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Preserving and advocating for essential care for women during the coronavirus disease 2019 pandemic

Erica F. Robinson, MD, FACOG; Janelle K. Moulder, MD, MSCR, FACS, FACOG; Matthew L. Zerden, MD, MPH, FACOG; April M. Miller, MD, MPH, FACOG; Nikki B. Zite, MD, MPH

Introduction

The coronavirus disease 2019 (COVID-19) poses an unprecedented health and social crisis. Owing to the massive strain placed on the healthcare system, a critical need exists to preserve resources. Varying restrictions are appropriately in place, limiting medical care based on regional disease impact and by recommendations from bodies such as The American College of Obstetricians and Gynecologists (ACOG).[1] "Essential" and "elective" are the terms used to determine what procedures are preserved. By categorizing time-sensitive reproductive health procedures (ie, abortion) as "nonessential," several states have limited women's reproductive health choices. The status of other procedures, such as sterilization and long-acting reversible contraception (LARC) insertions or removals, has been debated and restricted during the crisis. The maneuvering to impose barriers to women's reproductive autonomy during this time will affect vulnerable groups even more.

As obstetrician-gynecologists, we occupy a powerful space at the crossroads of politics, social justice, and reproductive rights. This is a call to action for obstetrician-gynecologists to fight for the preservation of reproductive healthcare. Our call to action highlights areas under threat with concrete solutions to preserve and improve women's reproductive health.

Abortion care during the coronavirus disease 2019 pandemic

Medication abortions: reduce barriers. In a 2020 joint statement of leading women's health organizations, abortion is affirmed to be a time-sensitive procedure to which access must be preserved.[2] With "no-test" protocols, appropriate patients at <77 days of gestation, are able to access evidence-based, safe medication abortion without in-person visits. This translates to a large percentage of patients receiving remote care entirely. These "no-test" protocols keep appropriate abortion patients out of clinics and hospitals, minimize the use of personal protective equipment (PPE), and maintain social distancing measures. Bans and restrictions on medication abortions are politically motivated, and not based in science. We call on the obstetrician-gynecologist community to fight against the recent efforts to restrict abortion and advocate for the removal of current state laws (ie, waiting periods, mandatory 2-visit medication abortion protocols) that place patients and healthcare workers at increased risk.

Procedural abortions. During this pandemic, when hospital resource preservation is paramount, procedural abortions in the outpatient setting are a low-cost and safe option with minimal PPE use. Labeling abortion as a "nonessential" procedure limits access, delays care, and unnecessarily increases the risks to maternal health. Understanding regional healthcare limitations, we advocate that outpatient facilities obtain and maintain the ability to perform procedural abortions. With outpatient abortion access maintained, hospital-based procedural abortions are appropriately limited to the most medically complex patients.

Contraceptive services during the coronavirus disease 2019 pandemic

Permanent contraception: the role of Medicaid extension. Postpartum care provides critical services encompassing contraception, mental health, lactation support, and management of chronic diseases. Currently, Medicaid covers more than 40% of all births in the United States, but for women with pregnancy-related Medicaid, coverage typically lapses after 60 days.[3] With this in mind, ACOG advocates for Medicaid extension to cover 12 months postpartum with comprehensive care to decrease maternal morbidity and mortality in this period.[3] Although ACOG leadership believed this was critical before the COVID-19 pandemic, the national emergency that ensued highlights the importance of this proposal.

Before the pandemic, almost 50% of women desiring permanent sterilization during their delivery admissions would not undergo the procedure,[4] and now this number is likely higher with fewer cases (postpartum and interval

From the Department of Obstetrics and Gynecology, Wake Forest School of Medicine, Winston-Salem, NC (Drs Robinson, Moulder, and Miller); Department of Obstetrics and Gynecology, WakeMed Health & Hospitals & Planned Parenthood South Atlantic, Raleigh, NC (Dr Zerden); and the Department of Obstetrics and Gynecology, University of Tennessee Medical Center—Knoxville, Knoxville, TN (Dr Zite).

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Corresponding author: Erica F. Robinson, MD. e.robinson@wakehealth.edu

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sterilization procedures) being performed. Even with the current limitations of resources and PPE, postpartum sterilization remains a time-sensitive, essential procedure that should be completed to support the reproductive autonomy of our patients.[5] Failing to provide this procedure because of the misclassification as "elective" minimizes reproductive choice and does not acknowledge that contraception is even more essential during a time of systemic stress with an uncertain economic future.

