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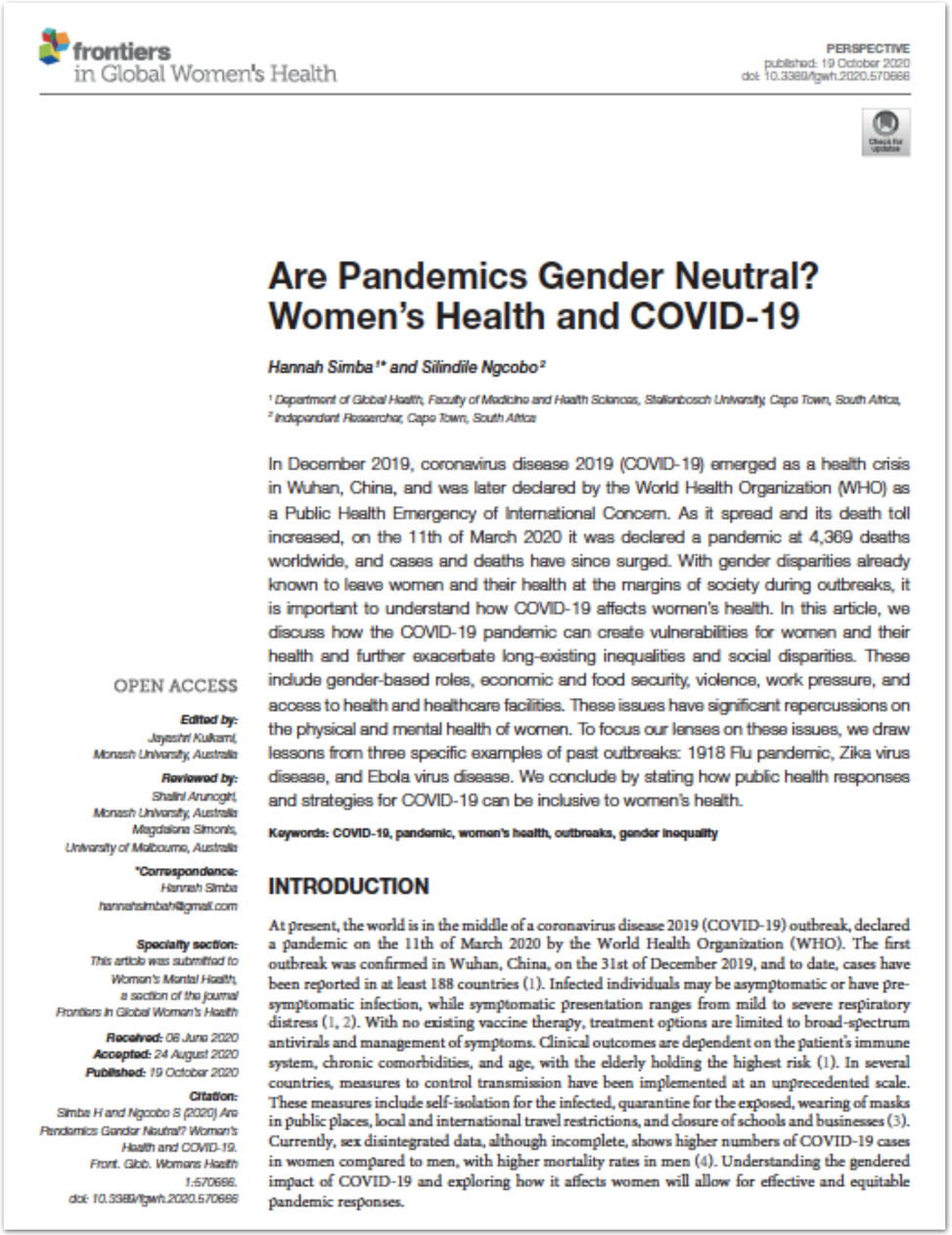
Sexual and reproductive health and rights (SRHR), COVID-19 and marginalised groups

- “Surviving a pandemic for women means more than just surviving the disease, as there are **threats beyond the risk of infection**” (Simba & Ngcobo, 2020)
- Exacerbates existing inequalities
- SRHR: A ‘heterosexual, childbearing women’ focus, amid severe existing challenges
- Some groups / services slip through the cracks, *even in gender-inclusive* responses:
  - Stigmatised services, e.g. abortion care
  - Adolescents
  - LGBTQI+ people



