10 May 2021

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolution 42/16.

I would like to invite you to respond to the questionnaire below. Submissions received will inform my next thematic report on the right of everyone to sexual and reproductive health – challenges and opportunities during COVID-19, which will be presented to the UN General Assembly in October 2021.

The questionnaire on the report is available at OHCHR website in English (original language) as well as in French, and Spanish: (<https://www.ohchr.org/EN/Issues/health/pages/srrighthealthindex.aspx>).

All submissions received will be published in the aforementioned website, unless it is indicated that the submission should be kept confidential.

There is a word limit of 3000 words per questionnaire. Please submit the completed questionnaire to srhealth@ohchr.org. The deadline for submissions is: **10 June 2021.**

Tlaleng Mofokeng

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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**Contact Details**

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

|  |  |
| --- | --- |
| Type of Stakeholder (please select one) | [ ]  Member State [ ]  Observer State**✓** [ ]  Other (please specify): Population Education Resource Centre (PERC), Department of Lifelong Learning and Extension (DLLE**\***), S. N. D. T. Women’s University (SNDTWU), Mumbai, India (<https://sndt.ac.in>) (Retired on June 30, 2020)**\*** DLLE was previously known as Department of Continuing & Adult Education & Extension Work (DCAEEW) |
| Name of State:Name of Survey Respondent: | Not ApplicableDr. Santosh Kumar Mishra (He/His) |
| Email | drskmishrain@yahoo.com |
| Can we attribute responses to this questionnaire to your State publicly\*? \*On OHCHR website, under the section of SR health |  Yes No **✓**Comments (if any): **(a)** The contributor (Dr. Santosh Kumar Mishra) has no objection to responses being published on the official webpage of the Special Rapporteur. **(b)** The contributor (Dr. Santosh Kumar Mishra) is submitting the contribution in his individual capacity. **(c)** Views expressed in response to the questionnaire are personal, and not of the Population Education Resource Centre (PERC), Department of Lifelong Learning and Extension (DLLE), S. N. D. T. Women’s University (SNDTWU), the contributor was employed with previously.  |

**NOTE:** The contributor (Dr. Santosh Kumar Mishra) herewith declares that he has no objection to responses being published on the official webpage of the Special Rapporteur.

**QUESTIONNAIRE**

# Background

The right to sexual and reproductive health is an integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights and a key priority theme for the work of the Special Rapporteur on the right to physical and mental health during her tenure.

The Special Rapporteur, Tlaleng Mofokeng will focus her next thematic report to the General Assembly on “The right to sexual and reproductive health – challenges and opportunities during COVID – 19”.

# Objectives of the report

With her report, the Special Rapporteur intends to shed light on the current status/level of realization of the right to sexual and reproductive health and the availability, accessibility, acceptability and quality of related services, during the COVID-19 pandemic. Building on the work and previous reports of the mandate, she aims to further develop understanding of the structural and systemic issues preventing all persons from freely and fully enjoying the right to sexual and reproductive health.

She will focus on elements historically neglected, including the impact of colonialism and racism in the enjoyment of these right, with an intersectional approach and will also analyze the impact of COVID -19 and related policies, legal developments and practices on access to sexual and reproductive health services. She will also aim to present challenges and opportunities in the operationalization of the right to sexual and reproductive health in the current context of pandemic.

*For the purpose of this questionnaire:*

*The* ***Right to sexual and reproductive health*** *entails the right to make free and responsible decisions and choices, free of violence coercion and discrimination regarding matters concerning one’s body and sexual and reproductive health. It also entails entitlement to unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of CESCR.*

***Sexual reproductive health care*** *refers to services, goods and facilities including:*

* *Pregnancy and post-natal related services*
* *Family planning and contraception, including access to safe abortion*
* *Prevention, diagnosis and treatment of reproductive cancers, sexually transmitted infections, and, HIV/AIDS*
* *Hormonal treatments*
* *Gender affirming treatments*
* *Access to information on all aspects of sexual and reproductive health issues.*

# Key questions

1. **Since the beginning of COVID-19 pandemic, States have adopted new policies, laws and other measures in response to the crisis. Please refer to the relevant measures in your country (or countries in focus) and their impact on the right to sexual and reproductive health. Please share information on opportunities and challenges.**
2. **Relevant Measures:**

The COVID-19 pandemic is endangering the sexual and reproductive health of both men and women (and boys and girls). Most vulnerable group includes women and girls (especially those located in poor countries with limited health infrastructure), across the regions of the globe. They (women & girls) are left without access to essential medical services, such as (1) contraception and abortion care, (b) HIV and STI testing, (c) reproductive cancer screenings, and (d) respectful maternal healthcare. The huge reduction in these services is putting lives, health and well-being of countless number of people at risk, particularly those of vulnerable groups whose only access may be through subsidized services provided by the health care providers and civil society members.

