IPPF International Planned Parenthood Federation

IPPF ADVOCACY KEY MESSAGES: SRHR and COVID-19

A. *Why SRHR matters in the response to COVID-19*

The novel coronavirus was first identified in December 2019 in Wuhan City, China and the outbreak of new coronavirus disease (COVID-19) was declared a pandemic by WHO on 11 March 2020. Since then, the number of cases of COVID-19 has risen exponentially throughout the world. The global increase in confirmed cases and reported deaths from COVID-19 led many countries to take stern measures to curb further spread of the disease. The COVID-19 pandemic and its consequences are negatively affecting the availability of and access to basic needs and services, including sexual and reproductive health (SRH) services. Many IPPF Member Associations (MAs) and other SRH organizations are faced with the difficult decisions to reduce, reorganize or close SRH services to protect service providers and clients; and/or called upon to support governments' responses to the pandemic to ensure that sexual and reproductive health and rights (SRHR) needs are addressed.

As many studies and research have demonstrated throughout the years, access to SRH services, information and commodities, including those related to contraception and menstrual health, cannot be separated from women and girls' rights, health, empowerment, and human dignity. Taking into account supply chain and logistical challenges to respond to the COVID-19 pandemic, the potential shortage of these commodities will disproportionately affect women and girls and underserved or marginalized groups. The impact of COVID-19 is unique as it is likely to increase SRHR-related needs for communities in lockdown and see increases in sexual and gender-based violence (SGBV), unmet needs for contraception, restricted access to safe and comprehensive abortion care, compromised SRH services, and a lack of comprehensive sexuality education (CSE). Furthermore, it is exacerbating already existing inequalities for women and girls, and for groups already marginalized and experiencing discrimination, including refugees, migrants, minority groups and people living with disabilities, members of the LGBTQI+ community, and those living in conditions of extreme poverty.

In these unprecedented and uncertain times, it is critical to ensure that SRHR remains an integral part of essential health services, that opportunities to improve policy /guideline frameworks for reduced barriers to SRHR are identified, and that governments ensure gender and human rights-based approaches to tackling the pandemic. This is especially needed in a context of shrinking space for civil society defending the human rights of underserved and marginalised population groups. Also, a gender lens is critical in any interventions and responses to the pandemic, whilst also acknowledging and recognizing the needs and rights of women and girls, and vulnerable people, including the elderly, adolescents and young people, people living with disabilities, members of the LGBTQI+ community, minority groups, migrants and refugees.

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B. *IPPF Key asks for the response to COVID-19*

IMPORTANT NOTE*: These are a set of general Asks, whose purpose is to identify key priority areas that are fundamental to ensure that human rights, gender equality and SRHR for all people throughout the world are not neglected in the fight against and in the aftermath of the COVID-19 pandemic. They are not meant to constitute a comprehensive set of recommendations and advocacy messages;* ***it is important that they are adapted to each national context or made more specific or complemented depending on the target audience or specific political processes being addressed.***

