Share–Net
International
The Knowledge Platform on
Sexual and Reproductive Health & Rights

POLICY BRIEF

COVID–19, SRHR AND GENDER EQUALITY

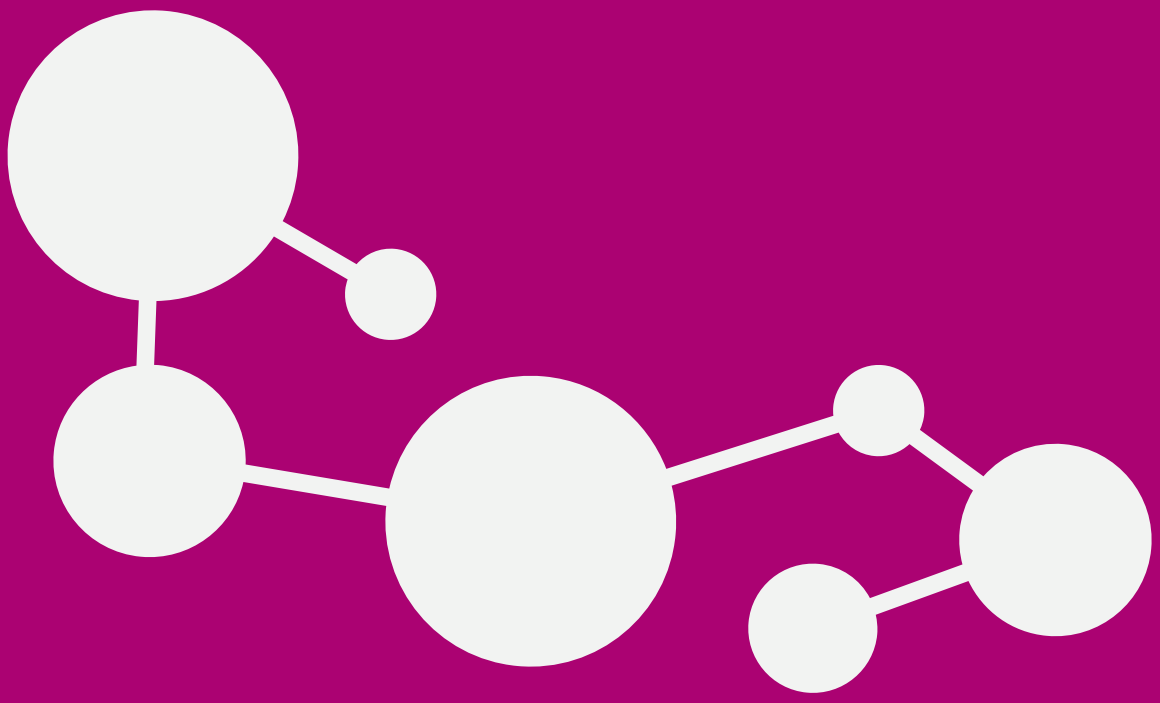
AUTHORS

Shahana Siddiqui, Hadir Barbar, Charlotte van Tuijl, Maria Codina & Julia Ahmed

ACKNOWLEDGEMENTS

With special thanks to Tasnia Ahmed, Myrrith Hulsbergen and Adewale Adeleye for their input and feedback. Layout by Tristan Bayly.

Cover image: Petra Lunenberg, Amref Flying Doctors, retrieved from https://sniartchive.com/artchive/motherly-love/



CONTENTS

BACKGROUND

On March 11, 2020, the World Health Organization (WHO) declared the world to be in a state of pandemic from the novel coronavirus - COVID-19. One-by-one, countries went into lockdowns with national and international transactions and travels coming to a sudden halt. The initial lockdown phases were marred with confusion and fear as global medical systems struggled to provide immediate healthcare responses with the backdrop of economic downturn and serious concerns about people's livelihood options during the lockdown.

