

Optimizing the World Health Organization COVID-19 Interim Guidance

*Working Recommendations for Sexual
and Reproductive Health Advocacy
During and Beyond the Pandemic*



On June 1, 2020, the World Health Organization (WHO) released “[Maintaining essential health services: operational guidance for the COVID-19 context](https://www.who.int/publications/i/item/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak),” hereafter referred to as “the WHO guidance.”¹ The WHO guidance outlines strategies governments should take to ensure populations retain access to essential health services, including sexual and reproductive health (SRH) care, during and beyond the current COVID-19 pandemic.

Civil society advocates and other stakeholders play a key role in ensuring access to SRH services and information remain available and that such services are not deprioritized during a health emergency. They are well-positioned to understand the policy and practical implications of crises on vulnerable populations and how these groups’ health needs can best be met. Sustaining positive SRH outcomes during the pandemic is critical to ensuring countries are better prepared in the long term — including in the event of future global health threats — to successfully expand upon SRH gains as a number of countries roll out universal health coverage schemes.

This document, developed with the input of international nongovernmental organizations and local civil society actors to support the implementation of the WHO guidance at the country level, recommends concrete policy, programmatic and budgetary decisions to optimize and implement the WHO guidance and other relevant SRH guidelines at the national and subnational levels. As a living document, the recommendations provide a snapshot of the current context. This document is designed to be updated with new evidence and advocacy recommendations by governments, technical experts, civil society and advocates worldwide with the COVID-19 response and through recovery.

To ensure SRH remains a priority and the SRH needs and rights of women, young people and vulnerable populations are met, this document:

1. Provides an overview of the WHO guidance as it relates to SRH;
2. Outlines some of the initial country-level adaptations of the WHO guidance related to SRH;
3. Proposes additional considerations necessary to ensure SRH for all populations and their diversity of needs across different contexts; and
4. Makes recommendations to operationalize the WHO guidance and prioritize SRH.



¹ World Health Organization. (2020, June 1). *Maintaining essential health services: operational guidance for the COVID-19 context*. <https://www.who.int/publications/i/item/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>



Overview of the WHO guidance related to SRH

This WHO guidance in response to the COVID-19 pandemic provides a framework with program-specific considerations and adaptations that decision-makers should tailor to their contexts at the national and subnational levels and the varying health needs of their populations. The information and suggested actions are organized by life-course stages taking into account SRH through sections on maternal and newborn health (MNH); child and adolescent health; and broader SRH. Below is a snapshot of the program activities outlined in the WHO guidance for each of the three areas of interest as they relate to SRH. The modifications and information on transitioning beyond the emergency period are available in the full document.

The WHO guidance provides modifications that countries should take for the safe delivery of these health services in the context of the pandemic, with additional information in its annex, as well as information on transitioning toward restoration of full health service delivery and activities post-pandemic, where applicable (MNH, pages 24-25; child and adolescent health, pages 26-27; and SRH services, pages 29-30). As countries around the world face increased demand for health care of people with COVID-19 — compounded by existing inequities in access to health — amid fear, misinformation and limitations on movement, it is critical that the WHO guidance and best practices for the delivery of SRH and other health services are adapted to local contexts to ensure health services and care continue for all.



Life-course stage

The WHO guidance suggested program activities relevant to SRH

MNH	<ul style="list-style-type: none"> • Delivery of eight antenatal care contacts according to national guidelines • Skilled care during labor, childbirth and the immediate postnatal period in a health facility for a minimum 24 hours after birth • Delivery of four postnatal contacts according to guidelines • Management of preterm and low-birth-weight newborns • Neonatal intensive care unit admissions • Registration of birth and maternal and perinatal deaths and review of maternal and perinatal deaths
Child and adolescent health	<ul style="list-style-type: none"> • Provision of school- and community-based health education • SRH and HIV services for adolescents • Prevention and response to intimate partner violence and sexual violence • Provision of menstrual products
SRH services	<ul style="list-style-type: none"> • Access to contraception • Fertility care • Safe abortion care (SAC) to the full extent of the law and post-abortion care (PAC) • Sexual health • Cervical cancer screening and prevention • Address violence against women and girls, sexual and gender-based violence (SGBV)

Table 1: Selected program activities relevant to MNH and SRH by life-course stage, per the WHO guidance. Full suggested modifications during the pandemic response and transitioning post-pandemic are provided in the WHO guidance.

