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# FACTORS INFLUENCING ACCESS AROUND CONTRACEPTION AND ABORTION SERVICES DURING THE COVID-19 PANDEMIC IN IRAN, BANGLADESH AND THE NETHERLANDS

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# AKNOWLEDGEMENTS

Our research team would like to thank the following persons and organizations for their contributions to this report. Without them, it would not have been possible to develop the proposal, collect all these valuable data, analyze the results and write this report within the timeframe as set by Share-Net International.

First and foremost, we would like to thank Share-Net International for the opportunity and funding to undertake this research project. Let us name crucial contacts in KIT and Share-Net like Kimberley Meijer, Maria Codina, The Regional Ethical Committee, Nicole Moran and English proof-reader Ophelia Chatterjee.

Secondly, our appreciation goes out to all participating women and service providers in Iran, Bangladesh and the Netherlands. Thank you for your help in finding answers to our objectives, by answering survey questions and by participating in time-consuming interviews.

Also, we would like to recognize the organizations in Iran, Bangladesh and The Netherlands that were instrumental in providing assistance pertaining to mentorship, advice and participant recruitment. In the Netherlands, these organizations were Doctors of the World, Women on Web, Abortion Clinic Amsterdam, Rutgers, Share-Net Netherlands, several medical specialists, general practitioners and Public Health services (Amsterdam, Alkmaar, Zuid-Limburg). In Iran, these organizations were health centers in the provinces Sistan and Baluchestan, Tehran and Fars. In Bangladesh, government facilities (Barishal, Cox's Bazar, Cumilla and Dhaka, Mohammadpur Fertility Services & Training Center), Marie Stopes Bangladesh, RHSTEP and Creative Pathways provided assistance.

In the Netherlands, the research team would like to acknowledge the contribution of Diede Besseling and Anna Kleiboer (University of Utrecht medical school), Floor Huijs (Psychology, university of Groningen) and Hillman Batuo (Maastricht university medical school) in relation to participant recruitment. In addition, the research team is also grateful to Anna and Diede who assisted in thematic analysis and commentary on the narrative drafts. In Bangladesh, we would like to thank six emerging young SRHR researchers who conducted field visits for data collection during the COVID-19 pandemic.

Lastly, we would like to thank all who we have not mentioned, for all the contributions and support they gave to this study.

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| COVID-19 | Corona Virus Disease 19 |
| GP | General Practitioner |
| ICoP | International Community of Practice |
| IUD | Intrauterine Device |
| LMIC | Low and Middle-Income Countries |
| MR | Menstrual Regulation |
| NGO | Non-governmental Organization |
| PPE | Personal Protection Equipment |
| SP | Service Provider |
| SRHR | Sexual and Reproductive Health and Rights |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |
| WoW | Women on Web |

# INTRODUCTION

Sexual and reproductive health and rights (SRHR) are a fundamental component of overall good health (Starrs et al., 2018). Universal access to sexual and reproductive health services remains an essential step in the achievement of sustainable development goal 3 (Ensure healthy lives and promote well-being for all at all ages). One of the major components of sexual and reproductive health and rights is access to contraception and safe abortion services (Starrs et al., 2018; WHO, 2020). Studies show that access to safe and effective family planning can prevent unintended pregnancies and unsafe abortions (Endler et al., 2020; Lindberg et al., 2020; Starrs et al., 2018). As a result, the number of maternal complications and deaths also significantly reduces. Moreover, it also reduces gender inequality and promotes women's empowerment. These services enable women to plan their families and participate in the workforce, helping to break the cycle of poverty (Lindberg et al., 2020). To date, access to timely safe abortion care and contraception services is still a challenge in many settings (Starrs et al., 2018).

## THE CONTRACEPTION AND ABORTION SITUATION IN IRAN, BANGLADESH AND THE NETHERLANDS

In 2019, the World Health Organization (WHO) reported that out of the 2 billion women of reproductive age (15-49 years), 1.1 billion have a need for family planning. Also, more than 800 million women are currently using contraceptive methods. Almost a third of the women (270 million) have an unmet need for contraception (WHO, 2020). A similar current report by the United Nations Population Fund (UNFPA) also reported that the global contraception prevalence rate was at 63%, with a 12% unmet need for family planning services (Unfpa, 2020). Overall, marked disparities in the contraception prevalence rates and unmet need for family planning have been observed between developed and developing countries (Unfpa, 2020; WHO, 2020). For instance, the 2020 contraception prevalence rate for women 15-49 years in the Netherlands was the same as the global rate (63%), while in Iran and Bangladesh, the contraception prevalence rates were lower (62%and 54%) respectively (Unfpa, 2020). In all three countries Iran, Bangladesh and the Netherlands, the contraception prevalence rate was increased for married women (81%, 65% and 73%) respectively. The contraception prevalence rate for modern contraceptives was highest in the Netherlands (61%) and markedly lower in Iran (46%) and Bangladesh (52%) Bangladesh reported the highest rate of unmet need for FP (9% in all women; 11% in married women) among the three countries (Unfpa, 2020). The rates of unmet need for FP were almost similar for the Netherlands (6% in all women; 7% in married women) and Iran (4% in all women; 5% in married women) (Unfpa, 2020).

Although there has been an overall decline in global maternal mortality, abortion-related morbidity and mortality rates remain high. Reports show that while over 50 million abortions occur annually, half of these (25 million) are attributable to unsafe abortions (Starrs et al., 2018). In many settings,

abortion laws are restrictive, thus the burden from abortion-related morbidity and mortality is markedly high. Also, limited knowledge on safe abortion practices and access challenges to SRHR services have been reported in Bangladesh In 2010, the abortion rates in Bangladesh were 18 cases per 1000 women of reproductive age (Hossain et al., 2012). In Iran, between 2009 and 2014, there was a 13% increase in abortion rates, from 68% in 2009 to 81% in 2014 (A Erfani, 2016). Of the three countries, the Netherlands has reported the lowest abortion rates (8.8 per 1000 women of reproductive age 15-49 years). As an alternative to abortion, the menstrual regulation (MR) was introduced in Bangladesh almost 20 years ago. Described as "an interim method of establishing non-pregnancy in women at risk of being pregnant". Thus, pregnancy of up to 12 weeks can be terminated under the MR scheme (Dixon-Mueller, 1988). Although MR is fully implemented at both government and non-governmental (NGO) healthcare centers to curb the abortion-related morbidity and mortality rates, studies still report a challenge in lowering unsafe abortion rates in Bangladesh. Also, some studies have reported that abortion-related data for unmarried women in Bangladesh is underrepresented (Asadi Sarvestani et al., 2017; Hossain et al., 2012). Pertaining to family planning, Iran has reported one of the highest rate of contraceptive usage among the predominantly Islamic nations; with similar rates to countries such as France and Germany (Randall, 2012). Until 2013, family planning services were offered free of charge, and this changed in 2013 to include only at-risk women (Sarvestani et al., 2017). Similar to Bangladesh, the abortion law in Iran is also restrictive, with legal abortion only permitted when the life of a pregnant woman is at risk and the gestation period is less than 4 months (A Erfani, 2016). It is estimated that annually, over 73.000 induced abortions are performed on married women of reproductive age in Iran (Amir Erfani, 2008) Among other challenges reported is the limited access to current abortion-related data, particularly in rural Iran (Abbasi-Shavazi, Hosseini-Chavoshi, & Delavar, 2004). In the Netherlands, timely access to family planning has been evidenced by consistently high contraception prevalence rates; similar to global rates (Unfpa, 2020). Unlike Bangladesh and Iran, the abortion law in the Netherlands was fully legalized more than 20 years ago, allowing for abortion to be performed on request from the pregnant woman or due to medical-related reasons such as fetal abnormalities at the cut-off point of 24 weeks in pregnancy (Ketting & Visser, 1994). Therefore, abortion care is easily accessible, and freely provided within the healthcare system (Pinter et al., 2005).

With the COVID-19 situation that began in March of 2020, there has been a worldwide disruption of SRHR service provision. (Endler et al., 2020). Mitigation measures for viral transmission, such as lockdowns and travel restrictions, have continued to complicate access to SRHR services (Endler et al., 2020). Projections from the 2020 COVID-19 UNFPA report shows that mitigation measures to curb virus transmission such as travel bans, movement restrictions and lockdowns could lead to almost 8 million unintended pregnancies, concentrated in LMICs (Lindberg et al., 2020; Schaaf et al., 2020). A Guttmacher Survey of Reproductive Health Experiences conducted at the beginning of the COVID-19 pandemic, found that for every three women surveyed, one of them reported challenges in access to a service provider and/or contraception service (Lindberg et al., 2020). Reports from top non-governmental SRHR service providers, also showed that at the beginning of the COVID-19

pandemic, reduced service hours and closures of country-based clinics in Nepal, Bangladesh and India occurred after lockdown measures were introduced (Cleland, 2020; Riley et al., 2020). Several studies investigating the impacts of COVID-19 on contraception and abortion care have found that some of the main effects of the pandemic on services include: i) limited access to contraception and safe abortion services ii) reduced service provision from government and private healthcare facilities iii) refocusing of efforts to COVID-related emergency care (Church, Gassner, & Elliott, 2020; Riley et al., 2020) iv) contraception stock-outs and v) the fear of contracting COVID-19 (Schaaf et al., 2020).

### SCOPE OF THE STUDY AND CONTRIBUTION TO KNOWLEDGE

The scale of the current COVID-19 situation warrants exploration of the effects of COVID-19 on access to contraception and safe abortion services in depth. Our main aim was to identify the barriers, challenges and experiences of women of reproductive age and service providers working in contraception and abortion care in Iran, Bangladesh and the Netherlands during the COVID-19 pandemic. The knowledge products include a detailed project report, an advocacy video, a policy brief and local bulletins. These knowledge products are intended to educate women on contraception and abortion care, to highlight existing barriers and challenges in access to contraception and safe abortion services, and to provide recommendations that can be applied to the three different country contexts. A mixed-methods approach was decided upon to enable data triangulation. The qualitative study was used to support and elaborate the findings of the quantitative study.

## OBJECTIVES

### OVERALL GOAL OF THE RESEARCH

To assess the impact of the COVID-19 pandemic on access to contraception or safe abortion services for women of reproductive age in Iran, Bangladesh and the Netherlands, to develop a range of written and digital knowledge products by March 2021 to inform relevant stakeholders on improving access to contraception and safe abortion.

### SPECIFIC OBJECTIVES

1) To identify barriers and challenges faced by healthcare workers in providing contraception and safe abortion services in the three countries during the COVID-19 pandemic.

2)To identify barriers and challenges faced by women of reproductive age in accessing contraception and safe abortion services in the three countries during the COVID-19 pandemic.

3) To identify changes in choice of contraception methods among women of reproductive age in the three countries during the COVID-19 pandemic.

# METHODOLOGY

Through a mixed methods study involving quantitative surveys and qualitative interviews, information was collected from two different types of respondents in the three included countries: women of reproductive age and service providers. Participants were recruited via convenience sampling. In each country, respondents for qualitative interviews were selected by the research team with the support of members of professional networks of service providers and facility staff. We tried to cover different socio-cultural groups aiming to achieve representative sampling, and three different settings including urban, semi-urban and rural areas were selected depending on the country contexts. Respondents for the quantitative survey were selected at clinic level and online by Survey Monkey in Iran and the Netherlands. In Bangladesh, respondents for the quantitative survey were selected at facility level only. Local NGOs and health facilities assisted with the convenience sampling of both service providers and users. The online survey was disseminated through professional networks, via leaflets and through social media.

Data collection was done between October 19$^{th,}$ 2020 and December 31$^{st,}$ 2020, and took place using either online surveys via Survey Monkey, telephone interviews, or in-person surveys and interviews through door-to-door visits depending on the context.

Qualitative findings were coded, and themes were identified after which the findings were analyzed. Two or more researchers in every country were involved to ensure objectivity and reduce bias. Quantitative data were analyzed using SPSS (version 18) by our researchers in Iran with support from the researchers in Bangladesh and the Netherlands. Comparison of the quantitative findings in the three countries was done. Findings were triangulated by qualitative and quantitative results to identify data patterns and to draw conclusions and recommendations for knowledge product outcomes.

## Inclusion criteria and ethical considerations

- Women of reproductive age, 15-49 years.
- Parental consent in the Netherlands: parental consent is required for women below 16 years of age. From the age of 16 parental consent is not needed anymore.
- Parental consent in Iran: parental consent is not required for married adolescents in Iran; adolescents included were all married.
- Parental/husband consent in Bangladesh: consent is required for married women below 18 years of age.
- Service providers in different types of standard registered health services, including urban, semi-urban and rural settings.

## Exclusion criteria

- Women below 15 or above 49 years of age.
- Those who were suffering from mental illness, not being able to write consent and fill in the questionnaire.
- Respondents unwilling to provide verbal or written consent.
- Adolescents of 15 years of age in the Netherlands whose parent/guardian was unwilling to provide written consent.
- Adolescents below 18 years of age in Bangladesh whose parent/husband was unwilling to provide written consent.

### Variables

Five experienced researchers with strong networks in the three different countries were involved in data collection, analysis, comparison, and reporting. Quantitative and qualitative analysis was carried out using the following broad variables:

Women of reproductive age as respondents:

- Socio-demographic profile.
- History and recent contraception or abortion choices.
- Changes in use and access during the COVID-19 pandemic.
- Barriers and challenges in access to contraception and abortion services.
- Method changes (contraception, abortion) and the reasons for change during the COVID 19 pandemic.
- Recommendations for maintaining contraception and abortion access during crises.

Service providers as respondents:

- Socio-demographic profile.
- Service provision of contraception and abortion care.
- Changes in use and access of contraception and abortion services during the COVID-19 pandemic.
- Barriers and challenges in access to contraception and abortion services from a service provider perspective.
- Measures taken to mitigate the change in access both at local and higher levels.
- Recommendations for maintaining contraception and abortion access during crises.

### Pre-testing

Pre-testing of the questionnaire was carried out in all three countries to enable researchers to improve the tools for final use.

### Data analysis:

In relation to the quantitative component, SPSS Version 20.0 was used to process the data obtained from the questionnaires. Regarding the qualitative component, all interviews were transcribed and

coded by at least 2 researchers. Thematic data analysis was employed, whereby the same overall themes were chosen across the three countries.

# RESULTS

This chapter provides a detailed account of the findings from the quantitative and qualitative data analysis of the three countries, Iran, Bangladesh, and the Netherlands. In total 731 participants responded to this study, of whom 614 were included in the quantitative and 117 were included in the qualitative part. Table 1 gives an overview of the respondents per country.

This chapter discusses results which address the situation at the beginning of the pandemic (also referred to as the first wave) and the situation after 8-10 months, which is referred to as the second wave.

In total, 542 women and 189 healthcare providers have been included in this study, divided over the three countries namely Iran, Bangladesh, and the Netherlands (Table 1). The quantitative survey questionnaire covered 199 women and 53 service providers in Iran, 149 women and 67 service providers in Bangladesh and 131 women and 15 service providers in the Netherlands. The qualitative interviews covered 20 women and 15 service providers in Iran, 39 women and 28 service providers in Bangladesh and 4 women and 11 service providers in the Netherlands.