As international efforts went into responding to the pandemic, as early as April 2020, feminist academics for a special issue of the Lancet, UNFPA, MSI Reproductive Choices, Guttmacher Institute, and other leading international organisations brought out publications, forecasting the impact of the lockdowns and healthcare crisis on global sexual and reproductive health and rights (SRHR). It was predicted that due to the lockdown as well as the interference in the global supply chain, there would be an estimated 10% decline in access to SRHR services (Riley et.al., 2020). That meant that almost 49 million women globally would have an unmet need for contraceptives with the possibility of over 15 million unwanted/unplanned pregnancies (Ibid.). There were predictions of sharp spikes in the number of unsafe abortions and from the very instance of the global lockdowns, incidences of domestic violence were observed and recorded to rise with nowhere to go, limited to no services available.

One year into the pandemic, many of these predictions and trends, like a self-fulfilling prophecy, were unfortunately proven to be true. With ground level information coming up in various forms, impact reports are showing stark data on the millions of lives affected in the realm of SRHR due to COVID-19. In a WHO survey of 105 countries, 68% reported disruptions to family planning (FP) and contraceptive services (JSI April 2021). UNWomen and other relevant stakeholders are calling the sharp rise in incidences of violence during COVID-19 as the "shadow pandemic" (UNWomen 2021). General lack of access to SRHR and legal services, especially with field clinics and human rights operations coming to a standstill during the global and national lockdowns, women and vulnerable communities were further victimised, pushed into corners. The impacts of such trauma are still emerging and in many regions, still occurring.

As it is in the case of a natural disaster, during the COVID-19 crisis, the emphasis became on immediate relief and health response, undermining the importance of SRHR as an integral, intricate, intimate part of people's lives. SRHR issues and concerns are often viewed as "additional" rights and needs that can be addressed at a later stage in the crisis management process.

The Small Grant Initiative at Share-Net International created an opportunity for ground level activists, researchers, health practitioners, NGO officers to collect data from a wide range of communities across 3 continents and 7 countries (Figure 1), demonstrating the need for bringing SRHR issues to the forefront during the pandemic. From Iran to Bangladesh, Kenya, Egypt to the Netherlands, these small grants allowed the research teams to gather tangible data that show the supply chain disruptions, the impacts of national policies, the shifts in resources that impacted various communities globally. In many instances, these small action research projects shed light on a "shadow" endemic to the coronavirus pandemic whereby SRHR needs and rights are undermined, pushing especially women, young girls, and various vulnerable communities into further socio-economic and health insecurities.

This policy paper aims to bring forward stories and experiences of the ground realities of communities as they tried to survive through the pandemic while at the same time struggling with accessing fundamental SRHR needs. There are strong public health warnings that with COVID-19 surges happening in different parts of the world, the socio-economic and health impacts of the pandemic will be that in the long term. The Bill and Melinda Gates Foundation reported that while the crisis may be now, the "aftershocks" of COVID-19, especially in the SRHR sector, will be felt for several years to come (2021).

In the light of the surfacing of these tangible data and stories, at the one year mark of the pandemic, pressing questions have appeared as to how the global community will respond and rebuild from the COVID-19 disaster? How will national governments and global actors address the critical needs of SRHR service as part of COVID-19 relief and rebuilding efforts? In the discussions around "building back", the structural inequalities that have appeared during these covid times, point towards the need to "build back better". This policy paper therefore is an urgent appeal to all national and global stakeholders responding to the current state of pandemic to include SRHR at the core of crisis response and recovery.

Share-Net International (SNI) is the Knowledge Platform on SRHR and a membership network made up of a unique and powerful combination of NGOs and private sector parties, researchers and students, policy makers and practitioners, media outlets and advocates. SNI aims to strengthen linkages between research, policy and practice through sharing, generating, translating and promoting the use of knowledge for the development of better policies and practices in SRHR.

COVID–19 GRANTS

To respond to the visible and expected effects of the COVID-19 pandemic on the SRHR and gender equality worldwide (see Background chapter), Share-Net International made funds available for short-term small grants projects. The small grants projects focused on better understanding and finding ways to reduce the negative impact of COVID-19 on different SRHR areas. In total, six projects benefitted from this funding, covering a geographical area of seven countries, including Bangladesh, Cameroon, Egypt, Iran, Kenya, the Netherlands and Nigeria (see Figure 1).

