

# LISTENING TO WOMEN

## Impact of COVID-19 on Abortion Services in India

Report of a multi-centric qualitative study in eight states  
conducted after the first phase lockdown in 2020

Study Period: October to December 2020



**CommonHealth**



**Sahaj**

towards alternatives in health and development



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CHALLENGING ABORTION IN INDIA PEOPLE





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# Abbreviations

AAA	Amhi Aamchya Arogyasathi
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANT	The Action Northeastern Trust
ASHA	Accredited Social Health Activist
CBO	Community Based Organisation
CHC	Community Health Centre
COVID	Corona Virus Disease
CSO	Civil Society Organisation
DH	District Hospital
ECP	Emergency Contraceptive Pill
ESI	Employees' State Insurance
GADSS	Guru Angad Dev Sewa Society
GGBK	Goranbose Gram Bikash Kendra
GH	General Hospital
GPS	Gramin Punar-nirman Sanstha
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
IUCD	Intra-Uterine Contraceptive Device
MA	Medical Abortion
MO	Medical Officer
MTP	Medical termination of Pregnancy
NGO	Non-governmental Organisation
OCP	Oral Contraceptive Pill
OPD	Out Patient Department
OTC	Over The Counter
PE	Peer Educator
PHC	Primary Health Centre
PNC	Post-Natal Care
PPE	Personal Protective Equipment
RCH	Reproductive and Child Health
RMNCAH+N	Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition
RUWSEC	Rural Women's Social Education Centre
SAHAJ	Society for Health Alternatives
SC	Scheduled Caste
SDH	Sub-District Hospital
SMO	Senior Medical Officer
SRHR	Sexual and Reproductive Health and Rights
ST	Scheduled Tribes
TYPF	The Young People's Foundation

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Abortion Theme Lead

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# Preface



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.

In a world trying to cope with a pandemic with unprecedented speed of spread, the health systems of individual countries on the throes of complete breakdown had far reaching impact on people's lives. As governments with single minded focus tried to contain the pandemic, the collateral damage done to reproductive health of the most vulnerable sections of population such as marginalised women was completely overlooked. There was a need to explore, understand and document women's need for and experiences with accessing time sensitive and highly stigmatised and misunderstood abortion services.

This year, 2021 happens to be the fiftieth year of the Medical termination of Pregnancy Act coming into existence in India. This report is an attempt to document abortion seeking experiences of women from marginalised groups in different regions of India after half a century of an Act that was formulated to safeguard their health and ensure safe abortion services for them. Ten CommonHealth member organisations from eight Indian states have carried out this research to understand abortion needs and the way these were met for women in adolescent age group, Dalit women, sex workers, HIV positive women and women from poor households. CommonHealth hopes that these experiences would pave the way for a more comprehensive response to women's abortion needs in future and in times of crises.



# Research Partner Organisations



**Amhi Amchya Arogyasathi (AAA):** Amhi Amchya Arogyasathi was established in 1984 as a not-for-profit Organization that works towards bridging the issues of community related to women, Tribal, farmers and weaker section through the community empowerment approach

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

**Goranbose Gram Bikash Kendra (GGBK):** Goranbose Gram Bikash Kendra 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.

**Gramin Punarnirman Sanstha (GPS):** Gramin Punarnirman Sanstha was established in 1992 in Gorakhpur 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.

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

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

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

**Society for Health Alternatives (SAHAJ):** Founded in 1984 in Vadodara, Society for Health Alternatives focuses on social accountability and citizenship building for children, adolescents and women in two specific sectors - Health and Education.



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**The Action Northeastern Trust (ANT):** The Action North-eastern Trust was established as a charitable trust in 2000 in Bongaigaon. The organisation works for development of villages in Northeast India especially on issues related to education, child protection, women’s empowerment, peace building and mental health.

**The Young People’s Foundation (TYPF):** In 2002 The Young People’s Foundation was established as a voluntary group for youth led social change dialogue and action. The organisation facilitates young people’s feminist and rights-based leadership on issues of health equity, gender justice, sexuality rights, and social justice.



# 1. Introduction



COVID-19 has severely disrupted lives, jeopardised the well-being of billions of people, and raised the possibility of a global health crisis with devastating outcomes. With most public facilities functioning with a COVID-19 management focus, diversion of the health system resources and caseload overwhelming the health system, even essential and time sensitive services have been relegated to the backseat.

Marie Stopes International's study in August 2020 estimated that a staggering 90 percent or 9.2 lakh women in India who required abortion services could not access them between January and June 2020 because of the stringent COVID-19 lockdown. These women were among the 13 lakh women who could not get any kind of sexual and reproductive health services during this period.<sup>1</sup> The study also reported that the inability to access sexual and reproductive health services in India could lead to as many as 6.5 lakh unintended pregnancies, 10 lakh unsafe abortions, and 2,600 maternal deaths in the country. India accounted for 75 percent of the total disruption in family planning and safe abortion care services across 36 countries quoted in the report. Highlighting the estimates, the report forewarned that as the lockdown-related restrictions are eased *"the need for sexual and reproductive health services will only increase especially for safe abortion and post-abortion care as there is likely to be an increase in the need for second-trimester abortions following the lockdown"*.

As a response to navigate the crisis, while medical abortion through digital counselling and support has been advocated as a safe alternative, countries like India continue to face a challenge as 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, a study conducted by the Foundation for Reproductive Health Services<sup>2</sup>, just before the lockdown during January-March 2020 with 1,500 chemists, showed acute shortages in the availability of medical abortion drugs in states like Delhi, Tamil Nadu, Punjab, Haryana and Madhya Pradesh, amongst others. While less than a tenth of the chemists in Punjab (1%), Tamil Nadu and Haryana (2%) and Madhya Pradesh (6.5%) stocked medical abortion drugs, even national capital Delhi reported drugs being stocked only by a third of the chemists.

There has been very little information on how did those in need of these services especially time sensitive services such as abortion cope with the unfolding pandemic situation, associated precautionary restrictions and their consequences. What have been lived in experiences of those who needed these services during this period of health and health

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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>

system crises? To review and revise policy and programme trajectory for reproductive health at a short notice in health crises situations it is important to understand these aspects of health needs and health seeking.

Anecdotal information and newspaper articles suggest that the impact of pandemic is significant on health service availability and accessibility. The combined impact of supply shortages and recession and disruption in service delivery is likely to be especially detrimental for the poor, who face a multitude of challenges related to access to services, even in normal times and given the social context in India where access is mediated by gender, caste, class and other social hierarchies, it is critical to understand the experiences of marginalized women. Whilst studies conducted during the pandemic have highlighted the constraints on the supply side of health services (that too predominantly contraceptive and maternal and child health), the experiences of women, especially women seeking abortion services, need to be understood in the context where job and income loss and lockdowns have changed household and community gender dynamics and increased the disadvantages faced by women. A surge in gender-based violence cases particularly domestic violence has revealed the gendered nature of the pandemic. Common Health conducted a study to fill in this gap. By documenting the experiences of most affected women and the service providers at the community level, it fills the void in data gathering in terms of the grass roots level impact on communities. The experiences of women documented in the study add another level of analysis that needs to be factored in any plans for immediate intervention for women's sexual and reproductive health, specifically during this situation of crisis.



## 2. Study Methodology



### 2.1. Study objectives

The exploratory study conducted by CommonHealth aimed to explore and document women's:

- need for contraceptive, abortion and maternal care services;
- access to contraceptive, abortion and maternal care services; and
- experiences with services in the course of the COVID19 pandemic and consequent countrywide lockdown and changes in health system priorities.

### 2.2. Study sample

- a. Scope:** Keeping geographical representation in bearing, eight Indian states (Delhi, Punjab, Uttar Pradesh, Maharashtra, Gujarat, Tamil Nadu, West Bengal, Assam) were covered spanning northern, southern, eastern and central part of India.
- b. Method:** Given the objective of the study, qualitative methods of data collection were deemed appropriate. In-depth interviews conducted with the respondents covering a range of issues (**Annex I** - Key Research Questions).
- c. Sample:** The sample for the study was purposive based on the willingness and ability of respondents to provide information on the topic. The study participants included women in the reproductive age group who relied on public services for their health and well-being. To facilitate a comprehensive understanding of the COVID19 impact, the sample comprised of women as clients in need of services and frontline workers and medical officers as service providers. Women's sample was purposively drawn to include representation of Dalit women, women living with HIV/AIDS, women with disabilities, sex workers and poor women living either in city slums or rural areas. Besides the women who were a primary cohort of respondents, other key stakeholders covered in the study included government functionaries, Medical Officers (MOs) and doctors from the government and private sector, frontline health workers such as Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs), Chemists and grassroots level non-government (NGO) or community based organization (CBO) or civil society organization (CSO) staff. A total of 132 interviews were conducted: 42 with women and 90 with service providers and CSO/NGO staff. (**Annex II** - CommonHealth Partners participating in the

study and study district/state with respective sample size).

