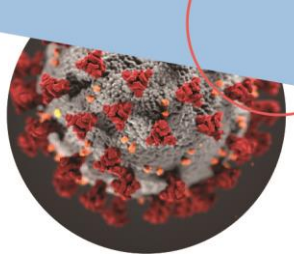
taskforce on bbvs
sexual health and covid-19

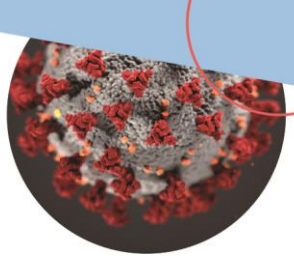


Women's health and COVID-19

This article examines the impact that COVID-19 has had on women's health, with a focus on sexual and reproductive health, and blood borne viruses.

Produced by Jessica Michaels ASHM, 10 July 2020

Disclaimer: The recommendations provided are the opinions of the authors and are not intended to provide a standard of care, or practice. This document does not reflect a systematic review of the evidence but will be revised to include relevant future systematic review findings. The recommendations are not intended to replace national guidance.



Article One: **Access to Sexual and Reproductive Health Services for women during COVID-19**

Clinical A/Professor Deborah Bateson - Family Planning NSW and Professor Kit Fairley - Melbourne Sexual Health Centre

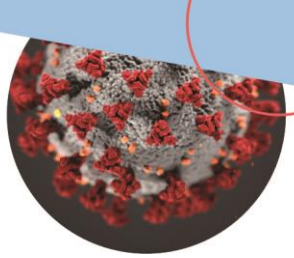
Key points

- All women have a right to access sexual and reproductive health (SRH) care information and services.
- Innovations including telehealth SRH consultations, home STI-testing and teleabortion increase access, and can be used to supplement but not replace in-person clinical consultations.
- The single most powerful control measure for STIs is access to clinical services for symptomatic individuals.
- Women in Australia over the last 10 years are increasingly at risk of both gonorrhea and syphilis and both of these infections are exquisitely sensitive to the provision of access to services.
- Screening for STIs plays an important role in the control of these infections, particularly screening in pregnant women and enhanced screening in pregnant women at risk of syphilis to prevent cases of congenital syphilis.
- Continued provision of contraception, including the highly effective long acting reversible contraceptives (LARCs), is essential and requires access to clinical services; general practitioners, nurses and midwives play a critical role in service delivery.
- Women experiencing unintended pregnancy need accessible information about their options and access to services providing medical and surgical abortion care.
- The COVID-19 crisis provides a unique opportunity for coordinated research and data collection to create the evidence-base for an optimal approach to SRH service delivery.
- It is critical that access to health services for women is not reduced so women can get symptomatic STI's treated and be provided with effective contraception and, if needed, safe abortion care.

All women have a right to access sexual and reproductive health information and services but there are predictions that inequalities during the COVID-19 crisis will lead to increased rates of untreated sexually transmitted infections (STIs), unintended pregnancies and short interpregnancy intervals. Vulnerable populations including young women, Indigenous women and those with disabilities are likely to be most impacted.

Data over the last century has clearly demonstrated that the single most powerful control measure for STIs is access to services. The rates of gonorrhoea and particularly syphilis fell precipitously with the introduction of penicillin and have never risen to the pre-antibiotic levels since that time.

Enhancing access to long acting reversible contraceptives (LARCs) has similarly been shown to be the most effective approach to reducing unintended pregnancies, including amongst teenagers, and these methods have been shown to be safe and acceptable for women across the reproductive lifecourse. Continued provision of LARCs is essential during the COVID-19 crisis and requires access



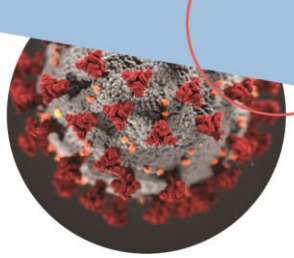
to clinical services including family planning organisations; trained general practitioners, nurses and midwives play a critical role in service delivery.

Innovations including the use of telehealth for asymptomatic sexual health consults and medical abortion provision (teleabortion), STI screening postal kits, and sending contraceptive pill scripts directly to the pharmacy can all enhance SRH access, and it is essential that the temporary COVID-19 Medicare Benefit Scheme (MBS) telehealth item numbers continue beyond September 2020. However, they cannot completely replace in-person clinical consultations. Despite its many benefits, telehealth does not always, for instance, lend itself well to screening for and disclosure of intimate partner violence including reproductive coercion, as conversations may be overheard or intercepted.

The provision of sexual and reproductive health services is less well funded than almost any other area of the health service and so it is eminently possible in times of crisis that governments forget about the importance of good access to clinical services for SRH. It is therefore critical for general practice, sexual health services and family planning organisations to continue to provide access to services for women and heterosexuals to maintain downward pressure on STIs and unintended pregnancies.

Sometimes the focus of a health service can move gently and imperceptibly away from the clients that the service exists to serve and towards the protection of the staff. Both are possible simultaneously. There has been some evidence of this occurring in Australia and it must be quickly remedied with appropriate steps put in place for the protection of staff, but not to the extent that these reduce the provision of services that control STIs and provide women with effective contraception and, safe abortion care.

The COVID-19 crisis provides a unique opportunity for coordinated research and data collection to create the evidence for an optimal approach to SRH service delivery which ensures that people's personal preferences and choices are protected.



Article Two: **Pregnancy and COVID-19**

Professor Kirsten Black -University of Sydney) and Clinical A/Professor Deborah Bateson - Family Planning NSW

Key Points

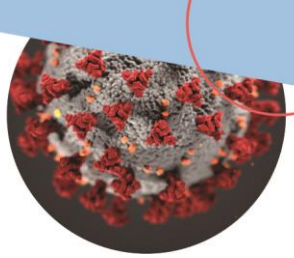
- COVID-19 infection during pregnancy appears to have a similar clinical presentation and severity to that in non-pregnant adults
- Infection during pregnancy is probably not associated with poor maternal outcomes
- Infection during pregnancy does not appear to increase the risk of adverse perinatal outcomes including stillbirth and neonatal death
- There is no evidence to date of vertical transmission during pregnancy
- Available data on breastfeeding in COVID-19 positive patients is reassuring; infected patients who wish to breastfeed should be encouraged and supported to do so
- Many obstetric services have been reconfigured to reduce the risk of COVID-19 transmission

Background

Pregnant women are considered a vulnerable group for COVID-19 and while data are limited a **systematic scoping review of 33 studies of COVID-19 during pregnancy and childbirth** published in late April is reassuring (1). COVID-19 infection during pregnancy appears to have a similar clinical presentation and severity to that in non-pregnant adults and it is probably not associated with poor maternal or perinatal outcomes including premature delivery and stillbirth (2). To date there is no evidence for vertical transmission of the virus and studies of breastmilk from infected patients have been reassuring with no reports of the virus being detected.

Effect of COVID-19 infection during pregnancy

COVID-19 appears to present significantly fewer maternal risks during pregnancy than other coronavirus infections. The recent **systematic scoping review of 33 studies of COVID-19 during pregnancy and childbirth** which included 385 pregnant patients found that the severity of the infection was similar to that of non-pregnant people (1). In most cases symptoms will be limited to mild or moderate fever and cough. Available evidence to date does not suggest an increased risk of miscarriage or stillbirth associated with COVID-19 infection – and while some babies born to women with symptoms of COVID-19 in China have been born prematurely it is unclear whether this was due to coronavirus or due to clinical decisions for an earlier delivery (2).