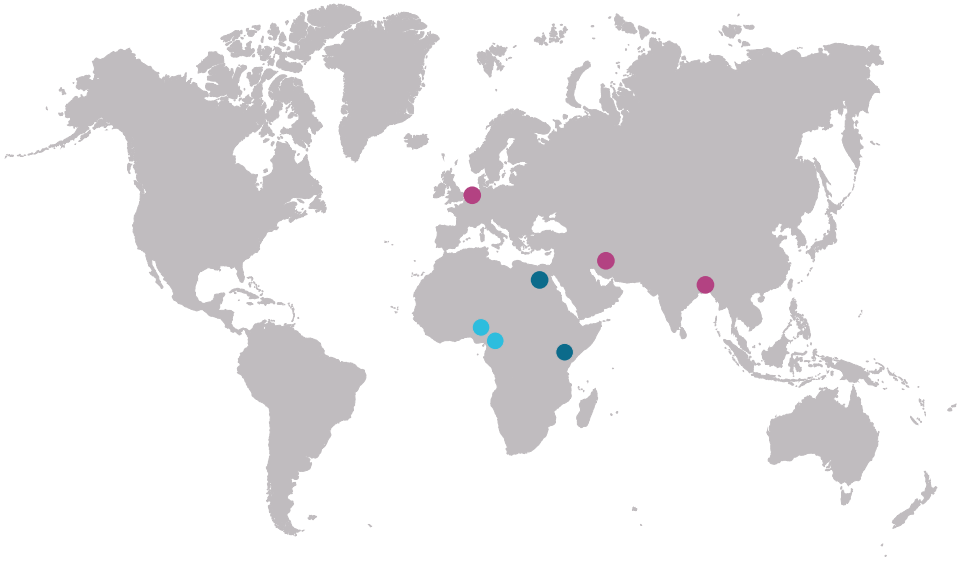


Figure 1. Map with countries in partnership and spread of small grants

The six projects are consisely described below:

Factors influencing access around contraception and abortion services during the COVID-19 pandemic in Iran, Bangladesh, and the Netherlands; a mixed-method study: The main objective of this research was to assess the impact of the COVID-19 pandemic on access to contraception and safe abortion services for women of reproductive age and from service providers providing contraception and safe abortion services in Iran, Bangladesh and the Netherlands. The aim was to develop a range of written and digital knowledge products to inform relevant stakeholders on improving the access to contraception and safe abortion services during crises. The research team used a mixed-methods approach, including a survey among 614 women and service providers and key informants interviews with 117 women and health service providers.

Exploring the menstrual experiences influenced by the COVID-19 pandemic in disadvantaged communities in Egypt and Kenya: This research explored and documented the menstrual health experiences and challenges of menstruating healthcare workers in the COVID-19 frontline response and menstruating adolescent girls in the community who are under the stay-at-home measures in Egypt and Kenya. The project aimed to inform best practices and programme design of prioritizing the integration of menstrual health in the SRHR response during the COVID-19 pandemic. Using data from 12 semi-structured interviews with female healthcare workers and 12 interviews with adolescent girls, the project team created four storytelling videos and three compelling reads.

Trans and hijra lives in times of COVID-19: This project examined the impact of COVID-19 on the socio-economic position, housing, access to healthcare services and experiences of violence at public and private space among transgender communities in the Netherlands and Bangladesh through an exploratory qualitative research. The COVID-19 pandemic has had a disproportionate impact on communities that were already socially marginalized, such as transgender communities. Understanding the experiences of transgender communities during this crisis will not only add to our knowledge about their situation but can also help develop appropriate strategies and policy responses to address their social exclusion. The findings of this exploratory research have informed the basis for the development of a research paper with policy recommendations.

Improving access to Sexual and Reproductive Health and Rights Services in Fragile and Humanitarian settings in Nigeria, and Cameroon during COVID-19 pandemic: This project aimed to bridge the knowledge gap between policymakers (both parliamentarians and executive), researchers and frontline service providers on the access to quality sexual and SRHR services in already fragile and humanitarian settings during COVID-19 and other crises. Through a systematic literature review, stakeholder consultations and validation workshop, a toolkit was developed for managing and improving the quality of SRHR services. A call to action for policy makers and service providers.