**Table 1: Study respondents per country**

| **Quantitative Survey** | **Iran** | **Bangladesh** | **Netherlands** | **Total** |
|---|---|---|---|---|
| **Women** | **199** | **149** | **131** | **479** |
| *Contraception* | *188* | *128* | *115* | *431* |
| *Abortion* | *11* | *21* | *16* | *48* |
| **Service providers** | **53** | **67** | **15** | **135** |
| *Contraception* | *47* | *44* | *11* | 102 |
| *Abortion* | *6* | *23* | *4* | 33 |
| **Total** | 252 | 216 | 146 | **614** |
| **Qualitative Interview** | | | | |
| **Women** | **20** | **39** | **4** | **63** |
| *Contraception* | *18* | *30* | *0* | *48* |
| *Abortion* | *2* | *9* | *4* | *15* |

| | | | | |
|---|---|---|---|---|
| **Service providers** | **15** | **28** | **11**[1] | **54** |
| *Contraception* | *12* | *16* | *10* | *38* |
| *Abortion* | *3* | *12* | *6* | *21* |
| **Total** | 35 | 67 | 15 | **117** |

| **Respondents** | **Methods** | | **Total** |
|---|---|---|---|
| | **Quantitative Survey** | **Qualitative Interviews** | |
| **Women** | 479 | 63 | **542** |
| **Service Providers** | 135 | 54 | **189** |
| **Total** | **614** | **117** | **731** |

## QUANTITATIVE RESULTS - IRAN

### *QUANTITATIVE ANALYSIS BASED ON DATA COLLECTED FROM SERVICE PROVIDERS IN IRAN*

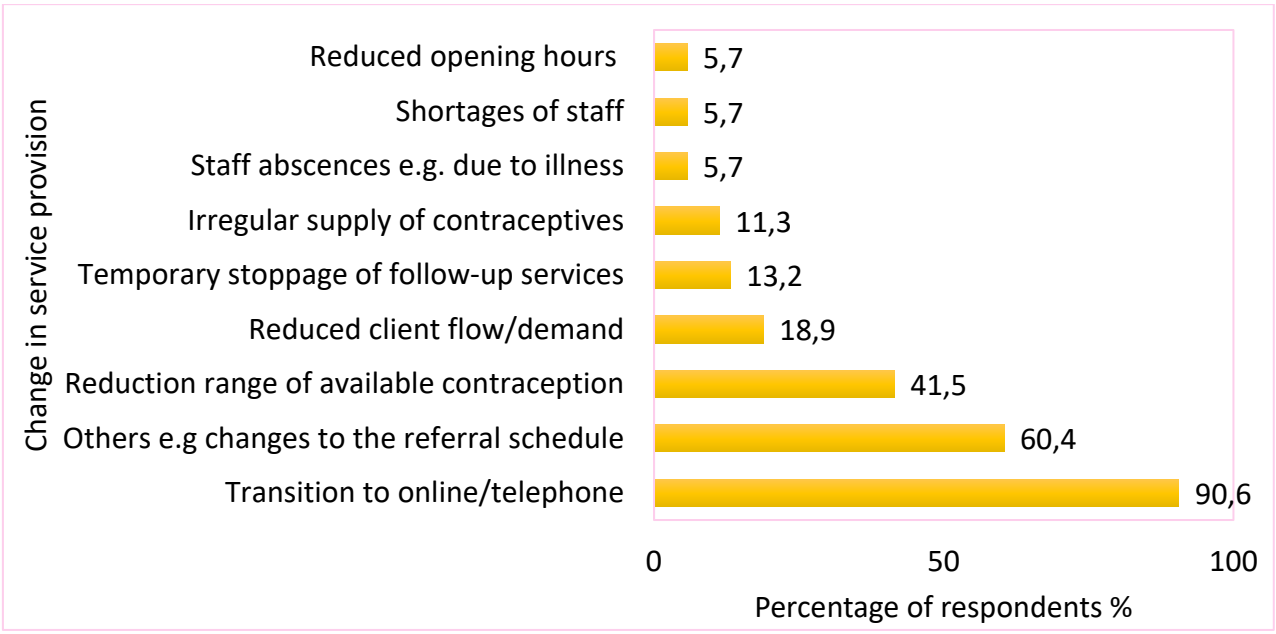
Annex 1, page 53, illustrates the demographic information of the service providers (SPs) who participated in the study. Almost half of all the service providers were aged between 20-30 years (49.1%), with most of them (87%) having a nursing diploma. Most contraception service provider study participants were assistant nurses (66.0%), while almost of all the providers worked in public government facilities. More than 50% of the SPs were based in urban areas, particularly the region of Tehran.

### Impact of the COVID-19 pandemic on contraception service provision

[1] *Netherlands: some of the service providers in the qualitative interviews provided contraception care and (actively referred to) abortion services.

More than 50% of the 53 participating service providers in Iran reported changes in contraceptive service provision during the COVID-19 pandemic (figure 1). During the first wave of the COVID-19 pandemic almost all service providers reported a transition from face-to face consultations to online/telephone consultations. Others opted to give clients scheduled appointments for visiting health centers. Less common changes were the reduction in the types of family planning/contraception methods offered (41.5%), reduced client flow/demand (18.9%), temporary stoppage of contraceptive follow-up services (13.2%) and irregular supply of contraceptives (11.3%).

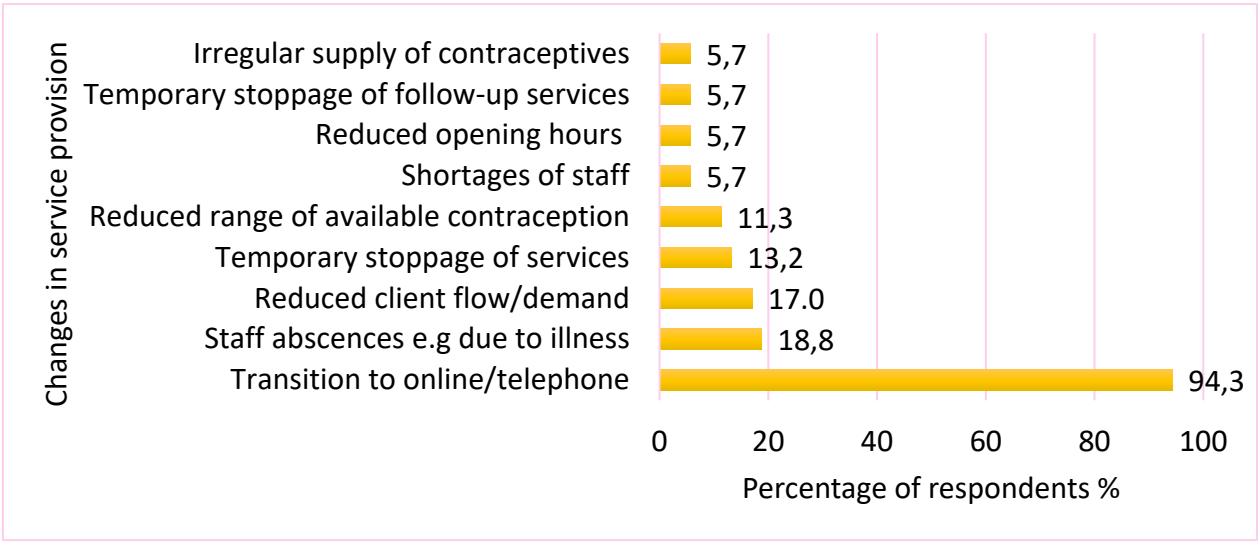
***Figure 1: Impact of COVID-19 on contraception service provision in Iran (beginning of the pandemic (first wave))***[2]




After 8-10 months (figure 2), 94.3% of SPs in Iran reported transitioning into online/telephone consultations. Some SPs also mentioned other changes such as the inability of some facility/clinic staff members to work (for example due to illness) (18.9%), reduced client flow/demand for contraception services (17.0%) and the temporary stoppage of follow-up of contraception services (13.0%). When asked about the causes of these changes, around half of the SP believed the changes to be COVID-19 related. More than a third of the SPs (37.7%) also reported an increase in the use of male condoms by clients, with 18.8% also giving an account of a change from short- acting to long-acting contraceptives.

[2] Figure 1: answers options which were not selected by any respondents were: reassignment of staff, closure of facilities, and temporary stoppage of services.

***Figure 2: Impact of COVID-19 on contraception service provision in Iran (after 8-10 months (second wave))***[3]




When asked about the measures which they had put in place to improve the accessibility of their contraceptive services, all the service providers (100%) had implemented rotation duties in their facilities. Other popular measures mentioned were the use of online/telephone consultations (94.3%) and the introduction of service points for collection of contraceptives for clients who were unable to come to the facility/clinic (7.5%).

## The impact of COVID-19 pandemic on abortion service provision

More than 80% of SPs believed that the COVID-19 pandemic had not impacted abortion service provision. Out of the SPs that reported a change in service provision, 25% of them reported that reduced client flow/demand and the inability of some facility/clinic staff to work (e.g. due to illness) were the main changes experienced in the beginning and after 8-10 months, respectively. With regards to mitigating measures, almost all the SPs (90.0%) reported that no measures had been put in place to ensure continued provision of abortion services during the COVID-19 pandemic. Furthermore, none of the SPs had any information on clients affected by COVID-19 when seeking abortion services.

# *QUANTITATIVE ANALYSIS BASED ON DATA COLLECTED FROM WOMEN RESPONDENTS IN IRAN*

[3] Figure 2: answer options which were not selected by any respondents were: reassignment of staff, and closure of facilities.

Annex 2, page 54, indicates the demographic characteristics of the 199 women respondents from Iran. Most of the women were aged 31-40 years (41.2%). Almost 50% of the women were college educated. In terms of occupation, most respondents were housewives/homemakers (57.0%), while 16.6% had a full-time job and 7.0% had a part-time job. More than 80% of the women were living in urban areas, with the largest percentage coming from Fars province (39%).

The withdrawal method was the most popular method of contraception (40.7%), followed by male condoms (22.6%) and female sterilization (18.6%) (figure 3). Most of the women reported that they obtained their contraception supply (37.7%) and follow-up services (36.2%) from government health facilities (figure 4). When asked whether the COVID-19 pandemic had affected their preferred choice of contraceptive method, almost all the women (92.5%) reported that they had not changed their usual method/s. Furthermore, only 6.0% women faced challenges accessing contraceptive supplies/consultation and care during the COVID-19 pandemic. The main challenges were arranging travel to the facility/clinic (9.5%), shortages of contraception (9.5%), and temporary stoppages of follow-up of contraception services (9.5%). Less than 5% of women reported any adaptations made by their health facility to overcome COVID-19 related barriers to accessing contraceptive supplies/consultations. Respondents were also asked about their main criteria for selection of service providers. Half of the respondents referred to proximity of the health facility (50.0%) as the main criterion for selection of a service provider. Thirty-one respondents were or had been pregnant. Seven of these respondents (23%) reported one or more unplanned pregnancies, of which six pregnancies ended in an abortion.

***Figure 3: Current contraceptive method usage in Iran***

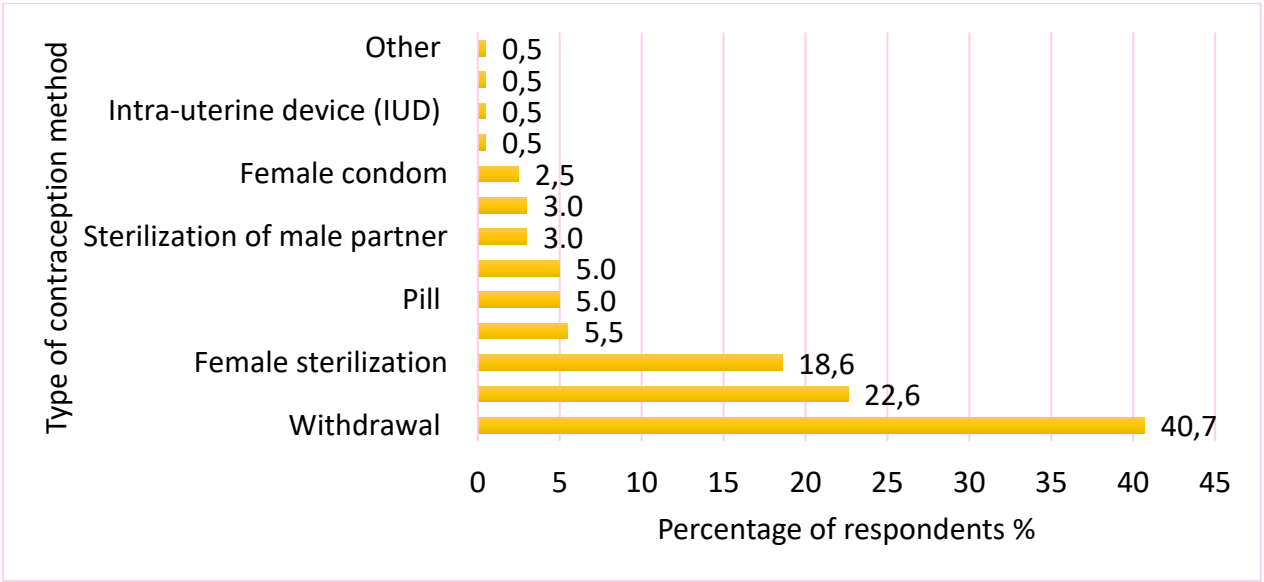
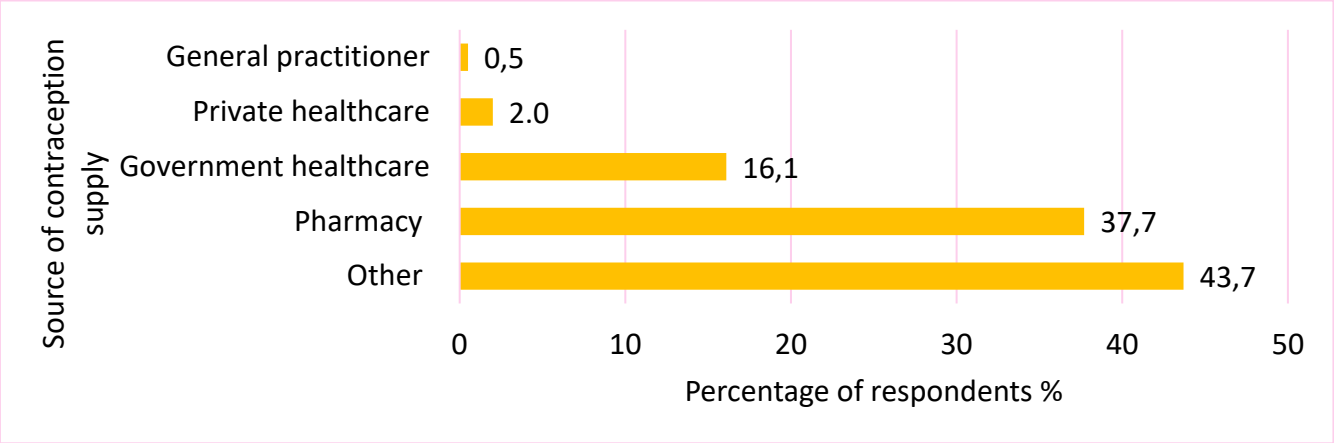


***Figure 4: Sources of contraception supply in Iran***[4]




### The impact of COVID-19 on abortion service provision

Less than 10% of women respondents faced challenges in accessing abortion care/services during the COVID-19 pandemic. The main challenge reported in both the beginning of the pandemic and after 8-10 months was fear of going outside because of COVID-19.

## QUANTITATIVE RESULTS - BANGLADESH

### *QUANTITATIVE ANALYSIS BASED ON DATA COLLECTED FROM SERVICE PROVIDERS IN BANGLADESH*

Annex 3, page 55, indicates the demographic characteristics of the 67 service providers (SPs) respondents in Bangladesh. Most SPs were between 41-50 years of age (38.8%). Nursing diplomas were the most common form of qualification (41.8%). Almost half of the SPs worked in government (public) facilities (47.8%) and 35.8% of the SPs were employed in non-governmental organizations (NGOs). More than half (53.7%) came from urban areas, and 34.3% from rural areas.

