Sexual and Reproductive Health and Rights during the COVID-19 pandemic

A joint report by EPF & IPPF EN

22 April 2020

Disclaimer:

- This report is based on two surveys, one carried out by EPF and another by IPPF/IPPF EN, conducted between 13 March and 10 April 2020.
- The landscape is dynamic; situations described below may have evolved since the response was provided and are changing daily, particularly in relation to government reactions.

Thank you to all IPPF EN Member Associations, EPF APPG Secretariats and MPs, and those who attended the webinar presentation on 22.04.20, who provided further input.

Contents

Introduction: women and girls left without care

COVID-19 is endangering the sexual and reproductive health and safety of women and girls and vulnerable people across Europe. They are left without access to essential medical services such as contraception and abortion care, HIV and STI testing and reproductive cancer screenings, and respectful maternal healthcare. The huge reduction in these services is putting lives, health and wellbeing at risk, particularly those of vulnerable groups whose only access may be through subsidised services provided by civil society. Gender-based violence has surged, with lockdown making it harder to provide support and shelter to women desperately in need of it.

The availability of abortion, as a time-sensitive medical intervention, is of particular concern. Several countries, such as France, Ireland and the United Kingdom (UK), have brought in legislation enabling the use of telemedicine and remote support of medical abortions. Other governments, such as in Poland and Romania, have taken advantage of COVID-19 to flex their reproductive bullying muscle to undermine women's health and safety just when this most needs to be protected.

Access to contraceptive supplies must also be monitored. While few organisations in Europe report immediate difficulties in sourcing condoms and contraceptives, lockdown-related disruptions in production in major manufacturing countries, combined with transport and supply chain issues, may have a longer-term knock-on effect in Europe. This will certainly be the case in developing countries.

Civil society organisations are not immune from the economic fallout of the pandemic. Those that have been forced to close services are in immediate financial difficulty and if donor funding is diverted from SRHR, some may face bankruptcy and closure if governments do not take action. Some countries have already moved to provide protections to civil society, a much-needed recognition that no state can afford to lose its third sector.

COVID-19 did not bring out the best of European cooperation at the beginning. But there are encouraging signs of emerging solidarity within and beyond Europe. The effects on poorer countries are likely to be grim, and it is reassuring to see the EU and majority of European states planning to reinforce international cooperation and development aid, especially on health systems and protection of vulnerable groups. However, a close eye needs to be kept to ensure that money is not diverted from SRHR to COVID-19 response or economic regeneration, and that all funding decisions are driven by human rights, (gender) equality, and social justice.

What is also encouraging is to see the entrepreneurship and innovation that exists in our region. Many organisations have immediately moved key services online, and sustained

advocacy from SRHR organisations has pushed governments to leverage the potential of telemedicine for SRH, most notably in the case of abortion. Learning is being taken from one country to another and informs the recommendations at the end of this report.

COVID-19 is a dynamic situation and things are changing daily, if not hourly. The information in this report has been gathered from IPPF EN Members, SRHR organisations, Parliamentarians and other actors who provided information that was valid at that moment. We hope to keep updating as things change, and to provide an information channel for the SRHR community in Europe to keep in touch with each other, know what is going on in other countries, and share ideas as to what you can best do in your organisations as well as advocate for in your countries so that women, girls and vulnerable people do not lose access to vital care. Such a loss could have repercussions that far outlast COVID-19, and must be avoided at all costs if we want to protect and care for all people in Europe. So please, keep in touch, update us and each other when things change, when you see a threat where we can help each other and where you see a great practice that others can emulate.

Caroline Hickson

Regional Director

IPPF European Network

Neil Datta

Secretary

European Parliamentary Forum for Sexual and Reproductive Rights

1. Access to essential SRHR services limited

Services closed or significantly reduced

Many SRH services across Europe are no longer available to women during the COVID-19 crisis due to closures or reduction in activities of service-providers. Taking just a snapshot of IPPF EN's membership provides an insight into the potential scale overall. *Of 18 service-providing organisations that responded,* ***17 (94%) reported a decrease in the number and frequency of services and outreach activities since the outbreak of COVID-19****.* 307 (78%) of clinics and community care points have been closed. Even where services are available, fears of infection or reduced income mean people are not using them. In Belgium, the family planning centres in Brussels and Wallonia are open but have seen an 80% reduction in visits. Staff express concerns about future impact: increase of STIs, a rise in demand for abortions and serious health implications of untreated gynaecological infections. In the UK, Marie Stopes International (MSI) estimates a reduction of over 50% in service delivery in the worst-case scenario.

