Listening to Women: Impact of COVID19 on Abortion Services in India

Report of a multi-centric qualitative study in eight states

Introduction

COVID-19 has severely disrupted lives, jeopardized the well-being of billions of people, and raised the possibility of a global health crisis. A staggering 90% or 9.2 lakh women in India estimated to require abortion services could not access them between January and June 2020 because of the stringent COVID-19 lockdown. These women were among the 13 lakh women who couldn't get any kind of sexual and reproductive health services, many of whom were impeded because of domestic abuse.

It is estimated that the inability to access sexual and reproductive health services in India could lead to as many as 10 lakh unsafe abortions, 6.5 lakh unintended pregnancies and 2,600 maternal deaths in the country. It would be worthwhile to note here that India accounts for 75% of the total disruption in family planning and safe abortion care services across 36 countries as reported by recent surveys conducted by leading service providers. Adolescents bore the double burden of this crisis, estimates noting that 73,500 fewer adolescents across 36 countries accessed reproductive health services, though their overall proportion at 15% of total clients remained consistent.

Further, leading global service providers have warned that as the lockdown-related restrictions are eased "the need for sexual and reproductive health services will only increase especially for safe abortion and post abortion care as there is likely to be an increase in need for second trimester abortions following the lockdown".

As a response to navigate the crisis, while medical abortion through digital counselling and support has been advocated, countries like India continue to face a challenge. Studies conducted at the time of the lockdown in India reported acute shortages in availability of medical abortion drugs in states like Delhi, Tamil Nadu, Punjab, Haryana and Madhya Pradesh, amongst others. While Punjab reported only one per cent of the chemists stocking drugs, two per cent in Tamil Nadu and Haryana, 6.5 per cent in Madhya Pradesh and 34 per cent in Delhi having stocked the abortion drug.

Central to this crisis has been women's experience of seeking abortion services. This is where the study conducted by Common Health in 9 states of the country becomes important. Whilst studies conducted during the pandemic have highlighted the constraints at the supply side of contraceptives, the study concluded by Common Health highlights the impediments at the demand side. By documenting the experiences of women who have been most affected including the service providers at the community level closest to the former, it fills the void in data gathering in terms of impact on communities.

It will be important to mention here that the combined impact of recession and disruption in service delivery is especially detrimental for the poor, who face multitude of challenges related to access to services, even in normal times. The experiences of women need to be understood in the context where income shocks and lockdowns have changed household and community gender dynamics and increased the disadvantages faced by women. A surge in gender-based violence cases particularly domestic violence has revealed the gendered nature of the pandemic. The experiences of women

documented in the study adds another level of analysis that needs to be factored in any plans for immediate intervention for women's sexual and reproductive health.

Study Methods and Objectives

The exploratory study conducted by Common Health aimed to explore and document women's:

- need for contraceptive, abortion and maternal care services
- access to contraceptive, abortion and maternal care services; and
- experiences with services in the course of the COVID19 pandemic and consequent country wide lockdown and changes in health system priorities.

Key Research Questions

1. How has Covid-19 impacted women's maternal health, contraceptive and abortion needs?
2. How has Covid-19 impacted the availability, accessibility and quality of reproductive health services in the public sector, especially contraceptive and abortion services?
3. What steps is the government health system taking to meet women's routine reproductive health needs as well as contraceptive and abortion service needs during the pandemic and lockdown period?
4. What are women doing in the absence of access to reproductive health services, especially maternal health, contraceptive and abortion services in the public sector?
5. What are women doing in absence of access to services they want / need?
6. What are the implications in terms of reproductive health outcomes of the steps they take in absence of access to services in the public sector?
7. What can be done to address the difficulties faced by women in accessing these services?

The method for the study was **qualitative** with key in-depth interviews conducted with a range of stakeholders. The respondents included women/girls (above age 18 who have need for or accessed contraceptive, maternal care of abortion services). Keeping geographical representation in bearing, 8 Indian states (Delhi, Punjab, Uttar Pradesh, Maharashtra, Gujarat, Tamil Nadu, West Bengal, Assam were covered spanning northern, southern, eastern and central part of India.

