**The Center for Reproductive Rights (the Center)—an international nonprofit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception 27 years ago, the Center has advocated for the realization of women and girls’ human rights on a broad range of issues, including on the right to access sexual and reproductive health services free from coercion, discrimination and violence; on the right to bodily autonomy; preventing and addressing sexual violence; and the eradication of harmful traditional practices.**

We are pleased to share this submission with the Special Procedures, highlighting human rights standards on sexual and reproductive health and rights and COVID-19 as emphasized by international human rights mechanisms and details country situations in all the regions the Center works in.

The Center is constantly monitoring the various impacts of the COVID-19 pandemic on the sexual and reproductive health and rights (SRHR) of women and girls and we have created a COVID-19 pro-bono clearing house which is regularly updated. You can access all of its [resources here](https://reproductiverights.org/resources-0).

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# Human rights and health standards on sexual and reproductive health and rights (SRHR) and COVID-19

* Please refer to the Center Factsheet on ‘[Access to Comprehensive Sexual and Reproductive Health Care is a Human Rights Imperative During the COVID-19 Pandemic’](https://reproductiverights.org/sites/default/files/documents/Access%20to%20Comprehensive%20Sexual%20and%20Reproductive%20Health%20Care%20is%20a%20Human%20Rights%20Imperative%20During%20the%20COVID-19%20Pandemic.pdf) for a detailed overview of the statements made by and recent standards set forth by international human rights mechanisms.

European institutions have also addressed concerns regarding SRHR during the COVID-19 pandemic:

* Council of Europe Commissioner for Human Rights has issued a [statement on COVID-19 and ensuring women’s access to sexual and reproductive health and rights](https://www.coe.int/en/web/commissioner/-/covid-19-ensure-women-s-access-to-sexual-and-reproductive-health-and-rights). The statement highlights how existing barriers in access to essential SRH services in Europe have been compounded during the COVID-19 pandemic and calls for a series of measures to guarantee SRHR. The statement reflects the Center’s work on a joint civil society statement on access to abortion during the pandemic signed by more than 100 NGOs and the E-bulletins we have published on the impact of COVID-19 on SRHR in Europe. The Commissioner has also issued a Human Rights Comment on “Learning from the pandemic to better fulfil the right to health” highlighting the importance of Universal Heath Coverage and the need to address inequalities including those based on gender in strengthening health care systems.
* The European Parliament in April adopted a [resolution on EU coordinated action to combat the COVID-19 pandemic](https://www.europarl.europa.eu/doceo/document/TA-9-2020-0054_EN.html) and its consequences. The resolution “Calls on the Member States to effectively guarantee safe and timely access to sexual and reproductive health and rights (SRHR) and the necessary healthcare services for all women and girls during the COVID-19 pandemic, especially access to contraception, including emergency contraception, and to abortion care; strongly rejects any attempts to backtrack on SRHR and LGBTI rights, and in this context condemns the attempts to further criminalize abortion care, stigmatize HIV positive people, and undermine young people’s access to sexuality education in Poland, as well as the attack on transgender and intersex people’s rights in Hungary.” The resolution also underlined that the pandemic must not be instrumentalized to undermine human rights and the rule of law. The resolution condemned as “totally incompatible with European values” both the decision by the Hungarian Government to prolong the state of emergency indefinitely, to authorize the Government to rule by decree without time limit, and to weaken the emergency oversight of the Parliament, and the steps taken by the Polish Government – namely changing the electoral code against the judgment of Constitutional Tribunal and provisions laid by law – to hold Presidential elections in the middle of a pandemic.”
* With regards to the provision of sexual and reproductive health information and services in humanitarian settings in the context of the pandemic, the Center led within the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) the drafting of an [Advocacy Brief](https://iawg.net/resources/advocating-for-sexual-and-reproductive-health-services-in-covid-19-response/covid-19-srh-full-advocacy-statement?utm_source=announcement&utm_medium=email&utm_campaign=advocacy-statement&mc_cid=2ba594627e&mc_eid=884680f757) that went through extensive field and clinical validation processes by frontline health care workers, civil society, clinicians and epidemiologists.

