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Review Article

Family planning and abortion services in COVID 19 pandemic

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ABSTRACT

Many routine and elective services have already been postponed or suspended by both Government and private setups in most parts of the world because of the unprecedented pandemic of COVID-19. Healthcare systems everywhere in the world are under pressure. Being a component of essential health services, family planning and abortion services should continue to cater the population in order to prevent the complications arising from unintended pregnancies and sudden rise in STIs. Due to airborne nature of transmission of the virus, it is advisable for all consultations relating to family planning services to be done remotely unless and until visit is absolutely necessary.

Contraception initiation and continuation can be done by telemedicine in most individuals. Post partum contraception can be advised before discharge from hospital. In an individual planning for pregnancy, currently it is not advisable to discontinue contraceptive and plan for pregnancy as not much is known about the effect of the virus on foetal development. Also, pregnancy requires routine antenatal and peripartum care and complications arising from pregnancy may necessitate frequent hospital visits, exposing the individual to the risk of infection. Abortion services are time sensitive therefore should not be denied or delayed beyond legal limit. We need to change from real to virtual consultation to prevent the rise in unplanned pregnancies, sexually transmitted infections and unsafe abortions.

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Introduction

The World Health Organization (WHO) declared the outbreak of SARS-COV-2 to be a public health emergency of international concern on 31st January 2020 [1]. The COVID-19 strain of coronavirus infection has a high rate of transmission by droplet and through fomites [2]. India declared the first diagnosed case of COVID-19 infection on 30 January 2020 [3] and the number of cases is rising since then. Most countries across the globe have recognized this as a national emergency and have started taking measures against the infection [4]. In this war against a minute invisible yet very strong enemy, countries will need to make difficult decisions to balance the demands of responding directly to COVID-19, while simultaneously planning in a coordinated manner to maintain essential health service delivery [5]. Both Government and private setups in most parts of the world have already suspended many routine and elective services. There are some essential health services, which by no means should suffer because of the present

COVID-19 pandemic, and family planning and abortion services include one such service.

The goal of family planning services is to improve pregnancy planning and spacing, and prevent unintended pregnancy. It allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for children, women, and families. Family planning services include contraceptive services for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, STD services (including HIV/AIDS), and other preconception health services [6].

Unintended pregnancies occur among women of all incomes, educational levels, and ages. Negative outcomes associated with unintended pregnancy include delays in initiating prenatal care, reduced likelihood of breastfeeding and increased risk of maternal depression and parenting stress [7]. Children from unintended pregnancies are more likely to experience poor mental and physical health during childhood, lower educational attainment, and more behavioral issues in their teen years [8]. To avoid the complications related to unintended pregnancy, contraceptive services must continue to be provided. Access to family planning is a human right; it saves lives and promotes healthier populations. Much progress has been made in the last 25 years to make family

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planning methods available to the needy population. As of March 2020, there were an estimated 450 million women using modern contraceptives across 114 low- and middle-income countries. Ending unmet need for family planning by 2030 is one of the three goals set by the UNFPA for Sustainable development. COVID-19 pandemic is already hampering in meeting the family planning needs. Women are refraining from visiting health facilities due to fears about COVID-19 exposure or due to movement restrictions. Disruptions to global manufacturing and supply chains may reduce the availability of contraceptive commodities. It is anticipated that many contraceptive methods are expected to become out of stock in the next 6 months in some of the lowest income countries. For every 3 months the lockdown continues, up to 2 million additional women may be unable to use modern contraceptives [9]. With the migrant labourers from cities of India going back home, the need for an effective contraception cannot be understated. Policies should focus on maintaining the manufacture and supply chain of contraceptive commodities so that they are continuously being delivered to the population in need.

An individual contacts the health facility for contraception under the following circumstances:

1. Initiation of new contraceptive:

Individuals requesting to start contraception can be assessed remotely by Teleconsultation for counselling, reviewing medical history for contraindications, information about safe and effective use and for selection of contraceptives. Face to face consultation should be arranged only if warranted [10].

First prescription of COCs would require complete remote assessment of medical eligibility and accurate self-reported blood pressure and Body mass index (BMI).

Individuals considering POP can safely start on it without face-to-face consultation and continue it till contraception is desired or the pandemic settles (whichever later). Prescription for 3–6 months can safely be given for the same.

Administration of DMPA or insertion of intrauterine contraceptive may be considered where concerns about adherence, individual intolerance of oral contraceptives or use of teratogens make longer-acting reversible contraception the only suitable option. Enzyme inducers do not affect DMPA, LNG-IUS and Copper-IUD; one of these can be option for women on enzyme inducers. Local protocol regarding infection control should be followed at the time of the procedure [10]. It should also be checked that the individual does not belong to a containment zone, that she has no history of contact with confirmed or suspected case of COVID-19 and also that she is not having any symptoms suggestive of COVID-19 infection, if so it is advisable to postpone the hospital visit and advise her or her partner to use a temporary method of contraception for the time being.

