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Examining the Impact of COVID-19 on SRHR: A review of the evidence on the provision of abortion services in India

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WHAT IS THE KTA PROBLEM?

Unsafe abortion is the third leading cause of maternal mortality in India, despite abortion being legal in the country since 1971 (1). Many women in India face socio-economic, cultural and geographical barriers in accessing abortion services (1,2). Additionally, data on abortion incidence in the country is incomplete and non-comprehensive (1,3). Given that the vast majority (estimated at around 80%) of abortions occur outside of medical facilities, an important source of data on abortion incidence is through women self-reporting their procedures (4). However, many women under-report their abortion practices. This is in part due to the stigmatization of abortion that persists in the country and the lack of awareness of the legality of abortion (1). Moreover, misconceptions about the legality of abortion persist both among women and healthcare providers, which further decreases access to safe abortion (2).

The lack of reliable and comprehensive data on abortion incidence and service provision hinders the making of evidence-informed policy decisions aimed at ensuring adequate access to abortion services and facilitating access to safe abortion for all women (1). Furthermore, the advent of the COVID-19 pandemic has significantly compromised access to safe abortion and has exacerbated the lack of provision of abortion in India (4). Among other barriers, the pandemic has disrupted the supply chain of medical abortion products. It has also resulted into a nation-wide lockdown causing mobility restrictions and interruption of public transportation, as well as the redeployment of healthcare practitioners and facilities towards COVID-19 care (4). As such, COVID-19 has exacerbated the pre-existing barriers in access to abortion care and comprehensive data collection on abortion incidence in India.

WHO DOES IT AFFECT AND HOW?

There are different stakeholders that have been affected by the limited evidence, access and information on abortion services in India. First of all, these gaps affect adolescent girls and women all over India, but more specifically in rural areas. Indeed, the lack of information on abortion services has led to unsafe abortions (as mentioned earlier, the third leading cause of maternal deaths in India) that are occurring in non-facility settings, and unintended pregnancies (5). These can have many consequences for women's health such as: major obstetric complications, miscarriages and psychological disorders, such as postpartum depression, due to unwanted pregnancies.

- According to a study by Yokoe et al.: “67% of abortions in the study population in India were classified as unsafe, varying widely across the states (range 45.1%–78.3%)” (6). Abortion was also reported to have consequences on the social and economic status of women, their families and their communities.
- “A renowned NGO’s policy brief states that logistical issues like non-supply, human resource issues and lack of access will lead to 26 million couples in India facing unmet need for contraception if the current situation continues. This will result in 2.4 million unintended pregnancies; **1.45 million abortions, out of which more than half would end up being unsafe**; and more than 1700 excess maternal deaths “ (7).

Furthermore, during the COVID-19 pandemic, there also are consequences in the health sector as the hospital services are reduced given that the services are redirected to provide emergency care only, and the global aid and development agencies have repatriated their employees (8). The availability of services decreased either by “decreased hours, sites, and number of working health services providers” (8).

Additionally, the disruption in the supply chain for contraception may result in more sexually transmitted infections, such as HIV. Thus, it could have major consequences on both the population and on the health sector, such as increased medical needs for seropositive patients and more in utero transmission of HIV. The risk of increased medical needs can lead to new public health, economic and political stakes.

DESCRIBE THE “K”



WHAT DO WE KNOW ABOUT IT? WHAT DO WE THINK WE DON'T KNOW?

According to the World Health Organisation, each year around 25 million unsafe abortions are performed around the world (9). Through scientific breakthrough, we know today that unsafe abortion drastically increases maternal mortality and morbidity (10). This practice increases the risk of short-term complications like hemorrhage, infection or organ injury. In the long run, it can alter women's physical and psychological health as well. For example, it fosters chronic pain, inflammatory disease or infertility (11).

Knowing that the implementation of safe abortion care is an effective solution to prevent the burden of unsafe practices, promoting safe abortion throughout countries is essential (12). Although abortion has been legal in India for almost five decades, a study from 2019 has shown that 2/3 of abortion practices in the country are considered unsafe (6). Each year, 12 000 women die because of unsafe abortions (13).

Considering this country's complex social and cultural context, many factors are considered to be responsible for the gap between the law and women's reality. For example, determinants such as the area of residence, the education level, the familial and spiritual background and the socio-economical context play an important role in abortion practices (13). Additionally, the COVID-19 pandemic and nation-wide lockdown have caused an increase in intimate-partner violence and unwanted pregnancies among women in India (5).

Despite the mobilization of numerous NGOs, the implementation of specific abortion programs and the training of many healthcare providers these efforts do not seem sufficient to cover the entire territory and stem the burden (13). The pandemic has worsened the situation. Even though we can identify the impact of these determinants on Indian women's health, it is complicated to provide an appropriate and personalized answer to each situation. In the end, what we do not know relies on which determinants should be prioritized and how much the government is ready to get involved.

