
Women's and girls' SRHR in situations of crisis – MSI's Submission to the Working Group on discrimination against women and girls, August 2020

Marie Stopes International (MSI) is one of the world's largest providers of sexual and reproductive health (SRH) services, providing women-centred contraception, safe abortion, and post-abortion care in 37 countries. Globally, the services that we provided in 2019 resulted in an estimated:

- 14 million unintended pregnancies prevented
- 6.5 million unsafe abortions averted
- 34,600 maternal deaths averted

By the end of 2019, there were 32 million people using contraception provided by MSI.

We would like to thank the 'Working Group on discrimination against women and girls' for this opportunity to highlight the impact of crises on the realisation of sexual and reproductive health and rights (SRHR), and to acknowledge actions taken by States to limit the negative impact of crises on these rights.

This submission will focus on MSI's experiences during the COVID-19 crisis, providing examples from our programmes in multiple countries, informed by our service data and the results of a recently commissioned Ipsos MORI survey. This survey asked 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.

The submission focusses on question 4 of the questionnaire on challenges and good practices on ensuring access to contraception and safe abortion services, question 6 on the impact of crises on SRHR, and question 7 on lessons learned.

Challenges – Question 4 (F and G)

Across our 37 country programmes, we have seen the impact of COVID-19 on SRH access and rights. With national lockdowns restricting movement, a lack of information about what services are available, and overwhelmed health systems diverting resources to the COVID-19 response, access to SRHR, including contraception, safe abortion and post-abortion care has been restricted and barriers have increased.

Restrictions on Movement

Quarantines, self-isolation rules, school closures which impact caring responsibilities, travel bans, borders closing, and reduction in availability of public services, all make it more difficult for both providers and clients to travel to deliver or receive safe abortion and contraceptive care, impacting people's SRHR. For example:

- **In Myanmar**, travel restrictions within the country have meant that our mobile outreach teams, which serve rural and marginalised communities with little or no other access to SRH services, have been unable to operate at their regular capacity. Travel restrictions have also prevented the delivery of reproductive commodities to service delivery sites, affecting the teams' ability to offer a full range of options to clients.
- **In Nepal**, strict lockdowns restricting movement affected the ability of clients and providers to access or deliver SRH services and put stresses on supply chains for reproductive commodities. The Government has since taken action to address these issues, declaring contraception, safe abortion and post-abortion care services as essential health services.
- **In Pakistan**, while centres and pharmacies are still able to provide services at a reduced rate, outreach teams serving rural and marginalised communities have been suspended due to the lockdown.
- **In Zambia**, the Government declared that mobile outreach teams providing contraceptive services to rural and marginalised communities were not essential, restricting access to SRH services for these communities during the pandemic.
- **In India**, the country went into a strict lockdown and did not declare SRH services as essential, causing our programmes to shut down. As the largest provider of contraceptive services outside of the public sector, our inability to offer services has had a substantial impact for hundreds of thousands, especially for people living in hard-to-reach locations or those from marginalised groups. After negotiation with the Government, some of our services have been re-initiated.

In the Ipsos MORI survey of women in India, we found that almost a third of women (31%) who were seeking a contraceptive service or product during the pandemic were unable to leave home to attend the service due to fear of COVID-19 infection, while 18% couldn't leave home because they needed to self-isolate, 18% because they had no means of transportation, and 15% because of caring responsibilities at home. These same restrictions were reported for those seeking abortion services, at slightly higher rates, and almost a third of respondents (30%) seeking an abortion reported that the clinic in their area was closed.

We gathered the experiences of providers, policy makers and clients on the frontline of the pandemic via a short survey on our digital resource hub on safe abortion, [SafeAccess](#). 95% of respondents to this survey shared that their abortion services had been affected directly by the pandemic, primarily due to roadblocks and restrictions on travel.

A lack of information or knowledge on what services are still available

A perceived reduced availability of abortion services has also been a barrier to access. For example, 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 abortion services from a clinic decreased from 61% to 44%.

Increased risk of sexual and gender-based violence

During crises, we know that rates of sexual violence can increase, with early reports suggesting a 30-60% rise in domestic violence in countries with COVID-related lockdowns.¹ 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.² 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.

Strained health systems

A shortage of health care providers and increased waiting times for procedures not related to COVID-19 can make it harder for individuals to access care, particularly in public facilities. In tandem, emergency reproductive and maternal health services are affected by over-stretched facilities and staff. A third (30%) of our respondents in India who sought a safe abortion service during the pandemic reported that the wait time for an appointment was 1–2 weeks and 9% reported a wait-time of more than 5 weeks.