This advocacy brief becomes ever more important because of [USAID’s recent letter](https://www.usaid.gov/news-information/press-releases/may-18-2020-acting-administrator-john-barsa-un-secretary-general-antonio-guterres) to the UN Secretary General Antonio Guterres contesting the classification of abortion as an essential health service within the [UN Global Humanitarian Response Plan for COVID-19.](https://www.un.org/sg/en/content/sg/press-encounter/2020-03-25/launch-of-global-humanitarian-response-plan-for-covid-19)

Some key highlights of the brief include:

* + Access to safe abortion and post abortion care are listed as essential health services along with contraception, intrapartum care for all births, emergency obstetric and newborn care, clinical care for rape survivors, and prevention and treatment for HIV and other sexually-transmitted infections.
	+ The technical guidance for health care workers articulates that risks of adverse outcomes from medical complications related to sexual and reproductive health outweigh the potential risks of COVID-19 transmission at health facilities.
	+ The framing continues to articulate SHR services in the context of an effective public health response as well as a rights fulfilling response.

# Projections of COVID-19 impact on access to SRH information and services

* While it is early to determine the long-term impact that COVID will have on SRH services. [Guttmacher Institute](https://www.guttmacher.org/article/2020/04/crisis-horizon-devastating-losses-global-reproductive-health-are-possible-due-covid), [UNFPA](https://www.unfpa.org/resources/impact-covid-19-pandemic-family-planning-and-ending-gender-based-violence-female-genital), and a recent article in the [Lancet,](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2820%2930229-1/fulltext) indicate potentially devastating consequences from the direct and indirect impact of COVID 19, such as, inter alia:
	+ **Contraception**: According to UNFPA[[1]](#endnote-2), Some 47 million women in 114 low- and middle-income countries are projected to be unable to use modern contraceptives if the average lockdown, or COVID-19-related disruption, continues for 6 months with major disruptions to services. For every 3 months the lockdown continues, assuming high levels of disruption, up to 2 million additional women may be unable to use modern contraceptives. If the lockdown continues for 6 months and there are major service disruptions due to COVID-19, an additional 7 million unintended pregnancies are expected to occur. The number of unintended pregnancies will increase as the lockdown continues and services disruptions are extended.
	+ **Maternal mortality**: According to the Lancet, disruption of services and diversion of resources away from essential sexual and reproductive health care because of prioritising the COVID-19 response are expected to increase risks of maternal and child morbidity and mortality.[[2]](#endnote-3) Also according to the Lancet, ‘While the COVID-19 pandemic will increase mortality due to the virus, it is also likely to increase mortality indirectly, as estimated in a Lancet study on the additional maternal and under-5 child deaths resulting from the potential disruption of health systems and decreased access to food.[[3]](#endnote-4)
	+ **Unsafe abortion**: The Guttmacher Institute models that a 10% shift in abortions from safe to unsafe would lead to 3,325,000 additional unsafe abortions and 1,000 additional maternal deaths[[4]](#endnote-5).
* **Universal Health Coverage (UHC**): In September 2019, the UN General Assembly (UNGA) adopted [resolution supporting UHC](https://undocs.org/en/A/RES/74/2). The USA supported the UNGA resolution, but disassociated itself from the para on sexual and reproductive health care services. The main stated goal of UHC is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. A summary of UHC can be found [here.](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-%28uhc%29) UHC is seen as integral to delivering the Sustainable Development Goals.

# Instrumentalization of the COVID-19 to roll back on women’s rights and SRHR

* International human rights mechanisms have highlighted the disproportionate impact of the COVID-19 pandemic on women and girls, including because of their traditional role as main caregivers notably within families, disproportionate representation in the health care workforce, and because of the heightened risk of violence against women and girls[[5]](#endnote-6) during the pandemic and in the context of confinement and quarantine measures.
* As State authorities and health systems focus their efforts on containing the pandemic and prioritizing the provision of essential health services, they need to ensure that sexual and reproductive health services are included in this list of essential health services.
* Some decisions made by certain governments in their response to the pandemic have not centered the human rights of women and girls and have on the contrary instrumentalized the pandemic to further restrict women’s rights and SRHR.
* This instrumentalization of the pandemic to further hinder the realization of women’s and girls’ rights is oftentimes part of a broader pattern of human rights restrictions and violations perpetrated in the name of ‘public health’ or ‘public safety’.
* Even though States are able to justify restricting some civil and political rights to protect public health and national security, and in other circumstances, under human rights law, they need to ensure that restrictions are necessary, lawful, proportionate, and non-discriminatory. They also need to be limited in duration and key safeguards against excesses must be put in place, including ensuring oversight and transparency.
* Certain rights, including the right to life, the prohibition against torture and other ill-treatment, and the right not to be arbitrarily detained cannot be restricted under any circumstances.
* Not only do States have the obligation to refrain from any action that will exacerbate the already disproportionate economic and social impact of this pandemic on women and girls, but they also need to keep ensuring the provision of the full range of sexual and reproductive health information and services free from coercion, discrimination and violence.
* Responses to the COVID-19 crisis must balance the safety and human rights of women and girls and health care workers and take into consideration the disproportionate impact restrictions on reproductive health services have on marginalized populations.