Lack of staff and personal protective equipment (PPE)

Even in countries that have categorized SRHR services as essential, such as Sweden and Belgium, SRHR services providers report difficulties. In North Macedonia, the government permits HIV screening to continue; however, doctors working in the state healthcare system are not allowed to work elsewhere, meaning any that were also working in specialist clinics can no longer provide services there. HIV testing can now only take place during a two-hour slot per week. Lack of staffing is a major challenge across the board. At the time of reporting, eleven organisations reported their own staff ill or quarantined; six reported staff seconded to the wider COVID-19 response, and most expected difficulties in maintaining the existing number of staff. Lack of PPE is a major issue cited by almost all respondents. For example, Portugal reported that they are no longer permitted to offer screening services by the Ministry of Health due to lack of PPE.

Endangering health through the halting of screening for HIV, STIs and reproductive cancers

COVID-19 is having a worrying effect on screening services. In Ireland, the two state-run public STI services are closed and routine smear testing and non-symptomatic STI screening has been reduced. In Switzerland, STI counselling and testing have been reduced. STI screening and care is affected in Poland. In Albania HIV and STI tests, cervical cancer screening and testing, and gynecological visits have all decreased.

Respectful maternity care compromised

A growing number of hospitals will not allow birth companions (France, Ireland, Czech Republic, Slovakia), while others are separating newborn babies from their mothers (France, Slovakia, Romania), decreasing drastically the access of pregnant women to medical monitoring services, interrupting breastfeeding procedures (Romania), or applying other practices not in line with WHO guidelines. Italy and Poland have also been called upon to ensure respectful maternity care and to continue to allow the presence of a birth companion.

Poor and marginalised people will suffer most

As always in a crisis it is the most vulnerable who suffer. In Norway, specialized services for sex workers and people who are HIV-positive have been cancelled and there is an overall drop in demand for appointments. In Bulgaria, Romania and Serbia, projects supporting the sexual and reproductive health of Roma girls and women have been suspended. Young people are also victims of the situation: 23 out of 28 IPPF EN Members reported they have halted the delivery of comprehensive sexuality education (CSE) sessions, 24 halted the training of other stakeholders such as teachers and peer educators, and in Finland and the UK, respondents reported that youth-friendly clinics have been closed.

Innovative responses; countries where care comes first

Many countries have enacted new, specific provisions in light of the COVID-19 restrictions to guarantee access to SRHR services during the crisis. Several governments have removed procedural or administrative barriers and have adapted their service delivery models, including by allowing telemedicine for SRHR services, i.e. through phone or online consultations. Telemedicine is key so that women do not have to travel to their doctors to get a prescription for contraception or access abortion care. It safeguards the health of both women and healthcare providers by avoiding unnecessary exposure to the virus.

Albania has enacted telemedicine provisions for prenatal care. Belgium is using telemedicine for prescriptions and abortion pre-meetings. Several countries have adopted telemedicine for SRHR services, but report problems with implementation. These include Azerbaijan, Finland and Spain. In Norway for example, telemedicine depends on local councils. Telemedicine is also available in Sweden and the UK, although this was already the case before COVID-19; as it was in Poland, depending on the willingness of individual providers. Portugal is in the process of reviewing its service-delivery model, including using telemedicine, notably for contraception prescriptions, but this depends on each regional health administration. Denmark, Turkey, Sweden, Cyprus and Spain did not adopt any new provisions.

Overall, 50% of the EN Members surveyed reported that they are providing SRH programmes through innovative approaches like telemedicine, mHealth services or in partnership with other sectors (online commercial platforms or commercial service deliveries). These approaches are particularly useful for delivering information and counselling on SRH.

New technologies are also key for the provision of comprehensive sexuality education (CSE), which cannot be provided in schools anymore in countries where they have closed. EN Members, including in Sweden and the Netherlands, are strengthening the accessibility of CSE online: both by providing SRH information and education directly on their website and through social media (Facebook, WhatsApp and Instagram), and by providing teachers with CSE packages that they can use for tele-schooling.

2. Spotlight on Contraception

Immediate risks of unintended pregnancy

IPPF Members in Albania, Austria, Belgium, Bosnia and Herzegovina, Denmark, Germany, Ireland, North Macedonia, Portugal and Spain have reported that they have been forced to scale back contraceptive care. Access to long-acting reversible contraception in particular is hindered in some countries. Reports from the UK suggest that many people who are following a course of scheduled contraceptive injections, as well as those who need to have their implants and IUDs (intrauterine devices) replaced, are now being told they must wait. A similar situation exists in other countries where SRH are considered non-essential service, such as Austria and Ireland.

