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Understanding the Impact of COVID-19 on SRH Services and SRHR:

A Comparative Study of Malawi and Palestine

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ABSTRACT

Among the many challenges linked to the outbreak of the novel corona virus disease (COVID-19) there are strong indications that the COVID-19 pandemic has adverse impact on sexual and reproductive health (SRH) services globally. To expand the literature in the field of sexual and reproductive health and rights (SRHR) and its associations to COVID-19, this study assess how COVID-19 has affected SRH services in The State of Palestine and Malawi. These countries are chosen to fit into a Most Different System Design, as these countries has diverse geographical, cultural, religious, political and historical backgrounds. The impact of COVID-19 on SRHR are assessed with a mixed method study design, where part one assesses data provided by organizations that offers SRH services in Malawi and Palestine and part two is a critical analysis of SRHR and COVID-19 policy strategies in Malawi and Palestine. The impact of COVID-19 on SRH service provision in part one is further seen in relation to the analysis of the policy documents in part two.

The study´s findings indicate that COVID-19 has affected both organizations´ overall provision of SRH services and that the organization in Palestine experienced more shut down of service delivery points than the organization in Malawi. Furthermore, the policy analysis reveals that the subject position of women was somewhat related to how this impact may have played out. The findings further demonstrate that COVID-19 policies exceed SRHR policies and that this policy priority is linked to the impact COVID-19 has had on SRH services in the organizations of study. By doing a comparative study of two distinctive countries, this study shed light on the geopolitical and contextual factors that contributes to the impact of COVID-19 on SRHR, especially concerning political instability, economical barriers, donor dependency as well as women and girls´ position in the pandemic.

Keywords: SRHR, COVID-19, SRH services, Malawi, Palestine

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Abbreviations:

AIDS - Acquired Immunodeficiency Syndrome

COVID-19 – Novel Corona Virus Disease

GBV – Gender Based Violence

GoM – Government of Malawi

GoP – Government of Palestine

HIV - Human Immunodeficiency Virus

INGO- International Non-Governmental Organization

IPPF – International Planned Parenthood Federation

MFPO – Malawi Family Planning Organization

MoH - Ministry of Health

NGO – Non-Governmental Organization

PFPO – Palestine Family Planning Organization

SDG – Sustainable Development Goals

SGBV – Sexual and Gender Based Violence

SRH – Sexual and Reproductive Health

SRHR – Sexual and Reproductive Health and Rights

WPR – "What´s the problem represented to be"

Chapter 1 Introduction

In December 2019, the first cases of the novel corona virus disease (hereby referred to as COVID-19) were identified in Wuhan, China. The World Health Organization declared the novel COVID-19 virus as an international concern in January 2020 and a global pandemic by March 2020. Among the many challenges linked to the pandemic, there are strong indications that the current COVID-19 pandemic will have an adverse impact on sexual and reproductive health and rights (herby referred to as SRHR) globally. In March 2020, many of the world's largest condom factories shut down because of COVID-19 (Huang, 2020). Subsequently, this led to a worldwide contraceptive shortage where several low -and middle-income countries were forced to exhaust their contraceptive supplies. As well as contraceptive shortage and supply disruptions, the pandemic has affected access to safe abortions in many countries (United Nations Population Fund, 2020b). Additionally, there has been an overall increase in reported cases of gender based violence, restricted and eradicated access to physical sexual and reproductive health care such as screening and preventive care, as well limited sexual education in school because of priority of topics in online learning, due to the COVID-19 pandemic (Lindberg, Bell, & Kantor, 2020).

An analysis conducted by United Nations Population Fund (2020a) suggest that lockdown-related disruptions in supply chains over 6 months could leave as many as 47 million women in low- and middle-income countries unable to use modern contraceptives. The same report predict that this could lead to 7 million additional unintended pregnancies. Even though these are rough estimates, they offer an alarming view of a potentially dire future for women and girls if efforts are not directly made to secure their welfare and ensure their rights.

Study aim

Unquestionably, there are grounds for assuming that COVID-19 will have an impact on sexual and reproductive health (herby referred to SRH) services and SRHR around the world. However, the pandemic is new, and there is limited scientific evidence on both how it affects the SRHR of the infected, as well as how it will affect SRH services. To expand the literature in the field of SRHR, this thesis aims to understand how COVID-19 has impacted sexual and SRH services and SRHR in two countries that are facing different challenges as a consequence of conflict and poverty, namely Malawi and The State of Palestine (hereby referred to as Palestine). The specific countries of Malawi and Palestine are chosen to fit into

a Most Different System Design (MDSD), as these countries have diverse geographical, cultural, religious, political and historical backgrounds. By doing a comparative analysis with two distinctive countries, attention is given to how the pandemic affect countries in adverse ways.

Palestine has been under the occupation of Israel for decades. The outbreak of COVID-19 poses a considerable challenge in a country such as Palestine, seeing its history of occupation, financial limitations and geographic division of territory. The government of Palestine (hereby referred to as GoP) worries that the pandemic may lead to destabilization of their health care system as they experience exhaustion of their health care services due to high rates of COVID-19 infected cases, both in the public sphere as well as amongst health personnel (Palestinian Ministry of Health, 2020). Simultaneously, in South East Africa, Malawi is a country that is ranked as one of the poorest countries in the world and has a historical background of colonialism and financial instability. As a consequence of deep poverty, Malawi experiences limited resources devoted to ensuring a resilient health care system (Chansa et al., 2018; Kanyuka et al., 2016). If the issue remains ignored in countries such as Malawi and Palestine, it is feasible to assume that long term COVID-19 measures are going to have large wide-reaching negative implications for citizens´ SRHR and access to SRH services in these countries.

To understand the impact of COVID-19 on SRH services and SRHR in these two countries, the study holds a two folded research aim and assess this impact in a mixed methods study design. The study therefore comprises two parts. The first part investigates data provided by organizations that offers SRH services in Malawi and Palestine, that concerns the impact of COVID-19 on SRH services in these organizations. Through a comparative analysis of the data, differences and similarities between the impact of COVID-19 on the SRH organizations in Malawi and Palestine is assessed. In the second part of the study, a critical analysis of SRHR and COVID-19 policy strategies in Malawi and Palestine is conducted. Bacchi´s (2009) "What´s the problem represented to be" (hereby referred to as WPR) approach is used to asses problem representations in the text. Further, a power dynamic perspective is applied when analyzing the policy documents. The impact of COVID-19 on SRH services in part one will further be seen in relation to, and sought to be understood by, the analysis of the policy documents in part two. The two parts are seen in relation to one

another to ensure a comprehensive understanding of the impact of COVID-19 has had on SRH services and SRHR in Malawi and Palestine.

To understand the impact of COVID-19 on SRH services and SRHR in Malawi and Palestine, the following three research questions are assessed:

1. In what ways has COVID-19 affected SRH services provided by family planning organizations in Malawi and Palestine?
2. What are the similarities and differences between the service delivery provided by family planning clinics in Malawi and Palestine due to COVID-19?
3. How can we understand the impact of COVID-19 on SRH services in the two organizations by looking at the problem representation in Malawi and Palestine´s national SRHR and COVID-19 policy strategies?

In terms of delimitation of research question one and two, these research questions are assessed by looking at data provided by one umbrella organization each in Malawi and Palestine. This delimitation is somewhat relevant for research question three as well, since the impact of COVID-19 on SRH services are assessed by data from these organizations and further understood by the problem representation in policy strategies of COVID-19 and SRHR. Furthermore, part one of the thesis delaminates the topic of SRHR to SRH services. Subsequently, the quantitative component merely looks at SRH services delivered and not the rights aspect of SRHR. Part two of the thesis assess SRHR strategies and consequently expands from assessing SRH services in part one to assessing problem representation of SRHR in general. The two concepts are seen in relation to each other since SRH services is an essential component of SRHR. Consequently, the terms “SRH services” and “SRHR” are used distinctively throughout the paper.

Definition of SRHR approached through the principles of human rights

SRHR are fundamental on the path to ensure social justice and is essential for achieving the national, regional and global commitments to the three pillars of the sustainable development goals (hereby referred to as SDGs): eradicating poverty, fighting inequality and stopping climate change (Starrs et al., 2018). The definition of SRHR applies especially to women and girls, particularly in respect to socially defined gender roles that discriminates against women. Starrs et al. (2018, p. 2646) define SRHR as a “[…] state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity”. The definition further includes individuals´

right to govern their own bodies and individual´s right to access essential SRH services. By defining SRH trough the principles of human rights, SRHR involves the right to reach the highest attainable SRH as well as the right to access to SRH services, goods and facilities (Starrs et al., 2018). The integrated definition of SRHR is central to ensure that every aspect of SRHR are accounted for in the promotion of individual health and social and economic development. Both SRHR policy strategies of Malawi and Palestine uses an integrated definition of SRHR which acknowledges the human rights aspect of SRHR and how access to SRH services is essential for fulfilling SRHR (State of Palestine & Ministry of Health, 2018; The Government of Malawi, 2017). Access to quality SRH services is an important aspect of the fulfillment of SRHR which demonstrates the importance of assessing the relation between the current pandemic and SRH services and SRHR.

The link between COVID-19 and SRHR

As a consequence of the global COVID-19 pandemic, numerous countries have declared a state of national emergency. COVID-19 represent a potential threat for reversing years of progress in improving SRHR, especially in low- and middle-income countries (United Nations, 2020; United Nations Population Fund, 2020a). In humanitarian or conflicted areas, sexual and reproductive rights are often be overlooked and violated, which involves rights like access to high quality SRH services, ownership of one's own body and sexuality as well as consent based partnerships (Starrs et al., 2018). Malawi and Palestine are two contrasting countries with discrete political, geographical and economic challenges that are believed to encounter severe challenges in the crisis management of COVID-19. What is more, progress in the field of SRHR is slowed down by limited economic means due to the pandemic of COVID-19 (Starrs et al., 2018). People will continue to have sex both voluntarily and involuntary, and by nature pregnancies and deliveries of birth will still occur during the COVID-19 pandemic. The predicted regression in SRHR should lead the attention towards how the pandemic has impacted SRH services and the human right to achieve the highest attainable SRHR.

Structure of the thesis

The thesis contains six chapters. Following the introduction, Chapter 2 contains an overview of the geopolitical context of the two countries Malawi and Palestine. Further, Chapter 3 entails related literature and theoretical frameworks that are applied in the discussion of the results. Chapter 4 presents the methodological choices of thesis and is

further described and elaborated on in this chapter. Chapter 5 comprises the analysis, findings and discussion of the results from this study. This section starts with a presentation of the findings in the quantitative component, thereafter the findings from the qualitative component, and lastly a discussion of the two components in relation to each other. Finally, chapter 6 includes concluding thoughts and remarks of the thesis.

Chapter 2 Geopolitical context

Previous literature on SRHR implies that humanitarian settings, conflict and poverty are linked with reduced access to SRH services and overall SRHR outcomes (Roxo, Mobula, Walker, Ficht, & Yeiser, 2019; Ssonko et al., 2017; Tran & Schulte-Hillen, 2018). The linkage between geopolitical context and SRHR illustrates the importance of countries´ historic and present situation. Understanding Malawi and Palestine´s geopolitical context might contribute to a better understanding of how COVID-19 impacts SRH services and SRHR in these different countries. This section presents an overview of the circumstantial situation in both Malawi and Palestine.

