Listening to Women

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

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.

Goranbose Gram Bikash Kendra (GGBK): GGBK was established in 1987 in West Bengal. It works for overall socio-economic development and for ensuring the deprived sections of the society have enough means to lead a life of dignity and self-respect.

Website: https://ggbk.in/

Rupantaran Foundation : Formed in 2009 with an aim to promote responsive citizenship among communities by engaging youth and adolescents. They work on the issues of gender equity, child protection, livelihoods promotion, education, health and nutrition.

Website: http://rupantaranfoundation.org/

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

GGBK and Rupantaran Foundation conducted this exploratory study in West Bengal 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 villages where the GGBK and Rupantaran Foundation 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 24 Paragnas 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 the local language, Bengali. 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 GGBK and Rupantaran Foundation team members were provided online training in qualitative research, study purpose, methodology along with COVID-19 related training. Interviews were telephonic or via mobile phones only. 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. Some felt mentally depressed. Many women revealed that lockdown dried up their finances and they had to struggle even for basic amenities and starvation.

Our income stopped during the pandemic. Most of the time we were facing household problems due to our poor economic conditions. Mentally I was depressed.

- Married woman

Income had stopped. We could not go out when needed as public transport was not available, and private transport that was available was very costly. Health was not good, and people were being aggressive due to the panic of the pandemic. We had to take some loans to meet the needs of the family.

- Married woman

Though the women had some autonomy and decision making in matters related to their health, fertility decisions, and well-being, they 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 and contraceptives. Only those women got services who lived near the government hospital or health centre.

We did not get government services. So, we had to seek a private doctor. To meet the need, we had to mortgage gold earrings and sell our cattle. I was very tense. I was mentally depressed. Now I have lost everything.

- Married woman

While government service providers acknowledged difficulties the community faced in accessing health services, they also talked about the limitations of the government system, their constraints and how all these increased the existing vulnerability of women.

The government is doing a few things for women's health. But how much they can do? It is not about health only, everything is interconnected. This is such a poverty-stricken area that whatever you do for health if other aspects are not fulfilled, it's not going to help. In this lockdown situation travelling to the hospital for access to health services was costly. Also, vehicles were not easily available. It was especially challenging for those who did not stay near the centres and so had no choice but to have the child.

- Government official

Increased reproductive health needs: Women's need for reproductive health services increased during the pandemic. Women had either lacked access or found it difficult to have continued access to contraceptives. Some women who reported being pregnant stated that the pregnancy was unwanted and unplanned and that they had conceived due to a lack of availability of contraceptives. Lack of availability of injectable contraceptives, commonly used by women and husbands'/men's' refusal to use condoms limited their options. Also, they had difficulties in accessing abortion services during this period.

> *When the services were closed for a short period of time, they didn't go anywhere. I told them that if injections are not available then use condoms till the time. But they said that not everyone's husbands are the same, they didn't want to use condoms at all. There is a lot of rise in pregnancy cases- the difference is huge. Our target is 200 women in one year but till September itself we had about 155 pregnancy cases. Women who have kids of one year, they are getting pregnant. Also within seven months of delivery, they are getting pregnant. These were not planned at all.*
>
> - ANM

NGO personnel and service providers in their area corroborated the plight of women and the non-cooperation of their spouses. They recounted their observations that sexual and reproductive health rights were affected as forced sex, early marriages, child trafficking, domestic violence seemed to have increased.

> *Women are suffering from domestic and sexual violence. The demand for abortion and contraceptives increased as many husbands are migrant workers and were back home. Even earlier, the married woman used to come and say my husband stays in Gulf and now coming in 5 years. So please save us as the expectation is a lot. No day will be free from sexual contact. During COVID the demand for abortion and contraceptive pills has grown so much- the men involved with outside work came back to the village and now women have to forcefully sleep with them.*
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> - NGO member

Overwhelmed and ill-prepared/ill-equipped health system: Situation of the health system 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 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.

