ENSURE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS – EVEN IN TIMES OF CRISIS:

REPORT ON ACCESS TO CONTRACEPTION IN EUROPE DURING THE COVID-19 PANDEMIC

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CONTENTS

ABOUT EPF

The European Parliamentary Forum for Sexual and Reproductive Rights is a network of Members of Parliament throughout Europe who are committed to protecting the sexual and reproductive rights (SRHR) of the world's most vulnerable people, both at home and overseas.

In advocating for these human rights, EPF undertakes joint ventures with parliamentarians and parliamentary fora from national/sub-national and regional/sub-regional parliaments to build capacities for increased political, financing and accountability commitments for access to contraception, comprehensive sexuality education, and gender equality among many others issues.

We believe that women should always have the right to decide upon the number of children they wish to have and should never be denied the education or other means to achieve what they are entitled to by law. We believe that it makes sense personally, economically, and environmentally for governments to stay committed to and fund protection of people's sexual and reproductive health and rights. EPF's Secretariat is based in Brussels, Belgium. For more information, please visit **www.epfweb.org**

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Country	Name of partner organisation / persons
Albania	Albanian centre for population and development (ACPD)
Armenia	Women of Armenia
Austria	Austrian Family Planning Association (OGF)
Belarus	UNFPA Country office
Belgium	Sensoa International
Cyprus	Cyprus Family Plannung Association
Czechia	Glopolis
Denmark	Danish Family Planning Association Sex & Samfund
Finland	Väestöliitto
Georgia	UNFPA Country office
Germany	Profamilia
Ireland	Irish Family Planning Association (IFPA)
Italy	AIDOS – Associazione Italiana Donne per lo Sviluppo (Italian Association for Women in Development)
Kosovo	UNFPA Country office
Latvia	Latvian Association of Family Planning and Sexual Health "Papardes Zieds"
Lithuania	Family Planning and Sexual Health Association
Luxembourg	Planning Familial
Moldova	UNFPA Country office
North Macedonia	Health Education and Reasearch Association (HERA)
Norway	Sex og Politikk
Poland	Federa – The Federation for Women and Family Planning
Portugal	P&D Factor - Associação para a Cooperação sobre População e Desenvolvimento
Romania	Filia Center
Slovakia	Centre for Reproductive Rights
Sweden	RFSU (Riksförbundet för sexuell upplysning)
Switzerland	SANTE SEXUELLE Suisse
The Netherlands	Rutgers & Aidsfonds
Ukraine	UNFPA Country office
UN	UNFPA – United Nations Population Fund
United Kingdom	SRH APPG – All Party Parliamentary Group on Sexual and Reproductive Rights UK Parliament
International	· European Institute for Gender Equality · I-SHARE (International Sexual Health and Reproductive Health) Survey network: Joseph D. Tucker, Elin Larsson, Pedro Nobre, Inês Tavares and Kristien Michielsen · World Health Organisation

GLOSSARY OF TERMS

COVID-19	Coronavirus disease 2019
GDPR	General Data Protection Regulations
IPPF	International Planned Parenthood Federation
LARC	Long-acting reversible contraception
LGBTQI	Lesbian Gay Bisexual Transgender Queer and Intersex
SRHR	Sexual and Reproductive Health and Rights
UNFPA	United Nations Population Fund
WHO	the World Health Organisation

EXECUTIVE SUMMARY

Access to modern methods of contraception is critical for women to make and act on decisions regarding their bodies, health, and childbearing preferences. As a pillar in sexual and reproductive health and rights it is integral to gender equality and human rights. Because of its use in preventing unintended pregnancies and promoting the health of women, children, families and communities, it is also intimately tied to global sustainable development. Long-acting reversible contraception is one of the effective and convenient methods available due to its durability and lack of need for additional action on behalf of the user. Users are, however, dependent on in-person consultations with a trained medical provider to access to such methods. In general, contraception is susceptible to interruptions in global and local flows of production and distribution, as well in service provision and availability of commodities.

To mitigate the COVID-19 pandemic, most of the countries in Europe implemented strict social distancing measures, effectively shutting down most of society for a longer period. As a result, most sectors suffered great disruptions, including health care delivery, and economic activity almost came to a halt. As vaccinations are rolling out, most countries have eased restrictions. However, 18 months after COVID-19 was declared a pandemic, governments are still trying to manage both the disease as well as the socioeconomic, political, and non-COVID-19 health-related consequences that containment strategies brought on their populations.

The aim of this report is to understand how restrictions on movement - such as countrywide lockdowns - and temporal reorganisation of health care systems that countries in Europe implemented to manage the COVID-19 pandemic impacted women's access to contraception, long-acting reversible contraceptives (LARCs).

This report bases itself on a desk review of available literature and media reports and complemented by a survey among partner organisations in 46 European countries to which 30 were able to respond. Key multilateral and non-governmental organisations were also consulted. The research was carried out between June and September 2021. In total, partners from 13 countries shared official studies. Partners from 14 countries shared information via the survey. Meetings were held with contacts in Ireland, Portugal and Romania.

Organisations were asked to share information about the following points:

1. How access to contraception had been impacted by the COVID-19 related restrictions including both barriers and enabling factors to ensure continued access.
2. How impact had varied by different groups in society
3. The contraceptives that were most difficult to access
4. If and how access changed between the first and second lock-down.

Reports and articles were translated when necessary and collated into this report which gives an overview of the situation in Europe based on information available as of September 13, 2021. Most of the reports that were shared were from earlier stages in the pandemic and had been published 2020. Many partners had not yet developed reports, nor were aware of any reports by public agencies or ministries. While some indicated that reports were underway and shared preliminary findings, others shared key insights from their activities informally through the survey, indicating that an overview like this report may be one of the first to be produced.

The main finding of this report is that there is great variation and inconsistency in how access to contraception is monitored around Europe. Thus far, no country in Europe has comprehensively and systematically monitored access to modern methods of contraception, including choice of method, even in times of crisis.