### The impact of Covid-19 on contraception service provision

Almost all SPs (90.9%) acknowledged that the COVID-19 pandemic had affected their contraceptive service provision during the beginning of the pandemic, which was mainly visible in the reduction of service hours (52.3%) and the reduced client flow (45.5%) (figure 5). Also, shortage of staff and temporary closure of facilities were quite common, reported by 13.6% and 11.4% of respondents, respectively. Other service providers mentioned that they could not provide quality care due

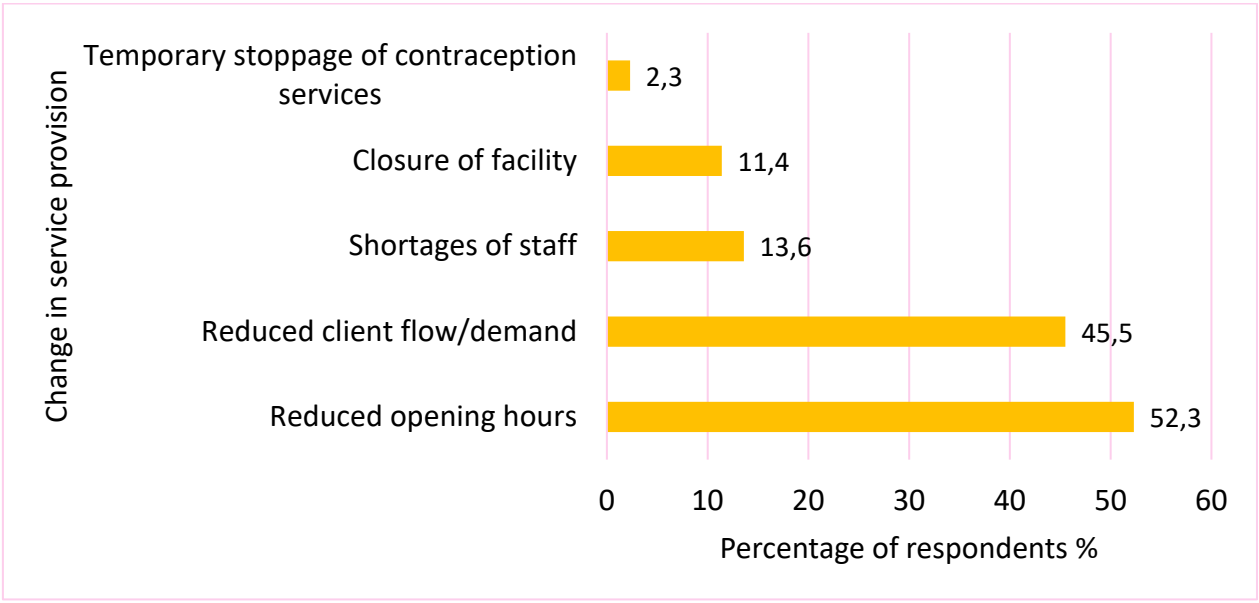
[4] Figure 4: most of those who indicated 'other' sources of contraception supply reported that they do not go to any center to obtain contraception. This is consistent with figure 3, in which more than 40% of the women indicated the use of the withdrawal method.

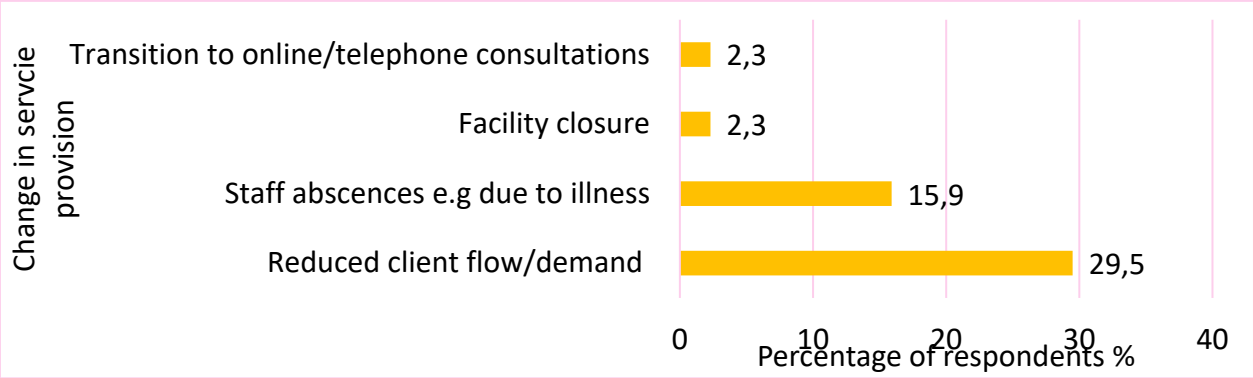
compliance with physical distance measures and communication difficulties (13.6%). This is not shown in figure 5. After 8-10 months (figure 6), the major changes reported were reduced client flow (29.5%) and shortage of staff (15.9%).

Almost 80% of the SPs believed that the COVID-19 pandemic had impacted their clients' choice of contraceptive method/s. Increased condom use was mentioned by 56.8% of the responding service providers and changes from short-acting (pill, Nuvaring) to long-acting methods (IUD, injectables, implants) were reported by 47.7%.

More than 75% of the SPs reported that their clinic had employed measures to increase the accessibility of contraceptives for their clients. The main strategies employed were rotation duties of the service providers (34.1%), ordering supplies from multiple sources (11.4%) and the introduction of service points for collection of contraceptives for clients who could not visit the clinic (9.1%).

***Figure 5: Impact of COVID-19 on contraception service provision in Bangladesh (beginning of the pandemic (first wave))***






## The impact of COVID-19 on abortion service provision

Forty-three percent (43.5%) of the SPs confirmed that the COVID-19 pandemic had also affected the provision of abortion services. In the beginning, the most common changes reported were reduced client demand for abortion services (26.0%), reduced opening hours (21.0%), and clinic closure (17.0%). After 8-10 months, the main change observed was that some staff members could not work (17.4%) while 4.3% of the SPs also mentioned reduced opening hours for abortion services and a shortage of staff.

Of all the SPs who participated in the study, 82.6% reported the implementation of measures at their clinics to ensure the continuation of abortion services during the COVID-19 pandemic. Among the main strategies implemented were expansion of telephone services (78.3%) and rotational duties (47.8%). Other service providers (17.4%) mentioned the introduction of COVID-19 awareness raising activities, personal protection measures such as the use of masks and hand-sanitizers, and provision of follow-up care via telephone.

### *QUANTITATIVE ANALYSIS BASED ON DATA COLLECTED FROM WOMEN RESPONDENTS IN BANGLADESH*

Annex 4, page 56, indicates the demographic characteristics of women respondents in Bangladesh. Most of the women (53%) were aged between 21-30 years and less than 40% were aged between 31-40 years. Most of the respondents were educated to primary level (36.0%), while just under 15% had no formal education. Sixty-four percent of the women were housewives, 19.5% worked full-time and 11.4% part-time. Most of the women who participated were from rural areas (47.0%), 36.2% from urban and 16.8% from semi-urban areas, with 36% from Dhaka.

The most popular contraception methods used by respondents were the contraceptive pill (32.8%), injectables (29.7%), and male condoms (9.4%) (figure 7). Most of the women obtained their contraceptives from a government facility (35.9%) followed by pharmacies (32.8%) (figure 8) and non-governmental organization (NGO) clinics (17.2%). For their follow-up, most respondents attended government health centers (31.8%) and NGO clinics (19.1%).

When asked whether they had changed their contraception method/s following the onset of the COVID-19 pandemic, 21.1% of the women stated that they had. Reasons given for this were the unavailability of contraceptive pills, and the 'door-step' availability of contraceptive methods which differed from their usual chosen method.

Almost 40% of respondents reported facing challenges when accessing contraceptive services. At the beginning of the pandemic this was due to unwillingness to go outside due to fear of contracting COVID-19 (22.7%), difficulty travelling to the clinic (21.9%), and fear of being stigmatized by neighbors/community due to possible contraction of COVID-19 (18.0%) (figure 9).

After 8-10 months, when the lockdown had been lifted, the changes in contraception access most reported were difficulty in accessing the facility (10.9%), inadequate information regarding COVID-19 and its effect on contraception services (10.9%) and fear of being stigmatized by neighbors/community (9.4%) (figure 10).

Twenty-nine percent of respondents mentioned that they themselves had taken measures to overcome these challenges. Some of these measures included change of contraception method (21.1%) or health facility (7.8%).

Women made the decision to visit certain facilities depending on where they could find their preferred contraceptive methods (35.9%) and based on recommendations by peers (relative/friend/colleague) (15.6%).

Some women (N=20, 15.6%) reported becoming pregnant during the pandemic. Eight of these pregnancies were unplanned (40%). Two of these pregnancies ended in an abortion.

***Figure 7: Current contraceptive method usage in Bangladesh***

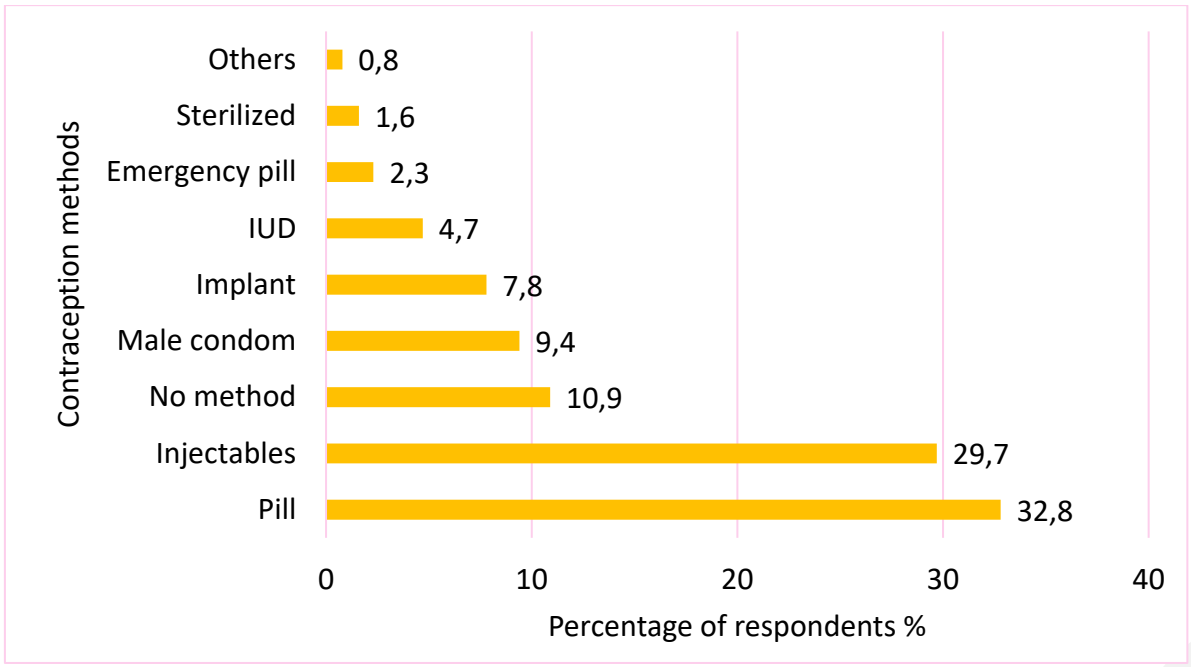


***Figure 8: Sources of contraception supply in Bangladesh***

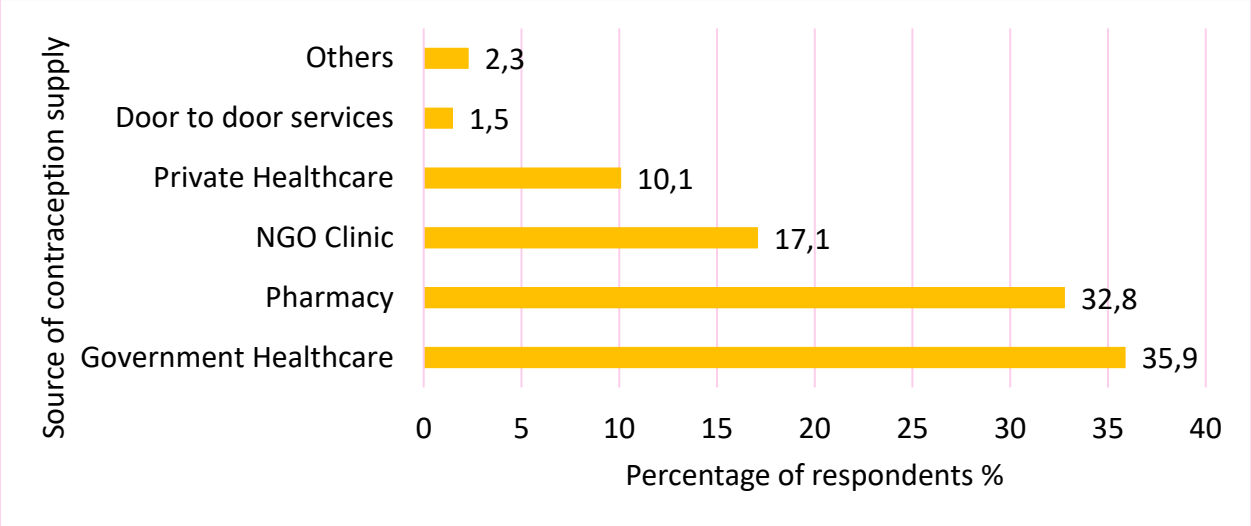



***Figure 9: Barriers/challenges faced by women in Bangladesh when accessing contraception services during beginning of the COVID-19 pandemic (first wave)***[5]

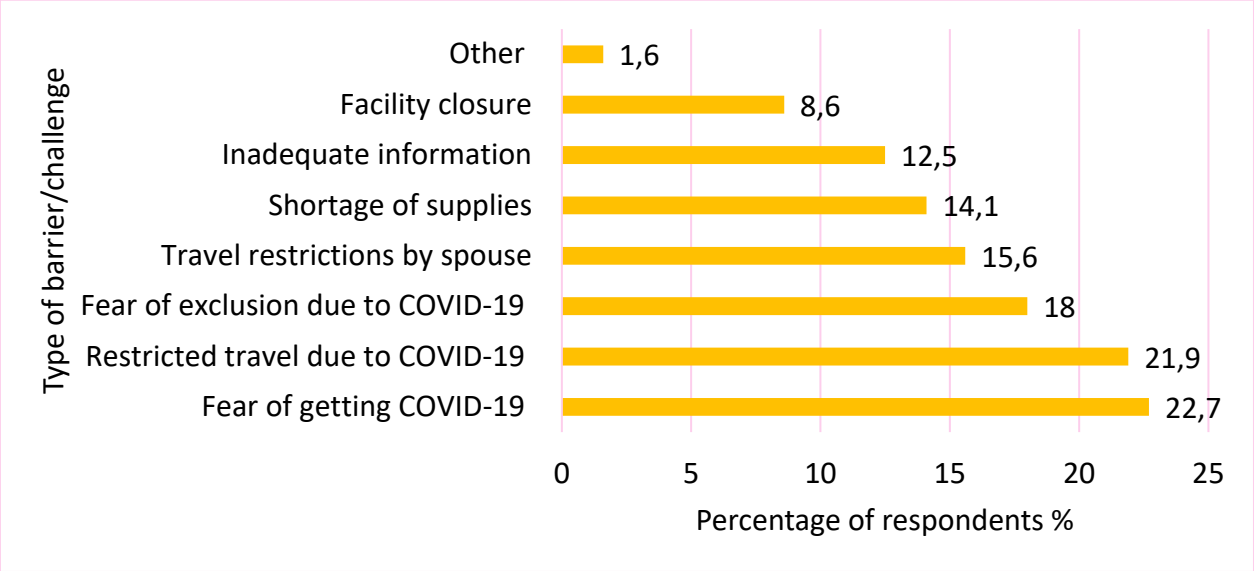
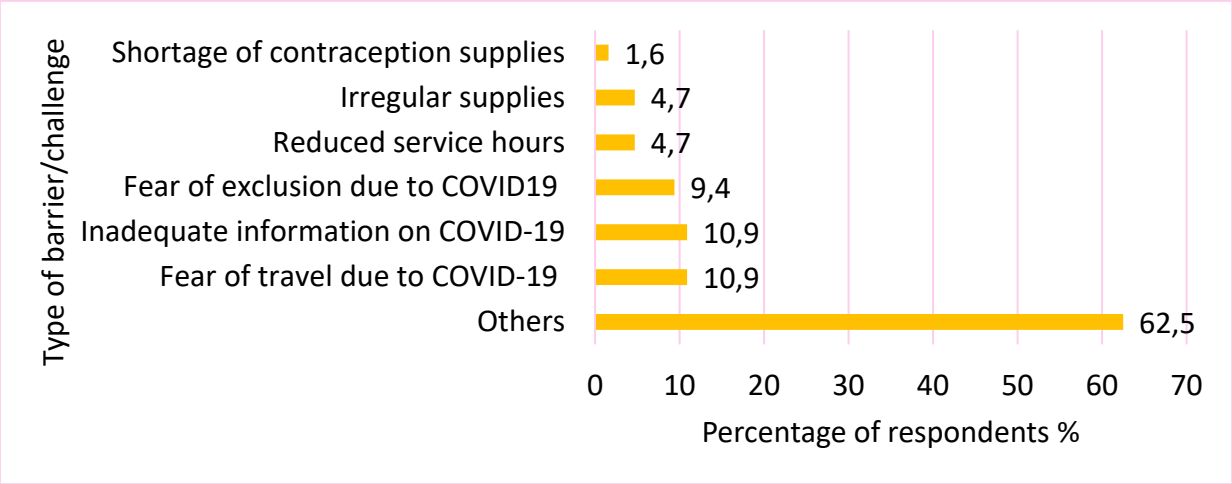



***Figure 10: Barriers/challenges faced by women in Bangladesh when accessing contraception services during the COVID-19 pandemic (after 8-10 months (second wave)***)[6]

[5] Figure 9: Other challenges reported by respondents included required COVID-19 testing prior to clinic visits, long service queues or waiting times, low quality care, and no availability of physical check-ups due to social distancing.

