

WISH COVID-19 Learning Brief #4:

Digital platforms

February 2021

In the face of restrictions imposed in response to the COVID-19 pandemic, organisations are having to rethink effective and safe ways to maintain sexual and reproductive health and rights (SRHR) service delivery. Lockdowns, social distancing, and emergency responses have impacted the delivery of SRHR services in traditional clinical settings. This Learning Brief summarises learning on the use of digital platforms to provide SRHR services and support, both prior to and during the COVID-19 pandemic. Written by WISH4Results, the Third-Party Monitoring Team for the FCDO Women's Integrated Sexual Health (WISH) Programme, this publication includes the experience of WISH partners and other SRHR organisations in adapting their analogue and digital approaches to COVID-19 response.

Key learnings

- 1) Use of digital health platforms can help SRHR organisations reach vulnerable and remote populations.
- 2) SRHR programmes integrating digital platforms should consider privacy protection, data management, and the availability of mobile and broadband networks.
- 3) The speed at which pivots to digital adaptations are made during a pandemic or emergency situation may jeopardise coordination and integration efforts with existing health systems and services, which are important for the sustainability of digital platforms.
- 4) Increased uptake of digital platforms during COVID-19 paves the way for closer integration of digital and analogue/'traditional' means of outreach and engagement for SRHR programmes going forward.

Overview and scope

COVID-19 has disrupted facility-based SRHR services in many countries with reduced face-to-face contact, leading to increased uptake of digital health platforms to enable access to SRHR services and information. This brief is the final Learning Brief in a series of four developed by WISH4Results during the COVID-19 pandemic. Previous briefs covered the following topics:

- [Remote training for contraceptive service delivery](#)
- [Approaches to support the delivery of self-managed medication abortion during COVID-19](#)
- [Adaptations to social and behaviour change communications during COVID-19](#)

The use of digital platforms has featured across the programme adaptations referenced in each of these Learning Briefs. This final paper extrapolates these key learnings and supplements them with further examples from WISH implementing partners and the wider SRHR community, alongside insights from a global literature review. It focuses on the use of digital platforms to directly facilitate access to SRHR services and information.

Box 1: Key terms

Digital health is an umbrella term for the use of information and communications technology (ICT) in support of health and health-related fields, including electronic health (eHealth) and mobile health (mHealth) as well as emerging areas like 'big data', genomics, and artificial intelligence (AI). **eHealth** refers to the use of ICT for health, and **mHealth** comprises health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants, and other wireless devices. mHealth interventions use mobile phone capabilities such as short messaging service (SMS), radio, mobile telecommunications (3G and 4G systems), global positioning system (GPS), and Bluetooth technologies.

Digital health platforms are digital health applications and systems, such as software, ICT systems, and digital tools. These are built upon information infrastructure ('infostructure') to support the delivery of health services.

Benefits of digital platforms**Global literature**

WHO guidance ([2010](#), [2019](#)) discusses the potential for digital health interventions to address health system challenges by supporting, complementing, or substituting for existing 'bricks and mortar' health service delivery. Wider literature indicates that digital health interventions may have transformative potential in low- and middle-income countries (LMICs), where staffing and other physical resource constraints on the health system can be more pronounced ([ITIF, 2020](#); [Novartis Foundation, 2018](#)).

Different audiences can benefit from digital health platforms. For patients, digital platforms may simplify information exchange and provide access to health services at a relatively low cost ([ITIF, 2020](#)). Digital health may also put health care in the hands of individuals by enabling self-care, such as in the case of self-managed abortion (see Box 3). Self-care interventions can encourage the development of digital health approaches and vice versa, in addition to strengthening health systems and health care delivery ([WHO, 2018](#); [WHO, 2019](#)). For health workers, digital platforms can support effective training and supervision for both specialist and non-specialist staff ([DFID, 2019](#)). An advantage of digital health interventions is the ability to target and adapt programmes for vulnerable or marginalised populations. For example, young people are a key population targeted by digital health interventions, for whom the flexibility, interactivity, and spontaneity of digital platforms may appeal ([Seko et al., 2014](#); [WHO, 2018](#)). Digital tools can also be an effective method of promoting Social and Behaviour Change Communications (SBCC) (see next section).

