**Women and girls face greater dangers during COVID-19 pandemic**

***Essential sexual and reproductive health services must be maintained***

The COVID-19 pandemic is having potentially catastrophic secondary impacts on the health of women and girls around the world. Decisions made at every level of the response to the pandemic are resulting in women being further cut off from sexual and reproductive health services, threatening sharp rises in maternal and neonatal mortality. Women and girls are often denied care outright or face dangerous delays getting the services they need. The impacts of misguided policies and barriers to care are especially severe in places with weak or overburdened health systems—including many of the places where Doctors Without Borders (MSF) works.

A hugely significant lesson from the West Africa Ebola outbreak of 2014-16 is that the [biggest threat to women’s and girls’ lives](https://pubmed.ncbi.nlm.nih.gov/28159028/) was not the Ebola virus, but the [shutdown of routine health services](https://pubmed.ncbi.nlm.nih.gov/28722621/) and people’s fear of going to health facilities where they could get infected. Thousands more lives were lost when safe delivery, neonatal, and family planning services became inaccessible due to the outbreak. Right now, we are witnessing the same dynamic on a much larger scale.

MSF teams at our medical projects around the world say they are already seeing the painful indirect effects of the pandemic on women’s lives. Based on interviews conducted with staff in Colombia, Honduras, Greece, Uganda, Mozambique, South Africa, Iraq, and Afghanistan, the biggest challenges facing women and girls right now include:

* closures and cuts to sexual and reproductive health services
* movement restrictions, including travel bans, lockdowns, and curfews
* global supply chain disruptions
* lack of clear public health information and guidance

In addition, there has been significant reporting about the economic impacts of the pandemic, with poor and marginalized communities hardest hit. Refugees, migrant workers, and people working in informal jobs already face extreme difficulties getting access to basic health care, and these challenges are compounded by COVID-19.

**Sexual and reproductive health care is essential health care**

Sexual and reproductive health needs are often neglected in the midst of an emergency—and COVID-19 has been no different. In March, the World Health Organization (WHO) issued [interim guidance for maintaining essential services during an outbreak](https://apps.who.int/iris/handle/10665/331561), which included advice to prioritize services related to reproductive health and make efforts to avert maternal and child morbidity and mortality. Nevertheless, as governments, ministries of health, and frontline providers were forced to make tough choices about which services are most important, women were often left out. Resources for women’s health care were sometimes diverted to support COVID-19 activities.

Although access to safe delivery care has long been acknowledged as an essential health service, many pregnant women suddenly found themselves with fewer options for care. In Likoni, Kenya, health centers where women normally deliver were shut down and health workers were reassigned to the COVID-19 crisis. In Mosul, Iraq, after a main government hospital was temporarily repurposed as a COVID-19 treatment center, MSF’s hospital started seeing much higher numbers of pregnant women coming in for delivery care.  MSF’s project in Choloma, Honduras, also saw a sharp rise in patients—as government hospitals in the city also became COVID-19 centers, MSF’s average births per month rose from 55 to 75, despite a paralyzing total lockdown on movement.

Some sexual and reproductive health services, such as contraception and safe abortion care, are often seen as non-essential or even illegitimate. These services have been highly politicized, making them all the more likely to be deprioritized during a crisis as we are seeing now.

The current US Administration is using its power as the largest funder of global health assistance to try to eliminate support for sexual and reproductive health care from the UN’s [Global Humanitarian Response Plan for Covid-19](https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf). This affects a wide spectrum of essential care for women, from safe deliveries to sexual violence treatment to cervical cancer screenings. US officials are objecting to the plan’s inclusion of sexual and reproductive health services as a priority, and warning the UN not to use the coronavirus crisis “as an opportunity to advance access to abortion as an ‘essential service.’ ” This is only the most recent example of how US policies intended to limit access to abortion around the world actually have far wider public health impacts. We have seen this before, with the US Administration’s [reinstatement and expansion of the Global Gag Rule](https://www.doctorswithoutborders.org/new-global-gag-rule-more-dangerous-ever) in 2017, cutting off funds for essential family planning services and also hurting organizations and health centers providing care for malnutrition, malaria, and HIV.