Five main barriers to accessing contraception in Europe during COVID-19

1. **Users' fear of COVID-19**, respect for restrictions in place and aversion to becoming an extra burden on health care system.
2. **Clinics and opening hours:** reduction in opening hours or full closure of them
3. **Lack of clear communication** about the reorganisation of sexual and reproductive health services so users would know here to turn to when ordinary services had been disrupted
4. **Stock-outs in pharmacies**
5. **Financial barriers** including loss of income and increase in prices of contraception

Five main enabling factors

1. **The use of telemedicine** to provide contraceptive care over the phone, sms, social media channels, applications on smart phones and other online, digital means.
2. **Making the provision of contraception more flexible**, through mailing prescriptions in the post or directly to the pharmacy
3. **Outreach campaigns** with information in different languages
4. **Change in routines** to ensure access to LARCs (e.g. post-partum women)
5. **Extra funds** to ensure access to particularly marginalised groups

The restrictions enforced as part of the strategy to manage the COVID-19 pandemic exposed pre-existing gaps in health care and social protection systems, often aggravating the situation the most for already marginalised people. Socio-economically disadvantaged women, adolescents and young people, women with a disability, women from underserved communities like Roma and undocumented migrants and refugees were some of the most reported on in terms of accessing contraception and quality care. There was very little data on access to contraception by women who wanted to start using contraception, women living with HIV, sex workers and LGBTQI people.

While data is patchy and uneven, there are indications that long-acting reversible contraception was particularly affected by the restrictions due in part to the need to see a medical professional for fitting, replacement, or removal of such methods.

In short, the available data echoes the results from the European Contraception Policy Atlas. Countries that prioritise sexual and reproductive health and rights are also more proactive in monitoring access to contraception than countries that lack such priorities, also in times of crisis. Given the fact that this issue was not monitored systematically in all countries in Europe, what has come out of this research is illustrative of what may be happening in other countries that did not monitor this issue. Ultimately, women in Europe are still limited in using contraceptive methods of their choice, effectively impacting their sexual and reproductive health and rights, their quality of life and ability to make and carry out decisions about their health and bodies with dignity, autonomy, and integrity.

Recommendations

1. Guarantee access to contraception and choice of contraceptive method through national health care plans and budgets.
2. Ensure that access to modern methods of contraception is defined as essential health care service to be delivered, and reimbursed, even in times of crisis.
3. Include the availability of health care professionals in policies for essential health service delivery, and ensure they are not transferred them to crisis/disaster/pandemic-related care.
4. Strengthen primary health care organisation and funding and integrate contraceptive care in such services.
5. Identify and track gaps to universal access to contraception and choice of method through systematic and comprehensive monitoring and evaluation, including underserved groups.
6. Ensure adolescents and young people have access to contraception and a method of their choice.
7. Continue to provide sexual and reproductive health care, including contraceptive counselling, via telemedicine and improve the digital tools already in place.
8. Recognise that communication and information are central components of the health care system and adapt communication to make information accessible to all target audiences.
9. Build on the lessons learned from the COVID-19 pandemic to develop and integrate innovative solutions to sustain and expand access to contraception and choice of method..
10. Encourage patients, clients, and users to continue to seek sexual and reproductive health care should they need it, even in times of a pandemic.

INTRODUCTION AND AIM

Women's ability to make, and carry out decisions about their bodies, including childbearing preferences, is crucial for their own health and quality of life, as well as for the health and lives of their children, families, and societies at large [1]. Sexual and reproductive health and rights (SRHR) are fundamental pillars of gender equality, integral to human rights and sustainable development for all [2], [3], (Box 1). When these rights are not ensured for example through disruptions to health care services, such as access to contraception, women face severe consequences to their health and wellbeing. These may include unwanted pregnancies and sexually transmitted infections, which can negatively impact women's socioemotional, mental as well as physical health [4]. Access to contraception – and contraceptive choice – is essential to respect the sexual and reproductive health and rights of women, and adolescent girls, and must be guaranteed even in times of crisis.

BOX 1. Definition of Sexual and Reproductive Health and Rights [1]
Sexual and Reproductive Health and Rights entail a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right

Contraception is recognised as preventive and essential health care because of its use in averting unwanted pregnancies and unsafe abortions. In addition, it can be an effective method to manage menstrual complications, such as heavy bleeding and cramps [5], [6]. The most effective methods are long-acting reversible contraceptives (LARCs), such as the implant and intrauterine device (IUD), which enable women to use contraception for years with minimal interference only to return to her usual fertility levels once the device is removed (Box 2). While LARCs are convenient and have many benefits, they require fitting, removal, and replacement by a certified health provider. As such, LARCs are contingent on health care service provision, such as availability of clinics and properly trained staff [7],[8]. Access to contraception at large is furthermore dependent on research, technology, production, trade, and distribution flows, as well as the funding and organisation of health care systems. This makes women's sexual and reproductive health and rights vulnerable to change in policies, interruptions in production and distribution lines as well as interference with knowledge sharing channels and platforms.

Globally, the COVID-19 pandemic and the way that societies responded to it have led to extensive disruptions in nearly all sectors and services and severely impacted the lives of most people. Not only did the pandemic directly impact communities through causing death and illness to millions, but it also had critical indirect effects on societies as governments implemented strict measures to manage the crisis [9], [10], [11]. In Europe, COVID-19 initially hit Italy very hard, but other countries soon followed. Most of them implemented severe restrictions on movement to enforce social distancing measures put in place to prevent transmission of the virus and overwhelming the health care system. While strategies varied to some degree in their roll-out across Europe, most countries carried out two nationally

mandated lockdowns between March 2020 and July 2021, effectively shutting down most of society, including schools, for weeks or even months, except for essential security, protection and select health care services **[12]**,**[13]**. As a result, economic activity came to a halt and people lost their jobs and incomes while rents and prices increased, and social protection turned out to be insufficient **[10]**, **[14]**. Underserved communities and people living just above subsistence levels, such as single-parent households and undocumented migrants, were further pushed away from resources. Those who had previously managed on their own, for example people employed on fixed-term contracts, now saw a reduction in economic stability and a rise in socioeconomic vulnerability **[14]**. A year and half since the World Health Organisation (WHO) declared COVID-19 a pandemic in March of 2020, and almost nine months after the first roll-out of the vaccines, governments are still trying to manage both the disease itself as well as the socioeconomic, political, and non-COVID-19 health-related consequences that containment strategies brought on people around the world.

