

Study on the Impact of the COVID-19 on Sexual and Reproductive Health and Rights (SRH&Rs) focusing on Women and Adolescent Girls in the Gulf Co-operation Council (GCC) Countries

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PREFACE

Several factors converged throughout the COVID-19 pandemic, which reduced the use of health services. These factors were mainly related to the mobilization of the entire health system to fight the pandemic, people's fear of being infected if they attend health facilities, and the concerns of health workers that they may jeopardize their safety if exposed to the disease. This potential disruption of health services has been affecting the sexual and reproductive health accessibility and the modalities of work in this area.

In this perspective, UNFPA, the sub-regional office for GCC countries, has commissioned a regional senior expert to issue a paper titled "Study on the Impact of the COVID-19 on Sexual and Reproductive Health and Rights (SRH&Rs) focusing on Women and Adolescent Girls in the Gulf Co-operation Council (GCC) Countries" to assess the impact of the COVID-19 pandemic on the service delivery of sexual and reproductive health facilities in the GCC countries and to what extent the rights of women and adolescent girls in terms of accessibility to reproductive health services in these countries. This study will result in a set of recommendations which be shared with the governments in the region, to ensure that women and adolescent girls' sexual and reproductive health rights are at the top of the development and pandemic recovery agenda, even in these extraordinary circumstances. This study also highlights the situation of SRH & RS in these countries and the gaps that could be identified, in addition to the areas of potential cooperation with UNFPA, as a leading UN agency. The study will also shed light on the needs and requirements of an integrated response that will support the continuity of these services in the current plans to respond to pandemic. It is intended to identify the possibilities for improve the integration of the COVID-19 dimension into the management of sexual and reproductive health services, including women's and adolescent girls' health, and ensuring accessibility to these services within the preliminary and dietary healthcare systems as part and parcel of the Universal Health Coverage (UHC) strategy.

This study consists of a couple of sections. The first one highlights the goals of the paper, and the situation of the COVID-19 pandemic in the Gulf countries, which have, to a large extent, managed to control the infection rates and the pandemic associated waves, by mobilizing great human and financial resources. The second section consists of the essential elements to study the impact of COVID-19 on sexual and reproductive health services, focusing on women and adolescent girls' health.

The main tasks of the consultant for the study were:

- Reviewing impacts on costing, budgeting, and financing for reproductive health services targeting women and adolescent girls in each country.
- Providing recommendations to the respective governments based on a situation analysis of the COVID-19 impacts.
- Highlighting the impact of the pandemic on UNFPA's mission to accelerate the implementation of global and regional commitments for access to SRH&RS.
- Providing a holistic situation analysis of the SRH services in these countries, and highlighting the gaps caused by the pandemic.
- Providing a qualitative and quantitative analytical review of the accessibility of the SRH&Rs to women and adolescent girls in the region based on the figures, data and statistics provided by official entities.
- Developing a risk analysis matrix related to the impact of the pandemic in this area of work.
- Developing a statistical and narrative knowledge product that can guide the future interventions of UNFPA GCC with the respective government entities to mitigate the impact of the pandemic in consideration of UNFPA's mandate.
- Specifying the magnitude of the impact in an analytical approach and triangulating data that highlights the effect of the current situation on the MoHs undertakings in light of the ICPD25 and the Nairobi Summit Declaration.
- Identifying and reviewing the extent to which the national RMNCAH, ASRH&RS, school health, and maternal health strategies and plans reflect the SRH&RS needs of women and adolescent girls, as defined in the ICPD Program of Action (ICPD PoA), the Lancet Guttmacher Commission on SRH&RS and/or RMNCAH/SRH&RS strategy.

- Assessing the impact of the strategies mentioned above and plans and drawing these conclusions supported by real-time statistics and data provided by the relevant partners and stakeholders.

This study is designed as a generic manual that countries, implementing agencies, and NGOs can adapt to their needs. It also aims to develop a set of recommendations for GCC governments to ensure respect for women and adolescent girls' sexual and reproductive rights. It will shed some light on the Sexual and Reproductive Health & Rights (SRH&Rs) situation in the targeted countries, the gaps that can be identified, and the areas of potential cooperation with the UNFPA sub-regional office for GCC countries (UNFPA GCC).

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1. Introduction

The United Nations Population Fund (UNFPA) is the United Nations agency, whose mission is to create a world in which every pregnancy is wanted, every child birth is safe, and every young person achieves their full potential. The strategic objective of UNFPA is to “achieve universal access to sexual and reproductive health, guarantee reproductive rights and reduce maternal mortality with a view to accelerating progress in the implementation of the Program of Action (PoA) resulting from the International Conference on Population and Development (ICPD) in 1994 and Nairobi Summit of ICPD25 in 2019, to improve the lives of women, adolescents and young people, based on population dynamics, human rights and equality of the sexes.” To achieve this goal, UNFPA articulate its work around three people-centered transformative results:

1. Eliminating preventable maternal deaths.
2. Eliminate the unmet need for family planning.
3. Eliminate gender-based violence (GBV) and harmful practices, including child marriage, and early or forced marriage.

These transformative outcomes will contribute to achieving the Sustainable Development Goals (SDGs), including good health and well-being (Goal 3), promote gender equality and empowerment of women and girls (Goal 5), and reduce inequalities within and between countries (Goal 10).

Furthermore, in line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to leave no one behind and provide assistance to the most disadvantaged first.

2. Study features

2.1 Rationale of the study

The entire world is facing an unprecedented health crisis due to the Covid-19 pandemic. There are more than 220,000,000 cases of the Coronavirus worldwide and 4,550,000 deaths until September 2, 2021. (COVID-19 data repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University).

With the increase of Covid-19 cases in March 2021 and healthcare facilities rapidly shifting their priorities, a real danger has emerged of undermining the availability of reproductive health services. Furthermore, the pandemic has also threatened to tighten restrictions on women’s mobility and ability to access sexual and reproductive health (SRH) services as their movement has been further restricted. It has, therefore, become necessary to assess the extent to which the rights of women and adolescent girls in GCC to access reproductive health services have been threatened during the pandemic and to develop recommendations for GCC governments, in order to ensure that women’s sexual and reproductive rights are maintained even in these critical circumstances.

The Gulf Co-operation Council countries seem to do better than the others, with disparities partly due to the inequality in the population, as well as the number of immigrants working in these countries: Saudi Arabia with nearly 370,000 cases and more than 6,300 deaths, the United Arab Emirates with almost 250,000 cases and more than 700 deaths, Bahrain with nearly 100,000 cases and more than 350 deaths at the beginning of January 2021, Qatar with almost 150,000 patients and nearly 250 deaths, Kuwait with more than 150,000 cases and nearly 1,000 deaths, Oman with more than 130,000 cases and more than 1,500 deaths, as of mid-January 2021 (according to World Meters Data collated by MEED).

2.2 Context

Since late February 2020, several COVID-19 cases have been confirmed in the GCC countries. Like many other regions of the world, GCC countries were affected by the outbreak of the Coronavirus, also known as COVID-19, or SARS-CoV-2. In March 2020, several more cases were detected in the region. Most of them were related to people who had travelled to affected countries. Infections have increased rapidly since March 2020, with a significant rate of testing that showed an increase in the number of COVID-19 cases in the community. In this unprecedented health crisis, an important goal was before the eyes of the governments of these countries, which was enhancing the ability to monitor the evolution and the spread of the pandemic. In this regard, the UNFPA sub-regional office for GCC countries (UNFPA GCC) is

conducting an exploratory study to map the effects of the COVID-19 pandemic on RH service accessibility. This study will identify the needs and requirements to have an integrated response and unified approach that will support the continuity and use of these services in the current response to the pandemic. It will also identify opportunities to improve the integration of the COVID-19 dimension in the management of the sexual and reproductive health services, including managing women's and adolescent girls' health and addressing their associated needs.

2.3 GCC countries: General and Demographic Data

The GCC population, total 45 million people in 2011, is less than 1% of the global population. It has one of the fastest-growing populations in the world however. In 2020 this population increased by a third to reach 53 million people. The vast majority 54% will be under 25 years of age. This is estimated to change to about 36% by 2050. The swift growth and the relative youth of the population present serious challenges as well as major opportunities¹.

2.3.1 GCC Demographic Structure

- **Size and Growth**

The GCC has a low population, when compared with other regions, totaling nearly 45 million people in 2011. The most populated country is Saudi Arabia with 28 million (65% of the total), followed by nearly 8 million in the UAE. The International Monetary Fund estimates a compounded growth rate (CAGR) of 2.41% in the next 5 years, increasing the population further to 49 million in 2016.

By 2025, the GCC is predicted to have a total population of 57 million, to grow by about 14 million more by 2050. As of 2011, the lowest median age in the GCC is 24 years in Oman² and the highest is 31 years in Qatar. The average age in the entire GCC region is 27 years with over 20% below the age of 15.

- **The Pyramids**

The young population will predominate in the GCC over the coming decade, which is different from the ageing populations of the US and western Europe. The proportion of the population under 15 years is substantial. The fertility rate in the GCC has been declining as there is a more prominent awareness of family planning. All GCC countries' fertility rates have diminished by more than 50%. This could likewise be associated with the increased average cost of basic items and increased education prospects for women. As the age of marriage increases, this diminishing pattern in birth rates is anticipated to persist. In addition, GCC pyramids have a skewed lump in the male section, particularly at working age, which is because of the high number of male expatriates in the countries.

- **Population trends**

Demographic trends normally change gradually and population totals usually are considered as being among the easier economic indicators to forecast. However, population growth in the GCC is profoundly driven by immigration trends, with expatriates making up 42% of the region's population in 2009. This leads to population totals being less foreseeable. There are three possible scenarios.

The GCC's population would flourish from an estimated 39.6 million in 2008 to 53.4 million in 2020– a 33% increase over 12 years. This level of population growth will need marked investment in infrastructure and services, including power, water, transport, housing, healthcare and education. This will place pressure on government budgets. Much of the GCC's current spending goes on wages, subsidies, healthcare and education. The need for these services will increase parallel to population growth.

Urbanization of the population is already there, and this will endure to remain the situation, with added pressure on urban infrastructure and housing. Where space permits, some governments will endeavor to develop new policies to decrease the stress on current cities, such as the "economic cities" in Saudi Arabia.

There is a challenge to provide adequate healthcare needs of the region over the next 10-20 years. Most governments in the region have already made important preparations to meet the challenge. Currently some 75% of healthcare spending in the GCC is funded by the public sector. Obesity and cardiovascular diseases are expected to account for a significantly larger proportion of total healthcare costs in the future.

The large size of the young population, and its rising access to education, the international media and new

¹ GCC Population Forecast to Reach 50 million in 2013, Business Intelligence Middle East, 18 February 2012

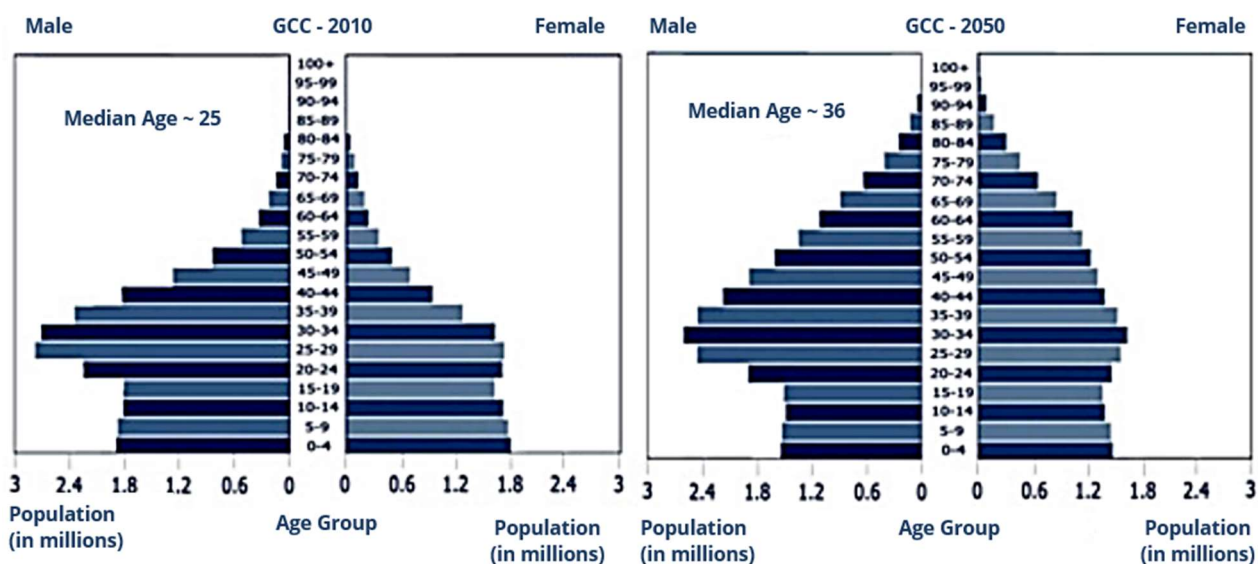
² Middle East Journal of Age and Ageing Volume 15, Issue 1, February 2018

technologies, indicates that social attitudes and norms will change fast. The new generation of young people in the GCC will be highly educated, and will thus have high expectations of high-status future employment. They will be progressively technologically literate. Many will be prosperous and well-travelled, and educated overseas, giving them a high awareness of different lifestyles, and cultures. Even those who are not educated abroad will be more likely to speak foreign languages and to use the social media to communicate with young people from other countries and cultures.

GCC Population: core scenario by country³

	2000	2005	2010	2015	2020
Total (m)	29.63	35.08	41.45	47.52	53.41
Average annual change over previous five years	2.80	3.44	3.40	2.80	2.40
Saudi Arabia	20.47	23.12	26.18	29.59	33.34
Kuwait	2.23	2.99	3.58	4.40	5.20
UAE	2.4	4.61	5.57	6.44	7.06
Bahrain	0.64	0.89	1.18	1.45	1.66
Oman	2.40	2.51	3.11	3.32	3.53
Qatar	0.64	0.97	1.82	2.33	2.79

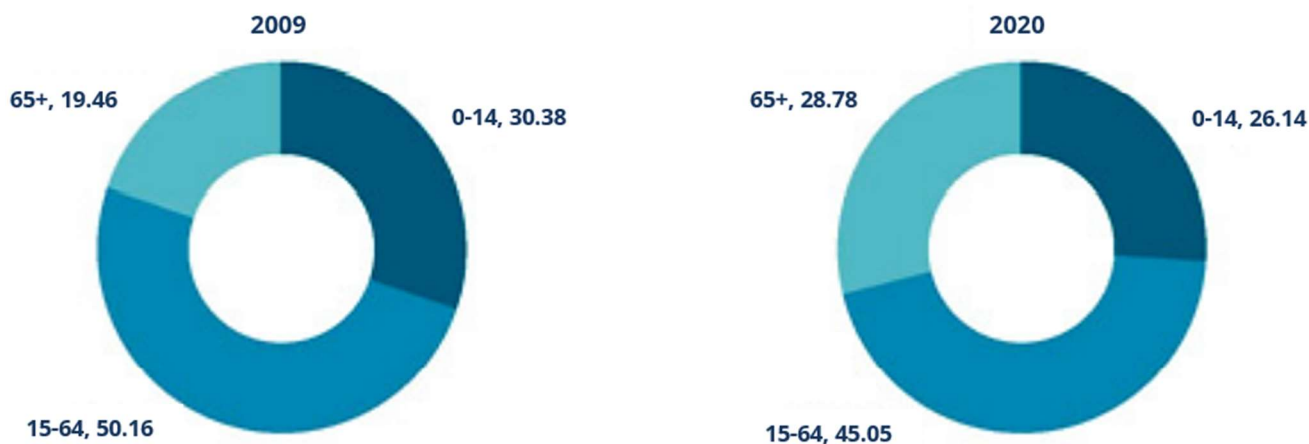
GCC Population Pyramid - 2010/2050



Source: US Census.

³ Sources: IMF; individual country statistical agencies (historical data); Economist Intelligence Unit long-term forecasts. (Our population growth estimates are based on separate projections for each GCC state and population growth is projected to be higher in some of the smaller countries.)

Age breakdown (% of population)



Source: Economist Intelligence Unit.

2.4 GCC National Policies and the SDGs

Gulf Cooperation Council (GCC) countries (i.e., Bahrain, Kuwait, Oman, Qatar, the Kingdom of Saudi Arabia (KSA), and the United Arab Emirates (UAE)) aligned their national development plans with the global development goals and affirmed their engagement and commitment to fulfilling these goals.⁴ Each country devised its national development plan based on its own priorities, available resources, and socio-cultural context. The title of SDG 3 is “Good Health and Well-Being,” which seeks to ensure healthy lives and promote well-being for all, at all ages equally and without discrimination. Within this overarching aim, there are nine smaller targets, two of these targets; namely SDG 3.1 and SDG 3.7 directly focus on women’s health.

SDG 3.1 endeavors, by 2030, to reduce the global maternal mortality ratio to less than 70 per 100,000 live births., noting that the Maternal Mortality (MM) is defined as “the death of a woman during pregnancy, childbirth, or within 42 days postpartum.”⁵ (See Table 1: GCC highlights of health-related SDG 3 indicators).

SDG 3.7 aims, by 2030, to “ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programs”.

⁶

By reviewing the latest reports published by each GCC state’s Ministry of Development and Planning, this paper examines how these states targeted women’s health and well-being. In addition, this review enabled us to explore the socio-cultural attitudes and perceptions of women’s well-being and how this is linked to other socio-demographic factors related to women.

It is important to note here that the WHO’s 2015 reports on the Millennium Development Goals (MDGs) indicate that all GCC countries reduced the MMR by roughly half between 1999 and 2015, as shown in Table 2.

⁴ Azar, E.; Raouf, M.A. Sustainability in the Gulf: Challenges and Opportunities; Routledge: New York, NY, USA, 2017.

⁵ Hogan, M.C.; Foreman, K.J.; Naghavi, M.; Ahn, S.Y.; Wang, M.; Makela, S.M.; Lopez, A.D.; Lozano, R.; Murray, C.J. Maternal mortality for 181 countries, 1980–2008: A systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010, 375, 1609–1623. [CrossRef]

⁶ WHO. SDG 3: Ensure Healthy Lives and Promote Wellbeing for All at All Ages. Available online: <https://www.who.int/sdg/targets/en/> (accessed on 18 August 2019).

Table1. GCC highlights of health-related SDG indicators
Summary of SDG 3 indicators: country-level values are reported as comparable estimates^a

Member State	2017	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019	2017	2016	2016	2019	2018	2019	2019	2019	2019	2019
	Maternal mortality ratio ^b	Under-five mortality rate ^c	Neonatal mortality rate ^c	New HIV infections ^d	Tuberculosis incidence ^e	Malaria incidence ^f	Hepatitis B prevalence ^g	Probability of dying from the four major NCDs	Suicide mortality rate ^e	Alcohol consumption ⁱ	Road traffic mortality rate ^e	UHC service coverage index	Air pollution mortality rate	WASH mortality rate ^e	Unintentional poisoning mortality rate ^{..}	Tobacco use prevalence ^k	DTP3 immunization	MCV2 immunization ^m	PCV3 immunization	HPV vaccine ⁿ	
Bahrain	14	7	3		12		0.03	16.1	8.9	1.1	5.2	77	40.1	<0.1	0.3	25.1	99	99	97		
Kuwait	12	8	5		22		0.03	11.9	2.9	0.0	15.4	76	103.8	<0.1	0.4	22.1	91	94	91		
Oman	19	11	5	0.04	8.5	0.0	0.13	21.5	4.9	0.9	10.6	69	53.9	<0.1	0.9	9.6	99	99	99		
Qatar	9	7	3		35		0.05	10.7	5.8	1.5	7.3	68	47.4	<0.1	0.3	14.0	98	95	98		
Saudi Arabia	17	7	4		9.9	<0.1	0.00	20.9	6.0	0.0	35.9	74	83.7	0.1	0.8	16.6	96	96	96		
United Arab Emirates	3	7	4		1.0	0.0	0.02	18.5	6.4	3.8	8.9	76	54.7	<0.1	0.4	18.2	99	99	99	27	

Table 2. Maternal mortality rates (MMR) (deaths per 100,000 live births) in Gulf Cooperation Council (GCC) countries from 2000-2017*

Country	2000	2005	2010	2015	2017	% reduction in MMR (2000-2017)
Bahrain	27	19	18	15	14	49
Kuwait	10	10	10	11	12	-20
Oman	20	19	18	19	19	5
Qatar	14	12	10	9	9	36
Saudi Arabia	24	22	19	17	17	29
United Arab Emirates	6	5	4	3	3	50

Source: UN Maternal Mortality Estimation Group (World Health Organization, United Nations Children's Fund, United Nations Population Fund, and World Bank); * The year 2015 marks the end of the millennium development goal (MDG) era and the beginning of the Sustainable Development Goals (SDGs) era. For the final evaluation in MDG 5 (which calls for a reduction of 75% in the MMR between 1990 and 2015), the United Nations Maternal Mortality Estimation Inter-Agency Group (UN MMEIG) carried out a comprehensive assessment of MMR levels and trends for 183 countries.

