



Disparities in Accessing Sexual and Reproductive Health Services and Rights Among Adolescents and Young People During COVID-19 Pandemic: Culture, Economic, and Gender Perspectives

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Abstract

Purpose of Review As the world grapples with the health systems' challenges during the COVID-19 pandemic, addressing the needs of the already vulnerable adolescents and young people is vital. This narrative synthesis is aimed to highlight the current gender, cultural, and socioeconomic dynamics fueling inequalities to accessing sexual, reproductive health and rights (SRHR) services among adolescents and young people in low- and middle-income countries (LMIC).

Recent Findings The COVID-19 pandemic has in most countries exacerbated already existing inequalities due to economic, gender, cultural, and legal aspects. Strategies implemented by most governments to mitigate the spread of the virus have also had a negative impact on the access to SRHR services, some of which are long term. Few published studies have assessed the extent to which the pandemic has fueled each of these paradigms regarding access to SRHR, especially among adolescents and young people (AYP). Additionally, there is paucity in data on the same in most countries, as the systems to track such effects were not available at the inception of the pandemic.

Summary Despite efforts to mitigate the effects of the pandemic on this population, deficits remain and a multi-stakeholder approach is needed to achieve the intended goals, especially where cultural and gender values are deeply rooted. Further research is needed to quantify how the pandemic has fueled economic, gender, and cultural aspects to influence access to SRHR services among AYP especially in LMIC.

Keywords Adolescents · Young people · SRHR · Inequalities

Key Messages

- COVID-19 has taken a toll on global progress toward equality in SRHR services including among adolescents and young people.
- Gender, socioeconomic, and cultural inequalities have been amplified by the pandemic.
- Government policies, new laws, and other structural adjustments have had both positive and negative effects in SRHR-service access.
- Re-adjusting to the original progress trajectory will require a multi-sectoral approach tailored to each country's specific dynamics.

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Introduction

Access to sexual reproductive health and rights (SRHR) has been and continues to be a challenge for many adolescents and young people (AYP), especially those living in low- and middle-income countries (LMIC). The global strategy (2016–2030) for children's, women's, and adolescents' health acknowledged that despite the tremendous achievements, far too many adolescents still are unable to access essential healthcare services [1]. The 2018 Guttmacher–Lancet Commission report also underscored this gap, highlighting more than 200 million women unable to access modern contraceptives while more than 350 million unsafe abortions are occurring globally [2]. An estimated 777,000 births were registered among adolescents younger than 15 years old in 2020, with 58% of these occurring in Africa, 28% in Asia, and 14% in Latin America and the Caribbean [3]. Nearly half

of adolescents in developing countries are sexually active by their 19th birthday, partly because they are married, and half of them have unintended pregnancies [4]. It should also be noted that adolescents and women in general are more at risk of acquiring sexually transmitted infections (STIs), including HIV.

Extensive evidence already exists about the vulnerability of AYP in LMIC [5]. Gender [6, 7] and socio-cultural [8, 9] and economic [10] factors influence access to healthcare services, including SRHR. With the COVID-19 pandemic associated with disruptions of routine healthcare services [11], including community level platforms where AYP receive information and support regarding SRHR services, existing gender inequalities [12] as well as sociocultural and economic disparities were expected to flare, with adolescents and young women taking the brunt. The extent to which the pandemic has exacerbated societal gender, cultural, and economic dynamics to limit access to SRHR services has not been extensively published. A synthesis, therefore, of available narratives is needed to underscore this extent, especially among AYP in LMIC.

With more than 861.7 million children and youth in 107 countries impacted by the nationwide school closures according to UNESCO [13] and travel restrictions hindering economic and social transactions, coupled with the initial existing inequalities, the need to unearth and document how the pandemic has impacted on SRHR services access among AYP is thus important. A 2021 report [14] by the Southern African Development Community (SADC) estimated that close to a million girls in sub-Saharan Africa (SSA) were at risk of not returning to school after becoming pregnant during the COVID-19 lockdown. Unmet needs for modern contraceptives, access to a skilled health facility delivery, and incidence of unsafe abortions could have worsened because of the epidemic. How gender, cultural, economic, and legal issues are influencing such reproductive health outcomes among AYP, especially in LMIC, is worth documenting. This narrative synthesis is, thus, tailored to explore evidence around disparities in accessing SRHR services among AYP during the COVID-19 pandemic in LMIC, highlighting gender, economic, cultural, and legal/policy perspectives. Findings from this synthesis will guide prioritization of interventions, resources, and formulation of policies customized to country-specific drivers of such disparities.

