Listening to Women

Impact of COVID-19 on Abortion Services in India (Assam)

A qualitative study conducted after the first phase lockdown in 2020
Study Period: October to December 2020

In a world trying to cope with a pandemic with unprecedented speed of spread, the health systems of individual countries in the throes of complete breakdown had a far-reaching impact on people's lives. Marie Stopes International's study in August 2020 estimated that a staggering 90 per cent or 9.2 lakh women in India requiring abortion services could not access them between January and June 2020 because of the stringent COVID-19 lockdown.[1] Medical abortion through digital counselling and support has been advocated as a safe alternative, but in countries like India it is not included in the list of services permitted through telemedicine and legal stipulations continue to come in the way of this approach. Moreover, just before the lockdown a study with 1,500 chemists, showed acute shortages in the availability of medical abortion drugs in various states.[2]

As governments with single-minded focus tried to contain the pandemic, the collateral damage done to the reproductive health of the most vulnerable sections of the population such as marginalised women were completely overlooked. There was a need to explore, understand and document women's need for and experiences with accessing reproductive services, especially time-sensitive, highly stigmatised and misunderstood abortion services. This research stemmed from the anecdotal experiences reported by CommonHealth members related to women's struggle to meet their abortion service needs during the pandemic.

The Action North East Trust (ANT): The ANT is an NGO established in 2000 in Western Assam. It works for the development of villages in northeast India on issues related to education, child protection, women's empowerment, peace building, and mental health.

Website: https://theant.org/en/

1 Resilience, Adaptation and Action: MSI's Response to COVID-19 - The survey recorded responses of 1,000 women aged 16-50 in India on their experiences and awareness of sexual and reproductive healthcare before and during the COVID-19 pandemic. https://www.msichoices.org/resources/resilience-adaptation-and-action-msis-response-to-COVID-19/?&subjectMatter=&resource=&year=&keyword

2 http://www.frhsi.org.in/pdf/FRHS%20India%20Study-Availability%20of%20MA%20drugs%20across%206%20Indian%20States.pdf

Need for the Study

The Action North East Trust (ANT) conducted this exploratory study in Assam for CommonHealth. It aimed to explore and document women's, especially of vulnerable women's:

- need for contraceptive, abortion, and maternal care services;
- access to contraceptive, abortion, and maternal care services; and
- experiences with services during the COVID-19 pandemic and consequent countrywide lockdown and changes in health system priorities.

The Methodology

Qualitative methods like in-depth interviews were conducted on a purposive sample based on the willingness and ability of respondents to provide information. Study participants included: women in the reproductive age group in rural villages where the ANT worked and who relied on government health services; Medical Officers (MOs) and doctors from the government and private sector; frontline service providers such as Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs); chemists; Government officers and grassroots level non-government organization (NGO) or community-based organization (CBO) or civil society organization (CSO) staff. A total of 16 interviews were conducted in Chirang district: six with women and ten with service providers, including government officers and CSO/NGO staff.

Process: Interview guides for each type of respondent were developed, and translated into the local languages, Assamese and Bodo. The proposal, consent form and interview guidelines were passed after rigorous scrutiny through the SAHAJ Institutional Ethical Committee. Girls/women above 18 years seeking reproductive services were identified in consultation with local service providers and field staff and with the prior consent of these girls/women. Selected team members were provided online training in qualitative research, study purpose, methodology along with COVID-19 related training. Interviews were in-person in full compliance with COVID-19 precautionary protocol for the field area. Interview notes were transcribed in the local language and entered in English in Excel. Data were analysed for emerging patterns and themes.