Brave Men campaign on COVID-19: The Brave Men campaign initiated an online policy dialogue on the impact that the COVID-19 pandemic had on gender-based violence in Bangladesh. Before the campaign was launched, online research using a mixed-method approach was conducted in Bangladesh. The research focused on four key areas; the status of intimate partner violence at the households; the status and forms of perpetration of online violence; violation of the rights in accessing SRHR services during COVID-19 crisis; and a mapping of the local and global best practices. The policy dialogues were conducted in the form of webinars. The webinars reached a total of almost 19,000 people via Facebook, were viewed by 6800 people and got 2271 engagements. During the webinars, recommendations on how to prevent violence against girls, women, and SOGI (Sexual Orientation and Gender Identity) people during the pandemic like COVID-19 ensuring better SRHR services and awareness were developed and shared with policy makers in Bangladesh.

Life in the Times of Coronavirus: A Gendered Perspective:This project aimed to capture and curate the life stories and experiences of men and women in both rural and urban Bangladesh during the time of COVID-19. Building on the national non-profit organization Manusher Jonno Foundation's (MJF) existing nation-wide research on violence against women, BRAC James P. Grant School of Public Health (BRAC JPGSPH) carried out a qualitative action research to understand the gendered nature of the pandemic. The qualitative research focused on both health and socio-economic aspects of the pandemic, focusing on issues of SRHR and gendered relations during COVID-19. The research findings were translated into: an initial draft process of a much-needed gender and SRHR policy in crisis times in Bangladesh, and a high-quality podcast series (12 episodes) that can be used as an advocacy tool for the findings as well as o an innovative way of showcasing data during times of lockdowns and social distancing.

More information on the different projects can be accessed via this link.

THEMES

The Small Grants recipients shared their findings via a Small Grants website, a social media campaign and webinars with other projects and SNI members, allowing for the wider team to draw on shared findings and challenges. Across the projects and geographical areas, recurrent themes became visible:

- Decreased access to essential and secondary healthcare services
- Increase of unpaid care work
- Economic impacts especially affecting women and vulnerable populations
- Increase in gender-based violence

Decreased access to essential and secondary healthcare services

Past epidemics, such as the Ebola outbreak and the Zika virus, have decreased the access to primary and secondary healthcare services, especially for women and marginalised groups (Davies & Bennett, 2016). It is estimated that the decreased access to healthcare services has caused more deaths than the actual viruses themselves (Khubchandani, Jordan, & Yang, 2020; Walker et al., 2015). The same expectation was voiced shortly after the break-out of the COVID-19 pandemic, especially since SRH services were considered to be secondary healthcare services. It did therefore not come as a surprise that accessing SRHR was found to be a major challenge in various settings. Especially those in fragile and humanitarian settings, and those already living at the margins of society were unequally affected by not only the novel coronavirus, but by structural inequalities in accessing basic services.

CASE STUDY - ENSURING CONTINUED SUPPLY OF CONTRACEPTIVES

During COVID-19 lockdown, door to door supplies of contraceptives suddenly stopped. As a result, women living in rural areas who otherwise did not know from whom to seek service felt helpless and vulnerable as they were exposed to risks from unintended pregnancy (qualitative interviews: woman from remote rural area in Bangladesh). Make-shift service points should therefore be installed from which door-steps service delivery can be ensured to guarantee the continuity of SRH services during emergency situations.

This multi-country study from Bangladesh, Iran and the Netherlands surfaced specific gaps and challenges faced by service providers and women during lockdown situations from supply and demand levels. From the supply-side, service providers indicated that they faced challenges in keeping usual hours of service provision, shortages of staff, and regular and adequate supplies of logistics, in particular with regard to protective measures (Personal Protective Equipment (PPE), masks, sanitizers). They reported feeling forced to provide compromised care-giving such as curtailing physical check-ups due to adherence to physical distance, which was beyond their control. It was hard for the service providers to reach the service facilities and go back home due to transportation problems. On the other hand, from the demand-side, women indicated that they faced specific constraints getting information whether service facilities were open; suffered stigma that they would be ostracized from visit to health facilities from the possibilities of getting infected and felt forced to buy high priced contraceptives from local pharmacies. These findings indicate that there were clear gaps in terms of public health responses handling this pandemic. It seemed the sole attention was on taking protective measures from the virus ignoring

ensuring contraceptive and abortion care, a fundamental component of meeting SDG 3: Universal Access to SRHR targets.

