Access to sexual and reproductive health services during the COVID-19 pandemic

A mixed methods assessment

MAY 2022

COX'S BAZAR, BANGLADESH

INTERNATIONAL
RESCUE
COMMITTEE

Contents

Acknowledgements

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Acronyms

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
COVID-19	Novel Coronavirus 2019
GBV	Gender-based Violence
IPC	Infection, Prevention and Control
IRC	International Rescue Committee
MISP	Minimum Initial Service Package
NGO	Non-Government Organization
PAC	Post Abortion Care
PHCC	Primary Health Care Centre
PNC	Postnatal Care
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
SRH	Sexual & Reproductive Health
STI	Sexually Transmitted Infection
WFS	Women-Friendly Spaces

1. Introduction and Background

Infectious Disease Outbreaks and Sexual and Reproductive Health

COVID-19 and other infectious disease outbreaks – like the outbreak of Ebola Virus Disease in West Africa and the Democratic Republic of Congo – have reduced access to essential sexual and reproductive health (SRH) services. These outbreaks led to strained health care systems, disruptions in the provision of care, resources being redirected to the treatment and prevention of the diseases at the center of the emergency.[1,2,3,4] These examples demonstrate the potential severity of an outbreak's indirect impact on mortality rates (including on maternal and neonatal mortality).[5,6] Additionally, efforts to mitigate the spread of infectious disease outbreaks – lockdowns and school closures, for example – further exacerbate gender-based violence (GBV) and health disparities. This is especially true for people who are displaced or affected by crisis. Women and girls are more likely than men and boys to lose their means of livelihood during an infectious disease outbreak, further exposing them to the heightened risk of GBV.[7]

Global responses to the COVID-19 pandemic are colliding with long-standing sexual and reproductive health inequities.[8] While COVID-19 has had a significant, and in some cases devastating, impact on health systems around the world, studies show that people whose human rights are least protected – such as refugees, displaced peoples, and conflict-affected populations – are the ones who suffer the most.[9]

In some places, lockdowns and social distancing reduced service provision and therefore access to services. The informal social safety nets and networks many women relied upon prior to COVID-19 for support and discrete access to SRH services were weakened by reduced mobility (travel restrictions, lockdowns, and social distancing).[10] Governments and health clinics diverted energy and attention away from SRH services. Many communities feared attending health facilities due to the risk of contracting COVID-19. In particular, the number of adolescents accessing health services decreased.[11]

According to a Guttmacher Institute projection using 2019 data on SRH services from 132 low- and middle-income countries, the COVID-19 pandemic has resulted in an estimated 10% reduction of SRH services. This equates to:

- Almost 48,558,000 additional women with an unmet need for contraceptives
- 15,401,000 additional unintended pregnancies
- An etimated 1,745,000 additional women experiencing major obstetric complications without care, resulting in 28,000 additional maternal deaths
- 2,591,000 additional newborns experiencing major complications without care, resulting in 168,000 additional newborn deaths
- 3,325,000 additional unsafe abortions, resulting in 1,000 additional maternal deaths from unsafe abortion[12]

The IRC's work in Bangladesh

The International Rescue Committee (IRC) began operating in the Cox's Bazar district of Bangladesh in 2018 in response to the sudden influx of Rohingya refugees in August 2017 following genocide in Myanmar. The IRC's programs in Bangladesh focus on the health and protection of women and children living in Kutupalong refugee camp – the largest in the world. IRC teams work with partners to provide comprehensive care for women and girls, including SRH services and Women's Protection and Empowerment programming to support survivors of GBV. The IRC's Women's Protection and Empowerment work empowers women and adolescent girls by teaching them new skills and building awareness to prevent GBV.[13]

In addition, the IRC has established mobile medical teams to serve harder-to-reach refugees in the sprawling camp, which is divided into smaller sub-camps. Kutupalong refugee camp is home to approximately 626,500 Rohingya people.[14] During the monsoon season, these mobile clinics also serve local Bangladeshi host communities whose health facilities have been shut down by flooding or landslides.

Additionally, the IRC implements Risk Communication and Community Engagement (RCCE) activities that integrate COVID-19 and SRH messages through a local partner organization. Our RCCE program supports the local health system in the Ramu and Chakaria districts of Cox's Bazar to deliver adolescent friendly SRH services.

During the COVID-19 pandemic, the Government of Bangladesh collaborated with the IRC and other humanitarian organizations on the COVID-19 response. Health sector NGOs worked together to ensure SRH provision continued with as few disruptions as possible.

IRC-supported health services in Cox's Bazaar as of January 2022

FACILITY TYPE	NUMBER
Primary Health Care Centers	4
Comprehensive SRH Facilities (including BeMONC)	1
Women's Friendly Spaces	42
Women and Girl Safe Spaces (Integrated SRH and Women's Protection Services)	3
Referral Hubs for Emergency Transport	13
Severe Acute Respiratory Infections Treatment Centers (SARI ITC)	1 (Which included a 4-bed maternity ward)
Isolation and treatment centers (ITC)	4

COVID-19 pandemic and SRH Bangladesh

Bangladesh's first case of COVID-19 was identified on March 8, 2020, with the first confirmed case in Kutupalong camp on May 14, 2020.[15,16]

Bangladesh experienced three large-scale waves of COVID-19 infection, with corresponding lockdowns imposed by the government to help limit the spread of the virus. During the first wave, the government imposed a "general holiday" (effectively a lockdown) on March 26, 2020. It was announced on March 23 and was initially set to run until April 4. However, the "holiday" was extended three times before being lifted on May 30.[17]

The second wave and lockdown came a full year after the start of the pandemic, although some restrictions (such as school closures) had remained in place throughout. From a relatively low number of infections (<5% positive testing rate) throughout January and February 2021, March saw a rapid increase to over 23% tests reported as positive in early April. To curb the rise in infections, a seven-day lockdown began on April 5, then limited restrictions continued until April 28.[18]

May saw another alarming rise in cases – the third wave. On May 29, the Bangladesh Directorate of General Health Services recommended a strict lockdown in several of the worst-affected districts, with more following during June. On July 1, 2021 Bangladesh went into another national lockdown. This was planned to last seven days. However, throughout the first half of July, Bangladesh regularly recorded its highest daily deaths since the pandemic began. The lockdown continued but restrictions were gradually eased in mid-July, as the government struggled to balance COVID-19 prevention with the dire economic hardship caused by safety restrictions. Most restrictions were lifted on August 1.[19] Schools – which were closed since March 2020 – remained closed until mid-September. School closures left children vulnerable to abuse at home, early marriage, trafficking and exploitation, particularly as their parents' income generating activities were severely impaired by restrictions.[20]

COVID-19 infection, prevention and control (IPC) measures taken by the government and health sector included strict restriction of entry to Kutupalong camp, dissemination of WHO-approved posters on mask wearing and handwashing, a published COVID-19 treatment protocol, social distancing and punitive enforcement. All NGOs in the camp implemented quarantine and isolation protocols for staff with suspected and confirmed cases of COVID-19. The IRC introduced 15 days of COVID leave for staff, dedicated staff for COVID-19 information dissemination and health support, food and medicine supplies for staff on COVID leave and socially distanced seating plans for vehicles.

