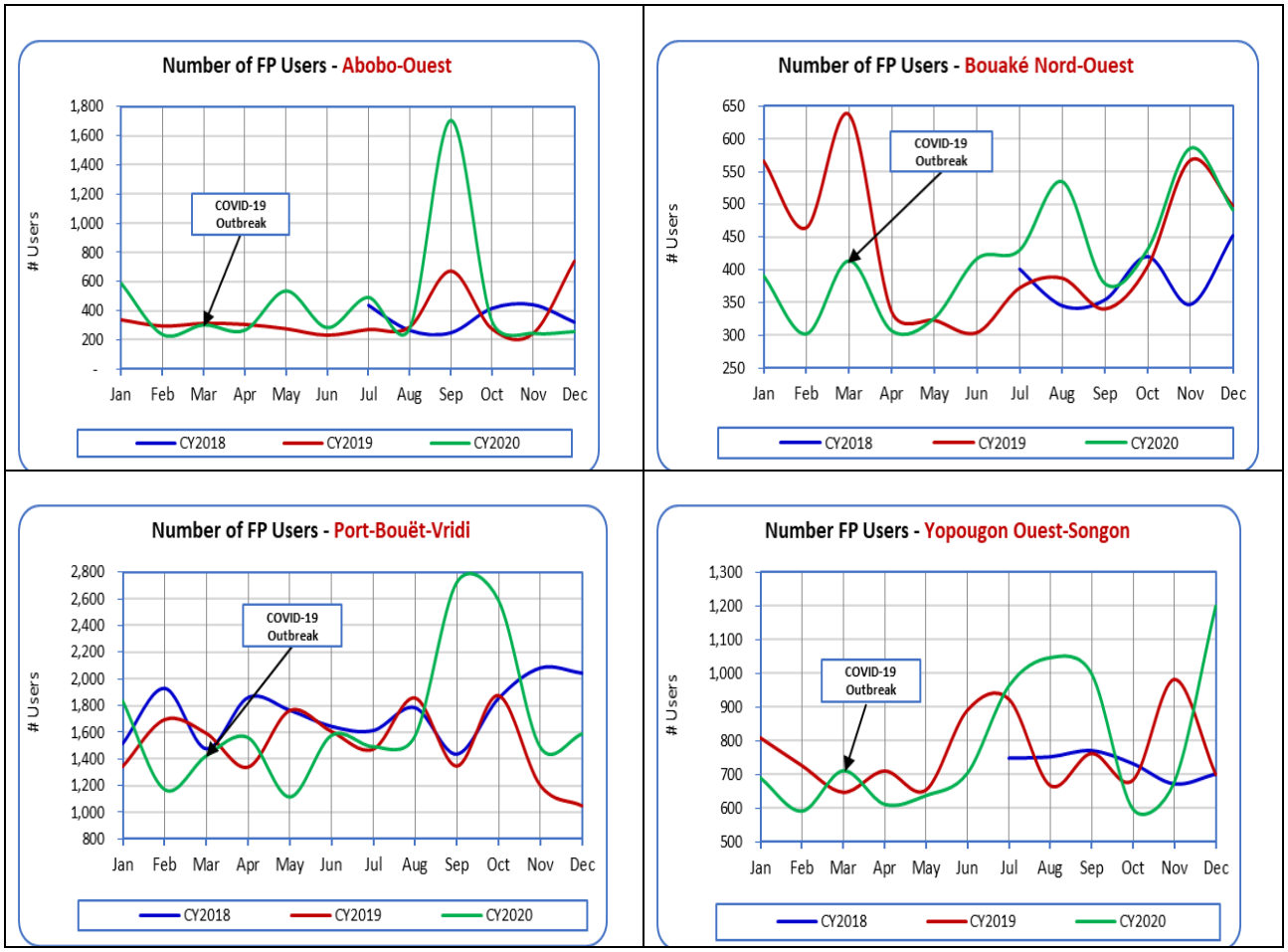
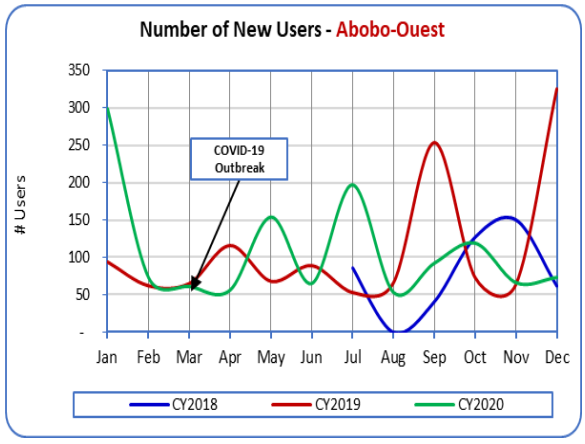
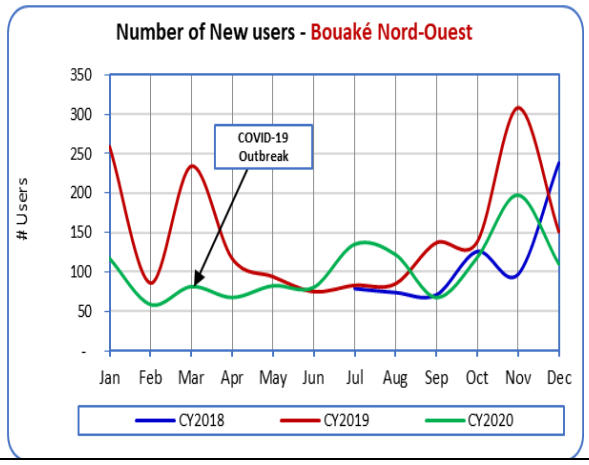
Appendices

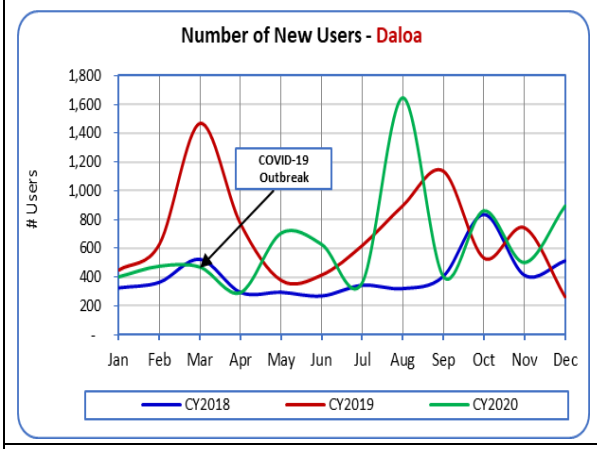
Appendix 1. Average number of FP users (both new and existing FP clients) served across four ILNs in Côte d'Ivoire over 2018, 2019, and 2020 calendar years

