**SUBMISSION TO THE UNITED NATIONS SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH FOR THE THEMATIC REPORT ON THE RIGHT OF EVERYONE TO SEXUAL AND REPRODUCTIVE HEALTH – CHALLENGES AND OPPORTUNITIES DURING COVID-19**

**10th June 2021**

**Countries:**

Bangladesh

Indonesia

**Coordinated and consolidated by:**

Asian-Pacific Resource and Research Centre for Women (ARROW)

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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.

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| --- | --- |
| Type of Stakeholder (please select one) | Member State  Observer State  Other (please specify)   * Regional and country level NGOs |
| Name of State  Name of Survey Respondent | Respondents:  **Country level NGOs:**   1. **Bangladesh**  * Name: Ashrafun Nahar Misti   Organisation: Women with Disabilities Development Foundation (WDDF)   * Name: Samia Afrin   Organisation: Naripokkho   1. **Indonesia**  * Name: Nanda Dwinta Sari * Organisation: Women’s Health Foundation   **Coordinated and consolidated by:**  Asian-Pacific Resource and Research Centre for Women (ARROW)  Note: The three country level respondents listed above are ARROW’s partners. ARROW is a Global South, Non-Government, women’s organisation based in Malaysia working to advance women’s health, affirmative sexuality, and rights - areas where progress is still slow and uneven, despite gains in health. We have strategic niche in the region and globally as a south-based feminist woman led advocacy organisation. Founded in 1993, ARROW aims to empower women and young people through information, engagement, communications, mobilisation, partnerships, strengthening women’s movement and social movement and monitoring and research around international commitments on women’s health, especially sexual and reproductive health and rights (SRHR). In this way, ARROW helps lead and sustain momentum for gender equality and SRHR agenda in the Asia Pacific region and the regions of Global South. |
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| Can we attribute responses to this questionnaire to your State publicly\*?  \*On OHCHR website, under the section of SR health | Bangladesh:  Yes No  Indonesia:  Yes No  Comments (if any): |

**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.**

**Bangladesh**

Challenges:

* + Many adolescents, especially adolescent girls in Bangladesh, are not provided with optimal conditions to develop their full potential and ensure their overall health in their transition into adulthood. The situation is even more worrying for women and girls with disabilities as their SRHR is a neglected area. Moreover, myths and misconceptions surrounding the sexuality of persons with disabilities has an adverse impact on person’s with disabilities and their ability to reclaim their SRHR.
  + Before COVID-19, the rate of institutional birth was at 45-50%. The number has decreased to approximately 41% (Health Department statistics) since COVID-19, indicating that more mothers are resorting to giving birth at home. The challenge is posed by the lack of data on those births but there are other statistics that paint a worrying picture. Maternal mortality during the time of COVID-19 has increased from 25% to 30% (EPI, World Health Organization). UNICEF has further reported that services related to maternal health and neonatal care has decreased by 19% since the pandemic started.

Other challenges cited in various government reports includes:

* + An overall rethinking is required for repositioning and prioritising the health sector in our development agenda besides expanding the budgetary allocation for health. Health is not only a sectoral agenda, rather health needs to be considered as a strategic agenda intertwined with many other sectors such as Ministry of Local Government, Rural Development and Cooperatives, Ministry of Women and Children Affairs; Ministry of Religious Affairs; Ministry of Social Welfare.
  + Public health needs to be prioritized many times more than the current level, not in just of increasing the budgetary allocation. Health budget should always be prepared from public health point of view. Hence, waste management, hygiene and cleanliness need attention and additional investment. Government needs to stress upon the strategic plan about increasing the public awareness, and use a ‘whole-society’ approach to tackle the pandemic. Community engagement is required to make people aware about the risk and follow social distancing and other hygiene and cleanliness measures.
  + The health system needs to be prepared to manage COVID-19 cases while the regular health care services need to be continued. In addition, adequate budget may need to be allocated for the massive vaccination programme once it is available. Government needs to delay or cut down some infrastructure development project and reallocate the money to the need of health sector.
  + Government needs to allocate resources for health research. If a vaccine become available in next budget year, Bangladesh might also be involved in the trial to get the advantage of being part of its first phase. In addition, an important lesson would be “proper documentation of the situation and public dissemination”.

