COMMENTARY

Don't Let Sexual and Reproductive Health become Collateral Damage in the Face of the COVID-19 Pandemic: A Public Health Perspective

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Abstract

South Africa, similar to many other countries in the African continent is still experiencing challenges in its efforts to provide sexual and reproductive health (SRH) care to women and adolescent girls, and it has become clear that the COVID-19 pandemic is the latest threat to universal access to SRH. In the face of this threat, the Sustainable Developmental Goals that call on the global community to "leave no one behind" may become a blurred vision unless we adopt a wider lens away from the tunnel vision that currently plagues health systems around the globe. This paper therefore exposes how SRH may become collateral damage in the face of the present COVID-19 pandemic. Previous disease outbreaks diverted attention from critical SRH services, including antenatal care, safe abortions, contraception, HIV/AIDS and sexually transmitted infections. Governments, policy makers, health system gatekeepers and civil society organisations should not allow the COVID-19 phobia to bar women and adolescent girls from accessing SRH services. In fact, the global and South African response to the COVID-19 pandemic must protect everyone's rights, particularly in the health care context. Gender considerations and a human rights approach must be embedded in ensuring the accessibility and availability of SRH services. *(Afr J Reprod Health 2020 (Special Edition); 24[2]:56-63).*

Keywords: COVID-19, pandemic, sexual and reproductive health, healthcare systems, collateral damage

Résumé

L'Afrique du Sud, à l'instar de nombreux autres pays du continent africain, connaît toujours des défis dans ses efforts pour fournir des soins de santé sexuelle et reproductive (SSR) aux femmes et aux adolescentes, et il est devenu clair que la pandémie du COVID-19 est la dernière menace. à l'accès universel à la SSR. Face à cette menace, les objectifs de développement durable qui appellent la communauté mondiale à «ne laisser personne de côté» peuvent devenir une vision floue à moins que nous n'adoptions une vision plus large loin de la vision tunnel qui sévit actuellement dans les systèmes de santé du monde entier. Cet article expose donc comment la SSR peut devenir des dommages collatéraux face à la pandémie actuelle de COVID-19. Les flambées de maladies précédentes ont détourné l'attention des services essentiels de SSR, notamment les soins prénatals, les avortements sans risque, la contraception, le VIH / sida et les infections sexuellement transmissibles. Les gouvernements, les décideurs, les gardiens du système de santé et les organisations de la société civile ne devraient pas permettre à la phobie du COVID-19 d'empêcher les femmes et les adolescentes d'accéder aux services de SSR. En fait, la réponse mondiale et sud-africaine à la pandémie du COVID-19 doit protéger les droits de tous, en particulier dans le contexte des soins de santé. Les considérations de genre et une approche des droits humains doivent être intégrées pour garantir l'accessibilité et la disponibilité des services de SSR. *(Afr J Reprod Health 2020 (Special Edition); 24[2]: 56-63).*

Mots-clés: COVID-19, pandémie, santé sexuelle et reproductive, systèmes de santé, dommages collatéraux

Introduction

The COVID-19 pandemic continues to wreak havoc around the globe[1]. As of this writing, 2.72 million positive cases of coronavirus infection have been confirmed while almost 200 000 people have died of the virus[2]. Public health is witnessing one of the most devastating pandemics in this and the previous century as it has been accompanied by the devastating disruption of societies and

economies[3]. Most disconcertingly, the pandemic has paralysed healthcare delivery systems in many countries[3,4] and is posing a dire threat to equitable access to healthcare resources[5]. One of the most significant debates surrounding the pandemic is the overwhelming need for prioritising public healthcare systems[4,5]. In fact, challenges to the public healthcare system during a pandemic of this nature include the distraction of attention from other serious health issues, the rerouting of medical resources, an interruption in medical supplies, the closure of health facilities, restrictions of primary healthcare services, reprioritisation of medical emergencies, an imbalance in healthcare provision, and a dire shortage of healthcare workers[4,5]. There is consensus that people may delay seeking healthcare or even avoid it in fear of contracting the coronavirus[6,7]. For instance, recent evidence suggests that the COVID-19 outbreak is associated with a decline in acute coronary syndrome admissions in Austria and it is argued that the response to the pandemic is likely to cause cardiac collateral damage[8]. There is thus increasing concern that collateral damage will strike healthcare services outside the COVID-19 focus[8].

