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COMMENT

# Women's Reproductive Health and Rights Through the Lens of the COVID-19 Pandemic

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The United Nations Population Fund (UNFPA) and The Regional Office for Asia and the Pacific have demonstrated that sexual and reproductive health and rights (SRHR) are critical challenges for public health that demand significant global speculation and investment.[1,2] In 2018, the Guttmacher-Lancet Commission on SRHR predicted that nearly all 4.3 billion reproductive-age persons worldwide will have insufficient reproductive healthcare over their reproductive years.[3] Estimating the potential impact of COVID-19 prevalence on sexual and reproductive health (SRH) in low- and middle-income countries suggests that there are challenges.[4] COVID-19 was reported by the World Health Organization (WHO) as a pandemic in 2020.[5] It is the largest global public health crisis in a century, with overwhelming health and socioeconomic consequences.[2,6] It seems that the pandemic is exacerbating prior inequalities and uncovering vulnerabilities in social, political and financial systems which are consequently enhancing the effects of the pandemic.[7]

Additionally, the clinical context of sexual and reproductive health (SRH), health sector effects and delays or interruptions in the routine availability of SRH facilities, such as prenatal and postnatal checks, safe abortion, contraception, HIV/AIDS and other sexually transmitted diseases, should not be ignored. Other factors merit attention, such as the potential increase in gender-based violence and sexual harassment as well as the impact of COVID-19 stigma and sexism and its impact on SRH clients and staffs.[8] The Inter-Agency Working Group on Reproductive Health has recommended that considering the effect of COVID-19 on health systems, comprehensive SRH programs should be retained as long as the infrastructure is not overstretched by COVID-19 case management.[9] Considering that realising the right to reproductive health for all, without discrimination, is a critical issue, the Programme of Action committed to ensure equal access to SRH by 2015.[10] The International Conference on Population and Development+25 Summit was convened in November 2019 to mobilise the political will and financial allocations desperately required to do so, but this promise is far from being fulfilled.[10] The 2030 Agenda for Sustainable Development clearly highlighted the comprehensive access to SRH care services in communities.[11] In addition, the WHO has stressed that during the COVID-19 pandemic "All countries must strike a fine balance between protecting health, minimizing economic and social disruption, and respecting human rights".[12] Ultimately, women's choices and rights to SRH services must be respected, regardless of the COVID-19 outbreak.[12]

Women and girls' special health needs include safe childbirth, family planning and reproductive healthcare.[7] However, their access to quality SRH services as well as insurance coverage for health costs is likely to be limited in disastrous circumstances. This can be seen in countries with catastrophic health spending such as some Asian and African countries as well as in marginalised communities and those subject to multiple inequalities based on ethnicity, age, race, socioeconomic status, disability, sexual orientation and geographical area.[7,13,14] Obstructive sociocultural norms and gender stereotypes can restrain women's capacity to receive health services too.[12] In previous pandemics, an increased level of detrimental health consequences such as reduced access to healthcare services in relation to family planning, abortion, prenatal care, HIV, gender-based violence and mental health were reported.[15,16] This poor level of accessibility resulted in increased rates and sequela due to unintended pregnancies, unsafe abortions, pregnancy complications, sexually transmitted infections (STIs), intimate partner violence, depression, suicide, post-traumatic stress disorder and maternal and infant mortality.[15] For instance, the Ebola epidemic was anticipated to cause 120,000 preventable maternal deaths due to poor accessibility to healthcare services and fears among pregnant women of being infected in healthcare facilities.[15] Based on the results of an ecological analysis in Guinea, the number of monthly visits for family planning decreased from an average of 531 during the pre-Ebola period to 242 visits at the Ebola outbreak peak (i.e. a 51% decrease); it did however recover during the post-Ebola period.[17] The