At the national level, the pandemic had a significant impact on the delivery of SRH services in Bangladesh and exacerbated pre-existing barriers to accessing SRH healthcare. Between March and August 2020, the number of adolescents seeking SRH services fell by 70%.[21] Within the month of August 2020 alone, antenatal care (ANC) visits decreased by 31%.[22] Prior to the pandemic, ANC coverage was reported to be at 92%, making this decrease a significant setback after years of steady progress. Fortunately, this appeared to improve in 2021, with ANC and postnatal care (PNC) in January 2021- before the second and third COVID waves – being between 70% and 80% higher than in 2020.[23]

Other pandemic-related barriers to accessing SRH services included strict restrictions on movement and a shortage of skilled healthcare workers. Bangladesh's healthcare system struggled to meet needs before the pandemic, with only 5.4 physicians and 3.4 nurses per 10,000 people. Due to reduced working hours, the redirection of frontline health workers, and the high incidence of COVID-19 among health workers, the health system's capacity was strained even further.[24] Service provider staff were concerned about contracting COVID-19 and spreading it to their families due to the lack of personal protective equipment (PPE).[25]

Meanwhile, public fear of contracting COVID-19 at health facilities, mistrust of authorities, and misinformation have all been linked to a decrease in health-seeking behavior.[26] Lockdowns and border closures disrupted supply chains for medical supplies. The cost of healthcare became prohibitive for many families who lost part or all their income because of the pandemic.[27] HIV testing rates fell by 86% in 2020, which, when combined with access and supply chain disruptions, could have serious consequences for the spread of HIV and mortality across Bangladesh.

The cost of transportation and distances to health facilities are significant barriers to accessing SRH services even without pandemic restrictions and price increases to contend with. Closures and conversions of SRH facilities into COVID-dedicated clinics exacerbated these issues, putting people's closest health facilities even further away.[28] Travel costs increased just when economic hardship caused by COVID-19 hit hardest and many people had lost their incomes.

GBV case management was disrupted, limiting GBV survivors' access to vital SRH services and psychosocial support.[29] To maintain support, many organizations pivoted to virtual service provision. However, many women and girls in humanitarian settings have little or no access to digital devices, so online consultations were not an option for them. Even when remote case management has proven to be effective in providing individual psychosocial support, decreasing use of other SRH health services remains an alarming problem.

In Cox's Bazar district, reported incidents of GBV among Rohingya refugees increased from the start of the pandemic, particularly physical abuse perpetrated by an intimate partner.[30] GBV reports spiked in April 2020, a month after the start of the first lockdown, and in September 2020, when the resumption of GBV case management services enabled women and girls to resume reporting incidents.

Despite the growing need for GBV programming, the Government of Bangladesh initially suspended GBV prevention activities, deeming them non-essential for prevention the spread of COVID-19. Suspended SRH programs catering to the Rohingya community includedIRC's Girl Shine, SASA by Raising Voices and IRC's Engaging Men through Accountable Practices (EMAP). Funding for GBV services in Cox's Bazar declined during the pandemic, with only 17% of budgeted GBV funding achieved. The decreased humanitarian presence in refugee camps and the decreased presence of protection partners reduced the Rohingya communities' trust. Learning centers and safe spaces closed – where women and girls normally access GBV information, case management, and services. Thankfully, the Ministry of Health included the clinical management of rape and intimate partner violence on its list of essential primary health services.

The IRC's work in Cox's Bazar inevitably became more challenging during COVID-19. This assessment explores the intersecting impacts of the pandemic on the demand, access, and delivery of SRH services and protective measures. It incorporates the perspectives of women, girls, and boys from Rohingya and host communities, as well as service providers (e.g., frontline health workers, doctors, midwives, etc.) and other key informants (e.g., local officials, NGO staff, etc.). It was also intended as a learning exercise, so that SRH services can be more accessible and prioritized during future public health emergencies.

2. Methodology

The objectives of this mixed methods assessment were to:

1. Describe factors influencing access to SRH services among Rohingya and host community members in Cox's Bazar during the COVID-19 pandemic
2. Document variations in SRH services uptake among Rohingya and host community members at IRC-supported health facilities in Cox's Bazar during the pandemic

These mixed methods assessments included four data collection methodologies:

1. Analysis of service delivery statistics for SRH among IRC-supported health facilities
2. A quantitative survey of SRH service users from refugee camps and host communities
3. Focus group discussions with a subset of clients for both communities
4. In-depth interviews with providers and health stakeholders in Cox's Bazaar

Survey respondents included both Rohingya refugee communities in Kutupalong camp and Bangladeshi host communities in Ukhiya, Teknaf, and Ramu Upazilla, all within Cox's Bazar. Rohingya respondents were from camps 2-E, 9, 22, 23, and 24. Host respondents were mainly from Ramu. The sample included adult women, adult men, adolescent girls, and adolescent boys (total sample: 372). Two stage stratified random sampling was used for the survey, using a 'probability proportionate to size' approach, so at first the total target population was divided into four strata as well as four types of facilities – such as Primary Health Care Centers (PHCCs), Basic Emergency Obstetric and Newborn Care (BEmONC), IRC's Integrated Women's Centers, and Women-Friendly Spaces (WFS). Next, the desired number of facilities were randomly selected for each category. Finally, the desired number of clients was selected from each facility. Participants at this stage were randomly selected from SRH facility registration lists dating from 2018 to 2021 – they appeared at intervals of 10, 15, or 20 names on the list according to the volume of the clients registered at each clinic.

The survey questions explored whether respondents faced challenges or barriers in accessing SRH services during COVID-19. A chi-squared test was performed to ascertain whether reported barriers vary significantly between Rohingya and host communities. Challenges and barriers were further explored through focus group discussions and interviews.

A subset of survey respondents also participated in focus group discussions. There were 10 groups in total. In the Rohingya communities there were three with women, two with girls, two with men and one with boys. In host communities, there was one with women and one with men.

Service providers serving Rohingya and host communities participated in in-depth interviews and included people with a range of roles – doctors, midwives, nurses, medical assistants, and other staff – and key informant interviews were conducted with other stakeholders, including IRC staff, staff from other NGOs, local officials, healthcare coordinators, managers, and community leaders.

Finally, service delivery data was compared with lockdown dates to measure the impact of COVID-19 on the uptake of SRH services. The three-month moving average method was used to smooth out the impact of seasonal variation. The types of SRH services accessed pre-COVID and during the three waves of COVID were also examined, to understand which services were most severely affected by the pandemic.

