UNFPA Consolidated Submission to the Call for contributions: *The right to sexual and reproductive health – Challenges and Possibilities during COVID-19,* by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health

June 16, 2021

Background:

UNFPA operates in over 150 countries to strengthen comprehensive sexual and reproductive health (SRH) systems and care, including access to contraception, maternal health services, prevention of unintended pregnancy, prevention of unsafe abortion and postabortion care, HIV prevention, and comprehensive sexuality education (CSE). We also work to advance gender equality and to empower women to decide freely on their fertility and sexuality free from coercion, discrimination and violence, including by preventing and addressing gender-based violence (GBV), female genital mutilation (FGM) and child, early, and forced marriage.

Consolidated UNFPA Submission to the Call from the Special Rapporteur:

Since the outset of the pandemic, UNFPA has been projecting that the crisis could seriously curtail access to life-saving and health preserving sexual and reproductive health services. Additionally, it has brought to attention the extent to which the lockdowns and economic disruptions have greatly increased the incidence of gender-based violence and harmful practices like child marriage and female genital mutilation.

In response to the Call from the Special Rapporteur, UNFPA reached out to its regional and country offices, encouraging them to share information, experiences and insights to this Call. The **thirty-nine submissions** received in response and summarized in this document, confirm the extent to which the crisis has taken its toll on the right to sexual and reproductive health, in particular for women and girls.

UNFPA has developed a large number of technical notes and advocacy briefs that further explain the impact of the crisis on SRHR and provide guidance for Governments and civil society in responding to COVID-19.[1] This consolidated UNFPA submission does not repeat what is already outlined in these UNFPA reports and tools, but instead collates the experiences and findings shared specifically by country, regional and global offices to this Call for submissions from the UN Special Rapporteur.

UNFPA received thirty-nine (39) submissions to the survey from the UN Special Rapporteur. These submissions include two reports from the disability team in UNFPA's Technical Division and the Commodity Security Branch, one consolidated report from UNFPA's

[1] These technical briefs can be found at: UNFPA - United Nations Population Fund

Pacific Sub-Regional Office (which includes Fiji, Kiribati and Solomon Islands), and one report from the Latin American and the Caribbean Regional Office.

A total of thirty-five (35) UNFPA country offices submitted answers to the call for contributions, from the following regions: Arab States (Algeria, Egypt, Lebanon, Morocco, and Tunisia), Asia Pacific (Afghanistan, Bhutan, Cambodia, China, India, Indonesia, Iraq, Iran, Jordan, Lao People's Democratic Republic, Maldives, Mongolia, Myanmar, Nepal, Philippines, and Sri Lanka), Eastern Europe and Central Asia (Bosnia and Herzegovina, Georgia, and Serbia), East and Southern Africa (Angola, Congo, South Sudan, Zambia, and Zimbabwe), and West and Central Africa (Burkina Faso, Central African Republic, Ghana, Guinea-Bissau, Mauritania, Tchad).

UNFPA's pivotal role in advocating for and supporting national partners in providing access to sexual and reproductive health and rights for all, as part of national COVID-19 responses, and recovery, is evident from the responses received.

Below is the summary of the responses received to the six 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.

The country submissions illustrated the different ways that States responded to the COVID-19 pandemic and the measures taken. Most country responses to the pandemic have included: restricting movement through lockdowns, curfews and closing of borders, closing educational institutions, labeling some services as essential and/or some health facilities as designated COVID facilities, prohibiting gatherings of people -including religious services, remote working arrangements, and providing telemedicine services and hotlines for medical assistance.

These measures have had a major impact on SRHR, as almost all the country submissions confirmed. Some countries explicitly diverted SRH human and financial resources to respond to the crises, or labeled SRH services as non-essential. In the majority of countries what caused the biggest impact on access to SRH services were the periods of lockdown, the limitations on transportation and movement, and the general fear of contracting the virus, as for example **Lebanon**, **Sri Lanka**, and **Zimbabwe**, among other country offices, have described.

The pandemic heightened existing inequalities and discrimination, and some vulnerable groups were more affected than others. For example persons with disabilities faced a number of challenges including: personal protective equipment (PPE), which limits the ability to lip read, and social distancing measures that prevented personal assistants from visiting and supporting them during the pandemic.