A total of 135 Key Informant Interviews were conducted. Besides women who were a primary cohort of respondents, other key stakeholders covered in the study included:

- Government functionaries
- Medical Officers and Doctors
- Frontline health workers ASHA and ANM
- Chemists

The **sample** for the study was purposive based on the willingness and ability of respondents to provide information on the topic. In order to facilitate a comprehensive understanding of the COVID induced impact, the sample represented the demand and supply side of service delivery. Women as clients in need of services at the demand side and the cohort of service providers at the supply side. Given the social context in India where access is mediated by caste, class and other social hierarchies, the study sought to understand the experiences of marginalised women including Dalit women, women living with HIV/AIDS, women with disabilities, sex workers and poor women living either in city slums or rural areas.

The data was collected by members of staff in organisations that are part of the Common Health Network and trained in qualitative research. All interviews were telephonic. Interview field guides for each cohort of respondent was developed, translated and used at all study sites.

Standard **ethical procedures** were followed. Before the interviews, informed consent from each respondent was sought using consent forms especially developed for the purposes. The consent was oral as the interviews were telephonic. The investigator signed the consent form after explaining the study to the respondent. The team leader in the member organisation countersigned the consent form after confirming that the investigator had explained the study purpose, assured confidentiality, given the option of refusing participation (with no adverse consequences for doing so) or withdrawing half way or refusing to answer some questions, informed about non-availability of any amount for participation, provided contact number of contact person in the organisation, and offered to send a copy of the consent form for their record. An **analysis plan** was developed. Interviews notes were transcribed in local language and entered in English in software developed for the purpose. Data was analysed for emerging patterns and themes. As the study is exploratory and qualitative study findings will not be interpreted to be representative of the community / area or statistically valid, however they provide valuable insights into women's experiences of seeking abortion services at the time of the pandemic.

Key Findings and Discussion

Profile of Women

Women were majorly in mid-twenties and mid-thirties; largely belonging to peri- rural and urban areas and were from low economic strata. Majority of the women reported parity of 2 or more children. There were also some women who were in their mid-thirties and had a parity of 3 or more. Most of them were homemakers and few worked as migrant workers.

The debilitating impact of COVID-19 on study participants

COVID-19 pandemic has been one of the most unprecedented events in the history of humankind that has altered what construes the normal. The impact has been on people's livelihoods, health, education of their children and their well- being. The sudden announcement of the national lockdown which severely hit the availability of essential services. However, while the data indicates that both men, women and children were affected, it is the vulnerable population (sex workers, HIV+ve women, lower caste women) who were doubly disadvantaged. Loss of livelihood, accessibility to basics such as food, shelter and facing violence at home. As one migrant woman belonging to the ST community from Punjab noted,

> "*Earning stopped for me and my husband. Mobility stopped due to curfew. Schooling of children stopped. Did not get ration, tried to go home to Bihar, no methods available. Even thought of suicide in those days."*

Increased episodes of violence were reported by the women,

> "*My husband works in a factory. During lockdown earning stopped. He started beating me out of frustration. There was sexual violence too. My children do not go to school. They are rag pickers. We had no food for days. I thought life would end*."

During the course of the study many women revealed how the lockdown dried up their finances and they had to struggle even for basic amenities. Many used up all their savings (if any), borrowed money and even resorted to begging to sustain themselves and their families. Some women respondents from Maharashtra who work as sex workers said their earnings had completely stopped and were dependent on the ration provided by the government. Owing to their status as sex workers, access to government rations was more difficult. Some HIV+ve women reported the discontinuation of ART regimen due to inadequate supply of medicines. The women whose spouses were migrant (formed large sample of respondents) laborers or worked as migrant laborers themselves lost their jobs and were forced return to their native states with no source of income. In addition to financial distress the women who were pregnant or got pregnant during lockdown had to deal with health issues with complete of limited lack of access and availability to RMNCH services. Many women respondents, particularly from Gujarat, Maharashtra and Punjab also shared that owing to limited mobility, accessing abortion was especially challenging when there was a spousal and familial pressure to continue the pregnancy and/or when cohabiting with an abusive partner—all of which resulted in increased risk of unacceptable/forced pregnancies, unsafe abortions, or miscarriages.

As the overburdened health system geared to meet the challenge of the pandemic, it resulted in resources and infrastructure being dedicated to COVID patients. This meant that other services were compromised. Majority of public health facilities and their staff were engaged on COVID-19 duties and closure of private health facilities compromised the access to RMNCH+N services including safe abortions, which is a time-sensitive procedure.