Health Systems for SRHR During COVID-19

Globally, the health infrastructure during the COVID-19 pandemic has severely crumbled, from human resources to medicines and other supplies as well as psychosocial

support to those infected and affected with the virus. Healthcare providers have either been infected or died because of COVID-19. Access to information by AYP amidst the travel and social distancing restrictions of the pandemic further deteriorated; a UNFPA global survey in 2021 [15] noted that mothers of adolescents were hesitant to speak about SRHR with their adolescent girls. The survey further states that AYP with disabilities were more affected, with many facilities lacking sign-language interpreters. Another comprehensive human resources for health (HRH) assessment report by the World Health Organization (WHO) stated that in five South American countries, between 3 and 12% of the healthcare workers were reported to have been infected with the virus as of December 2021, with an approximate 2% case fatality rate [16]; these findings have also been published elsewhere [17]. This report and others underscore how fragile healthcare systems in most LMIC have become due to the pandemic, and with worsening between-country inequalities around healthcare performances [18], the imperative to document and respond to SRHR disparities among AYP has never been clearer.

Availability and competence of HRH is within the critical path of accessing SRHR services. Most LMIC are yet to reach the required number of skilled staff to ensure universal coverage of health services, including SRHR. Before the pandemic, documented barriers limiting access to SRHR services and other services included low-quality services provided at inconvenient hours of operation in Botswana, Nigeria, and Uganda [19]; long waiting hours before accessing services among adolescents [20], healthcare providers perceived as having poor attitudes and being unfriendly [21], and limited knowledge about SRHR services [22]. With the pandemic-related travel restrictions, fear of acquiring COVID-19, and limited capacity building of healthcare workers to provide SRHR services, the healthcare system has fractured even more. Some countries have even explicitly diverted SRHR human and financial resources to respond to the crisis or labelled SRHR services as non-essential [23]. A significant proportion of women and girls (more than 90% in Kenya, up to 32% in urban Rwanda) reported decreased or no access to some menstrual hygiene products [24], while vulnerable urban and rural youth in Ethiopia [25] sited challenges in observing COVID-19 regulations such as social distancing, given their physical impairments. Reported mental health breakdowns among healthcare providers following the pandemic [26, 27] further limit their ability to offer high-quality SRHR services to the targeted beneficiaries, including AYP.

Supplies and the robustness of the supply chain system are also critical in ensuring that those who need SRHR services receive them at low or no cost [28]. In most LMIC, the

quality and diversity of SRHR services (e.g., highly effective treatment for sexually transmitted infections [STIs], different modern contraceptives, and post-abortion care) are guided by governments' spending on such supplies, as well as a functioning supply-chain framework. In Uganda, for example, SRHR supplies to public facilities are provided through one warehouse that has pre-determined delivery cycles, and its inflow of supplies also depends on the global supply chain systems. With COVID-19 affecting global supply chain systems [29], disruptions in delivery to the last mile (lower service points) occurred; hence, the rights for AYP to decide when to conceive and how to manage any sexually related complications were also compromised. In the Philippines, a possible 67% increase in unmet family planning occurred as a result of reduced access, which could have resulted in a 42% increase in unintended pregnancies [23]. In Georgia, as well, it was reported that the pandemic was associated with a 74% reduction in rates of cervical cancer screening [23].

