

## Accountability for SRHR in the context of the COVID-19 pandemic

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### Background

Governments and international organisations are focused on COVID-19 crisis decision-making. As a result, global and national health governance contexts are changing dramatically, as are the social and political determinants of sexual and reproductive health and rights (SRHR). Various gender dimensions of the pandemic are clear. While initial data suggest that men are more vulnerable to COVID-19 related mortality, in many high, middle, and low-income countries, the “essential workers” and informal workers who are disproportionately exposed are disproportionately lower social status women.<sup>1,2</sup> Intersecting injustices mean that certain disadvantaged groups are particularly hard hit.<sup>3</sup> They are left to reconcile the often-incompatible demands of precarious jobs, potential exposure to COVID-19, the stress of caring responsibilities under lockdown and, particularly for women, increased isolation exacerbating Gender-Based Violence (GBV).<sup>4,5</sup> In addition, they now face seriously disrupted health care services for SRH care.

In 2019, we authored a review regarding accountability ecosystems for SRHR.<sup>6</sup> The term accountability describes “*the processes by which government actors are responsible and answerable for the provision of high-quality and non-discriminatory goods and services (including the regulation of*

*private providers) and the enforcement of sanctions and remedies for failures to meet these obligations*”.<sup>6</sup> In the review we identified key cross-cutting considerations for fostering accountability for SRHR, including:

- macro-level politics and ruling ideologies,
- community voices,
- health system responsiveness, and,
- the complexity of health systems.

We build on those considerations here, to describe the implications of the COVID-19 pandemic for accountability for SRHR, and propose ways to promote greater accountability.

### Macro-level politics and ruling ideologies

Countries at all income levels experiencing COVID-19 outbreaks that have implemented lockdowns exempt “essential services.” Deliberations about what counts as “essential” SRH services reveal and perpetuate deep-rooted political and ideological rifts about sex, reproduction, and sexualities. When SRHR is deemed non-essential, health systems may be unable to fulfill these rights, and communities will lose a formal justification for claiming them. For example, some states in the United States have deemed abortion non-essential,

and the US Agency for International Development has asked WHO to stop describing SRHR as essential.<sup>7,8</sup> Moreover, mandated clinic closures, limits on movement, disrupted supply chains, and health system perturbations mean that critical SRH services such as abortion and contraception may be difficult to obtain. In several countries, including Pakistan, El Salvador, Zambia, Sudan, Colombia, Malaysia, Uganda, Ghana, Germany, Zimbabwe, and Sri Lanka, major private providers of contraception have been forced to close.<sup>9–11</sup> These gaps are not minor; an estimated 10% proportional decline in use of short- and long-acting reversible contraceptive methods in low- and middle-income countries would result in 15 million unintended pregnancies over a year.<sup>9</sup>

Responses to the pandemic in both high-income and low-income countries are embedded within the vagaries of domestic politics, and some political elites are prioritising their own patrons and/or constituents. In some cases, there is increasing hostility towards marginalised groups, including the poor at home or overseas, racial and ethnic minorities, and sexual “others”. The outbreak may be used to stigmatise certain populations as vectors of infectious disease.<sup>12</sup> To distract from domestic failures in the COVID-19 response, political actors can stoke nativism and disavow transnational responses. Such instances of scapegoating may threaten support to multi-lateral organisations, as happened with the World Health Organization, despite heightened need for their expertise.<sup>13</sup> It can also result in a decline in global assistance for SRH.<sup>14</sup> In this context, stigmatised groups will be less able to exercise their SRHR, as well as to demand accountability for them.

### *Community voices*

Lockdown imposes practical limitations on the freedom of association and collective action, making it more difficult for citizens to demand accountability. Challenges include decreased freedom of movement, funding cuts to programmes that support community participation, and poor access to mobile technology and the internet as organising becomes virtual. Moreover, increased governmental control over daily life and consolidation of power during the crisis can further constrain civic space.<sup>15,16</sup> For example, in Hong Kong and Hungary, the pandemic is being used as cover to mandate stringent measures on civil

liberties under the guise of national security.<sup>17,18</sup> Social actors may be pressured to drop what are perceived to be more controversial SRHR demands, such as access to health care for sex workers, or the continuity of gender reassignment surgery.

**In the context of COVID-19, knowing what your SRH rights are and how duty bearers are performing can be challenged by fast evolving standards and lack of data.** There are many unknowns in the evolving outbreak as scientific consensus remains unstable, standards shift, and there are difficulties in collating and transmitting information. Some governments might be deliberately non-transparent. They may decide not to track and/or release data that illustrate the full extent of the crisis, including its collateral impact on SRHR, such as pregnant women who die at home or in over-burdened hospitals.<sup>19</sup> As a result, civil society, activists and communities have less information about what they could and should demand.

