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‘What are you doing here?’: (mis)trust, COVID-19 pandemic, and sexual reproductive health rights

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Abstract: We explore how the government’s messaging on COVID-19 pandemic response perpetuated mistrust and impeded people’s ability to access and utilise sexual and reproductive health (SRH) services. While the need for SRH information increased, public health messages fostered mistrust in sexual and reproductive health services. We draw on in-depth interviews and focus group discussions conducted among women, girls, and healthcare providers in five African countries (Burkina Faso, Ethiopia, Kenya, Malawi, and Uganda) between May and October 2021. We show how trust was largely eroded through preventive measures, such as stay-at-home directives, social distancing, curfews, and lockdowns. We argue that, on one hand, while state-led epidemic preparedness and response were geared towards the common good, i.e., controlling the virus, on the other hand, de-prioritisation of much-needed services for sexual and reproductive health and rights (SRHR), as well as a lack of transparency among some of the service providers, bred mistrust in healthcare. We conclude that ambiguity in communication and implementation of COVID-19 prevention measures further compromised access to and utilisation of sexual and reproductive health services.

Keywords: COVID-19, pandemic response, (mis)trust, access, healthcare, sexual and reproductive health and rights, Africa.

Note on the authors: See end of article.

Introduction

In March 2020, the World Health Organization (WHO) declared COVID-19 to be a pandemic, that is, an international public health emergency (Mahase 2020, Wang *et al*. 2020)anxiety, depression, and stress during the initial stage of the COVID-19 outbreak. By early 2020, joint international guidelines and plans on safeguarding SRH services and information had been released by WHO, the United Nations International Children's Emergency Fund (UNICEF), and the United Nations Population Fund (UNFPA). The guidelines stipulated measures that countries should consider for the maintenance of good quality and equitable sexual, reproductive, maternal, and newborn, child, and adolescent health (SRMNCAH) services during the COVID-19 pandemic. Some of the principles in the guidelines included prioritisation and funding for continuity of SRMNCAH services and strengthening of the healthcare system (Endler *et al*. 2021, Haidara *et al*. 2022, Nanda *et al.* 2020, Schaaf *et al*. 2020).

The provision of services for sexual and reproductive health and rights (SRHR) was seriously affected due to social containment measures that disrupted and restricted access to and utilisation of these services (Caruana-Finkel 2020, Hyrink *et al.* 2022, Wood *et al*. 2021). While the effects of the pandemic on sexual and reproductive health (SRH) are not immediately known, early analyses showed a decline in modern contraceptive use (Dasgupta *et al.* 2020). The prioritisation of COVID-19 containment may have strained or drawn attention away from SRHR, resulting in inadequate provision of SRH services and information (Bukuluki *et al*. 2022, MacKinnon & Bremshey 2020, Okeke *et al.* 2022). Studies on previous pandemics have shown negative effects on SRHR, such as increases in unwanted pregnancies and reduced access to contraceptives (Bietsch *et al.* 2020, Sochas *et al.* 2017)

The public healthcare systems were the principal intervention points for managing COVID-19 disease. Responses by various governments to the pandemic were induced by fear of the anticipated devastating health impacts and the related social and economic repercussions (Essler *et al*. 2021). Social control measures, such as lockdowns, curfews, travel bans, social distancing, wearing masks, and sanitising, were prioritised. In addition, the healthcare system was tasked with biomedical interventions, including testing, treatment, and vaccination for containment of the pandemic. In this context, the need to control the pandemic overshadowed and may have impaired access to other health-related issues, including SRHR, that were not directly impacted by COVID-19 (Essler *et al*. 2021).

Compliance with the government-imposed COVID-19 mitigation measures was critical. Crucially, compliance is based on trust. Studies on COVID-19 show