Country-level SRH guidance

Several countries, in consultation with civil society and others, have begun the process of adapting the WHO guidance to their national contexts to ensure continuity of SRH and reproductive, maternal, newborn, child and adolescent health (RMNCAH) services and supply provision during the pandemic. Examples include:

- The government of Kenya has produced a detailed and actionable guide for the continuity of RMNCAH and contraceptive care and services in response to COVID-19, with outlined protocols adapted from previous WHO recommendations and other COVID-19 response plans.² The Kenyan guidelines address modifications during the pandemic for the provision of: antenatal, intrapartum and postnatal care; contraceptive services for continuing and new users, including extended prescriptions; SGBV care and response; and telemedicine for reproductive and maternal health and contraception.
- In Ghana, the Ghana Health Service has issued guidelines to all its facilities on the provision of SRH care to ensure essential services are still provided during the pandemic and contraceptive commodities are available throughout the country.
- The Ministry of Health (MoH), the World Bank, UNICEF and other partners in Burkina Faso have developed an action plan for the continuity of contraceptive services in the context of COVID-19. This plan includes a guide for community health worker service provision and coaching approaches. As of July 2020, contraceptive services are now available free of charge throughout the country and the scale-up of task shifting is in progress. Moreover, the public health code is in the process of being revised to allow for the self-administered injectable contraceptive. Once revised, providers at pharmacies and drug stores will be able to counsel clients on self-injection.
- The government of Madagascar has created a plan for the continuation of contraceptive services during the pandemic, including a focus on innovations such as telemedicine, virtual consultations and DMPA-SC self-injection. The government is also adapting services, such as dispensing multi-month refills for contraceptives.
- Recognizing that the pandemic makes it difficult, if not impossible, for some to access SRH services, the MoH in Niger has committed to identifying accessibility constraints and seeking to guarantee continuity of services.³ The ministry's March 2020 plan began the process of ensuring that contraceptive users retain access to quality services, including community distribution of contraception; telemedicine; multi-month supplies of contraception; and self-administration for DMPA-SC.

² Kenya Ministry of Health. (2020, April). *Kenya COVID19 RMNH Guidelines: A Kenya Practical Guide for Continuity of Reproductive, Maternal, Newborn and Family Planning Care and Services in the Background of COVID19 Pandemic*. <https://www.health.go.ke/wp-content/uploads/2020/04/KENYA-COVID19-RMNH.pdf.pdf.pdf>

³ Niger Ministry of Health. (2020). *Plan de continuité des services de Planification Familiale au Niger dans le contexte de la pandémie de COVID19 [Continuity plan for family planning services in Niger in the context of the COVID-19 pandemic]*. <https://pai.org/wp-content/uploads/2020/10/Niger-Plan-de-continute-des-services-Last1.pdf>

- The MoH in Senegal has created an RMNCAH plan to ensure availability and continuation of services.⁴ The plan includes guidance on: governance and coordination; an essential service package; a provider guide for essential services; stock management; and monitoring and evaluations. The MoH is discussing the financing of this plan with the WHO, the World Bank and the U.S. Agency for International Development. The plan will promote telemedicine and self-care, advise community health workers on the distribution of several months of contraceptive supplies — including oral contraceptive pills and the DMPA-SC self-injection — and promote counseling on long-acting reversible contraceptives (LARCs) prior to visits to health facilities.