Sexual and reproductive health including the provision of contraceptive methods and counselling also suffered disruptions to services **[15]**. According to global estimates, even lockdowns that lasted an average of 3.6 months may have impeded access to modern contraception for some 4 – 23 million women, possibly causing between 500,000 to almost 3 million unintended pregnancies **[16]**. Shutdowns of countries that host many of the producers of contraceptive commodities also raised concerns regarding the continuation of production, transportation, and distribution of such methods. Globally, the results so far appear to have been less detrimental than initial predictions and emerging evidence seem to point to the strength of health care systems **[16]**. However, data is still missing or inconsistent even in Europe. There is a need to understand both the factors that made health care systems resilient enough to sustain care, and the long-term impact of the disruptions which may still impede service delivery today as countries ease restrictions.

BOX 2. LARCs - Long-Acting Reversible Contraceptives [7]

Long-acting reversible contraceptives are methods that safely and effectively prevent pregnancy for up to many years, but that are not permanent. Intrauterine devices (IUDs) and contraceptive implants are examples of LARCs.

LARCs have many benefits. They are convenient to use as they do not require additional actions on behalf of the user to ensure adherence or to be used in an accurate way - whether daily as the pill or when having sexual intercourse such as the condom - to prevent pregnancy. They are also cost effective as they do not need to be continuously refilled. Almost anyone can use LARCs, including women who have never been pregnant, who have given birth, or who have had an abortion. While LARCs do not prevent sexually transmitted diseases, they are the most effective method to prevent pregnancy and once removed, there is a rapid return to regular fertility levels.

LARCs do however necessitate fitting and removal by a certified medical professional. Prior to using LARC, women may have to undergo a health assessment. Regardless of whether a health assessment is needed or not, starting, removing, or replacing a LARC require face-to-face interaction with a trained health provider.

Aim

The aim of this report is to understand how women's access to contraception, primarily long-acting reversible contraceptive methods (LARCs), has been impacted by the restrictions put in place by governments around Europe in efforts to stem the spread of the COVID-19 pandemic. This report does, however, not focus on access to safe abortion and other sexual and reproductive health care services.

METHODOLOGY

The report is based on a desk review of available literature and media reports, which was then complemented by a survey among partners in 46 European countries to which 30 were able to respond. In addition, we also reached out to key multilateral and non-governmental organisations such as the World Health Organisation Europe, UNFPA, Medicines du Monde, European Institute for Gender Equality and European Institute of Women's Health. The Eurostat database, the Lancet COVID-19 Resource Centre and I-SHARE (International Sexual Health And Reproductive Health) Survey were also consulted. The research was carried out between June and September 2021.

In total, partners from 13 countries shared official studies (Table 1). Partners from 14 countries shared information via the survey (Table 1). Meetings were held with contacts in Ireland, Portugal and Romania. Studies are underway in additional eight countries (Table 1).

Organisations were asked to share information about the following points:

1. How access to contraception had been impacted by the restrictions to manage the COVID-19 pandemic, including both barriers and enabling factors to ensure access to contraception.
2. How impact had varied by group, such as age, socioeconomic status, gender identity, sexual orientation, ethnicity, rural or urban residency, homelessness, level of ability (disability), legal status in the country and other relevant sociodemographic factors.
3. The contraceptives that were most difficult to access
4. If and how access changed between the first and second lock-down.

Reports and articles were translated when necessary and collated into this report which gives an overview of the situation in Europe based on information available as of September 13, 2021.

Table 1: List of countries that participated in the research

Reports by national organisations	Reports by international organisations	Responded to survey	Reports underway	No research
1. Armenia	10. Albania*	13. Austria	27. Bosnia and Herzegovina	33. Andorra
2. Latvia	11. Belarus	14. Belgium	28. Bulgaria	34. Azerbaijan
3. Luxembourg	12. Georgia	15. Czechia	29. Germany	35. Croatia
4. Netherlands		16. Cyprus	30. Kosovo	36. Estonia
5. Poland		17. Denmark	31. Moldava***	37. France
6. Romania^		18. Finland	32. Sovakia	38. Greece
7. Sweden^^		19. Ireland		39. Hungary
8. Switzerland		20. Italy		40. Iceland
9. UK		21. Lithuania		41. Malta
		22. North Macedonia**		42. Montenegro
		23. Portugal^		43. Norway
		24. Serbia		44. Russia
		25. Spain		45. Slovenia
		26. Ukraine		46. Turkey

^ Meetings were held with representatives from partner organisations in these countries.

^^ The report from Sweden only represents data from the sub-region of Stockholm and does not reflect national data.

* IPPF released a report on access to contraception in 2020 which mostly looked at access before the Covid-19 pandemic outbreak but includes a few initial observations regarding how access changed once the country implemented its containment strategies [17]. IPPF EN is currently preparing reports for Albania, Bosnia and Herzegovina, Bulgaria, North Macedonia and Kosovo that will have a more in-depth focus on access to SRHR during the Covid-19 pandemic [18].

** IPPF EN is currently preparing reports for Albania, Bosnia and Herzegovina, Bulgaria, North Macedonia, and Kosovo that will have a more in-depth focus on access to SRHR during the Covid-19 pandemic [18].

*** United Nations Human Rights Office of the High Commissioner released a report on the impact of COVID-19 on human rights in the Republic of Moldova in 2021. Reports focusing on access to sexual and reproductive health care during COVID-19 are currently being developed by partnerships between state and non-state actors together with the WHO and UNFPA [19].

Limitations

While we were able to produce a report in a short amount of time, and during the months of summer vacation in Europe, it became clear that data is limited. Most of the reports that were shared were from earlier stages in the pandemic and had been published 2020. Many partners had not yet developed reports, nor were aware of any reports by public agencies or ministries. While some indicated that reports were underway and shared preliminary findings, others shared key insights from their activities informally through the survey, indicating that an overview like this report may be one of the first to be produced.

RESULTS

The main finding of this study is that monitoring of access to contraception is incomplete, inconsistent, and uneven across countries in Europe. The COVID-19 pandemic including how governments have responded to it, has been an evolving crisis, making tracking and monitoring of its impact on sexual and reproductive health and rights challenging. Continuous changes to procedures, routines, funding and communication have led to shifts in behaviour, expectations and experiences of the patients and users of contraception. However, 18 months into the pandemic, far from all countries have monitored, mapped, or reported how women's access to contraception has been impacted by the measures that governments took to contain and mitigate the COVID-19 pandemic.