## Threats to women’s and girls’ sexual and reproductive health and rights in COVID-19 response – Regional Examples

## Africa

* The COVID-19 curfew is making it **difficult for women and girls to travel to health facilities** for contraceptives, access post abortion care and other reproductive health care, and has put a hold on outreach services that a lot of women in hard-to-access rural areas as well as informal settlement areas heavily rely on. For example, Marie Stopes Kenya, which normally operates 20 centers and 15 mobile outreach teams, has been forced to temporarily suspend its outreach programs because of Kenya’s curfew and restrictions on movements and group gatherings. In just one day, the organization says it received around 300 WhatsApp messages from women and girls inquiring if the clinics were still open and what their operating hours were.
* The curfews have been implemented in a way that does not make exceptions to allow those in need of care to reach health facilities. As a result, **many pregnant women have died** during curfew times for lack of transport as well as fear of police brutality if found moving around during curfew times (e.g. in Uganda and Kenya).
* There have been reports by the Ministry of Health (MOH) in Kenya indicating that there is **low hospital visitation** for health services during COVID-19. There is general fear that if one is found to be COVID-19 positive, they would be detained for more than 14 days at their own cost and so they would rather not go even when in need of care. This is worsened by the fact that increased surveillance in facilities is reducing privacy for patients and mean that women needing post abortion care may be deterred from seeking it.
* In humanitarian settings such as in the **South Kivu province in the Democratic Republic of the Congo,** lockdown measures are difficult to implement. Women and girls still need to circulate to go to markets and provide for their families, which, in a highly volatile context, puts them at a greater risk of sexual and gender-based violence and rape, leading to a potential increase of unwanted pregnancies and unsafe abortions. The pandemic has also led to a decrease in contraceptive use and the decline of income within households has led to women and girls being unable to access basic goods such as sanitary pads.

## Asia

* In some countries in Asia, **SRHR services have been characterized as non-essential** during the pandemic and at times this has meant that hospitals have suspended or limited the provision of SRH services. For example, in Nepal, two provincial hospitals temporarily suspended all SRH services.
* Even in countries that have affirmed that SRH services are essential and should be provided there have been **reports of denials of care**. For example, in the Philippines, there have been several reported cases of pregnant women who have been refused care by hospitals. While the government itself has been emphasizing the continued delivery of essential reproductive health services including maternal health care through statements and policies, the failure to address the weaknesses of the health care system as a whole and systematically implement reproductive health-related policies has led to denial of reproductive rights among women.
* As health systems have struggled to cope with responding to COVID-19 there have been calls in some countries (e.g. India) for **increased provision of SRH services via telemedicine** and for medical abortion to be made accessible.
* During the pandemic access to **abortion** related-counselling and post-abortion care has also become extremely limited in some countries (Sri Lanka).

