The Independent Panel Exchange

COVID-19: Delivering Sexual and Reproductive Health Rights in Crises Settings

Summary:

COVID-19: Delivering Sexual and Reproductive Health Rights in Crises Settings was held 28 January 2021. Watch a video of this Exchange.

Authoritative researchers, commentators, and SRHR advocates from around the world met virtually on 28 January 2021 to exchange first-hand experiences, innovations and lessons learned about the delivery of SRHR services during the COVID-19 pandemic. Their recommendations are intended to inform ongoing pandemic responses and preparedness for the future, including multi-sectoral actions to ensure access to SRHR services; and how to support front line workers and adapt delivery models. This Exchange was held in coordination with the International Planned Parenthood Federation (IPPF) and the Partnership for Maternal, Newborn, and Child Health (PMNCH).

Participants:

Moderated by Dr Nibedita S. Ray-Bennett, Founding President of Avoidable Deaths Network and Associate Professor of Risk Management at the University of Leicester, the panel included the Rt Hon. Helen Clark, Co-Chair of The Independent Panel, Nimisha Goswami, Head of the IPPF's COVID-19 Task Force, and Professor Karl Blanchet, Member of the BRANCH Consortium and PMNCH Knowledge and Evidence Working Group.

Following the panel presentations, participants from around the world added first-hand knowledge and experience to the discussion. Speakers included Dr Neha Singh, Assistant Professor at the London School of Hygiene and Tropical Medicine and Co-Director of the Health in Humanitarian Crises Centre, Jihan Salad, Officer-In-Charge of Puntland Sub-Office for UNFPA Somalia, Farnaz Babaei, Access Officer at the Family Health Association of Iran, Dr Kteera Abdulwahab, Manager of the Sudan Family Planning Association, Sarah Jane A. Biton, Head of the Program Operations Group of the Family Planning Organization of the Philippines, Lynda Gilby, researcher at Tampere University in Finland, and Desmond Nji and Beryl Ngwa from the Cameroon Youth Network.

Main themes:

COVID-19 has disrupted access to SRHR services

A WHO survey reported that nearly a third of SRHR services across 105 countries have been disrupted during the pandemic. On the demand side, restrictions on movement, increased childcare responsibilities due to school closures, and fear of the virus prevented people from seeking timely and essential services including contraception, safe abortion, testing and treatment for STIs including HIV, screening for reproductive cancers, antenatal care, skilled assistance at childbirth, and postnatal care. This has resulted in unintended pregnancy, unsafe abortion, and preventable morbidity and mortality among untold numbers of women and children.

SRHR is not treated as a priority

In crisis settings, sexual and reproductive health services are often considered non-essential. A WHO Pulse Survey published in August 2020 recorded 68% of countries reporting disruptions to the supply side of family planning and contraception services, with 9% reporting severe disruptions. Front line health workers reported major shortages in services, medications, and supplies. Funding, resources and attention has been diverted from SRHR to the pandemic, notably in humanitarian settings.

The pandemic has exacerbated the social determinants of health inequities

Global evidence indicates that the most marginalized are disproportionately affected by the socio-economic impacts of the pandemic, which in turn affect their SRHR and widen inequities between social groups, namely refugees, internally displaced persons, migrants, people living with disabilities, the LGBTQI+ community, and the extreme poor.

Women and girls were disproportionately affected by school closures and disruptions to the informal labour market. School closures increased women's childcare responsibilities. Women make up the majority of the informal labour sector and were more likely to suffer job losses or reduced income as a result of closed borders, markets, and restricted movement. Unable to attend school, girls were at increased risk of sexual violence, pregnancy, and early marriage. This trend was widely observed in areas affected by Ebola during the 2014-2016 epidemic in West Africa, and we are seeing emerging evidence of this during COVID-19.

Participants noted the increased risks and lack of services for those living in conflict zones or other humanitarian and LMIC settings. The newly released Lancet series on Women and Children's Health in Conflict Settings tells us that in 2017 alone, one in ten of the world's women and sixteen per cent of the world's children were displaced by conflict or lived dangerously close to it. Further, a Lancet series highlights that two in ten displaced women are estimated to have experienced sexual violence and this is most likely an underestimate. Up to one third of adolescent girls living in humanitarian settings reported that their first sexual encounter was forced.

The front lines lack resources and protection

In every crisis, including the COVID-19 pandemic, midwives are more likely to continue working and providing life-saving care, despite fears they experience for themselves and their families. There are fewer midwives in maternity wards; midwives are paid irregularly; they work long hours and experience burn-out and stress. This compromises the delivery and quality of care.

At the same time, these important front line health workers are being asked and have risen to the challenge of implementing many positive adaptations. For example, midwives in Jordan supported the establishment of telehealth and helpline services to ensure that women had continued access to sexual and reproductive health services, including antenatal care, postnatal care, and family planning. They are doing this with woefully inadequate resources, funding and support.

Data is not disaggregated by sex and other social stratefiers

Existing data does not allow us to analyse the differential impact of the pandemic on women and girls and other vulnerable groups. Only 52% of countries today provide sex-disaggregated data on morbidity and mortality related to COVID-19. While data is crucial, participants argued that government, non-government and private sectors have enough information to take action immediately.

Recommendations to the Independent Panel:

Preparedness:

1. SRHR must be deemed essential, time sensitive and given high priority. The implications of disruption for women and girls, especially the most vulnerable, are enormous. Business continuity plans for SRHR are a critical aspect of pandemic preparedness. As part of this:
    a. Funds should be earmarked for SRHR services within all relevant budgets.
    b. SRHR supply chains need to be protected and improved including in emergency settings
2. Innovative solutions like telehealth, digital health, harm reduction, and home health care needs to be scaled up and adequately funded.
3. Solutions require multi-sectoral actions. For example, the health, labor and education sectors need to work together to ensure that girls and boys can stay in school and employment.

4. Data collection needs to be disaggregated by sex and other social stratefiers to understand the differential impact of the pandemic on vulnerable groups and to plan equitable responses.

Response:

5. The humanitarian community should transfer power and resources to local actors, especially in humanitarian settings, so that these actors are able to respond more immediately and effectively to the SRHR needs of women and girls.
6. Essential workers, including midwives, must be prioritised for training on new health threats, for PPE , and for self-protection (to care for mental health, physical stress)