The World Health Organization ([WHO, 2020](#)) recommends prioritising digital health when facility-based services are interrupted, which has occurred in many countries due to the COVID-19 pandemic. Not only has the use of digital health services increased in response to movement restrictions and physical distancing requirements, but it has also released the pressure on health systems that are overwhelmed with the COVID-19 response ([Healthcare Innovation Group, 2020](#)). In the case of SRHR, digital health platforms for routine services can also enable physical facilities to focus their resources on services that require in-person care ([IAWG, 2020](#)). While countries focus on 'flattening the curve' of COVID-19 infections, now is the time to 'accelerate and bend the curve' of digital health ([Tourous et al., 2020](#)).

Digital platforms for SRHR during COVID-19

Digital health interventions include a diverse array of mobile and electronic platforms, which the SRHR sector has harnessed in both high- and low-income countries to increase access to SRHR services and information, improve quality assurance, and provide remote training. This section selects key examples on the use of digital platforms based on data collected from WISH implementing partners and wider SRHR practitioners. These examples are by no means exhaustive but are intended to illustrate the ways in which digital platforms can be used by programmes to improve and strengthen SRHR.

Use of online channels and social media

“COVID-19 has increased the prominence and importance of social media”
(MSI Global representative, September 2020)

The increased importance of online channels and social media to share SRHR information during COVID-19 was raised by almost all the WISH contributors to these Learning Briefs. As indicated in our Learning Brief on [adaptations to social and behaviour change communication during COVID-19](#), this has included features such as animations, live broadcasts and video testimonials to share information on SRHR during COVID-19 via Facebook, provider websites and WhatsApp.

Use of such platforms to interact with clients and direct them to services has also increased: MSI Reproductive Choices have now enabled clients to book appointments via their websites and report that globally the proportion of interactions received through social media platforms (vs. calls) increased from around 28% in January 2020 to nearly 40% in April, and continued to rise to 51% in August.¹ Further, MSI Reproductive Choices has introduced a formal platform in nine countries to manage social messaging, which also enables basic reporting for performance improvements. The common portal expands the ability of MSI agents to connect with and support clients through social messaging on Facebook and WhatsApp, allowing them to log on and respond from any location which can reduce disruption when agents need to work from home during lockdowns. Shujaaz, Inc. has used WhatsApp for focus groups, in compliance with data privacy and consent, that bring together young people from different areas of the same country. The privacy of these one-to-one platforms to connect with clients is particularly valuable during lockdowns, removing the risk of other people in confined spaces overhearing calls to teleservices.

Promoting access to telehealth services for key populations

Basic mobile phone technology can be used to engage vulnerable and hard-to-reach populations.² [Viamo](#) (Box 2) provide examples of marketing to specific groups via targeted communications through specific socioeconomic and geo-targeted parameters. In some countries Viamo may be able to receive data from mobile operators on individuals' level of phone credit, providing a basis for targeting SMS messaging to lower-income populations. Through Viamo's 3-2-1 service, topical audio information is available in multiple languages, thereby overcoming literacy barriers. While the service has been a powerful tool to reach poor and marginalised populations, gender gaps remain: over 80% of Mali's 1.7 million 3-2-1 users are men (see Box 5 on the gender digital divide). Population Services International (PSI) has also supported the Ugandan Ministry of Health to develop a similar call-in service, Platform 161.

¹ Source: MSI (2020) in Learning brief #3: [Adaptations to social and behaviour change communications](#)

² See: DeMulder, Krause-Perrotta, Zaidi, 2020; McCoy and Packel, 2020; Steinke et al., 2016.

Box 2: Viamo's 3-2-1 Interactive Voice Response (IVR) services

Viamo's 3-2-1 hotline currently operates across 18 countries in Africa and Asia. Callers dial a toll-free short code (such as 321) and receive a menu of options for topical information, e.g.: COVID-19, farming, news, and health, including SRHR. Content is created locally and offered in local languages. SRHR content is pre-recorded and delivered in three ways:

1. **Static content:** Information about contraceptive methods, instructions, risks and benefits.
2. **Games:** Choose-your-own adventure stories that allow participants to hear different stories and explore different paths in family planning.
3. **Radio dramas:** In partnership with media organisations, dramas play on the radio and are then made into clips to use on the 3-2-1 service as example dialogues, and to prompt user feedback on characters and stories.

