Contraception and abortion in times of COVID-19: access, policy responses and groups most affected in Argentina, Chile and Uruguay

Abstract

The COVID-19 pandemic is affecting access to family planning services in low- and middle-income countries. In the region of Latin America, the health crisis is undermining progress towards ending the unmet need for contraception by 2030. Here, I identify the factors that have determined access to contraception and abortion in Argentina, Chile and Uruguay during the COVID-19 pandemic. I conducted 23 semi-structured interviews to key informants and stakeholders from the concerned countries. I discuss how pre-existing conditions and policy actions on sexual and reproductive health shape access conditions in the current health emergency context, and identify the population subgroups most at risk. In those areas with solid primary health care systems and cross-cutting policies, fewer access barriers to contraception and abortion services were detected.

1. Introduction

Besides the direct consequences on human health, the coronavirus pandemic (COVID-19) is producing several social, economic and political effects that, either directly or indirectly, impact the demographic dynamics. With regards to human fertility, researchers' attention has been focused on how the COVID-19 pandemic and the lockdown policies, globally implemented, may affect fertility treatments (Anifandis et al., 2020; Requena et al., 2020; Gromsky et al., 2021), fertility intentions (Aassve et al., 2020; Micelli et al., 2020; Stone, 2020) and access to sexual and reproductive health (SRH) services (Guzmán, 2020; UNFPA, 2020). All these aspects have different implications across countries and may shape populations' fertility in the short- and mid-term to a varying extent.

In low- and middle-income countries in particular, the COVID-19 pandemic has proven to be a severe threat to the public healthcare system, by limiting access to outpatient services, including SRH supplies (UNFPA, 2020; Walker et al., 2020). In the region of Latin America and the Caribbean (LA&C), specifically, access to modern contraception is likely to reduce due to disruptions in the supply chain and to a drop in demand for contraceptives in the current emergency context (UNFPA, 2020). Policy decisions in the area of SRH have also affected access to these services, through budget-cutting of family planning programs, relocation of the healthcare staff and suspension of the services that are not directly linked to pandemic care (Fanta & Tumas, 2020; Guzmán, 2020). These factors, combined with long-standing structural barriers, have contributed to losing access to these priority services.

According to the United Nations Population Fund (UNFPA) (2020), the percentage of women with an unmet need for modern contraception in the region could raise, on average, from 11,4% to

17,7% between 2020 and 2021. This figure represents a thirty-year setback in the achievement of the Sustainable Development Goal (SDG) 3.7 (zero unmet need for contraception by 2030).

Assuming the pandemic does not reduce sexual activity significantly, the increase of unmet need for contraception may lead to higher rates of unintended pregnancies (Guzmán, 2020), whose regional average (69 per 1,000) is already above the world average (64 per 1,000)[1] (Bearak et al., 2020). Also, and in line with current legislations—whose orientation is tipically restrictive—, most Latin American and Caribbean countries have treated voluntary abortion as non-priority service. It is likely that this will lead to an increase of unsafe abortion procedures during the pandemic crisis (UNFPA, 2020).

In this paper, I seek to identify the factors that have determined access to contraception and abortion in Argentina, Chile and Uruguay during the COVID-19 pandemic. I discuss how pre-existing conditions and policy responses on this matter may influence accessibility, and identify the population subgroups most at risk. The study was carried out between October and November 2020; therefore, the characterisation presented herein comprises the early stages of the COVID-19 pandemic (March to September 2020), in which vaccination had not been implemented yet and the lockdown measures tended to be rather restrictive worldwide, as well as regionally.

Argentina, Chile and Uruguay are part of the Southern Cone subregion. Each of these countries have some kind of legislation and policy instruments aimed at protecting, to a greater or lesser extent, access to contraceptive methods and to voluntary termination of pregnancy. I carried out a desktop analysis in order to get an initial overview of these services in the countries concerned, including documentary review (legislations, agreements, public programs in the area of SRH, etc.)

