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A qualitative exploration of how the COVID-19 pandemic shaped experiences of self-managed medication abortion with accompaniment group support in Argentina, Indonesia, Nigeria, and Venezuela

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Abstract: *Globally, people self-manage their medication abortions without clinical assistance. Feminist activist collectives (accompaniment groups) support people through self-managed abortion with evidence-based guidance. We sought to understand the impact of COVID-19 and related restrictions on the need for and experiences of self-managed abortion with accompaniment support across varied legal and social contexts. Between May and October 2020, we conducted in-depth interviews with individuals who self-managed abortions with support from accompaniment groups during the pandemic in Argentina, Indonesia, Nigeria, and Venezuela. We conducted a thematic analysis to understand the impact of COVID-19 on participants' experiences with accompanied self-managed abortions. Across 43 in-depth interviews, participants in all four countries described how the COVID-19 pandemic created challenges at each step of their abortion process, from confirming the pregnancy, accessing abortion pills, finding a private, comfortable place, and verifying abortion completion. For most people, conditions related to the pandemic made it harder to self-manage an abortion; for a minority, being at home made aspects of the experience somewhat easier. Nonetheless, all participants reported feeling supported by accompaniment groups, and COVID-19 and related lockdowns reinforced their preference for accompaniment-supported self-managed abortion. These findings highlight the essential role that accompaniment groups play in ensuring access to high-quality abortion care in a multiplicity of settings, particularly during the COVID-19 pandemic. Efforts are needed to expand the reach of accompaniment groups to increase access to the high-quality abortion support they provide, filling a critical gap left by health systems and legal infrastructure.* DOI: 10.1080/26410397.2022.2079808

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Introduction

The SARS-COV-2 virus responsible for the coronavirus disease (COVID-19) pandemic has continued to wreak havoc on health systems and medical supply chains globally. As a result of the overburdening of health systems, people's access to health care has been severely impacted, thus reinforcing previously existing health disparities around the world, particularly in low and middle-income countries (LMICs).[1] In the latter contexts, barriers to health care and medical supplies were exacerbated by collapsed health systems, movement restrictions, border closures and the risk of contracting COVID-19.[2] Compounded within these circumstances, existing social, legal and logistical barriers to access to sexual and reproductive health services were disproportionately intensified. According to an estimate by the United Nations Population Fund, about 12 million women in LMICs lost access to contraception services during the COVID-19 pandemic, resulting in 1.4 million unintended pregnancies.[3,4]

Access to abortion services and medications – misoprostol alone or in combination with mifepristone – was also severely affected due to the COVID-19 pandemic.[5–8] Prior to the emergence of COVID-19, access to safe abortion services was hindered by a variety of factors, including stigma, legal restrictions, and logistical barriers such as lack of transportation or inability to afford services.[9–11] These barriers, particularly those related to financial and logistical factors, have been further exacerbated over the course of the pandemic. For instance, many countries where abortion was legal did not include abortion as an essential procedure during the first stages of the COVID-19 pandemic,[6,7] which severely limited in-clinic access to safe abortion care.[12] In addition, global supply chain disruptions created shortages for misoprostol and mifepristone (WHO-approved medications used for abortion),[13] which led to additional challenges in accessing medication abortion pills.

The COVID-19 pandemic and related barriers to clinical abortion care have raised the profile and interest in the self-use of abortifacient medications at home outside of a clinical context. For instance, demand for abortion pills through online sites that provide information on self-managed medication abortion has significantly increased since the COVID-19 pandemic started.[14,15] Furthermore, abortion accompaniment groups, which provide support and evidence-based guidance to people self-managing their abortion, have continued to play an essential role for people seeking an abortion during the COVID-19 pandemic. Accompaniment groups have helped ensure access to essential safe abortion and other reproductive health services around the world for many years, including in Argentina, Indonesia, Nigeria and Venezuela, the countries that this study focuses on.[16–21] People might choose to self-manage their own abortions due to the safety, privacy, convenience, and comfort this model can provide;[17,20,22] however, given the uniqueness and newness of the COVID-19 pandemic, little is understood about people's experiences self-managing their abortions with support from accompaniment groups during the COVID-19 pandemic. Research on the experiences of people who have self-managed their abortion during the pandemic is key to understanding the critical role accompaniment groups play in ensuring safe abortion access when clinical systems fail, and to identifying strategies to expand access to high-quality abortion care.

To address this gap in research, we set out to collect qualitative data from people self-managing their abortions with accompaniment support during the ongoing COVID-19 pandemic in Argentina, Indonesia, Nigeria and Venezuela, four countries that represent varied social and legal contexts (particulars outlined below). All countries had restrictive abortion laws in place throughout 2020.* The barriers posed by these legal restrictions were further heightened during the COVID-19 pandemic,[23] when all four countries implemented lockdown measures, including restrictions on domestic and international travel, limits on social gatherings and transportation, and closures of schools and non-essential businesses.

While the impact of COVID-19 on abortion service provision at health facilities has been

*In Argentina, abortion was legally restricted until December 2020, at which time abortion services were legalised through 14 weeks of pregnancy.

documented,[14,15,24] there has been little research on how the pandemic has directly impacted the abortion experiences of individuals in countries where clinic-based abortion access is already restricted. As such, this study aimed to answer the following question: among people who self-managed an abortion during the COVID-19 pandemic, how did the pandemic context, and related lockdowns, influence the decision to self-manage, as well as the experience of self-managed abortion? To achieve this aim, we conducted in-depth interviews with individuals who contacted accompaniment groups for various types of abortion support during the COVID-19 pandemic.