Viamo work with local partners to organise content development workshops with SRHR stakeholders and Ministry of Health representatives to foster national ownership from the outset. The COVID-19 pandemic has seen a significant increase in the use of the 3-2-1 service, doubling or tripling regular user numbers in some locations. Governments and mobile networks have promoted the service as a primary information source on COVID-19.

Source: Interview, August 2020

Digital platforms for self-managed medication abortion

As described in WISH4Results' Learning Brief on [approaches to support the delivery of self-managed medication abortion \(MA\) during COVID-19](#),³ online telemedicine services are an established way of delivering MA pills to women. Access barriers to clinic-based consultations for MA presented by COVID-19 can potentially be overcome by adapting care pathways to include telemedicine components. The International Federation of Red Cross (IFRC), WHO and UNICEF recommend that where access to health facilities is reduced, health authorities support trained community health workers to provide SRHR counselling and information, using digital decision support tools where available and appropriate.⁴ For example, use of hotlines can help women navigate access to self-managed medication abortion and supportive care, while providing discretion in contexts where abortion is highly stigmatised.

MSI Reproductive Choices has call centres in 28 countries offering advice and referrals on SRHR.⁵ In legally permitted settings, in relation to MA, contact centre agents are trained to provide support on dosage, warning signs and emergency referrals for women who purchase MA products from pharmacies or other outlets. Where the legal context allows, staff counsel and support women through their self-care choices, and can facilitate the collection of MA pills from a nearby pharmacy.

³Abortion self-care, or self-managed abortion is termination of pregnancy using pharmacological drugs – known as medical or medication abortion, or MA (either using a combination regimen of Mifepristone and Misoprostol, or a Misoprostol-alone regimen), with a woman managing as much of the process as she wants on her own and involving a health provider when she chooses to.

⁴Source: Learning brief #2: Approaches to support the delivery of self-managed medication abortion during COVID-19

⁵Source: Learning brief #3: Adaptations to social and behaviour change communications during COVID-19. This number will soon increase to 30, with the addition of Malawi and DRC.

Box 3: Telemedicine services for self-managed early MA in the UK and South Africa

During the COVID-19 pandemic, MSI Reproductive Choices began to provide telemedicine services for self-managed early MA in the UK and South Africa. A recent [WHO review](#) found that 94-96% of abortions carried out via telemedicine were complete: a similar range to those associated with clinic-based care. With MSI Reproductive Choices UK and MSI South Africa, clients are comprehensively counselled by a provider over the phone or video link. They are then sent medication through the post or via a courier, or can collect it from a nearby clinic, where possible. Clients have access to a 24-hour aftercare service staffed by dedicated trained nurses.

While these developments are a 'step in a positive direction' with regards to the use of digital platforms to meet client needs, in many countries the legal and regulatory context or infrastructure available may limit the use of telemedicine for SRHR, and the evidence on the cost effectiveness and equity of these strategies remains limited.

Source: Interview August 2020

Digital platforms for remote training

WISH4Results' Learning Brief on [remote training for contraceptive service delivery](#) featured examples of remote training of SRHR providers using mobile phone technology during COVID-19 where face-to-face training opportunities were limited. MSI Reproductive Choices tested remote competency assessments for contraceptive method provision in two countries, where the trained provider being assessed used video calls or clip recordings to go through a procedure, such as IUD insertion, after which a follow-up conversation would take place with the assessing supervisor on the other end of line. IPPF harnessed mobile phones to make master trainers available to trainees via phone call or WhatsApp messages for support and troubleshooting, accompanying existing job aides and resources. SRHR programmes also took steps to meet internet and phone connectivity challenges: as COVID-19 began to affect contraceptive self-injection training for health professionals in Madagascar provided through PATH and John Snow, Inc.'s Subcutaneous DMPA (DMPA-SC) Access Collaborative programme, a simple technology survey was sent out to districts and facilities to build a picture of trainees' internet and smart phone capabilities, which helped to inform their training adaptations.