According to document titled “Sexual and Reproductive Health and Rights during the COVID-19 pandemic” (A joint report by EPF & IPPF, submitted on April 22, 2020 (published by the IPPF European Network at wen link: <https://www.ippfen.org/sites/ippfen/files/2020-04/Sexual%20and%20Reproductive%20Health%20during%20the%20COVID-19%20pandemic.pdf>, accessed on June 10, 2021), gender-based violence (GBV), more specifically, has surged, with COVID-19 induced lockdown measures making it harder to provide support and shelter to women desperately in need of it. The availability of abortion, as a time-sensitive medical intervention, is of particular concern. Several countries, such as France, Ireland and the United Kingdom (UK), have brought in legislation enabling the use of telemedicine and remote support of medical abortions.

*Further*, many of the sexual and reproductive health (SRH) services are no longer available to women during the COVID-19 in many countries [especially those located in the European Union (EU) region]. This situation has resulted from the COVID-19 situation which, in turn, has resulted in (a) closure of borders, and/or (b) reduction in activities of service-providers. Even where services are available, fears of infection or reduced income mean people are not using them. In Belgium, for instance, the family planning centers in Brussels are open, but have witnessed an 80% reduction in visits. Staff express concerns about future impact: (a) increase of STIs, (b) a rise in demand for abortions, and (c) serious health implications of untreated gynecological infections.

*Further*more, *a*n overwhelming number of countries report significant increases of cases of sexual and gender-based violence (SGBV). In the wake of massive lockdowns imposed to contain the spread of the disease, reports of domestic violence have surged globally, including in most European countries. In France for instance, reports of domestic violence have increased by 32%. The restrictions on movement have forced women and children to be isolated with perpetrators, and hit women’s escape routes and support networks, such as hotlines and shelters. Economic and social distress has further increased the risk of domestic violence against women and children. This worrying situation has been pointed out by many, including the European Parliament and the EU Fundamental Rights Agency. All of them urged countries and Member States to include the protection of women in their national responses to tackle the pandemic.

1. **Opportunities and Challenges:**

**Opportunities:**

Civil Society Organizations (CSOs) play a key role in realizing human rights (including sexual and reproductive rights) for all, particularly the most marginalized, in performing community outreach, service-delivery and advocacy and watchdog activities. Women’s rights organizations, shelters for victims of domestic violence and s**exual and reproductive health** and rights (SRHR) organizations are key actors in the realization of women’s rights and SRHR. Their activities must continue during and after the crisis. There is a real and present danger both in Europe and across the world that many SRHR organizations will collapse through lack of funds. The lockdown measures have started to severely impact economies worldwide, with major consequences on various areas like trade, tourism, transport, employment, but also culture, housing, catering and more. This is affecting civil society, most immediately those who depend on service provision as a source of income, but also as governments start to reallocate funding towards the COVID-19 response. A number of SRHR organizations have already reported significant effects, for example, having to lay off staff and in one case, temporarily close operations completely. In order to protect their economies and reduce the social impact of the crisis, several countries have provided for a bailout funding programme. Some include support to NGOs and charities, as in in countries like Azerbaijan, Ireland, Norway, Poland, Portugal, Spain, Sweden, Switzerland and Turkey. Other countries have provided support programs but with no clarity as to whether NGOs are eligible or not: Albania, Belgium, Denmark, Finland, France, Italy and Portugal. There are, thus, many opportunities in the path to securing SRH rights and associated laws.