Regrettably, if Medicaid coverage lapses or Title XIX consent forms expire during the pandemic, many women will lose their opportunity to obtain a desired sterilization procedure. Fortunately, the Centers for Medicare & Medicaid Services (CMS) has announced the suspension of all reverification during the COVID-19 crisis, and coverage will continue for now.[6] We must advocate for expedited access to all contraceptive options. When a patient is unable to receive a desired method because of necessary COVID-19 restrictions, providers need to educate and counsel about alternate contraceptive methods to prevent this pandemic from leading to more short-interval, and potentially undesired, pregnancies.

Immediate postpartum long-acting reversible contraception insertion. Immediate postpartum (IPP) LARC is the placement of an intrauterine device or implant during a delivery admission. IPP LARC is safe, effective, and well supported by data and patient satisfaction. Facilitating IPP LARC would benefit patients, providers, and institutions, especially during a time when outpatient visits are limited. The lack of reimbursement from private payers is a significant barrier for many women. Now is the time to demand simple guidance for payment from all insurance providers. IPP LARC should be an option for all women after delivery, preserving it where existing and implementing it at hospitals not currently offering it, as it requires no additional PPE and COVID-19 is not a contraindication.

Continue to offer outpatient contraceptive management. LARC is highly effective with typical use and has few medical contraindications. LARC use continues to increase, and in populations wherein its use is widespread, unintended pregnancy and abortions have decreased. Fortunately, contraception counseling is appropriate for virtual or in-person encounters. When a patient desires to have a LARC insertion or removal, and the region is able to accommodate outpatient visits, LARC visits need to occur. We must advocate and create protocols for healthcare practices to minimize exposure during a LARC procedure. If LARC placement is unavailable or undesired, it is imperative to provide user-controlled methods of contraception (eg, pill, patch, and ring) and emergency contraception as desired. Refills and new prescriptions for short-acting methods can occur safely by using telemedicine. Preserving access to all contraceptive options will decrease unintended pregnancies and abortions.

Conclusion

Optimization of current standards of practice and elimination of barriers to postpartum and outpatient LARC and sterilization are essential, as is the preservation of abortion care in this unprecedented COVID-19 era. Our patients' reproductive autonomy depends on our commitment to both safely providing these services and advocating for their availability at the health-system, local, state, and national levels. Postpartum sterilization procedures and access to abortion are always time-sensitive and essential. The indefinite postponement of postpartum sterilization and the absence of IPP LARC programs frequently lead to hospital discharge without contraception and future unintended pregnancy. Especially during the COVID-19 pandemic, we must dedicate our work and advocacy to eliminating barriers to healthcare resources, such as mandating unnecessary visits to facilities, regulations against telehealth, and abortion waiting laws. Failing to provide our patients effective contraception and then forcing women to carry undesired pregnancies to term during a medical pandemic and social crisis is immoral. As reproductive health physicians and advocates, we need to "make our voices heard" to ensure access to essential healthcare and preservation of reproductive autonomy. ■

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ABSTRACT

Preserving and advocating for essential care for women during the coronavirus disease 2019 pandemic

The coronavirus disease 2019 pandemic has redefined "essential care," and reproductive healthcare has become a frequently targeted and debated topic. As obstetricians and gynecologists, we stand with our patients and others as advocates for women's reproductive health. With the medical and surgical training to provide all aspects of reproductive healthcare, obstetricians and gynecologists are indispensable and uniquely positioned to advocate for the full spectrum of care that our patients need right now. All patients have a right to these services. Contraception and abortion care remain essential, and we need to work at the local, state, and federal levels on policies that preserve these critical services. We must also support policies that will promote expansion of care, including lengthening Medicaid pregnancy and postpartum coverage. Although we continue to see patients, this is the time to engage outside clinical encounters by participating in lobbying and other advocacy efforts to preserve essential services, protecting the health, life, and welfare of our patients during the coronavirus disease 2019 pandemic.

Key words: abortion access, contraception, COVID-19 pandemic, obstetrics and gynecology, reproductive health, women's health