These government service providers were given the challenging task to provide services to the 'most vulnerable' service seekers. They found identifying the most vulnerable women impossible as all women coming to government facilities according to them lived in vulnerable situations.

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 the abortion facilities or their demand, however, accessing these services has been quite challenging for the women. 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. Going to quack doctors increased due to lack of availability of reputed doctors (private and public). 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.

For health needs, 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 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.

> *We searched for government service but the government hospital and the doctor are far away from home. We could not meet even the ANM. ASHA did not care about the pregnancy. All of them were busy with COVID. We did not get government services. So, we had to seek private service which was expensive. I was not well for a single day during the pregnancy. I always felt that I would not survive. I was pregnant during the whole lockdown period and could not access any government service.*
>
> - Married woman.

Attitude of service providers did not make health seeking easy for women. They talked about the community not complying with their advice. Many service providers were judgemental, actively discouraged abortions and looked at those seeking these from a negative perspective.

Few people want to do 'abortion'. In my area, if anyone came for abortion at all, we never encouraged doing an abortion. We usually talked about prevention by contraceptives. It should be about them not conceiving the child 'jeno naa ashe' (conception doesn't happen) rather than doing an abortion. Also, after marriage, we say don't have a child for two years, but now a lot of girls are getting married before 18. They are eloping and not waiting for their parents to get them married, So, they get pregnant early, despite we telling them so many times to not conceive. Even during the lockdown, a lot of girls got married by running away and this has happened in my area- they are like 14-15 years old.

- ANM.

Women recalled their travails in seeking services during the pandemic, mostly because of poor preparedness and quality of services. Accessing services from dubious private service providers or quacks had its own repercussions. Their frustration and despair were palpable.

Treatment was average. After delivery I became unconscious. Also, I could not move for three days. There was bleeding from my newborn baby's navel. I was very tense. The nurses misbehaved as I could not move. I was mentally depressed.

- Married woman

Lack of resources, training, and safety: 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. Most ANMs and ASHAs stated that they did not receive any proper training to handle the changes during COVID.

Since COVID started, we have not gone to the hospital or done any training, only got instructions. No training on why COVID happened etc. Just ANM Didi has said that this needs to be done, and about the symptoms of COVID, that's it. There is nothing else I received, no articles or paper or any training.

- ASHA

There was a lack of resources even for frontline service providers with a lack of safety kits and good quality masks.

Cap, sanitisers, masks we received only once from the hospital. I have been telling the ANM didi to give some more. The surgical masks they gave us were 10- that also is not in good condition anymore because we received it when COVID started (this interview was done in September). I have cleaned it with Dettol, washed it with soap and used it for a few weeks but those have all worn out now. We have been buying N-95 all for ourselves now. Initially, when the hospital was not giving anything, we used to buy all these for our own safety. If these materials are made available to us at least, then we would do better work.

- ASHA

Besides the lack of safety masks, in some field areas the service providers also had to fend for themselves and protect themselves from assault due to the pandemic fear. There was a widespread perception in the community that the ASHAs were protecting themselves and were getting people arrested instead of quarantined.

When I am going to the community - not all communities are the same right? Few are asking us, you wear these fancy masks and don't provide us with them so don't enter our village for any work if you don't give us mask also. So, in one community they took a sickle and chased me away from that village saying that I can't get inside.

- ASHA

The supply chain of pregnancy kits was also affected. Medical abortion pills if available at the Chemist, were too expensive for the poorer communities. Chemists mentioned increased demand for abortion pills as well as lack of stock. Several service providers such as Medical Officers, ASHA/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 service 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.

Lack of injectable contraceptives was another major issue faced by women, especially amongst the poorest communities both before and during the pandemic. Service providers pointed out that due to this shortage of injectable contraceptives, they had to make difficult choices about providing advice and services and at times face abuse or wrath of the women. Some of these women became pregnant and were very upset as the pregnancies were unplanned and unwanted.