Malawi

Malawi is a greatly populated, landlocked country. The country is ranked as one of the poorest countries in the world, and the country spends less per capita on health (33.37 EUR) than the average country in sub-Saharan Africa (83,42 EUR) (Chansa et al., 2018). Because of Malawi´s limited financial resources, external donor funding account for 66-70% of all health care expenditure in Malawi (Kanyuka et al., 2016). Studies indicate that both quantitative and qualitative measures of health care are affected by the limited financial resources in Malawi. This is clearly illustrated by some communities in Malawi having the nearest health care facility over 35 km away (Masefield, Msosa, & Grugel, 2020).

Malawi struggles with sufficient finances to support programs which aim to reduce poverty, illiteracy among citizens and they experience a critical shortage of capacity in institutions that aim to implement development programs (World Health Organization, 2018). However, Malawi have seen great progress in fertility rates in the last years. From having a fertility rate at 5.7 children per woman in 2010, this was reduced to 4.4 children per woman in 2015 (World Health Organization, 2018). Although reduced, children per woman is a population rate relatively high as compared to the global fertility rate (at 2.5) and an expansion of population is expected (United Nations Department of Economic and Social Affairs, 2020). From having an overall population at 13.1 million in 2008, the population is expected to duplicate to 26 million in 2030 (World Health Organization, 2018). Rapid increase in population is associated with an increase of challenges with efforts regarding national development and is therefore a point of concern for Malawi (World Health Organization, 2018).

The SRHR situation in Malawi

Over half of the births in Malawi is delivered by women under the age of 18 and early childbearing is associated with poorer health outcomes, lower socioeconomical status and lower education, both for the mother and the newborn (Nash et al., 2019; UNAIDS, 2020). Early pregnancy is one of the main reasons many girls drop out of school in Malawi, and about 9.8% of females aged 20-24 have completed secondary school (National Statistical Office Malawi & ICF, 2017). Furthermore, Malawi is a hotspot for Human Immunodeficiency Virus (hereby referred to as HIV), and the country´s low capacity for treatment and sufficient health care has consequently contributed to having one of the highest HIV/AIDS burden in Africa, with a HIV/AIDS prevalence at 9% of the overall population in Malawi (Nutor, Duah, Agbadi, Duodu, & Gondwe, 2020). The high prevalence of HIV, fertility rates and dropouts from school is associated with socioeconomic status, culture, region, structural drivers as well as gender equality (UNAIDS, 2020). Malawi also ranks low on the Gender Inequality Index, which is a composite measure of reproductive health, female empowerment and economic status (Nash et al., 2019). These statistics draw attention to the challenges related to SRHR in Malawi prior to the COVID-19 pandemic, and the pandemic is believed to worsen many SRHR outcomes. As an example, Malawi is currently reporting GBV to be a severe problem that has increased during the COVID-19 pandemic (UN Women, 2021). The current and predictive numbers of outcomes in SRHR in Malawi demonstrates why it is important to address changes in SRH care and SRHR outcomes in Malawi due to the current COVID-19 pandemic.

The COVID-19 situation in Malawi

The COVID-19 pandemic gained foothold in Malawi in March 2020, and The Government of Malawi (herby referred to as GoM) declared state of national disaster the 20th of March 2020. A year later, in March 2021, there has been a total of 32,864 confirmed cases of COVID-19 in Malawi. The country remains a state of national disaster in March 2021 due to a second wave and as a measure to prevent a third wave (UNICEF, 2021b). Furthermore, the first shipment of vaccines arrived in Malawi in March 2021 and by the entrance to April 2021, 155 thousand citizens had procured their first shot of the vaccine. Malawi is expected to receive 7.6 million doses of vaccines from the COVAX vaccine-sharing scheme, which accounts for at least 20% of the Malawi population. However, for the time being, the vaccinated population in Malawi accounts for less than 1% of the general population (UNICEF, 2021b).

Palestine

Palestine has a long history of conflict and military occupation by Israel. Political instability, military checkpoints and occupied areas in Palestine has led to rapid changes and made Palestine´s health budget rely heavily on external donor support (Bosmans, Nasser, Khammash, Claeys, & Temmerman, 2008). The external donor support is often provided on the basis of the donor's agenda and based on short term solutions. These short terms solutions has created barriers when trying to re-stabilize the health system in Palestine (Bosmans et al., 2008). Conversely, even though large parts of Palestine´s health budget rely on external donor support, Palestine faces challenges in receiving donor support due to not being fully recognized as a sovereign state by a number of countries (State of Palestine, 2020). Palestine´s status as a sovereign state is recognized by 138 countries as well as the UN General Assembly, yet because of not having full recognition as a sovereign state, Palestine struggle with international arrangement to receive donor funding. Subsequently, the state depends on external support but also experience receiving limited funding internationally because of Israeli occupation. These factors together has led to limited resources of re-stabilizing the country´s government and their respective policies and systems, including health, welfare and SRH services (Giacaman, Abdul-Rahim, & Wick, 2003).

The SRHR situation in Palestine

The SRHR situation in Palestine is characterized by high population growth, widespread child marriage practices as well as gender-based violence (herby referred to as GBV). The population in Palestine is growing and expected to duplicate from 4.75 million in 2015 to 9.5 million in 2050 (Courbage, Hamad Abu, & Zagha, 2016). Further, early marriage is a reality for many girls in Palestine, as 24% of women between the age of 20-49 are married before the age of 18 (Palestinian Central Bureau of Statistics, 2015). In addition to high child marriage rates, studies show that many women are exposed to GBV by the men they are married to, which often affect the physical and psychological health of the victims of violence as well as the victims' families (Courbage et al., 2016). Living in conflicted areas is strongly linked to high rates of GBV and estimates show that in 37% of all marriages, women experience being subjected to intimate partner violence caused by their husbands (29.9% in the west bank and 51.1% in the Gaza Strip) (Courbage et al., 2016).

Research conducted on SRH services offered for refugees in occupied areas of Palestine, shows that the access to these types of service were severely limited regardless of

status as refugees or non-refugees at the time their study was conducted (Bosmans et al., 2008). The same study reports that many humanitarian organizations were not able to offer these rights as medical treatment, drugs and contraceptives was long-delayed and difficult to provide. Additionally, military checkpoints became a barrier for health care for women in delivery as well as post-natal care (Bosmans et al., 2008). Furthermore, the study conducted by Bosmans et al. (2008), revealed that many women had to give birth at the checkpoints because they were not allowed to cross the boarders. Making women deliver in unsafe conditions, threatens both women´s and newborn´s health and rights, and is to be considered as GBV (Starrs et al., 2018). The situation in Palestine and Israel is in constant change, but the study conducted by Bosmans et al. (2008) still illustrates important implications conflict and political instability may have for SRHR in Palestine. Additionally, it illustrates how strict border restrictions and travel restrictions might create extra barriers for SRH care and SRHR and is especially relevant for the aim of this thesis, as many of the efforts made to prevent the spread of COVID-19 involves travel and border restrictions.

The relation between COVID-19 and SRHR in Palestine is also emphasized in a study conducted by Singh et al. (2020), where worryingly high rates of sexual gender based violence (herby referred to as SGBV) in Palestine is reported as a consequence of the pandemic. In the process of trying to control and stop the spread of the virus, victims are exposed to larger risks of SGBV in addition to not having the opportunity to distance themselves from their abusers. Shut down of clinics and crisis shelters are also making SGBV victims exposed to high risk factors. Consequently, it is reasonable to argue that the geopolitical context of Palestine will have an effect on how the pandemic will affect SRHR in the country.

The COVID-19 situation in Palestine

The COVID-19 situation in Palestine has been impacted by strict restrictions and quick spread of the virus. From March 2020 to March 2021 there have been 230 356 confirmed COVID-19 cases in Palestine (UNICEF, 2021a). President Mahmoud Abbas declared national state of emergency 4th of March 2020 and Palestine have faced long periods of total lockdown. All public and private schools have been closed, except from universities and educational institutes. These restrictions have been long lasting, except from an recent ease in Gaza in March 2021, but the threat of new rounds restrictions loom as new peaks of COVID-19 cases are expected (World Health Organization, 2021). The repercussions of COVID-19 are

believed to have long lasting aftermaths for the future of Palestine, especially because of limited financial resources (UNICEF, 2021a). Additionally, the economic challenges make Palestine reliant on Israel´s support to health system efficiency. The authorities of Palestine began vaccinating the Palestinian citizens through the international COVAX vaccine-sharing scheme in March 2021. This scheme is thought to cover around 20% of the Palestinian population (UNICEF, 2021a). At the same time, while millions of Palestinian people that live under the occupation of Israel is not offered the vaccine, Israel have vaccinated every fifth citizen (NTB, 2021).

Chapter 3 Related literature and theoretical framework

Related literature

As COVID-19 is relatively new, there are limited literature that shows the effect the current pandemic has had on access to SRHR services. However, literature exist on SRHR in humanitarian settings, areas of conflict and countries with limited financial resources. As the COVID-19 pandemic has produced similar effects, the related literature in this chapter focus on how SRHR has been preserved in contexts somewhat similar to what is now witnessed in the COVID-19 pandemic. The implications of previous crisis on SRHR are thought to further shed light on the importance of research on how the current COVID-19 pandemic has impacted access to SRH services in family planning organizations and SRHR in Malawi and Palestine. Further, a policy perspective as well as donor relationships in low-income countries are introduced to provide an insight into how actors involved in the formulation of policy strategies might affect how problems are represented in policy strategies.

Women and girls´ SRHR in countries of conflict, poverty and humanitarian settings

Research conducted on previous humanitarian crises show that national status of crisis have been a recurrent factor to disrupt and postpone reproductive health services (Spiegel, 2004; Spiegel et al., 2007). Disruptions are prone to happen during humanitarian crises in countries where health systems are already under pressure. This tendency is often seen in coherence with the fact that conflict affected populations are vulnerable because of poverty and political instability, which consequently make the repercussions of the crisis persevere for a long period of time (Spiegel et al., 2007).

The gendered aspect of SRHR in humanitarian settings display that girls and women are exposed to risk of gross violations of human rights (Jewkes, 2007; Roxo et al., 2019). Women and girls in crisis situations are at particular risk of harm when social and structural support systems collapse. This includes reduced access to reproductive health services, HIV prevention, rape as a weapon of war, trafficking, coercion, transactional and/or survival sex to support one self and depending family members (Jewkes, 2007; Roxo et al., 2019). Furthermore, studies show that a large proportion of global preventable maternal deaths, under-5 deaths and neonatal deaths happen in humanitarian crises or fragile contexts and that 97% of all cases of unsafe abortions happen in fragile and limited resourced countries (Bhaba et al., 2015; Sedgh et al., 2016). Furthermore, women in areas of conflict are shown to be

disproportionately affected by negative health and social consequences of displacement as compared to men (E. J. Mills, Singh, Nelson, & Nachega, 2006). This literature reflects a deeper issue of gender inequality and an increased risk to sexual and reproductive unhealth for women and adolescent girls.

As a consequence of the COVID-19 pandemic, a similar tendency is witnessed. In the process of trying to control and stop the spread of the virus, women and girls are exposed to larger risks of SRHR, including reduced access to SRH related services such as safe abortion, contraceptives, clinical care and sexual education (Huang, 2020; Singh et al., 2020; United Nations Population Fund, 2020a, 2020b). The extensive consequences the pandemic might bring for the future of women and girls in countries of conflict, poverty and humanitarian settings, illustrates the importance of investigating the impact the current pandemic has on SRH services and SRHR in conflict affected countries.