In addition, there is increasing concern that lowered income resulting from job losses may impact on the ability to purchase contraception in the near future. Many countries have also reported fewer people attending medical practices due to fear of contracting COVID-19, and this is also likely to have a knock-on effect where no form of telemedicine or online prescription is in place. In particular, the closures of mobile clinics and community distribution points are likely to impact women and girls in the most vulnerable groups.

However, a welcome development is that ***some countries have facilitated access to contraception***: by allowing women to buy contraceptives without having to renew their prescription, or to get a prescription through telemedicine (France), by ensuring that emergency contraception is available over the counter, by extending free access to contraception for certain key populations. For instance, Belgium will completely reimburse any contraceptive for women up until 25 years old, previously until 18, and the morning-after pill will be free for all women. While this measure was planned for before the start of the COVID-19 crisis, it will be key to continue ensuring access to contraception given the social and economic impact the crisis will have on women.

Potential serious shortage of contraceptives and reproductive health supplies

A longer-term effect can also be predicted as lockdowns are significantly impacting production of condoms and contraceptives in the main manufacturing countries, such as India, Indonesia, Malaysia, and Thailand. For example, one Malaysian factory in semi-lockdown produces 1/5 of the world's condoms. The Indian government has prohibited manufacturers from exporting products containing progesterone, a critical hormone used in many contraceptives. Issues at source are exacerbated by delays in shipping, regulatory approvals and general business slowdown.

While many of the respondents expressed their uncertainty about the availability of reproductive health commodity supplies, only a minority of countries are feeling the immediate effect so far. In Poland**,** many contraceptives and hormone replacement therapies are already out of stock or hardly available. Marie Stopes International (MSI) warns that up to 9.5 million women and men in 37 countries worldwide risk losing access to its contraceptive and safe abortion services in 2020 due to the pandemic. Organisations which expressed particular concern around potential future stock-outs, or increased prices, came from Albania, Azerbaijan, Portugal and Turkey.

Organisations in Belgium, Cyprus, Denmark, Finland, Ireland, Norway, Spain, Sweden and Switzerland, are, at the date of the survey, not reporting stock-outs of SRH commodities. While the effects of COVID-19 on contraception in Europe are hard to predict, there is a clear risk to European women and girls, particularly the most vulnerable, caused by the effects on production and the wider supply chain, combined with the threat to the availability and continuity of care. This is an area which urgently needs to be studied in more depth.

3. Spotlight on Abortion

As the COVID-19 pandemic is spreading around the globe, women's safe access to abortion has become one of many healthcare services thrown into jeopardy. Many women and girls in Europe are facing a range of difficulties accessing abortion care safely during the pandemic.

Increase of existing barriers

Most of the respondents listed various problems regarding safe access to abortion. In general, lockdown and governments' failure to adopt mitigating measures have indirectly increased existing barriers and, in various respects, limited access to abortion in many countries. In countries like Poland, barriers caused by highly restrictive abortion laws and arduous administrative requirements to access abortion services make safe access to this critical health care extremely difficult, or even virtually impossible. The temporary closure of borders only further worsens the situation. Public and private medical facilities are no longer providing abortion on the woman's request in Romania: the decision to suspend non-emergency procedures is in practice hindering women's reproductive freedom. In Germany, where there were already too few doctors providing abortion in some regions, this situation has been aggravated as clinics have to concentrate on absolutely necessary operations and some refuse to manage abortions. Italy issued guidelines clarifying that abortion cannot be discontinued, although in practice access remains difficult, notably due to a shortage of healthcare professionals willing to provide it. In the Netherlands, the Court of The Hague has refused to allow pregnant women to obtain the abortion pill outside of abortion clinics. Other states where the abortion procedure was previously accessible but where women now face various obstacles are Albania, Azerbaijan, Ireland, Spain and Turkey.

Cynical governments and politicians leveraging COVID-19 for further coercion measures

In some countries, governments and politicians have taken negative steps curtailing women's reproductive rights even further. In Lithuania, the Minister for Health has stated that women seeking abortion services should use their time in lockdown to re-think their decision. In Poland, the ruling party once again discussed bills that would virtually ban abortion and sexuality education, though these have now been referred back to committee for further consideration. The Hungarian government has used the introduction of measures to counter the Coronavirus allowing the prime minister to rule by decree, to propose a draft bill that would end legal gender recognition for transgender people.

