Policy brief

Sexual and reproductive health and rights after Covid-19

A forward-looking agenda

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Key messages

Despite several progressive responses aimed at maintaining sexual and reproductive health and rights (SRHR) during the Covid-19 pandemic, the availability of SRHR services and products has been restricted, and this is felt especially keenly by already-marginalised groups.

The following recommendations can embed an understanding of SRHR needs across multiple overlapping systems and structures, and use the opportunity created by Covid-19 to place SRHR firmly at the top of public health agendas and push for progressive and lasting social change.

At the **macro** level, there is a need for political will, concrete commitments and funding to prioritise SRHR-related services and programming. Governments can make tangible commitments at the Generation Equality Forum, the G7 and other spaces this year. It will be critical to resist further austerity and funding cuts in the wake of the pandemic and the likely recession to follow.

National-level commitments and policies need to be translated and operationalised into integrated and inclusive programming at the **meso** (or sub-national) level through the coordination of an inter- and multi-sectoral approach with different organisations with an interest in SRHR.

At the **micro** level, people-centred care approaches alongside community engagement are critical so that services are culturally appropriate, holistic, and user-friendly for girls, women and gender-diverse people. Community members, including end-users, need to be involved from the design of programmes through to delivery and monitoring and evaluation.

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1. Introduction

The Covid-19 pandemic has upended many global systems and structures, threatening to roll back progress on rights for many marginalised groups and hard-won gains on a range of social and economic indicators. Its effects have been especially notable on sexual and reproductive health and rights (SRHR), an area that already suffered from poor resourcing and an energised political opposition. When a crisis brings about such rapid reversals in services, benchmarks and commitments, and sees services overwhelmingly needed by women classed as 'non-essential', it is clear that the underlying norms around choice, bodily autonomy and the rights of women, girls and gender-diverse people have not meaningfully changed. These detrimental impacts underline a critical need, which has always been there, but is now cast into sharper relief, for an approach that embeds SRHR across multiple systems, levels and sectors, and that takes transformative change in gendered norms, led by women, girls and gender-diverse people, as a core part of its mission.

2. Setting the scene

The Covid-19 pandemic has catalysed a range of complex direct and indirect impacts on SRHR access around the world, conditioning both the availability of particular services and supplies, and barriers to access for particular groups of people. Global supply chains having been disrupted, health care facilities have been closed, contact between health practitioners and patients has been drastically reduced, and health-seeking behaviour has declined. Early on, a 10% decline in contraceptive usage and over 15 million unintended pregnancies were predicted (Haddad et al. 2021). Reduced contraceptive use will mean more births, with a growing proportion taking place without medical attention or in unsafe conditions. Gender-based violence (GBV) has increased, especially domestic violence, as has early marriage (Jones, 2021). Many of the restrictions and interventions imposed on pregnant people have been unnecessary for controlling virus spread, inconsistent with patient dignity and bodily autonomy, and not medically or scientifically justified. By July 2020, 'traumatic' incidents had been reported across 45 countries that defied World Health Organization guidelines, including deaths of pregnant women due to care delays, excess restrictions like not allowing pregnant people to be accompanied in childbirth, and caesarean sections performed without medical justification (Archer and Provost, 2020; Sadler et al., 2020). Travel restrictions have also meant that women are cut off from contraceptives and other services in places like Fiji (Hamilton, 2020), as well as safe abortion care in Northern Ireland (Kirk, 2021). These impacts fall especially hard on already-marginalised groups, including LGBTQIA+ people, refugees and migrants, racialised groups and sex workers (George et al, 2021; Limb, 2021; Ghimire and Samuels, forthcoming).

At the same time, a number of progressive responses aimed at maintaining SRHR have shown what is possible. Health systems and civil society organisations have developed innovative means – virtual consultations or counselling, self-testing (for STIs and pregnancy) and WhatsApp

groups to share information and seek help for survivors of GBV – of reaching people in need amid lockdowns and other restrictions, and some countries (overwhelmingly wealthy ones) have expanded access through telemedicine, extended gestational limits and at-home options (Hurtes and Boffey, 2021). Awareness has also been generated around SRHR, with 59 governments joining a statement reaffirming that SRHR services are essential.[1]

While gendered norms usually discriminate against girls and women, are slow to change and can be sticky or persistent (Harper et al., 2018), crises and shocks can sometimes create opportunities for positive change (Holloway et al., 2019; Samuels and Jones, 2015).[2] While Covid-19 may prove to be one of these moments – for SRHR if not for other areas[3] – this is not yet clear, nor is the durability of any such changes over the longer term guaranteed.