Opportunities:

* Bangladesh Health Watch (BHW) carried out the rapid review to assess the budgetary allocation in the health sector (including water and sanitation) on COVID-19 response by the government, private (for profit and not-for profit) organizations and development partners in terms of equity, transparency/corruption, efficiency and effectiveness. Data had been collected over the period of 16th April to 5th May, 2020 from three different sources: desk review, key informant interviews and collection of allocation statements from non-governmental organizations. This review revealed a number of important findings which are now part of the technical report titled “Different Aspects of Health Financing of COVID-19 Response” under the Ministry of Health.

(https://drive.google.com/file/d/16qkUExtiFiK7JkzEzVEezVA9X9JCwBfe/view?usp=sharing)

* + The Ministry of Family Planning is preparing a Disability inclusive standard operational procedure on SRHR and a woman with visual impairment is working as a consultant to produce this.
  + According to The Senior Secretary of General Economic Division’s Planning Commission is currently drafting the 8th Five Year Plan (FYP), which will be completed by July 2020.

(https://reliefweb.int/report/bangladesh/population-expert-group-discusses-impact-covid-19-maternal-health)

* + Different CSOs have taken few measures such as awareness online campaign, online training, virtual meetings with the leaders of rural area organizations and other rural area women representative so that vast information can get to be spread out during the pandemic situation.
  + Government has initiated an online service to advise on SRHR issues such as pregnancy, Family planning and contraception with Doctors during COVID-19.
  + The government and development practitioners, CSOs and youth groups are working together to tackle the challenges posed by COVID-19. International NGOs and UN agencies such as UNAIDS are supporting initiatives related to COVID-19 tests, surveillance, training health workers and on other awareness-raising related tasks around COVID-19 safety and security measures. UNICEF is also assisting in supplementing the government reserves for healthcare to prevent any scarcity arising out of increased demand of health equipment and necessities and is also assisting the government in the development of various guidelines related to COVID-19 and health.

**Indonesia**

* To respond to the limitations of health services during the COVID-19 pandemic, the government has issued Circular No. HK.02.01/MENKES/303/2020 concerning the Implementation of Health Services through the Utilization of Information and Communication Technology in the Context of Preventing the Spread of Corona Virus Disease 2019 (COVID-19). However, since the letter was circulated, the health care system, especially at level 1, has not been able to immediately adapt to the changes in the service model. From a brief search after the circular, the innovations carried out are still limited to opening online consulting services for non-emergency situations, but have not been able to provide complete services.
* 'Anti Sexual Violence Bill' has recently been withdrawn from 2020 National Legislation Program priority list because the legislative process has met a dead end. The 'Anti Sexual Violence Bill' has been advocated since 2016 and is still subject to debates and controversy until now.
* The health workers are constrained by limited personal protective equipment (PPE). Especially for ANC (antenatal care) and KB (contraception) services, the limitation of PPE is the main obstacle that has an impact on services. Due to this limitation, instead of serving patients according to the recommendations in the Practical Guidance Protocol for Maternal and Newborn Health Services During the COVID-19 Pandemic, health workers choose to directly refer patients to Advanced Referral Health Facilities (FKRTL). Whereas in this pandemic situation, strengthening ANC and reproductive health services available at the First Level Health Facility (FKTP) level is a very essential thing. FKTP is the only health facility capable of providing comprehensive services, including medical emergency management and referrals.

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.**

**Bangladesh**

There has been no introduction of any new laws or policies addressing the above.