## Europe

### COVID-19 and SRHR in Europe

* The COVID-19 public health crisis is impacting access to quality sexual and reproductive health care across Europe. The pandemic has thrown into sharp focus how pre-existing legal and policy restrictions, shortcomings and barriers in access to SRH care in the region are compounded and the harms they cause are gravely exacerbated during this public health crisis.
* **Abortion**: Access to abortion has been most acutely impacted by the pandemic and the issues that have arisen are gravest in the few European countries that continue to prohibit or severely restrict abortion, like Malta and Poland. Many women in those countries were previously travelling to other jurisdictions to obtain safe care or obtaining medical abortion from other countries. However, women in those jurisdictions are now left with few options and exposed to very grave risks to their health and wellbeing.
* **Examples of positive responses to COVID-19**: Only a small number of countries have taken steps to address barriers in access to abortion. For example, France, Ireland, and parts of the UK have adopted temporary measures to secure access to abortion care during the pandemic, including by legalizing teleconsultations and use of early medical abortion at home. However, in some of these countries (e.g. France) these measures are considered inadequate for meeting the needs of individuals seeking care and advocates are asking the government to adopt additional measures to extend time periods and broaden grounds for abortion.
* **Contraception**: There are reports that women are facing challenges in access to long-acting reversible contraception and hormonal contraception (UK, Austria).
* **Maternal health**: Some health facilities in a number of countries have introduced bans on the presence of a companion during childbirth, separating newborns from mothers and other practices contradicting WHO guidance. (Slovakia, France, Germany, North Macedonia).
* **ART**: Some countries such as Denmark, France, Greece, and the UK have suspended most treatments.

### Regression and threats to SRHR, gender equality and the rule of law in Europe

* In recent years the rise of nationalism and far right political movements, the increased influence of the religious right, and changing demographics and dwindling birth-rates have combined to create a context in which commitments to women’s reproductive rights and gender equality are increasingly endangered and prospects for further progress weakened.
* Over the past few years, the European region, and particularly Central and Eastern Europe, has faced an **organized opposition against gender equality, LGBTQ rights, and SRHR**. In many countries including Poland, Hungary, Croatia, and Slovakia right-wing populists, ultra-nationalist extremists, and anti-egalitarian groups have been using anti-gender and “gender ideology” narratives to promote an idea that gender equality, abortion rights, and LGBTQ rights are undermining the “traditional family” and ultimately the whole of society.
* These conservative, nationalist and far right political movements have gained ground, while the **influence of religious organizations**, including the Catholic and Orthodox Church, has also been growing. They are exercising influence over state policy, significantly affecting the public discourse on sexual and reproductive health and rights and on gender equality more broadly.
* These groups have been pushing for a conservative, anti-liberal agenda seeking to **ban or restrict access to abortion and sexuality education, oppose rights protections for LGBTI persons and marriage equality, attacking and undermining the work of NGOs and human rights defenders**, and opposing the ratification of the Istanbul Convention which seeks to combat domestic and gender-based violence.
* These resurgent threats seek to undermine the universality of human rights and in some countries, such as Poland and Hungary, they have been accompanied by attacks on independent institutions like the judiciary and ombudspersons. Government **attacks on the judiciary** in both Poland and Hungary which have sought to ensure executive influence over the appointment of judges have led the European Union to open infringement proceedings against these countries for breaches of EU law. However, the situation with respect of the rule of law has continued to deteriorate regardless.

### Hungary

* **COVID-19 response**: The government has used the pandemic to seize power and push through a bill allowing the prime minister, Viktor Orbán, to rule by decree indefinitely.
* **LGBTI rights**: A week ago Hungary’s parliament adopted a law making it impossible for transgender or intersex people to legally change their gender. The new law defines gender as based on chromosomes at birth and making it impossible for trans and intersex persons to change their gender on official documents.
* **Democracy and the rule of law**: In recent years the Hungarian government has sought to undermine the independence of the judiciary and media, attack academic institutions and civil society. The government has been very hostile towards human rights organizations in general, including reproductive rights advocates, and has adopted a set of measures aimed at obstructing their operation. The government has adopted laws imposing special requirements on civil society organizations that have received foreign funding and organized a nationwide campaign against George Soros and OSF. It has recently criminalized the provision of assistance (e.g. medical, legal) to undocumented migrants and has also recently criminalized homelessness. As a result of the hugely difficult operating environment many international NGOs (including OSF) have moved their European offices to other countries.
* **The abortion law** allows abortion up to 12 weeks on a woman’s request for reasons of severe crisis. Thereafter abortion is permitted only if a continuing the pregnancy would jeopardize a woman’s health or life, or in cases of severe fetal anomaly.
* **Regression**: A series of regressive legal provisions were added to Hungarian law on abortion in 1992 and in the years that followed. For example, for abortion on request up to 12 weeks women must claim to be in a “severe crisis situation” defined as “a situation that causes bodily or psychological disarray or renders the woman’s social existence impossible.” In addition the abortion law mandates two counseling sessions with a 3-day waiting period between the sessions before a woman can obtain an abortion. In 2011, Hungary adopted a new Constitution that includes a provision explicitly granting protection of life from the moment of conception.