While normal channels of rights claiming are interrupted, **the rights that need to be claimed may change.** New sources of vulnerability, such as harassment by the police of women seeking “non-essential” abortions or contraception, loss of employment, and increased care burdens, may force rapid reassessment of community priorities.

### *Health system responsiveness*

COVID-19 is putting significant stress on health systems and providers in countries at all income levels, **undermining their capacity to provide responsive, respectful care, and to support autonomous decision-making.**<sup>20,21</sup> Emergency protocols can place overstretched health workers in situations where they must override patient choice about important practices, such as skin-to-skin contact after delivery and having one’s birth partner of choice present. In the last decade, there has been some progress in recognising the importance of quality, respectful maternity care; and patient-centred contraception and abortion provision.<sup>22</sup> However, this fragile progress may be threatened. Given its “emergency” status, the demands of accommodating COVID-19 funding and activities threaten to crowd out these gains.

**The ability of the health system, local authorities, judicial actors and others to ensure implementation of laws and guidelines regarding SRHR may be undermined by the COVID-19 response.** SRHR laws and policies that lack

widespread support among providers, such as those relating to conscientious objection and abortion or to the provision of contraception to adolescents, may be less enforced, and avenues of accountability and redress may be closed or less accessible.

### *The complexity of the health system*

COVID-19 could spur many changes in the health ecosystem in countries at all income levels, including the balance of SRH service delivery between the public and the private sector or between the formal and the informal sector, changes in the cost of SRH care as governmental funding decreases due to COVID-19 budget shocks, changes in supply chain priorities, and a shift towards greater reliance on telemedicine.<sup>9</sup> For example, UNAIDS has raised concerns that constraints on freight shipments have resulted in less condom availability in many settings.<sup>23</sup> These changes challenge governments' ability to ensure SRH service accountability, particularly where regulation and monitoring of the private sector are weak. Moreover, telemedicine may be ungoverned terrain in many contexts, with less developed mechanisms for regulation and accountability.<sup>24</sup>

While emphasis on the clinical and epidemiological response is needed, **the socio-economic vulnerability of marginalised communities and the corresponding effects on SRHR should not be ignored.** This requires Ministries of Health to work outside the boundaries of their competence: to co-produce knowledge and enable responses in partnership with communities and other sectors.

### *How do we promote accountability in this changing environment?*

Crises can foment change – both for good and for ill. As old ways of working are reconfigured, we feel it is important to proactively take this opportunity to protect the gains that have been made and develop new ways to move towards greater accountability for equitable realisation of SRHR.

*Greater reflexivity:* The COVID-19 pandemic is a visible manifestation of the “lie of global health expertise”.<sup>25</sup> High-income country based “advisors” have less credibility when their own countries struggle with assembling a coherent public health response, while innovation in low- and middle-income countries receives inadequate attention and support in global policy-making. Donors and

others from high-income settings could benefit from re-orienting their funding and modalities of working to the priorities of governments and civil society in low- and middle-income countries. Participatory grantmaking and flexible reproductive justice funding offer opportunities for transnational solidarity that accommodates intersectional, contextually appropriate responses.<sup>26</sup>

*More vigilance:* We can build on learnings from international law and retrospective mechanisms for answerability and remedy, such as formal enquiries. There is a need to document accountability failures and human rights abuses for future remedy, and to study them to chart a way forward. Documentation may entail demanding transparent policy decisions about resource allocations, contracting, government support to victims of GBV, and criteria for deciding which services are “essential,” among others.

*Nurturing trust:* Concerned citizens and activists have developed adaptive ways of supporting authentic civil society input, community participation, and mutual aid amidst uncertainty and instability. Some have already sought to “close the feedback loop” by asking communities about their trust in the government response, their access to health care, and other concerns during the current pandemic.<sup>27</sup> Organic social mobilisation can be more catalytic if supported by governments (or other entities with power) that are perceived as legitimate and trusted by people. Though challenging, trust and collaboration are essential to foster during a pandemic.<sup>28</sup>

*Building solidarity:* As COVID-19 makes visible the inequities between people, it may create momentum for increased political commitment to wider social protection and Universal Health Coverage. Convincing those with social advantages and others with power to not look away; creating alliances among those working on primary health care, universal health care, and SRHR; and bolstering regulation of the private sector could help galvanise these movements and ensure their success.

### *Conclusion*

Given the importance of sex and reproduction in social life and in health, we cannot ignore them, particularly during crises. It is unsurprising that SRHR brings along particular political and accountability considerations during a pandemic, yet this has not received due attention. Promoting accountability is even more urgent, as SRHR health

and rights concerns grow more acute in crisis circumstances, and modes of governance and oversight practices are relaxed in the name of emergency response.

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