CME LIVE OPEN ACCESS

Journal of
Gynecology and Reproductive Health

Research Article

Slippery Road of Women's Reproductive Health, Preventive Possibilities, Crippling Potholes Due to Covid Pandemic and Pearls Found.

S. Chhabra*

Professor of Obstetrics Gynaecology, Mahatma Gandhi Institute of Medical Sciences, Sevagram. Chief Executive Officer, Akanksha Shishu Kalyan Kendra, Sevagram. Officer on Special Duty, Dr. SushilaNayar Hospital, Amravati, Kasturba Health Society, Sewagram, Wardha, Maharashtra, India.

Corresponding Author: S. Chhabra, Professor of Obstetrics Gynaecology, Mahatma Gandhi Institute of Medical Sciences, Sevagram. Chief Executive Officer, Akanksha Shishu Kalyan Kendra, Sevagram. Officer on Special Duty, Dr. SushilaNayar Hospital, Amravati, Kasturba Health Society, Sewagram, Wardha, Maharashtra, India.

Received: 2024 Mar 09 **Accepted:** 2024 Mar 28 **Published:** 2024 Apr 16

Abstract

Context: Road of women's reproductive health is slippery, but falls can be prevented even with low resources. Covid-19 pandemic crippled road, created potholes, but provided pearls too.

Objective: Information about challenges in women's reproductive health, preventive modes, impact of covid pandemic, new learning.

Material: Personal experiences, discussions have been added to information about women's reproductive health, thrust on adolescents, maternal health, preventive modalities, impact of Covid pandemic, alternatives discovered.

Slippery road: Globally women's reproductive health continues to be staggering challenge, deaths due to preventable complications during maternity, other preventable disorders continue with limitations of prevention. Struggle goes on for knowing facilitators, barriers, challenges, opportunities.

Covid-19: Women's reproductive health was affected much more by COVID-19 pandemic

Pearls: New modes, preventive, curative, adoption to digital technology, distance training, care.

Conclusions: Women suffer due to reproductive health, sufferings can be prevented with limited resources also. Covid had negative impact, but gave new learning

Keywords: Women, Reproductive Health, Slippery Road, fall, Preventive Possibilies, Covid-19 Pandemc, Crippling, Potholes and Pearls.

1. Introduction

The road of women's reproductive health is slippery with possibilities of falls but prevention of slips is possible even with low resources. Covid-19 pandemic crippled this road and created potholes. But potholes provided pearls too. All the four issues, need in depth understanding and possibilities of sustainable actions for best of the women's reproductive health.

1.1. Objective

To collect information about challenges in women's reproductive health, preventive possibilities, impact of covid pandemic and new learning.

2. Material

Information search about women's reproductive health, issues with thrust on maternal health and adolescents was added by personal experiences and discussions about impact of Covid pandemic and new sustainable modalities discovered.

Findings

Slippery Road of Women's Reproductive Health: Globally women's reproductive health continues to be a staggering challenge as they continue to die due to preventable complications during pregnancy, birth, postbirth and also due to other preventable disorders, like cervical cancer, more so in developing countries with limitations in prevention. Women's reproductive health gets affected by many factors, social, cultural, economic as well as environmental. Preventable deaths during pregnancy, birth, and post birth continue around the world, more so in the low resource regions.

Globally attempts continue to be made to prevent maternal deaths and sicknesses with failures and successes. Struggle goes on for knowing right actions for the best of the health of women and their babies. It is essential to understand ground realities for prevention, enablers, facilitators, barriers opportunities, even in challenging emergencies like Covid-19 pandemic. Child birth is traditionally believed to be second birth because of events with inherent dangers which can occur during pregnancy, birth and postbirth. Globally programs have been going on for prevention of complications, severe illnesses and deaths during maternity as well as other preventable killer disorders like cervical cancer for women's preventive, therapeutic and promotive health. Many lessons have been learned and continue to be learned from each programme like in India and more continue to be added, rural inclusive [1-8]. Also over the years various schemes programs have also been made to help women and children, all these programs did make a difference on the maternal health scenario, but impact has not been as per expectations.