To summarise, POP can safely be prescribed on Teleconsultation, COCs can be prescribed after ruling out contraindications. LARC may be considered in certain situations. All pre procedure assessment should be done remotely to minimize contact.

2. Post partum contraception:

As a result of the COVID-19 pandemic, access to sexual health and primary care contraceptive services is significantly reduced and immediate post partum time is the best opportunity to prescribe a desired contraception to the woman. Maternity centres must ensure that an effective post-partum contraception is provided to the woman before discharge. This will reduce the need for further contact with healthcare services in this Pandemic [11]. It is recommended that an effective contraception be commenced as

soon as possible after delivery by both breastfeeding and non-breastfeeding mothers. This allows individuals to avoid short inter-pregnancy intervals.

Most contraceptive methods (except Combined Oral Contraceptives) can be started safely after delivery. Long-Acting Reversible Contraceptive (LARC) methods are highly effective and should be offered to all women after delivery.

Post placental IUCD insertion is one of the most popular and effective methods of post partum contraception and should be offered to all women after normal delivery or with Caesarean section (Post placental insertion).

The POP is extremely safe and there are few contraindications to its use and can be started by Day 21 of delivery without any requirement for additional contraceptive precautions. It is recognised that fully breastfeeding individuals can rely on Lactational amenorrhea (LAM) for contraception for the first six months after delivery, so long as they remain amenorrhoeic and continue to breastfeed fully. Breastfeeding individuals must use an additional contraception as soon as possible after delivery as is difficult for many to fulfill the criteria for LAM. Women should be provided with clear information about how to use their chosen method and when to seek medical advice [11].

3. Continuation of existing contraception:

- a) *Combined Oral contraception (COCs)*: Existing users can reasonably be prescribed COCs for another 6–12 months by Teleconsultation without reviewing medical history rechecking BMI or blood pressure, provided all relevant medical history was taken and documented during the last consultation and no contraindication was found. The risk associated with unplanned pregnancy is likely to be higher than risk relating to continued COC use.
- b) *Progestogen only pill (POP)*: For existing POP users it is reasonable at this time to continue it for another 6–12 months without in person review.
- c) *Depot medroxyprogesterone acetate (DMPA)*: If an individual has no contraindications to DMPA, she is likely to have no contraindications to POP unless absorption or adherence issues or use of an enzyme-inducing medication is present. No additional contraceptive precautions are required if POP is started up to 14 weeks after the last DMPA injection [10].
- d) *Etonogestrel implant*: Implants are not very popular in India, but used widely as a LARC in most parts of the world. Replacement of implants can be deferred for a year after expiry to avoid unnecessary face-to-face contact with health care provider. Women have to be counseled that contraception cannot be guaranteed and they can additionally start using POP without face-to-face assessment, unless absorption or adherence issues are there. There is no indication to remove expired Implants at this time of pandemic unless they wish to become pregnant or have serious adverse side effects [12].
- e) *Levonorgestrel intra uterine system (LNG-IUS)*: Replacement of LNG-IUS can be deferred for a year after expiry to avoid unnecessary face-to-face contact at this time. Women should be made aware that contraceptive effectiveness cannot be guaranteed but is likely to be adequate, as with implant they can use POP to use in addition without face to face assessment [12].
- f) *Copper IUD (Cu-IUD)*: In case of IUDs licensed for 5 years, additional use of condoms/oral contraceptives is advised from the time of expiry of Cu-IUD. There is extremely limited evidence suggesting TCu380A to be effective for up to 12 years; due to the lack of evidence women should be advised to use condoms or other forms of temporary contraception

[13,14]. There is no indication to remove expired Cu-IUD at this time unless the user wishes to become pregnant, has significant signs of infection or has serious adverse side effects.

4. Emergency contraception (EC):

Remote assessment by telemedicine should be done for requirement of EC so that it can be made available as soon as possible after unprotected intercourse. Insertion of a Cu-IUD for EC should continue to be offered as first line, where this is possible, to qualifying individuals, as its benefits regarding further contraceptive cannot be underemphasized. Where there is a delay prior to Cu-IUD insertion, immediate oral EC should be offered in addition. With prescription of oral EC, individuals should be provided with COCs or POP for another 3 months by teleconsultation. They should also be advised about when to do pregnancy test and when to start taking the regular contraceptive [10].

5. Discontinuing existing contraceptive and planning for pregnancy:

As of now, very little is known about Covid-19 in pregnancy. As per the RCOG, pregnant individuals appear to be no more likely than the general population to contract the infection. While most pregnant individuals with Covid-19 are expected to have mild symptoms (or none), a small proportion of women, particularly those in the third trimester may have more severe symptoms with Covid-19 as a result of pregnancy [15,16]. Current opinion is that Covid-19 is unlikely to cause intrauterine infection and risk of miscarriage and fetal abnormality are not expected to be increased. Correlation with preterm birth is not known. Despite these unworrying points, it appears that it is not a good time to plan for conception because Covid-19 is likely to remain a problem for many months and very little is known at this time about the risks associated with COVID-19 for pregnant women and their babies as new evidences are coming up each day. Pregnancy requires routine antenatal and peripartum care: both require contact with health-care professionals. Complications arising from pregnancy may necessitate frequent hospital visits. Each time an individual contacts a health facility, he or she is exposed to the risk of infection. Thus women need to be advised that this is not a good time to plan for pregnancy and that they continue with the regular contraception they are already using. If one still desires to plan, she must take preconceptional folic acid and optimize her health before embarking on the journey of pregnancy.