- d. Process of data collection:** Keeping in mind the sensitivity of topic and ethical considerations related to informed consent (Annex III), girls/ women who were above age 18 and who sought reproductive services such as contraceptive, maternal care and abortion services were identified in consultation with local health workers and field staff of local NGOs and with prior consent of these girls/ women.

Staff from CommonHealth network member CSOs collected the data. They were provided training in qualitative research, purpose of the study and its methodology. Most interviews were telephonic, barring a few that were conducted by the CSO staff members who were already in the field to help with pandemic relief measures. The interview field guides for each type of the respondents was developed, translated in local language and used at all study sites (Annex IV - Interview Guide for each cohort of respondents). Interview notes were transcribed in local languages and entered in English in software developed for the purpose.

## 2.3 Dataanalysis

An analysis plan was developed. Data were analysed for emerging patterns and themes. As the study is exploratory and qualitative, study findings were not interpreted as representative of the community/area or statistically valid, however, they provide valuable insights into women's experiences of seeking abortion services at the time of the pandemic.

## 2.4 Ethical considerations

The Institutional Ethical Committee of Society for Health Alternatives (SAHAJ)<sup>3</sup> reviewed the study proposal and tools and provided ethical approval. Standard ethical procedures were followed. Before the interviews, informed consent from each respondent was sought using consent forms especially developed for the purposes. The consent was oral as the interviews were telephonic. The investigator signed the consent form after explaining the study to the respondent. The team leader in the member organisation countersigned the consent form after confirming that the investigator had explained the study purpose, assured confidentiality, given the option of refusing participation (with no adverse consequences for doing so) or withdrawing halfway or refusing to answer some questions, informed about non-availability of any remuneration for participation. They were provided with the contact number of contact person in the organisation, and were offered a copy of the consent form for their record if they so desired.

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<sup>3</sup> SAHAJ—Society for Health Alternatives, is a founder member of CH

## 2.5 Limitations

Sample was purposive. Additionally, following the pandemic restrictions, majority of the interviews were conducted telephonically. This led to limited reach as those having access to the phone or connectivity could only be contacted. Hence this may not be considered a representative sample. There were difficulties in reaching out to some respondents, especially the government sector service providers since they were preoccupied with the pandemic management.



## 3. Key Findings

### 3.1 Profile of the Women Respondents

The women respondents were young, mainly in their mid-twenties and mid-thirties; largely belonging to peri-rural and urban areas and were from low economic strata. Most of them were homemakers and a few worked as daily wage workers.

While 27 out of 42 (close to two thirds- 64%) women were multigravidas with three or more pregnancies, only eight of them, i.e. less than a fifth, had three or more living children, were not currently pregnant and only two reported child deaths, suggesting significant pregnancy loss either through stillbirths or abortions. Almost one-third of women did report undergoing induced abortions. Around the same number of women also reported having had spontaneous abortions.

**Table 1: Profile of women**

	Category	Number of women (42)
Age group	21-25 years	14
	26-30 years	19
	31-35 years	3
	36+ years	1
Marital status	Married	39
	Unmarried	3
Number of pregnancies	1	8
	2	7
	3+	27
Number of living children	0	6
	1	10
	2	17
	3+	9
Number of newborn deaths	0	35
	1+	7
Number of spontaneous abortions	0	27
	1+	15
Number of induced abortions	0	24
	1+	18

## 3.2 How did COVID-19 impact women's lives?

COVID-19 pandemic has been one of the most unprecedented events in the history of humankind that has altered what construes the normal. The sudden announcement of the national lockdown severely hit the availability of essential services and disrupted people's livelihoods. The respondents' narratives explicitly indicate how the loss of livelihood and income intensified vulnerabilities and impacted health-seeking priorities.

- a. **Loss of livelihood and income:** The women's partners who were migrant labourers or small vendors and daily wage earners lost their work. While migrant labourers were forced to return to their native states, local wage earners had to sit at home with no recourse to income. Many women revealed how the lockdown dried up their finances and they had to struggle even for basic amenities. Barring the families where at least one of the members was securely employed or his/her work fell under essential services could continue to work and bring income. While majority of others used up their savings (if any), borrowed money, sold jewellery or some even resorted to begging to sustain themselves and their families. Some women respondents from Maharashtra who work as sex workers said their earnings had completely stopped and they had to depend on the ration supplied by a local CSOs.
- b. **Increased vulnerabilities:** While women's narrative indicates that men, women and children all were affected by the pandemic, it was the vulnerable populations (sex workers, HIV+ve women, lower caste women), which was doubly disadvantaged. Multiple survival challenges such as loss of livelihood, non-fulfilment of basic needs such as food and shelter, starvation, domestic violence and lack of access to health especially reproductive health services, increased their vulnerabilities.

Some women described their state of total helplessness in the face of the situation. One migrant woman belonging to the Scheduled Tribe (ST) community in Punjab described her desperate state where death was seen as the only release as,

*"Earning stopped for me and my husband. Mobility stopped due to curfew. Schooling of children stopped. We could not get ration. We tried to go to the home in Bihar but transport was unavailable. The situation was so bad, I even thought of ending my life on some days."*

Women from Assam and Punjab reported increased violence due to the lockdown,

*"My husband works in a factory. During the lockdown, his work and income stopped. Out of frustration, he started beating me. The children do not go to school. They do rag picking. Sometimes we had no food for days. I thought life would end."*

CSO/NGO personnel from Punjab confirmed women's experiences and described the situation as,



*“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 did 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”*

A senior ASHA worker from Assam noted a similar observation,

*“Lockdown restrictions and the fear of police actions kept people inside their homes. Because of this livelihood of many families got affected. This increased stress levels that led to increased domestic violence.”*

This domestic violence took the form of verbal, physical and sexual abuse with extremely adverse health outcomes for vulnerable women. In addition to the problems of no income, scarcity of food and domestic violence, the women who were pregnant or got pregnant during the lockdown had to deal with health issues, when there was limited or no access to services. The majority of women reported low autonomy and decision making in matters related to their health and well-being even during normal times. The fertility decision according to many women, are largely those of family members, husbands in particular. Partners exercise control over their access to resources and mobility outside the house. These women have limited or no control over their lives. These conditions of limited control over their lives were further exacerbated by the lockdowns, curfews and mobility restrictions imposed by National and State governments.

Unemployed, frustrated partners were even less understanding of women's reproductive health needs and any measures to address those. Most women respondents, particularly from Gujarat, Maharashtra and Punjab shared that cohabiting with an abusive partner and lack of access to contraceptives resulted in an increased risk of unacceptable/forced pregnancies, limited resources and mobility made accessing abortion challenging for them. Lack of partner support for termination of these pregnancies, rather possibility of familial pressure to continue the pregnancy in many cases led them to access unsafe abortions clandestinely.

### **3.3 What were the challenges at the health system level?**

The pandemic created an unprecedented challenge before the public health system as it geared up to accommodate COVID-19 treatment protocols. The workload increased, since the medical teams were carrying out COVID-19 related services, from awareness building, testing, contact tracing to record maintenance, along with their regular work. The MOs at public facilities and health officials interviewed in the course of the study talked in detail about the changes and challenges posed by the situation and difficulties in carrying out their job despite overburdening, staff shortage and inadequate supplies of protective equipment.

The impact on the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) services was reported across public and private facilities as well as upon the outreach services.

- a. **Limited availability of services:** Many Public health facilities were converted to COVID-19 care centres, had their staff redeployed to provide services for those affected and services were diverted from Sub-District/Divisional Hospitals and Community Health Centres to District or Employee's State Insurance (ESI) hospitals that were not always accessible due to distance, mobility restrictions and lack of resources and transport..

MOs of both urban and rural public facilities reported disruption of services. While urban facilities were first to feel the pressure, the rural facilities came under grip of the pandemic a month later when migrant labourers started returning to their native states. A system barely surviving and coping with population health demands with well-known infrastructural shortcomings started showing signs of collapse within days.

