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EDITORIAL

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Providing women's health care during COVID-19: Personal and professional challenges faced by health workers

The coronavirus pandemic has reshaped the healthcare landscape, placing a strain on all healthcare workers, including those who provide critical health services for women. Around the world, healthcare workers have been facing increased workloads, shortages of personal protective equipment (PPE), harassment and violence, and ever-evolving clinical guidance on how best to care for their patients.[1–4] In fact, 90% of respondents of a global survey of health service providers for women reported increased levels of stress due to COVID-19.[5] Women's health services are provided by healthcare professionals from different disciplines and specialties who address care throughout the lifespan of a girl or woman, on issues related to and including sexual and reproductive health, pregnancy, childbirth and lactation, and the prevention and treatment of breast and gynecological cancers.[6] These include obstetrician-gynecologists, family physicians, general practitioners, midwives, nurses, doulas, skilled and traditional birth attendants, and lactation consultants.

WHO declared 2020 the Year of the Nurse and the Midwife to call particular attention to the vital role that these health professionals play, which became even more evident during the COVID-19 pandemic.[7] With an estimated 116 million babies to be born during and in the aftermath of the coronavirus pandemic, millions of women requiring lactation support, facing postpartum depression, being treated for cervical and breast cancer, and requiring abortion services, and millions more facing gynecological and menstrual disorders, and requiring preventive care and management of other medical conditions unique to women and girls, the role of health workers providing health care for women will continue to be essential as the global health system works to define new standards in care and service provision.[8] This editorial illustrates some of the key challenges faced by health providers for women during the COVID-19 pandemic and offers recommendations for ways to address these challenges.

1 | OFFERING PRENATAL SERVICES AND CONTINUITY OF CARE

Fears about the transmission of coronavirus, social distancing requirements, and diversion of resources to COVID-19 response have forced health workers to rethink care protocols, use technology in new ways, and increase reliance on telehealth and patient self-monitoring practices. For example, when it comes to prenatal care for low-risk women, patients are being encouraged to perform more aspects of routine monitoring, such as blood pressure monitoring and counting kicks, from their own homes, but these initiatives require education about and adherence to robust documentation.[9,10] In the United States, where routine prenatal care consists of 12–14 visits throughout a normal low-risk pregnancy, some maternal care workers, supported by research findings, have shifted protocols and reduced the overall number of in-person visits to five, combined services such as ultrasound, lab testing, and physical examination into a single visit, and have been relying on telehealth for additional check-ins.[11] Several countries in Africa, including Mozambique, have also reduced the number of recommended prenatal visits to one every 3 months (for a total of three, down from the recommended minimum of eight by WHO), raising concerns that many women will miss out on these crucial preventive visits, with negative impacts on the course of their pregnancies and their health and that of their babies.[12]

Although these changes protect health workers and patients by limiting in-person interactions, they require an investment of time and resources into patient education to ensure they have the knowledge and tools to implement effective and accurate self-monitoring.

The shift to telehealth is not a one-size-fits-all solution, of course, and may be particularly problematic for high-risk patients, including those with co-morbid conditions or those who belong to at-risk populations. More importantly, it requires that patients and providers have the infrastructure and capacity to practice telehealth, in the form of hardware (computers, tablets, smart phones) as well as Internet services. Prenatal telehealth, while promising, may only be a solution in certain parts of the world, given the "digital divide" associated with rural and remote areas, among poor women, and for those with low general and technological literacy. Additionally, the use of telehealth often requires a video interface. For women and girls whose complaints require an evaluation of the genitalia or breasts, conducting a physical assessment over a video connection can be problematic and an in-person evaluation may be indicated.