I. Key principles	***Upholding a human rights-based approach***	***Ask 1:*** *Governments should ensure a human rights-based approach in their response, specifically in relation to the provision of SRH services and the protection and respect for civil liberties.*
	Applying a gender lens to the COVID-19 response	***Ask 2:*** *Governments should use an intersectional and gender-responsive approach to address the impact of the COVID-19 crisis on women, adolescents and girls, as well as addressing the needs of women health workers.*
	Ensuring the meaningful engagement of civil society actors	***Ask 3:*** *Governments and donors must continue to support activists and civil society organisations (CSOs), who play a key role in realizing and defending SRHR and human rights for all.*
II. Fulfill Sexual and Reproductive Health and Rights	***Ensuring access to SRH services and information***	***Ask 4:*** *Governments should ensure access to essential SRH services and information, including Comprehensive Sexuality Education (CSE), during the response to the pandemic and in its aftermath.*
	Ensuring access to safe and comprehensive abortion care	***Ask 5:*** *Governments should ensure access to safe and comprehensive abortion care, including self-managed medical abortion as part of health policy, ensuring that commodities on the Essential Medicines list are available and of quality, and that women have access to quality information either digitally or through community health providers.*
	Supporting SGBV victims and survivors	***Ask 6:*** *Governments should ensure that services and resources are available and accessible for victims and/or survivors of sexual and gender-based violence (SGBV) while ensuring that SGBV services are included in the 'essential services' category, such as food, hygiene and health services*
III. Strengthen systems and resources	***Supporting the continued provision of resources for SRHR, including commodities and supplies***	***Ask 7:*** *Governments and donors should urgently mobilize and ensure adequate resources for SRHR, including specifically for the provision of essential SRH commodities and supplies.*
	Strengthening data collection and response systems	***Ask 8:*** *Governments should ensure that gender-related indicators are included in country -level response systems and that robust data disaggregated by sex and age are routinely collected.*
	Upholding commitments to UHC	***Ask 9:*** *Governments, donors and civil society should work in partnership to ensure that commitments to universal health coverage (UHC) are upheld, hence contributing to strengthening health systems with adequate resources for SRHR during the response to COVID-19 and to mitigate the impact of future outbreaks.*

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I. KEY PRINCIPLES

Upholding a human rights-based approach

Ask 1: Governments should ensure a human rights-based approach in their response, specifically in relation to the provision of SRH services and the protection and respect for civil liberties.

Rationale: The right to the highest attainable standard of physical and mental health for all must be respected, protected and fulfilled, regardless of wealth, gender, colour, race, sexual orientation, gender identity, HIV status, marital status, migration status or any other ground. Governments and implementation partners must define and implement people-centred programs grounded on a human rights-based approach which is gender transformative and youth centred.

Many governments have taken emergency measures restricting human rights and fundamental freedoms to respond to previous public health crises. Whilst many of these measures are legitimate, governments must ensure that all measures are strictly necessary, proportionate, with a definitive end date, and subject to scrutiny. Any instrumentalization of the crisis by governments in order to reinforce their authoritarian power, weaken democracy, or limit human rights for other purposes than public health, in particular those of the most marginalized, is unacceptable. This includes the imposition of abusive digital surveillance, police violence, and new powers of sentencing for ill-defined crimes relating to the state of emergency.

As the UN Secretary-General's Call to Action[1] outlines, the following measures need to be put in place to ensure that the principles of human rights, non-discrimination and inclusion are upheld, namely by 1) ensuring that access to testing or treatment is not denied due to discrimination, whether on grounds of gender, age, religion, sexual orientation, ethnicity, race or otherwise; 2) monitoring and swiftly responding to and publicizing incidents of discrimination and xenophobia; 3) disseminating accurate and evidence-based information and conducting awareness-raising campaigns as well as providing clear and timely information to reach everyone, in particular national, ethnic or religious minorities, indigenous peoples, persons living with disabilities or members of the LGBTQI+ community.

Applying a gender lens to the COVID-19 response

Ask 2: Governments should use an intersectional and gender-responsive approach to address the impact of the COVID-19 crisis on women, adolescents and girls, as well as addressing the needs of women health workers.

Rationale: As the previous pandemics demonstrated, women and girls are affected and experience outbreaks differently, in part due to patriarchal norms, traditional gender roles and deep-rooted inequalities. Applying a gender lens and ensuring women's participation in the decision making processes are critical in the response to the current pandemic, acknowledging and recognizing the needs and rights of women and girls, and vulnerable people, including the elderly, adolescents and young people, people living with disabilities, members from the LGBTQI+ community, minority groups, migrants and refugees.

[1] United Nations Secretary-General report entitled 'Shared responsibility, global solidarity: Responding to the socio-economic impacts of COVID-19', March 2020.