Since the COVID-19 pandemic began, thousands of [centers providing sexual and reproductive health services have shut down](https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world), and more closures are predicted. A [study](https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health) by the Guttmacher Institute predicts closures could eliminate as much as 80 percent of these services, including contraception and safe abortion care. The study estimates that even a 10 percent cut would mean some 15 million additional unintended pregnancies, more than 3 million additional unsafe abortions, and 28,000 additional maternal deaths. Unsafe abortion is already one of the top causes of maternal mortality worldwide, killing at least 22,800 women and girls and seriously injuring millions more every year. It is both the most easily preventable cause of maternal death—through access to contraception and safe abortion services—and the most difficult—due to deeply rooted stigma, criminalization, and political and social pressures.

By June, Latin America was the hotspot of the COVID-19 pandemic, with more confirmed cases than any other region. MSF’s project along Colombia’s border with Venezuela, in Arauca department, has continued to provide the essential sexual and reproductive health services that the country does not offer to refugees and migrants, including safe abortion care. Although abortion is largely decriminalized in Colombia, access to these services can be very difficult even for Colombian nationals. “In normal times, we’ve had cases of termination of pregnancy from the Colombian population,” says Anne-Cécile Trapy, MSF project coordinator in Arauca, “because they were encountering social barriers and barriers in the health facilities that couldn’t be overcome.” In the context of COVID-19, even more Colombians have been coming to MSF for safe abortion services primarily intended for Venezuelan refugees and migrants.

MSF published a study in 2019 that found nearly a third of the patients who came for safe abortion care at our project in Tumaco and [Buenaventura](https://www.doctorswithoutborders.org/what-we-do/news-stories/story/lifeline-colombia), in western Colombia, had been turned away by another facility first. Many of them described being humiliated or given wrong information regarding their legal rights. Many health care providers in Colombia cite religious or moral beliefs as reasons for refusal. COVID-19 has only made it easier to discourage women from accessing safe abortion services.

Abortion is a time-sensitive service, but Trapy says women needing safe abortion care are facing appointment dates well into the future. “It can delay the date of the [abortion] and then it can become more complicated,” she says. If a woman needs a second-trimester abortion, she has to go to the capital, Bogotá. This would be difficult in normal times, but during COVID-19—while curfews are in place, transportation is restricted, and incomes have plummeted—the challenges could be insurmountable.

In Rustenburg, South Africa, abortion services were initially shut down by health facilities due to the misperception that abortion services are not essential health care. MSF’s advocacy with local health authorities and providers helped get those services reopened. In Beira, Mozambique, MSF teams say that many women just assumed that abortion services would not be provided during the lockdown. Abortion there is legal up to 12 weeks, but women still face a range of barriers, including a mandatory three-day waiting period and the widespread belief that husbands must give their permission. In each of these three countries, a lack of clear guidance and information, on top of a history of institutional barriers, has impacted women’s access to the care they need.

**Travel bans, lockdowns, and movement restrictions compound the dangers**

Travel bans and movement restrictions imposed to limit the spread of the coronavirus have had unintended consequences on all aspects of sexual and reproductive care. MSF’s maternity hospital in Khost, eastern Afghanistan, saw a 40 percent drop in patients in early June. The facility typically delivers an average of 2,000 babies per month and treats sick newborns in its 22-bed neonatal unit, filling tremendous needs in an area with few high-quality, free health care services. Keeping the hospital open has been a struggle as staff have fallen ill and open midwife and gynecologist positions have gone unfilled due to international travel restrictions. (By the end of the month, the hospital was only able to accept women with complications who needed lifesaving emergency care.)

As challenging as it is to keep activities running, the drop in patient numbers is scary. Women in this area have faced difficulties getting transportation. Many are likely delivering at home with traditional birth attendants who have had no formal training, in an environment that may not be safe. “It’s very worrisome,” says Severine Caluwaerts, sexual and reproductive health advisor for the project. “We know some of those women are delivering at smaller community health centers that have built up capacity recently, which is good,” says Caluwaerts, but she warns that there are not nearly enough local clinics to meet the huge demands. Many of the maternal and neonatal deaths caused by movement restrictions—in Afghanistan and around the world—will likely never be counted, precisely because women never made it to a health facility.

