RESILIENCE, ADAPTATION AND ACTION

MSI'S RESPONSE TO COVID-19

MARIE STOPES INTERNATIONAL
Children by choice, not chance

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"In many countries the worst effects of COVID-19 are yet to come and in others a second wave is on the horizon, but there is an opportunity to use this as a catalytic moment to transform services and make women's lives better tomorrow than they are today.

"It costs around 3 cents per day to protect a young woman from an unintended pregnancy for one year, giving her the chance to finish her education or even saving her life. We call on donors, partners and the global community to learn from the impact we have seen so far and maintain their support and funding for sexual and reproductive health to ensure that women have timely access to essential services, such as contraception and safe abortion both during the pandemic and beyond."

– Simon Cooke, MSI's Chief Executive

As COVID-19 continues to devastate lives and communities across the world, this briefing shares new data on the impact on access to sexual and reproductive health and rights (SRHR), combined with insights and learnings from our frontline providers who have been doing all they can to protect access to lifesaving services and ensure that we build back better.

THE IMPACT OF COVID-19 ON WOMEN'S LIVES AND REPRODUCTIVE HEALTH

Across our 37 country programmes, we have seen the impact on reproductive healthcare access and rights. With national lockdowns restricting movement, a lack of information about what services are available, supply chain disruptions, and overwhelmed health systems diverting resources to the COVID-19 response, access to SRHR, including contraception, safe abortion and post-abortion care[1] has been restricted and barriers have increased.

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

- **Perceived reduced availability of abortion services:** In the UK, 81% of women thought that abortion services were available from an abortion clinic before the pandemic, compared to just 21% thinking that this service was available during the COVID-19 pandemic. This appears to be a global trend of lack of information and awareness of service availability during the COVID-19 pandemic. In South Africa, only 43% of women surveyed thought that people could access an abortion service from a private abortion clinic during the pandemic, compared to 76% before the pandemic. Likewise, in India, perceived availability of abortion[2] services from a clinic decreased from 61% to 44%.
- **Need remains high:** 13% of respondents in India reported a need for abortion services during the pandemic. The need for contraceptive services and domestic abuse services is also high in India, with over 1 in 3 women (35%) reporting a need for contraceptive advice, service or products and 1 in 10 women (9%) reporting a need for domestic abuse services during the pandemic.
- **Increased barriers to access:** Almost a third of women in India (31%) and a quarter of women in South Africa (26%) who were seeking a contraceptive service or product were unable to leave home to attend the service due to fear of COVID-19 infection. Almost a third of respondents in India (30%) seeking an abortion[3] report that the clinic in their area was closed, a third (30%) also report that wait time for an appointment was 1–2 weeks and 9% report a wait-time of more than 5 weeks..

These findings align with our concerns around how women's reproductive health and rights would be impacted: That barriers to access would increase, for example, due to a lack of awareness of which services are available and when, fears around infection and heightened risks of sexual and gender-based violence.

With the aim of building a live picture of the impact on frontline services, we have 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** shared that their abortion services had been affected directly by the pandemic, primarily due to roadblocks and restrictions on travel.

[1] A life-saving service following an unsafe abortion
[2] In India, our survey referred to abortion as abortion/MTP (Medical Termination of Pregnancy)\
[3] 95 of the 1000 women surveyed in India were seeking an abortion during the COVID-19 pandemic.

Despite the challenges facing both providers and women directly, and thanks to the perseverance of our providers and the flexibility of governments and our partners, the story has also been one of resilience and adaptation. Our 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.

