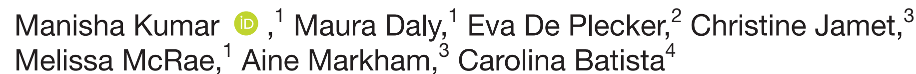
BMJ Global Health

Now is the time: a call for increased access to contraception and safe abortion care during the COVID-19 pandemic



Manisha Kumar,[1] Maura Daly,[1] Eva De Plecker,[2] Christine Jamet,[3] Melissa McRae,[1] Aine Markham,[3] Carolina Batista[4]

To cite: Kumar M, Daly M, De Plecker E, *et al*. Now is the time: a call for increased access to contraception and safe abortion care during the COVID-19 pandemic. *BMJ Global Health* 2020;**5**:e003175. doi:10.1136/bmjgh-2020-003175

Received 16 June 2020
Accepted 19 June 2020

© Author(s) (or their employer(s)) 2020. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

[1]Medecins Sans Frontieres Operational Centre Amsterdam, Amsterdam, The Netherlands
[2]Medecins Sans Frontieres, Bruxelles, Belgium
[3]Medecins Sans Frontieres, Geneva, Switzerland
[4]Medecins Sans Frontieres, Rio de Janeiro, Brazil

Correspondence to
Dr Manisha Kumar;
manisha.kumar@amsterdam.msf.org

With unsafe abortion a significant cause of maternal mortality and morbidity, especially in poor and crisis settings, Médecins Sans Frontières (MSF) calls for the urgent expansion of contraception and safe abortion care (SAC) during the COVID-19 pandemic. The development of self-managed models of care through engagement with women and their communities is needed to prevent a spike in these avertable deaths.

While the COVID-19 pandemic is unprecedented in many ways, experience from previous humanitarian emergencies shows that when routine healthcare services are disrupted, the consequences can be catastrophic, especially for women and children who are disproportionately affected by crisis.[1] For example, reports from the 2014–2015 Ebola epidemic suggest that the shutdown of routine services resulted in more maternal and child mortality and morbidity than the outbreak itself.[2 3] Here we argue that despite this compelling evidence on the indirect but devastating impact of epidemics, the global health community is dangerously close to repeating similar mistakes with regard to an often-neglected aspect of sexual and reproductive health (SRH): access to safe abortion and contraceptive services that reduce numbers of potentially fatal or debilitating pregnancy-related complications.

The current crisis has intensified the need for SRH services as social distancing, home isolation and increased stress all contribute to the likelihood of sexual and gender-based violence and exploitation. Several countries are already reporting significant increases in domestic violence.[4] In addition, movement restrictions and clinic closures render SRH services, including contraception, less accessible. All these factors will contribute to an increase in mistimed, unplanned and unwanted pregnancies. Consequently, in contexts where access to SAC is highly restricted, more women may resort to unsafe methods of abortion that can endanger their lives.

> **Summary box**
>
> - The COVID-19 pandemic has begun to severely limit access to sexual and reproductive healthcare, including contraception and safe abortion care (SAC), which have historically not been regarded as essential health services.
> - Shutdown or delays of contraception and SAC during COVID-19 will disproportionately impact the most vulnerable populations, including women and girls in low-income and middle-income countries, and lead to considerable and preventable death and lifelong disability.
> - Médecins Sans Frontières calls on the global health community to strengthen access to contraception and SAC for populations everywhere, and especially in poor and crisis settings, by engaging with women and their communities to develop self-managed models of care.

Unsafe abortion is one of the main causes of maternal mortality worldwide and the only one that is almost entirely preventable[5]: it accounts for at least 22800 deaths and over 7million hospitalisations each year.[6] Thus, every safe abortion provided is potentially an unsafe abortion and maternal death averted. As healthcare systems around the world struggle to respond to COVID-19, it is important to not lose focus on *all* the SRH services we know save lives, which include contraception and SAC.[7]

DEFINING 'ESSENTIAL' VERSUS 'NON-ESSENTIAL' SERVICES

During this pandemic, healthcare systems face difficult decisions about how to best adapt health services to ensure that increasingly

BMJ Glob Health: first published as 10.1136/bmjgh-2020-003175 on 19 July 2020. Downloaded from http://gh.bmj.com/ on July 25, 2020 by guest. Protected by copyright.

limited resources provide maximum benefit. Rationales such as 'essential' versus 'non-essential' and 'life-saving' are being used as guideposts for these decisions. Yet these terms are subjective, open to interpretation and highly influenced by personal values and social norms.