Limitations

All members of the public who participated in this assessment sought SRH services and registered with clinics at some point during the last year. Data collectors did not hear from people who did not seek SRH services. Thus, the potential barriers they faced trying to access SRH care are not a part of this study.

Sample numbers

	HOST COMMUNITIES	CAMPS	TOTAL
QUANTITATIVE			
Women	30	92	122
Men	30	60	90
Boys	20	60	80
Girls	20	60	80
			372
QUALITATIVE			
In-depth interviews	2	26	28
		Health Care Provider Doctor – 5 Nurse – 4 Medical Assistant – 3 Midwife – 3 Family Welfare Visitor – 3 Sub Assistant Community Medical Officer – 3 Community Healthcare Provider/Paramedics – 3 Family Welfare Assistant – 2 Health Assistant – 2 **Community Healthcare Volunteer** – 1 **Sr. Women's Protection and Empowerment Officer** – 1 **Medical Officer** – 1 **Field Facilitator** – 1 **Community Healthcare Worker** – 1	
Key informant interviews	Major Stakeholders – 8	Response Agencies – 20	28
Focus group discussions	2	8	10
	Women – 1 **Men** – 1	**Women** – 3 **Girls** – 2 **Men** – 2 **Boys** – 1	**Women** – 4 **Girls** – 2 **Men** – 3 **Boys** – 1

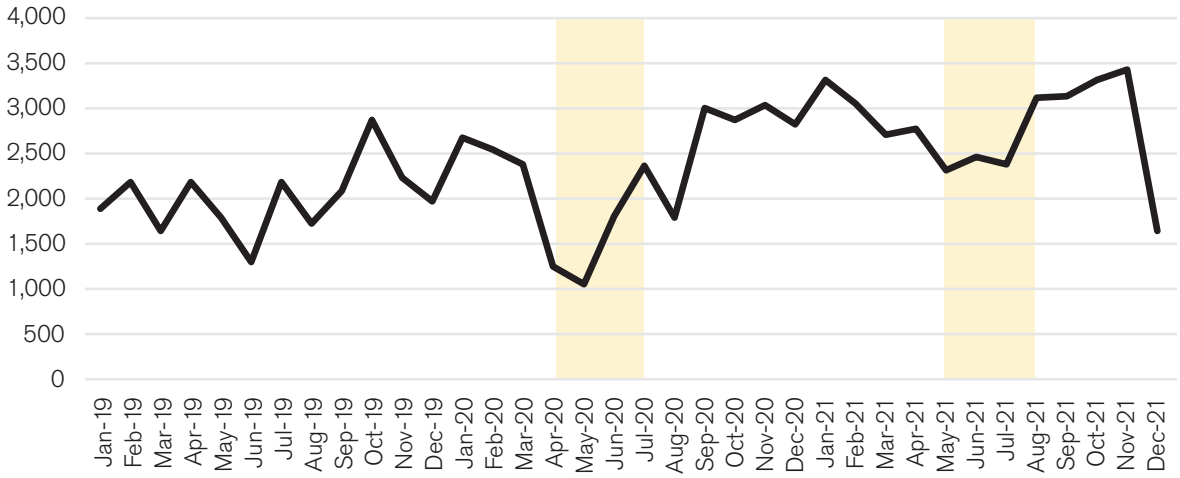
3. IRC Service Delivery Data

Contraception

Period of lockdown

After a big dip in contraception delivery in the first quarter of 2020, corresponding with the start of the pandemic and the first lockdown, there was a steady rise in contraceptive services accessed throughout the rest of 2020 and early 2021. Another significant dip in the second quarter of 2021 at all types of facilities with the first 2021 lockdown. Then, the trend recovered despite the second 2021 lockdown.

NUMBER OF CLIENTS ADOPTING FAMILY PLANNING METHODS, IRC BANGLADESH, 2019–2021

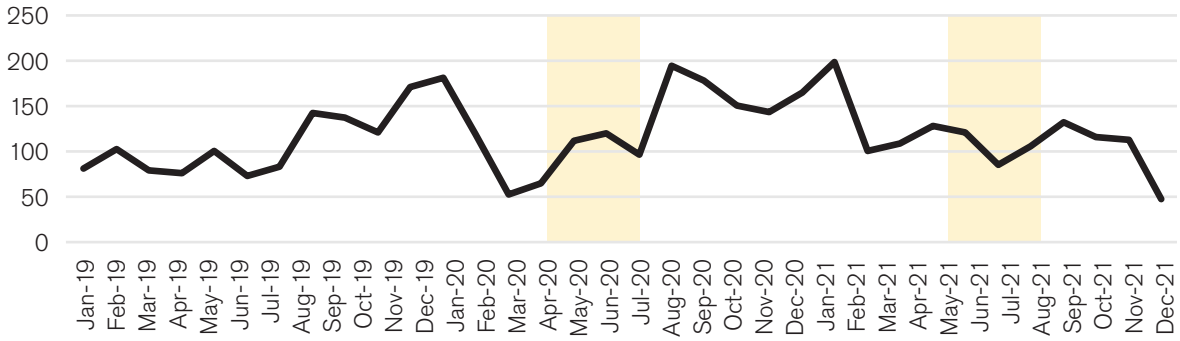


Menstrual regulation

Period of lockdown

Menstrual regulation services experienced a drop in early 2020, though it began prior to March. There did not appear to be a similar drop-in service uptake during the second and third waves.

NUMBER OF CLIENTS WHO RECEIVE MENSTRUAL REGULATION, IRC BANGLADESH, 2019–2021

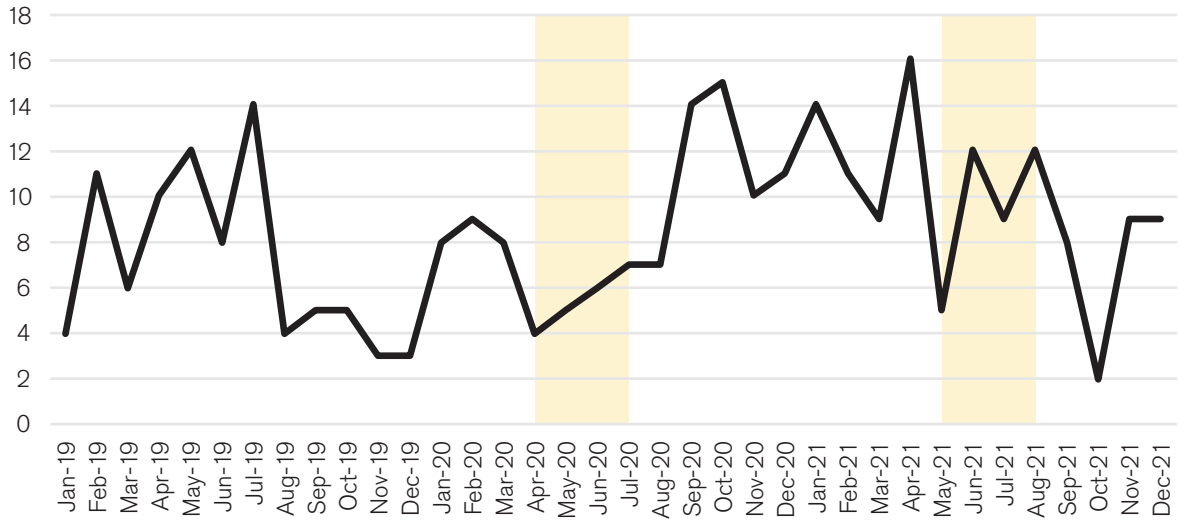


Post-abortion care (PAC)

Period of lockdown

The number of clients in receiving PAC services at IRC-supported facilities was relatively low and tend to fluctuate from month to month. Nevertheless, there was a slight drop in clients receiving services between March and April 2020, as well as during March 2021. The low numbers make it difficult to determine whether these drops were pandemic related.