**Challenges:**

During the COVID-19 pandemic, millions of people could lose access to essential sexual and reproductive health services due to bad policies and structural barriers. Even before the epidemic, many governments around the world failed to adequately support or fund sexual and reproductive health services. The global economic downturn is limiting the financial resources available to governments for such services. Structural issues during the pandemic include lack of supplies and equipment, staff diverted to other types of care, supply chain disruptions, people avoiding preventive care or choosing to deliver outside of facilities, and clinic closures. These estimates are shocking, but the reality could be much worse if more than 10% of services are compromised or disrupted. In addition, the scale of the impact could be many times greater in specific countries, regions, or populations, as the virus and the lack of effective response has and will hit certain populations and areas harder. There are still time to act but policymakers should move quickly to avert this catastrophe.

It may be possible to learn from past experience with another epidemic. In Sierra Leone, one of the countries most affected by Ebola, decreases in maternal and new born care due to disrupted services and fear of seeking treatment during the two years of the outbreak contributed to an estimated 3,600 maternal and neonatal deaths. This number approaches the number of deaths Ebola virus directly caused in the country. The Ebola outbreak shows the harmful impacts that can result from an epidemic when governments fail to protect the gains made in sexual and reproductive health over the past several decades. Outbreaks are inevitable, but catastrophic losses for sexual and reproductive health are not. By learning from prior epidemics like Ebola, putting in place critical resources and systems, and promoting sexual and reproductive health and rights, national governments and policy makers can prevent health system disruptions that would have overwhelming, lasting consequences on individuals, families and the global community.

1. **Please also specify legal or other measures introduced during the pandemic aiming at recognizing, or restricting, banning or criminalizing: a) access to legal abortion; b) consensual sex between adults; c) same sex sexual relations, d) consensual sex between adolescents of similar ages, e) sex work, f) same sex marriage, g) information on the right to sexual and reproductive health; h) HIV transmission and i) autonomy and free decision making on one’s body and sexual and reproductive health.**

Under the current health crisis, governments have struggled introducing lockdown measures that would keep the balance between keeping us healthy and safe, without limiting our liberty and freedoms too much. National equality bodies have been monitoring these measures, to make sure they do not undermine the rights to equality and non-discrimination. It proves to be even harder, under the current circumstances, to protect and not limit those fundamental rights, which were not fully implemented before the COVID-19 pandemic broke out. One blatant example of this is sexual and reproductive health and rights (SRHR). **SRHR are not only a crucial part of healthcare, but they also constitute an essential element for achieving gender equality and promoting women’s rights.**They give women the possibility to make autonomous decisions about their own bodies and sexuality. They keep women healthy, dignified and safe.

Sexual and reproductive health and rights cover a wide range of topics. Sexual rights may include the right to sexual education, freedom from sexual violence and coercion or the right to decide whether or not to have children. Reproductive rights on the other hand, can include access to contraception (including emergency contraception), access to menstrual and sanitary products, access to safe and legal abortions and ensuring safe pregnancies and childbirth. However, SRHR also deal with violations such as eliminating female genital mutilation (FGM) and forced sterilization or preventing sexually transmitted diseases.

*Furthermore*, what all these things have in common is that they require access to health care services and medicines, health education programs and awareness-raising campaigns. As such, SRHR constitute a part of our healthcare, and equal access to healthcare is guaranteed by article 35 of the EU Charter of Fundamental Rights. *Furthermore*, ensuring universal access to sexual and reproductive healthcare services is also enshrined in the UN Sustainable Development Goal 3 on good health and well-being. It is thus crucial to highlight, in order to understand and fully recognize, that when we discuss access to SRHR, we are not discussing an option for member states to consider. SRHR, as part of healthcare, are essential, meaning that member states have an obligation to ensure access to them, and failing to guarantee that, is inadmissibly a breach of fundamental rights.

National equality bodies are the watchdogs for national governments’ implementation of equality legislation and the promoters of equality and non-discrimination across Europe. They are mandated to tackle gender discrimination among other grounds. Equality bodies are thus well positioned to ensure that women’s rights are not infringed, equal access to health care is guaranteed and includes SRHR.