Emergency obstetric care (EMOC) was believed to do a lot of good for maternal health but did little. Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sevagram was Nodal centre for training of national trainers. During the journey itself, challenges could be envisioned. Document for maternal death review (MDR) for national use was also developed at MGIMS, Sewagram due to activities which were being done. MDR programme is going on well at some places but not in others. Looking at the evidence from MDR program, maternal near miss review program (MNMRP) was started. MGIMS Sewagram was head quarter for the pilot project for national MNMRP. Piloting was done in five states of India, some doing well in maternal health, others facing challenges. MNMR piloting revealed that hypertensive disorders of pregnancy (HDsP) were number one and medical disorders number two causes of MDs as well as MNM cases, 'Obstetric transition', in some better doing states of India, with better health indicators as in many developed countries of the world. In other states, bleeding and infections continue to kill women during maternity. The obstetric transition suggests that as states, countries develop socially and economically, the primary causes of maternal deaths change [9].

MNMRP also revealed that different regions needed different responses and actions of awareness, channelized services, and resources, human as well as infrastructure and eliminate delays at various levels quality care. Policies and programs need to be dynamic. MNMR provides better information for quality care than MDR, because survivor, the woman is alive to share experiences, positive and negative. Information about facilitators and challenging issues need to be understood holistically, taken positively to work on gaps, do research of the need for ensuring quality services. With MNMRP the gaps are revealed comprehensively, rapidly and in a precise way. MNMRP was believed to prevent MDs, severe illnesses and promote maternal health however many challenges continue in real implementation, struggle goes on. Over all MDs have reduced but challenges also persist. Some need simple solutions and others are complex. Women continue to die due to preventable conditions. Programs like 'Dakshta', (capacity building), training, empowering health workers, 'Laksh', (mission) upgrading facilities for high-quality care. Quality care was and is still badly needed at many places in India.

It is essential to have vision, understand and develop infrastructure and have skilled health providers. At MGIMS Sewagram, reduction in maternal deaths was possible because of, infrastructure, workers with global knowledge for evidence based management with attitude for management actions which are all essential. It was added by services to women in villages, wherever possible with linkages to referral health facility, timely, appropriate management of disorders which could become fatal during maternity. Years back community based maternal child services, basic antenatal care, and advocacy for intranatal and postnatal care through retrained supervised NM were started by MGIMS Sewagram and have continued. Delivery kits too used to be given for any emergency home births. There has been almost complete elimination of MDs in these villages with ripple effects in communities of nearby villages. System has helped a lot, though there have been some quality issues at referral in recent past. It is essential to understand drivers of quality care, strategies for improving maternal health by MD surveillance and response (MDSR) and MNM surveillance response (MNMSR). MDS and MNMS need to be visionary and action oriented. Sometimes funds get diverted to regions which have more MDs, for obvious reasons, but accountability needs to be fixed.

Also regions, countries and states doing well than others too have black spots, like some in. Maharashtra, India which has much better health indicators than many other states remote, rural, forestry and hilly region, Melghat, famous for tiger reserve, bird sanctuary, extremely low resources, forest regulations amongst four challenging regions which have high maternal, neonatal, infant and child mortality the province with better health indicators.

A health facility, reasonably equipped 50 beded hospital has been created with support of civil society, In this process more lessons were learned about conditions affecting maternal health, some obvious, others complex. In a short time essentiality of community level services, behavior change, motivation and also community mobilization was felt. Now after a decade there is a real change, but persistence of preventable MDs is worrisome. During the decade 50% MDs occurred in women who were severely anemic in the last weeks of pregnancy, a real challenge for preventive possibilities. Some had home births, postpartum hemorrhage (PPH), traumatic or atonic or mixed type.

While poverty was a major issue, families' strong beliefs, social perspective, refusal to use health facilities also seem to have contributed to deaths. Also it appears that at health facilities, knowledge, skills of providers, needed updating and change in attitude also. It is essential that communities work with the understanding of science. The science needs to engage communities and bring communities in net with a clear sense of community aligned science, which advocates 'science for society'.

