Listening to Women

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

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.

ARPAN: ARPAN was established in 1995 in Nangal, Punjab. It works on issues related to poverty alleviation, Dalit upliftment, health and human rights, women's empowerment, and environment.

Guru Angad Dev Sewa Society (GADSS): Guru Angad Dev Sewa Society was established in 1997 in Chandigarh. It works on health and other rights based issues of the community.

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

In Punjab, ARPAN and GADSS conducted this exploratory study 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 urban slums and rural villages where the GADSS and ARPAN worked respectively and who relied mainly 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 15 interviews were conducted in Ludhiana and Rupnagar districts: five 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 language, Punjabi. The proposal, consent form and interview guidelines were passed after rigorous scrutiny by 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 protocol. Interviews were telephonic 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 explicitly indicate how the loss of livelihood and income intensified vulnerabilities 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 faced starvation. These economic hardships were compounded by violence including sexual violence at the hands of their spouses. The feelings of helplessness, frustration, desperation and depression made some of them even contemplate suicide.

My husband works in a factory. During the lockdown, his earnings stopped. He started beating me out of frustration. There was violence during sex. My children do not go to school anymore. They are now rag pickers. We did not get ration. We had no food for days. We even tried to go home to Bihar, but no transportation was available. Mobility was restricted due to curfew. I thought life would end. I even thought of suicide in those days.

- Married woman

The women had limited or no control over their mobility and resources. These vulnerabilities got exacerbated during the government-imposed lockdowns, curfews and mobility restrictions. Venturing out in these sealed areas in search of food, water and medicines invited police brutality.

I and other family members are working as Domestic Workers but as COVID-19 started in our area in March our work stopped. My husband works as a vendor and his work also stopped. Our area was sealed 3-4 times for 7-10 days each time. There was no arrangement of food and other necessary items for us. As there is no source of water in slum and most of us take water from the nearby canal but due to curfew nobody was allowed to go out of home even for water. Police threatened us and beat some people. We were crying for help but nobody was listening to our problems. People started fighting with each other for food. Till now (November 2020) there is no work for us nor a source of income.

- Married woman

NGO workers confirmed these experiences of women.

Due to loss of work and restrictions on mobility, men stayed at home with nothing to do. They are not used to household chores and do not contribute to the work at home. They were jobless and frustrated and there was increased physical, verbal, and sexual violence within homes. We came across ample cases like these, many more than usual.

- NGO member

Almost all women reported they didn't have any say in decision making in matters related to their health and well-being even during normal times. The fertility decisions are largely those of husbands and elders in the family. In addition to the above-mentioned problems, the women who were or got pregnant during the lockdown had to deal with reproductive health issues, when there was limited or no access to services and transportation.

Increased reproductive health needs: Women's need for reproductive health services increased during the pandemic. All the women who reported being pregnant stated that the pregnancy was unwanted and unplanned. Most of them lacked access to contraceptives and abortion services during this period and many could not afford private health services. Women also complained that they were mentally affected because of unwanted pregnancies.

All the stakeholders corroborated the increased demand for contraceptives, abortion services and pregnancy testing kits. NGO members and chemists reported an increase in demand for consumables such as sanitary napkins, pregnancy kits and contraceptives, especially from government health facilities and frontline workers. Though the need for health services had increased, women found it challenging to access the services because of the restrictions and discontinuation of routine services in the government sector. Some of those who could access complained about the hostile and rude behaviour of service providers.

> *In the third month of lockdown, I missed my period. We decided to have an abortion. I was referred to ESI hospital. It was 6 KM away. No public transport was available. I reached somehow but was not attended to properly. The attitude of the staff there was negative. They said why did you indulge in sex when you did not have protection. Due to the rude behaviour of staff, I did not seek these services from that hospital.*
>
> - Married woman

Stakeholders involved in facilitating or actually providing services also mentioned that due to lack of availability within the government health system, women had to resort to purchasing medications or accessing services (as well as for consequences or complications arising due to lack of these), from the market or from the private health facilities including those of quacks. Both government medical officers and ANMs confirmed this trend.

> *Due to complete lockdown, there was no supply in the market and a cash crunch, so demand for contraception, sanitary napkins, pregnancy kits, abortion services from government health facilities increased. The adolescents, women living in slums and dalit bastis needed these facilities more. Due to rush, women have to wait more than 2-3 days. Due to the non-availability of sanitary napkins, the majority of needy girls and women used clothes. Women were feeling helpless.*
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> - NGO member

The demand for oral contraceptives, emergency pills, and condoms increased. During the lockdown, the demand for pregnancy testing kits also increased. As there was no service and supply of these from government staff, the demand from the market increased. As per my information, it increased by more than three times. About 70% of those seeking medications, especially for abortion came without prescriptions. As per government instructions we cannot give these without prescriptions.