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Are Pandemics Gender Neutral? Women’s Health and COVID-19

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In December 2019, coronavirus disease 2019 (COVID-19) emerged as a health crisis in Wuhan, China, and was later declared by the World Health Organization (WHO) as a Public Health Emergency of International Concern. As it spread and its death toll increased, on the 11th of March 2020 it was declared a pandemic at 4,369 deaths worldwide, and cases and deaths have since surged. With gender disparities already known to leave women and their health at the margins of society during outbreaks, it is important to understand how COVID-19 affects women’s health. In this article, we discuss how the COVID-19 pandemic can create vulnerabilities for women and their health and further exacerbate long-existing inequalities and social disparities. These include gender-based roles, economic and food security, violence, work pressure, and access to health and healthcare facilities. These issues have significant repercussions on the physical and mental health of women. To focus our lenses on these issues, we draw lessons from three specific examples of past outbreaks: 1918 Flu pandemic, Zika virus disease, and Ebola virus disease. We conclude by stating how public health responses and strategies for COVID-19 can be inclusive to women’s health.

Keywords: COVID-19, pandemic, women’s health, outbreaks, gender inequality

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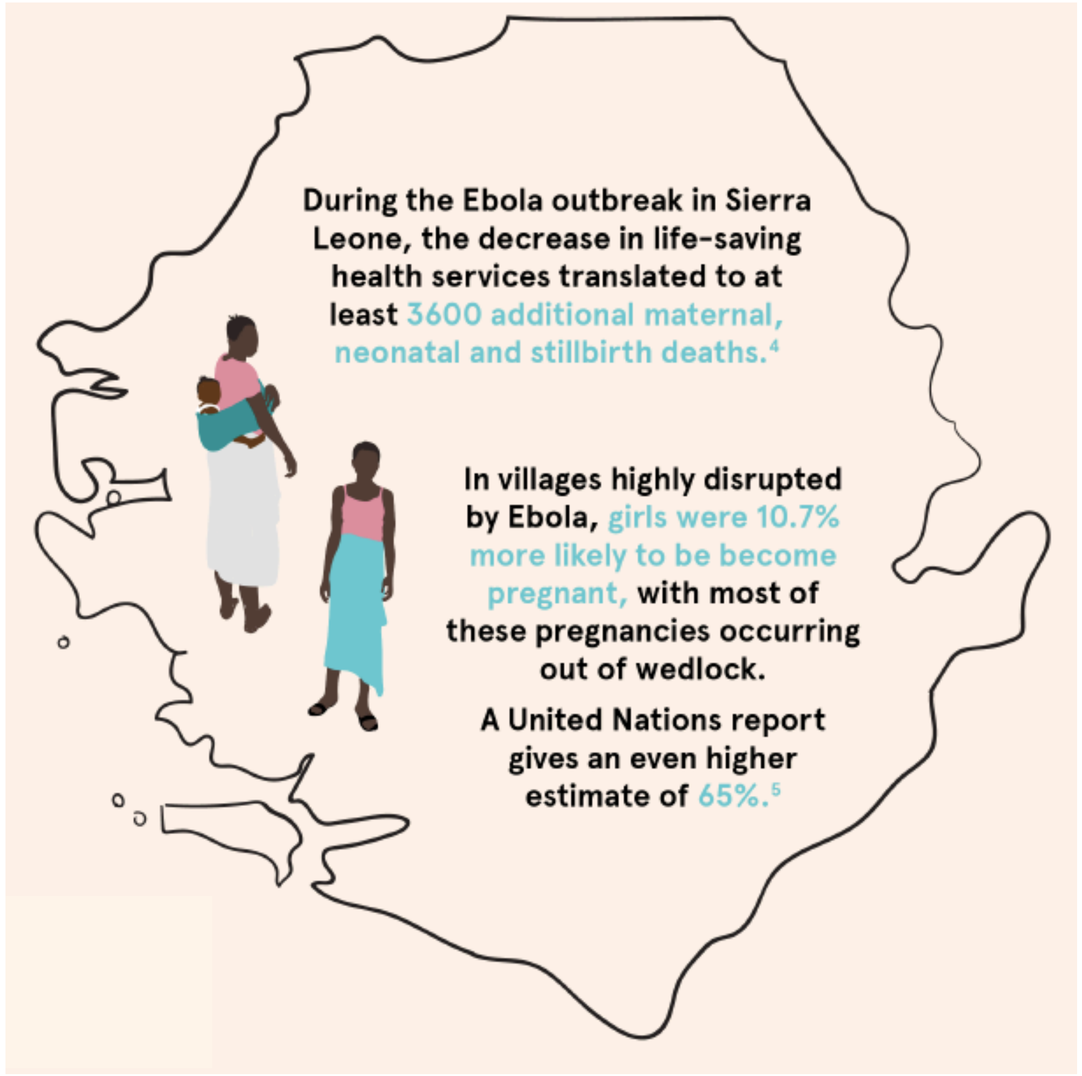
INTRODUCTION