Countries protecting reproductive safety

Abortion remains freely accessible in over 10 countries. The governments of Denmark, Norway, Sweden and Switzerland have managed to maintain access to abortion even under current circumstances. In Belgium, Finland, Portugal and the UK abortion centres are open but are working according to various corona protocols, for example, new safety measures have been introduced, such as online consultations and check of temperature before a woman proceeds to an appointment.

Eight countries have facilitated access to abortion. In France, the at-home-abortion-pill can now be used up to the ninth week (instead of the seventh), and all appointments for medical abortion can be done through telemedicine. Our EN member is still campaigning, together with practitioners and

parliamentarians, for an extension of the time limit to access surgical abortion from 12 to 14 weeks, a crucial measure in the context of COVID-19. In the UK, early medical abortion at home will now be allowed up to 10 weeks of gestation. In Ireland, a new model of care for early abortion has now been put in place and allows for remote consultation, with face-to-face contact in exceptional circumstances. Moreover, the Irish COVID-19 emergency laws include a provision allowing for nurses and midwives to take on tasks normally only undertaken by doctors. Germany and Spain (Catalonia) have made it possible for the mandatory counselling session prior to an abortion to take place over the phone or by video chat. The abortion procedure is still required to be carried out in a clinic though. The Catalonian government is currently working on amending their medical abortion legislation in order to allow women to do it at home.

SRHR advocates should use possible momentum after the pandemic to scrutinise current administrative provisions since once there is a realisation that things can be done safely more simply, there will be little incentive for reversal. Additionally, many provisions such as imposing mandatory counselling, multiple consultations at the doctor's office, or hospitalisation (as in Italy) before women can access abortion, were negotiated as a compromise many years ago. Such restrictions should be done away with permanently.

4. Spotlight on SGBV and domestic violence

Huge increases in sexual and domestic violence

An overwhelming number of countries report significant increases of cases of sexual and gender-based violence (SGBV). In the wake of massive lockdowns imposed to contain the spread of the disease, reports of domestic violence have surged globally, including in most European countries. In France for instance, reports of domestic violence have increased by 32%. The restrictions on movement have forced women and children to be isolated with perpetrators, and hit women's escape routes and support networks, such as hotlines and shelters. Economic and social distress has further increased the risk of domestic violence against women and children.

This worrying situation has been pointed out by many, including UN Secretary-General Antonio Guterres, the European Parliament and the EU Fundamental Rights Agency. All of them urged countries and Member States to include the protection of women in their national responses to tackle the pandemic.

Positive government responses

However, government responses vary greatly. Many countries have responded by reinforcing essential existing protection services through governmental campaigns and/or NGO actions (Belgium, Denmark, Finland, France, Portugal, Spain, Sweden) and/or by taking emergency measures that include: declaring services supporting victims of gender-based violence as essential services (Spain), setting up safe and flexible emergency warning systems in grocery shops or pharmacies (France, Spain), offering new assistance services by phone/email/text message for direct police outreach (France, Spain, Portugal), organising additional and alternative shelters for victims (Belgium, France, Spain), increasing funding to anti-abuse organisations and to victims of gender-based violence (France, Austria). Others like Albania have addressed the economic and social stresses that often lead to increases of domestic violence by providing general financial assistance to the most vulnerable, without specifically addressing the issue of GBV.

Procrastination and lack of action by others

Some governments are still discussing how to best use the existing support mechanisms (Italy, UK). In other countries like Ireland and Turkey, civil society has called for action and is still waiting for governmental response. Finally, governments in some countries where an increase of domestic violence has been reported have not adopted any response for now (Cyprus, Poland, Switzerland).

5. COVID-19 and European Development Cooperation

A pending disaster for sexual and reproductive health in poorer countries

As the virus reaches regions with weaker health systems and emerging economies, the impact on SRH is already massive. A survey by IPPF showed that 5,633 static and mobile clinics and community-based care outlets have already closed because of the outbreak, across 64 countries. The Africa region has been the most impacted, particularly Ghana, Uganda, Sudan, Zambia and Zimbabwe. This situation translates into the scaling down of HIV testing, limited access to contraceptive care services and services on gender-based violence, and reduced availability of abortion care. This will have a dire impact on lives and health; a recent study estimated that the COVID-19 pandemic could result in Low- and Middle-Income Countries in an additional 49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies over the course of a year (Guttmacher-Lancet Commission).