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study found that from an average of 2,053 visits per month pre-Ebola, antenatal care visits decreased by 41% during Ebola and then improved to just 63% of the pre-Ebola level (recovery gap of 37%; $P$ <0.001).[17] Furthermore, in another study, Ebola infection in pregnancy was associated with high maternal mortality and nearly 100% incidence of fetal death.[18] UNFPA has reported that during the COVID-19 pandemic unknown and unfolding social distance interventions and school closures has left teens and young people worldwide without access to critical knowledge, resources and protections related to SRH.[19] A World Vision report about school closures due to COVID-19 in sub-Saharan Africa stipulated that during crises, school closures "can result in girls spending more time with men and boys than they would were they to be in school, leading to greater likelihood of engagement in risky sexual behaviour and increased risk of sexual violence and exploitation".[20] Furthermore, lockdowns and quarantine as well as social distancing impedes the distribution of in-person comprehensive sexuality education (CSE).[19] To overcome these obstacles, it is important to provide young people with new and engaging ways to connect to each other such as remote channels and tools (e.g. Video and mobile telephone, emails, applications, social networks, interactive voice), which could provide virtual sex education by engaging participants from broad geographical areas who are excluded from conventional services.[18,19]

Commonly, women's and girls' challenges in relation to SRH during the pandemic include violence against women and girls (VAWG), lack of access to high-quality maternity services in pregnancy, loss of family planning, increased unplanned pregnancies and impaired maternal mental health, which is discussed.[8,21]

## Violence Against Women and Girls

Gender-based violence due to the COVID-19 lockdown has increased due to the increasing difficulties to provide safe shelters and support to women who are in need of help.[22] The challenge of VAWG will most likely worsen in the ongoing COVID-19 pandemic. This is because communities are confronted with insecurity as well as health and economic difficulties which themselves add pressure and strain on the general population and is heightened by the limited and confined living environment.[23] There is an approximately one-third reduction in progress towards eliminating gender-based violence by 2030 due to the COVID-19 pandemic.[23] In the future, the impact of COVID-19 movement restrictions and self-quarantine are the most important issues which could increase women's confrontation and conflict with violent partners.[24] Intensifying household pressures and financial strains could likewise have a role. Evidence shows that since the start of the COVID-19 pandemic, reports related to VAWG, especially domestic violence, have increased in different countries. However, gender-based violence is currently only recorded by few countries. For example, France reported a 30% rise in the incidence of domestic violence since 17 March 2020; Argentina reported a 25% increase since the beginning of their lockdown on 20 March 2020; Cyprus and Singapore experienced an increase in the amount of calls received for gender-based violence of 30% and 33%, respectively; and several other nations, such as Canada, Germany, USA and the UK, have reported a rise in the gender-based violence rates in their countries.[25] The UNFPA has forecasted that an estimated 31 million more cases of intimate partner violence will occur as a result and during an average lockdown of six months with a 14–16 million increase in cases every three months.[26]

Female genital mutilation (FGM) is classified as violence against women. Approximately 200 million women worldwide have currently experienced FGM, which is considered a human rights violation.[27] FGM is an expression of entrenched gender inequality.[27] The UNFPA stated that it is practiced in communities around the world, but is not endorsed or condoned by any religion; while it is often perceived to be an Islamic custom because it is practiced by some Muslim groups, it is also practiced by non-Islamic groups such as Christians, Ethiopian Jews and followers of traditional African religions.[27] Girls are reportedly at increased risk of undergoing FGM as a prerequisite to marriage in countries such as Ethiopia, Kenya, Nigeria and Sudan and suggests a harmful coping mechanism related to economic fallout and school closures.[28] It is anticipated that due to the disruptions caused by COVID-19, there will be a one-third reduction in the advancement towards ending FGM by 2030.[26] Avenir Health (Glastonbury, Connecticut, USA), Johns Hopkins University (Baltimore, Maryland, USA) and Victoria University (Footscray, Australia) estimate that substantial levels of 6-month lockdown-related disruptions may cause significant delays in ending FGM, possibly leading to around two million more FGM cases over the next decade than would have occurred otherwise.[29] The UNFPA and United Nations Educational, Scientific and Cultural Organization recommended that, where movement is restricted and areas are difficult to reach, priority should be given to ensure access to prevention, security and care resources for girls and women at risk.[30]