The UNFPA GCC office undertook an important role in the response to the COVID-19 outbreak in Oman, leveraging UNFPA community engagement experience and know-how in coordination with the Omani national partners and stakeholders to mobilize resources for several initiatives responding to women's needs at such critical time⁷. At the same time, UNFPA's sub-regional office for GCC countries (UNFPA GCC) has ensured cooperation and information flow between GCC countries.

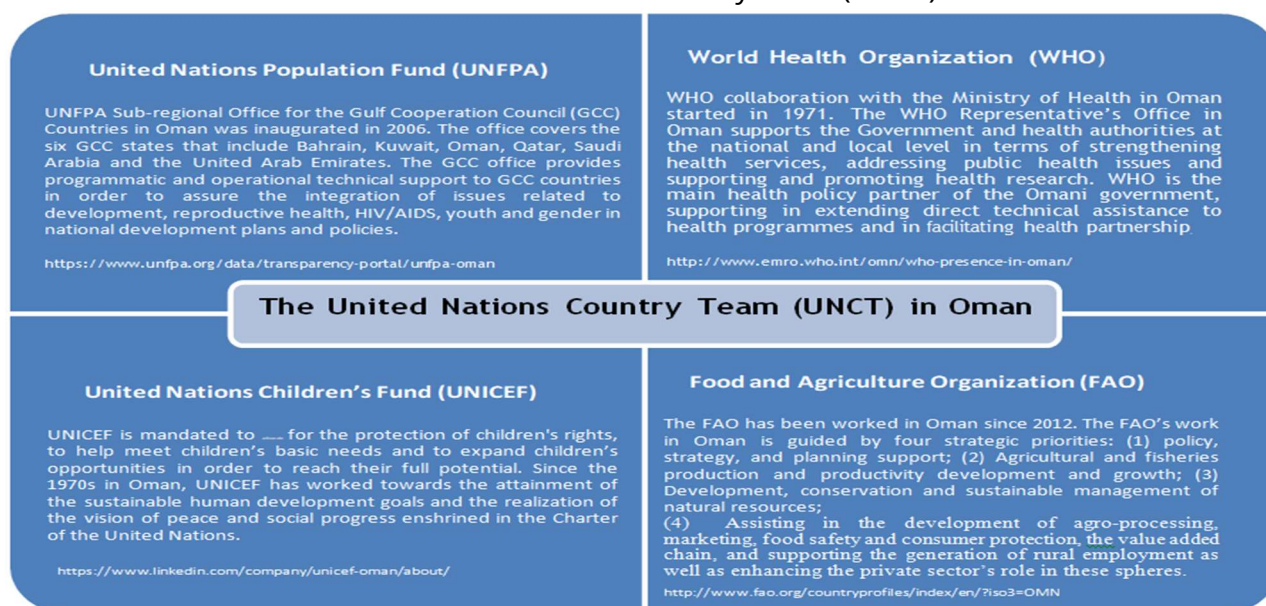
The United Nations Department of Economic and Social Affairs (UNDESA)⁸ indicated that country's preparedness in response to COVID-19 relies on solid commitments to, and its progress in implementing the Sustainable Development Goals (SDGs). In other words, those countries that have been the most advanced regarding SDGs

⁷ COVID-19: A Gender Lens, UNFPA, 2020.

⁸ Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19. United Nations Sustainable Development Group - Department of Economic and Social Affairs (UNDESA). (March 2020).

are experiencing a reduced negative impact in the face of the COVID-19 pandemic. Given that GCC has already witnessed significant progress toward the nationalization of the SDGs, the negative impact of COVID-19 on the population, particularly women, was quite limited compared to other countries in the Middle East.

Table 3. The United Nations Country Team (UNCT) in Oman



UN agencies and international organizations stress the importance of protecting women working in the health sector, given that they face significantly higher risks as the frontline public servants in the face of COVID-19. In fact, women represent approximately 70% of health workers around the world.⁹

Similarly, women represent the majority of public health workers in GCC countries, and given the significance of their work and their vulnerability in the context of this crisis, women deserve the best support and care in terms of access to appropriate Personal Protective Equipment (PPE) and social protection systems in case they are subject to the disease or unable to continue performing their duties.

Omani Women Working in Public Health Sector

Public sector female health workers in the country reached 16,699, representing 60.3% of the public health sector, as per Ministry of Health data (NCSI, Data Portal: <https://data.gov.om/OMHLTH2016/health>).

Omani Women in Private Health Sector

In the private sector, the case is quite different, where women do not constitute the majority of the workforce. In fact, they constitute only 24% of the health workforce in the private sector, with a total number of 5,078 female healthcare workers (NCSI, Data Portal: <https://data.gov.om/byvmwhe/labourmarket>). Like other economic activities, health system activities and services regressed relatively, due to the government's focus on responding to the pandemic and their relentless efforts to mobilize all sources and services to address its negative impacts, let alone the negative implications of the lockdowns.

In this regard, Dr. Shadha S. Al-Raisi, Director of Non-Communicable Diseases at the Ministry of Health in Oman, commented on this situation in the country, saying:

"Present figures and data do not necessarily show women to be as vulnerable to infection, or more affected by the virus, as men. Our figures show the contrary, that more men than women have been diagnosed with COVID-19 in the country, as was previously announced by the Minister of Health."

⁹ Gender equity in the health workforce: Analysis of 104 Countries, WHO, 2019, In addition to COVID-19: A Gender Lens: Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality, UNFPA, 2020.

Dr Al-Raisi further specified that the ministry's interventions are explicitly targeting the elderly population, as well as people with non-communicable diseases (NCDs) since these are amongst the most vulnerable groups to COVID-19. In this regard, there were other measures implemented by the ministry of health, which include:

- Public service announcements targeted mothers, lactating and expecting women, offering advice and instructions on coping with social distancing and encouraging them to take preventative measures, such as hand washing and the use of hand sanitizers.
- The development of a guideline by the Department of Women and Child health regarding the management and care of pregnant women during the COVID-19 pandemic.

Table 4: Health Infrastructure Indicators

Hospitals	81
Hospital Beds	6,823
Health Centers (With Beds)	55
Health Centers (Without Beds)	130
Extended Health Centers	22

Source: *Monthly Statistical Bulletin, National Centre for Statistics and Information (NCSI), Issue 31, Page 37, March 2020.*

The Sultanate of Oman has taken strict measures to fight the COVID-19 pandemic, including the creation of a Supreme Committee to follow up on the development of the pandemic. In addition, the Omani government has developed a plan for a comprehensive public health emergency response to COVID-19. The government has also been increasing and extending the scope of testing and examination in all governorates in order to facilitate the early detection and isolation of cases.¹⁰

As part of the Omani government's continued efforts to mitigate the pandemic impacts and ensure the continuity of services to the population, the Royal Hospital launched a virtual clinic phone service, which enables remote communication between patients and physicians. The service, which includes security measures to ensure privacy and confidentiality, allows doctors to send text messages at any time during the day. This offers regular situation assessments as well as the development of appropriate treatment plans.¹¹ In addition, on May 18th, 2020, UNFPA GCC launched a medical consultation service addressing the inquiries of women of reproductive age, pregnant and lactating women during the COVID-19 pandemic. The initiative was implemented in co-operation with the Ministry of Health's the Department of Women and Child Health, and with the support of the World Health Organization - Oman Country Office. All the Sexual and Reproductive Health (SRH) related Inquires/concerns were responded by experienced physicians of the Omani Society of Obstetrics and Gynecology (OSOG).

The use of and demand for health and medical equipment and supplies rise during such pandemics, and due to the global increment of the COVID-19 infections, supply chains efficiency has suffered significantly due to a global lockdown that has been influencing import/export operations (IPPF and IMAP, 2020).

To face the potential shortage of medical supplies and equipment, the Omani government has launched trade missions to increase and accelerate the transport and import of supplies and equipment from China.¹² In parallel, the government has prioritized regional cooperation to secure the demands of the healthcare sector through this time. During a virtual meeting of Ministers on April 4, 2020, the GCC countries agreed to ensure continued regional cooperation, setting up a ministerial-level "task force" to coordinate and monitor trade flows. Additionally, GCC countries agreed to implement a COVID-19 regional system to monitor the pandemic related statistics in the region, as a dashboard for infection and recovery data.¹³

¹⁰ https://timesofoman.com/article/3014155/oman/health/covid-19-health-minister-pays-fieldvisits?utm_campaign=layout&utm_source=article_page&utm_medium=layout_related_articles

¹¹ https://timesofoman.com/article/3014140/timestv/oman/Videos/virtual-clinic-service-launched-inoman?utm_source=Speakol_Ads&utm_medium=referral

¹² <https://timesofoman.com/article/2971370/oman/health/oman-sends-plane-to-import-medical-equipment-from-china>

¹³ <https://geogcc.gccstat.org/portal/apps/opsdashboard/index.html#/917d2690711b402192af82b7398e470c>

2.4.1 Nairobi Summit and COVID-19 in the GCC

Despite the global COVID-19 crisis, GCC governments maintain and strengthen their support for women's and girls' health in line with the Nairobi Summit of ICPD25. The Nairobi Summit, also known as ICPD+25, was held in Nairobi, Kenya, to celebrate the 25th anniversary of the International Conference for Population and Development (ICPD) and the Cairo Declaration, while the international community was working towards meeting the UN's Sustainable Development Goals by 2030.

The Summit reviewed all that has been accomplished since the first International Conference on Population and Development (ICPD) in 1994. The Summit pinpointed that the world has managed to lower maternal mortality and advance gender equality – but not nearly enough. Despite the achievements, a lot of efforts have to be exerted to continue achieving and implementing the SDGs and Agenda 2030.

As the COVID-19 pandemic continues to take a heavy toll on the health and economies of countries around the world, governments, non-governmental organizations, international financial institutions, and the private sector are stepping up and mobilizing political, economic, and in-kind support for programmes that protect the health of women and girls in their countries and ensure that their needs are met to address their issues related to accessibility to RH services and if they are being subject to GBV or domestic violence. Despite the challenges, however, GCC governments have been endeavoring to enhance and strengthen their support for women's and girls' health in line with the Nairobi Summit commitments and the ICPD25 PoA.

Despite the fact that the GCC government made no commitment to the statement of the Nairobi Summit, the governments of the countries were present throughout the proceedings of the summit and contributed effectively to the discussion. Although the commitments were not explicitly made, the governments have responded to the calls to prioritize the rights, health, and safety of women and adolescent girls and the protection of their sexual and reproductive health and rights. As observed in this crisis, the governments in the region have been promoting gender responsiveness in the COVID-19 crisis and placing women's needs at the top of their recovery agenda.

2.4.2 Women Situation in the targeted countries

Pregnant women in GCC

There is limited evidence on the impact of COVID-19 on pregnancy and new birth. A recent US study reported that pregnant women with COVID-19 are more likely to need hospital admission and are at increased risk for intensive care and mechanical ventilation than non-pregnant women¹⁴. However, this evidence is still very sparse, and a lot of information remains unknown about the impact of the virus on pregnant women in particular.

UNFPA has been calling for continuity of RH services. Therefore, maternity services should continue to be prioritized as an essential basic health facility, along with other significant sexual and reproductive health care services such as family planning, emergency contraception, and treatment of sexually transmitted diseases. Early data suggests a drop in facility-based care in many countries in GCC and projections of rising maternal mortality. However, the Ministries of Health in the region actively reached out to women and encouraged continued healthcare behaviors, and seized every opportunity to provide respectful, compassionate, and high quality healthcare services.

Maternity care providers (including midwives and all other health care workers providing maternal and newborn care), whether based in health facilities or within the community, are essential workers and they have to be also protected in order to continue providing services to childbearing women and their infants.

¹⁴ International Confederation of Midwives (ICM), Women's Rights in Childbirth Must be Upheld During the Coronavirus Pandemic. 2020, International Confederation of Midwives: The Hague.

Maintaining a healthy workforce will ensure ongoing high quality healthcare provision for women and their newborns; as without healthy midwives and other maternity health staff, there will be limited care for women and newborns and less possibility for them to receive the needed attention through the prenatal and postpartum stages.¹⁵

The UNFPA response to the COVID-19 pandemic in the area of maternal healthcare involves a 3-pronged approach:

1. **Protect maternity care providers and the maternal health workforce;**
2. **Provide safe and effective maternity care to the women;**
3. **Maintain and protect maternal health systems.**

Affected women	Interventions and Measures	The Case of Oman
Pregnant Women	<p>Pregnant women with respiratory illnesses require priority treatment due to the increased risk of adverse outcomes. In addition, antenatal, neonatal, and maternal health units must be separated from areas that have identified COVID-19 cases.</p> <p><i>Source: COVID-19: A Gender Lens, UNFPA, 2020.</i></p>	<p>The number of women visiting clinics through pregnancy has increased from 71.3% in 2014 to 75% in 2018.</p> <p>During the same period, the maternal mortality rate has decreased from 18.3 to 15.1 for every 100,000 births¹.</p>
Women with Disabilities	<p>Urgent protective measures: Governments should collaborate with organizations working with People with Disabilities (PwDs) to establish monitoring systems, including emergency hotlines and social service-based house calls and check-ups. Telecommunications firms could also collaborate to ensure that hotlines are fully inclusive and accessible.</p> <p><i>Source: COVID-19 and Implications for Inclusive Economic Empowerment in CARICOM: Policy and Programme Considerations, UN WOMEN, 2020.</i></p>	<p>There are existing programs and services that provide PwDs with the tools necessary to remain independent. In Oman, PwDs can acquire the needed services using “Disabilities” card, which allows them to receive many valuable services needed for their wellness.</p> <p>In 2018, 31,727 people received “Disabilities” card, of which 35% were adolescent girls and women.¹⁶</p>

¹⁵ UNFPA, Coronavirus Disease (COVID-19) Technical Brief Package for Maternity Services. 2020, UNFPA: New York.

¹⁶ Omani Women; Partnership and Development, NCSI and MoSD, Page 47, 2019.

<p>Women subject to domestic violence/G BV</p>	<p>Moving women support services online, in addition to stepping up advocacy and awareness campaigns that also target and educate men at home.</p> <p><i>Source: Policy Brief: The Impact of COVID-19 on Women, UNSDG, April 2020.</i></p>	<p>The Sultanate of Oman has worked to eliminate all types of discrimination against women, including discrimination occurring in the context of marriage and within families. Both Royal decrees and laws exist and aim to bring justice for women in all marital relations. Both family and women's associations provide premarital education programs, lectures, and seminars to enhance knowledge related to marital relations and social responsibilities. The Ministry of Social Development offers counseling and advisory services through in-person meetings or by phone. Individuals can also receive psychological, social, and economic counseling. In 2014, there was one recorded case of domestic violence, and 4 cases were registered in 2018. These cases were addressed in Dar Al-WEFAQ by judicial order¹⁷.</p>
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3. COVID 19 Impacts on Sexual and Reproductive Health, and Maternal Health in Oman:

According to the interviews held with officials, the following statements were captured:

Dr. Jamila Al-Abri and Dr. Fatma Al Hinai at the Woman and Child Health Department of MoH, and Dr. Badriya Al Fahdi, the President of Oman Society for Obstetrics and Gynecology (OSOG), have jointly stated that:

"In Oman, we have a standalone program focusing on women's and children's health that considers the needs of children up to 18 years old, so it covers the adolescents' health needs." Besides that, there are programs related to antenatal care, birth spacing, infertility and early screening for breast cancer. During the pandemic period, antenatal care interventions and all birth spacing activities were normally running, and women were able to access these services as needed."

The respondents stated that at the beginning of the pandemic, there was a minor change in the number of appointments for antenatal care. For women with low-risk pregnancies, the number of antenatal care visits were systematically reduced. **On the other hand, those who were in need of more visits and appointments, due to their health conditions during pregnancy term, were able to access the health facilities and arrange for the needed visits to consult with their physicians.**

The medical services continue to be provided at the Primary Healthcare (PHC) taking into account all the preventive measures to reduce infection exposure. At the secondary and tertiary hospitals, all services were normally provided as usual in the same manner.

Birth spacing and infertility services were also provided at the primary health care facilities. However, some secondary and tertiary infertility clinics had to make some changes in their schedules, and some appointments were cancelled or rescheduled because of the pandemic outbreak. The breast cancer screening at primary healthcare facilities was halted initially. This adaptation has affected all the screening services, especially for Non-Communicable Diseases (NCDs). Such a stoppage occurred only at the peak of the pandemic infection, i.e. last November 2020, when the number of cases escalated dramatically. Through the last 8 months, the number of cases have decreased dramatically in Oman.

¹⁷ Omani Women, National Centre for Statistics and Information (NCSI), Social Statistics Series No.3, Page 52-53, 2019.

Therefore, some of the services were resumed, including breast cancer screening and other services related to women's health that were suspended during the pandemic.

The appointments related to antenatal and birth spacing clinics were scheduled as usual, and the same services were regularly provided. Some services that have to be provided in the secondary healthcare facilities, were ceased, and the physicians resorted to innovative approaches to contact the patients, including tapping into the telemedicine healthcare system launched by the Ministry. Hence, consultations and medical advices were offered to the patients with chronic diseases, remotely.

The regular screening for breast cancer was ceased too, however, in case if a patient needs urgent consultation and had an acute issue, she was able to visit the healthcare facility and still receive the needed service.

The Ministry of Health of Oman adopted a very practical and useful approach, especially during the third wave of the pandemic. The Ministry embarked on what has been called "COVID-19 centers", where all cases that are suspected of being exposed to COVID-19 infection, or other confirmed cases with complications, can access the relevant services to receive the required treatment. Therefore, other national medical centers continued to work in the same modality as in the pre-pandemic period. They went on providing complex and extensive services and needed healthcare aids according to the RMNCAH policies in place.

3.1 Impact of COVID-19 on Reproductive Health Associated Services

3.1.1 Telemedicine Services and Hotlines

Due to the COVID-19 spread and the changes in the healthcare facilities modalities of operation, data collection by the respective parties at MoH became difficult. Undoubtedly, the lack of data has relatively affected the operation of the respective departments and made it a challenge to fulfill some healthcare related indicators. However, the Ministry was able to track the cases, continue collecting data and analyze it as usual, so they could reflect on the number of inpatients and outpatients, especially in the first quarter of 2019 and the quarters of 2020 in a comparative manner. As stated before, the MoH has continued to provide prenatal, maternal, and birth spacing services in a standardized way, as usual.

Women might be reluctant in some situations to attend health facilities, given their concerns about being exposed to COVID-19 or jeopardizing their infants. During the early stages of the pandemic, services were provided through a telemedicine modality. UNFPA, the Ministry of Health, and OSOG launched a midwifery hotline, two senior obstetricians were able to respond to women's concerns. The obstetrician also had the possibility to transfer the call to more specialized departments, when needed and prescribe over the counter medications, according to the woman's conditions and case. The hotline also provided the means for referral, where the physician was able to refer the woman, according to her conditions, to the nearest available healthcare facility to receive the needed care. The information was always provided in English and Arabic, so the nationals and expats were able to access the service and receive recommendations and advices.

3.1.2 COVID 19 impact on costing, budgeting, and financing for the Reproductive Healthcare targeting women and adolescent girls:

In Oman, the services related to reproductive healthcare are provided by the public health system, and they are free of charge. Since the Omani government provides healthcare services free of charge to its citizens, access to birth spacing, antenatal, postnatal, and maternal healthcare services was not hampered during the pandemic, and they were able to use these services whenever they needed to.

There is no specific budget assigned to woman and child health services, and thus there is very limited impact on the provision of such tailored services, since all allocations are made directly from the general budget "pot" of the MoH. As a result, there is no clear indication of whether the pandemic has had a negative impact on financial resources or caused a reduction in such budget for this healthcare area.

When COVID-19 started, there was a donation account controlled and managed by the MoH. The account's entire allocations were comprised of donations from companies, individuals, and government entities. The purpose of this

account was shifted to cover the healthcare expenses during the pandemic. It has covered ca. 80% of the services provided by the MoH targeting COVID-19 patients. This mechanism showed an appreciated and orchestrated coordination between the MoH and the private sector entities in the country.

In Oman, there is an established supreme steering committee that supervises and coordinates all matters, decisions, and resolutions related to the pandemic promulgation in the country. There is also a constant coordination between all parties in the health sector, and the Ministry of Finance, especially in areas related to the availability of drugs and vaccines. The government gave the opportunity to individuals and the private sector to contribute to the established financial modality to provide for the healthcare necessities related to vaccination and treatment.

As mentioned before, women's healthcare needs have been at the top of the work agenda of the Ministry of Health in Oman. Providing services related to antenatal, postnatal, and fertility and/or birth spacing services has been a priority for the MoH, even during the pandemic period. The MoH also established a statistical and supply system, where there are clear figures related to the commodities needed for this medicinal area, to ensure that the supplies are always provided to the healthcare centers and to avoid the occurrence of shortages in the stocks. Despite having such advanced systems, the stoppage of the supply chain internationally caused a delay and disruption in some commodities provision, as happened in any other part of the world.

3.1.3 RMNCAH, ASRH&RS, School Health and Maternal Health strategies and plans reflecting the SRH&RS needs of women and adolescent girls, according to the Nairobi Summit ICPD+25 PoA

As mentioned earlier, in Oman, there are national programs for reproductive health like antenatal, maternal & newborn health, and birth spacing. This program was kicked off in 1987 as one of the pillars of the national development plan. The activities and services related to this program are available not only in Muscat, but across the country. This strategy has ensured the woman's and her newborn's right to high-quality healthcare and excellent free services. Such interventions come consistent with the provisions and commitments mentioned in the Nairobi Summit statement and ICPD PoA.