Within the realm of SRHR, some services were affected by the pandemic more than others. While maternal health services (pregnancy and post-natal related services) were somewhat guaranteed in a majority of countries, other services such as family planning, HIV-STIs services, CSE and GBV services faced significant restrictions. For instance, in regards to maternal health, early during the pandemic -in February of 2020- **China** issued a guidance note explaining the requirements for maternal health and care work to ensure continuity of services. **Georgia** formally

declared that antenatal and perinatal care services should continue during the acute phase of COVID-19. **India** issued guidelines to ensure the continuity of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services,[2] taking additional steps to assure human resources deployment.

Regarding other SRH services, the submissions reflect that these were not given priority. For instance, the **Philippines**' submission notes that there may be a 67 percent increase in unmet family planning as a result of access and availability of family planning services being reduced, which may also lead to 42 percent increase in unintended pregnancies. Almost all countries reported an increase in GBV cases, including an increase in child marriage, for instance in **Ghana**. In **Georgia**, cervical cancer screening rates fell by around 74 percent from the same period the previous year. The report by the UNFPA regional **Latin America and the Caribbean** office stressed that the provision of CSE was deeply affected in the majority of the countries of the region due to the interruption of in-school learning. The provision of GBV services was also impacted, in particular for those vulnerable groups living in rural and/or hard-to-reach areas.

The deep impact of the pandemic on the right to sexual and reproductive health was a consequence of a combination of factors: lack of health workers in the health units to take care of SRH related cases (i.e., in **India**, **Ghana**, **Maldives**), lack of PPEs in maternal hospitals (i.e., in **Afghanistan**, **Indonesia**, **Jordan**), lack of supplies for family planning and other SRH services (i.e., in **Angola**, **Jordan**, **South Sudan**), unavailability of transportation and/or constraints in service accessibility in remote areas (i.e., in **Iraq**), confusing guidelines for different services using different terminology (i.e., in **Indonesia**), women and adolescents refusing to get antenatal and postnatal care, family planning consultations and even safe deliveries in institutions with skilled midwives due to their fear of contracting the virus (i.e., in **Bhutan**, **Burkina Faso**, **Jordan**, **Iran**), and lack or limited access to technology to access telemedicine and self-care, especially the rural population (i.e., in **Georgia**).

Humanitarian contexts compounded the difficulty to respond to the pandemic. **Myanmar** for example reported that fundamental interventions to control the COVID-19 pandemic have been reduced by 90 percent from January 2021, and surveillance and contact tracing is no longer observed in 67 percent of townships. In **Jordan** school closures bring the risk of increasing learning inequality and children dropping out of school, especially in camp settings with limited access to internet or phone and computer devices. The COVID-19 crisis in **Lebanon** has been exacerbated by an economic crisis that led to an increase among the Lebanese and Syrian refugees living below poverty to 50 percent and 80 percent respectively, and to a decrease in seeking health care services by around 25 percent, including for SRH services.

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.

[2] GuidanceNoteonProvisionofessentialRMNCAHNServices24052020.pdf (mohfw.gov.in)

According to the submissions received by UNFPA, during the pandemic some measures were adopted to explicitly *recognize* and/or protect or guarantee SRHR. For example, in September of 2020 the Supreme Court of **Nepal** ordered the government to ensure women's inclusive representation in any discussions, mechanisms or committees related to COVID-19 management and control. This helped ensure greater attention to addressing gender-based violence and protecting women's rights to SRH care. In **Morocco** the Ministry of Health, together with UNFPA, issued several statements stressing the importance of maintaining the quality of SRH services and the struggle against GBV. **Tunisia** established a central coordination body that enacted a ministerial circular on the continuity obligation of essential SRH services, including maternal, newborn and child health, and monitoring of vulnerable patients, such as people living with HIV, migrant/refugees, and drug users. In **China** UNFPA supported public communication and accurate and updated information on sexual and reproductive health and rights and gender-based violence. An estimated 4 million people were reached by these communication efforts. In December of 2020 **Argentina** passed a bill decriminalizing and legalizing abortion in the first 14 weeks of pregnancy.

However, some submissions provided examples that illustrate measures that *restricted, banned or criminalized* SRHR. Regarding (a) *access to abortion*, in November of 2020, **Angola** enacted a new Penal Code that establishes penalties for abortion, with the exceptions of protecting the life, physical or mental integrity of the woman, if the fetus is unviable, if the pregnancy is the result of rape, and if the abortion occurs during the first 16 weeks of pregnancy. In **Zimbabwe** the courts were not operating due to the lockdown, which affected access to legal abortion services where a judge needs to authorize access to the practice. In January of 2021, **Honduras'** national congress amended the national constitution to block the possibility of legalizing abortion in the future, without requiring another constitutional amendment. The initiative was called the "Shield against abortion in Honduras".