NUMBER OF CLIENTS WHO RECEIVED POST-ABORTION CARE, IRC BANGLADESH, 2019-2021

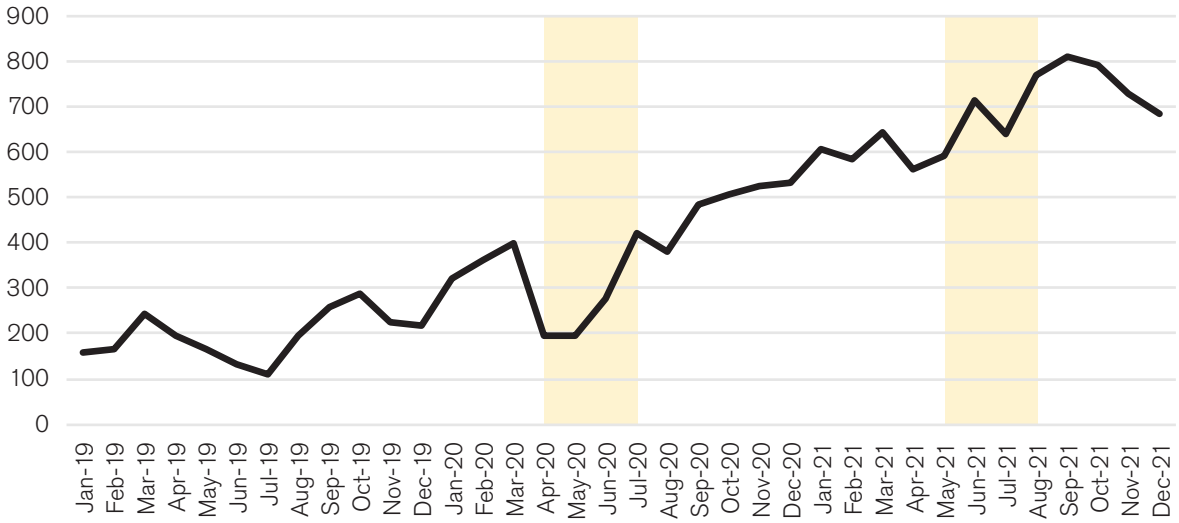


Ante-natal care

Period of lockdown

Antenatal care (ANC) showed a steady rise in services accessed prior to and during the pandemic as the IRC opened PHCC and BEmONC centers. However, as with contraception, there was a significant dip in the first quarter of 2020, with smaller but noticeable reductions during the second and third waves.

NUMBER OF PRENANT WOMEN PRESENTING FOR THEIR FIRST ANTENATAL CARE VISIT, IRC BANGLADESH, 2019-2021

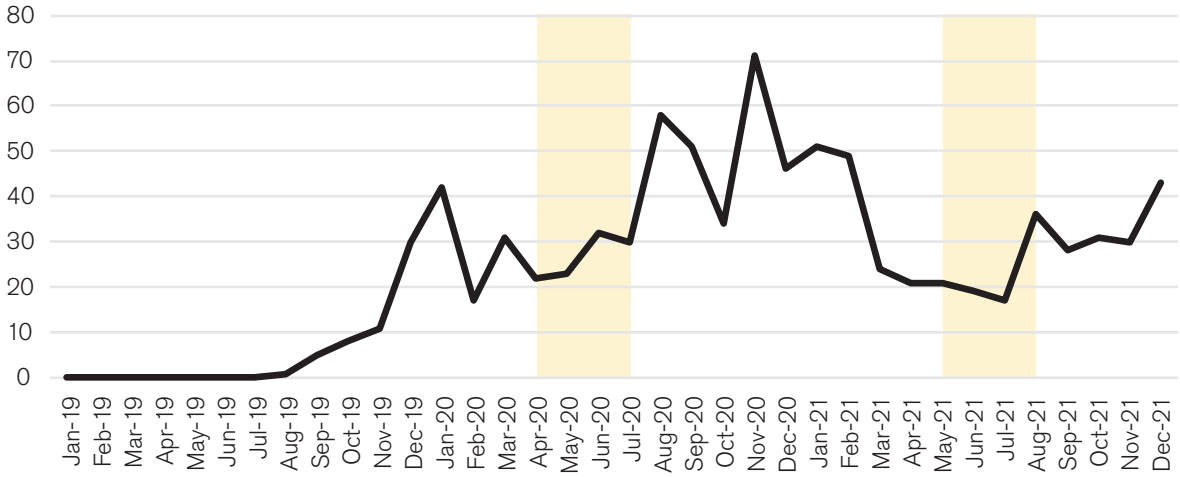


Safe delivery

Period of lockdown

The IRC began offering safe delivery services in the second half of 2019. Numbers remained relatively low as these services are offered at only one IRC-supported facility. There was a noticeable reduction in deliveries through the second and third waves, before beginning to grow following the third wave lockdown.