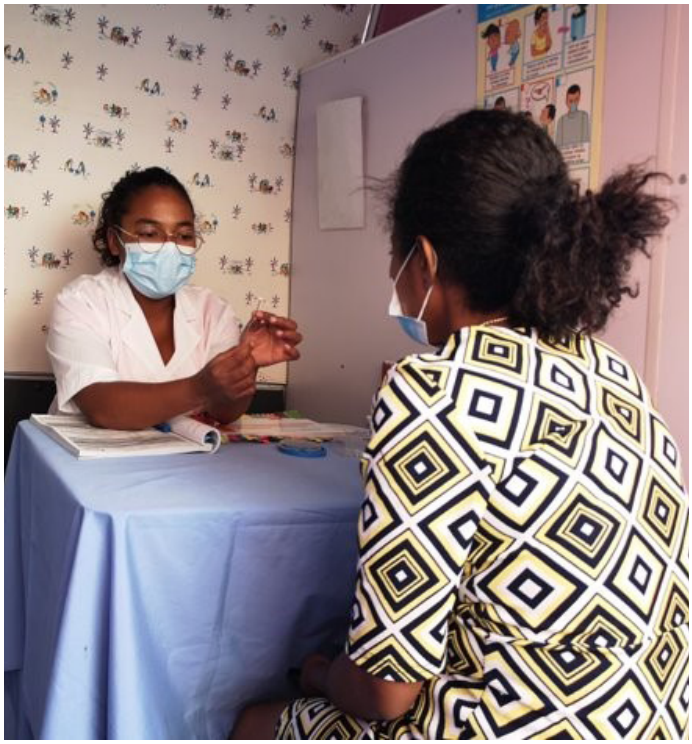
Due to COVID-19, 1.9 million fewer women have been served by MSI's programmes. We estimate this will lead to:

1.5M additional unsafe abortions

900,000 additional unintended pregnancies

3,100 additional maternal deaths

FACING AN INCREASED RISK OF 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 reports in countries with COVID-related lockdowns.

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

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

ADAPTATION AND RESILIENCE
INNOVATING HEALTHCARE TO PROTECT ACCESS

Our providers along with others 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 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.

Programmes have rapidly adapted sometimes with only 24 hours' notice of an impending lockdown to ensure access can be maintained, for example, by moving reproductive health supplies as close as possible to the last mile, before transport is restricted. Our response has been tailored and grounded in the local contexts, in line with national government response.

PARTNERING WITH GOVERNMENTS TO INTEGRATE SRHR IN THE COVID-19 RESPONSE

Across many of MSI's country programmes, we have advocated successfully 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.

This has been vital to maintain access, but it's not always enough. This message needs to be communicated and understood by local government officials and law enforcement officials, including police operating roadblocks. By doubling up with other essential services, such as immunization, food delivery programmes or COVID-related activities, we have found that programmes can continue to deliver SRHR services, whilst maximising health system resources.

In Zimbabwe, MSI's programme integrated family planning into the local immunisation programme, ensuring rural women could still access services. In Nigeria we partnered with the Ministry of Health to support 2,600 public health posts to remain open and when sexual and reproductive healthcare services were classed as essential, the Ministry of Health granted MSI's team members free movement between states, ensuring contraception and post-abortion care were not side-lined by the COVID-19 response.

In Nepal, we played an active role in a co-ordinated response between government, NGOs and multi-lateral organisations, to ensure continued access to SRHR services, even in the context of a strict lockdown. As a leading member of the Reproductive Health Sub-Cluster, a multi-stakeholder group led by the Family Welfare Division and UNFPA, we helped influence the swift approval of *'Guidelines on Reproductive, Maternal, Newborn, Child and Adolescent Health'*, which were then implemented across the country.

As well as allowing clients and health workers to have temporary exemptions from COVID-19 travel restrictions, the guidelines allow medical abortion (MA) services to be provided in client's homes. Trained service providers and volunteers are now allowed to provide door to door delivery of medical abortion drugs and services, and trained chemists can store and distribute MA drugs.