While there are multiple high-priority health needs, some services are traditionally more broadly recognised as such than others. Historically, contraception and SAC have been described as 'elective' or 'on request,' and therefore not universally considered essential, or in some cases even legitimate, healthcare.[8] Despite its impact on reducing maternal and infant mortality, contraception is often regarded more in terms of its socioeconomic benefit on development than as a life-saving health service.[9] Similarly, in much of the world, political controversies around abortion overshadow the reality that SAC is healthcare. Even though abortion is very common—an estimated one in four pregnancies end in abortion—it is also highly stigmatised.[10]

Such long-standing issues render safe abortion and contraceptive services particularly vulnerable to marginalisation or deprioritisation, especially during emergencies. A recent United Nations policy brief about the impact of COVID-19 on women fails to mention abortion at all and raises contraception only in passing.[11] Going beyond silent omission towards outright restriction, in response to COVID-19, some US governors have publicly categorised abortion as non-essential and ordered or supported the cessation of services.[12]

While restrictions to abortion access have severe consequences everywhere, they are particularly deadly in low-income and middle-income countries (LMICs). Epidemics magnify pre-existing health disparities and inequities, and they disproportionately impact the health and well-being of the most vulnerable and marginalised.[13] Before COVID-19, women and girls in low-resource settings already suffered disproportionately from non-existent or tenuous access to SRH care. Consequently, 99% of maternal deaths and 97% of unsafe abortions occur in LMIC.[14,15] This pandemic threatens to obliterate even the severely limited SRH services available to the most marginalised people.

A recent analysis by the Guttmacher Institute estimated the potential effects: it found that a 10% decline of SRH services in LMIC due to COVID-19 would mean an additional 15.4 million unintended pregnancies, over 3.3 million unsafe abortions and 28 000 maternal deaths.[16] Frontline reproductive health providers are already reporting thousands of clinic closures and predict far greater reductions ahead—as high as 80% of all services.[17,18] The true magnitude and impact of these disruptions will be nearly impossible to measure, as women and girls denied care in poor or crisis settings often suffer at home or hidden within communities.

MSF EXPERIENCE AS FRONTLINE SRH PROVIDERS IN CRISIS SETTINGS

As a medical humanitarian organisation, MSF witnesses first-hand the death and suffering due to unwanted pregnancy and unsafe abortion. In 2018, our teams around the world treated over 24 400 women with abortion-related complications, including haemorrhage, infection and traumatic injuries, some of which were fatal.[19] This experience has shown us the drastic measures women may turn to when they lack access to SAC. We have treated women who resorted to relatively common, less safe methods of abortion, such as taking various ineffective or potentially harmful medications without access to proper information, as well as more desperate, least safe examples, such as drinking poisons made from the phosphorous in match heads, chlorine or battery acid, inserting ink cartridges from pens or metal fishing hooks into the uterus and self-inflicted repeated blunt trauma to the abdomen.

Despite this experience, while MSF has always been committed to reducing maternal deaths and alleviating distress, we have not always prioritised contraception and SAC. In recent years, we have therefore invested in overcoming barriers and strengthening these services. As a result, from 2016 to 2018, the number of MSF projects providing SAC increased 400%, and the number of projects providing contraception increased 50%. In 2018, we conducted over 338 500 consultations for contraception and provided over 11 000 safe abortions.[19] This experience has deepened our understanding of contraception and SAC as essential, time-sensitive services that save lives and cannot be delayed or deferred without profound consequences for women, their families and communities.

However, these recent gains are fragile and threatened under the strain of the COVID-19 response. The potential direct and indirect mortality from this pandemic in humanitarian settings is enormous and difficult to bear. It is painful to consider that healthcare providers will have very limited capacity to save those who become severely ill due to COVID-19. This terrible truth highlights the critical need for all medical actors to do what we know works: continue and strengthen the essential health services proven to reduce mortality and morbidity, so as not to exacerbate an already horrific situation.

How can this feasibly be done? As an emergency medical organisation, at MSF, we know that effectively responding to crisis often calls for innovation. We cannot continue to provide services the same way we did before. We must adapt and provide care in new ways that meet the evolving needs of our beneficiaries. MSF teams are already modifying protocols for a variety of services to minimise direct contact between patient and provider and to reduce time patients must spend in a healthcare facility. As movement restrictions increase and brick-and-mortar facilities become less accessible, maintaining access to care will require us to shift our focus from standard facility-based approaches to community-based activities, remote support of services and self-care models.

BMJ Glob Health: first published as 10.1136/bmjgh-2020-003175 on 19 July 2020. Downloaded from http://gh.bmj.com/ on July 25, 2020 by guest. Protected by copyright.

SELF-MANAGED AND COMMUNITY-BASED SRH CARE

The concept of self-care recognises the ability of individuals, families and communities to promote and manage their own health and well-being, thereby upholding people's decision-making capacity, autonomy and dignity. Self-care and community-based models have been successfully employed to increase access to a variety of life-saving health services, including treatment of malaria and HIV, especially for marginalised populations. Certain contraceptive methods, including condoms, emergency contraception pills and the recently developed subcutaneous progestin-based injectable, are very safe, easy to use and thus well suited to similar approaches.

