

Digital provision of sexual and reproductive healthcare: promising but not a panacea

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Provision of sexual and reproductive healthcare (SRH) via digital services has seen an exponential expansion globally. This increase has been even more evident in response to the COVID-19 pandemic. Digital health is a broad umbrella term encompassing eHealth and includes online platforms and mobile device-based telehealth (mHealth). Benefits to healthcare delivery by these methods include reducing barriers to travel, decreasing the economic costs of absences from work for appointments, minimising the impact on caregiving, and privacy and convenience of accessing care from a person's home.

A cohort study published in this issue of the Journal by Rezel-Potts *et al*¹ describes the findings of a free-to-access online contraception service offered in two UK London boroughs with relatively high levels of socioeconomic disadvantage. The service provided a supply of oral contraceptive pills delivered by post to the client's home. Early adopters of the service broadly reflected the socio-demographics of the local population, however, black and ethnic minority (BME) clients were significantly less likely to make repeat orders of contraception. No conclusions could be drawn as to why this difference occurred and whether the mode of delivery of the service was responsible for this outcome. Previous studies demonstrate that BME groups are more likely to discontinue contraception at 12 months in face-to-face services.² An internet-based service for sexually transmitted infection (STI) testing delivered by the same UK platform has been shown to almost double the uptake of STI testing for all groups of users including high-risk groups.³ The authors conclude that further investigation into potential barriers for repeat access to contraception in BME groups should be undertaken. This small but encouraging study adds to the growing literature on the use of digital

and online platforms for contraception provision.

EXPERIENCE OF DIGITAL SRH DELIVERY FROM SIMILAR HIGH-INCOME COUNTRIES

Australia is the world's largest island with a population of almost 25.5 million. Around 29% of the population live in rural and remote areas. These Australians face unique challenges due to their geographic isolation, and often have poorer health outcomes than people living in metropolitan areas.⁴ Smaller countries with populations scattered over large geographical areas such as New Zealand and Scotland, and larger countries with vast distances separating small remote communities such as Canada, encounter similar challenges.⁵ In addition to barriers to access caused by physical remoteness, delivery of SRH services in rural Australia is hampered by conservative attitudes and the high prevalence of conscientious objection to the provision of contraception and abortion.⁶

Australian telehealth early medical abortion (EMA) services were launched by Marie Stopes Australia (MSA) and The Tabbot Foundation in 2015. EMA delivery by telehealth enables women living in remote and regional areas to access timely abortion care and has been shown to be safe, effective and acceptable to patients and positively received by staff providing the service.^{7,8} Although the MSA service was initially intended for rural clients, the telehealth service has become increasingly popular in metropolitan areas. Until recently however, this model of care did not attract any government funding, and was therefore essentially provided on a private basis. In response to the COVID-19 pandemic, the Federal Government authorised temporary funding to clinicians providing teleconferencing consultations.⁹ Unfortunately restrictions were recently placed on



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this funding, meaning it can only be accessed if the clinician has provided a face-to-face service to that patient within the preceding 12 months.¹⁰

Earlier this year, a novel Australian online contraceptive subscription service was launched.¹¹ Members can access new or repeat prescriptions for oral contraceptives for an annual fee and the cost of a private prescription. Customers complete an online health questionnaire and this information is reviewed by a doctor who then issues a prescription.

In the United States (US), a wide range of SRH services are provided via telehealth. One model of care is clinic-to-clinic, where a client attends a clinic and staff provide any necessary investigations, such as ultrasound. Results of tests are transmitted to a remote clinician who then consults with the patient via video-conference. Multiple services in the US offer the option to obtain contraception via online platforms through a mobile app or website.¹² These services include provision of combined hormonal contraceptives and the subcutaneous medroxyprogesterone acetate injection. Several companies in the US also offer STI testing and treatment and HIV prevention services via telehealth in the form of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) prescriptions.

Barriers to digital access

In many countries, delivery of SRH services via telemedicine is complicated by legislative requirements and financial constraints. In the US, health insurance coverage and Medicaid provision offer patchwork funding which varies by provider and state. Additionally, 18 US states explicitly prohibit telehealth for delivery of medical abortion.¹³ In the State of South Australia, women cannot access EMA via telemedicine due to existing abortion laws that only allow provision of abortion services in hospitals.

On an individual level, users of most digital services require a degree of information technology (IT), health and English literacy. Access will also depend on a reliable local internet service. Research concerning the provision of SRH-specific e-health services to culturally and linguistically diverse communities is lacking; however, a review of other culturally appropriate e-health services found barriers to provision that included differing cultural attitudes towards technology and socioeconomic barriers to accessing technology.¹⁴

Digital health should complement existing services

Rapid advances in technology, which are enabling providers globally to deliver digital SRH services, hold much potential for the future. There are, however, marked gaps in knowledge regarding the potential benefits or harms of these interventions in women's healthcare.¹⁵ Current enthusiasm should therefore be tempered with a cautious approach to the development of new services to ensure they do not exclude

disadvantaged people or marginalise those who do not have the ability or means to access such services. Online services must be rigorously evaluated and should be designed to complement and enhance existing health systems.¹⁶ They must remain supported by, and not replace, comprehensive in-person access. This is paramount to ensuring high-quality, equitable SRH care.

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