As the overburdened health system geared to meet the challenges of the pandemic, the resources and infrastructure were dedicated to COVID-19 patients and this meant that the availability of other services was compromised. The availability of and access to reproductive health services including safe abortions, which is a time-sensitive procedure, got considerably curtailed.

Almost all MOs 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 with the fear of facing punitive action by the police and women also refrained from visiting health facilities due to fear of COVID-19 exposure.

Under these circumstances, services got affected, admit the MOs.

*“Since COVID-19 became the priority, routine services, including RCH services and abortion, got disrupted. With a lack of adequate supply of family planning devices, these services became irregular. Even the district hospital services got disrupted because they were overburdened with the pandemic response,” stated MO, CHC Aatrauliya, Uttar Pradesh.*

A similar state was reported by SMO in Rupanagar district, Punjab. “Usually we refer patients to other hospitals since we do not have the operation theatre. The referred patients could not be attended as those hospitals could not handle any more burden.”

Situation did not improve even with lifting of official lockdowns as the public amenities took a long time to return to a semblance of normalcy. Explicitly stating the situation senior medical officer (SMO) in Ludhiana district, Punjab said,

*“For the first three months post the lockdown, there were no efforts (to reinstate the routine services) and we were asked to direct these females (seeking abortion) to ESI hospital. However, with lack of transport, they were unable to go.”*

Private hospitals, particularly those run by charitable trusts claimed minimal impact. A doctor from a private hospital run by a Charitable Trust in Navsari, Gujarat confirmed that in OPD footfall dropped, but the services were not shut down.

*“Hospital was open even during the lockdown and women could visit here to meet their needs. The government had asked not to give ante-natal services in the initial period of lockdown, which was resumed May-June onwards. All services were given and pregnant women for antenatal care started visiting as earlier. But because of the fear of the virus some women did not visit and missed their ANC check-ups.”*

This doctor observed no significant difference in the demand for abortion services during the lockdown. This was corroborated by NGO personnel and women as well in their area, some of who were pregnant; had received services these hospitals.

- b. Ill-prepared and ill-equipped facilities:** The healthcare personnel battled with problems such as unavailability or shortage of PPE kits.

*“Only ambulance drivers wore PPE kits here as and when they transfer a COVID-19 patient. The rest of the medical staff did not get PPE kits,” said a service provider.*

Additionally, instances like health staff getting infected reduced the staff strength further. Sometimes a facility was closed when doctors and staff got infected and the patients were directed to other nearby facilities or called at a later date. Sharing multiples pressures on the medical teams one staff member said,

*“We had to cope with limited supplies as the availability was less. As we were following COVID-19 protocols it was taking more time to attend to the patients than usually required. Therefore, very few patients could be attended in a day. Hence women had to wait, sometimes they had to come again and again for two to three days. Once two unmarried girls had visited but due to rush they could not get services in our centre.”*

Women from slum areas in Nangal as well as those from surrounding villages, normally access this health facility but were deprived of the services in the pandemic situation. Moreover, as shared by the doctor, during the strict lockdown period in March and April, all other services were completely stopped.

Thus, those who managed to reach the facilities also could not be attended. With no additional human power and funds given to them, the public health facilities were working under pressure and unable to attend to every patient reaching them.

Health staff in rural areas of different states did try to devise their own approaches to ensure that services were available while safeguarding their own health and safety and after initial apprehension about intent of these approaches, community did respond positively. As voiced by MO in CHC from Chirang district in Assam,

*“We didn’t know the status of the patients approaching us, especially the asymptomatic ones. So, there was initial screening based on their travel history and peculiar symptoms and then we referred them to appropriate centres for*

*diagnosis and further management. Initially, there was resistance from the community to get tested, which reduced with time and awareness. They became cooperative and volunteered to get tested if it needed for further treatment.”*

However, such instances were few and far between and came in late in the timeline of the pandemic. Though Ministry of Health and Family Welfare had affirmed RMNCAH+N services as essential services in mid-April 2020 and all government providers across states claimed that there was no significant change in the abortion facilities or their demand accessing these services has been quite challenging for the women.

Women across eight states shared that some approached the nearby sub centres and/or Primary Health Centres (PHCs) for abortion services but were turned away as the facilities were not equipped to deal with such cases. They were invariably referred to District Hospitals. They were ready to raise resources through whatever means for the purpose, but to no avail. But women could not travel there due to both restricted mobility due to lockdown and fear of exposure to COVID-19 in big hospitals.

Women usually approached the facilities available at Sub-district hospital (SDH) or District Hospital through the ASHA worker. Reported experiences of women across states indicate that during the pandemic this was not possible. It is important to point out that even frontline workers like ASHA/ANM across all eight states reported constriction in supply. Abortion service use decreased by 28% at some public facilities according to some providers. While the majority of women respondents from Assam, Punjab, West Bengal reported a lack of accessibility due to lack of transport and non-availability of services at the SDH/Community Health Centre (CHC) level, the situation of other states was comparatively better in this period.

As one ANM in Tamil Nadu PHC noted,

*“Usually married women prefer to continue, while unmarried use self-medication. It is common. Here in the PHC, we have limited staff and just one doctor. We can't give MA pills. We, nurses, collect women's history and after getting doctor's prescriptions we dispense medicines or refer them to the GH. But this was not possible during the lockdown period. Women did not approach us. I think women are using the private facilities more than public facilities for abortion in COVID-19 period.”*

- c. Issues related to supplies:** Stocks of contraceptive methods, medical abortion pills were depleted because of supply chain issues. This is corroborated with data published by the Health Management Information System (HMIS) under Union Health Ministry; the injectable contraception availability decreased from 66,112 in December 2019 to 42,639 doses in March 2020 (after the outbreak of the COVID-19 pandemic). While intrauterine contraceptive device (IUCD) insertion showed a 21% decrease in March 2020, the distribution of combined oral pill cycles and condom pieces reduced by 15% and 23%, respectively. Services got affected because of mobility restrictions and the COVID-19 focus of the health system.

The health providers pointed out that during the lockdown, many state governments temporarily suspended the provision of sterilisations, IUCDs and injectables at public facilities or any method that required interpersonal interaction was curbed. The availability and use of modern contraceptives were limited. Acute shortages of oral pills, condoms and emergency contraception pills were reported. Several public providers such as Medical Officers, ASHA/ANM, and chemists from Tamil Nadu, Assam, Punjab and West Bengal reiterated the shortage in availability of modern contraception. There were also curbs imposed on movement in urban areas and for ASHA workers in rural areas that made access to over the counter (OTC) contraceptives, condoms, oral contraceptive pills (OCPs), and emergency contraceptive pills (ECPs) at pharmacies is difficult.

The main reasons for the gap in the services as pointed out by the providers and the chemists were breakdown of supply chain for drugs and commodities, redeployment of facilities and staff for COVID-19 care, lack of transport, and restricted mobility.

- d. Misinformation and Ill-treatment:** The frontline workers like ASHA/ANM across all the eight states also pointed out other barriers such as the judgmental and hostile behaviour of service providers with patients that further deteriorated in times of overwork and frustration. As one of the ASHA workers from Punjab noted,

Accessing services for abortion was the most difficult because of the irregularity of routine services and lack of supply of medicines. Sometimes, however, discriminatory practices of service providers also created confrontation. I know two women who faced it, they told me that one doctor (GNM of a Government Hospital) reacted insensitively when they went to get abortion service. 'Is abortion greater than the infection? By chance if you get infected by COVID-19, then you will get to know the consequences of frequent coming in hospitals...,' said the doctor.

The fear of infection was used as an excuse to deny the service. Sharing her experience of visiting the public facility a woman respondent from Maharashtra said,

*"What do you want to have COVID-19 infection or unwanted pregnancy, he asked and sent me back."*

Public service providers are known to show scant regard for the standard operating guidelines to deny services to women and which lead them to choose unaffordable private services over the public ones. These practices were pronounced during this period where under the pretext of keeping track of infected and possible exposed case providers asked for un-necessary identity and documentary proof.

Describing their situation the female sex workers in Maharashtra said,

*"Government hospitals asked us for the husband's name/signature and other documents before they give us abortion service. So, for confidentiality*

*purposes, we prefer to go to private clinics, which charge more but don't bother us otherwise."*

- e. **Suspension of Outreach Services:** Outreach services were regular as earlier according to the service providers. While the government officials and government medical officers across four states barring Punjab and Tamil Nadu spoke about the community-level service delivery being smooth throughout the pandemic and women being attended to at home in case they were home quarantined and that in Maharashtra (rural and urban) and Gujarat supply of contraceptives such as condoms was regularly available and other services were functional too through frontline workers such as ASHA and ANMs.