Impact of Covid-19 Pandemic on Slippery Road of Women's Reproductive Health: The COVID-19 pandemic affected everything around the world, changed every body's life with significant influence on the health, globally. Even existing disorders were affected and health care too. Women's health was affected much more due to various reasons including gender inequalities. Efforts to hault the spread of COVID-19 lead to travel, restrictions, inaccessible and costly transport, reduced access to sexual reproductive health (SRH) services, commodity stockouts, limited availability of every day needs and fear of infection. Kikuchi reported changes in women's health status during the COVID-19 pandemic in rural Bangladesh following lockdown-mediated confinement even Body Mass Index (BMI) and blood pressure [10]. Maternity services were unique in that, the care was time sensitive and could not be rescheduled. Births continued regardless of the pandemic with challenges of care at homes, at Sub centres (SC) and Primary health centers (PHC). Women could not come to hospitals for seeking care. A woman in one of the service villages was given medication for post-partum fever. Medication lead to allergic reaction, skin rash which got infected.

Woman reported to the referral hospital in seriously ill condition and died within hours of admission due to septicaemia with multi organ failure with challenges of management during Covid pandemic. In some parts of India, there were more MDs, due to septic abortions [11]. There was a reduction in access to SRH, including family planning (FP) counseling services and contraceptive access, and safe abortions during the Covid pandemic, around the world. Aranda reported that study from 37 health facilities in low and middle-income countries (LMIC) revealed significant decline in first antenatal visits in Haiti, 18% and Sierra Leone 32% [12]. There was a drop in facility-based births in many countries. In a study by Wang in China, 45% women reported having at least one symptom of psychological distress during the Pendemic [13].

Hessami did systematic review of studies which provided evidence that the pandemic significantly increased anxiety during pregnancy and perinatal period with reduced access to antenatal and postnatal care, with lack of in person care impacting the ability to screen for physical, psychological and social issues [14]. Senol did a study in which information was collected online from Turkish married in context of women's reproductive health protective attitudes [15]. Study revealed that around 23% women experienced a reproductive health problem during the pandemic. More than 70% women did not seek health facility care. However 74.5% did not present to a health center because of risk of COVID. Around 40% of women used the therapy, they knew to relieve their problems and 16.0% women used medications previously prescribed by their doctors.

Larkin reported that disruption of SRH services might have contributed to as many as 2.7 million unwanted pregnancies in the first year of the Pandemic and 1.2 million unsafe abortions in the first 6 months [16]. Nearly one-third of the 83 studies included in the review examined documented declines in contraception, with the majority focusing on long-acting reversible methods. Substantial declines were found in injectable and emergency contraceptives, placement and removal of long-acting devices, and tubal ligation. More than half of US clinics canceled or postponed contraceptive visits of their clients while 86% of SRH clinicians and stakeholders in 29 countries said patients had less or much less access. In-person abortion services were curtailed and online consultations for medical abortion pills, ticked up. Declines were prevalent in the areas with restrictive abortion policies, 16% reduction in Ethiopia and 38% in Texas. Around 35% and 21% of SRH clinics closed in the US South and Midwest, respectively. Nearly half of included studies found decreased access to services for sexually transmitted infections (STI) including human immune deficiency virus (HIV) infecion.

STI testing reductions were reported in Jordan, Thailand, Uganda, and the US. Study revealed that 95% of community STI testing clinics in 53 countries in Central Asia and Europe reduced testing. While another study revealed significant reduction in asymptomatic STI screening in Australia and the US. HIV preexposure prophylaxis decreased by 80% in the US, and follow-up declined among vulnerable women in South Africa [16]. Gender based violence (GBV) increased and affected women's lives around the world. In a study by Aduragbemi one of two women reported either they had or knew a woman who experienced violence during the pandemic (17). Tang also opined about the increase in GBV, due to the COVID-19 pandemic [18]. Actually there has been around one-third reduction in progress towards elimination of GBV by 2030 [19]. The pandemic exacerbated prior inequalities, uncovering vulnerabilities in social, political and financial systems which were consequently enhancing the effects of the pandemic in various countries [20].

Findings of study by Owens revealed that stress and sleep disturbances related to the pandemic had adverse effects on women's menstrual cycles too [21]. Fifty-six percent of respondents reported change in their menstrual cycles and 54% women experienced reduced sex drive. In an anonymous digital survey via social media, 46% women reported a change in their menstrual cycles since the beginning of the pandemic, and 45% reported a reduced libido too. The pandemic increased the global gender gap from 99.5 to 135.6 years to reach equality, a 36-years setback [22].