[1] Rates of unintended pregnancy represent the number of those events per 1,000 women aged 15–49.

and key actors mapping. Then, semi-structured interviews were conducted with 23 key actors and stakeholders from the government sphere (5), the health system (8), the civil society organisations (CSO) (8) and academia (2). The interviews inquired about the state of contraception and abortion services before and during the COVID-19 crisis, the identified barriers of access since the onset of the pandemic, the groups most affected and governmental responses to the emerging demands in the area of contraception and abortion.

This paper is organised as follows. Section 2 gives an overview of the conditions of access to contraception and voluntary abortion during the pre-pandemic period in the countries involved. Section 3 outlines how the COVID-19 pandemic and the associated lockdown measures affected access to these services in each country. Section 4 describes the actions carried out from the different governments towards ensuring access to contraception and abortion during the health crisis. Based on the information gathered from the key actors and stakeholders, section 5 describes the population groups most at risk of experiencing unintended pregnancies and unsafe abortions due to accessibility barriers. The paper concludes by proposing cross-cutting and specific recommendations aimed at improving access to contraception and abortion in contexts of emergency, such as the COVID-19 pandemic.

2. Access to contraception and voluntary termination of pregnancy in Argentina, Chile and Uruguay in the pre-pandemic

Legislations and other normative tools in the area of SRH pre-existing to the pandemic may condition or facilitate access to contraceptive methods and abortion services in times of crisis, such as the COVID-19 pandemic.

In Argentina, the National Program for Sexual and Reproductive Health provides universal access to SRH services in general. This means that all people and communities should have access, without any discrimination, to comprehensive, timely and quality SRH services, as well as to safe, effective and affordable supplies, while ensuring that the use of these services does not expose users to financial difficulties, specially the most vulnerable groups (PAHO, 2014). The initiative includes an intersectoral management model that operates in coordination with provincial programs. The National Directorate of Sexual and Reproductive Health (DNSSR, in its Spanish acronym) is the entity responsible for its execution and implements the free distribution of modern contraceptive methods through the primary health care centers and hospitals across the country. The basic basket comprises a wide range of methods, including post-coital emergency contraception, contraceptive pills, male condom, long-acting reversible contraception (LARC)—such as subdermal implant and IUD—and misoprostol for voluntary termination of pregnancy.

At the time this study was conducted, access to abortion in Argentina was regulated by the "Protocol for the comprehensive care of persons with the right to legal termination of pregnancy". The Protocol compelled health care providers to guarantee and not to obstruct the right to terminate a pregnancy when the users' physical or mental health was at risk, or when pregnancy resulted from rape. Access to abortion under the health ground did not require the verification of illness,

nor did the act of rape. Since it is a federal country, the application of this and other regulations is subject to the political will of the provincial governments. By October 2020, the protocol had been adopted by 11 out of 23 jurisdictions in the country, suggesting that in more than half of the country's provinces, access to the legal termination of pregnancy was not guaranteed[2].

Among the main strategies pre-existing to the pandemic aimed at ensuring access to contraception and abortion, is the availability of a free and confidential telephone line (0-800 system) that provides individual assessment on SRH. According to the bimonthly report July-August issued by the DNSSR (2020), during the first eight months of 2020, the 0-800 line received nearly 11 thousand calls, of which 4,112 were made between July and August. 2.482 of these calls derived in direct referral to health services: 95% to abortion procedures and 2,7% to contraception services, while the remaining percentage corresponds to obstetric violence and LGTBI+ related complaints.

Chile, on the other hand, has been marked by a long-standing conservative scenario in terms of access to SRH services (Dides & Fernández, 2016). The documentary analysis shows that the few existing norms that regulate SRH services are, in general, fragmentary and do not recognise the priority of these services, nor do they promote the enforceability of the legal rights involved. The main normative instruments on this matter are the National Norms on Fertility Regulation, promulgated in 2006 by means of a supreme decree, and regulated by the National Ministry of Health. These Norms provide mechanisms for protecting the quality of and access to contraceptive services, specially in contexts of emergency. However, they have not been regulated yet. On the other hand, Law 20,418 provides free contraceptive methods to all the health units that comprise

[2] In December 2020, the Argentinean Congress sanctioned the National Law of Voluntary Termination of Pregnancy N° 27,610, which legalises and guarantees free access to induced abortion, as long as the gestation does not exceed the fourteenth week. This law has mandatory application throughout the Argentine territory.

the National Health Services System. Despite this, stakeholders from the CSOs and the health staff interviewed, agree that there is a shortage of supplies that precedes the pandemic.