Challenges of using digital platforms

Evaluating the impact of digital health interventions

A common framework for monitoring and evaluation of digital health interventions is '*vital to generate evidence required for decision-making on the appropriate approach to integrate effective strategies into broader national health systems*' ([WHO, 2016](#), p. 2), and to ensure they reach the most vulnerable populations ([Pedersen et al., 2020](#)).

SRHR programme implementers echoed the need for a robust evidence base to better understand the links between digital platform use and SRHR outcomes, including levels of service use. Tracking referral pathways from information sharing through to service delivery and contraceptive uptake can be challenging (Box 4). While COVID-19 has provided an opportunity to accelerate the use of digital platforms, preparing programme implementers to better-harness digital platforms in the future, integrating and capturing real-time learning through these rapid pivots is critical to understand what works and build on this experience.

Box 4: Tracking referral pathways

Viamo has been trying to link use of their 3-2-1 service to SRHR outcomes through the use of referral codes. For example, in Uganda, the 3-2-1 service provides callers with locations of PSI clinics and gives them a referral code to present at the clinic. Similarly, in Madagascar, the 3-2-1 service provides locations of MSI clinics, referral codes and vouchers for discounted services. The idea is that clients present the referral code to the clinic to enable Viamo to track impact by showing the links between information delivery and service delivery. However, evidence to date has been limited and highlighted the importance of clinic staff to ask for referral codes.

Source: Interview August 2020

ICT 'infrastructure' and the gender digital divide

A primary challenge facing digital health is ICT infrastructure. Target locations must have sufficient mobile connectivity or broadband networks for a digital health intervention to be successful. While lower-income countries may benefit from digital health platforms the most, they are more often the sites of poor connectivity ([ITIF, 2020](#)). Connectivity and the reliability of networks can limit the potential of digital platforms outside of metropolitan centres. Data bundles can be expensive, creating barriers for groups such as young people and women who may have less access to financial resources. The gender digital divide is a particularly acute challenge within these constraints for accessing marginalised populations (Box 5).

Box 5: The gender digital divide

The digital divide involves disparities in accessing and using digital platforms based on gender, race, ethnicity, class, sexuality, age, ability, or indigeneity.⁶ Of particular concern to the delivery of SRHR services is the *gender* digital divide, whereby women and girls have less access to digital devices, content and platforms as compared to their male counterparts. This divide is growing quickly ([ICT, 2019](#)) and is due in large part to structural factors within society ([Singh, 2017](#)). The most significant barriers to mobile phone ownership and mobile internet usage for women in low-income countries were identified by the [GSMA \(2020\)](#) as affordability, literacy and skills, and safety and security. One of the barriers to mobile phone ownership among women – lack of approval from family members – was also found to have increased in importance in recent years.

Ensuring privacy and data protection

With many partners relatively new to using a wide range of digital platforms to support clients with SRHR, management of data and privacy protection is an important consideration ([ITU, 2017](#), [UNICEF, 2018](#)). Privacy protection and data management must be guaranteed by the organisation designing a digital health intervention, as described in Box 6. However, the potential confidentiality risks must also be considered in the implementation of a digital health intervention where shared spaces, mobile phones, or computers may risk identifying someone as a user of a digital SRHR platform. In designing digital SRHR interventions, [Bacchus et al. \(2019\)](#) suggest that organisations should consider potential harms with input from users and stakeholders, with a view to understanding how digital media are used and shared, and the sensitivities, stigma and social and power dynamics around SRHR.

⁶ See: Lokot and Avakyan, 2020; Pick and Nishida, 2015, ICT, 2019, Singh, 2017

Box 6: Privacy and data protection challenges and considerations

The increased use of digital health platforms raises numerous concerns about data management and privacy protection for users. Standard health mechanisms, such as anonymisation, notice, and consent, are often difficult to achieve in digital health ([Caulfield, Murdoch, and Ogbogu, 2020](#)). There are data security risks, including but not limited to hacking ([Vayena et al., 2018](#)), which can significantly weaken trust in health systems. In one cautionary example, Privacy International found that multiple period-tracking apps were sharing data about users' sexual behaviour and fertility with Facebook without proper informed consent.