**Indonesia**

* Before COVID-19, women’s organization such as the Women’s Health Foundation (WFH) together with the networks were already advocating for access to safe and affordable abortion services for women in Indonesia. The advocacy work of WHF started by campaigning for a chapter on Reproductive Health (RH) to be inserted in the new Bill on Health at Parliament in 2001, which lasted for eight years with three different governments (2001 - 2009). The proposed chapter on RH, then, was finally adopted in the New Health Law No. 36/2009, but what remained unchanged is that abortion is only allowed when the mother’s life is at risk or in danger; to save the mother’s life and also for rape. In this law, abortion services should be performed based on the guidelines drafted by the Ministry of Health in collaboration with the Indonesian Gynaecologists Association. Only a physician with a certificate, which shows expertise in performing abortion, can provide abortion services. A woman must also be referred by a health care clinic, with a letter of reference from a doctor stating that the pregnancy threatens her life, the result of her pregnancy test, and her husband’s approval if married or the consent of her parents if unmarried, and a statement indicating a willingness to use contraception thereafter.
* The law should be equipped with implementation regulation issued by the Ministry of Health (MoH) No. 61/2004 about Reproductive Health that was enacted. Unfortunately, abortion is still restricted to saving women’s life. By advocating again for access to abortion with broader reasons, finally, the Health Minister launched Health Ministerial Decree No. 3/2016, which mandated training for health providers to perform abortion services and the provision of abortion services at appointed places. The reason for carrying out an abortion, however, remains unchanged; to save women’s life and to terminate the pregnancy of rape survivors. The abortion, however, is only allowed if the maximum gestation is 40 days.
* WHF worked closely with their network in order to make Health Ministerial Decree No. 3/2016 workable. Indonesian Planned Parenthood Association (IPPA) conducted training with the aim of enhancing the required skills of health providers when performing an abortion. Unfortunately, the government still seemed reluctant in appointing places where abortion services can be obtained. The only action taken by the government was in conducting a training on post-abortion care for physicians.
* This situation shows that not only is the certification of the general practitioners is key to ensuring access to abortion services but the appointment of places providing abortion services is among the necessary steps, which each local government should take, but unfortunately, until today, it has not been implemented.
* According to the Simfoni data established by the Indonesian Ministry of Women’s Empowerment and Child Protection, recorded cases of gender-based violence in Indonesia have reached to 10,839 cases with 9,330 of them victimizing women in 2020. Gender-based violence has actually increased during the COVID-19 pandemic where it reached 892 cases up until May 2020, equivalent to 63% of all recorded cases in 2019. Out of all these cases, the most striking in quantity being domestic violence and sexual violence, which of course relates to sexual and reproductive health and rights (SRHR).
* Besides the COVID-19 situation in Indonesia, conservatism rapidly gains power across the country, where women and non-binary people continue to face extreme threats. The existence and emergence of feminist and queer voices within the civic space are shrinking with conservative perspectives embedded in every sector; from health, education, media, to politics. Conservative policies in all levels - from government, corporations, to the education system - alienate and stigmatize progressive narratives that promote human rights such as gender equality, LGBTQIA rights, and 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?**
   2. **Please explain if there has been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID-19.**
   3. **Please also share information on other practical obstacles or challenges to access sexual reproductive services during the pandemic, and who were most affected.**
   4. **Please also share good practices and opportunities in the provision of sexual and reproductive health care during the pandemic.**

**Bangladesh**

Regarding sexual and reproductive health care, what services, goods and information is being provided in your country (or countries in focus), during the pandemic?

* The COVID-19 pandemic has had a profound impact on the delivery of sexual and reproductive health services in Bangladesh, including those related to maternal and child health. Multiple challenges to achieving the goal of zero preventable maternal deaths have emerged as a result of the pandemic. Addressing these issues, The Population Expert Group held its sixth meeting on Sunday 28 June 2020. The Population Expert Group is a think-tank that helps the General Economic Division (GED) to promote the International Conference on Population and Development (ICPD) and Sustainable Development Goals (SDG) agenda and to generate evidence-based information on critical population dynamics and its linkages to development. (<https://reliefweb.int/report/bangladesh/population-expert-group-discusses-impact-covid-19-maternal-health>)
* The maternal clinics are still operational 24/7. An additional least 2 thousand doctors and five thousand health service providers have been deployed to tackle the pressure on hospitals from COVID-19.

