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EDITORIAL

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The negative impact of COVID-19 on contraception and sexual and reproductive health: Could immediate postpartum LARCs be the solution?

The COVID-19 pandemic has taken much of the world by surprise. With over 4 700 000 infections to date across 188 countries and more than 310 000 deaths worldwide over the course of just 5 months, we were remarkably unprepared.[1] Although the focus has rightly been on the provision of adequate health care for those falling ill from the virus and the search for a cure or vaccine, we must be aware that looming in the background are the usual health issues that millions of people face every day, and that these will not go away during the pandemic. Worse than this is the realization that not only will those health issues not go away, but they will likely be compounded by the lack of attention we are giving them: routine childhood illnesses requiring immunization for prevention; the treatment and prevention of malaria; malnutrition; HIV; TB; chronic diseases; and maternal morbidity and mortality to name but a few. The question is what, if anything, can we do to ensure that the legacy of this disease is only its direct deaths rather than all the other additional deaths associated with the increased burden on our health systems.

History tells us that in previous large infectious outbreaks, such as the recent Ebola epidemic in DRC, Sierra Leone, and Liberia, contraception and routine maternal health care dropped dramatically.[2] The well described "three delays" in obstetric care were exacerbated, and the reluctance to come for antenatal, postnatal, and family planning consultations was clearly seen. A second major area of concern is the impending stock-outs of contraceptive methods which are about to ensue. UNFPA estimates that during the next six months, 46 countries that usually receive supplies from them will experience stock-outs of one or more modern methods, including: implants; depot medroxyprogesterone acetate (DMPA) intramuscular (IM) and subcutaneous (SC); copper intrauterine devices; oral contraceptive pills (combined and progestin only); and condoms.[3] Authors at the Guttmacher Institute have estimated that if there were a 10% decline over the course of a year in the use of contraception due to stock-outs, unavailable providers, or closed clinics, an additional 48 558 000 women would have an unmet need for contraception worldwide, resulting in 15 401 000 additional unintended pregnancies, 1 745 000 additional women experiencing major obstetric complications without care, and 3 325 000 additional women resorting to unsafe abortions.[4] This would set the world back in terms of what had already been achieved by the Millennium Development Goals and make the challenge of meeting the Sustainable Development Goals even more difficult.

Never before has the obstetric encounter for birth been more valuable than now. It will be one of the only face-to-face opportunities women may have with a qualified provider during the pandemic, and should allow for integrated health services to be provided—with contraception being an absolute priority. The advantages of birth spacing have been well documented,[5] and during the pandemic avoiding a pregnancy is wise for women not only on a personal level, but also from a public health perspective in terms of not adding to overburdened systems. The range of methods offered should include precise advice on lactation amenorrhoea method (LAM) to enhance its efficacy, barrier methods such as the condoms, plentiful supplies of the oral progestin-only pill (a minimum of 6 months), DMPA (preferably subcutaneous rather than intramuscular to enable self-administration), and perhaps the most advantageous of all—long-acting reversible contraceptives (LARCs). FIGO's Contraception and Family Planning Committee[6] joins other health authorities to voice the urgency with which maternity units across the globe need to turn their attention to offering and providing immediate postpartum family planning (PPFP) to all consenting women prior to discharge.[7]

Postpartum LARCs are of particular value during the pandemic given their low failure rates due to user independence, and the fact that women do not need to return for constant re-supplies.[8] With appropriate personal protective equipment, it is absolutely safe for providers to offer and provide this service to those who choose it, despite the pandemic. For women who are willing to accept the possibility of hormonal side effects, both the progesterone implant and the intrauterine system (IUS)[9] have now been categorised by the WHO as MEC Category 2 for breastfeeding women, and will provide 3 and up to 6 years of contraception respectively.[10,11] These methods have the added advantage of often resulting in amenorrhoea, which can be a welcome break for some women or an absolute necessity for those suffering with heavy menstrual bleeding. One major issue with these two methods is that patent laws mean that they are still prohibitively expensive for procurement by most low- and middle-income countries (LMICs). This denies the opportunity for many women in poorer countries not only to access this effective contraceptive method, but also to access adjuvant treatment for iron deficiency anaemia, a condition which we know to be highly prevalent in this context. The issue of inequality of access remains with modern contraception, as it does with other medicines.

The postpartum copper IUD (PPIUD), on the other hand, has been consistently shown to be safe and convenient, is categorized MEC 1 for breastfeeding and non-breastfeeding women,[10] is highly cost-effective,[12–14] and is a viable option for LMICs purchasing their own contraceptive methods. Two large multi-country initiatives using the same standard method of the long Kelly's forceps have shown that PPIUD expulsion rates are no different from interval IUD expulsion rates as long as a high fundal placement is attained.[15–17] A recently published meta-analysis provides further detail on this issue.[18] Infection rates were also demonstrated to be very low and perforations non-existent due to the large, thick-walled postpartum uterus.[15] The added advantage of inserting a PPIUD immediately postpartum is that the procedure is relatively painless compared to the interval IUD, as the cervix is already open following delivery, and it can be performed as a one-stop procedure within 10 minutes of birth if counselling has been given and consent obtained in advance.[19] It has also been demonstrated that task-shifting or sharing is absolutely feasible and safe to do, with appropriately trained midwives and nurses inserting PPIUD following vaginal delivery as routine practice in many countries.[20,21] Not only has task-sharing been demonstrated to be safe, it has also allowed the method to be much more accessible—for example to those women who have normal vaginal deliveries and do not have access to a doctor during their hospital birth.

Although the COVID-19 pandemic will no doubt cause many more deaths as it continues to spread around the globe, it is giving us the opportunity to rethink current policies and practice. We need to ensure we are providing truly appropriate and equitable care to all women at every opportunity. The provision of effective contraception around the world will result in a healthier future for all. This virus has reminded us that we are all inexorably linked in our common humanity. As the WHO Director General has stated in his COVID-19 press briefings, "No one will be safe unless everyone is safe".[22]

MEMBERS OF THE FIGO CONTRACEPTION AND FAMILY PLANNNING COMMITTEE, 2018–2021

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CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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