COVID-19 versus sexual and reproductive health

Africa is no stranger to epidemics, disease outbreaks and plagues and has not been spared from the COVID-19 crisis[9]. Moreover, low resourced health systems prevail in Africa[10] and currently the continent has a low healthcare to people ratio as hospital beds, ICU facilities and health professionals are limited in the face of this global threat. On average, there are 1.8 hospital beds per 100 people in Africa in comparison to 5.8 in France[10]. The African continent is also almost exclusively dependent on imported medicines and pharmaceutical products as approximately 94% of pharmaceutical stock is imported. Africa faces a dangerous situation as the COVID-19 pandemic has resulted in 71 countries imposing limitations on exports of certain essential supplies to combat COVID-19[10]. However, for many years sexual and reproductive health has been considered a major public health issue in Africa and there is consensus that emergency maternal, sexual and reproductive health services will be hard hit by the COVID-19 crisis[4-6,9], particularly as the rights of women and adolescent girls have long been marginalized on this continent[10,11]. Many women and adolescent girls lack education and have poor access to sexual and reproductive health services[11]. Sub-Saharan Africa accounts for 70% of the global infection of HIV[12] and the rate of infection in young women is eight times higher than in their male counterparts[12]. African women account for 58% of the people living with HIV in Sub-Saharan Africa[12,13] and they thus bear the brunt of the HIV burden. Of the 6.1 million people living with HIV in the western and central Africa regions, the majority (56%) are women[13].

In the last century and even in more recent times, African women and adolescent girls have borne the brunt of epidemics, wars, national crises and natural disasters and have been the victims of unwanted pregnancies, gender-based violence, HIV infection and maternal death[14-16]. It should therefore be a matter of international concern that a mathematical modelling tool that was used to understand the impact of COVID-19 on the sexual and reproductive health of women estimates that there will be a 10% decline in short and long acting reversible contraceptives and that this will result in an estimated 48 555 000 additional women with an unmet need for modern contraception in low and middle income countries[6]. In addition, 15 401 100 additional pregnancies may also result while a 10% decline in service coverage of essential pregnancy and newborn care during the pandemic may severely affect women and children. The analysis suggests that such a decline may result in an additional 1 745 000 women experiencing major obstetric complications, 28 000 additional maternal deaths, 2 591 000 additional newborn babies experiencing major complications without care, and 168 000 additional newborn deaths[6]. The mathematical modelling also predicts a 10% shift in abortions from safe to unsafe which will likely result in 3 325 000 additional unsafe abortions and 1 000 additional maternal deaths[6]. While the mathematical modelling estimates a 10% reduction in sexual and reproductive health services, frontline partners advise researchers that this 10% could be an underestimation and caution that sexual and reproductive health services could be reduced by 80% during the COVID-19 pandemic[6].

Earlier epidemics and disease outbreaks paralysed the sexual and reproductive health services in Sub-Saharan Africa. For instance, the Ebola pandemic in West Africa obscured gender issues and sexual and reproductive health and rights became invisible as countries accelerated their epidemic responses[4,6,14,17]. The Ebola outbreak reduced access to vital treatments for malaria, HIV/AIDS and even tuberculosis[7] and health inequity and social injustice impacting women were aggravated. Women and girls were subjected to multiple forms of violence, trafficking, child marriage, sexual exploitation and abuse as Ebola took a foothold in West Africa. During the Ebola outbreak, maternal deaths increased by 22% while the death of newborn babies increased by 25%[17,18]. The United Nations Population Fund reported that unplanned pregnancies increased by 44% and 172% in Kenema and Kailahun, Sierra Leone respectively[17]. It was also evident that adolescent sexual and reproductive health seeking behaviour declined significantly in Sierra Leone after the Ebola outbreak.[17,18] Moreover, approximately 40 healthcare facilities were converted into Ebola holding centres and this hindered people from accessing non-Ebola health services in Sierra Leone[17,18]. The health workforce also decreased dramatically as healthcare workers became victims of collateral damage during the Ebola epidemic. Research suggested that women with obstetric complications were less likely to present at public health facilities as they were afraid of being transferred to Ebola treatment centres, especially if their symptoms were similar to the Ebola case definition[14]. The Ebola example thus clearly suggests that sexual and reproductive health services may be deemed non-essential if health systems are strained by other outbreaks[4,5].