[6] Figure 10: Other challenges: COVID-19 testing required prior to visiting clinic, long service queues or slow service delivery, no adequate care due to social distancing, and increased costs of contraceptives.




### The impact of COVID-19 on abortion service provision

76.2% of respondents faced challenges when accessing abortion services during the COVID-19 pandemic. These challenges included unwillingness to go outside due to fear of contracting COVID 19 (62.0%), fear of being stigmatized by neighbors/community due to possible contraction of COVID-19 (42.9%), temporary stoppage of surgical abortion (42.9%), difficulties in arranging transportation (47.6%) and lack of permission from a spouse to travel to the clinic (52.4%). However, after 8-10 months, almost 80% reported that they did not face any barriers while accessing services or information. To overcome any barriers they did continue to face, respondents opted to seek help from other women (33.3%) or from other facilities/clinics (14.3%).

## QUANTITATIVE RESULTS - THE NETHERLANDS

### *QUANTITATIVE ANALYSIS BASED ON DATA COLLECTED FROM SERVICE PROVIDERS IN THE NETHERLANDS*

Annex 5, page 57, indicates the demographic characteristics of the 19 service providers study respondents from the Netherlands. All SPs were aged 31 years and over, with almost half of them (42.1%) having a medical degree. The most common specialty was general practitioner (GP) (63.2%), and these respondents all worked in GP clinics. Only two of the SPs were working in an abortion clinic. Zuid-Holland and Friesland were the most common regions in which SP study participants worked, the majority of whom were based in cities.

More than a one third of the SPs reported that the COVID-19 pandemic had affected contraception service provision. During the first wave, SPs reported that there was a reduced client demand for services (29.4% of the SPs) and the transition of services from face-to-face consultations to online/telephone (23.5%) (figure 11). These changes were also noted after 8-10 months (23.5% of SPs and 17.6% of SPs) respectively (figure 12). To improve clients' access to contraceptives in the first and second waves of the pandemic, 20% of the SP reported mitigation measures in their

clinics/facilities, with online/telephone consultations and information provision being the most common strategy employed (11.8% of the SPs). With regards to their clients' use of contraceptives during the pandemic, most SPs (93%) did not notice any changes. The remaining SPs (7%) reported that their clients opted for long-acting contraception methods.

***Figure 11: Impact of COVID-19 on contraception service provision in the Netherlands (beginning of the pandemic (first wave))***[7]

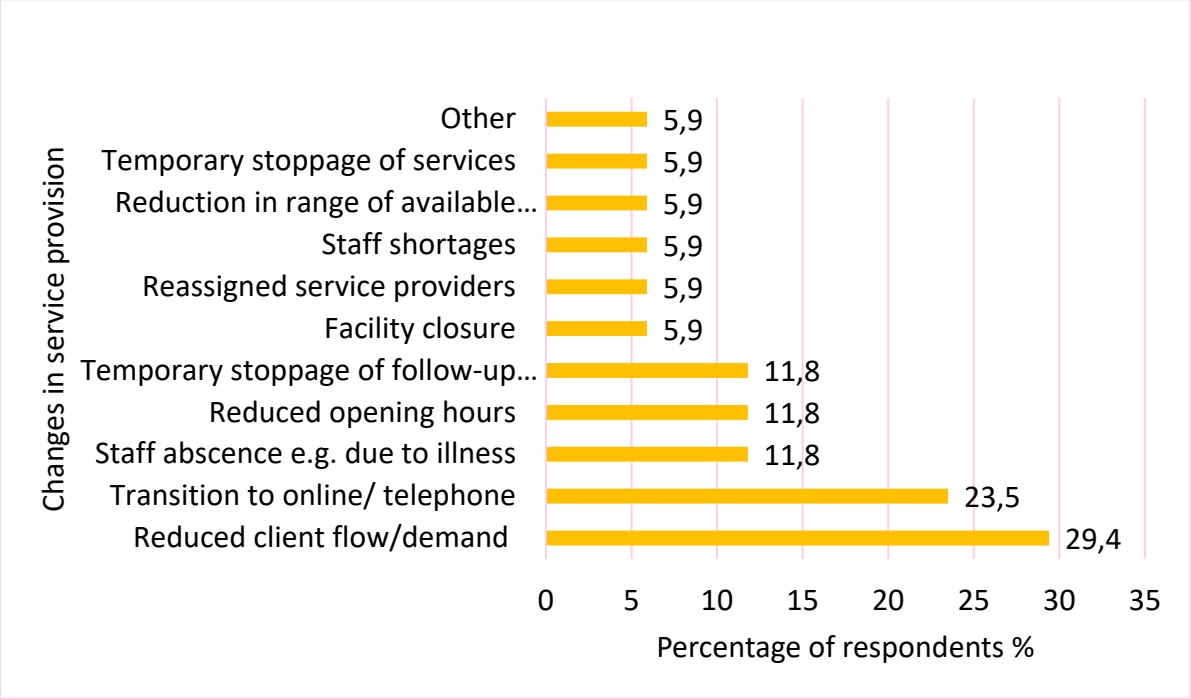
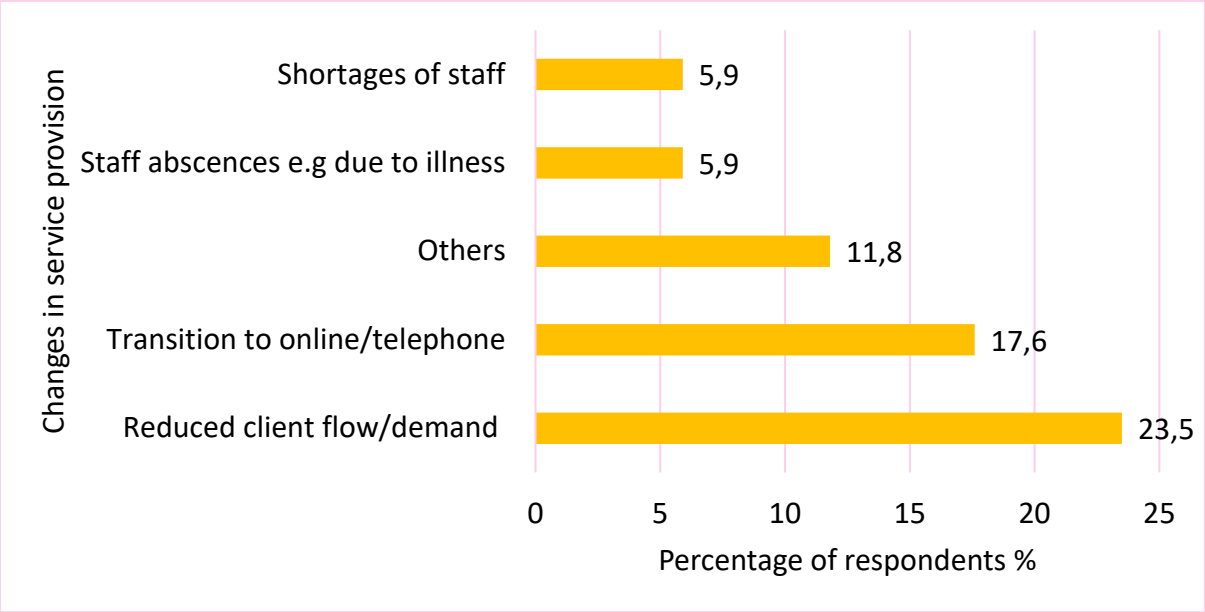



***Figure 12: Impact of COVID-19 on contraception service provision in the Netherlands (after 8-10 months (second wave))***[8]

[7] Figure 11: other: During the lock-down period, the practice was available for emergency purposes only, for approximately 4 weeks. During this period, consultations were usually handled by telephone.

[8] Figure 12: Answer options which were not selected by any respondents were:

reduced types of contraception methods offered, irregular supply of contraceptives, temporary stoppage of follow-up services, temporary stoppage of contraception services, reduced opening hours, reassignment of service providers and facility/clinic closure.




## The impact of COVID-19 pandemic on abortion service provision

With regards to abortion service provision, three quarters of the SPs (n=3) reported changes in the provision of abortion clinic services. At the beginning of the pandemic, one SP recounted that only emergency contraception services were provided. After 8-10 months, two of the SPs also recounted that some staff/clinic members were unable to work due to illness, which caused staff shortages. In terms of measures taken to increase their clients' access to abortion services, three quarters of the SPs (n=3) reported the use of several measures, of which transitioning to online/telephone consultations was the most common. Two of the SPs were aware of women who had not been able to access an abortion service they required, due to the COVID-19 pandemic.

### *QUANTITATIVE ANALYSIS BASED ON DATA COLLECTED FROM WOMEN RESPONDENTS IN THE NETHERLANDS*

Annex 6, page 58, indicates the demographic characteristics of 133 women respondents from the Netherlands. Most of the women were aged between 21-30 years (61.8%) and were educated to university level (76.3%). More than half of the women (63.0%) were students/in school. Noord-Holland (22.9%) and Groningen (22.1%) were the areas with the highest representation of women respondents.

The most popular contraception methods among respondents were the pill (26.5%), intra-uterine device (IUD) (25.6%) and male condom (23.9%) (figure 13). Twenty percent (20.0%) of respondents did not use any form of contraception. The more popular sources of contraception supply were from the general practitioner (GP) (46.0%) and the pharmacy (21.0%) (figure 14). Furthermore, contraceptive service follow-ups were mainly carried out through GPs (48.7%) and pharmacies (10%). When asked whether they had changed their contraception methods following the COVID-

19 pandemic, only 6.8% of the women stated that they had. Less than 10% of respondents reported experiencing challenges when accessing contraception services.

***Figure 13: Current contraceptive method usage in the Netherlands***

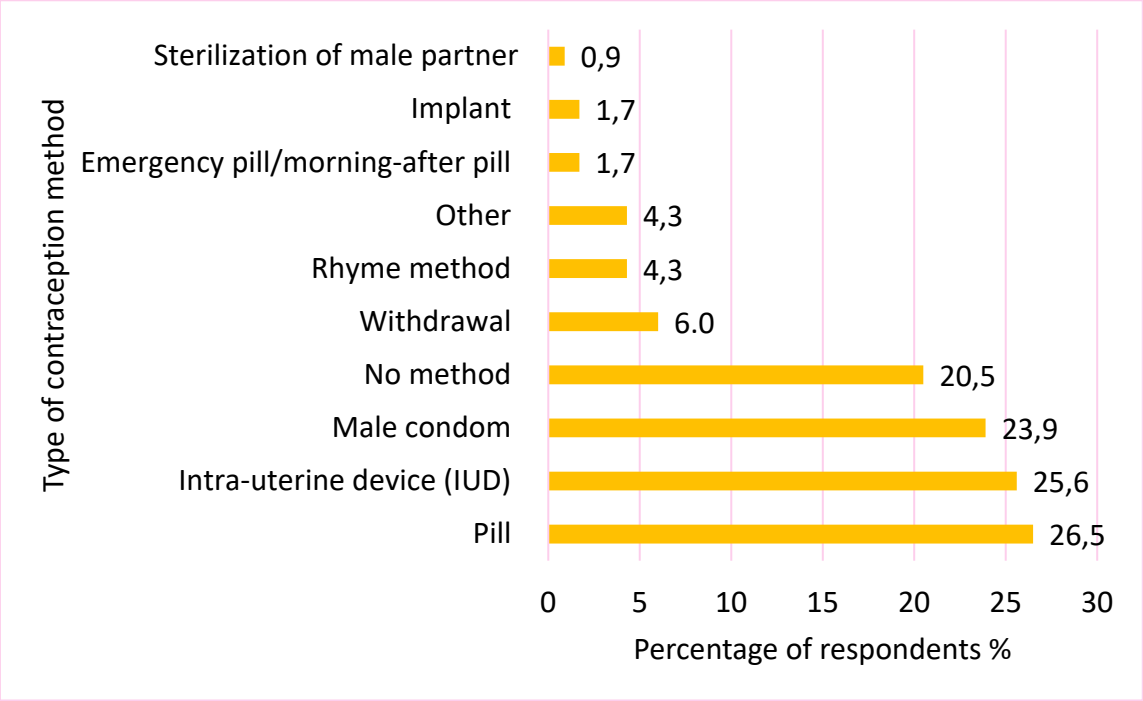
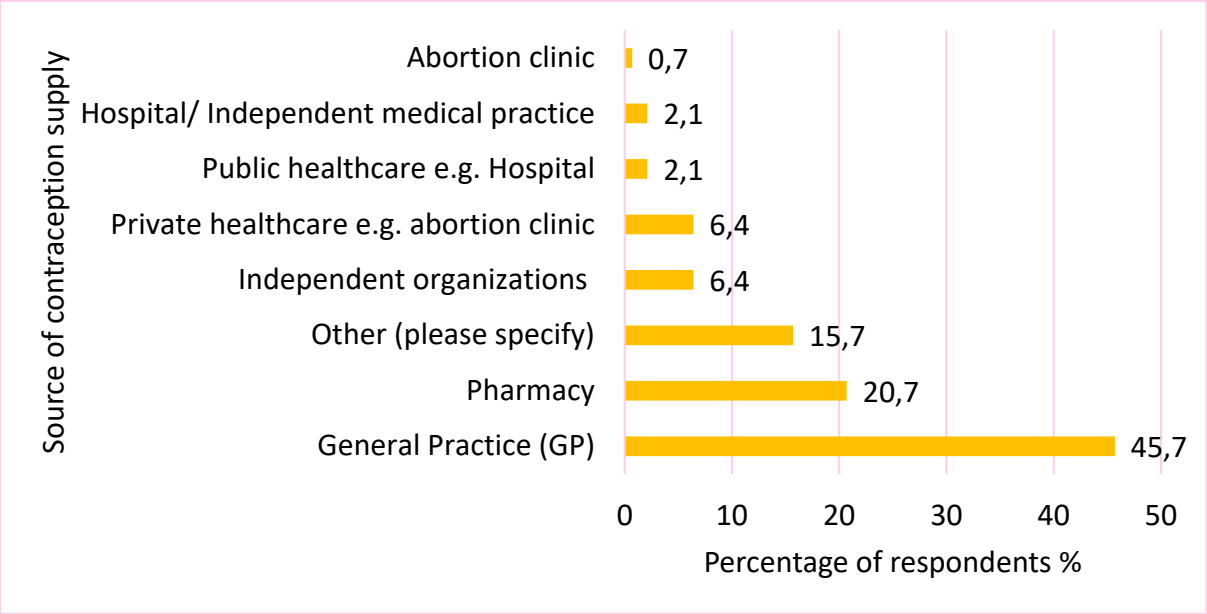



***Figure 14: Sources of contraception supply in the Netherlands***




During the first wave of the pandemic, 16.2% of respondents mentioned challenges such as no longer having the option of being accompanied to their consultation, financial constraints, their partners being away, and recent relocation to a new area. Other reported challenges included temporary stoppage of follow-up services (3.4%), long distances to a facility/clinic (2.6%) and fear of going outside due to the risk of contracting COVID-19 (2.6%) (figure 15). After 8-10 months (figure 16), 16.2% of respondents reported different challenges such as not being able to book a GP appointment, economic constraints, restrictions in clinic appointment options etc. Other challenges reported were reduced opening hours of contraception clinics/facilities (1.7%) and fear of contracting COVID-19 (0.9%). When asked about their main criteria for choosing a contraception service provider, women most commonly considered the proximity of the health facility (18.8%), the quality of contraception services offered at the facility/clinic (10.3%) and whether the facility/clinic had their family planning/contraception method of choice (10.3%). Less than 5% of respondents (n=4) reported pregnancies during the COVID-19 pandemic, of which two pregnancies were unplanned. One pregnancy ended in an abortion and one in a miscarriage.