In Kenya, pregnant women have struggled to find transportation to hospitals at night after curfew. At our project in Likoni, MSF has been writing notes for drivers to present to police if they get stopped after leaving the hospital. People were scared following news reports of a driver who was stopped and brutally beaten by police while driving a woman in labor to a health facility after curfew. In Mathare, also in Kenya, the lack of transportation for women at night led MSF ambulances to double their activity in April.

Lockdowns and social distancing measures have also contributed to a disturbing spike in reports of domestic violence, including sexual violence. Staying home is not safe for many women and girls who may be trapped with an abuser. The [World Health Organization](https://www.who.int/news-room/feature-stories/detail/violence-against-women) reports that one in three women experience physical or sexual violence, mostly from an intimate partner. During the COVID-19 pandemic, emerging data from around the world show that domestic violence has intensified, according to [UN Women](https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006). Tensions can build up in confined spaces, especially with added stress over health concerns, economic insecurity, and fear for the future.

Even as the need for sexual violence care is apparently growing, access to health services is more difficult. In many places, MSF is seeing a disturbing rise in reports alongside reductions in people actually coming for care. In South Africa, a national hotline that receives reports of sexual violence saw a three-fold spike in calls after the country-wide lockdown took effect. “But while there was an increase in reports, there was a decrease in clinic visits,” says Kgaladi Mphahlele, MSF safe abortion care and family planning activities manager in Rustenberg, a platinum mining city with a large migrant community. Across the city and surrounding area, other clinics reported the same. Many callers were likely not able to leave their homes or get transportation to a health facility, Mphahlele says. MSF provides transportation for people who seek treatment for sexual violence, and we have continued to do so throughout the lockdown. We have also started telehealth counseling.

Even in normal times, accessing care for sexual violence can be extremely difficult due to stigma, fear of retribution, and a lack of trust in authorities, among other reasons. Now women and girls face even more hurdles. Only emergency cases are being seen at many health facilities, and only by appointment. Treatment for sexual violence is time-sensitive: rape victims must come within 72 hours in order for post-exposure prophylaxis against HIV to be effective, and within five days for emergency contraception to work. Because sexual violence is a taboo subject, many people do not know about the urgent need for treatment—let alone that this is an essential service.

In Choloma, Honduras, our team is seeing a disturbing pattern. “It’s been reported that gang violence has decreased during [lockdown], but domestic violence has gone up—like it has everywhere,” says Dr. Jennifer Stella, MSF’s medical advisor in Choloma. Yet the number of women coming for MSF’s sexual violence treatment services has dropped, likely due to restrictions on transportation, she says. “When patients are able to get in touch with the social worker or the psychologist, we send taxis for them, to actually get them to the clinic.”

COVID-19 symptom screening is part of the infection control measures at many health facilities right now but may also present a barrier to care, especially for people seeking treatment for sexual violence. MSF’s project in Rustenberg has a carefully considered route to care to protect patient privacy, but this is not the case at many other facilities in the area. “On arrival at many primary health care centers, patients are asked, ‘What are you here for?’ before proceeding to be screened for COVID-19,” says Mphahlele. “For a person to answer, ‘I was raped,’ at the gate is not possible.”

**Desperately needed supplies out of reach**

Shortages of personal protective equipment (PPE) have been a major concern since the start of the COVID-19 outbreak, and this adds another barrier to health care for women and girls. In Mathare, Kenya, MSF teams have seen private health facilities where women usually receive sexual and reproductive health services shut down due to a lack of PPE. In Zimbabwe, where MSF supports a government-run cervical cancer program, services were greatly reduced, in part due to a lack of PPE. The number of screenings dropped from more than 400 in March to around 50 in April.