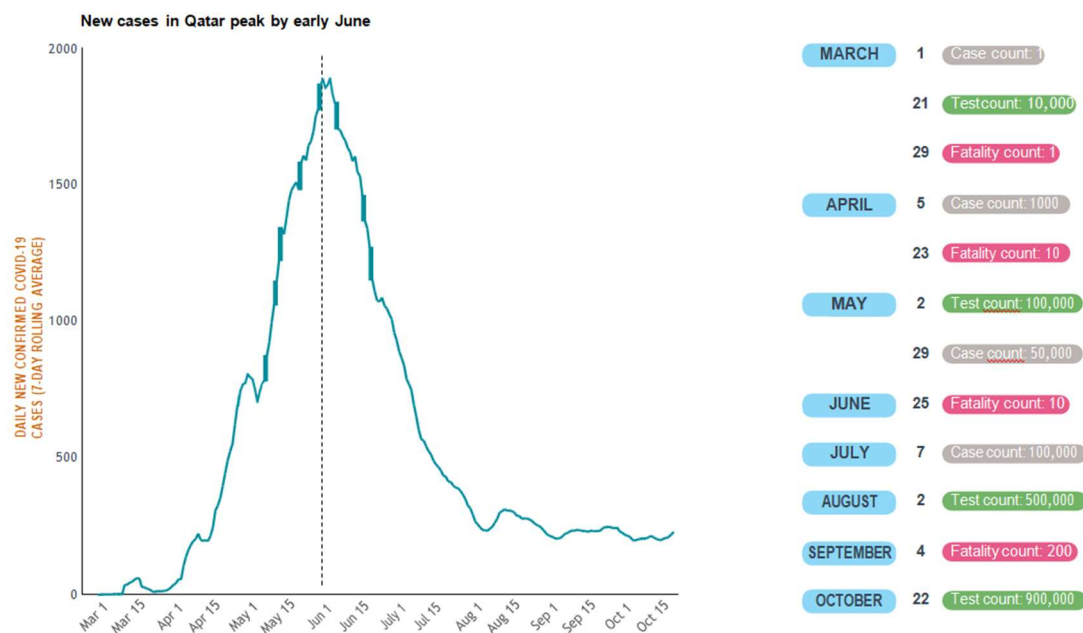
These targeted services are completely integrated at the level of the primary healthcare tier, ensuring easy accessibility to these services. Moreover, the availability of such services is an impeded cornerstone in all work plans of the MoH and the Health Vision of Oman 2050, which assures the sustainability of providing these valuable services in an equal manner. It is worth noting that the MoH is also managing a school health program, which is focusing on adolescents' health needs throughout the entire life stages of the young men and women of Oman. This program responds to their needs by promoting authentic health information and advocating for a healthy lifestyle for this population category. The program complements the availability of child law in the country, which caters to the needs of children in terms of the availability of safeguarding and protection social services. The School Health program ensures that the needs of the adolescents at schools and universities are identified by a specialized "School/University Nurse," who is able to refer the students to any specialized healthcare facility when required. It is noted that the UN Country Team in Oman has been working extensively with the Ministry of Social Development and Ministry of Health to develop joint programs that respond to the SRH needs of these targeted age groups in the Sultanate. Furthermore, there are several guidelines and booklets that have been developed promoting SRH&Rs and providing the needed knowledge in this area to school nurses, physicians and social workers.

4. COVID 19 Impacts on Sexual and Reproductive Health, and Maternal Health in Qatar:

In response to the epidemic, health authorities in Qatar have followed the approach defined in the Qatar Vision 2030, which aims to attain optimum public health through the implementation of sound and empirically tested and proven best practices in healthcare by utilizing cutting edge tools and the exceptional skills of the healthcare professionals. They benefited from the competence and expertise of scientists across the health sector in the country, and the inputs of the WHO in areas related to disease epidemiology and analytics, HIV/AIDS researches, sexually transmitted infections, and viral hepatitis. The Weill Cornell Medicine Faculty in Qatar has played a very important academic role in conducting researches in these domains. Based on the indications received by WHO EMRO and WHO HQ, Qatar's response to COVID-19 was guided primarily by THE Agency's relevant guidelines and recommendations. The Government of Qatar has used all essential background and knowledge to develop more than 100 documents, including policies, clinical guidelines,

and educational materials in all aspects of the response to COVID-19.

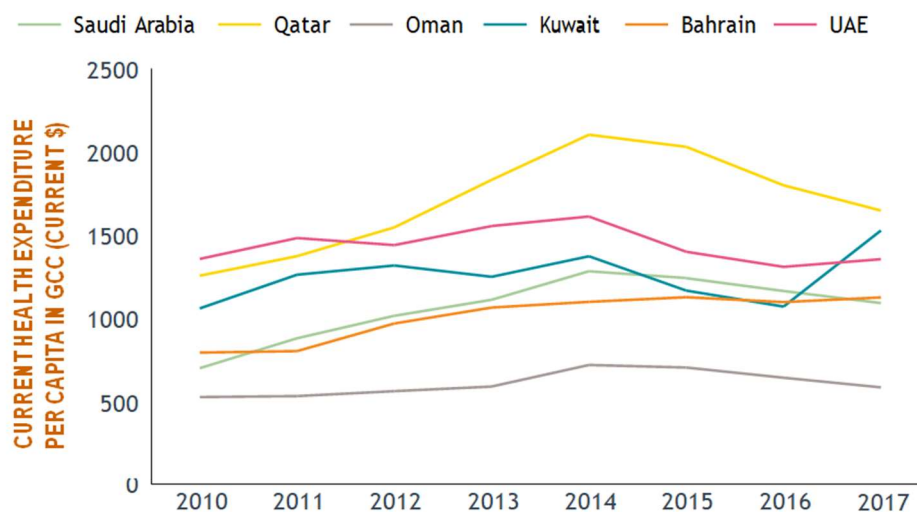
Qatar was able to effectively slow the initial spread of the virus within just a few months



Qatar is well known for its reputation in prenatal care, as statistics indicate that 92% of Qatari women received at least four medical examinations during pregnancy. In comparison, more than 95% of them reported having undergone blood pressure testing and analyzing urine and blood samples during those examinations. On the other hand, the available data document the widespread prevalence of pregnancy diabetes in Qatar, as obesity is one of the risk factors for developing

In Qatar, the Health expenditures per capita is the highest in the GCC Countries

	Physicians (per 1000 people, 2018 data)	Nurses and midwives (per 1000 people, 2018 data)
Qatar	2.5	7.3
Saudi Arabia	2.6	5.5



According to the interviews held with the officials at the Ministry of Health of Qatar, Dr. Najat Ali Mohsen Khenyab – the Lead of Healthy Women Leading to Healthy Pregnancies program and Sr. Consultant, Ob/Gyn, & Head of Fetomaternal Medicine, HMC and Dr. Sadriya Mohammed Al-Kohji Head Of Child & Adolescent Health & Community Medicine Consultant, PHCC, they stated that the primary healthcare sector provides pre-pregnancy testing for genetic disorders, which is an obligatory procedure for marriages.

“We have antenatal care provided at all levels, depending on the type of risk the patient poses. We have postnatal care offered to women with high and low risks. These services are provided at hospitals, primary healthcare facilities, or through the home care program. There are also some available birth spacing services. There are also specialized women’s health clinics that provide screening to patients to detect cervical cancer for those who are over 40 years old. There are also breast screening services available in the breast cancer screening clinics. Moreover, there is also

a. Impact of COVID 19 on Reproductive Health Associated Services

Dr. Najat Ali Mohsen Khenyab stated that the only facility that did not witness any interruption in services provision were the pregnancy and childbirth hospitals. They were operating regularly through the COVID-19. In addition, the number of deliveries and cesarean sections (C-sections) were not affected as well. However, through the pandemic’s frequent waves, there was an escalation in the number of pregnant women who had the viral infection, and the needed care was provided to them at the healthcare facilities around the country. Despite the continuity of such services, it is undeniable that COVID-19 reduced the number of admissions in general at hospitals.

b. Virtual Services:

Due to the impact of COVID-19 on the antenatal care service, several virtual antenatal consultation services or virtual clinic visits were introduced to the healthcare systems in GCC countries.

According to Dr Najat Ali Mohsen Khenyab :

We have developed guidelines to address the concerns of pregnant women with low or medium risks, who do not need to be present at the hospital. The guidelines state that the visits can be conducted virtually instead of face to face visits. So, the pandemic definitely changed the practices of the healthcare we provide. However, those who were seeking contraceptives or treatment for fibroids were put on hold for some time, especially during the first massive wave of the pandemic. The work hours and capacities of some physicians who are specialized in specific areas, such as aesthetic plastic surgery, were limited in the periods when COVID-19 was picking up. Afterwards, we were able to get back to normal, though the gynecological emergency departments were never affected and they continued to provide their services to women, regardless of their ages. Moreover, the cancer

Upon discussing with the respective physicians at MoH in Qatar, contraceptive consultations are provided at the Primary Healthcare level. Therefore, they were transferred to be provided online, and the pharmacies were able to deliver contraceptives and other medicinal products to the patients domiciles in order to reduce contact with the patients. These procedures and measures came in line with the national relevant guidelines that were developed by the government to overcome the COVID-19 waves.

As stated above, the government of Qatar has been supporting the pregnant women so they can access the needed services virtually, without being exposed to any viral infection through their pregnancy. Each pregnant woman, when needed, can also be monitored at home, according to the woman’s health conditions. At hospitals, and as indicated, all antenatal services, labor rooms, and C-Sections were operated as usual. On the other hand, significant service such as screening for cervical and breast cancer, continue to be carried out at the Primary Healthcare level.

c. COVID-19's impact on reproductive health costing, budgeting, and financing for women and adolescent girls:

Undoubtedly, the new innovative services that were launched in response to the pandemic, such as medicine delivery services, virtual services and the telemedicine facilities needed extra budget and allocations to continue providing these services, which might have impacted the provision of some specific healthcare services and interventions through this critical time.

d. RMNCAH, ASRH&RS, School Health and Maternal Health strategies and plans reflecting the SRH&RS needs of women and adolescent girls, according to the Nairobi Summit ICPD+25 Programme of Action:

In Qatar, there are very well-developed national programs for reproductive health like antenatal, maternal newborn health, and family planning which were running efficiently during the COVID-19 epidemic. Thus, ensuring the right of the woman and her newborn to access a good quality of care and free of charge services in consistent with the commitments of the Nairobi summit ICPD+25 statement.

In this respect, Dr. Sadriya Mohammed Al-Kohji said:

In Qatar, a married young pregnant woman can easily access the antenatal care she requires. However, in very rare cases when the adolescent girl is pregnant, out of marriage, there is a specific referral system in this aspect, and she will receive the antenatal healthcare service she needs. There will be several parties involved in such cases, including police, women's protection mechanisms, and multiple social and legal departments. At the same time, we are educating our adolescents and supporting them and providing them with authentic information related to their SRH&Rs, including information about irregular menstruation and pregnancy. Birth spacing and contraception program will be launched soon to be rolled out on the primary healthcare services level. There are also awareness programs targeting adolescents including healthy lifestyle information and health screening services, so any young adolescent can access this service and be referred to a health facility through his/her school.

5. COVID-19 Situation Analysis in Kingdom of Saudi Arabia

When the COVID-19 pandemic struck in early 2020, no one predicted the extent to which COVID-19 would impact the entire world, causing a lot of issues, implications and negative impacts. One of the main challenges that were faced by the KSA, as in any other part of the world, was to find a balance between reacting to the immediate needs caused by the pandemic, including healthcare needs, the protective measurements' necessities, and pursuing the goals established by the United Nations (Agenda 2030 and SDGs), which form the basis of the ambitious national plans of KSA, which are the Saudi Vision 2030, and the 10th Saudi Development Plan that ended in 2019, in addition to the UN Common Country Strategic Framework (UNCCSF 2017-2021). The UN Resident Coordinator Office of the UN in the Kingdom led the development of the United Nations Roadmap for the COVID-19 Recovery, ensuring that the promise of Leaving No One Behind is considered through the COVID-19 recovery process. In a pursuit to synthesizing these elements and balancing the country's prudence and need for immediate responses, the United Nations Country Team (UNCT) has published two significant reports, which were the United Nations COVID-19 Capacity Brief, which was released in July 2020; and the Diagnostics Paper on the Socioeconomic Impact of COVID-19 in the KSA and the way to "Build Back Better" that was released in December 2020 as result of a robust partnership between the United Nations Development Program (UNDP) and Prince Sultan University. Both reports have provided valuable contributions to the analysis and mitigation of COVID-19 in the country. UNFPA GCC office has provided technical assistance by providing messages and statements on the margin of the Saudi Family Forum.

5.1 United Nations COVID-19 Capacities in the Region:

The overall objective of the United Nations COVID-19 Capacity Brief was to propose to the Saudi Government a set of actions complementing already existing Government efforts. The Capacity Brief contains a collation of 67 ongoing activities and projects, which could accelerate Government responses to COVID-19. It has also proposed several new activities aimed at mitigating the COVID-19 negative impacts, and reducing the economic and social implications of the pandemic. Drawing on "the United Nations Development System Framework for the Immediate Socio-economic Response to COVID-19", the Capacity Brief lists the UNCT activities related to COVID-19, structured around the SDGs and the five developmental pillars that make up the framework. Under the guidance of the United Nations Secretary-General (UNSG) and the leadership of the Resident Coordinator, the United Nations Country Team (UNCT) in Saudi Arabia is determined to mitigate the negative impacts and lead the recovery process by emphasizing the

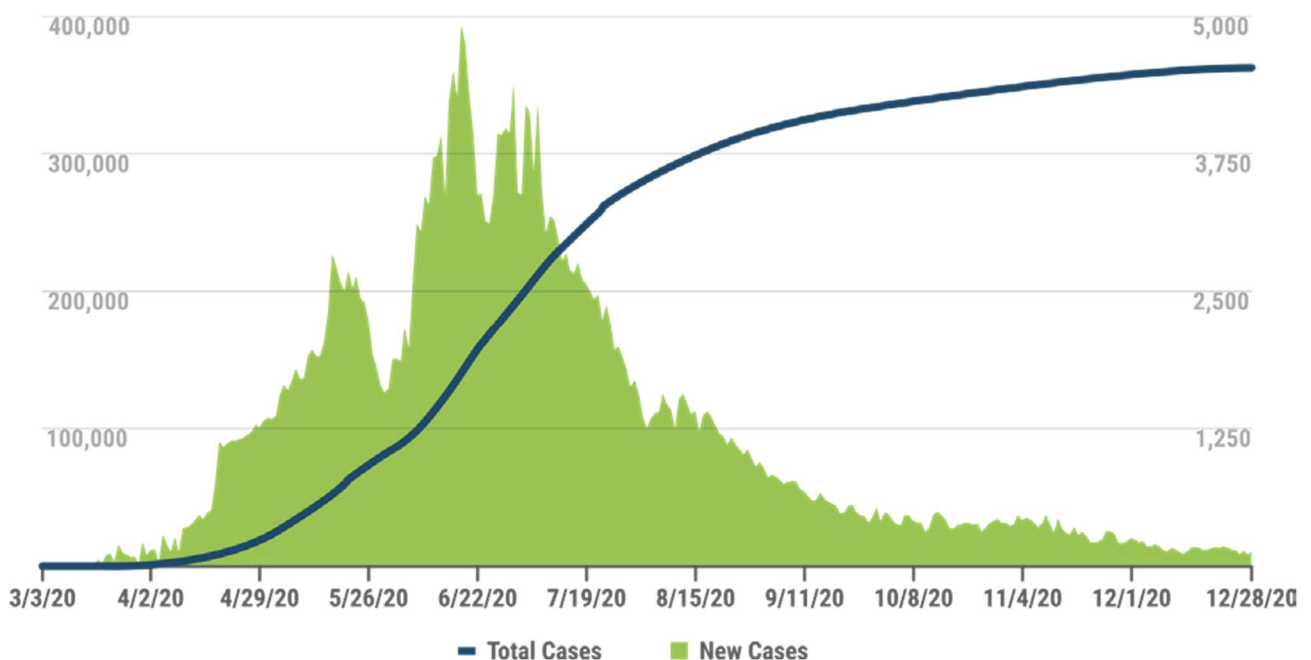
interconnectivity between health, environmental, social, and economic issues, in particular for some specific population groups, such as women, children, migrant workers, and temporary contracted workers and working migrants who might lack the social and health insurances and protection, and who are likely to suffer greatly from the adversities of COVID-19.

On the other hand, reporting and information management in the subjects and areas related to COVID-19 were among the major themes of the Capacity Brief. Accessing valid and authentic health information and combat hoaxes related to the pandemic was one of the concerns that were addressed in this significant paper.

The following figures are extracted from the COVID-19 monthly report for December 2020. Figure 1 provides primary COVID-19 data for 2020, including an annual average of 1,197 new cases per day. Figure 2 points out a peak of 4,919 new cases on June 18, 2020, and a substantial decline in the number of new cases in the fourth quarter, which is owed to swift and effective COVID-19 mitigation strategies undertaken by the government in co-operation with the UNCT.



Figure 1. General Data for the KSA on COVID-19, in 2020



5.2 Impact of COVID-19 on the Maternal Health in Saudi Arabia¹⁸

The Transmission of SARS-CoV-2, to neonates is thought to be predominately to occur primarily through respiratory droplets during the postnatal period when neonates are exposed to mothers or other caregivers with COVID 19 infection. Limited published reports have raised concern about possible intrauterine, intrapartum, or peripartum transmission Approximately 2-5% of infants born to mother with positive COVID-19 have positive COVID 19 positive tests in the first 24-96 hrs. Their immature immune system leaves newborns vulnerable to other severe respiratory viral infections, which may cause severe disease among neonates. The guidelines provide interim guidance for the management of infants born to mothers with confirmed or suspected COVID-19 infection. Neonates born to the

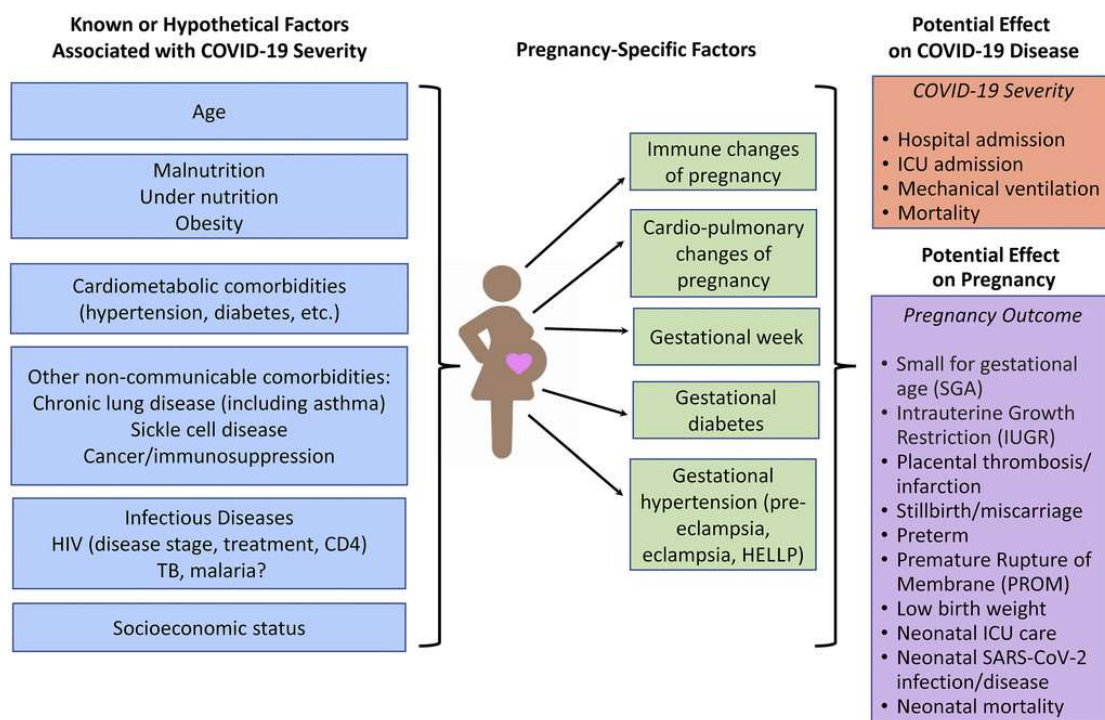
¹⁸ Saudia Arabia Ministry of Heath Publications

mothers who are suspected or confirmed COVID-19 infection can be divided to three main groups:

1. Healthy baby
2. Asymptomatic infected (or mild disease) neonate born at or near term who does not require neonatal intensive care.
3. Symptomatic or high-risk neonates requiring neonatal intensive care admission. (Preterm infants < 37 weeks gestational age and neonate born with comorbidities may be at higher risk of severe illness from COVID-19).

