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The impact of COVID-19 on contraception and abortion care policy and practice: experiences from a range of countries

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No area of healthcare is immune to the impact of COVID-19. The pandemic will affect sexual and reproductive health (SRH) worldwide in positive and negative ways. Home-isolation and fears of contracting the virus appear to have led to decreased uptake of SRH services, increased reports of intimate partner violence and in some settings reduced access to contraception and safe abortion care.^{1 2} Vulnerable populations are disproportionately affected, including young people, Indigenous people as well as refugees and asylum-seekers whose safety and care is deprioritised.³ Predictions have been made about higher rates of unintended pregnancy, unsafe abortion, short interpregnancy intervals, and untreated sexually transmitted infections.⁴

The pandemic has also led to rapid implementation of innovations and legal and regulatory changes that have transformed and improved care for some people. In many countries contraception and abortion care have been classified as essential services, and recognition for the pivotal role of nurses and midwives has grown. New policies, practices and even enactment of laws have removed barriers to care which could otherwise take years of bureaucracy to overturn. This editorial draws on the expertise of a range of international clinicians and researchers to examine these changes to policy and practice, many of which may have lasting benefits for women.

Contraception care

Many countries have recognised continuity of contraception provision, particularly long acting reversible contraception (LARC), as essential. There has been a significant shift to telemedicine, for instance in US, Canada, UK, France, Australia, Scandinavia, China, South Africa and Nepal.^{5,6,7} Some countries have been able to maintain LARC access through brief procedural visits with appropriate personal protective equipment (PPE) following a virtual consultation. In some parts of the world the rapid development of clinical guidance to permit the off-label extended use of LARC has served to support those unable to attend scheduled removal and reinsertion visits.^{5,7}

Innovations include 'click and collect' policies allowing contraceptive prescriptions to be sent directly to pharmacies after a 'telephone/ video visit' or a supply of pills to be sent directly to a woman's home. In France women have been enabled to obtain extra supplies of their combined hormonal contraceptive pills without renewed prescriptions. The UK Faculty of Sexual and Reproductive Healthcare and the Society of Obstetricians and Gynaecologists of Canada have supported use of the progestogen-only-pill during the pandemic, as it can be supplied for up to a year to new users without a baseline blood pressure, and both organisations support remote prescribing of an additional year's supply of the combined pill.^{5,7} California has rapidly approved drive-through contraceptive injection services and direct pharmacy provision of self-injectables, a change which may otherwise have taken years. Welcome changes have also occurred in some humanitarian settings, including amongst Syrian refugees in Lebanon who can now access free contraception through local clinics.

Abortion care

In many countries abortion has been designated an essential service in recognition that access cannot be delayed or postponed without impacting physical and psychological well-being, but others have used it as an excuse to constrain services. In the US, for instance, some states have attempted to restrict or prohibit abortion services, although injunctions against these policies have mostly been successful.⁸ Such limitations to services may increase the threat of unsafe abortions.¹

The need to keep women out of hospital, and to protect both women and clinicians from exposure to COVID-19, has resulted in a shift from surgical to medical abortion. Simultaneously, access to medical abortion has been enhanced by new policies, practices and even enactment of laws. While the benefits of self-managed medical abortion have been recognised for years, rapid adoption has occurred in some jurisdictions where it was previously unattainable. Abortion regulations in England, Scotland and Wales now allow home administration of both mifepristone and misoprostol supported by telemedicine, while regulatory changes have extended the upper gestational limit from 9 to 10-weeks in Finland, to 12-weeks in Scotland⁹ and from 7 to 9 weeks in France. New regulations in Northern Ireland do not permit mifepristone at home, but consultations can now be undertaken remotely followed by a short in-person visit.

Protocols for 'no-test/no touch medical abortion' have been published,¹⁰ and countries such as Canada,⁵ where abortion is fully decriminalized and has been regulated as a publicly funded health service for over 30 years, have quickly transitioned to a virtual health model. In Britain, policies include a service model where an ultrasound scan is only undertaken if a reliable Last Menstrual Period (LMP) cannot be provided or the history is concerning for an ectopic pregnancy.⁹ Similarly, while the 2019 NICE guidelines obviated the need for anti-D for Rhesus negative women undertaking medical abortion below 10-weeks, it had not been taken up in Australia or Canada until the start of the pandemic, and Scotland rapidly approved an extension to 12-weeks. Adoption of low sensitivity urine pregnancy tests that detect hCG levels over 1000 IU/L to confirm completion of a home medical abortion has also supported the shift to person-centred care.

Ensuring evidence-based sustainable change

Despite strong evidence of the safety and effectiveness of many of these practice changes, regulatory and legislative restrictions have impeded their implementation in many parts of the

world. During the pandemic, the most progressive jurisdictions have consolidated existing practices to ensure access to SRH services, while others have moved swiftly to lift unnecessary regulations. However, many still lag behind or, as in the case of Poland and Hungary and some US states, are taking advantage of COVID-19 to further restrict access.

The pandemic provides a unique opportunity for coordinated research and data collection through newly formed networks to support sustainable change. Sharing of these learnings could potentially reduce inequality of access to SRH services in a range of settings provided that quality and safety of care are not compromised. Despite its many benefits, telemedicine should not be blindly implemented as a cost-saving measure. It does not always, for instance, lend itself well to screening for and disclosure of intimate partner violence including reproductive coercion, as conversations may be overheard or intercepted. Care should also be taken to avoid the loss of a skilled surgical abortion workforce with the shift to medical abortion which will remove the opportunity to choose the method which best suits their circumstances. Consumer involvement is essential to protect personal preferences and choices for telemedicine or face-to-face consultation, for methods of contraception, and for medical versus surgical abortion.

The current global pandemic presents an unparalleled opportunity to advance sustainable policy and services ensuring person-centred contraception and abortion care. Sexual and reproductive health and rights must encompass equitable access to quality care which upholds the principles of autonomy, confidentiality and dignity. We need to make these changes endure.

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