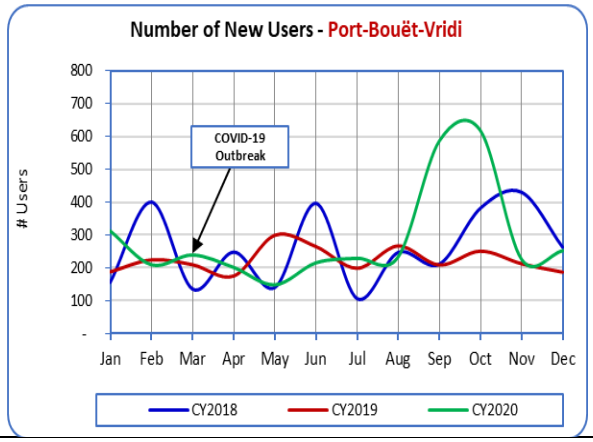


Appendix 2. Average number of new FP users recruited across five ILNs in Côte d'Ivoire over 2018, 2019, and 2020 calendar years

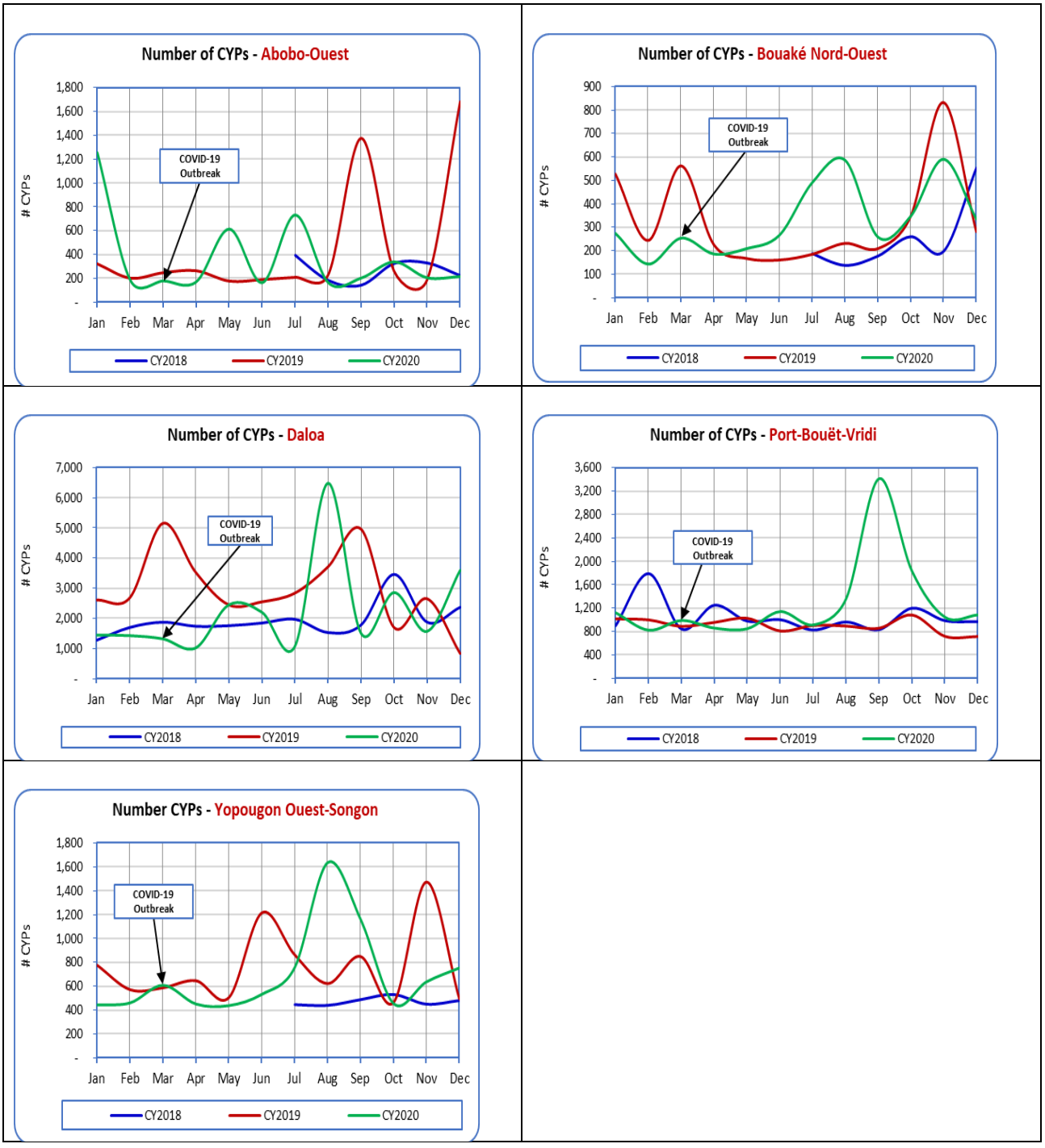




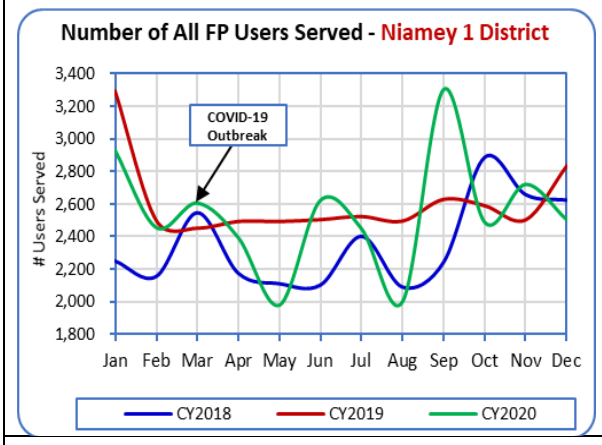


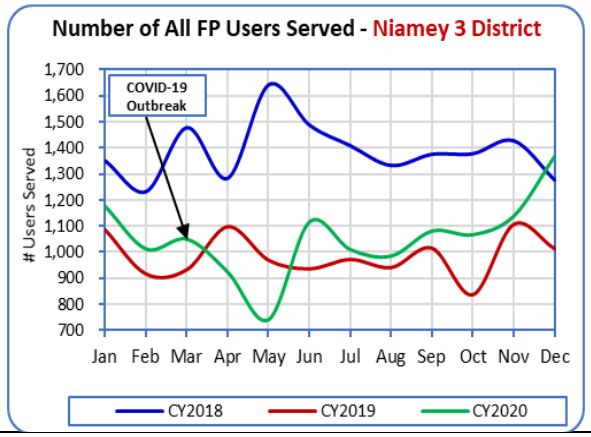


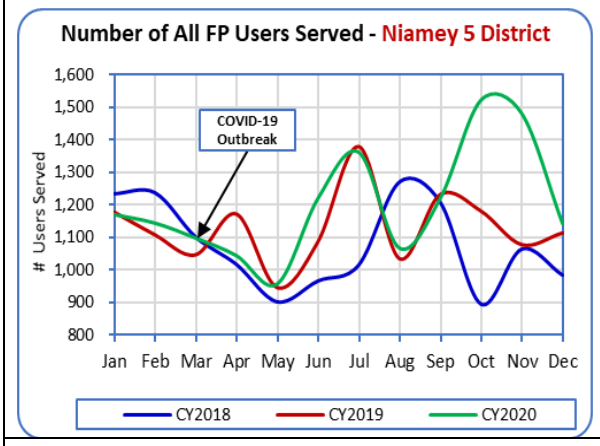
Appendix 3. Average number of Couple Years Protection across five ILNs in Côte d'Ivoire over 2018, 2019, and 2020 calendar years