***Figure 15: Barriers/challenges faced by women in the Netherlands when accessing contraception services during the beginning of the COVID-19 pandemic (first wave)***[9]

[9] Figure 15:

Factors influencing access around contraception and abortion services during the COVID-19 pandemic in Iran, Bangladesh and the Netherlands.

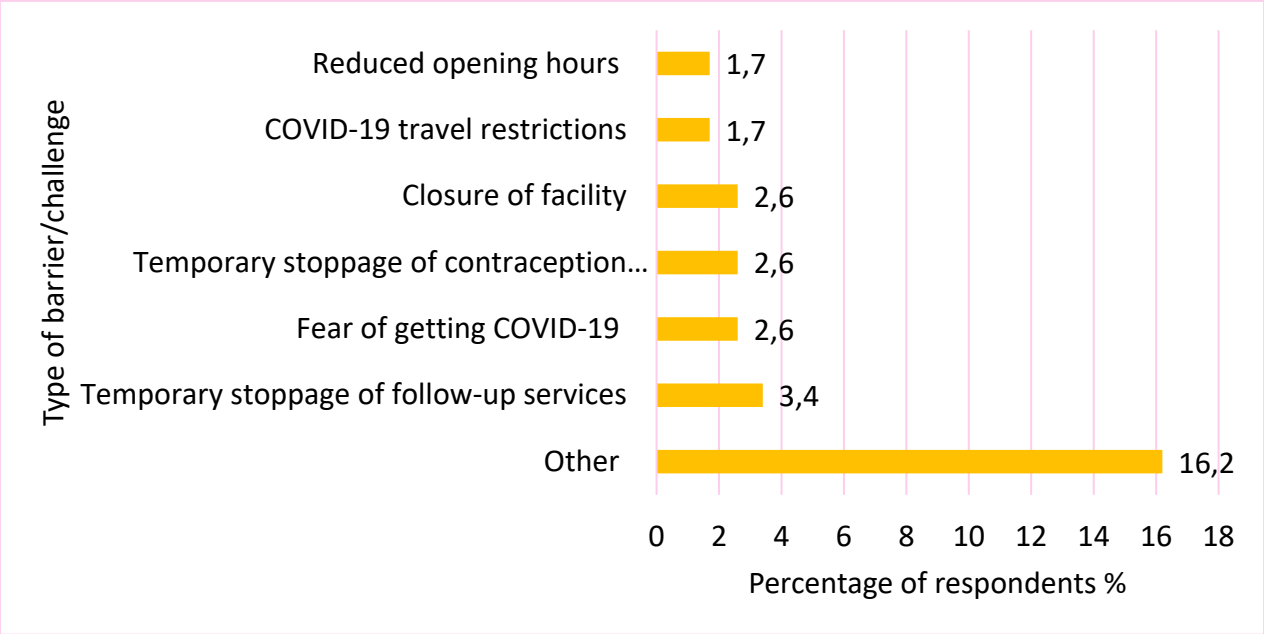
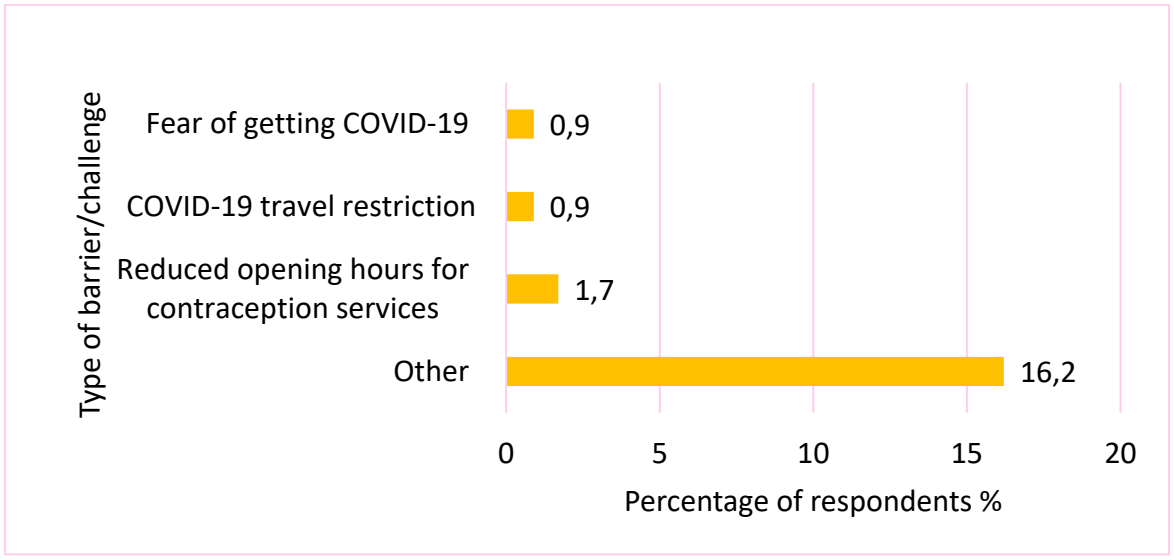



***Figure 16: Barriers/challenges faced by women in the Netherlands when accessing contraception services during the COVID-19 pandemic (after 8-10 months (second wave))***[10]

Answer options which were not selected by any respondents were: inadequate information to share connecting the COVID-19 pandemic and the contraception availability, reduced types of contraception methods offered, shortage of contraception supplies, fear of exclusion by neighbours/community due to possible contact with COVID-19, restrictions by spouse/partner to visit the facility/clinic.

Other: GP too busy or closed (n=2), reduction of time outside (n=1), financial (n=1) and no problem/not applicable (n=11)

[10] Figure 16:
Answer options which were not selected by any respondents were: inadequate information to share connecting the COVID-19 pandemic and contraception availability, reduction in range of contraception methods offered, follow-up services temporarily stopped, facility closure, shortage of contraception supplies, fear of exclusion by




### The impact of COVID-19 pandemic in accessing to abortion services

Only 25% of women faced challenges when accessing abortion care/services during the COVID-19 pandemic. Among the challenges reported were fear of going outside due to the risk of contracting COVID-19 (12.5%) and COVID-19-related travel restrictions (6.3%). To overcome these barriers, respondents sought help from other women (6.3%), sought help from other facilities/clinics (6.3%), and used public transportation to travel to further away clinics (12.6%). No graph is presented due to the small amount of data.Cross-cutting results areas

# SUMMARY OF THE QUANTITATIVE FINDINGS IN IRAN, BANGLADESH AND THE NETHERLANDS

**The impact of the COVID-19 pandemic on contraception/family planning provision (as reported by service providers)**

neighbours/community due to possible contact with COVID-19, lack of permission from spouse/partner to visit the facility/clinic.
Other: no company allowed during appointments (n=1), no GP (n=1), financial (n=1), busy pharmacy (n=1) and no problem/not applicable (n=13).

Around half of the service providers in Iran acknowledged that COVID-19 pandemic had affected their contraceptive service provision. With regards to COVID-19-related changes during the first wave, service providers reported clinic schedule changes (64%) and transition to online and telephone contraception consultations and information services (90%). Additional changes described by service providers included reductions in the range of family planning methods offered, temporary stoppage of contraception service provision and follow-up, and irregular supply of contraceptives. In Bangladesh, 91% of service providers reported changes such as reduced opening hours, reduced client flow/demand, shortage of staff members, and temporary closure of facilities during the beginning of the pandemic. Later, reduced client flow/demand for family planning/contraceptive services and staff shortages were noted. More than 30% of service providers in the Netherlands acknowledged that both at the beginning of the COVID-19 pandemic and after 8-10 months their ability to provide contraception services was affected. They reported that the main changes they experienced were a reduction in client flow/demand for family planning services, and transition to online and telephone consultations for the provision of contraception care.

**The impact of COVID-19 pandemic on contraceptive use (as reported by service providers)**

When asked about the impact of COVID-19 on contraception usage, half of the service providers in Iran reported an increased use of condoms by their clients as well as shifts from long-acting to short-acting contraception methods. Service providers in Bangladesh also noted changes in condom use, but they saw the opposite shift in contraceptive method type usage, namely from short-acting to long-acting methods. In the Netherlands, no considerable changes in contraception use were noted by the service providers.

**Measures introduced by service providers to increase clients' access to contraceptive care during COVID-19 (as reported by service providers)**

All service providers in Iran reported the implementation of COVID-19-related measures at their facility/clinics, to increase remote client access to services. These included rotation duties, provision of online/telephone consultations, and provision of information regarding contraception services online. Service providers in Bangladesh also reported the application of similar measures to those reported in Iran, in addition to the use of multiple contraception suppliers to ensure uninterrupted supply of contraceptives, and the introduction of service points within the community to increase access to contraceptives. In contrast, only a fifth of the service providers in the Netherlands reported the use of such measures. They reported that their clinics remained open and that phone and/or online consultations were already in place and in use before the COVID-19 pandemic.

**The impact of the COVID-19 pandemic on abortion services provision (as reported by service providers)**

In the first wave of the pandemic, four out of five service providers in Iran reported a reduction in the number of clients visiting their clinics/facilities. As the pandemic progressed, the inability of

some facility/clinic staff to work was a notable challenge 8-10 months after the beginning of the pandemic. This was comparable to the Netherlands where three out of four service providers also reported staff shortages after 8-10 months. However, their practices remained open for emergency abortion service provision and phone consultations in the first wave. Service providers in Bangladesh experienced a reduced number of clients due to restricted opening hours and temporary closure of their clinics/facilities in the beginning. After 8-10 months, the most noted changes were the inability of staff to work, staff shortages, and reduced opening hours.

**Measures introduced by service providers to increase clients' access to abortion care during COVID-19 (as reported by service providers)**

In both Bangladesh and the Netherlands, the main measure introduced to increase clients' access to abortion care during the COVID-19 was the use of telephone and online consultations. Rotation duties for service providers were also introduced to ensure continued provision of services in Bangladesh. In Iran, service providers reported that no measures of this nature were applied.

**The impact of COVID-19 pandemic on contraceptive/family planning use, main strategies to overcome challenges and rate of pregnancies during COVID-19 (as reported by women)**

The withdrawal method and female sterilization were the most popular contraception methods used by women respondents from Iran, whereas the pill, injectables, IUD and male condom were more widely reported by women in Bangladesh and the Netherlands. In all three countries, women mostly accessed contraceptive services through pharmacies and government facilities or GPs. Women in Bangladesh and Iran also made use of non-governmental organizations. In Bangladesh, 21.2% of women respondents reported a change in their usual choice of contraception method, compared to 7.5% and 6.8% of women respondents in Iran and the Netherlands, respectively.

With regards to accessing the clinics/facilities, women respondents in Iran reported contraceptive pill shortages, lack of follow up services, and challenges in travelling to facilities/clinics. In the Netherlands, similar challenges were faced, in addition to fear of contracting COVID-19 and reduced clinic opening hours. In Bangladesh, in addition to these challenges, women respondents also reported a fear of neighbours/community excluding and ostracizing them following possible contraction of COVID-19.

In Iran 31 respondents were or had ever been pregnant. Seven were unplanned (23%), of which six ended in an abortion. In Bangladesh, 20 women (15.6%) reported becoming pregnant during the COVID-19 pandemic. Eight of these pregnancies were unplanned (40%) and two of these pregnancies ended in an abortion. In the Netherlands less than 5% of the women (n=4) reported being pregnant during the COVID-19 pandemic, of which two pregnancies were unplanned. One pregnancy ended in an abortion and one in a miscarriage.

**The impact of COVID-19 pandemic on access to abortion services (as reported by women)**

Most of the women respondents in Bangladesh (76.2%) had experienced challenges accessing abortion services during the COVID-19 pandemic, while in the Netherlands, only 25% of respondents faced any challenges. The country context in which the lowest percentage of women respondents experienced challenges in accessing abortion services during the first wave of the pandemic was Iran (10%). In all three countries, the main challenge in accessing abortion services was fear of going outside and contracting COVID-19. Furthermore, COVID-19 related travel restrictions also deterred women respondents in the Netherlands from accessing abortion services. In Bangladesh, half of the women respondents reported that their spouses/partners would not allow them to travel to the facility or go outside, and they also feared being ostracized by their neighbors and community due to possible contraction of COVID-19. The temporary stoppage of surgical abortion and follow-up services was also an additional challenge for women respondents in Bangladesh. In the Netherlands, a quarter of the women respondents overcame the challenges faced by seeking help from other women, other facilities/clinics and using public transportation to travel to more distant facilities. After 8-10 months there was a large reduction in reported challenges.

### QUALITATIVE RESULTS

This chapter describes the findings from the qualitative interviews with service providers and service users in Iran, the Netherlands and Bangladesh. Three themes were identified: 1) challenges and barriers to access to contraception and abortion services during the COVID-19 pandemic, 2) measures taken by clinics to improve access to contraception and abortion services and 3) recommendations provided by service providers and service users to improve the access to contraception and abortion services during future crises.

## RESULTS OF THE QUALITATIVE INTERVIEWS - IRAN

Of the fifteen service providers (SPs) who were interviewed in Iran, twelve worked in contraception service provision while the rest provided abortion care services. Twelve were nurses and three were medical doctors. Most of them were aged between 30 and 40 years old. All service providers were women.

Twenty women were interviewed in Iran. Only two of them had used abortion services during the COVID-19 pandemic. Most of them were aged between 21 and 30 years, and three were less than 20 years old. Fourteen of them lived in urban, and six in rural areas. Sixteen of the twenty women were housewives. Most of the women interviewed had access to family planning services and abortion services in the first wave, while half had access after 8-10 months of the pandemic.

**Theme: Challenges and barriers**

Cancellation of free contraceptive provision was the main challenge faced by centers in the delivery of contraceptive services. Until September 2020, health centers provided contraceptives free of charge to high-risk groups such as women with certain medical conditions, women with children younger than two years old, and women above 40 years of age. However, since September 2020, because of a change in Iran's population policy, only counseling is provided free of charge. Clients must purchase contraceptives themselves, after which they can be placed at the health center free of charge.

***"Cancellation of free contraceptive provision has created many challenges, especially for families who cannot afford to pay for contraception. Some women have been forced to use traditional methods due to their inability to obtain contraception. This increases the risk of unwanted pregnancies. I have seen several unwanted pregnancies during this period, and some have been trying to have abortions." (service provider)***

***"I know some women who are unable to afford contraceptives. Some of them are reluctant to have intercourse with their husbands for fear of pregnancy, which has caused problems in their relationships with their husbands." (service provider)***

***"Due to changes in population policies, free contraceptives have not been available to any population group since September 2020. Free counseling concerning contraceptive use is still provided. People can also have their ampoules injected or IUD embedded free of charge provided that the contraceptives are supplied by them. This change has caused problems for many people, and it seems that these problems are more prevalent in rural than in urban areas." (woman rural health center)***

***"I used to get contraceptives for free from the health center, but now it is difficult for me to access contraceptives because there is no pharmacy in our village and I have to use the withdrawal method." (woman, village)***

Rising contraceptive prices (particularly for condoms), was a problem cited by many consumers, as well as the lack of availability of some contraceptives. This meant that contraception users had to change their usual methods of contraception during the pandemic, which was a challenge for many, including some who stopped using modern contraceptives and switched instead to the withdrawal method.

***"During the pandemic, economic pressure has increased. My wife is a worker, and if I want to buy a regular condom pack, we must pay half of our income for it. So I chose to use the withdrawal contraceptive method instead of the condom. It adds to my stress about unwanted pregnancies." (husband, service user)***

***"I used to take Cyclofem ampoules, but during the COVID-19 pandemic, the availability of this ampoule has decreased and I had to use medroxyprogesterone ampoules (quarterly). This change has caused a lot of mental tension for me." (woman)***

Reductions in referrals to health centers due to fear of COVID-19 was described by many of the service providers interviewed.