Guidelines are produced by the Saudi MOH and include instructions to guide the care of pregnant mother with infected corona virus. Instructions for health care givers for pregnant patients infected or suspected to be infected with corona virus:

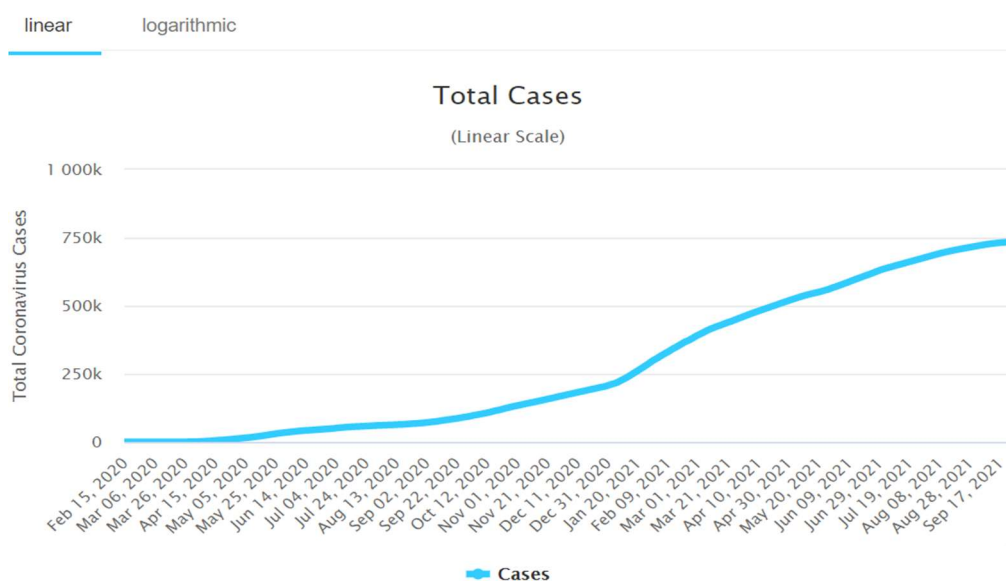
- Exposed to an infected patient with infected corona virus: If a pregnant woman is exposed to infected patient with corona virus, the health care provider should follow the latest edition of MOH corona virus-19 guidelines.
- **Antenatal:**
 - Isolation measures, supportive treatments should be applied following the MOH corona virus disease guideline.
 - Any pregnant woman diagnosed with COVID-19 disease will not attend to antenatal clinic till she is cured.
 - Routine antenatal clinic appointments can be delayed till patient is cured
 - COVID-19 is not known to cause fetal congenital anomalies E. Serial ultrasounds every 4 weeks for fetal anatomy and fetal wellbeing starting from 24 weeks of gestation is advisable
- **Labour & delivery:**
 - Delivery should occur in an isolated room and the room should be disinfected right after the patient is discharged to the ward following the infection control measures
 - Continuous fetal monitoring during labour.
 - Normal vaginal delivery with delaying rupture of membranes is advised.
 - Caesarean section is for obstetrical reasons.
 - Operative vaginal delivery is not contraindicated
 - Labor, delivery and recovery should be done in the same room.
 - All care givers in contact with the patient should use protective gears (minimum to include) face mask with eyes shield , gloves , head cover and disposal gowns as per infection control policies
 - Caregivers handling a patient with corona virus should change all their clothing's (if they are not wearing protective gowns and head cover) and wash hands before handling another patient.
 - Routine types of anesthesia and analgesia are not contraindicated.
 - New born babies of covid-19 infected mother should not be allowed to be in contact with their mothers till the mother is cured or declared free of the disease (following the current isolation measures in MOH COVID-19 disease guidelines
 - Isolation of those babies till they are declared clear from the virus or for 14 days
 - If the new-born is tested positive for covid-19, it should be kept in isolation until it is cured or test negative.
 - Transfer a new born from delivery room: a gentle bath with warm water and soap should be done.
- **Postpartum care**
 - Midwives/nurses should encourage women to express breast milk (after appropriate breast and hand hygiene).
 - Breast pumps and components should be thoroughly cleaned in between pumping sessions based on the manufacture guidelines that must include cleaning the pump with disinfectant wipes and washing pump attachments with hot soapy water.
- **Newborn care**
 - Midwives should carry out all non-urgent neonatal care and examination in isolation room e.g. weighing, immunization.
 - All newborns delivered to a mother with suspected /confirmed with COVID-19 should be kept in isolation incubator.
 - Isolation of those babies till they are declared clear from the virus or for 14 days.
 - If the newborn is tested positive for COVID-19, it should be kept in isolation until it is cured or test negative.



6. COVID-19 Situation Analysis in UAE

The United Arab Emirates (UAE) has taken unprecedented precautionary measures including complete lockdowns against COVID-19 to control its spread and ensure the well-being of individuals. In Abu Dhabi, primary care was provided at ambulatory healthcare centres (AHS). The Primary Care Team (PCT) consists of primary care physicians and allied healthcare professionals.¹⁹ PCTs have responded to curb the spread of the virus by working alongside the government on the frontline by prioritizing five key areas outlined in this article. These aim to protect the health, safety and wellbeing of the community in order to ensure the best possible care for the population.

Total Coronavirus Cases in the United Arab Emirates (worldometers.info)



¹⁹ Paulo MS, Loney T, Lapão LV. The primary health care in the emirate of Abu Dhabi: Are they aligned with the chronic care model elements? BMC Health Serv Res 2017;17(1):725. doi: 10.1186/s12913-017-2691-4. [Search PubMed](#)

6.1 Impact of COVID-19 on Reproductive Health Associated Services

According to the declaration of UAE Ministry of Health officials:

At the start of the pandemic, the MCH services were affected due to high burden on the health system as a whole and fear of people to visit the clinics. As a management of this emergency situation, the MCH section in Ministry of health and prevention worked collaboratively with all stakeholders to establish a well- organized plan that includes policies and protocols to support the continuity of the services in this situation based on the WHO updates.

The Main policies & Protocols:

- Maternal & child health services policy during emergency (COVID 19)
- Protocol for Assessment and Management of Pregnant Women with Confirmed Novel Coronavirus (COVID-19)
- E-clinic workflow for postnatal services for low risk mothers
- E-clinic workflow for low risk newborn at 1st week visit
- Breastfeeding and BFHI policy During Emergency (COVID 19)
- Process of Lactation Telehealth Counseling for positive COVID-19 mother and pregnant women in isolation building
- Drive through child vaccination services policy during emergency (COVID 19)

As the outbreak period prolonged a recovery plan was developed aiming at resuming comprehensive and elective services like preconception care services, periodic health and cancer screening, premarital screening and counseling, taking in consideration duration and the setting of these services as well as the safety of individual and staff.

During COVID-19 pandemics, MCH has modified the following services:

Antenatal care:

- Clean PHC centers were allocated in each district to provide antenatal services.
- During this pandemic all antenatal follow up and contacts are provided at the Clean PHC until delivery or clean maternity hospital according to area.
- In collaboration with the hospital department OBS /GYN physicians were allocated in each PHC to provide follow up for pregnant women after 32 weeks of gestation for low risk category and from the beginning of pregnancy for high risk category.
- Antenatal visits were modified to reduce the number of contacts for low risk pregnancy and some visits shifted to be provided through e-clinics.
- Algorithm of care to assess and categorize the suspected or confirmed pregnant women with novel corona virus was created and shared with hospitals and isolation buildings to decide on the setting of care.
- Messages about importance of antenatal care visits was shared to the public through MOHAP official social media Channels

Postnatal care:

- Numbers of postnatal contacts were reduced from four contacts to two contacts within 6 weeks post-delivery, will be provided first at hospital and the 2nd visit through the e-clinic for low-risk group
- Postnatal follow up for high-risk women were provided by OBS/GYN specialist at PHC as per individual cases / clean maternity hospital.

Preconception care:

- The service was incorporated within the premarital services as per national preconception guideline and provided virtually through e-clinic.

Cancer screening:

- Cancer screening was provided through the periodic clinic as a part of the provided services.
- There was no active recruitment or campaigns during the situation however the service was provided if requested by the client
- Positive screened cases (who was tested before the pandemic or during) were followed and managed as required

Baby friendly initiative:

- Breastfeeding and BFHI policy During Emergency (COVID 19) were developed by National Breastfeeding committee to provide integrated support, based on WHO and international recommendations for breastfeeding during COVID19 outbreak.
- The plan for an external assessment of BFI facilities was postponed due to the COVID-19 situation. However, all health facilities intending to start a baby-friendly journey were supported regarding the BFHI policy and process.
- Since September 2021, a hybrid of virtual/onsite external assessment has been re-started.

6.2 The analysis of the situation of SRH in UAE with the highlighting of the gaps due to the pandemic

There was no clear change in the SRH situation in UAE. Access to the sexual and reproduction health information and services were not affected and the continuity of services and care were ensured during the pandemic. The gaps were fulfilled through the emergency plan.

6.3 The impacts of COVID 19 on costing, budgeting, and financing for reproductive health services targeting women and adolescent girls within the UAE

Reproductive health services within the UAE were the same in terms of cost, budget and financing as these services were available to national and non-national before the pandemic and during it.

In the wake of COVID-19, the UAE demonstrates high levels of commitment and prowess in maintaining the services depending on its stable governance system.

6.4 The accessibility of the SRH of women and adolescents in the UAE

The SRH services are simple to access and use in the UAE. The services are available in the PHC centers and hospitals, in the public and private sectors. All healthcare centers – both public and private – have websites and/or helplines that allow women to make appointments by phone or online.

6.5 RMNCAH, ASRH&RS, School Health and Maternal Health strategies and plans reflecting the SRH&RS needs of women and adolescent girls, according to the Nairobi Summit ICPD+25 Program of Action:

The RMNCAH, School health strategies and the Plan are tailored to the need of women and adolescents in UAE and to the goals of ICPD

Moreover, in line with [SDGs targets for maternal, newborn and child health](#) UAE achieved the following:

- MMR: 3 /1000 live birth (2019)
- U5MR: 6.5/1000 live birth (2019)
- NMR: 3.6/1000 live birth (2019)
- IMR: 5.2/1000 live birth (2019)

- Percentage of deliveries under medical supervision: 99.9 % (2019)
- Postnatal coverage rate for the mother within 48 hrs. Of delivery: 100% (2019)
- Exclusive Breast-Feeding rate at 6 months of age: 48.8 % (2020)

6.6 Overview of GBV in UAE during the corona outbreak

Before the outbreak, in August 2019, the UAE issued Federal Decree Law No. (10) of 2019 regarding Family protection from domestic violence, and in November 2019, the family protection policy has been launched and adopted. The Family Protection Policy seeks to strengthen social ties in the UAE's families and communities. The policy defines family or domestic violence as any abuse, violence or threat committed by a family member against any other family member or individual exceeding his guardianship, jurisdiction, authority or responsibility, resulting in physical or psychological harm.

The UAE has made many efforts in light of the (Covid-19) epidemic, providing the opportunity for pregnant women and mothers with children in the ninth grade and below to work remotely as an early precautionary measure to prevent infection with the virus. As a result, Ms. Michelle Bachelet, High Commissioner for Human Rights, praised the measures and measures taken by the UAE to protect women from the (Covid-19) epidemic, during a recent webinar to discuss "international gender advocacy in times of crisis."

The UAE considers the security and safety of women to be of paramount importance, as domestic violence is a serious crime in the country punishable by law, and the state periodically reviews and evaluates laws to ensure the protection of women as well as other members of the family.

In the context of the Ministry of Community Development's endeavours to find out the nature of societal conditions during the outbreak of the Covid-19 pandemic, it conducted a survey of the authorities' opinion on the impact of the spread of the Covid-19 virus on family conditions in society, based on the reports and complaints received by the concerned authorities in this regard.

The responses were as follows:

There was no increase in the reports received by the authorities, as some of those authorities reported a decrease in complaints at a rate of 60% of family dispute cases, and other parties reported a decrease in applications submitted to the guidance and family reform departments in the courts since the beginning of the Covid-19 pandemic crisis. The procedures for receiving applications did not stop in the departments throughout the period. Many cases of reconciliation were recorded by family counselors at the request of the parties to close the file, and this was a positive indication, given the exceptional situation that families were facing, which created a kind of rapprochement among family members in the face of the pandemic.

In an inquiry about the classification of these communications within the framework of the usual problems they received, or the presence of problems or phenomena that have risen during this period, the results showed that there were no developments in this scope, except for some problems related to the mechanism and how to organize the children's vision after divorce in accordance with the partial ban decision, and the fear of previously imposed expenses and the economic repercussions of the crisis.

Since the beginning of the crisis and the application of remote work, these parties have taken measures to deal with the problems that come to them by relying on applications and programs to intervene and provide the necessary treatments, such as scheduling appointments for the parties remotely, through the closed-circuit television system, to ensure that the services provided to customers do not stop, in addition to receiving applications electronically.

As for disputes that are emergency and there are cases of violence, the parties are summoned to the social support centers, considering the work to implement the precautionary and preventive measures adopted.

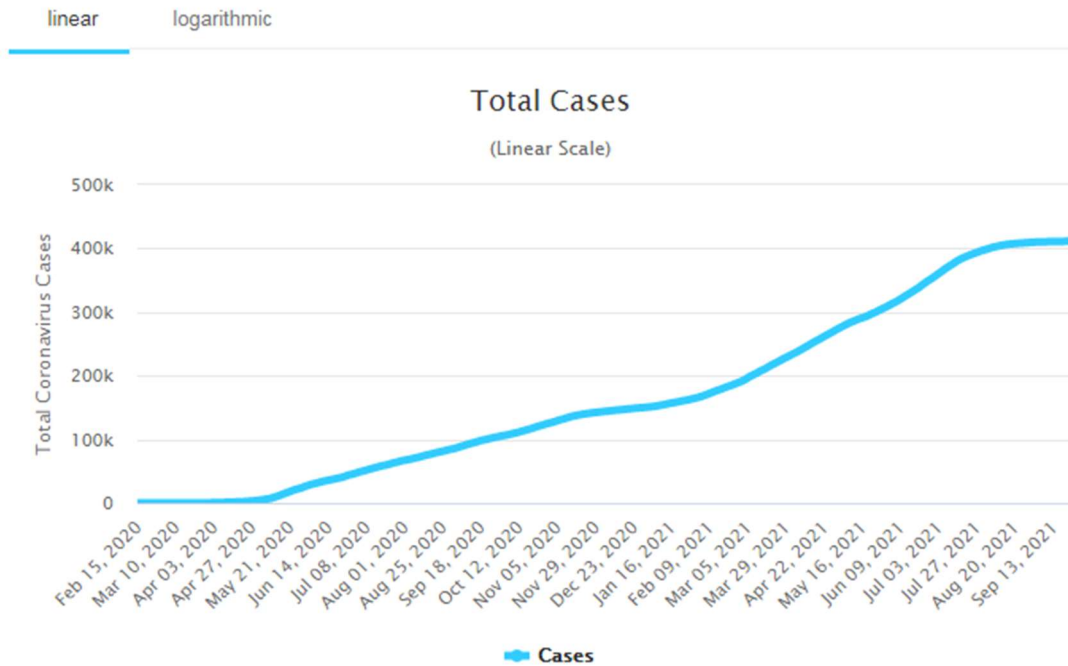
7. COVID-19 Situation Analysis in Kuwait

The first COVID 19 case of Kuwait was announced on 24th February, 2020 and the forecast of new cases and death recorded daily was crucial so that health experts and citizens can be guided in order to avoid escalation of the pandemic.

The government's measures were based on the Kuwaiti constitution, which considers caring for the public health and well-being as one of its top responsibilities. According to article 15 of the constitution "The State shall care for public health through measures of precaution and cure of diseases and epidemics." Furthermore, article 25 of the constitution

stipulates that “The State shall guarantee the solidarity of Society in bearing burdens arising from catastrophes and public calamities.”²⁰ Using those two articles, the government enforced several laws and measures to contain the spread of Covid-19. While these measures came as a surprise to the citizens and residents of Kuwait, they reflected the government’s vigilance and strong feeling of responsibility. At the same time, the people in Kuwait considered these strict and swift measures necessary for their wellbeing.

Total Coronavirus Cases in Kuwait (worldometers.info)



7.1 Impact of the COVID-19 on the reproductive Health activities (Study): ²¹

According to a study conducted in Kuwait titled: Maternal and perinatal characteristics and outcomes of pregnancies complicated with COVID-19 in Kuwait the effect of infection in pregnant women and new-borns is incompletely understood. Preliminary data shows a rather fluctuating course of the disease from asymptomatic or mild symptoms to maternal death. However, it is not clear whether the disease increases the risk of pregnancy-related complications.

The retrospective national-based study, analyzed the medical records of all pregnant women infected with SARS-CoV-2 and their neonates who were admitted to New-Jahra Hospital (NJH), Kuwait, between March 15th 2020 and May 31st 2020. During the study period and as part of the public health measures, a total of 185 pregnant women infected with SARS-CoV-2, regardless of symptoms, were hospitalized at NJH, and were included. Maternal and neonatal clinical manifestations, laboratory tests and treatments were collected. The outcomes of pregnancies included miscarriage, intrauterine fetal death (IUFD), preterm birth and live birth were assessed until the end date of the outcomes follow-up (November 10th 2020).

In this national-based study, most of the pregnant women infected with SARS-CoV-2 showed mild symptoms. Although mother-to-child vertical transmission of SARS-CoV-2 is possible, COVID-19 infection during pregnancy may not lead to unfavorable maternal and neonatal outcomes.

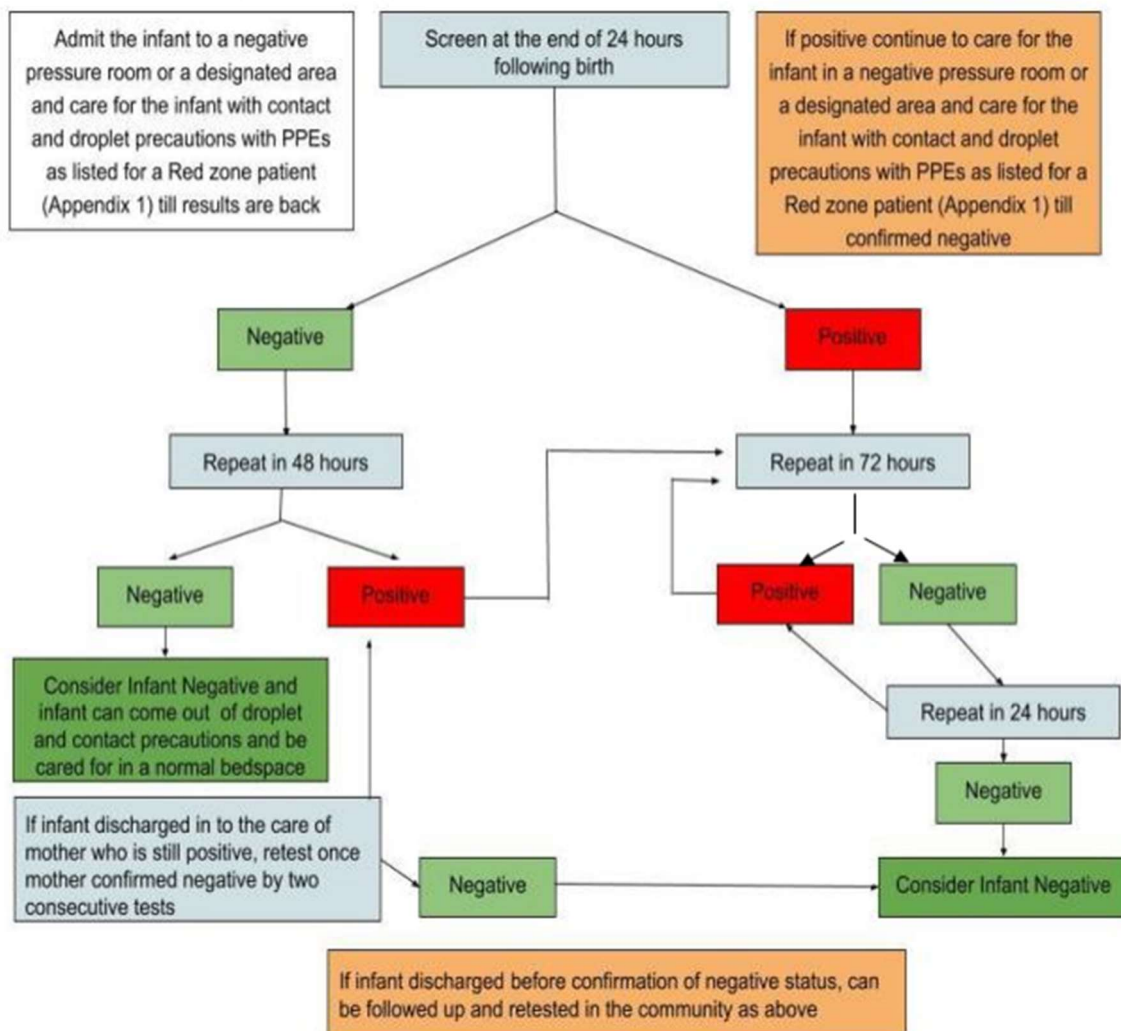
²⁰ “Kuwait Constitution”, Constitution Project website, n.d. Retrieved from : https://www.constituteproject.org/constitution/Kuwait_1992.pdf?lang=en

²¹ *BMC Pregnancy & Childbirth* journal.