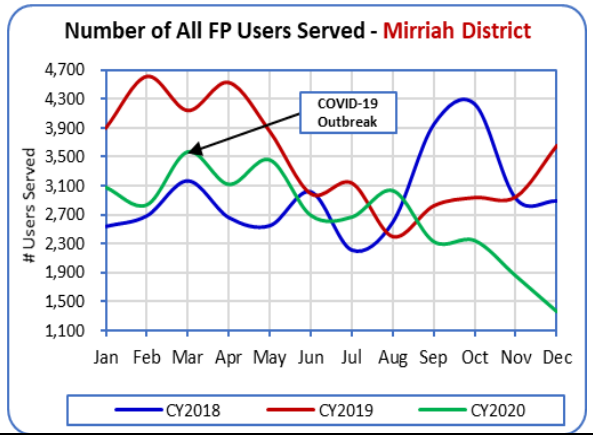


Appendix 4. Average number of FP users (both new and existing FP clients) served across five ILNs in Niger over 2018, 2019, and 2020 calendar years

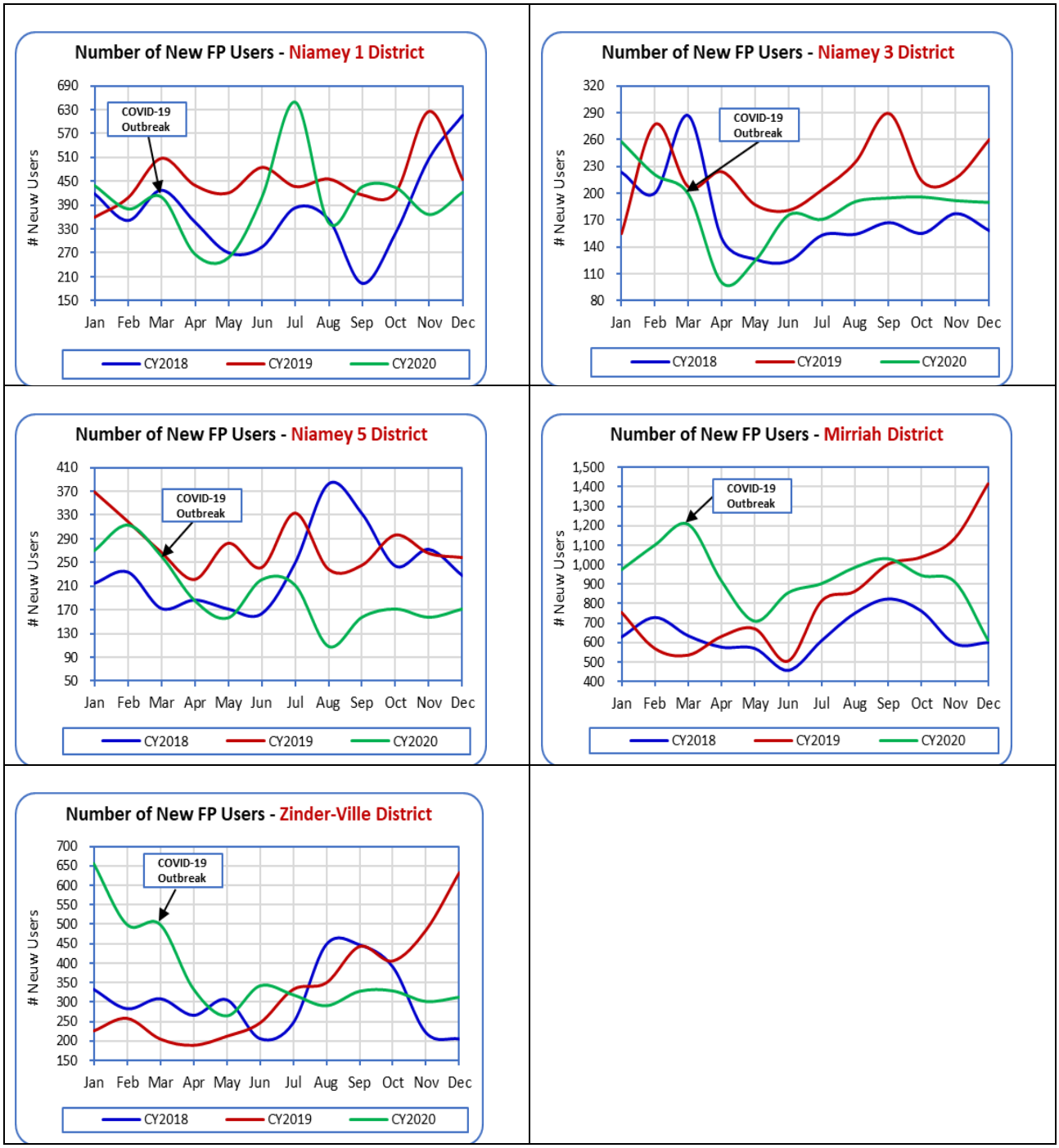




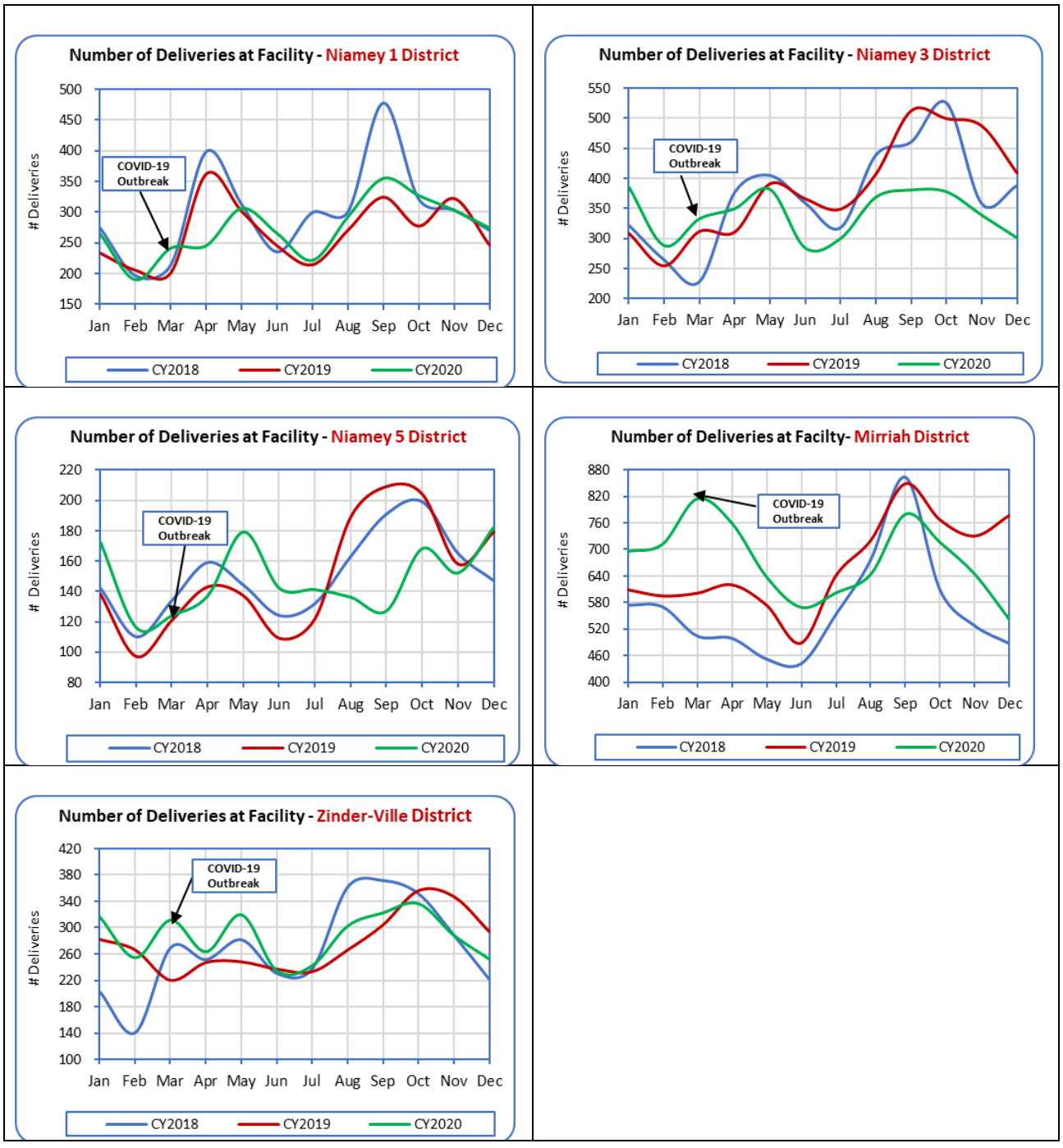




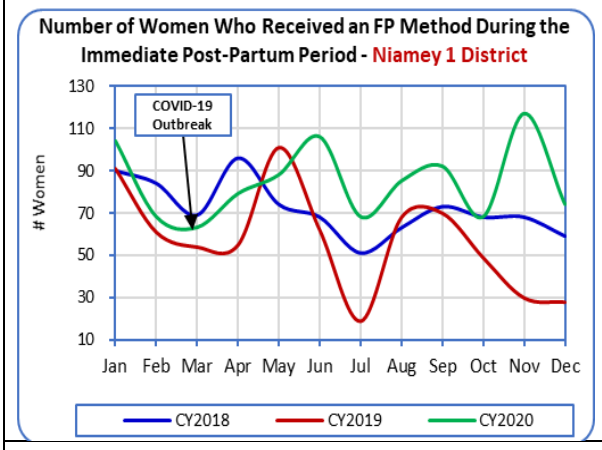
Appendix 5. Average number of new FP users recruited across five ILNs across Niger over 2018, 2019, and 2020 calendar years

