


# A call to action: documenting and sharing solutions and adaptations in sexual, reproductive, maternal and newborn health care provision during the COVID-19 pandemic

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## Introduction

Beyond the direct effects on women and newborns,<sup>1</sup> the COVID-19 pandemic has resulted in large, multidimensional and ongoing negative indirect effects on the provision of sexual, reproductive, maternal and newborn health.<sup>2</sup> These effects have been documented worldwide, ranging from lockdowns preventing patients and staff from accessing health facilities, shortages of essential supplies, and re-allocation of healthcare staff and equipment toward COVID-19 wards. Many of these have resulted in unnecessary deviations from timely, evidence-based, respectful care (for example, routine separation of newborns from COVID-19 positive mothers, lack of support for breastfeeding, denial of abortion care, suspension of reproductive cancer screening activities).<sup>3</sup> These negative impacts have been documented across different health systems and a broad range of country income levels, exposing the underlying lack of prioritisation, attention and funding to these critical areas of health, exacerbated by a global pandemic.

Maintaining timely and high-quality essential services during the past months has been a herculean task, often dependent on individuals and teams from different organisations who have adapted work processes, human resources, guidelines, physical spaces, and communication channels in order to continue providing care, and at the same time documenting and advocating for attention to these issues. However, many of these problems were predictable. As a global sexual and reproductive health and maternal/newborn health community, we have had a chance to learn lessons about the collateral effects of health system disruptions from previous natural disasters, epidemics (such as Ebola), and other situations.<sup>4</sup> Yet, other issues were completely unexpected because of the unique situation of the COVID-19 pandemic. Examples include the inability or unwillingness of some countries to send assistance (such as personal protective equipment) to other affected countries, as well as the heavy disruption of transportation and distribution channels of key commodities produced in a few global locations (e.g. family planning methods). The novelty of the disease, heterogeneous nature of the epidemic across countries, and urgency of mitigation actions gave rise to a wide range of challenges, and resulted in a proliferation of local, context-specific and adapted solutions.

\*The full name of the working group is The Global Study of Maternal Health Provision During the COVID-19 Pandemic (MATCO) Solutions and Adaptations Working Group. A list of additional members of the working group, who also co-authored the present paper, can be found before the reference list.

However, the problems have been documented better than the solutions, which have not been retained or shared sufficiently. This is particularly the case with local adaptations (in communities, health facilities, within provider networks and professional associations), many of which are not likely to be seen as “scalable” or even “break-through”. Yet, the smallest of such fixes or solutions can be insightful to others facing similar problems, even if thousands of kilometres away. More so, they can give us an opportunity to see the underlying problems and weak links in a new light, garner energy to tackle both immediate and long-standing barriers and bottle-necks with a renewed spirit, and to coalesce around a future which is better than the pre-COVID-19 era. So much of the information currently available is produced by the communication departments of United Nations agencies, large international NGOs and funders; and it is extremely useful. However, based on a health workers’ survey<sup>5</sup> and speaking with health workers across the globe – we find that it is local health workers and teams working in public and private sectors that are creating some of the most innovative and well-adapted local solutions. Whether it is rearranging consultation spaces to permit social distancing, maintaining contact with patients and clients through mobile applications, or sharing innovations with colleagues over social media, the activities being put in place are important for understanding the extent of success of the response to COVID-19 and its collateral effects. Yet, even before COVID-19, these actions were poorly documented, and are even more at risk of being lost now. These are the stories that we want to hear and be heard.

***What we propose: document and share solutions to improve sexual, reproductive, maternal and newborn health care***

We are calling on our global community of clinicians, community health workers, health facility managers, researchers, policy-makers, NGO leads, programme managers, professional associations, community (traditional and religious) leaders, patient advocates, patient/women’s organisations, youth groups, sexual and reproductive health educators, and broadly anyone involved in sexual, reproductive, maternal and newborn health, not to let the opportunity to document and share solutions from the COVID-19 pandemic go to waste. What we have already learned from the COVID-19

pandemic in sexual, reproductive, maternal and newborn health leads us to posit that the solutions/adaptations/innovations that were considered, tried and tested can contribute to improving the provision and uptake of sexual, reproductive, maternal and newborn care along three dimensions:

- (1) **Immediate solutions to continue delivering safe care during the COVID-19 pandemic, including for people diagnosed with or suspected of having SARS-CoV-2 infection.** For example, to reduce exposure among nurses, we have seen how an obstetrics/gynecology department in a referral hospital in Nigeria used a baby monitor to communicate with pregnant women in the COVID-19 isolation area. In Brazil, a volunteer group of obstetric nurses offer telemedicine consultations for pregnant women about labour and COVID-19. This non-profit service *Talk to the midwife* (“Fale com a parteira”) was created to serve to connect pregnant women and health professionals via WhatsApp.<sup>6</sup>
- (2) **Solutions and adaptations addressing problems created by the COVID-19 response and its indirect or collateral effects.** This dimension might include: addressing problems created by re-prioritisation of healthcare resources away from non-COVID-19 activities; tackling lack of access to health care due to reduction in face-to-face consultations; minimising negative effects of reduced movement due to lockdowns and curfews; dealing with shortages of equipment and supplies; and ways of addressing financial affordability of care in light of rising unemployment and poverty. These ideas can be instructive beyond the COVID-19 pandemic in that many are relevant to long-standing problems in sexual, reproductive, maternal and newborn health service delivery and use. Examples of existing adaptations that we have encountered personally include the use of text messages to communicate with adolescent girls who were previously participating in a face-to-face sexuality education programme in Nigeria, expansion of availability of medical abortion using telemedicine in the United Kingdom, and a system to overcome the breakdown of transportation (Wheels for Life in Nairobi).<sup>7</sup> The latter example illustrates how informative some solutions may be for persistent challenges – in

this case, on how to design a sustainable emergency obstetric care referral system in low-resource settings. Further, invaluable lessons are being learned about dealing with supply chain ruptures, social and behaviour change communication, improving healthcare worker retention (including shift composition, health worker motivation, compensation and hands-on training provision), collecting good quality and timely routine health data, and on using health information systems in a timely manner to improve care quality and availability.

- (3) Solutions which allow a **better preparation and response to future emergencies** affecting health systems and disrupting health service delivery, or for COVID-19 resurgence. For example, a representative from the Ghana Ministry of Health highlighted in a Network for Improving Quality of Care for Maternal, Newborn and Child Health webinar that the move to training online has meant that they can communicate a lot of information to people without health workers having to travel – and this is something that they plan to use post-pandemic.

### *Call for action: what can you do?*

If you have an idea for tackling a particular problem, or tried to do so, we encourage you to complete a simple form to share this experience with others. The form is accessible in multiple languages at [tinyurl.com/COVID19adaptations](http://tinyurl.com/COVID19adaptations). This documentation project has been approved by the Institutional Review Board of the Institute of Tropical Medicine in Antwerp, Belgium (1428/10). In return, we commit to setting up a publicly accessible and updated webpage where these ideas, solutions, and adaptations can be found by others looking for information and inspiration ([www.COVIDadaptations.org](http://www.COVIDadaptations.org)). We also recognise that we have not yet understood all the problems and challenges, so if you only have a problem to share, please also participate. Every submission is

welcome, no matter how complicated the issue or how simple the solution is. If we do not jointly document these challenges and adaptations now, we risk losing an immense amount of valuable lessons for the COVID-19 pandemic, and beyond.

### **List of additional working group members**

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### **Disclosure statement**

*No potential conflict of interest was reported by the author(s).*

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