that the public's trust in the government was central to containment of the pandemic (Apeti 2022). Trust is associated with the public's willingness to collaborate, support, and adopt recommended policies and guidelines (Beshi & Kaur 2020, Chan 2021, Hall *et al*. 2001). An analysis of data encompassing 84 countries showed countries with a positive correlation between higher levels of economic inequality and lower levels of some aspects of social capital, such as civic participation and trust in state institutions, had higher COVID-19 mortality rates (Lindström 2020)group affiliations, civic engagement, confidence in state institutions. Another comparative analysis (Reiersen *et al*. 2022) conducted a separate study of 127 nations revealed a negative correlation between the level of trust in health authorities and the incidence of COVID-19-related fatalities. Conversely, the study found a positive association between the level of trusting fellow citizens and a lower number of deaths caused by the virus. Suppose individuals have confidence in health authorities to enact impartial and knowledgeable interventions, and anticipate their fellow citizens to adhere to them. In that case, this could result in a substantial level of overall compliance, hence reducing the number of individuals who contract infections (Reiersen *et al*. 2022). Elements of trust include, but are not limited to, safety, quality, provider knowledge, credibility, satisfaction, acceptance transparency, and communication (Robinson 2016). Several studies on COVID-19 linked high public trust to compliance with social measures (Freeman *et al*. 2022, Lim *et al*. 2021, Schmelz 2020).

This study examines (mis)trust in the healthcare system, specifically in SRHR, an area which has been characterised by mistrust in numerous African countries. Effective public health initiatives need to understand pandemic behaviour variables. Institutional, generalised, and interpersonal trust influence individual behaviour; therefore, public health efforts should consider these elements. Building trust in public health actors and organisations can raise the possibility that people will protect themselves and others during a pandemic (Skirbekk *et al*. 2011, 2023). Research has demonstrated that trust has a significant role in influencing crucial behaviours and attitudes, such as patients' inclination to seek healthcare, disclose sensitive information, and comply with treatment among other things (Rhodes and Strain 2000). In this study, trust can broadly be defined as public or client confidence in availability, access, utilisation, and satisfaction in the service and healthcare system in line with human rights principles, such as respect, confidentiality, privacy, autonomy, informed choice and decision-making, equity and non-discrimination. Trust is strengthened through democratic principles, such as accountability, transparency, and participation (Kerrissey & Edmondson 2020).

Mistrust or a lack of trust in institutions is brought about by inconsistencies, lack of transparency, and misinformation (Gilson 2003, Tarrant *et al.* 2003). The

majority of online information about COVID-19 is inaccurate and misleading. Misinformation and mistrust can cause people to disregard public health regulations (Mechanic 2001, Nazir 2021). Mistrust is associated with fear, resistance, hesitancy, and non-compliance with policies or initiatives, as well as the adoption of alternative initiatives. It is anchored in power imbalances between patient and provider, political beliefs, inconsistencies, misinformation, indecisiveness, and poor quality of services. Practices that communicate dominance, fear, doubt, suspicion, and non-adherence to human rights principles are likely to induce mistrust. The paper is a modest attempt to analyse the intersection between COVID-19 mitigation measures, health providers' practices and clients' SRHR access, utilisation, and practices in five African countries.

Methods

We conducted the study in five African countries, viz. Burkina Faso, Ethiopia, Kenya, Malawi, and Uganda. Initial cases of COVID-19 were reported in these countries between February and March 2020. Data was collected in both urban and rural areas. We targeted public and private health facilities, including those run by non-governmental organisations (NGOs), to determine how the COVID-19 pandemic affected the availability, access, and use of SRH services.

In each country, a list of health providers that were fully operational as of December 2020 was obtained by research consortium partners, and from the list stratified random was used to select the facilities that were included in the study in the five counties. We also considered healthcare facilities that were owned by, supported by, or working in conjunction with the various organisations in June 2020, and were currently offering a variety of SRH services (such as contraception and family planning (FP), safe abortion, postpartum care, newborn care, post-abortion care, delivery services, HIV services, and services for sexual and gender-based violence). We focused only on healthcare professionals offering SRH services at the selected facilities. One healthcare professional per facility was chosen, and they were questioned regarding the health centre's status in terms of SRH services, as well as their own experiences in SRH service provision during the COVID-19 pandemic.

In all of the health centres chosen for the study, we focused on women and girls aged 18 to 49 years seeking SRH services at the time of the study. We informed these potential participants about the study, allowed them to consent, and interviewed those who provided their consent. The data was collected as part of a larger project on the impact of COVID-19 on SRHR across the five countries in February

and April 2021. We draw on qualitative data collected through in-depth interviews (IDIs), focus group discussions (FGDs), and key informant interviews (KIIs). As shown in Table 1, we conducted in-depth interviews with 176 healthcare providers across the five countries, and 211 women and girls in all countries except Ethiopia. We conducted key informant interviews with 13 policymakers, including Ministry of Health officials, and 64 representatives from civil society organisations (CSOs) and non-governmental organisations. In Ethiopia, we conducted eight focus group discussions among women and girls.