Research from many countries indicates that SAC can also be safely and effectively supported via self-care and community-based models.[20–22] The development of medication abortion means that abortion is no longer necessarily a surgical procedure, but rather a process similar to miscarriage that can be safely and successfully induced with pills.[23] Despite this advance, most healthcare systems continue to heavily regulate medication abortion by requiring both in-person consultation with a healthcare provider as well as medical tests, which ultimately limits access. However, abortion medications are so safe and effective that most people can successfully manage without these interventions. Consequently, in recent years, self-management of medication abortion has gained increased acceptance by the formal health sector as safe and appropriate.[24] Self-managed abortion includes self-administration of abortion medications at home, often with remote support from sources such as hotlines, digital platforms, peer educators and so on.

Faced with COVID-19, some health systems have adapted abortion services towards more self-managed strategies. For example, the UK's Department of Health and Social Care has modified its regulations to allow women to obtain abortion drugs via mail after phone or telehealth consultation with either a doctor or a nurse.[25] We applaud these efforts to increase access to abortion services by deinstitutionalising and task-shifting, and we call on the global health community to find similar yet adapted approaches in humanitarian and fragile settings.

At MSF, we have experience with simplifying protocols and moving towards more self-managed models of care in poor and crisis settings. In alignment with WHO guidelines,[23] since 2017, most medication abortions in our projects are provided by midwives or nurses, without routine blood tests or ultrasound. Women typically self-administer the drugs and manage the abortion process at home, returning to the clinic only if they have questions or concerns. Some MSF projects have also started to explore partnerships with local health promoters, peer educators and hotlines to support medication abortion in the community. Preliminary findings are encouraging, with high success and low complication rates that are comparable with global averages, which supports the concept that the only necessary elements for safe and effective medication abortion are accurate information, quality medications and mutual trust.

ENGAGING WITH WOMEN AND THEIR COMMUNITIES

In responding to COVID-19, global health actors, including MSF, need to build on this experience and engage further with women and their communities to develop more locally driven and locally tailored responses. For example, existing collaborations with traditional birth attendants, community health workers or women's groups could be expanded to facilitate distribution of contraceptives and abortion medications in the community. In settings with mobile services, hotlines and SMS systems could be used to disseminate information, respond to questions and provide remote support regarding contraception and abortion care.

While engaging with communities about stigmatised topics like abortion may seem daunting, especially in contexts where abortion is restricted, MSF's experience in recent years has shown that these conversations can be immensely informative and productive if: (1) they are approached from the perspective of discussing a common goal to reduce maternal death and suffering caused by unwanted pregnancy and unsafe abortion and (2) they are broadly inclusive and framed in a way that helps everyone feel comfortable sharing their experiences and opinions. The extent to which MSF and other health actors are willing to be flexible and truly listen to women and their communities throughout this crisis will ultimately determine health outcomes for the most vulnerable populations.

As the COVID-19 pandemic progresses, it is clear that no country will remain untouched. The impact will be felt on every continent, in every community and in all aspects of society in both the short and long term. It is also clear that we will emerge from this pandemic somehow transformed from the way we were before. Let us learn from the past and seize this opportunity to respond differently this time. Now is the time to be bold and ensure that when the dust settles, women and girls have not yet again paid a disproportionate price in lives lost.

Acknowledgements We give our deepest thanks to the Médecins Sans Frontières (MSF) staff in over 150 projects around the world whose dedicated efforts make it possible to provide contraception and/or safe abortion care (SAC), as well as other SRH services, via the models of care discussed in this paper. We would like to thank the MSF Reproductive Health and Sexual Violence Care Working Group for its work and support on this topic. We also give thanks to Patricia Kahn (MSF-USA) for medical editing support and input to the manuscript and to Michelle Bosché (MSF-USA) for editorial assistance.

Contributors MK heads MSF's Safe Abortion Care Task Force and coordinates related efforts to increase access to contraception and SAC in MSF projects. MD and EDP are reproductive health advisors for MSF and guide related activities, including contraception and SAC. EDP also leads MSF's Reproductive Health and Sexual Violence Care Working Group. As MSF Director of Operations and Medical Director, respectively, CJ and MM oversee the Safe Abortion Care Task Force and direct many of the MSF operational activities and programmes described in this paper. AM and CB are members of the MSF International Board who contribute to guiding and steering MSF's recent statements, resolutions and positioning regarding safe abortion care. MK and MD had the idea for the article, performed the literature search and drafted the manuscript. EDP, CJ, MM, AM and CB contributed

