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Submission of Research Evidence on Sexual Reproductive Health Rights and COVID-19: Unequal Impact

Submitted to the Women and Equalities Committee Inquiry into 'Unequal Impact: Coronavirus and the impact on people with protected characteristics'

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CORTH

Submission of research evidence on sexual reproductive health rights and COVID-19

1. Sexual Reproductive Health Rights and COVID-19

The ongoing coronavirus COVID-19 pandemic has above all exposed systemic inequalities in healthcare and the powerlessness and vulnerability of individuals and groups to access safe and high quality Sexual Reproductive Health (SRH) services and care. This submission highlights the importance of framing sexual and reproductive health matters through human rights standards and a reproductive justice framework (especially during pandemics when they can be most easily overlooked). We define reproductive justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Sister song 2020). This submission draws on experiences from within the UK as well as India, Bangladesh, Nigeria, Belgium and Estonia.

As care for pregnant and postnatal women is an essential service (RCOG 2020) it is matter of SRH Rights that they are upheld. As SRH matters are human rights issues (tied to non-derogable rights), a human rights-based approach needs to be in place *before* a pandemic arises (Oja, 2020).

1.1 Pregnancy

As yet there is no focus on pregnant women as part of a high-risk population (such as the elderly or those with underlying conditions; Lancet Global health 2020).

Individual responses to viral infection are different for different women and for different viruses though studies in coronavirus infections such as SARS and MERS suggest a significant increase in critical illness in later pregnancy compared with early pregnancy (RCOG and RCOM 2020).

Emerging evidence suggests that vertical transmission from mother to baby antenatally is probable although the proportion of pregnancies affected and significance to the neonate is yet to be determined (RCOG and RCOM, 2020). Pregnant women with co-morbidities are at greater risk of being infected by coronavirus and experiencing complications that might lead to increased morbidities and mortalities. Evidence has shown that these co-morbidities are more prevalent in ethnic minority and vulnerable communities, requiring the use of a justice, rights based intersectional approach to understanding risk and responding and providing support to women who are pregnant during this Covid-19 crisis.

As care-providers of children, other family members and in the workforce, pregnant women face special challenges given their requirements for regular contact with maternity services and clinical settings where risk of exposure to infection is higher (Hussein 2020:1).

1.2 Domestic Violence and Pregnancy

Measures to control the spread of the virus can enhance the vulnerability of pregnant women. The pandemic lockdown has exacerbated conditions that result in violence, cutting off avenues of support and escape, with social distancing reinforcing the isolation that abusers impose (Madre et.al 2020). Stress and anxiety brought on by the outbreak can leave abusers feeling out of control, triggering violence that is rooted in a sense of entitlement and power.

Pregnant women have the right to freedom from domestic abuse. The lockdown measures make it more difficult for survivors of violence to access needed psychosocial care and support required, both informal and formal sources of support might not be accessible to them. In some countries, codes have been developed that allow women to communicate quickly that they are survivors of violence with a number code. Such measures should be developed, as well as remote services that are encrypted, and support services, to ensure that there is continued access to support.

It is important to integrate domestic violence prevention messaging into Covid-19 prevention materials for health care providers, humanitarian aid and outreach workers.

It is also important that surveys are done to assess the impact of Covid-19 on the prevalence of domestic violence and incorporate a gender-based violence analysis into government and global health institutions' responses to COVID-19, including in public policy, economic and health solutions (MADRE et. al 2020:8).

1.3 Birth

Three delays to accessing care: In these times, with the burden of the Covid-19 crisis, it is important to understand and remember how Covid-19 influences the three delay model; "Delay in decision to seek care"," Delay in reaching care" and "Delay in receiving adequate health care" (https://www.maternityworldwide.org/what-we-do/three-delays-model/). The lack of adequate information about infection rates and preventive measures might affect the decision making of women to access routine ANC care and emergency care. Women who do access care might face health systems that are overwhelmed and might experience delay in access to basic emergency or comprehensive obstetric and neonatal care required. Efforts should be made to ensure that information and resources are made available in easily accessible language for women to understand how Covid-19 affects their pregnancy.

Care should also be made to ensure that sufficient resources are made available to ensure that there are enough service providers and health infrastructure to deal with the intensive care that Covid-19 patients will require, as well as the specific needs of pregnant women, who may or may not be infected by Covid-19.

Community or grass-roots responses might need to involve supportive care and advocacy for ethnic and minority populations who might experience delay in reaching and receiving adequate care.

Rights to a birth partner: "Labour companions play a number of roles in supporting women: they can bridge communication gaps between clinical staff and women (e.g. companions can take the role of a translator for a woman who speaks sign language/does not speak the local language), provide emotional support and also act as advocates for women, speaking up in support of their preferences. Thus, having a birth partner of one's choice is a human rights matter" (Oja 2020). In order to balance the risks of providing supportive care and preventing increased infection rates, resources will need to be made available to ensure birth partners are educated on infection control and have access to protective gear, to allow them to accompany the pregnant women.

Advice from the RCOG regarding intrapartum services states that, 'a single, asymptomatic birth partner should be permitted to stay with the woman though pregnancy and birth (unless the birth takes place under general anaesthetic' RCOG 2020:15)

Right to information on birthing options: Women have a right to know if there is a restriction in the birth options available during COVID-19 as well as related access to accurate health information on the birth options available and the risks and benefits on home birthing, caesareans etc. during the epidemic.

1.4 Contraception

The right to contraception. Although professional organisations such as the Faculty for Sexual and Reproductive Health Care and the British Association for Sexual Health and HIV were quick to respond with guidelines to support clinical practice including a switch to online and telephone care (https://www.fsrh.org/fsrh-and-covid-19-resources-and-information-for-srh/) the reduced access to face-to-face care has caused difficulty for those using long acting reversible methods who have struggled to obtain injectables, intrauterine devices and implants or help with the management of side effects of these methods.