In reference to abortion, the Chilean legislation allows it when the pregnancy endangers the user's life, in cases of rape and of foetal infeasibility. Members from the CSOs state that, since its sanction in 2017, just over 2,000 treatments have been applied in the public health system, while the bill estimated 3,000 per year.

In Uruguay, access to SRH services is provided through the State Health Services Administration (ASSE, by its acronym in Spanish), an entity that acts as a public health provider within the scope of the National Integrated Health System. ASSE has a wide network of primary health care centers, and serves users who, although being able to access a private coverage system, choose this public health provider, as noticed by members of the SRH Area of the Ministry of Public Health. Modern contraceptive methods are free of charge and include hormonal contraception, intrauterine device (IUD), tubal ligation and subdermal implant, among others. Users are given annual coupons that, by prescription, enable access to any of these methods in pharmacies for a year-period. In addition, since 2019 midwives have autonomous prescription capacity for contraception, thus expanding access to modern methods. According to the information provided by members of the SRH Area of the Ministry, the prevalence of LARC has increased since subdermal implants and the IUD were incorporated as free SRH supplies a year ago.

Access to voluntary termination of pregnancy in Uruguay is ruled by Law No. 18,987, which considers the emergency nature of the service. The law states that users should have access to consultation with a multidisciplinary team within the first 48 hours, after expressing their desire to

terminate the pregnancy in the presence of a health staff member. All health providers are required to cover the cost of this service, by guaranteeing access to misoprostol and ephedrine treatments.

3. Impacts of the COVID-19 pandemic on contraception and abortion services in Argentina, Chile and Uruguay

In Argentina, Chile and Uruguay, the COVID-19 crisis monopolised the health agenda, affecting access to SRH services in different ways and to a different extent. The key informants from the three countries agree that the first barrier of access to contraception and abortion was the constraint in demand for these services due to fear of contagion, specially during the first four to five months of the pandemic. The increasing demand for health personnel derived from the pandemic, also limited the availability of these services. In Argentina and Chile, in particular, the interviewed health professionals highlighted the absence of replacement staff for ensuring access to consultations in the area of SRH. Due to border closures and restrictions on manufacturers' delivery flows, supply chains were also constrained in these two countries, specifically between March and July, when movement and traffic restrictions were more severe (UNFPA, 2020).

According to the information provided by local stakeholders, it is likely that the fear of police controls in times of confinement may have influenced the drop in demand for contraception in the first stages of the pandemic. Argentina maintained a strict circulation control between March and August 2020, implemented through the decree of Social, Preventive and Compulsory Isolation (ASPO, in its Spanish acronym). In Chile, a more flexible regime was applied, with quarantines by communes and circulation restrictions in specific areas and day-times. Uruguay, on the other hand, did not implement compulsory confinement measures between March and September 2020,

although the national government limited public transportation, suspended classes at all educational levels and imposed restrictions to certain economic and public administration activities.

Noteworthy is the fact that the fear of police controls do not affect people in equal terms. Migrants, indigenous, racialized populations, adolescents and low-income sectors are more exposed to them. For this reason, the contraction in demand for contraception reported by the interviewed health professionals from Argentina and Chile may have been influenced by both, the fear of contagion and the intention to avoid security controls.

The COVID-19 crisis led to the reorganisation of the health system, producing negative impacts on abortion and contraception access in the three concerned countries. According to the information provided by members of the DNSSR, in Argentina many primary health centers across the country stopped working between March and April 2020. In Chile, stakeholders from MILES Corporation—a recognised OSC in the area of sexual and reproductive rights in the country—warned about the disruption of the Adolescents' Friendly Health Spaces, which provide orientation and assessment on SRH to adolescents and young people, while ensuring confidentiality and respect for privacy. In Uruguay, the authorities of the SRH Area from the Ministry of Public Health identified that, since most of the health staff members are multi-employed, many of these professionals stopped attending their workplaces when a focus of transmission was detected in another unit where they worked.