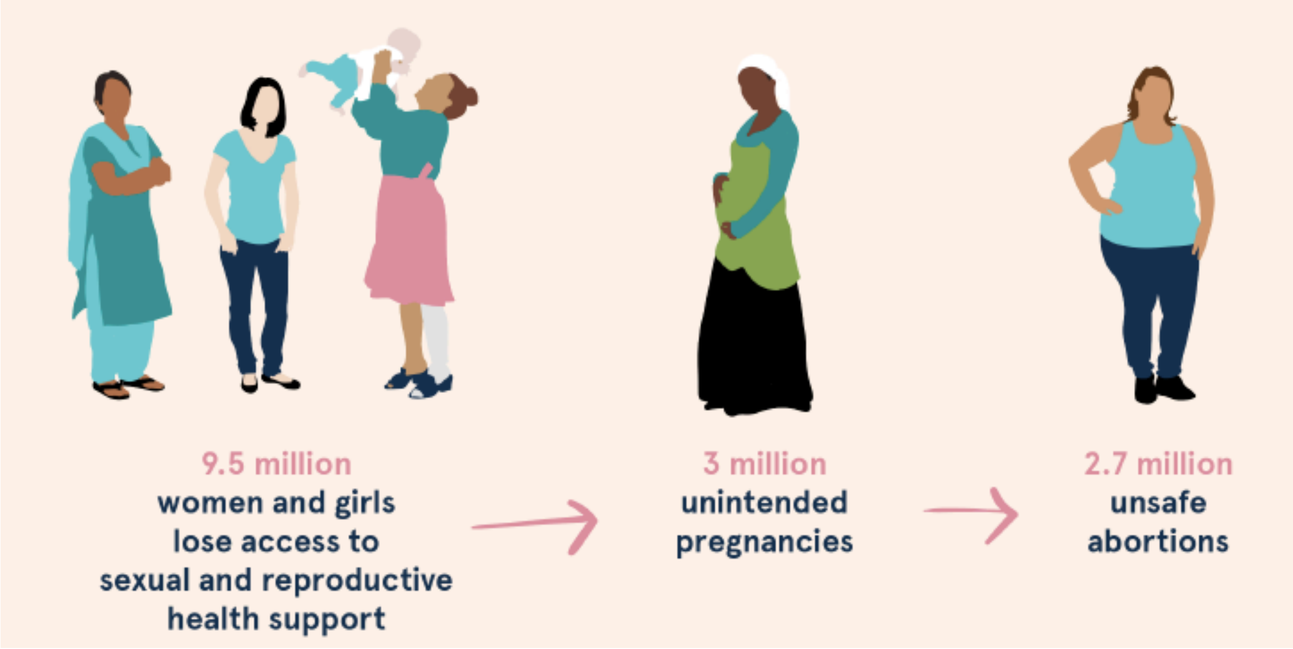
At present, the world is in the middle of a coronavirus disease 2019 (COVID-19) outbreak, declared a pandemic on the 11th of March 2020 by the World Health Organization (WHO). The first outbreak was confirmed in Wuhan, China, on the 31st of December 2019, and to date, cases have been reported in at least 188 countries (1). Infected individuals may be asymptomatic or have pre-symptomatic infection, while symptomatic presentation ranges from mild to severe respiratory distress (1, 2). With no existing vaccine therapy, treatment options are limited to broad-spectrum antivirals and management of symptoms. Clinical outcomes are dependent on the patient’s immune system, chronic comorbidities, and age, with the elderly holding the highest risk (1). In several countries, measures to control transmission have been implemented at an unprecedented scale. These measures include self-isolation for the infected, quarantine for the exposed, wearing of masks in public places, local and international travel restrictions, and closure of schools and businesses (3). Currently, sex disintegrated data, although incomplete, shows higher numbers of COVID-19 cases in women compared to men, with higher mortality rates in men (4). Understanding the gendered impact of COVID-19 and exploring how it affects women will allow for effective and equitable pandemic responses.