**Table 1:** Actions in response to the sexual and reproductive health emergency during the COVID-19 pandemic[21,41–43]

| Challenge | Action |
|---|---|
| **Violence against women and girls** | Implementation of the online course "Essential services package for women and girls' survivors of violence".[41†] |
| | Coordination for the creation of a mobile application to assist survivors of sexual abuse.[41†] |
| | For youth at risk of violence in or near their homes, locating safe homes, shelters or social service referrals.[42] |
| | Training public officials and healthcare professionals on the national protocols for response to sexual assault.[42] |
| | Strengthening the capacity of the telephone hotline for receiving complaints about gender-based violence and providing survivors with support and referrals.[42] |
| **Maternity service in pregnancy** | Providing SRH care at home for pregnant women to prevent the risk of infection.[41†] |
| | Developing a telephone-based model for information and advice for pregnant women, postpartum women and caregivers of newborns.[41†] |
| | Working together with other humanitarian agencies and officials to fulfil the needs of priority medical centres and temporary shelters for returnees, with a focus on the needs of pregnant women and young people.[41†] |
| | The use of telemedicine for counselling and screening for known risk factors for COVID-19.[42] |
| | Distribution of PPE/SRH supplies both through the Health for Peace Project and the interagency strategy for reduction of maternal mortality in indigenous populations.[41†] |
| **Family planning and unintended pregnancy** | Providing mobile family planning services for priority areas.[41†] |
| | Providing telemedicine services and the delivery of contraceptives.[41†] |
| | Informing teens on when and how to receive contraceptive counselling and services during the COVID-19 response including changes, if any, to service delivery times, location, etc.[42] |
| | Providing multi-month supplies with clear information about the method and how to access referral care for adverse reactions.[42] |
| | Creating alternate service modalities (such as pharmacy, shops or community-based service) for contraception that are more available to teenagers.[42] |
| | Setting up hotlines to offer information and guidance on self-use of contraceptives, side effects, choice of method and other SRHR questions for teens.[41†] |
| **Maternal mental health** | Using formal mental well-being screening of new mothers.[21] |
| | Providing occupational therapy for infants and their mothers due to nutritional concerns.[43] |

*SRH = sexual and reproductive health; PPE = personal protective equipment; SRHR = sexual and reproductive health and rights.*
**This report focused solely on Latin American and the Caribbean Region; †In coordination with a Ministry of Health/government entity/national authority.*

## Maternity Services in Pregnancy

Pregnancy is a physiological state that predisposes women to viral respiratory contaminations. Due to the physiological changes within the immune and respiratory systems, pregnant women are at greater risk and more susceptible to the morbidity and mortality caused by COVID-19 including much more severe respiratory infections.[31] Respiratory illness due to COVID-19 in pregnant women must be considered with utmost priority and should be treated immediately because of increased risk of its adverse consequences.[32] The UNFPA proposed a sustainable antenatal care service delivery model in line with the context of various countries that identifies how services should be organised to provide a core antenatal care package. It particularly focuses on whom (cadre), where (system level) and how (platform) in relation to the set of interventions that should be provided at each antenatal care contact.[33] Redistributing maternity care staff away from general medical areas during the pandemic will probably lead to an increase in poor maternal and neonatal outcomes.[32] It is expected that pregnant women and their families will probably encounter increased anxiety and stress within the community concerning the spread of COVID-19.

