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How COVID-19 Related Isolation Measures Impacted Access to Selected Sexual and Reproductive Health Services in Georgia

Final Report

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Disclaimer:

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Abbreviations

ANC	Antenatal Care
CPR	Contraceptive Prevalence Rate
CRRC	Caucasus Research Resource Center
FGD	Focus Group Discussions
GoG	Government Of Georgia
IDI	In-Depth Interviews
MoH	Ministry Of Internally Displaced Persons From Occupied Territories, Labor, Health And Social Affairs
PPE	Personal Protective Equipment
RGA	Rapid Gender Assessment
RT	Research Team
SEI	Short Exit Interviews
SQDA	Secondary Quantitative Data Analysis
SRH	Sexual And Reproductive Health
SRHR	Sexual & Reproductive Health And Rights
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency For International Development
WHO	World Health Organization

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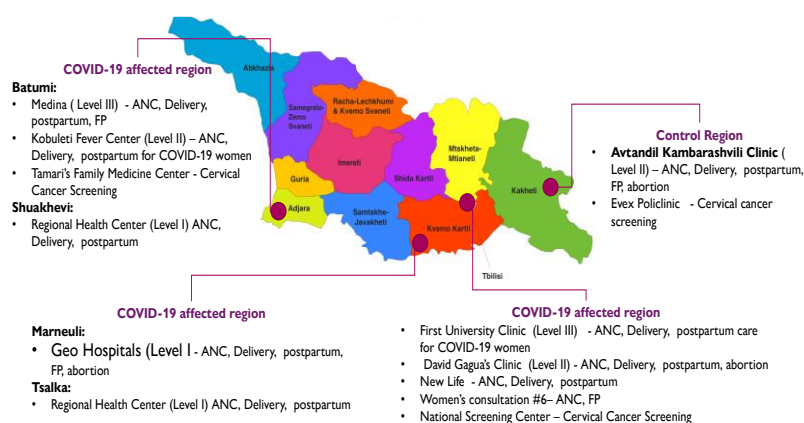
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Executive Summary

Since December 31, 2019, the disease (COVID-19) caused by the novel Coronavirus (SARS-CoV-2) has spread rapidly worldwide. On January 30, 2020, the World Health Organization (WHO) declared a Public Health Emergency of International Concern, and on March 11 - a pandemic. The Georgian Government has responded to the pandemic by restricting both internal and external travel. Social distancing measures have been enforced to reduce spread within communities, and isolation has been encouraged for the population except for necessary travel. Swift and expeditious preventive and control measures taken by the Government of Georgia (GoG) contained the virus spread and minimized death rates¹. Despite this progress, the economic and social impacts of the pandemic were challenging. COVID-19 pandemic has ushered in restrictive social measures that could each have a profound influence on Sexual and Reproductive Health (SRH) and rights (SRHR). For this purpose, GoG decided to assess the effectiveness of its pandemic response in February-June 2020, in order to understand how measures aimed at controlling the pandemic have affected the access to essential healthcare services, including SRH, and make corrections where shortcomings are identified.

The purpose of this qualitative research is to determine the impact of COVID-19 social restriction measures on access to essential SRH services, which for the sake of this study encompass: maternal health (antenatal, intrapartum, and postpartum), family planning services (including access to contraceptives), abortion and post-abortion care and cervical cancer screening services, and recommend refinements where needed. The research aims to answer the following main

Figure 1: Geographical Scope



questions: i) What is the pandemic's impact on access to SRH services and the full realization of women's reproductive rights? ii) What was done by the Government to ensure access to SRH during the crisis? iii) How effectively did the state provide and adapt SRH services to COVID reality?; iv) Was the access to the SRH services restricted during the pandemic/state of

emergency, particularly during the lockdown?; v) How accessible was COVID-19-related reliable information to Women of Reproductive Age (WRA)?; vi) Did WRA receive the support they needed during the pandemic?; vii) What are the promising international practices in terms of combating the negative consequences of COVID-19 for pregnant women?; and viii) What should the Government do to better respond to the needs of pregnant women and WRA in the time of future waves?

The qualitative study was carried out in four regions of the country, sampled on the basis of worst impact from COVID-19 (Tbilisi, Kvemo Kartli, Adjara Autonomous Republic) and one control region, least affected by pandemic (Kakheti region) during February-June 2020 (see **Error! Reference source not found.**). Study results presented in this reports are based on the information collected from decision-makers; health facility managers and service providers at maternity homes/departments, women's consultations, cervical cancer screening centers; from direct service recipients (pregnant women, young mothers, and women of reproductive age) in all four study regions, and analysis of statistical data.

¹ Voluntary National Review – Georgia <https://sustainabledevelopment.un.org/memberstates/georgia>

The worsening overall COVID-19 epidemiological situation in the country challenged the data collection process and these limitations have to be taken into account in the interpretation of findings. Specifically: i) Research Team (RT) was not able to travel to the Adjara region. The given challenge was mitigated through replacing face-to-face IDIs with online, remote IDIs with service providers in selected health clinics. For service recipients, with the help of clinics' management, instead of originally planned Focus Group Discussions (FGD), RT conducted individual phone interviews; ii) Deteriorated epidemiological situation caused difficulties in the organization of FGDs in almost all studied regions. Instead of FGDs, individual phone interview and individual face to face interview methods have been used; iii) The rapid aggravation of COVID-19 cases also restricted RT's access to key decision-makers from the ministries in Tbilisi and Adjara regions, albeit information was collected from mid-level management staff; and finally, iv) Quality and completeness of quantitative data from the pharmaceutical industry restricted more comprehensive analysis of access to contraception. Thus, the data presented in the report is only based on one data source.

Main Findings

National Response: Georgia formally declared antenatal and perinatal services as priority SRH services for continuation during the acute phase of COVID-19 pandemic. Instructions and recommendations on the modalities of SRH service delivery during the state of emergency and lockdown, except COVID-19 specific Infection Prevention and Control (IPC) guidelines, were largely lacking. Nevertheless, to ensure access and quality care provision to pregnant women with COVID-19, the Ministry of Internally Displaced Persons from Occupied Territories, Labor, Health and Social Affairs (MoH) designated specific health facilities as service points. Furthermore, to regulate provision of Antenatal Care services (ANC) during COVID-19, with UNFPA support, the protocol instructing ANC service provider to minimize direct patient contact in non-urgent situations in an attempt to minimize the spread of COVID-19 was approved in May 2020 and placed on ministry's website. However, the protocol did not reach service providers and was not effectively applied in practice.

The Government extensively utilized all possible media sources to inform population regarding the Coronavirus and was successful in managing the rapid spread of misinformation via social media platforms and preventing complications. Despite of effective communication, the Government paid little to no attention to informing population about new regulations introduced for accessing SRH services. To fill the information gap, some clinics used different communication means, including social media to deliver information on availability and mode of SRH service delivery.

Several hotlines launched within record-breaking deadlines and aided the government in effectively managing epidemiological situation during the state of emergency and lockdown. In April an additional line for issuing emergency one-time vehicle movement permits during the lockdown became operational. Introduction of vehicle permits allowed population to seek health care, including SRH services, pharmacy visits, emergency hospitalizations and doctor's appointments.

Access and utilization of SRH services during state of emergency and lockdown: The COVID-19 crisis and ensuing restrictions complicated access to essential SRH information, services and goods for women and girls.

The provision of antenatal care services was continued, but utilization deteriorated during the state of emergency and lockdown. Antenatal care was provided without interruption during state of emergency and lockdown. While some clinics continued traditional, face-to-face service provision, others quickly adopted a blended model of in-clinic and remote consultation using telehealth solutions. Although access to services was maintained, utilization deteriorated. The routine statistical data analysis shows a decline in the share of pregnant women who received their first ANC consultation before 12 weeks of pregnancy and completed 8 ANC visits during the state of emergency and lockdown compared to the same period in 2019. Utilization of the 1st ANC consultation was deteriorating at the beginning of the COVID-19 pandemic when national media

and social media platforms widely discussed the first information about the virus and its consequences. Only after the lift of lockdown in June, utilization rates started to recover. Deterioration of utilization rates was mostly pertinent to COVID-19 affected regions (Tbilisi, Adjara, Kvemo Kartli), where more severe restrictions were introduced much earlier than nationwide.

Several reasons can explain worsening utilization rates of ANC services during the state of emergency and lockdown. Travel restrictions constrained service providers to continue early identification of pregnant women and provision of the 1st ANC consultation in the first trimester of pregnancy. Limiting the number of days per week for facility-based ANC consultations with strict adherence to IPC guidelines and appointment scheduling undoubtedly affected the number of pregnant women served by clinics. In the absence of government regulation on the provision of ANC services during the COVID-19 pandemic, some health facilities introduced an alternative mode of ANC service delivery (telehealth consultations) as a self-initiative. These consultations were not registered and claimed for reimbursement. Consequently, remote consultations during the state of emergency and lockdown are not officially counted and did not appear in routine statistical data.

Lack of available medical staff also affected the number of pregnant women served by ANC clinics. Notably, the medical staff in studied clinics have not been diverted to respond to the COVID-19 pandemic. The medical staff over 70 years old (a risk group for COVID-19) were instructed to stay home and provide services remotely. In contrast, remaining medical professionals could not deal with the workload, limiting coverage of pregnant women with ANC consultation as per schedule. Staff shortages were mostly severe at small clinics with few medical staff. Fear of contracting the coronavirus influenced health seeking behavior of pregnant women during state of emergency and lockdown.

Access to delivery services and postpartum care was maintained during the state of emergency and lockdown. Maternity clinics/departments continue providing delivery and postpartum care without interruption and with strict adherence to social distancing, hand and cough hygiene, and other infection prevention and control requirements. Fewer numbers of deliveries were reported during February – June 2020 compared to the same period of 2019. This can be explained by a decrease in overall annual birth rate, as it was not accompanied by an increase in home deliveries. However, the higher number of deliveries observed during the complete lockdown, end of March – beginning of May, compared to the period before and after lockdown, indicates the absence of access barriers to delivery services during this period. ²

A noticeable increase in C-sections is reported during the state of emergency in the country and all studied regions except Tbilisi³. It is unclear whether the observed changes in cesarean section rates had been accounted for exclusively by those considered unnecessary. Factors associated with an increase in cesarean births may include health clinics' motivation to perform more C-sections and recuperate financial losses from reduced caseloads, consequent lower revenues and bloated expenditures on IPC measures.⁴ Besides, an observed increase in C-sections could also be the effect of deliberation of the moratorium on financial sanctions for medically unjustified C-sections announced verbally by MoH at the beginning of the state of emergency.

State of emergency and lockdown did not affect women and their family members' decisions when and where to seek care. Travel time from home to the healthcare facility have not changed significantly since before the outbreak. Women in labor mostly used personal transport to reach the clinic, some used Emergency Ambulance Services. To avoid crowding and minimize hospitalization time, health clinics introduced phone consultation before admission advising women not in active labor to stay home and explained signs of active labor when they had to come to the clinic.

² NCDC, Routine medical Statistics for 2019 and 2020, researchers calculations

³ Ibid

⁴ On request C-sections are reimbursed by State at the rate of a normal delivery - 500 GEL, thus the financial incentive could be partly caused by revenues from the patient's co-payment. Medically justified C-section is reimbursed at 800 GEL by the State Social Agency and it is not difficult for health professionals to provide medical justification for C-sections and get reimbursed at a rate of 800 GEL from public funding.

Various measures have been applied by maternity clinics to ensure quality service provision. All clinics surveyed introduced rigorous testing and IPC measures to prevent Coronavirus spread and ensured adequate and continued supply of medicines, consumables, and Personal Protective Equipment (PPE). If at the beginning of the state of emergency shortage of face masks and PPE were experienced by almost all health clinics, clinic managers soon resolved supply related issues and procured PPEs. No problems have been reported in supply chain breakdown during the studied period.

Maternity clinics also prioritized health, safety, and wellbeing of staff by the introduction of everyday screening at entry into the facility, introduced duty schedules for core medical and support staff, maintained a pool of reserve staff on call in case of emergency and/or staff sickness and offered by-monthly testing of staff. Clinics organized internal staff training on testing and IPC measures, alternative service delivery methods internal to particular clinics, and new work schedules.

Clinics also ensured safe and positive childbirth experiences during emergency state and lockdown. Where infrastructure allowed, providers ensured labor and postpartum care of women in the single-patient rooms to avoid contact with other women. Appropriate pain relief strategies were applied by all studied clinics and allowed mobility in labor where possible, and birth positions. However, partner deliveries were barred during the emergency, going against the World Health Organization (WHO) guidance and undermining pregnant women's rights and the support systems they count on. Post-discharge follow-up consultations were performed by remote counseling, risk assessment, and clinic invitation for those at risk of complications.

COVID-19 clinics⁵ received extensive MoH/NCDC training on COVID-19 testing, social distancing, hand and cough hygiene, IPC measures, clinical management of COVID-19 women during pregnancy and childbirth, and periodic supportive supervisory visits by teams of NCDC epidemiologists and clinicians. Non-COVID-19 clinics were left with limited support from the Government.

The COVID-19 pandemic restricted access to safe abortion services. Access to abortion services is not a service widely provided by maternity clinics in the country and is not covered by the Universal Health Care (UHC) Programme, except for complicated abortions. In the wake of COVID-19, the Government recommended temporary discontinuation of non-urgent and planned health appointments. Consequently, health clinics categorized non-emergency abortion as “elective” or “non-essential”, which further constrained access to abortion care during the emergency state and lockdown.

While most clinics complied with the Government recommendations, some abortion care providers decided to continue business as usual and established telemedicine services, including pre- and post-abortion counseling and post-abortion follow-up over the phone. D. Gagua clinic in Tbilisi piloted management of medical abortion at home. Trained nurses and doctors provided counseling and medical abortion monitoring to clients at their homes via telephone or video links. Abortion pills were delivered to pregnant women at home using "courier service". The dual model of service provision, using telemedicine to supplement clinic abortion care, had minimized the need for clients' travel to clinics, removed challenges of movement restrictions, reduced in-person client-provider interactions and associated risk of infection. This approach aligns well with WHO guidance, which confirms that self-managed abortion is safe if pregnant individuals have information and access to follow up health care when needed.^{6,7}

Fewer women accessed abortion services during the emergency state. The most severe cessation of abortion care is observed during the complete lockdown, followed by an upsurge when

⁵ First University Clinic in Tbilisi and Kobuleti Fever Center

⁶ The World Health Organization (WHO) recommends that medical abortion can be safely self-managed by women up to the twelfth week of pregnancy, where accurate information and support from a healthcare provider are available.

⁷ Medical Management of abortion, 2018, WHO <https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/>

restrictions were partially lifted⁸. The pandemic has exacerbated existing disparities in access and worsened utilization of abortion care in all studied regions. Service users from rural areas and ethnic minorities report lower abortions rates caused by geographical and financial access barriers. All these obstacles risk preventing or, at the very least, delaying access to abortion services. International human rights explicitly recognize the rights to sexual and reproductive health and bodily autonomy. The recommended suspension of non-emergency procedures, without clarifications for particular services concerned, is in practice hindering women's reproductive freedom. These rights give rise to positive Government obligations to ensure abortion-related information and services and remove medically unnecessary barriers that deny practical access. Thus, GoG has to ensure that individuals do not have to undertake unsafe abortions when faced with an unwanted pregnancy and/or threaten their life or health.