Recent evidence on the impact of COVID-19 on access to contraceptives in LA&C based on public procurement conditions of reproductive health supplies and on macroeconomic indicators (UNFPA, 2020), suggest that the three countries included in this study will experience some kind

of decrease in the use of contraception, although it is not possible to determine precisely to what extent this drop will be. Evidence regarding the effects of the pandemic on access to voluntary termination of pregnancy in these countries has not yet been published. It should be noted that in Argentina and Uruguay the International Sexual Health And REproductive Health Survey (I-SHARE) is being conducted. This source will provide relevant empirical data for a better understanding of SRH services during the pandemic (Michielsen et al. al., 2020).

The main barriers of access to contraception and abortion services in Argentina, Chile and Uruguay in times of COVID-19 crisis are outlined below.

3.1. Barriers of access to contraceptive methods

The interviewed authorities from Argentina in the area of SRH at the national and provincial level, noted there was a contraction in demand for short-term contraceptives during the three months after the lockdown announcement on March 20. They also drew attention to the fact that long-acting contraceptive users whose method expired during the first months of the ASPO, or who wanted to start using LARC for the first time, abstained from attending health consultations to place the method, especially in reference to the subdermal implant, which is best accepted among users and health professionals compared to the IUD.

The DNSSR reported that access to contraceptives has not been affected by supply disruptions. Instead, delays in delivery were observed between March and September 2020. In turn, the lower demand for contraceptives during the first months of the pandemic (March-July) led to increased stock, thus alleviating the impact of eventual shortages.

Chile presents a complex scenario with regards to contraceptives access. As stated by local stakeholders and members of the Chilean Medical Chamber, the public health system experienced a shortage in SRH supplies, while the pharmaceutical market increased the prices of contraceptives. In June 2020, MILES Corporation conducted an online survey on Access to Sexual and Reproductive Health in Times of COVID-19 Pandemic, aimed at monitoring access to SRH services and supplies in the current emergency context. The survey—based on a non-probabilistic sample of 533 people, with an average age of 26 years and 94% of female respondents—showed that 45% of the people surveyed (238 persons) could not access some kind of SRH service, of which 74% were contraceptive methods. The main reasons given for the lack of access to contraception were supply shortage in the public sector and economic difficulties in meeting the costs of contraception in the private sector.

In August 2020, the Chilean Institute of Public Health withdrew from the market Anulette CD contraceptives due to blister packaging errors—the pills with active ingredients were replaced by placebos and vice versa—and to the absence of pills. Government authorities informed that, by the time these faults were detected, 276,000 blisters had been distributed, most of them to primary health centers, and at least 5 thousand had been delivered to contraceptive users. By February 2021, MILES Corporation reported that there were 111 confirmed cases of pregnancy as a result of the use of these contraceptives.

In October 2020, two other contraceptives were withdrawn from the market (Minigest-15 and Minigest-20) because they had a lower amount of active ingredients than registered. The interviewed health professionals and CSOs members agree that these events will likely deepen the problems of supply coverage, leading—as it already happened—to unintended pregnancies.

With regards to Uruguay, the different key informants declare that, thanks to the yearly coupon system, it was possible to ensure the continuity of access to contraceptives during the pandemic. However, members from the NGO Women and Health in Uruguay (MYSU, by its Spanish acronym) pointed out that the purchase of supplies made in October 2019—with an expected coverage for one year—had not been renewed yet. According to members of the SRH Area of the Ministry of Public Health, the synchronicity between the moment the current government took office (1 March 2020) and the onset of the COVID-19 pandemic, led to a delay in the bidding process, as the political agenda was entirely taken by the health crisis. Although a new purchase was agreed in September 2020 through UNFPA, supplies would have been available only at the beginning of 2021, which may have generated a contraceptive shortage between November and December 2020.

3.2. Barriers of access to voluntary abortion

A cross-cutting aspect to the three concerned countries, identified by the key informants, is the relevance of pre-existing conditions of access to abortion in determining the level of accessibility to this service and its legal enforceability. The contraction in demand due to fear of contagion and to lockdown policies, the scope of the information provided by health agencies with regards to abortion access, and the official recognition (or not) as priority service, are also factors that determine differential access to voluntary interuptions of pregnancy.

