The right to sexual and reproductive health – Challenges and Possibilities during COVID-19: UN Office of the High Commissioner for Human Rights

MSI Reproductive Choices submission: 10/06/2021

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 X☐ **Other (please specify) Non-profit abortion and contraception provider**
Name of State Name of Survey Respondent	MSI Reproductive Choices
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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): This response can be publically attributed to MSI Reproductive Choices. MSI Reproductive Choices (MSI) is one of the world's largest providers of sexual and reproductive health services, and a global advocate for gender equality and reproductive choice. We work in 37 countries as a key partner to ministries of health. By the end of 2020, over 37 million women globally were using a form of contraception supplied by MSI.

<u>QUESTIONNAIRE</u>

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.**

MSI UNITED KINGDOM
REPRODUCTIVE CHOICES

Overview

The impact of COVID-19 for sexual and reproductive health and rights has been significant. The pandemic has created access barriers for abortion and contraception. The main drivers have been domestic and international travel restrictions, pressures on health care systems, disruption of existing mitigation plans or support systems in countries with limited access or restrictive laws, threats to employment and financial independence, and an increase in demand.

In 2020, we estimated that 1.9 million fewer women have been served by our programmes due to COVID-19, and that this would lead to:

- 1.5 million additional unsafe abortion
- 900,000 additional unintended pregnancies
- 3,100 additional maternal deaths

However, thanks to the perseverance of our providers and the flexibility of governments and our partners, the story has also been one of resilience and adaptation.

Case study: Telemedicine

In March 2020, the home use of both mifepristone and misoprostol was permitted in England, Scotland and Wales as part of the UK Government's response to the COVID-19 pandemic.

This decision allowed abortion providers in the UK to demonstrate what we have long argued: that Early Medical Abortion at Home ("telemedicine") is an effective, and in many cases, preferred abortion method. Multiple peer-reviewed studies[1] have concluded that there is no clinical or safeguarding reason not to maintain telemedicine as an option post-pandemic.[2] The National Institute for Clinical Excellence (NICE)[3] and the Royal College of Obstetricians and Gynaecologists (RCOG)[4] both recommend that telemedicine should be seen as an improvement in abortion care.

The telemedicine pathway priorities safety, clinical effectiveness, and privacy. Robust measures were put in place by providers to ensure safeguarding can be carried out in a full and proper way via telemedicine, in alignment with NICE guidance. Many vulnerable clients reported that accessing an abortion via telemedicine was safer for them, as they did not need to attend a clinic in person, which can be very difficult if, for example, a client lives with an abusive partner or parent.

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[1] Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes, BMJ, Porter Erlank C, Lord J, Church K. BMJ Sex Reprod Health Published Online First: [please include Day Month Year]. doi:10.1136/ bmjsrh-2020-200954

[2] Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study, BJOG, ARA Aiken, PA Lohr, J Lord, N Ghosh, J Starling

[3] Quality statement 4: Early medical abortion | Abortion care | Quality standards | NICE

[4] Telemedicine abortion – a patient-friendly pathway that could help expand safe abortion access globally (rcog.org.uk)

Following the success of this service, UK Government, along with the regional Scottish and Welsh Government (health policy is devolved in the UK) held public consultations on whether telemedicine should remain as an option after the pandemic. A decision is expected in due course. The global evidence in favour of retaining telemedicine as an option for those who choose remote access is very strong. MSI Reproductive Choices struggles to see any reason to remove this option which is not political or ideological.

MSI Reproductive Choices is now sharing learnings from our UK programme to explore similar models for remote provision in low resource settings, such as South Africa, India, and Nepal. An Ipsos MORI survey we commissioned found that 48% of women who reported seeking a contraceptive service or product during the COVID-19 pandemic in the UK reported doing so remotely (online or over the telephone).

We must remember that telemedicine is not always suitable for low resource settings where internet or phone access is limited, for people who are look for a long-acting form of contraception to be fitted, people seeking an abortion at later stages of pregnancy or people who are facing complications from a previous abortion attempt.

It is therefore essential that we also keep facility-based services open safely and maintain a choice of options for contraception and safe abortion. This is particularly important as we could see a greater demand for second trimester abortion services following lockdown.

2. **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.**

N/A

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

   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?
   3.2. Please explain if there has been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID – 19.
   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.
   3.4. Please also share good practices and opportunities in the provision of sexual and reproductive health care during the pandemic.

To help us to better understand how COVID-19 has impacted women's access and rights, MSI Reproductive Choices commissioned a survey with Ipsos MORI, asking an online sample of 1000 women aged 16-50 per country in the UK, South Africa and India about their experiences and awareness of sexual and reproductive healthcare before and during the COVID-19 pandemic. Top line results show that access to sexual and reproductive health information and services has been impacted significantly, finding:

- **Perceived reduced availability of abortion services:** In the UK, 81% of women thought that abortion services were available from an abortion clinic before the pandemic, compared to just 21% thinking that this service was available during the COVID-19 pandemic. This appears to be a global trend of lack of information and awareness of service availability during the COVID-19 pandemic. In South Africa, only 43% of women surveyed thought that people could access an abortion service from a private abortion clinic during the pandemic, compared to 76% before the pandemic. Likewise, in India, perceived availability of abortion2 services from a clinic decreased from 61% to 44%.