CASE STUDY - HOW COMMUNITIES MAINTAINED SERVICE DELIVERY DURING EBOLA CRISES

The Ebola epidemic of 2014 in West Africa is a good example of a recent disease outbreak with global implications. Major Ebola epidemic control measures included the organising of rapid response by local health authorities; triage, contact tracing and quarantine; isolation, clinical management, and safe burials; training and community sensitization. The activities undertaken to manage Ebola, reduced the spread of infection and the impact of the disease in mothers and children, although the Ebola outbreak reduced the number of patients at hospital level (Quaglio,2016). These could therefore be adapted for the COVID-19 pandemic response.

Another lesson from the Ebola epidemic was the need to take the experiences of midwives and healthcare workers into account when developing guidelines. Experiences of midwives caring for pregnant women admitted to eight Ebola centres in Sierra Leone during the outbreak in 2014-16 showed how personal and public fears of Ebola infection affected the midwives' professional and personal lives. Motivation and support espcially helped them to cope with challenging midwifery care and competency, creativity and courage were described as essential for improving clinical guidelines and to learn for the future. They emphasized the need for sufficient training and equipment for safe midwifery and competence sharing and support by colleagues during epidemics. Their experiences should be considered when developing guidelines on best practises on how to care for pregnant women during such outbreaks. Notably, balanced information, sufficient training, adequate equipment and access to support among colleagues assist midwives in coping with challenges (Erland, 2017).

In Nigeria and Cameroon, the COVID-19 pandemic exacerbated the already existing lack of access to SRHR services caused by crisis and fragility, exposing people to higher risks of transactional sex, teenage pregnancies, STIs and HIV, unplanned pregnancies, poor pregnancy care and outcomes, unsafe abortions, sexual and gender-based violence and other challenges. People were hesitant to seek healthcare services, expressing fears of contracting the virus from medical/health facilities. Infected healthcare workers in already overburdened facilities and service strapped countries, led to further shortages in staff.

This fear was also found among hijra and transgender communities in Bangladesh. The majority of them had completely withdrawn from seeking help from medical institutions as a result of the COVID-19 pandemic, whereas transgender refugees and sex workers in the Netherlands received inconsistent guidance on whether and how to receive healthcare. According to the interviewees, healthcare services have effectively ceased in Bangladesh and many hijras simply have stopped seeking healthcare services. In the Netherlands, interviewees reported being barred from seeking medical help, either because they presented COVID-19 symptoms or because they did not present COVID-19 symptoms. In either case, many potentially life-threatening medical issues have been left untreated in both countries since the COVID-19 pandemic began. Moreover, interviewees in both countries reported feeling disrespected by medical staff and, in some cases, being denied treatment due to their gender identity.

Increase of unpaid care work

Past epidemics, such as the Ebola outbreak and the Zika virus, have decreased the access to primary and secondary healthcare services, especially for women and marginalised groups (Davies & Bennett, 2016). It is estimated that the decreased access to healthcare services has caused more deaths than the actual viruses themselves (Khubchandani, Jordan, & Yang, 2020; Walker et al., 2015). The same expectation was voiced shortly after the break-out of the COVID-19 pandemic, especially since SRH services were considered to be secondary healthcare services. It did therefore not come as a surprise that accessing SRHR was found to be a major challenge in various settings. Especially those in fragile and humanitarian settings, and those already living at the margins of society were unequally affected by not only the novel coronavirus, but by structural inequalities in accessing basic services.

Health and social responses to the novel coronavirus brought forth severe gendered structural inequalities across the countries and communities. In addition to women being unable to access healthcare on time, the lockdown methods to contain the infection led to an increase in the burden of work for women globally. In Bangladesh, women in both urban and rural households expressed how strenuous their household situations were due to the lockdown, with all family members confined to their respective houses, women had extra household chores with little to no support or respite.

