

Knowledge to **Action** Briefs

Ask #1: Sexual, reproductive, maternal, newborn, child and adolescent health services, supplies and information, and demand generation

These seven knowledge-to-action briefs support partners to carry forward the PMNCH [Call to Action on COVID-19](#), which aims to increase investment and policy support to mitigate the devastating effects of the COVID-19 pandemic on the health of women, children and adolescents, and the societies and economies that support them. The knowledge-to-action briefs synthesize relevant evidence to the COVID-19 Call to Action, focusing on: 1) key impacts of COVID-19; 2) policies and mitigation strategies; and 3) strategic gaps in knowledge and action, including in humanitarian and fragile settings.



Background

The 2014–2016 Ebola outbreak in West Africa led to the collapse of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services in the region. Women were unable to access maternal health services due to over-burdened health facilities, the diversion of health workers to Ebola treatment centres, mobility restrictions and fear of contracting the disease. Sierra Leone's surgical facilities saw a 20% decrease in caesarean sections and other deliveries; at facilities offering basic emergency obstetric care, average attendance dropped by between 27% and 37%, and in heavily affected districts it fell by 50%. In Liberia, facility-based deliveries in one district fell to 9% of the previous months' peak utilization. In Guinea, delivery care declined by between 74% and 81% in the two regions most heavily affected by the outbreak.¹ Child health was similarly affected: Guinea saw a 30% reduction in childhood vaccinations during the outbreak.² There are fears that COVID-19 is having similarly disruptive effects on access to SRMNCAH services.

Key impacts

Maternal and child mortality

Studies have predicted that, as SRMNCAH service coverage contracts due to mobility restrictions, supply chain disruption and diversion of the health workforce, COVID-19 may also result in large increases in maternal and child mortality. One study found that, across 118 countries, a reduction in coverage of SRMNCAH services by 9.8% to 18.5% would result in an additional 253 000 child deaths

and 12 000 maternal deaths in six months, while reductions in coverage of 39.3% to 51.9% over the same time period would result in an additional 1 157 000 child deaths and 56 700 maternal deaths.³ A reduction in coverage of parenteral administration of uterotonics, antibiotics and anticonvulsants, and of clean birth environments, would account for 60% of these additional maternal deaths, while reduced coverage of antibiotics for pneumonia and neonatal sepsis and of oral rehydration solution for diarrhoea would account for 41% of additional child deaths.³

Pregnancy

A growing body of evidence suggests that COVID-19 is not transmitted in late pregnancy, during vaginal delivery or through breastmilk, and that the prognosis for healthy newborns who contract the virus is generally good. However, a systematic review notes a number of reports of birth complications: of COVID-19 positive mothers, 64% had preterm births, 61% fetal distress and 80% caesarean section, while 77% of newborn required admission to a neonatal intensive care unit and 43% had low birth weight.⁴ There is also evidence of high mortality rates among pregnant critical COVID-19 cases admitted to intensive care, including relative to other critical cases.⁵ Ongoing research is now focusing on the effects of COVID-19 during early pregnancy and on complicated pregnancies, the risk of postpartum transmission to newborns, and appropriate treatment for pregnant women.

Sexual and reproductive health

There are serious concerns about the pandemic's impact on sexual and reproductive health. COVID-19 began to disrupt the supply chain for reproductive health technologies and services early on. Lockdown policies led many contraceptive and/or active pharmaceutical ingredient manufacturers to halt or reduce production.⁵ UNFPA Supplies, the largest provider of reproductive health commodities to low- and middle-income countries globally, found that stock levels of both contraceptives and maternal health commodities in 46 focus countries were near risk of stock-out relative to projected consumption. A large decline in numbers of women attending reproductive health clinics has also been documented. International Planned Parenthood Federation (IPPF) found that 5633 of its static and mobile clinics and community-based care outlets across 64 countries had closed, representing roughly 14% of the total IPPF service delivery points.⁶

Child health

COVID-19 is also disrupting child health services worldwide. Weighing the risks of stopping childhood immunization against the risk of accidentally spreading COVID-19 through mass vaccination campaigns, in late March 2020, global health agencies began recommending that governments pause mass vaccination campaigns in settings where there is active outbreak of the disease, and to work hard to regain lost ground once COVID-19 is under control. Agencies have since recommended restarting vaccination wherever possible. Provision of routine immunization has slowed in at least 68 countries, affecting 80 million children under the age of one.⁷ By April 2020, at least 21 low- and middle-income countries were reporting vaccine shortages.⁸ Childhood vaccine coverage during COVID-19 is also decreasing in health clinics, with lockdowns preventing parents from travelling to clinics, and hesitancy due to fear of contracting the virus.