In addition, women globally spend 2.5 times more time on unpaid care and domestic work as men,[2] and they are more likely than men to face additional caregiving responsibilities, when schools close, in addition to domestic chores. Women are also typically expected to care for their sick relatives, further exposing them to the risk of contracting COVID-19. This expected role of caregiver makes it harder for women to maintain paid employment, exposing them and their families to the risk of economic hardship.

Women's representation in the health sector has increased over time; they represent 70%[3] of the primary healthcare workforce globally and are in the front lines responding to the COVID-19 crisis. Responses to the current pandemic need to be mindful of the gendered nature of the health workforce. Data from the State Council Information Office in China showed that more than half of the doctors and 90% of the nurses in Hubei Province are women.[4] In the African region, female workers make up the majority (65%) of the nursing workforce.[5] In the US, women represent 78% of the workforce in the healthcare sector[6] and 84.5% of the nurses in Spain.[7] According to the WHO Regional Office for Europe, the salaries of nurses and midwives are still below the national salary average in many European countries. Also, nurses are paid less than employees in comparable public services that are more male dominated.[8]

As the Secretary-General's Call to Action indicates, governments must ensure gender expertise in national, regional and global level response teams and task forces. Additionally, social protection plans and emergency economic schemes must take a gender perspective and take into account unpaid care provided by women, specific constraints for women entrepreneurs and women in the informal sector.

Ensuring the meaningful engagement of civil society actors

Ask 3*: *Governments and donors must continue to support activists and civil society organisations (CSOs), who play a key role in realizing and defending SRHR and human rights.

Rationale: Activists and civil society organisations (CSOs), including women's rights organisations, shelters for victims of domestic violence, SRHR organisations, play a key role in realizing human rights for all, both as service-providers and as watchdogs. As part of their response to the crisis, it is crucial that governments maintain an enabling environment for activists and CSOs, including sufficient level of funding for civic action and solidarity, so that their activities can continue during and after the crisis. As quite often CSOs serve the most marginalised and vulnerable groups, they have a key role to play in community outreach, services delivery and advocacy, when it comes to SRHR. Therefore, it is critical that CSOs are fully and meaningfully involved into existing and new formal platforms of engagement (such as Government-led technical working groups, tasks forces, response committees, advisory and oversight groups, etc.). In many settings, the meaningful participation of CSOs will require identifying new ways of engagement with civil society representatives – requiring adequate resources and political will. Through making funding available and accessible to them, donors should prioritise support for CSOs, local women rights and SRHR organisations, which have

[2] ILO, World Employment and Social Outlook: Trends for women 2017 (Geneva, 2017). Available at: http://www.ilo.org/global/research/global-reports/weso/trends-for-women2017/lang--en/index.htm
[3] Boniol M et al. (March 2020). Gender equity in the health workforce: Analysis of 104 countries. WHO. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?sequence=1&isAllowed=y
[4] Yiquing W. (10 March 2020). Women's Day awakening to the needs of frontline female staff. China Daily. https://global.chinadaily.com.cn/a/202003/10/WS5e66cfb6a31012821727da1f.htm
[5] Boniol M et al., *id.*
[6] Miller C. (21 January 2020). Women's Gains in the WorkForce Conceal a Problem The New York Times. https://www.nytimes.com/2020/01/21/upshot/womens-gains-in-the-work-force-conceal-a-problem.html
[7] Redacción Médica (8 March 2020). Radiografía del papel de la mujer en la sanidad española https://www.redaccionmedica.com/secciones/sanidad-hoy/radiografia-del-papel-de-la-mujer-en-la-sanidad-espanola-1050
[8] WHO. Data and Statistics. Retrieved from: http://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/data-and-statistics

extensive experience and reach in delivering services to communities and to those who are often excluded from public health interventions, and in representing the voice of these communities in decision-making processes.

II. FULFILLING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Ensuring access to SRH services and information

Ask 4: Governments should ensure access to essential SRH services and information, including CSE, during the response to the pandemic and in its aftermath.