Lessons from previous health and humanitarian crises



COVID-19-related modelling:

- increased HIV-related deaths
- unplanned pregnancies (teenage ↑ ; queer women? - GBV)
- unsafe abortions
- maternal morbidity and mortality



Sources: The Equality Institute; Think Global Health; Marie Stopes International

Pandemic-related SRHR impacts in Gauteng (Adelekan et al., 2020)

- Analysis of 5 week period following introduction of lockdown
- Primary healthcare facilities in Gauteng
- Drop already evident in month preceding lockdown: Interplay of supply, demand

Reduction in contraceptive and TOP services

- **45%** reduction in injectable contraception;
- **48%** reduction in subdermal implants;
- **10%** reduction in IUD use;
- Oral contraceptives similar to pre-lockdown period

Contraceptives provision, Department of Health, March - July 2020

Method of contraception	March	April	May	June	July
Barrier methods					
Female condoms distributed	1 261 603	781 599	542 191	1 300 931	1 500 018
Short-acting hormonal methods					
Medroxyprogesterone injection	462 527	391 237	464 855	444 069	431 978
Norethisterone enanthate injection	168 855	146 479	193 002	203 093	218 143
Oral pill cycle	310 923	307 422	296 726	261 253	274 769
Long-acting reversible contraception					
Intrauterine device inserted	4 704	3 483	4 131	4 024	3 908
Subdermal implant inserted	11 586	8 429	10 585	10 743	10 559
Permanent contraception					
Sterilisation – female	4 042	3 727	3 813	3 238	3 185

Source: Chimbwete, 2020, analysis of South African Department of Health, Health System Data

Access to safe abortion care

- Safe TOP seen as an ‘elective procedure’
- Gauteng public health: **17%** decline in 2nd trim; **5%** overall
- MSF: 80% drop in April in accessing abortion
- Mary Stopes self-managed abortion care
  - under 9 weeks pregnant
  - via telemedicine
  - April to July 2020, consistent uptake

“Tshireletso, a 35-year old woman, came to us today requesting a ToP. I was unable to help her as she was 27 weeks pregnant.

I asked why she had waited so long to see us. She told me the procedure was initially booked for March 27, but that was the first day of the national lockdown, and she couldn’t get to the clinic.

She came back a week later, but was told that there were no abortions taking place and she needed to come back when the lockdown was over”

- Provider at MSF

Impact on marginalised persons

LGBTQI-friendly and youth NGOs often recourse for sexual and gender minorities, young people.

Yet, pandemic-related impacts:

- reduced hours of operation
- curtailed outreach programmes
- school closures mean no CSE, commodities
- travel to and from LGBTQI clinics conspicuous
- risk of violence from those enforcing lockdown
- interrupted transgender healthcare, including hormone treatment

"There is a long waiting list. This thing is now killing me because I don't know what to do…

If I'm coming to the transgender clinic and I see the others [who have transitioned], I'll feel so disappointed in myself and so ashamed."

Polite, 39-year-old trans woman, Tembisa

Early recommendations: SRHR

- Blanket regulations compound negative SRHR outcomes for marginalised groups
- Pandemic-related SRHR interventions need to be rooted in reality of deepening impoverishment
- Support NGOs - often the only recourse for marginalised groups
- Address critical SRHR data gaps
  - abortion care
  - adolescents
  - LGBTQI persons
  - persons with disabilities, the incarcerated, street communities, sex workers…
- Most important: Address the risks *that put people at risk*