Globally, most countries have not recovered from the effects of the pandemic. Funding from those who had promised to support the global efforts towards access, availability, and equity of SRHR services, such as Norway, UK, and the USA [30] are also settling home affairs and funding might not be provided as soon promised. Health systems in most LMIC may be left to struggle, and priority groups such as AYP may continue to be challenged in accessing SRHR services. AYP, for whom the health system needs to prioritize in provision of SRHR, the pandemic has dented their aspirations and essentially slowed attainment of key SRHR targets within the global Sustainable Development Goals (SDGs), as well as diminished their quality of life. With the current financial demands in the health sector, integration of available resources and stimulus packages from global funders would be advised.

Gender and SRHR Disparities

Ascribed roles across different cultures influence access to SRHR services [31, 32]. Harmful masculine norms might influence men's access to treatment of STIs, as well as women's willingness to disclose their health needs, including contraceptive use, premarital abortion, and child spacing [33–35]. Deeply rooted gender inequalities still exist as described in one Ugandan study [36] highlighting how a boys' initiation in sex was considered normal and acceptable whereas in similar circumstances a girl is perceived as a prostitute and untrustworthy. Also, despite global calls under the SDGs to end child marriage by 2030, this human rights violation is still practiced and fueled by entrenched gender inequalities in many communities including sub-Saharan Africa, south and east Asia, the Caribbean, and the Pacific [37].

Despite this global evidence of the linkage between gender and SRHR, little has been documented regarding how COVID-19 has fueled existing gender disparities to influence access to SRHR services among AYP in LMIC. Available evidence alludes to a reduction in access and utilization of SRHR services [38–40] with some countries reporting a decrease in the number of domestic violence incidents, citing accessibility and availability challenges during lockdowns and other social distancing measures [41]. Large data analyses in eight Asian countries also showed that Internet searches related to violence against women and help-seeking rose significantly during the COVID-19 lockdowns [42]. Violence-related online searches increased by 47% in Malaysia, 63% in the Philippines, and 55% in Nepal between October 2019 and September 2020 [43, 44]. The United Nations sustainable development group also affirms heightening of existing vulnerabilities and inequalities [45]. Closures of schools and colleges have negatively affected 91% of the world's student population [46] and countries such as Uganda, Yemen, and Togo have large margins in the mean years of schooling between males and females [47] that are likely to worsen, in tandem affecting access to SRHR-related information among AYP.

The United Nations (UN) women's report on South-east Asia noted that 30% of women in this region were unable to see a medical doctor when needed, and the same proportion of increased intensity in unpaid domestic work [48] was observed following the COVID-19 pandemic. In Zimbabwe and South Africa, early data from United Nations Population Fund (UNFPA) indicated increased incidences of gender-based violence and rape cases reported during the pandemic [49]. UNFPA research findings [49] among female sex workers in Ethiopia also highlighted a significantly increased incidence of physical and sexual violence and threats by police, which further limits their access to SRHR services. An assessment of the impact of COVID-19 on gender equality [49] by UN women and UNFPA further noted that among the 57% coverage in southern and eastern Africa (SEA), of online teaching methods improvised during the lockdown, girls compared to boys were less likely to use such platforms. Additionally, because of economic hardships faced by many households, more pressure on AYP to look for inexpensive labor is inevitable. For the girl child, however, sexual exploitation, early marriage, domestic violence, and female genital mutilation (FGM), all of which are risks associated with school closures and increased poverty [49] may have been exacerbated by the pandemic.

Although available findings do not delineate age disaggregated effects of the pandemic (specifically highlighting AYP) secondary to gender-related disparities, these narratives point to a heightened negative impact of the pandemic

on the already existing gender inequalities and limited access to SRHR services in the vulnerable groups, including AYP in LMIC.

Cultural Norms, Practices, and Access to SRHR

The influence of culture on the uptake of healthcare services can never be underestimated, at either individual or system levels. Many sociocultural practices hindering access to SRHR services were still prevalent in most LMIC even before COVID-19. Cultural values such as early marriages, taboos pertaining to sex education, and other traditions have had a huge impact on how AYP view and access SRHR services [50]. A cross sectional study in Lao People's Democratic Republic [51] demonstrated that it is a taboo for adolescents to discuss SRHR issues with adults, a similar issue seen elsewhere in some African countries [52, 53]. Cultural lack of acceptance of premarital sex had caused adolescent girls to be shy to access SRHS, and healthcare providers have also become reluctant to provide SRHS to adolescents in such countries, especially in the remote areas, due to concerns that the community would perceive their work as promoting premarital sex [51]. In Nepal, sexual behavior among unmarried adolescents is labelled as "bad behavior," and adolescents who are sexually active are judged to be "bad influences" to others and, therefore, experience stigmatization and rejection in their communities [54].