Effect of COVID-19 on newborns

There is no evidence to date of COVID-19 causing teratogenic effects but data are limited. There is also no evidence of an increased risk of complications from the infection amongst newborn babies and infants. Vertical transmission from mother to child does not seem to be a major issue – in the systematic review the mode of transmission was unclear for the four out the 256 babies born to COVID-19 infected mothers found to be positive for the virus with no evidence of vertical transmission (1). Available data on breastfeeding in COVID-19 positive patients is reassuring with negative tests in breastmilk for the 26 reported cases worldwide and women who wish to breastfeed should be encouraged and supported to do so. Mothers with COVID-19 infection should not be automatically separated from their babies but enhanced precautions including general hygiene and consideration of a face mask when feeding should be taken (3).

Obstetric services in Australia during COVID-19

To reduce the risk of COVID-19 transmission, obstetric services have been reconfigured to reduce face to face appointments and ensure social distancing. Staff have access to appropriate PPE and are trained in its use (4). Routine antenatal investigations, ultrasounds, maternal and fetal assessments are generally continuing as before although, where appropriate, antenatal visits may occur via telemedicine. In some services partners are not permitted to accompany their partner to antenatal and ultrasound appointments and some antenatal visits. The experience of labour and vaginal birth, or caesarean section, should not be significantly impacted during the pandemic and pregnant people should be supported to approach this extraordinary time of their lives without fear or apprehension (5).

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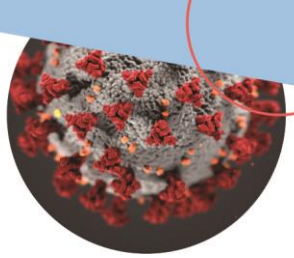


Article Three: **Contraception and COVID-19**

Clinical A/Professor Deborah Bateson - Family Planning NSW and Dr Catriona Melville -Marie Stopes Australia

Key points

- Access to contraception – in particular LARC - has been negatively impacted by the COVID-19 pandemic
- Utilising telehealth consultations has helped maintain access
- LARC insertion is a non-aerosol generating procedure and should be prioritised with appropriate precautions
- In worse affected countries clinical guidelines support the extended use of methods and changes to prescribing (out of product licence)
- Pharmacists play an essential frontline role, including the provision of emergency contraceptive pills
- Collaboration, coordinated research and data collection will support equitable contraceptive access during and beyond the COVID-19 crisis

Background

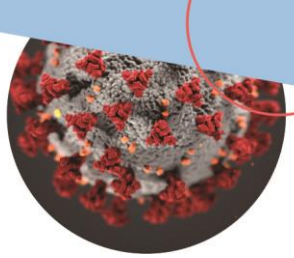
Sexual and reproductive health (SRH) including reproductive autonomy is fundamental for overall health and wellbeing,(1) and evidence-based contraceptive information, resources and affordable services are essential to achieve this. The impact of the COVID-19 pandemic on use of contraception in Australia is not yet known however evidence from the Ebola epidemic in 2013-2016 showed sharp declines in contraceptive use and family planning visits in some countries.(2) Continuity of contraception, in particular long acting reversible contraception (LARC), is essential in preventing unplanned pregnancy.

Access to contraceptive services during COVID-19

Contraceptive services have been impacted during the pandemic through a combination of staff shortages due to illness and quarantine restrictions, an initial lack of PPE and a shift from in-person to telemedicine consultations. Male and female sterilisation procedures were suspended in hospitals and day surgeries due to elective surgery restrictions (although vasectomy under local anaesthetic was continued in some clinics), and hospital based out-patient contraceptive clinics were temporarily closed at the height of the pandemic. There have also been reports of decreased uptake of contraceptive services due to people home-isolating, confusion around availability of services and, even where in-person appointments continued to be available, fear of attending due to the virus.

Overcoming barriers: telemedicine and temporary changes to prescribing practices

The rapid adoption of funded telemedicine contraceptive consultations is making it possible to provide services to people in previously hard to reach groups including those in rural and remote areas. The



UK Faculty of Sexual and Reproductive Health (FSRH) of the Royal College of Obstetricians and Gynaecologists (RCOG) has provided guidance on extended use of LARCs and remote prescribing of an additional 12-month supply of a combined hormonal contraceptive pill for people unable to attend clinics during the pandemic (3). However, the impact of the pandemic has been significantly less in Australia and on the whole these additional measures have not been required. Service innovations such as undertaking a pre-LARC assessment via telemedicine followed by a brief face-to-face procedure appointment have enabled continued access to the most effective contraceptive methods.

Pharmacists are also playing an essential frontline role in the supply of emergency contraception and new legislation brought in during the pandemic allows pharmacists to dispense an emergency one month continued supply of a combined hormonal contraceptive pill when a new prescription cannot be obtained (4).

Summing up: contraception during COVID-19

The COVID-19 pandemic has the potential to increase inequalities in access to contraceptive care, especially amongst marginalised groups including young people and Indigenous people. However, it also provides a unique opportunity for collaboration, coordinated research and data collection to support equitable access during the crisis and into the future.

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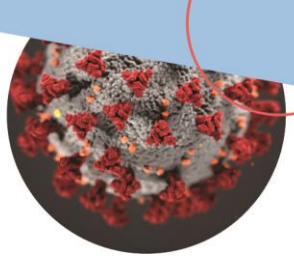


Article Four: **Abortion Care During COVID-19**

Dr Catriona Melville and Ms Jacquie O'Brien -Marie Stopes Australia

Key points

Like many other countries, COVID-19 has had a significant impact on the provision of abortion care in Australia.

- Surgical abortion is classified as a Category 1 procedure.
- During the pandemic a number of Governments across the country have deemed abortion care an essential service.
- Despite this, abortion access across the country has faced significant challenges.
- Most of these challenges existed prior to the pandemic, however COVID-19 has magnified them during the public health response.
- Abortion care providers have had to innovate and advocate to keep services open and accessible to Australians who need to access an abortion during COVID-19.
- There are a number of learnings from the impact of COVID-19 including the need for a more harmonised approach to abortion laws and regulations.
- Applying these learnings will increase equity of access to abortion care as the nation recovers from the impacts of COVID-19.

Background

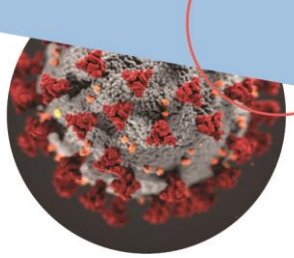
Like many countries, Australia has had to act fast to address the impacts of COVID-19. The pandemic has created new and magnified existing barriers to the provision of equitable healthcare across the country. These impacts have been felt keenly in the area of sexual and reproductive health. This is particularly true in abortion care given that equity of access in Australia has always been challenging.