Pearls from Potholes

The Covid-19 pandemic has disproportionately impacted women's lives more so because they are highly represented in healthcare and childcare, which were the key sectors in the pandemic. The situation demanded an out of box thinking for survival, for an update in infrastructure and technical knowledge to face events like the Covid Pandemic in future also [23]. The pandemic did open doors to new opportunities like digitalization and much more adoption of digital technology. Because of happenings during Pandemic there has been an inevitable surge in the use of digital technology, effects of social distancing norms and lockdowns. People and organizations all over the world have had to adjust to

new ways of work and life, work-from-home (WFH), making life for women easier with ideas for sustainable long term programs with possibilities of work from home for income generation and being self-sufficient in countries like India. Expertise was developed for distance training and learning, increased family support, sharing of knowledge and awareness, empowerment of peripheral health workers, task shifting and so on.

Hessami reported that family support played an important role on pregnant women's mental health during the pandemic [14]. This helped a lot in the best of maternity outcome, a real pearl. There is evidence, that many adaptations have been implemented for getting SRH services, closer to women's reach, based on guidance and best practices and, in many cases, leveraged evidence-based interventions. Evaluations carried out resulted in increased outputs and efficiency following the implementation of various adaptations. Pandemic also gave birth to opportunities of providing health services from distance, making families more knowledgeable and empowered to take care of their own health, families and friends by using nearby places and preferences of care by using Telemedicine, self-help groups etc. Society, as a whole used a lot of innovative modalities, networking, pooling of services and low cost education modalities. Virtual patient education, guidance for awareness of quality antenatal care was initiated. All such activities continue to be a good mode.

Silverio did a study in London and reported that virtual care replaced disrupted in-person care with changes in birth place preferences, increase in remote care and electronic guidance, though some women reported an under- reliance on healthcare professionals for support, turning to challenges for family too, another pearl [24]. Epidemic presented unique challenges between complex scientific, socioeconomic, and international cooperation. While reduction in food with affordability lead to consumption of cheaper, unhealthy foods with weight gain, increasing susceptibility to obesity and nutrition related chronic diseases and their squeal, there was other side to this. Lack of resources and shut downs, travel restrictions led to alternative eating habits, consume whatever was really essential, available and homemade, low cost and healthy , real pearl.

Sheil opined that development of a 'hospital within a hospital' system, separate physical care pathways with development of robust virtual care gave many ideas for working environment [25]. The use of social media and the availability of comprehensive sex education (CSE) were crucial aspects of effective SRHR in response to the pandemic [26]. Governments called for global efforts to strengthen preparedness and responses to health emergencies, learning from the pandemic. They emphasized the need for an aligned global health architecture with WHO at the center with 70% of the health workforce and 90% of frontline health workers women [27]. In India, accredited social health activists (ASHAs), community health workers and programme supporters for rural communities were at the frontline during the pandemic. Gore opined that ASHAs' contribution to the health system, improved the indicators related to maternal and child health during the pandemic.

Challenges and Lessons

Women Suffer due to Various Issues Related to Reproductive Health but Sufferings Can be Prevented Even with Limited Resource: Covid - 19, the largest global public health crisis with overwhelming health and consequences provided platform to learn from each other, networking and sharing. It revealed that health policies should be planned in accordance to the need of continuation of reproductive health and sexual health services. Various actions emphasized the importance of health professionals, especially women, in planning policies, and financial decision-making to ensure that decisions are made by 'on-the-ground expertise and benefit women.