Deterioration of access to abortion care during emergency state is not unique to Georgia. Limited access to abortion has been reported in many low and high-income countries. In countries like Poland, barriers caused by highly restrictive abortion laws and arduous administrative requirements to access abortion services make safe access to this critical health care extremely difficult, or even virtually impossible. Public and private medical facilities are no longer providing abortion on the woman's request in Romania, the decision to suspend non-emergency procedures is in practice hindering women's reproductive freedom. In Germany, where there were already too few doctors providing abortion in some regions, the situation has been aggravated as clinics had to concentrate on absolutely necessary operations and refused to manage abortions. Italy issued guidelines clarifying that abortion cannot be discontinued, although in practice access remained difficult, notably due to a shortage of healthcare professionals willing to provide it

State of emergency and imposed stay at home regulations further fueled already restricted access and utilization of family planning services. Georgia faced key reproductive health challenges even before the pandemic, evident from the country's overall unmet need for contraception of 31%, and the contraceptive prevalence rate (CPR) of only 41%.⁹ The low CPR results from contraceptives not being covered by the Universal Health Coverage (UHC) program; high prices in private pharmacies and the conservative influences of the Orthodox Church.¹⁰ The use of contraception in Georgia declined substantially between 2010 and 2018 (from 53% to 41%). It may be assumed that it has been caused by a serious reduction of availability of free of charge contraceptive supplies that had in the past been made available by USAID and UNFPA.¹¹

The effect of observed lack of family planning counseling during a pandemic is not the direct result of the pandemic; instead, it's more of a consequence of weak family planning practices. Most women interviewed lack correct knowledge about the effectiveness of modern methods of contraception. This finding is not surprising in the context where health professionals do not provide adequate and regular counseling. A significant source of information on contraception named by respondents is either friends, relatives, neighbors, or in best-case scenario advice given by pharmacists on the concrete method of contraception.

Amid the COVID-19 pandemic, supply and sales of contraceptives deteriorated. The analysis of data obtained from the largest pharmaceutical companies¹² revealed a reduction in the supply of contraceptive commodities during the emergency state, except for contraception pills, the supply of which has increased by 25% during Feb-June 2020 compared to the supply levels of the same period in 2019. In parallel to constraint supply levels, the data shows a drop in sales (utilization), albeit not following the same pattern as supply of contraceptive commodities. It isn't easy to find the rationale behind the pharm industry strategy prioritizing one item over the other.

⁸ NCDC, Routine Medical Statistics 2019 and 2020, researchers calculations

⁹ Multiple Indicator Cluster Survey (MICS), 2018,

<https://www.geostat.ge/ka/modules/categories/625/mravalindikatoruli-klasteruli-gamokvleva>

¹⁰ Gynopedia. <https://gynopedia.org/Tbilisi>, Accessed 19-10-2020.

¹¹ Georgia MICS 2018 Sexual & Reproductive Health related data in-depth analysis, UNFPA 2019

<https://georgia.unfpa.org/en/publications/sexual-and-reproductive-health-georgia>

¹² Researchers were only able to obtain accurate data from GEPHA. Data was also received from PSP pharm company, however annual data received for 2020 and 2019 was not disaggregated by months to run analysis.

Economic hardship faced by women during the state of emergency and lockdown along with increased prices (on average 20%-30%) of pharmaceutical commodities negatively affected financial access to contraceptives. Furthermore, women living in settlements distanced from the regional centers, where the largest pharmacy networks operate, mostly relied on local small private pharmacies where modern contraceptive commodities are usually low in stock.

In this critical emergency and lockdown period vulnerable women are more exposed to unplanned pregnancies. Women living in remote and hard to reach areas are the least likely to access or be able to pay for pharmacy-supplied contraceptives. There is an increasing concern that lowered income resulting from job/income losses and price increase heavily affected women's ability to purchase contraceptives.

Cervical cancer screening program has been curtailed during state of emergency and lockdown. In response to COVID-19 cervical cancer screening program was temporarily paused from the third week of March 2020 till mid- June countrywide. Cancer screening services have been completely discontinued by the provider clinics studied in Adjara, Kakheti, and Kvemo Kartli regions, except for the National Screening Centers in Tbilisi. National screening center in Tbilisi continued offering services only to those who completed PAP tests and awaited results and/or required additional investigations and treatment. Preventive measures included daily individual appointments to avoid overcrowding and maintaining one meter distanced queues to promote social distancing.

Women had to decide whether to skip or postpone cervical cancer screening during the current pandemic to avoid potential exposure to the Coronavirus. Although patients and hospital systems are advised to reschedule their preventive services, the full impact of this delay in regular screening has yet to be seen.

Conclusions

As the pandemic spread, Georgia implemented tough lockdowns and travel restrictions in a bid to slow down transmission. Imposed restrictions along with MoH recommendations to temporarily suspend non-emergency services negatively affected the sexual and reproductive health and safety of women and girls, particularly of vulnerable people. As in many other countries, suspension of non-emergency services denied women' access to time-sensitive and potentially life-saving services and further distanced them from already difficult-to-access care.

Though antenatal, delivery and post-delivery care have been maintained during the emergency state and lockdown, women were left with limited access to essential medical services such as abortion care, family planning and access to contraceptives and cervical cancer screening.

The extent of the impact of COVID-19 emergency and lockdown at the population level is generally partial but large enough to affect the availability of and access to high-quality services for the most vulnerable populations. While the country has loosened restrictions since late June 2020, a second wave of the pandemic or infection hotspots may force providers to restrict in-person care again.

As public leaders and officials monitor the health system's capacity to respond to patient needs during the COVID-19 pandemic, they will also continue to be faced with difficult decisions on how to regulate many SRH services critical to women's health. Devastating consequences for women and their families are possible if core sexual and reproductive health services are reduced or deemed non-essential during the pandemic's future waves. This reinforces the need for strategic adaptations to ensure the maintenance of essential health services during the pandemic.

The COVID-19 pandemic impact on the health service providers during emergency and lockdown is already evident and may be felt more severely beyond the pandemic. Those who have been forced to discontinue services or shift to unpaid remote service provision face declining caseloads and are in immediate financial difficulty. The Government is advised to think through reimbursement and reporting mechanism for remotely delivered services.

While there is no end in sight for the pandemic, there is a hope that the existing inequalities that COVID-19 has further brought to the foreground will encourage more action by the Government in the future. With the pandemic growing in many places, the Government has to make difficult

decisions about how best to protect their citizens' health. Safeguarding the essential health, particularly SRH services, is a critical policy response and must be based on the best evidence of what works so that gains in survival and women's health are not reversed. Effective execution of response will require financial resources, political will, and commitment. These will be pivotal drivers, securing COVID-19-specific gains and overall protection and improvement of women's health.

Recommendations:

Outbreaks are inevitable, but catastrophic losses for sexual and reproductive health are not. By learning from prior epidemics, putting in place critical resources and systems, and ensuring the provision of essential sexual and reproductive health services, the country can prevent health system disruptions that would have devastating, lasting effects on individuals, families, and the entire country population. The Government and their partners are advised to take swift, decisive actions to avert potential sexual and reproductive health crisis. Implementation of recommended measures (detailed in the report) will mitigate the impact of COVID-19 on SRH services in the short term and provide benefits over the longer term, as innovations are adopted and institutionalized.

Recommendation 1: Include sexual and reproductive health services as essential services in contingency planning and the response to the COVID-19 pandemic.

Recommendation 2: Adapt policies, technical guidelines and protocols for alternative SRH service delivery models, including telemedicine, to ensure access to sexual and reproductive health and rights during and after the pandemic.

Recommendation 3: Strengthen the abortion care delivery system and enable self-managed abortion by guaranteeing access to medications and telemedicine counseling.

Recommendation 4: Develop overarching guidance on the continuation of cancer screening services during the crises.

Recommendation 5: Institutionalize a mechanism for improved access to modern contraceptives during the crises.

Recommendation 6: Build SRH service provider capacity in the application of alternative service provision modalities, management of SRH clinical cases, and IPC measures through the establishment of a supportive supervision system.

Recommendation 7: Prioritize the collection of accurate and complete data with appropriate disaggregation to understand how COVID-19 impacts access and utilization of SRH services.

Recommendation 8: Intensify culturally sensitive public information and education campaign to communicate messages about the epidemic and SRH service provision modalities.

Chapter 1: Introduction

1.1 Background and rationale

Since December 31, 2019, the disease (COVID-19) caused by the novel coronavirus (SARS-CoV-2) has spread rapidly worldwide, after the first cases were originally reported in China. On January 30, 2020, the World Health Organization (WHO) declared a Public Health Emergency of International Concern, and on March 11 - a pandemic.

COVID-19 has posed an existential challenge to governments everywhere, requiring them to balance the imperative of protecting their citizens' health with the human rights limitations and the consequences for livelihoods of border closures and economic shutdowns. There have been no easy answers, and governments have been pushed to adopt bold and unprecedented decisions. A failure to act in time or with sufficient impact has meant high death tolls and overwhelmed hospital systems & services, including Sexual & Reproductive Health services.

The Georgian government has responded to the pandemic by restricting both internal and external travel. The borders have been closed to non-citizens to slow the rate of infection from external entrants. Social distancing measures have been enforced to reduce spread within communities, and isolation has been encouraged for the population except for necessary travel, such as grocery shopping or exercise.

COVID-19 pandemic has ushered in restrictive social measures (self-isolation, quarantine, cordon sanitaire measures) that could each have a profound influence on SRHR. COVID-19 measures may decrease the number of pregnant women delivering in hospitals,¹³ cause delays in care-seeking,¹⁴ increase intimate partner violence,¹⁵ etc. Evidence from other public health emergencies (e.g., infectious disease epidemics, wars and humanitarian disasters) suggests that many women cannot obtain family planning services to avoid unwanted pregnancies. The Guttmacher Institute has noted that many countries have reduced or stopped providing sexual and reproductive health services, interrupting supply chains for condoms and other contraceptives.¹⁶ During this period, women who do become pregnant may be at greater risk of adverse outcomes, including stillbirth, spontaneous abortion, and small for gestational age fetuses.¹⁷

By December 10, the number of confirmed cases in Georgia reached 174,383, with 145,287 patients fully recovered, and 1,614 patients deceased.¹⁸ The evident alleviation of the spread and comparatively low mortality rate can be ascribed to the swift and expeditious preventive and combative measures taken by the Government of Georgia (GoG) since the early January of 2020.¹⁹ This success earned Georgia a place among the 15 non-member states whose citizens were cleared for non-essential travel to the European Union as of July 1, 2020. Despite this progress, economic and social impacts are anticipated to be challenging, and the consequences of the outbreak still need to be comprehensively assessed. Even for countries like Georgia that have so far controlled the outbreak, experts predict the onset of a "second wave" in the next few months. This makes it urgent for the government to assess the effectiveness of its response to the pandemic so far and make corrections where shortcomings are identified. It is also vital for the

¹³ Grünebaum A, McCullough LB, Bornstein E, et al. Professionally responsible counseling about the birth location during the COVID-19 pandemic. *J Perinat Med* 2020 doi: 10.1515/jpm-2020-0183 [published Online First: 2020/05/14]

¹⁴ Masroor S. Collateral damage of COVID-19 pandemic: Delayed medical care. *J Card Surg* 2020 doi: 10.1111/jocs.14638 [published Online First: 2020/05/19]

¹⁵ Hall B, Tucker JD. Surviving in place: The coronavirus domestic violence syndemic. *Asian Journal of Psychiatry* 2020

¹⁶ Purdy C. How will COVID-19 affect global access to contraceptives—and what can we do about it? 2020 [Available from: <https://www.devex.com/news/sponsored/opinion-howwill-covid-19-affect-global-access-to-contraceptives-and-what-can-we-do-about-it-96745>]

¹⁷ Kasraeian M, Zare M, Vafaei H, et al. COVID-19 pneumonia and pregnancy; a systematic review and meta-analysis. *J Matern Fetal Neonatal Med* 2020:1-8. doi: 10.1080/14767058.2020.1763952 [published Online First: 2020/05/21]

¹⁸ <https://stopcov.gov.ge/ka#footer>

¹⁹ Voluntary National Review – Georgia <https://sustainabledevelopment.un.org/memberstates/georgia>

GoG to understand how measures to control the pandemic have affected access to healthcare services, including SRH services.

For this purpose, GoG, in partnership with international organizations, including UN agencies, initiated a broad COVID-19 Impact Assessment. Under the broad framework of the assessment (in which the UN will concentrate on Human Rights issues) it was decided to develop a separate research segment on "Gender Equality and the pandemic" - to be commissioned by UNFPA²⁰, UN Women²¹ and UNDP²² - which, among others, will include a separate sub-chapter on SRHR related topics. Named agencies agreed that the quantitative part of the assessment would repeat the Rapid Gender Assessment (RGA) that was carried out back in May-June to allow for comparative analysis. The Caucasus Research Resource Center (CRRC) has been selected for this task (since they did the previous RGA and are best positioned to do this job). The RGA entails carrying out a nationally representative phone survey (*sample size of 1,200 respondents*) using the same questionnaire and methodology employed in the previous RGA. However, the RGA standard questionnaire does not provide a full picture of the impact of COVID-19 related restrictions on women's access to SRH services and the extent to which the current situation still prevents persons from gaining timely access to the essential SRH services. Thus, UNFPA initiated the qualitative study to contribute to the comprehensive COVID-19 Impact Assessment commissioned by the GoG.

1.2 Report structure

The Report on “ How COVID-19 related isolation measures impacted access to selected Sexual and Reproductive Health Services in Georgia” is structured as described below:

- Chapter 1:** The present chapter provides a rationale for the research and report structure.
- Chapter 2:** Explains the purpose of the research, its objectives, the scope, and the beneficiaries of the study results. It also illustrates the research methodology by detailing the conceptual framework, research questions, the framework, the data collection and analysis methods, and the expected limitations and implementation phases.
- Chapter 3:** Highlights main findings and attempts to explain observed trends in access and utilization of SRH services. It outlines factors that negatively affected access and utilization of SRH services and summarizes approaches applied by health services providers to deal with challenges faced during the emergency state and lockdown.
- Chapter 4:** Provides research conclusions and presents promising practices applied in different countries during the COVID-19 pandemic and stipulates recommended actions to avert potential sexual and reproductive health crises.

Several annexes support these chapters.

²⁰ United Nations Population Fund

²¹ United Nations

²² United Nations Development Programme

Chapter 2: Purpose, Objective, and Research Methodology

The purpose of the qualitative research is to determine the impact of COVID-19 social restriction measures on access to essential SRH services, which for the sake of this study encompass: maternal health (antenatal, intrapartum, and postpartum), family planning services (including access to contraceptives), abortion and post-abortion care, and cervical cancer screening services and recommend refinements where needed.

Figure 2: Geographical Scope



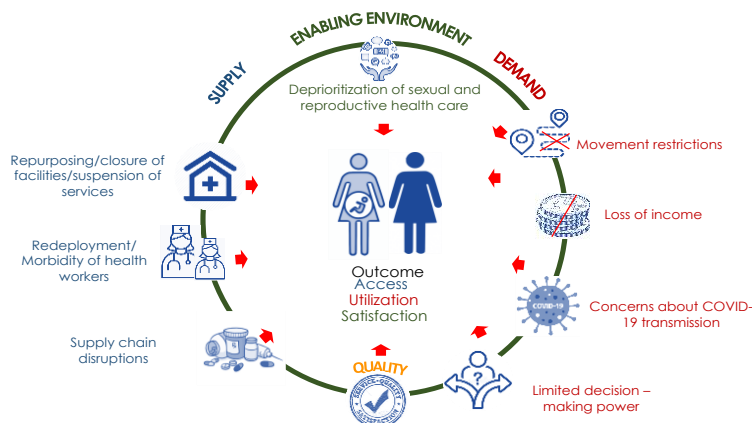
The research was carried out in four regions of the country, sampled on the basis of worst impact from COVID-19 (Tbilisi, Kvemo Kartli, Adjara Autonomous Republic) and one control region least affected by pandemic (Kakheti region) during February-June 2020 (see Figure 2: Geographical Scope).

Study results presented in this report are based on the information collected from decision-makers; health

facility managers and service providers at maternity homes/departments, women's consultations, cervical cancer screening centers (see Annex 1); from direct service recipients (pregnant women, young mothers, and women of reproductive age) in all four study regions and analysis of routine medical statistical data.

The findings of this research and recommended actions will benefit multiple users. It is expected that the findings and lessons learned stemming from the research will help MoH and their partners in formulating guidance document (s) for maintaining essential SRH services during a pandemic. Study findings and recommendations will inform UNFPA advocacy efforts and ongoing support to MoH and Georgia's Government.