Policy perspective and donor relationships in low income countries

Despite of the evident individual, economical and societal benefits of investing in SRHR, progress in this field has been slow in many countries, especially in low-income countries (Starrs et al., 2018). Factors such as weak political commitment, gender inequality as well as taboos concerning speaking openly about sexuality and the importance of sexual health are associated with slow progress in SRHR in low-income countries (Starrs et al., 2018). These inhibiting factors may also be embedded in national SRHR policy strategies. Subsequently, SRHR policy strategies will in some circumstances ensure the rights of SRHR while in other circumstances, fail to ensure these rights. SRHR strategies might fail in ensuring SRHR through ignoring topics like same sex marriage or focus on restriction of sexual contact, whereas other times, SRHR policy strategies might have a clear agenda to ensure SRHR, yet the political or economic environment of the country hamper the promised SRHR strategy (Starrs et al., 2018). Consequently, there are many factors involved in SRHR progress in low-income countries, and SRHR policy strategies is one important aspect of ensuring SRHR progress in a country.

Many low-income countries experience underfinanced health care, including SRH care, and this will often impact the adequacy of health care services. Prioritizing scarce resources, irregular service provision, unavailable interventions or geographical coverage are examples of challenges that might appear due to underfinanced health care (Masefield et al., 2020; Orach, 2009). Many low-income countries therefore depend on external donor support

to be able to provide health care services to their citizens. As such, major investments in SRHR are often provided by NGOs and International non-governmental organizations (hereby referred to as INGOs). Due to the current COVID-19 pandemic, there is now an extra call for urgent responses from outside stakeholders, particularly in low income countries with already stressed health systems.

A study conducted on challenges to effective governance in health care systems conducted qualitative interviews with different outside stakeholders operating in Malawi, to reveal their experiences and perceptions of the health system and decision making in health care in Malawi (Masefield et al., 2020). Masefield et al. (2020) found that external stakeholders viewed governance challenges as barriers to an effective and equitable health system in Malawi. One of the categories identified was unequal power in stakeholder engagement. In this study, one human rights organization talked about lack of political will in regard to financial variability in health care facilities, as the government was perceived to have authority over public services. Further, donors were perceived as the only stakeholder to have influence over the health system governance, but some reported that donors did not trust the government and as such operated in Malawi without governmental support (Masefield et al., 2020). Another study conducted on donor relationship, found that donors sometimes appeared to be political actors who used their funds to shape policies through "working behind the scenes" in order to manage operating in challenging contexts. Subsequently, the INGOs agency and power were concealed through different practices of secrecy (Storeng, Palmer, Daire, & Kloster, 2019). The study of Storeng et al. (2019) revealed how INGOs working in Malawi and South Sudan became key actors of SRHR policy development in these countries. They described a power asymmetry between donor and recipient since INGOs were believed to wield financial power as well as normative and epistemic power (Storeng et al., 2019). As many INGOs claim to derive from moral standards and expertise, these INGOs are believed to have greater influence on policy formulation and consequently formulated policies that resembled with their normative views and standards (Shiffman, 2014; Storeng et al., 2019). Arguably, these INGOs normative views and standards may sometimes inflict with perspectives of public health issues and burden of disease. As illustrated, financial limitations create barriers in ensuring equitable health access as well as quality services in many low-income countries. Consequently, manly low-income countries depend on outside stakeholder support to facilitate public health in their countries. Both Malawi and Palestine are countries

that are highly dependent on donor contribution and it is therefore reasonable to argue that power might be an aspect appearing when assessing COVID-19´s impact on SRH services and analyzing related policy documents.

Theoretical framework

This section gives an overview of frameworks and approaches used in the thesis. The theoretical frameworks are chosen as they are central to how policies are shaped and formed through discourse and different sources of power. Firstly, the theoretical approach of Bacchi´s (2009) "What´s the Problem Represented to Be" (hereby referred to as WPR) approach is presented and thereafter the theoretical frameworks concerning power and power structures are represented.

What is the problem represented to be?

Social constructionism takes the stance of emphasizing the importance of how our understandings of the world is produced by social forces (Burr, 2015). Pereira (2014, p. 111) argues that "if we understand how power operates through the knowledge embedded within certain discursive frames [..], we are better placed to resist the unquestioning authority of such knowledge". Bacchi´s (2009) WPR approach draws upon constructionist stances as the approach seeks to understand assumptions and taken-for-granted information in the way problems are represented in policy texts. In addition to capture how knowledge acts as truths and rules, the WPR approach also include the dimension of the privilege of governments to shape their versions of problems and as such make these problems constituted in legislations. This way, as Bacchi (2009, p. 33) states "[..] these versions of ´problems´ take on lives of their own. They exist *in the real*.".

Consequently, analyzing problem representations in SRHR and COVID-19 policy strategies in Malawi and Palestine lay the grounds for encompassing how the problem is constructed and rationalized and further how underlying assumptions of the problem representations are shaped by political environment, epistemological grounds and historical contexts. By using WPR approach, one can also look at what is not questioned nor problematized and what implications this gives for the problem and how it is thought to be solved through interventions in the policy texts. Through looking at problem representation, one can disclose and affirm deep seated cultural values.

What is power?

Traditional understandings of power often involve power as something an agent do with intent or as a property an agent have (Manokha, 2009). Contrary to describing power as a phenomenon of how one individual dominates over others or how one group or class is above others, Foucault (1980) introduces power as something that only function in chains or circulations. Foucault (1980) describe power as:

> Power is employed and exercised through a net like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only it´s inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application. (p.98)

This form of power is more specifically described as productive power and concerns how knowledge is produced, shaped, experienced and changed through discourse and social processes (Shiffman, 2014). Consequently, power can be understood as a mechanism that produces effects that affect others and possibly determine others´ outcomes. Productive power is often talked about as how we create meaning through categories that lead us to think about the world in specific ways and eliminates other ways of thinking about it (Barnett & Duvall, 2005). Further, through discourses of real-life practices and social fields, action is made possible, as these sites then become imaginable. Social fields of actions that are not talked about and shaped through discourses are not imaginable and therefore does not exist in the same way (Dreyfus, 1983). Productive power can, therefore, unfold in the way concepts about burden of disease, treatment cost effectiveness and the right to receive care are created (Shiffman, 2014). These concepts will affect policy priority and is therefore relevant when analyzing policies and assessing impact of health service access.

Reproductive governance and subject positions

How knowledge takes form through discourse and social processes will consequently produce effects that might affect others through forms of productive power (Manokha, 2009; Shiffman, 2014). Morgan and Roberts (2012) refer to reproductive governance as how different actors use legislation to control sexual and reproductive behaviors and practices. Reproductive governance is a concept building on Focault´s regimes of truth, that entails how history produce ideas that works as truths in the society (Focault, 1990). SRHR may involve moral truths which are tied to deeply rooted perceptions of sexual and reproductive behavior.

Consequently, moral truths can act like dichotomies for either appropriate or inappropriate sexual and reproductive behavior. This way, reproductive governance is an approach that aims to understand political rationalities regarding reproductive behavior. Therefore, reproductive governance looks at the power behind the creation of moral truths regarding sexual and reproductive behavior (Morgan & Roberts, 2012). The moral truths can affect how SRHR is perceived and in this way affect how problems of SRHR is represented in SRHR policy documents.

Following the logic of how reproductive governance and moral regimes can affect how reproductive behavior is perceived and represented as a problem, subjects with reproductive health and/or unhealth are also positioned within the problem representation. Individuals might, through discourse, be positioned in the frames of the problem representation in a policy text, since perceptions of human nature is thought to reinforce policy proposals. In this way, reproductive government discloses how governmental practices constitute "subjects" as "governable" through promoting characteristics that is perceived as good reproductive behavior (Bacchi & Goodwin, 2016, p. 50). Subsequently, whether subjects are positioned as either bearers or victims of a problem depends if they behave in accordance to the desired sexual and reproductive behavior.

Subjects are ascribed to subject positions that entails characteristics and behavior the subjects are encouraged to adopt. Scholars argue that subject positions might determine the subjects´ available course of action and subsequently reduce subjects´ margin to act (Bacchi & Goodwin, 2016; Boréus & Bergström, 2018, p. 361). This understanding of subject positioning draws upon the Foucauldian notion of subjectification, where the human actor is a subject acting upon and determined by, contextual conditions (Foucault, 1977; Staunæs, 2010). Therefore, one can argue that representing individuals as either bearers or victims or passive or active decision makers in the problem representation of a public health matter such as SRHR, might determine individuals' ability to maneuver to improve their health conditions.

Structural violence

Studies on gender inequality indicates that power relations regarding social structures, legislation and ideologies are contributive factors to gender inequality (George, Amin, de Abreu Lopes, & Ravindran, 2020). Consequently, power relations shape the social environment, and policy implementation over time can lead to structural determinants

attaining long term effects for groups under suppression (George et al., 2020). As Bacchi (2009) argues, policy documents might reproduce problem representations that are deeply rooted in social structures and society. Certain deeply rooted social structures or institutions may create barriers for some groups to fulfill their basic needs, a concept called structural violence (Galtung, 1969). In relation to SRHR and COVID-19 one can argue that if citizens experience challenges in accessing SRH services as a result of the pandemic, these citizens face structural barriers in fulfilling their basic SRHR needs. In fact, some scholars argue that COVID-19 has amplified inequities in specific SRHR issues that were existing prior to the pandemic, through the mechanism of structural violence (Nandagiri, Coast, & Strong, 2020). Along with the expressed worry of COVID-19 worsening SRHR through structural violence, previous literature on women and girls´ positioning in humanitarian settings emphasizes that women and girls´ SRHR are at particular risk during times of crisis (George et al., 2020; Jewkes, 2007; Roxo et al., 2019). Seeing this together with women and girls being continuously discriminated against in legislative and financial arenas (George et al., 2020), it is reasonable to draw the line between structural violence and women and girls´ SRHR in the current COVID-19 pandemic.

Chapter 4 Method

The thesis holds a two folded research aim and assess the impact of COVID-19 on SRHR services in Malawi and Palestine with a mixed methods study design. Consequently, the study composes two parts: part one containing a quantitative component and part two containing a qualitative component. Part one is a comparative analysis of survey data that displays how COVID-19 has affected family planning organizations in Palestine and Malawi. Part two is a critical policy analysis of documents on SRHR and COVID-19 strategies in Malawi and Palestine. The two parts are further incorporated by looking at the findings from the survey data in part one in relation to the critical policy analysis in part two. Accordingly, looking at the two parts together is thought to provide an in depth understanding of the impact of COVID-19 on SRHR in Malawi and Palestine. This section will elaborate on the methodological choices that were made along the way.

Part one: comparing survey data from family planning clinics in Malawi and Palestine

Data access

The impact of COVID-19 on SRH service in family planning organizations in Malawi and Palestine is explored through a data set from a survey conducted by The International Planned Parenthood Federation (IPPF). IPPF distributed their online survey to their 150 member associations (MA) across the world, to assess the impact of COVID-19 on the SRH service provision in their MAs. The family planning organizations of Malawi and Palestine are chosen to get a more in depth understanding of the situation in these specific organizations and countries.