Rationale: The COVID-19 pandemic, its consequences and the restrictive measures that have been put in place by many countries to contain the spread of the disease, have the potential to negatively affect access to essential SRH services, including information and counselling on SRHR and comprehensive sexuality education (CSE); contraception services, safe abortion services, maternal and newborn health services, services for gender-based violence, STIs/HIV, infertility and reproductive cancers, which could result in increased risk of unintended pregnancy, unsafe abortion and possible complications of pregnancy and childbirth, and maternal and new-born morbidity and mortality.[9]

As the pandemic takes hold, it is clear that critical SRH services are being scaled down and essential services are being compromised. In a survey conducted by IPPF among its Member Associations (MAs), it was found that 92 of the 104 MAs who are providing services **(88%) reported having to scale down the availability of services** either by decreased hours, number of sites or providers working – **Asia-Pacific, Africa and Latin America and Caribbean are the key regions affected**. Among IPPF MAs, the main services that have been scaled down include: HIV testing services (44 MAs); contraceptive services (41 MAs); SGBV services (36 MAs) and safe abortion care (23 MAs). While most of this is likely to be a function of decreased hours and sites, we are also beginning to see a worrying decrease in the numbers of trained staff able to continue working and with the values to provide rights based SRH services. MAs have documented loss of staff across all skills and expertise, including skilled staff specialised in the provision of SRH services, especially those with the soft skills to provide services to youth and adolescents or deliver comprehensive abortion care and sexual and gender-based violence (SGBV) care. The loss of this expertise poses a significant risk to ensure the continued provision of both short and long-term and sustainable care and can be an expensive effort to regain. In addition, we are seeing a significant decrease in the capacity to provide community-based services and community outreach activities. Those who are most marginalised, including those from remote and rural communities, adolescents and the elderly, risk not being able to access critical SRH information and services. For example, twelve IPPF MAs have already reported having to suspend and furlough staff as a result of COVID-19. Others have already taken bold actions to tackle the crisis: thirteen IPPF MAs (five from Africa, two in each of the Arab World, Latin America and the Caribbean and South Asia regions, and 1 in each of the Europe and East Asia and Pacific regions) have dedicated health facility space to test or manage COVID-19 patients as part of the national response. In some cases, MAs assume additional functions - for instance in the Philippines where the IPPF MA (FPOP) functions as a temporary regional HIV hub to free up government health facilities as dedicated COVID-19 treatment centres.

[9] IPPF (2020) IMAP Statement on COVID-19 - Sexual and Reproductive Health and Rights.

In this regard, Governments should promote and adopt innovative approaches which will also assist in decongesting health services, such as: digital health (telemedicine, mobile apps, information through SMS, etc.) for counselling, to deliver sexual health information and sexuality education and for follow-up; selfcare; providing counselling and selected SRH services outside the clinic setting (e.g. alternate contraceptive/ abortion options from provider induced to self-managed), including through community-based providers; mailing as well as doorstep distribution of contraceptives, medical abortion and other essential SRH products where appropriate.

Additionally, as resources are being reallocated, Governments need to ensure that all women and girls have access to quality and affordable maternal health care, including antenatal care, normal labour care where possible, post-partum and post-natal care, as well as addressing complications of pregnancy and childbirth without discrimination of any kind, such as race, ethnicity, migrant or refugee status. In this regard, the rights and access to quality health services for pregnant women and newborn children must be protected, respected and fulfilled.

Ensuring access to safe and comprehensive abortion care

Ask 5: Governments should ensure access to safe and comprehensive abortion care, including self-managed medical abortion as part of health policy, ensuring that commodities on the Essential Medicines list are available and of quality, and that women have access to quality information either digitally or through community health providers.