Key Findings

Increasing vulnerabilities: The respondents' narratives explicitly indicate how the loss of livelihood and income intensified vulnerabilities including violence and impacted health-seeking priorities during the lockdown. Many women revealed that lockdown dried up their finances and they had to struggle even for basic amenities and starvation. Almost all also reported low autonomy and decision making in matters related to their health and well-being even during normal times. The fertility decisions are largely those of woman's in-laws especially mother-in-law or sister-in-law, followed by husband. The women had limited or no control over their mobility and resources. These vulnerabilities got exacerbated during the government-imposed lockdowns, curfews, mobility restrictions, particularly for those from migrant families and minority communities who were subjected to intense negative campaigns. In addition to the problems of no income, scarcity of food and domestic violence (all stakeholders interviewed reported an increase in domestic violence) and emotional, financial, and social deprivation, the

women who were or got pregnant during the lockdown had to deal with health issues, when there was limited or no access to services and transportation.

Lockdown restrictions and the fear of police actions in case these were not followed, kept people inside their homes. Because of this livelihood of many families got affected. This increased stress levels that led to increased domestic violence.

ASHA worker

Among women, the most vulnerable groups were reverse migrant women, daily wage labourers, those who faced domestic violence and those who were without access to Family Planning methods.

NGO member

Increased reproductive health needs: Women's need for reproductive health services increased the pandemic. According to NGO personnel, the chances of women getting pregnant increased during the lockdown as partners/husbands were at home without much outdoor activity and contraceptives were not available. Women who reported being pregnant stated that the pregnancy was unwanted and unplanned. Most lacked access to abortion services and contraceptives during this period and had conceived due to lack of services and unavailability of contraceptives. NGO personnel, service providers and women in their area corroborated this. Even local chemists alluded to increased demand for pregnancy kits.

Yes, the number of demands for abortion is more than before the pandemic because of the unavailability of contraceptives during lockdown.

NGO member

There was a rise in demand for pregnancy kits and abortion pills, around 10% demand increased.

Chemist

Among women, the need for maternal, contraception and abortion services was more amongst the most vulnerable groups of women. And because of their situation and exposure, they were more in need of safety kits like masks, sanitisers, soaps supplies

- NGO member

Overwhelmed and ill-prepared/ill-equipped health system: The situation of health system in Assam was compromised and overburdened as resources, infrastructure and personnel were dedicated to COVID-19. Interviewed government health providers talked in detail about the changes and challenges in carrying out their job despite overburdening, staff shortage and inadequate supplies of protective equipment. Almost all MOs reported a drastic drop in the out-patients department (OPD) turnout. This was a result of the suspension of public transport facilities, curbs on movement and

women refrained from visiting health facilities due to fear of COVID-19 exposure. Also, Assam has a difficult terrain and long distances make travelling difficult, especially for rural inhabitants.

While urban facilities were first to feel the pressure, the rural facilities came under the grip of the pandemic a month later when migrant labourers started returning to their native villages. Health staff in rural areas did try to devise their own approaches to ensure that services were available while safeguarding their own health and safety and after initial apprehension about the intent of these approaches, the community did respond positively.

> *Primary health centres were made COVID care centres, delivery ward and abortion services got affected as they were shifted to other centres. It created havoc for us as no information was given. There were no backup services.*
>
> - ASHA

> *We didn't know the status of the patients approaching us, especially the asymptomatic ones. So, there was initial screening based on their travel history and peculiar symptoms and then we referred them to appropriate centres for diagnosis and further management. Initially, there was resistance from the community to get tested, which reduced with time and awareness. They became cooperative and volunteered to get tested if needed for further treatment.*
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> - CHC MO

Though the Ministry of Health and Family Welfare had affirmed maternal health services as essential services in mid-April 2020 and all government providers across states claimed that there was no significant change in the abortion facilities or their demand.

> *All hospitals had specified services/facilities and all were available during the pandemic. All the Programs and Services which are provided during normal days were in place, the UIP (immunisation programme) has since been resumed, VHNSD is conducted with precautions. Sub-Centres, PHCs are functioning normally, the family planning services are in place with sufficient oral contraceptive pills, emergency contraceptive pills and IUCD at Sub-Centres and PHCs.*
>
> - Government Official

However, accessing these services was quite challenging for the women. Women reported that they had a bad experience when seeking contraceptive and abortion services, and as health care providers were missing, they did not know what to do. Even the service providers reported that women had no choice but to continue the pregnancy especially if they could not afford to buy pills from chemists.