6. Opting for permanent method of sterilization:

All interval permanent methods of contraception (Sterilization) should be deferred till the pandemic is over and couples should be advised to use a temporary method of contraception best suited to them from the available options. Post partum tubal sterilization by minilaparotomy and tubal ligation with Caesarean section can be done if requested by the woman. Aerosol generating procedures should be avoided. Regional anaesthesia is preferable as patients being operated can be asymptomatic carriers of COVID 19.

Role of ASHA workers in providing contraceptive advice and access to contraceptives during their home visits

ASHA (Accredited Social Health Activist) is instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as a part of the National Rural Health Mission (NRHM). She is a resident of the same community who selects her; she is trained and supported to function in her own village as a health

activist and a front-line basic health care provider. She acts as a link between the community, the dispensary and government hospitals. A primary responsibility of ASHA workers is to educate people about family planning and to distribute contraceptives to the couples in her community. An ASHA can be very well utilized in this era of COVID-19 pandemic, as she can act as the bridge to provide uninterrupted supply of contraceptives to needy people in her locality.

Termination of pregnancy (MTP) in times of COVID-19

Provision of abortion may be affected by delayed presentations by the woman due to non-availability of transport services due to the lockdown. It is of utmost importance to ensure that women who seek abortion and family planning do not suffer from lack of access. The provision of abortion services is time sensitive as it is a well-established fact that early abortions are safer for women and the MTP Act places limits on the gestational age for abortions. It is also well known that women who seek abortion tend to get it one way or another. Therefore abortion services should continue to be provided by both public and private providers [4]. Teleconsultation services should be utilized to take history, counseling of patient and advising investigations (if required) before MTP kit prescription, but prescription of MTP kit needs direct non-virtual consultation [17]. All precautions to be taken during hospital visit should be advised to the woman during Teleconsultation. Medical methods for termination should be provided as long as they are not contraindicated.

If surgical methods are indicated, local or regional anaesthesia should be used and general anaesthesia should be avoided. The woman should be advised and be prescribed with a contraceptive suitable for her immediately after the abortion.

Pregnancy testing and counseling as a part of family planning services in COVID 19 pandemic

Pregnancy testing and counseling services should be provided as part of core family planning services, as recommended by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics [18,19]. A detailed reproductive and medical history must be taken by teleconsultation and patient be advised to perform kit based urine pregnancy test at home. She should be advised to continue folic acid supplements or to start taking if not already on it. She should also be advised to visit the health facility in case of any emergency.

Family planning and abortion services in a COVID-19 suspect or confirmed case

Individuals with suspected or confirmed COVID-19 infection should be advised home isolation if there is minimal or no symptoms. It is advisable to wait till the infection clears off. If an individual is seeking abortion services and she is well within the legal gestational limit for MTP, it is advisable to wait. If it becomes mandatory to attend the hospital, the woman should be advised to attend via private transport where possible.

If an ambulance is required, she should alert the providers that she is currently in self-isolation for possible or confirmed COVID-19 affecting either her or her household contact [16]. To minimize contact, most part of the consultation can be done by teleconsultation. The woman should be clarified on telephone about the exact location so that risk of spread of infection can be minimized. She should also be advised to use all measures to prevent spread of infection while leaving from her place. The woman should be asked to alert a member of medical staff about when she would

be reaching the hospital, as soon as she reaches the hospital she must be provided with a fluid-resistant surgical mask, which should be removed only when she is isolated in a suitable room. Staff providing care to the woman must be in appropriate PPE [20]. Isolation area should ideally have a defined area for staff to put on and remove PPE, and suitable bathroom facilities. Only essential staff should enter the area and visitors should be kept to a minimum. All non-essential items should be removed prior to the woman's arrival. Operating room facility should ideally be within the same limits of donning and doffing areas. If any surgical procedure (for example Suction evacuation) is required, local or regional anaesthesia should be used. All clinical areas used must be cleaned after use. A suspected patient should be treated as a confirmed case until test results are available. Any emergency diagnostic or therapeutic procedure should not be delayed for non-availability of COVID-19 report and should be managed immediately with full precaution.

To conclude, Health care facilities should continue to provide Family planning and abortion services, as they are components of Essential Health Services. We urgently need to change our method of providing routine family planning services from direct consultation to remote consultation by telemedicine. Without this, we will see serious adverse reproductive health outcomes, including a rise in unplanned pregnancies, sexually transmitted infections and unsafe abortions.

Declaration of Competing Interest

All the authors declare that there are no conflict of interest.

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