In Chile, the interviewed health professionals and members of the Chilean Medical Association revealed that there is a lack of protocols and supplies (mifepristone and misoprostol) to allow the proper implementation of the legal termination of pregnancy, as well as discontinued patient

registration. According to the information provided by local stakeholders, gender-based violence (including sexual violence) has increased in the context of lockdown policies, suggesting a higher exposure to pregnancy risk. In spite of this claim, current regulations do not address strategies to ensure timely access to abortion for rape and incest victims. Furthermore, the current legislation forbids professionals of the primary health system to give users information for accessing legal termination of pregnancy at the second level of care. Therefore, many health providers do not have proper resources to refer users who request the service.

Argentina, on the other hand, has carried out specific actions since the early stages of the pandemic aimed at mitigating the adverse impacts of the ASPO on access to SRH services. However, the scope of these actions differs widely from one jurisdiction to another, in part due to the federal system of government. Provinces ruled by conservative governments are typically resistant to implementing protocols for the legal termination of pregnancy and guaranteeing the availability of health professionals capable of carrying out this procedure, especially in the North area of the country. Authorities of the DNSSR recognise there is uneven access to abortion in Argentina, and highlight the fact that access inequalities among jurisdictions have exacerbated during the ASPO.

The last report issued by the DNSSR (2020) shows that, at the country level, the 0-800 line received 5,125 calls between March and August 2020, that ended up in abortion. To date, no standardized record system for monitoring access to abortion at the province level has been developed. However, the province of Buenos Aires began implementing its own registration system from the calls received to the 0-800 line, accounting 5,028 consultations between January and June 2020 that were referred to abortion services (Ministry of Health of the Province of Buenos Aires, 2020). Although these data involve different time periods and data collection systems, the high number of consultations recorded in the province of Buenos Aires may suggest that the efforts

of the national government towards improving access to voluntary termination of pregnancy still have limited results in other provinces of the country. Indeed, key informants from local CSOs that carry out follow-ups on abortion procedures, point out that the 0-800 resource is insufficient by itself in those areas with scarce healthcare networks. They also declare that the 0-800 line is not always effective due to the high flow of incoming calls. Considering that many health care providers carry out informal articulations with CSOs in the absence of supplies, it is likely that abortion procedures are underreported.

In Uruguay, SRH services were recognised as priority services during the pandemic crisis and continued to operate normally. Stakeholders from the NGO MYSU declared they had received an increasing number of consultations from people in advanced stages of pregnancy (11-12 weeks) wanting to terminate their pregnancy. The interviewed health professionals and members of the academia agree that, due to the contraction in demand in the first months of the pandemic, some users may have delayed the consultation for voluntary abortion. Also, the increase of gender-based violence and the lockdown conditions impose difficulties to carry out the procedure on an outpatient basis (e.g. when sharing housing with children or other family members).

Complaint mechanisms for health users who wish to report difficulties in accessing voluntary abortion in Uruguay must be done in person at the same unit where the barrier of access was experienced. If users do not receive a satisfactory reply to their complaint, they must appeal to the Ministry of Public Health, also in person. This mechanism is not effective in emergency contexts, such as the COVID-19 crisis, because of the presence requirement and the urgency nature that characterises abortion.

4. Government actions implemented during the COVID-19 pandemic

Government responses aimed at ensuring access to contraception and abortion in the early stages of the public-health crisis, vary from one country to another. The actions deployed by each government have been subject to the extent of the pandemic impact, the normative and programmatic mechanisms pre-existing to the health crisis, and the pandemic dynamic itself. The following sections describe the actions implemented by the concerned countries between March and September 2020 in relation to contraceptives and abortion access.

Argentina

In Argentina, SRH services are priority services. This means that contraceptive supplies and abortion services should be guaranteed in all circumstances, especially in critical situations such as the COVID-19 pandemic. In the onset of the health crisis, the National Ministry of Health issued an official statement addressed to all the health agencies of the country, urging them to organize their healthcare services in order to maintain the continuity of contraception service delivery and information, and abortion procedures. Through this action, the Argentinean government reaffirmed the priority character of these services.

