INTERNAL DOCUMENT

SAFEGUARDING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS DURING THE COVID-19 CRISIS: KEY ADVOCACY MESSAGES FOR MDM

This document is aimed primarily at MdM field teams, whether or not the activities they are engaged in are related to sexual and reproductive health and rights (SRHR). It was compiled on the basis of observations from the missions in Burkina Faso, Côte d'Ivoire and Madagascar, as well as international recommendations..

>> Key source: SRH and COVID-19 Protocol, available in the internal MdM Sharepoint dedicated to Covid-19

'This new data shows the catastrophic impact that COVID-19 could soon have on women and girls globally. The pandemic is deepening inequalities and millions more women and girls now risk losing the ability to plan their families and protect their bodies and their health.'
Dr. Natalia Kanem, Executive Director of UNFPA

1. COVID-19: SIGNIFICANTLY INCREASED IMPACT ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

Crisis situations of any kind destabilise healthcare systems. They disrupt community protection mechanisms by causing population displacements and isolating people and they exacerbate the gender inequalities and socio-economic vulnerabilities experienced by women. Lockdown and movement restrictions increase the risk of domestic and gender-based violence. They keep women away from health centres and make it more difficult for them to exercise their **rights** and to access **sexual and reproductive health** services and supplies.

The epidemics of recent years, particularly in Africa, have had a significant impact on women's sexual and reproductive health and rights. For example, Ebola (in 2013) led to a drastic fall in the number of women using family planning (up to 75% in some parts of Guinea). During the same epidemic Sierra Leone recorded as many maternal deaths as deaths linked to Ebola .
It is therefore feared that the COVID-19 health crisis will have a major impact on the sexual and reproductive health and rights of women – and especially young women – all over the world.

ANTICIPATED EFFECTS OF COVID-19 ON ACCESS TO SRHR

15 MILLION UNINTENDED PREGNANCIES

Use of short and long-acting contraceptive methods will decline by 10% in low and middle-income countries as a result of reduced access and lead to 15 million additional unintended pregnancies over the course of a year.[2]

49 MILLION WOMEN WITH AN UNMET NEED FOR MODERN CONTRACEPTIVES

use of short and long-acting contraceptive methods will decline by 10% in low and middle-income countries and lead to 49 million additional women with an unmet need for modern contraceptives.[2]

15 MILLION EXTRA CASES OF GENDER-BASED VIOLENCE

For every three months the lockdown continues, there could be 15 million extra cases of gender-based violence.[3]

2,7 MILLION UNSAFE ABORTIONS

the loss of services due to COVID-19 could lead to 3 million additional unintended pregnancies and 2.7 million unsafe abortions.[4]

11 000 DEATHS

the loss of services due to COVID-19 could lead to more than 11,000 pregnancy-related deaths.[4]

SIGNIFICANT REDUCTIONS TO PLANNED PARENTHOOD

On 9 April, the International Planned Parenthood Foundation (IPPF), warned that it had already seen significant reductions to its services. [5]

2. WHAT TO ASK OF GOVERNMENTS?

THE NEED FOR A POLITICAL VOICE ON SRHR

Crisis situations lead to a rapid erosion of sexual and reproductive health and rights. Particular vigilance is required due to the risks of sexual violence, unintended pregnancy, lack of antenatal care and unassisted births. In addition, attention must be paid to women in vulnerable situations who already have limited access to information, prevention and care and are more likely to be exposed to violence. As we seek to make sure access to and availability of essential SRHR services are maintained within our programmes, it is essential **to ensure that the governments of the countries in which we work do the same.**

Reallocation of financial and human resources to the COVID-19 response

Deprioritisation of SRHR =
- Closure of health centres / reorientation of activities
- Women are afraid to attend centres and/or staff are afraid of being infected
-Disruption to supplies of drugs and other items

- Unmet contraceptive needs (incl. emergency contraception)
- Disruption to antenatal care

- Significant increase in unintended pregnancies
Non-existent or inadequate perinatal care
- Inadequate care and treatment of conditions that can affect pregnant women

- Increase in the number of unsafe abortions
- Unidentified high-risk pregnancies;
- Increase in HIV infections

Increase in maternal and neonatal morbidity and mortality

OUR MAIN RECOMMENDATIONS ARE AS FOLLOWS.

➡ **Implement the recommendations of the Minimum Initial Service Package (MISP)**[6], especially the emergency contraception and safe abortion care components, and also the response to sexual violence. The MISP comprises a coordinated set of priority activities together with guidelines for implementing them.

The MISP[7] for sexual and reproductive health is a set of priority activities to be implemented from the onset of a crisis. It is a recognised international standard which defines the essential sexual and reproductive health services which enable continuity of care to be assured. This includes perinatal care for all deliveries, emergency obstetric and neonatal care, post-abortion care, safe abortion services within the limits established by law, contraception, clinical care for survivors of gender-based violence and prevention and treatment of HIV and other STIs.