Methods

Partnership and study design

This study was a collaborative effort between researchers at Ibis Reproductive Health, a non-profit research organisation based in the United States and South Africa, and activists affiliated with accompaniment groups in Argentina, Indonesia, Nigeria, and Venezuela. We intentionally structured this partnership rooted in a commitment to shared decision-making and building shared power between researchers and activist partners. In order to build shared power, we included partners in decision-making at every step of the process, were transparent in the budget development process, supported partners to develop research skills, facilitated connections to funders and highlighted their advocacy work in dissemination efforts. This partnership is built on years of previous collaborations, including the Studying Accompaniment model Feasibility and Effectiveness (SAFE) study in three countries.[25,26] During discussions with each partner organisation, a need was identified for a study with the aim of understanding the ways in which the pandemic, and related lockdown measures, were affecting the abortion experiences of people contacting each accompaniment group.

Researchers at Ibis led the development of the study design, instruments, research protocol, and the analysis process, while partner organisations led recruitment and data collection. At each step of the process, individuals from each of the accompaniment groups provided feedback to the Ibis researchers on instrument design, preliminary analyses, and contributed to manuscript drafts.

Study setting

The legal context in each of the four study countries varied. In Argentina, at the time of the interviews, abortion was only legally available if the pregnancy put the pregnant person's life and/or health at risk, or if the pregnancy was a product of rape. In Indonesia, abortion is permitted in the case of medical emergencies and severe fetal anomaly, as well as in cases of rape, but only up to six weeks' gestation.[27] In Nigeria, abortion is legal only to save the pregnant person's life.[28] In Venezuela abortion is only legally permissible in the case that it endangers the life of the pregnant person.[29]

The accompaniment groups with whom we collaborated for this study provide informational and emotional support to individuals seeking to terminate their pregnancies with medications (misoprostol alone, or in combination with mifepristone) in the four study countries: Argentina, Indonesia, Nigeria, and Venezuela. All of the included accompaniment groups follow a model whereby individuals contact the accompaniment group by phone or online, and then receive gestational age-specific counselling on how to safely use medications to terminate their pregnancy without clinical support, based on World Health Organisation (WHO) approved protocols. While some of the accompaniment groups previously provided in-person information sessions and support, they transitioned to providing support over the phone or through secure internet-based platforms during the COVID-19 pandemic.

Sample size

Given the exploratory aim of this research, we anticipated that 40 in-depth interviews would be sufficient to reach thematic saturation on the experiences of self-managed abortion during the COVID-19 pandemic. Additionally, we estimated that interviewing approximately 10 individuals per country would allow for an assessment of contextual similarities and differences across countries.

Participant recruitment

Eligible participants included anyone who contacted one of the four included accompaniment groups after the start of the COVID-19 pandemic seeking information about terminating their own pregnancy and was at least 13 years of age,

able to give informed consent, and able to speak the local language (Bahasa Indonesia, English, Igbo, Spanish, Yoruba). Recruiters utilised two distinct recruitment approaches based on differing circumstances at recruitment sites: in Argentina and Venezuela, all eligible callers were invited to participate at the completion of their accompaniment counselling session, regardless of any COVID-19 related barriers experienced. If interested, the participant was contacted by the interviewer several weeks after their abortion for an informed consent process, followed by the interview. In a more targeted approach, callers in Indonesia and Nigeria were recruited based on reporting at least one or more COVID-19 related barrier during their abortion experience in a survey for an ongoing research study[21] which was administered three weeks after their abortion. Eligible callers were contacted via phone or secure messaging apps, by a member of the research team. Eligible participants who were invited but declined participation were not documented during the recruitment period; however, no participants dropped out after enrolling in the study. All participants provided verbal consent to participate in an interview and to be audio recorded; the interviewer documented verbal consent by signing and dating a consent form for each interviewee at the time of the interview.

Data collection

We used the same semi-structured interview guide across all study sites (Supplementary File I). The interview guide elicited information on the impact of the pandemic on each participant's life broadly, on their need for self-managed abortion, and on their experiences obtaining and taking the medications, as well as seeking health care during or after. The interview guide also collected data on a limited set of sociodemographic characteristics and details of the index pregnancy: age, occupation, relationship status and duration of pregnancy based on last menstrual period (LMP), blood/urine test or ultrasound. All study team members across the four countries were trained in conducting ethical research and trained on conducting qualitative interviews, including empathetic interviewing techniques. BG, IK, IE, MM, IT, SL, SS, served as interviewers, all identify as women and were affiliated with an accompaniment organisation to ensure the confidentiality of both the accompaniment groups and accompanied individuals. Interviewer/interviewee pairings were arranged to ensure that no pre-existing relationship existed between the two individuals. Interviewers conducted all interviews over the phone between May and October 2020, and utilised an encrypted device to audio-record the 45–60 minute conversations. Both participants and interviewers were asked to find a private space in which they could speak for the duration of the call. Interviewers in each country were fluent in the languages in which they conducted interviews. A professional transcription service transcribed all recordings in their original language. Participants received approximately $US 10 remuneration for their time and to cover the cost of phone or internet. Each accompaniment group decided the remuneration amount based on the local context.