There is also a remaining risk of diversion of funds from critical SRHR programmes due to competing government and donor priorities - this occurred during the 2014-2016 Ebola crisis in West Africa, leading to a 75% increase in maternal mortality in three of the affected countries.³

Good Practices – Question 4 (F and G)

Our providers along with other health professionals in the public and private sector have worked tirelessly to adapt and innovate so that services can stay open safely. From the use of effective personal protective equipment (PPE), to social distancing with clients, leveraging of government partnerships and a shift to remote service delivery models, our programmes have worked hard to protect access. A few key good practices which we would recommend be replicated:

Designating SRHR services as essential

Across many of MSI's country programmes, we have advocated with partners to ensure that contraception, safe abortion and post-abortion care are defined by governments as 'essential services' and available in the basic package of services. Countries that have designated SRHR services as essential, or have provided explicit permission for MSI and other SRH service providers to continue operations include (but are not limited to): Afghanistan, Burkina Faso, DRC, Ethiopia, Madagascar, Mali, Nepal, Nigeria, Papua New Guinea, South Africa and Zimbabwe. The Government of Australia also declared abortion care an essential service but did not include contraceptives or other SRH services under this categorisation.

¹ Pathfinder International, Technical Guidance: Gender-Based Violence during COVID-19, June 2020. Available at: <https://www.pathfinder.org/wp-content/uploads/2020/07/Technical-Guidance-GBV-and-COVID-19-1.pdf>

² Marie Stopes International, Marie Stopes UK sees a 33% rise in domestic violence reports under COVID-19 lockdown, June 2020. Available at: <https://www.mariestopes.org/news/2020/6/marie-stopes-uk-sees-a-33-rise-in-domestic-violence-reports-under-covid-19-lockdown/>

³ Wenham, C., Smith, J. and Morgan, R., 2020. COVID-19: the gendered impacts of the outbreak. *The Lancet*, 395(10227), pp.846-848; Davies & Bennett, "A Gendered Human Rights Analysis," International Affairs. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7124625/>

Integrating SRHR services with other essential or pandemic-related activities

Declaring SRHR as essential has been vital to maintain access, but it is not always enough. This message needs to be communicated and understood by local government and law enforcement officials, including police operating roadblocks. Our programmes in Zimbabwe and Madagascar have reported that despite central government support for continued SRH services during lockdowns, local authorities or police have prevented providers or clients to travel to some service delivery sites, severely limiting access to SRHR in those communities.

MSI has found that by doubling up with other essential services, such as immunisation, food delivery programmes or COVID-related activities, programmes can continue to deliver SRHR services, whilst maximising health system resources. In Zimbabwe, for example, MSI's programme integrated family planning into the local immunisation programme, ensuring rural women could still access services.

Where feasible, implementing telemedicine programmes

MSI programmes and partners have worked closely with governments to remove unnecessary policy barriers and pilot innovative ways to provide services. For example, in the UK after national regulations were changed,⁴ we launched a telemedicine service in April,⁵ enabling women to receive tele-consultations and self-administer medical abortion drugs at home. Telemedicine can prevent time-sensitive procedures from being delayed and reduces the risk of COVID-19 exposure for clients. It has also been proven to be as safe as medical abortion administered at a facility.⁶ Feedback from our programme, which has provided over 7,000 women with medical abortions via telemedicine since April, shows that it is well received by both clients and providers, with 98% of clients rating their experience as good (14%) or very good (84%). Our programmes in South Africa, Kenya, Nepal and India are also working with government partners to remove policy restrictions and scale up or initiate new telemedicine programmes in response to COVID-19.

Remote provision of services is one example of how the COVID-19 response is catalysing positive change in how healthcare is provided. For example, our Ipsos MORI survey found that around half of all women (48%) 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). However, telemedicine is not a panacea. It is not always suitable for low resource settings where internet or phone access is limited, for people who are looking for a long-acting form of contraception to be fitted, are seeking an abortion at later stages of pregnancy or 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.

Bringing services to women and girls

As noted above, with multiple restrictions on mobility many women have been unable to reach facilities. To overcome this barrier, providers can adapt their service delivery models to bring services directly to women and girls in their homes. For example, in Madagascar, travel restrictions

⁴ UK Department of Health and Social Care, Temporary approval of home use for both stages of early medical abortion, March 2020.