For example, we could ask ourselves who would struggle the most to find a safe abortion healthcare service:

- A woman from an upper caste but living in a rural area?
- A woman from a lower caste but living in a big city?
- A woman from an upper caste, a wealthy family, and living in a big city but in an anti-abortion community?
- A woman seeking care in a facility where a healthcare provider is choosing not to provide abortion care, given uncertainty surrounding the legal framework and fear of repercussions?

WHAT ARE THE BIGGEST GAPS?

In addition to the barriers and gaps that needed to be addressed prior to COVID-19, the pandemic brings upon many more gaps that must be further studied. Majority of gaps revolve around the lack of knowledge various stakeholders currently have on various issues regarding abortion and abortion care. Acknowledging these gaps are essential to such a time sensitive matter.



WHAT ARE THE BIGGEST GAPS? (CONTINUED)

To begin with, there is a knowledge gap of the current legal status of abortion medication and abortions themselves. The federal government has recently legalized telemedicine in order for the public to be able to connect to a physician and have access to their medications during lockdowns. Yet the policy around using telemedicine for prescribing and providing access to abortion care and medications is vague. In a study done by Foundation for Reproductive Health Services India researchers found that 21% of chemists (pharmacists) did not know abortion was legal in the country, while 62% stated it was legal under specific conditions (14). They also found that the Drug Control Authorities barely communicated to these pharmacies regarding selling abortion medicines, with one state being instructed to take the details of the women that purchase them (14). The lack of clarity has resulted in pharmacies not stocking medical abortion drugs, as they either do not know if the drugs are legal or want to avoid excessive documentation and paperwork (14).

The vagueness and constantly shifting policies such as the Telemedicine Practice Guidelines has not only confused pharmacists, but also physicians. Physicians and healthcare centres have been refusing services, postponing scheduled abortions, and/or requiring increased testing due to COVID-19, further delaying an already time sensitive issue (15,16). Many abortions that could have been managed by medications are shifting towards surgery due to lack of access to abortion drugs (16). This ultimately places a greater financial burden and increases risks for health complications (16). Even so, a major barrier is that many care providers and women are unaware that abortions are legal up to 20 weeks, with certain cases permitting up to 24 weeks (5). Training regarding current regulations and abortion care services would help aid this knowledge gap.

Secondly, there is a knowledge gap regarding the changes in aid seeking practices. With the perpetual changing conditions of going in and out of lockdown and various changes to policies nationwide, there is a state of uncertainty and confusion depicted in various news media articles. Though abortion has been set as an essential service in India, the policy has not trickled down to the ground level (16). For example, during lockdown, a couple was stopped on the road while trying to get to an abortion clinic and were asked for what their essential service was (17). The existing stigma against abortion discourages people to seek care. As a common pre-COVID practice, people would travel to further pharmacies to buy contraceptives for anonymity and to be free of judgement (18). Yet due to the lack of transportation and the constant surveillance of the police, people are worried of being shamed. The fear of being judged and shamed is a strong influencer in preventing access to resources.

Another major reason that abortion policies have not successfully reached the ground level would be the lack of systems in place for collecting, surveilling and translating data on the topic (1). There is very little data on the impact of COVID-19 on the provision of abortion services and the incidence of abortions amongst various groups (1). Data regarding the ages of those affected (minors and majors), status of marriage/partnership, presence of abuse, different geographical locations (urban and rural), cultural/ethnic/caste groups would help organizations create initiatives that identify and aid those in need (1,2). Studying the specific groups and their path to receiving (or not receiving) abortion care would enable us to better identify and address the gaps prohibiting them from receiving the care they need. Having current regulations along with such data available and translated for policymakers, media and the public would be helpful in ensuring that information is well delivered.

The largest gap would be the lack of acknowledging existing biases that would favour the most visible and accessible cohorts such as ethnic majorities or cases where the families are supportive. Data regarding such groups would be easier to accumulate and create resources for, which is why it is important to consider those in need of the resources yet are not visible to the existing systems, with the goal of promoting equity in access to care.



RECOMMENDATIONS AND ADAPTATION FOR LOW-RESOURCE SETTINGS

Based on the six WHO Health System Building Blocks (19)

1. Leadership and governance

- Raise awareness about the state of the legality of abortion in India among communities.
- Engage all stakeholders in the decision-making process to ensure equity.

2. Health service delivery

- Ensure that provision of abortion services is included as an essential service during lockdown, in theory and in practice by maintaining reproductive health services (family planning, abortion care, etc).
- Adapt provision of abortion services to unique social contexts in the different regions (caste, religion, values, etc.).

3. Health system financing

- Include abortion in the governmental universal healthcare plan and ensure funding for the provision of abortion services.

4. Health workforce

- Build healthcare worker capacity in provision of abortion services (ethical training, de-stigmatization).
- In the long term, with decrease of lockdown, organize community mobilization around provision of abortion services with the aim of having sustainable interventions and empowering women.

5. Medical products, vaccines and technologies

- Create a non-judgmental anonymous free telemedicine platform for information and education on provision of abortion services in each region.
- Ensure that the supply chain of abortion medication is maintained.