Table 1: Respondents per country.

	Girls/women	Providers	Policymakers	CSO	FGDs
Burkina Faso	32	15		7	
Kenya	111	42	6	19	
Uganda	41	85	3	16	
Malawi	6	13		13	
Ethiopia	21	21	4	9	6

All interviews were audio-recorded and recordings uploaded to the researcher's computer. A professional transcribed the recordings verbatim and translated them into English (where necessary). We inductively and deductively developed a coding framework and coded data using qualitative data analysis software—Nvivo 10 (QSR International). We used a thematic analysis approach to summarise key findings. National ethics and scientific review committees in Burkina Faso, Ethiopia, Kenya, Malawi, and Uganda reviewed and approved the study protocol. Additional permits and approvals were obtained from national research commissions and from each participating health facility. Individual written consent was obtained from each study participant.

Findings

The COVID-19 crisis provides a window to explore citizen's trust in governments; in particular, regarding health and healthcare. We show how encounters as well as non-encounters with COVID-19 can tell how people view and approach trust in healthcare. We analyse governments' COVID-19 containment measures, and how they shaped trust issues, including doubt, suspicion, anxiety, skepticism, insecurity, resistance, hesitancy, and fear.

Government mitigation measures

After the identification of the first COVID-19 cases in the countries, governments led efforts to contain the virus. Governments adopted universal precautions, including prioritisation of COVID-19 prevention and treatment. Key informants report that containment and treatment of the COVID-19 pandemic were a priority over provision of other healthcare services. Governments' healthcare focus shifted to COVID-19 response and health emergencies only. Other health services, including immunisation, maternal care, outreaches and enrichment, were suspended:

> *COVID interfered with the government offering services to the people in the health sector where actually service delivery was changed from essential services to emergency services. For example the immunisation coverage went down because the government priorities were altered and the response by the government affected the utilisation of the services by the public.* (key informant, Uganda)

As a threat to human life and healthcare systems, public health measures were instituted. Measures comprised lockdowns, curfews, travel bans, social distancing, wearing of masks, treatment, and vaccination. In addition, communication was critical. In all sites, multiple communication channels were used by governments to provide information or directives to the public:

> *A number of communication channels were created by the government to the public especially on the televisions and radios on how to access health services by the public.* (key informant, Uganda)

Other issues communicated included positive cases and deaths, and the policing of social mobility, including stay-at-home directives, curfews, and lockdowns.

While the government took the lead, citizens were resposible to protect themselves and others by accepting and applying prevention measures. However, the containment measures were likely to be more acceptable in urban areas. Participants intimated that people in urban areas were more knowledgeable about COVID-19 compared to those in rural areas. Feelings about the government micro-managing lives in addition to low numbers of COVID-19 cases resulted in controversies and mistrust. Suspicions were noted around government reports, especially where the messages or information and prevention measures did not correspond with the low number of COVID-19 cases. There is a belief that COVID-19 does not exist because of the low or no account of COVID-19 cases. Some study clients in rural areas were skeptical that COVID-19 was a hoax in rural areas where day-to-day lives had not altered in relation to positive and death cases and government measures.

> *... there are some people who don't believe. They don't believe it. You tell them, 'I was sick.' And she tells me, 'no, you played the government, I don't believe you.' So, they don't observe those measures.* (client, Kenya)

For instance, in Burkina Faso, a country with low numbers of COVID-19 cases, government messaging on the existence of COVID-19 failed to gain acceptance. Both urban and rural study participants narrated how women found it challenging to understand the virus and distrusted government and doctors' messaging because they had not encountered COVID-19 cases, but doctors at health facilities told clients about it:

> *No, well frankly I heard that there was coronavirus* [from] *our doctors here. They told us ... so we did not even see the disease, we didn't even see anyone here with this disease. ... Some participants did not trust even the testimony of other people who claimed to be COVID-19 positive. Instead, they believed that these individuals had other reasons for claiming that they were afflicted with the virus.*

Agreeing to governments' containment measures for collaborative control of COVID-19 was problematic. The participants' curiosity was directed toward the encounter with the implementation of government measures by law enforcement officers. In urban areas, however, mistrust in government COVID-19 containment measures was embedded in the implementation of government measures. Containment measures were more punitive than preventive. They lamented police brutality on those caught violating these measures. In Nairobi, Kenya, participants discussed police brutality at the height of the COVID-19 pandemic. Pregnant women were compelled to give birth at home because they feared the brutality that would be meted out to them by the police:

> *People used to give birth at home. At night, you look for someone to take you, maybe you don't have [transport] means, and he tells you, 'With this curfew, where will we go?' Though they ... you could go to hospital but there was that challenge, like, I will meet with the police and they beat me ... People used to say the police don't understand. They [police] beat you before you explain to him what you want to do. So, you will meet with the policeman and he tells you, 'where are you going at night?' He has already hit you, and you tell him you are taking a patient to the hospital. Yeah, and again you know it was at night so people were afraid, there are not many people who are walking, so you are also scared. ...*

Such policing questioned the government measures and dented trust in government measures. SRH study participants questioned why they were punished with restrictive social measures. While masks were responsible for prevention, SRH study participants reported masks put on to escape being beaten by the police officers on patrol, but not as a responsibility to protect against transmission of

COVID-19:

> *Yes, there are some who wouldn't wear them because you see someone saying, 'I am wearing a mask so that I don't get arrested.' ... There are some who don't believe. There are those who don't sanitize.* (client, Kenya)

SRHR services and COVID-19

In all countries, key informants stated that SRH services were greatly affected. Guidelines for the continuity of sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH) services were developed by WHO, UNICEF and United Nations Family Planning Assistance (UNFPA) by April 2020, for adoption by countries. Despite the threat of COVID-19 to SRHR, adoption of the guidelines varied. Key informants, mainly policymakers and healthcare providers in study countries, indicated that governments formulated new guidelines and policies in relation to SRH to guide service provision during the COVID-19 pandemic.

Key informants, including policymakers, health providers, and civil society organisations' representatives spoke about how the shift in government priority focus on COVID-19 adversely affected SRHR services.. A health provider in Kenya noted: 'This area [SRH] was greatly affected and not much was done by the government…'. In Ethiopia, for example, a policymaker reported the SHR services were closed in the first three months.

When SRH services became available, policymakers, health providers and CSO representatives reported the lowest uptake of SRH services, which they attributed to trust issues. Healthcare providers in the study explained how government directives created fear and mistrust in health facilities:

> *... people got scared of coming for services because they felt that health facilities were the center of where COVID clients can easily get infected ..... So many patients started running away from our services because they were scared of the Corona issue and they felt that anybody closer to a hospital would be bringing a COVID-19 issue and they ran away.* (health provider, Kenya)

Another health provider discussed how such fears were informed by the information circulating in communities:

> *Same to family planning clients, they had fear because of the information going round that nurses and doctors are having COVID-19 and some of them have even died [...] and because of that most of our clients didn't come back for their return visits.* (health provider, Kenya)

SRHR clients, on the other hand, attributed low uptake to fear of contracting COVID-19, fear of being tested for COVID-19 and quarantined, and challenges in accessing health facilities, including being turned away or rejected by health facilities. In Uganda, participants stated that most people were afraid to go to health facilities, drastically affecting utilization of SRH. The situation was, of course, not unique to SRH but to all health services except emergency cases:

> *... access to the SRH access, especially the family planning utilization, drastically went down, and antenatal service utilization also went down; there was a reduction in the health facility deliveries, prompting increased cases of home deliveries.*

In addition, several social prevention measures, including stay-at-home, curfews, and related lack of transport, were cited to have contributed to the decline in access to services:

> *Okay. We have… COVID-19 Reproductive Maternal New Born & Child Health guidelines on how to offer services to a mother who is COVID-19 positive … that is also what is in Child health Covid-19 guidelines for children. These were, in fact, disseminated on 5th May. On 5th February we disseminated the pediatric Covid-19 guidelines, which are already in place and they are guiding even the health care workers to offer services. So, we have RMNCH COVID-19 guidelines and pediatric COVID-19 guidelines guiding our services of RMNCH, including family planning; they guide us on to manage COVID-19 during deliveries and during postnatal.*

The 'no mask, no service' mandatory in all health facilities countries resulted in denial of services to those who did not wear masks; they were sent away.