Analysis

Bilingual researchers (CB and SF) analysed English (Nigeria) and Spanish (Argentina and Venezuela) interviews in their original language. A professional translator translated interviews conducted in Indonesia from Bahasa Indonesia to English for analysis. To ensure the quality of transcription and translation, members of the research team reviewed audio files and transcripts in tandem for completion and accuracy.

In order to examine and describe the impact of COVID-19, and the related lockdown measures, on the different stages of people's self-managed abortion experiences, we undertook a thematic analysis approach. We created an initial codebook based on the interview guide as well as a preliminary review of interview audios, field notes, and transcripts. After creating an initial list of primary codes and sub-codes, SF pilot-tested the codebook by applying it to four randomly selected transcripts (two from Argentina, two from Nigeria), after which the codebook was refined to include emergent codes from the data. The final codebook was applied to all of the transcripts by CB and SF. Additionally, to ensure both inter-coder reliability and reliability across translated versions of transcripts, IK coded all of the transcripts in Bahasa Indonesia, while CB coded the same transcripts in English. The two met to reconcile discrepancies in the codebook application and to discuss emergent themes. Researchers coded all transcripts using MAXQDA, Verbi Software.

After completing the coding process, CB and SF drafted code summaries, wherein they grouped and examined together individual codes, as a

way to understand the most salient themes. CB and SF drafted a country summary for each country that outlined the ways in which participants described COVID-19 impacting their self-managed abortion experiences. We shared the country summaries with each of the accompaniment groups to internally validate the interpretation of the findings. The research team then compared these four validated country summaries to examine patterns in the data across countries and compiled these findings into this manuscript. Due to concern for the security of participants and medication abortion (MA) supply chains, we do not present details about how participants obtained MA pills or much detail on how their experience obtaining pills was affected by the pandemic. We translated all interview excerpts into English for the purpose of this manuscript. Original quotes, in Spanish and Bahasa Indonesia, are available in Supplementary File II. We report results in accordance with the COREQ checklist for qualitative research in Supplementary File III.

The Allendale Investigational Review Board, based in the United States, served as the central institutional review board (IRB) of record for this multi-country study and reviewed and approved the study protocol in April 2020 (Approval Number: SAFE032019). Local ethical review was not sought for this study due to safety and security concerns expressed by the partner organisations. However, we followed local guidelines and regulatory procedures for research with human subjects in Argentina, Indonesia, Nigeria and Venezuela.

Results

Sample description

We conducted a total of 43 semi-structured in-depth interviews (IDIs) to understand people's experiences with self-managed abortion during the COVID-19 pandemic with support from accompaniment groups in four countries: 12 (28%) in Indonesia, 11 (26%) in Argentina, 10 (23%) in Nigeria, and 10 (23%) in Venezuela (Table 1). Participant's ages ranged from 18 to 43 years, with a median age of 27 years. All participants had a self-managed medication abortion with support from an accompaniment group. Most participants (n = 35, 81%) reported a gestational age of up to 12 weeks. Few (n = 5, 12%) participants reported having a prior abortion and 18 (42%) reported having at least one child. With regard to relationship

Table 1. Participant characteristics (n = 43).

	N = 43
	n (%)
Country	
Argentina	11 (26%)
Indonesia	12 (28%)
Nigeria	10 (23%)
Venezuela	10 (23%)
Age (years)	
18–25	17 (40%)
26–35	18 (42%)
36–43	5 (12%)
No data	3 (7%)
Gestational age (weeks)	
≤12 weeks	35 (81%)
>12 weeks	5 (12%)
No data	3 (7%)
Abortion method	
Medication abortion	43 (100%)
Surgical abortion	0 (0%)
Previous abortion	
Yes	5 (12%)
No	37 (86%)
No data	1 (2%)
Relationship status	
Single	13 (30%)
In a relationship	17 (40%)
Married	13 (30%)
Children	
Yes	20 (46.5%)
No	23 (53.5%)

status, 17 (40%) participants reported being in a relationship, 13 (30%) reported being single, and 13 (30%) were married at the time of the interview.

Overall impact of the COVID-19 pandemic on abortion experiences

Across all contexts, the COVID-19 pandemic and resulting lockdowns imposed additional barriers to accessing timely and high-quality abortion care. Many participants reported that COVID-19 and related lockdown measures brought notable financial hardship to them and their families. For some participants, this was due to lost income because of temporary business closures, limited mobility, reduced working hours, withheld pay from employers, and/or an inability to earn daily wages. For instance, Amina,[†] a participant from Nigeria, shared how they lost their main source of income once lockdown measures were put in place since they were no longer able to obtain daily wages as a market seller:

"*It has been very tough, especially for us that don't have a sound business … , we just sell things and gain our income every day. So since the COVID-19 came in, and the lockdown, we've not been selling anything again, nobody is buying from us, and I cannot even go to the market to buy fruits, so it's been very hard for me and my family now.*" (Amina, Nigeria, age 37)

Additionally, many participants mentioned reduced access to public transportation, movement restrictions, and police enforcement of lockdown measures as significant barriers in accessing abortion medications. Further, participants from all four countries mentioned medication abortion access challenges, including struggling to find vendors, being unable to afford the pills, and difficulty finding excuses to leave home without family finding out or being interrogated by police at COVID-19 related checkpoints. Closure of health centres and pharmacies during the initial phases of the pandemic presented a challenge to participants at various stages of their abortion process, including accessing contraception, pregnancy tests, or other health supplies. Layered on all of this, concerns about contracting the SARS-COV-2 virus influenced whether and where participants sought care at health facilities during their abortions.