NUMBER OF FACILITY-BASED DELIVERIES, IRC BANGLADESH, 2019-2021

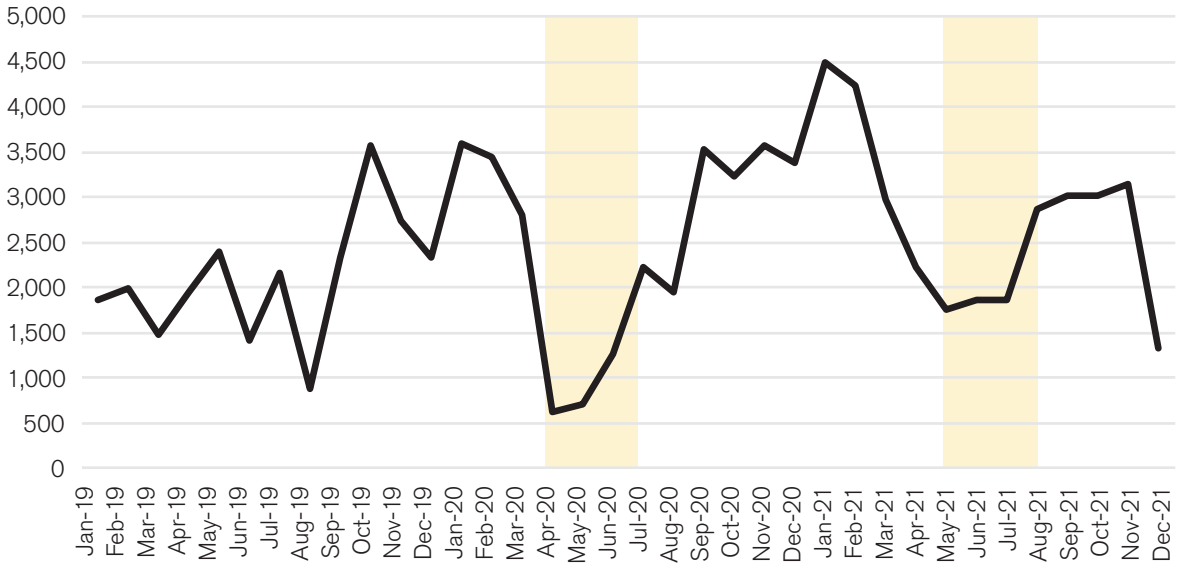


Sexually transmitted infection (STI) consultations

Period of lockdown

The number of consultations for STIs saw a large drop during the first wave in 2020. It grew following the end of lockdown. A similar trend was observed in the second wave and throughout the third wave. The IRC sees many clients for STIs, with stakeholder reporting that normal vaginal discharge is often mistaken for an STI, which is why the number of consultations is generally high.

NUMBER OF STI CONSULTATIONS, IRC BANGLADESH, 2019-2021

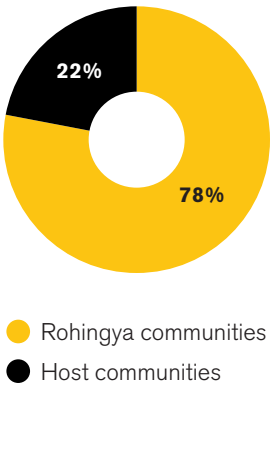


4. Quantitative Findings

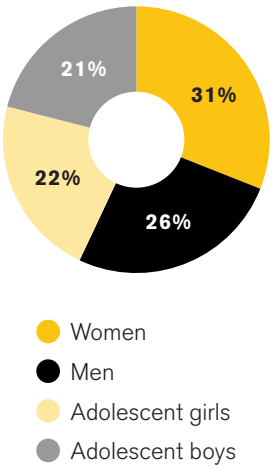
Survey respondents

These charts demonstrate additional details about the 372 respondents who participated in the survey.

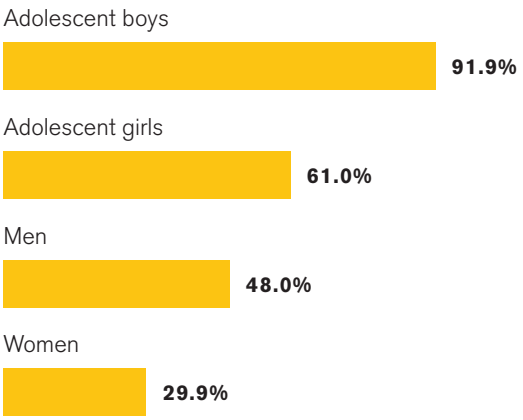
BY COMMUNITY



BY GENDER



BY SELF REPORTED LITERACY



The survey showed a decrease in overall access to SRH services, contraception, and GBV support services, which could be attributable to reduced availability of services and the inability of patients to travel to clinics during lockdowns. Reduced availability of services and medicine during the pandemic, as well as improved hygiene and IPC measures, were noted consistently across settings and respondents.

Barriers to access during COVID-19

- The main barrier to accessing SRH services during COVID-19 was transport and lockdown according to 100% of women and boys, 57% of men, and 33% of girls
- 20% of adolescent girls and 26% of women reported that a lack of medicine or service availability were barriers
- 83% of girls and 94% women reported receiving the services they sought
- 33% couldn't access any kind of service due to lack of transport and/or lockdowns preventing them from getting to a clinic
- 10% of men and 3% of women said they had financial difficulty in accessing SRH services and products

Service delivery during COVID-19

- Most participants, including all women, noticed improved hygiene at facilities during COVID-19
- 32% of women, 30% of adolescent girls, and 66% of adolescent boys reported a perceived reduced availability of medicine or services during COVID-19
- 99% of women, 95% of girls, 78% of men, and 49% of boys said they were satisfied with service delivery during COVID-19
- 98% of women, 91% of girls, 65% of men, and 43% of boys felt that the waiting time was appropriate for receiving services

Inclusivity of services

- 92% of women and 81% of girls felt that the health facilities they had visited had enough staff.
- Facilities were described as friendly to their gender by 96% of women, 93% of girls, 82% of men, and 37% of boys
- Most respondents stated that "assisting support" (as far as they know) was the most widely available way for people with disabilities to access facilities

Acceptability of the COVID-19 vaccine

- When asked their opinion of the COVID-19 vaccine, about half of female respondents (56% of adult women versus 52% of adolescent girls) reported that it prevents infection
- Nearly all (90.5%) adult male respondents reported that the vaccine prevented infection, but only 20% of adolescent boys held this view
- 21% of adolescent boys claimed that only the elderly or sick needed a COVID vaccine

5. Qualitative Findings

5.1 General barriers and pathways to access SRH services

The focus group discussions and interviews focused on barriers to accessing SRH services during the COVID-19 acute phase. A few general barriers and pathways to access SRH services emerged. The focus group discussions highlighted the strong link between awareness of SRH services and uptake. They also underscored the need for SRH services for different groups. Women and girls from both Rohingya and host communities demonstrated a good knowledge of SRH services and their relevance to their lives. Men and boys, however, showed minimal awareness of SRH services. These groups felt SRH services are for women, despite being registered with clinics for such services.

> *"We know enough about SRH. Weekly meetings are being conducted to make us understand about SRH services."*
> **– ROHINGYA WOMAN**

> *"We do not exactly know about SRH, but we understand that the services are for women's health. The WFSs provide such services. We understand the importance of the need of these services, specifically for female family members."*
> **– ROHINGYA MAN**

> *"Yes, we know about SRH services a bit. The district hospital provides such services. They are important for us, especially for female relatives."*
> **– BENGALI MAN**

5.2 Barriers and pathways to access SRH services due to COVID-19

Availability of services

Contraception, ANC, PNC, specialist delivery, menstrual regulation, and advice on leucorrhoea (a common medical condition) were the most common services women and girls reported accessing during COVID-19. They expressed high levels of satisfaction with SRH services during COVID-19. Sometimes, they received additional services when visiting a clinic for advice. Medicines and materials were provided by facilities.