Promising signs of global solidarity, despite concerns on impact on development funding streams

Faced with this situation, several donor countries and international institutions have stressed the need to reinforce development cooperation and humanitarian aid and to target low-income countries in the response to the pandemic. **Funding priorities differ from donor to donor, but include in particular:**

- **Providing humanitarian support** with a specific focus on vulnerable groups such as refugees and addressing the specific needs of women and girls, with SRHR being explicitly mentioned by some donors (e.g. EU);
- Strengthening of health systems; and addressing **Universal Health Coverage (UHC)**
- Helping developing countries address the **economic and social consequences**.

Coordination of donors is taking place little by little, through the EU for its Member States, but also through the G7, G20 and the UN. Donor countries have channelled their funding through different initiatives and modalities, with an attempt (sometimes limited) to coordinate their response:

- **Funding for vaccine development & epidemiology** through the Coalition for Epidemic Preparedness Innovations (Belgium 5M Eur, Denmark 10 million DKK, Norway 2,2 billion NOK, Germany, Sweden, Netherlands, UK, Finland);
- **New funds and/or re-channelling funds to multilateral organisations**: WHO (including the Contingency Fund for Emergencies), UNICEF, UN (UNFPA, UN Multi-partners fund, UN's Global Humanitarian Response Plan), humanitarian relief organisations like the IRC, IMF (including Catastrophe Containment and Relief Trust), World Bank's Pandemic Emergency Unit, UN Refugee Agency (Denmark, Sweden, Ireland, Canada, Netherlands, UK, Germany, Norway). In this framework, Norway has issued a call for a joint UN fund focusing on strengthening health-systems (as was the case during the Ebola crisis response). The UN Secretary General has set a target of raising 1 billion USD for the fund. Norway has already contributed 150 million NOK;
- **Bilateral financial assistance** (Germany, UK, Norway, France);
- **Supporting debt relief or cancellation for LICs** as suggested by the IMF (Germany, France); and
- **Increased flexibility** in how NGOs are re-allocating their funding to be able to respond to the pandemic (Belgium)

- Some donors (Norway, Sweden) have also announced that they would **not require co-funding for CSO implementing partners**, in order to ease the consequences of the crisis on civil society, which is one of the first responders in developing countries.

The need to be on our guard as the SRHR community

Despite this initial solidarity, some limits in donor countries' response to the crisis have been identified in the short-term. In the medium term it must be recognised that where development aid is pegged to GDP, the huge expected reduction in GDP in donor countries will inevitably mean reductions in the overall envelope. While proportionately more may go towards health, this does not obscure the fact that funding to the SRHR sector, along with many others, is likely to fall in 2021, if not already in 2020.

Most COVID-19 response packages are not funded by new money but by a reshuffling of ODA. This is a concern particularly, as funding allocated to SRHR could be reassigned to the COVID-19 response. Some donors have already reaffirmed their commitment to SRHR in their ODA, such as Finland, the Netherlands, Norway and Sweden. While the EU has mentioned SRHR as an important need in the COVID-19 pandemic, SRHR are not identified as a priority in its response to the crisis, raising some concerns from civil society. Some donors, such as France, Italy, Portugal, Spain and Switzerland have yet to develop their response.

A second concern is the focus of the response from some major donors. While the EU has announced it would allocate 15 billion euros to its global response to COVID-19, the fact that the response focuses more on responding to the economic and financial consequences of the crisis, rather than on the human development aspects, suggests that SRHR could be omitted. In addition, civil society and developing countries have raised concerns around the modalities used by donor countries in their global response to the COVID-19 pandemic. The fact that France for example, has announced that it would provide loans to African countries, rather than donations, has been seen as highly problematic, and a risk for the sustainability of basic services, including health systems. Finally, the US move to halt their funding to the WHO (400M $) has been widely condemned by world leaders and shows the risk of lack of coordination between donors in responding to the current crisis.

6. Organisational sustainability in jeopardy

Civil Society Organisations (CSOs) play a key role in realising human rights for all, particularly the most marginalised, in performing community outreach, service-delivery and advocacy and watchdog activities. Women's rights organisations, shelters for victims of domestic violence and SRHR organisations are key actors in the realization of women's rights and SRHR. Their activities must continue during and after the crisis.

There is a real and present danger both in Europe and across the world that many SRHR organisations will collapse through lack of funds. The lockdown measures have started to severely impact economies worldwide, with major consequences on various areas like trade, tourism, transport, employment, but also culture, housing, catering and more. This is affecting civil society, most immediately those who depend on service provision as a source of income, but also as governments start to reallocate funding towards the COVID-19 response.