3.1. Any changes compared to pre-COVID-19? Has any service, good or information been deprioritized or defunded? Who is this affecting in particular?

* Harmful practices and sexual and gender-based violence against women and girls have significantly increased during the pandemic. Since the start of the pandemic, the closure of schools, limited mobility arising from lockdown and the influence of social media/online information have fueled some negative developments such as the spreading of misconceptions, superstitions and myths surrounding SRHR. Child marriage rates have increased since COVID-19 started in Bangladesh and women and girls, including those who are in need of urgent maternal health services and information, are reluctant to approach health care centers or other service providers. Messages on social distancing etc are also discouraging service providers to provide one-on-one care towards those in need of assistance. This is affecting women and girls with disabilities in particular.
* There is also a decreased trend that is being observed in the use of contraceptive services and less and less people are using contraception pills etc. Almost half of the contraception pills are provided by the government to meet the nationwide needs but increased fund allocation towards COVID-19, together with a decrease in the use of these methods will have an overall impact on the SRHR of young people especially. Before the pandemic, it was a challenge to advocate for use of contraception. The COVID-19 pandemic has made this task even more challenging.
* Lastly, the overall health sector in Bangladesh is already weak and underfunded. Data sourced from various NGOs show that at 74 % of health costs are still borne by any individual seeking any kind of health care in Bangladesh. There is only one doctor available for 1, 581 persons. The overall sector is in need of modern equipment and trained health service providers and the current allocated budget was already falling short of putting such measures/procurement needs in place. The COVID-19 has complicated the situation and the country is tackling the crisis collectively with government, CSOs, NGOs and UN agencies all working together.

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

* Since the pandemic situation came, the need for accessibility has emerged more prominently than before. The pandemic poses a major concern of safety issue and social distancing. So, now if anyone suddenly wants to go to health care service center, there might not enough service provider because of this highly infectious disease. Accessibility of getting service and information is less and limited than before.
* Lack of getting more service in person than before, disability issues is still being ignored.
* Lack of adequate deployment of trained human resources in health care service centers, means that service providers do not have training or awareness how to behave with women and girls with disabilities. The service providers have no training on the use of sign language and have no information on how to assign an interpreter. Persons with intellectual disabilities are ignored as service providers lack the knowledge on how to communicate with them directly.
* Marginalized communities, especially persons with disabilities and adolescents are highly affected by the pandemic because of limited care and service provided. Most of the community clinic, health field workers do not expect the presence of young women, young people from the LBTIQ community or women with disabilities in the service centers, especially for their SRHR needs.
* The maternal clinics are still operational 24/7 but due to COVID-19, lockdown etc, the rate of maternal services provided by at least four clinics have been reported to have decreased to 25%. The number of maternal health service-seeking mothers in these four centres have also dropped to 27 %. The number of young people accessing SRH services is also on the decline. In Tangail, at least four thousand young people have accessed SRH services before the pandemic in 2019. From January to April 2020, only 527 young people approached SRH service providers for their SRHR needs. The number has continued to be on the decline ever since.
* There is a lot of mismanagement, corruption in the health sector. Also unregulated institutions and organizations have cropped up and the services provided by them is of questionable quality.

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

* The most vulnerable, the marginalized women and children, are mostly affected and deprived from exercising their SRHR.
* Unavailability of accessibility options for the disabled women and girls to have proper knowledge and getting proper service.
* Inappropriate behavior from health care service provider towards disabled women and girls.
* Lack of access to SRHR information and knowledge and the lack of quality and accessible health services including SRH services and information also needs to be addressed.
* Non-prioritization of SRHR in general leading to increased child marriages, unwanted/unplanned pregnancies, increase in SGBV where the victim is usually adolescent and young girls and women and girls with disabilities.