> *"We get SRH advice at the BEmONC Centre. We get injections, condoms and medicine for leucorrhoea [vaginal discharge, likely confused with STI] from the center."*
>
> **– ROHINGYA WOMAN**

> *"Information was available for us. contraception visitors and women visit door to door for giving services and counselling."*
>
> **– ROHINGYA WOMAN**

> *"Quality was maintained at the service center, especially the advice they offered made it next level. We are extremely satisfied with it."*
>
> **– ROHINGYA ADOLESCENT GIRL**

Women and girls suggested introducing C-sections in some centers to reduce the need for referrals during complications. They also suggested increasing medicine stock and staff to keep pace with their needs.

> *"C-sections and postnatal care for mothers and babies should be introduced to BEmONC. And more medicine and female doctors should be available at the WFS."*
>
> **– ROHINGYA WOMAN**

However, availability of services varies by health facility type. Respondents told us that they can't usually access the full range of SRH services at one single facility.

Treatment and materials were not as available to boys. SRH services targeted for boys consisted of outdoor sensitization sessions." Men reported that they didn't have services, information or guidance available to them. Men suggested setting up a separate service for them. Boys suggested providing nutrition advice.

> *"We get minimal advice, but we're not really interested, so we don't understand what SRH is very well."*
>
> **– ROHINGYA BOY**

> *"The WFS provided us with enough information. Their field level advice was helpful for us. But due to lockdowns we sometimes couldn't go to the center. Some of the centers were a long way away, so referrals for treatments were challenging for us to get."*
>
> **– ROHINGYA GIRL**

> *"The information was available at the WFS but only for women. There were some advice sessions for males, but these were only for adolescent boys. There were no alternatives for us."*
>
> **– ROHINGYA MAN**

Gender-based violence

Perceptions of GBV among Rohingya people varied from camp to camp. Some respondents reported a perceived increase in the number of GBV incidents during the pandemic. Others reported the same levels as usual or even a reduction. Certainly, global data indicates a rise in GBV wherever lockdowns occurred. Or in locations where people faced increased hardships.[31] Participants were aware of medical services and psychosocial support for survivors of GBV. Men mentioned that men are usually the perpetrators of GBV.

> *"In our camp, 2-E, GBV increased during COVID, and we got services regarding this. All the midwives, nurses and doctors are very supportive and caring, and treatment was given within a very systematic manner."*
>
> **– ROHINGYA WOMAN**

> *"There have been no GBV cases here so far. But GBV-related meetings have taken place."*
>
> **– ROHINGYA WOMAN**

> *"GBV is our doing most of the time, but we also resolve cases by ourselves. GBV increased during COVID, but service centers provided counselling on this."*
>
> **– ROHINGYA MAN**

Transport

Transport issues were exacerbated during the pandemic. Travel was prohibited during lockdowns, so people were unable to leave their homes to attend clinics. Other barriers commonly mentioned by both Rohingya and host participants included: unsupportive family members, a shortage of medical providers, small spaces at clinics, long queues at clinics, and the possibility of contracting COVID-19.

> *"COVID-19 created panic and made our lives miserable as we faced lockdown and were prohibited to go outside of home. We also faced some cultural barriers in accessing SRH and other treatments as our family members were very unsupportive to us going out of the home and accessing SRH Services."*
>
> **– ROHINGYA WOMAN**

While women may normally have left home without many people in their families knowing they were going to visit a SRH clinic, this became impossible during lockdown and ongoing restrictions. "Unsupportive family members" as a barrier to accessing services was reportedly exacerbated by the pandemic.

> *"Lockdown, transport problems, lack of providers at the hospitals were the main challenges. Before COVID-19, such challenges did not exist. Due to lockdown, vehicles were not available. Sometimes we had to avoid getting services due to lack of transportation."*
>
> **– BENGALI MAN**

It was clear that there was continuous information and communication provided to women and girls throughout COVID-19. There were community visits, door-to-door rounds, and follow-up visits. All service centers also had a referral system.

Infection Prevention and Control (IPC)

The COVID-19 IPC protocol in Cox's Bazar, including social distancing, reportedly resulted in long queues and wait times at clinics. This doesn't seem to have curbed women and girls' appreciation of service delivery. Men and boys had no clear feedback about whether service delivery was of a high quality or not.

> *"I noticed some changes, such as the line was big and time consuming."*
>
> **– BENGALI WOMAN**

> *"No problem was faced at the clinic during COVID-19, rather treatments improved gradually. I am very hopeful of continuous improvement."*
>
> **– ROHINGYA WOMAN**

5.3 Barriers and pathways from the perspectives of providers and other health stakeholders

Inter-agency collaboration

Stakeholders reported that health cluster coordination across humanitarian organizations was strong throughout the pandemic – including in the early months. The SRH Working Group, which is part of the health cluster and in which IRC is a member, provided continuous guidance on how to provide safe SRH services throughout the pandemic, while mitigating substantial disruptions. The SRH Working Group applied the Minimum Initial Service Package (MISP) to inform SRH service delivery priorities through the pandemic. While clinical care for survivors of sexual assault was considered essential by government authorities (in line with the MISP), GBV case management was not. Prioritization of SRH services across partners at the early phase of COVID-19 also varied in practice. This variation could be attributed to staffing shortages when staff became infected with COVID-19. There were not enough reserve staff to maintain all services equitably.

Despite these challenges, the SRH Working Group took the following measures to maintain essential SRH services:

- Organized IPC trainings for clinical staff
- Built awareness among all implementing partners on COVID-19 and necessary IPC measures
- Introduced a home-base care modality for COVID-19 mild cases
- Launched dedicated referral services for COVID-19 cases to reach SARI ITC or maternity COVID-19 treatment centers
- Reduced the recommended number of ANC visits from 8 to 4 to decrease visits to health facilities

Service providers supporting the Rohingya community worked collaboratively during COVID-19, with interviewees reporting that there was positive coordination between two or more humanitarian agencies at every single health facility. Organizations shared staff and services with each other. In the host community, there was also effective coordination between humanitarian organizations and government agencies. Each organization followed its own protocol, but every facility managed to continue providing services during COVID-19.

> *"CHW [community health workers] and the Mukti team did field visits and helped them [patients] to come to the center."*
>
> **– NURSE SERVING A ROHINGYA COMMUNITY**

> *"Other agencies provide the similar services. IRC, as well as IMO, Hope, CARE Bangladesh, UNHCR, SHED all work here. All the partners work very well, their efforts were assessed, and we are satisfied with their work."*
>
> **– COMMUNITY HEALTH WORKER SERVING A HOST COMMUNITY**

Availability of services

Despite facing multiple challenges simultaneously during COVID-19, service providers did not stop the provision of any services and did not turn away any patients who attended their facilities. At the beginning of the pandemic (March 2020), the flow of patients seeking services slowed down – community visits and monthly community sessions were also interrupted. But service providers were able to continue providing access to services by maintaining IRC's COVID-19 IPC protocol (masks supplied, handwashing stations set up, and limited number of patients allowed inside clinics), referring COVID patients, and taking other measures to tackle COVID-19. Providers used communications tools like posters to spread hygiene messages to the community. A focal point was dedicated to address COVID-19 at every facility.