Regarding (g) *information on the right to sexual and reproductive health*, in **Indonesia**, Ministerial Regulation no 5 was instituted because of fears of "hoax" during the pandemic. The new Regulation governs all private social media companies like Google, Facebook, Twitter, and TikTok. These companies are required to "ensure" that their platform does not contain or facilitate the distribution of "prohibited content," which implies that they have an obligation to monitor content. Failure to do so can lead to the blocking of the entire platform. Pornography is considered prohibited content. As SRH information may be incorrectly labeled as pornography, platforms which share SRH content risk being banned as a result of this Regulation. Finally, regarding (i) *autonomy and free decision making*, in **Egypt**, at the onset of the pandemic, the Ministry of Health gave a recommendation for couples to postpone pregnancy, due to the decrease in the immunity of the pregnant mother. This recommendation was circulated via social media platforms.

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?

As the submissions received by UNFPA confirmed, COVID-19 has had a major impact on SRH services, information and goods, in particular regarding access. The pandemic and the extended confinement affected the socio-economic and financial situation of households across the globe, and vulnerable and marginalized populations were especially hard hit. **Algeria**, **Bosnia and Herzegovina**, and **Sri Lanka**, among others, reported that people with disabilities, chronic illness -including HIV-, migrants, the elderly, and sex workers faced multilayered challenges during the pandemic.

People living in rural and hard-to-reach geographical areas also faced more severe consequences due to lack of transportation and general measures limiting movement and travel, as for example **Nepal** and **Maldives** have reported. Within households, women and girls have been more affected by having to take on additional care work of family members, and domestic chores, as for example **South Sudan** and **Central African Republic** have described.

Several country offices have reported "a change in priorities" to address the pandemic, which led to health workers being transferred to COVID-19 response, and as a consequence limited availability of staff to support SRH services. **Angola**, **Cambodia**, **Central African Republic**, **Fiji**, **India**, **Iraq**, **Maldives**, **Solomon Islands**, and **Tchad** were some of the countries reporting this shift.

Lao PDR redirected funding within the health sector to prioritize COVID-19 response and rollout of vaccines, resulting in an estimated 30 percent cut for all health services, including family planning and maternal health services, affecting the overall universal health coverage for women and adolescent girls.

In **Mongolia**, compared to pre-COVID-19 times, maternal mortality ratio (MMR) increased. The MMR for 2019 was Mongolia's record low at 23.0 per 100,000 live births. The MMR for 2020 has increased to 30.2, and as of the end of May 2021, the MMR has further increased to 43.5. Deaths due to COVID-19 constitute 23.1 percent of maternal deaths According to the "Why did mother die?" confidential enquiries into maternal deaths, incidental maternal deaths have also increased, which is directly linked with the increasing rates of gender-based violence during the pandemic

In **Nepal** the closure of routine services affected the continuity of essential SRH services. Even though the directive was reversed and the Ministry of Health announced its commitment to the continuity of essential SRH services, the initial interruption and reduction in service utilization was reported in a number of assessments, including a decrease in institutional births by over 50 percent in the first two months of the lockdown period, putting women and their newborns at greater risk.

Some countries however have reported no significant changes compared to the pre-COVID-19 era, or they have not received reliable data yet (Bhutan, Burkina Faso, Ghana, Guinea-Bissau, Sri Lanka, Zambia, Indonesia, Iran).

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

Almost all of the submissions received by UNFPA described negative impacts on the availability, accessibility, acceptability or quality of SRH services as noted above

Some examples are provided to further illustrate these points. Regarding maternal health and family planning, **Algeria** reported that more than 87 percent of the respondents of their impact study conducted during September of 2020 saw a decline in antenatal visits and family planning services during confinement. **Lao PDR** reported that it is anticipating at minimum, 262 additional maternal deaths, and 44,322 additional unintended pregnancies (DHISH) in 2021.

In **Nepal**, a study conducted by the Nepal Research Health Council and WHO in November 2020, found that maternal deaths during antepartum and intrapartum period in the eight months after the pandemic had increased by 50 percent compared to the same months prior to the pandemic, while the postpartum deaths increased by 9 percent. Media reports indicated that maternal deaths had increased by nearly 200 percent. The lack of accurate data on maternal deaths prompted the Ministry of Health to conduct a maternal deaths survey in 2021 with the support of UNFPA.