Solutions to all of the above challenges includes a holistic approach that takes into account water and sanitation issues and its impact on SRHR, mental health of both health service seekers and health service providers (especially since the start of the pandemic), the effects of natural disasters, the situation in urban slums and unavailability of quality health services in the remote areas (*haor – lake areas*, hill tracks, tea plantation areas) of Bangladesh.

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

* Different online training currently being provided on SRHR could be increased.
* Training of rural area leaders and community members by different NGO and CSOs, can be continued so that the leaders can convey the information.
* Online virtual meeting on different issues needs to be modified in existing different policies on SRHR issue.
* Online health service information provided by doctors can be expanded to emphasize more on services related to MR, contraception and maternal health.
* Online SRHR related helpline for young people is a good practice that could be scaled up.

**Indonesia**

* Data from the National Population and Family Planning Board (BKKBN) shows that contraceptives access has decreased up to 47% during pandemic. This causes increasing number of unplanned pregnancies. It is predicted that there will be an additional 370,000-500,000 (15%-20%) births in the first half of 2021. Unplanned pregnancies have wide impact, increase in abortion cases, an increased risk of maternal and child mortality, anemia in pregnant women, malnutrition of both mother and fetus, premature babies born and stunting.
* Indonesian government has tried to respond regarding contraceptive policy in the pandemic situation especially at the national level, but only a few regions have implemented the policy according to their capabilities. (because of decentralization system).
* With implementation of the Large-Scale Social Restrictions, it will cause some problem in the availability of contraceptives services, restriction on type of services, women postponing their visits to health facilities because of fear. In addition to this, family planning service providers do not fully have facilities to prevent the transmission of COVID-19 such as Personal Protective Equipment (PPE).
* The decrease in contraceptive use is also caused by reduced income during the pandemic situation making the use of contraception not a priority, especially it is not covered by national health insurance.
* SRH services should be essential services that need to be available even during disaster situation. The role of CSOs is to carry out advocacy work to ensure that reproductive health services are available and easily accessible to all levels of society during a pandemic.
* CSOs who are working with community would not be able to do full offline activity, they should modify to include both offline and online method.
* With Indonesia being one of the biggest user of leading digital platforms, women, LGBTQIA people, and youth are among these users spending large portions of their time on social media. Many of them are digital creators with significant influence among their peers. Social media has gone beyond means for socializing and has become a space for expression, learning, and community organizing, which is an opportunity.

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.**

**Bangladesh**

No information.

**Indonesia**

Please refer to response under Q3.

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.**

**Bangladesh**

No information.

**Indonesia**

* Sexual and Reproductive Health (SRH) services not part of essential services even in the disaster situation. It also means there is no emergency budget for the services and it will challenge women to fulfil their rights on SRH.
* During this pandemic there is a decrease in financial support for SRHR, many donors only focus on handling COVID-19.
* Although there is financial support, the portion for overhead costs is small/limited that the organization does not really have the support or opportunity to improve the quality of their work.
* There is a special need for financial support for minority groups (women’s, girl, LGBTQ, disability, etc) which is not only limited to programs but how these groups are able to survive economically as it’s difficult for them to access government program because their existence is not recognized.

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.**

**Bangladesh**

The onset of the pandemic led to funds being re-directed towards vaccination and other COVID-19 related initiatives. This is leading to non-prioritization of SRHR and lack of funds for the welfare of persons with disabilities. However, the main problem arose after Bangladesh has been declared as middle-income country because many foreign donors have stopped supporting various projects. For example, WDDF had a project named wish to Action, but the donor has stopped the project on Bangladesh and has shifted the project towards Africa based country. Because they might assume that the country has become the middle-income country so it does not need much supporting. But small organizations like us, who wants to develop an inclusive society ensuring all human rights through different advocacy, are being affected because of lack of donation or financial aid support.

**Indonesia**

Please refer to response under Q5.