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Submission of the International Planned Parenthood Federation

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on the right of everyone to sexual and reproductive health – challenges and opportunities during COVID-19

Introduction

COVID-19 has had an unprecedented impact on sexual and reproductive health and rights (SRHR) services across the world, from both the health crisis itself and the consequences of the lockdowns, travel restrictions and waves of transmission in many countries. The key concerns for IPPF with regards to Covid19 response has been to ensure an inclusive and equitable, resilient and rights-based ecosystem to continue sexual and reproductive health (SRH) service provision, and to support Member Associations (MAs) to advocate for sexual and reproductive health programmes in their communities. Our response, mitigation and rebuilding efforts are structured around three essential pillars: ensuring continuity of SRH programmes; protect, promote and advance the SRHR agenda as responsible advocates; and build resilience in IPPF MAs to weather current and future disruptions effectively.

To assess this work, IPPF administered a survey to all IPPF MAs and collaborating partners (n=135) at three points during the COVID-19 pandemic: Round 1 in March 2020, Round 2 in June 2020, and Round 3 in November 2020. The survey was administered through an online platform in three languages (English, French and Spanish). Key highlights of the survey and the impact assessment are provided below in response to the questions of the Special Rapporteur on Health.

121 MAs and collaborating partners completed the survey in March; 124 in June; and 118 in November. 83 MAs have completed all three rounds of the survey, providing three data points to assess situation development, based on select indicators between each round of survey. Regional response rates are:

- Africa Region (AR) – 21 (64%)
- Americas and Caribbean Region (ACR) – 8 (80%)
- Arab World Region (AWR) – 9 (64%)
- East & South East Asia and Oceania Region (ESEAOR) – 18 (82%)
- European Network (EN) – 19 (63%)
- South Asia Region (SAR) – 8 (100%)

Key challenges faced by MAs to their operations include supply of contraceptives, safety and support to frontline workers (both providing services safely and access to PPE for staff), clinics closures due to service delivery restrictions, staff unavailability, or movement restrictions, and low client flow.

Opposition, Advocacy and National Policy Change (Question #1)

IPPF MAs report seeing opponents of SRHR stepping up pressure during the COVID-19 pandemic, attempting to use the crisis as cover to try to push back against progressive reforms, revealing the opposition to SRHR employing a range of tactics to try to undermine sexual and reproductive rights.

Tactics used by the opposition to SRHR include:

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- Spreading misinformation (reported by 18 MAs);
- Framing the pandemic as an opportunity to reinforce traditional values (reported by 15 MAs);
- Increasing discrimination against vulnerable populations (reported by 10 MAs);
- Pushing for regressive measures against SRHR (reported by 8 MAs); and
- Blocking progressive debates on SRHR laws and policies (reported by 7 MAs).

IPPF MAs are actively resisting this opposition and defending laws and policies that support SRHR, reflecting their dual role as advocates and service providers. Almost 50% of all MAs responding to the survey reported working with governments to ensure continuation of SRH services as part of health services, including continued provision and access to SRH services (61 MAs), advocating to increase access to contraceptive services (61 MAs), and advocacy efforts on comprehensive sexuality education (CSE) (51 MAs). 59 MAs advocate ensuring the continuation of access to SHR for vulnerable groups during COVID-19; and 54 MAs report working with governments to find ways to combat sexual and gender-based violence (SGBV), with 31 MAs from across the six regions contributing to successful policy initiatives or legislative changes in support of SRHR since January 2020.

MAs report positive changes in laws and policies to integrate SRHR into national pandemic response, including:

- 27 MAs reporting national governments either approving or allowing telemedicine guidelines (27 MAs) for SRH services, the majority of which focus on consultations, contraceptive services, maternal care and abortion care. Other services include sexually transmitted infections (STI), HIV care and gender-based violence (GBV).
- 29 MAs report removal of barriers to improve access to SRH services.
- 29 MAs report opening of hotlines or call centres for SRH service/information provision.
- 9 countries report opening of aid centres to provide SRH information.

In addition, 56 MAs (53% of respondents) reported that their national government had included SRH as part of the Essential Health Services Package. Of these, 84% indicated that this had a positive impact, while 13% indicated that it had not had an impact, and 3% said they did not know. All respondents in SAR reported an impact, while in ESEAOR, 3 out of 15 MAs (20%) reported no impact from the inclusion of SRH in the Essential Health Services Package.