Women, however, had a different story to tell. They reported the unavailability of community-level services, especially contraceptive information and supplies. The need for contraceptives was evident, but frontline workers who are close to the community were not trained and equipped to handle the reproductive needs of women under the threat of the pandemic, so they could not do much. Frontline workers (ASHAs and ANMs) verified these experiences of women and some even attributed increase in unintended pregnancies, childbirths, and maternal health concerns to the suspension of outreach services. The impact on abortion services was especially pronounced.

*"During the initial 2-3 months of lockdown, women were going to chemists, quacks or trying some home remedies. They tried to approach ASHA and ANM but we could not help much as we were doing other duties. Approximately 60% continued with their pregnancy," said ASHA in Punjab.*

This problem was more acute in urban health facilities, as the COVID-19 load was much higher in urban areas initially and the impact was more severe in states like Punjab, West Bengal and Maharashtra.

An ASHA worker working in the urban area in Ludhiana from Punjab expressed her helplessness to help women approaching her. "Both ANC and PNC services were ignored. Women were unable to access abortion services as the nearest government hospital was closed."

Narrating the problems of the urban women, a doctor from SDH Nangal, Punjab said,

*"Women from containment zones could not leave homes and were therefore unable to visit hospitals. The curfew also posed restrictions on the mobility and thereby the access to health facilities at the same time our ASHAs and ANMs could not make household visits."*

*"During the lockdown period, I came across three pregnant women who were unmarried and were 6-8 months pregnant when I met them. They had to continue it and got married. But there are also instances of incomplete abortion and morbidities, but not all cases get known," said one ASHA worker in Delhi.* She added that there is a greater demand for abortion among women who lacked any kind of family support.





## 4. Paths Women Adopted



### 4.1 Continuation of the unwanted pregnancy

Across all the eight states several women respondents who were using modern contraceptive methods such as condoms reported being unable to procure them from the frontline workers or even chemists. Women also shared that when they tried to access these contraceptives from health centres (PHC and SDH) or chemists, they reported short supplies. Further with limited agency and escalating instances of domestic violence, many women were unable to negotiate safe or reduced sexual activities with their partners and this led to unplanned pregnancies.

*“When the services were closed they couldn’t go anywhere. I told them that if injections are not available then use condoms in the meantime. So they were using it. But they said that not everyone’s husbands are the same. When the husband is reluctant to use condoms, we are helpless”, ASHA, Delhi*

It is important to note here that all the women across eight states, who reported being pregnant stated that the pregnancy was unwanted and unplanned. Frontline corroborated this and said,

“There is a considerable rise in the number of pregnancies. Usually, in a year (April to March), we attend around 200 pregnant women, which is our target. But this year I had about 155 cases by September, that is in the first six months.”

The Chemists also alluded to increased demand for pregnancy kits. In Maharashtra, Chemists (urban) shared that the sale of pregnancy kit had increased. Chemists from other states also reported the same.

### 4.2 Reliance on home remedies and quacks

One ANM from Nangal, Punjab public health facility shared that most women who come to her facility are from local slums and nearby villages.

*“Two unmarried girls had come with pregnancy, but due to rush of COVID-19 cases they could not get the services they sought at the centre.”*

Already there are multiple barriers to getting abortion services, especially for single women and unmarried girls. Withholding these services to give priority to COVID-19 cases further lessened their access. Women with an unwanted pregnancy were left with only two options - to continue the pregnancy or adopt home remedies or approach quacks (for termination).

*“Due to the unavailability of services at government health facilities women felt helpless and most of them tried home remedies or went to quacks.”*

### 4.3 Approaching private doctors

The private sector service providers were also 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.

One doctor respondent said. *“For the initial first month we closed the clinic due to fear, as there is the end for it then we opened the clinic in the next month with all safety measures, social distancing, masks, and hand wash etc. Patients were coming to our clinic with one or more symptoms of COVID-19 and we asked them to get a test done if the problem continues for more than two-three days.”*

A private Gynaecologist in Delhi running a registered abortion clinic observed no significant increase in demand for abortion services during COVID-19. “Abortion cases have instead reduced in the period,” she said. A private clinic in Thirukazhukundrum, district Chengalpattu, Tamil Nadu observed the same. “Number of pregnant women has certainly increased, but not the abortions.”

On the other hand, as anticipated the case load of abortion increased with relaxation in lockdown. As described a service provider,

*“Initially, there was a decrease in patient load but now it has increased multifold. There are instances of repeated abortions; when they come for a second time many decide to continue it. Men are not taking any responsibility for it. So I would suggest women meet us to get some advice beforehand about protection or go to the in-law’s house to maintain distance.”*

This wasn’t a practical piece of advice for women, who were already vulnerable because of being homebound.

Two examples from Tamil Nadu highlight the difficulties women faced in government facilities and paths the reasons they finally approached private providers:



**Case 1:** “When my periods got delayed for about 10 days, we bought a pregnancy confirmation kit from a private pharmacy and it showed positive. Immediately I spoke to the Village Health Nurse in my village and asked about abortion tablets but she didn’t respond. Then I went to a nearby PHC and asked for medicines (abortion pills) and the nurse at PHC told me that they do not provide abortion services. She referred me to the government medical college hospital in Chengalpattu as the pregnancy crossed 8 weeks. She gave me a chit to show it to the doctor there. But we were scared that there are many COVID patients in the Chengalpattu hospital. I already have two children we could not manage the third child during this pandemic time. Finally, I went to a private hospital in Chengalpattu and had an abortion”.

**Case 2:** “I had a doubt when my date got delayed. First I consulted a private doctor and she confirmed my pregnancy. Then we contacted Village Health Nurse and then went to nearby PHC. There was no doctor and the nurse at PHC and they referred me to go Chengalpattu government medical college hospital. She said I have already crossed 8 weeks of gestation and the abortion pills will not terminate my pregnancy. Then I went to the hospital and did a blood test (Haemoglobin). They asked me to come the next day. But I was afraid to go there for abortion services as I saw many Corona patients in the hospital. Moreover, the nurse at the hospital also told me to continue the pregnancy saying it is not advisable to do abortion during the pandemic period. Then we went to a private medical college hospital in another town and terminated my pregnancy believing that we can earn money at any time but never regain a life”.

#### 4.4 Attempt self-medication

Some women reported using OTC drugs to avert pregnancy and/or induce abortion. Overuse of EC pills was reported wherever women could access these. In a few states like Punjab, Maharashtra, West Bengal and Assam, women respondents noted private facilities being closed further limiting their options to seek emergency contraception.

Most chemists, more notably in Punjab and Gujarat, revealed that due to strict implementation of policies, they were not authorised to sell Medical Abortion pills without prescription. During the pandemic, however, they noted a 20 to 30 per cent increase in demand for medical abortion (MA) pills, which they could not fulfil due to these restrictions.

The chemists from Assam, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal also reported an increase in the demand for abortion pills in the lockdown months.

*“Around 75% of cases came without prescriptions,” said a chemist respondent in Punjab.*



# 5. Unending Trauma for Women



## 5.1 Consequences of unsupervised, unguided abortion attempts

Women often could not prevent pregnancy and had no one to guide termination of unwanted pregnancy either. Resolute in their decision to not continue with it, in their desperation they often resorted to consumption of pills without any knowledge about eligibility, recommended doses, mode of action and possible outcomes. As reported by one ANM,

*“A woman managed to get abortion pills but did not know how to consume them. She took all three dosages in a very short interval and experienced excessive bleeding. Another woman took abortion pills and ate something that someone suggested to her as a home remedy for abortion. The foetus in her womb was shredded into pieces and her bleeding did not stop for 15 days. She got an ultrasound for Rs.400 and came to know that a mass of flesh was attached to the uterus resulting in the bleeding. She had to get an abortion again and spent around Rs.3000-4000”.*

## 5.2 Debilitating cost of services in times of economic crises

Women reported exploitation by service providers, especially those from the private sector. Exorbitant cost of abortion services based on marital status and period of gestation are known. Some service providers took advantage of limited alternatives available to women and further inflated these costs. In states like West Bengal, Assam, Punjab, women reported incurring big expenses to seek abortion services spending from Rs 1500 to 15000 for services from private facilities. This is at a time when economic duress was high amongst the families. Using savings; borrowing money from friends and relatives or incurring debts were cited as methods for arranging the additional money required for seeking abortion services.