Figure 3: Conceptual Framework: Factors that potentially affect the use of reproductive health services during the COVID-19 pandemic



Research framework: Previous public health emergencies (Ebola and Zika epidemics) have shown that the impact of an epidemic on sexual and reproductive health often goes unrecognized because the effects are often not the direct result of the infection, but instead the indirect consequences of strained health care systems, disruptions in care and redirected

resources.²³ Available international evidence guided the elaboration of the conceptual research framework (see [Annex 2](#)). The latter examines factors that could potentially impact the use of sexual and reproductive health services and rights during the COVID-19 pandemic. These factors are grouped by four main health system domains: i) enabling environment, ii) supply, iii) demand, and iv) quality, schematically presented in Figure 3.

Research questions: The research contains answers to the following main questions:

1. What is the impact of the pandemic on access to SRH services and the full realization of women's reproductive rights?
2. What was done by the Government to ensure access to SRHR during the crisis?
3. How effectively did the state provide and adapt SRH services to COVID reality?
4. Was the access to the SRH services restricted during the pandemic/state of emergency, particularly during the lockdown?
5. How accessible was reliable COVID-19-related information to Women of Reproductive Age (WRA)?
6. Did WRA receive the support they needed during the pandemic?
7. What are the promising international practices in terms of combating the negative consequences of COVID-19 for pregnant women?
8. What should the Government do to better respond to the needs of pregnant women and WRA in the time of future waves?

Data collection methods and data analysis: A mix of qualitative (Desk-review (DR), In-depth Interviews (IDI), Short exit interviews (SEI)) and secondary quantitative data collection and analysis (SQDA) methods were used to respond to the specific research questions and sub-questions. Both qualitative and quantitative data have been triangulated and analyzed to arrive at conclusions and formulate recommendations.

Research limitations: The worsening of the overall COVID-19 epidemiological situation in the country challenged the data collection process, and these limitations have to be taken into account in the interpretation of findings. Specifically:

- The Research Team (RT) was not able to travel to the Adjara region. The given challenge was mitigated through replacing face-to-face IDIs with online, remote IDIs with service providers in selected health clinics. For service recipients, with the help of clinics' management, instead of initially planned Focus Group Discussions (FGD), RT conducted individual phone interviews²⁴.
- Due to the deterioration of the COVID-19 epidemiological situation, the RT found difficulties in the organization of FGDs in almost all studied regions. Although social distancing and all precautions for prevention of infection were offered to FGDs participants, the health clinic managers and FGDs participants were hesitant to gather their patients for FGD discussions. Thus, instead of FGDs, individual phone interview and individual face-to-face interview methods have been used.
- The rapid aggravation of COVID-19 cases also restricted RT's access to key decision-makers from the ministries in Tbilisi and Adjara regions, albeit information was collected from mid-level management staff.
- And finally, the quality and completeness of quantitative data²⁵ from the pharmaceutical industry (detailed in section 3.2.4 of the report) restricted more comprehensive analysis of access to contraction. Thus, the data presented in the report is based only on GEPHA data.

²³ World Health Organization, COVID-19: operational guidance for maintaining essential health services during an outbreak, 2020, <https://www.who.int/publications-detail/covid-19-operationalguidance-for-maintainingessential-health-services-during-anoutbreak>

²⁴ Clinic management obtained verbal consent from service users for participation in the research and consent on contact information being shared with RT.

²⁵ Data not provided by Aversi Pharma. Data obtained from PSP lacked disaggregation by months and regions.

Chapter 3: Main Findings

The global increase in the number of confirmed cases and reported deaths from COVID-19 has necessitated many countries, including Georgia, to take stern measures to curb further spread of the disease, involving strict movement restrictions and containment efforts. This chapter examines the emergency state and lockdown (February – June 2020) and presents the main findings on national response during COVID-19. Specifically, this chapter presents regulations and mechanisms introduced by the Government for ensuring continued access to core SRH services; State of maintenance and utilization of SRH services by target population, particularly by vulnerable and disadvantaged groups of women; Main problems observed in SRH service provision and approaches applied by health care facilities to overcome them.

3.1 National Response

Core SRH services not included in contingency planning and the response to the COVID-19 pandemic except antenatal and perinatal services. To avert indirect morbidity and mortality and to prevent reversal of gains made during the past several decades, countries should identify context-relevant essential health services that will be prioritized for continuation during the acute phase of the COVID-19 pandemic²⁶. At the beginning of the pandemic, the Government has been profoundly mobilized to respond to the acute needs of people infected with the virus and focused less on ensuring access to needed services for non-COVID patients and clients. Georgia formally declared antenatal and perinatal services for continuation during the acute phase of the COVID-19 pandemic. Having a previously defined package of core SRH services funded from the public purse made a country more likely to maintain and continue providing these services during the emergency state and lockdown. Therefore, a core set of SRH was not considered as one of the important priorities during the strategic planning of the COVID-19 response.

SRH have always been considered as essential services and funded through state programs...

No changes were introduced in service provision and financing...

Quotes: Key Informants – MoH and NCDC

The Government regulated provision of antenatal and safe delivery services during COVID-19 pandemic. GoG acknowledged pregnant women as one of key risk groups acquiring COVID-19 and to ensure access and quality care provision to pregnant women with COVID-19, the Ministry of Internally Displaced Persons from Occupied Territories, Labor, Health and Social Affairs (MoH) designated specific health facilities as service points for such patients. Furthermore, the MoH provided instructions for testing, screening, and referral to designated health facilities of those with COVID-19 like symptoms and/or contacts with COVID-19 individuals.

Protocol on how to provide ANC services during lockdown has been developed in close collaboration with UNFPA, professional associations, and leading health facilities...

We only identified designated health facilities as service points for COVID-19 pregnant women...

Quotes: Key Informants – MoH

In response to UNFPA's advocacy, MoH took decisive steps to also regulate the provision of Antenatal Care services (ANC) during COVID-19. With technical support from UNFPA, the MoH developed an Antenatal Care protocol during the COVID-19 pandemic instructing ANC service

²⁶ World Health Organization, COVID-19: operational guidance for maintaining essential health services during an outbreak, 2020, <https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>

provider to minimize direct patient contact in non-urgent situations in an attempt to minimize the spread of COVID-19. The protocol proposes adjustments to service delivery modalities according to the standard eight ANC visit schedule and allows selected ANC appointments to be conducted using telehealth²⁷, that is virtually by phone or video chat (remote contact). The brief instructions for perinatal services during the new coronavirus (SARS-CoV-2) infection have been annexed to the MoH Decree.

Service providers lacked the information on SRH service provision modalities during the state of emergency. In general, key informants from all surveyed health facilities noted the lack of concrete Government instructions and recommendations on the provision of SRH services during the emergency state and lockdown, except COVID-19 specific IPC guidelines. The ANC service provision protocol during COVID-19 was only approved in May 2020 and has not been widely disseminated for effective application in practice.

The Government extensively utilized all possible media sources to inform the population regarding the Coronavirus, albeit how to access SRH services was not in the focus of the GoG's communication strategy. Mass media and social media platforms (Facebook, Twitter, Instagram, WhatsApp) played a crucial role in providing information regarding the Coronavirus. During the COVID-19 pandemic, social media offered immediate COVID-19 related information to exchange among the people in real-time. Consequently, government organizations began using social media to notify people.

The continually evolving social media has become a key platform for communication during a crisis along with tele-media. Since little was known about COVID-19, various fake news, misinformation and rumors spread across the social media that influenced people to make panic-driven decisions. The rapid spread of misinformation and stories via social media platforms became a vital concern of the Government and public health authorities. The Government has taken actions to contain the pandemic of misinformation to prevent complications. For example, most of the respondents acknowledged that they followed the instructions published on social media by the officials or the operations team of COVID-19. The participants were frightened of COVID-19 and took the orders seriously. The majority of people living in Tbilisi and Batumi districts investigated the information presented from the official sources about COVID-19 on social media and compared it to the information from international sources.

Instructions for perinatal services during the new Coronavirus (SARS-CoV-2) infection (COVID-19)

- Maximize the use of telephone and internet resources to consult pregnant women;
- The visit to the facility should be scheduled at a time to exclude contact with other patients;
- Additional visits for pregnant women should be limited as much as possible;
- When a pregnant woman visits the facility, she should wear a surgical mask and treat her hands with a hand antiseptic/sanitizer before entering the facility;
- All health care providers should be equipped with a surgical mask and strictly adhere to appropriate safety precautions.

Quotes from MoH Decree, Annex 18

No instructions have been received from MoH regarding continuing ANC, delivery, FP, abortion care, and cancer screening services...

We received the Government Decree, and annex #18 of the decree briefly instructs that face to face ANC visits can be replaced with remote counseling for healthy pregnant women. In contrast, in case of complicated pregnancies, we had to invite pregnant women to the clinic...

This is the first time I hear about a particular protocol describing which ANC visits can be performed remotely...

Quotes: from service providers

When I needed to get information on how to receive ANC consultation during the lockdown, I had to call my physician...

I searched for information on social media and asked my friends for advice on whether it was appropriate to go to my ANC clinic for the follow-up visit during the lockdown...

I had to go to the ANC clinic for the follow-up visit but could not get any information on whether I will be examined for financial sanctions if I travel during the lockdown until I called my clinic...

Quotes: from service recipients

²⁷ Telehealth involves the use of telecommunications and virtual technology to deliver health care outside of traditional healthcare facilities

Unfortunately, the Government paid little attention to informing the population about new regulations introduced for selected SRH services. In response, some clinics replaced traditional face-to-face engagement by social media, Facebook, Instagram, Messenger, and WhatsApp at scale to deliver information on availability and mode of SRH service delivery.

To ensure effective management of epidemiological situation during the state of emergency and lockdown, the Government introduced several hotlines in the country. The state hotline 114 was developed throughout the state of emergency based on the Public Safety Management Center 112. The hotline was launched within record-breaking deadlines on March 30, 2020. On April 17, an additional line, 114-1, was launched for issuing emergency one-time vehicle movement permits, and on April 25, the regional hotline 144-2 started to operate.

One time travel permits were issued after processing and verifying relevant information, only for activities allowed by the Government and for movement with legitimate purposes. The introduction of one-time vehicle movement permits allowed the population to seek health care, including SRH services, in case of emergency, pharmacy visits, emergency hospitalizations, and doctor's appointments.

By allowing pharmacies to remain open, the Government ensured access to medicines and other supplies, including contraceptives. On April 22, the Government issued a regulation about pharmacy workers' transportation requirements during the lockdown.

StopCoV.ge

PREVENTION OF CORONAVIRUS SPREAD
IN GEORGIA

Frequently Asked Questions Regarding the State of Emergency

- Transportation is permitted for getting a medical service.
- If you experience clear signs of need in terms of medical services (e.g., childbirth, fracture, etc.), transportation is permitted to get a medical service (with an accompanying individual).
- If you require transportation for an essential scheduled medical service (e.g. dialyzes, cancer disease treatment, etc.), you should carry evidence of such a requirement issued by a healthcare facility.
- If you do not have such evidence, you should first call the treating doctor/healthcare facility that will communicate your data to the Ministry of Health (MOH) via electronic means if medical assistance is proven required. On the grounds of such communication, you will be issued electronic permission of targeted transportation. If you fail to receive it, the District Office of the Social Service Agency, a legal entity of public law, will deliver it to the designated healthcare facility for you.

Traffic Permits for Pharmacy Network

- The staff of network and non-network pharmacies should have the certificate issued by the company (digital or printed) while traveling by car
- The certificate should indicate the employee's identification data, job title, movement schedule, route of the movement, and should be stamped.
- The transportation of the pharmacy employee can be performed by other person provided he/she holds the certificate issued by the pharmacy (digital or printed version)
- In case of queries, the network and non-network pharmaceutical companies to address the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia.

3.2 Access and utilization of SRH services

3.2.1 Antenatal Care

Antenatal care services were provided continuously, but utilization deteriorated during the emergency state. Health facilities and providers have been forced to adapt to the evolving landscape of the coronavirus pandemic. Health clinics provided antenatal care without interruption. While some continued traditional, face-to-face service provision, others quickly adopted

Regardless of the emergency state, we continued the provision of ANC services daily...

During the emergency and lockdown, we assigned only two days per week to provide ANC services...

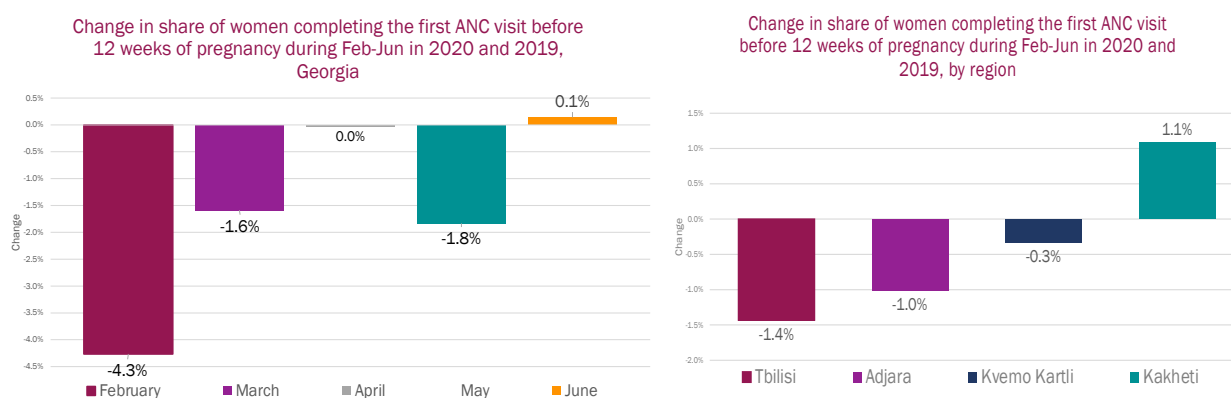
Right after the first case of COVID-19 reported end of February, we developed an internal Standard Operational Procedure (SOP) on performing risk assessment remotely and invite-only risk group for pregnant women for face to face consultations with strict adherence to IPC guidelines. This approach allowed us to provide ANC services without interruption...

Quotes: Service Providers and Health Clinic Managers

telehealth solutions in order to continue to see patients. Clinics used Facebook, Messenger, and WhatsApp at scale to deliver information on available services. Only a couple of clinics operated on reduced hours by reducing the number of days when pregnant women were scheduled to receive services.

Although ANC service provision continued in all studied regions, the routine statistical data analysis shows decline in the share of pregnant women who received their first ANC consultation before 12 weeks of pregnancy during the emergency state and lockdown (Figure 4 on the left). Utilization of the 1st ANC consultation has deteriorated at the beginning of the COVID-19 pandemic when the first information about the virus and its consequences in China was widely discussed in national media and social media platforms. Only after the end of the emergency state in June utilization rates started to recover.