The [OECD Recommendation on Health Data Governance](#) sets out an international consensus on the use of personal health data to serve the public interest while promoting privacy protection and data security. It recommends a health data governance framework that provides for:

1. Engagement and participation
2. Co-ordination within government and promotion of cooperation
3. Review of the capacity of public sector health data systems
4. Clear provision of information to individuals
5. Informed consent and appropriate alternatives
6. Review and approval procedures
7. Transparency
8. Maximising the potential and promoting the development of technology
9. Monitoring and evaluation mechanisms
10. Establishment of appropriate training and skills development
11. Implementation of controls and safeguards
12. Require organisations to demonstrate that they meet national expectations for health data governance

Alignment with health systems strengthening efforts

There is evidence that digital health interventions can be uncoordinated in terms of funding, duplicated efforts, and interoperability between entities and levels of care ([Broadband Commission, 2018](#); [Lennon et al., 2017](#); [UNICEF, 2018](#)). SRHR programme implementers suggest this was true for adaptations made rapidly at the outbreak of the COVID-19 pandemic, which left little time to think about integration with broader systems. Others suggest a risk that digital health may also distract from broader efforts of health system strengthening ([ITU, 2017](#); [Financial Times, 2020](#)). For example, digital health interventions may be adopted by providers and patients, but not accepted or integrated by national health systems to the extent that would 'promote sustainability and population-wide application' ([Huang, Blaschke, and Lucas, 2017](#)).

Digital health interventions may also be limited in scope and geographic scale ([UNICEF, 2018](#)). [GSMA](#) (2020, p. 28) states that '*most digital health solutions rolled out to date do not have a viable business or revenue model for serving those at the bottom of the pyramid.*' The WHO's [recommendations for digital health interventions for health system strengthening](#) (2019, p. ix) conclude that digital health has been '*characterized by implementations rolled out in the absence of a careful examination of the evidence base on benefits and harms*' and '*with a limited understanding of their impact on health systems and people's well-being.*'

Digital platforms beyond COVID-19

Although the impact of digital platforms may be limited by ICT 'infrastructure' and the gender digital divide and raise concerns about privacy, data protection, and health system strengthening, digital platforms have many potential benefits. Increased use during COVID-19 has demonstrated the potential of digital platforms to reach target populations and maintain service delivery, and the opportunity for SRHR programmes to test new and innovative methods of outreach. Evidence from the early, acute phase of the pandemic in particular should be taken into account in reflections on what should be 'taken forward' in terms of digital platform integration in a post-COVID-19 context.

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Further information

About the WISH Programme

The UK government has committed to providing family planning services to an additional 24 million girls and women by 2020. To help realise this commitment, the UK Foreign, Commonwealth and Development Office (FCDO) is investing in the Women's Integrated Sexual Health Programme (WISH). The WISH programme, implemented in two lots led by different consortia, will operate in 27 countries in Asia and Africa and will deliver at least 2.95 million additional FP users by December 2020.

The WISH4Results team, composed of staff from the e-Pact consortium – Itad and Oxford Policy Management – acts as the third-party monitor for the WISH programme, providing verification, evidence and learning for FCDO, WISH implementing partners and wider stakeholders.

About WISH COVID-19 Learning Briefs

COVID-19 is very likely to have severe impacts on access to sexual and reproductive health and rights (SRHR) services for all people but for women and girls especially. The WISH programme's implementing partners, WISH4Results and global health partners are collaborating to capture rapid adaptations to SRHR service delivery in order to maintain vital access to rights-based, high-quality care.

This publication is one of a series of Learning Briefs produced by WISH4Results focusing on adaptations to SRHR delivery driven by the COVID-19 pandemic. Olivia Engle, Mary Lagaay and Pippa Page contributed to the drafting and editing of this brief, with support from other members of the WISH4Results team. Content was compiled through a series of semi-structured interviews and follow-up emails with representatives from the organisations listed below. We are particularly grateful to members of the WISH COVID-19 Technical Working Group for their insights on digital platforms in COVID-19 and specifically to the following organisations who contributed information to this brief:

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- Milly Kaggwa, Senior Clinical Advisor for Africa, PSI

Please share your feedback and comments on the materials discussed in this brief, contribute related resources and discuss other adaptations relating to digital platforms by emailing pippa.page@itad.com.