***"Although health centers try to communicate with their clients by phone or online, not all clients have a phone line, mobile phone, or internet connection. These (clients) are often from lower socioeconomic classes and tend to be at greater risk of unwanted pregnancies." (service provider)***

Insufficient access to information during the pandemic on sexual intercourse, emergency contraception, family planning and reproductive health was also a challenge mentioned by several respondents. Lack of information about the specific risks associated with becoming pregnant during the COVID-19 pandemic constituted one such concern.

***"I did not intend to become pregnant, but with the onset of COVID-19, I began to feel stressed about what would happen to me and the fetus if I was pregnant." (woman)***

***"A topic hardly discussed, even on social media, is whether or not we should have intercourse during the COVID-19 pandemic. I have tried not to have sex because I have been afraid of COVID-19 as well as unwanted pregnancy." (woman)***

***"Many people, including me, do not wish to be pregnant in critical situations such as the current one. However, there is insufficient information about emergency contraception. It is better to direct further attention to the training of emergency contraception providers in all situations, especially in critical situations." (woman)***

**Theme: Measures taken to improve access to services**

Telephone counseling was introduced or expanded by all centers providing contraception and abortion services. An employee of one health center explained that:

***"We provide free counseling during office hours to people who need counseling services concerning contraceptive use and legal abortion." (nurse assistant)***

***"Telephone services facilitated it for us, so we do not need to leave the house to seek counseling. Once the condom broke during intercourse, and I was very worried about getting pregnant. Upon my phone call to the health center, they gave complete instructions on emergency contraception and, fortunately, no pregnancy occurred." (woman)***

Online counseling was also provided by service providers. Although the delivery of online services by health centers is not an official method of service provision, some staff were able to provide online advice to clients with whom they have established close relationships.

***"I have been working in the health center of this village for more than 20 years, and I have a close relationship with some clients. As I know some of these women, for example, the less educated women or women who are in high-risk groups in terms of pregnancy – those who may face more problems – I contact them via WhatsApp or Telegram applications and give them the necessary advice." (service provider, health center)***

The introduction of a client appointment schedule was another strategy employed to improve access to family planning services. During the COVID-19 outbreak, all women who were referred for counselling or injection of contraceptive ampoules were therefore assigned a visit time to prevent crowding in health centers.

***"I had to go for the (contraceptive) injection. I called the health center, and they appointed a time for me. I visited there without a problem." (woman)***

**Theme: Recommendations**

*Free access to counseling services and contraceptives*

The need to resume free of charge provision of contraceptives was frequently raised by respondents.

***"Given that contraceptives were previously provided free of charge to high-risk groups, it would be better to provide free counseling and contraceptives not only to these groups but also to all those who want to use contraceptives. Why? Many cannot afford these devices, especially because the COVID-19 outbreak has exacerbated economic problems, and some groups are now even more vulnerable." (Nurse)***

***"It is better to have contraceptives available, as in the past, free of charge to all people, especially to couples who are less literate or have fewer financial resources. Besides, it should be borne in mind that in times of crisis, such as the present, some people face economic problems. Hence, they may refuse to purchase a contraceptive. Thus, it is better, at least in these circumstances, that these be available to everyone for free." (service provider)***

*Stability in family planning policies and contraception services*

Service providers recommended maintaining consistency in family planning policies and contraceptive service provision during crises to reduce the occurrence of sudden changes, as described above in the discussion of the theme of challenges.

***"Changing the manner and type of family planning services should occur in a situation where society is relatively stable. Many believed that the authorities could have postponed the implementation of this policy, rather than implementing it during the critical COVID-19 pandemic and exacerbating problems experienced in such circumstances." (service provider)***

*Provision of door-to-door delivery services was recommended by service users*

***"Some women are unable to leave home in times of crisis, such as the COVID-19 pandemic, because of a specific disease, small children, sick family members, and the like. Therefore, it is best to identify such people and provide them with contraceptives at their home." (woman)***

*Ongoing education and training*

Education on family planning and reproductive health, and how to manage related problems in times of crisis, should be a major part of the Ministry of Health's educational agenda.

***"Now that fertility growth policies have been adopted in Iran, family planning education should not be underestimated or neglected. Both before and during the crisis, people should receive education regarding contraceptives, reproductive health in times of crisis such as the COVID-19 outbreak, pregnancy risks, pregnancy preservation, and more." (service provider)***

***"Official media can play an important role in times of crisis. Unfortunately, family planning issues have not received much attention from the national media, despite the fact, that they would be able to provide the necessary training and information under cultural restrictions." (service provider)***

*Education before marriage was seen as a vital step in improving reproductive health.*

> ***"To enhance knowledge about contraceptives, this information should be given to people before marriage and during their studies at school or university so that they can make informed decisions in all situations, especially in crises." (service provider)***

*Other*

Furthermore, respondents recommended equipping health centers to enable them to ensure client privacy and provision of improved services, such as through regular attendance of general practitioners. Better communication with clients was recommended to encourage a wider range of people to visit health centers and receive necessary services. It was also recommended that health centers improve their monitoring of covered populations, particularly during emergencies.

> ***"Our district health center is so small that the male staff can hear us during contraceptive counseling. I feel embarrassed but I cannot go anywhere else to get counseling services." (woman)***

# RESULTS OF THE QUALITATIVE INTERVIEWS – BANGLADESH

A total of 67 qualitative interviews took place in Dhaka, Cumilla, Cox's Bazar, and Barishal districts, with 28 service providers and 39 women of reproductive age interviewed.

Among the 28 service providers (SPs), two were male. Thirteen service providers were from Dhaka. Of these SPs, most (two thirds) were from NGOs, followed by government facilities, then the private sector. Seventeen service providers were employed as paramedics, while others were nurses, doctors, or in training. Twelve service providers were aged between 31-40 years, while the rest were between 20-30 and 41-50 years of age. Eighteen service providers held diploma qualifications.

Among the 39 women of reproductive age interviewed, one third of them came from Dhaka city, while the rest were from Cumilla, Cox's Bazar and Barishal. Sixteen women were from rural areas. Around half of the women (18) were aged between 21-30 years, while 11 were aged between 16-20 years. Fifteen of the women were educated to secondary level, the highest educational level of any respondent. The majority (29) of the women were housewives or domestic workers.

**Theme: Challenges and barriers**

The most significant challenge faced by both SPs and women was the lack of transportation services, mentioned by 19 respondents. Most of the SPs had to walk long distances to reach their clinics due to a lack of transportation and the strict restrictions on movement between areas. These

transportation problems were mentioned by many of the women as well. Another problem was related to commodity supplies. Due to supply shortages, the cost of many commodities increased, which negatively affected their availability in clinics. The high price of commodities and services in pharmacies and services centers was an economic challenge faced by women. Other issues were reduced service hours in the first three months of the pandemic, and reduced client flow in private clinics, whereas government service centers were overwhelmed with patients. This caused difficulties for most of the women in accessing services and many women did not have adequate information on service opening times and access criteria.

***"Though clinics attempt to be in touch with the patients over the phone or through online counseling, it was impossible to collect contact details or connect with clients online, because many of these clients were from lower socioeconomic classes." (service provider)***

***"A woman whose husband believes in misconceptions about using or taking contraceptives shared her experiences. He asked her not to use any kind of contraception, as he believes that using contraception is a sin. But when she did not listen to him, she experienced domestic violence." (service provider)***

***"There was not enough manpower or service providers in the clinics to provide services." (service provider)***

COVID-19 tests were expensive and were unaffordable for some women. In addition, being tested takes time, and results were often only provided after one or two weeks.

***"During lockdown unprotected sexual intercourse increased. If I did not respond to my husband's wish, it became an issue of mental and even physical violence" (woman from semi urban area)***

***"At the beginning of lockdown, some of the significant service centers only provided menstrual regulation services on a specific day. But as I am a garment worker, it was tough to manage my time and arrange leave so I could access the services." (garment worker urban area)***

***"Phone counseling was the only option for us to get check-up or follow-up services. However, it was not easy to connect when I needed a service. Because most of the time the number was busy, as this was the only number to be connected." (woman from slum)***

***"As the SRHR outreach and door-to-door services were suddenly closed, it created a problem to get service; it was especially challenging for remotely placed women." (A woman rural area).***

Most of the service providers interviewed were able to provide abortion/menstrual regulation (MR) services despite their fear of contracting COVID-19, although they faced some significant challenges. Service providers mentioned that they could not adhere to physical distancing guidelines as service

seekers were not aware of the pandemic or were not concerned enough about COVID-19 to adhere to mitigation measures such as sanitization, using masks and personal protective equipment (PPE). Shortage of PPE materials and the fear of contracting COVID-19 caused a reduction of service provision and downscaling of services. Almost all women interviewed also feared getting infected in clinics and mentioned the difficulties in adhering to social distancing guidance as well. This reduced their access to services.

***'In the beginning of the pandemic, it was tough to provide services as there were not enough health and sanitation measures in place. As an example - there is only 1 set of PPE for 10 doctors, and they have to share it among themselves, thereby breaching COVID-19 guidelines." (service provider)***

***"It was tough to maintain physical distance in terms of providing abortion/MR services. To ensure the size of uterus prior doing the MR procedure, it was necessary to do per vagina examination. But during corona time we faced challenges to ensure that" (service provider)***

**Theme: Measures taken to improve access to services**

One significant measure taken by the service providers was the provision of phone counseling. If any clinic was unable to provide services, patients were referred to other clinics or providers. Other measures were the introduction of rotational duties and change of service hours. These measures were noted by women interviewees as well. Also, transportation was improved.

***"During the first two weeks, most of the services centers were closed or the service hours were decreased. But after the Eid vacation in August, service centers restarted their regular service hours with normalization of client flow." (service provider)***

***"In some places, zone wise duties have been introduced to reduce the impact of long distances on service providers. Even after July, door to door services were introduced widely so that women who are unable to travel to services can access them in their own homes." (service provider)***

Due to shortages of supplies in items like IUDs and contraceptive implants, people had to book their appointment long in advance.

***"I had to go for my injection. So, I called the health center, and booked an appointment time. Then on that specific day, I accessed the family planning service without any difficulty." (women urban area)***

The clinic authorities initiated door-to-door services. Women said that in some rural areas, group services or counseling/consultations were carried out by door-to-door service providers, so that women did not have to travel to clinics.

Measures to prevent transmission of COVID-19 were taken, including social distancing, use of PPE or masks, use of disinfectants, and temperature checks. Clinic authorities ensured the provision of more COVID-19 equipment in June 2020 and started quarantine facilities for service providers.

The clinic authorities took measures to support service providers, including the promotion of family planning services through behavioral change communication materials or advertisements. Also, they provided regular follow-up with facilitators to provide moral or technical support.

Women mentioned several other positive measures taken by the service providers or the clinics: most of the pharmacies were open during lockdown so menstrual regulation kits were available to help women avoid unwanted pregnancies; some service providers were very cooperative and offered to provide services outside of regular working hours using mobile counseling.

> ***"Before August, during the first wave of COVID-19, it was hard to access services and that's why I became pregnant. But I was unable to access abortion services. Some of my neighbors who were newly married had some horrible experiences, and one of my neighbors even died as she was not able to access services in April." (woman urban area).***

**Theme: Recommendations**

*Awareness campaigns and knowledge development programs*

Some service providers and women stressed the need to arrange outreach campaigns and meetings, including involving males, to create awareness and highlight the importance of family planning. Online and offline knowledge-sharing methods should be combined to combat misconceptions about contraception and abortion.

*Health facility improvements*

Most of the service providers and women interviewed recommended to introduce standardized care like the use of international guidelines during emergency situations with adequate preventive and treatment facilities against COVID-19. Some service providers recommended collaboration between government and non-government organizations, to avoid replication of programs and services.

Flexible service hours, or even increased service center opening hours, can be implemented when levels of client demand are high, to ensure those seeking services are able to access them. If services hours are expanded, more service providers should be appointed to fill the gaps in duty rosters.

***"The service providers should be well trained so that a comfortable and friendly environment could be ensured for the women." (woman urban area)***

***"Enough manpower is needed to solve the staff problem during the crisis. Otherwise, it will be difficult to face the challenge of COVID-19." (service provider)***

Most of the women and service providers recommended that online consultations and counselling should be in place to be able to provide follow-up care to women at home. This would allow even women who are completely unable to travel to services to access them.

***"Free counseling online and offline to the married and unmarried should be provided for all, particularly those from vulnerable and marginalized communities." (woman)***

Commodity supply must be improved, and agreements with manufacturing companies, suppliers, and garment factories must be strengthened so that supply issues can be remedied. Service providers and users suggested that the price of contraceptives can be reduced through decentralization of services. Most women in rural areas requested free access to services, and low-cost commodities.

*Transportation*

Improvement of the transportation system is necessary to ensure that service providers can travel to clinics, as many providers must travel long distances to service centers.

*Improvement of door-to-door services*

Most of the women interviewed emphasized the need to improve service accessibility through expansion of door-to door or one-stop services for women who are unable to leave their homes.

***"Some women are not able to go outside to access services because of the fear of COVID-19, family barriers, having young infants, or due to diseases. For them, a door-to-door service will be a blessing to solve their problems." (service provider)***

## *RESULTS OF THE QUALITATIVE INTERVIEWS – THE NETHERLANDS*

Out of the eleven service providers (SPs) who were interviewed, nearly half worked in contraception service provision while the rest provided abortion care or referral services. Almost all SPs were women. All interviewees were above 21 years of age, and half were aged over 51 years. Nine were doctors, mainly general practitioners (GP), public health, and abortion doctors.

Four women were interviewed, all of whom had used abortion services during the COVID-19 pandemic. They were aged between 21 and 40 years. Three of them lived in urban areas, and one

in a semi-urban area. All were employed in the Netherlands. Half of the women interviewed had accessed an abortion service at the beginning of the pandemic and the other half had done so after 8-10 months. The sensitivity of the issue prevented us from achieving a higher response rate.

**Theme: Challenges and barriers**

All women interviewed reported that they were able to access abortion care promptly, although they mentioned institutional challenges such as a 2-hour delay in phone consultation with their GP, unfriendly treatment at first contact, and inadequate information provision at both the GP and abortion clinic. This was consistent with responses from the service providers, who confirmed that abortion service provision and most elements of GP and public health service provision remained uninterrupted from the beginning of the COVID-19 crisis, except for sick women who needed to recover before being treated.

SPs did report that foreign women had experienced challenges. Women in neighbouring countries could not leave their home countries to come to Dutch clinics or feared travelling through border checkpoints. Women without adequate health insurance who were unable to leave the Netherlands and return to their home countries due to COVID-19 restrictions experienced access problems related to travel and financial barriers. These women sought assistance from, for example, the online Women on Web (WoW) service. One of the measures taken by WoW was a legal appeal to the government through the courts to allow online abortion clinic consultations and the prescription of abortion pills by GPs. This appeal was a huge challenge for WoW.

One woman, living in a semi-urban area, pointed out that she would have had problems accessing an abortion clinic if her GP had not helped her to avoid this issue by ordering abortion pills for her. She reported that travelling to an abortion clinic would have been difficult due to the costs involved, the need to travel with her children, and the fear of contracting COVID-19.

> ***"Access to abortion is important, especially during this time of the pandemic. It is not something that can wait. When you are pregnant you feel it, at least I felt it. And I felt every day this 'fruit' is getting a little bit larger, it is getting difficult, more difficult to do this every day, so yes, abortion should not be delayed." (abortion service user)***

At the beginning of the pandemic, access to care was reduced in four institutions due to discontinuation of care, and after 8-10 months it was reduced in one institution. For one service provider who runs two clinics, a GP practice and a sexology clinic, limitations in provision of care only affected the sexology clinic. Examples of discontinuation of care included the decision to prescribe emergency contraception only, and the suspension of intra-uterine device (IUD) placement in the first wave of the COVID-19 pandemic. The referral system for IUD placement was

also interrupted, causing delays of up to 10 weeks and wasted time for the referring service providers. SRHR outreach services to vulnerable groups were suspended.

***"There are other GPs who are very reluctant (to see patients). And that is partly due to personal fear, like how do you estimate the risk. We (in our practice) may be a little more relaxed about this." (general practitioner)***

Due to the escalation of the COVID-19 crisis, regulating authorities requested efforts to refocus healthcare services towards COVID-19 care, while SRHR services were deprioritized. This was evidenced by the reassignment of service providers to the COVID-19 response in 4 clinics.