Figure 4: Change in share of women completing the first ANC visit before 12 weeks of pregnancy during Feb-Jun in 2020 and 2019

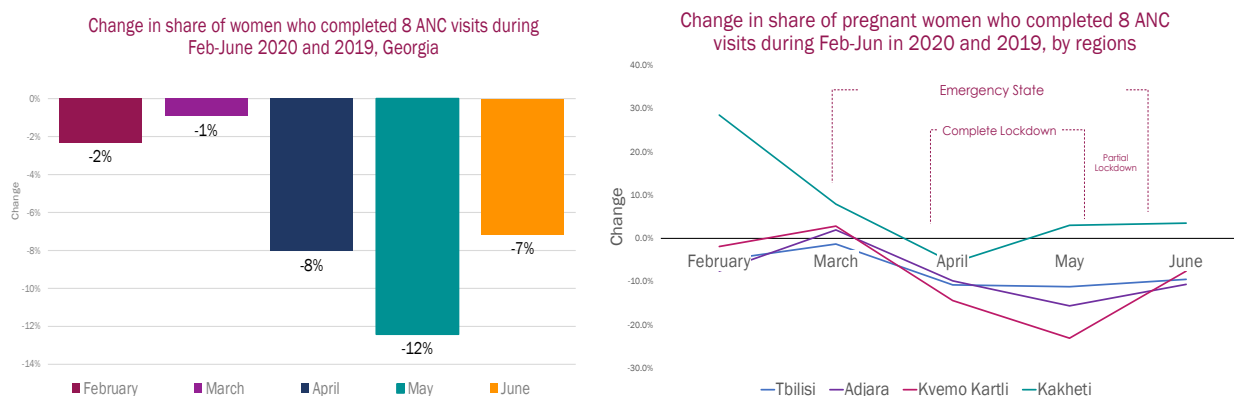


Source: NCDC, Medical Statistics

Less pregnant women received their first ANC consultation before 12 weeks of pregnancy in February – June 2020, compared to the same period of 2019. Deterioration of this indicator was mostly pertinent in COVID affected regions (Tbilisi, Adjara, Kvemo Kartli), where more strict restrictions were introduced much earlier than nationwide. Kakheti region, which remained a "green zone" during the reporting period, demonstrates an increase in the share of pregnant women who received their first ANC consultation before 12 weeks of pregnancy (Figure 4 on the right).

Fewer pregnant women completed 8 ANC visits in Georgia during the state of emergency than in the same period of 2019.

Figure 5: Change in share of pregnant women completing 8 ANC visits during Feb-Jun in 2020 and 2019



Source: NCDC, Medical Statistics

The share of pregnant women who did not complete 8 ANC visits during February-June 2020 was higher in COVID-19 affected regions than the control region, Kakheti. The decline of this indicator is most severe during lockdown (end March-May) in all four districts.²⁸ Pregnant women started to intensively seek ANC care when the lockdown was eased in a phased manner from May in all virus affected and not affected regions (see Figure 5, on the right). Several reasons are behind worsening utilization rates of ANC services during the state of emergency and lockdown.

Due to travel restrictions, service providers **discontinued early identification of pregnant women and the provision of the 1st ANC consultation** to pregnant women in the first trimester of pregnancy. They mostly relied on pregnant women's knowledge and behavior to seek ANC services.

Limiting the number of days per week for facility-based ANC consultations with strict adherence to IPC guidelines and appointment scheduling also affected the number of pregnant women served.

In the absence of government regulation on the provision of ANC services during the COVID-19 pandemic (guideline was developed end of May), some health facilities introduced **an alternative mode of ANC service delivery** (telehealth consultations) as a self-initiative. However, these consultations are not registered and claimed for reimbursement. Consequently, remote consultations during the emergency state and lockdown are not officially counted and did not appear in routine statistical data.

Lack of **medical staff** also affected the number of pregnant women served by ANC clinics. While medical staff of the studied clinics were not redirected to respond to COVID-19 pandemic, clinics instructed medical staff over 70 years old (a risk group for COVID-19) to stay at home and provide services remotely, whereas remaining younger medical professionals could not deal with the workload, limiting coverage of pregnant women with ANC consultation as per schedule. Staff shortage mostly affected small clinics with few medical staff.

Some pregnant women avoid clinic visits due to the fear of being exposed

If before the pandemic, we proactively worked to identify pregnant women at the early stage of gestation, due to the travel restrictions, we no longer were able to reach them ...

Women know that 8 ANC visits are fully covered by the state. Thus, they tried to use this opportunity fully and contacted us to schedule the visit...

We mostly relied on pregnant women to contact us and schedule an appointment for their 1st ANC visit...

Quotes: ANC Service Providers

Due to the COVID-19 prevention measures, our management decided to establish only two days for ANC consultations...

We introduced an appointment system and allocated 20 minutes for the 1st ANC and 10 minutes for the follow-up visits, which restricted the number of pregnant women we could see per day...

Quotes: ANC Service Providers

We called all pregnant women enrolled in our clinic, assessed possible risks, and if no risks were identified, counseled on various pregnancy and COVID-19 related topics. Only risk group pregnant women have been invited for clinic-based ANC consultations, appointments were scheduled and information on infection prevention requirements and measures during the visit provided...

We did not register phone consultations as it was not required by the State Social Agency (for reimbursement) and NCDC (for routine statistical reporting)

Pregnant women often contacted us by phone, and we consulted them. Phone consultations are provided free of charge, thus not recorded...

Quotes: ANC Service Provider

Patients are afraid of getting infected if they seek care at the clinic ...

Fear of the possibility of getting infected stopped pregnant women from seeking scheduled ANC services...

Quotes: ANC Service Providers

I was terrified to get infected, therefore decided to postpone my visit...

I was criticized by my pregnant friends for going to the clinic. They said that they decided to skip the visit because there is a risk of acquiring COVID-19...

Quotes: Pregnant women

²⁸ To benefit from state funded ANC services, the pregnant women has to register before 12 weeks.

to risks. Fear to contract the coronavirus was named as one of the factors affecting pregnant women's health-seeking behavior during emergency and lockdown. Interviewed service providers and pregnant women reported being fearful of accessing in-person ANC services, and thus, decided postponing the scheduled visit and limiting themselves only to phone consultation when needed.

Notably, **travel restrictions and lack of transportation during emergency state and lockdown had a limited negative impact on access and utilization** of ANC services. The system of issuing one - time movement permits aided pregnant women to access ANC services during the lockdown without any problem.

All respondents interviewed noted the given system's effectiveness, allowing patients' easy movement to and from health facilities. Occasionally, when the pregnant women

lacked the information or could not obtain the travel pass, police treated such cases with caution by verifying the purpose of the travel with the facility.

The system of issuing transportation passes for pregnant women and accompanying persons worked extremely well...

Quote: ANC Service Provider

The doctor arranged an appointment at the clinic and sent me an electronic version of the pass with my details...

On the way to the clinic, we were stopped by police, but when we showed the e-pass, they did not charge us for violation of regulation...

I did not know about the need to obtain the pass and was stopped by the police. When my husband explained the reason for the violation of the travel restriction regulation, the policeman verified the purpose of the travel with the clinic ...

Quotes: Pregnant women

3.2.2 Delivery and Postpartum Care

Access to delivery services and postpartum care was maintained during the emergency state and lockdown. All surveyed

maternity clinics/departments continued providing delivery and postpartum care without interruption and strict adherence to social distancing, hand and cough hygiene, and other infection prevention and control requirements.

Every single woman in labor received screening at admission and, in case of fever, was referred to COVID-19 clinics. In emergency cases (eclampsia, bleeding, etc.), women with suspected COVID-19 received care in designated isolation

spaces and, after stabilization, transferred to COVID-19 clinics for testing and follow-up treatment.

The number of deliveries shows a decline during February – June 2020 compared to the same period of 2019, which can be explained by a decline in overall birth rate, as the decline in delivery services' utilization was not accompanied by an increase in home deliveries. The upsurge of deliveries observed during the complete lockdown (end March – beginning of May), compared to the periods before and after lockdown, indicates the absence of access barriers to delivery service during this period (Figure 6).

We continued admission of pregnant women for delivery during the lockdown without interruption but administered IPC measures rigorously...

If the women at admission had a fever, we referred them to a designated COVID-19 clinic...

There was one emergency case when the woman had a fever at admission and was in labor. It was too late to transfer her to the designated clinic, therefore we provided necessary services in an isolated area and only afterward transferred both mother and her newborn to a COVID-19 clinic...

At the beginning of the state of emergency, we temporarily stopped partner deliveries but shortly realized the importance of partner deliveries and lifted restriction with an enhanced screening of partners...

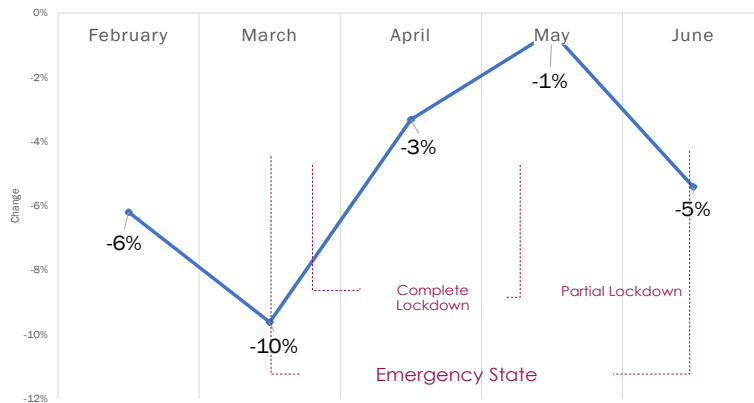
Quotes: Service Providers

My husband was allowed to attend the delivery after thermal screening...

Visitors were not allowed... Although my partner was present during the delivery, he was not allowed to see us after delivery...

Quotes: Pregnant women

Figure 6: Change in the number of deliveries during Feb-Jun 2020 and 2019



Source: NCDC, Medical Statistics

Maternal mortality is often attributed to the “Three Delays Model,²⁹” whereby women experiencing obstetric complications are delayed in deciding to seek care, in traveling to the healthcare facility, and in receiving the appropriate care once inside the facility. The research examined all three possible delays to assess access to delivery and postpartum care during emergency and lockdown.

Delay 1: Decision-making – Being isolated at home during emergency state and lockdown did not affect the decision of women on when and where to seek care. Respondents reported no changes

in decision-making or delays to seek care during childbirth. ANC service providers always recommend women when and where to seek care subject to risks during pregnancy and delivery.

Based on the ANC service provider's advice, the vast majority of pregnant women identify health clinic and seek consultation with selected doctors in the third trimester of pregnancy. There were few exceptional cases reported in Tbilisi and Adjara region when clinic, where the selected clinic was reassigned as a COVID-19 clinic³⁰ and a pregnant woman had to seek care in another clinic without prior arrangements.

Delay 2: Getting to the facility - Travel times when getting from home to the healthcare facility have not changed significantly since before the outbreak. On the contrary, the absence of traffic jams during the emergency state and lockdown, and effective functioning of a one-time travel permit system eased and shortened the time required to reach the facility. Women in labor mostly used personal transport to reach the clinic, while those without personal transport used Emergency Ambulance Services.

We always advise pregnant women on which clinic to choose for delivery, especially for those belonging to risk groups ...

Quote: from the service provider

I had a complicated pregnancy, and my doctor advised where to deliver...

As I had two C-sections in the past, the doctor advised going to a specific clinic...

The clinic where I planned to deliver was admitting only COVID-19 pregnant women, and I had to seek care in another clinic ...

Quotes: Service Recipients

During ANC consultations, we advised pregnant women to call before coming to the clinic for delivery. During such consultations, we performed testing and risk assessment and explained when to come. Such an approach helped to avoid crowding and minimized hospitalization time ...

Quote: from the service provider

I called the clinic when labor pain started. The doctor said that it was too early to go and gave instructions when to go to clinic ...

Quotes: Service Recipients

I called the clinic when labor pain started, and the clinic sent an e-pass for me and my companions...

I called an ambulance to take me to the clinic. They arrived in 10 minutes, and within the next 10-15 minutes, I was in the clinic...

Quotes: Service Recipients

²⁹ Thaddeus S, Maine D. Too far to walk: maternal mortality in context. *Social science & medicine*. 1994;38(8):1091-110.

³⁰ The First University Clinic in Tbilisi and Kobuleti Fever Center

To avoid crowding and minimize hospitalization time, health clinics introduced phone consultation before admission. Those not in active labor were advised to stay home and were given explanations on active labor signs and when they had to come to the clinic.

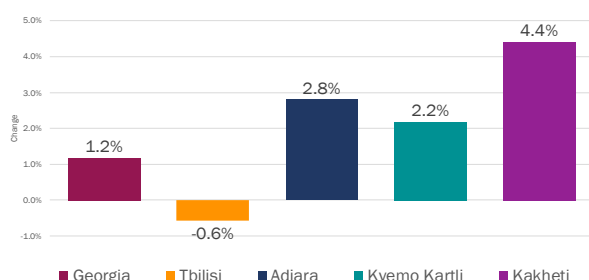
Delay 3: Receiving care at the Facility -All pregnant women and their newborns, including those with confirmed or suspected COVID-19 infections, have the right to high quality care before, during, and after childbirth.³¹ **Clinics managed to maintain and ensure the provision of delivery and postpartum care during the emergency state and lockdown.** The study revealed various measures applied by maternity clinics to ensure quality service provision. To name a few:

We were short of face masks for about ten days. We asked the clinic staff to sew masks themselves. We designed and produced face shields on our own ... During the shortage of PPEs service provision was limited... We had a three-month stock of surgical masks, medications and other consumables...

Quotes: Service Providers

- All clinics surveyed introduced rigorous testing and IPC measures to prevent the spread of coronavirus maintained "isolation spaces/rooms" for suspected cases;
- Ensured adequate and continued supply of medicines, consumables, and Personal Protective Equipment (PPE). If at the beginning of an emergency shortage of face masks and PPE were experienced by almost all health clinics, clinic managers soon resolved supply related issues. No problems have been reported in the breakdown of the supply chain during the studied period.
- Maternity clinics prioritized health, safety, and wellbeing of staff by the introduction of everyday testing at entry into the facility, the introduction of 24-hour clinic duty schedules for core medical and support staff in non-COVID-19 clinics and 14 days duty schedules for COVID-19 center staff; maintaining a pool of reserve staff on call in case of emergency and/or staff sickness; and regular by-monthly testing of staff.
- Clinics organized internal staff training on testing and IPC measures, alternative service delivery methods internal to the particular clinic, and new work schedules.
- COVID-19 clinics³² received extensive MoH/NCDC training on testing, social distancing, hand and cough hygiene, IPC measures, and clinical management of COVID-19 women during pregnancy and childbirth.
- Only COVID-19 clinics received periodic supportive supervisory visits by teams of NCDC epidemiologists and clinicians.
- Post-discharge follow-up consultations were performed by remote counseling, risk assessment, and an invitation to the clinic of those needed.

Figure 7: Change in the share of C-Sections during Feb-Jun 2020 and 2019 by regions



Source: NCDC, Medical Statistics

Tbilisi (Figure 7).

An increase in the share of Caesarean Sections (C-section) is reported during the emergency. C-section is a surgical procedure that can effectively prevent maternal and newborn mortality when used for medically indicated reasons. Cesarean birth is associated with short- and long-term risks that can extend many years beyond the current delivery and affect the health of the woman, the child, and future pregnancies. A visible increase in the share of C-sections is reported during the emergency in the country and in all studied regions except

³¹ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth>

³² The First University Clinic in Tbilisi and Kobuleti Fever Center

Remarkably, maternity clinics in Tbilisi continued to rigorously control C-section rates during the emergency state in fear of financial sanctions. Studied clinics were not able to provide explanation how they control and manage C-sections, whereas the manager of D. Gagua's Clinic explained that the indicator is identified as a Key Performance Indicator for the department, teams on duty, and individual medical professionals.

We introduced a strict control on C-section rates back in 2019 by establishing Key Performance Indicators and targets for the department, teams on duty, and individual professionals. It helped to decrease C-section rates and avoid financial sanctions ...

Quote: Health facility Manager

Performance evaluation is performed monthly and cases, where deviation from standard indications are found are discussed among professionals. At the repeated poor performance, financial sanctions are applied to medical professionals.

The factors contributing to the rise in C-section rates are complex. It is unclear whether the observed changes in cesarean section rates had been accounted for exclusively by those considered unnecessary. Factors associated with an increase in cesarean births may include changes in the characteristics of the population such as an increase in the prevalence of obesity and multiple pregnancies, and increase in the proportion of nulliparous women or of older women, women increasingly wanting to determine how and when their child is born, etc.

In the context of fallen caseloads resulting in lower revenues, health clinics' motivation to mobilize higher revenues at the expense of C-sections could explain the increasing trend of C-sections. Perverse financial incentives in reimbursement of normal deliveries and C-sections motivate clinics to perform more C-sections and recuperate financial losses and bloated expenditures on IPC measures³³.

As C-section reimbursement is higher than normal delivery, clinics are disposed to promote caesarian births...