In line with this, post-coital emergency contraception supplies were reinforced, by increasing the distribution and stressing the recommendation to health providers to deliver this method as a preventive strategy for unintended pregnancies.

Coordinated actions between the DNSSR with provincial agencies and CSOs were enhanced, by carrying out regular online meetings, organized by great groups of provinces according to

geographic areas. Noteworthy is the fact that the national director of the DNSSR participates in each of these instances. As stated by key informants, this strategy—with focus on good practices—has contributed to mitigate the resistance that arises from some provincial health systems to implement abortion treatments.

In relation to the 0-800 line, the DNSSR increased and trained members of the service teams, and the line became a direct channel for the resolution of access to SRH services, and abortion in particular.

Coordinated actions between the National Program for Sexual and Reproductive Health and the National Program for Unintended Pregnancy in Adolescence (ENIA, by its Spanish acronym), were also carried out. Among its actions, the ENIA program involves the participation of SRH advisers in schools, who act as mediators between adolescents and health centers. According to the DNSSR, the preexistence of this link favoured the counseling follow-ups, and contributed to reducing the obstacles for the first consultation on SRH in adolescence during the health crisis. In addition, the online implementation of Comprehensive Sexual Education in the educational system was maintained.

Counseling on SRH has been adapted to the teleconsultation model, through telephone calls or online video calls, depending on internet availability. In places like the Autonomous City of Buenos Aires, the local Ministry of Health implements standardised guidelines for the teleconsultation functioning, while in many other jurisdictions of the country it operates as an informal strategy according to the available resources in each healthcare center.

In the province of Buenos Aires, the head of the local SRH department noticed that the increasing use of digital communication in the health system pushed by the lockdown policies, favoured the

frequency and coverage of online training for health providers, incorporating staff members from geographic areas that were previously hard to reach due to access difficulties. Also, a few days before the ASPO was decreed, the provincial Ministry of Health distributed 80 thousand misoprostol tablets, corresponding to six thousand treatments for early pregnancy termination. According to the provincial SRH authorities, the distribution of these supplies in the public health system served to improve the registration of abortion procedures among the health professionals.

Finally, the DNSSR is currently promoting a law for delegating tasks in midwives, that would authorize them to prescribe contraceptives and place LARC to health users. If approved, this measure will contribute to expand SRH coverage and promote access to the IUD in particular.

Chile

According to the information provided by key informants from the CSOs and the Chilean Medical Association, only few actions have been implemented by the government so far aimed at guaranteeing access to contraception and legal termination of pregnancy during the health crisis. Combined with the preexisting access barriers, this has led to a critical scenario in terms of accessibility and coverage of SRH services.

Furthermore, the Ministry of Women and Gender Equity—a crucial entity in SRH matters—remained headless for approximately two months after the pandemic onset, and experienced several leader changes in the following months.

After the blister packaging errors in contraceptives were detected, no official follow-up actions were carried out for preventing affected users from unintended pregnancies. Instead, health

professionals developed informal follow-up strategies aimed at informing users about the manufacturing faults.

The survey on Access to Sexual and Reproductive Health in Times of COVID-19 Pandemic conducted by MILES Corporation had a strong media impact. After the dissemination of the results, a draft agreement was issued by the Ministry of Health, by which the entity commits itself to guarantee access to family planning services in times of public emergency. However, this document has not been regulated nor implemented yet.

Uruguay

Since Uruguay has not been affected so far by the collapse of the public health system, nor by lockdown measures, only few additional actions were implemented during the pandemic aimed at keeping accessibility to contraception and abortion services.

Regarding the provision of modern contraception, the Ministry of Public Health decreed an ordinance that compels health institutions and professionals to automatically renew contraceptive prescriptions expiring during the pandemic crisis. This procedure works as follows: health providers access users' medical history by means of a centralised digital storage. Before the current prescription expires, they call users and send them a new online prescription for a one-year-period.

In addition, a law on telemedicine was implemented. However, the deadline for its regulation has completed and it has not been implemented yet. In line with this, the first stages for accessing abortion (i.e. the interview with a multidisciplinary team and the prescription of Misoprostol) are being carried out online.