References

1. http://nutrition-health-education.blogspot.com/2014/01/child-survival-and-safe-motherhood.html
2. https://hetv.org/india/mh/healthstatus/reproductive-child.htm
3. https://gmch.gov.in/sites/default/files/documents/Reproductive%20&%20Child%20Health.pdf
4. https://www.lstmed.ac.uk/emoc
5. http://tripuranrhm.gov.in/Guidlines/MDRGuidelines/MDR_Guidelines_Pg9_36.pdf),/nhm.gov.in/images/pdf/programmes/maternal health/guidelines/Maternal_Near_Miss_Operational_Guidelines.
6. https://www.cdc.gov/reproductivehealth/global/programs/strengthening-maternal-newborn-health-surveillance/maternal-death-(/nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/Dakshata-in-New-States.pdf),
7. Gausman, J., Oviedo, D., Langer, A., Jolivet, R. R. (2023). Exploring the intersection between country context and priority setting to prevent maternal mortality: A multi-methods study comparing expected vs observed priorities in five countries to validate the obstetric transition model. Journal of Global Health, 13.
8. Lorková, M., Gazarova, M. (2023). Impact of the COVID-19 pandemic on the changes in dietary habits, lifestyle and physical activity in the Slovak population. Roczniki Państwowego Zakładu Higieny, 74(3).
9. Kikuchi, K., Islam, R., Nishikitani, M., Sato, Y., Izukura, R., et al (2022). Women's health status before and during the COVID-19 pandemic in rural Bangladesh: A prospective longitudinal study. PloS one, 17(5), e0266141.
10. Carrieri, A. D. P., Papadopoulos, D., Quaresma Júnior, E. A., Silva, A. R. L. D. (2021). The ontology of resistance: Power, tactics and making do in the Vila Rubim market. Urban Studies, 58(8), 1615-1633.
11. Aranda, Z., Binde, T., Tashman, K., Tadikonda, A., Mawindo, B., et al (2022). Disruptions in maternal health service use during the COVID-19 pandemic in 2020: experiences from 37 health facilities in low-income and middle-income countries. BMJ global health, 7(1), e007247.
12. Wang, Y. N., Yuan, Z. J., Leng, W. C., Xia, L. Y., Wang, R. X., et

al (2021). Role of perceived family support in psychological distress for pregnant women during the COVID-19 pandemic. World Journal of Psychiatry, 11(7), 365.
13. Hessami, K., Romanelli, C., Chiurazzi, M., Cozzolino, M. (2022). COVID-19 pandemic and maternal mental health: a systematic review and meta-analysis. The Journal of Maternal-Fetal & Neonatal Medicine, 35(20), 4014-4021.
14. Kaya Senol, D., Polat, F. (2022). Effects of the pandemic on women's reproductive health protective attitudes: a Turkish sample. Reproductive Health, 19(1), 106.
15. Larkin, H. D. (2022). COVID-19 limited access to sexual and reproductive health services. JAMA, 328(19), 1896-1897.
16. Banke-Thomas, A., Yaya, S. (2021). Looking ahead in the COVID-19 pandemic: emerging lessons learned for sexual and reproductive health services in low-and middle-income countries. Reproductive health, 18, 1-8.
17. Tang, K., Gaoshan, J., Ahonsi, B., Ali, M., Bonet, M., et al (2020). Sexual and reproductive health (SRH): a key issue in the emergency response to the coronavirus disease (COVID-19) outbreak. Reproductive Health, 17(1), 59.
18. UNFPA. (2020). Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage. Interim Tech Note, 7.
19. Women, U. N. (2020). Policy brief: The impact of COVID-19 on women. UN Women.
20. Owens. L.A., (2022). Endocrine news COVID-19 Pandemic Associated with Disruptions to Women's Reproductive Health.
21. Toker, H. UNDERSTANDING COVID-19'S IMPACT ON WOMEN IN IRAQ. GENDER EQUALITY AND SOCIAL COHESION IN IRAQ, 31.
22. Paul, M. An Analysis of Pandemic 2020 impacts on Primary, Secondary and College Education in Urban and Rural India.
23. Silverio, S. A., De Backer, K., Easter, A., von Dadelszen, P., Magee, L. A., et al (2021). Women's experiences of maternity service reconfiguration during the COVID-19 pandemic: a qualitative investigation. Midwifery, 102, 103116.
24. Sheil, O., McAuliffe, F. M. (2021). Reorganisation of obstetric services during the COVID pandemic–experience from National Maternity Hospital Dublin Ireland. Best Practice & Research Clinical Obstetrics & Gynaecology, 73, 104-112.
25. Europe, C. P. A. (2020). European Parliamentary Forum for Sexual&Reproductive Rights.
26. https://womeningh.org/fund-us/
27. Gore, M., Kawade, A., Smith, P., Pinnock, H., Juvekar, S., et al (2022). Working as frontline health facilitators, service providers, program supporters, and social health activists in Indian hilly terrain areas: a qualitative study of accredited social health activists' experiences before and during the COVID-19 pandemic. Journal of Global Health, 12.