Zimbabwe reported that the average monthly deliveries (April to December) in health facilities declined from 32,035 in 2018 to 30,778 in 2020 while average monthly home deliveries increased from 2,417 in 2018 to 3,356 in 2020 indicating that women were delivering at home and sometimes without a trained midwife.

Bosnia and Herzegovina reported that a SRH Inquiry conducted by the National Ombudsmen in 2020 [3]showed that the pandemic significantly reduced the availability and quality of sexual and reproductive health services, especially the accessibility of family planning services, sexual and reproductive health education and reproductive cancer services, as well as abortions.

China reported that even though 63.8 percent of women of reproductive age used contraceptive methods, still 50 percent of new pregnancies were unintended, indicating an unmet need for contraceptives. 70.5 percent of reproductive age women interviewed had a demand for sexual and reproductive health information, while more than half reported that this information was unavailable to them (survey conducted in June 2020 coordinated by the Resident Coordinator's Office, UNDP, UNFPA and UNICEF together with China International Center for Economic & Technical Exchange (CICETE).

South Sudan reported that disruption of schools, routine health services, and community-based services directly and indirectly affected vulnerable young people, including those in IDP camps, young refugees, and the homeless who are living in precarious conditions. As the pandemic spread across the country, reports of teen pregnancies and child marriage increased.

Regarding HIV services, the **Latin American and the Caribbean** office reported that a survey conducted to 2,800 people living with HIV in 28 countries in the region by UNAIDS, showed that 5 in 10 people living with HIV have difficulties accessing their medication during the pandemic.

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.

Perhaps the most common obstacle mentioned in the submissions, was fear of contracting the virus, which led to people not going to health service centres to seek SRH services (for example

[3] Ombudsmen.gov.ba - Ombuspersons at launch of report Inquiry on Sexual and Reproductive Health and Reproductive Rights in Bosnia and Herzegovina

reported by **Egypt**, **Iraq**, **Jordan**, **Lebanon**, **Myanmar**, **Sri Lanka**, **Tchad**, **Tunisia**, and the **Latin America and Caribbean** office, among others). Fear was mentioned as a barrier from the "demand side" (people seeking services), but also from the supply side, connected with other factors already mentioned above such as lack of PPE and overworked health personelle, as well as stigma and discrimination faced. As **South Sudan** reported, health workers suffered from poor working conditions, stigma and discrimination from their communities who feared that they might be carriers of the virus. This also negatively affected their mental health.

Other obstacles mentioned were: security threats (**Afghanistan**), confusion regarding official information, for example which health facilities were isolation sites (**Egypt**), and weak referral mechanism and inadequate ambulance service (**Nepal**). In **Mongolia**, health care providers were not fully trained to transport pregnant and postpartum women between the hospitals. Transportation of a newly delivered mother with COVID-19 and her baby from a maternity hospital to the National Center for Communicable Diseases in light clothes during winter led to public outrage and demonstrations. Consequently, the Prime Minister and his cabinet resigned.

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

Almost all the submissions reported good practices around the following four areas:

1- Use of technology (mainly, telemedicine and hotlines, but also social media groups) to monitor access and quality of SRH (i.e., reported by **Algeria**, **Bhutan**, **Bosnia and Herzegovina**, **Cambodia**, **China**, **Egypt**, **Guinea-Bissau**, **India**, **Indonesia**, **Jordan**, **Lao PDR**, **Lebanon**, **Maldives**, **Morocco**, **Myanmar**, **Nepal**, **Philippines**, **Serbia**, **South Sudan**, **Fiji** and the **Latin America and the Caribbean** office).