Accessing the survey data from IPPF was made possible through cooperation with IPPF Norway and the selection of organizations was partly based on IPPF Norway´s cooperation partners. IPPF Norway works with the Norwegian Ministry of Foreign Affairs development project[1], which involves 17 partner countries. The 17 partner countries are divided into two categories: “cooperation countries for long term development” and “cooperation countries for stabilization and conflict prevention”. One country from each category is included in the study so that the countries would exhibit features suitable for a

[1] See https://www.regjeringen.no/no/tema/utenrikssaker/utviklingssamarbeid/partnerland/id2514932/ for more information

MDSD. The MDSD is a theory-driven small-N analysis, that is chosen to compare cases that are maximally different on all but the variable of interest (A. J. Mills, Durepos, & Wiebe, 2010). This method is suitable to understand the impact of COVID-19 on SRHR, especially since it allows a perspective of how the geopolitical context might give contextual understanding to the impact of COVID-19 on SRHR.

Additionally, "prevalence in literature" is added as a selection criterion, as access to supporting literature is important to supplement background information on the countries selected. The systematic search through the database Academic Search Ultimate included the search terms "sexual health AND access AND *partner country*". The country that gave most results in the category "long term development" was Malawi. In the category "need for stabilization and conflict prevention", there were fewer results, but as Palestine was prevalent in the literature search, this country was selected. Hence, the family planning organizations in Palestine and Malawi are selected for assessing the impact of COVID-19 on SRH services. The organizations in Malawi and Palestine were further contacted to gain permission and consent to use their specific data sets. As for ethical considerations, the two organizations are anonymized and labeled "Malawi Family Planning Organization" (MFPO) and "Palestinian Family Planning Organization" (PFPO).

About the data sets

Three surveys were sent out by IPPF to their MAs, throughout the year of 2020 to assess the impact of COVID-19 on SRHR service provision. The first survey was sent out in March 2020 and had a primarily focus on the nature, scale and disruption of COVID-19´s impact on organizations. The second survey was sent out in May 2020 with the focus of programming and operations during the pandemic. Lastly, the third survey was sent out in November 2020 and focused on assessing information on innovation and mitigation plans during the pandemic. As one of the organizations included in this study did not reply to the second survey, there are no grounds for comparison within this round and thus the second survey is excluded from the data analysis. Hence, the data sets from survey one and three are included in the analysis to assess the impact of COVID-19 on the services provided by PFPO and MFPO.

The data set provided by IPPF accommodated answers from the main office in each of the two MAs. That is, the main office responded on the behalf of all service delivery points (8 in Palestine and 64 in Malawi), including clinics, mobile stations, sexual education in school,

seminars and telephone hotlines in the respective countries. Consequently, the two data sets are compared, one representing the situation in Malawi, and the other representing the situation in Palestine. Because of the small *n* (*n* = 2) it was manageable to do the comparative analysis without using a statistical software and hence, part one is called a quantitative *component* of the thesis.

Procedure

Although the data sets are not analyzed in a statistical software, the analysis is conducted with a step by step, systematical procedure. Firstly, the data sets are read through four times to form a general overview of the material at hand. Secondly, in order to systematize the data, the survey questions are divided into the two following categories: "relevant for research questions" and "not relevant for research questions". The category "not relevant for research question" is excluded from the analysis, either because answers of the questions or the questions themselves would not contribute to answering the thesis´ research questions. One example of a question that is excluded due to neither of the organizations reported providing such services answer is "Does your MA provide in patient care or critical care during regular times?". A question that is excluded because of not being relevant is "Can we contact you for more detailed case studies, client´s experiences and other COVID-19 impact-related data that your MA may have access to, in order to complete the round 3 situation analysis data collection?". The category "relevant for research question" is included as this category included survey questions appearing to be relevant to this study´s aim. Examples of such questions are "as a result of COVID-19 measures, have any service delivery points in your MA stopped providing SRH services?" and "Which of the following program efforts have been cancelled/postponed due to COVID-19 measures in your country?".

The included questions are further synthesized to reveal the most central answers that provides an understanding of COVID-19´s impact on SRH provision in the two organizations of study. The synthesized data is the basis for answering both RQ 1: "In what ways has COVID-19 affected sexual and reproductive health services provided by PFPO in Palestine and MFPO in Malawi?" and RQ 2: "What are the similarities and differences between the service delivery provided by PFPO and MFPO during the crisis of COVID-19?".

Part two: policy analysis

Accessing policy documents

In part two, national policy documents are critically assessed through a power dynamic perspective. The policy analysis is based on policy documents updated after 2015 that pertained to SRHR and COVID-19 strategies in the two selected countries. The documents are accessed through governmental websites and the search engine Google. The search terms are constructed from reading secondary texts and policy documents related to the subject matter. The terms "SRHR policy and Malawi", "SRHR policy and Palestine", "COVID-19 policy and Malawi", "COVID-19 policy and Palestine" are used in the search process.

The national COVID-19 response strategy is accessed from Malawi MoH official website[2] and the SRHR strategy is accessed from United Nations Populations Fund (UNFPA) Malawi [3]. Due to language barriers, accessing governmental documents from Palestine were challenging. However, the COVID-19 response strategy is accessed in English through the official governmental Website in Palestine[4]. Regarding the SRHR strategy, UNFPA Palestine was contacted to request an English version of the SRHR strategy. An official English translation of the strategy was not available, but UNFPA Palestine gave permission to use their unofficial English version of Palestine´s SRHR strategy. Hence, the policy analysis is based on an unofficial English version of the Palestine SRHR strategy (2018-2022) and an official English version of the Palestine COVID-19 response strategy (2021) along with the official English versions of the Malawi SRHR strategy (2017-2022) and COVID-19 response strategy (2021). All four policy strategies are made in corporation with different national ministries, NGOs as well as INGOs. Central international actors for all four are different United Nation organizations, such as UNFPA, WHO and UNICEF. The different national and international stakeholders have been involved in both formulating policies as well as provided financial support in implementing policies.

[2] https://malawipublichealth.org/index.php/resources/COVID-19%20National%20Preparedness%20and%20Response%20Plan/National-COVID-19-Preparedness-and-Response-Plan_Version1_April%202020%201.pdf/detail

[3] https://malawi.unfpa.org/en/resources/national-sexual-and-reproductive-health-and-rights-srhr-policy-2017-2022

[4] http://palestinecabinet.gov.ps/WebSite/Upload/Documents/Corona%20Crisis%20Management%20version%20Final%20English.pdf

Basis of analysis

The policy analysis is inspired by Bacchi´s (2009) WPR approach. Bacchi (2009) has developed six analysis questions to use as guidelines for what to search for in a policy analysis. Due to time constraint and word limit of this thesis, three out of six of Bacchi´s questions are chosen to answer this study´s research questions. The following three analysis questions are evaluated to be most relevant to answer this study´s research questions, and are applied in the analysis of the policy documents to identify and examine ideas and dimensions of power:

1. What´s the "problem" represented to be in a specific policy?
2. What presuppositions or assumptions underlie the representation of the "problem"?
3. What effects are produced by this representation of the problem?

Procedure

The categories of data are identified through a deductive "top down way", as they are revealed through a social constructivist approach, and more specifically, through a critical analysis with a power dynamic perspective. The following text provides a step by step procedure of the analysis to get a clear and transparent guide of how the findings are constructed.

The first step in the policy analysis involved reading the documents to acquire an overview. Along this process, ideas of themes and codes are developed and further explored and reflected upon. These ideas mainly derived from Bacchi´s guiding questions. As the analysis is conducted with the theoretical perspective of power dynamics, the topics that appeared to be relevant to power are emphasized. The second step in the analysis is further generating the initial codes, as well as finding elements in these codes that answers the guiding questions from WPR. This process identifies several topics that appears relevant for representation of problem and power dynamics. Consequently, the analysis is achieved in an already existing coding frame. At this point, several of the initial ideas from the first stage of the process are revised. The third step involves understanding the relationship and context between the codes and to extract these into themes. The fourth step involves revising the themes as well as looking at the themes in relation to the wider meaning that the policy documents formed. The fifth step involves defining and naming the themes identified.

About the Methodological Design

Validity

Validity regards whether the instrument used measures what it intended to measure, and some scholars claim that using a methods-centric discussion is appropriate for examining validity in mixed methods study designs (Hesse-Biber, 2010). Due to the utilization of a mixed method study design in this study, the validity of this study is assessed through implications of using two different approaches to understand the data. Consequently, this studies' methodological choices have been under constant evaluation of whether the design procedure was conducted correctly. This included reflection about questions like "does the study give a good reason for using mixed methods?" and "does the study clearly state the mixed methods steps involved in analyzing the data?" (Hesse-Biber, 2010, p. 86). By asking these questions, the main focus of assessing the study´s validity is looking at the use of correct methodical elements rather than exploring the research findings´ validity. The strengths and weaknesses regarding the methodological choices in this study are therefore further elaborated in the following paragraphs.

Mixed methods

This study is conducted through a study design that includes both a quantitative and a qualitative component. Performing a comparative analysis of survey data and combining the findings with a critical discussion of related policies, incorporates two methodologies with rather different epistemological approaches. Quantitative methods convey to the theoretical background of naturalism which uses empirical data to provide basis for explaining phenomena. In this view, the concepts that are under study is thought to be objectively measured (Risjord, 2014). Qualitative measures, on the other hand, originates from interpretivist theory, and argues that concepts should be defined on the basis of how they are used by the person who provides the data, be that research participants or authors of a policy document. This is justified by the belief that knowledge is never neutral and always influenced by human interests (Risjord, 2014).

However, scholars argue that it is possible, and often beneficial, to make a theoretical bridge between the different ways of approaching data (Hesse-Biber, 2010). Using a combination of the two methodologies when assessing impact of COVID-19 on SRH provision in Malawi and Palestine, arguably gives the thesis a more comprehensive understanding of the issue that is explored. That is, the qualitative approach gives an

understanding of, and consequently strengthens, the findings from the quantitative component through a social constructivist approach. Operating with a mixed methods design in the service of a power dynamic perspective provided insight into the power of policy and the meanings constructed. This insight is thought to reveal answers about the impact of COVID-19 on SRH service in the family planning organizations in Malawi and Palestine. The two methods together are therefore thought to shed light on the complexities of the issues explored, that otherwise would not appear as relevant.

Quantitative component

The data from the survey are provided by the main office in both PFPO and MFPO. That is, there was one office each in Malawi and Palestine answering on behalf of all service delivery points provided by PFPO and MFPO. Further, the two organizations were different in size and scope of services, as MFPO has 64 service delivery points and PFPO has 6 delivery points. This distinctive difference might have skewed the data in the sense that organizations might have faced different effects due to COVID-19 depending on how many services they had to shut down or reduce. However, as a MDSD is applied in this comparative analysis, differences between the countries, as well as the organizations under study, are expected to appear and are seen as contributive to the study, through the process of making them visible. As such, the differences are thought to shed light to possible understandings of why the two organizations and countries faces different or similar challenges.

Furthermore, one of the benefits of using quantitative measures is normally being able to represent large samples that can be generalized. However, the data in this thesis does not represent a rigorous and independent data collection. The selection of data in this analysis have a low n ($n = 2$), and the data set cannot account for statistical significance, reliability or validity. Consequently, the findings face issues in regard to generalization. However, the data set does provide accurate numbers and text regarding how COVID-19 affected the service provision in PFPO and MFPO. Therefore, the data set is thought to contribute to the thesis´ aim by mapping challenges and changes in service provision due to COVID-19 in the two specific SRH organizations PFPO and MFPO. When the similarities and differences are further seen in relation to policy documents in the countries of focus, the study´s methods design give the thesis grounds for answering the research questions in a sufficient and comprehensive manner.