The IRC and service providers put in place several program adaptations throughout the 18 months of COVID-19 restrictions to mitigate the impact on services. These adaptations included:

- Conducting door-to-door visits
- Hiring a reserve staff of midwives
- Ensuring adequate PPE
- Maintaining IPC protocols
- Setting isolation points within each health facility
- Screening and triaging using digital thermometers
- Setting dedicated maternity beds in PHCCs, BEmONC and SARI ITC for COVID-19 cases
- Providing vehicle support for referral cases
- Setting staff duty of care protocols to support staff motivation during the stressful situation (e.g. organization support to ensure food and medicine while a staff being in quarantine or isolated with mild symptoms).

Outreach sessions were suspended due to restrictions on public gatherings, but other SRH services were provided both at clinics and via door-to-door visits. Clinics provided the Minimal Initial Service Package (MISP) on SRH services, though the scale and scope of this package of services varied by facility type and GBV case management was suspended during lockdown. Most patients were and continue to be women and girls. All providers host some female-only facilities that men are strictly prohibited from entering.

> *"We did not stop any services during COVID in BEmoNC. We also served general and COVID patients. We added COVID treatment to the hospital."*
> **– DOCTOR SERVING A ROHINGYA COMMUNITY**

> *"We provide ANC, PNC, Natural Vaginal Delivery (NVD), PAC, menstruation regulation [abortion32], contraception and STI treatment services in our SRH service package. PAC is not possible because the working period is 8 hours. So, patients needing PAC go to the hospital directly."*
> **– MIDWIFE SERVING A ROHINGYA COMMUNITY**

> *"Door-to-door services provided through community health volunteers raise awareness on COVID – wearing masks, hand washing, maintaining distance – and collecting samples was a new system."*
> **– DOCTOR SERVING A ROHINGYA COMMUNITY**

Staff, facilities, and logistics

Stakeholders from the IRC were able to hire additional staff in anticipation of staff shortages because of turnover and providers becoming ill, which helped to mitigate disruptions in SRH service delivery. However, many other agencies were operating with similar numbers of providers as before the pandemic, which made it difficult to maintain sufficient staffing. Frontline staff were vulnerable to catching COVID and were often sick in quarantine. Long shifts during COVID-19 also left staff exhausted and stressed. These stressors inevitably impacted on the quality of services and the patient experience. Staff turnover was particularly high during the first wave, when many providers became ill and PPE was in short supply.

> *"There was a shortage of staff – one staff member had to fulfil so many responsibilities at once, which made them exhausted and struggling mentally."*
> **– CLINICAL COORDINATOR**

> *"We provide door-to-door services, but because of the workforce shortages, some of our field work wasn't as good as previously."*
> **– COMMUNITY HEALTHCARE PROVIDER**

Limited space at facilities made it challenging to comply with social distancing regulations. Shortages of medicines and materials due to delays in shipments and other logistics problems meant providers were unable to treat some patients. Interruptions to community visit schedules due to lockdowns and restrictions also left some people without the treatment they needed. Lack of sufficient infrastructure made it difficult for healthcare providers to comply with IPC protocols when managing expected or confirmed COVID-19 cases. For example, most health facilities with labor and delivery services did not have sufficient space for women in labor who were suspected COVID-19 cases. Though one facility was able to set up a separate isolation room in their maternity section, others had "isolation corners" where suspected COVID-19 cases were somewhat separated from other women in labor. When facilities received a woman in labor who potentially had COVID-19, they would transport her to a COVID-19 treatment center with an on-site maternity where she could deliver with stronger IPC protections for providers and other patients. However, service providers at non-specialized facilities noted that they were prepared to support a woman to deliver if she was in the later stages of labor.

> *"I would like to recommend something; when COVID positive patients come for delivery it is difficult to isolate them and we have to refer them to other hospitals. Besides, we have no warmer for the newborn babies. It would be better if we could arrange a warmer session for the newborn."*
>
> **– MIDWIFE SERVING A ROHINGYA COMMUNITY**

> *"During COVID, door-to-door visits were a challenge. Community people were scared, and they didn't let us in at the beginning. We also faced a shortage of masks and hand sanitizer."*
>
> **– FAMILY WELFARE ASSISTANT SERVING A HOST COMMUNITY**

During lockdowns, entrance to the camp was restricted to certain times and required approval, which affected shift timing for service providers. While staff usually rotated 12 hour shifts to run 24/7 facilities, the IRC used 8- to 16-hour shift rotations to accommodate these restrictions.

Service providers felt that they provided non-discriminatory services – prioritizing the needs of women, people with disabilities, children, and emergency patients. Facilities aren't generally equipped or built to ensure easy access for people with disabilities, but healthcare workers shared they provide additional care and advice to patients with disabilities and their caregivers. Some clinics are equipped with wheelchairs and dedicated stretchers for people with disabilities.

> *"Disabled people need extra facilities like separate toilets, chairlifts etc. In our all-IRC health centers, we have gaps in such infrastructure for providing a disability-friendly environment."*
> **– SENIOR HEALTH MANAGER**

> *"We give priority to pregnant women, disabled people and children. Sometimes we refer them to a disability center as we have no such infrastructure now."*
> **– NURSE SERVING A ROHINGYA COMMUNITY**

A lack of fully equipped facilities means that patients often can't access the care they need, especially if there are complications. At the same time, a center for people with disabilities will not be equipped to provide SRH or other specialist services, so SRH facilities need to ensure people with disabilities can access care there.

> *"Sometimes we have to refer newborn babies to the nearest hospital if complications occur during delivery. It is problematic and takes too long. If we had enough better equipped facilities to provide primary health care, it would be easy to refer them to another hospital as per requirement."*
> **– MIDWIFE**

Barriers relating to physical access to required services were exacerbated by COVID-19-related barriers – such as COVID IPC measures and lack of transport. Key informants described their efforts to maintain quality services during COVID-19, but explained that it was not always possible to "hold the quality at a top-level."

> *"We couldn't do much field work. We had to shorten public awareness meetings to ensure social distancing."*
> **– NURSE SERVING A HOST COMMUNITY**

> *"IRC established an ITU [isolation and treatment unit] and other facilities, as well as recruiting new staff to focus on COVID."*
> **– MONITORING, EVALUATION, ACCOUNTABILITY & LEARNING MANAGER**

One key informant suggested that to continue providing quality services during any future pandemics, staff at all levels need to be mentally prepared and require more support.