7.2 COVID-19 Management:

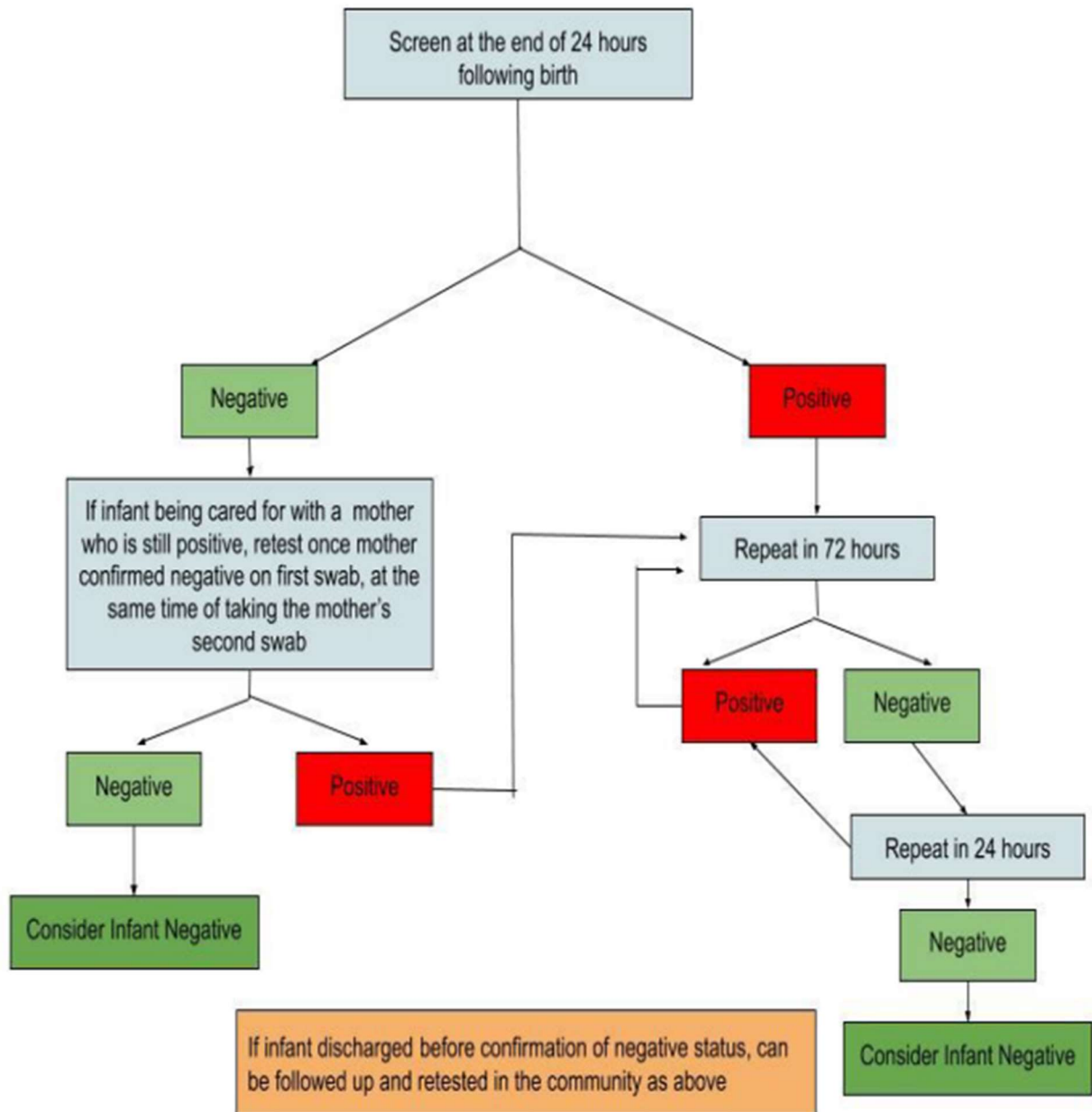
- In cases of uncertainty, providers should investigate and treat as suspected COVID-19 any maternity patients who are admitted to the hospital from the community until a negative test result is obtained. All women with epidemiologic history of contact should be carefully monitored.
- Pregnant women with a suspected, probable or confirmed COVID-19 infection, including women who may need to spend time in isolation should have access to woman-centered specialized care (hospital).
- Appropriate IPC measures and prevention of complications, also apply to pregnant and recently pregnant women including those with miscarriage, late pregnancy fetal loss and postpartum/post abortion women.
- Mode of birth should be individualized based on obstetric indications and the woman's preferences (hospital)
- Recently pregnant women with COVID-19 or who have recovered from COVID-19 should be provided with necessary information and counselling on safe infant feeding and appropriate IPC measures to prevent COVID-19 transmission.
- All pregnant women undergoing or recovering from COVID-19 should be provided with counselling and necessary information related to the potential risk of adverse pregnancy outcomes.

Screening of infants born to COVID-19+ mothers admitted to NICU²²

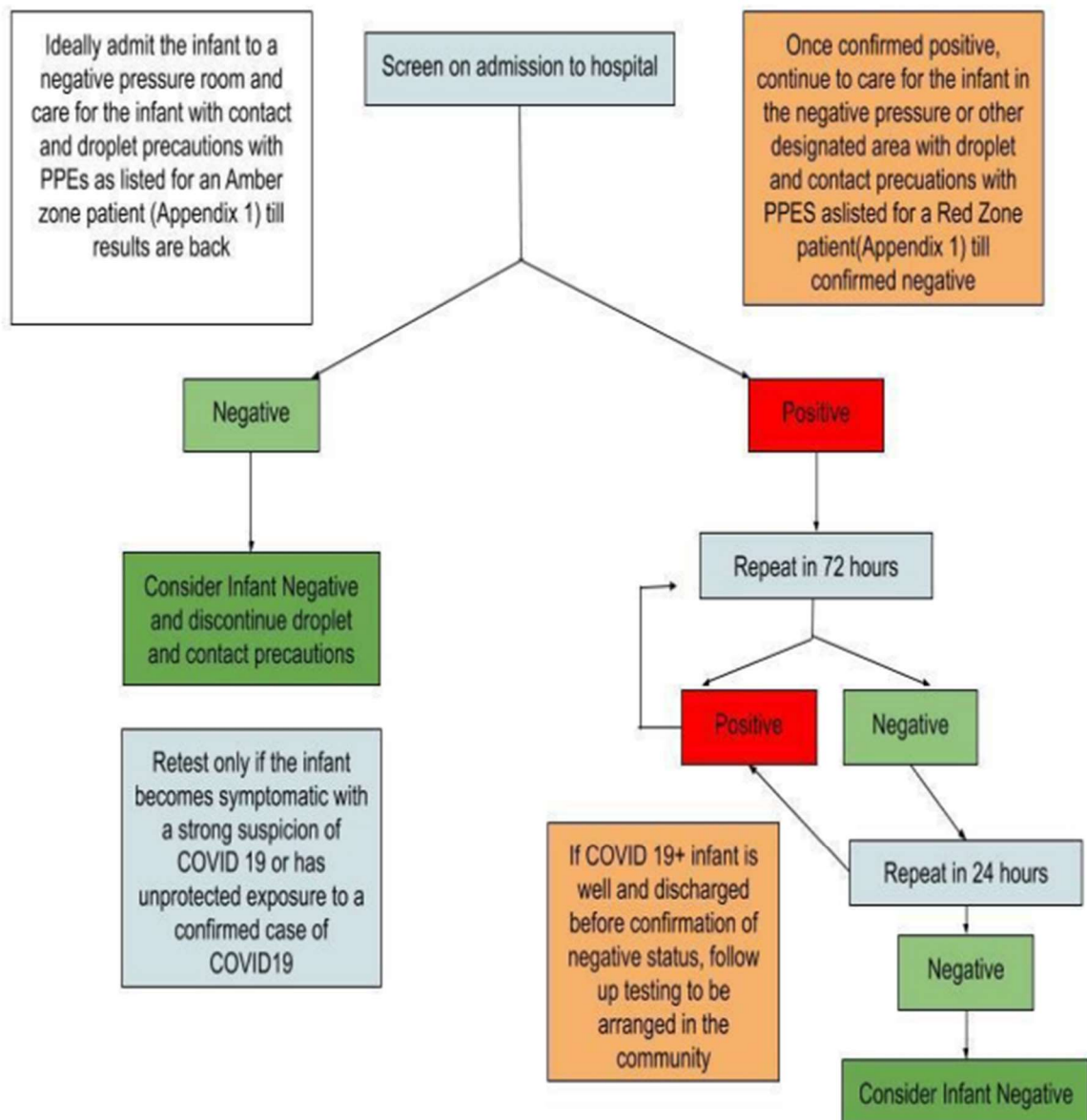


²² National Guidelines for Clinical Management and treatment of COVID-19. Version 4.0 : Updated 1st June 2020

Screening for infants born to COVID-19+ mothers admitted to the postnatal ward



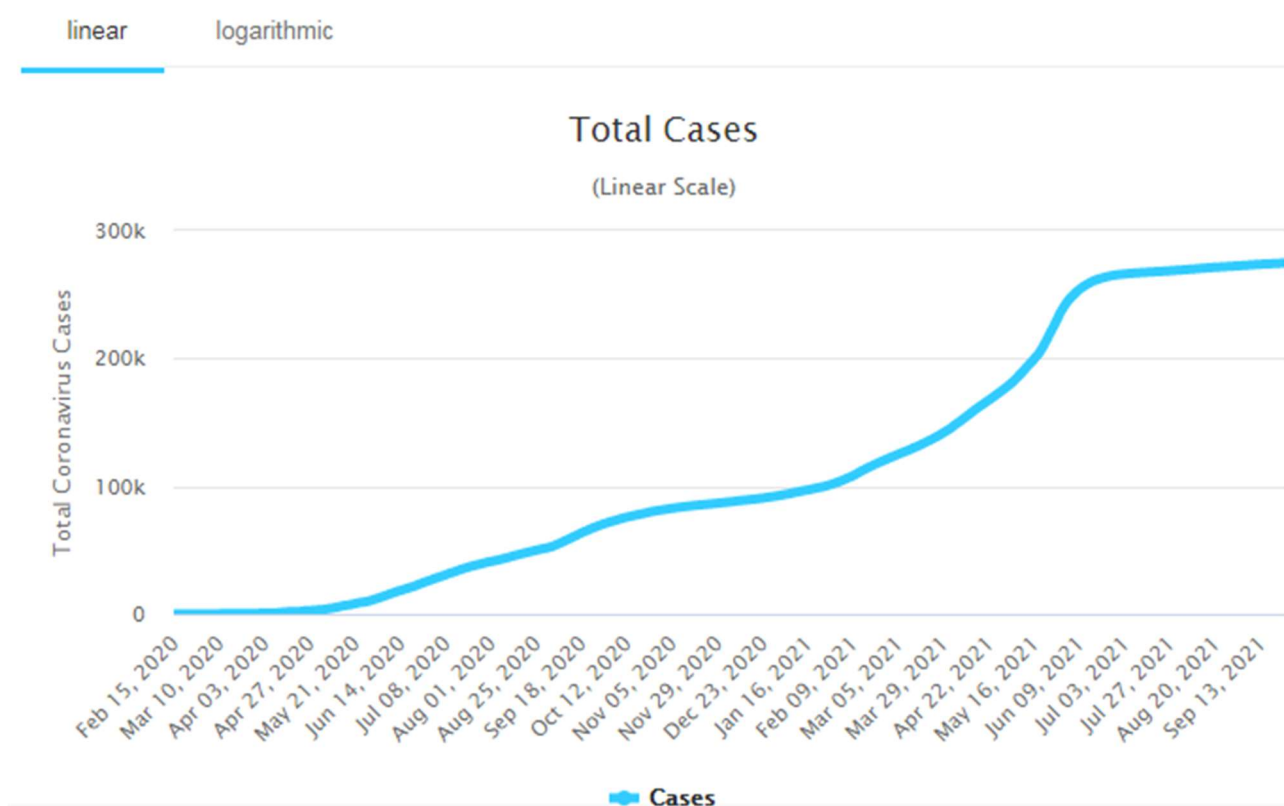
Screening for infants mothers admitted to the hospital from the community



8. COVID-19 Situation Analysis in Bahrain

Since the infection started to spread universally, Bahrain has shown its sincere commitment to keep up the health and well-being of its population. As a result, a wide range of decisions, precautionary measures, and preventive measures have been taken in Bahrain. The government of Bahrain had made efforts to contain the virus and to reduce its spread to the broader population. Since the start of the pandemic, it has followed the WHO's guidelines, implementing a strategic response plan that included tracking the contacts, increasing the preparedness of healthcare facilities, and finding ways to communicate with the target groups. (E Government, [2020](#)).

A comprehensive national plan was developed for surveillance to confront the virus and to control its spread. A surveillance and control committee was formed in the Military Hospital to control the virus' spread at the beginning of February 2020 to decide the protocols and to set strategies that must be followed by the citizens and residents of Bahrain.



Government of Bahrain, spearheaded by the National Taskforce for Combating the Coronavirus, and its associated ministries and authorities have been quick to implement their own strategies to limit both the spread of COVID-19 and its impact upon Bahrain's economy, with such strategies receiving high praise from the World Health Organization.

8.1 Mother and Child Health and Reproductive Health

The Kingdom of Bahrain has paid special attention to maternal and child health care programs, which have been and continue to be priorities of the Ministry of Health. Maternal and child services are provided in over 25 health centers accessible to all individuals and distributed throughout the kingdom. Health services are provided by family physicians and community service nurses who have been well trained through workshops and lectures to provide high quality services to all citizens and residents of The Kingdom. Child and maternity care services are divided into:

1. Pregnant Women Care

The service includes examination and treatment of all cases that can affect the health of the mother and fetus and helps mothers to pass the stage of pregnancy and childbirth with positive experience by ensuring:

- Taking the required vaccination.
- taking folic acid and iron supplements during pregnancy.
- having a healthy lifestyle before conception.
- Monitor the pregnant mother throughout her pregnancy to ensure the health both the mother and the fetus by physical examinations, laboratory tests.
- Referring mothers with risk factors to secondary care for follow up.

2. Child Periodic Screening Services

These include:

- Provide an expanded vaccination program for all children from birth with new vaccinations when needed.
- A comprehensive periodic examination of the child to monitor physical and psychological development, nutrition, early detection of diseases and intervention to treat them.
- Education of mothers through child nutrition and safety for every age.
- Referral of children to secondary care for cases requiring follow-up.

3. **Family Planning Services**

It aims to provide all information women needs about contraceptive methods and monitors women on contraception.

4. **Premarital Screening Services**

It aims to help reduce the incidence of hereditary blood disorders among Bahraini population. It also Provide vaccinations and treatment to the parties if necessary. Support both parties to health and explain family planning methods. Providing psychological and social support by the social worker.

5. **Post-Natal and Screening Services**

The post-natal period is six weeks and includes the following services:

- Ensure that the mother returns to her previous health status.
- Encourage follow-up breastfeeding.
- Identify the contraceptive methods that suit the patient.
- Discuss with the mother the matters that concern her health and the health of the child and the family.
- Treatment of residual health complications after pregnancy.
- Early detection of post-natal depression symptoms.

6. **Periodic Examination of Women**

Is an integrated health program for the early detection of breast and cervical cancer diseases in women and work to reduce the burden of disease on society and health through:

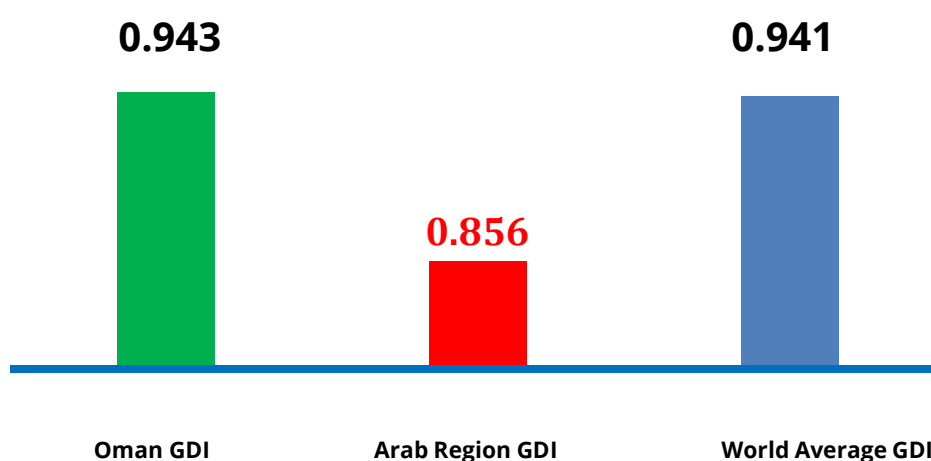
- Increase community awareness of breast and cervical cancer diseases.
- Encourage the target group of women (30 – 65 years) to take a date for periodic examination.
- Encourage women aged 20 to self-examine the breast.
- Periodic screening of women aged 30 – 65 years by taking cervical smear.
- Breast screening through clinical breast examination and mammogram for 40 years old women or older.

9. The Impact of COVID-19 on Gender Equality in the GCC Countries

In light of the COVID-19 implications, UN Women, the Economic and Social Commission for Western Asia (ESCWA) and partner United Nations agencies have prepared proposals on formulating consistent policies and programs for the short and long term, as part of an urgent regional response to mitigate the impact of the COVID-19 pandemic on women. They included these proposals in a comprehensive guidance titled “The impact of COVID-19 on Gender Equality in the Arab Region”. The paper suggests that for this response to be effective, it must take into consideration the social prejudices and gender norms that discriminate against women in the public and private spheres in the Arab region.

Likewise, the response of the COVID-19 pandemic in the GCC countries, should consider the gender norms in this area and the structural specifications. In this respect, it is notable that in the GCC countries, the Gender Development Index indicates a high level (0.943) of gender equality in Oman (see Box 1), also it is indicating that the Human Development Index for Omani Women is very close to the human development index for Omani men.

The Gender Development Index (GDI) in Oman, the Arab Region and the World²³



9.1 Measures taken to address the consequences of the COVID-19 pandemic on gender inequalities

Given what have been mentioned above, and the willingness of the United Nations agencies to address the consequences of the pandemic on gender inequalities, there are several undertakings and measures which can be considered:

- Strengthening health care systems from a gender perspective;
- Providing policy advice and supporting the procurement of health equipment and supplies;
- Raising advocacy and awareness about the unequal impacts of the COVID-19 on women comparing to men;
- Ensuring the continued availability of health services and support for girls and women, including the availability of online health counselling;
- Assisting health providers in conducting awareness campaigns and providing psychological support for pregnant women;
- Providing a continuous flow of data and statistics from other countries for the purpose of comparison and decision-making.

9.2 COVID-19 Impact on Adolescent Girls

In one of its recent publications, the United Nations Sustainable Development Group (UNSDG) recognizes that women and adolescent girls will be particularly impacted by the 'care work burdens' of COVID-19. For example, adolescent girls spend significantly more hours on chores compared to their male counterparts. Moreover, the paper argues that current negative impacts will overload the burden of young women at home in addition to forcing them to drop out of education paths "school closures do not just mean that girls are taking on more chores at home, it could also lead to millions more girls dropping out of school before they complete their education".²⁴ It is also noted that the probability of these negative impacts is higher for adolescent girls living in poverty, young women with disabilities. The measures taken during the pandemic to stop virus spread have forced unusual lifestyles for everyone, imposed restrictions on movement, which affect most of the population. However, these restrictions will have more significant negative impacts on young women and girls since, since young women and girls are at higher risk of partner violence and other forms of domestic violence

²³ The Impact of COVID-19 on Gender Equality in the Arab Region, Economic and Social Commission for Western Asia (ESCWA), 2020, Policy Brief No.4.

²⁴ Policy Brief: the Impact of COVID-19 on Women, UNSDG, April 2020.

during the pandemic.²⁵

10. Impact of COVID-19 on the three Transformative Results of UNFPA

The COVID-19 pandemic has exposed vulnerabilities and exacerbated inequalities within and between countries, hitting the poorest and most vulnerable particularly hard. Many of the highest-risk groups with whom UNFPA worked prior to the onset of the pandemic are those that stand to lose the most from its fallout. UNFPA continues to prioritize leaving no one behind, filling gaps in service delivery and outreach where standard interventions have fallen short. Through data and vulnerability assessments, building on community relationships, and using technology and alternative communication strategies to reach those furthest behind or most marginalized, UNFPA is making strides to deliver the services needed even through the pandemic, including in humanitarian settings.