The impacts of COVID-19 on equity of abortion access

Abortion is a procedure that is extremely time sensitive in that the procedural complexity and associated risks increase with gestational age. In Australia, abortion can be classified as an elective, semi-elective or essential procedure. Classification varies by state/territory government, health and hospital system, and at the individual clinic level. Both the World Health Organisation (WHO) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) have urged that reproductive healthcare, including abortion, be considered an essential service during the pandemic.[1, 2.3, 4]

Classification matters

Australia started preparing its health sector for the COVID-19 pandemic from late February.[5] As infection rates across the country increased, the Australian Federal, State and Territory governments coordinated infection control measures. One such measure was the cancellation of non-urgent surgery across the country from the start of April.[6] Prior to this announcement, RANZCOG, Marie



Stopes Australia (MSA) a number of sexual and reproductive health rights advocates publicly called for abortion care to be deemed an essential service. Classification of abortion as an essential service during the pandemic has proved critical as it influences the ability of healthcare professionals to travel to provide services amidst border closures. It also impacts the ability of healthcare providers to access vital PPE and it provides certainty for people who need to access an abortion service during the pandemic. However, despite the classification of abortion as an essential service, the reality of the public health response to the pandemic has created challenges to its delivery.

Access to PPE

All health services need personal protective equipment (PPE) in order to provide abortion care. Following media publications on PPE shortages, MSA contacted multiple private suppliers however availability of PPE was intermittent.

Despite being an essential service, a number of private suppliers declined to process PPE orders from MSA as the service and organisation were not viewed essential by those PPE providers. The organisation was also deemed ineligible for access to the National PPE Stockpile. Prices of PPE were also inflated (sometimes as much as by 300%).

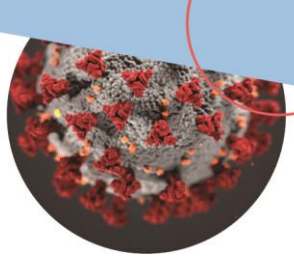
As the country moves into the recovery stage, PPE price increases continue to escalate and there have been a number of inferior PPE supplies arriving in the country. While this is a challenge that most health services are facing, abortion care providers have a low buying power due to the relatively low volume of PPE required. This continues to be an issue for organisations such as MSA.

It is as important as ever to consider mental PPE. In Australia we are transitioning from an emergency context to a longer term crisis management situation. While parts of Australia may begin to reflect pre-pandemic routine, the global pandemic continues, as does the strain on mental health for healthcare professionals and their families. There is a continued risk to health professional mental health including compassion fatigue, vicarious trauma, trauma and burn out.[7, 8, 9, 10,11]

Travel and movement restrictions caused fear and uncertainty

Clinics have experienced staffing shortages due to movement restrictions, decreasing flight availability, quarantining of staff or staff needing to be at home for caregiving. Clinical capacity has also been affected by reduced capacity for patient volume due to physical distancing measures. On days when State, Territory and Federal Government announcements were made about further movement restrictions and punitive measures to enforce movement restrictions, clinical staff at MSA saw increased rates of last minute cancellations or patients not feeling safe to present for their appointment.

State, Territory and Federal inter, and intra-state movement restrictions also contributed to patients' feelings of confusion, uncertainty and fear. Staff within the MSA National Support Centre noted considerable patient confusion in shifting movement restrictions, over-policing and state/territory border checks, fear of police discrimination due to reason for movement being to access abortion care, and fear of barriers to returning home after abortion care. These impacts were likely to have



been compounded for people experiencing intersections of discrimination such as racism, ableism, and ageism. Some may also have been at risk of deportation.

Provision of abortion care across Australia, particularly outside of metropolitan areas often requires 'fly-in, fly-out' healthcare professionals.[12] Travel restrictions across State and Territory borders during the pandemic and the grounding of domestic airlines created a significant barrier to access particularly in the large states of Western Australia and Queensland. In response, MSA, has, for example, chartered a private aircraft to ensure services can continue in Rockhampton and Townsville.[13] In Victoria, gestational limits [14] for services have been limited due to the inability of specialist clinicians from interstate travel across borders.[15]

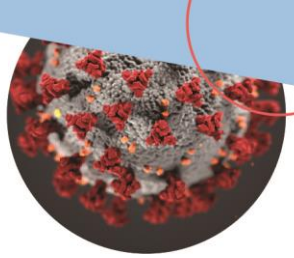
Innovations and clinical improvements

While the pandemic has challenged the provision of abortion care, it has also generated and fast-tracked innovations and placed increasing importance on more remote, self-managed approaches to abortion care.

The pandemic has underscored the importance of medical abortion and streamlined the ways in which the process can be safely completed. Early medical abortion (EMA) in Australia has tended to involve up to two face-to-face appointments; a consult for assessment and dispensing or prescribing of the drug regimen, and a follow-up appointment to ensure the process has been successful. During COVID-19, MSA moved to a remote form of medical abortion follow up using a Low Sensitive Urine Pregnancy (LSUP) test that was recently granted TGA-approval in Australia. LSUP tests typically detect *human chorionic gonadotropin* (hCG) levels above 1000 mIU/mL. The amount of hCG in most women's urine will have fallen to this level by 2 weeks post-EMA.[16, 17] The implementation of the test has decreased the need for repeat clinic visits and further streamlined the medical abortion via telehealth process.

Blood group testing for rhesus status determination and the administration of Anti-D immunoglobulin to rhesus negative women is recommended in Australia for EMA. Blood group testing and administration of anti-D immunoglobulin can cause delays to care, and potentially increase the risks of exposure to COVID-19 (as it requires two face-to-face appointments), therefore MSA removed this requirement. This change was supported by the Royal Australian New Zealand College of Obstetrics and Gynaecology (RANZCOG)[18] and is endorsed by extensive international evidence. [19, 20]

While EMA via telehealth has been available in Australia since 2015, it has become particularly important for the provision of timely abortion care during COVID-19. Throughout the pandemic MSA has seen a 25% increase in demand for the service. Several other countries have studied Australia's medical abortion via telehealth model for abortion provision during COVID-19, including the United Kingdom.[21] Unfortunately, medical abortion via telehealth is not in South Australia due legal restrictions.



Lessons Learned and Next Steps

COVID-19 has starkly revealed the areas of disparity in abortion care access across Australia. While these inequities existed before COVID-19, the pandemic has magnified them. With the focus on these inequities fresh in our minds, now is the time to learn from what we have experienced and to drive evidence-based reforms to sexual and reproductive health, and particularly abortion care. These reforms include:

- Harmonising abortion laws and regulations across the country: this will avoid inequities in access driven by varying gestation limits, public health access and provision of medical abortion via telehealth (currently illegal in South Australia).
- Governments need to fully fund abortion care, particularly for people with Health Care Cards and those without Medicare access. Organisations such as MSA and their partners continue to provide hardship support to a degree that it is no longer economically sustainable. The economic impacts of COVID-19 will continue for the foreseeable future so now is the time to publicly fund abortion care.
- Models of abortion care need to evolve to increase agency and access to abortion provision into the future, including the introduction of nurse-led models of abortion care: this requires continued collaboration across the sexual and reproductive health, women's health and broader health sector.