Where online services or remote services have not been commissioned then this has resulted in significantly reduced access to basic contraceptive services which is likely to be reflected in an increase in unintended pregnancy over the next 12 months.

1.5 Abortion

The right to abortion should be upheld. Abortion services can be hardest hit during pandemic outbreaks (Hussein 2020) and yet are essential, time-bound matters. There must be no restrictions to abortion access. Governments have an obligation to ensure safe access to both medical and surgical abortions and follow WHO guidelines to allow primary care workers such as nurses and midwives to manage both surgical and medical abortion in the first trimester (WHO 2015; APPG report 2018)

Abortion services can only be obtained in abortion clinics after a counselling process. With the current lockdown measures it is difficult for most women and especially women from ethnic minorities to access abortion services. Telemedicine and remote consultations are currently being used and upscaled for diagnostic and simple treatment procedures. Lessons from this can be applied and up-scaled to ensure access to safe abortion services especially for first trimester abortions.

Current RCOG COVID-19 guidelines suggest, 'providers in England, Wales and Scotland, providers to offer a complete early medical abortion service with consultation taking place via video or teleconferencing, and a treatment package sent to the woman's home by courier or post. This will help to limit the spread of COVID-19 and allow women access to abortion care if they are self-isolating. Providers should now organise their services to adopt this new model of care'. (RCOG 2020, April 9). In addition, it is suggested that a registered medical practitioner can rely on the information obtained by other members of their team when certifying an abortion. This certification can therefore be performed remotely, including through use of an electronic signature.

We suggest that these procedures be separately communicated to ethnic minority communities. There is a chronic issue of misinformation and poor knowledge pertaining to contraceptive and abortion care that constrains reproductive wellbeing and decision-making among Pakistani, Indian and Bangladeshi communities in Britain (Unnithan and Kasstan 2017). In areas with large BAME communities, healthcare providers should produce community-specific SRH COVID-19 information to address these issues.

1.6 Mental and maternal health care

The COVID-19 epidemic increases the risk of perinatal, postnatal and postpartum anxiety and depression. Are we supporting women who are at risk of post-partum, post-natal depression?

Restricted access and self-isolation during the Covid-19 lockdown can increase the risk of postpartum depression and perinatal mental health issues among pregnant women. Access to psychosocial support, is difficult during the covid-19 epidemic, and policy and programme responses are focused on the emergency response, but not necessarily inclusive of mental health responses.

State led policies that respond to the Covid-19 epidemic must integrate mental health and psychosocial support. This might involve allocating funding to support more training and skilled resource persons, as well as setting up remote systems to support women, who might not be able to transport themselves to counselling centres or experience delay in reaching the centres.

Assessing the impact of the Covid-19 crisis on perinatal mental health issues is also important to understand the impact of the disease.

1.7 Right to deliver SRH services safely and freely

The pandemic has exposed the vulnerability, stigma and stress faced by healthcare professionals. Their presence is vital to ensuring women's sexual and reproductive rights are upheld. Lack of antenatal check-ups and immunisation due to virus restrictions could cause increase in infant and maternal mortality/health complications.

Emerging accounts on the lived experience of health care workers and nurses in India working in SRHR during a global pandemic have led several states to curtail outreach services for immunisation and maternal health services such as ante-natal check-ups. Public health experts have warned that such a move could lead to an increase in maternal mortality and further lower the already low immunisation levels in most states (Nagarajan 2020). In response health activists have demanded that the State government launch door-to-door immunisation and antenatal care (ANC) activities to address the issues of malnutrition and infection among women and children (Iqbal 2020).

1.8 Broader Issues, Gendered Impact

Disease outbreaks affect men and women differently. Emerging research suggests that more men than women are dying due to sex-based immunological or gendered differences (Wenham, Smith and Morgan 2020). They suggest that it is critical to understand how disease outbreaks affect men and women differently to begin to estimate the primary and secondary effects of a health emergency on individuals and communities.

Other viral epidemics such as Zika and Ebola have highlighted the significance of recognising the gendered power dynamics that come into play when women don't have autonomy of their sexual and reproductive lives with vulnerabilities further compounded by inadequate access to health care (e.g. abortion) as well as financial resources (Wenham et.al ibid, 2020).

Right to follow-up: Increasing frequency of chest pain in women in particular (Eziefula, experience on ward). This should be up-scaled. Are women's symptoms being taken seriously? Drawing on data from British Heart Foundation that women are under investigated and under-treated for cardiac symptoms https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/women-and-heart-disease/download-bias-and-biology-briefing).

2. Recommendations

Integrate a rights-based, reproductive justice and intersectional framework to SRHR policy responses to Covid-19, with an understanding that ethnic and minority populations are more affected during the epidemic.

Allocate resources to ensure there is integration of mental and psychosocial support services to responses developed. These should be prioritised, and remote interventions should be trialled and supported

Through online and social media campaigns, health promotion and awareness activities should be carried out to educate pregnant women on their rights to access care and resources available to them during the covid-19 crisis

Create multidisciplinary panels that work closely with grass roots and civil society to ensure that responses are grounded, and resources allocated to services and interventions for the people who need it most.

There is a crucial need for greater research and a global research network to evaluate the use of new COVID-19 treatments and vaccines in pregnant women (Lancet Global Health 2020) including social and behavioural responses to vaccine anxieties among ethnically diverse groups of women. It is important to consider plausibility-based evidence frameworks for evaluating the impact of human rights-based approaches (Unnithan 2015) of COVID-19 on maternal health.

3. Further Information and Resources

3.1 Contacts

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Further information about our research projects can be found at:
http://www.sussex.ac.uk/corth/research/current

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