The IPPF COVID-19 Task Force has been active in hosting and participating in webinars for MAs and has raised visibility of SRHR needs in the context of Covid-19 in regional and international fora. A strong online presence – reaffirming the importance of SRHR in Covid times – has been assured via our websites, media and social media presence. IPPF has also participated in global evidence generation platforms for COVID-19 such as the World Health Organization (WHO) Independent Panel; presentation during the Online Seminar on Impact of COVID-19 Pandemic on Gender hosted by the Asian Forum for Parliamentarians on Population and Development (AFPPD); preparatory meetings for World Health Assembly; and we recently signed the WHO Vaccination Equity Declaration and the Vaccination Equity Support Statement.

Sexual and Reproductive Health Services, Goods & Information (Question #3)

Service Delivery Points (Questions #3.1 & #3.2)

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In March 2020, IPPF MAs reported significant strain and breakdown to an ecosystem that enables individuals to seek and receive rights-based SRH: 104 out of the 121 MAs provided SRH services and 69 of the 104 MAs (66%) indicated a decrease in the number of service delivery points (SDPs) since the outbreak of COVID-19, reporting 5,633 SDPs closed since the outbreak (approximately 11% of all SDPs). The highest numbers of closures were community-based distribution sites (CBDs) (45% of all SDP closures) and mobile clinics (22% of all closures), but static clinics were also significantly affected, with 546 static clinic closures or 22% (1 in 5 that reported services in 2019).

By November 2020, 5,051 SDPs had resumed/re-opened, 3,443 SDPs of which resumed service provision between June and November 2020. Static clinic closures fell from 238 to 65 by November, with only 273 mobile sites closed in November compared to 847 in June. 37 MAs (35% of those providing services) still reported at least one SDP closure in November, 35% of which were due to lack of government approvals. Challenges in ensuring health worker safety and availability are significant concerns that have limited MAs' ability to resume operations, including lack of availability of service providers (12%), lack of PPE (12%), low client flow (11%) or other reasons (11%).

While all regions have improved the number of SDPs that are operational since March 2020, the reopening of SDPs have had the most impact in ACR (966 SDPs reopened), AR (1,037 SDPs reopened) and SAR (1,856 SDPs reopened). ESEAOR (299 closures) and AR regions (859 closures) continue to experience the most SDP closures.

47 MAs (45%) reported an increase in client flow in November 2020 compared to June 2020, and 11 reported no change. Among MAs reporting an increase in the number of client flow, the majority report up to 25% increases from June 2020 and 7 MAs report increase of over 50%.

Sexual and Reproductive Health Services (Question #3.2)

In March 2020, 92 of the 104 MAs (88%) reported having to scale down the availability of at least 1 SRH service category either by decreasing hours, sites or the number of providers working, with 36 reporting scaling down all SRH services. Some SRH services were more affected than others, with the most common being HIV testing services (44 MAs), contraceptive services (41 MAs), SGBV services (36 MAs), and safe abortion services (23 MAs).

By June, 32 MAs (up from 11 in April 2020) reported no reduction in the offering of SRH services due to COVID-19 (as compared to pre COVID-19 times) and 58 reported improvements in availability of SRH services through their network, particularly in SRH counselling, contraceptive services, obstetric services and SGBV services. This number declined in November, with 32 MAs reported scaled down of HIV services, 29 for contraceptive services and 24 for gynecological services as compared to 44, 39 and 40 respectively in June 2020. 32 MAs (up from 11 in April 2020) report no reduction in the offering of SRH services as compared to pre Covid-19 times.

Contraceptive services are showing the highest availability, with 54 MAs reporting that these services are 'scaled up' compared to June 2020 or back to pre-COVID-19 levels. 48 MAs reported this for specialized counselling services, 41 for SGBV services and 41 for gynecological services. However, most impacted was safe abortion services, with only 29 out of 105 MAs reporting that abortion services are scaled up or back to pre-COVID-19 levels.

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SRH Commodities and Supplies Disruptions (Question #3.3)

IPPF noted a strain on all aspects of supply chain, which has varied by region, throughout the duration of the pandemic.