[†]All quoted participants have been given a pseudonym to protect their privacy and confidentiality.

Beyond these broader influences, we explore below in more detail how the COVID-19 pandemic impacted different aspects of participants' overall self-managed abortion experiences, specifically: pregnancy confirmation, abortion decision-making, privacy during the abortion, and health care seeking during and after their abortion.

Impact of the COVID-19 pandemic on people's ability to confirm their pregnancy

Across study locations, most participants confirmed their pregnancy with an at-home urine pregnancy test, and did not report particular barriers or difficulties in being able to confirm their pregnancy, related to COVID-19 or resultant lockdowns. However, among those that did report difficulties in their ability to confirm that they were pregnant, common barriers stemmed from pandemic-related movement restrictions, and closure of, or difficulty finding, open clinics or pharmacies. In Nigeria, a few participants described transportation restrictions and police enforcement of lockdown measures as barriers that hindered their ability to get to a pharmacy to buy a pregnancy test; this led to them having to visit multiple pharmacies.

While most participants expressed a preference for confirming their pregnancy at home, rather than going to a hospital or clinic, some participants mentioned that they would have preferred to confirm their pregnancy at a hospital, clinic, or lab but given concerns and restrictions related to the pandemic, they opted for an at-home test.

On the other hand, participants who were able to confirm their pregnancies at labs, hospitals, or clinics often found it challenging to schedule appointments, find somewhere nearby to confirm their pregnancy or find somewhere that was open, with some participants reporting travelling long distances to find an available clinic or having to wait much longer than usual. Alicia, a participant in Venezuela, described how they had been able to schedule an appointment but, when they arrived, the clinic was closed:

"*I had decided to do it in one place, and when I got to that place the employees hadn't arrived, they hadn't been able to arrive because there was little transport due to the quarantine, and I had to find another place, when I already had an appointment scheduled for the first place and for a specific test, it cost me but I managed to do it the same day, but*

not at the place where I had hoped to do it." (Alicia, Venezuela, age 30)

Relatedly, Micaela, a participant in Argentina, explained that due to not having a pass that allowed for movement during the lockdown, they faced delays in getting to the clinic for an ultrasound, which resulted in them getting an abortion later than when they had planned:

"*It was a whole issue to go do the ultrasound, we didn't know how to get out [of the house], I didn't have permits. With my husband, well, he took me, we did the ultrasound, at this point I was ten weeks. Ten weeks. And when I was finally able to go get the ultrasound results and see the doctor again, I was 14 weeks. That was a lot."* (Micaela, Argentina, age 27)

In just a few cases, primarily in Argentina and Venezuela, participants were able to confirm their pregnancies with blood or urine tests at a hospital or clinic and did not report any problems accessing the care they needed. In these instances, participants were able to access facility-based pregnancy confirmation primarily because of the proximity of the facility to their home (thereby reducing limitations related to a lack of public transit or lockdown movement restrictions), as well as because they received a direct referral to a specific provider or clinic from their accompaniment counsellor.

Impact of the COVID-19 pandemic on people's decision to have an abortion

The majority of participants said that their decision to have an abortion was unrelated to the pandemic and that they would have made the same decision regardless; others described how the pandemic helped to solidify their decision to have an abortion. For a minority of participants, the pandemic was a major factor in their decision to have an abortion. Most decisions were nuanced and included participants' plans for their lives, their financial situation, their ability to provide for the children they already had, as well as their mental and physical health.

Among those for whom the pandemic strengthened their decision to have an abortion, some mentioned that their decision layered on the uncertainty of the moment generally, while others specifically mentioned concerns about their future financial stability, or lack of family or social support, given the pandemic. Ufoma, a participant in Nigeria, described:

"*Ok, because assuming I keep the pregnancy, with this lockdown everywhere I'm the one who will suffer, nobody will help, there is no money. Nobody will look after me in terms of going to the hospital, going and checking on the baby, registering for antenatal care, there is no money for that, nobody will look after me. I will be the one suffering. So I now have to make up my mind and do what I did."* (Ufoma, Nigeria, age 23)

A few participants mentioned that the pandemic contributed to their fears around continuing the pregnancy because of their perception that pregnancy made them more vulnerable to COVID:

"*I wasn't ready to become a mother […] perhaps, if [the pregnancy] continued, it'd be difficult. Many pregnant mothers contract COVID. And the baby and the mother are at risk. That is what I was afraid of."* (Indah, Indonesia, age 18)

Similarly, a few other participants also expressed concerns over the pregnancy exacerbating any mental health concerns they had. A smaller number of participants mentioned that they might have made a different decision were it not for the pandemic. Sofía in Venezuela explained that they felt worried that they would be unable to care for themselves during pregnancy, and they might have considered something else had their economic situation been more stable:

"*The pandemic or the quarantine influenced me a lot in the decision because I said, 'I don't have transportation, I do not have the means to eat because there is no electricity, there is no gas. How do I feed my baby in the womb?' It was very traumatic. Apart from that, if we hadn't been in quarantine, I said, I would have to see how I was doing on an economic level, if I could count on even a little stability."* (Sofía, Venezuela, age 32)

Impact of the COVID-19 pandemic on pursuing an accompanied self-managed abortion versus an abortion in a clinical setting

Almost every participant noted that they would have preferred to terminate their pregnancy on their own with accompaniment group support rather than in a health facility, regardless of the pandemic. For some, concerns around facing judgment or stigma from providers, fear of disclosing their need for an abortion, or contracting COVID-