The online survey was designed to facilitate questions that 150 different MAs in different countries with different contexts, could answer. Consequently, the survey questions are general, open ended and possibly not equally accountable for all organizations. Because of this, the survey might not reflect the complete picture of the impact COVID-19 had on the different organizations. Moreover, as one of the organizations included in the analysis did not respond to the second round of the survey, this round is excluded from the analysis. This might give implications for the results as the relative change between the different surveys would perhaps not be as apparent as if the second survey were to be an additional point of comparison. However, survey one and two represent the first and latest update on the impact of COVID-19 on SRHR services in Malawi and Palestine, and consequently, these surveys does lay grounds of comparison on their own, especially in regard to assessing general impact over time. Bearing this in mind, the analysis therefore ensured a more general and simple comparison of data to provide findings of tendencies in development and similarities and diversities between the organizations in Malawi and Palestine.

Qualitative component

The document used to analyze the Palestinian SRHR strategy is an English unofficial version of the document. This should be taken into consideration as the analysis was not conducted on an official governmental document. However, the positive aspect of using this document is that it was made accessible in English through UNFPA and that the policy document is a translated version of the official policy document. Hence, the content in the unofficial document represents the Palestinian MoH´s strategical aim.

Another potential factor that should be mentioned, is that the SRHR policy strategies in Malawi and Palestine are formulated on a policy level and this does not necessarily represent how the policies are implemented in MFPO and PFPO. Thus, the study does not focus on whether the policies actually are implemented in MFPO and PFPO. As mentioned earlier, how the problem is represented to be is perceived to have implication for the policies as well as the direction of progress in the respective field of health (Bacchi, 2009; Starrs et al., 2018; Storeng et al., 2019). Consequently, the qualitative component aims to disclose how the problem of SRHR is represented in Malawi and Palestine which is believed to give a broader understanding of how COVID-19 has impacted the organizations' SRHR services.

Chapter 5 Results, analysis and discussion

This section comprises a presentation of the quantitative component, the qualitative component as well as an incorporation of the findings from the two methodological components. Consequently, these sections build upon each other, and the complexity of analysis gradually increases as the process evolves. That is, the first part consists of a mere description of the results of the survey data. The second part comprises both the description as well as an interpretation of the results of the analysis of the policy documents from Malawi and Palestine. Lastly, the third part embodies a complete discussion of theory and interpretation of the results in the quantitative component seen in the light of the findings in the qualitative component of the thesis.

Part 1: Quantitative component

This section contains a description of the findings from the comparative analysis of data from MFPO and PFPO. The results are described categorically and are presented in a chronological order, starting with the survey conducted in March 2020 and then moving over to the November 2020 survey.

March 2020 survey

Service delivery changes due to COVID-19

In regard to COVID-19´s impact on service provision, there is an obvious distinction between MFPO and PFPO. In the March survey, MFPO reports no reduction in the number of operational service delivery points, but the frequency of outreach activity has decreased as a result of COVID-19 measures. When asked about whether they had to scale down hours, sites or providers in their organization, MFPO reports having to scale down activities that required people to gather as this is against COVID-19 prevention guidelines. PFPO reports a reduction of operative service in both number and frequency of outreach activities. All of PFPO´s SRH service categories have scaled down either in the form of decreased hours, sites or providers. This includes HIV & AIDS services, sexual transmitted infections, abortion related services, contraceptive related services, SGBV services, gynecological services as well as SRH related counselling services and pediatric services. Thus, MFPO reports COVID-19 having an impact on operative services that requires gathering of people whereas PFPO reports an impact on all their operative services. Consequently, PFPO experience larger impact of COVID-19 on their operative services as compared to MFPO.

Government involvement

To prioritize health services, governments make use of different mechanisms to assure that these services are made available for their citizens (El-Jardali et al., 2019). One mechanism is through implementing an essential package of health services. Both the GoM and GoP declared SRHR as an essential part of the health care package during the pandemic of COVID-19. Related to this, MFPO reports that the package of health services made an impact on community based SRHR delivery, while PFPO reports that since many of their service delivery points had stopped providing SRHR services due to lock-down, they could not provide service in full. To summarize, the two organizations have the same government recognition of SRHR as a priority but are impacted differently by the essential package of health services due to the COVID-19 restrictions making it harder to provide services in general for PFPO.

Commodities, supply chain and distribution

Neither MFPO nor PFPO reports experiencing shortage of SRHR commodities, but PFPO reports delays in goods within country and from the government, while MFPO on the other hand does not. Both organizations report anticipating supply challenges due to border restrictions and curfews. MFPO emphasizes that the Malawi government has assured all essential supplies priority, while PFPO reports a worry of curfews and priority of the Palestinian MoH affecting the needs of COVID-19 provisions, delayal and cancelations of certain SRHR requests.

Advocacy, training & community engagement

Both MFPO and PFPO reports that training for health workers, community consultation and comprehensive sexuality education sessions being cancelled or postponed due to COVID-19. Additionally, MFPO reports COVID-19 having an impact on communication campaigns, which PFPO do not report. Both organizations listed physical meetings as a challenge which have led to cancelation and postponement of activities.

Human resources

Human resource, branches and field offices staff in MFPO operated as normal, while the staff in PFPO were operating from home offices. Neither of the organizations had to suspend or terminate staff due to COVID-19.

Management

In regard to management and critical assessment for the needs of the future, the two organizations emphasize different needs. MFPO reports experiencing a budgeted deficit due to COVID-19 expenditures and increased demands for infection prevention supplies. MFPO further report having to adjust their budget and to seek approval of this where necessary. Additionally, they expect increased expenditures related to maintaining social distance on the planned gatherings, as they have to arrange more gatherings because of national restrictions in number of people meeting. PFPO on the other hand, reports a need to provide kits to their beneficiaries, by reaching them in their homes with hygiene supplies and basic Family Planning methods. Further, PFPO reports needing phones and laptops to facilitate staff working from home, as to make consultations and awareness raising possible without face to face interaction. This was also regarded as important in order to provide hotlines free of charge for clients. Furthermore, PFPO reports needing prevention and protection supplies for service providers and clients after the lockdown when clients and staff were expected to meet physically again. They also report needing support to develop an app to increase access to SRH services in light of the fact that the majority of the population were in lockdown. This indicates that the issues for MFPO is more related to how COVID-19 directly had brought extra costs in regard to infection prevention provision and the extra cost of having to do SRHR related arrangements done more times than planned. PFPO, on the other hand, report more issues related to having functional and adaptive equipment to offer services in ways they had not offered before (online consultations, hot lines and awareness raising on online platforms). Even though PFPO mentions COVID-19 protection supplies, they touch upon the need for SRHR-related provision and technical services to assist the method of reaching out to clients.

Innovative SRH programming

Both MFPO and PFPO reports implementing SRH programs such as telemedicine, mobile health services or partnership with other sectors (online commercial platform or commercial service deliveries). MFPO make use of WhatsApp, Social media and the MFPO website and PFPO make use of Skype, WhatsApp and mHealth services. The nature of the service offered through these innovative approaches are for both organizations provisions of information and messages on SRH and referral services, and PFPO additionally mentions counselling service.

When asked about the interest and technological capacity to explore initiating program activities through virtual health services, MFPO reports that they would like to adopt technologies that support provision of counseling services via media platforms rather than face to face, having clinical follow ups and treatment choices as well as making use of other health technologies. They do not mention any lack of technological capacity. PFFPA on the other hand, reports that although they are currently providing psycho-social support through one hot line, they need more phone lines and computers/laptops for service providers to provide a larger scope of similar services as well as expanding their services through hot lines. Additionally, they also aim to provide sessions virtually for groups of youth and men, but experience barriers in doing so because of limited equipment as staff were working from home. PFPO reports being positive towards receiving any capacity building training for their staff in regard to any innovative methods that could be utilized in this aspect. They are now trying to use WhatsApp groups, Skype and Zoom meetings for virtual health services.

November survey

Changes in service delivery

In the survey conducted in November, MFPO reports having to reduce or adjust 25% - 49% of their services since June[5] due to COVID-19. Further, they report that COVID-19 measures has not made any service delivery points completely halt the provision of SRH services, but that there has been an overall decrease in their client load by 50-74% since June 2020. PFPO, on the other hand, reports 0%-24% of their operations being reduced or adjusted in the time frame June 2020 to November 2020 due to COVID-19. An interesting finding is that even though PFPO reports having an impact or reduction in their service provision due to COVID-19, they report an increase of clients by 25%-49%.

The change in service delivery for MFPO and PFPO from June to November are also somewhat different. MFPO reports a reduction in services related to HIV, contraceptives and sexual and gender-based services. Further, they report initiating the modes of service delivery of self-care for contraception, door delivery of SRH commodities as well as reorganizing their service delivery points to be COVID-19 secure. PFPO on the other hand, reports scaling up their service delivery from June to November, including services related to HIV,

[5] As mentioned previously, the survey conducted in June is not included in this comparison, but a number of the questions in the November survey uses June as a referral point for development in the impact of COVID-19. I chose to include these questions to get an understanding of overall development of COVID-19 impact.

contraceptives, sexual and gender-based violence, gynecology, obstetric, counseling and non SRH services. They report no change in abortion related services. PFPO have initiated remote/virtual consultation, counselling and follow up for SRH commodities as well as online prescription for SRH commodities and door delivery of SRH commodities and services since the outbreak of the COVID-19 pandemic.

Challenges

MFPO reports experiencing challenges with last mile distribution of SRH commodities at the current time the survey was sent out (November). PFPO also reports challenges with last mile distribution of SRH commodities, in addition to commodity procurement, supply and distribution. When reporting key challenges with each of the services provided by the two organizations, they report different barriers and different solutions (see table 1).

Table 1

Key challenges in service provision in MFPO and PFPO

	Malawi (MFPO)		Palestine (PFPO)	
	Key Challenges	How these challenges were dealt with	Key Challenges	How these challenges were dealt with
SRH service delivery	Ensuring that quality and safe service were being provided while ensuring that the safety of the service providers was guaranteed.	Ensuring Covid-19 prevention and making use of community structures for service delivery to relieve some workload for the clinics.	Closure of Service delivery points and limitations in number of participants gathering	Conducted remotely through phones and social media channels, door to door distribution of family planning methods
Youth Programming	Not applicable	Not applicable	Same as above	Conducted youth programming remotely and youth volunteers participated in remote sessions
Community engagement	Restrictions for group gatherings. This lasted over time until a few people were allowed to gather.	Meeting the community to share SRHR information. As smaller groups were allowed, MFPO utilized this even though it was costly.	Same as above	Follow up meetings and coordination via zoom meetings and phone calls in addition to distributions of kits.
Information provision	Packaging information to meet the needs of different age groups. Expenses due to using media as youths were now in their homes and not in the school. Therefore, there was also a need to balance what people would like to hear and what is important for each age group.	Working together with other members of the health cluster that assisted MFPO in learning about different approaches to make messaging both exiting and educational.	Same as above	Information provision was given through phones and social media channels.
Comprehensive sexuality education	Difficulties regarding reaching youths with this package virtually as most youths do not have access to phones and internet. In addition, physical meetings were almost impossible due to restrictions	Though expensive, MFPO continued to provide this package using the Youth Action Structure. This enabled some rural youths to access the information. With resources from many partners MFPO was also able to air SRHR information via radios and TV	Lockdown	Comprehensive sexuality education sessions were conducted digitally.
Advocacy on SRH	Not applicable	Not applicable	Lockdown	Meetings and follow up was conducted virtually with national committees
MA operations (HR and admin)	Increased expenditure on resources to support staff with airtime as they were working from home	MFPO communicated the need of airtime with donors and approval was granted for this expenditure. There was also an allowance for a few people to be operating on rotational basis especially on implementation to ensure that personnel costs were in line with some implementation on the ground.	Lockdown	MA operations were given from home via phones and social media, following up with clients etc.
Commodities management and supply	Not applicable	Not applicable	Lockdown, restriction in movement	Supplies were stored in homes of focal points in local community and through direct distribution the kits were distributed directly to homes of beneficiaries.

