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EDITORIAL

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COVID-19: What implications for sexual and reproductive health and rights globally?

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On the 11 March 2020, coronavirus disease (COVID-19) was declared a pandemic by the World Health Organization.[1] Other coronavirus outbreaks which have occurred include the 2002–2003 severe acute respiratory syndrome (SARS) and the Middle East respiratory syndrome (MERS), first reported in 2012. Outbreaks like these can impact sexual and reproductive health and rights in various ways, at individual, systems and societal levels, and some of these implications are considered below.

MERS and SARS are known to cause adverse pregnancy outcomes including miscarriage, prematurity, fetal growth restriction and maternal death.[2] Experience of COVID-19 in pregnancy is limited. In one reported case, the pregnant woman required mechanical ventilation and a caesarean section at 30 weeks gestation.[3] Fetal distress and preterm delivery were reported in some other cases where infection occurred in the third trimester.[4] Intrauterine virus transmission from mother to baby before delivery is a recognised risk.[5,6] Pregnant women with COVID-19 respiratory illness should be treated with priority because of the risk of complications. So far, there is no evidence that pregnant women are more susceptible to COVID-19 than the general population,[7] but pregnancy is nevertheless a risk factor for increased illness and death in outbreaks of influenza.[8] Systematic screening of suspected infection during pregnancy with extended follow-up of confirmed cases has been called for,[9] although the practicability of such measures – given often mild symptoms, lack of test kits and so on – is uncertain. Pregnant women face special challenges because of their responsibilities in the workforce, as caregivers of children and other family members, and their requirements for regular contact with maternity services and clinical settings where risk of exposure to infection is higher.[8]

Functioning, well-resourced health systems are undoubtedly needed to manage the situation effectively. The outbreak is already placing health services in developed countries under considerable strain. The recommendations for maternity services alone, to limit pregnant women's exposure to ill persons, while ensuring that women receive essential care, means identifying potential cases *before entry* at health service points, delaying routine appointments and using strict isolation and infection control measures to limit transmission to other patients and staff.[6] In low-resource health systems, putting these recommendations in place may not always be feasible. Dealing with COVID-19 is likely to create imbalances in health care provision, disruption of routine essential services and to require redeployment of scarce health personnel across health services.

Acute and emergency maternal and reproductive health services may be hit hardest, with limited facilities for isolation areas to assess and care for women in labour and the newborn. Life-saving procedures, from caesarean sections to abortion care, may be delayed due to staff deployment and shortages and lack of infrastructure, e.g. operation theatres and ward space. Women who have to spend time recovering in hospital wards in low-income countries are often reliant on relatives for food and care, making isolation and infection control measures difficult and intensifying the risks of COVID-19 spread.

The effects of the pandemic could also affect routine health care services. Clinic appointments are rare in low-income settings and people can wait long hours at crowded clinic waiting areas for antenatal care, contraceptive counselling or other reproductive health services, which will increase risk of infection transmission. Cancellation of routine clinics may be necessary with deployment of staff away to acute care. Those most disadvantaged

may incur costs, suffer travel for long distances and other inconveniences needlessly, or even not attend for care at all. To compound the organisational problems within the health services, health workers themselves may fall ill. It was estimated during the swine influenza (H1N1) pandemic that up to 50% of health staff could be expected to be away from work due to sickness.[10] Shortages of essential medical supplies may be experienced. Due to the closure of factories and restrictions on transport, import and export of raw materials in countries which produce medical goods, fears of condom, progesterone and antibiotic shortages have been raised,[11] and stock outs already reported in some countries.[12]

Although the consequences of COVID-19 on health and health services are uppermost in the public consciousness, epidemics can trigger and shape broader discourse. The Zika virus outbreak in 2015 provides one example. Infection with Zika virus causes pregnancy complications and specifically, congenital deformities in fetal brain development, with microcephaly. In Latin America, the epidemic sparked a debate on the need to extend abortion laws to protect women's rights to safe abortion[13] and raised concerns of reproductive and social justice which continue to this day.[14] The Ebola virus outbreak in West Africa between 2014 and 2016 revealed that gendered norms of women as family caregivers and frontline health workers led them to be at higher risk of infection. Calls for addressing the gendered impacts of disease outbreaks should not be ignored.[15] Other positive or negative impacts may ensue from the current pandemic. Could the face-to-face social isolation rendered necessary for infection control result in increased violence in the home? Are such measures even possible to implement in crowded urban slums, or where people simply cannot survive without a daily income from formal or informal work? Will social imbalances of race, ethnicity, gender and wealth be accentuated by the economic pressures from COVID-19? Could lockdown of countries lead to increased insularity of societies which begin to revert to xenophobic and prejudicial views? Lost income, poverty, powerlessness, intolerance – these are all factors well known as determinants and influencing factors on sexual and reproductive health and rights.[16]

We do not know exactly how the theatre of this current pandemic will play out in terms of downstream implications on sexual and reproductive health and rights. A historical analysis of global epidemic response has described a toxic mix of blaming, exploitation of social divisions and government deployment of authority, with potential for social conflict and power imbalances.[17] We are already seeing some of these effects: stories of racial abuse,[18] violence[19] and discrimination[20] are coming in from all over the world. The principles of human rights can help us think through how to take action: through fostering community participation; focusing on non-discrimination; working to ensure the availability, accessibility, acceptability and quality of services; providing access to information; and striving to ensure transparency and accountability[16] in the response to the pandemic. This time round, let us defy history, work toward international co-operation and pull together to develop inclusive, global views on how to learn from, resolve and come through this latest threat to health for all.

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