This has indeed been the case in the wake of the COVID-19 outbreak that has been expanding across the African continent with just over 24 000 known cases to date[19]. Francoise Girad, President of the International Women's Health Coalition (IWHC), highlights that fact that, as COVID-19 has taken hold globally, "…access to sexual and reproductive healthcare services, from routine services and testing for STIs to antenatal care, contraception and abortion, have suffered significantly"[20].

Currently, the number of COVID-19 cases is surging in South Africa and a plateau has clearly not been reached. Faced with the COVID-19 outbreak, the South African government announced in March 2020 that this pandemic was a national disaster and prohibited entry into the country if travellers came from high risk countries/regions. The government also enforced the closure of border crossings and schools, announced limitations in internal travel and a nation-wide lockdown, and proposed mobile testing for the virus[21]. However, South Africa is plagued by the burden of other contagious diseases such as HIV/AIDS and tuberculosis (TB) and multiple non-communicable diseases such as maternal, newborn and child disease outbreaks as well as criminal- and gender-based violence and other health threats. The COVID-19 outbreak is now colliding with other epidemics[22] while the public health system in South Africa remains under-resourced and overstretched. A primary concern is that South Africa has the highest Gini coefficient in the world which is an indication of the high inequity in South Africa[23,24]. COVID-19 is therefore highly likely to compound existing inequities in maternal health and limit infectious disease care for HIV/AIDS and TB.

Women in South Africa are vulnerable to unemployment, insecurity in the job market, poverty, poor health and low educational status[25]. It is therefore inevitable that, with the COVID-19 outbreak, inequalities, poverty and poor health among women will be exacerbated. The United Nations acknowledges that, as a result of COVID-19, the health of women will be affected by the diversion of resources and priorities, including sexual and reproductive health services[3]. Maternal mortality in South Africa may have declined but the maternal mortality ratio remains high[26], and therefore the reallocation of resources and the diversion of critical attention to sexual and reproductive health, maternal health care and gender based violence services will worsen maternal mortality and morbidity[3,4,6]. The closure of hospitals or parts of hospitals and the creation of COVID-19 treatment units may result in limited infrastructure for other healthcare services such as operating theatre and ward spaces and this will in turn create havoc for acutely necessary and

emergency maternal and reproductive health services[3,4,6,14].

Services that are likely to be marginalised by the COVID-19 crisis include abortion services, emergency contraceptives, family planning, a regular source of contraception, diagnosis and treatment of cervical cancer and STIs, and antenatal care[3,4,6]. Thousands of women and adolescent girls in South Africa rely on public sector clinics for the provision of long acting contraceptives[11]. At the best of times overcrowding and long waiting times at clinics increase the risk of infection for women and adolescent girls who try to access contraceptives[3,4,6], and this situation has already been exacerbated during the COVID-19 lockdown as access to these services has been blocked, particularly as taxi transport was prohibited during level 5 of the lockdown. A shortage of contraceptives and condoms is also likely during the COVID-19 crisis as suppliers may be on lockdown as well and disruptions to pharmaceutical manufacturing may occur[4,6]. For instance, pharmaceutical plants in China that supply India with materials to produce generic drugs were shut down[14]. There is thus an increasing concern that such disruptions in the pharmaceutical supply chain will lead to shortages of contraceptives, anti-retroviral medication for HIV/AIDS, and antibiotics to treat sexually transmitted infections[14]. The United Nations Population Fund estimates that approximately 18 million people in Latin America and the Caribbean will lose access to regular contraceptives during the COVID-19 crisis[3]. By reducing access to family planning, abortion, antenatal clinics, HIV treatment as well as gender-based and mental healthcare services, catastrophic events are likely to follow such as numerous unintended pregnancies, unsafe abortions, pregnancy complications, post-traumatic stress disorder, suicide, and maternal and infant mortality[6]. The inadequate provisioning of HIV-related services for women whose sexual and reproductive health is at risk is thus highly likely to result in maternal and newborn deaths as well as HIV infection in newborns[12].