1. **Regarding sexual and reproductive health care, what services, goods and information is being provided in your country (or countries in focus), during the pandemic?**
	1. **Any changes compared to pre-COVID 19? Has any service, good or information been deprioritized or defunded? Who is this affecting in particular?**

**Access to all sexual and reproductive health and rights was already limited before the pandemic broke out.** Although abortion is now accessible under certain circumstances in 39 countries in Europe, several countries still have time limits on performing abortions ending around the first trimester, and in Malta abortions are still not allowed under any circumstances. When it comes to accessing various contraception, according to the Contraception Atlas [I](https://www.contraceptioninfo.eu/sites/contraceptioninfo.eu/files/map_cci-english_english_v9-web.pdf)ndex by the European Parliamentary Forum for Sexual & Reproductive Rights (EPF), several European countries’ national health systems still do not provide proper reimbursement for contraceptive supplies nor provide enough supporting information on how and where to get them. Furthermore, women still face obstacles due to requirements of third-party consent. This means that they must see a doctor first, who decides whether to allow the use of contraceptive methods and then whether to write a prescription, for example, for hormonal contraception. This need to obtain a prescription from the gynecologist is another obstacle in countries where general healthcare is not always accessible. In Poland, which scores lowest on the index, even emergency contraception pills are not available without a prescription. This creates additional stress caused by the limited time available to obtain and take the emergency contraception while it is still effective. With access already limited and the complicated doctoral procedures that also imply additional financial burden in the process, it is inevitable that such restrictions further disproportionately affect women living in poverty, women with disabilities, Roma women as well as trans and gender non-binary people.The **social stigma** created around the matter has further contributed to deteriorating women’s dignity and safety in attempting to access such services. Criminalizing women and medical professionals who act outside of the legal framework to provide abortion, lack of proper sexual education and the use of the conscience clause even when the health risks are visible and prevailing are just a few examples of what contributes to the perceived ‘acceptableness’ of neglecting access to SRHR.

* 1. **Please explain if there has been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID – 19.**

**During the COVID-19 pandemic and the lockdown measures that followed, access to SRHR has become even more complicated than before.** Women living in countries with the most restrictive abortion laws usually travel abroad to neighboring countries with more liberal laws if they need the procedure. Current **travel restrictions**make it impossible for these women to do that. The issue has been highlighted, for example, by activists from Malta. Another alarming issue is the **disruption in supply chains**caused by higher demands and cuts in personnel working in production and delivery services, leading to **shortages of contraception and emergency contraception** available in pharmacies. This issue is even more critical now, with the alarming rise of sexual and gender-based violence for instance, in cases of domestic abuse or rape. Various state-imposed rules, aimed at reducing the spread of the virus, have also affected **carrying out safe pregnancies and childbirth and respecting all rights and wishes of mothers.** The National Centre for Human Rights in Slovakia was the first to report cases of **fathers not allowed to be present during birth** in certain hospitals. Experiencing similar problems, the Ombudswoman in Cyprus released an official statement establishing that “women’s rights during childbirth, must be protected during the COVID-19 pandemic, if all of the necessary precautionary and protective measures are taken to avoid the risk of spreading the virus. Otherwise it would constitute direct gender discrimination against pregnant women wishing to have the person of their choice present during childbirth”.

* 1. **Please also share information on other practical obstacles or challenges to access sexual reproductive services during the pandemic, and who were most affected.**

National governments need to observe how the COVID-19 pandemic is affecting women’s health and draw conclusions. Now more than ever the world is observing the dangerous effects that restricting access to SRHR has on women. Governments should see the health crisis as a chance for a new approach to sexual and reproductive health and rights and the protection of women. **The additional obstacles, created by lockdown measures, should serve as an incentive to ensure proper access to SRHR.** Every cloud has a silver lining and there are also some countries, which have **loosened laws governing SRHR in response to the conditions that COVID-19 is creating for women**. In France, women are temporarily allowed to use expired scripts to renew their oral contraceptive prescriptions. In Belgium, the morning-after pill is now free, along with other forms of contraception for those aged 18 to 25. These examples show that **the pandemic can also be used to give impetus to governments to ensure full and proper access to sexual and reproductive health and rights.**

* 1. **Please also share good practices and opportunities in the provision of sexual and reproductive health care during the pandemic.**