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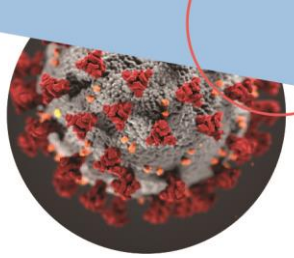

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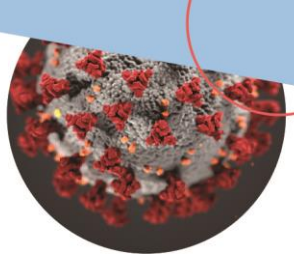


Article Five: **Sexual and Reproductive Health, Violence and Coercion during COVID-19**

Dr Catriona Melville, Ms Jacquie O'Brien and Ms Bonney Corbin - Marie Stopes Australia

Summary

- The COVID-19 global pandemic has required countries across the world to respond with strong, unprecedented preventative measures in order to decrease the risk of infection.
- In the absence of therapeutic measures, the most powerful means of slowing the spread has been strict and far-reaching restrictions on travel and movement.
- The pandemic has also significantly impacted global economies and placed strain on the mental health and physical health of many people.
- Within this context, initial trends and analysis from Australia and internationally has indicated that COVID-19 has exacerbated conditions for violence and reproductive coercion.
- It is important to highlight that COVID-19 is not a direct cause of violence and coercion, rather that restricted movement and isolation should be considered a trigger for first-time and escalating violence and coercion.

Background

As a global pandemic, COVID-19 has enhanced existing and created new stresses and strains on the structural and interpersonal aspects of our lives. The initial evidence that is emerging from countries across the world is indicating that the pandemic has increased the risk and occurrence of violence, including reproductive coercion and gender-based violence[1].

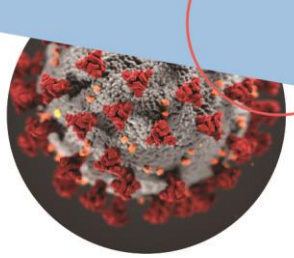
While it is important to investigate the impacts that COVID-19 has on gender-based violence, including various forms of family, domestic and sexual violence, it is important to note that the pandemic has not directly caused this violence and coercion to occur. Rather the pandemic has contributed to stress factors, coercion has escalated and some people have experienced reproductive coercion or physical violence for the first-time.

People who already have restricted bodily autonomy have faced uniquely coercive contexts during COVID-19, including people with disability, people on temporary visas, people who are incarcerated and people in institutional or state care.

Global trends and statistics

There are established links between environmental disasters and pandemics with violence and coercion[2, 3, 4]. Evidence from events such as Zika, Hurricane Katrina, Ebola and bushfires in Australia has shown that the social, economic and psychological consequences of such intense events can lead to increased family, domestic and sexual violence[5, 6, 7].

A number of countries have indicated an increase in family and domestic violence help-seeking during COVID-19. While we are yet to have broader prevalence studies undertaken, these initial



changes have been measured by increased calls to police, numbers of people accessing refuges and support services [8] and search terms on Google[9].

The far-reaching economic impacts of COVID-19 have also placed many people and households in financial distress, limiting their abilities to access health care, support services and, exacerbating household tensions. Such tensions can increase the likelihood of violence and coercion[10].

Given the economic impacts of COVID-19 are likely to continue for a decade[11] the risk of increased violence and coercion driven by household economic tensions will also remain long after the initial threat of COVID-19 has passed[12].

Isolation and restricted movement

In Australia some of the most effective measures in limiting the spread of disease has been strict quarantine, physical distancing (including working and schooling from home arrangements) and isolation measures that have supported so many people to be house bound. While these measures have supported our healthcare response, they have meant that some people have had additional time spent in already coercive or violent environments.

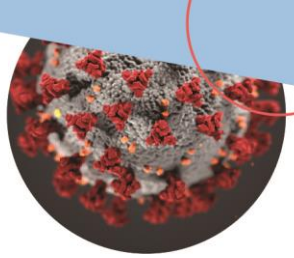
Unfortunately, the isolation and restricted movement measures inadvertently bear a strong resemblance to measures used by perpetrators of violence and coercion to maintain power and control over victim-survivors[13]. For women with disabilities, isolation measures have highlighted and reinforced aspects of interpersonal and structural coercion that further limit decision making powers and reduce bodily autonomy.

We are yet to see whether restrictions have limited opportunities for people experiencing violence to access formal support services, such as refuges, General Practitioners, social workers and family violence responders. Restrictions have meant that people have found creative ways to access community, cultural and peer support networks. One day we will be able to reflect on the pandemic and consider how, where and when formal and informal support opportunities during the pandemic supported everyday survival for people living in coercive contexts.

Long term health impacts of violence and coercion during COVID-19

The impacts of violence and coercion that are perpetrated during COVID-19 will have long term health impacts. Exposure to violence, particularly for children, can result in impaired cognitive development, learning and behavioural difficulties, mental and physical health and wellbeing problems such as depression, anxiety, suicidal thoughts, self-harm, eating disorders and chronic pain[14, 15, 16].

Adult victim-survivors are also at increased risk of sexual and reproductive health problems such as increased prevalence and exposure to STIs, gynaecological issues such as vaginal bleeding, fibroids and chronic pelvic pain. There are also potential long-term impacts on maternal and perinatal health 17].



Structural reproductive coercion has increased through decreased access to sexual and reproductive healthcare related to movement restrictions and strain on health systems. Isolation and restricted movement measures have also impacted on people's abilities to access pregnancy choices during the pandemic. These include access to timely abortion care, contraception, maternal and neonatal health and pregnancy choices counselling[18].

Addressing the violence and coercion during COVID-19 recovery

The Australian Government's announcement of an initial $150 million to support people experiencing domestic violence and coercion has been an important measure to address the increased risks and reporting during COVID-19. However, as the nation moves towards recovery, the prevention of, and responses to violence and coercion must also be considered in long-term recovery plans led by the various State and Territory Governments across Australia.

Specific considerations and recommendations must include adequate funding and support to front-line family, domestic and sexual violence response and for women's health services to address the short, medium and long-term health impacts. This includes resourcing for specialist women's support services and women's alliances who provide policy and practice guidance on gender equity, trauma-informed care and anti-discrimination in healthcare.

COVID-19 has shown us that reproductive coercion needs to be a key consideration in community-wide pandemic plans so that risks can be addressed or avoided prior to the onset of quarantine and movement restrictions. Preventative measures such as resourcing Community Controlled Health providers to be in key decision making positions, supporting public health literacy campaigns related to sexual health, and having publicly available access to condoms, gloves, dental dams and pregnancy test kits can be powerful.

Pandemic recovery requires social, cultural, environmental and economic recovery for all. It is impossible to consider recovery from COVID-19 without integrating recovery from violence and coercion. Now is an opportune time to invest long term in better health outcomes for all communities, with community led, person centred, trauma informed care.

If you or anyone you know needs support, you can contact the National Sexual Assault, Domestic and Family Violence Counselling Service on 1800RESPECT (1800 737 732)

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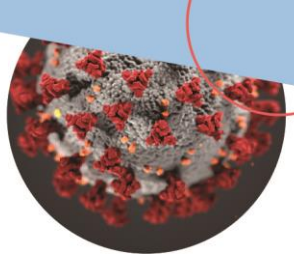

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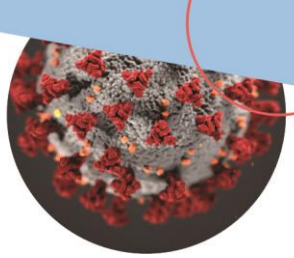

Article Six: **Sexually Transmitted Infections in Women and COVID-19**

Dr Anna McNulty - Sydney Sexual Health Centre

The impact of COVID on STI rates in women is unknown. Some speculate that rates will decrease as people have less sex with fewer partners (1) Others argue that rates may not decrease as there is less screening as sexual health clinics scale back services and there are fewer visits to GPs.(2) Lower rates of screening would particularly affect women as they are more likely to have asymptomatic infection.