Several partners stated that there was no official reporting from public agencies, ministries, or the government (Austria **[20]**, Cyprus **[21]**, Finland **[22]**, Serbia **[23]**, Ukraine **[24]**). Available reports have been published by civil society organisations, researchers, and scientists as well as international multilateral organisations. Most of the documents were produced in 2020 and did not account for how the healthcare system responded to and resolved challenges that may have caused barriers in the first wave of the pandemic. Many reports focused on sexual and reproductive health at large and while most of them did discuss key barriers and enabling factors, far from all monitored the same factors. For example, there was little information on access to LARCs. Some reports focused on specific groups, such as young people (the Netherlands **[25]** and Belarus **[26]**). However, no partner was able to relay complete picture of how women's access to contraception had been impacted by the COVID-19 pandemic as per the questions in this study. This may be an indication of the extent to which civil society organisations and public agencies were caught off guard by the crisis.

As a result, this report presents a picture of the situation in Europe, based on information available to date. It discusses structural barriers, enabling factors, the impact on different groups and access to LARCs. In addition, it reflects the knowledge gaps that have surfaced because of this review. These indicate the steps necessary to take if countries are to live up to national, regional, and international commitments of respecting human rights for all and leaving no one behind, even in a time of crisis.

Barriers

During the COVID-19 pandemic, there have been a range of barriers to accessing contraception and ensuring contraceptive choice. There have been barriers on both the demand and supply side, financial barriers have also been reported as well as pre-existing systemic flaws that have further exacerbated challenges to accessing contraception in a public health emergency. Restrictions are thought to have indirectly affected the use of LARCs because they require interactions with medical professionals; interactions that social distancing measures and recommendations sought to minimise **[27]**. Because the barriers are interlinked and interdependent, delineating the effect of one over another is difficult and may not prove useful. Rather, it demonstrates how structural they are in their execution and in their impact, highlighting the need to take a systems' approach to understanding and addressing access to sexual and reproductive health and rights, including contraception, especially in times of crisis. The main barriers that were identified are discussed below.

Barriers due to social distancing measures and restrictions on movement. COVID-19 and associated social distancing measures had an impact on the demand side of accessing contraception. For example, women refrained from visiting clinics which was one of the most documented issues in most countries. Women avoided making appointments and visiting clinics due to a fear of either contracting COVID-19 oneself or transmitting it to a person in the home - fears that may have been held by the woman herself or by those living in her household. Wanting to avoid queues, adhering to restrictions on movement and concerns about becoming a burden on the health care system were other reasons for women not visiting service providers, including pharmacies **[25]**, **[28]**, **[27]**, **[14]**, **[29]**.

Barriers due to the reorganisation of health care services to prioritise COVID-19 related care. To manage the overwhelming number of COVID-19 patients and prevent new infections, many health systems redirected their resources, primarily staff but also facilities and funds, away from regular services to address the urgent COVID-19 related needs. Often, staff were sourced from service points that provided sexual and reproductive health care, including contraception prescription and counselling, such as primary health care and family doctors in the UK, but also hospitals in Serbia, where even gynaecologists were redirected to work with COVID-19 patients **[23]**. In Austria, some gynaecological offices were kept closed or did not accept new clients during lockdowns in 2020 **[20]**. Walk-in clinics closed in the UK, and Sweden **[27]**, **[30]**. This affected the groups, such as young people, who usually prefer these services due to their anonymity and flexibility.

Facilities that remained open were understaffed and almost all documents reviewed reported disruptions to opening hours and availability of face-to-face counselling and prescription. Limitations on service provision may risk increasing the stress on the staff who do remain on duty, as demands may not decrease to an equivalent level and when resources are strained contraceptives may not be considered a priority **[27]**. Official guidelines to help prioritise the use of reduced resources recommended service providers to postpone fittings, removals and replacements of LARCs, further limiting access **[27]**.

Spotlight on Communication

When clinics closed down, or moved and when services were reorganised, these changes were not always communicated clearly. In Latvia, much of the information on sexual and reproductive health care during COVID-19 was considered uncoordinated and even contradictory **[31]**.

Women in the UK and Latvia for example, were not aware of where to go when their regular clinics closed or decreased their opening hours **[27]**,**[31]**. Among underserved groups, there was confusion about which services were actually open and where, how, and when to access them. In addition to the lack of communication about the reorganisation of services, there was also new information related to the use of contraceptives. Prior to the pandemic, health assessments, such as checking blood pressure and the Body Mass Index (BMI), were required to get prescriptions for the combined hormonal contraceptive pill for instance **[32]**. Women who were using IUDs and implants were told to respect recommended end-dates, ensuring removal and replacements of these devices in time. These recommendations now changed as health care providers were informed through new guidelines that such services could wait. This caused some confusion and even anxiety about the products,

possible side-effects, and other possible negative outcomes [32]. In Georgia, new users of contraception turned to pharmacies or "peer experience" when there was a lack of information on where to access contraception [33]. Unclear, confusing, and contradictory communication around contraception and sexual and reproductive health care in general, risks undermining the patients' confidence and trust in the health care sector and its ability to provide accurate information and quality care, which may in the long-term lead to a decline in the use of modern methods as clients turn to other ways of preventing pregnancy.

Financial barriers were reported by many, including organisations in Georgia, Serbia, and Switzerland - countries which lack comprehensive coverage for contraceptives and where users often have to pay out of pocket to access them [34]. In Switzerland, these barriers primarily affected young people and migrant women [35]. In Georgia, prices on birth control increased and it became harder for those who were already socioeconomically disadvantaged to access contraception, including women who lived in rural areas that lacked larger pharmacies and where smaller, more local and private pharmacies were not able to stock them [33]. In Serbia, contraceptives became even less affordable when many women suffered the loss of wages and a worsening household economy, as a result of the devastating impact that lockdowns had on income generating activities [23]. When households face a more financially strained situation, it may be even more important to delay childbearing, making contraception an especially urgent service to ensure universal access to.

Barriers due to disruptions in production and distribution of contraceptives. This barrier also impeded access in different parts of Europe. In the UK, there is anecdotal evidence that there have been "temporary delays to deliveries" [27]. In Belarus, stock-outs in pharmacies seemed to be the main problem, which was a much larger issue in rural areas, compared to urban centres [26]. This may be related to the financial barriers discussed above. In Albania, shortages were reported as a result of delays in transporting contraceptives around the country [17]. According to reports from Georgia, there was a dramatic reduction in supply of primarily IUDs, as compared to both condoms and contraceptive pills (the latter which interestingly increased in supply, although sales were down) [33].