Global responses to the coronavirus disease 2019 (COVID-19) pandemic are converging with pervasive, existing sexual and reproductive health and justice inequities to disproportionately impact the health, wellbeing, and economic stability of women, girls, and vulnerable populations. People whose human rights are least protected are likely to experience unique difficulties from COVID-19. Women, girls, and marginalised groups are likely to carry a heavier burden of what will be the devastating downstream economic and social consequences of this pandemic. A sexual and reproductive health and justice framework (one that centres human rights, acknowledges intersecting injustices, recognises power structures, and unites across identities) is essential for monitoring and addressing the inequitable gender, health, and social effects of COVID-19. The complex interplay between biological and behavioural risk factors needs to be recognised during the COVID-19 pandemic. It is not yet known whether the higher COVID-19 case fatality rates reported in men compared with women in China, South Korea, and Italy to date are attributed to sex-specific biological susceptibility, variations in pre-existing comorbidities, behavioural risk factors, or some combination of these factors. In terms of behavioural risk factors, women's risk of contracting COVID-19 may be higher than men's risk as women are front-line providers, comprising 70% of the global health and social care workforce, and they do three times as much unpaid care work at home as men. Moreover, pregnant women could be at risk of pregnancy-related complications during the COVID-19 pandemic. Severe acute respiratory syndrome and Middle East respiratory syndrome were associated with increased risk of pregnancy-related morbidity and mortality, but data on COVID-19 are scarce.

1. **In connection to questions 1 to 3, please also share other relevant information on legal, policy or other changes affecting the right to sexual and reproductive health and related health care in your country or countries in focus, unrelated to COVID-19.**

All the efforts must be community driven. Recognition of inequitable power structures, distribution of resources, and a collaborative approach dictates the way forward. Advocates must continue to fight the exploitation of the COVID-19 crisis to further an agenda that restricts access to essential sexual and reproductive health services, particularly abortion, and targets immigrants and adolescents. A sexual and reproductive health and justice policy agenda must be at the heart of the COVID-19 response. The response must ensure that universal health coverage includes pregnant women, adolescents, and marginalized groups and must designate sexual and reproductive health, family planning, and community health centres as essential health providers, reallocating resources accordingly. Policy makers should scale up telemedicine for needed, evidence-based care for women and girls, including sexual and reproductive health care. Finally, the response must eliminate legal and policy restrictions to sexual and reproductive health service provision.

1. **Please indicate if your country, institution or organization has decreased financial support or aid to other State, donor or institution or programme in the area of sexual and reproductive health, including through international cooperation, compared to pre-Covid time.**

As the COVID-19 pandemic continues to take a heavy toll on the health and economies of countries around the world, governments, non-governmental organizations, international financial institutions and the private sector are stepping up political, financial and in-kind support for programmes that protect the health and rights of women and girls in developing countries. In India, UNFPA’s efforts led to Government of India guidelines on continuation of critical RMNCH+A (Reproductive, Maternal, Newborn, Child and Adolescent Health) services during COVID-19, which has helped to strengthen overall RMNCHA service delivery.

1. **Please indicate if your country, institution or organization has been affected by a decreased in financial support or aid, including through international cooperation, compared to pre-COVID time, and how this has affected sexual and reproductive health care.**

Humanity is confronted with the unprecedented threat of COVID-19. Around the world, the pandemic is having a devastating impact on health systems, economies and the lives, livelihood and wellbeing of all, particularly older people. Responding effectively to this fast-growing pandemic requires solidarity and cooperation among all governments, scientists, civil society actors and the private sector. The COVID-19 affects women and men differently. The pandemic makes existing inequalities for women and girls, as well as discrimination of other marginalized groups such as persons with disabilities and those in extreme poverty worse and risk impeding the realization of human rights for women and girls. Participation, protection and potential of all women and girls must be at the center of response efforts. These efforts must be gender-responsive and consider different impacts surrounding detection, diagnosis and access to treatment for all women and men. The restrictive measures designed to limit the spread of the virus around the world, increase the risk of domestic violence, including intimate partner violence. As health and social protection as well as legal systems that protect all women and girls under normal circumstances are weakened or under pressure by the COVID-19, specific measures should be implemented to prevent violence against women and girls. The emergency responses should ensure that all women and girls who are refugees, migrants or internally displaced are protected. Sexual and reproductive health needs, including psychosocial support services, and protection from gender-based violence, must be prioritized to ensure continuity. Any restrictions to the enjoyment of human rights should be prescribed by law, and in accordance with international law and rigorously assessed.

**Important note:**

1. Contribution (to: The right to sexual and reproductive health-Challenges and Possibilities during COVID-19, <https://www.ohchr.org/EN/Issues/Health/Pages/sexual-reproductive-health-covid.aspx>) submitted on **June 10, 2021** to:

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