In particular, women have borne multifaceted burdens brought on by this disease, facing increased care responsibilities, higher incidence of employment loss, increased incidence of violence, and reduced access to health and social services that they typically would depend on for support in times of need. As schools and childcare facilities closed, the increased childcare responsibilities have also fallen disproportionately to women. When quarantine and lockdown measures were in place, there were significant increases in intimate partner violence; there was also increased risk of harmful practices, particularly against girls, including child, early and forced marriages. This increase in violence was coupled with disruptions in accessing support and response services. “By 2021 around 435 million women and girls will be living on less than \$1.90 a day — including 47 million pushed into poverty as a result of COVID-19. The shift of funds to pandemic response is hampering women’s access to sexual and reproductive health.”²⁶

The economic impact of COVID-19 and the resulting psychosis at the social level, due to social perceptions and cultural realities, have fatally shaken in places social cohesion and the foundation of family and social ties with the rise of the individualism fostered by social distancing, the struggle for survival and stigma. Certain vulnerable people with fragile health or any handicap (children, elderly people) are sometimes left to fend for themselves for lack of means. The COVID-19 pandemic has highlighted a relative disparity in access to basic services and in the management of the different forms of vulnerabilities provided for in the response measures put in place by the State.²⁷

10.1 Impact on ending preventable maternal death

There is emerging evidence on the impact of COVID-19 on pregnancy and newborns. The overall risk of severe COVID-19 is low²⁸. However, in a Swedish study, compared to non-pregnant women, pregnant women who contract the virus have a fivefold risk of being admitted to an intensive care unit (ICU) and fourfold risk of requiring mechanical ventilation²⁹. The majority of women who have become severely ill from coronavirus were in their third trimester of pregnancy.³⁰ Preterm birth rates are higher in pregnant women with COVID-19 than in pregnant women without the disease³¹. In 2020, the COVID-19 pandemic tested the capabilities and limits of health-care systems and societies around

²⁵ Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19, United Nations Sustainable Development Group (UNSDG), March 2020.

²⁶ <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/gender-equality-in-the-wake-of-covid-19-en.pdf?la=en&vs=5142>

²⁷ UNFPA Benin Annual Report 2020, Internal.

²⁸ John Allotey and others, “Clinical manifestations, risk factors and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis”, *BMJ*, vol. 370, No. m3320 (2020)

²⁹ J. Collin and others, “Public health agency of Sweden’s brief report: pregnant and postpartum women with severe acute respiratory syndrome coronavirus 2 infection in intensive care in Sweden”, *Acta Obstet Gynecol Scand*, vol. 99 (2020), p. 819.

³⁰ Marian Knight and others, “Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population-based cohort study”, *BMJ*, vol. 36 (2020).

³¹ John Allotey and others, “Clinical manifestations, risk factors and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis”, *BMJ*, vol. 370, No. m3320 (2020). <https://www.bmj.com/content/370/bmj.m3320>; Marian Knight and others, “Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population-based cohort study”, *BMJ*, vol. 36 (2020).

the world. Health-care providers, both formal and community-based, were forced to scale down SRH services, putting women and adolescent girls and their newborns at a higher risk of death and disability.

The complex interaction of health determinants during the COVID-19 pandemic has had a profound impact on women's health. Health inequalities remain stark among and within countries, exacerbated by such factors as education and housing, gender, race, ethnicity and socioeconomic status. It must be acknowledged that men and women are exposed to determinants of health in different ways. As the COVID-19 pandemic continues, concerns are increasing about the effect of the pandemic on women's and girls' SRH and their access to care.

Previous public health emergencies have shown that the impact of an epidemic on sexual and reproductive health often goes unrecognized, because the effects are often not the direct result of the infection, but instead the indirect consequences of strained health care systems, disruptions in care and redirected resources. Moreover, responses to epidemics further exacerbate gender-based and other health disparities. Evidence from the Ebola virus outbreak in 2013–2016 in Western Africa shows the negative, indirect effects that such crises can have on sexual and reproductive health.

Maternal mortality is generally a difficult statistic to measure, as in many countries, maternal deaths occurring outside of a health-care facility remain unreported. Even in cases of institutional delivery, record-keeping may be poorly understood or under-prioritized. UNFPA assists countries to establish maternal mortality record-keeping and analysis to prevent future maternal death, and to integrate Maternal Perinatal Death Surveillance and Response (MPDSR) systems into national statistics data sets and policy frameworks. MPDSR is a continuous cycle of notification, review, analysis and response. It works to increase the avoidability of preventable maternal and perinatal mortality by involving all stakeholders in the process of identifying maternal deaths, understanding why they happened and taking action to prevent similar deaths from occurring in the future. Some countries have been able to provide data on the impact of COVID-19 on maternal death, revealing grave figures.

With an increase in the number of COVID-19 positive cases, including increasing infections among frontline health workers compounded by the existing inadequate human resources for health, the continuation of essential SRH services [was] seriously impacted in 2020. Due to the fear of transmission, travel restrictions and lockdown in early days, the service utilization at the service delivery points reduced from 30% to 50% compared to [2019] for antenatal care, institutional delivery, and family planning services. Further, the health facilities also faced shortages of lifesaving maternal and newborn health medicines and family planning commodities, largely due to the transportation restrictions and weak procurement and supply chain management systems.³²

Countries experiencing humanitarian situations, in which health systems were already fragile and ill-equipped to respond to COVID-19, have shown a significant drop in health-facility deliveries, skilled birth attendance, antenatal care, postnatal care and family planning attendance, sounding alarms for maternal mortality and morbidity. As part of the Global Humanitarian Response Plan for COVID-19 (GHRP) Monitoring Framework, institutional birth trends have been used as a proxy to monitor continuity of access to maternal health services. 92 per cent of GHRP countries reported a decrease in institutional births in at least 25 per cent of the reported facilities during at least 1 month between March and December 2020³³, with December showing the highest number of countries with a drop in institutional births (56 per cent).

10.2 Impact on ending gender-based violence, including harmful practices

The global pandemic has taken a disproportionate toll on women. GBV has been dubbed the “pandemic within the pandemic”: incidence of GBV has increased at the same time that prevention and protection efforts have been drastically reduced and social services and clinical care have been stretched. Stay-at-home orders and movement restrictions in 2020 increased women's exposure to violent partners; mounting household tensions and economic stresses also contributed to the upsurge in domestic and GBV. Globally, the pandemic has at the same time increased barriers to access and increased demand for essential services for gender-based violence survivors. Some countries reported a decrease in women and girls seeking help due to the lack of availability of services, mobility restrictions

³²UNFPA Nepal Annual Report 2020. Internal.

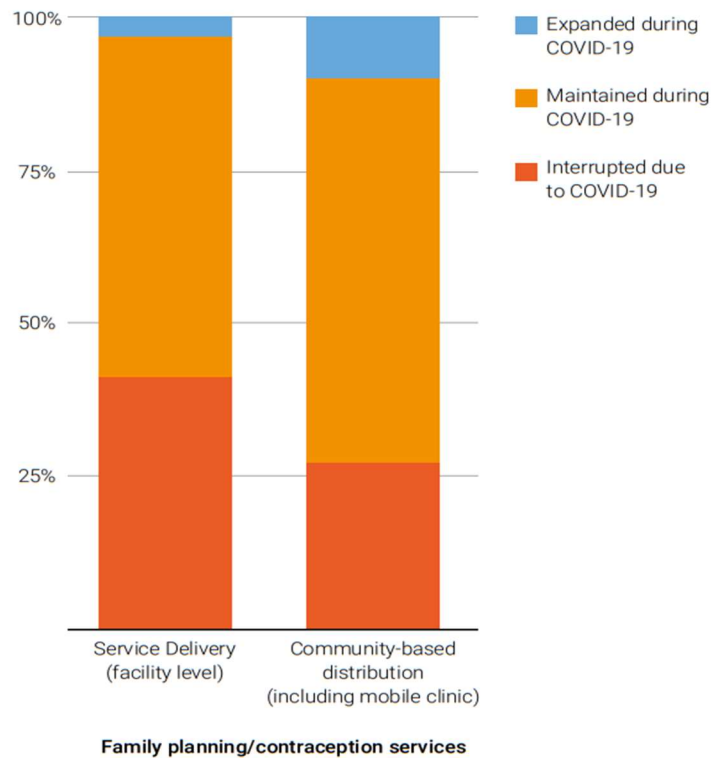
³³ 49 GHRP countries reported monthly data on institutional births for at least 3 months of the period March–December 2020. The threshold used to define a decrease in the number of births is 25 per cent. Reported records with fewer than 30 births/month in 2019 or with no baseline data have been excluded from the analysis.

and fear of contracting the virus.³⁴ In April of 2020, UNFPA and partners projected that if violence were to increase by 20 per cent during lockdown, there would be:

- An additional 15 million cases of intimate partner violence in 2020 for an average lockdown duration of three months.
- An additional 31 million cases for an average lockdown of six months.
- An additional 45 million cases for an average lockdown of nine months.
- An additional 61 million cases if the average lockdown period were to be as long as a year.

These projections were global – inclusive of all 193 United Nations Member States – and accounted for the high levels of underreporting seen with GBV. It was therefore predicted that the COVID-19 pandemic is likely to set back progress towards ending GBV by 2030 by one third.

INTERRUPTION TO FAMILY PLANNING SERVICES DUE TO COVID-19 PANDEMIC



11. UNFPA COVID-19 Response Interventions³⁵:

In terms of women health, it is undeniable that the physical and immune system changes that occur during and after the pregnancy have be considered in any response to the pandemic situation. It is inevitable for all women to have access to safe birth, continuum of antenatal and postnatal care, and cancer check-ups including screening tests according to the national and international guidelines and standards, in order to ensure that pregnant women, women in labor and delivery, and lactating women are able to access these essential services. In its interventions and co-operation frameworks with the governments, UNFPA has been considering the following principles:

³⁴ UNFPA Annual Report of the Executive Director, 2020.

³⁵ Update on UNFPA COVID-19 response interventions

- The importance to keep the health system functioning, maintaining sexual and reproductive health and rights (SRH&RS) counselling and services, protecting health workers, and limiting the spread of COVID-19;
- As the human and financial resources are often diverted from various health programs to respond to infectious disease outbreaks during public health emergencies, sexual and reproductive health services are usually impacted by the pandemic. Therefore, it is critical to prioritize SRH&Rs related services in the healthcare systems during the COVID-19 response stages.
- Due to the COVID-19 pandemic impact in straining the health systems especially in low and middle-income countries, let alone the countries in humanitarian context, hence; the preparedness and response support provided to the countries with high maternal mortality rates will be critical. Such measures must pay special attention to ensuring essential services such as maternal and newborn health and sexual and reproductive health services and supplies.
- Pregnant women with respiratory illnesses must be treated with utmost priority due to the increased risk of adverse outcomes, and antenatal, neonatal, and maternal health units must be segregated from identified COVID-19 cases.
- The protection of health workers, particularly midwives, nurses, obstetricians, and anesthesiologists, must be prioritized as critical and lifesaving. They should be provided with personal protective equipment if they are treating patients with COVID-19.
- Safe pregnancies and childbirth depend on functioning and accessible health systems and strict adherence to infection prevention measures.
- Surveillance and response systems should be disaggregated by sex, age, gender, and pregnancy status. Where relevant, special attention should be given to persons with disabilities, HIV-positive persons, adolescents, the elderly, and migrants.

11.1 Short-term interventions

11.1.1. Facilitate coordination, participation, and consultation

In order to facilitate coordination, participation and exchanged consultations between the UN agencies and government stakeholders, it is advisable to consider the following principles:

- Encourage activation of the UN coordination mechanism in sexual and reproductive health and rights, support efficient coordination mechanisms to ensure obstetric and newborn care is prioritized.
- Strengthen advocacy and leadership of the sexual and reproductive health (SRH) sub-working group under the health cluster where humanitarian coordination architecture is in place to channel support to the maternal health program and specific response.
- Establish necessary situational analysis that is gender, sex, and age disaggregated as part of joint activities of United Nations Country Team.
- Support Ministry of Health and its partners to strengthen, fund, implement and integrate gender and sexual and reproductive health into COVID-19 preparedness and response and operationalize joint plans and maintain ongoing programs.
- Organizations of young people, women, people living with human immunodeficiency virus (HIV), and persons with disabilities (PwDs) should be consulted and involved in all stages of COVID-19 response.

11.1.2. Maintain continuity of maternal health and other sexual and reproductive health services

To reach this optimum goal, there are some criteria that have to be adopted to ensure that the pandemic does not influence the SRH provided services, and women and adolescent girls rights are ensured through this process:

- Ensure women's and girls' choices and rights to sexual and reproductive health are respected regardless of their COVID-19 status, including access to birth spacing commodities...etc.;

- Ensure that, when medical resources are scarce, accessibility to healthcare services, including sexual and reproductive health services, have to be maintained, with special attention to pregnant women among vulnerable populations such as PwDs, persons living with HIV, and people living in rural areas.;
- Ensure pregnant women with suspected, probable, or confirmed COVID-19, including women who may need to spend time in isolation, have access to woman-centered, respectful, skilled care, including obstetric maternal screening tests, fetal medicine, and neonatal care, as well as mental health and psychosocial support with readiness to care for maternal and neonatal complications;
- Work with the Ministry of Health, relevant line ministries, and the private sector to ensure availability and access to essential SRH services, including maternal and newborn related facilities. In humanitarian contexts, this should include implementing the Minimum Initial Service Package (MISP) for Reproductive Health in Emergencies, which is endorsed by UNFPA³⁶;
- Ensure sufficient training/refresher training of health care personnel in Infection prevention and control (IPC)³⁷ to reduce risk of human to human transmission. The training should be based on the World Health Organization (WHO) guidance note (Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease -13 March 2020)³⁸;
- Support supply chain (birth spacing commodities, maternal and newborn life-saving drugs and supplies, maternal health equipment, IPC material and supplies, educational and counseling materials) so everyone can access such services and commodities equally and freely;
- Train health workers, particularly midwives, on the risk and mitigation of stigma and discrimination, and engage them and other relevant cadres in programs of the sensitization of pregnant women on the COVID-19 infection symptoms and related prevention and hygiene messages³⁹;
- Particular attention is to be paid to the care and protection of young people, especially girls, in areas with high HIV prevalence.

11.1.3. Analyze situation of women directly affected by COVID-19

Pregnancy might entail several risks to both the mother and her infant; therefore, some guidelines have to be ensured through this critical time for safe delivery:

- Pregnant women who have recovered from COVID-19 should be enabled and encouraged to access routine antenatal, delivery, and postpartum care to full extent.
- Ensure that pregnant women infected with COVID-19 at the time of delivery are attended and/or admitted in the second level of healthcare system, to ensure appropriate attention if respiratory complications arise.
- It is important also to monitor the situation, including obstetric activity, service readiness and utilization, hygiene status, and staff protection, at all the national healthcare facilities.

11.2 Policies and interventions that enhance joint coordination

UN agencies have to continue providing technical guidance on reinforcing infection control measures within facilities, including triage flow and segregation of neonatal and maternal health units in exceptional cases and according to governments' decisions.

Triage and risk screening

*The Clinical Assessment during the Triage Process is recommended to include several clinical procedures

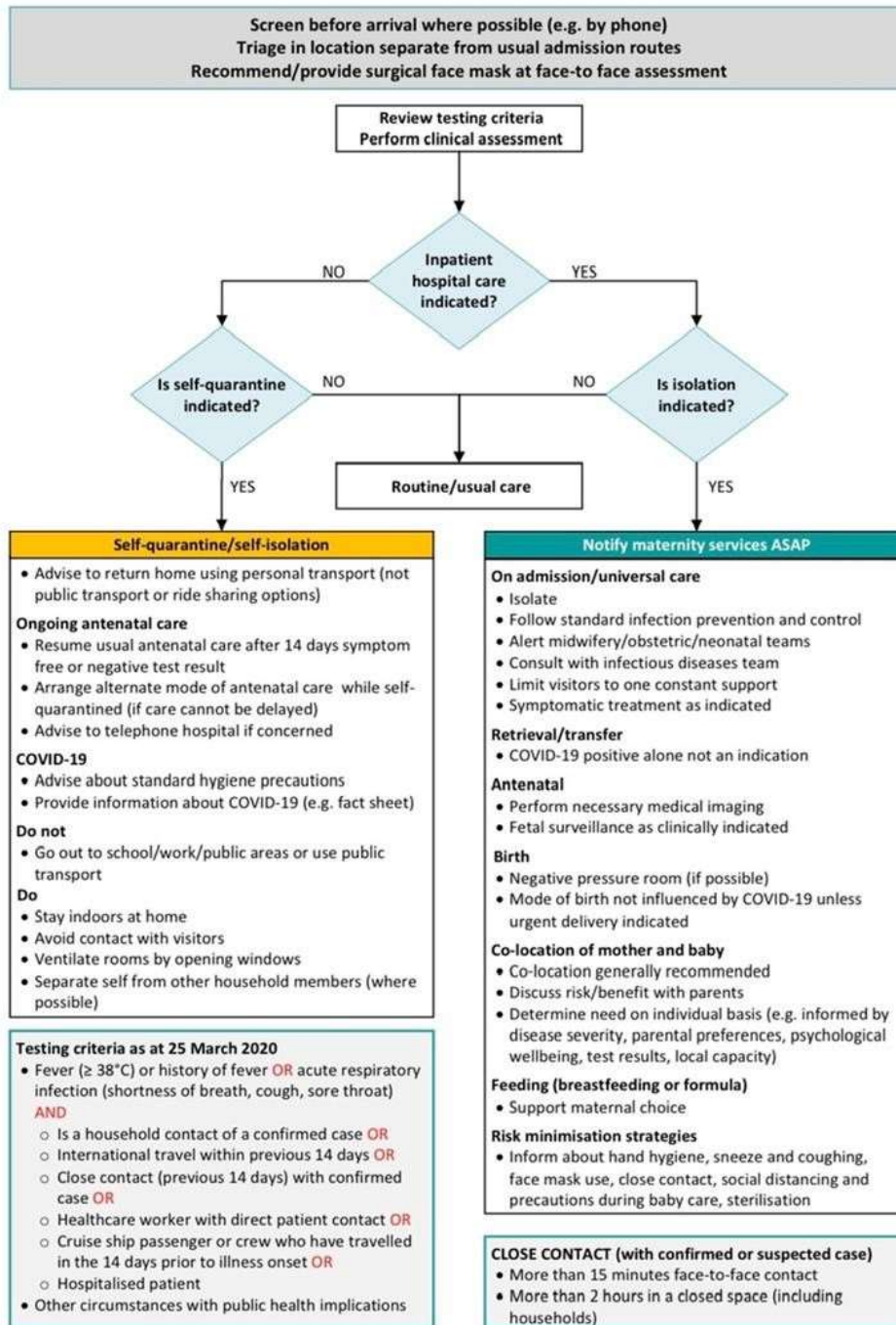
³⁶ <https://iawg.net/resources/minimum-initial-service-package-misp-resources>

³⁷ [https://www.who.int/publications-detail/clinicalmanagement-of-severe-acute-respiratory-infection-when-novel-coronavirus-\(ncov\)-infection-issuspected](https://www.who.int/publications-detail/clinicalmanagement-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-issuspected)

³⁸ [https://www.who.int/publications-detail/clinicalmanagement-of-severe-acute-respiratory-infection-when-novel-coronavirus-\(ncov\)-infection-issuspected](https://www.who.int/publications-detail/clinicalmanagement-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-issuspected)

³⁹ [https://www.who.int/publications-detail/risk-communication-and-community-engagement-\(rcce\)-action-plan-guidance](https://www.who.int/publications-detail/risk-communication-and-community-engagement-(rcce)-action-plan-guidance)

Flowchart: Triage and risk assessment of suspected or confirmed COVID-19 woman



Pregnant women with respiratory illnesses must be treated with utmost priority due to the increased risk of adverse effects. Antenatal, neonatal, and maternal health units must be segregated from suspected and confirmed COVID-19 cases. The following measures have to be considered in this regard:

Ensure appropriate Infection Prevention and Control (IPC) measures to stop any complications applicable to pregnant women, including those with miscarriage, late pregnancy fetal loss, and postpartum⁴⁰;

- Manage antenatal care, delivery, postnatal care, and maternity ward flow to keep a safe distance (at least 2 meters);
- Ensure that all pregnant women with COVID-19 or who have recovered from COVID-19 are provided with information and counseling on safe infant feeding and appropriate infection prevention and control measures to prevent COVID-19 transmission⁴¹.

11.3 Long-term interventions

To recover from the COVID-19, the GCC countries undertook several long term interventions, such as:

- Strengthening health systems to ensure a continuum of services that integrate gender-based violence services during public health emergencies;
- Extend strategies for comprehensive Maternal and Newborn Health interventions at a national and sub-national scale to all countries with a maternal mortality rate above 140/100 000 live births;
- Utilize and communicate best practices from current program countries that can implement and monitor maternal and newborn health (MNH) programs nationally to be replicated in all countries.

12. Challenges to SRMNCAH services during the pandemic

The pandemic has resulted in societal and economic disruption including shocks to health and social care systems in the countries of our Regions. Containment and shielding measures as well as huge stress placed on health systems because of large proportion of COVID-19 patients have led to risks of disruption of routine healthcare services in multiple ways:

- Diversion of resources and attention to COVID-19 measures can de-prioritize some services.
- Reorganization of existing health services: Some hospitals may be entirely designated as COVID-19 hospitals and SRMNCAH workers diverted for COVID work.
- Financial barriers to access services because of interruption in employment and stressed financial and banking services.
- Physical barriers to access services due to movement restriction, non-availability of transport during lock down conditions.
- Fear of contracting infection or concern about prolonged separation from family may discourage people from coming to hospitals and health workers from providing services.

13. COVID 19 in GCC states: Challenges and limitations

The GCC countries have been proactive in response to COVID-19 launching tremendous efforts to control the infection prior to detecting the first case. Here, we review the status of COVID-19 in GCC countries, summarize the control measures taken by each country, and highlight some future challenges.