With schools closed in Bangladesh for over a year, children of all age groups are staying at home. Mothers had expressed their concerns regarding the future of their children and the difficulties of caring for them with any support or assistance. For many of these extremely poor families, schools provided meals and care support, allowing mothers, in particular, to work from home or outside. With schools staying closed, female respondents with children expressed the increased pressure of taking care of everyone in the household, especially with children remaining idle.

The overburden of unpaid care work on women also intensified during the lockdown periods. Respondents from various of the short studies expressed their inability to inability to access healthcare services due to household chores and obligations. Lockdowns also limited paid work options for women whereby due to pandemic fears, men were found to go outside of the house in search of income opportunities, leaving the entirety of household support on the women. This meant that due to the pandemic, there had been a significant decline in women's mobility and access to income, pushing them further into economic dependency and therefore overall vulnerability.
Economic impacts, particularly for women and vulnerable populations
COVID-19 pandemic has been as much of a health crisis as an economic turbulence for economies and communities alike. With global trade and transactions coming to a sudden halt, different countries have found it difficult to sustain economically during this period. For certain vulnerable communities, COVID-19 became a question of lives versus livelihoods whereby without going out, without risking contracting the virus, families faced severe poverty and hunger.

Socially and economically vulnerable groups like the transgender and hijra communities have been hit hard by the COVID-19 pandemic. The majority of the trans people that this project worked with were sex workers who were unable to make their ends meet during the pandemic. Those with refugee status, especially in the Netherlands, were subject to

violence and discrimination during the pandemic. The hijras in Bangladesh usually earn through performances and social gatherings and found themselves in a challenging situation with all their traditional sources of income interrupted due to COVID-19 related lockdowns. While the findings mentioned above elaborate on the experiences of trans and hijra population, they can serve as evidence of the various experiences of discrimination faced by gender-variant people in other countries and communities.

Similar to the economic hardships of existing vulnerable groups like the trans and hijra communities, women and young girls have been pushed into socio-economic fragility due to COVID-19. In Egypt and Kenya, female healthcare workers reported delays in their salaries and payments, leading to further debts. Women in rural Bangladesh stated that they had to forgo the small economic opportunities due to COVID-19 lockdown and fear of contracting the virus, resulting in further dependency on external debts from family and friends. Moreover, with schools remaining closed in many parts of the world, families already experiencing poverty expressed serious concerns about their children's future. Education is regarded as a "ticket out" of poverty for many such families globally, which no longer comes across as a possibility for many.

CASE STUDY - PRIORITISE THE MENSTRUAL NEEDS OF MENSTRUATING HEALTHCARE PROVIDERS

I am Sarah, a medical doctor at a big public hospital in Giza city. When COVID-19 started to spread in Egypt, my hospital was suddenly switched to quarantine hospital where unclear schedule and rules were settled. There was only one toilet for everyone; males and females: doctors, nurses and patients with zero privacy and cleanliness. I had to go to my mom's house to shower and change my pad. As a female healthcare provider, I urge the Ministry of Health to prioritize the menstrual needs by ensuring the accessibility to clean and private toilets. Fundamentally, Menstrual products should be supplies free of charge to workers. Finally, conducting training on menstruation for all healthcare workers would break the silence around menstrual needs.

More people have been pushed into risky activities as schools closed and opportunities for additional income have been limited. Reports from Kenya, Nigeria, and Cameroon state that due to pandemic induced economic crisis, adolescent girls were forced to engage in sex work in order to afford menstrual products and other household basic needs. With continuing COVID-19 surges and slow and limited vaccination drives in many of these low- and middle- income countries, there are deep issues that more young girls will be pushed into high-risk work such as sex work or be married off as it was found in Bangladesh.

Increase in gender-based violence

Hijras in Bangladesh were stigmatized as "carriers and spreaders" of COVID-19 and were thus subjected to violence from the public and law enforcement. Along with COVID-19, many members of the public spread malicious rumours about hijras carrying the virus, which launched a series of attacks from public and law enforcement officials on these individuals.