Notification data for NSW shows a 21% decrease in chlamydia notifications for March – April of 2020 compared with the same period in 2019 (3) however the number of tests done is unknown.

There is some evidence that SARS-COV-2 is recoverable from the semen of patients with COVID-19. In a Chinese study 4 of 15 (26.7%) of patients with acute illness had a positive RT – PCR assay as did 2 of 23 (8.7%) recovering patients (4). However, an earlier study of 12 patients in China, found none had detectable SARS- COV-2 RNA in their semen (5). Whilst tantalising, commentators caution that there are no reports of sexual transmission of SARS-CoV-2 and the presence of RNA in semen does not demonstrate infectivity.

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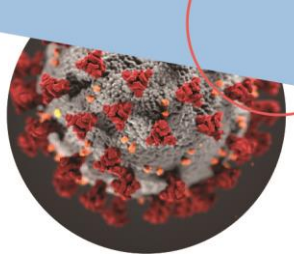


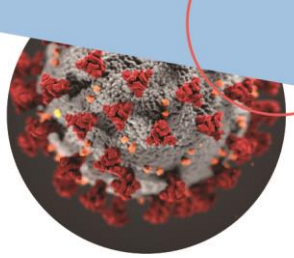
Article Seven: **Women who are sex workers and COVID-19**

Ms Jules Kim - Scarlet Alliance

Sex workers have been greatly impacted by COVID-19 pandemic. The impact of travel restrictions, business closures, self -solation and quarantine requirements have resulted in an unprecedented loss of work and income for sex workers. Sex workers, like most Australian workers have been facing a range of challenges, however for many of us, without access to current relief or support packages. For a number of sex workers they are ineligible for government income support, including those who are unable to show proof of income, for those who have no fixed address or are on a temporary visa, such as international students and other migrant sex workers. And unlike other Australians, sex workers have been told we can't return to work. In the 3 Step Plan for easing of restrictions, brothels and strip clubs are the only businesses instructed to remain closed, even when other businesses with person to person contact are able to return to work. The 3 Step Plan's approach to sex work via the restrictions on brothels and strip clubs has created a situation where many sex workers and sex work businesses are seeing no end in sight to their current difficult circumstances. This has created incredible levels of stress for sex workers. The impact of the restrictions, lack of financial supports and stigma and discrimination in the responses to COVID-19 will continue to be felt in the sex worker community.

Evidence and past experiences have demonstrated that overly restrictive and unfair regulations results in driving the sex industry underground. Enabling legal frameworks around sex work have been critical to the successful public health outcomes for sex workers and in ensuring workplace health and safety for sex workers. Prohibiting sex work businesses to operate, even when all other businesses are back at work, will result in the creation of a less transparent industry and will damage the hard fought gains in public health and workplace health and safety, as well as endangering the wellbeing and financial livelihood of sex workers.

The centrality of sex workers in Australia's successful public health approach to the prevention of blood borne viruses and sexually transmissible infections has been widely acknowledged, including in our suite of National BBV and STI Strategies. The Australian government has worked in partnership with sex workers, supporting peer led responses and programs, resulting in sustained low rates of STIs and BBVs, high rates of testing and the virtual elimination of HIV among sex workers. Sex workers have a long track record of effective leadership in responding to communicable diseases and our response to COVID-19 has been no different. Scarlet Alliance and our member organisations have worked together to develop a COVID Safe Plan for sex workers to be able to safely return to work. We hope the government will listen and enable sex workers to return to work just like other Australians. In the meantime, please support sex workers left behind and ineligible for government financial aid through donations to the emergency fund https://chuffed.org/project/emergency-support-sex-workers-australia



Article Eight: **Aboriginal and Torres Strait Islander Women and COVID-19**

Michelle Tobin Chairperson - ANWERNEKENHE National HIV Alliance

Key points

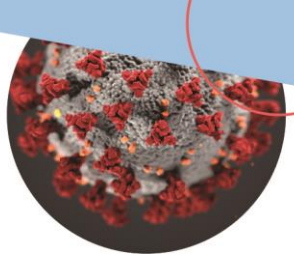
- Thus far Aboriginal and Torres Strait Islander communities have fared relatively well during COVID-19 with just on 60 cases reported nationally.
- This had been led by Aboriginal leaders and with close support by Governments nationally.
- However, several intractable issues have been again highlighted during COVID -19 for Aboriginal and Torres Strait Islander communities. These include crowded housing, employment fragility, health care access, food and necessary supply security, family and domestic violence, all which exacerbate risks for Aboriginal women and their children during a crisis.
- However, several issues have been addressed during COVID-19 including access to SARS COV 2 testing especially in remote areas, expansion of telehealth initiatives reducing times at clinics, rapid deployment of health promotion materials about COVID-19, Biosecurity Determination Acts being put in place to reduce risk of travellers to remote regions, communities being in command and locking down communities, food security commission investigating longer term options for Aboriginal and Torres Strait Islander communities to name a few.

Women and Family Violence issues

- Even in non-crisis periods Aboriginal communities struggle with living day to day.
- Aboriginal and Torres Strait Islander women and their children are overrepresented in family and domestic violence data and while women who live with violence show great agency and resilience there are fears that Aboriginal women may be at greater risk of experiencing violence during a period of lockdown and travel restrictions. This is in part because Aboriginal family violence programs have experience a major funding cut in federal funding. [1]
- Also contributing to this risk is that during COVID-19 and ironically crowded housing just became more crowded especially in remote community settings as many people were transported back to traditional country to mitigate risk in the larger urban centres and because school children are not at school. Pressures can quickly arise in already crowded and impoverished communities.
- Much concern exists that family violence will increase as time goes on during COVID-19.

Crowded and poor housing

- Ironically crowded housing has peaked during COVID-19 with many community members arriving back into communities from major cities to stay safe from COVID-19. Many have been transported back. [2] The profile of home ownership is very different to non-Aboriginal Australians, with a majority of Australians owning their own home (38% vs 69%).



- Further, almost a third (29%) of Indigenous Australians were living in a dwelling with major structural problems. Most commonly, these were major cracks in walls or floors, followed by major plumbing problems, nearly 1 in 5 (19%) Indigenous Australians were living in a house that did not meet an acceptable standard—that is, at least 1 basic household facility was unavailable or there were more than 2 major structural problems.
- In 2016, 1 in 5 Indigenous Australians (20%, or about 114,400 people) were living in overcrowded dwellings.
- The increased overcrowded housing during COVID-19 has implications on practising physical distancing measures, safety, nutrition, sleeping, infectious disease risk, general health and wellbeing.