3. Where and how can we start?

What can we do both better and differently in relation to SRHR? How can we use the opportunity created by Covid-19 to push for progressive and lasting social change? To simplify a complex reality, we propose a multi-level framework, with each level – macro, meso, and micro – having specific roles and responsibilities, but interacting with the other with some crossing cutting elements.[4] This model is by necessity a simplification of a complex set of systems and dynamics. Nevertheless it is a helpful tool for policy-makers and others to think strategically on how to embed an understanding of SRHR needs across multiple overlapping systems and structures.

3.1 Macro level: policy

At the macro level, rights to bodily autonomy and reproductive choice have long been challenged by conservative, religious and anti-choice political movements. The pandemic is therefore demonstrating the precarity of progress on rights and inclusion – that no matter how much progress is made, regression is always possible. The pandemic may also be revealing the shallowness of political commitments on SRHR when we see services very quickly or unnecessarily withdrawn, undue restrictions imposed or funding cut – all with the pandemic as justification.

The shrinking political space around SRHR is part and parcel of the wider global backlash against gender justice, LGBTQIA+ rights and abortion rights. This political opposition to SRHR in general

1 See joint statement: www.government.nl/documents/diplomatic-statements/2020/05/06/protecting-sexual-and-reproductive-health-and-rights-and-promoting-gender-responsiveness-in-the-covid-19-crisis

2 See also www.alignplatform.org/resources/conversation-zainab-bangura

3 Overall, the pandemic has produced adverse impacts on women and girls with marked socioeconomic decline and exclusion, a crisis in care related to caring for sick family and community members as well as home schooling, and unequal risks and secondary effects (Smith et al., 2021).

4 This framework is developed and described in further detail in Samuels et al. (2017), and was also recently applied to think through a comprehensive approach to addressing Covid-19 within health systems more widely (Samuels et al., 2020).

and abortion in particular can be seen in the dilution of UNSCR 2467 (2019) on sexual violence in conflict to exclude SRHR, after threats by the United States to veto the resolution. Until very recently, the US Mexico City Policy blocked organisations in receipt of US funding from providing abortion counselling or referrals and from participating in related advocacy. In the context of the pandemic, particular services or spaces have been designated as 'essential' or 'non-essential', in order to restrict access in the United States and a number of European countries (McCammon, 2020; Hurtes and Boffey, 2021).

To build comprehensive and inclusive SRHR access now and in the future, there is a clear and pressing need for political commitment by leaders and champions at every level. To that end, this year the W7 Summit called on G7 leaders to support the 'strongest possible language' on bodily autonomy, including explicit advocacy for access to safe abortion, emergency contraception, self-managed care and comprehensive sexuality education (CSE). Governments can also make tangible commitments under the Generation Equality Forum's Action Coalition on Bodily Autonomy and SRHR.

Adequate and appropriate funding is essential but all too often lacking. The UK's sudden withdrawal of 85% of its funding to the UN Population Fund's reproductive health work is a clear illustration of the fragility of material support for SRHR. In the wake of the pandemic and the likely recession to follow, it will be critical to resist further austerity and funding cuts. These macro-level components of political will, concrete commitments and funding then filter down to be operationalised as services and programming.

3.2 Meso level: implementation

The meso (or sub-national) level is where national-level commitments and policies are translated and operationalised into programmes and interventions with appropriate resourcing envelopes. This entails coordination and development of partnerships with different organisations with an interest in SRHR – governments, NGOs, faith-based organisations, the private sector. Each organisation brings its own skills and expertise, and these need to be combined to achieve a unified, effective and sustainable response.

As with the macro level, champions are required to spearhead and coordinate a response to SRHR at sub-national level. These champions must be aware of the latest initiatives and directives related to SRHR and how these can be operationalised at sub-national level. This may fall naturally within the ambit of government and ministries of health. However, SRHR should not be the sole responsibility of ministries of health or organisations just focusing on health – an inter- and multi-sectoral approach coordinated at the meso level is required. Working with the education sector and through schools, for instance, will be critical to coordinate CSE. The water, sanitation and hygiene sector is essential to ensuring adequate responses to SRHR-related challenges, for instance, in relation to hygiene practices during menstruation.