### Poland

* **COVID-19 response:** Access to abortion, which was already extremely limited due to Poland’s restrictive abortion law has become even more difficult during the pandemic.
* **Poland’s abortion law** permits an abortion up to the first 12 weeks of pregnancy if the pregnancy is a result of sexual assault. Abortion is also permitted when the woman’s life or health is at risk or the pregnancy involves a severe fetal impairment (up to viability only in the latter circumstances). Poland’s law is one of a small number of remaining highly restrictive laws in Europe which do not allow abortion on request or broad socioeconomic grounds. In Poland it is notoriously difficult for women to access legal abortion care. Refusals of abortion care are widespread in Poland and represent a significant barrier and only around 1000 women in Poland are able to access legal abortion care each year. Most women in Poland who decide not to continue a pregnancy are forced to seek clandestine abortion in Poland, import medical abortion pills from another country, or travel outside of Poland to access safe and legal abortion care. In defiance of landmark judgments from the European Court of Human Rights affirming that Poland must remove barriers to women’s access to legal abortion care, Poland has taken no effective measures to give effect to the Court’s rulings.
* **Regression**: In Poland there have been multiple attempts to further restrict the already very limited access to legal abortion. In 2011, 2013, 2015 and 2016 draft legislative proposals were introduced that contained total or near total bans on abortion. In 2015, the Constitutional Court invalidated the referral obligation on doctors in Poland who refuse abortion care on grounds of conscience. In 2016, a proposal to ban abortion completely and introduce criminal penalties for women was introduced following a citizens’ initiative. Following significant public pressure known as the Black Protest it was abandoned by the legislature. The latest proposal to restrict legal access to abortion would ban abortion in situations of severe or fatal fetal impairments and would in effect make abortion inaccessible by removing the ground under which the majority of the around 1000 legal abortions in Poland are performed. A draft bill is also currently pending before the Parliament which if enacted would introduce criminal penalties for providing any form of sexuality education and evidenced-based information on sexual and reproductive health and rights to adolescents.

### Malta

* **Abortion**: Malta’s law on abortion bans it under all circumstances. A public discussion about decriminalization of abortion in Malta has recently been initiated. However, abortion remains a highly stigmatized topic and there were strong negative reactions following the visit by the Council of Europe Commissioner for Human Rights who criticized the total ban on abortion and called for liberalization of the law. Last year, a number of civil society organizations in Malta launched the first pro-choice coalition, Voice for Choice, committed to advocating for reproductive rights and justice and Doctors for Choice in Malta was also set up.

## Latin America and the Caribbean (LAC)

* Kindly see submission on LAC sent in addition to this submission.