Meanwhile, policymakers reported governments concern with the decline in access of SRH, and attempts to reclaim patient's/client's trust in health facilities. A policy maker explained:

> *There were Zoom meetings organized by the government to talk to the health managers and the assistant DHOs (maternal and child health) to guide the public to maintain and improve the service access to the public.*

Fear of health facilities being COVID-19 hotspots

The COVID-19 containment measures were to make health facilities safe for healthcare providers and patients or clients. Governments and related stakeholders were to ensure that facilities have containment measures such as sanitisers, water, and PPE (personal protective equipment). In addition, health facilities were to enforce social distancing. Despite these efforts, however, health facilities turned out to be sites for COVID-19 infection in all study sites. Healthcare providers acknowledged a reduction in the number of health seekers in health facilities,

attributed to trust issues around their safety. Health facilities were considered COVID-19 high-risk places. A healthcare provider in Kenya alluded to clients not trusting the health facilities:

> they had fear because of the information going round that nurses and doctors are having COVID-19 and some of them have even died ... and because of that most of our clients didn't come back for their return visits.

This, combined with the fear of being tested and quarantined against their will if found positive, meant trusting in healthcare was dangerous:

> *Most women do not come to health facilities due to fear of COVID-19. People have fear of quarantine—isolation, fear of stigmatisation from their families due to COVID infection. Even for me, I did not come into health facility during its first phase of COVID pandemic. Some antenatal mothers missed their scheduled visits for Tetanus injection. The number of skilled deliveries in both public and private facilities also declined, all because of the fear of contracting COVID-19 in health facilities.* (healthcare provider, Ethiopia)

A health provider in Kenya noted:

> So people stayed home for some time. … They come on condition that maybe somebody is very sick. … Because they had heard the doctors are also dying, nurses are also dying, these people are dying. And you are going to intermingle with them … you are also going to affect the … family members.

Healthcare providers explained how, at the height of the pandemic, clients or patients avoided health facilities for fear of contracting COVID-19 and being tested for it, especially if they had symptoms such as high fever or chest problems, they likely would have had to be isolated or placed in quarantine. By not trusting the health facilities with their health, some of them turned to self-care with over-the-counter medication or herbal medicines.

Healthcare providers too feared contracting COVID-19 from clients and patients. In Kenya, health providers reported that 15 of their staff members and more than 30 in the entire sub-county had tested positive for COVID-19:

> There is a time, especially in March, most of our staff tested positive. So, in fact healthcare workers feared clients as much as clients feared them.

In Ethiopia, according to the Ethiopian Medical Association, about 1,500 healthcare providers were infected and more than 50 health workers died due to COVID-19. Some hospitals were closed because several providers became infected. Health providers saw clients as potential carriers of COVID-19.

As such, healthcare providers, due to the fear of contracting COVID 19, were very vigilant about the implementation and enforcement of government prevention measures among clients to protect themselves from being infected by clients.

SRH Clients' feelings of rejection and loss of autonomy

> *There they don't care about people. ... Yeah even if you sit there you are in pain no one will ask you anything, no one. You go there the whole day it reached* [unclear] *I got very sick at that place even now I am unwell. I really hate that hospital.* (SRH client, Ethiopia)

Participants provided accounts of being turned away for various reasons, including lack of masks, social distancing, lack of services, not being sick, stay-at-home policy, and being suspected to be COVID-19 positive. An SRH client seeking abortion services in Ethiopia explained how she came for family planning and found the clinic closed, and ended up with an unplanned pregnancy. At the time of the interview, she had come for abortion care. While the health facilities provided free sanitizers and water points for washing hands and took temperatures, patients and clients who did not have masks were turned away. They reiterated:

> *I could not get FP [family planning] without face a mask.* (client, Uganda).

While health providers and policymakers report a decline in the number of clients seeking services and attributing this to fear of contracting COVID-19, SRH clients raised concerns about provider attitudes. A provider in Kenya stated how health providers reinforced COVID -19 containment measures.

> *... the health providers were asking those who visiting health facilities, 'what are you coming to do here if you know that you are not that sick? Why can't you stay at home? What are you searching for?' You see such—such a comment.*

Such statements discouraged clients from seeking services from health facilities created mistrust in healthcare.