Uruguay has a long tradition in integrating health and social policies, throughout interventions focused on specific population groups that articulate with the health sector. Especially in the context of the health crisis, this policy management has contributed to removing access barriers to SRH services. Likewise, academia has historically had a strong influence on policy-making, mainly through the University of the Republic, thus strengthening the response capacity of public entities to the demand for services. This convergence, together with the implementation of a comprehensive framework that addresses the promotion of primary health care (the National Integrated Health System), has allowed to reduce many of the access barriers to SRH services experienced by other countries.

5. Population subgroups most at risk

There is broad agreement among key informants and stakeholders that access barriers to modern contraceptives and abortion may delve into increasing levels of unintended pregnancy, thus threatening the goal achievement of ending unmet need for family planning by 2030 (UNFPA, 2020). Also, restrictive normative frameworks and policy resistances that still prevail in some countries and smaller jurisdictions with regards to voluntary abortion, as well as the limitations of access to this health service may derive into unsafe procedures of pregnancy termination and increasing rates of maternal mortality.

The impacts of this unprecedented health crisis have not been homogeneous across countries nor within them. Due to certain sociodemographic characteristics and living conditions, some population subgroups have been more affected by the identified barriers of access to contraception and abortion during the COVID-19 pandemic. Usually, the social determinants that condition

access to SRH services overlap, thus deepening social vulnerability and exposure to unintended pregnancy risks. For example, the confluence of being adolescent, woman and migrant from low-income groups, determines an exacerbation of the social disadvantages (Bauer, 2014).

When assessing the COVID-19 impact on contraception and abortion accessibility, we should be aware that there are structural and systemic inequalities (preexisting to the pandemic) that determine the level of vulnerability (Lokot & Avakyan, 2020). Also, the available protection mechanisms for these groups and policy measures addressed to remove access barriers in each country, shape the level of risk exposure.

In Chile, Argentina and Uruguay the following groups were identified as most at risk by the key informants and stakeholders:

- *Adolescents*, as many of them become sexually active in this stage of life. They are exposed to greater vigilance of caregivers, economic barriers for buying contraception and abortion supplies, displacement limitations due to adults dependence, reduced first contact with the SRH system, less adherence to the health system and greater exposure to sexual abuse, increased in the context of lockdown policies. Typically, adolescents attend health centers in advanced pregnancy stages, imposing additional obstacles to carry out abortion procedures, due to the "*moralizing look of the health teams for having initiated sexual activity early*" (P., Health professional from Argentina).
- *Women* in general, and especially those who—in the event of an unintended pregnancy—decide to either terminate or continue the pregnancy, due to the complexity of both situations in the current health crisis.
- *LGTBIQA community* (lesbian, gay, transgender, bisexual, intersex, queer & asexual). Key

informants from both the health sector and CSOs, highlight the deep level of vulnerability that affects this group, as they have been systematically invisible to the health system. In Chile, local stakeholders from NGOs addressed to members of the LGTBIQA community, declared that during the first six months of the pandemic they were not able to distribute male condoms due to shortages.

- *Rural and peri-urban population*. As reported by key actors from the health sector and CSOs in Chile and Argentina, the demand for SRH services in general decreased due to fear of contagion. In rural and peri-urban areas, the drop in demand was also affected by disruptions in the visit service provided by health professionals.
- *Sectors with low educational and low-income levels, informal workers, unemployed and / people from socio-segregated areas*, due to limited economic resources and lower access to information and internet devices to access online consultation.
- *Migrants in general, and those racialized in particular*. As stated by key actors from the health, academic, and CSO areas, this group has been particularly affected in Chile, since migrants in an irregular situation are allowed to access SRH facilities only for pregnancy care, birth and health emergencies. Primary health centers, as well as health units from the second level of attention, continue to request identity documents to migrants, thus limiting accessibility. In addition, MYSU warns that in Uruguay, access to voluntary abortion is guaranteed only to migrants who have accomplished one year of legal residence.
- *Prison population*. As declared by the members of the DNSSR, in Argentina there are no infrastructure conditions to practice abortion procedures. During the health crisis, transferring the prison population to health centers is virtually impossible, due not only to the increasing demand of the health system, but because this population subgroup tends to

be socially overlooked.