Warnings have been issued that the national lockdown to curb the spread of COVID-19 will fuel the collateral damage associated with sexual and reproductive health care[4,6]. Some healthcare services will be deferred during the lockdown if they are considered non-essential. Healthcare staff in the sexual and reproductive health domain may be redeployed to other service areas as required during the COVID-19 crisis[4.6]. A case in point is that abortion services have been halted in other low- and middle-income countries like Nepal and India[6]. As restrictions in access to abortion services intensify, women are likely to be exposed to unsafe abortions[6] that already account for 37 maternal deaths per 100 000 live births[27] in Sub-Saharan Africa. Unsafe abortions entail the use of harmful methods like oral and injectable substances, trauma to the abdomen, the insertion of foreign objects into the uterus, and the induction of unsafe vaginal preparations[27]. The maternal mortality rate of unsafe abortions in Sub-Saharan Africa is 950 times higher than in the USA[27] while 50% of the high maternal morbidity rate in South Africa is attributed to unsafe abortions[28].

Gender-based and domestic violence has spiralled upwards around the globe during the COVID-19 pandemic[3,29] as nationwide lockdowns and social distancing have been trapping women in violent and abusive relationships. Emerging data from around the globe have revealed that violence against women and girls has intensified since the outbreak of COVID-19[29]. For instance, domestic violence in France increased by 30% since the lockdown in March and domestic violence in Brazil has increased between 40 to 50% since the COVID-19 outbreak[29]. Emergency calls for domestic violence cases have increased by 25% in Argentina since the lockdown[29] and there have been a 30% and 35% increase in calls to helplines in Cyprus and Singapore, respectively. Moreover, the demand for emergency shelters as a result of domestic violence has increased in Canada, Germany, Spain, the United Kingdom and the United States.[29] The global cost of violence against women and girls is a huge burden and it is estimated at 1.5 trillion dollars[29]. The United Nations Women organisation estimates that this figure is likely to increase as violence escalates during the COVID-19 crisis and it is inevitable that this will negatively impact economic recovery[29].

Intimate partner violence against women and girls exacerbates sexual and reproductive

health problems such as sexually transmitted infections, HIV infection and unplanned pregnancies[3,29]. Numerous women and girls who are subjected to violence have limited or no access to sexual and reproductive health services. Moreover, the patriarchal nature of the South African society that often promotes violence as a means of resolving gender-based conflict exacerbates this problem. Exposure to physical and sexual violence results in depression, anxiety, substance abuse and little control over sexual decision making in women[29,30]. Gender-based violence has also been linked to high HIV prevalence. The COVID-19 crisis will of necessity exacerbate the risk of violence against women through ineffectual social distancing measures, the disruption of their livelihoods, the extension of the nationwide lockdown, and the scaling down or even closure of hotlines, crisis centres, shelters and protection services as well as the disruption of social and protective networks[30]. Moreover, the perpetrators of intimate partner and domestic violence are likely to impose harsh restrictions on their victims' use of the internet, social media and cell phones to curtail their ability to seek help[30].

Intimate partner violence is pervasive in South Africa and is ranked as the second highest burden of disease after HIV/AIDS[31]. Approximately 53% of female homicides are committed by intimate partners in this country[32]. In addition, South Africa has the highest rate of intimate partner violence in the world and its female homicide rate is six times the rate of the world average[33]. An escalation in reports of domestic violence has surfaced in South Africa since the national lockdown[34] to the extent that many crisis centres and shelters in South Africa have reported that they have reached their full capacity and have become unable to assist new victims of domestic violence due to the lockdown and social distancing measures[35]. The Minister of Police, Bheki Cele, reported in the media that the police had received more than 87 000 gender-based complaints in the first week of the lockdown in South Africa[34], yet he was silent on how this crisis would be addressed. In fact, the massive deployment of the South African National Defence Force, which is male dominated, has had no reported effect to date on the plight of abused women. Dr Lesley Ann Foster of Masimanyane Women's Rights International cited the loss of employment, income and food security as factors leading to violence during the COVID-19 crisis[35]. Incidences of female homicide have also been reported during the lockdown in South Africa[34].