Access to care

- It became apparent very quickly during COVID-19 that many communities rely significantly on locum staff to operate clinics. The reliance on locum staff became very apparent when for example many interstate and even New Zealand locum staff providing mostly nursing services to remote communities needed to be quarantined for 14 days. This increased pressure on existing staff and required a rethink and a need for a third workforce to cover quarantine periods. This also increased pressure on clinic times in many communities.
- This impacts women's and children's health including management of underlying chronic disease management. There is also a fear that for many people with an undisclosed illness like HIV this may reduce medication adherence during this period when clinic times are reduced and overcrowding is at a peak.
- Prior to COVID-19 many remote communities were experiencing a syphilis outbreak, many more women were diagnosed during this outbreak than men. Much concern exists about the trajectory of this outbreak, complications arising and developing because of reduced focus on the outbreak and the need to resume this effort ASAP.

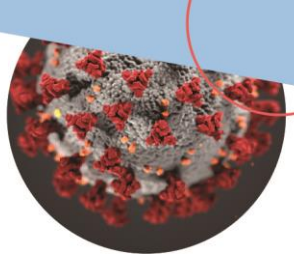
Severe shortages of food and other essential supply chains

- Many communities experienced severe shortages and unscrupulous behaviour such as price gouging. However, the Australian Government has made food security, including ensuring supply to regional and remote communities, a high priority throughout the response to the COVID-19 pandemic.

While all of the above can be confronting there have been some rapid work completed to ensure some of these issues risk are reduced.

There are also some benefits to arise for Aboriginal women in the current climate, which are:

- Spending more time with family.
- In some cases longer prescription periods for essential medicines have been offered reducing need to travel and visit community clinics.
- Tele Health initiatives have been expanded to urban and regional areas to offer flexibility during COVID-19- this should be capitalised on in the Sexual health and BBV sector.



- Limited access for Covid-19 to enter communities.
- Elders being taken out to country, where they were protected.

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Further reading

- https://www.mja.com.au/journal/2020/first-nations-people-leading-way-covid-19-pandemic-planning-response-and-management
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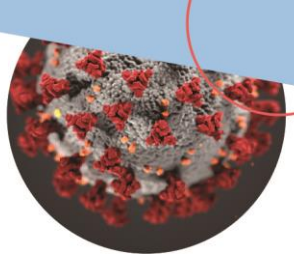


Article Nine: **Women and HBV infection and COVID 19**

Nicole Allard - WHO Collaborating Centre for Viral Hepatitis, Victorian Infectious Diseases Reference Laboratory, Doherty Institute

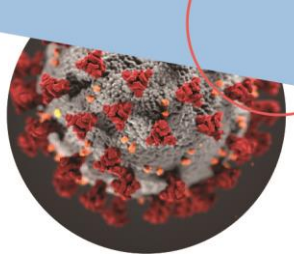
Key points

- There is no current evidence that COVID 19 outcomes are different in people living with CHB without cirrhosis however susceptibility to severe disease is influenced by increasing age, gender and other comorbidities.
- People with comorbidities, including hypertension, cardiovascular disease, lung disease, cancer, diabetes and chronic liver disease have increased risk of poor outcomes in COVID 19 disease
- COVID 19 disease can cause liver injury which is currently explained as likely the result of immune mediated mechanisms rather than direct cell injury from the virus.
- People who are immunosuppressed e.g. post liver transplant are susceptible to COVID 19 infection and severe disease and should take extra precautions to physically distance themselves from others.
- Drugs used in trials to treat COVID 19 may be hepatotoxic and have the potential to cause liver injury.
- Diagnosis enrolment in care and treatment of CHB is currently not meeting national targets and late diagnosis causes lost opportunities for presentation of liver complication including hepatocellular carcinoma (HCC) liver cancer. Delaying in receiving care during the pandemic may result in worse health outcomes in the longer term.
- Standard of care in CHB involves 6-12 monthly blood tests and regular review and during the pandemic telehealth consultations can be used for routine review and the arrangement of blood tests and HCC surveillance ultrasounds

CHB has not been shown to be an independent risk factor for susceptibility to SARS-COV2 infection or severe COVID 19 disease (1, 2). Women with advanced liver disease or those immunosuppressed due to liver transplantation and those with comorbidities including hypertension, cardiovascular disease, lung disease, cancer and diabetes have increased risk of severe COVID 19 disease and mortality (3). Aboriginal and Torres Strait Islander women with CHB are potentially more susceptible to COVID 19 due to higher rates of comorbidities as in other Indigenous people who have been affected by COVID 19(4, 5).

Chronic Hepatitis B (CHB) infection in Australia affects women born in high and intermediate prevalence countries, Aboriginal and Torres Strait Islander women and women at increased risk of blood borne viruses (BBV) (6). Women represent approximately 40% of current notifications and approximately 10% are Medicare ineligible (7). While women are routinely screened for CHB in pregnancy they are not always connected to care. Diagnosis, enrolment in care and treatment is not meeting national targets with only 1/3 of people diagnosed receiving care and nearly 80,000 people in Australia undiagnosed (6, 8).

The COVID 19 pandemic has changed access to primary and tertiary care in Australia with a shift to online or telehealth for routine consultations. This change has the potential to disrupt routine



chronic disease care as well as presenting opportunities to make chronic disease care more responsive and convenient to patients. Other implications of the public health measures to mitigate the impact of the COVID 19 pandemic for women with CHB may include financial hardship, housing instability, loss of income, poorer mental health and increase caring responsibilities that may affect their health status and ability to access health care (9).

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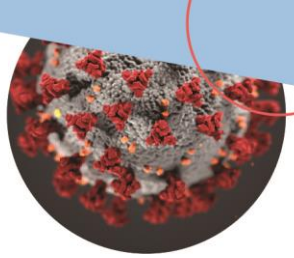
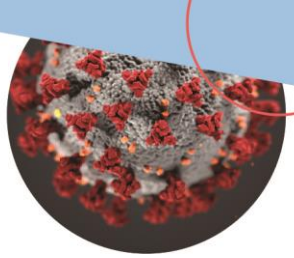


Article Ten: **The Impact of COVID-19 on Women Seeking Care for HCV**

Professor Margaret Hellard - Epidemiology and Preventative Medicine Alfred Hospital Institute

There is no data currently available on the impact of COVID-19 on women at risk of hepatitis C infection seeking testing or those infected accessing treatment. However, it is highly likely that COVID-19 has impacted on women's health seeking behaviour. First, there are reports of people delaying attending their primary care doctors for various chronic health conditions, hepatitis C falls into this category. Second, many women have carried much of the extra burden of home schooling and caring for children during the period of COVID-19 "lock-down", making it difficult for women to take care of their own health care needs. Third, there is evidence that people with a history of injecting drug use are reluctant, even in normal times to seek care for their health needs due to a combination of both internal and external stigma and believing that they are less deserving of quality health care. As well, COVID-19 is having a profound economic impact on the community disproportionately impacting on vulnerable communities, many of who are at increased risk of hepatitis C such as people who inject drugs (PWID). These factors combined are likely to have impacted on women at risk of or infected with hepatitis C attending their health service for hepatitis C care during the COVID-19 outbreak.

It is also important to recognise that even as the government relaxes the current control strategies for COVID-19, that the epidemic has not fully disappeared; there may be clusters or waves of ongoing infection that cause anxiety and concern. As well, the unintended consequences of the government response to COVID-19 on the Australian economy will continue for months, if not years, and is likely disproportionately impact on vulnerable populations, including PWID, particularly females. There is clear evidence that providing hepatitis C testing and care in community settings increases the likelihood of people engaging in testing and starting DAA treatment and being cured of their hepatitis C. Over the coming months, as primary health care service and drug and alcohol services normalise it will be important that government, key community organisations and health services work together to ensure women at risk of hepatitis C are encouraged to engage and re-engage with health services. It will be important that services are provided so they are accessible to women and that women feel safe accessing hepatitis C related health care.