⁴Senegal Ministry of Health and Social Action. (2020, May). Plan de Contingence pour Assurer la Disponibilité et l'Utilisation Continue des Services SRMNIA dans le Contexte de COVID19 [Contingency plan to ensure the availability and continued use of RMNCAH services in the context of COVID-19]. <https://pai.org/wp-content/uploads/2020/09/Senegal-plan-de-contingence-DSME.pdf>

- In Bangladesh, the Directorate General of Family Planning, Directorate General of Health Services and other key stakeholders among donors and civil society have developed joint recommendations for contraceptive use during the COVID-19 pandemic.⁵
- To address the need for delivery of essential health services amid the pandemic, with a focus on specific subpopulations, the Ministry of Health and Family Welfare in India formulated guidelines on enabling delivery of essential health services during the COVID-19 outbreak in April 2020. Services related to RMNCAH, along with family planning services, were included as essential non-COVID-19 services in the guidelines to be prioritized by all states. A detailed guidance note was also released on May 24, 2020, with more detailed guidelines on service provision at different levels in COVID-19 containment and buffer zones across the country.
- Provinces in Pakistan have developed and adopted guidance on delivery of contraception and broader RMNCAH services during the pandemic. Sindh was the first province to develop guidelines for family planning and reproductive health during COVID-19, with family planning and reproductive health declared essential services. Punjab has developed a business plan for continuation of family planning services as well. At the national level, the Federal Ministry and WHO are working with a group of experts to develop SRH guidelines for COVID-19, with family planning, PAC and postpartum family planning included. An RMNCAH framework, devised by United Nations agencies, is in the draft stage and the WHO will present it to the Federal Ministry and all four provincial governments.
- The MoH of Indonesia has established guidelines for family planning and reproductive health services during the pandemic with protocols for the safe delivery of services. Some of the strategies include: ensuring the use and availability of personal protective equipment for health workers; prioritizing appointment-based services, especially for intrauterine device, implant or injection renewal; promoting condom use and traditional contraceptive methods; encouraging postpartum family planning services using LARCs; and optimizing mass media campaigns for information and education, and telemedicine for counseling. Additionally, the National Family Planning Coordinating Board (BKKBN) in early 2020 had already begun developing technical guidelines for family planning services in emergency and crisis settings. These had to be adjusted in response to the COVID-19 pandemic,⁶ and will complement the MoH's guidelines with more elaboration on implementation.

⁵ Directorate General of Family Planning, Directorate General of Health Services, Obstetrical and Gynaecological Society of Bangladesh, et al. (2020, May 14). Bangladesh: Recommendations for Contraceptive Use during COVID-19 Pandemic. Minutes of Zoom meetings 22 and 26 May 2020. <http://www.familyplanning2020.org/resources/bangladesh-recommendations-contraceptive-use-during-covid-19-pandemic>

⁶ Indonesia Ministry of Health (2020). Panduan Pelayanan Keluarga Berencana dan Kesehatan Reproduksi dalam Situasi Pandemi Covid 19 [Guidelines for Family Planning and Reproductive Health Services in COVID-19 Pandemic Situation]. https://infeksiemerging.kemkes.go.id/download/Panduan_Pelayanan_KB_dan_Kespro_Dalam_Situasi_Pandemi_COVID-19.pdf

Ensuring SRH access for all



As countries begin implementing the WHO guidance and developing their own plans, governments and civil society advocates can take concrete actions to address key SRH aspects in their responses to COVID-19, taking into account the particular vulnerabilities and diverse needs of various communities. They should work to adapt, apply and expand upon the WHO guidance and the following considerations and recommendations, which draw from statements, calls to action and other materials developed by civil society organizations, international nongovernmental organizations and relevant health coalitions.

Equitable service delivery

The WHO operational guidance briefly calls for its adaptation to situational contexts and the specific needs of subpopulations. With the onset of COVID-19, gaps and disparities within populations have grown wider. Individuals in underserved areas and minority and vulnerable populations have been hit the hardest during the pandemic, reflecting underlying inequities. This is equally true in humanitarian settings throughout the world, where settlements for refugees and internally displaced people are densely populated, with limited public health infrastructure. SRH and MNH needs do not change when populations are in crisis or displaced, and emergencies may put them at increased risk of violations of their sexual and reproductive health and rights. Women and girls are at an increased risk of sexually transmitted infections (STIs), including HIV, unintended pregnancy, maternal morbidity and mortality and SGBV. As the pandemic has become a global humanitarian crisis, national-level responses to COVID-19 should also reference the Minimum Initial Service Package (MISP), which provides a useful framework on the activities that must be implemented to ensure quality SRH care.