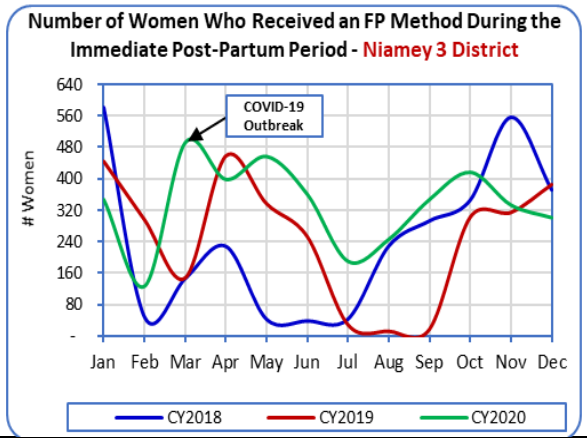


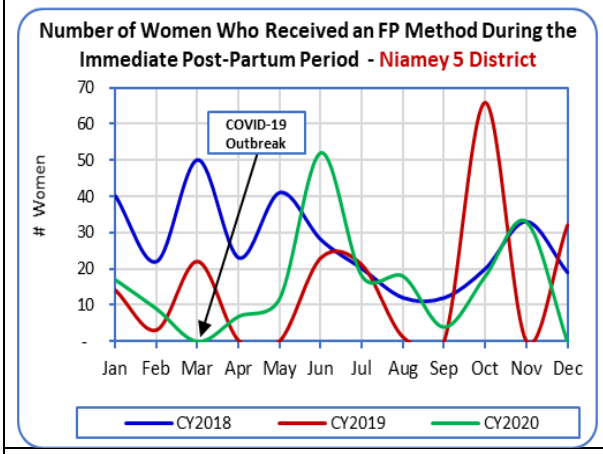
Appendix 6. Average number of deliveries at health facilities across five districts in Niger over 2018, 2019, and 2020 calendar years

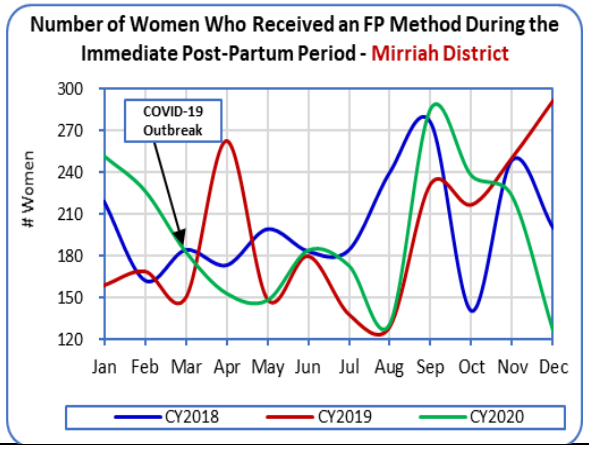


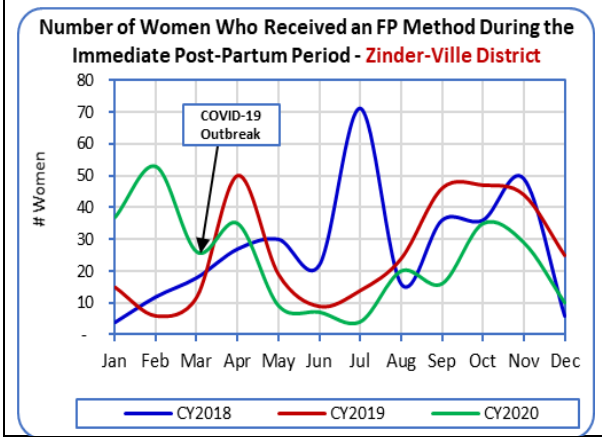
Appendix 7. Average number of women who received an FP method during the immediate post-partum period across five districts in Niger over 2018, 2019, and 2020 calendar years