2- Partnership with local organizations/local governments and/or communities that have physical presence in insecure and hard to reach areas (i.e. reported by **Afghanistan**, **China**, **Guinea-Bissau**, **India**)

3- Communication campaigns on the importance of continuing SRH consultations and services and accessing GBV support services (i.e., reported by **Algeria**, **Kiribati**, **South Sudan**) and CSE (**Jordan**), targeting adolescents and young people (**Morocco**)

4- Collaborative partnerships between governments and UNFPA, to provide technical and other assistance (i.e., reported by **Angola**, **Bosnia and Herzegovina**, **Georgia**, **Iraq**, **Jordan**, **Lao PDR**, **Mongolia**, **Tunisia**)

There were other good practices reported in the submissions received, worth mentioning. For instance, regarding people with disabilities, the government of **Tajikistan** in partnership with UNFPA, provided access to information, free SRH services, sanitation and hygiene products, and psychosocial support for persons with disabilities, to ensure their SRHR during the pandemic. The "National COVID-19 Preparedness and Response Plan" in **Malawi** identified persons with disabilities and pregnant and lactating women as people needing special protection during the COVID-19 period, including related to preventing violence, accessing education, meeting basic needs, and detection and treatment of COVID-19, and accordingly were a priority of responses.

Morocco issued guidance for parents of people with disabilities during the confinement period, and organized a webinar on emotional health to support them.

Initiatives were also taken to address the fear that people felt in seeking health care services, due to possible risks of COVID infection. The Ministry of Health in **Bolivia**, for example, produced a video reassuring women about safety precautions for COVID-19, and encouraging them to seek prenatal care and family planning services. In **Ethiopia**, training for nearly 1,000 health professionals and extension workers focused on postpartum family planning and long-acting reversible contraceptives while also reducing fear of COVID-19 transmission.

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.

Several submissions received by UNFPA reported changes affecting the right to sexual and reproductive health. Some examples depict measures having a positive impact on the provision of SRH, while others show measures that restrict, deprioritize or delay access to SRH services.

Among the first group -changes positively affecting SRHR- we can mention for example that in **Egypt** the cabinet approved a draft law amending some provisions of the Penal Code promulgated by Law No. 58 of 1937, to establish a deterrent punishment for FGM crimes - Article 242 bis and 242(a) bis. In **Zimbabwe** the Public Health Act is currently being debated in Parliament in order to allow access to SRHR services for young people regardless of age of consent. The Termination of Pregnancy Act is also currently under review. **China** reported three significative changes in legislation/policy: 1- "Sexual harassment" has been included in the Civil Code which was adopted by the National People's Congress on May 28, 2020 and will be enforced from January 1, 2021. The Civil Code clearly defines the forms of sexual harassment. 2- The Law on the Protection of Minors, for the first time, includes the provision of sexuality education as the responsibility of schools, and HIV prevention education has been made compulsory to college students by the Government and it is expected to be in effect from July 2021. 3- It was announced on 31 May 2021 that a policy would allow all couples to have up to three children, in place of the current universal two-child policy.

Among the submissions that reported changes negatively affecting SRHR, we can mention the case of **Indonesia**, where a Sexual Violence Bill was proposed to address many of the failings of previous legislation on GBV and to provide a more comprehensive criminal justice response. In July 2020 however, the Bill was removed from the National Legislation Program priority list and rescheduled for discussion in 2021. In **India**, in 2018 the Supreme Court read down Section 377 of the Indian Penal Code and decriminalized same sex consensual sexual relations. This was followed by the enactment of the Transgender Persons (Protection of Rights) Act, 2019 that aims to ensure protection of and non-discrimination against transgender persons in all spheres of life. However, more efforts are required for the recognition and realization of equality for all individuals. In February 2021, during court proceedings in the Delhi High Court on the recognition of same-sex marriage, the Central Government dismissed the petitions and said that decriminalization of Section 377 does not translate into a fundamental right of same sex couples

to marry. The government further said there is a 'legitimate State interest' in limiting the recognition of marriage to persons of opposite sex.

The situation in **Myanmar** deserves a special mention. Following the 1 February coup by the Myanmar Armed Forces (MAF), the country has seen widespread protests with intensification of violence by MAF and the Police Force against peaceful protesters. A growing Civil Disobedience Movement (CDM) is having a significant impact on the functioning of transport, supplies, banking and financial sector and provision of health and social services with many government employees, including at the ministries declining to report to work. UNFPA and partners are unable to access stocks of reproductive health commodities from government-warehouses where all medical commodities are stored. Supply chain challenges are further compounded by limited availability of transport due to participation in the CDM. Many suppliers are also temporarily closed to participate in an extended general strike. The protracted crisis and CDM risks disrupting government health and protection services including limited access to emergency obstetric and newborn care (EmoNC) and delay in emergency SRHR and GBV care and referrals. This has resulted in a shift of service delivery to private hospitals/clinics with cost implications, subsequently leading to low uptake of SRHR. There has also been concerns of sexual assault in detention centers, resulting in increased requests for post-rape treatment. All these developments are resulting in increased maternal and infant morbidity and mortality among women adolescents, youth and other vulnerable populations.