***"the (staff) capacity determines your prioritization." (doctor public health)***

Service providers faced difficulties in carrying out organizational tasks and COVID-19 protection measures, and a lack of management guidance and supervision was mentioned several times. Arranging the use of personal protection equipment (PPE) was difficult due to PPE shortages, which caused a reduction of service provision and increased the risk of contracting COVID-19 for SPs. Consultation times generally increased due to sanitation measures taken, but in one of the public health services sexually transmitted disease consultation time reduced due to the suspension of contraception counselling which had previously been conducted during these consultations. Another challenge was how to encourage patients to continue to attend GP practices, as services reported a reduction in demand for care.

Women mentioned the lack of face-to-face contact due to the use of face-masks as being impersonal, which was acknowledged by one of the abortion doctors. Another challenge was the 5 day waiting period, during which one woman feared contracting COVID-19.

***"I really want to see their facial expression, and I really want them to see my expression!" (abortion doctor)***

**Theme: Measures taken to improve access to services**

Measures taken in the clinics as reported by service users included prevention measures against COVID-19 transmission (social distancing, face-masks, use of disinfectants, no partners in the clinic, temperature checks), first appointments being held by telephone, and the ordering of abortion pills by one GP. These measures were confirmed by the SPs. One service provider also regularly tested staff for COVID-19. Face-masks and disinfectant measures were taken too late according to one SP, which meant that working at the beginning of the pandemic made her feel that she was at higher risk of contracting COVID-19. A restriction on the use of masks was necessary due to mask shortages.

One of the women interviewed opted to bypass the GP and reached out to the abortion clinic instead, due to fears of contracting COVID-19.

Another woman said that no measures were taken in the clinic she visited, and she responded to the questions relating to how she felt about the measures taken as follows:

> ***"well, eh, on the one hand I think that, if they really had used masks and screens and these things, it would have been less comfortable in this type of care. But maybe better. Because they really did not take any measures so to speak." (woman)***

Other measures taken by SPs included a shift towards telephone/online/E-consultations and triage, and changes in work-plans including evening consultations and working from home. Adjustments to (social) media communication materials were made, and contraception care practitioners mentioned the use of a national newsletter for GPs to emphasize the importance of the continuation of contraception and abortion care and the need to keep patients informed. Website adjustments were made to inform patients about the continuation of services and COVID-19 measures, and to triage patients. Preparations were made including roadmaps and meetings, and the prioritization of acute services were emphasized. Lastly, consultations for patients with suspected COVID-19 were adapted. Consultation times were increased, special consultation hours were established, and even use of a separate building with (newly appointed) staff was implemented.

**Theme: Recommendations**

*Stigma and costs*

Service providers emphasized the importance of reducing stigma surrounding abortion, and of decriminalizing abortion. The global gag rule should be ended to ensure funding for SRHR. Out of the eleven SPs interviewed, five recommended free or subsidized costs of contraception for all women and the inclusion of contraception in basic health insurance packages. In addition, free access to contraception and abortion for migrant women was also suggested.

*Government campaigning and online education*

Service providers would like to see government campaigns to encourage people not to delay seeking care. Topic-specific media campaigning for abortion and contraception care was recommended,

including inclusive dissemination of information in clear and easy to understand language, and in braille and sign language. This should be disseminated through both digital and traditional channels of knowledge-sharing and education on contraception and abortion. In addition, SPs should be trained in communication.

*GPs to provide menstrual regulation and abortion care*

Access should be improved by bringing care closer to women, including ultrasounds. It was recommended, for example, that GPs should provide menstrual regulation. Two women also recommended that GPs be registered to provide abortion pills. One of these women also stated that hospitals could be involved in the provision of abortion care during crises.

***"If women can have an ultrasound close to their house, they can just receive either the abortion pill from their GP, by mail, or via the internet. Because then it is like normal healthcare, like I can send antibiotics or hormones for menopausal complaints to the pharmacy after video-conferencing with the patient, so why can't I do that with abortion care?" (service provider abortion)***

***"Women still have to travel to abortion clinics even if they live on an island in the North of Holland, they have to travel several hours using public transport at the same time that our government is saying do not use public transport, stay at home as much as possible." (service provider abortion)***

*Continuation and adjustment of service provision*

Contraception service provision should continue during crises. One service provider suggested revising the waiting period required between the first and second consultations in abortion clinics due to the risk of women contracting COVID-19 during this period.

*Handbook on SRHR*

Service providers indicated that a handbook on SRHR, specifically contraception, abortion and menstrual regulation during crises, as well as task division between different SPs and crisis management should be available. Also, it was requested that smaller institutions be considered in decision-making on PPE, testing personnel and task division during crises.

*Continuation of the online/telephone consultations after the crisis*

Several SPs recommended the continued provision of online/webcam and telephone consultations after the pandemic. This was also suggested by some women, as well as pre-abortion counselling and improved access to information via websites. This is understood to be part of government plans for the improvement of SRHR service provision as already being discussed.

*Other recommendations*

Prioritization of social support, both during the waiting period and during the follow-up after the abortion procedure, was recommended by three women. Two of these women regretted the absence of their partner or another supportive person at the abortion clinic. One woman was not satisfied with the COVID-19 measures taken by the clinic at the beginning of the pandemic, and recommended improvement of these.

A woman gave a personal note at the end of the interview:

***"through all the grief you can also feel so good, how happy you are."***

# SUMMARY OF THE QUALITATIVE FINDINGS IN IRAN, BANGLADESH AND THE NETHERLANDS

*Challenges and barriers*

The qualitative interviews highlighted some common challenges and barriers across country contexts, such as a reduction in client visits/demand. In Bangladesh and the Netherlands shortages of PPE were mentioned, resulting in reduced service provision and increased fear of contracting COVID-19. Contraception provision in Iran was a major challenge, due to low supply, increased price of condoms and the cancellation of free provision. This resulted in a negative increase in use of the withdrawal method. Knowledge about family planning, especially knowledge about pregnancy-related risks during COVID-19, was also of concern in Iran. In Bangladesh the cost of contraceptives also increased and supplies were low. However, the biggest challenge in Bangladesh was the lack of transportation, which posed difficulties for both service providers and women in travelling to clinics. In the Netherlands it was mentioned that abortion care was not delayed, but foreign women had challenges accessing abortion services. Access to contraception was said to be reduced due to discontinuation of care, mainly at the beginning of the pandemic. Also, reassignment of staff towards COVID0-19 care caused difficulties, and organizational challenges were faced due to the crisis, the lack of good guidance, and supervision.

*Measures*

Measures taken by service providers in all three countries to improve access were telephone and/or online counselling, consultations and triage. In Bangladesh group counselling in rural areas and door-to-door services were also provided. Services in Iran and Bangladesh started a client appointment schedule, and in the Netherlands work plans were adjusted and a special consultation for COVID-19 positive patients was organized at GP practices to ensure they were kept apart from non-infected patients. Also, some GPs supplied patients with abortion pills instead of referring them to an abortion clinic and (social) media was used to inform patients about COVID-19 regulations and access to care. In Bangladesh rotational duties and a referral system were organized. Clinic authorities promoted family planning services through behavioural change communication materials and advertisements, and improved transportation, service hours and quarantine facilities.

Pregnancies were avoided in Bangladesh due to the availability of menstruation regulation kits in pharmacies during lockdown.

*Recommendations*

Recommendations as given in the qualitative part of this study are described in the recommendations chapter.

# DISCUSSION

This section is delved on the triangulated data from quantitative and qualitative findings. The study aimed to provide an answer to our main questions: what barriers and challenges did service providers and women of reproductive age face in provision of and access to contraception and safe abortion services during the COVID-19 pandemic in three different countries; namely Iran, Bangladesh and the Netherlands. In addition, changes in chosen contraception or abortion methods by women of reproductive age were identified. Additionally, this study gave insight into the measures taken by service providers to continue service provision and to mitigate challenges. Lastly, recommendations from service providers and service users for service provision in future crises were explored. These form the basis of the recommendations chapter at the end of this report.

## KEY FINDINGS

*Barriers and challenges:* A total of 542 women and 189 health service providers participated in this mixed methods research study. Quantitative findings showed that service provision has been affected to differing degrees in the three countries, with responses from the Netherlands indicating least difficulties in maintaining service provision. The most notable barriers and challenges in all three countries were the reduced client flow, staff shortages, closure of health facilities, the shift from face-to-face consultation to telephone and online consulting, irregular supplies of contraceptives in Iran, and transport problems in Bangladesh. These findings were consistent with several other studies that reported similar barriers and challenges (Lindberg et al., 2020; Tolu, Feyissa, & Jeldu, 2021; Vora, Saiyed, & Natesan, 2020). For service providers, one of their main challenges was the shortage of PPE, which was highlighted during the qualitative interviews in the Netherlands and Bangladesh. The same was true for frontline healthcare workers in other countries where supply of gloves, face-masks and PPE was gravely affected during the COVID-19 pandemic (Aly et al., 2020; Church et al., 2020).

*Changes in contraception or abortion methods:* Contraception prices were a problem for service users in both Iran and Bangladesh. Contraception used to be free of charge in Iran, however this policy was ended during the COVID-19 pandemic. In Bangladesh, shortage of supplies resulted in an increase of contraception costs. Contrasting results were found with regards to changes in contraception use among the countries. Women participants in Iran reported a transition to long-acting methods, whereas in Bangladesh, women were more likely to opt for short-acting methods

during the COVID-19 pandemic. Riley et. al found that, because of disruptions in SRHR services, there was an overall decline (10%) in the usage of both short-term and long-term contraception among women in most LMICs. A 10% decline would cause 15 million unintended pregnancies in one year (Riley et al., 2020).

Abortion services remained open in Iran and the Netherlands during the COVID-19 pandemic, both at the beginning and after 8-10 months, although there were staff shortages and client demand was reduced. In Bangladesh, changes were made to the opening hours of abortion clinics and sometimes clinics were closed. These results are similar to those of other studies (Abbasi-Shavazi et al., 2004; Aly et al., 2020) that have projected that following temporary closures and reduced hours for abortion clinics, the number of unsafe abortions in many settings will rise rapidly. Therefore, it is imperative that governments and policy makers put in place adequate measures to ensure the continuity of abortion care provision during the COVID-19 pandemic.

In Iran, out of 31 pregnancies reported by women during the pandemic, seven were unplanned (22.6%), of which six ended in an abortion. In Bangladesh, 20 women (15.6%) reported becoming pregnant during the COVID-19 pandemic. Eight of these pregnancies were unplanned (40.0%) of which two ended in an abortion. In the Netherlands less than 5% of the women (n=4) reported being pregnant during the COVID-19 pandemic, of whom two reported unplanned pregnancies. One pregnancy ended in an abortion and one in a miscarriage. In several study reports it was found that in LMICs, the rate of increase in unplanned pregnancies is higher compared to HICs, which has been attributed to infrastructural challenges in LMICs (Habib et al., 2017). The study of Endler et. al also found out that in countries with restrictive abortion laws, the infrastructure was not changed, and in countries with less restrictive laws measures were taken to improve access to contraception and abortion services (Endler et al., 2020). National data from Iran suggest that a high rate of unintended pregnancies is not uncommon, as discussed by Sarvestani who placed it at 17% (Abbasi-Shavazi, Hosseini-Chavoshi, & Delavar, 2004; Asadi Sarvestani et al., 2017; Sedgh, Singh, & Hussain, 2014). In our study, the reported rate of unintended pregnancies is higher at 23%. This could be investigated further in another research study.
In the Netherlands, Women on Web, an important online supporter of abortion services for women, showed that women in the Netherlands do experience access problems due to stigma, financial barriers, lack of knowledge, problems communicating with SPs, and the critical attitude of SPs, problems which vulnerable groups like foreign women and single parents are more at risk of. However, most of these access problems pre-date the COVID-19 pandemic. Access problems primarily related to COVID-19 were mentioned in the qualitative interviews. Clinical symptoms of COVID-19, the risk of contracting COVID-19 when travelling to clinics, and the fact that a companion could not be taken to the clinic were mentioned (Holten et al., *in press*). Our mixed methods study supports the findings that some access problems were related to COVID-19.

*Measures:* Providers of both contraception and abortion services implemented online and phone consultation or rotational duties to improve access. The changes in contraception services were

implemented mostly in Iran and Bangladesh, and in abortion services in Bangladesh and the Netherlands. These counselling measures were also mentioned in the qualitative part of this study, in addition to information provision for service users via (social) media and a change in service hours or work-plans. Care was brought closer to service users, for example in Bangladesh where door-to door services were provided, and in the Netherlands where some GPs supplied patients with abortion pills. Changes in the prescription of abortion pills by the British Pregnancy Advisory Service (BPAS) in England have shown improvements in access during the recent crisis ("Abortion Pill Treatment at Home | BPAS," 2015). This is also supported by human rights considerations (Todd-Gher & Shah, 2020).

## STRENGTHS AND LIMITATIONS

A mixed methods approach was employed for two main reasons: Firstly, to strengthen the evidence base of findings through the triangulation of data from both qualitative and quantitative sources. Secondly, the findings from our quantitative study were able to inform the objectives of our qualitative study component. Other strengths of this study include the international focus and comparison, with highly motivated and experienced researchers from different cultural and educational backgrounds. In addition, due to the increased importance of online spaces following the onset of the pandemic, our study incorporated the use of different social media channels for recruitment of respondents in Iran and the Netherlands. This increased the scope of our reach to participants and service providers, including to those who would have otherwise been missed had the study only employed conventional recruitment methods. Thirdly, surveys were available in four different languages (English, Dutch, Persian and Bangladeshi) to ensure improved comprehensibility of the questions asked. Fourthly, all principal researchers were involved in protocol and tool development and have either conducted interviews themselves, or trained interviewers before the start of data collection.

Like all studies, our mixed methods study had limitations ranging from the choice of sampling methods, participant recruitment, data collection and analysis. Firstly, convenience sampling was used to recruit participating service providers as well as women of reproductive age. This reduces the generalizability of the results. Secondly, the sensitivity of the topic (especially unplanned pregnancy and abortion) meant that women, but also service providers, may have been less willing to participate in this study. This is reflected in the number of participants included and can cause selection bias. The researchers managed this issue by providing extensive explanations about the objectives and aim of the research, by ensuring confidentiality, and securing informed consent. A counselling system was also in place. Thirdly, due to limited time and recruitment challenges related to COVID-19, the number of interviews was much lower than expected (especially in the Netherlands). The use of online surveys made it difficult to target the recruitment and caused different selection biases depending on which online platform was used. Fourthly, some of the service users were not comfortable discussing challenges experienced.

# RECOMMENDATIONS

These recommendations are based on those suggested by interview respondents as described in the results chapter. Recommendations were given at both governmental and institutional level. The research team has added recommendations on further research.

## RECOMMENDATIONS AT GOVERNMENTAL LEVEL

- Reduce abortion stigma through public desensitization campaigns and advocate for the decriminalization of abortion through campaigns in the Netherlands.
- Government awareness campaigns and (online) knowledge development programs about sexual and reproductive health during crises (all three countries).
- Provision of free or affordable contraception and abortion services (all three countries).
- Advocate to allow free and safe transportation services of service providers in emergency care in future crises (Bangladesh).

## RECOMMENDATIONS AT INSTITUTIONAL LEVEL

- Continuity of services, including the continuation or adaptation of service provision by online/telephone consultations (all three countries).
- Bring care closer to the people: provision of abortion services by general practitioners (Netherlands) and enhancement of door-to-door contraception services (Iran, Bangladesh).
- Improvements in health facilities: development of a handbook for service providers on SRHR in crises (Netherlands), collaboration of service providers, adjustment of opening hours and enhancement of supplies (Bangladesh).

## RECOMMENDATIONS FOR FUTURE RESEARCH

- Access to contraceptive services and abortion care for undocumented women during future global health crises.
- The role of men in family planning and reproductive health during the COVID-19 pandemic or other global health emergencies.
- Implementation research with a focus on abortion care given by general practitioners.