As a result, maternity services should be prioritised as fundamental core health services throughout the COVID-19 pandemic.[32,33]

## Family Planning and Unintended Pregnancies

Provision of contraceptive methods as well as different SRH services and supplies, which are essential to womens' and girls' health, empowerment and dignity, will be influenced by the COVID-19 pandemic, as supply chains are affected globally. In consideration of the influence of COVID-19 on the restrictions to access to family planning facilities, it is predicted that there will be an increase in teen pregnancies, which in turn may cause those teenagers to drop out of school and have adverse consequences in their future.[32] Teenage pregnancy is related to a lack of knowledge and facilities for SRH, child marriage, risks to health and well-being and elevated poverty and insecurity.[34] Social norms on sex and limited resources are barriers to gaining crucial knowledge about SRH, thus raising the risk of unintended pregnancies, STIs and transmission of HIV. For women, the effects of an unmet demand for contraceptives may be devastating, leading to high maternal mortality and illegal abortions.[35] Issues of stigma and social norms can result in health providers and the individuals' families to marginalise unmarried pregnant teenage girls when they attempt to pursue SRH services.[36] Evidence shows that the effect of reduced reproductive health services and products between March and August 2020 in 37 countries has led to an extra 1.3 million unintended pregnancies.[37] This may result in an additional 1.2 million unsafe abortions and 5,000 pregnancy-related complications.[37]

## Maternal Mental Health

The risk of perinatal mental health morbidity can be inflated by factors such as acute stress, emergency and crisis circumstances as well as natural disasters. It is also possible that pregnant women became vulnerable during the COVID-19 pandemic to mental health issues.[38] To reduce the risk of COVID-19 infection, maternal services have been impacted, which has resulted in the incidents where women are unable to get the advantage from the routine use of caesarean section. They were refused the right to breastfeed, could not be accompanied by a birthing companion during labour and experienced routine isolation of birthing persons from their infants.[39] Undoubtedly, economic implications of the extended pandemic and financial uncertainties associated with it could further increase the psychological strain and exacerbate the emotional well-being of pregnant women and new mothers. Some may adopt unhealthy strategies, such as alcohol consumption and substance abuse, to cope with the effects of the pandemic, thereby contributing to current mental health concerns.[38] There is recent anecdotal evidence that indicates maternity-related workers limit maternal options and rights (such as using regular labour induction, separation of mother and infant) to protect the mother and/or infant; however, such procedures are not acceptable on the basis of existing evidence and are likely to be correlated with physical and psychological damage for both mother and infant.[39]

## Actions to Achieve Sexual and Reproductive Rights during the COVID-19 Pandemic

In periods of crisis, particularly health crises, the role of SRHR advocacy is paramount; it helps to hold governments responsible for their national and international SRHR commitments and their responsibility for delivering critical services as well as emphasise the essential nature of SRHR programmes. In response to health crises, such as the COVID-19 pandemic, advocating for new methods of providing SRH programmes is important. Advocacy for the implementation and/or acceptance of telemedicine, online meetings and the use of social media resources and the availability of CSE have been crucial aspects of an effective SRHR response to the pandemic.[40]

The current COVID-19 outbreak has had some additional impacts on individuals' SRH because of quarantine measures as well as social distancing that have been put in place for all, troubles in provision of standard healthcare services due to the acute burden that COVID-19 has placed on health systems and as a consequence of the conceivable collapse of the health care systems and prioritisation of specific services and techniques other than SRH.[26] Therefore, international agencies and researchers published various actions to ensure SRH throughout the COVID-19 pandemic [Table 1].[21,41–43]

## Conclusion

In critical situations such as disease outbreaks, the health sectors focus their resources on managing critical issues and preventing adverse events in healthcare. As a result, access to SRH services becomes more difficult and this mostly affects women

and girls who have unique needs. Policymakers and healthcare providers must be aware of the significant link between the global prevalence of COVID-19 and the challenges posed by the pandemic to SRH to take appropriate action. Lack of adequate attention to the health needs of girls and women in crises may lead to devastating consequences such as increased maternal and infant mortality, increased number of unsafe abortions and failure to prevent pregnancy. Therefore, providing SRH services to girls and women, despite the changing economic status, social environment and logistic barriers that enable inadequate access to SRH services, should be a priority for health interventions and should occur at different levels of healthcare systems in developed and developing countries.

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