Despite the paucity of data concerning how the COVID-19 pandemic has impacted cultural values and practices to influence the way AYP access SRHR services, the evidence that exists shows that the pandemic may have fueled such norms, thereby further derailing efforts towards the global SRHR targets by 2030. Jones et al. (2020) study in Ethiopia [55] revealed that gendered cultural norms such as early marriage and childbearing reduced accessibility of SRHR services, especially in remote areas where most adolescent women were illiterate. Results from the global program to end child marriage (GPECM) in Ethiopia, Mozambique, Uganda, and Zambia showed increased numbers of cases of violence, child marriage, and teenage pregnancies [49] during the pandemic. The wrath of COVID-19 did not spare the sex workers in the SEA region either, with many reporting increased stigma and discrimination, unlawful arrests from police, and/or sexual or economic violence from their clients [56]. Adolescents reported that their autonomy in decision-making, their access to SRHR services, and their ability to obtain information were hindered during the "new normal" [57].

FGM, prevalent in some east African countries, is another cultural norm that could have been amplified during the pandemic. Prevalence of FGM [58] is as high as

97.9% in Somalia and 93.1% in Djibouti. UNFPA estimated that the disruptions due to COVID-19 will attribute only one-third reduction in the expected progress by 2030, with close to two million cases likely to be reported in the next decade [59]. More research, however, is needed to quantify the extent to which these cultural norms may have influenced AYP's decisions in accessing SRHR services in most LMIC.

Economic Perspectives and Impact on SRHR

Access to SRHR services among AYP is critical not only for meeting SDGs but also for benefiting from their associated demographic dividend [60–62]. The World Bank (WB) estimates that African countries are likely to increase their gross domestic product (GDP) by 10–15% [63] by 2030 if young people are at the center stage of their development plans and initiatives. The COVID-19 pandemic has taken a toll on the economic status of many communities worldwide, challenging sales, consumption, and economic growth, as well as borrowing capacity of many entities. In Uganda, for example, the World Bank estimated GDP to have grown at 2.9% in financial year 2020 (FY20), less than half the 6.8% recorded in FY19 [64]. UNICEF [65] points out that the pandemic's influencing factors, such as limitations to economic activities, school closures, and physical distancing, reduced access to health services, and, hence, increased children's and adolescents' vulnerability and exposure to violence. The pandemic's restrictions further exacerbated levels of poverty in LMIC, with most people losing their jobs, and exerted pressure that increased anxiety for both healthcare providers and AYP [46, 66–69].

Government funding towards SRHR services in LMIC was still below the required threshold before the pandemic [30]. During the pandemic, the World Bank deployed more than \$157 billion in healthcare financing, which is the largest crisis response in the bank group's history [70]. The threat attributed to the pandemic on debt repayment and additional funding to LMIC for health and social interventions is likely to cloud provision of services, according to a UNICEF policy brief [71]. The global financing facility (GFF) [67] reported close to 25% global reduction in life-saving health interventions for women, children, and adolescents because of COVID-19. Economic constraints in a number of LMIC, including low domestic federal funding amidst high expenditures, have placed an additional burden on financing health interventions, including SRHR programs.