2 | PROVIDING ACCESS TO SEXUAL, REPRODUCTIVE, AND FAMILY PLANNING SERVICES AND SERVICES FOR SURVIVORS OF SEXUAL AND GENDER-BASED VIOLENCE

In addition to adjustments to prenatal care protocols, the COVID-19 pandemic has forced health workers to rethink, and in some cases

reduce, access to sexual, reproductive, and family planning services and services for survivors of sexual and gender-based violence (SGBV). The reduction in access to these essential services due to safety concerns about exposure to the coronavirus and travel restrictions poses short- and long-term risks to women and girls, while also increasing the burden of care on health workers now and in the future.[13] Some restrictions on service provision of healthcare services for women, for example, access to family planning and abortion care in some states in the United States, have been put in place despite opposition from health workers and medical associations.[14] The Guttmacher Institute, a US-based think tank focusing on sexual and reproductive health and rights, estimates that a 10% decline in the use of reversible contraception (a conservative estimate as some areas report reductions as high as 80%) in low- and middle-income countries due to service restrictions because of coronavirus could result in "49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies over the course of a year".[15] Additionally, the organization estimates that if 10% of safe abortions become unsafe, this could result in "more than 3.3 million unsafe abortions and 1000 maternal deaths".[15]

For survivors of sexual violence, changes in care have included moving care for survivors to telehealth, in some cases utilizing self-swabbing for forensic evidence collection, and reducing contact during face-to-face interactions where telehealth is not possible.[16] These measures have impacted the ability of health workers to provide survivor-centered care. As the COVID-19 pandemic has increased the risks for SGBV, ensuring these services are available to survivors is essential.[16]

As protocols and practices continue to shift due to the coronavirus pandemic data, empirical evidence and the experiences of health workers and patients should inform these changes. Rigorous research must continue to evaluate outcomes of modified or remote care, compared to traditional or in-person care, for essential services.

3 | ENSURING PROVIDER SAFETY AND ACCESS TO PERSONAL PROTECTIVE EQUIPMENT

Ensuring provision of adequate PPE for health workers has been a major concern globally, and shortages have contributed to high rates of infection and even deaths among health workers, including doctors, nurses, and midwives.[17–19] A global survey of maternal and newborn health professionals found that 60% of them reported not having access to sufficient gloves, masks, and aprons.[5]

In the UK, a survey by the Royal College of Midwives showed that 35% of midwifery staff felt unsafe at work, of which 61% attributed this to insufficient PPE.[20] Additionally, 54% felt unsafe about entering patients' homes, of which 46% cited insufficient PPE as the primary cause of concern.[20] The same concerns have been documented for midwives in Bangladesh, Ethiopia, and Iran, among other places.[21,22] Uniquely for health providers for women, many of whom are women themselves, there has also been a concern about being overlooked or forgotten when provision of PPE is considered, given the focus on health workers in emergency rooms and intensive care units, or others caring for patients with COVID-19.

Shortages of PPE have had a major impact on those working in labor and delivery units, whose job entails spending many hours attending to multiple laboring women, being in close proximity to women, and being exposed to bodily fluids.[23,24] Questions arose specifically related to the second stage of labor and whether it should be considered an "aerosol-generating procedure" requiring specific PPE products (such as an N95 respirator, a face shield, and a full gown). Guidance from US-based government agencies and medical associations on what PPE is required and when to use it, especially during labor and delivery, has been varied, at times conflicting, and informed by limited data.[25] For example, in the United States, the Centers for Disease Control and Prevention (CDC) has found that there are limited data on the extent of aerosol generation during the second stage of labor and concluded that labor and delivery do not require respiratory PPE (e.g. N95 respirator) when the supply of such masks is low.[24]

However, recent publications argue that the second stage of labor—which can last for several hours—should be considered an aerosol-generating period and therefore all health workers in labor and delivery contexts should use full PPE, including N95 respirators.[26] Notably, both the Society of OB/GYN Hospitalists (SOGH) and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) in the United States label obstetric workers as frontline personnel and recommend use of full PPE for all second-stage labor where universal coronavirus testing is not available.[25]

To address shortages of PPE in the short term, PPE for health workers addressing women's health should continue to be prioritized by clinics, hospital systems, and governments. Labor and delivery units should develop special protocols for COVID-19 and low-cost innovations to protect maternal health providers, based on experiences from other countries, such as China and elsewhere.[27]