Impact of COVID-19 on RMNCH+N Services

Despite affirming RMNCAH+N (Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition) services as essential in mid-April health service during COVID-19, accessing these services has been quite challenging for the women and adolescent girls. Lockdowns, overburdening of the health system, shortage of healthcare personnel and fear of hospitals were attributed as reasons for low access and availability of services. This is corroborated with data published by the Health Management Information System (HMIS) under Union Health Ministry; the number of injectable contraception decreased from 66,112 in December 2018 to 42,639 in March 2019 (after the outbreak of the covid-19 pandemic). While intrauterine device (IUD) insertion showed a 21% decrease in March 2019, distribution of combined oral pill cycles and condom pieces reduced by 15% and 23%, respectively. Abortion services decreased by 28%. The low absorption of services is corroborated by the experiences validated by women in the study.

The experiences of women and that of the frontline workers indicate the following:

- Many Public health facilities were converted to Covid-19 care centers, or services were diverted from SDH/CHC to district or ESI hospitals that were not always accessible. Thus, limiting the availability of sexual and reproductive health [or SRH] services.
- Clinical staff including frontline workers were overburdened with COVID duties and many citied lack of personal protective equipment to provide services safely. Their engagement also hampered outreach activities such as immunization, contraceptive distribution, IEC and counseling and referral.
- Private health facilities were either closed or limited their service provision due to provider unavailability, inadequate protective gear, or lack of mandatory Covid-19 testing arrangements

- Supply chain disruptions limited availability of contraceptives and stock-outs of many contraceptive methods
- Suspension of public transport facilities, curbs on movement with the fear of facing punitive action by the police. Women also refrained from visiting health facilities due to fear of Covid-19 exposure.
- Temporary suspension of the provision of sterilizations and IUCDs in line with the Ministry of Health and Family Welfare's advisory till about mid-May till guidelines were revised. This meant that women were unable to use their preferred method of contraception especially if they needed long-term contraception.

Impact of COVID 19 on RCH Supply Chain

While medical facilities and retail chemists were exempted from the lockdown, the curbs on movement, as well as enhanced fear of infection among patients and health providers, resulted in low availability of services. In fact, many frontline workers and chemists shared about their inability to work smoothly and deliver services effectively partially owing to their own fear of contracting the virus and partly owing to fear among the general public as well. It emerged from the interviews of public service providers such as Medical Officers and other frontline workers such as ASHA, ANM and Anganwadi workers that, the use of essential health services suffered a setback at the supply as well as demand side. From the data it appears that the impact was more severe in states like Punjab, West Bengal and Maharashtra.

On the demand side, women and adolescent girls expressed their inability to avail or even seek information about various RMNCH services. This is attributed to several reasons: the most being the disruption in the link between ASHA/ANM with the community as the former were pulled into COVID specific duties. The pandemic perhaps illustrates best the critical role that the frontline service providers perform in ensuring that RCH services and information are available at the community level. This link was effectively disrupted during the pandemic and the lockdown even while MNCH and RCH services were categorized as essential services. Across all six states this disruption in linkage is cited by women as a primary reason for increase in unintended pregnancies, child births, and maternal health concerns. The ASHAs also shared how adolescent girls were particularly affected as it is difficult for young girls to seek SRH services even during normal times. Many of the young women across states reported difficulties in procuring sanitary pads, resorting to old methods like using cloth during the menstrual cycle.

Facilities and Service Delivery

The government officials across four states barring Punjab and Tamil Nadu spoke about the service delivery being smooth throughout the pandemic and women being attended to at home in case they home quarantined. For doctors in Gujarat and Maharashtra there was increase in workload and reported a significant increase in institutional deliveries but there was concern regarding service of adolescent health suffering. However, some doctors from Assam, Punjab and West Bengal pointed that there was not much difference, as they referred all cases to SDH or district hospital as abortion services are not available at PHC level. The medical practitioners from Maharashtra (rural and urban) and Gujarat noted that the supply of contraceptives such as condoms, were regularly available and other services were functional too. This was corroborated by NGO personnel and women as well, some of who were pregnant; received services from the SDH and district hospital, some women from Gujarat, Tamil Nadu and Assam even spoke about receiving support form ASHA/ANM during their

pregnancy and a few in terms of counseling and referral of services. However, majority of women respondents from states like Assam, Punjab West Bengal reported lack of accessibility due to lack of transport and non-availability of services even at the SDH/CHC level. In these states' women reported having to travel to long distances to district hospitals to seek services.