Before the pandemic, numerous AYP had challenges accessing SRHR services because of geographical, cognitive, and psychosocial accessibility barriers [51] whereas others lacked the facilitation to purchase SRHR supplies

such as condoms and contraceptives [69, 72]. Travel restrictions, unemployment, and limited or constrained government funding for SRHR services during the pandemic further limited the ability of AYP to access such services. Published literature on the economic impact on access to SRHR following the pandemic is limited, and this synthesis has focused on the likely possible effects following the observed global challenges. A 2018 Lancet report underscored that meeting the unmet need for contraceptives in LMIC would avert an additional 67 million unintended pregnancies in 2017 and reduce maternal and neonatal mortality by 73% and 80%, respectively [2]. With current economic challenges among donor countries following the pandemic, LMIC's progress towards reducing maternal mortality, especially among AYP, and neonatal mortality has stalled or even reversed and limits attainment of the global SDGs by 2030. With many LMIC still struggling with COVID-19 vaccine coverage, prioritization of funding for SRHR is not on the agenda.

In 2020, the International Monetary Fund (IMF) launched the COVID-19 crisis capacity development initiative to meet the urgent needs of its member countries, but the fruits from this initiative are yet to be seen. Hence, LMIC are likely to continue with the soaring rates of unemployment, fragile health infrastructure, and limited government healthcare financing. In the 2021 African Economic Conference, the African Development Bank (ADB) estimated that African governments required an additional financing of approximately \$484.6 billion within the next 3 years to close the financing gap and emerge more resilient from the COVID-19 crisis [73]. Real GDP of most LMIC stalled during the first year of the pandemic and is likely to continue the following years, meaning that most governments, even with financial support from IMF and other financial entities, will focus on boosting the economy through quick fixes. Financing for healthcare support, particularly towards SRHR, will stagnant for some time and, consequently, reverse even the few gains that countries had made before the pandemic. With other co-existing systematic challenges among AYP in most LMIC, economic initiatives or incentives provided by governments to young people such as the youth fund in Uganda [72] will require building capacity in economic entrepreneurship, as well as linking them to markets for their products. In the current state of travel restrictions, reduced out-of-pocket expenditures, and global supply chain constraints, AYP will have to wait longer to see changes in their day-to-day lives. This extended time mounts additional pressure, stress, and anxiety on them, and further limiting their access to SRHR services.

This situation will, therefore, require an expedited special fund ear-marked for SRHR for AYP and women

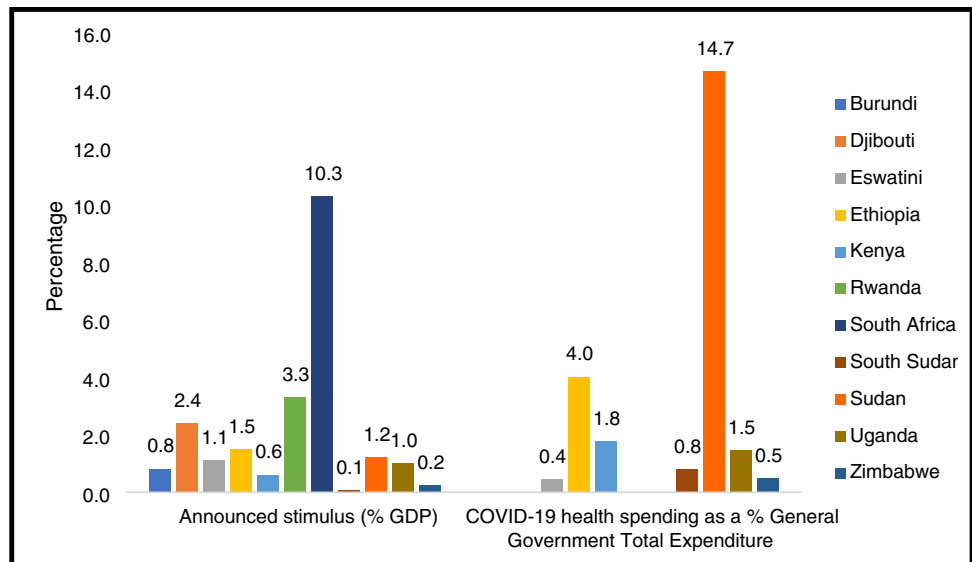
in countries hard hit by the pandemic and, particularly, with minimal interest rates. This will also require a more robust transparent policy and implementation of already existing evidence-based interventions to increase access to such services. Additionally, success of economic interventions implemented for AYP will require multiple players, including stability of international markets, donor financial incentives, governments' potential to negotiate for better markets of products, individual mindset change, and awareness among AYP regarding future business prospects, individual responsibility, and appreciating integration in all government programs using the limited resources available.