A number of SRHR organisations have already reported significant effects, for example, having to lay off staff and in one case, temporarily close operations completely. In order to protect their economies and reduce the social impact of the crisis, several countries have provided for a bailout funding programme. Some include support to NGOs and charities (which may come with conditions attached), as in Azerbaijan, Ireland, Norway, Poland, Portugal, Spain, Sweden (with a specific 100 million EUR grant to organisations working against domestic violence), Switzerland and Turkey.

Other countries have provided support programs but with no clarity as to whether NGOs are eligible or not: Albania, Belgium, Denmark, Finland, France, Italy and Portugal.

7. Ten recommendations to decision-makers

General recommendations on Government responses to the COVID 19 emergency:

1. Governments must ensure that all **emergency measures** taken to respond to the public health crisis pursue a legitimate purpose, are strictly necessary, proportionate, with a definitive end date, and subject to democratic scrutiny. Governments have a **duty to uphold democracy, the rule of law and human rights**, in particular those of the most marginalised, i.e. transgender persons, women seeking abortion care, victims of SGBV or refugees, among others. The EU and Council of Europe must **monitor the implementation of emergency measures** in Member States to ensure the respect of European values.

2. Governments and the EU must adopt an **intersectional and gender-sensitive response** to the crisis, and include women's perspectives in decision-making, to ensure that the economic and social response to the crisis addresses the specific situation of women and does not reinforce existing inequalities.

Recommendations on Government responses on SRHR and SGBV during the COVID-19 emergency:

3. Governments must continue to **guarantee access without discrimination to all SRHR services, information and commodities** during the crisis by recognising that they are **essential, life-saving and often time sensitive services** (ie. contraception, including emergency contraception, safe abortion care, maternal healthcare, STIs/HIV and reproductive cancers prevention, detection and treatment, hormone treatment for transgender persons). In doing so, Governments should follow WHO guidelines and adopt a patient-centred, human rights-based approach.

4. Governments must **adapt their policies, technical guidance and service-delivery models** to guarantee access to SRHR during the crisis, by allowing: telemedicine for SRHR consultations; access to contraception (particularly emergency contraception) without prescription; early medication abortion from home; removing medically unnecessary administrative obstacles (mandatory trips to healthcare facilities or hospitalisation for women seeking abortion care); ensuring refusals of care by doctors due to their private beliefs do not jeopardize access to abortion care; limiting the impact of COVID-19 on childbirth experiences and ensuring dignified maternal healthcare.

5. Governments must **address immediate needs for RH commodities and PPE** (supplier identification, support for shipping, centralized procurement) and, **in the medium term, engage with UNFPA, RHSC, manufacturers and other global SRH organisations** to exchange information on supply chains, manufacturing and transportation so as to anticipate any potential future stock outs.

6. Governments must **ensure that services and resources remain available and accessible for survivors of SGBV as essential services** (hotlines, shelters, referral mechanisms, and other SGBV services either provided by the state or civil society) in their national and international responses to the epidemic. The EU must support Member States in these efforts through funding and sharing of best practices and guidelines.

Recommendations on the sustainability of SRHR CSOs and service delivery:

7. The EU and donor countries must **support partner countries and specifically their health systems** so as to respond to the crisis in a comprehensive manner to minimise the impact of the current outbreak and prevent future outbreaks. This includes ensuring access to SRHR, combating SGBV and striving for Universal Health Coverage. Human development, which includes health and SRHR, must remain a priority of donors in their COVID-19 response.

8. Governments and the EU must **maintain an enabling financial environment for CSOs**, including by removing co-funding requirements and allowing greater flexibility to reallocate funding to respond to the crisis**.** This should include the support from donor countries to local and national CSOs in partner countries.

9. The European Commission should propose a **contingency plan for 2021(-2022)** to ensure continuity of funding and implementation should an agreement on the 2021-2027 MFF not be reached in time. If a **new MFF** is proposed, it should safeguard funding allocated to civil society organisations, the defense and promotion of human rights, women's rights including SRHR and gender equality, both within and outside the EU. The Citizens, Equality, Rights and Values Programme, the Health strand of the European Social Fund Plus, and the NDICI are particularly important instruments in this regard.

10. **Gender equality, women's rights including SRHR, must remain priorities** of the new MFF proposal and the contingency plan, and **the EU annual Work Programme must not delay initiatives** to improve gender equality and protect human rights.

* * *