The Covid-19 Pandemic and Sexual and Reproductive Health and Rights in the Pacific

Background

Pacific Island countries are amongst the most vulnerable in the world to natural disasters and have a long history of responding to infectious disease epidemics. While remoteness may have provided initial protection from the COVID-19 pandemic alongside appropriate response measures, the threat of future infections from a possible "second wave" remains. In preparation for this possibility a Western Pacific Regional Action Plan for Response to Large-Scale Community Outbreaks of COVID-19 has been developed.[1] However, sexual and reproductive health (SRH) and rights are notably absent in this document. We review the challenges delivering SRH care in Pacific Island countries during the pandemic, and the responses concerning contraception, the management of unintended pregnancies, and gender-based violence (GBV).

Contraceptive commodities

A Joint Incident Management Team (JIMT) was established on 27 January 2020 to support Pacific COVID-19 preparedness and response efforts, including ensuring the continuity of essential SRH and GBV services.[2] Key achievements up to July 2020 include the UNFPA led disbursement of a quarter of a million US dollars to provide essential SRH services [2], including reproductive health kits in response to the combined impact of COVID-19 and Cyclone Harold in Vanuatu. However, gaps in the forecasting and procurement of supplies remain mostly due to a lack of pre-existing technical skills and weak logistic management information systems at service delivery points.[3] However, there have been considerable efforts to build capacity in SRH for emergencies under the SPRINT Initiative by International Planned Parenthood Federation (IPPF) across the Pacific.[4]

Sexual and Reproductive health workforce and the supply of PPE

Women comprise the majority of health care workers (largely nursing and midwifery) in Pacific Island countries. In Tonga and Tokelau, for example, 70% of health care staff are women. In some locations, midwives and nurses are being deployed for COVID-19 preparedness activities reducing their ability to deliver clinical SRH services.

Health workers are also at risk of exposure to COVID-19. There are reports of women being turned away from healthcare facilities due to provider fear and confusion regarding pre-triage procedures for emergency and routine care at hospitals.[5] Access to personal protective equipment (PPE) and education is therefore essential. While global PPE demand has been found to outstrip supply in many countries, the Pacific has experienced timely arrival of supplies in affected countries and territories.

Uptake of SRH services

Reduced clinic operating times and fear and anxiety associated with contracting COVID-19, will potentially affect the numbers of people seeking SRH care.

As distancing measures are put in place, and people are encouraged to stay at home, disrupting social and protective networks, the risk of intimate partner violence is likely to increase. Many local services for survivors, including hotlines, shelters, rape crisis centres, and counselling services have been closed or have limited hours. While some services may be on-line, these are unavailable to those without internet access.[6]

Opportunities for Action

There have been high-level commitments from Governments globally, including Australia, New Zealand, Fiji, and Tuvalu to protect SRH and rights in the COVID-19 crisis. This commitment is critical to ensure the prioritisation of SRH and continued procurement and distribution of commodities. However, women and young people's participation and leadership are essential for formulating and implementing local solutions that address the gendered impacts of emergencies, including the COVID-19 pandemic.[6]

The pandemic has also led to increased recognition of the benefits of task-sharing of selected health interventions. Examples of task-sharing include engaging appropriately trained community health workers in contraceptive counselling and distributing emergency contraceptive pills and condoms, and the insertion and removal of long-acting reversible contraceptives (LARCs), in particular implants, by trained and credentialed nurses and midwives.

The long tradition of telemedicine in parts of the Pacific can facilitate scale-up during COVID-19, including The Pacific Island Health Care Project in the Marshall Islands, Federated States of Micronesia and Palau [7], and well-established telephone counselling services in Fiji and Samoa.[8] However, digital interventions must not inadvertently exacerbate existing healthcare access inequalities for women with low digital literacy or an inability to access phone or computer networks. Challenges remain as internet access remains costly, and reliable bandwidth and service is patchy. However, several initiatives are focused on providing affordable and reliable networks for emergency communication for disasters including Small Island Development Action Plans which to take advantage of unused satellite capacity and bundled software packages.[9] Ensuring privacy and confidentiality during virtual consultations can also be challenging, especially in the context of domestic and family violence, and clear protocols are essential for all SRH care interactions. Research in Papua New Guinea and the Solomon Islands has identified that community education may be required to support and encourage the use of mobile phones for clinical consultations, and training is essential for healthcare providers to optimise consultation outcomes.[10]

Wherever possible clients should be counselled on the benefits of LARC, as part of a wider range of contraceptive methods, as these methods will provide long-term protection and reduce the need for clinic visits. IPPF advises informing clients about; keeping subdermal implants for five years regardless of their type, using levonorgestrel-releasing intrauterine systems (LNG-IUS 52mg) for seven years, and copper intrauterine devices (Cu-IUD) for up to 12 years during the pandemic if access to a clinic for removal or replacement is not possible.

Essential health services that must continue during COVID-19, such as obstetric and postnatal care, should adopt a no-missed opportunities policy to address gender-based violence and contraceptive needs including the provision of post-partum LARC before a woman leaving a birthing facility and the offer of contraceptive counselling during child immunization visits. The Minimum Initial Service Package can guide this, a minimum standard of care in humanitarian response.

In summary, the Pacific Island countries have the capacity for resilience and innovation. Each of the actions summarised in Fig. 1 will potentially mitigate the pandemic and other

disasters' impact in the short term and provide sustainable benefits as innovations are adopted and institutionalised.

Fig 1. Key calls to action

Services
• Promoting contraceptive services as essential services. This will allow people to travel for SRH services—even in areas under stay-at-home orders or with travel restrictions—without fear of legal consequences. Safe abortion care, including medical abortion, should be accessible to the full extent of the law where legal. • Promoting the use of the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, including the Minimum Initial Service Package (MISP) as a minimum standard of care in humanitarian response.
Reproductive Commodities
• Strengthening national and regional SRH supply chains (via a mix of private-sector, governments and NGO providers) by prepositioning commodities and identifying alternative suppliers and other strategies • Making short-acting contraceptives available without a prescription and facilitating over-the-counter purchase of OCPs and ECPs; decentralising distribution of contraceptives and other SRH supplies from the national to regional and community level (to prevent bottlenecks); delivering services at people's home when possible, and facilitating multi-month dispensing of contraceptives. Promoting and strengthening distribution of selected commodities from non-formal sites, for example condoms from betel nut and cigarette sellers, liquor shops, grocery shops, pubs and dance halls. • Increasing community-led service delivery and distribution of commodities, with peer support for accessing SRH services. • Ensuring the distribution of Reproductive Health kits containing contraceptives, and supplies for safe delivery and emergency obstetric and newborn care, the management of complications of miscarriage, the treatment of STIs and post-rape care, as well as Dignity Kits including sanitary protection and other personal care items as part of the MISP.
Models of Care
• Adopting innovative models of care, including telehealth, and a no-missed opportunity approach for contraception, gender-based violence, and unintended pregnancy services; preventing diversion of resources and staff away from SRH care.
Populations
• Addressing the unique needs of vulnerable and marginalised populations, who often face pre-existing barriers to care that are exacerbated during a crisis.

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