Recommendations:

- In addition to the RMNCAH- and SRH-related services outlined in the WHO guidance, countries should further guarantee that all SRH services and supplies continue to be available throughout the COVID-19 response. This includes contraception, intrapartum care for all births, emergency obstetric and newborn care, PAC, SAC to the full extent of the law, clinical care for rape and sexual assault survivors and prevention and treatment for HIV and other STIs.
- It is essential that SRH coordination in humanitarian settings is integrated with the broader pandemic response coordination. This includes all antenatal care, postnatal care, newborn care, breastfeeding support, contraception services, cervical cancer screening and care for those experiencing intimate partner violence. Auxiliary services remain critical, including ultrasound, laboratory services and blood bank services.
- Specialized SGBV response must be redefined in collaboration with the security authorities that are highly involved in the COVID-19 response at the country level. With increased SGBV, including rape cases due to pandemic-related restrictions, it is necessary to update guidelines with additional guidance for post-rape care, adolescent-specific responses and for marginalized populations. These include populations living in poverty or in rural communities, people with disabilities, indigenous people, internally displaced people, refugees, sex workers and people with diverse sexual orientations, gender identities, gender expressions and sex characteristics.

Young people and adolescents

Young people below age 24 face significant barriers to SRH services, supplies and information, which are exacerbated in crisis settings. Specifically, 10- to 14-year-old adolescents are especially vulnerable, and early and forced marriage is increasing in some communities. Evidence also suggests that young people are at high risk of SGBV and coerced and/or transactional sex, which can result in unintended pregnancy, STIs, HIV or other negative health outcomes. In humanitarian settings and crises, young people are also at higher risk for psychosocial problems, which can further exacerbate poor SRH outcomes. As young people and adolescents are a heterogeneous group, their needs vary by age, sex, education, marital status, local and cultural contexts, gender, gender identity, bodily identity, sexual orientation and disability status. Key subpopulations such as adolescents with disabilities and LGBTI youth are especially vulnerable and have unique needs and risks. Additionally, with stay-at-home orders and quarantines during the pandemic, there may be heightened vulnerability to sexual abuse, which children may be unable to report.

Recommendations:

- In addition to the recommendations for equitable service delivery, an adolescent lens should be applied across all services so the varied SRH needs of young people, including adolescent-friendly SRH services and age-appropriate SRH information and education, are not overlooked.
 - Service providers and advocates should partner with local youth-led organizations that can assist health providers in community-based distribution and promotion. These organizations can expand access to quality SRH services for the wider community as well as for their peers at the community level.
 - SRH services should be integrated where young people are most likely to seek services.
- For example, antenatal care for pregnant adolescents as well as SRH-adjacent services, such as nutrition, should be integrated and responsive to the needs of young people. Given that certain private clinics or other locations where young people typically seek services may be closed, additional outreach efforts should inform young people where they can seek services and SRH information on how to self-administer contraception.
- Additional considerations should be taken into account for the SRH and protection needs of adolescent mothers and for young girls who are at increased risk of SGBV, early and forced child marriage and sexual exploitation during crises.



Marginalized populations

Marginalized populations, including people living with disabilities, people living with HIV and LGBTI populations, have SRH needs and challenges in accessing SRH services, supplies and information. They often face stigma that contribute to fear of testing and seeking health services. People living with disabilities in particular are at a higher risk of sexual violence, exacerbated by stay-at-home orders and other mobility restrictions, as well as a higher level of dependence on caregivers who can potentially be abusive.

Recommendations:

- In addition to the above considerations to ensure equity in care, SRH service delivery should link to community organizations for marginalized groups, including people with disabilities. These organizations often have resources that health providers can use to ensure clinical care is provided to sometimes hidden and/or stigmatized populations.
- Engage with LGBTI community organizations and rights groups to make health facilities and pandemic responses more respectful of diversity in gender identity and sexual orientation, allowing critical health services to become more accessible.
- Given existing stigma, addressing psychosocial barriers that contribute to fear of testing and seeking health services should be considered.