In March 2020, 37 of 104 MAs (36% of the MAs that completed the survey) have indicated a shortage of key SRH commodities, 29 MAs a shortage of contraceptives, 12 MAs for safe abortion supplies, 16 for HIV related medicines, 14 for pregnancy test kits, and 8 for Emergency Obstetric medicines. These shortages were compounded by delays in moving goods within countries (59 MAs), delays in receiving re-supply from governments (41 MAs), and delays in clearing customs for shipments (19 MAs). This is an ongoing and complex issue as there are challenges are across the supply chain, compounded by regional and national distribution challenges.

By June 2020, some MAs were able to mitigate supply chain disruptions, with 11 MAs across Europe and Asia reported adequate SRH commodities, as compared to a stock out in early April 2020. However, upstream disruptions in the SRH supply chain, especially for contraceptives in March and April 2020, compounded by regional COVID19 transmission dynamics began to impact on-the-ground availability, with 22 MAs across Africa and Europe reporting an SRH commodity shortage for the first time in June.

In November 2020, 32 MAs reported no challenges, 78 MAs reported procurement challenges (excluding last mile distribution and challenges in in-country distribution), and 8 MAs reported an SRH commodity shortage for the first time during this survey. ACR was the worst affected region, with 15 of 17 responding MAs reporting procurement challenges. AR reported 29 MAs with challenges, 78% of the total. Only 15% of EN MAs reported challenges at that time.

IPPF has so far been supporting MAs with supplies of personal protective equipment and family planning and reproductive health commodities. IPPF managed to reach MAs in hard-to-reach destinations such as Yemen, Syria, Somaliland, Sierra Leone, Iran, North Korea, Afghanistan, and others. IPPF is further working with its MAs to ensure a smooth supply chain and logistics management system to respond to COVID-19.

Good Practices and Opportunities (Question #3.4)

Adaptation of SRH Services

Since the outbreak, MAs have continued to focus on expanding their digital work to make information, education, services, and commodities available to their communities using innovative methods.

> Telemedicine: In March 2020, at least 9 MAs (including Austria, Georgia, Estonia, Philippines, India, Pakistan and others) used telemedicine to provide SRH services. This number grew to 29 MAs providing telemedicine for SRH services, focused on abortion, contraception and STI management in June, and to 69 MAs providing telemedicine for SRH services, including virtual counselling, consultation and follow-up, and online prescriptions in November. As of May 2021, 78 MAs are currently providing services through digital health interventions (DHI) which includes provision of SRH information, education, counselling, consultation and follow up care, or referrals, as well as comprehensive sexuality education (CSE). MAs such as Aruba, Australia, Estonia,

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Georgia, India, the Philippines and others offer clinical consultations through telemedicine. One of the most severely impacted organizations, the MA in Seychelles, has now (May 2021) been able to scale up its GBV and FP services through the implementation of teleconsultation and hotlines for its clients.

Comprehensive Sexuality Education: During the pandemic, the MAs observed high incidence rates of adolescent pregnancies, early marriage and sexual and gender-based violence. Young people made a significant contribution, through a peer-to-peer approach, to prevention of COVID-19, adolescent pregnancy and SGBV, and MAs were able to deliver CSE through online and in-person approaches. In March 2020, 24 MAs offered CSE through social media, Whatsapp, Skype or other virtual channels, with others evincing interest to either start or scale up the range of services through this. Through funding from Global Affairs Canada and Danish International Development Agency, MAs developed, revised, and modified CSE curricula to suit digital needs. MAs in the AWR and Benin, for example, also provided capacity development for trainers on CSE, and the MAs in Spain and Latvia adapted their CSE curriculum to online sessions. By November 2020, 57 MAs reported integrating online innovative CSE programmes into their current programming to mitigate the impact of Covid-19.

Home Service Delivery and Testing: In March 2020, only 12 MAs offered home delivery/doorstep delivery of SRH products like contraceptives, pregnancy test kits, but there was immense potential to scale up and expand to other MAs. In June 2020, the number had increased to 26 MAs. By November 2020, 53 MAs were offering home based care or door delivery of SRH commodities and 33 were providing support for self-care or self-testing including for HIV testing, medical abortion, and contraception.