Also affected were mothers who arrived for deliveries. Clients shared how they were not treated well when they presented for delivery:

> *I was not coming here because there, Mtopanga, is a government hospital but they are not working. I went there and I was turned away. Yes I went there with my husband and I was told we will not be attended to. I pleaded they did not listen. So, even the last time that I came here for clinic, they told me in advance—to go back to Mtopanga, or to look for a hospital where you will deliver ... I already feel bad. Because they did not. I tell you I have been helped by God. ... maybe I could even have hurt the baby, maybe I would have killed the baby ... even the senior doctor was not there. Because the senior doctor is someone I know. So it's like I was talking to ghosts or I don't know what because if the senior doctor was not there, so when I arrived, I was turned back*

Another client on ART (antiretroviral therapy) explained:

> *I use ARTs so I was coming to the hospital but there were many challenges that I was going through because of this COVID-19. I go to the hospital we were told that we were not supposed to be so many in one place. So you have to go back home and the day you are supposed to go for the drugs has come and what you had is over. So you have to move forward the dates you don't take any because you have been told that you should not be at the hospital as a crowd, your dates have arrived so getting the drugs was a problem. ... It is like is like you are forcing the doctors, the doctor sees you as if you are going to infect him or what, he just takes you lightly. In July, August I decide to come to go to these small organisations.*

Experiences of rejection in health facilities were typical. In some private health facilities, clients suspected of having COVID-19 were mishandled by hurriedly being referred to other facilities. In Kenya private health facilities dissociated with COVID-19 cases for fear of being closed downhurriedly referred clients with symptoms such as high fever and coughing to other facilities. Those who did not comply with containment measures, such as wearing masks, were turned away.

According to clients, healthcare providers violated clients' autonomy to reinforce, encourage, or implement COVID-19 mitigation measures,even though autonomous decision-making is a key SRHR principle. Clients seeking family planning and abortion services explained how healthcare providers made decisions on their behalf. Healthcare providers asked clients to switch to COVID-19-compatible contraception methods. In some cases, this was based on COVID-19 prevention measures articulated in government policies and guidelines, such as Uganda's 'no touch' policy. Clients were discouraged from using intra-uterine contraceptive device (IUCDs) and implants, which require close contact and invasive procedures during insertion and removal. Instead, against their wishes, they were encouraged to use short-term methods, such as pills and injections that do not require physical contact between provider and client, or they were advised not to remove the IUCDs or implants if they already had these. Some clients seeking IUCDs and implants were dissatisfied with healthcare providers' recommendations to switch to short-term methods, particularly where family planning use was secret, as described below:

> *... somebody had a long-term family planning method. Now her time had come for removal. ... So this client was told that 'no, those procedures of removing we are not doing them now'... until COVID-19 cases reduce. ... Because you also want to protect against unwanted pregnancy ... clients will be advised to take another method, maybe pills, we can give them that ... . They feel like they are not handled well when they are not given the correct thing.* (healthcare provider, Kenya*)*

In Ethiopia, greater attention was given to use of long-acting FP services and self-care with medical abortion drugs. Similarly, in Kenya, the manual vacuum aspiration (MVA), a medical procedure was not done for those seeking abortion services. This was in line with the country's COVID-19 protocols, which discouraged the procedure and recommended the use of medical abortion drugs. While comprehensive abortion care provides for a range of services or procedures, healthcare providers reported that the presence of the pandemic potentially limited choices. Clients were stripped of decision-making autonomy and were left with the choices made for them by healthcare providers. A healthcare provider explained:

> *... you give medication rather than do a procedure because you [fear being] infected ... that reduces that comprehensiveness. So you are limiting this patient to just a certain service, especially if a client was suspected to be COVID-19 positive. So, you give medicine to complete the abortion at home, rather than do an MVA ...*

Some clients reported not trusting or wanting to use the medicine to complete an abortion at home due to fear of excessive bleeding. Others who wanted to be discrete about their abortion feared being found out by family members.

Increased charges for services

In all countries, government SRH services remained free but evasive. Stock-outs were reported in government facilities, which was blamed government prioritisation of COVID-19 at the expense of SRHR and other health needs. Clients complained about the acute shortage of injectable contraceptives (Depo-Provera) in public health facilities. A civil society representative in Kenya speaking about the affected SRH services said:

> *... of course, the prioritising of COVID-19 over other health services affected the delivery of the commodities to our institutions. ... KEMSA was seen to be focusing on COVID-19 commodities more than reproductive health commodities, and that meant that women and girls lacked access to those services. ... We had no stock, and pharmacies were closed.* (CSO representative, Kenya)

