

Reproductive health under COVID-19 – challenges of responding in a global crisis

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The COVID-19 pandemic has rapidly and dramatically altered the programming landscape for sexual and reproductive health (SRH) care. Frontline service delivery capacity has been threatened since the March 2020 declaration of a global pandemic. Like many providers, our organisation, Marie Stopes International (MSI), one of the world's largest non-governmental SRH care providers, is rapidly evolving its service delivery models to respond. This perspective is built from the experience of the authors, who head the evidence, marketing and global operations divisions in MSI, and of our staff, with information gathered from situational analysis tracking, internal communications, working groups, and meetings across the 37 country programmes where we operate.

A growing number of reports from frontline service delivery organisations indicate that the supply and provision of contraception, abortion, post-abortion care and wider sexual health services is being heavily affected by COVID-19.^{1,2} In our own experience, this is affecting multiple service delivery channels. In several countries, our static clinics were forced to close due to strict lockdowns, and most are operating on reduced hours. In some countries, like Bangladesh, India, Nepal, and Zimbabwe, strict lockdowns are easing; in others, there is optimism that services can resume as governments recognise contraception and abortion services as essential. Many donor-funded international SRH programmes use mobile outreach to deliver free contraception in remote rural or under-served urban locations. Ours have either been suspended (due to travel restrictions

or fear of coronavirus transmission, from providers to clients, or vice versa), or teams have had to drastically reduce their geographical coverage. Some have been limited to delivering care in larger, more urban, static health facilities; and others have had to cease delivery of permanent and long-acting contraceptives. The pandemic is also affecting provision of technical assistance by international organisations to the public sector: internal travel restrictions limit training and quality assurance work, and in several countries where we operate, primary care providers have needed to refocus on COVID-19 response or limit contact with clients. We have also observed declining client numbers across all channels, due to inaccessibility, reduced community engagement, or fears of infection. In some instances, the latter has increased stigma towards health care providers and against clients.

Helped by flexible donors, service delivery organisations can adapt, although programme pivots are unlikely to compensate for the overwhelmingly negative impact of the pandemic on SRH services. Rapid adaptations that we have been able to make include physical distancing policies (for example through the introduction of appointment systems in clinics), enhanced infection prevention, and repurposing of community engagement or health promotion activities to deliver accurate COVID-19 information and SRH information. Marie Stopes Uganda, for example, is helping district health offices to share national infection prevention information using megaphones and door-to-door visits. Traditional face-

to-face engagement is also being replaced by community radio messages and social media: in many countries, we are now using Facebook Messenger and WhatsApp at scale to deliver information on availability of SRH services. Some programmes report that where SRH messaging is supplemented with COVID-19 messaging and reassurance of the safety of health services, we are seeing higher uptake of family planning services.

The crisis presents an opportunity for rapid regulatory change and programme innovation. Several countries are now allowing wider use of telemedicine to provide medical abortion at home: in the UK, for example, both MSI and the British Pregnancy Advisory Service (BPAS) rapidly implemented this model following a long-awaited legal change on the 30th March.^{3,4} While the model has been successfully adopted in its first weeks (nearly half of MSI-UK's abortions were delivered "at home" between 14th April and 10th May 2020), the ability of other countries to implement similar remote services may be constrained by shortcomings of political will, regulation, finances, and weak infrastructure. Nevertheless, the crisis is spurring change; for example, our programmes in Ghana, South Africa, Ethiopia and Mexico are hopeful that this can become a viable service in these contexts in the upcoming weeks and months.

SRH organisations are also playing an important role in supporting self-use of SRH products, since pharmacy remains an important point of access for many women. In MSI's case, we are working with our contact centre network in 28 countries (who deliver counselling and advice via phone, SMS, WhatsApp, Facebook), to increase agent capacity, fast-track implementation of client relationship management systems, and to offer expanded information and counselling on COVID-19. These contact centres are also providing referral services and reassurance that personal protective equipment (PPE) and triage systems are in operation, thus helping clients to overcome growing fear and distrust of healthcare workers. WhatsApp and phone are also being used to provide remote supportive supervision, or capacity building to public and private providers, where previously technical assistance was delivered in person. Partnerships are also proving crucial: in Nepal, we have worked with ambulances services and local foundations installing hand-washing stations to transport medical abortion stock to pharmacies in remote locations.

Despite these innovations, the challenges of rapid programme adaptation in the current context cannot be overstated. Global supply chains for SRH commodities have been severely disrupted, due to combinations of manufacturing shut-downs and import delays.⁵ We have also observed major operational and managerial challenges: for example, significant numbers of both support and frontline staff have been unable to work, due to movement restrictions, illness, family demands or inability to work remotely in settings with poor internet connectivity. The crisis also threatens financial sustainability: for example, some of our programmes have experienced cash flow shortages due to reduced banking availability, reductions in client numbers, loss of income in fee-paying sites, and the need to redirect budgeted resources to purchase PPE equipment or buffer stocks. As global demand for PPE surges, procurement of adequate PPE stocks is also increasingly challenging.

But perhaps most importantly, movement and travel restrictions are impacting upon the ability of frontline providers to reach the most vulnerable with SRH services. Donor-funded SRH programmes often focus their delivery in poor, rural, marginalised communities – but when mobile outreach programmes are suspended or heavily restricted, women and girls in these areas may be left with no alternatives; they are the least likely to access or be able to pay for pharmacy-supplied products, to access any form of telemedicine or to be able to travel further to towns to find care. The flexibility to pivot towards self-care and telemedicine is also limited by national policy restrictions and lack of regulatory approvals in many countries (for example where medical abortion or injectable contraceptives for self-administration are not approved). The distribution and sale of products through pharmacies is also limited during the pandemic: travel restrictions, reduced priority assigned to RH products by distributors and pharmacists, tight credit and loss of income, are some of the factors that are making it difficult to maintain recent stock levels. Partnerships with online pharmacy retailers may be one additional means of distribution, although use will be limited to those with internet access. And despite intensive efforts to adapt quickly, we anticipate that reduced access to RH services and products will have major health consequences and disproportionately affect the most marginalised groups that we aim to serve. We are monitoring our programmes weekly and

our most conservative estimates of the impact of service reductions between March and August 2020 suggest that we could see an additional 1.3 million unintended pregnancies in the 37 countries where we work this year.^{6,7} We estimate that this increased scale of unintended pregnancies could mean an additional 1.2 million unsafe abortions and 5000 pregnancy-related deaths. Our forecast, based on 37 countries, will likely be greatly amplified if public sector SRH services falter across the Global South, as recent estimates from

the Guttmacher Institute suggest.⁸ Thus, while the impact of COVID-19 is evidenced daily through reported infections and deaths, the true scale of its wider impact on SRH outcomes across the globe may become more apparent in the months to come.

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