4 | ALLOWING PATIENT SUPPORT DURING LABOR AND DELIVERY

In the early stages of the coronavirus pandemic in the United States, two of the largest hospital networks in New York City suspended any support people from accompanying women into labor and delivery rooms, a decision that was later reversed after an outcry from women and their advocates.[28] In other instances, women were being advised that they could only have one person in the delivery room with them, forcing patients to make difficult decisions in choosing between familial support (partners, parents, siblings) and professional birthing support personnel, such as doulas.[29] These restrictions, while enacted to curb coronavirus transmission, were seen as especially harmful for women with low incomes, as well as for women of color who are at high risk of morbidity and mortality, and where having an advocate in the room during labor, delivery, and post-delivery can be particularly important for ensuring a positive birth outcome.[30] Such restrictions

have also placed an added pressure on members of the health team who are asked to provide the emotional support often given by family members or doulas.[30]

One solution to address such visitor limitations is to consider doulas and/or other professional supportive care as members of the care team and not an optional visitor. This would relieve the burden of finding constant workarounds to accommodate their presence, acknowledge the role they play in the delivery process, and normalize their inclusion instead of treating them as ancillary or expendable staff.

5 | FACING HARASSMENT AND ABUSE

As the COVID-19 crisis unfolded, health workers around the world found themselves facing another serious challenge: harassment, abuse, and even violent attacks. From Bangladesh to India, from Mexico to the Philippines, from the UK to the United States and beyond, nurses and doctors have been yelled at, spat on, attacked with acid, beaten, and stoned by people who considered them vectors of the disease.[31] WHO noted that the attacks were the result of "misunderstanding and lack of information and education" and were "senseless acts of violence and discrimination that must be resisted".[31,32] The team at Physicians for Human Rights, along with the International Council of Nurses and the World Medical Association, published a joint call to action in *The Lancet* calling for international cooperation in documenting, prosecuting, and preventing these crimes.[4]

6 | CONCLUSION

Health workers providing health care to women and girls during the COVID-19 pandemic face a wide range of challenges in protecting themselves and their patients, while balancing their professional obligations to provide care within a rapidly changing work environment. Maternal, sexual, reproductive, women's, and girls' health must be considered a priority and clinicians who focus on girls' and women's health must be recognized for their contributions during this difficult time.

Governments, regional and local health systems, and private institutions should promote the safety and security of these healthcare workers. This requires firmly promoting health workers' right to sufficient resources, including training, sufficient PPE, rapid testing, and adequate conditions in healthcare facilities. It also requires updated policies for provision of care that recognize conditions and circumstances that vary from patient to patient, as well as access to transparent and accurate information about the coronavirus threat level and associated health impacts in their community and place of work. Lastly, when these elements are not available, healthcare professionals should have the freedom to speak out in defense of their basic rights and the rights of their patients.

AUTHOR CONTRIBUTIONS

LG, DF, DG, TM, TN, and RM contributed to the conception of the piece. DF and DG conducted the literature review. LG drafted and led the coordination of the piece. All authors conducted critical revisions of the piece and reviewed and approved the final version to be submitted.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

KEYWORDS

COVID-19; Health workers; Maternal health; Midwives; Nurses; Pregnancy; Sexual and reproductive health

Lindsey Green[1,*]
Dahlia Fateen[2]
Devanshi Gupta[1,3]
Thomas McHale[1]
Tamaryn Nelson[4]
Ranit Mishori[4,2]

[1]*Physicians for Human Rights, Boston, MA, USA*
[2]*Georgetown University School of Medicine, Washington, DC, USA*
[3]*Wellesley College, Wellesley, MA, USA*
[4]*Physicians for Human Rights, New York, NY, USA*

***Correspondence**
Lindsey Green, 434 Massachusetts Avenue, Suite 503, Boston, MA 02118, USA.
Email: lgreen@phr.org

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