Supply chain breaks affect much more than PPE. The impact of these disruptions is being felt all over the world, but especially in low- and middle-income countries. In April, the UN Population Fund, the agency dedicated to family planning, reported [likely stockouts of critical products in 46 countries](https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Update_No-3_UNFPA_Supplies_16April.pdf) over the following six months—including contraceptives, medication abortion pills, and maternal health medicines like oxytocin, an essential drug that prevents and stops bleeding during childbirth. Manufacturers are seeing shipping charges spike due to reduced numbers of flights and staff. If these costs are then passed on to the buyer, sexual and reproductive health could become even harder to access for poor women. If authorities don’t do more to ensure that essential medical supplies are accessible to those who need them, the result will be even more maternal deaths.

There have been a series of reports by [news media](https://foreignpolicy.com/2020/05/04/coronavirus-africa-abortion-access/) and by [major manufacturers](https://www.devex.com/news/opinion-how-will-covid-19-affect-global-access-to-contraceptives-and-what-can-we-do-about-it-96745) about the domino effect of the supply chain breakdown resulting in shortages of family planning products. Manufacturing halts in countries like China, India, and Thailand earlier this year meant that regular orders of everything from condoms to mifepristone—an abortion medication—could not be filled. Now, factories face a long list of backorders. Shipments of products have gotten stuck at airports and seaports, so now shipping and customs clearance services also face long backlogs. Supply deliveries are further delayed along transportation routes due to curfews, lockdowns, and checkpoints.

MSF’s programs have also been impacted by supply issues. Our teams have been able to mitigate the worst effects by having essential stocks pre-positioned—or placed in strategic locations close to our projects. This is something we do to prepare for emergencies. Nonetheless, many of our programs worldwide, including our sexual and reproductive health projects, have been affected by a lack of medicines and PPE. The impact varies from project to project: at one of our programs for Rohingya refugees in Cox’s Bazar, Bangladesh, major shortages in medications, as well as staff, forced our team to limit antenatal care services only to women in their third trimester. In other places, MSF is able to temporarily support health facilities with critical items.

At our project in Arauca, Colombia, MSF is providing women with long-term supplies of contraception. In order to help avert an increase in unwanted pregnancies and potential unsafe abortions after the lockdown period, the team is recommending that women take several months’ worth of contraception pills or consider using longer acting contraceptive methods. The same strategy is being used in many MSF projects that have adequate supplies.

**Misinformation can be deadly**

Another challenge facing women and girls is the thicket of rumors and misinformation about the coronavirus itself. Especially in places where there is already a lack of trust in authorities and in the safety of health facilities, fear can be a powerful barrier to care. Clear information and guidance from trusted sources are critical. This is yet another lesson from the West Africa Ebola crisis: the fear surrounding infectious disease outbreaks can be more deadly than the virus itself as people avoid going to hospitals and health centers, or delay seeking care until it is too late.

In normal times, nearly all MSF projects rely on health promoters in the communities and facilities where we work to give people clear guidance on what to do if they have a health issue. These health promoters, who are often members of the local communities themselves, play a critical role in connecting people to sexual and reproductive health care. Early on, many of these outreach teams transitioned to a focus on preventing the spread of the coronavirus—telling people what symptoms to look for, how to prevent the spread of infection, and where to go in order to get treatment. Since then, some teams, including in Rustenburg, South Africa, have added back important messaging on sexual and reproductive health services.

Many of these health promotion teams have had to change how they work. It’s risky to meet with large crowds of people during an outbreak, so in Arua, Uganda, health promotion teams are working with community leaders. “We are still very active in the community,” says Marielle D. Celicourt-Toussaint, activity manager for MSF’s sexual and gender-based violence program in Arua. “We modified the health promotion method to maximize our village health team, including the youth group leaders, the block leaders, the religious leaders, and the chairperson as well. So what we do, it's the old telephone line—we meet one on one or one on two, since we need to keep social distancing. And we raise awareness with these leaders, who in turn inform other leaders or other community members.”

Some projects have found creative ways to try to reach people with critical information. In Kasese, Uganda, MSF saw a drop in attendance at the Kasese Adolescent Center, a program that provides contraception and treatment for sexually transmitted infections (STIs), among other services. The center supports mainly teenagers who have no other way to access this care in a culturally conservative area. The team was concerned, knowing that reports of domestic violence, including sexual violence, were on the rise during lockdown. In order to keep the channels of communication open, the Kasese team started a community radio show in collaboration with the Ministry of Health where people can call in with questions. “The main topic we talk about is COVID … and mental health management due to lockdown,” says Alix Jobbe Duval, manager of the center. “We also raise awareness about domestic violence and sexual and gender-based violence.” The team uses the show to remind people that their health facilities are open.