Quote: Key informant from MoH

To decrease the rate of unjustified C-sections, the State Social Agency introduced targets for maternity clinics and financial sanctions in 2019. Several maternities have been sanctioned since then. With the emergence of COVID-19, we announced a moratorium on financial sanctions...

Quote: Key informant from MoH

An observed, an increasing trend of C-sections to a certain extent could also be a result of deliberation of the moratorium on financial sanctions for medically unjustified C-sections announced verbally by MoH at the beginning of the emergency.

Clinics, to some extent, ensure safe and positive childbirth experiences during emergency state and lockdown. All pregnant women and their newborns, including those with confirmed or suspected COVID-19 infections, have the right to a safe and positive childbirth experience³⁴, which includes: i) being treated with respect and dignity; ii) having a companion of choice present during delivery; iii) clear communication by maternity staff; iv) appropriate pain relief strategies; and, v) mobility during labor where possible, and birth position of choice.

To avoid contacts with other women in labor, each woman was placed in a patient room where we managed childbirth and provided postpartum care...

Due to the space constraints, we managed labor in the labor room and transferred mother and baby to the patient room. Tried our best to maintain at least a 2-meter distance between patient beds...

Quotes: Service Providers

I shared the room with another patient. The room was big enough to maintain distance with her...

Between contractions, I was allowed to move around...

Medical staff were attentive and communicated clearly and frequently...

Quotes: Service Recipients

³³ On request C-sections are reimbursed by State at the rate of a normal delivery - 500 GEL, thus the financial incentive could be partly caused by revenues from the patient's co-payment. Medically justified C-section is reimbursed at 800 GEL by the State Social Agency and it is not difficult for health professionals to provide medical justification for C-sections and get reimbursed at a rate of 800 GEL from public funding.

³⁴ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth>

Where infrastructure allowed, clinics provided labor and postpartum care for women in the single-patient rooms to avoid contact with other women. Appropriate pain relief strategies were applied by all studied clinics and ensured mobility in labor where possible, and birth position of choice. Almost all service recipients interviewed were satisfied or highly satisfied with the services received at maternity clinics.

For the safety of the mother and baby, maternity clinics/departments barred partners and other visitors during childbirth, going against guidance from the World Health Organization (WHO) and undermining pregnant women's rights and the support systems they count on. Partner deliveries were temporarily discontinued during the emergency state, and family members were not allowed to

At the beginning of the emergency state, we temporarily stopped partner deliveries but shortly realized the importance of partner deliveries and lifted restriction with the enhanced screening of partners...

Quotes: Service Providers

My husband was not allowed to attend the delivery ...

Visitors were not allowed... Although my partner was present during the delivery, he was not allowed to see us after delivery...

Quotes: Pregnant women

visit women and newborns to prevent the spread of coronavirus. Women were left without emotional support from a companion of choice.

3.2.3 Abortion and Post - abortion Care

The COVID-19 pandemic restricted access to safe abortion services. Abortion service is not a service widely provided by maternity clinics in the country. Decisions whether to be a provider of abortion service are made by private clinic owners, management and physicians themselves. Therefore, findings of this study are based on information collected at few clinics providing abortion services and have to be treated with caution.

There are few health professionals willing to provide abortion services...

Quote: Key informant from MoH

Abortion services are not covered by the Universal Health Care (UHC) Programme, except for complicated abortions. In the wake of COVID-19, the Government recommended temporary discontinuation of non-urgent health and planned appointments. Consequently, health clinics categorized non-emergency abortion as “elective” or “non-essential”, which further constrained access to abortion care during the emergency state and lockdown.

Elective surgery have been postponed for 4 months due to measures taken to prevent COVID19 in the country. The statement was made by the Minister of Health of Georgia Ekaterine Tikaradze on March 24.

Abortion care providers changed the way of operation to support social distancing and limit the need for face-to-face appointments to keep clients and staff as safe as possible during the coronavirus pandemic and temporarily discontinued provision of surgical (induced) abortions. While majority of clinics complied with the Government recommendations, some abortion care providers decided to continue business as usual. According to respondents, the main driver for this decision was minimizing financial losses due to reduced caseloads during COVID-19 emergency. Clinics established

We decided to continue provision of surgical abortion services, but with strict compliance of IPC measures...

We continued provision of services for spontaneous abortions only ... During emergency we canceled surgical abortions and provided services only to clients with spontaneous abortions

Quote: Service Provider

The clinic procured abortion pills and we offered medical abortion to women in the clinic...

Quote: Service Provider from Kakheti region

I contacted the doctor and she consulted on different methods of abortion, gave 1 week for decision-making. When I informed the doctor on my decision to get abortion pill, she scheduled a visit, provided me with medication and monitored me...

Quote: Service user

telemedicine services, including pre- and post-abortion counselling and post-abortion follow-up over the phone. Telemedicine services were provided alongside in-clinic care, with clinics continuing to provide induced abortion through an appointment system for clients who chose that method. Clients were given information and the time to fully think things through before giving informed consent for abortion care, if that was what they choose. During phone consultations, health care professional discussed and advised clients on precautions they had to take when travelling to the clinic and during the appointment.

A clinic in Kakheti region offered surgical abortion along with medical abortion during the reporting period. The clinic procured a stock of abortion pills and provided in-clinic medical abortion and post-abortion care to their clients under the direct physician supervision.

One clinic in Tbilisi also changed the way they provide medical abortion with the help of externally funded pilot project. This pilot enabled clients, who choose medical abortion method, to safely manage aspects of their medical abortion (using pills to end pregnancy in the first trimester) at home, with the guidance from a service provider over the telephone or via video link. The clinic trained nurses and doctors to start providing medical abortion for clients at their homes. Abortion pills were delivered to pregnant women at home using

Our clinic decided to continue provision of surgical abortions to clients during the emergency state. We introduced pre-and-post phone counselling of women. For those who opted for surgical abortion, an appointment system was introduced...

Our clinic was included in the donor-funded project, which helped piloting remote management of medical abortions (pills) at home. Clients who agreed to medical abortion were supplied with medicine using mobile distribution services and closely monitored professionals remotely. These services were free of charge for the patients...

Quote: Service Provider from D. Gagua clinic

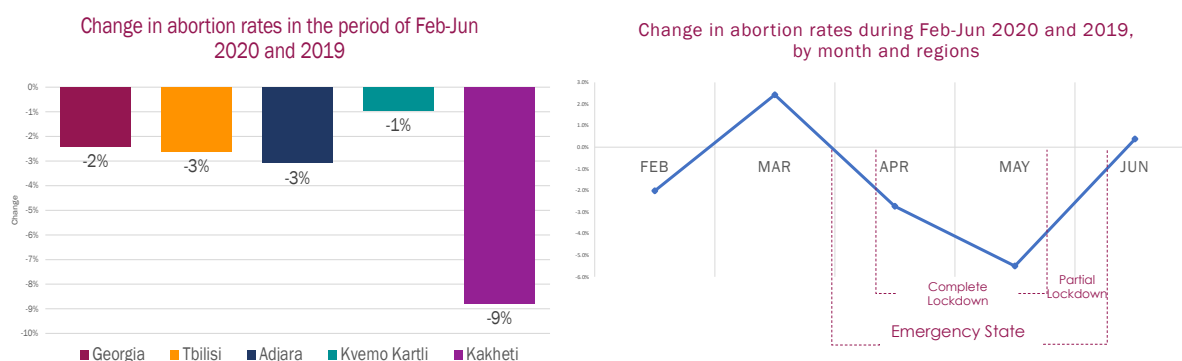
After video consultation, the clinic sent a pill and instructions ... The doctor called several times and asked about my condition... I am very satisfied with the service I received... I never though abortion could be such an easy service to get during the lockdown...

Quotes: Service recipients

“home delivery service”. The approach of home based medical abortion aligns well with WHO guidance, which confirms that self-managed abortion is safe if pregnant individuals have information on effective protocols and access to follow up health care if needed³⁵.

The dual model of service provision, using telemedicine to supplement in-clinic abortion care, had minimized the need for clients’ travel to clinics, removed challenges associated with movement restrictions, reducing in-person client-provider interactions and associated risk of infection. Clients have expressed their satisfaction with this model of care.

Figure 8: Change in abortion rates



Source: NCDC, Medical Statistics

³⁵ The World Health Organization (WHO) recommends administration of mifepristone followed by misoprostol for medical abortion, which it says can be safely self-managed by women up to the twelfth week of pregnancy where accurate information and support from a healthcare provider are available.

Those seeking to access abortion services frequently face practical barriers and the COVID-19 pandemic has exacerbated them. Due to COVID related disruptions less women accessed abortion services during emergency state. The pandemic has exacerbated existing disparities in access. Access and utilization of abortion care deteriorated in all studied regions. The most severe deterioration is observed in Kakheti region, which remained as a “green zone” during the emergency state (Figure 8 on the left). The most severe cessation to abortion care is observed during complete lockdown, followed by upsurge when restrictions were partially lifted in certain regions of the country (Figure 8 on the right).

Lower rate of abortions reported by service users from rural areas and Azeri women from Kvemo Kartli, suggests that access to services is unequal and mostly affecting disadvantaged groups. Having to travel far to access care was not feasible for women living in rural areas and women having no access to a private vehicle or difficulties in affording transportation costs, particularly when public transportation was limited. In that sense, socioeconomic status challenged access to abortion services. Geographical access barriers were also problematic for women in Kakheti, who had to take medications under medical supervision, as in “traditional” medical abortion.

The lockdown measures made it more challenging for those seeking abortion services to get to a clinic even if they lived within close proximity to the clinics. With schools closed and increased caretaking responsibilities, in some cases, the move to at-home working, made it difficult to leave the house alone. Even for those who do not have caretaking responsibilities leaving the home was associated with a risk of infection that they were unwilling to take, particularly if they or someone they live with had an underlying health condition.

I was not able to leave my children at home and go for abortion
...
I was afraid to get infected and infect my parents who belong to risk group...

Quotes: Service users

Lockdown and quarantine orders restricting movement also exacerbated the harm of existing abortion restrictions that require mandatory waiting period and impeded confidentiality. During lockdown, people could travel outside the home for health emergencies, but had to provide justification to authorities if stopped and faced fines for violations. The prospect of telling authorities that woman travels to seek an abortion services was itself a deterrent.

I was not able to call the doctor to discuss abortion. As I was already reaching the cut-off date to get legal abortion, decided to go to the clinic. On the way was stopped by police and asked to present e-pass, which I did not have. I felt uncomfortable telling that I was going to the clinic to get abortion. As a result, the policeman issued a fine ...

Quote: Service user

All these obstacles risk preventing or at the very least delaying, access to essential abortion services. Abortion is a time-sensitive service, where delays lead to unsafe abortions. Some health care providers advising pregnant women to come back in a few weeks, raised the chance of a second trimester abortion or pushing them to unsafe, illegal abortions. Evidence shows that where abortion is restricted or safe abortion is unavailable, people turn to other, often unsafe means to end their pregnancies. The study was not able to estimate rates of illegal abortions, as service recipients not able to seek care in the clinics, either refrained from disclosing alternative methods used for the management of unwanted pregnancies or continued unwanted pregnancy. Compelling continuation of unwanted pregnancies is recognized as a human rights violation in several circumstances.

My neighbor was pregnant, and the doctor told to retain pregnancy or to come within few weeks ...
When I called a doctor, she advised to continue pregnancy as the clinic was not providing abortion services during the emergency state...

Quotes: Service users

Deterioration of access to abortion care during emergency state is not unique to Georgia. Limited access to abortion has been reported in many low and high-income countries. In countries like Poland, barriers caused by highly restrictive abortion laws and arduous administrative requirements to access abortion services make safe access to this critical health care extremely difficult, or even virtually impossible. Public and private medical facilities are no longer providing

abortion on the woman's request in Romania, the decision to suspend non-emergency procedures is in practice hindering women's reproductive freedom. In Germany, where there were already too few doctors providing abortion in some regions, the situation has been aggravated as clinics had to concentrate on absolutely necessary operations and refused to manage abortions. Italy issued guidelines clarifying that abortion cannot be discontinued, although in practice access remained difficult, notably due to a shortage of healthcare professionals willing to provide it.

International human rights explicitly recognizes the rights to sexual and reproductive health and bodily autonomy. The decision to suspend non-emergency procedures is in practice hindering women's reproductive freedom. These rights give rise to positive Government obligations to ensure abortion-related information and services and to remove medically unnecessary barriers that deny practical access. Thus, GoG has a duty to ensure that individuals do not have to undertake unsafe abortions when faced with a pregnancy that is unwanted and/or threatens their life or health.

3.2.4 Family Planning

Emergency state and imposed stay at home regulations aggravated already restricted access and utilization of family planning services. Georgia faced key reproductive health challenges even before the pandemic, evident by the country's overall unmet need for contraception of 31%, and the contraceptive prevalence rate (CPR) of only 41%.³⁶ The low CPR results from scarce contraceptive supplies during decades; contraceptives not covered by the Universal Health Coverage (UHC) program; high prices in private pharmacies and the conservative influences of the Orthodox Church.³⁷

Access to family planning services was challenged by the suspension of planned non-emergency services during the COVID-19 pandemic. Women who are following a course of contraceptives, as well as those who need to have their implants and IUDs (intrauterine devices) replaced, are being told to postpone their visits.³⁸

In this period, we minimize in-person accouters with patients and advise women to postpone their visits to the clinic...
Quote: Service provider

Family planning counseling was not a common practice during the emergency state. The majority of study respondents failed to answer questions related to access to contraception or sources of contraception during the coronavirus pandemic (mostly ethnic minorities in the Kvemo Kartli region). Those who responded noted having no access to contraception counseling during the reporting period. Young mothers received no counseling and/or information about family planning methods before discharge from maternity homes. In the absence of information on where to get family planning services, new clients mostly relied on peer experience and/or sought advice on contraception choice at pharmacies.

Doctor counseled on various issues related to a child and breastfeeding, but not on family planning ...
My child is on formula, I am afraid to get pregnant, but do not know should I ask my doctor or rely on a pharmacist's advice on the most appropriate contraception...
I use pills advised by my friend and, during the lockdown, continued receiving it...
Quotes: Service users
Contraception counseling remains challenging despite mandated by regulation, ...
Quote: Key Informant, NCDC

The effect of lack of family planning counseling during a pandemic is not the direct result of the pandemic; instead, it's more of an indirect consequence of weak family planning practices. Contraceptive counseling at the time of induced abortion has been mandatory since 2000 in Georgia. Despite legal regulations, family planning counseling around the time of having an

³⁶ Multiple Indicator Cluster Survey (MICS), 2018, <https://www.geostat.ge/ka/modules/categories/625/mravalindikatoruli-klasteruli-gamokvleva>

³⁷ Gynopedia. <https://gynopedia.org/Tbilisi> , Accessed 19-10-2020.

³⁸ Pharmacies and online services provided access to contraception, but increased the financial burden.

abortion remains quite limited. According to MICS 2018, nearly 37% of women do not receive any family planning counseling services around the time of having an abortion in the last 5 years.

In this critical emergency and lockdown period, vulnerable women are more exposed to unplanned pregnancies.

This group includes those women with low income, those living in rural or isolated and remote regions, and those living with chronic diseases. Women who were unable to attend a consultation on family planning due to any number of reasons such as money issues or inability to access transport or purchase the contraceptive were short

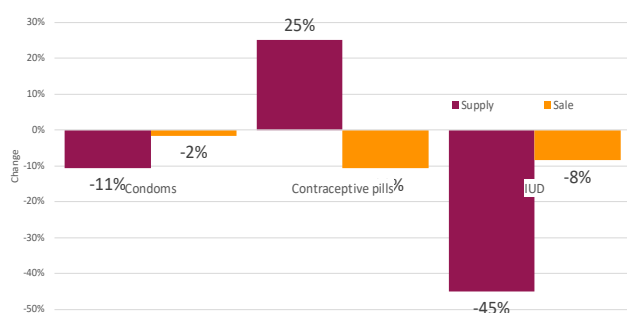
of the opportunity to get adequate family planning counseling and services. Women living in remote and hard to reach areas are left with no alternatives. These women are the least likely to access or be able to pay for pharmacy-supplied contraceptives. There is increasing concern that lowered income resulting from job/income losses and price increase heavily affected women's ability to purchase contraceptives.