Case history narrated by an ASHA in Tamil Nadu: One woman with 11-weeks pregnancy suddenly experienced pain in her stomach and came to me. I told her to get an ultrasound done. She visited a private facility where she was asked to immediately go to the doctor. I accompanied the woman to the doctor, where he told us that the baby is already dead and she should immediately have an abortion. The woman's family asked me to come with her for an abortion. I told them that the General Hospital is not treating anyone without a COVID19 test and suggested they go to a private facility. I still took her to the General hospital where the doctor misbehaved with us and told the woman to come the next morning to the OPD and get registered. We then went to a private nursing home. After waiting for almost 3 hours, we were asked to pay Rs. 7,000 for abortion. But the woman only had Rs. 3000. She returned deciding to go to the General Hospital the next morning. But, she experienced excessive pain at 3 am. The family somehow arranged for money and took the woman to a private facility where they had to give Rs.5,000 for the abortion. Along with this, they spent Rs.12,000 on blood because the woman had very little haemoglobin.

One CSO representative in Uttar Pradesh reported another case,

*“One woman had to undergo a major operation for delivery but General Hospital denied her treatment. 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”.*

### 5.3 Mental stress and trauma

The fact that most frontline workers were deputed for COVID19 response created a gap between women and them. Most of the women who were forced to continue their unplanned pregnancy or had miscarriages reported at length the mental and emotional drain that they experienced. At times like this, they reiterated the need for counselling services which the frontline workers often meet during their household visits.



## 6. Roles played by Non-Government Organisations



NGOs across the states 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 organisations often played a critical role in coordinating with ASHAs, anganwadi workers to establish support mechanism in the community for immediate referrals and with medical officers directly to provide relevant information and facilitating services through the public health facilities.

NGO staff in Assam said, *'Our organisation creates awareness and support through counselling on sexual and reproductive health, maternal care and availability of services in government hospitals among our SHG members through monthly and quarterly meeting. In this way our organisation is able to provide support to women for accessing required services'*

Recognising the sexual and reproductive health care needs and difficulties in accessing those, a few of them provided essential services such as antenatal care, laboratory services and contraception. They mapped and formed a network of health care providers who were providing services at the local level, so that they could refer women who needed in-person services. Women who needed counselling services were counselled using mobile phone and followed up through local health workers.

NGO staff in Tamil Nadu said, *'Women who need psychosocial counselling services were counselled through mobile phone and followed up through local health workers. We have formed a network of service providers to refer women to avail the services'*

Some other organisations that worked primarily on sexual and reproductive health rights of women supported women who reported domestic violence. They arranged for counselling support through helplines and referred women and adolescents to public health facilities in case clinical services were required.



# 7. Discussions and Conclusion



This section diverges from the standard discussion and conclusion format based on findings alone. It integrates women's own views on what they needed, wanted and what they received instead to highlight the need to reset programmatic and service delivery priorities and direction.

## 7.1 What women needed and wanted

One of the overwhelming response and recommendation of women was to prioritise abortion services as key critical and essential service even during the pandemic. The women reiterated the key role that front line health workers like the ASHA 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. Many a time the frontline workers play this role however due to COVID-19 duties, the latter was not available.

Further, as many government hospitals were converted into COVID-19 facilities, they had to travel long distances to seek abortion services. The need for localised, affordable abortion services at the government hospitals was duly highlighted.

## 7.2 What did women get instead?

Clinical staff including frontline workers was overburdened with COVID-19 duties and many cited a lack of personal protective equipment to provide services safely. Their engagement also hampered outreach activities such as contraceptive distribution, IEC counselling, commodity supply and referral.

The pandemic perhaps illustrates best the critical role that the frontline service providers perform in ensuring that RMNCAH+N services and information are available at the community level. This link was effectively disrupted during the pandemic and the lockdown even while reproductive and child health services were categorised as essential services.

So while there was an increase in the demand for abortion services, these services in both public and private health facilities, were simply not available. Women complained about the blatant disregard for their needs in times of crises.

Moreover, abortion is still heavily stigmatised, women are unable to discuss seeking an abortion with their families and accessing transport to go to hospitals, especially

in rural areas. There are cultural limitations on their mobility or access to finances to pay fares or buy contraceptives or MA drugs. These challenges were exacerbated during this pandemic. Women's health needs became the first and major casualty of economic constraints and systemic breakdown.

Even prior to the pandemic, lack of trained staff and poor access to medical supplies and equipment have been known to prevent public health services from providing surgical abortion services. This was emphasised in a recent study by the Guttmacher Institute that recommended that the availability of all abortion services, including medication abortion, be improved in public health facilities (Singh et al. 2018). In such situation women are often forced to access services and pay exorbitant amounts for safe abortions in private sector clinics. Private-sector medical abortions are known to be expensive, costing anywhere between Rs. 500-10,000. These exploitative practices are known to feed on women's vulnerabilities. Women who cannot afford this have no recourse but to approach quacks, chemists or try home remedies.

These available shreds of evidence are corroborated by the current study. The data indicated clearly that amongst RMNCAH+N services, abortion services were the worst affected. The taboo associated with abortion services were heightened during the pandemic. ASHAs who form a critical link in villages in facilitating access of women to abortion services without the knowledge of family members were no longer available to help them. With this link broken during the pandemic, a vacuum was created resulting in many women across the eight states having to continue the pregnancy despite their will to the contrary. With their absence more than half of the women interviewed continued the pregnancy while the remaining tried getting abortion services from a private facility, or using traditional methods or going to quacks.

### **7.3 What do local NGOs recommend?**

NGOs working locally at the community level with the women articulated the need for a strong institutionalized support systems for women to ensure that their health and other needs are met at all times. In view of constant nature of some of these needs, according to them, a system that is impervious to any systemic crises needs to be conceptualized. Special programmes and robust alternative approaches to mitigate crises related breakdown needs to be part of the plan even before the crises occur. 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.

### **7.4 What can be done to address the situation?**

The COVID-19 pandemic has important lessons for the public health delivery system. The situation was undoubtedly unprecedented and caught the system unawares and unprepared in the early stages of the pandemic. The pandemic spread overburdened the system, which stretched itself to meet the emerging needs. As resources and facilities were being dedicated to containing the virus, it created a vacuum for other

critical services like RMNCAH+N. However, given the unrelenting course of the pandemic, mitigating strategies had to be devised.

It is critical that in times of crisis like COVID-19, sexual and reproductive health and rights (SRHR) and particularly abortion services being time sensitive are prioritised. The role of the frontline workers like ASHA and ANM at duress times like this cannot be emphasised enough.

The aggravated vulnerabilities of specific communities, such as female sex workers, HIV positive women, women from SC/ST communities need to be addressed on a priority basis. It is important that a public response system recognises the structural impediments that vulnerable communities face in seeking services, which get amplified during a crisis, particularly of the scale of COVID.

The pandemic has shown how a crisis has a direct bearing on gender-based violence. The absence of services, especially SRHR and abortion, increase women's vulnerability manifold. Thus, prioritising and centralising support services for health and violence become imperative.



# Annexure I

## Key Research Questions



1. How has COVID-19 impacted women's maternal health, contraceptive and abortion needs?
2. How has COVID-19 impacted the availability, accessibility and quality of reproductive health services in the public sector, especially contraceptive and abortion services?
3. What steps are the government health system taking to meet women's routine reproductive health needs as well as contraceptive and abortion service needs during the pandemic and lockdown period?
4. What are women doing in the absence of access to reproductive health services, especially maternal health, contraceptive and abortion services in the public sector?
5. What are women doing in absence of access to services they want / need?
6. What are the implications in terms of reproductive health outcomes of the steps they take in absence of access to services in the public sector?
7. What can be done to address the difficulties faced by women in accessing these services?





