Listening to Women

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

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 stigmatized, 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.

Rural Women's Social Education Centre (RUWSEC): Rural Women's Social Education Centre is a non-government organization established in 1981 in Chengalpattu taluka near Chennai, Tamil Nadu. It has a rich history of conducting research on health issues from marginalized women's perspectives.

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 Rural Women's Social Education Centre (RUWSEC) conducted this exploratory study in Tamil Nadu for CommonHealth. They aimed to explore and document women's, especially 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 field areas where RUWSEC worked and who relied on government health services; and private sector; frontline service providers such as – Anganwadi workers (AWWs) and Auxiliary Nurse Midwives (ANMs); chemists; private doctor 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 Chengalpattu district: six with women and nine with service providers including government officials.

Process: Interview guides for each type of respondent were developed, and translated into Tamil, 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 RUWSEC and with the prior consent of these girls/women. Selected team members of RUWSEC 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 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 during the lockdown, their finances were affected and they had to struggle even for basic amenities and starvation.

> *My husband has been unable to go to work during lockdown so we are suffering a lot. No money in our hands. We were unable to meet medical expenses when our children fell sick. There have been days when we had one meal during the lockdown. We are under severe mental stress. Due to the financial crisis, he frequently quarrelled with me during the lockdown.*
>
> - Married woman

Women had better autonomy and decision making in matters related to their health and well-being even during normal times as compared to the other states where similar study was conducted. The fertility decisions were also largely those of the women. Most women had control over their mobility and resources. However, these situations got affected during the government-imposed lockdowns, curfews, and mobility restrictions. They lost their sexual rights and had unwanted pregnancies. 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.

We face a lot of difficulties in visiting a health facility for ANC check-ups, there is no public transport facility and so we use our bike to visit the hospital even in this last month of pregnancy. I have to ride on a two-wheeler to visit a health facility. It is the most uncomfortable time for me.

- Married woman

Women accessing abortion services reported that they experienced sexual violence. They also found difficulty in deciding to terminate or continue the pregnancy. Due to lockdown, many women were not able to come out of home and there was no support from the family. The non-availability of services forced many poor women to borrow money to avail of private services. They went into debt.

- NGO personnel

Increased reproductive health needs: Women's need for reproductive health services increased the pandemic. Women who reported being pregnant stated that the pregnancy was unwanted and unplanned. Most lacked access to abortion services and contraceptives or it was too expensive during this period and thus, conceived due to lack of services and unavailability of contraceptives. NGO personnel, service providers and women in their area corroborated this.

Yes definitely, the number of pregnant women in the community has increased noticeably as husband-wife are at home and there is no other work. Sexual violence has also increased.

- NGO personnel

The sale of pregnancy confirmation kits increased noticeably. The increase has been 1.5 times more than normal days. There has been a heavy demand for condoms. Earlier we placed monthly orders and then by April weekly orders of condoms and pregnancy kits and medicines. Now we place orders for medicines, condoms, and pregnancy kits on daily basis. Before COVID, daily two persons came for pregnancy kits, but now on an average 10 persons come. Say monthly 10 kits were sold but now daily 10-20 kits go.

- Chemist

Overwhelmed and ill-prepared/ill-equipped health system: The situation of health system in Tamil Nadu was compromised and overburdened as resources, infrastructure and personnel were dedicated to COVID-19. Frontline 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 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.

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 there was no significant change in reproductive health facilities and that all services were provided by them, NGO personnel, ANMs and women contradicted them and stated that reproductive services were not available in the initial phase.

> *During COVID, abortion services have been temporarily stopped in the government hospital, due to the shortage of staff and doctors. All are diverted to COVID work. There has been no increase in such cases at the facility as no one accesses for abortion due to fear of COVID. Only those who came with incomplete abortion after having some self-medication are treated in the government hospital. Women should take precautions, as abortion is done to terminate unwanted pregnancy so, it is not an essential service and not a compulsory one during COVID time.*
>
> - ANM

Women usually approached the facilities available at a Sub-district hospital (SDH) or District or tertiary care government hospital through the ANM or other frontline service providers. 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. During the lockdown period, outreach services such as the Village Health and Nutrition Day (VHND) were suspended, and the AWW/ANM were unavailable for most women. Women reported that they had a bad experience when seeking contraceptive services, and as health care providers were missing, they did not know what to do.