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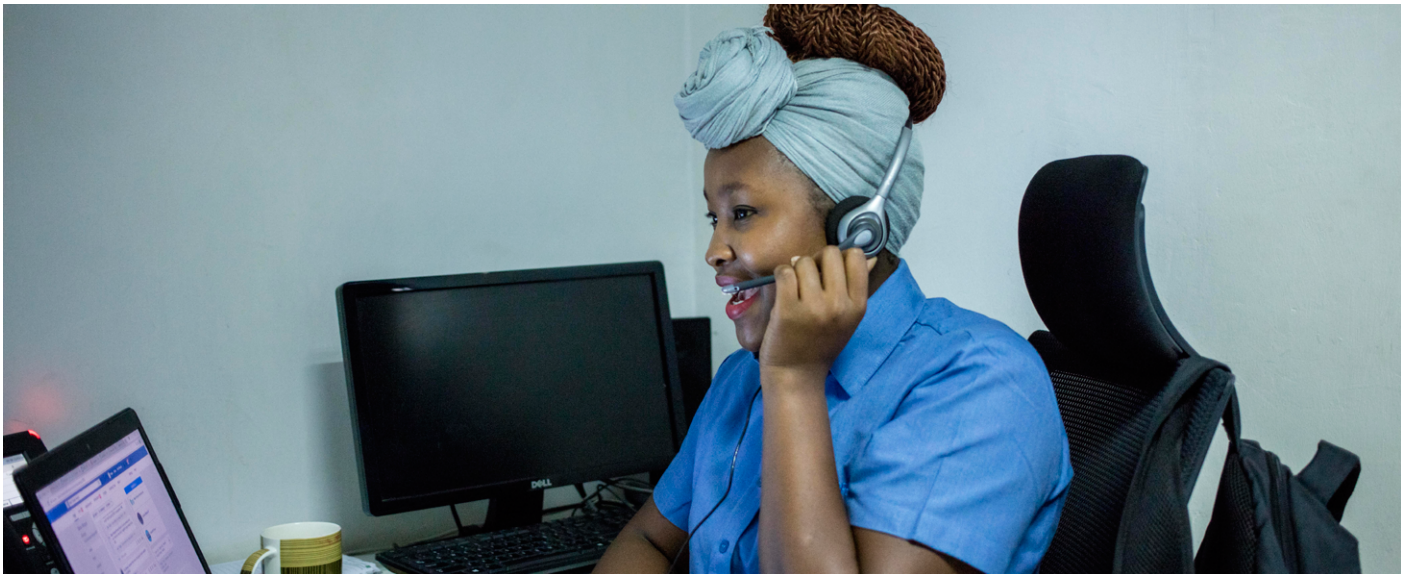

ESTABLISHING TELEMEDICINE TO DELIVER HOME-BASED CARE

MSI programmes and partners have worked closely with governments to remove unnecessary policy barriers and pilot innovative ways to provide services. In the UK, we launched a telemedicine service in April, 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, and 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%).

98% **clients rating their experience as good (14%) or very good (84%)**

We are now sharing learnings from our UK programme to explore similar models for remote provision in low resource settings, for example South Africa, India and Nepal. 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 look 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.

GETTING SERVICES TO THE HANDS OF WOMEN

With lockdowns leading to curfews, transport blocks, and the cancellation of market days, which would usually provide a cover for women wanting to access services discreetly, many women have been unable to reach facilities. In response, MSI teams have pivoted to get services directly to women.

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

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

Below: An MSI provider delivers reproductive health services via motorbike in Burkina Faso

IN UGANDA, THE MSI TEAM SET UP A SCHEME IN PARTNERSHIP WITH UNFPA TO DELIVER HEALTHCARE PRODUCTS VIA MOTORBIKE USING THE SAFEBODA RIDE-HAILING MOBILE APP.

LETTING WOMEN KNOW THAT WE ARE SAFE, OPEN AND HERE FOR THEM

As shared, 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 has been to ensure that women are aware of the safe services available and their right to access them.

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. Under lockdown, our programmes adapted quickly to set up home-based call centres, allowing us to serve over 1 million clients since the start of the year. 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.

