Listening to Women

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

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

CommonHealth

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.

Amhi Amchya Arogyasathi (AAA): Established in 1984, AAA is a not-for-profit organization that works towards bridging the issues of the community related to women, tribals, farmers and other weaker sections through a community empowerment approach.

Saheli Sangh: Formed in 1998, Saheli Sangh is a sex worker's collective based in Pune. It brings women in sex work together to resolve their issues through a rights-based approach. It works with brothel and non-brothel based sex workers to enhance and enable greater levels of self-protection among them through a sense of togetherness, collective action, and creation of an identity.

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.pdf5

Need for the Study

The Amhi Amchya Arogyasathi and Saheli Sangh conducted this exploratory study in Maharashtra for CommonHealth. They 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/tribal villages in field areas of AAA and sex workers in urban areas where Saheli Sangh 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 30 interviews were conducted in Gadchiroli and Pune districts: ten with women and twenty service providers, including government officers and CSO/NGO staff.

Process: Interview guides for each type of respondent was developed, and translated into Marathi, the local language. 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 of AAA and Saheli Sangh and with the prior consent of these girls/women. Selected team members of AAA and Saheli Sangh were provided online training in qualitative research, study purpose, methodology along with COVID-19 related training. Interviews were telephonic or via mobile as well as 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 indicate how the loss of income impacted health-seeking priorities during the lockdown. Many women revealed that during lockdown their finances were affected and some had to take loans or borrow money. Most reported low autonomy and decision making in matters related to their health and well-being. The fertility decisions were largely those of husbands/men and elders in the family and in the case of sex workers, it was mostly their own decision. Women had limited or no control over their mobility and resources. These vulnerabilities got exacerbated during the government-imposed lockdowns, curfews, and mobility restrictions. Sex workers had no earnings during this period.

Covid-19 affected my life. The lockdown came all of a sudden. We didn't even know what to do or not to do. How long it will last. The first few days customers came. We took all the customers who came. Customers who filled the ration in our house. But then there was no cooking gas. Then there were no customers. We did not earn money, the question was what will we eat? I was begging and was asking for money as there were no clients. Due to lockdown, no one came out. So, our dhanda (business) was affected. There were no earnings.

- Female sex worker

Women with health issues had limited or no access to services and transportation, especially in the initial phase. NGO members confirmed these experiences of poor women.

Health was affected, mobility was affected, work and income were affected and we faced financial problems because of Corona. There was no bus service, because of which we had problems travelling to the hospital. We had to borrow money from relatives.

- Married woman

In terms of health seeking, poor families were impacted the most because of the lack of public transport and other facilities. People faced problems in going to hospitals. Some had to get themselves treated by 'jholachhap' practitioners (quacks) who come to villages. Those people suffered; they spent a lot of money on treatment.

- NGO member

Increased reproductive health needs: Women's need for reproductive health services increased during the pandemic. Yet, most lacked access to reproductive health services during this period mainly due to lack of transportation and their fear for contracting COVID from government hospitals. In absence of access to contraceptives and other services during the lockdown, more women had to deal with issues like unwanted pregnancies and miscarriages.

Demand for contraceptives increased during this period. There was an increase in demand for abortion and contraceptive services. And in case of pregnancies, there was an increase in antenatal and postnatal care requirements.

- ASHA

Yet, service providers in tribal areas like MOs, ASHAs and ANMs said there was no increase in abortion rates during the pandemic.

There has been no change in demand. It is the same as earlier. Women come for tablets for body ache. Some also asked for contraceptives and there was also demand for pregnancy testing kits. But these were stable as before. Increased demand was for sanitizers and masks.

– Chemist

Overwhelmed and ill-prepared/ill-equipped health system: The situation of the health system in these areas of Maharashtra was comparatively better as compared to other states where this study was also conducted. COVID-19 related workload was high. The health system was compromised and overburdened as resources, infrastructure and personnel were dedicated to COVID-19.

Though the Ministry of Health and Family Welfare had affirmed maternal health services as essential services in mid-April 2020. All interviewed Government officials and government service providers in these areas claimed that there was no significant change in reproductive health facilities and that they provided all services.

> *No challenges as such as wherever there were containment zones, women were provided services at home. During the COVID outbreak, ANC/PNC and other facilities were provided following social distancing and precautions for staff and patients, other programmes weren't affected. All these activities were regularly conducted following the social distancing norm. All services were regularly provided so women didn't face any problems.*
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> - Government official

While the NGO workers corroborated these assertions of service providers, they also acknowledged declining health facility caseloads. This according to them 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.

> *Usually, during the rainy season the clinics and OPDs would be full of patients but during COVID there was less footfall in OPD clinics. This was despite the fact that both government and private health care facilities were functional 24 hours, and services were not denied. People had fear of COVID infection, so they did not go there.*
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> - NGO member

Women contradicted them and said that reproductive services were definitely not available in the initial phase. They usually approached the facilities available at a Sub-district hospital (SDH) or District or tertiary care government hospital through the ASHA worker or other frontline workers. But most women reported a lack of accessibility due to lack of transport and non-availability of health services even at the Community Health Centre (CHC) level. Those engaged in sex work also talked about fear of police. During the lockdown period, in the rural/tribal areas outreach services such as the Village Health and Nutrition Day (VHND) were suspended, and the ASHA/ANM were unavailable for most women.