> *If the services were available in the public health facility and if the Village Health Nurse had responded, I would not have had to spend the heavy amount for abortion. Medical abortion services should be available at the local level always.*
>
> - Married woman

Lack of resources and training: While the government claimed services were available, women and health workers reported that there was a lack of resources even for frontline workers with a lack of safety kits (Personal Protective Equipment-PPE) and good quality masks. The frontline service providers said they did not receive any training to handle the changes during COVID.

We did not receive training but received messages and information from our doctors' group and media.

- Medical Officer

The supply chain of pregnancy kits was also affected. Chemists alluded to increased demand for pregnancy kits. Several service providers such as MOs, AWW/ANM, and chemists reiterated the shortage in the availability of modern contraception 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.

Condoms were not available even at private medical stores, we asked the Village Heath Nurse and private medical stores. If we had gotten it, we could have avoided the pregnancy and abortion.

- Married woman

It was an unplanned pregnancy, my husband used condoms but during this pandemic, there was no supply in the nearby PHC and in the medical shop. They told him that they do not have stock. He could not get it so I got conceived. As we already have two children and did not plan to have another child, we decided to have an abortion. If he had used condoms this unplanned pregnancy and the expenses for abortion services could have been avoided.

- Married woman

Steps taken by women: Despite unwanted pregnancies, few women came for abortion services. Some took pills without medical advice or bore the heavy expenses of a private hospital, 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 health workers like the Community Health Workers (CHWs), AWW 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.

I got pregnant due to contraceptive failure (Copper-T). I plan to continue the pregnancy, as we are afraid to visit the General Hospital due to COVID and as we are unable to meet the heavy expenses (25000/- 30000) in the private hospital to terminate the pregnancy. Anyway, now it is too late to undergo a medical abortion.

- Married woman

During COVID women mostly accessed PHCs as the cost of care in the private sector was very high. Otherwise, women mostly use private facilities for abortion services, as in government centres they try to counsel women and ask them to continue their pregnancy, so they do not prefer government services.

- ANM

After pregnancy confirmation, self-medication was more common. Government hospital was overcrowded, PHCs were closed, so, people went to private clinics. Earlier there were traditional practitioners, but not now. The use of over the counter drugs is common. There are women who come with incomplete abortion, as pharmacists don't provide complete information. There are instances when women had to continue pregnancy when they did not get abortion services.

- Medical Officer

Fear of COVID and heavy expenses for abortion services have been two major barriers.

Under such situations, they mostly decided to continue the pregnancy with severe mental stress and trauma. In the private hospitals, in normal situations they ask 3000-4000 for medical abortion. But during this pandemic period, it costs 10 to 20,000 rupees depending on gestation and marital status. So, many women decided to continue their pregnancy. Few others attempted to terminate using herbal medicines and drugs obtained from pharmacies. If it did not end in abortion, they don't have any other option but to continue.

- NGO personnel

Role of NGOs: NGOs across the state responded to the needs of the women by adopting different strategies as they were unable to continue their village level visits during the lockdown. They mostly contacted community members telephonically or through their health workers who lived in the same community. 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 CHW, Anganwadi workers to establish support mechanisms in the community for immediate referrals and with MOs directly to provide relevant information and facilitate services through the public health facilities.

We were unable to make village visits and run the community level workshops as we did on normal days. We have community health workers in each village and through them, we provided counselling and referral services through mobile. We also followed up with patients with chronic illnesses to get drugs from PHC and RUWSEC hospital. We also supplied relief food materials to poor, single and aged persons. We continued our health care services, with strict safety measures.

- NGO personnel

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.

SAHAJ on behalf of CommonHealth

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