Rationale: Abortion is an essential, time-sensitive, life-saving medical service. Restricted access to abortion care facilities or pharmacies that provide misoprostol during quarantine periods may lead to unsafe abortions, and increased mortality among women, especially SGBV survivors. Lack of access to safe and comprehensive abortion care and timely treatment can put the health and life of women and girls at risk. Therefore, governments must support the provision of safe abortion care, including through self-managed medical abortion up to 12 weeks, post--abortion- care as well as menstrual regulation. Whenever possible, digital health technologies should be used to support critical tasks, such as self-managed medical abortion, including counseling. To this end, Governments and healthcare institutions must also remove all legal and administrative barriers to access abortion care, including revoking criminal sanctions on abortion. For example, the U.K. and Irish governments are in the process of changing their regulations on abortion to allow for women to take abortion pills at home without having to travel to a clinic.

Furthermore, a pandemic cannot be used as an excuse to undermine women's rights to make decisions regarding their reproductive and health rights. The consequences of these measures will probably be evident in a peak of unintended pregnancies and in the use of illegal methods exposing pregnant women and girls and their families into legal and physical risks.

Supporting SGBV victims and/or survivors

Ask 6: Governments should ensure that services and resources are available and accessible for victims and survivors of sexual and gender-based violence (SGBV), while ensuring that SGBV services are included in the 'essential services' category, such as food, hygiene and health services.

Rationale: UNFPA and other authoritative sources have documented that pandemics may increase risks of abuse and exploitation of women and girls forcing them to be locked down with their perpetrators. Different forms on SGBV, including intimate partner violence, have shown to escalate due to heightened tensions in the household. For example, in China, an anti-domestic violence non-profit organisation of Hubei Province reported that intimate partner violence nearly doubled since cities were put under lockdown. The police station in Jianli County registered three times more cases of SGBV in February 2020 than in the same month in 2019. According to its founder, 90% of the SGBV cases were related to fear, anxiety, economic difficulties, and extended quarantine due to COVID-19. The lockdowns and delays in screening also affect the collection of data, which leads to decreased reporting and missed opportunities for identification and immediate intervention. It also means that medical services and support for SGBV survivors may be cut-off or deprioritised as a result of overburdened health systems that are focused on managing COVID-19 cases. Prevention of SGBV and provision of care and support services to women and girls who experience SGBV is essential and should be ensured during the COVID19 pandemic through a flexible and adaptive approach that protects the safety of both the service providers and the survivors.[10] Where it is not possible to provide these services directly, providers should give information about services available for survivors, including their opening hours and contact details and establish referral links.[11] Given the sensitivities around SGBV, health workers must ensure the safety, privacy and confidentiality of survivors, as they may not be able to continue case management.

A best practice of government action can be seen in Spain, where the Spanish Ministry of Equality launched a national plan acknowledging the exponential risks of SGBV, recognising the difficulties faced by SGBV survivors to seek help in confinement and therefore adapts services to prevent, address, and reduce these risks under the current circumstances. The services include, among other measures, emergency centres for the reception of SGBV survivors at risks, safe accommodation for SGBV survivors, a hotline for information and an emergency line to send alert messages with geolocation that will be received by the State Security Forces. It has also been announced that an instant chat-messaging system for containment and psychological assistance will be activated. Similarly, the Secretary-General in his latest Call to Action, requests States to ensure that special services are available to prevent and respond to gender-based violence, such as special hotlines, police units and new protocols for shelters.

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[10] IPPF (2020) COVID-19 and Sexual and Gender-Based Violence. Recommendations for IPPF Member Associations

[11] World Health Organization (2020) COVID-19 and violence against women: What the health sector/system can do.Available at: https://www.who.int/reproductivehealth/publications/emergencies/COVID-19-VAW-full-text.pdf

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III. STRENGTHEN SYSTEMS AND RESOURCES

Supporting the continued provision of resources for SRHR, including commodities and supplies

Ask 7: Governments and donors should urgently mobilize and ensure adequate resources for SRHR, including specifically for the provision of essential SRH commodities and supplies.