## The United States (U.S)

* WHO has been at the center of attacks by the Trump Administration on the handling of the COVID-19 response. As a result, the US has suspended its funding to WHO. While SRHR have not been expressly targeted in this attack against WHO, in a resolution on the Covid-19 response introduced by the EU and Australia at the May 2020 [World Health Assembly](https://www.who.int/about/governance/world-health-assembly)-- the decision making body of WHO-- the US administration in rejecting the resolution included in its statement strong anti-choice language, condemning parts of the resolution which showed support for SRHR.
* The COVID-19 pandemic, and government responses, have exacerbated and deepened inequities in maternal health in the U.S. It has also provided an opportunity for some government officials to further their ideological opposition to abortion and restrict access to essential health care.
* Maternal Health
* Before the arrival of COVID-19, the U.S. was entrenched in a [public health and human rights crisis](https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html) characterized by rising maternal mortality and morbidity and wide racial and ethnic disparities in maternal health outcomes. The majority of maternal deaths in the U.S. are preventable, reflecting weaknesses in the health care system and structural inequalities that discriminate along lines of gender, race, and income.
* The same communities that are at greatest risk for maternal death and illness are disproportionately affected by COVID-19. Black and Indigenous women in the U.S. are much more likely to die from pregnancy complications than white women are, and women of color suffer disproportionately high rates of maternal morbidity. Early data show strikingly high rates of infection and death from COVID-19 among communities of color. For women of color, the pandemic’s impacts are further amplified by societal expectations that they take on caregiving roles and perform other “essential” work in exchange for low-wages and few labor protections.
* Indeed, reports indicate that the COVID-19 pandemic has put further strain on the maternal health care system and is exacerbating the underlying maternal health crisis facing Black and Indigenous women.[[6]](#endnote-7)
* For more information on the impact of COVID-19 on existing inequities and inequalities in maternal health in the United States, and recommendations for government and health care decision makers to safeguard maternal health and rights during the COVID-19 pandemic, see this [fact sheet by the Center for Reproductive Rights](https://reproductiverights.org/sites/default/files/documents/Safeguarding%20Maternal%20Health%20and%20Rights%20in%20the%20United%20States%20During%20the%20COVID-19%20Pandemic.pdf).
* Access to Abortion Care
* Elected officials in several U.S. states have used the COVID-19 pandemic as an opportunity further their ideological opposition to abortion and block or severely limit access to time-sensitive, essential abortion care. In the days and weeks after the COVID-19 outbreak, [government orders in a number of states](https://reproductiverights.org/sites/default/files/documents/How%20State%20COVID-19%20Orders%20Can%20Impact%20Abortion%20Access.pdf) forced clinics providing abortion care to turn away hundreds of patients, many of whom had no other option. Others seeking care had to travel hundreds of miles across state lines during a public health emergency. These actions are part of an ongoing and long-standing effort by states to limit, and in many cases prohibit, abortion access in the U.S.
* The Center for Reproductive Rights and partners [filed litigation](https://reproductiverights.org/covid-19-cases-and-resources) and successfully sought emergency relief from courts in several states to ensure that abortion care could continue. COVID-related orders blocking abortion in other states have expired. Yet emergency litigation and the passage of time cannot fully reverse the damage. By denying access to time-sensitive abortion care, officials place the health and economic security of pregnant people and families at risk and exacerbate systemic inequities.In addition, restrictions on essential health care services such as abortion undermine public health efforts to respond to COVID-19. There is emerging consensus among medical and health professionals and experts in the U.S. and globally that [abortion continues to be essential during the COVID-19 crisis](https://reproductiverights.org/sites/default/files/documents/CRR%20Columbia%20COVID%2019%20Abortion%20FINAL.pdf) and must remain available. Indeed, rather than retreating from human rights-based standards of care during the COVID-19 pandemic, government and healthcare decision makers must maintain comprehensive sexual and reproductive health services and center the health and rights of pregnant individuals.
1. See <https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf> [↑](#endnote-ref-2)
2. See [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30801-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2820%2930801-1/fulltext) [↑](#endnote-ref-3)
3. [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30229-1/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2820%2930229-1/fulltext) [↑](#endnote-ref-4)
4. See <https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health> [↑](#endnote-ref-5)
5. See <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25749&LangID=E> and <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25746&LangID=E> [↑](#endnote-ref-6)
6. *See, e.g.,* Sandhya Raman, *COVID-19 amplifies racial disparities in maternal health*, Roll Call, May 14, 2020 *available at* <https://www.rollcall.com/2020/05/14/covid-19-amplifies-racial-disparities-in-maternal-health/>; Joia Crear-Perry, *Black Mamas Can Thrive During Childbirth, COVID-19 Or Not*, Essence, March 19, 2020 *available at* [https://www.essence.com/feature/ black-mamas-childbirth-covid-19-coronavirus/](https://www.essence.com/feature/black-mamas-childbirth-covid-19-coronavirus/); Claire Cleveland, *Coronavirus Is Stressing Pregnant Women And New Mothers Out. These Researchers Are Trying to Understand How to Help*, CPR News, May 23, 2020 *available at* <https://www.cpr.org/2020/05/23/coronavirus-is-stressing-pregnant-women-and-new-mothers-out-these-researchers-are-trying-to-understand-how-to-help/>; Nina Martin, *What Coronavirus Means for Pregnancy, and Other Things New and Expecting Mothers Should Know*, ProPublica, Mar. 19, 2020 *available at* <https://www.propublica.org/article/coronavirus-and-pregnancy-expecting-mothers-q-and-a>. [↑](#endnote-ref-7)