> *I tried to get pills but I did not have money and when I went to the hospital, the nurse said what is more important getting infected by Covid or pregnancy? I did not know what to do. I tried contraceptives from the chemist but wasn't successful as they costed around Rs. 1500/-.*
>
> - Married woman

Women had difficulty accessing abortion services. In one case, a woman wanted to abort but due to financial constraints she couldn't do her ultrasound and without an ultrasound report, the doctor refused to proceed. There was no sonography and ANC blood testing facility available in the civil hospital.

- ASHA

Women by no choice had to conceive due to the non-availability of abortion services in the reachable location. Weekly camps were affected as very few women turned up for the check-up out of fear of police and no commuting facility.

- ASHA

Women expressed their disappointment with the health system and described the difficulties they faced. Women usually approached the facilities available at a Sub-district hospital (SDH) or District Hospital through the ASHA worker. But most women reported a lack of accessibility due to fear of police action, lack of transport and non-availability of health services even at the Community Health Centre (CHC) level. During the lockdown period, outreach services such as the Village Health and Nutrition Day (VHND) were already rare, were completely suspended, Anganwadi centres restricted themselves to the distribution of some Take Home Ration and the ASHA/ANM were unavailable for most women. They also talked about the hostile behaviour of health staff.

My pregnancy was unplanned. I wanted to abort but due to financial problems and strict lockdown, I was unable to visit the doctor. I couldn't go for abortion as it was very far and no commuting facilities were available and mobility was restricted. So, I took pills from the Chemist three times to abort but was not successful. It was expensive as one strip cost around 500 rupees. We sought loans from the relatives, as savings were spent. Also, without a sonography report, the doctor refused to proceed. The doctor and the staff behaved very rudely even to our ASHA for not having a sonography report. Due to financial problems, I could not bear the cost of sonography and hence I had to continue the pregnancy. Our ASHA helped by giving counselling and doing regular follow up. But I am very sad with the health system as I didn't receive any services to which I am entitled to.

- Married woman

I did my abortion at the PHC. Due to fear of COVID, the staff were a little over conscious as I came from the minority community. I was charged Rs. 1000/- for the abortion process. As there was no means to travel so I went by walking with the ASHA and returned. I was not allowed to rest or stay for a longer time due to COVID fear.

- Married woman

Women suggested that service providers who provide services to women should not be involved in handling the pandemic as women's and children's health needs continue irrespective of the pandemic and they need timely services.

Health centres should continue like before the pandemic, the behaviour of staff should be good. There should be some relaxation for poor people like us. Health workers dedicated to mother and child should not be engaged for Covid duty.

- Married woman

Lack of resources and training: While the government claimed services were available, women and service providers reported that there was a lack of availability of 108 ambulances and if available, many were charging. There was a lack of resources even for frontline service providers with a lack of safety kits and good quality masks. The Medical Officers stated they did not receive any training to handle the changes during COVID.

For Family Welfare and Family Planning Services, all 29 hospitals and 87 sub-centres are well equipped. Designated hospitals provide specific services which they are continuing without any difficulty. For instance, male and female sterilization services are available only at District Civil Hospital, CAC services are available only at 5 hospitals.

- Government Official

Service providers, especially ASHAs confessed that they were ill-equipped to deal with the pandemic and their routine mandated services. They were not provided with any training to deal with the situation nor were they provided with any safety supplies.

No, we did not receive training. Even gloves, masks were inadequate in numbers. In fact, one of our staff nurses got affected by COVID, who worked in the labour room. We realised so many antenatal women checked and referred by us turned out to be COVID positive, once we referred them to a higher facility.

- ASHA

They talked about vested interests taking advantage of the crises and exploiting vulnerable women and the need for accountability mechanisms to keep such rampant exploitation in control.