6. Health information systems

- Systemically collect data on provision of abortion services in all settings (facility, non-facility, community, telemedicine, etc.).



What is the KT problem?

Unsafe abortion is the third leading cause of maternal mortality in India, despite abortion being legal in the country since 1971. Among the many barriers in abortion provision access, women experience socio-economic, cultural and geographical obstacles, which are exacerbated by cultural norms, values and gender inequities. Additionally, the incidence of abortion provision in India is poorly documented due to stigmatization of the issue, under-reporting, lack of awareness of the legal status of abortion and a lack of a national centralized system for collecting data on abortion. The lack of reliable and comprehensive data on abortion incidence and provision hinders the making of evidence-informed policy decisions aimed at ensuring adequate family planning services and facilitating access to safe abortion for all women.

Furthermore, the advent of the COVID-19 pandemic has further compromised access to safe abortion and has exacerbated the lack of abortion services in India. Due to nation-wide lockdown, disruption in supply chain of abortion medication, redeployment of healthcare workforce towards COVID-19 and the interruption of public transportation, among other barriers, access to safe abortion is further compromised during the COVID-19 pandemic.

Who does it affect and how?

The COVID-19 pandemic in India affects many stakeholders, ranging from the population, especially adolescents and women, to the actors working in public health and politics. The pandemic underlines the inequities regarding women's health. Indeed, the whole health system has been shaken by the consequences of COVID-19. This is seen, for example, in the reduced healthcare services, as most health workers are redeployed in the provision of emergency care. We stress that the right to abortion and family planning has to be considered as an essential health service, in theory and in practice, and especially during the COVID-19 crisis. Otherwise, the lack of provision of abortion services will have many public health consequences, notably an increase in maternal deaths, and increased sexually transmitted diseases.

What do we know? What do we think we don't know?

We know that the lack of access to safe abortion services has devastating consequences. It can deteriorate women's physical and psychological health and can also result in death. Although abortion has been legal in India since 1971, most abortions performed within the country are considered unsafe.

This phenomenon is due to obvious causes such as the insufficient number of:

- abortion care facilities;
- trained healthcare providers;
- therapeutic availability

Moreover, several health determinants are implicated in safe abortion service accessibility such as:

- Area of residence;
- Education level;
- personal situation,
- spiritual and socio-economical background

SYNTHESIS (Continued)



In addition to these barriers already making it hard for Indian women to find proper health care for abortion, the arrival of the COVID-19 pandemic and the lockdown guidelines have worsened the situation. In the end, we are able to identify the aggravating factors that trigger unsafe abortion practices. However, considering the complexity of the Indian societal structure, we struggle to find an efficient and adaptive solution that reduce this burden for every single Indian woman in need of abortion. The pandemic taught us that we need to find solutions that can be sustainable and strong enough to survive crises.

What are the biggest gaps?

In addition to highlighting the existing gaps and barriers, the pandemic has also brought upon more gaps that should be further investigated. These gaps primarily consist of forms of lack of knowledge by various stakeholders. To begin with, there is a knowledge gap of the current legal status of abortion medication and abortions themselves. Secondly, there is a knowledge gap regarding aid seeking practices, with changes being made to previous practices that were more confidential. The existing stigma of abortions and the fear of being judged paired with the system barriers discourages the public from receiving help. Another key gap is the lack of systems currently in place to collect, survey, and translate data on various cohorts. Finally, the lack of acknowledging existing biases that favour more visible groups as opposed to groups that need support yet are not visible to the current system. Without addressing this gap, all efforts placed to help those in need would be ineffective. Though abortion has been set as an essential service, it is not treated as such. Therefore, by identifying and addressing the gaps in our knowledge and practice we will be able to better tackle the issues at hand.

Promising Practices (Recommendations)

Leadership and Governance	<ul style="list-style-type: none">◆ Raise awareness about the state of the legality of abortion in India among communities◆ Engage all stakeholders in the decision-making process to ensure equity
Health Service Delivery	<ul style="list-style-type: none">◆ Ensure that provision of abortion services is included as an essential service during lockdown, in theory and in practice by maintaining reproductive health services (family planning, abortion care, etc).◆ Adapt provision of abortion services to unique social contexts in the different regions (caste, religion, values, etc.)
Health System Financing	<ul style="list-style-type: none">◆ Include abortion in the governmental universal healthcare plan and ensure funding for the provision of abortion services.
Health Workforce	<ul style="list-style-type: none">◆ Build healthcare worker capacity in provision of abortion services (ethical training, de-stigmatization).◆ In the long term, with decrease of lockdown, organize community mobilization around provision of abortion services with the aim of having sustainable interventions and empowering women
Medical Products, Vaccines and Technologies	<ul style="list-style-type: none">◆ Create a non-judgmental anonymous free telemedicine platform for information and education on abortion provision in each region.◆ Ensure that the supply chain of abortion medication is maintained.
Health Information Systems	<ul style="list-style-type: none">◆ Systemically collect data on provision of abortion services in all settings (facility, non-facility, community, telemedicine, etc.)



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