
Marie Stopes International's Submission to the Joint Questionnaire of the UN Special Procedures on Covid-19

Marie Stopes International (MSI) is one of the world's largest providers of sexual and reproductive health services (SRH), providing women-centred contraception, safe abortion, and post-abortion care in 37 countries. Globally, the services that we provided in 2019 resulted in an estimated:

- 14 million unintended pregnancies prevented
- 6.5 million unsafe abortions averted
- 34,600 maternal deaths averted

By the end of 2019, there were 32 million people using contraception provided by MSI.

We would like to thank the UN Special Rapporteurs for this opportunity to highlight the impact of Covid-19 on the realisation of sexual and reproductive health and rights (SRHR), and to acknowledge actions taken by States to limit the negative impact of the pandemic on these rights. This submission focuses on one of the questions proposed by the Joint Questionnaire:

- **Please explain the impact of the pandemic on the enjoyment of human rights and what actions have been taken by the State to respect, protect and fulfil human rights?**

The key priority for MSI in this pandemic is ensuring the safety and security of clients and team members, for example by providing personal protective equipment and enhanced guidance on infection prevention. We are also working with governments to incorporate infection prevention and Covid-19 messaging into our counselling and services. Despite our efforts to continue providing essential SRH services, the crisis has created unprecedented challenges due to lockdowns and restrictions of movement. Our programmes have been continuously adapting to the restrictions.

As one of our centre managers in Hanoi, Vietnam stated, *"All the regulations of preventing the disease need to be followed very strictly, and the epidemic has become increasingly complicated, but we cannot leave our clients unserved"*.

Impact of the pandemic on SRHR

The pandemic and measures implemented to limit its impacts have had a serious impact on the right to health, and in particular SRHR, in multiple countries across the globe. Impacts affecting SRHR include:

- **Increased barriers to accessing safe services:** due to quarantines, self-isolation rules, school closures which impact caring responsibilities, travel bans, borders closing, and reduction in availability of public services, it has become more difficult for both providers and clients to travel to deliver or receive safe abortion and contraceptive care, impacting people's SRHR in particular. With school closures, Comprehensive Sexuality Education programmes that assist adolescents in understanding and accessing SRH care and rights have also been curtailed. Furthermore, economic insecurity for many, in particular those already living in vulnerable situations, is increasing as a result of the pandemic, leading to greater difficulty in paying for care.
- **Supply chain failures:** National lockdowns have also led to disruptions to reproductive supply chains, leading to an increasing shortage of abortion medications and contraceptives and further limiting individuals' ability to access abortion and contraceptive care that suits their needs and preferences. Many of MSI's programmes, including Uganda, Sierra Leone, Myanmar, Nepal, and Yemen have reported increased difficulties and delays in securing and/or transporting reproductive health commodities.
- **Strained health systems leading to lower access:** A shortage of health care providers and increased waiting times for procedures considered to be non-emergency care, are also making it harder for individuals to access care, particularly in public facilities. In tandem, emergency reproductive and maternal health services are affected by over-stretched facilities and staff. There is a remaining risk of diversion of funds from critical SRHR programmes due to competing government

and donor priorities - this occurred during the 2014-2016 Ebola crisis in West Africa, leading to a 75% increase in maternal mortality in three of the affected countries.¹

To forecast the potential effect of the evolving global pandemic, in March 2020 MSI modelled several scenarios of disruptions to supply chains and service delivery activities to project the potential impact on the communities we serve. We estimated that between 4-9.5 million fewer women and men would be served by us as a result of coronavirus-related disruptions. This would lead to an additional estimated 1.3-3 million unintended pregnancies, 5,000-11,000 maternal deaths, and 1.2-2.7 million unsafe abortions within the 37 countries where we operate.²

While there is not yet sufficient data to effectively measure the impact that Covid-19 and prevention measures have had on SRHR, some preliminary information based on MSI's services and experiences in the countries where we work suggests that the above predicted impacts are being felt at varying levels across all the countries we work in.

Some specific examples below demonstrate how lockdown and other restrictions on mobility have affected the continuity of SRH services during this crisis.