19 if they visited a health facility played an important role in their decision to terminate their pregnancy with an accompaniment group rather than at a clinic. Furthermore, participants perceived that having a medication abortion with the support of an abortion accompaniment group was more private, less expensive, safer, and more convenient than going to a hospital or clinic for an aspiration or surgical procedure. For some participants, this was because they had previously been supported by a hotline through an abortion and appreciated the information and support they received in a private and convenient format. Others mentioned that they had heard of the accompaniment groups or seen the information they shared on social media, found the organisations to be trustworthy, and wanted to have their abortion with them based on their online presence. Natalia, a participant in Venezuela, explained their reasoning for choosing a self-managed abortion,

"*I went on the internet looking for, pursuing the idea of, an assisted, supported, well-advised abortion, for some reason I already had the idea that this was possible. I got on the internet and saw the abortion accompaniment network, I saw the website, I saw that they had a number to contact, I saw that they offered that advice, and that was what I was looking for […] I would not have done it in any other way."* (Natalia, Venezuela, age 35)

Aside from a proactive preference for self-managing their abortions with support from an accompaniment group, participants mentioned that they chose self-managed abortion over facility-based abortion because of the challenges in accessing healthcare services during the pandemic. Several participants explained that they were afraid of contracting COVID-19 if they went to the hospital to obtain abortion care, "*I contacted Ms. Rosy [the accompaniment hotline] because I don't want to go to the hospital, like what I told you, I don't want to go to the hospital, and I may contract the COVID-19."* (Amina, Nigeria, age 37)

However, in Indonesia, Nigeria, and Venezuela, the most commonly mentioned reason for avoiding the healthcare system was not COVID-19; rather, it was fear of judgement from providers and a desire to maintain privacy. One participant in Nigeria, Yemisi, explained,

"*If I had gone to hospital, of course my doctor would have seen me ok… of course he knew about it, but not just the doctor, the nurses there, and you never can tell which nurse knows anybody I know, at the end of the day, is this your friend, they might see me tomorrow with whoever, this your friend she came to the hospital the other day and did abortion and all that, so I think Ms. Rosy helped me to avoid that."* (Yemisi, Nigeria, age 26)

Beyond the level of support from clinical providers versus abortion accompaniment groups, several participants mentioned that a medication abortion either felt safer to them or more "normal" than an aspiration or surgical abortion. One participant in Indonesia, Annisa, mentioned that they preferred a medication abortion because taking a pill felt familiar and easy, whereas "*[surgical abortion] would involve a lot of equipment, penetrated. The idea of it is just terrifying for me so I prefer to take the pills because it seemed more normal to me"* (Annisa, Indonesia, age 26).

Only one participant, who had had serious complications during a previous pregnancy, said that they would have preferred to have a surgical abortion with their trusted provider in Venezuela (rather than medication abortion with accompaniment support) had it not been for the pandemic.

Impact of the COVID-19 pandemic on having space and privacy during a self-managed abortion

Participants mentioned that COVID-19 and related lockdown measures impacted the location where they self-managed their abortions, as well as their comfort in that location. Privacy was a driving factor for many participants when deciding where to take the pills. While many participants felt comfortable aborting at home, some participants struggled to find a comfortable, private location to have their abortions because of the pandemic. This was primarily the case for individuals who lived at home with their families or had family members unexpectedly staying with them as a result of COVID-19-related lockdowns. Those with the means to do so often went to a friend or relative's home, or rented a room, in which they could have their abortion. In Nigeria, Amina explained,

"*I went to my friend's place. That's where I took the pills […] Because my husband's brothers, and my children, we are living in 2 rooms only. So there is no space for me to be where they would not, you*

know, notice what is going on. That is why I went to my friend's place so that nobody will know about it." (Amina, Nigeria, age 37)

Layered on top of desires for privacy, some participants emphasised the importance of other factors in choosing where to take the pills, such as having a private bathroom accessible. One participant in Indonesia highlighted this,

"*I really need my own bathroom. And because my partner's bathroom is outside his room, we rented a room in an exclusive boarding house, with an in-suite bathroom."* (Dewi, Indonesia, age unknown)

For younger participants who lived with their parents, finding an excuse to leave the house and be away overnight during their abortion was described as a challenge that was exacerbated by COVID-19.

As a result of these challenges, some participants ended up having their abortions in situations that felt uncomfortable to them. For some, this meant having an abortion wherever they were when the lockdown went into place, such as the home of a boyfriend or other family member. Participants described experiencing the unwelcome involvement of parents, partners, or other family members as a result – involvement that they otherwise would have preferred to avoid but could not due to restrictions on movement imposed by the pandemic. One participant in Argentina, Victoria, described this,

"*[T]he quarantine doesn't give you the possibility of choosing. So I did it at home, and beyond the fact that I was accompanied and I was very supported by my parents, it is not the same because there are times when you really want to be alone. And even though you might be physically alone, you know that they there in the house and that they are worried and that energy transmits to you."* (Victoria, Argentina, age 23)

While most participants found a safe and comfortable location to have their abortion, the pandemic and the related lockdowns meant that they were navigating additional challenges around space, privacy, transportation, and finances that complicated what might otherwise be a more straightforward part of the self-managed abortion experience.

