Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Not a luxury: a call to maintain sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic

Published Online
April 21, 2020
https://doi.org/10.1016/S2214-109X(20)30190-X

About 1·8 billion people live in fragile contexts worldwide,[1] including 168 million individuals in need of humanitarian assistance. Approximately a quarter of those in fragile contexts are women and girls of reproductive age.[2] Experience from past epidemics in these settings has showed that discontinuing health-care services deemed unrelated to the epidemic response resulted in more deaths than did the epidemic itself.[3] Issues related to sexual and reproductive health are among the leading causes of mortality and morbidity among women of childbearing age, with countries affected by fragility and crisis accounting for 61% of maternal deaths worldwide.[4]

Poor health outcomes will surge from the absence or disruption of lifesaving services, including emergency obstetric and newborn care, contraception to prevent unwanted pregnancies, and the management of abortion complications. Gender-based violence and sexual exploitation and abuse might increase during outbreaks because of confinement, increased exposure to perpetrators at home, economic precarity, and reduced access to protection services. The care for children and others confined at home further reduces women's ability to properly care for themselves.[5]

In the context of the pandemic preparedness and response, members of the Inter-Agency Working Group for Reproductive Health in Crises have issued various field guidance documents on sexual and reproductive health and coronavirus disease 2019 (COVID-19). Building on the overarching need for humanitarian actors to coordinate and plan to ensure that sexual and reproductive health is integrated into the pandemic preparedness and response,[6] there are four prongs on how to mitigate the impact of COVID-19 on mortality and morbidity due to sexual and reproductive health conditions in crisis and in fragile settings.

First, with the understanding that the risks of adverse outcomes from medical complications outweigh the potential risks of COVID-19 transmission at health facilities, the availability of all crucial services and supplies as defined by the Minimum Initial Services Package for sexual and reproductive health should continue.[6] These services include intrapartum care for all births and emergency obstetric and newborn care (caesarean sections should only be performed when medically indicated as a COVID-19 positive status is not an indication for a caesarean section[7]), post-abortion care, safe abortion care to the full extent of the law, contraception, clinical care for rape survivors, and prevention and treatment for HIV and other sexually transmitted infections. Early and exclusive breastfeeding and skin-to-skin contact for neonates should be promoted, and mother and neonate should not be separated unless one or both are critically ill in cases of suspected or confirmed COVID-19 infections.[7]

Second, comprehensive sexual and reproductive health services should continue as long as the system is not overstretched with COVID-19 case management. For relevant consultations and follow-up, remote approaches should be considered where feasible (eg, telephone, digital applications, text messaging). In addition to the Minimum Initial Service Package, these comprehensive services—ie, all antenatal care, postnatal care, newborn care, breastfeeding support, and cervical cancer screening, as well as care for individuals experiencing intimate partner violence—should remain available to all individuals who need them, including adolescents.

For more on this **guidance** see www.iawg.net

Third, clear, consistent, and updated public health information crafted with representatives of the targeted audiences should reach the community and health-care workers. This information should reaffirm that medical complications outweigh the potential risk of transmission at health facilities and that community members should continue to seek and receive care during childbirth and for all other essential sexual and reproductive health needs or emergencies resulting from other diseases, trauma, or violence. The community should understand that any changes in routine services are for patients' benefit to ensure support to the COVID-19 response, avert undue exposure to the risk of contracting the virus in a health facility during the

outbreak, or both. However, the coordination and planning to re-establish such comprehensive services should occur as soon as the situation stabilises.

Fourth, COVID-19 infection prevention and control precautions, including hand hygiene, physical distancing, and respiratory etiquette should apply to patients (and accompanying family members if their presence is necessary). Additionally, staff should be protected with adequate personal protective equipment. Facilities also need to establish a patient flow that incorporates triage before entrance into the facility, and an isolation area and separate consultation room for suspected or confirmed cases.

To minimise preventable deaths, crucial health-care services, including sexual and reproductive health services, should remain accessible during public health emergencies, even when resources from already fragile health systems are often redirected for outbreak response. The COVID-19 pandemic will magnify the risks inherent to resource reshuffling at the expense of other services; however, sexual and reproductive health cannot be viewed as a luxury.[8] On March 31, 2020, the United Nations Secretary-General highlighted in relation to COVID-19 that "we are only as strong as the weakest health system in our interconnected world".[9] To echo this statement, we have offered guidance on sexual and reproductive health and COVID-19, and we call on health authorities to prioritise these lifesaving services in humanitarian and fragile settings. Such interventions should be considered as indispensable components of health services that do not strain, but strengthen health systems during COVID-19 preparedness and response efforts. The collective health of women, girls, and the wider community depends on these services.

We declare no competing interests.

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1 Organisation for Economic Co-operation and Development. States of fragility 2018. Paris: OECD Publishing, 2018.
2 United Nations Office for the Coordination of Humanitarian Affairs. Global Humanitarian Overview 2020. Dec 4, 2019. https://www.unocha.org/sites/unocha/files/GHO-2020_v9.1.pdf (accessed April 2, 2020).
3 McQuilkin PA, Udhayashankar K, Niescierenko M, Maranda L. Health-care access during the Ebola virus epidemic in Liberia. *Am J Trop Med Hyg* 2017; **97:** 931–36.
4 UNFPA, WHO, UNICEF, World Bank Group, the United Nations Population Division. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization, 2019.
5 Logie CH, Khoshnood K, Okumu M, et al. Self care interventions could advance sexual and reproductive health in humanitarian settings. *BMJ* 2019; **365:** 1083.
6 Inter-Agency Standing Committee. Interim guidance: scaling-up COVID-19 outbreak readiness and response operations in humanitarian situations, including camps and camp-like settings. March 17, 2020. https://interagencystandingcommittee.org/system/files/2020-03/IASC%20Interim%20Guidance%20on%20COVID-19%20for%20Outbreak%20Readiness%20and%20Response%20Operations%20-%20Camps%20and%20Camp-like%20Settings.pdf (accessed April 2, 2020).
7 WHO. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected: interim guidance. March 13, 2020. https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected (accessed April 2, 2020).
8 Vann B. Sexual violence in populations affected by armed conflict. 2005. World Health Organization Health in Emergencies. https://www.who.int/hac/network/newsletter/Final_HiE_n20_%20Jan_2005_finalpdf.pdf (accessed April 2, 2020).
9 Guterres A. Opening remarks at virtual press encounter to launch the Report on the Socio-Economic Impacts of COVID-19. March 31, 2020. United Nations Secretary-General. https://www.un.org/sg/en/content/sg/speeches/2020-03-31/remarks-launch-of-report-the-socio-economic-impacts-of-covid-19 (accessed April 2, 2020).