**A push to adapt and innovate**

Many MSF projects are adapting to the curbs on face to face care by using some form of telehealth, whether it’s establishing hotlines for people with health concerns or reaching out by phone for counseling sessions. In Arauca, Colombia, the MSF team has been using telehealth for antenatal care (ANC)—regular consultations with pregnant women in the months before they deliver—and post-natal care (PNC) during the weeks after delivery. “We have to balance between the [possible] danger of their coming to the health facilities and getting infected with COVID-19, and the need to follow up on their pregnancies,” says Trapy, the project coordinator. If a patient does not have complications, they are advised not to come for an in-person consultation.

At MSF projects, ANC and PNC services usually involve large crowds of expectant or new mothers waiting for their turn in the consultation room. Infection prevention and control measures during this pandemic have required our teams to adapt. Some projects are reducing the number of ANC visits to the minimum of four prior to delivery, or scheduling women to be seen over several days rather than having everyone come on the same day. Clinicians are also giving women a long-term supply of iron pills to prevent anemia.

At MSF’s project for sexual and reproductive health on the island of Samos, Greece—where a camp originally set up for around 650 migrants and refugees now hosts more than 6,000—the team is using telehealth in a different way. After health promotion activities were cancelled due to the risks of spreading the virus, the team started identifying people with medical backgrounds who were living in the camp and wanted to participate in outreach support. There is now a network of around 30 people recruited from this community of migrants and refugees who are actively identifying individuals with health needs. They communicate by phone with the MSF team and connect those patients with care.

Adapting services to make them safer is crucial during the pandemic. But this is also the time for innovation. The COVID-19 pandemic could be an opportunity to fundamentally change aspects of how sexual and reproductive health services are delivered, in order to make them more accessible. “We have to simplify the process and meet women where they are,” says Dr. Manisha Kumar, head of MSF’s task force for safe abortion care, “not sit around and wait for them to come to health facilities. Women need to be trusted and empowered to care for themselves.”

A move towards more community-based and self-managed care for some services has already begun at a few MSF projects. In Malawi and Mozambique, MSF runs programs specifically for sex workers who have a difficult time getting the health care they need due to stigma. MSF teams have trained full-time peer workers, all of whom are current or former sex workers, to help provide contraception care, HIV screenings, and other services—and to refer their peers to MSF staff for specialized care. This makes essential health care much more accessible for some of the most vulnerable communities.

The safety and effectiveness of medication abortion—or abortion with pills—has opened up more possibilities for self-managed abortion care. A self-managed abortion is when a woman administers the abortion pills herself at home, with support from those who share accurate information, help her to access quality medicines, and provide other assistance, if needed. Medication abortion is proven to be more than 99 percent safe and more than 95 percent effective. Most women do not need to come to a health facility for an ultrasound or a follow-up visit, which is particularly relevant during a pandemic. The United Kingdom’s Department of Health and Social Care made headlines in late March when it announced that due to the COVID-19 lockdown, they would temporarily support women to access medication abortions at home after a telephone consultation with a health care provider. MSF has also started to explore more self-managed models of safe abortion care.

We know that more women and girls are likely to die due to the secondary impacts of the COVID-19 pandemic than due to the disease itself. Governments, health authorities, and health providers need to act now to eliminate barriers to care and save as many lives as possible. Most immediately, movement restrictions must be adapted to allow for women to access all essential health services when they need them. Health facilities must continue to offer essential health care—including contraception services, safe abortion care, and treatment for sexual violence—to anyone who needs them. Communities need to receive clear communication and guidance to prevent the misinformation and fear that prevents women from accessing the services they need. Supply chain disruptions affecting medical materials, including contraceptives and key sexual and reproductive health medications, must be addressed.

The lives and health of women and girls must be prioritized, during COVID-19 and always.