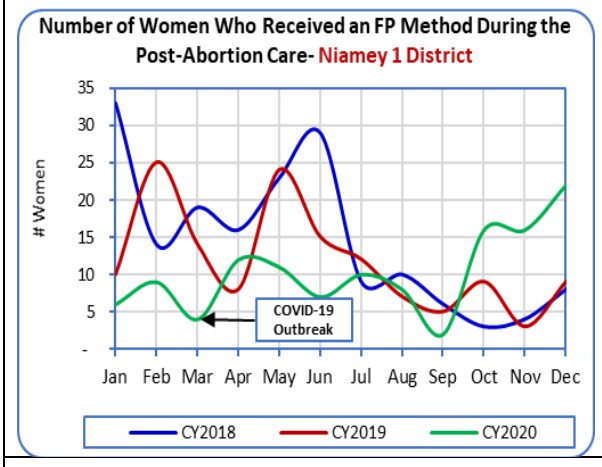


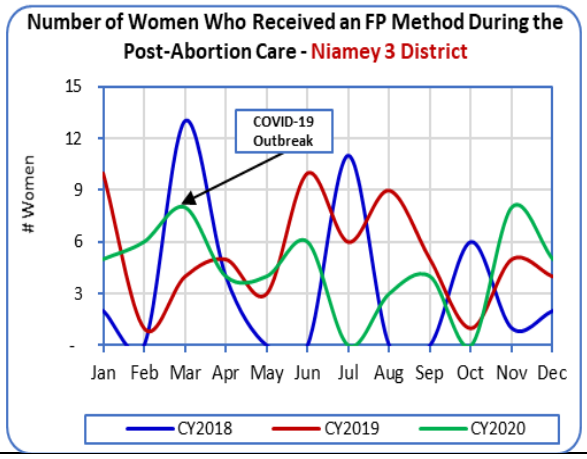


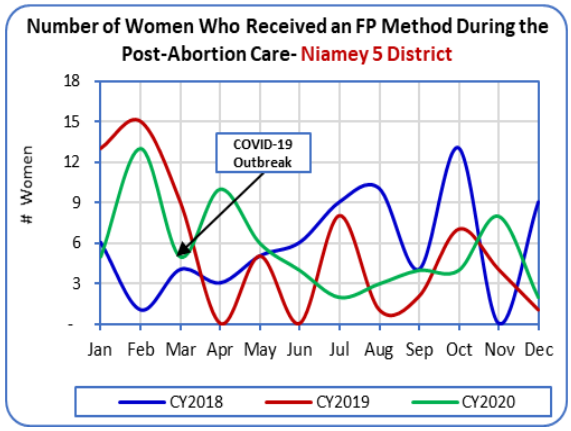


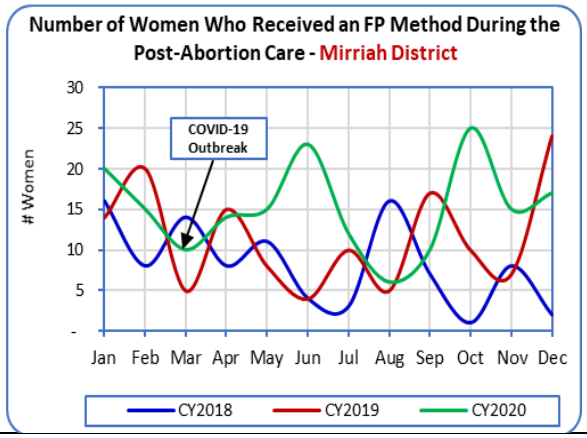


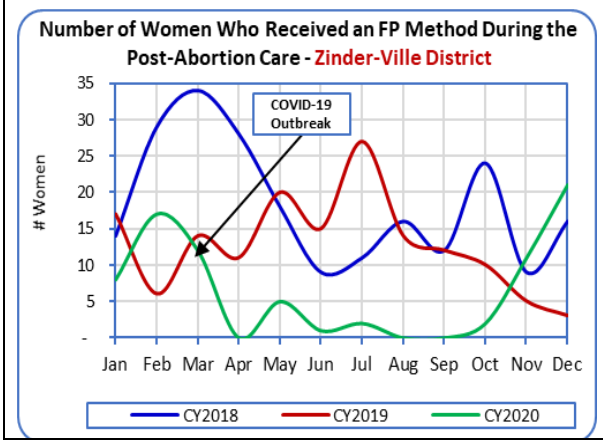
Appendix 8. Average number of women who received an FP method during the post-abortion care across five districts in Niger over 2018, 2019, and 2020 calendar years