Available at: <https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion--2>

⁵ Marie Stopes UK, At Home Abortion Pills – Telemedicine. Available at: <https://www.mariestopes.org.uk/abortion-services/online-medical-abortion/>

⁶ Ender, M et al. Telemedicine for medical abortion: a systematic review, March 2019. Available at: <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15684>

meant women were unable to travel to clinics, 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. We also worked with the government in Ethiopia to initiate a pilot programme allowing nurses to provide medical abortion to clients in their homes in the city of Addis Ababa.

Ensuring women and girls know that safe services are open and available to them

Our Ipsos MORI surveys reflected a global trend of lack of information and awareness of service availability during the COVID-19 pandemic, so a key priority is to ensure that women are aware of the safe services available and their right to access them. Using existing contact centres is one way of doing this. At MSI, our network of contact centres across 28 countries have played a key role, with over 300 call agents providing free sexual health advice and service referrals over the phone, WhatsApp and social media. Between March and April 2020, our contact centres saw a 50% increase in clients interacting via social media messages, and in Ghana calls requesting information more than tripled under lockdown, implying that having discreet ways to access information on SRHR is particularly important during the pandemic, when young women might be stuck at home with parents, or with abusive partners. Ensuring that providers and contact centre agents are trained on safeguarding and referral pathways can also ensure that clients facing sexual and gender-based violence under lockdown are being supported, safely.

Impacts of the Crisis (Question 6)

MSI's service delivery data shows that the impact of COVID-19 on women's access to reproductive health services has not been as grave as initially expected. However, due to COVID-related disruptions, **1.9 million fewer women** have been served by MSI's programmes than originally forecast for January – June of 2020. We estimate that this will lead to:

- 1.5 million additional unsafe abortions
- 900,000 additional unintended pregnancies
- 3,100 additional maternal deaths.⁷

Importantly, the impact has varied hugely by country, with MSI's countries in Asia facing the greatest impact. Our programmes in India have faced a particularly strict lockdown, resulting in 1.3 million fewer women served than forecast, with 920,000 fewer safe abortion and post-abortion care services being delivered. Due to this drop in MSI's services, it is estimated that there will be an additional 1 million unsafe abortions, an additional 650,000 unintended pregnancies and 2,600 maternal deaths in India alone.

⁷ These figures have been calculated using MSI's Impact 2 tool. This is an innovative socio-demographic mathematical model that allows us to estimate the impact of our work, and the wider social and economic benefits of offering access to contraception and safe abortion. The tool is available for download, along with more information about its methodology and how to use it from the Marie Stopes International website: <https://www.mariestopes.org/what-we-do/our-approach/our-technical-expertise/impact-2/#:-:text=An%20innovative%20tool%20for%20measuring%20the%20impact%20of%20reproductive%20health%20programmes.&text=We%20believe%20that%20we%20should,of%20work%20that%20we%20do.>

Lessons Learned (Question 7)

In many countries the worst effects of COVID-19 are yet to come, with a second wave on the horizon in several settings. The economic impact of COVID-19 in the global north is also likely to present funding challenges for healthcare programmes globally.

Our experience shows that there are cost effective and simple solutions that when implemented can save lives and maintain access. We therefore continue to urge governments, donors and the global community to work together to prioritise access to sexual and reproductive healthcare services in their COVID-19 response, to collaborate with service providers to ensure the regulatory landscape supports safe access and to learn from the impact we have seen on access under the pandemic so far, to ensure women have timely access to essential services when needed most.

Our key recommendations based on our experience in this pandemic so far are to:

- Call on donors and partners to maintain their support and funding for SRHR and to remain flexible so that programmes can adapt swiftly and ensure services reach where they are most needed
- Define safe abortion and contraception as ‘essential services’ and include them in the basic package of services available, ensuring this is rolled out and communicated to all stakeholders particularly at sub-national level (e.g. including service providers on sub-national COVID-19 committees to ensure SRHR is included in the COVID-19 response at community level; ensuring providers can travel)
- Implement the WHO Guidance on ‘Maintaining essential health services: operational guidance for the COVID-19 context’,⁸ ensuring that adequate resourcing is allocated for implementation.
- Remove unnecessary barriers and delays to SRHR access, for example, through implementing the use of telemedicine and removing the need for prescriptions and multiple doctor signoffs.

⁸ World Health Organization, Maintaining essential health services: operational guidance for the COVID-19 context, June 2020. Available at: <https://www.who.int/publications/i/item/10665-332240>