Mental health

As in previous epidemics, both the COVID-19 emergency itself and lockdown measures have taken a disproportionate toll on women's mental health. In numerous countries, women are experiencing more post-traumatic stress, depression, anxiety and altered cognition or mood than men. Children and adolescents have suffered increased mental health issues, with reports of children and adolescents experiencing depression and anxiety during lockdown, while attention deficit hyperactivity disorder symptoms and eating disorders have been exacerbated. COVID-19 may worsen existing mental health conditions in humanitarian settings, lead to new conditions, and further reduce access to the already limited mental health services available.

Actionable interventions and solutions to mitigate impact

Maintaining essential SRMNCAH services

WHO recommends that all SRMNCAH services be maintained and that access to care be available at all times, including referrals for management of maternal or reproductive health complications, and auxiliary services, including laboratory, blood banks and transport to health facilities. This includes ensuring

continuity of provision of reproductive health services to women, adolescents and girls, as well as routine immunization of children in essential service delivery. Additionally, mental health should be integrated into the COVID-19 response.

Implementation of safety protocols

Existing services are being adapted to limit physical contact as much as possible. Strategies to minimize risk when providing SRMNCAH services include: 1) triage and risk screening for exposure to and symptoms of COVID-19 for all arrivals in health facilities; 2) dedicating separate rooms or buildings for sick visits and well visits (e.g. administering vaccinations in dedicated areas; closing waiting and registration areas); 3) improving patient flow in order to reduce wait times and contacts with other patients (e.g. reducing the number of patients seen at one time); 4) ensuring mothers and newborns remain together after birth, regardless of their COVID-19 status, to allow for rooming-in, establish breastfeeding and allow skin-to-skin contact or kangaroo mother care; and 5) early discharge for uncomplicated deliveries, with systems in place for home-based or telephone follow-up support.

Move to telehealth where possible

SRMNCAH providers in some settings have been using virtual consultation and telehealth (for example via text messages, WhatsApp, video calls or telephone calls) whenever possible for counselling, shared decision-making and management of side-effects or complications.

Maintaining the supply chain

To address concerns about projected national-level stock outs of contraceptive supplies and maternal health medicines, a concerted effort has been made by governments and global partners, including the United Nations Population Fund and workstreams of the Reproductive Health Supplies Coalition, to use tools such as fast-track procedures for bidding and export waivers. Additionally, the means by which people access SRMNCAH commodities are being adjusted where possible (e.g. multi-month prescriptions to limit trips to the pharmacy or clinic; provision of counselling and access to postpartum contraception before discharge from hospital).

Implementing the Minimum Initial Service Package (MISP) in humanitarian settings

Due to work by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, women's and children's health has been strongly prioritized by humanitarian actors. The IAWG's technical and programmatic guidance, first published in 1999, sets out a MISP through which humanitarian actors can plan an SRMNCAH response. Recognizing that COVID-19 will worsen existing gaps in service delivery and utilization, IAWG has prepared additional clinical and programmatic guidance on SRMNCAH service delivery under COVID-19. Meanwhile, the Inter-Agency Standing Committee has recommended key actions to minimize COVID-19's impact on mental health in humanitarian settings.

Priority knowledge gaps

COVID-19's disruption of SRMNCAH services is unfolding in the context of major disparities between low-, middle- and high-income countries, as well as across wealth quintiles, between rural and urban populations, and between those with education and those without. There are also major equity gaps with respect to morbidity and mortality among ethnic minority and low-income populations. However, the extent to which inequity of access to SRMNCAH services affects COVID-19 health outcomes among disadvantaged populations is not well understood. There is limited data on the impact of COVID-19 on SRMNCAH outcomes and mental health conditions for people in humanitarian and conflict settings.



References

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