Note.

Future innovations

MFPO reports that their top three innovations in SRHR programs since the COVID-19 outbreak are increased door to door services, using the pandemic to push for youth participation and making use of Zoom and virtual meetings. PFPO reports the top three innovations in SRHR programs as distribution and food kits, utilizing social media channels to raise awareness sessions for women and youth and establishing a free of charge hotline for GBV services. Common for the two organization are therefore door to door services and making use of internet and social platforms to communicate and raise awareness of SRHR.

Gender aspect

The two organizations use the pandemic to address gender issues in different ways. MFPO reports addressing gender issues during the COVID-19 pandemic with participating in the campaign against rape in Malawi through a match and posts on social media. They also provide integrated SRHR, HIV and GBV services to people with emphasis on GBV during the pandemic. PFPO report taking action to address gender issues during the COVID-19 pandemic through hotline service as well as through kits of contraceptives and sanitary products distributed.

Part 2: Qualitative component

This section contains an analysis of policy documents on SRHR and COVID-19 in Malawi and Palestine. The findings are presented according to the three specific themes that appeared by focusing on the analysis questions inspired by Bacchi (2009), that regards problem representation, underlying assumptions and effect. The three themes "target level", "vulnerable groups" and "economic challenges and donor dependency" are presented in the following section. Extracts from the policy documents are used to underline the findings.

Level of target Malawi

Customary policy strategies usually have both individual and structural components integrated in their strategical aims. However, one of the most obvious distinctions between the four policy documents in this analysis appears to be whether the problems of SRHR and COVID-19 are represented as mainly arising from individual behavior patterns or if the problems are mainly represented to lay outside the hands of the individual.

Regarding what level the interventions are targeted at in the COVID-19 policy strategy and the SRHR policy strategy in Malawi, there is a clear distinction between the two strategies. In the COVID-19 strategy of Malawi the overall strategical aim is targeted at the structural level. This is illustrated by the following citation: "The plan has been developed to establish *operational procedures for preparedness and response* to COVID-19 based on risks identified by the Ministry of Health (MoH) and the World Health Organization and other emerging context-based criteria" (The Republic of Malawi, 2020, p. 10). This example illustrates how the problem of COVID-19 is represented to lay outside individuals' hands, and consequently believed to be a problem that should be solved by governmental action. On the other hand, the Malawi SRHR policy strategy has an overall strategical aim that targets interventions towards the individual level, and as such, the problem of SRHR in Malawi is represented as something that occurs from individual behavior patterns. This is illustrated by the following extract: "The goal of the program is to promote through informed choice, safer reproductive health practices by women, men and youth including use of quality and accessible reproductive health services"(The Republic of Malawi, 2020, p. 7).

The targeting level of interventions demonstrates important underlying assumptions about citizens´ role in facilitating good health. In the SRHR policy strategy of Malawi many of the interventions are targeted towards the individual level which holds the underlying assumption of citizens being bearers of the problem. Such assumptions portray individuals as "active citizens" that are responsible for their own SRHR risk management. On the other hand, the COVID-19 policy strategy of Malawi aims the overall strategical aim towards a structural/institutional level and as such, the underlying assumption comes forward as citizens being victims rather than bearers of the problem of COVID-19.

Level of target Palestine

The COVID-19 policy strategy of Palestine has an overall strategical aim to target the interventions towards the individual level. This is illustrated by the following extract: "National containment measures, supported by an evidence-based communications campaign to encourage our citizens to protect themselves and follow government guidance" (State of Palestine, 2020, p. 2). By encouraging their citizens to protect themselves and follow government guidance, the preventative measures of COVID-19 monitor an underlying assumption of citizens´ actions as being crucial to stop the spread of the virus.

In the SRHR policy strategy of Palestine, on the other hand, it is stated that "Through the process of strategic planning for the SRH sector, the MoH seeks to institutionalize and develop SRH services and programs and integrate gender issues into the national policies of key sectors that target women´s empowerment"(State of Palestine & Ministry of Health, 2018, p. 7). Thus, the SRHR strategy of Palestine seems to have an overall strategic aim to target the institutional/structural level. This notion is further strengthened as SRHR is understood through a social paradigm, as illustrated in the following extract:

> This strategy considered the status of SRH in Palestine and national efforts to achieve sustainable development in this area. It developed strategic frameworks for its development, in addition to developing an action plan for the upcoming five years. This is in line with the national priorities, including safe pregnancy and childbirth, SRH for all, and the sustainability of the SRH sector, as an essential element in the Palestinian health sector. (State of Palestine & Ministry of Health, 2018, p. 3)

Vulnerable groups Malawi

The policy documents frames challenges and risks related to vulnerable and marginalized groups in different ways. Social factors such as being a member of a marginalized group or having certain economic and social statuses are described as factors that could make some groups at larger risk of infection by the COVID-19 virus in the Malawi COVID-19 policy strategy. Subsequently, the problem of COVID-19 is framed through a health gradient approach, making structural factors a solution to the problem of COVID-19. As the COVID-19 policy strategy of Malawi has an overall strategic aim to solve the problem of COVID-19 at the structural/institutional level, the Malawi government creates specific economic and environmental contexts to reduce the harm of these groups risk of getting infected by COVID-19. This representation of the problem of COVID-19 in the Malawi strategy, further illustrates how groups affected by COVID-19 as victims rather than bearers of the problem of COVID-19.

The SRHR policy strategy of Malawi puts an emphasis on women's vulnerable position in the problem representation of SRHR. However, the representation of the problem of SRHR clearly frames SRHR as a woman´s issue. This can be illustrated in the representation of GBV facts: "34% of women are physically abused, 20% have experienced violence while pregnant" (The Government of Malawi, 2017, p. 31). Here, women are given a subject positioning in the problem representation of GBV, while the man´s subject positioning

in the problem representation of GBV is silenced. The subject positioning of women as active and men as passive service seekers are further illustrated by the following citation: "[…] although knowledge of family planning is high and almost universal at 99%, the unmet need for family planning among married women is at 19% […]"(The Government of Malawi, 2017, p. 24). The effect of framing GBV and the usage of family planning as a woman´s issue, is directing the majority of the interventions towards how women, rather than men, can change their behavior in these issues. The active role of women is further demonstrated by the problem representation of unprotected sex in the following citation: "Emergency contraception shall be made available to all women who have had unprotected sex" (The Government of Malawi, 2017, p. 25). As exemplified, the interventions regarding the problems of GBV, unmet family planning and having unprotected sex are directed towards women´s rather than men´s, active role in SRHR management. Subsequently, men´s role are neither emphasized as constitutive, nor the solution, to the problem of GBV, unmet family planning and unprotected sexual behavior.

However, there is one section in the Malawi SRHR policy strategy called "male involvement in reproductive health" which aims to promote men's role in SRHR. Nonetheless, this section continues to target women and frames male unfriendly practices as well as women as a part of the issue of males not being involved in SRHR. This is demonstrated by the following statement: "Male unfriendly infrastructure at the health facility, illiteracy, ignorance, poverty, increasing rural urban migration, and cultural beliefs contributes to lack of involvement in SRHR issues" (The Government of Malawi, 2017, p. 32). Here, the initiative to involve men in SRHR is not constitutive of the man´s active role in SRHR involvement, it is rather an assignment of the passive role of men, that needs a facilitated environment to be involved in SRHR. Furthermore, one out of the four proposed interventions contrast the subjected passive role of the man with the subjected active role of the woman. This is illustrated by the following extract: "Encourage couple initiatives, i.e. women to personally invite their husbands to patronize SRHR services" (The Government of Malawi, 2017, p. 32). As such, the problem representation of "male involvement in reproductive health" further demonstrates the positioning women have been subjected to in the strategy, namely having the active role of SRHR risk management.

Consequently, even though the position of vulnerable groups is emphasized and included in the Malawi SRHR strategy, these groups are framed to be constitutive to the

problem of several SRHR issues and these groups´ behavioral change are perceived to be the main solution to SRHR problems in Malawi. By placing the accountability of SRHR to women rather than to structural factors, these policy documents constructs SRHR risk as individualized rather than socialized. Individualizing "bad" reproductive health might lead to the conception of illness stemming from "bad" individual behavior patterns rather than structural mechanisms unproportionally affecting some groups in society, referring to the concept of reproductive governance (Morgan & Roberts, 2012). An effect of holding such assumptions can potentially be generating stigma and discrimination towards individuals that gets ill (Bacchi, 2009).

Vulnerable groups in Palestine

The Palestinian COVID-19 strategy address vulnerable groups´ position during the pandemic, as illustrated in the following extract: "The GoP approach is containment and suppression, which is designed to protect our citizens (particularly the most vulnerable) from infection while also mitigating the stress on our already strained health system" (State of Palestine, 2020, p. 2). Even though it is not explicitly stated who the vulnerable groups are in this context, the Palestinian COVID-19 policy strategy has an overall strategical aim of protecting the public with an emphasis on vulnerable groups against the infectious disease. It is noteworthy that the policy strategy states that the GoP does not have the capacity to cover other social or economic consequences of the pandemic. This is illustrated in the following extract: "We will also have insufficient funds to cover the scheduled government transfers to the most vulnerable population, with greater numbers of Palestinian expected to need government support due to the economic impact of COVID-19" (State of Palestine, 2020, p. 6). Thus, vulnerable groups are discussed and accounted for in the Palestinian COVID-19 policy strategy, yet it is stated that financial obstacles may come in the way of ensuring sufficient protection. Additionally, the vulnerable groups are only described through a biomedical paradigm of health. That is, through ensuring the absence of ill health caused by COVID-19 infection.

The strategical aim of the Palestinian SRHR policy strategy is, as mentioned above, directed towards a structural level. The main objective of the strategy is to ensure availability and access to high-quality SRHR services. In the section of ensuring availability and access to high-quality SRHR services, all ten policy interventions are targeted towards a structural/institutional level. This is illustrated by the following extract: "Providing and

integrating preconception services and counseling for young spouses in primary care services." (State of Palestine & Ministry of Health, 2018, p. 20). Here, the problem of preconception services is represented to be inadequate access to services provided by institutions that provides SRH services. Subsequently, Palestinian citizens lacking preconception are represented as victims of the problem of not being able to utilize preconceptions, as the accountability of this issue is placed on an institutional level. However, interventions regarding promotion of SRHR across different age groups are directed towards individual levels in the Palestinian SRHR strategy. The problem representation of fertility rates in Palestine demonstrates a subjected active role of women and a subjected passive role of men in interventions aiming to reduce fertility rates in Palestine. This is illustrated by the following example of intervention: "Providing and supporting nutritional promotion services for women and children of reproductive age. Providing nutritional supplements, observing health indicators, and awareness and counseling" (State of Palestine & Ministry of Health, 2018, p. 25). This intervention entails promotion SRHR across different ages, yet the intervention merely abbreviates the women´s role in preconception, nutrition, raising community awareness and training. Hence, the silenced aspect of the problem representation of SRHR subjects a passive role of men. The active role of women and the passive role of the men in SRHR is further illustrated by "Community awareness about the importance of men´s participation in supporting wife SRH" (State of Palestine & Ministry of Health, 2018, p. 25). Here, the men are subjected as having supportive roles rather than active and essential decision maker roles regarding SRHR. Consequently, the underlying assumption is brought forward as men having a passive role in SRHR.

