Listening to Women

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

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 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.

Gramin Punarnirman Sanstha (GPS): Gramin Punarnirman Sanstha was established in 1992 in Gorakhpur in Uttar Pradesh, with a vision to realize the dream of a developed and self-dependent rural community sufficiently empowered to achieve Gram Swaraj (Rural Self-Governance) in its true sense.

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 Gramin Punarnirman Sanstha (GPS) conducted this exploratory study in Uttar Pradesh 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 areas where GPS 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 15 interviews were conducted in Azamgarh district: 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 Hindi, 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 GPS and with the prior consent of these girls/women. Selected team members of GPS 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 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 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 as local markets closed down and they had to travel long distances to buy essential goods. Fear of police beating them made them stay at home without having access to basic food and other amenities.

> *This lockdown has affected our work. CORONA has affected everyone whether it is poor or rich but it had affected the poorer more because we survive on daily wages. Before lockdown, we used to get necessary things near our house. Now we have to go to another big market which is 12 kms away. But during lockdown because of fear of getting infected with CORONA and also, the police used to beat us if we tried to go out, so we had stopped going out of the house.*
>
> - Married woman

Most women lacked autonomy in decision making in matters related to their health, fertility and well-being even before the pandemic. They also had limited control over their mobility and resources. These vulnerabilities got exacerbated during the government-imposed lockdowns, curfews, and mobility restrictions. In addition to the problems of no income, and scarcity of food, the women had to deal with limited or lack of access to health services, service providers including lack of availability of contraceptives, resulting in unwanted pregnancies.

ASHA's husband is my husband's friend so he gets it from her husband. But during the lockdown, ASHA told him that they have not been getting stock of condoms, so he was not getting condoms. There was a need for it but if it was unavailable then what can we do? ASHA's husband had told him that he can get it from the medical store but even the market was closed. During this time there had been negligence at our end and because of that I got pregnant and I had to face a lot of difficulties because of that.

- Married woman

Seeking services often led to exorbitant expenditures and debilitating debts for women and their families.

One woman had to undergo a major operation for delivery but the District Hospital denied her that service. She had to go to a private hospital where she spent Rs. 35,000 on her delivery. Her child was born dead. The family had mortgaged their house to arrange for money and are paying interest on the borrowed amount".

- CSO personnel

Increased reproductive health needs: Women's need for reproductive health services increased during the pandemic. Women either lacked access or found it difficult to have continued access to contraceptives. Government service providers acknowledged that women found it difficult to access health services, especially contraceptive services and prevent pregnancies that happened as the spouses had migrated back, were jobless at home, frustrated, violent and forced themselves on their wives. Chemists alluded to increased demand for pregnancy kits, condoms, and abortion pills.

Some women who reported being pregnant stated that the pregnancy was unwanted and unplanned and that they had conceived due to lack of access to contraceptives. Also, they had difficulties in accessing abortion services during this period.

Before lockdown people used to stay careful because contraceptive measures were available with us. But now as it is not available, then how will they get it? Also, those whose husbands have returned from outside, those women can't even deny their husbands. Therefore, during the lockdown, there was an increase in the number of unwanted pregnancies. Few kept the pregnancy but others accessed private or quack or got medicines from medical stores and got abortion done.

- ASHA

In the case of a few government service providers, prejudices and judgemental attitudes were amplified multi-fold, they held the couples responsible for their lot and the difficulties they faced.

> *I don't think cases (abortion/unwanted pregnancy) have increased because of COVID. These services are needed because rural women are more careless regarding family planning methods and men don't understand their responsibilities and it leads to unwanted pregnancy. Family planning methods are made available at the VHND level by the health department, so people should not have problems like unwanted pregnancy and even if such a situation arises then, they should avail services at the district hospital. People should take initiative on their own for use of family planning methods. At our level, we are trying our best to spread awareness via ASHA.*
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> - Government Officials

Overwhelmed and ill-prepared/ill-equipped health system: The situation of 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 drop in the out-patient department (OPD) turnout. Due to the suspension of public transport facilities, curbs on movement and fear of contracting the infection, women refrained from visiting health facilities. The shift in the venue of the OPD from enclosed rooms that offered some degree of privacy to open grounds added to the decline in caseload with reproductive health issues. Though all the interviewed service providers mentioned that they received some level of training to handle the changes during COVID, they could not examine pregnant women because of open venues and social distancing norms that did not allow for a proper examination.

> *Since COVID-19 became the priority, routine services, including RCH services and abortion, got disrupted. My CHC was never closed but the number of patients was reduced. We started taking OPD in open spaces. Because of social distancing, it was not possible to examine patients in a closed chamber. Even the district hospital services got disrupted because they were overburdened with the pandemic response.*
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> - Medical Officer

> *Doctors at the government health centre stopped sitting in the OPD room (Cabin) and started checking in an open area near the gate. In such a situation, how is it possible to carry out the checkup of pregnant women? They were not checking women by touching them but were asking them from a distance only and then prescribed medicines. Women who went for delivery complained that the nurse did not touch them, stayed away and instructed Dais from distance.*
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> - NGO personnel

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 they provided all requisite essential and emergency services, women contradicted them and said that reproductive services were not available in the initial

phase. Some government officials did acknowledge some disruptions in these services in the early phases of the pandemic.

When COVID19 related lockdown started in March, it was difficult to visit women in the village. VHND at the village level stopped working. Ambulance services were available for the transportation of pregnant women to the CHC for delivery, except that everything else was closed.