As soon as cases of COVID-19 were confirmed in the GCC countries, these countries began to initiate stringent control measures to limit the spread of infection.

The GCC response to the pandemic is a multi-leveled protocol requiring the enactment of regulations by multiple government Departments, the limitation of physical movement, and the interruption of 'normal life' at varying degrees depending on the alert level at which the country is placed.

Some of the most pressing issues and challenges to SRH care included:

⁴⁰ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infectionprevention-and-control>.

⁴¹ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infectionprevention-and-control>.

- Closure and cuts to sexual and reproductive health services and some activities like breast and cervical cancer screening have been put on hold.
- STI-related interventions, and the treatment of cancers of the reproductive system, were offered on a limited, disrupted or inequitable basis depending on the site visited or the type of service sought.
- The challenges faced at health facilities; challenges arose due to the broader measures implemented in response to the pandemic
- Movement restrictions, including travel bans, lockdowns, and curfews;
- While many workplaces encouraged workers to work from home where possible, essential frontline workers had no choice but to attend work daily.

The UNFPA and WHO document, COVID-19 Strategy Update⁴² guides the public health response to COVID-19 at national and sub national levels, including strategic actions. It reminds that the pandemic is much more than a health crisis and requires a whole-of-government and whole-of-society response to respond to the pandemic and maintain essential healthcare services.

The contingency planning for COVID-19 pandemic has meant that the entire health sector had to be reconfigured. Gulf Council Countries have had to make difficult decisions to balance the demands of responding directly to COVID-19, while concurrently planning to maintain essential health service delivery, minimize the negative health impacts on individuals who depend on essential, non-COVID-19-related services.

While doing so, the GCC governments prioritized the SRMNCAH services for continuation to protect the rights of all sections of populations comprising women, children and adolescents. Core SRMNCAH services include:

- Antenatal care
- Intrapartum care
- Postnatal care
- Newborn care and breastfeeding
- Child care and feeding
- Care of adolescents
- SRH care: Gender considerations, family planning, gender-based violence.

During the pandemic response, the GCC countries have supported the continuation of primary health care services with functional referral systems and linkage with higher-level hospitals. They have optimized service delivery settings and platforms including the use of technological solutions such as telemedicine and identify mechanisms to maintain availability of essential medications, equipment and supplies.

At the same time, maintaining trust of people in the capacity of the health system to provide services safely, while controlling the risk of infection in health facilities is key to ensuring appropriate care seeking and adherence to the health advice.

14. Recommended actions for continuing SRMNCAH Services

Building upon the guiding principles and strategic actions for continuity of SRMNCAH services in the previous Regional Guidance, operational actions to sustain services for each specific area of SRMNCAH life-course continuum are described below. These are based on information available in the previously published guidance from UN agencies and other international organizations. In the first section health system actions for reorganizing the healthcare services are described.

It is important that the situation of the COVID-19 pandemic in the country must be periodically reviewed and routine SRMNCAH services restored fully, as early as possible.

⁴² WHO. COVID-19 strategy update; 14 Apr 2020 https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_6

15. Actions to Reorganize Service Delivery during COVID Pandemic

Health infrastructure for SRMNCAH:

- Mapping should be done of hospitals, health facilities and pharmacies in government and private sectors that continue to provide SRMNCAH services. It is understood that some of the hospitals that normally provide SRMNCAH services may have been designated totally as COVID-19 hospitals. Hospitals providing SRMNCAH services may also need to earmark isolation areas for managing COVID-19 suspected or positive cases.
- To avoid crowding of higher-level health facilities, family planning, antenatal care (ANC), postnatal care (PNC), and well-baby/child visits can be redirected to lower level health services, where possible. Outreach mechanisms to deliver essential SRMNCAH services could also be considered, when needed.
- Identify components of SRMNCAH services that can be delayed or relocated to non/low- affected risk areas, shielding capacity for prioritized essential SRMNCAH services.

Digital health interventions:

During this pandemic, existing online digital platforms and mechanisms (i.e., telemedicine) should be leveraged to complement and support delivery of SRMNCAH information and services. WHO recommendations include: ⁴³

- Client-to-provider and provider-to-client telemedicine via phone, email or internet for booking appointments for check-ups, clinical advice, prescription of medicines and first line response to survivors of violence.
- Provider-to-provider telemedicine to link less skilled with expert health workers, e.g., online systems to facilitate consultations with specialists for case management.
- Targeted communications with specific groups of clients to increase knowledge about where to find and access SRMNCAH services, e.g., internet-based information and education programmes, including videos and podcasts for clients.
- Training and on-the-job support for healthcare workers: Digital training courses, materials and job-aids like algorithms and flow charts for SRMNCAH available on internet, mobile apps, podcasts, videos etc., could be used for primary and refresher trainings.

Self-care:

WHO recommends self-administration of preventive, diagnostic and therapeutic SRH medicines and devices that can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health care personnel⁴⁴. Self-care interventions may require governments to temporarily change policies on how and where these medicines and devices are made available to individuals, including whether they can be provided through prescriptions for several months or without prescription:

- Oral contraception, self-injectable contraception, condoms, vaginal rings, lactational amenorrhea method, and if no other methods are available other fertility awareness-based methods and non-prescription emergency contraception to reduce unintended pregnancy.

Health Workforce for SRMNCAH:

All health care workers with skill-mix to provide care for women, children and adolescents, whether based in health facilities or within the community, are essential health care workers and must be retained to continue providing care to

⁴³ WHO. 2019. *WHO Guideline: recommendations on digital interventions for health system strengthening*, World Health Organization, Geneva: <https://www.who.int/publications-detail/who-guideline-recommendations-on-digital-interventions-for-health-system-strengthening>

⁴⁴ WHO. 2019. *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights*, World Health Organization, Geneva: <https://www.who.int/reproductivehealth/publications/self-care-interventions/en/>

childbearing women and their infants and children.⁴⁵ Deploying midwifery care workers away from providing maternity care to COVID-related work or general medical care during this pandemic is likely to increase poor maternal and newborn outcomes.

Nevertheless, COVID-19 will likely have some impact on the availability of health workers to provide essential SRMNCAH services. Absenteeism should be expected, as staff are exposed to the virus and forced to remain home or to care for family. Therefore, the need to recruit additional skilled staff is likely. Surge capacity is particularly important to help allow existing health workers to dedicate their time to key services. Multiple strategies can be implemented to increase health workforce capacity:

- Request part-time staff to expand hours, re-assign staff from non-affected areas;
- Identify additional qualified workers (e.g. retirees, trainees) through registration records;
- Mobilize non-governmental and military workforce capacity through temporary employment;
- Consider establishing pathways for accelerated training and early certification of medical, nursing, midwifery and other key trainee groups, along with supportive supervision;
- Facilitate safe task-sharing, and consider expanding scopes of practice for high-impact clinical interventions, where possible, and arrange rapid training sessions;
- Use web-based platforms to provide key trainings, clinical decision support for direct clinical services;
- Increase capacity of informal care givers for home care support (e.g., family, friends, neighbors) and formalize lay provider systems (e.g., Red Cross/Crescent volunteers);

Options for task shifting may be considered. For example, if the country has an existing qualified community cadre, they may be deployed for home visiting for antenatal care (ANC), postnatal care (PNC) and childcare, etc. Other cadres of workers who could share task of providing SRMNCAH services should be explored. Any legislative or policy enablement action for authorizing the new cadre to provide specified services should be undertaken.

Measures should be taken to protect the health, safety, and security of health workers, including prevention of violence, addressing fatigue, and access to health care and social support⁴⁶. Personal protective equipment (PPE) should be available to all staff. Capacity and confidence of health workers can be enhanced through virtual trainings, mentorship and job aids.

Essential SRMNCAH supplies:

Arrangements must be made for uninterrupted supplies for SRMNCAH health services during the pandemic and lockdown conditions.

- A country-specific list of essential medicines, commodities and equipment must be prepared for the prioritized essential SRMNCAH services (routine and emergency care) including contraception and abortion care where legal.
- Similarly, a list of diagnostic equipment and labs including testing for COVID-19 infection, as well as blood banks must be maintained.
- It is critical to ensure uninterrupted supplies of IPC like hand sanitizers, masks and PPE in adequate quantities to cover the need of healthcare teams and patients.
- An appropriate quick reaction platform should be created for monitoring of stock-outs of listed items (prioritizing lifesaving drugs) along with a mechanism for re-distribution and mobilizing fresh supplies.

Access to SRMNCAH services:

⁴⁵ WHO. 2015. *Health worker roles in providing safe abortion care and post-abortion contraception*, World Health Organization, Geneva: https://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/

⁴⁶ IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. *Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak*, Interim Briefing Note. Version 1.5. February 2020.

There are several barriers that clients may face when trying to access essential services, especially SRMNCAH services, during a pandemic situation. Some actions to address such barriers are suggested below:

- Transport barriers: Free of cost transport services from home to health facility should be made available, as private transport may not be operating.
- Financial barriers: All conditional cash transfer schemes should be sustained. Additional mechanisms may be considered to provide financial support for accessing services through community processes etc.
- Psychosocial barriers: People may be fearful of getting infected in the health facility. A communication plan should be undertaken to provide information, reassure and dispel such fears. Information could be provided via multiple media platforms (e.g., TV, radio, and social media) on how and when to access SRMNCAH services in designated centers that may be different from usual facilities, details of COVID-19 designated facilities, and safe care seeking using recommended preventive actions.

Long term and chronic care:

Several SRMNCAH clients are on long-term care and need to continue the prescribed treatments. Any interruption of care would be detrimental for immediate and long-term outcomes. There is a range of such situations like clients receiving care for family planning, menstrual management, patients on treatment for hypertension, diabetes, chronic kidney disease, epilepsy, thalassemia, cancer etc. Consider alternate mechanisms to continue long-term care:

- Use alternate mechanisms like outreach and mobile teams, e-health services.
- Ensure supplies for long-term care like IFA tabs, sanitary pads, OCPs, condoms, medicines for hypertension, diabetes, HIV, TB etc. Map private and public pharmacies that could deliver medicines to homes.
- Consider alternate non-health agencies to deliver supplies like runners, teachers, agriculture workers, postal services, police etc.

16. Recommendations for continuing SRMNCAH Services in Gulf Council Countries

The GCC governments were highly responsive to engagement with civil society and health sector experts to develop a pandemic response that reflected the reproductive health needs of the population. Nonetheless, it is valuable for the government to consider the continuity of the SRH services during a pandemic. Women and adolescent girls have to be able to access all needed services at any time through the pandemic, in equal manner.

Below are few recommendations to improve women's access to reproductive health services:

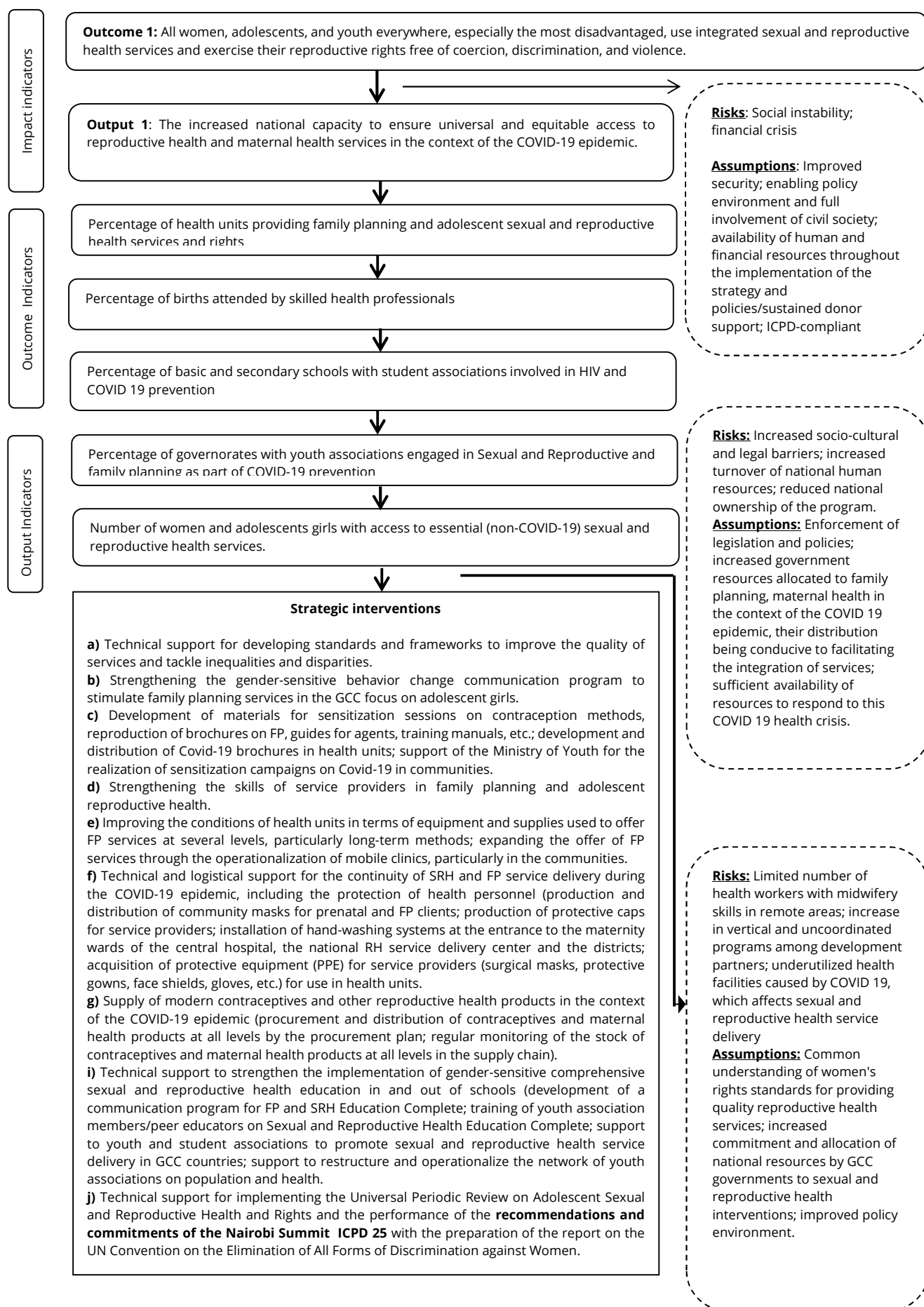
- Issue directives that establish reproductive health services as "essential" services during the pandemic;
- Include women and women's organizations at the heart of the COVID-19 response agenda;
- Ensure that reproductive health services, including obstetric care, family planning services, continue to be provided in public health facilities during the pandemic;
- All women and accompanying persons need to be screened for infection by asking about general wellbeing, underlying medical conditions (e.g., rheumatic heart disease, past tuberculosis, diabetes or other cardiac, respiratory, or metabolic conditions), presence of respiratory symptoms and have their temperature checked and documented. Any person with a fever or reporting fever and respiratory symptoms should be considered as possibly having COVID-19;
- Implement an integrated reproductive health service model to meet the needs of women, adolescent girls, and those living with a disability that provides reproductive health, family planning, and gender-based violence protection services within a shared set of guidelines across programs;
- Conduct qualitative analysis and provide accurate data on women and their conditions during the outbreak period to provide appropriate psychological and Reproductive health support, especially for pregnant women;
- Health systems emergency preparedness is critical to protect health workers, maintain essential health services and improve health outcomes in all settings. Therefore, we call on all the GCC governments to invest in preparedness and strengthening of the health systems to make them more resilient and responsive, in order to

ensure a continuum of services, including SRH, under such circumstances. The governments have to be encouraged to promote public and private partnership by mobilizing the private sector to step up for the enhanced social responsibility programs (e.g., supplies of sanitary items, medical equipment), and in fact there were several materialized good experiences in GCC countries in this respect.

- The GCC governments have to ensure that all health workers have personal protective equipment, and to ensure their commitment to use them, as this is essential to decrease the risk of infection.
- The GCC governments have to provide psychological care for affected individuals, families, communities, and health workers. This has to constitute a critical part of the governments' response.

17. The Theory of Change

The following theory of change describes the concept behind the study and its goals. The Theory of Change (ToC) is a very essential part of this paper, since it highlights the objectives, the outcomes and the impact of such activity.



Annex 1 Risk Analysis Matrix



Risk Analysis
Matrix.xls

Risk assessment related to the COVID-19 pandemic

Answer: Yes (1) or No (0) to the following questions, in order to determine the risk score related to COVID-19 during SRH activities.

Specific risk of COVID-19 linked to SRH activities	Yes (1) / No (0)	Score
Do SRH's activities take place in an environment in which the transmission of COVID-19 is active?		0
Will the SRH activities take place in multiple locations?		0
Will SRH's activities include beneficiaries from areas that have reported active transmission of COVID-19?		0
Will SRH's activities include a significant number of beneficiaries (women, children, or adolescent girls) at higher risk of serious illness with COVID-19 (for example, some pregnant women with underlying health conditions)?		0
Will SRH's activities include conditions that could increase the risk of the spread of COVID-19 (for example, mass departure or the arrival of beneficiaries, unavoidable contact or limited distancing measures)?		0
Are SRH activities provided in one or more structures?		0
COVID-19 specific risk score		0

List of risk reduction measures during SRH activities

This tool assesses the effectiveness of measures taken to reduce the risk of the spread of the COVID-19 disease for SRH activities. As risk reduction measures minimize the risk of the spread of COVID-19, they must be taken into account after the risk assessment to better understand the overall risk of transmission and spread of COVID-19 during the process of the SRH activities. Therefore, the score of the mitigation measures will be considered in the decision matrix and will influence the assessment of the overall risk of transmission and spread of COVID-19 concerning SRH activities.

Subject	Key measure	Score Yes / Completed (2), Possible / in progress (1), No / is Not taken into account (0)	Weighting	Global score	Comments	
SRH managers' understanding of the current status of the COVID-19 pandemic	Have SRH managers been informed of the latest developments available on the COVID-19 epidemic (official web resources available from WHO, local public health authorities)?		1	0		
	Are SRH managers aware of the daily reports on the global and local situation provided by WHO or local public health authorities?		1	0		
	Do SRH managers understand the risks and pathways of transmission of COVID-19, measures that recipients of SRH activities can take to limit spread, recognized best practices (including barrier measures).		1	0		
Emergency preparedness and response plans	Has an emergency medical response plan for COVID-19 been developed for SRH activities?		3	0		
	Is there a COVID-19 coordinator within the MoH to coordinate health preparedness and pandemic response planning?		3	0		
	Has a COVID physician been designated to coordinate the health response to the epidemic?		2	0		
	Did the SRH managers ask for the support of the MoH authorities?		3	0		
	Have SRH managers acquired the following to reduce the risk of COVID-19 transmission?					
	Personal protective equipment (e.g., masks, gloves, gowns) for medical personnel		3	0		
	Is the wearing of a mask required for providers outside of SRH activities?		3	0		

	Is a mask required for beneficiaries outside of SRH activities?		3	0	
	Availability of hand sanitizer and hydro-alcoholic gels, tissues, frequently stocked soap dispensers, closed garbage cans for safe disposal of sanitary products (such as tissues, towels, sanitary products) in restrooms?		3	0	
	Availability of hand sanitizers and hydro alcoholic gel at all entrances and in all SRH facilities?		3	0	
If a person does not feel well, or has symptoms of an acute respiratory infection during SRH activities:					
	Is there a procedure for providers or beneficiaries of SRH activities to identify who to contact if they are not feeling well?		2	0	
	Is there a formal protocol for the COVID physician to report suspected cases and request tests and epidemiological investigations in the GCC countries?		3	0	
	Is first aid or other medical services in place and equipped to assist patients with respiratory symptoms?		2	0	
	Are there isolation rooms or mobile isolation units available on site?		3	0	
	Are there transport services with trained health professionals to transport patients with severe acute respiratory infections to a hospital when needed?		2	0	
	Has a cleaning schedule been established to ensure cleanliness and hygiene of the premises (regular wiping of surfaces and all equipment with disinfectants)?		3	0	
	Are there established medical screening measures for beneficiaries at the entry-level of SRH facilities?		2	0	
	Does the medical response plan include a protocol for SRH managers to inform all beneficiaries of possible exposure to COVID-19 in the event of suspected or confirmed cases that have received SRH activity?		3	0	
Coordinated actions of partners	Is there an established procedure for coordination between medical and security services at SRH facilities?		2	0	
Command and control	Are there an authority/decision-making body and an agreed procedure to modify, restrict, postpone or cancel SRH activities related to the evolution of the COVID-19 outbreak?		3	0	

	Have SRH managers been trained and exercised on personal safety procedures and risk mitigation measures (including those specifically listed here)?		2	0	
Communication risks	Is there a designated person(s) to manage all external communications with government officials, the general public, and the media?		3	0	
	Has coordination been established with major official media channels and social media sites such as Twitter, Facebook and Instagram to coordinated posts; is this measure important to deliver targeted messages from SRH managers (including messages to counter fake news and rumors)?		3	0	
Public health messages towards the risks of COVID-19 during SRH activities	Has public health advice on the clinical characteristics of COVID-19, preventive measures, particularly barrier gestures, hand hygiene and physical distancing, been communicated to all personnel involved in SRH activities? And to the beneficiaries?		3	0	
	Has information on populations at risk been provided to all SRH providers, beneficiaries, and others so that they can make an informed decision about their participation in SRH activities based on their risks?		2	0	
	Were public health arrangements made for emergencies during the conduct of SRH activities (suspected and confirmed cases of COVID-19)?				
Ability to deal with a crisis situation	Is equipment (e.g., personal protective equipment, etc.) stocked in case of an emergency?		2	0	
	Do these emergency measures include the training of additional staff?		1	0	
Specific risk mitigation measures	Were medical measures imposed for the beneficiaries before they arrived at the SRH facilities?		3	0	
	Do these measures include a PCR-type viral test?		3	0	
	Do these measures include a dedicated medical questionnaire?		3	0	
	Will there be daily health checks for providers of SRH activities?		3	0	
	Will pregnant women be separated from other beneficiary groups to limit the risk of transmission?		3	0	

Is the layout of SRH services for SRH beneficiaries adequate to maintain physical distance?		3	0	
Are there measures to limit the sharing of materials, equipment, water bottles, towels, etc.?		3	0	
Will beneficiaries of SRH activities be provided with closed containers to safely dispose of sanitary materials (e.g., handkerchiefs, towels, etc.)?		2	0	
Has the space reserved for beneficiaries been adapted to the situation? (based on recommendations)?		3	0	
Has the space reserved for service providers been adapted to the situation		3	0	
Is there a restriction for beneficiaries?		3	0	
Is access to SRH facilities secure for beneficiaries to avoid contact with patients infected with COVID 19?		3	0	
In waiting rooms for beneficiaries, is it limited secure to maintain safety distances?		3	0	
Is access to the examination rooms secure and the beneficiaries kept at a distance from the providers?		3	0	
Are the chairs in the waiting rooms sufficiently spaced?		3	0	
Is access to the antenatal service limited only for pregnant women?		3	0	
Do beneficiaries who have completed their exams have to wear the mask?		3	0	
Do beneficiaries collect their exam results themselves?		3	0	

123	0
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Global score Somme	0
Risk reduction score (%): (Global score Somme/ (Weighting Somme*2)) *100	0 %

Global risk score for COVID 19 and SRH

The decision matrix takes the risk score and the mitigation score to provide a color determination. This color determination identifies the real risk of transmission and spread of COVID-19 about the SRH activities. The "Color determination" key under the decision matrix describes the total risk for each color.