Barriers due to pre-existing policy and funding gaps of sexual and reproductive health care. One of the main outcomes of the COVID-19 pandemic has been the vast realisation of the extent to which the pre-existing gaps in systems for health care and social protection impacts everyone in a society, even those that may be more economically secure. Below are some issues that have been observed in this study.

Routines and regulations are not optimised. While policies and guidelines may be available, these are not necessarily implemented and integrated into routine care. For example, in Latvia, despite the government's recent plan to improve maternal and child health (2018–2020) and empower socially disadvantaged women, full access to the most preferred state-funded method has not been ensured [31]. In Georgia, contraceptive counselling for women who have just given birth is not routine [33].

Full access to contraception is guaranteed by national health insurance schemes. The lack in coverage undermines women's rights to autonomously make and act on decisions about their bodies and health with dignity and integrity. It reinforces existing inequalities as socioeconomically disadvantaged users must pay for contraception out of pocket, further obstructing access to contraception. Women who

are at risk of social exclusion, disadvantaged or undocumented, are some of the most marginalised in Switzerland where contraception is not covered by the national health plans **[35]**. In Serbia, sexual and reproductive health care services are not considered an essential service despite recommendations from the WHO and only one pill is free of charge, while completely covered by the health insurance it requires a prescription **[23]**. In addition, inconsistent coverage can be compounded by other social barriers. For example, in Georgia, the high unmet need for contraception and the low prevalence rates are explained by a variety of underlying social and institutional factors. Birth control is for example not covered by the Universal Health Coverage program, important religious actors, such as the Orthodox Church, do not support their use, the contraceptive counselling offered in the health care system is of low quality and many women also lack knowledge of modern contraceptives **[33]**.

Privatised health care may be limited in providing access to sexual and reproductive health care. Private health care providers may not always be the most effective in ensuring universal access to contraception. Some of the concerns in the UK include how private doctors may be disincentivised to provide LARCs because of their durability **[27]**. Private pharmacies in Georgia are reported to be unable to stock contraceptives because they are too expensive **[33]**, and in Poland, there are concerns over the capacity of private gynaecologists to provide universal access to contraception **[36]**. In the UK, the lockdowns raised concerns over how current procurement systems may be too fragmented to fully serve contraceptive care in times of intensified demand. **[27]**.

Budget cuts and new pandemic-related policies are barriers to ensuring access to contraception. In North Macedonia, the government's budget to ensure access to contraception (including condoms, the contraceptive oral pill and IUDs) for socioeconomically disadvantaged women and women who have had more than one abortion decreased by half from 200.000MKD in 2020 (around 3.000EUR), to 100.000MKD (1.500EUR) in 2021**[18]**. Access to sexual and reproductive health care has also been limited by policies initiated because of the pandemic. Upon declaring COVID-19 a state of emergency, the Latvian government effectively restricted the availability of health care. While some sexual and reproductive services, such as emergency care, HIV / AIDS and STD treatment as well as antenatal and postnatal care were permitted, gynaecologist consultations were not **[31]**. Likewise, Georgia restricted access to contraceptives and counselling as it was not considered to be part of planned emergency services **[33]**.

COVID-19 tested the sustainability and resilience of health care systems and exposed gaps in organisation, funding, staffing, provision, monitoring and communication. The fact that the pandemic rolled out as quickly as it did, further demonstrated the level to which countries were unprepared to respond to the public health crisis, including to create or maintain systems of thorough monitoring of essential health care services, including access to contraception and LARCs in particular.

BOX 3. Five main barriers to accessing contraception in Europe during COVID-19

1. Avoiding clinics due to fears of COVID-19, becoming an extra burden on health care system, or respecting restrictions in place
2. Clinics and opening hours: reduction in opening hours or full closure of them
3. Lack of clear communication about reorganisation of SRH services so users would know where to turn to when ordinary services had been disrupted
4. Stock-outs in pharmacies
5. Financial barriers including loss of income and increase in prices of contraception

Enabling Factors

Most countries tried to mitigate the social distancing restrictions and ensure access to contraception, mainly using digital means. "Telemedicine" or "telehealth" was widely reported in almost all countries from Belarus, Germany, Georgia and Latvia, to Kosovo, Luxembourg, the Netherlands, Sweden and the UK. Most of the health care providers relied on the internet, applications, or the phone to set up appointments and consultations with patients. In Belgium, even social media channels, such as WhatsApp, were also used to communicate and provide prescriptions for contraception, although this may be hard to continue due to privacy regulations, such as GDPR [37]. In Georgia, older staff were told to work from home to avoid contracting COVID-19 and provide consultations over the regular phone [33]. It was also possible to order and buy contraception online, like condoms in Latvia and combined hormonal contraceptive pills in Georgia [31], [33]. To minimise face-to-face interaction and respect social distancing measures, doctors in the UK started using the postal service to send prescriptions either to the patient's home or directly to the pharmacy [27]. There are indications that routines are indeed changing, including both digital tools for first contacts with options to proceed to face-to-face meetings should they be needed or requested.

Online outreach campaigns in different languages were used in Germany to ensure that as many as possible had correct information regarding where and how to access contraception during the pandemic. Organisations in Luxembourg also initiated campaigns on social media on the importance of sexual and reproductive health and rights during the pandemic and restrictions. Some service delivery points saw an increase in appointments mainly due to online consultations, but also because some doctors managed to maintain their services [14].

To address financial barriers, Switzerland designated extra funds to ensure that marginalised groups, particularly socioeconomically disadvantaged groups, could access contraception [35]. There were also reports that some policies have been adapted to better ensure access. For example, in the UK, offering LARC fittings are to some extent becoming standard procedure in post-partum settings [27].