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.

UNFPA country offices reprogrammed and repurposed programme resources to address the vast, emergent needs, and adapted programmes to provide continuity of SRH services. In the early stages of the pandemic, UNFPA issued operational, programmatic and technical guidance to its regional and country offices, particularly regarding reprogramming, repurposing and the reprioritization of planned activities to ensure that interventions were COVID-19 sensitive and integrated an immediate humanitarian response with early and longer-term recovery actions. Many of these activities revolved around ensuring adequate protective equipment and prevention measures in place, leveraging public-health education opportunities at every possible juncture, and educating health-care workers and the public about how to protect themselves and their communities from COVID-19. UNFPA demonstrated an acute awareness of and sensitivity to the power of data in emergencies, as well as a unique understanding of the mental health needs brought on by the stress and isolation of this challenging period.

The submissions also reflect the catalytic role that UNFPA played in mobilizing resources for SRHR in the country. For example, UNFPA **Jordan** successfully mobilized additional financial support to protect SRMNAH workers while ensuring essential SRMNAH service continuity in response to the decreased national health budget, diminishing resources of donors, increased out-of-pocket payments, and other financial barriers due to the pandemic. In **Mongolia**, UNFPA mobilized resources for SRHR from traditional and non-traditional donors to support the

training of health care workers, strengthen a diagnostic capacity for COVID-19, improve outreach services, and protect the health and dignity of women and girls. **Sri Lanka** reported receiving emergency funding for the procurement and distribution of Dignity kits (which include elements to meet basic hygiene and sanitary needs) for vulnerable populations like sex workers, LGBTQI community, people with disabilities and older persons. Additional $4.6 million US dollars was raised from Takeda to further supplement the SRMNH response in **Benin**, **Togo** and **Guinea** during the pandemic. UNFPA **Iran** reported having increased financial support in the area of sexual and reproductive health, especially maternal health, through building partnership and mobilizing resources from various donors, especially the EU Humanitarian Protection (ECHO).

Several countries reported some reallocation of funds to COVID-19 related activities and responses (i.e., **Bosnia and Herzegovina**, **Central African Republic**, **Egypt**, **Indonesia**, **Lao PDR**, **Nepal**, **Sri Lanka**), and some submissions reported cuts in the financial resources destined to SRH. **Myanmar** for example, reported that the Government reduced the domestic expenditures on family planning and commodity security which was part of their FP2020 commitments. In **Angola**, the National Development Plan (NDP) 2018-2022 was reviewed in 2020 and the two specific programs related to women's empowerment and to combating domestic violence were cut. Finally, the following countries reported not having enough information to answer this question: Cambodia, Georgia, Guinea-Bissa, Iran, Iraq, Maldives, South Sudan, Tchad, Zimbabwe.

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

In April of 2021 UNFPA was informed that the Government of the United Kingdom (UK) was implementing an approximate 85 percent cut to UNFPA Supplies, reducing their contribution from $211 million US dollars, to $32 million.[4] Several submissions stressed the impact of this decreased financial support to the work of UNFPA country offices, and in general the provision of SRH services and supplies.

Mauritania for example reported a cut of 85 percent of the budget allocated for family planning, following the UK announcement. **Myanmar** has also reported how the UK reduction in aid to UNFPA will have dire implications on maternal and child deaths, unintended pregnancies and unsafe abortions. **Nepal** reported that the cuts in UNFPA Supplies will have a devastating impact on UNFPA's support for commodities and capacity development across the country. The country offices of **Burkina Faso**, **Central African Republic**, **Tchad**, **Solomon Islands**, **Lebanon,** and the **Philippines** also reported a significant decrease in funding, as a consequence of the UK decision. **Ghana** reported that as a result of the global funding cut by the UK government for UNFPA Supplies Partnership Program, the cascading effect to countries including Ghana is a 35% cut in funding for activities planned for 2021.

[4] Statement on UK government funding cuts | UNFPA - United Nations Population Fund

Additional information on the impact of the COVID-19 pandemic on SRHR, and UNFPA global response can be found in the latest report by UNFPA - https://www.unfpa.org/sites/default/files/pub-pdf/2021_Covid19_Report_UNFPA.pdf