- **Need remains high:** 13% of respondents in India reported a need for abortion services during the pandemic. The need for contraceptive services and domestic abuse services is also high in India, with over 1 in 3 women (35%) reporting a need for contraceptive advice, service or products and 1 in 10 women (9%) reporting a need for domestic abuse services during the pandemic.

- **Increased barriers to access:** Almost a third of women in India (31%) and a quarter of women in South Africa (26%) who were seeking a contraceptive service or product were unable to leave home to attend the service due to fear of COVID-19 infection. Almost a third of respondents in India (30%) seeking an abortion3 report that the clinic in their area was closed, a third (30%) also report that wait time for an appointment was 1–2 weeks and 9% report a wait-time of more than 5 weeks.. These findings align with our concerns around how women's reproductive health and rights would be impacted: That barriers to access would increase, for example, due to a lack of awareness of which services are available and when, fears around infection and heightened risks of sexual and gender-based violence.

Separate from the Ipsos MORI survey, MSI Reproductive Choices also gathered the experiences of providers, policymakers, and clients on the frontline of the pandemic, via a short survey on our digital resource hub on safe abortion, SafeAccess. 95% of respondents shared that their abortion services had been affected directly by the pandemic, primarily due to roadblocks and restrictions on travel.

4. **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.**

COVID-19 has had an indirect impact on sexual and reproductive health and rights as well as a direct one. In many of the countries in which we operate, people have established support networks, coping strategies and other survival mechanisms.

With lockdowns leading to curfews, transport blocks, and the cancellation of market days, which often provide an opportunity for women in countries with illiberal laws to access services discreetly, many have been unable to reach facilities. In response, MSI teams have pivoted to get services directly to those who need them, especially women and girls.

For example, in Madagascar, travel restrictions meant women were unable to access maternity hospitals, post-abortion care or contraceptive services, so we accessed government permits for our MSI buses to be allowed on the roads, allowing both the delivery of services to women in their homes and the transportation of women to health facilities.

In Uganda, strict travel restrictions prevented women from accessing services, so the MSI team set up a pilot project, in partnership with UNFPA, to deliver healthcare products using the SafeBoda ride-hailing mobile app. Women can now order contraception and have them delivered to their door by motorcycles, known as boda bodas.

During crises, we know that rates of sexual violence can increase[5], with early reports suggesting a 30-60% rise in domestic violence reports in countries with COVID-related lockdowns[6]. Service data from our country programmes reinforces this.

For example, in the UK, we have seen a 33% increase in domestic violence reports to our safeguarding team. Our Ipsos MORI survey found that 1 in 10 women (9%) surveyed in India reported needing domestic abuse services during the pandemic and a fifth of respondents (21%) seeking an abortion service reported not being able to attend a face to face appointment for fear of leaving their home due to domestic abuse, with 18% of women reporting the same when seeking contraceptive services or products.

By strengthening the knowledge and confidence of providers and contact centre agents on safeguarding and referral pathways, MSI has remained committed to ensuring that clients facing sexual and gender-based violence under lockdown are being supported, safely.

5. 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.

[5] The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis, Vu A, Adam A, Wirtz A, Pham K, Rubenstein L, Glass N, Beyrer C, Singh S. The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis. PLOS Currents Disasters. 2014 Mar 18 . Edition 1. doi: 10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7.
[6] Technical Guidance: Gender-Based Violence During COVID-19

Ostensibly to manage the economic impact of the pandemic domestically, the UK Government has made the decision to reduce international development spending from 0.7% of GNI to 0.5%. The decision will amount to a 'real terms' cut of £4 billion from 2020 investment levels. A 40% cut has been made across areas of global health.

The cuts will disproportionately impact women and girls. Specifically, the cuts will disrupt access to sexual and reproductive healthcare which is a key enabler in delivering on girls' education.

In particular, cuts to the United Nations Population Fund (UNFPA) and to the Women's Integrated Sexual Health programme (WISH) will disrupt access to sexual and reproductive healthcare. With the full funding from the UK for 2021 and 2022, UNFPA Supplies-led efforts would have averted an estimated 250,000 maternal and child deaths, 14.6 million unintended pregnancies and 4.3 million unsafe abortions.

Frontline healthcare workers have been impacted by the reduced funding to the UK government's flagship WISH programme, which over the last two years has saved the lives of 22,000 women and provides six million couples with access to life-saving contraception every year. Over the next two years, WISH funding would enable 11 country programmes to achieve an estimated 1.7m fewer unintended pregnancies, 5,500 fewer maternal deaths and 665,000 fewer unsafe abortions over two years.