Article Eleven: **Women who use/inject Drugs and COVID-19**

Jude Byrne, Lauren Bradley and Melanie Walker - Australian Injecting & Illicit Drug Users League

Key Points:

- Owing to the criminalisation of illicit drugs, women who use/inject drugs have been distinctly affected by COVID-19 in terms of health outcomes and being a focus of law enforcement.
- Women who use/inject drugs have faced significant challenges to abide to social isolation and physical distancing measures whilst accessing pharmacotherapy and harm reduction services.
- Clinicians can help reduce women's exposure to the community be facilitating more takeaway doses of pharmacotherapy.
- Substance use patterns have changed during the pandemic with the use of alcohol and benzodiazepines use increasing.

Background

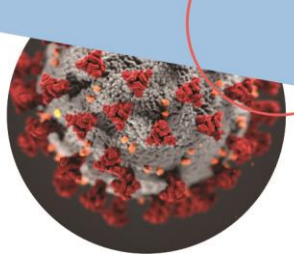
Because of the criminalisation of illicit drugs, people who use/inject drugs are stigmatised, marginalised and discriminated against. The impact of and response to COVID-19 has had a profoundly negative impact on this cohort, with effects being distinctive for women who inject/use drugs. It is important to remember that women who access health services face barriers stemming from such stigma which hinders meaningful engagement with the healthcare system. A person-centric, human-rights focussed mindset should always be adopted when assessing and treating people who use/inject drugs.

Increased risk of infection due to pre-existing health issues

The level of comorbidity of people who use drugs is extremely high with hepatitis C (HCV), hepatitis B (HBV) and various issues with respiratory, cardiovascular, and metabolic systems, as well as a range of psychiatric comorbidities being of concern to this cohort [1].

For women who use/inject drugs, the emergence of COVID-19 has presented challenges in terms of delivery of and access to opioid substitution treatment (OST). Women have been told to adhere to the principles of physical distancing and social isolation whilst engaging with a model of care which is at odds with such principles. The requirement for people with health vulnerabilities to attend a pharmacy to undertake supervised dosing also puts them at risk.

To reduce such risks clinicians should be informed by the *Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response*, developed by the Royal Australasian College of Physicians in collaboration with the Australian Injecting and Illicit Drug Users League (AIVL) and a range of other national peak bodies and professional associations [2].



In order to access harm reduction services such as needle and syringe programs, some women have been put in positions where they need to disobey restrictions. Additionally, risky behaviors such as sharing drug-using paraphernalia - in particular, smoking equipment - puts women who use drugs at a higher risk of COVID-19 infection[3].

There may also be an increased risk of transmission for women who rely on public transport to access pharmacotherapy, harm reduction and other services.

Early detection of COVID-19 infection in people who use/inject drugs can be difficult as symptoms could be confused with withdrawal symptoms[4].

Changes in drug use

Anecdotal evidence indicates that women who had used drugs recreationally prior to the pandemic may have increased their use due to the loss of employment, disruption to routines, added stress and/or boredom. These gaps are readily filled for some through an increase in drug consumption.

During the pandemic, the price and availability of some drugs has been affected. The result of this being that some people have changed their patterns of use to other hazardous substances such as alcohol and benzodiazepines. Benzodiazepines are known to be an independent risk factor for hepatitis C (HCV) transmission, and alcohol is a risk factor for liver damage[5].

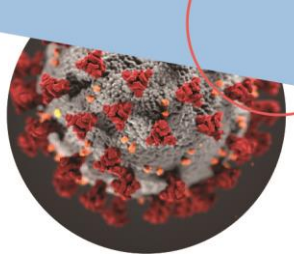
Furthermore, the consumption of alcohol by someone with HCV is a known risk factor to induce liver disease: *"…alcohol intake and HCV infection are independent risk factors to induce liver disease but in subjects with high levels of alcohol intake the coexistence of HCV infection multiplies the alcohol associated risk of onset of and/or of hospitalization for liver cirrhosis."[6]*

When assessing patients, clinicians should be mindful of women who use/inject drugs and how their patterns of use may have changed due to COVID-19 restrictions, what the flow on health implications may be, and what may be done to ameliorate those harms.

The effects of criminalisation & COVID restrictions

The criminalisation of women who use drugs results in levels of stigmatisation and loss of personal agency which differ to the experience of men. For instance, women often go second in the injection process. This puts women who use/inject drugs at a higher risk of viral transmission[7].

Anecdotal information also indicates that women are currently being requested by men to pick up drug supplies, as they are less likely to be noticed by law enforcement. With the marked decrease of social interaction in public settings, certain activities are currently highly visible to the police. This puts women at a higher risk of criminal convictions and receiving fines for non-compliance with COVID-19 related restrictions. As such, women who are already vulnerable are under additional pressure in the current environment. Additionally, women who work in the sex industry are also currently being impacted by increased policing and enforcement measures.



Managing a family and/or a partnership while using drugs is challenging at the best of times. The restrictions imposed during the pandemic have exposed some women's drug taking behaviour both inside and outside of the home. For instance, most mothers who use drugs implement strategies to shield their children from their drug using behavior as much as possible. However, this has become a challenge during the pandemic when children are constantly present in the home[8]. This has placed pressure on both some mothers and children. Given that women with children are subject to the threat of state intervention, they can be deterred from seeking the necessary healthcare assistance by fear of intervention from child protection authorities.

Reports have indicated that rates of domestic violence have been on the rise throughout the pandemic due to partners and families being required to socially isolate[9]. Clinicians should be aware that women who use drugs are particularly vulnerable to domestic violence.

Care and treatment

Clinicians should be informed by the *Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response*, developed by the Royal Australasian College of Physicians in collaboration with the Australian Injecting and Illicit Drug Users League (AIVL) and a range of other national peak bodies and professional associations. In that context, it is also worth noting that the expansion of telehealth services during the pandemic has been a primarily positive response to facilitate access to health care services.

The provision of prescriptions without the need to attend a clinic in person has been one of the key strategies which has helped reduce the risk of exposure to viral transmission. The ongoing use of telehealth services would be beneficial in enhancing access to services for women who use/inject drugs but requires significant consideration as barriers regarding access to technology may create new challenges, particularly for people from marginalised and disadvantaged sub-populations.

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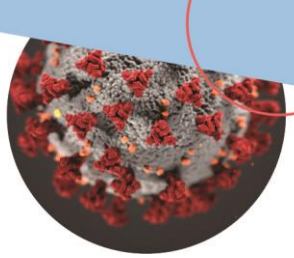

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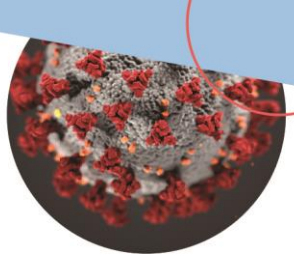


Article Twelve: **Women living with HIV and COVID-19**

A/Prof Edwina Wright - Alfred Health Monash University and Jessica Michaels - ASHM

Key points

- Where possible, care should be streamlined for women living with HIV
- Healthcare workers should be mindful of health and wellbeing issues such as mental health, financial and housing insecurity, domestic violence and the burden of care of dependents
- Women living with HIV should continue to be supported to engage in routine health care and maintenance
- Clinical guidance on COVID-19 and adults living with HIV can be found here

Streamlined Care

For women living with HIV who are well and have been stably virologically suppressed for at least 12 months, scheduling fewer regular appointments, ideally via Telehealth, and deferring HIV viral load and CD4+ cell tests and other routine bloods for up to 6-12 months are reasonable measures. Scripts can be posted to patients, or pharmacies. Blood slips can be posted to patients. This approach will help well women living with HIV adhere to social distancing measures and minimise their contact with people who are acutely unwell.