COVID-19 Specific Risk	0
Risk Reduction Score	0

COVID-19 Risk vs. Risk Reduction measures

Global Risk Analysis	Very well prepared risk mitigation plan (76-100)	Fairly well prepared risk mitigation plan (51-75)	Rather poorly prepared risk mitigation plan (26-50)	Very poorly prepared risk mitigation plan (26-50)
0 - Negligible	Very weak	Very weak	Very weak	Very weak
1 - Very low risks	Very weak	Very weak	Weak	Weak
2 - Low risks	Weak	Weak	Weak	Moderate
3 - Moderate risks	Weak	Moderate	Moderate	Moderate
4 - Moderate (high) risks	Moderate	Moderate	High	Very high
5 - High risks	High	High	Very high	Very high
6 - Very high risks	Very high	Very high	Very high	Very high

Meaning of Color Codes	
VERY WEAK	Very low overall risk of transmission and spread of the COVID-19 pandemic is linked to sexual and reproductive health activities.
WEAK	Low overall risk of transmission and spread of the COVID-19 pandemic is linked to SRH activities. Evaluate opportunities to improve risk mitigation.
MODERATE	Moderate overall risk of transmission and spread of the COVID-19 pandemic is linked to SRH activities. It is recommended that significant efforts be made to improve risk mitigation.
HIGH	High overall risk of transmission and spread of the COVID-19 pandemic linked to SRH activities. It is recommended that significant efforts improve both the COVID-19 total score and the risk mitigation measures.
very HIGH	Very high overall risk of transmission and spread of the COVID-19 pandemic linked to SRH activities.

Annex 2 Data collection Methods

Primary data collection features four **independent methods/sources** as per the Table below. While essentially **qualitative**, quantitative (or quantifiable) data will be sourced from secondary sources (literature review and portfolio analysis) and Social media tracking, Key Informant Interviews (KIIs), Online consultation, Stakeholder Consultations and, case studies included in the study methodology will be used for the collection of primary qualitative data, focusing on UNFPA's mandate.

Data collection methods and tools per study phase

Collection Method	Details: Sub-method/Location/Target number/Profile etc.
Literature review	Identifying documents, which are unfolding reproductive health impact of Covid-19 on women and girls and the responses of healthcare workers as they coped with service provision.
Key informant	Online interviews with frontline medical staff, community health workers, and staff members working in service providing Non-Governmental Organizations (NGOs).
Online consultation	With stakeholders from leading local and international Non-Governmental Organizations working in the relevant sectors, to cross-check findings and for further insights and advocacy suggestions.
Stakeholders consultation	A series of additional online consultations with focal points at the Ministry of Health level in each GCC country, and with Women Association(s) in each respective country.

Annex 3 Detailed Stakeholder Analysis

Type of stakeholder	Consulted during inception phase	Interest in the study	Participation in the study (indicate whether primary (have a direct interest in the study) or secondary (have an indirect interest in the study) stakeholder)	Who
Internal UNFPA stakeholders				
UNFPA GCC	Yes	<ul style="list-style-type: none"> Primary users of study findings and recommendations Allow the study to be shared with partners and stakeholders. 	<ul style="list-style-type: none"> Primary stakeholders and Key informants of the study Review/provide comments on Inception and study report Facilitate planning, logistics arrangements for the field phase in GCC, if the COVID 19 allows it. Source of information for the consultant on partners contacts, programme implementation, context etc. Arrange for interviews. 	<ul style="list-style-type: none"> HR, communications Programme, Logistics, Finance & Admin
UNFPA Arab states Regional Office - Cairo	No	<ul style="list-style-type: none"> User of study findings/ recommendations User of study tools Interest in evidence and lessons learnt. 	<ul style="list-style-type: none"> Stakeholders and key informants of the Study. Source of information, when needed. 	<ul style="list-style-type: none"> Regional Programme Advisors

<p>Ministries of Health of the GCC countries</p>	<p>Yes</p>	<ul style="list-style-type: none"> • Users of study findings and recommendations. • Adopt the recommendations, when required. 	<ul style="list-style-type: none"> - Primary stakeholders and Key informants of the study - Facilitate planning, logistics arrangements for the field phase in GCC countries, if the COVID 19 allows. - Source of information for the consultant on partners contacts, programme implementation, context, etc. 	<ul style="list-style-type: none"> - Focal points
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Annex 4 Tables of health statistics by GCC country⁴⁷

The statistics shown below represent official of the World Health Organization statistics for selected health-related Sustainable Development Goal (SDG) indicators and selected Thirteenth General Programme of Work (GPW 13) indicators, based on evidence available in early 2021. In addition, summary measures of health, such as (healthy) life expectancy and total population, are included to provide a general indication of the current situation.

ANNEX 4 Part 1 Data type	Total population ^a (000s)			Life expectancy at birth ^{b,c} (years)			Healthy life expectancy at birth ^{b,c} (years)			Maternal mortality ratio ^d (per 100 000 live births)
	Comparable estimates			Comparable estimates			Comparable estimates			Comparable estimates
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	
Member State	2019			2019			2019			2017
Bahrain	1 055	586	1 641	75.0	77.0	75.8	66.0	65.5	65.9	14
Kuwait	2 563	1 644	4 207	79.3	83.9	81.0	69.5	71.1	70.1	12
Oman	3 284	1 691	4 975	73.0	75.3	73.9	64.5	64.5	64.7	19
Qatar	2 134	699	2 832	78.0	76.6	77.2	68.1	65.1	67.1	9
Saudi Arabia	19 784	14 485	34 269	73.1	76.1	74.3	63.8	64.4	64.0	17
United Arab Emirates	6 767	3 004	9 771	75.1	78.4	76.1	65.8	66.2	66.0	3

3.1	3.2		3.3					Member GCC State
Proportion of births attended by skilled health personnel ^e (%)	Under-five mortality rate ^f (per 1000 live births)	Neonatal mortality rate ^f (per 1000 live births)	New HIV Infections ^g (per 1000 uninfected population)	Tuberculosis incidence ^h (per 100 000 population)	Malaria incidence ⁱ (per 1000 Population at risk)	Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years ^j (%)	Reported number of people requiring interventions against NTDs ^k	
Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	
2011–2020	2019	2019	2019	2019	2018	2019	2019	
100 ^{ai}	7	3	-	12	-	0.03	5	Bahrain
100 ^{aj}	8	5	-	22	-	0.03	0	Kuwait
99	11	5	0.04	8.5	0.0	0.13	80	Oman
100	7	3	-	35	-	0.05	22	Qatar
99 ^{ai}	7	4	-	9.9	<0.1	0.00	1 113	Saudi Arabia
100 ^{ai}	7	4	-	1.0	0.0	0.02	55	United Arab Emirates

⁴⁷ WorldHealthStatistics2018:MonitoringhealthfortheSDGs.Geneva:WorldHealthOrganization;2018(https://www.who.int/gho/publications/world_health_statistics/2018/en/, accessed 1 May 2021).

ANNEX 4		3.4		3.5	3.6	3.7		3.8
Part 2		Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 ^{cl} (%)	Suicide mortality rate ^{cl} (per 100 000 population)	Total alcohol per capita (> or = 15 years of age) consumption ^m (litres of pure alcohol)	Road traffic mortality rate ^{cl} (per 100 000 population)	Proportion of women of reproductive age who have their need for family planning satisfied with modern methods ⁿ (%)	Adolescent birth rate ^o (per 1000 women aged 15–19 years)	UHC: Service coverage index ^p
Data type		Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Comparable estimates
Member State		2019	2019	2019	2019	2011–2020	2011–2020	2017
Bahrain		16.1	8.9	1.1	5.2	–	12.5	77
Kuwait		11.9	2.9	0.0	15.4	–	5.0	76
Oman		21.5	4.9	0.9	10.6	39.6 ^{am}	8.1	69
Qatar		10.7	5.8	1.5	7.3	68.9 ^{am}	7.2	68
Saudi Arabia		20.9	6.0	0.0	35.9	–	–	74
United Arab Emirates		18.5	6.4	3.8	8.9	–	3.8	76

3.8		3.9			3.a		Member State
Population with household expenditures on health > 10% of total household expenditure or income ^a (%)	Population with household expenditures on health > 25% of total household expenditure or income ^a (%)	Age-standardized mortality rate attributed to household and ambient air pollution ^{cr} (per 100 000 population)	Mortality rate attributed to exposure to unsafe WASH services ^{cr} (per 100 000 population)	Mortality rate from unintentional poisoning ^{cl} (per 100 000 population)	Age-standardized prevalence of tobacco use among persons 15 years and older ^s (%)		
Primary data	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates		
2011–2018	2011–2018	2016	2016	2019	2018		
–	–	40.1	<0.1	0.3	25.1		Bahrain
–	–	103.8	<0.1	0.4	22.1		Kuwait
–	–	53.9	<0.1	0.9	9.6		Oman
–	–	47.4	<0.1	0.3	14.0		Qatar
–	–	83.7	0.1	0.8	16.6		Saudi Arabia
–	–	54.7	<0.1	0.4	18.2		United Arab Emirates

ANNEX 4 Part 3	3.b						3.c		
	Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds ^t (%)	Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age ^t (%)	Pneumococcal conjugate 3rd dose (PCV3) immunization coverage among 1-year-olds ^t (%)	Human papillomavirus (HPV) immunization coverage estimates among 15-year-old girls ^t (%)	Total net official development assistance to medical research and basic health sectors per capita ^u (US\$), by recipient country	Proportion of health facilities with a core set of relevant essential medicines available and affordable on a sustainable basis ^v (%)	Density of medical doctors ^w (per 10 000 population)	Density of nursing and midwifery personnel ^w (per 10000 population)	Density of dentists ^w (per 10000 population)
	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Primary data	Primary data	Primary data	Primary data
Member State	2019	2019	2019	2019	2019	2011-2019	2010-2019	2010-2019	2010-2019
Bahrain	99	99	97	-	-	-	9.3	24.9	1.0
Kuwait	91	94	91	-	-	-	26.5	74.1	6.7
Oman	99	99	99	-	-	-	19.3	40.9	3.0
Qatar	98	95	98	-	-	-	24.9	72.0	6.1
Saudi Arabia	96	96	96	-	-	-	26.1	58.2	5.0
United Arab Emirates	99	99	99	27a ^z	-	-	25.3	57.3	6.5

3.c	3.d			1.a	2.2			Member State
Density of pharmacists ^w (per 10 000 population)	Average of 13 International Health Regulations core capacity scores ^x	Percentage of bloodstream infections due to methicillin-resistant Staphylococcus aureus ^y (MRSA) (%)	Percentage of bloodstream infections due to Escherichia coli resistant to 3rd-generation cephalosporin (e.g., ESBL-E.coli) ^y (%)	Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) ^z (%)	Prevalence of stunting in children under 5 ^{aa} (%)	Prevalence of wasting in children under 5 ^{aa} (%)	Prevalence of overweight in children under 5 ^{aa} (%)	
Primary data	Primary data	Primary data	Primary data	Comparable estimates	Comparable estimates	Primary data	Comparable estimates	
2010-2019	2020	2019	2019	2018	2020	2011-2020	2020	
1.6	-	40	54	7.2	5.1	-	6.4	Bahrain
4.9	84	-	-	8.9	6.0	2.5 ^{ba}	7.1	Kuwait
5.3	79	-	55	8.0	12.2	9.3 ^{bd}	4.8	Oman
8.9	92	34	49	6.3	4.6	-	13.9	Qatar
8.6	79	49	57	10.9	3.9	-	7.6	Saudi Arabia
8.8	96	36	46	7.2	-	-	-	United Arab Emirates

ANNEX 4 Part 4	2.2 continued	5.2		6.1	6.2		6.3	7.1
	Prevalence of anemia in women of reproductive age (15–49 years) ^{ab} (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months ^{ac} (%)	Proportion of ever-partnered women and girls aged 15–49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime ^{ac} (%)	Proportion of population using safely-managed drinking-water services ^{ad} (%)	Proportion of population using safely-managed sanitation services ^{ad} (%)	Proportion of population using a hand-washing facility with soap and water ^{ad} (%)	Amount of water- and sanitation-related official development assistance that is part of a government-coordinated spending plan ^{ae} (current US\$ millions)	Proportion of population with primary reliance on clean fuels and technology ^{af} (%)
	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Comparable estimates	Primary data	Comparable estimates
Member State	2019	2018	2018	2017	2017	2017	2019	2019
Bahrain	35.4	-	-	99	96	-	-	100 bn
Kuwait	23.7	-	-	>99	>99	-	-	100 bn
Oman	29.1	-	-	90	-	97	-	100 bn
Qatar	28.1	-	-	96	96	-	-	100 bn
Saudi Arabia	27.5	-	-	-	78	-	-	100 bn
United Arab Emirates	24.3	-	-	-	96	-	-	100 bn

11.6	16.1	GPW 13				Member State
Annual mean concentrations of fine particulate matter (PM _{2.5}) in urban areas ^{af} (µg/m ³)	Mortality rate due to homicide ^{c,l} (per 100 000 population)	Number of cases of poliomyelitis caused by wild poliovirus (WPV) ^{ag}	Age-standardized prevalence of raised blood pressure among persons aged 18+ years ^{ah} (SBP of >140 mmHg and/or DBP >90 mmHg)	Prevalence of obesity among children and adolescents (5–19 years) ^{ah} (%)	Age-standardized prevalence of obesity among adults (18+ years) ^{ah} (%)	
Comparable estimates	Comparable estimates	Primary data	Comparable estimates	Comparable estimates	Comparable estimates	
2016	2019	2020	2015	2016	2016	Member State
69.0	0.3	0	21.4	17.2	29.8	Bahrain
58.9	1.8	0	23.6	22.9	37.9	Kuwait
36.2	0.7	0	24.8	14.9	27.0	Oman
91.7	0.5	0	22.4	19.5	35.1	Qatar
86.7	1.9	0	23.3	17.4	35.4	Saudi Arabia
37.2	0.7	0	21.1	17.3	31.7	United Arab Emirates

Annex 5 List of Interviewees/Respondents

ORGANISATION	FIRST NAME	LAST NAME	FUNCTION / TITLE	PLACE	GENDER	DATE
Ministry of Health Oman	Dr. Jamila	Al-Abri	Director of women and child health at the Ministry of Health	Remote	F	11/07/2021
Ministry of Health Oman	Dr. Fatma	Alhinai	Head of women department at the Ministry of Health	Remote	F	11/07/2021
Oman Society for Obstetrics and Gynaecology	Dr. Badriya	Al Fahdi	President	Remote	F	14/07/2021
Ministry of Health Qatar	Dr Najat Ali	Ali Mohsen Khenyab	National Lead of Healthy Women Leading to Healthy Pregnancies Sr. Consultant, Ob/Gyn, Head of Fetomaternal Medicine, HMC	Remote	F	22/08/2021
Ministry of Health Qatar	Dr.Sadriya	Mohammed Al-Kohji	Head of Child Health & Adolescent Health & Community Medicine Consultant, PHCC Reproductive health in Qatar	Remote	F	22/08/2021
UAE Ministry of Health	Dr. Suad_	_Alawar	Head of the family health section	Remote	F	10/10/2021
UAE Ministry of Health	Dr. Esmet	Mohammed Amin Abdelrahman Alqassim	Head of maternal and child Health section	Remote	F	10/10/2021

Annex 6 Statements and quotes

"Since the Nairobi Summit, the road to 2030 and the achievement of sexual and reproductive health and rights. All has grown steeper due to COVID-19," says UNFPA Executive Director Dr. Natalia Kanem. "Yet we continue to forge ahead, to back up words with deeds and action on the ground. The new High-Level Commission will help all of us who made commitments in Nairobi to keep those promises."

Dr. Djamila El Abri, Director of women and child health at the Ministry of Health in Oman, said, "the medical services continue to be provided at the primary health care level, taking into account all the safety measures to reduce the infection and the spread of COVID-19 infection. At secondary and tertiary hospitals, all services continue to run in the same way as before the epidemic".

Dr. Fatma Alhinai, Head of women department at the Ministry of Health in Oman, said, “from May 2019 to May 2021 the number of COVID-19 positive cases lowered in Oman; so, some of the services have been resumed. For example, the screening for breast cancer and services related to women health were suspended during the pandemic and now they re resumed again”.

Dr. Badriya Al Fahdi, president of the Oman Society for Obstetrics and Gynecology, said, “since the rise of the COVID-19 epidemic, the delivery, labor room and cesarean services were regular, with high consideration of the safety precautions to protect the pregnant women”.

Dr. Najat Ali Mohsen Khenyab, National Lead of Healthy Women Leading to Healthy Pregnancies Sr. Consultant, Ob/Gyn, Head Of Fetomaternal Medicine, HMC, said, “we decided to set specific guidelines for the antenatal care for a woman at low risk, who do not need to be present at the hospital daily. We have created an online/virtual system, so she can access the advice remotely. COVID-19 has changed the modality of providing the needed care to our patients”. “The government of Qatar is supporting pregnant women to have a virtual modality in order to follow-up on their pregnancies. Each pregnant woman can be monitored at home. At the same time, all services have resumed at our hospitals”.

Dr. Sadriya Mohammed Al-Kohji, Head of Child Health & Adolescent Health & Community Medicine Consultant, PHCC, said, “we are developing an informative guidance to introduce our young men and women to authentic health related information that addresses their SRH&Rs concerns”.

Dr. Sadriya Mohammed Al-Kohji, Head of Child Health & Adolescent Health & Community Medicine Consultant, PHCC, said, “birth spacing commodities are provided at the primary healthcare facilities level. During the pandemic, pharmacies were able to deliver the maternal and birth spacing medications to the patients’ domiciles”.

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Annex 8 Acronyms

ANC	Ante Natal Care
ASRH&RS	Adolescent Sexual Reproductive Health and Rights
CO	Country office
COVID 19	Corona Virus Diseases 2019
HIV	Human Immunodeficiency Virus
KSA	Kingdom Saudi Arabia
GCC	Gulf Council Countries
ICPD	International Conference Population Development
IPPF	International Planned Parenthood Federation
IPC	Infection Prevention and Control
IMAP	International Medical Advisory Panel
GBV	Gender-based violence
GBV	Gender-based violence
GDI	Gender Development Index
GPW	General Programme of Work
LNOB	Leave No One Behind
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MMR	Maternal Mortality Rate
MNH	Maternal and newborn health
NCSI	National Centre for Statistics and Information
NGOs	Nongovernmental Organization
NCDs	Non-Communicable Diseases
PNC	Post Natal Care
PwDs	People with Disabilities
PPE	Personal Protective Equipment
RMNCAH	Reproductive Maternal New born Child and Adolescent
SARI	Severe acute respiratory infection
SARS-CoV-2	Severe Acute Respiratory Syndrome Corona Virus 2
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
UAE	United Arab Emirates
UN	United Nations
UNFPA	United Nations Population Fund
UNSDG	United Nation Sustainable Development Group
UNCT	United Nations Country Team
UNCCSF	United Nations Common Country Strategic Framework
WHO	World Health Organization