# Annexure II

## Research Partners and Sample Size



#	Organisation	District /State	Primary respondents*	Key informants				
				Government Officers	MOs and private Doctors	ASHA ANM, AWW PEs	Chemists	NGO/ CBO staff
1	Amhi Amchya Arogyasathi	Gadchiroli, Maharashtra	5	1	3	8	3	2
2	ANT	Chirang, Assam	6	2	2	2	2	2
3	GPS	Azamgarh, Uttar Pradesh						
	5	2	2	2	2	2		
4	GADSS/ ARPAN	Ludhiana and Nangal, Punjab	5	2	2	2	2	2
5	GGBK	24 South Paragnas, West Bengal	5	1	2	4	1	2
6	RUWSEC	Chengalpattu, Tamil Nadu	6	-	1	4	2	2
7	SAHAJ	Vadodara, Gujarat						
	5	-	1	4	2	2		
8	Saheli	Pune, Maharashtra	5	-	1	2	1	1
9	The YP foundation	North-East Delhi, Delhi	-	-	2	3	3	2
<b>Total</b>			<b>42</b>	<b>8</b>	<b>16</b>	<b>31</b>	<b>18</b>	<b>17</b>
<b>Grand Total</b>			<b>42</b>	<b>90</b>				

\* Women above age 18 who have need for or accessed contraceptive, maternal care of abortion services



# Annexure III

## Informed Consent



### Basic information

Namaskar. My name is \_\_\_\_\_. I am from \*\*\*\*\*. I am associated with the study on “Access to Safe Abortion Services during Pandemic Situation in India”. The study is conducted by CommonHealth, a rights-based, multi-state coalition of organizations and individuals that advocates for increased access to sexual and reproductive health services to improve health conditions of women and marginalized communities.

The purpose of this exploratory study is to systematically document the need for abortion services, the access to these services and women’s experiences with services in the course of the COVID19 pandemic and consequent country-wide lockdown and changes in health system priorities.

For this, I would like to have your permission to discuss some issues related to selected reproductive health services, especially safe abortions services during the pandemic period. The information you provide us has the potential to help improve these services in your area during this period as well as in future health crisis situations. In view of the current restrictions on mobility and social distancing norm, the interview will be mostly telephonic and will require about 30-45 minutes.

All the data that we gather will be used for research purposes only and your identity will not be revealed. Only our research team will have access to the information you provide us. Your participation is voluntary. You may decide not to participate if you choose not to do so. You have the right to refuse to discuss any question if you feel uncomfortable about it. This will be without any consequences for you now or in the future and there is no penalty for refusing to take part. However I do expect that you will give me permission for this good cause. You may ask me if you have any questions. If at any later stage you have questions, you can also contact: \*\*\*\*\*, Study team lead, Organisation \*\*\*\* (Contact number \*\*\*)

If I have your consent, please sign the consent form below. I will provide you with a copy of the signed form. May I begin the discussion?

## Participant consent

I, \_\_\_\_\_, have understood the purpose of and topics to be covered during the interview. All of my questions have been answered. I understand that my participation is voluntary. I know that if I choose to refuse to participate, there will be no harm that will come my way. I voluntarily agree to participate in this study.

### Verification of Consent

The benefits, risks, and procedures for the research study have been explained to the respondent, her/his questions have been answered and she/he has agreed to participate.

\_\_\_\_\_Signature of interviewer\_\_\_\_\_Date (dd/mm/yyyy)



# Annexure IV

## Interview Guides



### A. Interview Field Guide Women in Reproductive Age Group

#### 1. Background information

- a. Location
  - i. State
  - ii. District
  - iii. Urban / Rural
  - iv. Containment zone at any stage during the pandemic: Yes/no
- b. Family profile
  - i. Religion
  - ii. Caste
  - iii. Family type
  - iv. APL/BPL
  - v. Health insurance
  - vi. Migration details
- c. Respondent's profile
  - i. Age
  - ii. Education
  - iii. Marital status
  - iv. Occupation
  - v. Member of any SHG / women's group
- d. Obstetric profile
  - i. Number of pregnancies
  - ii. Number of living children,
  - iii. Number of newborn deaths
  - iv. Number of spontaneous abortions
  - v. Number of induced abortions

#### 2. Impact of COVID19 Pandemic

- a. How has COVID19 pandemic affected your life? What are the changes in your life? (Probe for changes in: mobility, earning, health, violence, effect of migration and schooling of children)
- b. How have you coped with these changes? What did you do / what do you do to cope?

### 3. Access to contraceptive during the pandemic

- a. Have you been using contraceptive methods for spacing or preventing pregnancies?

If yes:

- b. What methods of contraception have you been using? Since when? What has been the source of your method?
- c. How have your contraceptive needs changed in the last 3-4 months during the pandemic / lockdown period? (Probe for all methods including emergency contraceptive pills)
- d. Who in the health system have you been in contact with in the last 3-4 months about your need of contraception? What information and help have you received from them?
- e. How has been your experience of seeking contraceptive services in the last 3-4 months? What challenges you faced in seeking care? (Probe for lockdown, restricted mobility, shortage of supplies, unavailability of health staff, cost of methods etc.)
- f. How affordable were the services you accessed during this period? How did you manage the expenses?

If contraceptives of choice were unavailable

- g. If contraceptive of your choice / one which you were using was not accessible, what steps did you take? Did these help meet your needs?

If did not seek contraceptive services:

- h. If you did not seek services, why did you not do so?

### 4. Access to Maternity care /Abortion

- a. Did you have a pregnancy in the last four months period? How did you come to know about it? Was it wanted?
- b. If unwanted, why? (Probe for: failed / unavailable contraception, forced/ violence)
- c. What was the decision about this pregnancy? Why? (Probe for – plan for continuation or abortion)
- d. Whose decision, was it? Was the decision acceptable to you?

**If planned to continue the pregnancy:**

- e. Did you access services during your pregnancy?

If yes:

- f. Where did you seek/are you seeking services? Why? (*Probe for public / private sector, large / small hospital, AWC, VHND/ ANM/ASHA/AWW, male / female doctor, near / far from residence, explore any other reasons for choice of facility*)

- g. Were the community-based healthcare services available? Did ASHA/ANM visit regularly? (Probe- ICDS facility open? VHND organised?)
  - a. How was your experience of seeking the healthcare services for pregnancy/delivery/post-natal care? What challenges did you face in seeking care? (probe-discrimination /rude behaviour and support system available-family/frontline workers/NGO etc)
- h. How affordable were the services you accessed? How did you manage the expenses?
- i. How has continuation of pregnancy impacted your overall health? (Probe for physical, mental impact) What steps have you taken to seek relief from these health issues? (Probe for type of facility where help was sought, sources of information etc)
 

If services were unavailable
- j. If services were not available, what did you do?
 

If did not seek services:
- k. If you did not seek services, why did you not do so?

***If planned to abort the pregnancy:***

- b. Did you access abortion services in last 3-4 months period?
 

If yes:
- c. Where did you seek/are you seeking services? Why? (Probe for public / private sector, large / small hospital, male / female doctor, near / far from residence, explore any other reasons for choice of facility).
- d. How was your experience of seeking the abortion services, specifically in terms of behaviour of service providers? What challenges did you face in seeking these services? (probe-discrimination /rude behaviour and support system available-family/frontline workers/NGO etc)
- e. How affordable were the services you accessed? How did you manage the expenses?
- f. How was the experience of abortion? In terms of behaviour of the service provider? Did you have any complications after abortion? If yes elaborate. What help are you seeking and from where?
- g. How has this abortion impacted your overall health? (Probe for physical, mental impact) What steps have you taken to seek relief from your health issues? (Probe for type of facility where help was sought, sources of information etc)
 

If services were unavailable
- h. If services were not available, what did you do?
- i. Did you use any alternative method for abortion? If yes, elaborate. How did you manage? Who did you seek help from?
 

If did not seek services:
- j. If you did not seek services, why did you not do so?

## 5. **Autonomy**

- i. Do you have freedom to go out without permission? (Market, Friend's /relatives house, Health centre)
- ii. Do you have freedom to spend money? (probe- for shopping/Household items/ medical care). Do you own a personal bank account?
- iii. Do you have your own mobile phone? If yes, Experience of using it? (Probe for money for charging, privacy to use it, and so on)
- iv. Do you have freedom to make own decisions? (decisions about children/use of contraception/accessing health services/terminating pregnancy)

## 6. **Recommendations**

- i. What are your suggestions to make health services accessible to the women during the COVID pandemic / crisis such as this?

# **B. Interview Field Guide NGO/CBO Staff**

## 1. **Background details**

- a. Name of NGO
- b. Location
  - i. State
  - ii. District
  - iii. Urban / Rural
  - iv. Containment zone in the pandemic: Yes/no
- c. Major area of work / focus of work
- d. Respondent's profile
  - i. Designation
  - ii. Age
  - iii. Education

## 2. **Role and responsibilities**

- a. How long have you been associated with the organisation? What are your responsibilities in the organisation?
- b. Tell us about your work with the community? (Probe for work related to reproductive health awareness creation, Covid related awareness creation, facilitating service provision through referral linkages, women's empowerment and rights etc.)
- c. Which community/groups do you work with? (Probe for urban slums, rural areas, Dalits, sex workers, HIV+ve , adolescents, people with disability etc.)