The impact of the COVID-19 pandemic on care seeking during or after self-managed abortion

Overall, very few participants decided to seek care at a health facility during or after their abortions. Most participants did not seek care because they did not feel that they needed any – their abortions were complete, and they did not have any concerns about their health. For others, they did not seek health care because of fears of judgement from providers, concerns about overburdening the health system, or being suspected of having COVID-19 themselves. Others did not seek care due to COVID-19-related scheduling difficulties and fears of contracting the virus in a clinic or hospital. In Venezuela, Olga described the fear that circulated around contracting COVID-19,

"*[M]y decision was to look for a hospital in case of a complication, but I also thought that I could be infected, because we did not know for sure if there was a lot of [COVID-19] transmission in Venezuela, we didn't know what the situation was, so … in that sense I was really unsure."* (Olga, Venezuela, age 33)

Another participant in Indonesia, Siska, expressed that they were afraid of going to the hospital and being judged for needing medical attention not related to COVID-19 and being turned away,

"*I think I was afraid to meet people, then I felt that I might be judged by the medical staff because of course, they were anticipating sicker people … for people with symptoms of COVID … sometimes ordinary patients were not admitted to the hospital because they said that if the pharmacy could handle the sickness, just go to the pharmacy.*" (Siska, Indonesia, age 20)

Several participants worried that they might be suspected of having COVID-19, given normal side-effects of the medication abortion process. Paulina, a participant in Argentina, experienced this exact scenario and was admitted to the hospital for about two weeks after being suspected of having COVID-19,

"*I said that I was nine weeks pregnant, that I had had bleeding, they treated me super quickly at the clinic, and immediately they took my temperature and I had a very high fever. I was flying with a fever. Obviously the fever was due to the whole abortion process, I think one of the symptoms is also fever, I had a lot of fever, the nurse took my temperature and they tried to lower it but the fever wouldn't go down, so they immediately put the COVID protocol into place, because here there are no cases and anyone who has a fever or any*

symptoms of COVID, they consider it as a suspicious case." (Paulina, Argentina, age 25)

Participants in Argentina and Nigeria frequently had to confront police at COVID-19 checkpoints on the road; this was a significant deterrent from seeking care during their abortions. One participant in Nigeria, Emem, explained,

"*I would have loved to carry out a scan, you understand, to be sure that everything came out very well. But with the whole lockdown and everything I didn't really want to take my chances … the police are still harassing people you know and transportation issues. The whole COVID-19, the whole disease still in the air, flying around, you don't know where it, you don't know how you can contract it. I just felt there was no need for me to go out, let me stay back at home and just check on normal [pregnancy] strip."* (Emem, Nigeria, age 25)

This sentiment was common, particularly among participants who wanted to get ultrasounds to confirm that their abortions were complete but did not because of fear of contracting COVID and difficulty scheduling appointments with overburdened facilities.

Participants who did obtain care during or after their abortions mentioned that finding transportation presented a challenge. Some participants visited private health facilities and mentioned that they were able to do so because they had already identified a place or had been able to directly contact a doctor at the facility. Some participants expressed interest in visiting a private clinic but did not have the financial means to do so.

Only one participant in Indonesia sought post-abortion care for bleeding and cramping that continued after their abortion was complete – they were able to obtain the care they needed, despite pandemic-related challenges.

The unexpected positive consequences of the COVID-19 pandemic on the self-managed abortion experience

Some participants reflected on the ways in which the pandemic, and related lockdowns, created an environment for them that enhanced the convenience and privacy of their self-managed abortion experiences. Namely, participants mentioned that the pandemic and related lockdowns allowed them more flexibility and choice in when to have their abortions, as well as greater privacy in some settings and an excuse to stay home.

In some instances, participants described how remote work set-ups facilitated their ability to take the medications when they wanted, without having to plan around work schedules,

"*I think that the quarantine, yes, in that sense for me, under the conditions that I have, the physical space, the possibility of going to have an ultrasound quickly. Because I do social work, so when they hand you a case you have to get up and go … so I think that, deep down, all this helped me a lot so that I didn't have to give any explanations either at work or to anyone."* (Florencia, Argentina, age 37)

Similarly, a participant in Indonesia, Restu, who contracted COVID-19 and, as a result, was in isolation, described the convenience of being allowed to work from home while going through her abortion process,

"*[M]y office was supportive … I mean, they did not complicate me to work from home […] In the end, I thought, alright, I am going to do this [abortion] while isolating, maybe I'll be just fine […] I just happen to live in a boarding room with an en suite bathroom. So, I just stayed there, in my room."* (Restu, Indonesia, age 25)

Participants also mentioned that in certain situations, the lockdown provided them with more privacy in which they could have their abortions. Participants living in shared housing, particularly students, mentioned that other people had gone home leaving them with more privacy to manage their abortions. Others described how the pandemic and shelter-in-place orders gave them an excuse to be able to stay home without their family members getting suspicious. Adamma, in Nigeria, explained,

"*[S]omehow I will tell you that this lockdown also helped me because the hostel where I stay in school, all the students left … even my roommate left, because assuming she was around during the time I was going through this she would have noticed it and she might go out telling people or making it known to friends that I committed abortion […] nobody noticed my movement or what I was going through."* (Adamma, Nigeria, age 22)

These unexpected positive consequences highlight the core characteristics of the self-managed abortion experience (privacy and flexibility) that

drew participants to accompanied self-management in the first place.