BMJ Glob Health: first published as 10.1136/bmjgh-2020-003175 on 19 July 2020. Downloaded from http://gh.bmj.com/ on July 25, 2020 by guest. Protected by copyright.

important reflections and critically reviewed the paper. All authors approved the final version. MK is the guarantor of the article.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement Data are available in a public, open access repository.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iD
Manisha Kumar http://orcid.org/0000-0002-2668-6261

REFERENCES

1. UNOCHA. *Global humanitarian overview*. New York: United Nations Office for the Coordination of Human Affairs, 2019. https://www.unocha.org/publication/global-humanitarian-overview/global-humanitarian-overview-2019
2. Elston JWT, Cartwright C, Ndumbi P, *et al*. The health impact of the 2014-15 Ebola outbreak. *Public Health* 2017;143:60–70.
3. McQuilkin PA, Udhayashankar K, Niescierenko M, *et al*. Health-care access during the Ebola virus epidemic in Liberia. *Am J Trop Med Hyg* 2017;97:931–6.
4. WHO. *COVID-19 and violence against women*. Geneva, Switzerland: World Health Organization, 2020. https://www.who.int/reproductivehealth/publications/vaw-covid-19/en/
5. WHO. *Preventing unsafe abortion*. Geneva, Switzerland: World Health Organization, 2019. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion
6. Worldwide IA, Inst G. Induced abortion worldwide, 2016. Available: https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide [Accessed 5 May 2020].
7. Tran NT, Tappis H, Spilotros N, *et al*. Not a luxury: a call to maintain sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic. *Lancet Glob Health* 2020;8:e760–1.
8. Bayefsky MJ, Bartz D, Watson KL. Abortion during the Covid-19 pandemic - ensuring access to an essential health service. *N Engl J Med* 2020;382:e47.
9. Guttmacher Inst. Adding it up: investing in contraception and maternal and newborn health, 2017. Available: https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017 [Accessed 7 May 2020].
10. Sedgh G, Bearak J, Singh S, *et al*. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *Lancet* 2016;388:258–67.
11. United Nations. Policy brief: the impact of COVID-19 on women, 2020.. Available: https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women
12. Tanne JH. Coronavirus pandemic stirs fight over abortion rights in US. *BMJ* 2020;369:m1733.
13. Hall KS, Samari G, Garbers S, *et al*. Centring sexual and reproductive health and justice in the global COVID-19 response. *Lancet* 2020;395:1175–7.
14. WHO. *Maternal mortality fact sheet*. Geneva, Switzerland: World Health Organization, 2014. https://apps.who.int/iris/bitstream/handle/10665/112318/WHO_RHR_14.06_eng.pdf
15. Ganatra B, Gerdts C, Rossier C, *et al*. Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model. *Lancet* 2017;390:2372–81.
16. Riley T, Sully E, Ahmed Z, *et al*. Estimates of the potential impact of the COVID-19 pandemic on sexual and reproductive health in low- and middle-income countries. *Int Perspect Sex Reprod Health* 2020;46:73–6.
17. Marie Stopes International. Methodology for calculating impact of COVID-19, 2020. Available: https://www.mariestopes.org/resources/methodology-for-calculating-impact-of-covid-19/ [Accessed 23 Apr 2020].
18. IPPF. COVID-19 pandemic cuts access to sexual and reproductive healthcare for women around the world, 2020. Available: https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world [Accessed 23 Apr 2020].
19. MSF. *International activities report 2018*. Geneva, Switzerland: Médecins Sans Frontières, 2018. https://www.msf.org/international-activity-report-2018
20. Moseson H, Herold S, Filippa S, *et al*. Self-managed abortion: a systematic scoping review. *Best Pract Res Clin Obstet Gynaecol* 2020;63:87–110.
21. Foster AM, Arnott G, Hobstetter M. Community-based distribution of misoprostol for early abortion: evaluation of a program along the Thailand-Burma border. *Contraception* 2017;96:242–7.
22. Grossman D, Baum SE, Andjelic D, *et al*. A harm-reduction model of abortion counseling about misoprostol use in Peru with telephone and in-person follow-up: a cohort study. *PLoS One* 2018;13:e0189195.
23. WHO. *Medical management of abortion*. Geneva, Switzerland: World Health Organization, 2018. http://www.who.int/reproductivehealth/publications/medical-management-abortion/en/
24. WHO. *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights*. Geneva, Switzerland: World Health Organization, 2019. https://www.who.int/reproductivehealth/publications/self-care-interventions/en/
25. UKDHSC. *Temporary approval of home use for both stages of early medical abortion*. UKDHSC, 2020. https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion-2

BMJ Glob Health: first published as 10.1136/bmjgh-2020-003175 on 19 July 2020. Downloaded from http://gh.bmj.com/ on July 25, 2020 by guest. Protected by copyright.