There is a small private pharmacy in our village that does not sell contraceptives. I can't afford to travel to the district pharmacy... My husband lost his job and we hardly manage to buy food... With the lockdown, we can't sell agricultural products, which are the family's main source of income. Furthermore, prices on all products, including medicines, have increased... In this period, the prices of all goods, including medicines and contraceptives, increased...

Quotes: Service users

Amid the COVID-19 pandemic, supply and sales of contraceptives deteriorated. It is expected that couples could be more prone to increase the time dedicated to sexual intercourse due to physical distancing, isolation, and working from home. Parallel to that, lockdowns and other restrictions could have hampered access to contraceptive supplies mostly obtained at pharmacies. These factors could have led to additional unplanned pregnancies, unsafe abortions and possible resulting deaths. To assess this hypothesis, the data obtained from the largest pharmaceutical companies³⁹ have been analyzed.

Figure 9: Change in supply and sales of contraceptive commodities by GEPHA during Feb-June 2020 and 2019.



Source: GEPHA

The analysis of available data revealed a reduction in the supply of contraceptive commodities during the state of emergency, except for contraception pills, the supply of which has increased by 25% during Feb-June 2020 compared to the supply levels of the same period in 2019 (Figure 9). The most severe shortage is observed in the supply of Intrauterine devices (IUD), which shows a drop of 45%. Notably, commodities such as implants, contraceptive patches, female condoms and diaphragms were

not readily available on the market, neither before pandemic nor during the state of emergency. In parallel to constraint supply levels, the data shows a drop in sales (utilization), albeit not following the same pattern as supply of contraceptive commodities (Figure 9).

It is not easy to find the rationale behind the pharm industry strategy prioritizing one commodity over the other. De-prioritization of IUD supply can be explained by estimated declines in facility-based visits during emergency state and lockdown, given that IUD insertion requires face-to-face contact with medical provider, which women generally avoided during lockdown.

The drivers behind an increase in the supply of contraceptive pills could be women's preference to contraceptive pills which can be taken per pharmacy staff or friend advise instead of using IUDs that require facility visits; a well-developed "courier" services in big cities allowing women to purchase pills online, especially during the lockdown. While on the one hand, this does not explain

³⁹ Researchers were only able to obtain accurate data from GEPHA. Data was also received from PSP pharma company. However, annual data received for 2020 and 2019 was not disaggregated by months to run the analysis.

why supply of condoms deteriorated since 2019, on the other hand, it can be explained by the following facts: a) condoms have neither been regarded as essential commodities nor received enough attention in contingency planning for COVID-19 in Georgia; and b) a global shortage of condom supply in the world due to enforced lockdowns of countries halting many industries and commercial activities, including condom manufacturers.

Financial access to contraceptives has deteriorated during the emergency state. Women's economic hardship during the emergency state and lockdown along with increased prices (on average 20%-30%)⁴⁰ of pharmaceutical commodities negatively affected financial access to contraceptives. Pharma companies expect a further increase in prices on pharmaceutical commodities, which will further deteriorate access to contraceptives.

Medications have become more expensive. The main factor here is the GEL exchange rate. The national currency has been depreciating since January 1, 2020, so the pharmaceutical sector is among the businesses that have had to raise prices on imported products...

Quotes: Business Media Georgia, May 14, 2020

Geographical access barriers to contraceptive commodities observed in settlements distanced from the regional centers where the largest pharmacy networks usually operate. Women facing economic hardship during an emergency state and not being able to travel to the regional or district center had to purchase contraceptives at small private pharmacies located nearby. However, most respondents noted that small pharmacies do not sell modern contraceptive commodities due to the low demand and high prices.

The pharmacy in our village does not sell contraceptives...
I was not able to travel to the district pharmacy and buy my contraceptive pills...
I went to the local pharmacy to get a refill of my pills but in vain. The pharmacists, my neighbor, told me that because the sale of pills is very low and the price high, she decided not to keep pills in stock...

Quotes: Service users

3.2.5 Cervical Cancer Screening

Cervical cancer screening programs have been curtailed almost everywhere. In response to COVID-19, screening programs were temporarily paused from the third week of March 2020 till mid-June countrywide. Cancer screening services have been completely discontinued by the provider clinics studied in Adjara, Kakheti, and Kvemo Kartli regions, except the National Screening Centers in Tbilisi.

Social distancing guidelines forced cancer screening providers in Tbilisi to rethink service provision modalities. To ensure patients' and employees' safety and continue offering services in the context of the continuing pandemic and stay-at-home orders, providers have developed strategies to minimize time spent in the clinic and make their care accessible for critical patients.

Cervical cancer screening was delayed for new clients to protect people from COVID-19 and allow the staff who run screening programs to support critical cases.

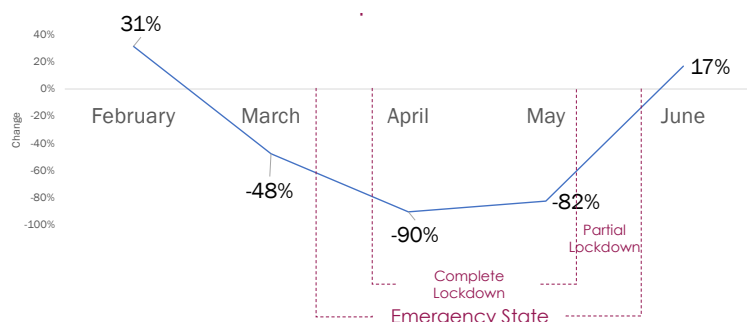
We had to weigh the risk of virus exposure against the risk of delaying cervical cancer screening for a month. As a result, we significantly limited our schedule to women with urgent needs such as newly diagnosed with cancer and needed further studies and treatment...

Quotes: Service Providers

Following strict COVID-19 preventive measures, national screening centers in Tbilisi continued offering services only to those who completed PAP tests and awaited results and/or required additional investigations and treatment. Preventive measures included daily individual appointments to avoid overcrowding and maintaining one meter distanced queues to promote social distancing.

⁴⁰ Business Media Georgia, <https://bm.ge/ka/> accessed on October 28, 2020

Figure 10: Change in the number of women with cervical cancer screening



Source: NCDC, Medical Statistics

Access to cervical cancer screening services deteriorated during the emergency state and lockdown. Screening rates for cervical cancer fell as much as 74% from the average for this period (February – June) in 2019 in all regions of Georgia, except Tbilisi (Figure 10).

Women have been faced with the decision of whether to skip or postpone cervical cancer screening during the current pandemic to avoid potential exposure to the coronavirus.

Although patients and hospital systems are advised to reschedule their preventive services, the full impact of this delay in regular screening has yet to be seen. Life years lost from delayed screening may be compared to life years gained from COVID precautions with future research.

3.3 Summary of factors affecting access and utilization of SRH services during emergency state and lockdown and approaches applied by health clinics to deal with challenges

This section of the report summarizes factors that had negative implications on access to SRH services during the emergency state and lockdown. Factors are grouped according to four domains - enabling environment, supply, demand, and quality.

Enabling environment:

The Government's recommendation to temporarily seize planned services during an emergency state, without clarification of services concerned, adversely affected access and utilization of abortion and cancer screening services. Ultimately, the impact on patients is expected to depend on the likelihood that treatment is canceled or delayed and how much a cancellation or delay could exacerbate a condition.

Despite effective communication run by the Government through all means of media, the mode of SRH service provision has not been the focus of Government's communication strategy, and the responsibility of informing the population was handed over to service provider clinics in order to ensure the continuation of SRH service delivery to their customers. To decrease the risk of transmitting the virus to either patients or health care workers within their practice, providers are deferring elective and preventive visits.

Reassignment of some ANC and maternity clinics into COVID centers created a barrier for pregnant women to enroll with other clinics and maintain eligibility for the state ANC program.

Supply:

Government recommendations restricting travel and non-essential services during emergency state influences both provider and patient behavior. Canceling elective services had a substantial impact on patients and cumulative, potentially devastating consequences for the health system. Delaying time-sensitive elective services, such as cancer screening and abortion care, may lead to deteriorating health, worsening quality of life, and unnecessary deaths. Cancellation or postponement of routine procedures such as abortion, family planning, and cervical cancer screening, risks widening the gap in access to SRH services.

The COVID-19 pandemic has dramatically changed how SRH services are delivered in health care practices. To decrease the risk of transmitting the virus to either patients or healthcare workers within their practice, providers are deferring elective and preventive visits. When possible, they are

also converting in-person visits to telemedicine visits, thus ensuring the provision of ANC, postnatal and post-abortion care in case of emergency abortions.

Reduced contraceptive supplies were not the leading cause of low sales. Reduction in contraceptive supplies caused by the closure of factories and restrictions on transport, import and export of raw materials in countries which produce medical goods was not the main cause of low sales, it is rather more of a health system problem, which fails to provide routine family planning counseling to women, as well as a problem of deteriorated socio-economic status of women.

Insufficient staff and increased workload to a certain extent affected quality of care. Almost all clinics worked with lower staff count. Older staff received paid annual leave, while younger ones faced transportation problems to and from clinics because of transport shortages during the lockdown. This has had a direct effect on the uptake of ANC services.

According to respondents, insufficient personal protective equipment (PPE) available for health care providers to provide services at the initial stage resulted in a temporary slowdown of service provision. If at the beginning of the emergency state shortages of face masks and PPE were experienced by almost all health clinics, clinic managers quickly resolved supply related issues. No problems have been reported in the breakdown of the supply chain during the studied period. However, many costs are borne by health facilities during this pandemic, which likely under-represents the true financial impact that clinics and health systems will face in the near future. Some of these critical additional costs are:

- Clinics experienced losses from canceled and delayed procedures. We have observed declining client numbers across almost all services, except delivery services. Precipitous declines in demand for routine services have reduced providers' revenues. Providers' vulnerability to these demand fluctuations raises a fundamental question about their financial viability during an emergency state and puts them into an unfavorable financial situation to ensure staff payments and procurement of medicines, supplies and consumables;
- Additional costs associated with purchasing the necessary PPE;
- Additional support clinics provide to their staff, including transportation costs for staff during COVID-19, screening for COVID-19 for workers and remuneration for those who have been sent on annual leave, stayed at home, or isolated.
- Devaluation of national currency and increased prices of medicines and consumables.

The totality of these costs, combined with the uncertainty of the pandemic's duration and possible future lockdowns, is certain to imperil health facility finances. This system has several adverse effects in normal times. It creates incentives to raise prices and push up volumes, causes shortages of poorly compensated services, and an undersupply of services to poor and vulnerable women.

Demand:

Insufficient information provided to the public. As a result of insufficient information provided to the public on the service availability and procedures of getting SRH services in response to the pandemic, disadvantaged and marginalized women face worsening reproductive health inequalities. Women avoid visits to the health facilities due to their unwillingness or inability to leave their homes and exposure risk.

Economic hardship constrained access to SRH services. Women living in remote and hard to reach areas are the least likely to access SRH services. Lowered income resulting from income losses and price increase on all products (food, medicine, fuel) put women against the dilemma of prioritizing survival against receiving health services. The latter decisions heavily impacted access to some SRH services, particularly family planning. Those without private transportation means find it difficult to afford transportation costs to and from health clinics.

Changing lifestyles during emergency state and avoidance of care due to concerns over contracting the virus: The lockdown measures made it more challenging for women to seek care, especially for routine and planned services. With schools closed and increased caretaking responsibilities, in some cases, the shift to working at home made it difficult to leave the house. Even for those who

do not have caretaking responsibilities leaving home was associated with a risk of infection that they were unwilling to take, mainly if they or someone they live with had underlying health conditions.

COVID-19 hits women harder: Economic impacts hit women and girls harder. For many families, school closures and social distancing measures have increased the unpaid care and a domestic load of women at home, making them less able to take on or balance paid work. A larger share of people is employed in the informal economy, including in the agriculture sector, in which there are far fewer social and health protections. Discriminatory social norms are likely to increase the unpaid workload of COVID-19 on women, especially those living in poverty or rural, isolated locations.

Quality:

An individualized approach to service delivery: Absence of clear national guidelines on the ways and modalities of some SRH service delivery during emergency state and lockdown resulted in individualized approach to service delivery by health clinics. Without adequate information on the service quality, it is difficult to conclude whether SRH service quality was maintained during this period and how it affected the outcomes.

The failure to widely distribute the new protocol on ANC provision during COVID-19 and capacity building of service providers in new approaches to ANC visits harmed the pregnant women's service uptake during emergency and lockdown. Decisions on online versus in-clinic ANC visits were typically based on the clinic professionals' subjective judgment and lacked a standardized approach. The latter raises questions of service quality.

Lack of clear guidance on remote consultations: Clinics that utilized telemedicine for various services also lacked clear guidance on remote consultations and standard algorithms for risk assessments.

Absence of supportive supervision system questions whether SRH service providers ensured the provision of quality services.

3.5 Summary of approaches applied by health clinics to deal with challenges

Digital Health strategies adopted during the outbreak could be turning the crisis into an opportunity. The COVID-19 pandemic has changed how SRH services are delivered in health care practices. Clinics have introduced creative ways of offering care during the COVID-19 crisis. Many of these new procedures, like expanded telehealth and offering self-administered medical abortions, are common-sense solutions that have been shown to remove barriers to reproductive health care and could increase access even after the pandemic eases. The traditional face-to-face engagement has also been replaced by social media, Facebook, Instagram, Messenger and WhatsApp at scale to deliver information on the availability of SRH services. This flexibility benefited all patients, but it is particularly crucial for those who face barriers such as lacking reliable transportation, living far away from any clinic, not having time to visit a clinic.

Digital health technologies offer significant opportunities to reshape the current health care system. Adopting electronic medical records to mobile health applications and digital health solutions can promise a better quality of care at a more sustainable cost. However, the wide scale adoption of these solutions is yet to be seen.

Clinics were proactive in developing operating procedures and trained staff to implement alternative modes of service delivery. In the absence of national guidelines, clinics took decisive steps to reshape service delivery. SRH clinics developed alternative service delivery mechanisms, procedures, care protocols, trained staff to ensure access to quality services. Using different communication means clinics moved to remote testing, where patients are assessed by phone or online before they access health professionals. Clients are informed on newly introduced rules on how to access antenatal, delivery, postnatal, and in one case, medical abortions at home. Understanding how this has affected access to SRH service will be critical. A key factor will be to learn whether these changes were introduced across the board, the ease with which service

providers have been able to move to online working, and whether an appropriate patient contact level has been maintained.

Health facilities reshaped the workforce to contain the infection and protect the most vulnerable.

The COVID-19 pandemic placed a significant strain on health care workers. Clinics were forced to shift tasks to the younger staff, sometimes less specialized health workers, and allowed older staff members to stay at home and provide remote services and serve as a back-up when needed. Clinics also introduced duty schedules to reduce the potential risk of infection and transmission. During the lockdown, some clinics also organized staff transportation at the clinics' expense.

Extensive use of social media and other technologies to disseminate information to the population on rules of transportation during lockdown.

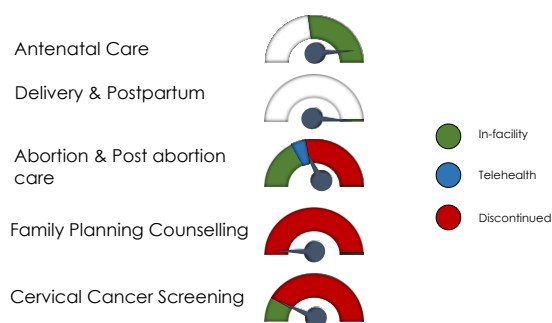
Clinics benefited from Government's regulation on the one-time travel permit system and established close partnerships with dedicated hotlines, as well as used different communication means to widely disseminate information to their clients and patient that proved to ease access to needed SRH services.

CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The COVID-19 crisis and ensuing restrictions complicated access to essential sexual and reproductive health information, services, and goods for women and girls. As the pandemic spread, Georgia implemented tough lockdowns and travel restrictions in a bid to slow transmission. Imposed restrictions along with MoH recommendations to temporarily suspend non-emergency services negatively affected the sexual and reproductive health and safety of women and girls,

Figure 11: Mode of service delivery & service disruptions across service areas



particularly of vulnerable people. As in many other countries, suspension of non-emergency services denied women' access to time-sensitive and potentially life-saving services and further distanced them from already difficult-to-access care.

Though antenatal, delivery and post-delivery care has been maintained during the emergency state and lockdown, women were left with limited access to essential medical services such as abortion care and cervical cancer screening (Figure 11). These services were no longer available to women

during the COVID-19 crisis due to closures or reduction in service-providers' activities, even where services were available, fears of infection, or reduced income restricted people using them.

Like in many other countries, emergency state and lockdown had a worrying effect on Georgia's screening services. Partial or complete disruption of cancer screening services was observed during the quarantine and lockdown. The reduction in these services is putting lives, health, and well-being at risk, particularly those of vulnerable groups.

The extent of the impact of COVID-19 emergency and lockdown at the population level is generally partial but large enough to affect the availability of and access to high-quality services for the most vulnerable populations. While the country has loosened restrictions since late June 2020, a second wave of the pandemic or infection hotspots may force providers again to restrict in-person care. As public leaders and officials monitor the health system's capacity to respond to patient needs during the COVID-19 pandemic, they will also continue to be faced with difficult decisions how to regulate many SRH services critical to women's health. Devastating consequences for women and their families are possible if core sexual and reproductive health services are reduced or deemed non-essential during the pandemic's future waves. This reinforces the need for strategic adaptations to ensure the maintenance of essential health services during the pandemic.

Implementation of telemedicine using mobile phones and social media as an adjunct to improving information and access to SRH services during pandemic became vitally important. The use of digital health tools has been explored before, but now is the time to capitalize on pilot interventions such as using a mobile phone, websites, social media, and other communication platforms, which have been shown to work in various clinics studied.

What is encouraging is to see the entrepreneurship and innovation found in one of the studied clinics in Tbilisi, where the clinic immediately moved vital services online and introduced remote medical abortion services. Both telemedicine for abortion counseling and consultation, and home provision of medical abortion, are critical strategies for ensuring continued access to abortion care in Georgia, where a significant population is living in remote and hard to reach locations, with limited mobility, which has been further restricted by COVID-19 lockdown. The novel way of providing medical abortion at homes of women proved to be useful and benefited women. The flexibility to turn towards self-care and telemedicine is limited by a lack of regulatory approval of medical abortion or injectable contraceptives for self-administration. Thus, the institutionalization

of the given approach as an alternative to in-clinic services should be institutionalized and applied not only during emergencies but also in the post-pandemic era.

The delivery of contraceptive products to people's doorsteps in Tbilisi and Batumi during the lockdown, though not an innovation, showed a significant improvement in access. However, access to family planning counseling and modern contraceptives remains an unaddressed challenge during and after the emergency, predominantly affecting those living in remote areas and ethnic minorities.

Access to contraceptive supplies must also be monitored as lockdown-related disruptions in production in major manufacturing countries, combined with transport and supply chain issues, may have a longer-term knock-on effect. There is increasing concern that lowered income resulting from job/income losses in parallel with a price increase on medical goods may impact the ability to purchase contraception in the near future.

The COVID-19 pandemic impact on the health service providers during emergency and lockdown is already evident and may be felt more severely beyond the pandemic. Those that have been forced to discontinue services or make a shift to unpaid remote service provision face declining caseloads and are in immediate financial difficulty.

Improving the quality of care in pregnancy and childbirth and care for women of reproductive age along with educating, supporting and training healthcare providers in control of infection epidemic and provision of standardized remote services need to be prioritized by the Government.

While there is no end in sight for the pandemic, there is hope that the existing inequalities COVID-19 has further brought to the foreground will encourage more activity in the future. With the pandemic growing in many places, the Government has to make difficult decisions about how best to protect their citizens' health. Safeguarding the essential health, particularly of SRH services, is a critical policy response and must be based on the best evidence of what works so that gains in survival and women's health are not reversed. Effective execution of response will require money, political will, and commitment. These will be pivotal drivers, securing COVID-19-specific gains and overall protection and improvement of women's health.

5.2 Promising Practices

As many countries in the world are refining their response to the COVID-19 pandemic, some countries applied innovative strategies to mitigate disparities and inequities in access to essential health services, including SRH. This section of the report summarizes key promising practices observed worldwide that can be of interest to policymakers and health service providers in Georgia.

Safeguarding essential health services during the crisis: When Covid-19 measures were put in place in **Kenya** at the end of March, the Government prioritized Covid-19 preparedness and care.⁴¹ As in other countries, providers were afraid that safe abortion services and other reproductive health care would be considered less essential. Therefore, development partners seized the opportunity of their strong collaboration with the Ministry of Health by providing technical contributions to the development of the national Guidelines for continuity of reproductive, maternal, newborn, and family planning care and services during Covid-19. These Guidelines now include a section on post-abortion care, safeguarding that these services can continue during this crisis.⁴²

Use of telemedicine: Many countries have enacted new, specific provisions in light of the COVID-19 restrictions to guarantee access to SRH services during the crisis. Several governments have removed procedural or administrative barriers and have adapted their service delivery models, including telemedicine for SRH services, i.e., through phone or online consultations. Telemedicine is critical so that women do not have to travel to their doctors to get a prescription for contraception

⁴¹ Provision of Essential Services During Covid-19.

⁴² Covid-19: The resilience of safe abortion providers in Kenya, Rutgers International, May 2020

or access abortion care. It safeguards the health of both women and healthcare providers by avoiding unnecessary exposure to the virus.

Albania has enacted telemedicine provisions for prenatal care. **Belgium** is using telemedicine for prescriptions and abortion pre-meetings. **Portugal** is in the process of reviewing its service-delivery model, including using telemedicine, notably for contraception prescriptions.⁴³

The Government of the Chinese province of Shandong, one of the most affected regions, established a comprehensive telemedicine program in March of 2020. The program has provided guidance on prevention and treatment directly to the patients, training for health care professionals, and remote consultation with medical staff specialists in different locations. This platform has been a great success and a model for other Chinese cities.⁴⁴

In Brazil, telemedicine activities were exceptionally authorized due to the recent coronavirus disease (COVID-19), being valid only while the pandemic lasts. The necessary regulation of telemedicine is still being discussed and was subjected to a presidential veto on the grounds that the regulation of medical activities utilizing telemedicine after the end of the current pandemic is a matter that should be regulated by law.⁴⁵

Respectful maternity care: A growing number of hospitals allow birth companions (**France, Ireland, Czech Republic, Slovakia**), while others are separating newborn babies from their mothers (France, Slovakia, Romania), decreasing the access of pregnant women to medical monitoring services drastically, interrupting breastfeeding procedures (Romania), or applying other practices not in line with WHO guidelines.⁴⁶

Comprehensive Sexuality Education: New technologies were also key to providing comprehensive sexuality education (CSE), which cannot be provided in schools anymore in countries where they have been closed. **Sweden** and the **Netherlands** are strengthening CSE accessibility online: both by providing SRH information and education directly on their website and through social media (Facebook, WhatsApp, and Instagram), and by providing teachers with CSE packages that they can use for tele-schooling. These approaches are particularly useful for delivering information and counseling on SRH.⁴⁷

Supportive Supervision: WhatsApp and phone are also being used to provide remote supportive supervision or capacity building to public and private providers, where previously technical assistance was delivered in person.

Access to abortion: Several countries, such as **France, Ireland, and the United Kingdom (UK)**, have brought in legislation enabling the use of telemedicine and remote support of medical abortions.⁴⁸ In **France**, the at-home-abortion-pill can now be used up to the ninth week (instead of the seventh), and all appointments for medical abortion can be done through telemedicine. In the **UK**, early medical abortion at home is now allowed up to 10 weeks of gestation. In **Ireland**, a new care model for early abortion has now been put in place and allows for remote consultation, with face-to-face contact in exceptional circumstances. Moreover, the **Irish** COVID-19 emergency laws include a provision allowing nurses and midwives to take on tasks typically only undertaken by doctors.

⁴³ Sexual and Reproductive Health and Rights during the COVID-19 pandemic, A joint report by EPF & IPPF EN, April 22, 2020

⁴⁴ Song X, Liu X, Wang C. The role of telemedicine during the COVID-19 epidemic in China-experience from Shandong province. *Crit Care*. 2020;24(1):178. <https://doi.org/10.1186/s13054-020-02884-9>

⁴⁵ Telemedicine, legal certainty, and COVID-19: where are we? Divisão de Pneumologia, Instituto do Coração, Hospital das Clínicas, Faculdade de Medicina da Universidade de São Paulo - HCFMUSP - São Paulo (SP) Brasil. https://www.scielo.br/scielo.php?pid=S1806-37132020000400103&script=sci_arttext#B6

⁴⁶ Sexual and Reproductive Health and Rights during the COVID-19 pandemic, A joint report by EPF & IPPF EN, April 22, 2020

⁴⁷ Sexual and Reproductive Health and Rights during the COVID-19 pandemic, A joint report by EPF & IPPF EN, April 22, 2020

⁴⁸ Sexual and Reproductive Health and Rights during the COVID-19 pandemic, A joint report by EPF & IPPF EN, April 22, 2020

Germany and Spain (Catalonia) have made it possible for the mandatory counseling session before an abortion takes place over the phone or by video chat. The abortion procedure is still required to be carried out in a clinic, in any case. The Catalan Government is currently working on amending their medical abortion legislation in order to allow women to do it at home.⁴⁹

In **Australia**, telehealth services have been an effective way of providing abortion services. At the beginning of the pandemic, the Australian Government expanded telehealth services, which could be billed to the public health system, Medicare. Telehealth consultations for early medical abortion have increased by 25% since the pandemic began, indicating that telehealth services can improve access when distance and out-of-pocket costs are barriers.⁵⁰

Other countries that have tried to enable access to medical abortion outside of health facilities include **South Africa**, where telehealth services are in place for remote consultations including the dispensing of medical abortion pills, and **Ethiopia**, where the Government has approved a pilot scheme for nurses to provide medical abortion in homes in Addis Ababa.⁵¹

Changes in national guidelines in **Nepal** stipulate that medical abortions can be delivered outside of healthcare facilities. In **India**, the Government has issued telemedicine guidelines that do not rule out medical abortion.

Access to contraceptives: In **Australia**, the Government quickly responded by expanding the telehealth services for access to contraception, which was bulk billed to Medicare.⁵² The utilization of telehealth consultation in Australia has helped maintain access to contraception during this crisis. Telehealth contraception consultations have paved the way for the provision of services to the hard-to-reach groups, including ethnic minorities and those in rural areas.

Government removal of user fees: For instance, Belgium completely reimbursed any contraceptive for women until 25 years old (previously until 18). While this measure was planned for before the start of the COVID-19 crisis, it will be critical to continue ensuring access to contraception given the social and economic impact the crisis will have on women.⁵³

5.3 Recommendations

Outbreaks are inevitable, but catastrophic losses for sexual and reproductive health are not. By learning from prior epidemics, putting in place critical resources and systems, and ensuring essential sexual and reproductive health services, the country can prevent health system disruptions that would have devastating, lasting effects on individuals, families, and the entire country population. To avert potential sexual and reproductive health crisis, the Government and their partners are advised to take swift, decisive actions. Implementation of recommended actions detailed below will mitigate the impact of COVID-19 on SRH services in the short term and provide benefits over the longer term, as innovations are adopted and institutionalized.

Recommendation 1: Include sexual and reproductive health services as essential services in contingency planning and the response to the COVID-19 pandemic

Beyond the direct impacts of COVID-19, the pandemic has triggered access to SRH services, severely undermining prospects of achieving SDG 3. This reality shows that health care services and systems matter more than ever. It is not surprising that the additional burden of planning and responding to the pandemic runs the risk of overwhelming health systems, leaving ongoing

⁴⁹ A Revolution in the Healthcare is on the Horizon, <https://mariestopes.org.za/a-revolution-in-healthcare-is-on-the-horizon/>

⁵⁰ Natalia Kanem, COVID-19 has a "devastating" effect on women and girls, *The Lancet*, Vol. 396, August 1, 2020

⁵¹ Natalia Kanem, COVID-19 has "devastating" effect on women and girls, *The Lancet*, Vol. 396, August 1, 2020

⁵² Ibid

⁵³ Belgium introduces free morning-after pills to all women, February 2020, <https://www.brusselstimes.com/news/belgium-all-news/96491/reimbursement-of-contraceptives-and-morning-after-pill-expanded/> accessed on October 30, 2020

preventive care neglected. This inevitably leads to increased secondary morbidity and mortality, particularly in vulnerable populations. Therefore, while the Government must scale up immediate health response to curb the spread of COVID-19, it must also ensure essential health services, including core SRH services, continue, keeping progress towards SDG3 at the forefront of the health agenda.

New guidelines are drawn up to help countries maintain essential health services during the COVID-19 pandemic⁵⁴, the WHO defines 'reproductive health services' as one of the seven essential services for which governments should produce continuity plans. In particular, family planning services (including emergency contraception and post-abortion care) should be maintained for people of all ages. The Government is called to treat sexual and reproductive health services, including safe abortion, contraceptive services, cancer screening, and maternal and newborn care as a life-saving priority and integral to the national response to the COVID 19. This will allow people to travel for sexual and reproductive health services—even in areas under stay-at-home orders or travel restrictions—without fear of legal consequences. Meeting these core obligations is essential and mandatory in the time of COVID-19.

Recommendation 2: Adapt policies, technical guidelines, and protocols for alternative SRH service delivery models, including telemedicine, to ensure access to sexual and reproductive health and rights during and after the pandemic.

Digital Health strategies adopted during the outbreak could be turning the crisis into an opportunity. Digital health technologies offer significant opportunities to reshape current health care systems. From the adoption of electronic medical records to mobile health apps and other disruptive technologies, digital health solutions have promised a better quality of care at a more sustainable cost⁵⁵. However, the wide scale adoption of these solutions is lagging.

The use of telemedicine in health care is legally allowed since 2001 in Georgia and regulated by the Law on "Medical Activities"⁵⁶ and has become a critical component during the pandemic. However, uncertainty on the topic is still common among health care professionals and health institutions. The use of telemedicine is not adequately reflected in state health programs and contracts signed between health facilities and SSA. Consequently, SRH services provided through telemedicine during the emergency state are not subject to reimbursement. Telemedicine needs to be properly regulated in order to become available after the end of the COVID-19 pandemic. To this end, all interested parties in its approval should be convened to create an adequate legal framework for the promotion of telemedicine activities.

The Government may also consider the establishment of green zones for elective services in a separate location with robust pre-operative COVID screening.

In support of telemedicine, which benefits service users and the public more widely, we strongly believe that irrespective of consultation modality, best practice and guidelines must be adhered to at every user contact to ensure safety and quality of care. Therefore, the Government jointly with professional associations is advised to develop a set of 'best practice' standards of care for those providing SRH services (ANC, postnatal care, family planning, medical abortion, cervical cancer screening) through avenues other than traditional face-to-face services. These could include a range of modalities from real-time interactive health care via a video link to web-based questionnaires. This recommendation should be implemented while ensuring patient and staff safety regarding cross-contamination (See [Annex 3](#)).