Policy, Legal, and Structural Changes Influencing SRHR Services

Government policies have in the past contributed to the limited access of SRHR supplies. For example, the 1984 Mexico city policy (global gag rule, GGR) led to termination of SRHR services, stock-outs, and contraceptive supplies, as well as increased fear to advocate for or share information about legal abortion among non-governmental organizations' staff and healthcare providers [30, 74]. A "new normal" was observed globally as a result of COVID-19 restrictions. To minimize spread of the virus, governments introduced new policies and regulations requiring changes in status quo, including access to healthcare services. Policies that influence access to SRHR services have had both positive and negative connotations.

Loan negotiations, tax holidays from commercial banks towards women, and social protection in Uganda, Seychelles, Mauritius, and South Africa [49] could be seen as policy measures positively influencing access to SRHR services. Other countries including China, Georgia, and India provided guidance on continuity of maternal, child, and neonatal health as well as antenatal, postnatal, and SRHR services [23], during the pandemic, thereby indirectly promoting SRHR access. In Tunisia and Morocco, guidance at a ministerial level ensured continuity of SRHR services during the pandemic, including inclusion of women at planning levels of all COVID-19-related meetings, and prevention of gender-based violence against women [23]. Nonetheless, the World Economic forum report (2020) noted that in most of the existing legislations, there are features that discriminate women. During the pandemic, countries passed different regulations that negatively influenced access to SRHR services, including AYP. For instance, in Eritrea [74] a nation-wide, 21-day, stay-at-home policy also included postponement of court sessions; Uganda and Sudan allocated significant proportions of their total health spending to fight COVID-19, as shown in Fig. 1.

Fig. 1 Fiscal response to COVID-19 in ESA, 2020



Lao PDR was another country that redirected funds from its health budgets to facilitate COVID-19 efforts and in return limited access to contraceptives and MCH services by 30%. Angola, Zimbabwe, and Honduras are additional countries that implemented new COVID-19 regulations that restricted access to safe abortions; with Angola enacting a penal code establishing penalties for abortions, Zimbabwe's seldom open courts limiting access to legal abortion services, and Honduras's national constitution blocking any future possibilities of legal abortions [23]. Overall, policy and structural changes during the pandemic amplified existing SRHR inequalities. A robust evaluation of the extent to which such regulatory adjustments affected disparities among AYP is not yet available and underscores the need for conducting research in this area.

Implications of Findings on SRHR Services

Overall, the COVID-19 pandemic has slowed global progress toward 2030 SRHR targets within the SDG agenda in most countries, with LMIC more affected. Continued funding to mitigate its effect is likely to affect even the small gains some countries had made towards reducing the existing inequalities, including gender-based violence against women. Maternal, neonatal, child, and adolescent health targets might not be met in time for most of the heavily affected regions in LMIC. These diversions are also likely to reinvigorate unacceptable gender and cultural norms, as well as increase the socioeconomic divide between males and females. At policy levels, all provisions in support of equality in accessing SRHR services that were about to be concluded were also affected because of the pandemic.

Government funding and loans to service COVID-19 interventions will have a long-standing negative effect on SRHR service funding and, in turn, limit improvements in the quality of life among many vulnerable groups in LMIC.

Conclusion

Access to appropriate SRHR services among AYP globally is still a large challenge, especially in LMIC. There are remarkable efforts, including advocacy taken to ensure this population is reached with all the necessary services, have been made. However, existing socio-cultural, gender, and economic constructs deeply founded within societies have not facilitated such efforts. The COVID-19 pandemic has further slowed these efforts, as it prompted many communities to enforce their values even more despite infringing on the rights of AYP. Further research is needed to assess the extent to which the pandemic has fueled economic, gender, and socio-cultural aspects to facilitate or inhibit access to SRHR services among AYP especially in LMIC.

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