> *I came to know about my pregnancy after ASHA did my pregnancy test. I wanted this pregnancy. I faced problems in accessing the sub-district hospital as they didn't provide services. My health suffered due to lockdown; miscarriage happened. I took a loan from my Self Help Group. I bled, had stomach pain, and due to low Hb (haemoglobin), blood had to be transfused. It affected me mentally.*
>
> - Married woman

Lack of resources and training: Frontline workers lacked resources especially safety kits (Personal Protection Equipment-PPEs) and good quality masks. Almost all the service providers complained about the lack of safety kits like PPEs, masks, sanitizers, and gloves. Service providers in the government sector however said that they received training to handle the emerging challenges in service delivery during the COVID pandemic and they found this very helpful.

In order to provide regular services, the Government provided training to the health staff and they took all the necessary precautions to deliver the services to beneficiaries. These measures were 100% effective.

- Government official

There were reports of a short supply of consumables, especially those on long terms treatment for chronic health issues. These commodity shortages along with economic challenges impacted health seeking of sex workers.

Some women are HIV+ so they faced problems with those tablets. And also they faced financial problems too. Their treatment was affected.

- NGO member

According to Chemists in urban areas, there was no stock out or shortage of contraceptive and abortion pill supplies. They reported that they had enough stock of condoms and oral contraceptive pills. Those in urban areas of Saheli Sangh said that they had abortion pill stock to meet the usual demand. And as the demand for abortion pills did not increase, they could meet existing demand. While they generally provided the sex workers with abortion pills without prescription, they did recommend these women to go to the hospital to get services. In rural areas, the Chemists said that abortion pills were not available at their level.

Steps taken by women: Women reported that they had a bad experience when seeking contraceptive services, and as service providers were missing, they did not know what to do. Many of them ended up conceiving though they did not want to have a child. Of those who conceived, some suffered miscarriages.

Despite unwanted pregnancies, few women came for abortion services. Some took pills without medical advice while others just continued with their pregnancy. Fear of COVID-19 from government hospitals, made some women prefer traditional healing methods and visiting quacks.

Due to poor economic conditions, women prefer government hospitals for abortion. But due to fear of COVID-19 infection, the compulsion for COVID-19 test and reporting, lack of support from family, and confidentiality issues, women did not come to government hospitals during the pandemic. They went to private clinics or continued the pregnancy.

- ANM

In terms of health seeking, poor families were impacted the most because of lack of public transport and other facilities, people faced problems in going to hospitals. Very few women who had trust in government services went there, rest went to private and some followed traditional methods at home for healing or visited quacks or 'jholachap' practitioners who come to villages. Those people suffered; they spent a lot of money even on this treatment as they had no option.

- NGO member

At the government health facilities, there were complaints about service provider attitudes and behaviour. These service providers are known to show scant regard for the standard operating guidelines and deny services to sex workers which lead them to choose unaffordable private services over the government. These practices were pronounced during the pandemic period where under the pretext of keeping track of infected and possible exposed cases, service providers asked for unnecessary identity and documentary proof. Describing their situation, the female sex workers in Maharashtra said:

We are aware that for abortion there should be no need for the signature of the husband. But the doctors at government hospitals asked us for the husband's name/ signature and other documents before conducting an abortion. They charge fees. I personally had a very bad experience though my partner paid for the abortion. So, for confidentiality purposes, we prefer to go to private clinics, which charge more but don't bother us otherwise.

- Female sex worker

Thus, women's health needs become the first and major casualty of economic constraints and systemic breakdown. The peer educators reiterated the key role that front line service providers like the ASHA and ANM play in women's seeking of institutional care and strongly advocated for their services to be continued under all circumstances. Women echoed the need for counselling support during such times.

Women earlier were going to government hospitals for services, as ASHAs were their first contact and guided them there and also because these services are free. And during COVID-19 lockdown only government hospitals were open but due to fear of COVID-19 some women preferred to give birth to the child at home only. Women avoided going to the hospitals.

- Peer educator

Role of NGOs: NGOs and CBOs responded to the needs of the women by adopting different strategies such as using phones and mobiles for providing guidance and counselling. 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 frontline workers mainly ASHAs and Anganwadi workers to establish support mechanisms in the community for immediate referrals and in coordinating with government doctors directly to provide relevant information and facilitate services through the government health facilities. The NGO members and peer educators were especially helpful in addressing the issues faced by sex workers during the pandemic.

Due to the lockdown and curfew, I was not able to visit brothels. So, I started phone counselling. This was the major change in our working style. During the lockdown, I received phone counselling training from SIIAP organisation. Later on, we did ration distribution, masks and sanitiser distribution and arranged for passes for those who wanted to travel back to their hometown.

- Peer educator

Sex workers confirmed the help received.

Covid-19 affected my life. When there were no customers, we did not earn money. We got ration from NGO people and also sometimes from police.

- Female sex worker

Even in rural area, NGO members played an active role in facilitating women's access to health services.

Wherever women had problems in accessing health services, at that level, we contacted ANM, ASHA, Block health officers and MOs and made efforts to resolve the issues. For example at one subcentre, one of the patients didn't get service. Her son called me for help. I contacted the MO who in turn contacted the ANM and through her the services were made available to the patient.

- NGO member

Limitations of the study: There were difficulties in reaching out to some respondents, especially the government 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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