A section of clients reported some facilities refused to provide services to clients. In Kenya, some healthcare providers evaded duty while some turned away clients, and other facilities preferred to refer clients to other facilities. However, in Burkina Faso and Uganda, key informant and healthcare providers reported that free services were available:

> *There was repeated calls to the people that services were still available at the health facilities in spite of the pandemic. There was also close supervision on the health workers not to abandon the health facilities.* (policymaker, Uganda)

The CSOs that usually provided free services closed. Some of them had repurposed funding to support governments' COVID-19 efforts. In Kenya, CSOs' clients whom they referred to public health facilities and those who sought services in public health facilities were forced to seek services from private (for-profit) SRH providers, who depend on out-of-pocket payments from clients. Overall, in all countries, participants seeking services from the private for-profit entities decried the increased cost of services,

> *Yes, the health facility is quite expensive compare to when the pandemic is not yet in place.* (SRH client Uganda)

Participants in Uganda, Kenya, and Ethiopia hinted at their suspicion about healthcare providers' integrity. While private for-profit health entities reported the high cost of commodities and providing healthcare services and passing on increased costs to clients, a section of the SRH clients alluded to the fact that they were taking advantage of COVID-19 to increase prices of services under the watch of governments. Some SRH clients in Ethiopia and Kenya stated that they could not afford the cost of healthcare services yet the governments were less concerned. A participant in Ethiopia elaborated:

> *... People lost employment ... the majority and then the country's economy at that particular point, everything was bad. ... People did not have money ... they did not have money. So actually, I think I met someone who once told me that instead of getting treatment, I only have money to buy food. I am sick, yes. I cannot be treated simply because I do not have money. The few coins that I have...* [are] *to buy food for my family and I continue being sick, yeah.*

Discussion and conclusions

The non-transparent nature of government decision-making processes may have been the main obstacle to maintaining client trust in SRH services. Mistrust in SRH healthcare is intertwined with the complexities of pandemic management and implementation of COVID-19 prevention measures. Although governments and their agencies have been able to contain the pandemic, their failure to recognise SRHR as an essential service is profound.

SRH clients are among the health seekers who have observed and experienced significant changes in the healthcare system brought about by the COVID-19 pandemic. These changes include the number of clients allowed inside facilities, clinic operations, autonomy in decision-making, and unpredictable SRH services. Institutions need public trust to implement changes. Trust acts as a stand-in for

knowledge and adaptive response in the face of uncertain futures and indeterminate threats. Social prevention measures were supposed to enhance safety in health facilities, which in turn would motivate trust in health services and promote the continuity of service promotion and uptake. However, the study shows that, to the contrary, health facilities were perceived as unsafe spaces. At the time, SRH was regarded as not being an illness and its provision a non-essential service. Healthcare providers in public health facilities were keen on implementing preventive measures instituted by governments, such as stay-at-home directives, social distancing, mask wearing and controlling the number of clients in facilities,and denying SRH service provision to clients. Moreover, the government's neglect of private SRH service providers who are legitimate partners, may have contributed to clients' mistrust of healthcare services. Passing on the cost of necessary investments (e.g., in PPE) to clients, increased the cost of services in healthcare facilities.

Other measures that contributed to mistrust in health systems and COVID-19 management included the imposition of punitive measures by law enforcement agents. The institution of government measures increased pressure on law enforcement officers. While COVID-19 containment measures were necessary, travel restrictions to health facilities interfered with access to services, contributing to mistrust in the healthcare system.

The lack of information on COVID-19 posed a significant challenge to containment of the coronavirus. This insufficient information caused public confusion and frustration, and many people felt uninformed and uncertain about the virus and the actions needed to protect themselves and their families. Instead, people looked for information from various media sources, including social media, where they encountered misinformation, rumours, and conspiracy theories, resulting in further confusion and mistrust. Fake cures and treatments for COVID-19 were proposed and shared on social media platforms, while others used social media to target vulnerable people or to spread hatred and fear. Social media has also been used to spread misinformation about the pandemic, leading to public panic and hesitancy in taking needed precautions.

SRHR remains uncertain, as much in crisis as ever, and clients have nowhere to turn. Misinformation and weaknesses in implementing COVID-19 government measures no doubt combined to create fear and reduce trust in SRHR health care. The present situation of COVID-19, and future crises and pandemics needs to sharpen the continuity of SRHR by placing trust at the centre of healthcare.

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