66%

of countries reported disruptions to contraceptive provision

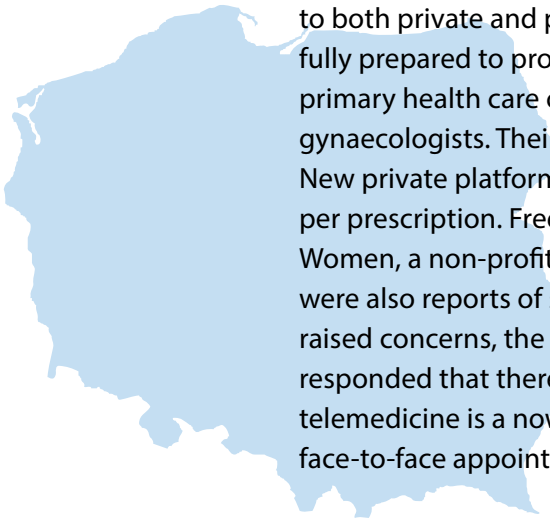
Generally, using digital means to ensure access to contraception appears to have worked well. For example, the WHO survey on continuity of essential health services during COVID-19, shows that the sexual and reproductive health service that rebounded the fastest were those services related to contraception [15]. While about 66% of countries included in the survey reported disruptions to contraceptive provision in the first round, that number was down to 44% by the second round. At the same time, 22% of countries reported the use of telemedicine for contraceptive services [15]. These numbers seem to suggest that digital tools played a critical role when health care services tried to recover from disruptions and develop resilience to ensure access to contraception.

For many people the use of distance or telemedicine, has worked very well. Those who have benefitted the most have often been people who may have experienced limitations to accessing birth control before the pandemic. These include for example women who live in rural and remote areas, those with limited financial means to pay for transport to clinics, those who have difficulty taking time

off work risking loss of income, those who have demanding family and childcare responsibilities or those who live with a physical disability [30], [27]. Online services, such as sending prescriptions through the post or to the pharmacy may mean a decrease in waiting times, which can make a difference for many women [27] . In the UK, there are indications that telemedicine may lead to a decrease in stigma surrounding visiting a sexual and reproductive health clinic among some groups of women, such as those whose first language is not English and those women who live in contexts where the use of contraception is not fully accepted [27].

While telemedicine has proven to be very useful to ensure continued access to some contraception, there are groups of women who are at risk of being left further behind. First, telemedicine requires access to a stable internet connection, which may vary throughout most countries, and therefore cannot ensure equitable access. In addition, telemedicine may not guarantee access to women who do not have a smart phone, or for example lack the digital means of self-identification required to access most online services in Sweden [30]. Women who have low digital literacy skills, who are not literate or face other language barriers such as needing interpreters may also experience telemedicine as a barrier rather than as an enabler in ensuring access to pregnancy prevention [30]. Finally, many women may not have the privacy even in their own homes to go online for contraception counselling [27], [30]. There are indeed concerns that the lack of face-to-face consultations will reduce the opportunities to support women who are subject to gender-based violence or sexual abuse [14], [27]. Finally, not all countries in Europe managed to leverage internet connectivity to ensure access to sexual and reproductive health services. In Armenia, there has been very little use – if any - of telemedicine for medical consultation purposes, including contraception [38].

Spotlight on Poland



Out of 46 countries in Europe, Poland ranks the lowest in ensuring accessibility to modern methods of contraception [34]. When the COVID-19 pandemic struck, it created new and aggravated pre-existing gaps in sexual and reproductive health care services. Just like in many other countries, the lockdown in Poland limited access to both private and public providers, but many primary health care clinics were not fully prepared to provide access to contraception using telemedicine. As a result, primary health care clinicians referred clients who needed prescriptions to gynaecologists. Their availability was also limited due to their insufficient number. New private platforms emerged online to address the ensuing need, charging €15-20 per prescription. Free emergency contraception was only provided by Doctors for Women, a non-profit project. Beyond a lack of availability of affordable options, there were also reports of shortages in pharmacies. When non-governmental organisations raised concerns, the Ministry of Health and the Chief Pharmaceutical Inspectorate responded that there were no such issues limiting access to contraception. While telemedicine is a now favoured way of accessing care, patients can request face-to-face appointments should their medical condition require it [36].

While telemedicine can contribute to ensuring access to sexual and reproductive health care, it cannot replace all services as in-person consultations are still necessary to ensure full access to sexual and reproductive health and rights including choice of contraceptive method, such as LARCs.

Impact on Marginalised Groups

Groups that are most affected by the barriers are almost always those groups that are already marginalised and furthest away from accessing resources under normal circumstances. One key finding from this desk research is the gap in systematically collecting data to identify these groups across countries in Europe. Available data does however confirm that those women who were already the most underserved before the pandemic, were also the ones who were most impacted by the barriers discussed above.

While underserved groups vary to some extent between countries, many of them are reoccuring, such as socioeconomically disadvantaged women, young women, women living with a disability, women who live in rural or remote areas, refugees, migrant and undocumented women as well as women from ethnic minorities such as Roma and Yezidi **[23]**, **[27]**, **[29]**, **[32]**, **[34]**, **[37]**, **[38]**. Other groups, such as women living with HIV, LGTBQI people and sex workers also experience limitations to accessing services, but these groups were very rarely discussed in any of the reports with the exception of the report from Armenia **[38]**.

Women in remote areas of for example Belarus and Georgia, were much more likely to lack access to contraceptives compared to women living in urban areas **[26]**, **[33]**. Women from different ethnic groups were more severely impacted according to reports from Armenia, Georgia, Moldova, and Serbia. While the report from Moldova does not specify access to contraception, Roma people were reported to have less access to the healthcare system than the general population. Roma people not only facing financial barriers to pay out of pocket for contraception and other "informal" costs, but also faced discrimination as medical staff refused to provide them with consultations[39]. Roma people were also identified as a particularly marginalised group in Serbia **[23]**. Data in the UK indicates that there has been a decrease in use of services by people of Black, Asian & Minority Ethnic (BAME) backgrounds during COVID-19[27]. Those who have a higher unmet need for contraception in the UK have been identified to include young people under the age of 25, BAME and those who are socially disadvantaged as they have higher rates of abortion compared to the rest of the population **[27]**.

Due to the economic consequences of the lockdowns, many women also found themselves becoming economically marginalised during the pandemic. In Serbia, thousands of women lost their jobs and income during the lockdown. As a result, primarily Roma women, single mothers, women with disabilities and young women, stopped using contraception as they could no longer afford it even after the social distancing measures had been relaxed **[23]**.