In the Netherlands, violence operated in perhaps more covert ways. In some cases, it declined because people were under lockdown, but in other cases, lockdown meant increased exposure to perpetrators. This manifested itself differently in different contexts, including refugee camps and asylum centres, but also in the work environment. Sex workers reported that they were subject to greater forms of violence - from both clients and law enforcement- because of the precarious situation in which they were placed by conducting sex work during the lockdown.

The study among women and service providers in Bangladesh, Iran and the Netherlands also highlighted increased violence during lockdown situations as spouses were at home all the time. A woman from a semi-urban area in Bangladesh reported: ***"During lockdown unprotected sexual intercourse increased. If I did not respond to my husband's wish, it became an issue of mental and physical violence."***

Studies from Bangladesh, Kenya and Egypt demonstrate the alarming rise in intimate partner violence and domestic violence due to the economic insecurities caused by COVID-19 lockdowns. Women in both rural and urban areas of Bangladesh expressed the added stress of the pandemic causing emotional and physical abuse. Thirty-one per cent of cases (13,494 cases out of 53,340 women and children- MJF national survey, May 2020) were found to be first ever incidences of violence during the peak lockdown period from March - April 2020. Female respondents also expressed the sense of helplessness with legal services unavailable and medical support being limited during the initial phases of the pandemic.

Similar issues of gender-based violence were found in research projects in Egypt and Kenya where adolescent girls reported to have faced emotional and physical abuse within the family. They stated that due to stay-at-home measures leading to decrease in family income and overall stress in the households, their caregivers became their perpetrators. In Bangladesh, because of economic instability, parents felt compelled to marry off their daughters during the pandemic times. Parents also stated that since there is no school and thus, the girls have ***"nothing to do"***, they might as well get married and run their own households.

KEY RECOMMENDATIONS

The Small Grant Initiative of Share-Net brought forth the critical issue of prioritising SRHR during COVID-19 response and recovery globally. A sincere commitment to the SRHR mandates as human rights shall monitor the scale of impact of any emergency and instantly enforce pre-determined mitigation strategies. The following recommendations contribute to achieving this goal.

International and national actors need to focus on and invest in building resilient and people-centred health systems inclusive for marginalised communities

As demonstrated, health services globally have structural gaps that need to be strengthened, especially for marginalised communities, during times of crises including but not limited to health emergencies, natural disasters and conflicts. Moreover, health services must take into account the following issues:

- Include SRHR products in emergency relief packages
- Ensure the continuation of SRHR services, particularly field/community/door-to-door products and services (such as a supply of contraceptives, abortion services, HIV testing kits, and other STI medical support)
- Improve effective health messaging, in particular that on SRHR services during a pandemic to ensure safe health seeking behaviour by communities, e.g. pregnant women accessing delivery support
- Build the capacity of health care providers to better respond to vulnerable communities (especially towards LGBTQI+ community members) during times of crisis
- Develop strategies to provide preventive and protective services for incidences of violence during the lockdown period
- Support and continue community-based health services and responses including telemedicine and home-based care

CASE STUDY - ROLE OF TELEMEDICINE FOR SRH INFORMATION AND SERVICES

Ndolo360 the first mobile app of its kind in Cameroon and Africa which delivers learning by providing open, honest and judgement-free education, information and services on Sexual and Reproductive Health (SRH) to teenagers, adolescents and young people. It provides open, honest and judgement-free sexuality education and information to help young people make informed choices about their sexual health. Ndolo360 provides information from health experts, allows chats to ask questions and gain unlimited access to vital Sexual and Reproductive Health and Rights services (WSA, n.d.). Ndolo360 is available in English and French, but there are plans to incorporate other African languages as it grows. The app can be used and explored by SRH implementers for adolescents and young persons in conflict situations during the COVID-19 pandemic.

The Ndolo360 app can be downloaded here.

Increase safe access to comprehensive SRHR services especially for marginalised groups

Marginalised groups such as LGBTQI+ communities, people with mental or physical disabilities, refugees, IDPs and migrants, and adolescents and those disproportionately affected by the pandemic need greater attention in national strategies and interventions.