Discussion

In an analysis of 43 in-depth interviews with people who self-managed an abortion with accompaniment support in Argentina, Indonesia, Nigeria, or Venezuela, we found that the COVID-19 pandemic and related lockdowns were influential in people's overall abortion experiences. The pandemic amplified existing barriers to abortion care, namely increasing people's financial hardships and worsening access to both health care and abortive medications. Participants also noted a number of challenges that arose specifically related to the pandemic, including movement restrictions, less privacy, pharmacy and health facility closures, overburdened health centres, and fear of contracting COVID-19. Accompaniment groups offered people support in navigating both existing barriers and new barriers that arose related to COVID-19, with compassion, privacy, dignity, and autonomy.

Despite the challenges that participants encountered across four distinct contexts, all ended up with a common solution – self-managed abortion (SMA) with support from accompaniment groups. Participants in this study overwhelmingly preferred to self-manage their medication abortions with the support of accompaniment groups, regardless of the pandemic. Factors such as fear of judgment from providers, a perceived lack of privacy and concerns around convenience and cost were more predominant than the COVID-19 pandemic in participants' decision not to seek clinical care and instead go to accompaniment groups for guidance and support. As such, this indicates the importance of accompaniment groups in any context beyond just the pandemic. Specifically, participants believed that self-managing with the support of accompaniment groups was more private, comfortable, and convenient than going to a clinic. These findings echo other studies that have shown increased demand for SMA during the pandemic[14,30] and highlight the essential role of accompaniment organisations in providing abortion access always and in the face of challenges created by and/or exacerbated by a global pandemic.[31]

The accompaniment model of abortion care helped reduce people's unwanted interactions with health systems during a time when they were overburdened by the pandemic. The majority of participants in this study did not visit a health facility at any point during their SMA, nor did they desire to, for a myriad of reasons. Interactions with health systems during or after an abortion are not necessary requirements for having a safe abortion. In fact, a growing body of evidence points to the safety and efficacy of medication abortion with accompaniment support, almost entirely without clinical support.[25,26] Clinical abortion care should be readily accessible if and when a person having an abortion chooses it. However, this study furthers our understanding of the critical role of accompaniment models of care and suggests that accompaniment groups can be at the forefront of safe and effective abortion care provision, with health systems providing auxiliary support services if needed or desired by people having abortions.

This paper supports already published commentaries and articles on access to abortion during the COVID-19 pandemic, providing further evidence as to why abortion should always be considered essential health care, particularly during a pandemic when additional barriers to accessing safe abortion care exist.[30,32] Additionally, the barriers to safe abortion care experienced by participants in this study, such as restrictive laws, financial hardship, police presence, and limited access to transportation, illustrate the ways in which the COVID-19 pandemic highlights the pre-existing structural constraints in which inequity has always been embedded in access to abortion.[33] Furthermore, this paper reinforces the idea that SMA, with support from accompaniment groups, and other alternatives to abortion in clinical settings such as telemedicine models, are not just provisional solutions to a pandemic but valuable, and often preferable, models of care.[34] To our knowledge, this study is unique in that it explores people's experiences of SMA with accompaniment support during the COVID-19 pandemic. The findings provide key insights into the types of barriers that people seeking abortions faced during COVID-19 and related lockdowns and could be utilised to mitigate the ongoing challenges that people are facing in the midst of the current pandemic as well as for future pandemics or lockdowns.

As with all research, we recognise that this paper has limitations that are worth noting. While we were able to interview 43 individuals across four unique social and legal contexts, in

analysing these data together, we lose some contextual nuances and do not provide insight into the variations between country contexts. We also only spoke with people who were able to successfully access a safe abortion during the pandemic, and thus we did not capture the perspectives of people who either accessed unsafe abortion care or failed to access abortion care due to insurmountable challenges. It is likely that people who accessed unsafe care or were unable to access abortion care altogether faced additional challenges not represented in this manuscript. Data from these perspectives would be instrumental in understanding ways for accompaniment groups to further expand their reach to these individuals. To minimise the risk of social desirability bias based on the role of accompaniment partners in data collection, we ensured participants were interviewed by study team members with whom they did not interact during their abortion; during the informed consent process, participants were assured that everything they shared would be confidential and that it would not impact their ability to receive abortion support in the future; the interview guide did not contain questions regarding the role of the accompaniment group in participants' abortion experiences; and, finally, analysis was conducted by Ibis, an independent research organisation.

Our findings from this study are relevant beyond the ongoing COVID-19 pandemic and have wide-ranging implications for improving accessibility of and quality of abortion services generally, whether in clinical settings or self-managed at home. This analysis highlights the essential role that accompaniment groups play in ensuring access to high-quality abortion care in a multiplicity of settings, and underscores how the need for this type of person-centred, community-facilitated care is amplified in situations such as the COVID-19 pandemic. Accompaniment groups and safe abortion hotlines can also play an important role in ensuring access to safe, supported abortions in contexts where abortion is legal or has recently been legalised, such as Argentina. As such, advocacy strategies to legalise abortion should include accompaniment groups and ensure that attempts to legalise abortion do not criminalise self-managed abortion or accompanied SMA.[35] Funding to support interventions that expand the reach and services offered by accompaniment groups could greatly improve access to high-quality and supported medication abortion care. Future research is needed to understand the barriers people continue to face in accessing abortion care in the ongoing pandemic and strategies for expanding the reach of accompaniment group services to improve access to this preferred model of care.