Economic challenges and donor dependency Malawi

Financial constraint is a topic described as a problem in both the COVID-19 policy strategy and SRHR policy strategy of Malawi. In the COVID-19 policy strategy of Malawi it is repeatedly mentioned that the country has limited resources and are dependent on outside stakeholders´ involvement as they already had great challenges in regard to health and preparedness systems prior to the COVID-19 pandemic. This is illustrated by the following statement in the Malawi COVID-19 policy strategy:

> Government institutions at the national and district level face many challenges, including the following:

- Scarce financial resources for maintenance of existing disaster response structures and to ensure effective emergency response
- Inadequate capacity (human, technical, material and financial) for coordination at both national and district levels which negatively impact timely and effective assessment, response and information management during disasters. (The Republic of Malawi, 2020, p. 19)

The challenge of financial resources is further illustrated by the following extract: "The major operational constraint in the implementation of the plan is unavailability of resources. The cluster will engage all stakeholders in mobilizing resources for the implementation of the activities." (The Republic of Malawi, 2020, p. 31). Accordingly, the problem of stopping the spread of COVID-19 is represented partly as having to do with financial limitations in the implementation of interventions that are represented as solutions to the problem of COVID-19. As expressed in this section, economic challenges are the most apparent limitation with implementing interventions in the Malawi COVID-19 policy strategy. Consequently, the policy strategy states that donors and outside stakeholders have important roles in the accountability of implementing interventions. The assumption behind the essential role of donors and outside stakeholders, is that Malawi needs economical support if they are to get control over the COVID-19 pandemic and the effect of this is donor dependency.

As parts of the government's budget is covered by external stakeholders, the budget is described to be rigid in regard to reorganizing existing resources. In line with this, donor dependency presents its own set of challenges, in the way that the budget could become strictly set and leave less room for flexibility. This is reflected upon in the Malawi COVID-19 strategy when describing challenges of: "availability of new funding and possibilities of re-programming existing resources (flexibility)" (The Republic of Malawi, 2020, p. 67) and further: "current funding is tied to the 2019 flood response. Partners are exploring the possibilities of re-programming" (The Republic of Malawi, 2020, p. 56).

The problem representation of financial barriers is also witnessed in the SRHR policy strategy of Malawi. Economic challenges is a recurring topic in the strategy, and it emerges through the justification of why spending money on SRHR is important: "The Malawi Government is committed to implementing the comprehensive and integrated approaches to SRHR despite financial and institutional challenges" (The Government of Malawi, 2017, p. 6). The country´s economic challenges further appears though statements such as: "The

government of Malawi is making efforts to provide substantive financial resources to SRHR services, however, there is very high and overwhelming demand for SRHR services and therefore the allocated resources are not adequate" (The Government of Malawi, 2017, p. 18). Furthermore, the SRHR policy strategy of Malawi states how much of their budget is accounted for by NGOs "The Christian Association of Malawi and other private-non-for-profit NGOs provide about 37% of the health care services" (The Government of Malawi, 2017, p. 16). As such, a large part of the budget covering SRHR issues are funded by stakeholders other than the government. Hence, the problem of both SRHR and COVID-19 are represented as being partly due to economic challenges in Malawi´s policy strategies.

Economic challenges and donor dependency Palestine

The dependency of international funding and the economical aspect was represented as a problem arising from being under Israeli occupation in the COVID-19 policy strategy of Palestine. This is illustrated by the following statement:

> As a nation already suffering from a decades-long military and economic occupation, we recognize that the State of Palestine is already handicapped in our fight to contain the COVID-19 outbreak. We do not have the necessary sovereignty (control over borders, etc) and national resources (medical, financial, etc) to cope with a significant outbreak, particularly when our population has many high-risk characteristics (crowded cities and refugee camps, poverty, food insecurity, non-communicable diseases etc.). (State of Palestine, 2020, p. 5)

Here, the policy document clearly express that the economic situation of Palestine constitutes many of the challenges Palestine faces in the current COVID-19 pandemic. The underlying assumption behind this problem representation is that Palestine depend on funding and support if they are to ensure public health for their citizens. Further, as Palestine is under occupation of Israel, the strategy of COVID-19 stresses an additional power dimension that include both Palestine´s financial constraints and constraints regarding receiving donor funding. This is illustrated by the following citation:

> […] the Government of Palestine is not able to raise funds through the methods used by other countries due to challenges imposed on us by the occupation: namely we are not able to borrow money as a state from international mechanisms and we cannot lower interest rates or print additional money, because we do not control our own currency. (State of Palestine, 2020, p. 7)

As exemplified, in addition to representing the problem of COVID-19 as partly related to donor dependency and financial constraints, constitutive to the problem is the fact that Palestine do not have full financial control because of Israeli occupation. The financial aspect of the problem is therefore represented by underlying power dimensions that arguably create additional barriers to the COVID-19 response.

In the SRHR policy strategy of Palestine the economical aspect of ensuring public health is not explicitly represented as a problem even though the state´s reliance upon on international involvement and support is emphasized. The emphasis of NGOs´ involvement in SRHR is illustrated by the following citation in the SRHR policy strategy of Palestine:

> The non-governmental and private sector play a central role in providing services, spreading community awareness, and highlighting SRH issues" (State of Palestine & Ministry of Health, 2018, p. 8) and further "Civil society and non-governmental institutions in Palestine play a major role in the SRH sector, along with effective contribution to the service delivery, it works effectively, in collaboration with the government sector, on raising the level of knowledge, awareness and development of young people´s life skills in SRH field. (State of Palestine & Ministry of Health, 2018, p. 8)

This extract illustrates that even though the problem is not explicitly represented as arising from economical limitations, the underlying assumption of emphasizing gratitude for NGOs, is that there does exist economical restraints in working with SRH issues merely from the country´s health budget. The effect of this assumption is dependency, and as such this was a theme present in both the COVID-19 and the SRHR strategy of Palestine.

Incorporating part one and part two

This section interprets the findings in part one in light of the findings in part two. The interpretation is based on theory accounted for in chapter 2. This is thought to give a broader understanding of how COVID-19 have impacted the two organizations in Malawi and Palestine.

Differences and similarities in impact and why

The main difference between the countries is how COVID-19 has impacted specific SRHR services in PFPO and MFPO. The results from the empirical survey indicate that PFPO experienced more services being shut down and a higher decline of service operations than MFPO, due to COVID-19. This difference is additionally evident in the policy documents of

Malawi and Palestine, as both strategies in both countries untangle different challenges the two countries deal with. The countries are distinctive in regard to population size, political context and financial challenges (Bosmans et al., 2008; Chansa et al., 2018; Giacaman et al., 2003; Kanyuka et al., 2016). Both Malawi and Palestine are small and densely populated countries. However, they do differ as Palestine has two separated self-governing territories, namely Gaza and the West Bank. Even though both countries have high population rates in relation to their land areal, the COVID-19 pandemic has struck Palestine much harder compared to Malawi, both in severe numbers of detected COVID-19 cases and consequently also by strict restrictions and measures to postpone the spread of the virus (UNICEF, 2021b; World Health Organization, 2021). Arguably, the larger scope of COVID-19 cases in Palestine compared to Malawi, led to stricter restrictions in Palestine. Facing both the challenge of strict restrictions as well as dived geographical area and asymmetrical power dynamics from being under occupation, these factors might be thought to contribute to an understanding of the witnessed differences in SRH service provision in Palestine and Malawi.

As discussed, the strategies of COVID-19 were targeted towards the structural level in Malawi and towards the individual level in Palestine. Underlying reasons for this difference could hold a range of factors, yet, the power dimension of being under occupation in the case of Palestine stands out as a major challenge for the GoP. Arguably, not having sovereignty over land, resources and consequently also their health capacity is partly involved in why many of the measures implemented to stop the spread of the virus is targeted at the individual level. Additionally, their unacknowledged status as a sovereign state makes Palestine face difficulties also with receiving funding from outside stakeholders. Studies from previous crisis in Palestine reported restrictions of humanitarian organizations involvement in providing medical treatment and contraceptives as well as military checkpoints acting as barriers for health care of women in delivery (Bosmans et al., 2008). It is therefore reasonable to argue that the asymmetrical power dimension of being under occupation is affecting how Palestine target interventions to ensure public health. Subsequently, the most effective way of stopping the spread of COVID-19 is considered to be making their citizens active decision makers who have to manage their own risk of infection.

On the other hand, Malawi has indeed financial limitations, but these limitations are of other origin than Palestine´s financial challenges. The GoM do, contrary to the GoP, have room for action, as they do have sovereign power over their land, finance and health system. Having

sovereign control over land, finance and health system stands out as an important component of the strategical aim of the analyzed policy documents. As seen in the Malawi COVID-19 and SRHR policy strategy, Malawi are offered more support from outside stakeholders compared to Palestine, and arguably this enable the GoM to target the COVID-19 strategy at a structural level. In this way, the GoM leave the risk management regarding COVID-19 infection to the government and the citizens´ are therefore framed as victims rather than bearers of the problem of COVID-19 in Malawi.

Donor Relationship

The problem representation and the underlying assumption behind donor relationships should be understood within the context of asymmetrical power dynamics, especially through the dependency it discloses. Even though productive power produces positive outcomes and progress in health policy, studies also show that unequal power relationships in stakeholder engagements may act as barriers in policy making (Masefield et al., 2020; Storeng et al., 2019). In relation to this matter, both Malawi and Palestine experience challenges in their health systems due to COVID-19 and are dependent of donor contribution. In this case, the power dimension emerges from donor dependency, which acts as a consequence of the two countries´ financial situation.

Further, the policy strategies analyzed are in part formulated and implemented trough financial support from NGOs and INGOs. This discloses yet another power dimension as some scholars argue that donor dependency may follow both financial power as well as normative and epistemic power over the recipient countries as these organizations claims that they derive to global moral standards and professionalism (Shiffman, 2014). It could be argued that NGOs and INGOs have the financial power to influence strategies´ focus areas as well as implementation and prioritizing of policies in both Malawi and Palestine. Scholars argue that productive power entails creating concepts of how to think about priority settings such as burden of disease (Shiffman, 2014), which is an interesting aspect of how COVID-19 has, and arguably still is, affecting SRHR in Malawi and Palestine. Following this line of thought, influence from stakeholders might, through asymmetrical power dimensions, affect the prioritization of one public health area (possibly COVID-19) over the other (possibly SRHR). That is, in every power relationship, there may appear conflicting approaches and contextual disparities in how to understand the problem and therefore also how a problem is represented (Bacchi, 2009; Storeng et al., 2019). As all four policy documents were made in

cooperation with different INGOs and NGOs, it can be argued that ideas of health and how to evaluate the burden of disease in the analyzed strategies has been influenced by INGOs and NGOs through their understandings and priorities of health issues. As central outside stakeholders mainly were UN organizations and WHO, arguably, this is through a western understanding of burden of disease.