Impact on Vulnerable Groups

According to the providers the most vulnerable groups in Assam were the marginalized and minority groups. The ASHA and women respondents from Assam attributed this to the rumor that was generated that painted a particular community as the carrier of the virus. In states like Punjab, Gujarat providers considered adolescent girls and poor women requiring more services. In Maharashtra the data attest to sex workers, HIV+ve women facing additional constraints in accessing services. The disruption of HIV positive women in accessing their ART regimen posed a significant barrier. As one of the CSOs from the state noted,

> "S*ome women are HIV+ so they are facing problems for getting their tablets… and also they face financial problems too. In case of non availability of services, they mostly go to the private hospitals and some time they ask medical shop person regarding medication. This is a difficult situation*".

At the same time states like Punjab, Assam and Tamil Nadu which houses a large proportion of migrant workers were considered as the most vulnerable category of respondents most impacted by the pandemic.

Impact on availability of contraception

The availability and use of modern contraceptives were limited. Acute shortages of oral pills, condoms and emergency contraception pills were reported. The government had temporarily stopped IUD insertions and providing injectables. The shortage in availability of modern contraception was reinforced by several public providers such as Medical Officers, ASHA/ANM, and chemists from Tamil Nadu, Assam, Punjab and West Bengal. The women also shared that they tried to access these contraceptives from health centers (PHC and SDH) and market but failed, including private chemists which reported short supplies. It is important to note here that all the women across six states, who reported being pregnant stated that the pregnancy was unwanted and unplanned.

Impact on Abortion Services

Abortion is still heavily stigmatized, and women are unable to discuss seeking an abortion with their families. Even where women are able to travel, women often have trouble accessing transport to go to hospitals, especially in rural areas. There are also often cultural limitations on their mobility or access to finances to pay fares or buy contraceptives or MA drugs.

Lack of trained staff and poor access to medical supplies and equipment prevent public health services from providing surgical abortion services. This was also emphasized by the recent Guttmacher study that recommended that the availability of all abortion services, including medication abortion, be improved in public health facilities (Singh et al. 2018). Hence, women are often forced to pay for safe abortions in private sector clinics. Private-sector medical abortions are expensive, costing anywhere

between 500-10,000 rupees with all testing and user fees included. Women who cannot afford this are excluded.

These available evidences are corroborated by the current study. The data indicates clearly that amongst RMNCH services, abortion services were the worst affected. The taboo associated with abortion services were heightened during the pandemic. ASHAs form a critical link in villages establishing access of women to abortion services which are often sought by women without the knowledge of family members. With this link broken during the pandemic, a vacuum was created resulting in many women across the 6 states reporting having to continue the pregnancy despite their will. With their absence more than half of the women interviewed continued the pregnancy while the remaining tried getting abortion services from private facility, or using traditional methods or going to quacks: The reasons for the gap in services as pointed out by the provider including the chemists was in the supply chain for drugs and commodities, redeployment of facilities and staff for COVID-19 care, lack of transport, and restricted mobility. In a few states like Punjab, Maharashtra, West Bengal and Assam, women respondents noted private facilities being closed further limiting their options to seek emergency contraception.

Women across all the six states shared that some approached the nearby sub centers and/or PHC for abortion services but were turned away as the facilities were not equipped to deal with such cases. They were invariably referred to District hospitals that women could not cover due to restricted mobility due to lockdown and also due to fear of exposure to COVID-19 in big hospitals.

Interestingly though, all government providers across states claimed that there was no significant change in the abortion facilities or its demand. The facilities were accessible mostly at SDH or district hospital, and the women usually approached these facilities through the ASHA worker. This seems to be in contravention with the reported experiences of women across states. However, it would be important to point out here that frontline workers like ASHA/ANM across all 6 states report constriction in supply. As one of the ASHA worker from Punjab noted,

> "*Accessing services for abortion was the most difficult because of irregularity of routine services, lack of supply of medicines and sometime discriminatory practice of service providers also created confrontation. For instances two women reported that one service provider, i.e., one GNM of a Government Hospital insulted 2 women by asking 'Is abortion greater than infection of Covid-19? By chance when you get infected by Covid-19 then will only know the consequences of frequent coming in hospitals*."

Some women reported misusing drugs to avert pregnancy and or induce abortion. Overuse of EC pills being cited as one such example.