- ANM

During these 4 months, the focus was on COVID 19. There was unavailability of trained health workers as they had fear of getting COVID. During the lockdown, women had to face some difficulties regarding unavailability of reproductive health services. Because of crowd control measures, ANC work was happening every alternate day, while family planning operations were closed. But from July all the services started with COVID protocol. From August for outreach work, micro plans were made and services were provided, along with regular VHND in which all the services are provided as per protocol.

- Government Official

Women 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/denying of health services at the Community Health Centre (CHC) level. According to them, 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.

NGO personnel indicated that handling of women with reproductive health needs who did reach the facilities was perfunctory and insensitive. Also, despite their representation and assurances of authorities nothing much changed.

Doctors and nurses at government health centres examined women only if there was an emergency. Else they did not touch the woman. When we spoke to the medical superintendent regarding this, he said that this should not have happened and that he will look into this matter. He assured me that such a thing will not happen again. But nothing changed

- NGO personnel

Lack of resources and training: Service providers informed that they had an adequate supply of safety kits (Personal Protective Equipment-PPE) including good quality masks, sanitisers, gloves, and caps. However, most service providers such as MOs, and ASHA/ANM reported a shortage in the availability of modern contraception. They attributed this to the breakdown of the supply chain for drugs and commodities.

Women reported the non-availability of supplies and services, especially outreach services such as VHNDs and household visits of frontline workers.

When I spoke to the ASHA, she told me that because of non-supply of pills and condoms at the government hospital, she does not have it. My village ASHA helped me a lot earlier, but now she is not there.

- Married woman

During COVID lockdown VHND at the village level were stopped and the availability of different contraceptives like condom, and pills which I used to supply in the village were not available. When I approached the CHC, I was told that there was no supply and that's why it is unavailable. There was less availability of even medicines in the government hospital, so medicines were prescribed from outside (medical store). Because of COVID, there was a lot of migration happening. Husbands returned and couples didn't want more pregnancies. So women asked for condoms but due to unavailability, how could we provide them with different family planning contraceptives?

- ANM

Chemists alluded to increased demand for pregnancy kits, condoms, and abortion pills and reported that they had enough stock but that curfew timings affected their business house. Also, people were still hesitant in buying these and most came without a doctor's permission as doctors had started charging more.

There was an increase in the demand for contraceptives and there was enough availability of stocks. So, we didn't face issues with respect to demand. Whatever was requested, was provided. But then, during this time, it was not possible to stay at the shop for a longer time. People were hesitant to buy contraceptives and abortion pills. Most of the people who come to take abortion pills didn't have a doctor's prescription because if they went to the doctor, they would make more money from them.

- Chemist

Steps taken by women: Women reported that they had a particularly bad experience when seeking contraceptive services, and as service providers were missing, they did not know what to do. Either they continued with the pregnancy or opted for alternative, often unsafe methods for abortion. Some women were also advised of abortion for improper development of the foetus or their own health issues. As government services were unavailable, they sought abortion services from private doctors or quacks. NGO/CSO personnel reported that women mostly went to quacks as government services were inaccessible and private were expensive.

Women mostly go to quacks only for abortion because more money is required in a private hospital. In an unwanted pregnancy situation, women first approach the ASHA and then they visit a service provider based on ASHA'a suggestion. Few women continue such pregnancies as they do not get permission for an abortion from the family. Women prefer to go to those service providers who charge less money, keep confidentiality and are available near their house. In such conditions, only quacks can provide such services.

- NGO Personnel

The lack of government services added to their already strained economic burden. Some took pills without medical advice or bore the heavy expenses of a private hospital, while others with no recourse to any service, just continued with their pregnancy. Those who sought unsafe services often at quacks had to face adverse health consequences.

Here in the government hospital abortion services were not provided. The doctor over there was conducting it privately and was charging more money. We had less money so ASHA told me to visit private (quack). When I went there, the doctor gave us the medicines and took Rs. 750. I took the medicine at night. I got scared because of heavy bleeding and pain. The next day my husband took me and ASHA to the same doctor. He checked and said there is no need to worry, and he gave me 7 days of medicine worth Rs. 500 and said everything will be fine. My health condition got better in 7 days but I still have some weakness.

- Married woman

We never wanted a third child, so in consultation, with my husband, I consumed an abortion pill from the medical store. But after consuming tablets I felt dizzy and bleeding started. My husband took me to a Nursing Home and with the help of our ASHA, I got an abortion done and I was prescribed some medicines worth Rs. 3500. After coming home my condition deteriorated more. I went to my natal family and I told them everything. My parents called the ASHA from their village and informed her my health condition. She spoke to a private female doctor from the health centre. The private lady doctor checked me and said that my condition is very bad, and if abortion was not done properly, then anything could happen. The doctor told us that Rs. 4000 will be needed for treatment and medicines will have to be purchased from outside. After a lot of negotiations, she agreed on Rs. 2500 but medicines should be purchased from outside. Then she did my abortion in one of the rooms in the hospital campus after that I felt better but now also, I have a lot of weakness. In all we had spent around 14,000/- and now we are under debt because of the lockdown as my husband is also at home and all the expenses were done from the money we took as a loan.

- Married woman

Thus, 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 as well government services for reproductive health to be continued under all circumstances.

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 organizations often played a critical role in coordinating with ASHAs, 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.

Through my organization, we have started a COVID help desk in three villages. In that, we have kept condoms at the desk. People take it from there but we as an organization also have limits. One Sakhi helpline is also working for the organization through which information is provided to people on family planning, safe abortion, domestic violence etc.

- 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.

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