- **In Myanmar**, travel restrictions within the country have meant that our mobile outreach teams, which serve rural and marginalised communities with little or no other access to SRH services, have been unable to operate at their regular capacity. Travel restrictions have also prevented the delivery of reproductive commodities to service delivery sites, affecting the teams' ability to offer a full range of options to clients.
- **In Nepal**, strict lockdowns restricting movement affected the ability of clients and providers to access or deliver SRH services and put stresses on supply chains for reproductive commodities. The Government has since taken action to address these issues, declaring contraception, safe abortion and post-abortion care services as essential health services.
- **In Pakistan**, while centres and pharmacies are still able to provide services at a reduced rate, outreach teams serving rural and marginalised communities have been suspended due to the lockdown.
- **In Zambia**, the Government declared that mobile outreach teams providing contraceptive services to rural and marginalised communities were not essential, restricting access to SRH services for these communities.
- **In Zimbabwe and Madagascar** despite central government support for continued SRH services, local authorities or police have prevented providers or clients to travel to some service delivery sites, severely limiting access to SRHR in those communities.
- **In India**, the country went into a strict lockdown and did not declare SRH services as essential, causing our programmes to shut down. As the largest provider of contraceptive services outside of the public sector, our inability to offer services will have a substantial impact for thousands, in particular those living in hard-to-reach locations or those from marginalised groups. After negotiation with the Government, some of our services have been re-initiated.

While restrictions on gatherings and mobility are necessary to prevent the spread of Covid-19, there are actions that governments and providers can take to ensure continued access to SRH services.

These include defining SRHR services such as contraception and safe abortion as 'essential', and removing regulations to allow for pharmacy provision of SRH services, to allow for telemedicine programmes, to allow for tasksharing of SRH services in line with WHO standards, and to facilitate importation and transport of reproductive health commodities.

In one of our countries where there has been a strict nationwide lockdown, our programme has reported that client flow reduced by 25-65% depending on the delivery channel. This is concerning as we know that SRH needs do not stop during a pandemic. The continuing need for these services was clear in Ghana, where our contact centre saw a record number of calls in one day – 422, a substantial increase from the usual 140 - when a temporary lockdown restricted mobility in Greater Accra and Greater Kumasi.

¹ Wenham, C., Smith, J. and Morgan, R., 2020. COVID-19: the gendered impacts of the outbreak. *The Lancet*, 395(10227), pp.846-848; Davies & Bennett, "A Gendered Human Rights Analysis," International Affairs

² You can read about the methodology used to calculate this impact here: <https://www.mariestopes.org/resources/methodology-for-calculating-impact-of-covid-19/>

Actions taken by States to protect, respect and fulfil SRHR during the pandemic

Some countries have **declared access to contraception and/or broader SRH services as “essential” health services or as part of the national Covid-19 response**, ensuring that these services continue to be available throughout the pandemic. Countries that have taken this step include, but are not limited to, **Burkina Faso, DRC, Ethiopia, Mali, Nepal, Nigeria and South Africa**. The Government of Australia also declared abortion care an essential service but did not include contraceptives or other SRH services under this categorisation.

Other countries, while not declaring SRH services as essential, have **provided permission for the continual of MSI services** (and in some cases, other specific providers’ services) – partially limiting the negative impact of Covid-19 prevention measures on SRHR. These countries include **Afghanistan, Madagascar and Zimbabwe**.

In **Papua New Guinea**, the Government granted MSI with domestic travel exemptions to allow for continued service delivery, in particular, to allow for mobile outreach teams to travel to service delivery sites.

In **Sierra Leone, Nepal, and Kenya**, the Government has worked with civil society to develop guidelines or strategies for the safe provision of SRH services within the context of Covid-19. Similar guidelines are also currently under discussion in **Malawi, Tanzania, and the DRC**.

Some countries have amended guidelines and regulations, or provided temporary permission, for the scale up of **telemedicine programmes** which allow individuals to access health care remotely, ensuring these services remain accessible despite Covid-19-related restrictions on movement.

Countries which have taken action to either implement telemedicine programmes through their public health system and/or to allow for telemedicine programmes to be implemented by private/NGO providers such as MSI include: **the UK, South Africa, Kenya, and India**.

In **Nepal**, the Government also made changes to the national reproductive health guidelines, allowing for medical abortion to be delivered outside of registered facilities. This has allowed providers to be more flexible in their delivery, and to ensure continuity of access to medical abortion despite Covid-19 measures.

In **Ethiopia**, the Government allowed a pilot for the provision of medical abortion by nurses in clients’ homes in Addis Ababa.