SRH for men and boys

Service providers and other stakeholders reported that most women attend their facilities for contraception, ANC, PNC, and delivery services, while girls are largely seeking STI advice and menstrual hygiene products. But that there is no separate center for men and boys, who can only access SRH services, information, and advice by going to a PHCC or hospital. Others described advice sessions and outdoor sensitization sessions on SRH for adolescents – a major source of information . Providers consequently suggested the introduction of a separate system for male SRH services and improving adolescent care, again reflecting findings from the focus group discussions.

> *"Our facility is very congested, so the place should be enlarged. I would like to suggest including separate adolescent SRH and male SRH services."*
> **– DOCTOR SERVING A ROHINGYA COMMUNITY**

> *"Our nutritionist and midwife advises the adolescent girls and boys if they come to the center, and treatment is given as per need. A community health worker or community health volunteer is assigned to every household."*
> **– MEDICAL OFFICER SERVING A ROHINGYA COMMUNITY**

Community engagement

Access to the camps was strictly scrutinized by government authorities and armed forces, which created access difficulties for humanitarian agencies. This was especially true when gaining approvals for community engagement and RCCE. Long lines of vehicles at checkpoints created traffic congestion and many agencies were turned back from the checkpoints. Furthermore, a shift from community information sessions to door-to-door visits made reaching people with key messages more time consuming. Early in the pandemic, many community volunteers did not have masks or PPE, which made them fearful of conducting activities during which they engaged with the public. These access barriers made it more difficult to conduct community engagement activities.

Staff reported finding it difficult to convince the community to follow COVID-19 IPC protocols, as well as struggling to dispel superstition and misconceptions about COVID-19 and vaccines. Some community members were concerned about contracting COVID-19 if they engaged with staff from humanitarian agencies, others believed their religion would protect them from COVID-19 and so were reluctant to follow recommended precautions.

> *"Knowledge gaps and superstitions were the main challenges in providing service. Everyone was scared of COVID. We faced challenges to make them understand about COVID IPC protocol."*
> **– DOCTOR SERVING A ROHINGYA COMMUNITY**

> *"It was hard to convince them to take the vaccine. Some of them thought vaccine could infect them with COVID."*
> **– COMMUNITY HEALTH VOLUNTEER SERVING ROHINGYA COMMUNITIES**

> *"As we have to maintain the three feet distance according to IPC protocol, we faced challenges in space limitations and the service delivery system was time-consuming."*
> **– FIELD FACILITATOR SERVING ROHINGYA COMMUNITIES**

To overcome these challenges, the IRC and partners engaged community and religious leaders around COVID-19 awareness. PPE was provided to community volunteers and camp residents. We used multiple methods to deliver key messages, including door-to-door visits, posters, leaflets, and mass messaging through megaphone.

Gender-based violence

There were similarities between the focus group discussions and interview findings on perceived influence of the pandemic on gender-based violence. In some camps, service providers described an increased number of GBV cases, whereas other camps reported no cases. Interviewees reported a significant increase of GBV during COVID-19 in Rohingya communities compared to host communities.

> *"There was an increased case of GBV. We tried to advise them."*
> **– MEDICAL ASSISTANT SERVING A ROHINGYA COMMUNITY**

> *"GBV cases increased in the camp but not in the host community."*
> **– FAMILY WELFARE ASSISTANT SERVING A HOST COMMUNITY**

6. Conclusion & Recommendations

The three pandemic waves in 2020 and 2021 in Cox's Bazar affecting access to SRH services and their quality – impacting refugees and host community members. Staff shortages, COVID-19 IPC measures, transport restrictions, and logistical problems led to long waiting times for patients, reduced outreach sessions, and shortages of medicines and materials. These barriers compounded with travel expenses, fear of contracting COVID-19, and general stigma associated with SRH services reduced clients' ability and willingness to seek services. The findings of this assessment echoed other reports which demonstrated a perceived increase in gender-based violence because of the pandemic lockdowns – however verifying these reports is difficult to confirm due to stigmas around reporting GBV and given the challenges of reporting during periods of social distancing.

The IRC, partners, and service providers put in place several program adaptations throughout the 18 months of COVID restrictions to mitigate these challenges. Effective collaboration with other health sector agencies through health sector and the SRH Working Group was critical to our response. This collaboration was also a success story, as collaboration is often a challenge during emergencies and infectious disease outbreaks. This work paid off for clients, with survey respondents and focus group discussion participants expressing overall satisfaction with provision of services, as well as a clear rebounding of the volume of services provided each month following each COVID-19 wave. At the same time, the toll on health care workers was significant, with many experiencing exhaustion and burnout due to the strain of maintaining COVID-19 precautions with limited resources, as well as managing staff turnover and absences due to illness.

Despite the implementation of successful COVID-19 mitigation strategies, men and boys continued to express feelings of exclusion from SRH services. They also lacked knowledge about SRH and perceived that SRH services were not for them or accessible to them. This is the result of reasonable attention to SRH for women and girls – given that the burden of morbidity and mortality falls most heavily on their shoulders – but also demonstrates an opportunity to further engage men as partners, as well as clients.

Access to SRH is only possible when multiple factors come together: women's knowledge and empowerment, ease and affordability of travel, and services available, affordable and high quality. Access can be lost when one or more of these factors is strained, as happens during infectious disease outbreaks. This assessment demonstrated that investment and attention are required to put in place context-responsive program adaptations to maintain access to essential SRH services.

Recommendations

The following recommendations aim to improve SRH service provision and access for future public health emergencies.

1. Maintain and strengthen collaboration with other facilities and agencies to ensure strong coordination of SRH services during public health emergencies
2. Prioritize the continuity of SRH services in line with the MISP for all emergencies, including infectious disease outbreaks
3. Develop interagency emergency preparedness plans for SRH services that include considerations for infectious disease outbreaks, in line with the MISP
4. Convene stakeholders to share lessons learned from delivering SRH services during emergencies, including infectious disease outbreaks, and use these lessons to inform preparedness plans
5. Coordinate with the camp infrastructure sector (with support from other affected sectors, such as the education sector) to find solutions to ongoing and deepening transport and access problems
6. Extend services through community-based and self-care interventions, in line with global evidence, as a means of providing more options to ensure access to services in the event of an emergency, such as an infectious disease outbreak
7. Create a pool of reserve clinical staff ready to be placed on-call – including qualified and skilled medical staff, staff to provide logistics support to prepare for infectious disease outbreaks, as well as those trained in cleaning and procurement
8. Provide regular training for service providers on the MISP, SRH clinical service provision, and IPC to improve their capacity to deliver SRH services in the context of an infectious disease outbreak
9. Pre-position supplies and equipment for SRH and IPC/ PPE materials (e.g., masks and sanitizer) to use in the event of an emergency, including an infectious disease outbreak
10. Ensure the inclusion of men and boys in SRH service delivery, design, and promotion – in addition to girls and women
11. Provide a full range of adolescent-friendly SRH services and information at all times – while incorporating specific adolescent-friendly provision in emergency plans

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