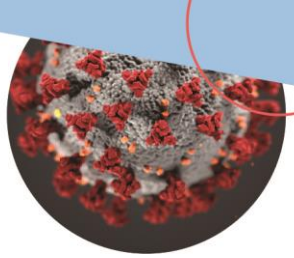
Health and Wellbeing

- **Mental health issues** may become more common, or more severe during the COVID19 pandemic
- **Financial insecurity** may impede women meeting their HIV healthcare needs and may lead to **housing insecurity**
- **Domestic violence** rates have escalated globally since SARS-CoV-2 emerged Clinicians are encouraged to use regular appointments to routinely evaluate these issues in all women and refer to specialists, community nurses, social workers, peer support, community organisations and other appropriate services, as needed. Clinicians should encourage women to seek help between appointments if these issues arise
- **Burden of care** of dependents may be exacerbated. This may result in the emergence or worsening of mental health issues, feelings of stress, time constraints and reduced capacity to engage in regular health maintenance.

Routine Health Care

Women living with HIV should continue to be supported to engage in routine care and health maintenance.

- All women living with HIV should be offered the influenza vaccine and also the pneumococcal vaccine as indicated, albeit its supply is currently low worldwide
- All women living with HIV, including young and well patients should be supported to cease smoking, exercise appropriately, optimise their sleep and adhere to the current National Health and Medical Research Council draft recommendations on alcohol intake [1], or amounts relevant to underlying health conditions
- All women living with HIV should be supported to undertake cervical and breast screening as appropriate



Clinical guidance on COVID-19 and adults living with HIV can be found here

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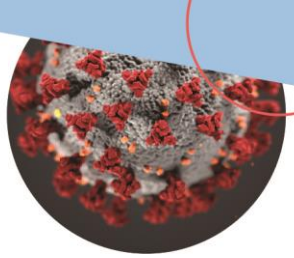

Article Thirteen: **COVID-19, Pregnancy and Women who are living with HIV, Hepatitis B, Syphilis and other STIs**

Dr Tammy Meyers - University of the Witwatersrand and A/Professor Michelle Giles – Alfred Health Monash University

Key points

- There are no current data on outcomes of HIV positive pregnant women with COVID-19 illness and their newborns.
- Despite alteration in contact visits because of the risk of COVID-19, antenatal services should continue to offer the recommended antenatal tests for infectious diseases in pregnancy which include HIV, syphilis, hepatitis B and hepatitis C [1].
- According to the WHO, recommendations for the triple elimination of the HIV, syphilis and hepatitis B in the Asia and Pacific includes repeat HIV and syphilis testing in the 3rd trimester in previously negative high-risk women [2].
- Testing for other sexually transmitted infections (STIs) should occur only if indicated (if symptomatic or have known risk factors)
- Clinicians are advised to seek specialist advice or referral as needed, to optimise health outcomes for HIV, hepatitis B and C, and syphilis positive women or those with STI's seeking to become pregnant, or who are currently pregnant during the COVID-19 pandemic.
- Strategies should be considered to support adherence to antiretrovirals for pregnant women whose contact with services may be decreased because of COVID-19. Plans should also be in place to provide sufficient supplies of medication for exposed infants.
- Post-delivery specialist input for maternal and neonatal care is required to optimise maternal and infant health outcomes through early diagnostic testing and appropriate prevention and treatment strategies [3].
- Mental health may be negatively impacted during pregnancy especially in relation to HIV, hepatitis B or other STIs. This may be more pronounced or difficult to detect during the COVID-19 pandemic. All members of the clinical team, community services, patients and carers should be alert to mental health issues and know how to respond to them.
- Pregnant women with HIV, hepatitis B, or other STI's and COVID-19 are expected to have similar COVID-19 outcomes and should receive equal access to high level of care for COVID-19, including hospital admission, oxygen, intensive care, ventilator support as those without HIV, hepatitis or STIs.

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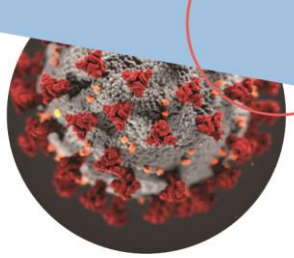


Article Fourteen: **Women from Culturally and linguistically Diverse Backgrounds and COVID-19**

Dr Dean Murphy – Kirby Institute & Alfred Health

International evidence suggests that among some racial and ethnic minority groups are experiencing higher rates of hospitalisation and/or death from COVID-19 [1,2,3]. These outcomes are largely attributable to long-standing systemic health and social inequities have put some members of racial and ethnic minority groups at increased risk of getting COVID-19 or experiencing severe illness, regardless of other factors such as age or gender [4, 5].

Some types of work and living circumstances can place people at increased risk of acquiring, or transmitting, SARS-CoV-2. Some of these conditions may be particularly pertinent to people from migrant communities. Examples include:

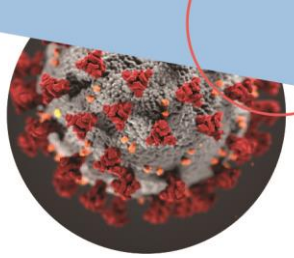
- Working in an essential industry: The risk of infection may be greater for workers in essential industries and particular roles – including in health and aged care – and some may have difficulty taking time off because their economic circumstances [6,7,8].
- Working in a casual role: Workers without paid leave may be less likely to seek testing or care because of the cost of missing work, and more likely to keep working when they are unwell [7].
- Living in a multigenerational and/or multi-family household: In larger households, it may be more difficult to protect older family members or isolate those who are sick (if space is limited) [7].
- Reliance on public transport: Use of public transport, which is more common among some members of racial and ethnic minority groups, may make it more challenging to practice social distancing [9].
- Mistrust of government and other institutions: People may not seek care because of distrust of the healthcare system [7].
- Lack of access to subsidised health care: People may delay or avoid seeking health care if they are excluded from Medicare coverage.
- Lack of access to information in community languages and in culturally appropriate forms.

The conditions in which people live, learn, work, and socialise contribute to their health. These conditions, over time, lead to different levels of health risks, needs, and outcomes among some people in certain racial and ethnic minority groups, including women [7, 10].

Health and healthcare inequities, which are sustained through racism, stigma, and systemic inequities, undermine prevention efforts for many health conditions, including COVID-19 [7, 11].

Addressing the health needs of marginalised groups also includes improving building on the strengths of these groups, which can include the faith, family, and cultural institutions that are common sources of social support.

Disparities in the health outcomes of people with COVID-19 based on cultural background and ethnicity need to be studied alongside age, sex, gender, and socioeconomic status [2].



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