### **3. Changes since COVID19 pandemic**

- a. How has your work changed since COVID19 outbreak? (Probe for strategy for reaching community after Covid outbreak, what work/activities were undertaken with what groups)
- b. What challenges do you face in working in the community and with the health care set up in the present situation? (Probe for availability of safety kits, clarity about guidelines and protocols, availability of staff, social support etc)
- c. From your observations and experience of work in the community, what have been the changes in women's health needs? What health needs have you observed amongst the women (Probe for contraception, maternal care, abortion)?
- d. Which women have these need more? Why do you think these women have these needs more than other women? (Probe for adolescents, migrants, those facing domestic violence, rural, Dalit, sex workers, those without access to FP methods)
- e. How are these health needs being met during the lockdown and pandemic period? Where are women going for services? Why? (Probe for lockdown, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, services available at home)
- f. What are the major barriers in accessing care for women with SRH issues? (Probe for lockdown, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, services available at home)
- g. What are women doing in case of unavailability of services at government health facilities? (Probe for going to private facilities, traditional healers, chemists, approaching frontline workers, trying home remedies etc.
- h. Who is most affected in terms of health needs and healthcare access? (Probe for vulnerable groups such as adolescents, poor women, rural women, Dalit women etc.) Why do you think their access is especially affected?

### **4. Abortion service seeking by women in the community**

- a. What are the various health facilities available in your area where abortion services are provided? (Probe for government, private, untrained, frontline workers)
- b. How accessible are these to all sections of the society? What are women's preferences for facilities based on their health need or profile (age, marital status, economic status)?
- c. How did the availability of these services get affected during lockdown and post-lockdown? What is the usual demand for abortion services in your area? What is the profile of those seeking these services? (Economic, marital, obstetric status) What do you usually do when anyone approaches you for these services?
- d. What were the changes in the demand for abortion services during the lockdown / last 4 months? Can you share a few details about such cases?
  - I. Has the number been more than before the pandemic?



- II. What was the profile of those who sought these services?
- III. Whom do/did they approach first? Why do/did they choose to go there?
- IV. How easy/difficult was/is it accessing services for abortion? Have there been any specific issues reported by women – related to seeking abortion services? (Probe for domestic violence, lack of support from family, lockdown restrictions, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, insistence on COVID19 test results, confidentiality issues, discriminatory practices of service providers), cost of services
- V. What alternatives have women used to meet their abortion needs? (Probe for continuation of pregnancy; seeking services from traditional healers, frontline workers, chemists; home remedies etc)
- VI. What have been the outcomes in such cases? (Successful abortion, continued pregnancy, complications, death)

#### **5. Response of NGO to women's needs**

- a. In what way is your organisation able to provide support to women for accessing required services?
- b. What are your suggestions/recommendations for helping women in need during this time? What should be done at community and health system level?

## **C. Interview Field Guide Government Officer**

### **1. Background details**

- a. Location
  - i. State
  - ii. District
  - iii. Urban / Rural
  - iv. Containment zone in the pandemic: Yes/no
- f. Respondent's profile
  - i. Designation
  - ii. Age
  - iii. Gender
  - iv. Education
  - v. Department/facility:
  - vi. Years of service at present location:

### **2. Role and responsibilities**

- a. Tell us about your roles and responsibilities in your current job

### 3. COVID19 situation and changes

- a. What is the current status of COVID19 pandemic in your area/village/tehsil/block? (probe- in terms of number of covid positive cases, number of deaths, number of cases under quarantine/treated?)
- b. How has COVID19 pandemic affected your work? How have your responsibilities and your programmes changed in the last 4 months / since the COVID19 pandemic? (probe change in programmatic aspects/area of work/department/location/reporting /additional work etc)
- c. What has been your experience of working last 4 months since the COVID19 pandemic? Was health service provision stopped/discontinued through government facilities in your area at any time? If yes, When and for how long?
- d. If No, what were the strategies adopted for providing services? (Probe any specific preventive measures or safety measures undertaken: suspension of certain services, screening of population; Covid19 awareness creation; use of PPE, referral of COVID19 positive cases, telemedicine, online consultation)
- e. What are the specific challenges in provisioning routine reproductive services to women, especially to women seeking contraception, maternal care and abortion services in the last 4 months / since the COVID19 pandemic? (Probe for focus of facility on Covid case management, availability of trained health staff, medicine stocks, safety kits/ equipment, fear of contracting infection, etc.)
- f. How are the outreach services been affected in the last 4 months / since the COVID19 pandemic? (Probe for VHNDs, household visits, AWC services, village development committee meetings/Village Education committee meetings)?

### 4. Healthcare access and challenges

- a. What are the various health facilities available in your area where contraception, maternal care and abortion services are provided? (Probe for government, private, untrained, frontline workers)
- b. How accessible are these to all sections of the society? What are women's preferences for facilities based on their health need or profile (age, marital status, economic status)? Why?
- c. What have been the changes in the demand for these services during the last 4 months / since the COVID19 pandemic?
- d. What are the major challenges faced by these women with respect to access to health services in the last 4 months /since the COVID19 pandemic? (Probe for lockdown and restricted mobility, closed facilities, denial of routine services, availability of health staff, medicine stocks, safety kits/ equipment, fear of contracting infection, etc.)
- e. What are women doing in absence of availability of services they seek in t he last 4 months / since the COVID19 pandemic?

## 5. Response of government health system

- a. What measures have been taken by the government to ensure reproductive health care service provision, especially contraceptive, maternal care and abortion services in the current COVID19 pandemic situation?
- b. How helpful have been these measures in meeting women's needs?
- c. What are your suggestions/recommendations for helping women with these health needs during this time? What should be done at community and health system level?

## D. Interview Field Guide Healthcare Providers (Medical Officer / Doctors)

### 1. Background details

- a. Location
  - i. State
  - ii. District
  - iii. Urban / Rural
  - iv. Containment zone in the pandemic: Yes/no
  - v. Type of Health facility
    - Government / Private
    - Clinic/ Nursing home / Hospital / PHC / CHC /District hospital
- b. Respondent's profile
  - i. Designation
  - ii. Age
  - iii. Gender
  - iv. Education
  - v. Specialisation if any:

### 2. Role and responsibilities

- a. How long have you been practicing? How long have you been at this facility? How long have you been at this position? What population do you serve?
- b. What are your job responsibilities in at the health facility?
- c. Tell us about the type of your work you do? (Probe for work related to health awareness creation, counselling, providing clinical services)

### 3. Changes since COVID19 pandemic

- a. How has COVID19 pandemic affected your work? What has been the average daily caseload in you facility? Has it changed with the COVID19 pandemic?

- b. Was the service provision stopped/discontinued at your facility at any time? If yes, When and for how long?
- c. If No, what were the strategies adopted for handling caseload to the facilities? (Probe any specific preventive measures or safety measures undertaken: suspension of certain services, screening of population; Covid19 awareness creation; use of PPE, referral of COVID19 positive cases, telemedicine, online consultation)
- d. Did you receive any training or inputs for handling these changes in your activities? Please elaborate about when, where by whom were you trained?
- e. What challenges do you face in carrying out your job in the health facility and in interacting with patients in the present situation? (Probe for availability of latest information, safety kits, clarity about guidelines and protocols, availability of staff, equipment and medicines at health centres, social support etc)
- f. From your observations and experience, what have been the changes in women's health needs? What health needs have you observed amongst the women (Probe for contraception, maternal care, abortion, victims of domestic violence)?
- g. Which women have these need more? Why do you think these women have these needs more than other women? (Probe for adolescents, migrants, those facing domestic violence, rural, Dalit, sex workers, those without access to FP methods)
- h. How are these health needs being met during the lockdown and pandemic period? Where are women going for services? Why? (Probe for lockdown, closed facilities, unavailability of routine services, lack of supplies, cost of services, fear of COVID19, services available at home)
- i. What are the major barriers in accessing care for women with SRH issues? ? (Probe for lockdown, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, stigmatisation or denial of services because of COVID positive status, cost of services, issues of privacy and confidentiality, services available at home)
- j. What are women doing in case of unavailability of services at government health facilities? (Probe for going to private facilities, traditional healers, chemists, approaching frontline workers, trying home remedies etc.)