RMNCAH and SRH supplies

Health supply chains, including contraception, have been burdened with manufacturing delays in countries impacted by the pandemic. This also includes other RMNCAH medical and essential lifesaving commodities and equipment shortages, including supplies for SAC and PAC. As outlined in the WHO guidance, contraceptive continuity can be supported through innovations in telehealth, digital health and making SRH products available in locations away from health care facilities. These should be closer to clients, including through pharmacies, drugstores and with community health workers. However, these efforts should be developed while also maintaining client rights and privacy, including for young people and adolescents as well as marginalized populations, while also addressing community concerns around COVID-19 and service continuity.

Recommendations:

- As feasible, use telehealth (including text messaging, WhatsApp and phone follow-up) for counseling and sharing of messages related to safe and effective uses of contraception and for selection and initiation of contraceptives.
- Include contraceptives and other RMNCAH supplies on the lists of essential COVID-19 medicines, and prioritize the supplies at the same level as other essential medicines.
- Quantify, procure and run at least six- to 12-month supplies of contraceptive stocks with the appropriate modern method mix.
- Eliminate client payments for contraception and RMNCAH medications for the duration of the pandemic and ensure their inclusion in social security schemes.
- Allow for the provision of over-the-counter access of contraception, including emergency contraceptives, without prescriptions or with out-of-date prescriptions, regardless of age, marital status and parity.
- Anticipate provision of several months of supplies to help clients reduce the number of visits they make to suppliers and distribute emergency contraception in advance to clients, irrespective of age, marital status and parity.
- Ensure adequate inventory of the full modern method mix and other RMNCAH supplies and ensure products are close to populations by strategically repositioning stock and providing remote supply chain management support as needed. Encourage health care facilities, pharmacies and community health workers to have additional short-acting contraceptives in stock, including emergency contraception.

SRH communication

In order to meet the SRH needs of diverse populations — alongside the expansion of telehealth — digital health for services and provision of contraceptive supplies, educational and informational communication efforts on SRH and access to health services and supplies should target specific subpopulations.

Recommendations:

- Run media campaigns to communicate the provision of contraceptive methods and options for access during and beyond the pandemic response. Develop media that targets young people and adolescents as well as marginalized populations by involving these groups and other community organizations in the development of messages and programming.
- Ensure the delivery of accurate, age-appropriate, evidence-based SRH information and education for adolescents through multiple accessible platforms, including digital and radio.
- Embrace comprehensive, integrated message development to maximize opportunities, including during routine health services and SRH-adjacent services, such as nutrition programs.
- To the extent feasible, consider communication with private sector provider partnerships to share SRH service access guidance.
- Develop a communication package specific to decision-makers, including representatives at the national and local levels, for championing and informing their constituencies on the importance and availability of SRH services and contraception.
- Provide guidance to parents on how to communicate with young people and adolescents about their SRH needs, particularly with the changes in services during the pandemic.

Policy action and governance

To ensure the rights of all populations to health during and beyond the pandemic, the WHO guidance and implementation of national guidelines should be adopted and adapted. Dissemination of the domesticated guidelines must be communicated and implemented at the relevant subnational levels. For the equitable implementation of the WHO guidance and to respect the rights of different populations, policy action is required, particularly for the provision of SRH services for young people, adolescents and marginalized populations. This includes SAC to the full extent of the law. SAC and PAC services are necessary — particularly for young people, as they are vulnerable to unprotected sex and SGBV, have higher rates of discontinuation or ineffective use of contraception and overall have more limited access to contraception. As unmet need increases with the discontinuation of contraceptive availability or SRH services, or due to the increase in SGBV during the crisis, there may be an increase in instances of unsafe abortions.

Recommendations:

- Reduce administrative and legal barriers to access SAC and PAC to the full extent of the law for all populations.
- Lift policy restrictions on access to contraceptives, including age restrictions for young people and adolescents, restrictions based on marital status and requirements for spousal, parity or parental consent.
- Accelerate authority for and investment in telemedicine and self-care in line with the WHO guidance.
- Fast-track regulatory approvals and registration for all modern contraceptive methods from a range of manufacturers, including emergency contraception.
- Implement task-sharing policies proven to support continued provision of SRH services, and if possible, extend the services mid-level health care professionals are safely able and qualified to provide.