Women and girls with disabilities have been disproportionately affected by the COVID-19 crisis in Serbia and Armenia **[23]**, **[38]**. This particularly vulnerable segment of the population encompasses a variety of conditions and impairments and has faced many barriers throughout the pandemic and in general. Not able to access the contraception services during the COVID-19 outbreak for the same reasons as other vulnerable groups, their sexual and reproductive health may have deteriorated given their marginalised situation to begin with. In Armenia, the Nagorno-Karabakh war that broke out in September of 2020 further aggravated access to essential sexual and reproductive services, including access to modern methods for pregnancy prevention. While the authorities did take steps to prioritise maternal health care during and after the war, access to contraception was not included in such policies leaving women to manage as best they could with the resources they had **[38]**.

Spotlight on young people

Young people are particularly vulnerable to the physical and mental health consequences of not accessing contraception, such as unwanted pregnancies at a young age. About 1 in 10 to 1 in 5 young people were impacted negatively in for example, the Netherlands, North Macedonia, and Belarus **[18]**, **[25]**, **[26]**. Many young people faced similar disruptions as the rest of the population, i.e., temporary closures of clinics or clinics not offering contraceptive services, a lack of availability in pharmacies or contraceptives that were too expensive **[26]**. However, young people are thought to have been particularly impacted by the decrease in outreach activities, such as drop-in/walk-in services and those targeting schools and colleges in for example the UK **[27]**.

Research in Scotland shows that young people experienced new information about contraception as conflictual and unclear causing uncertainty and worry **[32]**. For example, prior to the pandemic, women had been informed of the importance of removing and changing IUDs by the recommended end-date, whereas during the pandemic, they were told to postpone removal as staff was unavailable. Young people have also had to navigate the restrictions by adapting their health seeking behaviour through "self-censoring their sexual and reproductive needs", i.e. refraining from visiting health care clinics or the pharmacy in order to avoid being a burden on health care despite having a need for such services **[32]**. Some have had to advocate for their own sexual and reproductive needs when they encountered medical professionals who were gatekeeping services. Young people who either lived with their parents or who had to move back in with their parents, experienced difficulties in securing the privacy necessary to engage with health providers over the phone or though applications. In addition, these young people may not have been able or comfortable to receive contraception through the post sent to their family home. With lockdowns effectively closing many of the places where young people would normally access contraception – such as walk-in clinics, public restrooms, or university/college clinics – young people have had to find other places to access it which may have meant a relinquishing of anonymity leading to a termination of contraceptive use, despite continuing to have sexual relations **[32]**.

Impact on Long-Acting Reversible Contraceptives

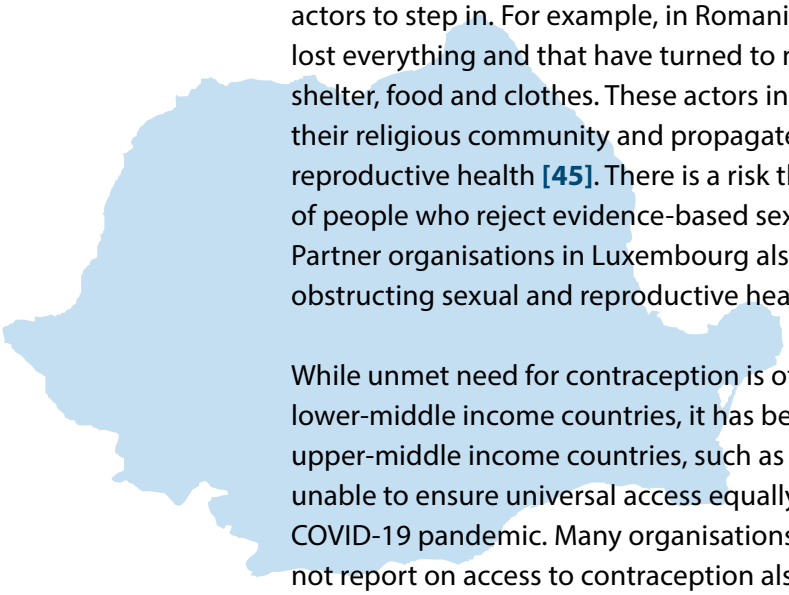
According to the WHO, contraceptive counselling service was the sexual and reproductive health service most severely affected by the restrictions implemented as part of the COVID-19 response **[15]**. Consistent data across countries per contraceptive method is sparse. For example, in Spain, there are reports of a reduction in the number of contraceptives purchased throughout 2020, but data is not specified by method **[40]**. In Portugal and Sweden there are indications that access to condoms was affected **[29]**, **[30]**. The social distancing measures and reorganisation of service delivery made it more difficult to get prescriptions necessary to access contraceptive methods in the pharmacy for example in Albania, Belarus, Netherlands, Serbia, Sweden and the UK **[17]**, **[23]**, **[25]**–**[27]**, **[30]**. In Spain for example, one study showed that 12.5% of the women who stopped using the hormonal pill did so because of lacking access to a prescription **[41]**.

There are, however, indications that LARCs may have been particularly impacted even though contraception, including LARCs and emergency contraception, are essential health care services [4]. According to recommendations, LARC fittings and replacements could wait in order to reduce demand on health care facilities that were understaffed due to COVID-19[27]. There were indications that restrictions had an impact on access to LARCs in Portugal [42], Sweden [43], Spain [40] and the UK, where up to 54% of providers restricted access to LARCs [27]. In Switzerland, LARCs were the methods most funded by the dedicated fund set up to ensure access to marginalised groups [35]. In pharmacies in Georgia, IUDs was the contraceptive method least available of all methods in comparison to both condoms as well as the contraceptive pill which increased in supply compared to previous years [33].

The restrictions associated with the COVID-19 pandemic effectively limited the choice of contraception, and far from all women could access the contraception and related care they needed. This had consequences for both routine fitting of LARCs and addressing complications. Georgia restricted access to contraceptives and counselling as it was not considered planned emergency services, which impacted women who needed to replace their implants and IUDs and had to have their appointments rescheduled [33]. In Latvia, IUD fittings were delayed as "administration was not possible" [31].
In Austria, women with no or low income usually visit the Austrian Family Planning Association's counselling centres to obtain contraceptives free of charge or for a small donation. The copper IUDs are the most preferred method. However, during the pandemic, demand dropped; compared to 2019, less than half of all IUDs were provided in 2020 [20]. In the UK, there are indications that unintended pregnancies are caused by a lack of LARCs specifically, especially for women who do not want or are unable to use other methods of birth control [27].