The COVID-19 pandemic undoubtedly acts as a serious threat to public health in Malawi and Palestine. At the same time, all evidence speaks for SRHR and access to SRH services being essential for health development in these two countries. COVID-19 is a at the center of priority in almost all parts of the globe and this clearly put other policies, such as SRHR, on hold. The empirical material from the survey in this thesis show that SRH care in Malawi and Palestine have been seriously impacted by the current COVID-19 pandemic. As INGOs, NGOs as well as private donors do exercise power, be that voluntary or involuntary, they will have a share in shaping the global discourse of which policy areas should be given most priority. The empirical data from both organizations indicates that the COVID-19 strategy is given more weight than the SRHR strategy in both countries. Even though the prioritization of COVID-19 to some extent needs to be expected, it is important to question and juxtapose the consequences this priority setting follows, especially bearing in mind the severe impact low priority of SRHR might bring for citizens´ SRH services and consequently SRHR in general in the countries of Malawi and Palestine.

Human rights aspect

Both Malawi and Palestine acknowledge SRHR as a human right by using a definition of SRHR that describes SRH as a human right. The definition that is used in Malawi and Palestine´s SRHR policy strategies includes the right to achieve the highest attainable standard of health as well as physical, psychological, intellectual and social safety and as access to quality SRH services. By legitimizing SRHR as a human right, the policy strategies emphasize why SRHR is important for health development. However, many of the measures made to stop the spread of COVID-19 in both Malawi and Palestine´s COVID-19 policy strategies includes restrictions of personal movement and limited close contact. The comparative analysis of SRH services provided by PFPO and MFPO revealed that the organizations had to reduce services like HIV care, abortion care and in person counseling due to COVID-19. Previous evidence indicates that shut down of clinics and shelters during the pandemic might make women and girls even more vulnerable, because of other mediating

factors following the pandemic (Singh et al., 2020). As an example, factors such as losing income, social stress and lack of childcare in conflicted settings are shown to be related to increases in GBV in both Malawi and Palestine and thus illustrates the importance of having places to seek treatment or/and shelter accessible for people in vulnerable positions (Courbage et al., 2016; UN Women, 2021). As COVID-19 restrictions are affecting the adequacy of SRH service access, these results indicate that COVID-19 strategies does affect SRHR. From a human rights perspective, one can argue that citizens of Malawi and Palestine risk a violation of the human right to achieve the highest attainable standard of SRHR, because of inadequate SRH service access.

Emphasis on marginalized groups

The social paradigm of not being able to access essential health care services, such as SRH services, is not emphasized nor questioned in either of the COVID-19 policy strategies analyzed. This is an interesting finding as the problem is represented to be purely biomedical, that is, merely trough ensuring extra protection against COVID-19 infection for vulnerable groups. Consequently, the repercussions vulnerable groups in both Palestine and Malawi might experience due to the strict restrictions, are silenced in both the COVID-19 policy documents. Because neither of the COVID-19 policy strategies in Malawi nor Palestine considered how the means to stop the spread of the virus might make these groups extra vulnerable, these effects are not accounted for in the current pandemic. Furthermore, the data from MFPO and PFPO reveals that both organizations experienced a decline in service provision, service operation and minimal face to face treatment. Evidence predicts that vulnerable groups, especially in low-income countries, face additional challenges from the pandemic than the biomedical one as being infected by the virus (Lindberg et al., 2020; United Nations Population Fund, 2020a, 2020b). As barriers in accessing SRH care is a reality, it is reasonable to argue that women and girls in Palestine and Malawi faces larger risk of sexual and reproductive unhealth. Not accounting for this type of harm in policy strategies, illustrates a tendency of how women and girls are positioned in the pandemic.

Structural violence and subject positioning

Previous literature indicates that barriers in access to SRH services might be harmful to women and girls´ SRHR (Barot, 2017; Sedgh et al., 2016) and it is therefore reasonable to argue that women and girls might be prone to be exposed to harmful effects of COVID-19 as they were already vulnerable prior to the pandemic. Disputably, the pandemic might cause

harm on these groups in other ways than strictly attached to being infected by the COVID-19 virus, as women and girls face the risk of having reduced access to SRH services due to COVID-19.

In the way the problem is represented in these policy strategies and the outcome of COVID-19´s impact on SRH services, one can argue that social structures creates barriers for these women to fulfill their basic needs, which make them prone to structural violence (Galtung, 1969). Furthermore, the SRHR strategies in both Malawi and Palestine give women the subject position of being active decision makers regarding SRHR, whereas men´s role are not emphasized in the documents and thus given the subject position of passive participants regarding SRHR involvement. Accordingly, rather than challenging ingrown patriarchal structures, women are given their subject position through patriarchal structures as well as they are made accountable for improving SRHR outcomes. By reproducing deeply rooted moral truths regarding perceived responsible reproductive behavior (Boréus & Bergström, 2018; Morgan & Roberts, 2012; Nandagiri et al., 2020), women are constructed as either good or bad reproductive citizens depending on they act in the desired reproductive behavior. This can potentially create a discordant understanding of the cultural ideals of SRHR and women´s lived realities of SRHR. Arguably, a double burden is laid on these women.

Ending on a positive note

Even though COVID-19 in most ways acts as a barrier for MFPO and PFPO, the two organizations express innovative solutions of offering services during the pandemic. Both organizations emphasize virtual care through different programs of communication. An interesting finding is that PFPO reported that COVID-19 had an impact or reduction in their service provision due to COVID-19 in addition to reporting an increase of clients. These findings indicate that even though PFPO had to reduce their operational service delivery points, they found other ways to provide services to their clients as they experienced an increase in client load. As for the situation of MFPO it seems like they were able to still operate with the same amount of service delivery points, but that it was the client´s choice of not making as much use of the services, hence the decrease in client load. This illustrates how the institutional structures of Palestine potentially might give more space for creative innovations than for the institutions in Malawi as the COVID-19 strategies in the two countries were aimed at different levels. These findings point to how local and geographical contexts might facilitate innovate technologies to provide SRH services during times of crisis.

Chapter 6 Conclusion

To get a comprehensive understanding of the impact of COVID-19 on SRH services and SRHR in Malawi and Palestine, this study utilized a mixed methods study design and comprises a two folded research aim. The first part of the study investigated data concerning the impact of COVID-19 on SRH services in MFPO and PFPO. The data was used to understand what ways COVID-19 has affected SRH services as well as the similarities and differences between the service delivery provided in the two organizations. The data revealed that the pandemic made both MFPO and PFPO reduce or shut down several of the SRH services they provided. This includes both medical treatment and SRH-counseling. In terms of differences between the two organizations, PFPO reported a larger impact on offered services, shut down of clinics and number and frequency in service provisions compared to MFPO. Interestingly, a positive impact of the pandemic is that both MFPO and PFPO reported an increase in e-services due to the pandemic, including virtual consultation, e-learning, and mobile health. The data further suggest that this development was necessitated by the COVID-19 restriction's impact on service provision. As a possible result of innovative thinking, PFPO even reported client growth. The different contexts of Malawi and Palestine and their different needs and experiences with, especially innovative technologies for service provision, brings alternative perspectives on progress of SRH service. Arguably, these perspectives may contribute to future interaction between local and global actors when influencing the direction of health system development through innovative solutions of SRH service provision.

The second research aim contains a policy analysis of SRHR and COVID-19 policy strategies in Malawi and Palestine. To understand the impact of COVID-19 on SRH services provided by the organizations, the problem representation in Malawi and Palestine´s national SRHR and COVID-19 policy strategies was analyzed. The assessment of the problem representation was further seen in light of the power dynamic perspective and uncovered concerning trends in power asymmetry within the policy documents. The problem representation of SRHR and COVID-19 in the national policy strategies gave access to a comprehensive understanding of the impact of COVID-19 on SRH services and SRHR in general. First and foremost, women and girls' position during the pandemic become apparent when viewing the policy analysis and the impact of COVID-19 on SRH services together. The empirical material from the survey illustrates how the pandemic has reduced SRH service

provision in Malawi and Palestine. In addition to meeting barriers in obtaining the highest attainable SRHR through reduced access to SRH services, the policy analysis also indicates that women and girls are framed as bearers of the problem of SRHR in Malawi and Palestine´s national policy strategies. Further, the analysis of the SRHR policy documents in the two countries, indicates that the impact of COVID-19 might potentially abbreviate the positioning of vulnerable groups in Malawi and Palestine. These groups are given the subject position as active care seekers and at the same time they experience reduced access to SRH services they need for fulfilling SRHR, due to COVID-19. Because of their subject positioning as active care seekers in the strategies, these groups are destined to be "bad" reproductive citizens during the current pandemic. The impact the COVID-19 restrictions might have on women and girl´s positioning during the pandemic is something that is discussed both in the media and by political agents (Collinson, 2020; "COVID-19 risks exacerbating women's vulnerabilities in Palestine, warns UN Women," 2020; Ford, 2020; Tembo, 2020), yet this outcome of the pandemic is not accounted for in Malawi nor Palestine´s COVID-19 policy strategy. This is a troublesome finding when the demand of SRH care continues to rise (United Nations Population Fund, 2020a, 2020b), and the supply side of SRH services are evidently reduced due to COVID-19.

This thesis has, by combining the two parts in a MDSD, illustrated the importance of considering geopolitical context when policy makers prioritize policy areas. As both Malawi and Palestine are to a large extent dependent on donor support, the donors do to some degree exercise financial and moral power and, at least to some degree, influence how policy areas are prioritized. Consequently, an important note to take away from this study is the importance of evaluating the burden of disease within a contextual frame. Only by doing this, one can ensure exposing the public to the least harm. Even though COVID-19 is a threat to public health, the efforts made to postpone the spread of the virus is clearly threatening other public health areas, such as SRHR. The contextual background of Malawi and Palestine show that women and girls become especially prone to risk if their access to SRH care are not ensured during times of crisis.

Concluding remarks and directions for future research

Clearly, SRHR is an important public health issue that should be considered a priority also during times of crisis. While the need of SRH services arguably will rise as months pass with strict COVID-19 restrictions affecting citizens access to SRH care, SRH services are reduced

and shut down due to COVID-19. This study illustrates why the pandemic can give immense consequences for SRHR progress in countries such as Malawi and Palestine as well as how it might give disproportional harm for women and girls´ SRHR. Furthermore, the power asymmetry in donor relations points to a need for governmental involvement in order to exchange knowledge of burden of disease and the geopolitical context of the country that receives donor support. If not, one risks lack of coordination between different stakeholders which may lead to sub-optimal outcomes for public health, and in this case for SRH services and SRHR of the general population in Malawi and Palestine.

COVID-19 has, and will likely continue to have, an impact on SRH services and SRHR in low- and middle-income countries for the foreseeable future. This study illustrates what areas might be of interest for future studies concerning the pandemics´ impact on SRH services and SRHR over the coming years. In this study, two organizations, one in Malawi and one in Palestine, have been assessed to understand how the COVID-19 pandemic has affected service provision in these organizations. Even though these organizations provided data for service provision country wide, other SRH service providers in Malawi and Palestine have not been accounted for. In this respect, future research should incorporate complementary SRH service providers in order to draw the full picture of SRH service and SRHR during and after the COVID-19 pandemic.

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