- Chemist

The contraceptive needs of women increased. Both antenatal and post-natal care were ignored. Women were unable to access abortion services.

- ANM

The number of abortion seekers has risen. The demand for contraceptives has also risen. However, we could not do much as this facility was closed for females since COVID started. They went to quacks, private doctors or were trying home remedies.

- Senior Medical Officer

Overwhelmed and ill-prepared/ill-equipped health system: The situation of the health system in the state was compromised and overburdened as resources, infrastructure and personnel were dedicated to COVID-19. Interviewed government service 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-patient department (OPD) turnout. This was due to suspension of public transport facilities, curbs on movement and women refraining from visiting health facilities due to fear of COVID-19 exposure.

Though the Ministry of Health and Family Welfare had affirmed maternal health services as essential services in mid-April 2020 and all government service providers across states claimed that overall there was no significant change in the health and abortion service availability, they did acknowledge that suspension of routine/non-emergency and outreach services was a step taken in the early phase of the pandemic which was rescinded after sometime.

Government health centres are accessible and are preferred by most women but unmarried, widows, single women prefer to go to quacks and private hospitals for confidentiality. Economically sound women also prefer good quality private hospitals. Some chemists also sell medicines and even MTP kits over the counter. During lockdown all these services were totally stopped by the government and private hospitals also closed the services.

- Chemist

During this early phase when services were suspended, women were either denied or asked to come later or were referred to other health facilities for routine and essential services and even for a time sensitive service such as abortion service. Medical officers at the government facility confirmed this.

Most of the staff in the health facility was on COVID-19 duty. There was a problem for those seeking abortion services because there was a big rush of women coming for delivery and abortion services. As these services are not regularly available and MO is also on COVID-19 duty, so it takes about one week for this service to be availed.

- Married woman

Due to the COVID-19 pandemic all field activities and outreach services related to Reproductive Health, ANCs, PNCs, immunization at the village level, VHNDs, household visits, etc. were stopped. This was the only government facility that used to provide reproductive health services to females in this area. It had stopped providing services and we didn't know how long would take it to come back to normal. In the last 4 months, we have been advising women coming to us for contraception, maternity care, or abortion services, to go to ESI hospital that is the only functional government hospital at this time. However, women find it difficult to go there. The ANMs are doing COVID duties, ASHAs also. So, field visits have stopped.

- Senior Medical Officer

Women usually approached the facilities available at a Sub-district hospital (SDH) or District Hospital through the ASHA. Most women during this period reported a lack of accessibility due to fear of the police, 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 suspended, and the ASHA/ANM were unavailable for most 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. Frontline workers reported that many women had no choice but to continue the pregnancy due to lack of services, delays, COVID protocols, inability to afford to buy pills from chemists or to access private hospitals.

The women faced great difficulty seeking an abortion due to multiple reasons … lockdown restrictions, closed facilities, lack of supplies with chemists and closure of routine services in health facility. Later when facilities opened, they started insisting on COVID negative reports before handling any case. Some women continued with pregnancy as they did not have any alternative.

- ANM

Service providers at the government facilities reported that as soon as the services were resumed there was a rush of those in need of reproductive health services, specifically abortion services, perhaps because of the suspension of contraceptive services in the early phase.

During the lockdown, routine services were totally stopped by the government and private hospitals. As the government started these services, there was a big rush of women seeking abortion services. Most of the women who come for abortion services are from local slums and nearby villages. Two unmarried girls also came but due to rush, they could not get these services in this centre.

- Medical Officer

According to interviewed women, despite government assertion that the services were interrupted only in the early phase, even six months later the challenges in accessing services especially outreach services continued.

Till date community based healthcare services are not available. There is no ASHA in our area and no ANM visits regularly. ICDS facility is also closed in our area. In the government hospitals that are working, there is no test facility and staff there demands tests from private labs. Private is not affordable.

- Married woman

Lack of resources and training: There was a lack of resources even for frontline service providers with a dearth of safety kits and good quality masks. Additionally, the government staff said they did not receive any training on COVID protocols and the ever changing guidelines made it difficult for them to handle the changes in health care requirements during the pandemic.