The pandemic and associated restrictions also pointed to underlying gaps in the health care system, further impacting access to LARCs. In the UK, there were concerns over private facilities and their incentives to provide long-acting methods [27]. Possible risks were brought up, that LARCs may be relegated to specialised care instead of integrated into routine primary care when the health care system recovers after the pandemic [27]. LARCs are also reported not to be fully covered by the national health insurance system, such is the case with implants in Luxembourg [14]. In addition, LARC fittings were reported to already be suffering from funding cuts and restructuring of sexual and reproductive health services in the UK [27]. Other elements of the health care sector that have been put on hold during the pandemic, is continuous professional development of health care providers [27]. While some training has been made available online, others have been postponed all together which could delay certification for LARC fittings, and in turn impede staff capacity to deliver such services. In Lithuania, however, some LARCs, such as implants, were never available in the first place [44]. In Latvia, women continue to use ineffective and unsafe birth control methods [31].

Much of the data underlying this report examines earlier stages of the pandemic, therefore there is more focus on immediate rather than long-term impact. However, the resilience of the health care system is dependent on the capacity to look after, develop and maintain staff competences and motivation. For example, more research must be carried out to learn whether there is an accumulation of clients who need contraceptive services now that most restrictions have eased and been removed. This may create further pressure on health care services to keep up with demand; staff that may already be both physically and mentally affected after having worked with the COVID-19 pandemic and may lack the energy or the capacity to efficiently manage this demand [27].



Spotlight on Romania

In the wake of the economic disaster that the restrictions brought on in Romania pushed poor people further to the margins. When people's needs are not prioritised by formal and official systems and public agencies, it may open the door for other actors to step in. For example, in Romania, there are accounts of people who have lost everything and that have turned to new religious actors to meet their needs for shelter, food and clothes. These actors in turn, see this as an opportunity to widen their religious community and propagate a conservative agenda for sexual and reproductive health [45]. There is a risk that they manage to increase the number of people who reject evidence-based sexual and reproductive health care services. Partner organisations in Luxembourg also raise concern over conservative agendas obstructing sexual and reproductive health and rights for all [14].

While unmet need for contraception is often discussed as an issue in low and lower-middle income countries, it has become clear through this study that high and upper-middle income countries, such as most countries in Europe[1], have also been unable to ensure universal access equally and equitably to contraception during the COVID-19 pandemic. Many organisations that answered that their governments do not report on access to contraception also have a lower score on the European Contraception Policy Atlas for Europe, for example Cyprus, Serbia and the Ukraine, which all score yellow or orange, but also Poland which is the country with the worst score out of all countries in Europe [34]. These results echo the outcomes of the Policy Atlas; that SRHR is not prioritised by these governments. The countries that score higher on the Policy Atlas are generally more effective in ensuring continued access to contraception in a time of emergency. Overall, they also monitor the issue more systematically, for example in the UK.

CONCLUSIONS

While there is insufficient data to draw conclusions about the long-term impact of the pandemic and the associated restrictions, the immediate effects on access to contraception varied greatly throughout Europe. In Denmark, facilities and pharmacies have remained open and doctors have been available both in the clinic and for online appointments [47]. In Sweden, 8% of women who were using contraceptives were unable to access it due to the pandemic [28], and in the Netherlands, there was virtually no change in the risk of unintended pregnancies during the pandemic compared to before [25]. While in the Czechia there were no reported disruptions of contraceptive services, including emergency contraception [48], in Serbia the access to contraception and the right to abortion were fully jeopardised [23]. Given the fact that this issue was not monitored systematically, the results of this research are illustrative of what may have happened during the pandemic across countries in Europe. Ultimately, during the pandemic women throughout Europe were limited in accessing contraceptive methods of their choice, effectively impacting their sexual and reproductive health and rights, their quality of life and ability to make and carry out decisions about their health and bodies with dignity, autonomy, and integrity.

[1] Ukraine is a lower middle-income country according to the latest categorisation by the World Bank [46].

RECOMMENDATIONS

1. Guarantee access to contraception and users' choice of contraceptive method through national health care plans and budgets. It is insufficient to only cover one method.

2. Ensure that access to contraception, including long-acting reversible methods and emergency contraception, is defined as essential health care service to be delivered, and reimbursed, even in times of crisis.

3. Include the availability of health care professionals in policies for essential health service delivery. Staff providing essential sexual and reproductive health care need to be protected, to the fullest extent possible, from potential reorganisation of health care which transfers them to crisis/disaster/pandemic-related care. Any reforms or restrictions to services must consider their experience and expertise as they have direct insight into the possible risks to their patients' and communities' health and wellbeing.

4. Strengthen primary health care both organisation and funding, if that is where access to contraception is provided. If not, integrate contraception and related counselling in primary health care facilities and not specialised clinics to avoid disincentivising LARCs and underutilisation of the staff that has been trained to provide them.

5. Identify and track gaps to universal access to contraception and choice of method through systematic and comprehensive monitoring and evaluation. Address identified gaps to ensure that all groups, especially those whose needs are not met, can access quality contraception and related care, information, and counselling.

6. Ensure adolescents and young people have access to contraception and a method of their choice. Adapt service delivery points and information and train staff to facilitate access to, and awareness of different methods of pregnancy prevention.

7. Continue to provide sexual and reproductive health care, including contraceptive counselling, via telemedicine and improve the digital tools and services already in place to make them more inclusive and equitable. Consider training providers in effectively delivering quality sexual and reproductive health care and counselling through digital means.

8. Recognise that communication and information are central components of the health care system. Communication efforts need to be proactive; making use of a wide range of accessible channels and languages, providing relevant, evidence-based information in a timely and easy-to-understand manner. This is especially important in times of emergencies when changes to regular services may occur quickly.

9. Build on the lessons learned from the COVID-19 pandemic to develop and integrate innovative solutions to sustain and expand access to contraception and choice of method. These may include for example reviewing routines to facilitate access to contraception after giving birth or abortion; task shifting between different health care professions or expanding delivery points to for example pharmacies, supermarkets and online platforms.

10. Encourage patients, clients, and users to continue to seek sexual and reproductive health care should they need it, even in times of a pandemic.

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