Training and support for service providers

The competence of SRH service providers must be taken into account in the development of new programming. Additionally, service providers are at risk of COVID-19 infection and workplace safety obstacles that affect the size and availability of the health care workforce. Targeted and focused investments in health care staff — including their safety, training and skills updates — and recruitment should ensure the capacity needs of staff are met and that use of innovations in telehealth do not compromise quality of care, especially in counseling and diagnostics.

Recommendations:

- Ensure health extension workers or community health workers are considered essential health workers in countries that do not already do so.
- Support for reproductive health providers, including community health workers, must ensure provision of personal protective equipment.
- The redeployment and hiring of health workers should account for those with skills, training and capacity to offer services to young people and adolescents as well as marginalized groups.
- With the development of telemedicine and other digital services, providers must be trained on confidentiality and privacy, with a lens for young people and adolescents as well as marginalized groups.
- Community health workers and telehealth professionals should receive training to identify and report signs of abuse of adolescents, particularly very young adolescents and marginalized populations.

Finance health equity and access

To ensure the adoption and dissemination of the WHO guidance at the national and subnational levels and make necessary changes for the adequate and equitable provision of SRH services and medicines, domestic resource mobilization will need to be increased. These recommendations are in service to the equitable provision of SRH across populations, including the vulnerable and marginalized groups identified above.

Recommendations:

- Advocate for budgeting and the release of funds to the subnational level for implementation of the adapted WHO guidance.
- Allow reallocation of funding and swift disbursement toward the redistribution of supplies and services across all levels of provision as needed.
- Set up a joint accountability mechanism for health financing to promote sound fiduciary practices for guaranteed SRH services provision.
- Ensure budgets account for health personnel, including community health workers, who are operating at adjusted schedules due to safety.
- Invest in monitoring and quality data collection.

Accountability

Civil society organizations and other stakeholders must hold governments accountable for their commitments on implementation of the WHO guidance, both during and after the pandemic.

Recommendations:

- Continue to collect and share data, including data disaggregated by age, sex and disability for use of RMNCAH and contraceptive supplies, services and health outcomes for decision-making and to course-correct as needed.
- Monitor and track policy developments and commitments to guidance implementation.
- Monitor and track budgets and resource allocation for guidance implementation.

Moving forward with the WHO guidance

These considerations and recommendations, based on current information and lessons learned from past global health crises, will continue to evolve with the development of the COVID-19 pandemic and government responses. As countries begin adapting the WHO guidance and other recommendations to their contexts, the above recommendations and calls to action will change. To provide information and resources relevant to RMNCAH and SRH to contribute to this working document, please contact Jamie Vernaelde, senior research and policy analyst at PAI, by email at jvernaelde@pai.org



Additional Resources

The Advocacy and Accountability Working Group of the Reproductive Health Supplies Coalition. (2020, June 18). Reproductive health supplies are essential: Call to action for uninterrupted access to reproductive health supplies during and after the COVID-19 crisis. https://www.rhsupplies.org/fileadmin/uploads/rhsc/Working_Groups/Advocacy_and_Accountability/Documents/AAWG_call_to_action.pdf

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Disclaimer: Family Planning 2020 is a diverse, inclusive and results-oriented partnership encompassing a range of stakeholders and experts with varying perspectives. As such, the views expressed and language used in this document do not necessarily reflect those of some members of the partnership.

About PAI

At PAI, we are motivated by one powerful truth: A woman who is in charge of her reproductive health can change her life and transform her community.


Our mission is to promote universal access to sexual and reproductive health and rights through research, advocacy and innovative partnerships. Achieving this will dramatically improve the health and autonomy of women, reduce poverty and strengthen civil society.

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What is FP2020?


Family Planning 2020 is a global community of partners working together to advance rights-based family planning. The FP2020 partnership was launched at the 2012 London Summit on Family Planning, with the goal of enabling 120 million additional women and girls in 69 of the world's poorest countries to use voluntary modern contraception by 2020.

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