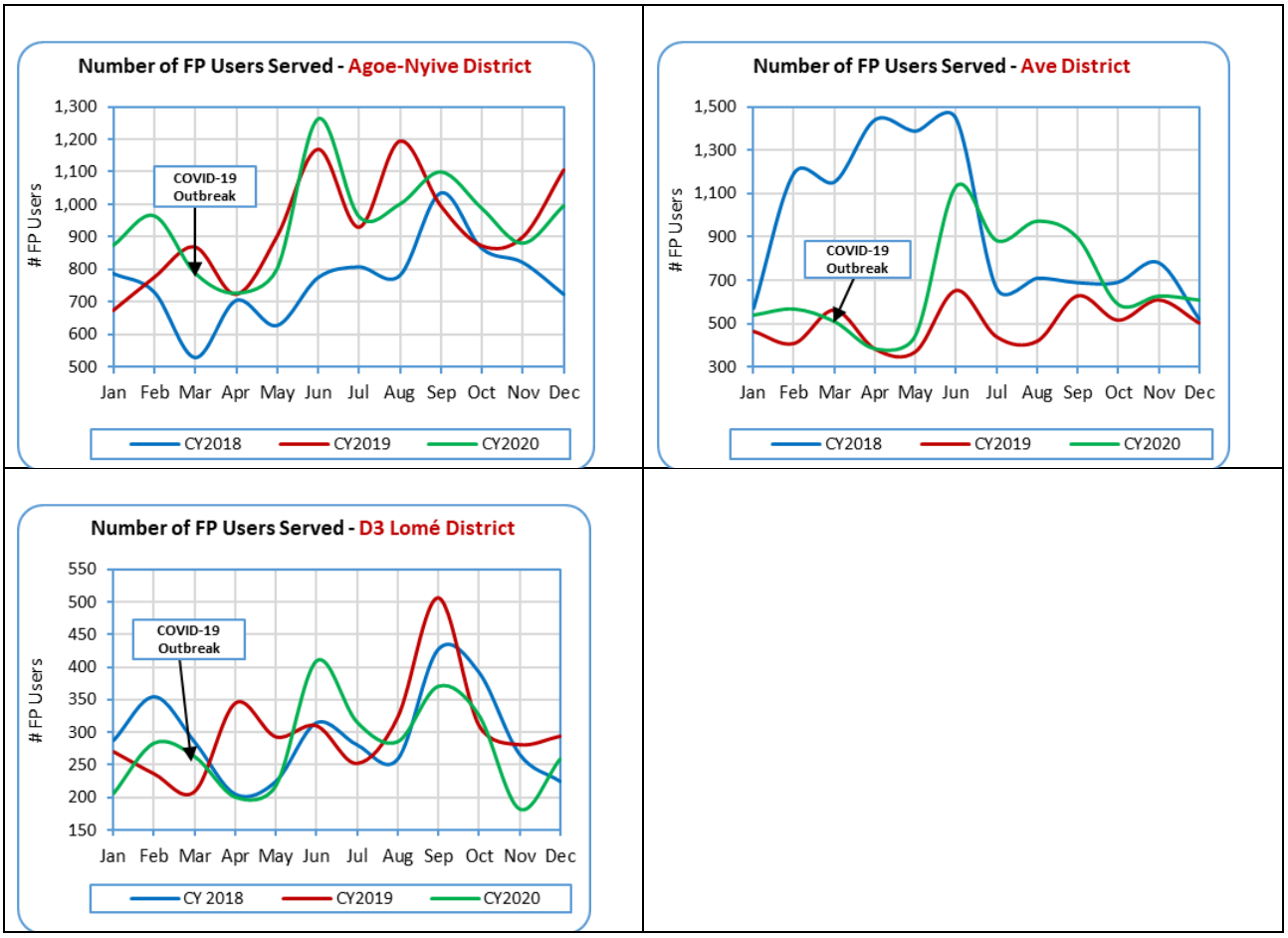




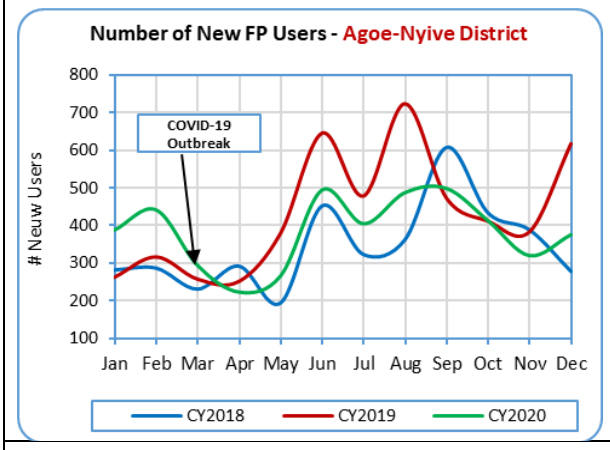


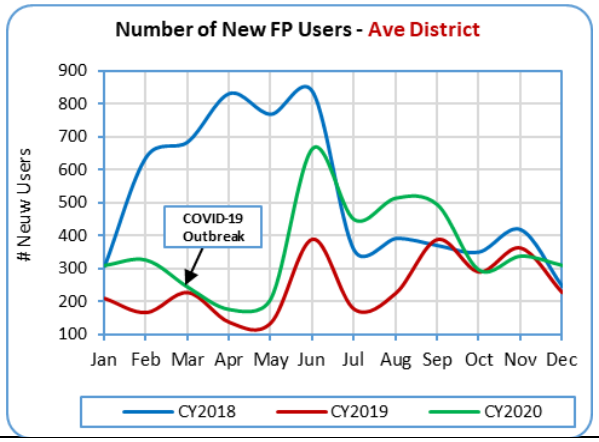


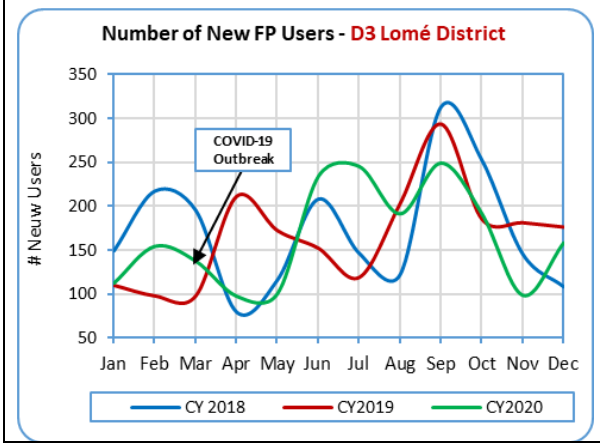
Appendix 9. Average number of FP users (both new and existing FP clients) served across three ILNs in Togo over 2018, 2019, and 2020 calendar years



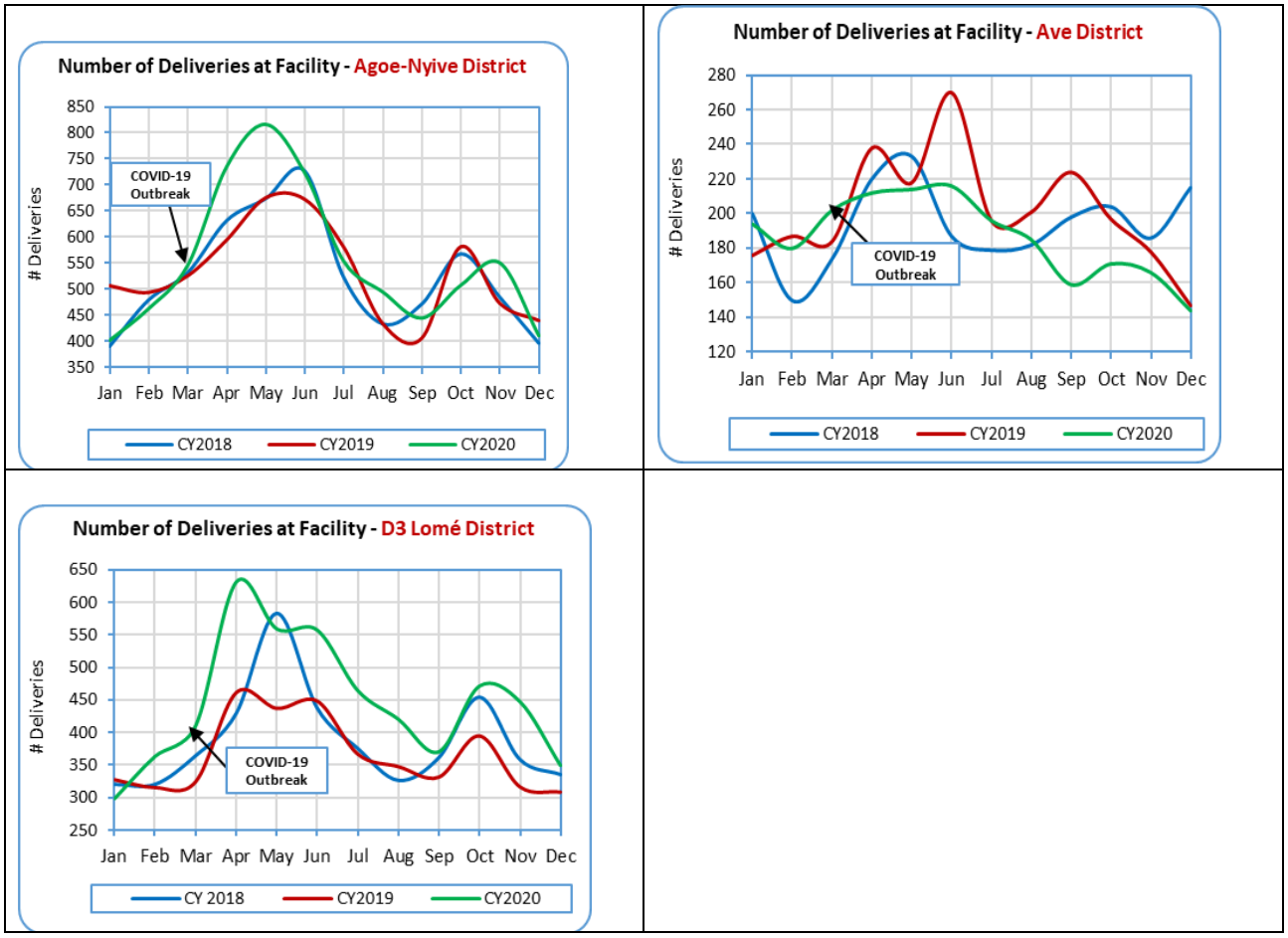
Appendix 10. Average number of new FP users recruited across three ILNs in Togo over 2018, 2019, and 2020 calendar years