#### **4. Abortion service seeking by women in the community**

- a. What are the various health facilities available in your area where abortion services are provided? (Probe for government, private, untrained, frontline workers)
- b. How accessible are these to all sections of the society? What are women's preferences for facilities based on their health need or profile (age, marital status, economic status)?

- c. How did the availability of these services get affected during lockdown and post-lockdown? What is the usual demand for abortion services in your area? What is the profile of those seeking these services? (Economic, marital, obstetric status) What do you usually do when anyone approaches you for these services?
- d. What were the changes in the demand for abortion services during the lockdown / last 4 months? Can you share a few details about such cases?
  - I. Has the number been more than before the pandemic?
  - II. What was the profile of those who sought these services?
  - III. Whom do/did they approach first? Why do/did they choose to go there?
  - IV. How easy/difficult was/is it accessing services for abortion? Have there been any specific issues reported by women - related to seeking abortion services? (Probe for domestic violence, lack of support from family, lockdown restrictions, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, insistence on COVID19 test results, confidentiality issues, discriminatory practices of service providers), cost of services
  - V. What alternatives have women used to meet their abortion needs? (Probe for continuation of pregnancy; seeking services from traditional healers, frontline workers, chemists; home remedies etc)
  - VI. What have been the outcomes in such cases? (Successful abortion, continued unwanted pregnancy, complications, death)

## **5. Response to women's needs**

- a. What steps has government taken to provide support and care to these needs of women? Please elaborate.
- b. In what way are you able to provide support to women for accessing required services?
- c. What are your suggestions/recommendations for helping women in need during this time? What should be done at community and health system level?

## E. Interview Field Guide

### Chemists

#### 1. Background details

- a. Location of respondent
  - i. State
  - ii. District
  - iii. Urban / Rural
  - iv. Containment zone in the pandemic: Yes/no
  - v. Chemist facility
    - Location of facility (village/town/urban/rural/ near public/private hospital/clinic)
    - Years of establishment
- b. Respondent's profile
  - i. Age
  - ii. Gender
  - iii. Education

#### 2. Impact of COVID19 pandemic

- i. What changes has happened since the COVID19 outbreak? How has it affected the sales and supplies of medicines in your area/town? Please elaborate
- ii. How has COVID19 affected your business? What challenges have you faced in running the business? (Probe for procuring supplies, unavailability, transport restrictions, demand)
- iii. Sales of which items /medicines have increased during this time? In what proportion increased compared to earlier? (Probe for masks, sanitizers, medicines for fever, chloroquin, vitamin, ayurvedic medicines, immunity boosters, contraceptives, pregnancy testing kits, abortion pills etc)
- iv. What are the various health facilities available in your area where abortion services are provided? (Probe for government, private, untrained, frontline workers)
- v. How accessible are these to all sections of the society? What are women's preferences for facilities based on their health need or profile (age, marital status, economic status)?
- vi. How did the availability of these services get affected during lockdown and post-lockdown?

### **3. Reproductive health/Contraception during pandemic**

- i. What were the stocks and supply issues related to sanitary pads during the lockdown/last 4 months? What kind of changes were there in demand for sanitary pads? What changes were there in gender profile of those buying sanitary pads during lockdown?
- ii. What was done to address the demand issues? How is the situation at present?
- iii. What were the stock and supplies issues related to contraceptives during the lockdown/last 4 months? Which contraceptives? What was done to address these issues? How is the situation at present?
- iv. What kind of changes were there in the demand for contraceptives in your area? For which contraceptives? Which age group and gender sought more of these contraceptives? What was done to address these issues? How is the situation at present?
- v. What kind of changes stock and supplies issues related to pregnancy kits during the lockdown/last 4 months? What were the changes in the demand for pregnancy kits? If yes, in what proportion?
- vi. What were the changes in the price of sanitary pads, contraceptives, pregnancy kits during this period? Why did these changes occur?

### **4. Abortion related supplies/demand during pandemic**

- i. What is the usual demand for abortion pills in your area? What is the profile of those seeking these pills? (Economic, marital, obstetric status) What do you usually do when anyone approaches you for purchase of abortion pills?
- ii. What were the changes in the demand for abortion pills during the lockdown / last 4 months? What was the profile of those approaching for abortion pills?
- iii. What kind of changes stock and supplies issues related to abortion pills during the lockdown/last 4 months?
- iv. What challenges did you face in meeting the demands? How were these addressed?
- v. Which age group and gender sought more of these?
- vi. How many cases came without prescriptions?? What did you do in such cases?

## F. Interview Field Guide

### ANMs/ASHAs/AWWs

#### 1. Background details

- a. Location
  - i. State
  - ii. District
  - iii. Urban / Rural
  - iv. Containment zone in the pandemic: Yes/no
- b. Respondent's profile
  - i. Designation
  - ii. Age
  - iii. Education

#### 2. Role and responsibilities

- a. How long have you been working as ANM/ASHA /AWW? What population do you serve?
  - i. What are your job responsibilities in the community / at the health facility?
  - ii. Tell us about the type of your work with the community? (Probe for work related to health awareness creation, counselling, providing immunisation, antenatal care etc, facilitating service provision for high risk cases through referral linkages, formation of women's groups etc.)

#### 3. Changes since COVID19 pandemic

- a. How has your work changed since COVID19 outbreak? (Probe for strategy for reaching community after COVID19 outbreak; work/activities undertaken: screening of population; Covid19 awareness creation; provision of contraceptives, ANC/PNC care; conducting delivery at home)
- b. Did you receive any training or inputs for handling these changes in your activities? Please elaborate about when, where by whom were you trained?
- c. What challenges do you face in working in the community and with the health care set up in the present situation? (Probe for availability of latest information, safety kits, clarity about guidelines and protocols, availability of staff, equipment and medicines at health centres, social support etc)
- d. From your observations and experience of work in the community, what have been the changes in women's health needs? What health needs have you observed amongst the women (Probe for contraception, maternal care, abortion, victims of domestic violence)?



- e. Which women have these need more? Why do you think these women have these needs more than other women? (Probe for adolescents, migrants, those facing domestic violence, rural, Dalit, sex workers, those without access to FP methods)
- f. How are these health needs being met during the lockdown and pandemic period? Where are women going for services? Why? (Probe for lockdown, closed facilities, unavailability of routine services, lack of supplies, cost of services, fear of COVID19, services available at home)
- g. What are the major barriers in accessing care for women with SRH issues? ? (Probe for lockdown, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, stigmatisation or denial of services because of COVID positive status, cost of services, issues of privacy and confidentiality, services available at home)
- h. What are women doing in case of unavailability of services at government health facilities? (Probe for going to private facilities, traditional healers, chemists, approaching frontline workers, trying home remedies etc.)

#### **4. Abortion service seeking by women in the community**

- a. What are the various health facilities available in your area where abortion services are provided? (Probe for government, private, untrained, frontline workers)
- b. How accessible are these to all sections of the society? What are women's preferences for facilities based on their health need or profile (age, marital status, economic status)?
- c. How did the availability of these services get affected during lockdown and post-lockdown? What is the usual demand for abortion services in your area? What is the profile of those seeking these services? (Economic, marital, obstetric status) What do you usually do when anyone approaches you for these services?
- d. What were the changes in the demand for abortion services during the lockdown / last 4 months? Can you share a few details about such cases?
- e. Has the number been more than before the pandemic?
- f. What was the profile of those who sought these services?
- g. Whom do/did they approach first? Why do/did they choose to go there?
- h. How easy/difficult was/is it accessing services for abortion? Have there been any specific issues reported by women – related to seeking abortion services? (Probe for domestic violence, lack of support from family, lockdown restrictions, closed facilities, unavailability of routine services, lack of supplies, fear of COVID19, insistence on COVID19 test results, confidentiality issues, discriminatory practices of service providers), cost of services

- i. What alternatives have women used to meet their abortion needs? (Probe for continuation of pregnancy; seeking services from traditional healers, frontline workers, chemists; home remedies etc)
- j. What have been the outcomes in such cases? (Successful abortion, continued pregnancy, complications, death)

**5. Response to women's needs**

- a. What steps has government taken to provide support and care to these needs of women? Please elaborate.
- b. In what way are you able to provide support to women for accessing required services?
- c. What are your suggestions/recommendations for helping women in need during this time? What should be done at community and health system level?







**CommonHealth**

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