…. Usually, the demand for injection is much more as a lot of women don't understand the timings of the medicines. They did not want to have medicines because they tend to forget about them. Women opted for and received injections every three months. However, there was a shortage of these injections from the hospitals that provided them. Since February supply of these injections was stopped. It started again from August actually and for every ASHA only two were provided. We were asked by the supervisor to provide to the poorest of women who would not be able to afford another child. I said there are so many of them in poverty, how would I decide whom to give, but was asked to manage. So, I gave it to two women during the regular health check-up and asked them not to tell in the village, but they did. Soon a pool of pregnant women came to me for doing partiality, they gave verbally abused me and it was horrible to listen to all of those.

- ANM

Steps taken by women: Despite unwanted pregnancies, few women came for abortion services. Some took pills without medical advice from chemists or quacks while others just continued with their pregnancy. Also, with the lack of availability of doctors, who got busy with COVID treatment, women began to seek more help from quack doctors.

I did not receive any health support. None took care. I am taking care of myself. The pregnancy was not wanted because I already have four children. So we decided to abort the child. I bought a pill for abortion from the medical store. I got to know about the pill from my sister-in-law. We managed to buy it from savings of household expenses.

- Married woman

Frontline workers such as ASHAs and ANMs confirmed women's plight and their desperation in seeking services from whichever provider was available and willing to provide. The quacks contested this perception that they were the last option for desperate women. According to them, they were a considered choice for women disillusioned and disappointed with the formal health system.

Mostly poor housewives visit us. The government doctor is not willing to explain to them the situation. It's about behaviour- women get no opportunity to speak in their presence. The quacks listen and that's an emotional behaviour. Usually, doctors hardly check, they just give certain tests that need to be done- the tests are expensive and these people are very poor. Some tests may cost like Rs. 2000 and they don't even know what has happened to them.

- Quack doctor

Most ASHAs/ANMs informed that hardly any abortion cases came to them even before COVID. ANMs said that quacks were the preferred source of services as they offer confidential services closer to the home of women. But these services came at the cost of side effects of medicines and complications. Then women have no choice left but to come to the government service provider.

There are many quack doctors, who give abortion medicines. For some cases, it works but for most of the cases, they bleed a lot and when it is uncontrollable then they come to me. Around my centre, there are 10-12 such doctors. Initially, women get scared to come to us and they don't want us to know at all.

- ANM

Thus women's health needs and choices of service providers become the first and major casualty of economic constraints and systemic breakdown. Women echoed the need for free accessible health and nutrition support, testing and counselling during such times and even otherwise.

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 kits/ration. 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.

We did relief work after taking permission from the Sub Divisional Officer, and the Block District Officer. We did several awareness camps during that time. We also did a health screening camp. We tried to provide sanitiser and masks always. We tried to tell the community to always wash their hands. We also supplied a lot of masks during this time. We maintained all social distancing protocols. We did not face any problem going to the villages in our project area or outside our project area. No one said don't come, they gladly accepted us.

- NGO member

Government staff talked about the difficulties they faced. In such cases, NGOs played a major role. They paid special attention to vulnerable, pregnant women. They ensured requisite nutrition during this period of uncertainty and challenges. Women acknowledged the help they received from NGOs.

They asked me to make a list of 8-10 pregnant women to give food. In my area, they are very poor and many poor pregnant women. My supervisor asked me to choose between 200 such women. Then I decided to choose women whose 'child died' post-delivery and women who had 'abortion' (miscarriage). If I can't provide it to everyone, they come and do a ruckus in my house, asking why aren't they getting the food. I feel hurt to ask them, have your children died? This is how I deliver food; I can't give it to everyone here.

- ANM

It's important to support pregnant women in these times, with nutrition and food which they are unable to get from the family due to economic crisis. From the government, very few are getting and what they are getting is not sufficient. I realised that for pregnant women food is only very important, as there are about 6-7 members in the family. We decided to provide it.

– NGO member

Income had stopped. Health was not good, and people were being aggressive due to the panic of the pandemic. My family and GGBK (NGO) helped me to cope with the situation. We also took loans to meet the needs of the family.

- Married woman

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 it is purposive sampling. However, they 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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