In states like West Bengal, Assam, Punjab, women reported incurring big expenses to seek abortion services spending from Rs 1500 to 15000 for services from private facilities. This is at a time when economic duress was high amongst the families. Using savings; borrowing money from friends and relatives or incurring debts were cited as methods for arranging the additional money required for seeking abortion services. It will be important to mention here that in some states like Maharashtra and amongst the female sex workers, the preference for seeking abortion services was in private facilities compared to government. As one of the FSW noted,

"In Some government hospitals they ask for the husbands name and aadhar card. So for confidentiality we prefer the private clinics".

At the supply side of the services, most chemists, more notably in Punjab and Gujarat revealed that due to strict implementation of policies, they are not authorized to sell Medical Abortion pills without prescription. At the same time, during the pandemic, they report 20 to 30 percent increase in MA pills which they could not provide due to these restrictions. The Chemists in other states in the study did allude to increased demand in pregnancy kits but the demand for MA drug was variable, more in states like Assam and Maharashtra. In Maharashtra chemists (urban) shared that there no supply issue and demand for sanitary items was the same as before but the sale of pregnancy kit had increased.

Experience of Violence

Across several states covered in the study, women reported increased incidence of violence in their marital life. The health providers pointed out that during the lockdown, the government suspended provision of sterilizations and intra-uterine contraceptive devices (IUCDs) at public facilities. There were also curbs imposed on movement in urban areas and for ASHA workers in rural areas that made access to over the counter contraceptives (OTC), condoms, oral contraceptive pills (OCPs), and emergency contraceptive pills (ECPs) difficult. This was corroborated by many women across all the six states. In fact, women using modern contraceptive measures such as condoms reported being unable to procure them from the field workers or even chemists. As a result, many women shared that they were unable to negotiate safe or reduced sexual activities with their husbands that led to unplanned pregnancies. Some women from Assam and Punjab also reported increased violence due to the lockdown that increased their vulnerability. As one NGO personnel from Punjab summed up the situation,

" Due to loss of work, mobility men stayed at home with nothing to do and no contribution to care work at home. As a result, there was growing domestic violence, physical and verbal and that included sexual relations also".

Autonomy and Decision making

Majority women reported low autonomy and decision making, with an exception to women in Tamil Nadu who seemed to fare better than women in other states. They reported restricted mobility and needed either permission or had to be accompanied to go out. While access to phones, and finances was available, but control was exercised by their spouses. The fertility decision according to many women was largely in consultation with family members, husbands in particular. However, some women reported submitting to their spouse decision to continue the pregnancy against their own wishes.

What Women Want- Recommendations

One of the overwhelming response and recommendation of women was to prioritize abortion services as key critical and essential service even during the pandemic. The women reiterated the key role that front line health workers like the ASHA and ANM play and strongly advocated for their services to be continued under all circumstances. The fact that most frontline workers were deputed for COVID duties created a gap between women and their access to critical abortion services. Most of the women who were forced to continue their unplanned pregnancy or had miscarriages reported at length the

mental and emotional drain that they experienced. At times like this, they reiterated the need for counselling services. Many a times the frontline workers play this role however due to COVID19 duties, the latter was not available. Women echoed the need for counselling support during such times. Further, as many government hospitals were converted into COVID facilities, many women had to travel long distances to seek abortion services. The need for localized abortion services at government hospitals which are affordable were duly highlighted.

Conclusion

The COVID19 pandemic has important lessons for the public health delivery system. As pandemic spread it, it overburdened the system which stretched itself to meet the emerging needs. However, as resources and facilities were being dedicated to contain the virus, it created a vacuum for other critical services like RMNCH+A. The role of the frontline workers like ASHA and ANM at duress times like this cannot be emphasized enough. However, as the findings from the study clearly indicate, the absence of the frontline workers from their regular role of being a link between the community and SRHR services, the impact of it was borne by women directly: Unavailability of contraceptives; rise in unintended pregnancies and lack of referral services. It is critical that in times of crisis like COVID19, SRHR and particularly abortion services are prioritized. This becomes all the more important given that abortion services are often stigmatized and difficult to access. The study clearly indicates the aggravated vulnerabilities of specific communities: female sex workers; HIV positive women; women from SC/ST communities. It thus becomes imperative that a public response system recognizes the structural impediments that vulnerable communities face in seeking services which gets amplified during crisis, particularly of the scale of COVID. The pandemic has clearly shown how a crisis situation has a direct bearing on gender-based violence. The absence of services particularly SRHR and abortion in particular increase women's vulnerability manifold. Thus, prioritizing and centralizing support services for violence become imperative.