- *Girls with childbearing capacity*. Key informants from the governmental area and CSOs emphasise that there is a greater risk of incest and rape for those who are confined with sexual abusers.
- People with reduced mobility, due to greater difficulties in accessing face-to-face care.

In Chile, along with the above cited groups, the following population subgroups were also identified:

- *Girls within the protection network of the National Service for Minors*, as they present greater difficulties in accessing contraception and abortion, especially due to the restrictive norms that regulate this service. In addition, preferential attention of SRH for this group has not been fulfilled.
- *Mapuche population*: due to the social and racial discrimination suffered by this native group and to intercultural barriers of access to SRH.

6. Good practices for action in the SRH arena

Based on the information collected in this study, I propose a series of recommendations and good practices, considering the opinions and statements made by the key informants and stakeholders. These recommendations may contribute to improving the response capacity to new outbreaks or future health crises.

General recommendation on SRH services

- Increase the budget for SRH services in general, and for contraception and abortion services in particular. This will ensure supply availability and expanded coverage, and will contribute to improve the registration system, through greater control capacity.
- Reaffirm the nature of SRH services as priority services within a regulatory framework, in order to protect accessibility in emergency contexts, such as the COVID-19 pandemic.
- Put in prospective value the benefits of SRH services, by making visible the advantages of improving access to these services and by institutionalizing available resources through protocols, guidelines, training and other standardised instruments and tools.
- Incorporate and deepen the gender approach in policy actions in order to improve access to contraception and abortion.
- Implement regulations of existing laws, decrees and norms on SRH, and train the public health staff on its application.
- Enhance policy actions addressed to adolescents and youth, with a view to empowering them in the exercise of their sexual and reproductive rights.
- Implement effective policies for the equal distribution of SRH supplies, and strengthen the information channels with the aim of reaching the entire population.
- Implement intersectoral and intersectional committees on SRH to generate comprehensive and timely responses, and develop actions towards building a virtuous dialogue between knowledge, public policies and society, in order to gain incidence capacity.
- Apply and enhance comprehensive sexual education.
- Strengthen strategies to prevent and address gender violence in general and sexual violence in particular.

- Promote the update of the discussion on the health services scheme. Populations are diverse (in ages, ways of accessing knowledge, and coping with sensitive issues, etc); therefore, health services and facilities must be adapted to the emerging needs of the population.

- Design strategies with a community approach addressed to rural and indigenous communities, including the implementation of radio stations for the dissemination of information on SRH services.

Contraception services

- Develop multiple and diverse access routes to contraception (home delivery, mobile clinics, pharmacies, among others).
- Continue to promote the implementation of LARC, removing the barriers that persist around IUD use.
- Dismantle access barriers to tubal ligation practices in women who require it.
- Implement and strengthen the obstetric post-event contraception service in all levels of care.
- Implement spontaneous demand for contraception. Extending the prescription of contraceptive pills for at least 6 months to 1 year, even in a non-crisis context, has proven to be a good practice in the experience of Uruguay.
- Consider the contraception prevalence dynamics when stock purchases are made. As a contraceptive method becomes popular and gains acceptance, it is necessary to guarantee its availability (for example, the female condom in Uruguay).

- Implement standardised online counseling and mobile clinics, as means to reach populations that would not otherwise have access to these services.

Abortion

- Improve the dissemination of information on access to voluntary interruption of pregnancy in different contexts, in order to prevent unsafe abortions.
- Promote protected and friendly spaces for carrying out abortion procedures within health spaces.
- Improve the quality of the abortion device, care and working conditions for health teams that carry out pregnancy termination procedures.
- Improve the referral system with the second level of care, especially in relation to second trimester referrals, given the higher complexity they entail.
- Incorporate the use and guarantee the availability of Mifepristone in voluntary termination of pregnancy services, since it is faster, more efficient and safer.
- Implement analgesia in all abortion procedures.
- Develop actions for addressing the multiple aspects involved after the interventions, such as gender violence, housing insecurity and care needs, among others.

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