➡ **Include family planning and reproductive health as essential services in contingency planning and the response to the COVID-19 pandemic.** In new guidelines drawn up to help countries maintain essential health services during the COVID-19 pandemic, the WHO[8] defines 'reproductive health services' as one of the seven essential services for which governments should produce continuity plans. In particular, family planning services (including emergency contraception and post-abortion care) and supply chains should be maintained for people of all ages. It is essential to plan and manage how uninterrupted supplies of contraceptives are to be maintained. Ensure adequate stocks NOW to reduce shortages and enhance monitoring of contraceptive use to identify any shortages that may arise. Consider moving stocks around between healthcare facilities or sharing stock between districts.

➡ **Adapt policies, technical guidelines and service delivery models to ensure access to sexual and reproductive health and rights during the crisis.** This recommendation should be implemented while ensuring the safety of patients and staff regarding cross-contamination. Encourage healthcare establishments, pharmacies and community health workers to have additional short-acting contraceptives in stock (pills, condoms and injections); anticipate provision of several months' supply to help clients reduce the number of visits they make to healthcare facilities. Distribute emergency contraception in advance (WHO recommendation). Continuity of services can be ensured by alternative means: telehealth[9], digital health and provision of family planning supplies and services at locations other than healthcare facilities (pharmacies and drugstores, with community health workers, home delivery, etc.). Access to contraception (and especially emergency contraception) should be made possible without prescriptions or with out-of-date prescriptions. The pandemic won't stop unsafe abortions: reduce administrative and legal barriers to access to post-abortion care and safe abortion services. Run media campaigns (radio and social media) to communicate messages about the provision of family planning methods during the epidemic, etc. Lobby health decision makers to ensure that healthcare facilities specialising in SRH are appropriately equipped for infection prevention and control[10].

➡ **Gender inequalities and gender-based violence** should be taken into account in the response to the crisis by establishing / maintaining prevention and protection mechanisms which have been adapted to the situation.

3. WHERE SHOULD THESE MESSAGES BE COMMUNICATED?

Everywhere. The aim is that Médecins du Monde should take the opportunity whenever possible (crisis response meetings, cluster meetings – health-related but also humanitarian) to point out that crises take a heavier toll on women and that sexual and reproductive health and rights are the first areas to feel the impact; that the consequences in terms of maternal and neonatal mortality may be substantial; and that simple measures can be put in place to avoid these impacts.

Depending on the context and who they are speaking to, these messages can be communicated by anyone who is in contact with the authorities:

- As part of every public statement made by MdM – in the field, in France or at the international level
- Within the framework of platforms for advocacy on SRHR, family planning etc.
- During meetings with the Ministry of Health and its technical services for responding to the crisis
- During meetings of all clusters and humanitarian platforms
- In communication with civil society representatives (CSOs, INGOs etc.)

Focus on measures that facilitate access to family planning and reduce unintended pregnancies:

Make all methods of contraception free for all women, regardless of age;

Provide healthcare staff (midwives) and community workers with masks, hydroalcoholic gel etc. so that they can respond to contraception needs and distribute and explain how to use emergency contraception;

Systematically include condoms when supplies of masks and hydroalcoholic gel etc. are being distributed;

Allow community-based distribution of contraceptives to continue and incorporate the MISP (especially Kits 1-5);

Allow old prescriptions to be used to facilitate access to contraception;

Maintain the minimum level of SRH staff necessary to ensure sexual and reproductive healthcare resource centres can function effectively; ensure these staff members are trained in COVID-19 prevention measures; within the triage systems of these centres, ensure training and the establishment of specific COVID-19 pre-triage systems for suspected cases; and ensure maximum protection for these healthcare professionals (PPE etc.).

1. Sochas L, Channon AA and Nam S, Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone, *Health Policy and Planning*, 2017, 32(Suppl. 3):iii32–iii39, http://dx.doi.org/10.1093/heapol/czx108.
2. **Institut Guttmacher** Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health
3. **UNFPA** www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues
4. Source: **MSI (Marie Stopes International)**, a major provider of contraception and safe abortion services
5. www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world
6. IAWG has made available a range of key operational and advocacy resources on SRHR / COVID.
7. See here for an information sheet on MISP: https://cdn.iawg.rygn.io/documents/MISP-Reference-English.pdf?mtime=20200322131753&focal=none#asset:26025
8. https://www.who.int/reproductivehealth/publications/emergencies/COVID-19-SRH/en/
9. Including SMS text messages, WhatsApp and telephone appointments.
10. See MdM SOP infection and control protocol and position on masks.

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