# CONCLUSION

COVID-19 has had a considerable impact on access to contraception and abortion care during both the beginning of the pandemic and 8-10 months into the crisis. Since universal access to sexual and reproductive health services remains an essential step in the achievement of Sustainable Development Goal 3, “Ensure healthy lives and promote well-being for all at all ages”, and especially target 3.7, “ to ensure universal access to sexual and reproductive health care services, including for

family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030", it is important to address SRHR in policy response**.** All stakeholders need to act collaboratively to ensure access for all, both during the current COVID-19 crisis and in any future crises. Stakeholders can learn from their experiences during the COVID-19 pandemic, which should act as a catalyst for improved understanding of the realities of ensuring equitable access to sexual and reproductive health for all.

# REFERENCES

Abbasi-Shavazi, M. J., Hosseini-Chavoshi, M., Aghajanian, A., Delavar, B., & Mehryar, A. (2004). Un in tended Pregnancies in the Is lamic Re pub lic of Iran: Lev els and Correlates. *Asia-Pacific Population Journal*, *19*(1), 27.

Abbasi-Shavazi, M. J., Hosseini-Chavoshi, M., & Delavar, B. (2004). " Unwanted" pregnancies and its determinants in Iran. *Journal of Reproduction & Infertility*, *5*(1).

Abortion Pill Treatment at Home | BPAS. (2015). *Bpas.Org*. Retrieved from https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/

Aly, J., Haeger, K. O., Christy, A. Y., & Johnson, A. M. (2020). Contraception access during the COVID-19 pandemic. *Contraception and Reproductive Medicine*, *5*(1). https://doi.org/10.1186/s40834-020-00114-9

Asadi Sarvestani, K., Ahmadi, A., Enayat, H., & Movahed, M. (2017). Level and Factors Related to Unintended Pregnancy with a Brief Review of New Population Policies in Iran. *Iran J Public Health*, *46*(7), 973–981.

Church, K., Gassner, J., & Elliott, M. (2020). Reproductive health under COVID-19–challenges of responding in a global crisis. *Sexual and Reproductive Health Matters*, *28*(1), 1773163.

Cleland, J. (2020). The complex relationship between contraception and abortion. *Best Pract Res Clin Obstet Gynaecol*, *62*, 90–100. https://doi.org/10.1016/j.bpobgyn.2019.04.007

Dixon-Mueller, R. (1988). Innovations in reproductive health care: menstrual regulation policies and programs in Bangladesh. *Stud Fam Plann*, *19*(3), 129–140.

Endler, M., Al-Haidari, T., Benedetto, C., Chowdhury, S., Christilaw, J., El Kak, F., … Gemzell-Danielsson, K. (2020). How the coronavirus disease 2019 pandemic is impacting sexual and reproductive health and rights and response: Results from a global survey of providers, researchers, and policy-makers. *Acta Obstet Gynecol Scand*. https://doi.org/10.1111/aogs.14043

Erfani, A. (2016). Levels, Trends and Correlates of Abortion in Tehran, Iran: 2009-2014. *Int Perspect Sex Reprod Health*, *42*(2), 93–101. https://doi.org/10.1363/42e1316

Habib, M. A., Raynes-Greenow, C., Nausheen, S., Soofi, S. B., Sajid, M., Bhutta, Z. A., & Black, K. I. (2017). Prevalence and determinants of unintended pregnancies amongst women attending antenatal clinics in Pakistan. *BMC Pregnancy and Childbirth*, *17*(1), 156. https://doi.org/10.1186/s12884-017-1339-z

Hossain, A., Maddow-Zimet, I., Singh, S., & Remez, L. (2012). Menstrual regulation, unsafe abortion, and maternal health in Bangladesh. *Issues Brief (Alan Guttmacher Inst)*, (3), 1–8.

Ketting, E., & Visser, A. P. (1994). Contraception in The Netherlands: the low abortion rate explained. *Patient Educ Couns*, *23*(3), 161–171. https://doi.org/10.1016/0738-3991(94)90032-9

Lindberg, L. D., VandeVusse, A., Mueller, J., & Kirstein, M. (2020). Early impacts of the COVID-19 pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences. *New York, NY: Guttmacher Institute*, *10*(2020.31482).

Mazza, D., Burton, G., Wilson, S., Boulton, E., Fairweather, J., & Black, K. (2020). Medical abortion. *Australian Journal for General Practitioners*, *49*, 324–330. Retrieved from https://www1.racgp.org.au/ajgp/2020/june/medical-abortion

Pinter, B., Aubeny, E., Bartfai, G., Loeber, O., Ozalp, S., & Webb, A. (2005). Accessibility and availability of abortion in six European countries. *The European Journal of Contraception & Reproductive Health Care*, *10*(1), 51–58. https://doi.org/10.1080/13625180500035231

Riley, T., Sully, E., Ahmed, Z., & Biddlecom, A. (2020). Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health In Low- and Middle-Income Countries. *Int Perspect Sex Reprod Health*, *46*, 73–76. https://doi.org/10.1363/46e9020

Schaaf, M., Boydell, V., Van Belle, S., Brinkerhoff, D. W., & George, A. (2020). Accountability for SRHR in the context of the COVID-19 pandemic. *Sexual and Reproductive Health Matters*, *28*(1), 1779634. https://doi.org/10.1080/26410397.2020.1779634

Sedgh, G., Singh, S., & Hussain, R. (2014). Intended and unintended pregnancies worldwide in 2012 and recent trends. *Studies in Family Planning*, *45*(3), 301–314.

Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., … Roa, M. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *The Lancet*, *391*(10140), 2642–2692.

Todd-Gher, J., & Shah, P. K. (2020). Abortion in the context of COVID-19: a human rights imperative. *Sexual and Reproductive Health Matters*, *28*(1), 1758394.

https://doi.org/10.1080/26410397.2020.1758394

Tolu, L. B., Feyissa, G. T., & Jeldu, W. G. (2021). Guidelines and best practice recommendations on reproductive health services provision amid COVID-19 pandemic: scoping review. *BMC Public Health*, *21*(1), 276. https://doi.org/10.1186/s12889-021-10346-2

Unfpa. (2020). World Population Dashboard. Retrieved from https://www.unfpa.org/data/world-population-dashboard

Vora, K. S., Saiyed, S., & Natesan, S. (2020). Impact of COVID-19 on family planning services in India. *Sex Reprod Health Matters*, *28*(1), 1785378. https://doi.org/10.1080/26410397.2020.1785378

WHO, W. H. O. (2020). Family planning/contraception methods. World Health Organization: WHO. Retrieved from https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception

# ANNEXES

## ANNEX 1: DEMOGRAPHIC BACKGROUND OF THE PARTICIPANTS IN IRAN (SP) (N=53)

| Variables | N | % |
|---|---|---|
| **Age group (years)** | | |
| Below 20 | 0 | 0 |
| 20-30 | 26 | 49.1 |
| 31-40 | 20 | 37.7 |
| 41-50 | 7 | 13.2 |
| Above 50 | 0 | 0 |
| **Education** | | |
| Medical specialist license | 0 | 0 |
| Medical Doctor license | 7 | 13.2 |
| Nursing Diploma | 46 | 86.8 |
| **Service Provider Type** | | |
| Nurse | 5 | 9.4 |
| Medical doctor | 1 | 1.9 |
| Medical Specialist/Gynaecologist | 0 | 0 |
| Pharmacist | 0 | 0 |
| Paramedic | 35 | 66.0 |
| Other | 12 | 22.6 |
| **Types of Health Facility** | | |
| Government/public facility | 52 | 98.1 |
| Private facility | 0 | 0 |
| Non-governmental organization facility | 0 | 0 |
| Pharmacy | 1 | 1.9 |
| Other | 0 | 0 |
| **Geographic location** | | |
| Rural | 19 | 35.8 |
| Semi-urban | 0 | 0 |
| Urban | 34 | 64.2 |
| **Area/Region of Health Facility** | | |
| Fars Province | 10 | 18.9 |
| Tehran Province | 25 | 47.2 |
| Sistan and Baluchestan Province | 18 | 34.0 |

# ANNEX 2: DEMOGRAPHIC BACKGROUND OF THE PARTICIPANTS IN IRAN (WOMEN) (N=199)

| Variables | N | % |
|---|---|---|
| **Age group (years)** | | |
| 15 | 3 | 1.5 |
| 16 -20 | 15 | 7.5 |
| 21-30 | 71 | 35.7 |
| 31-40 | 82 | 41.2 |
| 41-49 | 28 | 14.1 |
| **Education** | | |
| No formal education | 3 | 1.5 |
| Primary education | 4 | 2.0 |
| Secondary education | 20 | 10.1 |
| College | 57 | 28.6 |
| University | 99 | 49.7 |
| Other | 0 | 0 |
| **Profession/work** | | |
| Housewife/Stay-at-home | 113 | 56.8 |
| Employed part-time | 14 | 7.0 |
| Employed full-time | 33 | 16.6 |
| Owns their own business/self-employed | 10 | 5.0 |
| Student/in school | 29 | 14.6 |
| Other | | |
| **Geographic location** | | |
| Rural | 34 | 17.1 |
| Semi-urban | 0 | 0 |
| Urban | 165 | 82.9 |
| **Area/Region** | | |
| Fars Province | 78 | 39.2 |
| Tehran Province | 56 | 28.1 |
| Sistan and Baluchestan Province | 65 | 32.7 |

# ANNEX 3: DEMOGRAPHIC BACKGROUND OF THE PARTICIPANTS IN BANGLADESH (SP) (=67)

| Variables | N | % |
|---|---|---|
| **Age group (years)** | | |
| Below 20 | 0 | 0 |
| 20-30 | 14 | 20.9 |
| 31-40 | 26 | 38.8 |
| 41-50 | 22 | 32.8 |
| Above 50 | 5 | 7.5 |
| **Education** | | |
| Medical specialist license | 1 | 2.3 |
| Medical Doctor license | 6 | 9.0 |
| Nursing Diploma | 29 | 41.8 |
| Bachelor of Arts | 7 | 15.9 |
| Paramedic | 16 | 23.9 |
| Other | 13 | 17.9 |
| Missing | 1 | 1.5 |
| **Service Provider Type** | | |
| Nurse | 4 | 6.0 |
| Medical doctor | 6 | 9.0 |
| Consultant | 2 | 2.9 |
| Paramedic | 40 | 59.7 |
| Drug Seller at Pharmacy | 11 | 16.4 |
| Midwife | 3 | 4.5 |
| Counsellor | 1 | 1.5 |
| **Types of Health Facility** | | |
| Government/public facility | 32 | 47.8 |
| Private facility | 0 | 0 |
| Non-governmental organization facility | 24 | 35.8 |
| Pharmacy | 11 | 16.4 |
| Other | 0 | 0 |
| **Geographic location** | | |
| Rural | 23 | 34.3 |
| Semi-rural | 8 | 11.9 |
| Urban | 36 | 53.7 |
| **Area/Region of Health Facility** | | |
| Dhaka | 16 | 23.9 |
| Cumila | 15 | 22.4 |

| | | |
|---|---|---|
| Barishal | 17 | 25.4 |
| Cox's Bazar | 18 | 28.4 |

# ANNEX 4: DEMOGRAPHIC BACKGROUND OF THE PARTICIPANTS IN BANGLADESH (WOMEN) (N=149)

| Variables | N | % |
|---|---|---|
| **Age group (years)** | | |
| 15 | 0 | 0 |
| 16 -20 | 11 | 7.4 |
| 21-30 | 79 | 53.0 |
| 31-40 | 52 | 34.9 |
| 41-49 | 7 | 4.7 |
| **Education** | | |
| No formal education | 22 | 14.8 |
| Primary education | 54 | 36.2 |
| Secondary education | 51 | 34.2 |
| College | 17 | 11.4 |
| University | 1 | .7 |
| Other | 2 | 1.3 |
| Missing | 2 | 1.3 |
| **Profession/work** | | |
| Housewife/Stay-at-home | 96 | 64.4 |
| Employed part-time | 17 | 11.4 |
| Employed full-time | 29 | 19.5 |
| Owns their own business/self-employed | 2 | 1.3 |
| Student/in school | 2 | 1.3 |
| Other | 3 | 2.0 |
| **Geographic location** | | |
| Rural | 70 | 47.0 |
| Semi-urban | 25 | 16.8 |
| Urban | 54 | 36.2 |
| **Area/Region** | | |
| Dhaka | 53 | 35.6 |
| Cumila | 27 | 18.1 |
| Barishal | 27 | 18.1 |
| Cox's Bazar | 42 | 28. |

# ANNEX 5: DEMOGRAPHIC BACKGROUND OF THE PARTICIPANTS IN THE NETHERLANDS (SP) (N=19)

| Variables | N | % |
|---|---|---|
| **Age group (years)** | | |
| Below 20 | 0 | 0 |
| 20-30 | 0 | 0 |
| 31-40 | 8 | 42.1 |
| 41-50 | 4 | 21.1 |
| Above 50 | 7 | 36.8 |
| **Education** | | |
| Medical specialist (gynaecologist) | 4 | 21.1 |
| Medical doctor | 8 | 42.1 |
| Nurse | 1 | 5.3 |
| Pharmacist | 0 | 0 |
| Other | 6 | 31.6 |
| **Service Provider Type** | | |
| Nurse | 1 | 5.3 |
| Primary care physician | 0 | 0 |
| General Practitioner /AIGT | 12 | 63.2 |
| Abortion specialist/doctor | 3 | 15.8 |
| Medical Specialist/Gynaecologist | 3 | 15.8 |
| Pharmacist | 0 | 0 |
| Paramedic | 0 | 0 |
| **Types of Health Facility** | | |
| Public healthcare facility | 1 | 5.3 |
| Independent organization | 1 | 5.3 |
| Public health service (GGD) | 1 | 5.3 |
| Abortion clinic | 2 | 10.5 |
| General practitioner | 13 | 68.4 |
| Pharmacy | 0 | 0 |
| Other ( Own practice for sexology) | 1 | 5.3 |
| **Geographic location** | | |
| The countryside | 2 | 10.5 |
| A village | 5 | 26.3 |
| City | 12 | 63.2 |
| **Province** | | |
| Friesland | 5 | 26.3 |
| Drenthe | 1 | 5.3 |
| Utrecht | 3 | 15.8 |
| Noord-Holland | 2 | 10.5 |
| Zuid-Holland | 5 | 26.3 |
| Gelderland | 1 | 5.3 |
| Noord-Brabant | 1 | 5.3 |

| | | |
|---|---|---|
| Zeeland | 1 | 5.3 |

# ANNEX 6: DEMOGRAPHIC BACKGROUND OF THE PARTICIPANTS IN THE NETHERLANDS (WOMEN) (N=131)

| Variables | N | % |
|---|---|---|
| **Age group (years)** | | |
| 15 | 1 | 0.8 |
| 16 -20 | 24 | 18.3 |
| 21-30 | 81 | 61.8 |
| 31-40 | 18 | 13.7 |
| 41-49 | 6 | 4.6 |
| Missing | 1 | 0.8 |
| **Education** | | |
| No formal education | 0 | 0 |
| Primary education | 0 | 0 |
| Secondary education | 22 | 16.8 |
| College | 7 | 5.3 |
| University | 100 | 76.3 |
| Other | 1 | 0.8 |
| Missing | 1 | 0.8 |
| **Profession/work** | | |
| Housewife/Stay-at-home | 1 | 0.8 |
| Employed part-time | 15 | 11.5 |
| Employed full-time | 24 | 18.3 |
| Owns their own business/self-employed | 3 | 2.3 |
| Student/in school | 82 | 62.6 |
| Other | 5 | 3.8 |
| Missing | 1 | 0.8 |
| **Geographic location** | | |
| The countryside | 1 | 0.8 |
| A village | 10 | 7.6 |
| City | 118 | 90.1 |
| Missing | 2 | 1.5 |
| **Location** | | |
| Groningen | 29 | 22.1 |
| Friesland | 1 | 0.8 |
| Flevoland | 2 | 1.5 |
| Overijssel | 3 | 2.3 |
| Utrecht | 11 | 8.4 |
| Noord-Holland | 30 | 22.9 |
| Zuid-Holland | 16 | 12.2 |
| Gelderland | 2 | 1.5 |
| Noord-Brabant | 5 | 3.8 |
| Limburg | 28 | 21.4 |
| Missing | 6 | 4.6 |

# LIST OF TABLE AND FIGURES