A human rights approach to addressing sexual and reproductive health during the COVID-19 crisis

On a positive note, sexual and reproductive health does not have to become collateral damage in the face of the COVID-19 pandemic. Health systems need to ensure that sexual and reproductive health services remain accessible during the COVID-19 outbreak[4,6]. Sexual and reproductive health is a human rights issue and it is essential that health systems maintain a human rights approach to ensure the accessibility and availability of sexual and reproductive health services[3,29]. It is important to sustain a human rights climate during the COVID-19 threat, particularly with regards to community participation, non-discrimination, transparency and accountability[3,7,29]. A key aspect that the government and policymakers need to consider is that the maintenance of sexual and reproductive health is an essential service. It is thus vital that sexual and reproductive health medicine supplies be made available to healthcare providers and their clients[6] and that reputable suppliers be allowed to sustain the supply chain to ensure that there is an adequate supply of such medicines[6]. Various recommendations have been outlined for sexual and reproductive health services during the COVID-19 crisis such as allowing people to access these services during travel restrictions without legal implications, allowing access to contraceptives without a prescription, the delivery of sexual and reproductive health services to the homes of patients, and decentralising the distribution of medicine supplies[6]. The World Health Organization has recommended that travel restrictions and resource allocation during COVID-19 lockdowns should not impede comprehensive healthcare service delivery[3,6,29]. Moreover, the United Nations emphasise that women need to be considered in all COVID-19 response planning and decision making[3,29], and thus antenatal and postnatal delivery services and

emergency obstetric care must not be interrupted[4,6].

Governments and civil society need to ensure that women and girls are protected from violence by ensuring that essential services to support them are available at all times[3,29]. The United Nations Women recommend innovative solutions such as the use of online and mobile technologies, instant messaging services, and recruiting help from postal workers and delivery drivers to look out for and report signs of violence and abuse[3,29]. These suggestions presume that women have access to such technology, which is not necessarily the case in many rural areas. Some countries abroad are using a virtual justice system to ensure that court proceedings still take place[3,29]. Health institutions are central to providing information about services such as hotlines, rape crisis centres, shelters and referral linkages[29]. Healthcare providers are pivotal in extending support to victims of domestic violence by listening to their cries for help, offering advice without judgement, and probing the problems and needs of women[3,29]. Communities should also be sensitised to the increased risk of violence to which women and girls are exposed during the COVID-19 pandemic[3,29]. Enlisting the help of communities will also ensure that victims of violence are supported.

Conclusion

According to the United Nations, COVID-19 is a pandemic of global proportions that is unparalleled in history. During a virtual press conference on COVID-19 on the 11th of March 2020, Dr Tedros Adhanom Ghebreyesus, the World Health Organisation Director-General emphasised "All countries must strike a fine balance between protecting health, minimising economic and social disruption, and respecting human rights"[36]. In this context, epidemiological research and surveillance are warranted to ensure the sexual and reproductive health and rights of women and girls during the time that the COVID-19 pandemic is raging in our communities. No one should be left adrift as a result of disruptions in the health system, while we are fighting this pandemic. The gendered impacts of diseases outbreaks must be addressed by policies and public health efforts. In fact, all stakeholders should embrace this opportunity to address the need for greater investment in the safety of vulnerable women and girls and to ensure that they have access to uninterrupted sexual and reproductive healthcare. Past epidemics have taught governments, policy makers and healthcare providers valuable lessons about humanity and the value of human life, and these lessons are particularly applicable during the COVID-19 pandemic.

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Competing Interest

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

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