International actors need to ensure the increase of safe access to comprehensive SRHR services. Stakeholders need to implement adaptive and responsive strategies to reach adolescents and young people with appropriate SRHR and COVID-19 related information and services, targeting in-school and especially out-of-school youth.

Map and mitigate the socio-economic impacts of a health crisis

COVID-19 prevention methods such as lockdowns brought about a number of negative societal consequences. Economic and social support for various communities must be recognised and restructured. This includes the following:

- Create more income-generating activities for especially women and other economically vulnerable groups as part of COVID-19 response
- Address the issues of extended school closure and their effects on children, particularly girl, as well as the rise in child marriage
- Develop national COVID-19 recovery funds for at community level

Strengthen multi-sectoral partnerships, stakeholder collaboration and national, state and local accountability and political commitment for COVID-19

Community-based organisations, but also sectors working in silos. Most aid programmes work in parallel to each other and to national or state programmes. Collaboration therefore needs to be ensured.

- Create a clear and engaging pathway for all stakeholders (including international organisations, global institutions and national governments) for a coordinated response as part of the national emergencies strategy, including clear responsibilities, a clear monitoring and accountability system, etc.
- Make SRHR a priority in national recovery mechanisms
- Develop multi-sectoral disaster management plans for health crises, building on and learning from multi-sectoral disaster management plans from e.g., climate change mitigation plans
- Public-private partnership in the delivery of healthcare products (e.g., taking the Last Mile project case from Nigeria and Cameroon)

Ensure funding to mitigate the impacts of health crises on SRHR

- Adopt appropriate and flexible funding models to ensure sustainable investments into comprehensive SRHR programmes in fragile states.
- Invest into funding for Global Humanitarian Response Plan for COVID-19 and include comprehensive and non-discriminatory SRHR services.
- Formulate and adopt policies that guard the continuum of the funds allocated to SRHR related to programmes and research
- Support initiatives such as Share-Net International Small Grant Initiative and similar projects to bring forth voices from the field to help design and implement people-centric policies and interventions

REFERENCES

Davies, S. E., & Bennett, B. (2016). A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies. International Affairs, 92(5), 1041-1060.

JSI (2021). Building Resilient Sexual and Reproductive Health Supply Chains During COVID-19 and Beyond: Community Roadmap for Action and Technical Findings. Accessible via https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=24430&lid=3

Khubchandani, J., Jordan, T. R., & Yang, Y. T. (2020). Ebola, Zika, Corona… What is next for our world?. International Journal of Environmental Research and Public Health, 17(9), 3171. https://doi.org/10.3390/ijerph17093171

Riley, T., Sully, E., Ahmed, Z., & Biddlecom, A. (2020). Estimates of the potential impact of the COVID-19 pandemic on sexual and reproductive health in low-and middle-income countries. International Perspectives on Sexual and Reproductive Health, 46, 73-76. Accessible via https://www.guttmacher.org/sites/default/files/article_files/4607320.pdf

Walker, P. G., White, M. T., Griffin, J. T., Reynolds, A., Ferguson, N. M., & Ghani, A. C. (2015). Malaria morbidity and mortality in Ebola-affected countries caused by decreased health-care capacity, and the potential effect of mitigation strategies: a modelling analysis. The Lancet Infectious Diseases, 15(7), 825-832. https://doi.org/10.1016/S1473-3099(15)70124-6

WSA (n.d.). Ndolo 360. Accessible via https://wsa-global.org/winner/ndolo360/

UN Women (2021). Impact of COVID-19 on Violence Against Women and Girls and Service ProvisionL UN Women Rapid Assessment and Findings. Accessible via https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/impact-of-covid-19-on-violence-against-women-and-girls-and-service-provision-en.pdf?la=en&vs=0

Share-Net
International

The Knowledge Platform on
Sexual and Reproductive Health & Rights

Mauritskade 63
1092 AD Amsterdam
The Netherlands

P.O. Box 95001
1090 HA Amsterdam

T: +31 (0) 20 56 88 701
E: info@share-netinternational.org
www.share-netinternational.org