The health department did not provide any training or inputs for handling these changes in my activities. Also, due to the increasing number of positive cases in our area, most of our staff was on COVID-19 duty. There was a problem with the testing facility which are not available in the hospital. Lack of safety kits for staff is also a big problem. There are no OT services in this hospital and if we refer the patient to some other hospital. The staff of that hospital do not take care of our patients due to an overload of work.

- Medical Officer

Our work changed due to COVID-19, increasing patients, daily changing guidelines and instructions, lack of safety kits, lack of awareness, overload of work, non-cooperation from people were major challenges we were facing during COVID.

- ANM

The private sector service providers also in absence of any orientation or training were grappling with COVID-19 related issues, particularly fear of contracting the viral infection. Hence, there was a hesitation to attend to the patients. Private doctors said they closed their facilities till they received clear-cut guidelines, hence their services were disrupted.

The impact of supply chain disruptions was palpable. Medical pills if available at the Chemist, became too expensive for the poorer communities.

> *Due to complete lockdown, there was no supply at health centres. And due to the cash crunch, women found it difficult to purchase from the market. Supply issues later affected the market too. Some women got pregnancy test kits, contraceptives, abortion kits from chemists or private health centres, some from quacks. Some tried traditional methods or home remedies.*
>
> - NGO personnel

In absence of requisite supplies, those from low socio-economic strata of the society who are the main service seekers at government facilities tried to seek alternatives as they saw fit but mostly had to face the consequences of the crippling cost of services from the private sector.

> *Pregnancy happened in the second month of lockdown. I have enough children. Our local ASHA was on COVID duty, and did not have supplies and could not help me. Anganwadi was closed, so no nutrition, no pills. I did not have money so I could not buy or go to a private hospital. It has affected me mentally and physically. I tried to go to the nearest government hospital, but that was closed. I could do nothing.*
>
> - Married woman

> *There are no free services for our poor people and often they say to purchase pregnancy related medicines from market. I tried for abortion of this pregnancy from health department but didn't get. Private is not affordable. It's not good impact for me because I was not physically and mentally prepared for this child.*
>
> - Married woman

Steps taken by women: Due to the unwanted pregnancies, 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. Some women did not receive the help they required to fulfil their reproductive health needs, neither from their husbands nor from the service providers in both rural and urban areas.

My supply of oral pills finished in early days of lockdown. I tried to contact ASHA. She said she was on COVID duty. ANM was also not available. I asked my husband to procure condoms. He said no. We had unprotected sex. I did not want any more pregnancy. A friend advised me to go to chemist for emergency contraceptive pill. It was not available due to shortage of supplies. Government left us to fend for ourselves.

- Married woman

In absence of any supplies, services and support, women fended for themselves.

Major barriers in accessing care for women were no field services during lockdown and curfew. Due to myths and misconceptions about COVID-19, women were afraid that if they went to the hospital, they will be COVID positive. Private clinics increased rates and due to financial crisis, people in slums could not afford it. Due to the unavailability of services at government health facilities, women felt helpless and many women tried home remedies or went to quacks for services. Some just continued with the pregnancy.

- ANM

The women and service providers reiterated the key role that front line service providers like the ASHA and ANM played as the first contact for women in the community and strongly advocated for their services to be continued under all circumstances. Women also mentioned the need for guidance and counselling support during such trying times which the frontline workers did routinely.

The grassroots workers like ASHA and ANM are very useful to females like us. They should not be put on any other duty or some alternate arrangement should be made. ASHA and ANM should not stop coming. There should be adequate stock of contraceptives with them. They guide us on how we can get services for reproductive and sexual health.

- Married woman

At the health system level, the ANMs and ASHAs should not be disturbed from their duties. The continuity of services at the community level should be ensured even during disasters. At the community level, more help should be given to women in distress.

- ANM

Role of NGOs: In spite of initial hitches of not being able to visit their field areas due to curfews and lockdown, NGOs responded to the needs of the women by adopting different strategies such as establishing contact with the community in their field areas via phone/mobiles. 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.

> *Due to COVID-19, our work stopped as entry to these slums were not allowed. We started contacting people on phone and came to know about their problems. There was no service from the government for women, adolescents, children, etc. After about one month and discussions with the local administration, we started some services. Due to the non-supply and unavailability of contraceptives, sanitary napkins, there was a big crisis. We tried to provide some services but due to lack of sources, we were also helpless. Now our team is working in the field. We do awareness about health services and facilities available in government hospitals. We connect women to health workers and help them in getting supplies. For abortion services, it is still a difficult task as MCH hospital is still COVID only hospital*
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> - 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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