Contributions to National COVID-19 Response

By March of 2020, 37 MAs (6 each from AR, EN and ACR, 5 from AWR and 4 from SAR, 10 from ESEAOR) had either allocated or already deployed their staff to support the national COVID-19 response, 13 of whom had dedicated health facility space to test or manage COVID-19 as part of the national response. By June 2020, 27 MAs formed part of a government-led national taskforce to co-ordinate the COVID-19 response. 13 of these are MAs in Africa, 4 each from ESEAOR and SAR and 2 each from AWR, EN and WHR. As part of these Government taskforces, particularly across Africa, IPPF MAs played a critical role to support the existing health systems in responding to the crisis through contributions to the public health response and ensuring prioritization of SRH within national responses.

MA contribution to COVID -19 public health response included providing testing services for COVID -19, case management of COVID 19 patients, support to medical workers caring for COVID -19, contributions to multi-sectoral coordination. MA contributions to SRH as part of National Taskforces in country include development and delivery of service delivery guidelines on SRHR, access to/provision of services to vulnerable individuals, and responding to Gender Based Violence (GBV) efforts at national level, including through collaboration with the government and UN agencies.

Financial Impacts (Question #6)

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In early 2021, the United Kingdom's (UK) Foreign, Commonwealth & Development Office made significant cuts to the UK aid budget, including allocated funding for vital sexual and reproductive health services. These cuts will directly affect the world's poorest and most marginalized women and girls. The significant loss of funding for IPPF – totaling around £72 million (approximately $100 million USD) – will mean massive reductions to several large research projects and programmes delivering life-saving contraception and sexual and reproductive health services for women and girls in some of the world's poorest and most marginalized communities.

The funding loss of £72 million includes support for the Women's Integrated Sexual Health (WISH) programme. WISH, implemented by a consortium of organizations led by IPPF and MSI Reproductive Choices, has supported a scaling up of integrated SRHR services in 27 countries across Africa and Asia. Since the WISH programme began in October 2018, it has prevented an estimated 11.7 million unintended pregnancies, 4.3 million unsafe abortions and 34,000 maternal deaths. If the current programme continued for another 21 months as it is operating now, the services provided would avert an estimated additional 7.5 million unintended pregnancies, 2.7 million unsafe abortions and 22,000 maternal deaths. Unfortunately, as no further funding has been allocated beyond the initial three-year project period, activities will immediately be scaled down towards closure within a six month no-cost extension period.

Without additional funding, IPPF will be forced to close services in Afghanistan, Bangladesh, Zambia, Mozambique, Zimbabwe, Cote D'Ivoire, Cameroon, Uganda, Nepal and Lebanon and may be forced to close services in an additional 9 countries, withdrawing support for SRH services from approximately 4,500 service delivery points globally. It will also mean the loss of over 480 IPPF staff supporting SRH service delivery in the FDCO supported countries.

The 85% funding cut for UNFPA Supplies will also severely impact IPPF service delivery. IPPF estimates suggest that unless alternative funding is sourced, the UK government's £131 million ($186 million) cut to UNFPA Supplies will lead to an estimated additional 2.4 million unintended pregnancies, 685,000 unsafe abortions and 7,447 maternal deaths across IPPF's services alone before the end of 2021. For 2021, IPPF has received just $1.5 million worth of contraception out of the $14 million requested for the year. There is increasing concern that the remaining $12.5 million worth of contraception will no longer be available, meaning Member Associations will be dangerously close to running out of stock by the end of 2021, with shortages becoming increasingly acute for 2022 unless replacement funding can be found. The $14 million equates to 40% of IPPF's overall budget of $35 million for contraceptive supplies across the entire Federation. [1]

The UK aid budget cuts come in the midst of the COVID-19 pandemic when gender inequality and gender-based violence are increasing significantly, and healthcare services are stretched to the limit. Without access to contraception and sexual health clinics, millions of women and girls in some of the world's most impoverished communities will fall pregnant, forcing them to choose between continuing an unintended pregnancy or having an unsafe abortion – putting their lives and health at risk.

[1] For more information, see https://www.ippf.org/news/aid-cuts-could-lead-more-two-million-pregnancies-end-year-continued-blows-women-and-girls