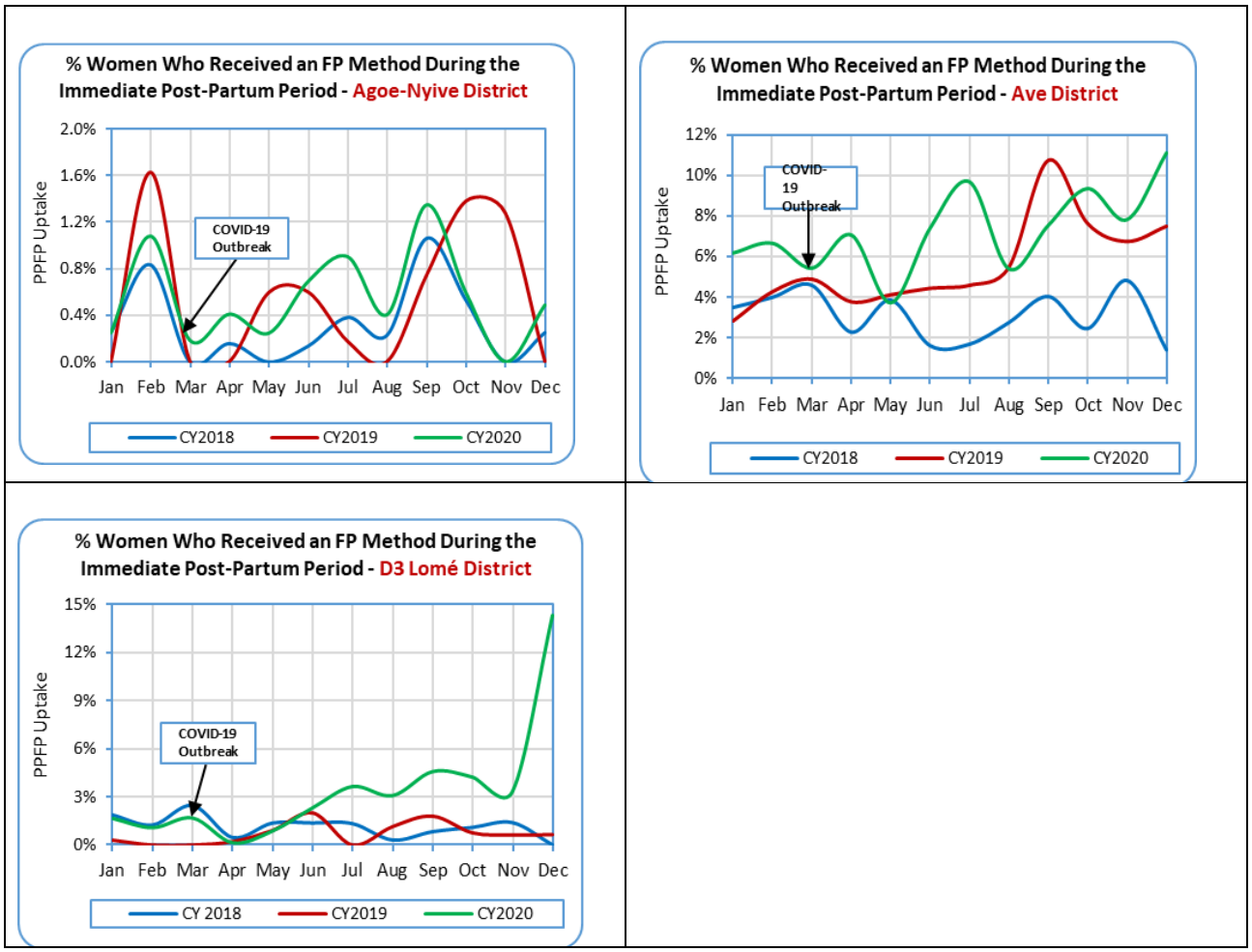




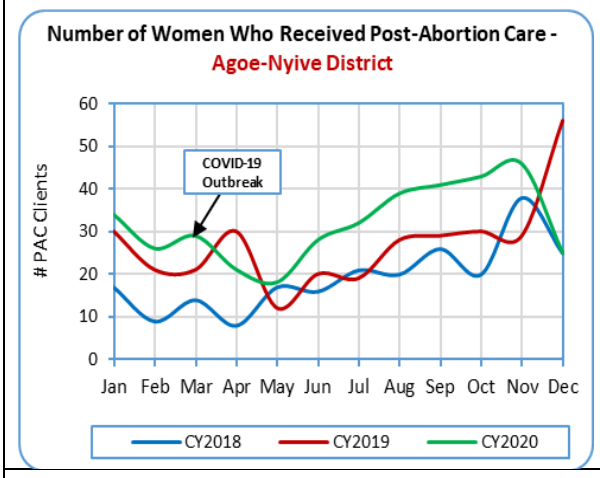
Appendix 11. Average number of deliveries at health facilities across three ILNs in Togo over 2018, 2019, and 2020 calendar years