Rationale: The COVID-19 pandemic has resulted in a global supply chain crisis due to the increased demand for essential medical and health equipment and supplies, the increased nonevidence--based use of personal protective equipment (PPE), and the simultaneous lockdown of countries around the world. This situation is impacting production and distribution of medical health products. Export restrictions in China and India, where approximately 70% of active pharmaceutical ingredients (APIs) are manufactured and made into final products, are threatening the critical supply chain of essential health products and could result in its disruption over the next several months. Global shortages of PPE and essential SRH commodities and supplies have been documented in many countries. For instance, DKT International, one of the largest providers of family planning products in the world, reported that supply of raw material such as progesterone was impacted after China closed down some factories during the height of COVID-19 in the country. Likewise, DKT has also alerted about stock-outs of contraceptive implants in Myanmar, and shortages of condoms in Mozambique.[12]-

At the same time, due to the de-prioritization, disruption and decrease in the provision of SRH services as well as mobility restrictions and changes in health-seeking behaviour, the COVID-19 pandemic has strongly impacted access to SRHR, whereas SRH services are essential and can be lifesaving. In that regard, it is vital that donors do not redirect current funding, including through ODA, already allocated to SRHR to other sectors as part of the pandemic response. In addition to these commitments, donors should allocate new funding to SRHR specifically as part of their response to the crisis, to tackle the impact of the pandemic on SRHR and to ensure that every person has access to SRHR services.

As the UN Secretary-General's Call to Action on the response to the socio-economic impacts of COVID-19 points out *"Governments must ensure the continued delivery of sexual reproductive health services, such as access to contraceptives without prescription during the crisis*."[13]

Strengthening data collection and response systems

Ask 8: Governments should ensure that gender-related indicators are included in country -level response systems and that robust data disaggregated by sex and age are routinely collected.

Rationale: Response systems must be designed to provide timely information and analyses that will allow decision makers to assess the gender dimensions of the impact of COVID-19 at country level, including the ways in which women and girls, and underserved or marginalized groups, are disproportionately impacted by the outbreak (i.e. SGBV, loss of income, impact on health workforce, food insecurity, malnutrition, lack of access to information, limited access to SRH services).

[12] Purdy C. (2020) DEVEX publication Opinion: How will COVID-19 affect global access to contraceptives — and what can we do about it?

[13] United Nations Secretary-General report entitled 'Shared responsibility, global solidarity: Responding to the socio-economic impacts of COVID-19', March 2020.

Disaggregated data collection must be integrated into national efforts to monitor, trace and document the evolution and impact of the epidemic at national levels, as well as its overall footprint globally. Collecting sex and age disaggregated data is important for preparing and responding to the specific health needs of populations disproportionately affected, including on SRHR, further allowing for gender analyses that identify differential consequences of the pandemic between sex and across specific age groups, ensuring that the crisis does not disproportionately burden women and girls, as well as to understand the wider socio-economic impacts of this crisis. The UN Secretary-General, in his latest call to action, underscored the importance of collecting sex-disaggregated data to ensure that the crisis does not disproportionately burden women.

Upholding commitments to universal health coverage

Ask 9: Governments, donors and civil society should work in partnership to ensure that commitments to universal health coverage (UHC) are upheld, hence contributing to strengthening health systems with adequate resources for SRHR during the response to COVID-19 and to mitigate the impact of future outbreaks.

Rationale: The global crisis caused by the COVID-19 pandemic requires bold actions, leadership and coordination between international as well as local partners to ensure that health systems can continue to respond to populations needs. Upholding the commitments made to strengthen primary health care and health systems, including agreed intergovernmental commitments towards Universal Health Coverage, will be essential to respond to the current pandemic and minimise the impact of future health crises. Transparent and inclusive decision-making are key to ensure that the needs of women and girls, as well as underserved and marginalised groups, are met. It is crucial that Governments, parliamentarians, civil society, private sector, and other actors involved in health systems strengthening efforts, work in partnership to uphold and advance the commitments towards Universal Health Coverage, including strong political leadership, addressing health inequities, building quality and responsive health systems, and ensuring sufficient public spending on health and harmonize health investments.