108 emergency services should be made available. It is free of cost but drivers charge so, the government should monitor and ensure zero exploitation and free services are in place. Government should ensure maximum resources be at a place in the hands of frontline workers. Sonography/ultrasound services should be at the state dispensary level. ASHAs should be given training, preparatory sessions and measures to work during pandemics. Supply safety kits and good quality masks for frontline workers.

- ASHA

The supply chain was also affected. This led to exploitation that was not limited to the government health system. Medical pills if available at the Chemist, were too expensive for the poorer communities. Several public providers such as Medical Officers, ASHA/ ANM, and chemists reiterated the shortage in the availability of contraceptive methods both at facilities and during outreach due to the imposed curbs. The main reasons for the gap in the services as pointed out by the providers and the chemists were the breakdown of the supply chain for drugs and commodities, redeployment of facilities and staff for COVID-19 care, lack of transport, and restricted mobility.

Stock and supply of contraceptives, abortion and pregnancy kits were affected during the lockdown and last 4 months as of other medicines. Choice and Mala-D were the most commonly demanded contraceptives. We needed to carry in small quantities through our bikes to address the issue. The situation is becoming better now.

- Chemist

Steps taken by women: Despite unwanted pregnancies, few women came for abortion services. Some took pills without medical advice while others just continued with their pregnancy. Women's health needs become the first and major casualty of economic constraints and systemic breakdown. The women reiterated the key role that front line service providers like the ASHA and ANM play and strongly advocated for their services to be continued under all circumstances. Women echoed the need for counselling support during such times.

Role of NGOs: NGOs across the state responded to the needs of the women by adopting different strategies. While most NGOs /CBOs conducted awareness camps and meetings and established help desks to inform the community about COVID prevention and availability of services, some of them also provided hygiene supplies and food. These organisations often played a critical role in coordinating with ASHAs, Anganwadi workers to establish support mechanisms in the community for immediate referrals and with medical officers directly to provide relevant information and facilitate services through the public health facilities.

Our organisation created awareness and support through counselling on sexual and reproductive health, maternal care, and availability of services in government hospitals among our Self-Help Group members through monthly and quarterly meetings. In this way, our organisation was able to provide support to women for accessing required services'

- NGO member

Limitations of the study: There were difficulties in reaching out to some respondents, especially the government sector service providers since they were preoccupied with pandemic management. Findings cannot be interpreted as representative of the community/area or statistically valid as sampling for interviews was purposive. However, they do provide valuable insights into women's experiences of seeking abortion services at the time of the pandemic.

Lessons for the government health delivery system

The COVID-19 pandemic was undoubtedly unprecedented and caught the health system unawares, unprepared and overburdened. Their COVID engagement hampered outreach activities such as contraceptive distribution, IEC counselling, commodity supply and referral. The need for localised, affordable, legal, and safe abortion services during the pandemic situation was evident, rather higher than ever because of the inaccessibility of contraceptive services and the increased potential for both unwanted and unplanned pregnancies.

NGOs working locally at the community level with the women also articulated the need for a strong institutional support system for women to ensure that their health needs are met even in a crisis situation. Thus, a system that is impervious to any systemic crises needs to be conceptualized and established. Given that NGOs have the reach and rapport with the most marginalized groups, co-opting them during these situations should be part of such contingency health plans.

Interactions with different stakeholders brought out three critical lessons for uninterrupted service delivery to the community. Firstly, a continuation of routine and essential reproductive health services has to be ensured irrespective of prevailing health crises. Secondly, the frontline workers who are the first point of contact and a critical source of information, support and reproductive health related commodity supplies in the community have to be spared from long term deployment for such work. And finally, a consistent supply of commodities (contraceptives, sanitary napkins, pregnancy test kits) has to be ensured through the establishment of local depots.

In times of crisis like COVID-19, it is important that sexual and reproductive health, and rights (SRHR), particularly abortion services are prioritised as they are time-sensitive. The absence of these services, increase women's vulnerability manifold. Prioritising and centralising support services in this area thus becomes a necessity.

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