Conclusion

This study provides a detailed description of the ways in which people's abortion experiences were affected by COVID-19 and the related lockdowns. The pandemic created social, emotional and financial burdens that were apparent and amplified in people's self-managed abortion experiences. The pandemic also created barriers to accessing health care prior to, during, and after participants' self-managed abortions; as such, participants' primary point of care during their abortions were accompaniment groups. The accompaniment model not only filled a critical gap in health care provision in a time when health systems were overburdened, but it was also overwhelmingly people's preference to have an SMA with accompaniment support regardless of the pandemic, highlighting the importance of this model of care. Further work is needed to expand the reach of accompaniment groups to provide information and emotional support during SMA to ensure access to high-quality abortion care is preserved, particularly given the ongoing COVID-19 pandemic.

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contributed significantly to writing and editing the manuscript. IE, SN, RZ, BG, IAK, MM, MSL, SS, IT, GS conducted data collection, data validation, and contributed to the final manuscript. All authors read and approved the final manuscript. All authors have read and approved this manuscript. The findings of this study have not already been published, and it has not been submitted elsewhere and is not otherwise under consideration elsewhere.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

The dataset generated and analysed during the current study is not publicly available in order to maintain confidentiality and reduce risk to the participants. The interview guide is published as supplementary material to this manuscript.

Ethics approval and consent to participate

This study was approved by Allendale Investigational Review Board based in the United States. All participants provided verbal consent to participate in the study.

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Résumé

Dans le monde, les personnes autogèrent leurs avortements médicamenteux sans assistance clinique. Les collectifs d'activistes féministes (groupes d'accompagnement) soutiennent les femmes pendant les avortements autogérés avec des conseils à base factuelle. Nous souhaitions comprendre les conséquences de la COVID-19 et des restrictions liées sur le besoin et l'expérience de l'avortement autogéré avec un soutien d'accompagnement dans différents contextes juridiques et sociaux. De mai à octobre 2020, nous avons mené des entretiens approfondis avec des personnes qui ont autogéré leur avortement, avec le soutien de groupes d'accompagnement pendant la pandémie en Argentine, en Indonésie, au Nigéria et au Venezuela. Nous avons réalisé une analyse thématique pour comprendre l'impact de la COVID-19 sur l'expérience vécue par les participantes lors d'un avortement autogéré accompagné. Dans 43 entretiens approfondis, les participantes dans les quatre pays ont expliqué comment la pandémie de COVID-19 avait créé des difficultés à chaque étape du processus d'avortement, depuis la confirmation de la grossesse et l'accès aux pilules abortives, jusqu'à la recherche d'un lieu privé et confortable et la vérification de la complétude de l'avortement. Pour la plupart des personnes, les conditions relatives à la pandémie ont rendu plus difficile d'autogérer un avortement ; pour une minorité, le fait d'être à la maison a quelque peu facilité l'expérience. Néanmoins, toutes les participantes ont indiqué qu'elles s'étaient senties soutenues par les groupes d'accompagnement, et la COVID-19 et les confinements liés ont renforcé leur préférence pour un avortement autogéré avec le soutien de groupes d'accompagnement. Ces conclusions soulignent le rôle essentiel que jouent les groupes d'accompagnement pour garantir l'accès à des soins d'avortement de qualité dans une multiplicité d'environnements, en particulier pendant la pandémie de COVID-19. Des efforts sont nécessaires pour étendre le champ d'action des groupes d'accompagnement en vue d'élargir l'accès au soutien de qualité qu'ils prodiguent pendant l'avortement, comblant ainsi une lacune du système de santé et des infrastructures juridiques.

Resumen

Mundialmente, las personas autogestionan sus abortos con medicamentos sin asistencia clínica. Los colectivos de activistas feministas (grupos de acompañamiento) apoyan a las personas durante el aborto autogestionado con orientación basada en evidencia. Buscamos entender el impacto de COVID-19 y restricciones relacionadas en la necesidad y las experiencias de autogestionar el aborto con apoyo de acompañamiento en diversos contextos legislativos y sociales. Entre mayo y octubre de 2020, realizamos entrevistas a profundidad con personas que autogestionaron su aborto con el apoyo de grupos de acompañamiento durante la pandemia en Argentina, Indonesia, Nigeria y Venezuela. Realizamos análisis temáticos para entender el impacto de COVID-19 en las experiencias de las participantes con abortos autogestionados acompañados. En 43 entrevistas a profundidad, las participantes en los cuatro países describieron cómo la pandemia de COVID-19 creó retos en cada etapa de su proceso de aborto: confirmar el embarazo, obtener pastillas de aborto, encontrar un lugar privado y cómodo, y verificar que tuvo un aborto completo. Para la mayoría de las personas, debido a las condiciones relacionadas con la pandemia les resultó más difícil autogestionar el aborto; para una minoría, por estar en su casa, ciertos aspectos de la experiencia fueron un poco más fáciles. Sin embargo, todas las participantes informaron sentirse apoyadas por los grupos de acompañamiento, y COVID-19 y los cierres relacionados reforzaron su preferencia por el aborto autogestionado apoyado con acompañamiento. Estos hallazgos destacan el papel esencial que desempeñan los grupos de acompañamiento en garantizar acceso a servicios de aborto de alta calidad en una multiplicidad de entornos, en particular durante la pandemia de COVID-19. Se necesitan esfuerzos para ampliar el alcance de los grupos de acompañamiento con el fin de ampliar el acceso al apoyo de alta calidad al aborto que brindan, mediante el cual llenan una importante brecha creada por el sistema de salud y la infraestructura legislativa.