Recommendation 3: Strengthen the system of abortion care delivery and enable self-managed abortion by guaranteeing access to medications and telemedicine counseling

⁵⁴ WHO guidelines to help countries maintain essential health services during the COVID-19 pandemic [Internet]. 2020 Mar 30. <https://www.who.int/news-room/detail/30-03-2020-who-releases-guidelines-to-help-countries-maintain-essential-health-services-during-the-covid-19-pandemic>

⁵⁵ Pol Perez Sust, et al., Tuning the Crises into an Opportunity: Digital Health Strategies Deployed During the COVID-19 outbreak, JMIR Public Health Surveill, May 2020

⁵⁶ Law of Georgia on Medical Activities #904, 08.06.2001

Incorporating measures to ensure safe abortion services into state pandemic responses and eliminating abortion barriers is essential. The COVID-19 outbreak has illuminated several weaknesses of the healthcare system. One lesson should be that the system of abortion care delivery must be strengthened in ways that prevent abortion access from being so easily rescinded in times of health system stress, whether minor or substantial. The Government has a duty to ensure that individuals do not have to undertake unsafe abortions when faced with an unwanted pregnancy and/or threatens their life or health.

Enabling self-managed abortion by guaranteeing access to medications and telemedicine counseling could be a critical step towards fulfilling country's binding human rights obligations and avoiding preventable abortion complications, including during the COVID-19 crisis. Both telemedicine for abortion counseling and consultation, and home provision of medical abortion, are critical strategies for ensuring continued access to abortion care in Georgia, where a significant population live in remote and hard to reach locations, with limited mobility, which has been further restricted by COVID-19 lockdowns. There is a need to systematically collect and document evidence on the effectiveness of these new abortion care models to secure guidelines enabling the continued provision of abortion care outside of a clinic setting following the end of the pandemic.

Recommendation 4: Develop overarching guidance on the continuation of cancer screening services during the crises.

Suppose it is not possible to offer usual healthcare for cervical cancer screening during a pandemic. In that case, the Government is encouraged to develop guidance to assist clinicians in decision-making on screening appointments, including deferral and rescheduling, depending on individual patient circumstances. Clinical procedures must be thought through and adapted to patients' unique and changing needs. For example, the clinic calling patients with upcoming appointments and working out a personal action plan to ensure that they get the care they want and need while minimizing time inside the clinic.

Recommendation 5: Institutionalize a mechanism for improved access to modern contraceptives during the crises.

To improve access to sexual and reproductive health services for all, particularly vulnerable and disadvantaged women and girls, the Government is recommended to enforce two prone strategies, one for all times and another specific to emergencies.

- Include family planning counseling and free access to contraceptives into the UHC program. In case of insufficient fiscal space, consider introducing a co-payment scheme, which will provide free access to contraceptives to the most vulnerable and disadvantaged women and girls.
- Intensify the work on strategic approaches for price regulation initiated back in 2019. Ensure that strategy also targets the regulation of prices on contraceptives.
- During the emergency, design a mechanism, which enhances and promotes family planning counseling. Based on existing hotlines used for COVID-19 during the emergency state, establish a separate line for family planning counseling, and inform the population accordingly. This strategy will help to reach out to those women who do not seek care at health facilities.
- Maximize contraceptive availability not only in private pharmacies but also in health facilities. The Government should request the pharmaceutical industry: i) to ensure adequate stocks of contraceptives NOW to reduce shortages and enhance monitoring of contraceptive use to identify any shortages that may arise; and, ii) pharmaceutical industry to strengthen national and regional supply chains of contraceptives by taking such steps as prepositioning commodities to make contraceptives more accessible to providers and patients.
- Furthermore, efforts at integration of contraceptive counseling and distribution where feasible, should be pursued. The option of requesting health facilities to maintain a stock of contraceptives at health facilities (for sale) may maximize contraceptives access. Service users will obtain prescribed contraceptives right at the facility after being counseled. Encourage healthcare facilities and pharmacies to have additional short-acting

contraceptives in stock (pills, condoms, and injections); anticipate provision of several months' supply to help clients reduce the number of visits they make to healthcare facilities and pharmacies.

Recommendation 6: Build SRH service provider capacity in the application of alternative service provision modalities, management of clinical cases, and IPC measures through the establishment of a supportive supervision system

A good practice of supportive supervision at COVID centers should be extended to SRH service providers to ensure quality SRH services and IPC guidelines. Supportive supervision should ensure the provision of technical guidance on reinforcing infection control measures within facilities, including testing flow.

Professional associations should play an active role in providing on-job training/refreshment training, mentoring, and coaching of health professionals in the safe and effective delivery of SRH services at all levels during the supervisory visits, with particular emphasis on new standards for alternative service delivery modalities.

Supportive supervision should be planned and budgeted for in the COVID-19 response plan of action. It should not be considered an add-on activity done ad hoc and during staff and volunteers' time.

Recommendation 7: Prioritize the collection of accurate and complete data with appropriate disaggregation to understand how COVID-19 impacts access and utilization of SRH services

There is a need to improve the real-time monitoring of changes in service delivery and utilization. Decisions about the nature and timing of adaptations to service delivery must be informed by the use of accurate and timely data, and there is a need to improve real-time monitoring of changes in service delivery and utilization, as the outbreak is likely to wax and wane over the coming months.

Surveillance and response systems must also collect, track, and analyze a core set of SRH indicators to monitor the utilization of selected essential services. Data analysis should be done at the lowest geographical or health care unit level that is feasible as access to essential health services is likely to vary by area, and national and sub-national data will not reflect local variations. Population numbers should be kept in mind when interpreting the results as small numbers may cause fluctuations in the indicator value.

There is a need to improve understanding of the potential impact of disruptions on morbidity and mortality and weigh the benefits and risks of pursuing different mitigation strategies carefully.

Recommendation 8: Intensify culturally sensitive public information and education campaign

Run public media campaigns (tele/radio and social media) to communicate messages about the epidemic's and SRH service provision modalities. Information should be made available to the public in all languages (state and ethnic minorities), sign language and accessible means, modes, and formats, including accessible digital technology, captioning, text messages, easy-to-read and understandable language on hygiene practices, including those related to COVID-19 and procedures for accessing SRH services. Ensure communication and outreach activities are accessible to the most hard-to-reach and most at-risk women and girls.

Annexes

Annex 1: Selected regions and health facilities

Region	District	Type of Facility	Facility Name
Tbilisi	Gldani Nadzaladevi	Maternity	First University Clinic (Level III)
		Women's consultation	Women's consultation #6
	Didube Chugureti	Maternity	David Gagua's Clinic (Level II)
		Women's consultation	New Life
		Cervical Cancer Screening	National Screening Center
Adjara	Batumi	Maternity	Medina (Level III)
		Women's consultation	Kobuleti Fever Center
	Shuakhevi	Maternity	Regional Health Center (Level I)
		Women's consultation	
	Batumi	Cervical Cancer Screening	Tamari's Family Medicine Center
Kvemo Kartli	Marneuli	Maternity	Geo Hospitals (Level II/III)
		Women's consultation	
		Cervical Cancer Screening	
	Tsalka	Maternity	Regional Health Center (Level I)
		Women's consultation	
Kakheti	Telavi	Maternity	Avtandil Kambarashvili Clinic (Level II)
		Women's consultation	
		Cervical Cancer Screening	
	Dedoplistskaro	Maternity	Regional Health Center (Level I)
		Women's consultation	

Annex 2: Research Framework

Domain	Research sub-questions	Data Collection Method				
		DR	SQDA ⁵⁷	IDI	GI	FGD
Outcome						
Outcome	Share of women completing the first ANC visit before 12 weeks of pregnancy during Feb-Jun in 2020 and 2019					
	Share of pregnant women who completed 4 ANC visits during Feb-Jun in 2020 and 2019		*			
	Share of home deliveries out of total deliveries during Feb-Jun in 2020 and 2019					
	Number of Maternal death during Feb-Jun in 2020 and 2019					
	Abortion rate per 1000 live births during Feb-Jun in 2020 and 2019					
	Sales of modern contraceptives during Feb-Jun in 2020 and 2019					
	Q1: Was the access to the SRHR services (ANC, delivery, FP, abortion and cervical cancer screening) restricted during the pandemic/state of emergency, particularly during the lock down?		*	*	*	*
Enabling environment						
Enabling Environment	Q2: What was done by the Government to ensure access to SRHR (ANC, delivery, FP, abortion and cervical cancer screening) during the crisis?	*		*	*	
	Q3: Was SRH service provision (ANC, delivery, FP, abortion and cervical cancer screening) adjusted to the pandemic context?	*		*	*	
	Q4: If yes, which SRH services (ANC, delivery, FP, abortion and cervical cancer screening) have been sustained, suspended temporarily or discontinued?	*		*	*	*
	Q5: How the Government ensures monitoring of SRH service provision (ANC, delivery, FP, abortion and cervical cancer screening) during the pandemic?	*		*		
	Q5a: Have the SRH specific funds been diverted to COVID-19 response?					
Supply						
Repurposing/ closure of facilities/ suspension of services	Q6: Were clinics providing ANC, delivery, FP, abortion and cervical cancer screening reassigned as COVID-19 centers?	*		*		
	Q7: Were clinics closed during the lockdown? If yes, were alternative mode of service delivery offered to pregnant women, women in labour and women of reproductive age?			*		*
	Q8: If yes, were alternative service providers identified and population in respective catchment area informed accordingly?			*	*	*
	Q9: Which services (ANC, delivery, FP, abortion and cervical cancer screening) have been sustained, suspended temporarily or discontinued and what were reasons?			*	*	

⁵⁷ Secondary Qualitative Data Analysis

Domain	Research sub-questions	Data Collection Method				
		DR	SQDA ⁵⁷	IDI	GI	FGD
	Q10: How facilities re-worked facility budgets to allow adequate funding for use of electronic and virtual consultations, monitoring and meetings?			*		
Redeployment/ Morbidity of health workers	Q11: Do these facilities ensure adequate number of health professional to provide uninterrupted services during the pandemic/state of emergency, particularly during the lock down?			*	*	
	Q11a: How many SRH workers have been absent from work because of COVID related issues (quarantined, proceeded on long leave or quit voluntarily)?			*	*	
	Q12: If not, how staff shortages affected provision of uninterrupted SRH services (ANC, delivery, FP, abortion and cervical cancer screening)?			*	*	*
	Q13: What were challenges faced in provision of (ANC, delivery, FP, abortion and cervical cancer screening services during the pandemic/state of emergency, particularly during the lock down (high workload, lack of Information technology/communication support, work schedule, etc.) ?			*	*	
	Q14: How staff motivation was maintained during the pandemic/state of emergency, particularly during the lock down?			*	*	
Supply chain disruptions	Q15: How would you assess availability of medicines and consumables and operation of basic medical equipment at your facility during the period of February – June 2020, particularly during the lock down? Where there any stock outs in the period of Feb-June? If yes, which supplies?			*	*	
	Q16: How often do you use personal protective equipment (PPE)? If not, what are the reasons?			*		
	Q17: How would you assess availability of modern contraceptives either at health facility or in pharmacies?			*	*	*
Demand						
Movement Restrictions	Q18: Did you receive SRH (to be specified per each FGD) services during the period of February – June 2020?					*
	Q19: How movement restrictions affected your SRH service seeking behavior?					*
Loss of income	Q20: Did you and your family lose income during the COVID-19 and particularly during the lockdown?					*
	Q21: How loss of income during lockdown affected access of SRH services (payment or co-payment for services)?			*		*
	Q22: Please specify service for which you had to pay and cannot afford					*
Concerns about COVID- 19 transmission	Q23: Please specify all reasons for not seeking care? Do you think that fear of getting infected was the main reason for not seeking care?					*
	Q24: Have you received sufficient information about prevention of COVID-19?					*
	Q25: What were the main sources of information on i) COVID-19 and ii) how to access SRH services?					*
	Q26: Who in your family makes decisions?					*

Domain	Research sub-questions	Data Collection Method				
		DR	SQDA ⁵⁷	IDI	GI	FGD
Limited decision – making power	Q27: If anyone other than you makes decisions when and where to seek care in your family, how did it affect, your ability to receive needed care?					*
	Q28: Which SRH services were inaccessible due to this reason?					*
Quality						
Quality of services and satisfaction	Q29: Have service providing facilities received the Ministry of Health guidelines on i) services to be provided, ii) Infection Prevention and Control during COVID-19; iii) Management of pregnancies and delivery during COVID-19, etc.?			*		
	Q30: Have staff been trained on Infection Prevention and Control during COVID-19 and other guidelines?			*	*	
	Q31: How social distancing and testing of patients/clients is organized in your facility?			*	*	
	Q32: What is the level of your satisfaction with the services received?					*

Annex 3: SRH service provision modalities

Service	Facility Based	Remote
Family Planning	<ul style="list-style-type: none"> - Optimize opportunities for integration with other essential services, including immediate postpartum and post-abortion care. - - Manage and treat contraceptive side effects, if possible. 	<ul style="list-style-type: none"> - Explore and use phones and other digital technologies for screening, triaging, and referral for care; education and counseling when feasible; responding to questions about method use, side effects, and management, and supporting client continue using the method. - Establish telehealth mechanisms for individual counseling of new clients and adolescents that adhere to the principles of confidentiality and non-coercive decision making. - Provide additional counselling and information on fertility awareness methods and correct and consistent condom use in case disruptions occur in the supply of other contraceptive commodities. - Educate clients on emergency contraception
Antenatal	<ul style="list-style-type: none"> - First visit at any gestational age (12 weeks), to include ultrasound estimation of gestational age - Visits at 30, 36, and 40 weeks - Catch-up of missed ANC contacts, including delivery of tetanus toxoid vaccination, and HIV and syphilis testing - Evaluation and management of danger signs - In- or outpatient management of complications 	<ul style="list-style-type: none"> - Assess risk: co-morbidities; under- or overweight; < age 19; tobacco, alcohol, or other substance use; mental health conditions (e.g., anxiety, depression); GBV; and other vulnerable groups - Test and provide advice on common discomforts, concerns or preoccupations, and danger signs. - Provide counseling on FP, pregnancy spacing, and birth preparedness/ complication readiness plan (adapt for changes to services). - Advise on self-care. - Advise on visit schedule based on risk assessment. Prioritize third trimester visits.
Delivery and postpartum	<ul style="list-style-type: none"> - Provision of essential and emergency maternal and newborn care during labor, childbirth, and the immediate postpartum period - Prioritization of support for initiation of skin-to-skin contact and early and exclusive breastfeeding, with appropriate precautions - Performance of cesarean section operations based solely on obstetric indications independent of COVID-19 transmission scenario and the COVID-19 status of the woman - Where possible, initiate or continue counseling and access to immediate postpartum contraception before hospital discharge, particularly as access to postpartum visits becomes limited. 	<ul style="list-style-type: none"> - Testing and advice for women who think they are in labor - Testing postpartum women using risk assessment checklist and when needed schedule a clinic visit
Abortion & Post abortion care	<ul style="list-style-type: none"> - - Counsel clients on contraception and screen for medical eligibility - Educate clients on emergency contraception 	<ul style="list-style-type: none"> -

Service	Facility Based	Remote
	<ul style="list-style-type: none"> - Continue to offer insertion of LARC methods, such as intrauterine devices and contraceptive implants, to new users where possible with adequate safety preparations for the procedure 	
Cervical Cancer Screening	<ul style="list-style-type: none"> - Clients should be pre-screened for COVID-related symptoms remotely before screening appointments. - Any individuals who are experiencing symptoms of cervical cancer (such as unexplained abnormal vaginal bleeding - after sex, between periods, or after menopause; unexplained persistent unusual vaginal discharge; or deep pain during sex) should be clinically assessed and investigated according to the Clinical Management Guidelines. - Scheduling of appointments should allow for physical distancing between patients, and longer appointment times, if needed, to avoid crowding in waiting rooms and patient care areas - 	<ul style="list-style-type: none"> - Counselling services for at risk populations and shared decision making on screening, provide information on where and when the screening services will be provided, and provide management including psychotherapy for those already on follow up during this worrying and stressful moment - Providing health education on cervical cancer preventive measures such as adherence to routine screening and follow ups, importance of cervical cancer vaccination, safe sex practices, healthy eating and exercise

Ensuring access to affordable and quality medicines as countries shift from external support to national systems