There is a need to develop integrated and inclusive SRHR-related programming at the meso level. Thus, SRHR programming needs to take into account different population groups (age, gender, sexuality, ethnicity, disability) at sub-national level and tailor programmes appropriately. It also needs to consider how to deliver these targeted services building on existing programming, services and infrastructure (questions to address might include whether youth-friendly health services are the most appropriate way to deliver SRHR services, or whether broader life skills programming may be an appropriate way to get messages across around SRHR).

Addressing gender norms at this level includes ensuring that SRHR service providers are gender-sensitive and welcoming, that there are sufficient female health providers, and that health providers are aware of gender norms and attitudes (including their own) that discriminate against girls and women and constrain their access to SRHR-related services. Capacity-building on eradicating bias and discrimination in service delivery and creating environments centred on patient dignity and respect will be necessary here, alongside effective communication. Actors at this level will feed information up from the micro level (e.g. supplies of family planning products are running out), and down from the macro level (e.g. a new national policy related to sex education in schools is being rolled out).

3.3 Micro level: users and communities

The micro level is where end-users become engaged and where services and programming are accessed. It is also where communities and individuals negotiate norms and behaviours, adapt to their contexts, make choices and navigate and make sense of the wider cultural, legal and political environments. This includes continuing to adhere to discriminatory gender norms such as early marriage for girls, taking girls out of school and dowry practices, irrespective of the law.

To ensure that communities and individuals can access SRHR-related services and programming, people-centred care approaches alongside community engagement are critical so that services are culturally appropriate. Community members, including end-users, need to be involved from the design of programmes through to delivery and monitoring and evaluation. Existing local (government, NGO, informal) structures should be engaged and built on to ensure sustainability and ownership.

Community health workers are often the first port of call: they are based in the community and are trusted and respected. They also often provide family planning information and services and act as traditional birth attendants. As such they are key members of a health system, albeit not always appropriately integrated, paid and valued.

The people for whom services are targeted also need to be involved, including people of all genders and ages. In order to address norms which may constrain girls and women from accessing SRHR-related services, gatekeepers or norm enforcers at community level also need to be engaged: older people, local leaders and religious leaders in communities, and gatekeepers

such as front desk staff and security guards in clinics. Raising awareness around the importance of ensuring the SRHR of girls and women, and addressing discriminatory gender norms around these, would be important components of a holistic SRHR approach. Similarly, ensuring that SRHR health services are user-friendly for girls, women and gender-diverse people (language, accessibility, gender of service providers) is critical.

Working with schools and teachers to provide age-appropriate and tailored CSE in schools is critical, with wider ramifications for girls' fertility and life choices, employment opportunities and their empowerment broadly writ. Engaging parents and other key community stakeholders to obtain support and buy-in is vital also to avoid backlash; this may be through parents' and teachers' associations or other community fora. Using role models is also an effective approach.

4. Conclusion

Covid-19 has revealed and exacerbated problems related to SRHR, rather than creating them. The pandemic has had (and continues to have) wide-ranging negative effects on SRHR, and has highlighted the fragility of access to SRHR-related services and products. Equally, there are windows of opportunity and glimmers of positive or progressive effects from the crisis, but these are elusive and there could easily be further push-back and backlash. This is especially the case since SRHR has often been viewed as the Cinderella of public health – because it deals with difficult topics like sexuality, and because it often entails confronting patriarchal norms and power structures around control of women and their bodies. These are hard to shift, but shocks such as Covid-19 can provide opportunities to build back differently and more inclusively.

We need to think holistically across different levels, taking an intersectional and multi-sectoral coordinated approach. This also entails recognising the need to engage and partner with a diversity of stakeholders with distinct roles and responsibilities, including end-users, community members, policymakers and the private sector.

For too long, SRHR has gone under the radar of many debates in public health, including discussions related to universal health coverage. We must use the opportunity provided by Covid-19 to explicitly place it firmly at the top of public health debates: politically prioritised, properly resourced and with the 'rights' in SRHR as a non-negotiable part of the conversation. We also need to partner with local organisations and women's movements, many of whom have been challenged during the pandemic, but remain vocal advocates and change-makers for SRHR.

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