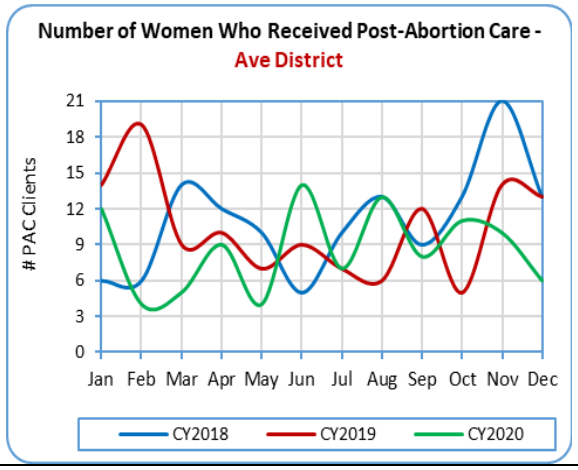


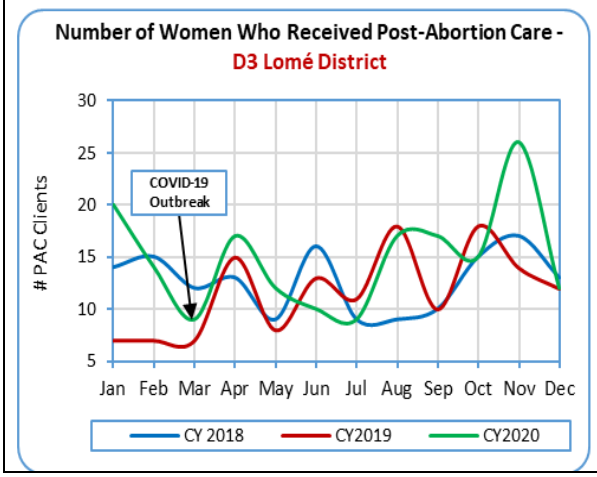
Appendix 12. Percentage of women who received an FP method during the immediate post-partum period (PPFP Uptake) across three ILNs in Togo over 2018, 2019, and 2020 calendar years



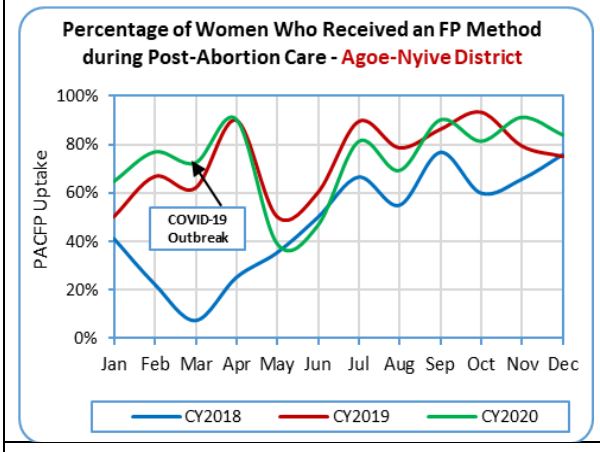
Appendix 13. Average number of women who received post-abortion care across three ILNs in Togo over 2018, 2019, and 2020 calendar years

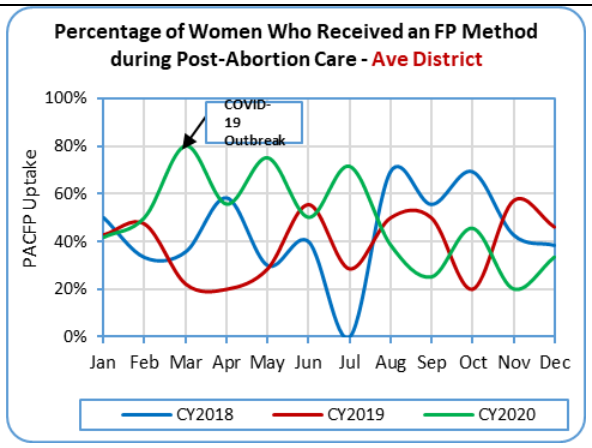


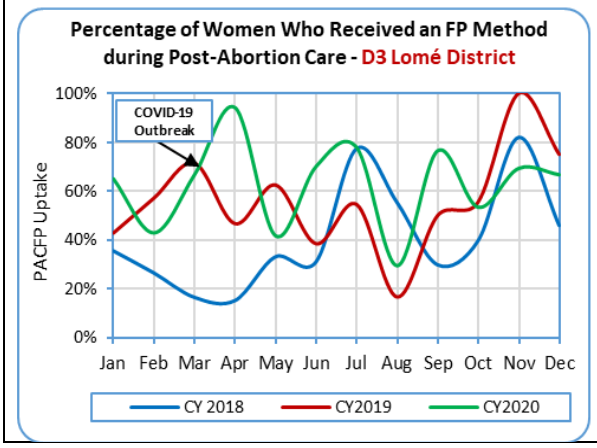




Appendix 14. Percentage of women who received and FP method during post-abortion care across three ILNs in Togo over 2018, 2019, and 2020 calendar years







Appendix 15. Measures desired, but unable to be taken during the period of interest by ILN Stakeholders

Measures Wished For	Reason for Not Implementing	ILN Stakeholder/ Country
Acquire tarpaulins and chairs to fully enforce compliance with the social distancing protocols in health facilities with high client load and limited waiting area capacity.	Lack of financial resources	FP providers/ Côte d'Ivoire MoH official/Togo
Revamp or rehabilitate infrastructure (e.g., waiting areas) to enforce distancing protocols.	Lack of financial resources	FP providers/ Côte d'Ivoire FP provider/Togo MoH official/Togo
Reach youth in schools with health messaging.	School closures Lack of financial resources	MoH official/Burkina Faso
Have enough internet data to conduct online activities.	Lack of financial resources	MoH official/Burkina Faso
Work with women's associations to serve as community relays.	Lack of financial resources	MoH official/Burkina Faso
Integrate the screening and management of COVID-19 in referral hospitals.	Lack of financial resources	MoH official/Côte d'Ivoire
Maintain a steady supply of infection prevention products and protective equipment to health care providers.	Lack of financial resources	MoH officials/Côte d'Ivoire FP providers/Côte d'Ivoire
Sustain awareness-raising campaigns throughout the course of the pandemic. Raise awareness among populations in more remote areas.	Lack of financial resources	FP providers/Burkina Faso MoH officials/Côte d'Ivoire
Provide more contraceptive pills to clients to cover more cycles and reduce repeat visits to health facilities.	Lack of financial resources	FP providers/Niger
Implement a less resource-intensive client follow-up system	Lack of financial resources	FP providers/Niger
Provide at least a 3-month supply of contraceptives to all integrated health centers.	Lack of financial resources	MoH official/Niger
Undertake mass testing.	Lack of financial resources	MoH official/Niger
Alternative layout/redesign of the FP room due to their small size.	Lack of financial resources	FP provider/Niger
Train all providers on infection prevention and control and acquire related equipment.	Lack of financial resources	MoH official/Burkina Faso
Advertise health messages on leaflets and to display them in the health facility.	Lack of financial resources	FP providers/Côte d'Ivoire
Need for more female community relays.	Lack of financial resources	FP provider/Niger
A more participatory campaign involving municipalities and regional and district health directorates.	Lack of financial resources	MoH official/Burkina Faso
Undertake a study on the impact of COVID-19 specific to RH and FP in the country.	Lack of financial resources	MoH officials/Côte d'Ivoire
Scale-up DMPA-SC (Sayana Press).	Lack of financial resources	MoH officials/Côte d'Ivoire
Create COVID-19 screening and treatment sites.	Lack of financial resources	MoH officials/Côte d'Ivoire
Increase resource allocation towards management of the free FP services program.	Lack of financial resources	MoH official/Burkina Faso
Conduct supportive supervision visits to all health facilities during the pandemic.	Lack of financial resources	MoH official/Togo