"… a young girl called whispering that she needed a SA service but was stuck at home… I asked her to tell her boyfriend to contact me. He was supportive but both were panicked and lost on what to do... so I booked an appointment for them at our centre and also helped them through how to get out of the house and what to say to the police if they got stopped and so they were able to get the service." **– contact centre agent, Marie Stopes International Nepal**

As some women are cautious of visiting health facilities during the pandemic, our programmes have worked to build community awareness around our commitment to COVID-19 prevention. Marie Stopes Mali conducted a major awareness campaign, both to build public awareness around COVID-19 risks and of the measures the programme is taking to protect clients. Through radio shows, Facebook broadcasts and community-based campaigns, the team were able to ensure that their local communities felt comfortable accessing MSI's services and were armed with accurate information on how to guard against infection.

LEARNING FROM FORMER CRISES

We know that in previous health crises, diverting resources away from reproductive healthcare can lead to additional deaths. During the Ebola epidemic, as many, if not more people died from increased barriers to maternal and reproductive healthcare than from the virus itself.

In Sierra Leone, the government were keen to prevent a repeat of the spike in teenage pregnancies seen during the Ebola crisis, so immediately involved the Marie Stopes Sierra Leone programme. The Ministries of Education and Gender collaborated with us at district level and through emergency committees to focus on contraceptive access for young people, while publicising sexual health advice and information on youth services via school radio programmes.

THE IMPACT OF COVID-19 ON MSI'S PROGRAMMES

While our efforts to mitigate the impact of COVID-19 have allowed us to protect services across several settings, we have still seen a considerable reduction in the number of women who have been able to reach our services.

Between January and June, our programmes served 1.9 million fewer clients than originally forecast for the same period. Based on these declines and national health and demographic data, we estimate through the Impact 2 methodology that this loss of services will result in:

1.5M additional unsafe abortions

900,000 additional unintended pregnancies

3,100 additional maternal deaths

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 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, due to lack of access to MSI's India services alone. When India's service data is excluded, across our remaining country programmes we are delivering nearly 90% of services that were forecast for the year, pre-COVID.

Dr. Rashmi, Clinical Director for FRHS India (one of two MSI programmes in India) shared:
"Women's needs do not suddenly stop or diminish during an emergency – they become greater. And as a doctor I have seen only too often the drastic action that women and girls take when they are unable to access contraception and safe abortion.

"This pandemic has strained healthcare services all over the world, but sexual and reproductive healthcare was already so under prioritised that once again women are bearing the brunt of this global calamity."

We had initially feared that adolescent access would be particularly badly hit by the pandemic. However, our service data so far is reassuring, showing that overall, the proportion of adolescent clients has remained consistent, at around 15% of our overall client numbers.

Another concern was that due to supply chain disruptions and challenges facing specific delivery channels, women could face a reduced choice in contraceptive methods available. However, we have not yet seen evidence of this, with our recorded method mix remaining consistent.

FACING THE PANDEMIC IN PARTNERSHIP

These findings provide a snapshot of the current crisis. It is important to remember that 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.

Fortunately, 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 CALLS TO ACTION

- It costs around 3 cents per day to protect a young woman from an unintended pregnancy for one year. This could save her life or allow her to finish her education. We therefore 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 WHO Guidance on 'Maintaining essential health services: operational guidance for the COVID-19 context', 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.

TECHNOTE ON OUR IPSOS MORI SURVEY

1. The research was conducted online using Ipsos MORI Access Panels and approved partners.
2. Online interviews were carried out amongst females aged 16-50 in the UK, India and South Africa
3. 1000 interviews were conducted in each market, with quotas set on age and region
4. Fieldwork was conducted between the following dates:
   a. UK – 29th July and 1st August 2020.
   b. India – 31st July and 10th August 2020.
   b. South Africa – 1st August and 11th August 2020.
5. The data are weighted to known offline population profiles as follows:
   a. UK – age, region, working status and education
   b. India – age, region and working status
   c. South Africa – age, region and education

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