

Preparing for an Increased Need for Abortion Access in India during and after COVID-19: Challenges and Strategies

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Access to safe abortion is a reproductive rights and justice issue, and it is imperative that safe abortion access during and after the COVID-19 pandemic is a reality for all. India imposed a lockdown in March 2020 to contain the spread of the pandemic. Limited mobility, lack of clarity about abortion as an essential service and abortion as a service permitted through telemedicine, shut down of services providing long-acting and permanent methods of contraception, and changes to decision-making about birthing and parenting during a pandemic are factors that may impact the demand for abortion during and after the lockdown. Shortage of raw materials and limited inter- and intra- state transport of drugs may result in breakages in the supply of medication abortion. Given that 73 percent of abortions in India in 2015 occurred outside of health facilities, the pandemic may have several implications on the need for evidence-based information and quality abortion services, as well as if and how medication abortion is accessed in India, and what self-managed abortion looks like in the COVID-19 era. We discuss factors contributing to reduced access to abortion, changes in abortion need, and suggest strategies to respond to an increased demand for abortion in India.

INTRODUCTION

Access to safe abortion is a reproductive rights and justice issue, and it is imperative that safe abortion access during and after the COVID-19 pandemic is a reality for all. India imposed a lockdown on its 1.3 billion population on March 25, 2020 to contain the spread of COVID-19 (BBC News 2020a). In the year 2015, a study by the Guttmacher Institute estimated that 15.6 million abortions took place in India and 73 percent of these abortions occurred outside of health facilities (Singh et al. 2018). An abortion assessment study published in 2005 found

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that public sector availability of safe abortion services was grossly inadequate (Duggal and Ramachandran 2004). The more recent Guttmacher study also recommended that the availability of all abortion services, including medication abortion, be improved in public health facilities (Singh et al. 2018). In this commentary, we discuss factors that may exacerbate lack of access to safe abortion in India and highlight opportunities for protecting and expanding access during the pandemic and beyond.¹

REDUCED ACCESS TO ABORTION AS A RESULT OF COVID-19

The lockdown imposed by the Indian government did not allow people to step outside their homes except for obtaining food, medicines, or other essentials, and all public transport was suspended (R. Srivastava 2020). More than 20 days after the lockdown was imposed, the Indian government clarified that abortion was considered an essential service (Ministry of Health and Family Welfare, Government of India 2020). Telemedicine Practice Guidelines were introduced (Indian Medical Council 2020); however, safe abortion services were not specifically identified as approved services. Thus, limited mobility and lack of clarity about availability of abortion services could lead to reduced access to abortion services.

Prior to the lockdown, India was already facing shortages of raw material from China needed for the manufacture of medication abortion pills (Santoshini 2020). For over two weeks after the lockdown, there was lack of clarity as to whether there were restrictions on inter- and intra- state transportation of goods (India Today 2020), thereby resulting in potential breakages in the supply chain. In March 2020, a coauthor on this commentary was involved in an internal survey (International Planned Parenthood Federation 2020) of the International Planned Parenthood Federation's (IPPF) member associations across 122 countries to document the impact of the pandemic on abortion service provision. In this survey, the IPPF affiliate in India reported facing challenges in moving stocks from warehouse to branches across the different states. Existing shortages were likely exacerbated by the confusion about inter- and intra- state mobility, potentially resulting in transportation of drugs and distribution to wholesale and retail sellers being further impacted. Ultimately, these shortages and breaks in the supply chain will have the greatest adverse impact on the end user—those seeking reproductive health services, specifically abortion.

Several factors may also cause a delay in accessing care. First, due to the lockdown, those needing an abortion may have less mobility to access safe services. Medication abortion makes up the majority of abortions in India, and past research has suggested that often medication abortion pills were purchased by male partners from local pharmacists, already creating a barrier to women getting the direct care they need (A. Srivastava et al. 2019; Ganatra et al. 2005). With greater restrictions on movement under COVID-19 (Chandna and Chakrabarti 2020), women may be even more dependent on male partners to obtain medication abortion pills. These challenges are further compounded by care-giving

1 Not all people who seek abortions identify as women, and those people may face additional barriers to care. While we recognize that the language is not inclusive, we use the term “women” in the commentary. We uphold these values for all people, regardless of gender.

responsibilities, limited public transport, and/or fear of contracting the virus, resulting in additional delays in seeking care. Second, couples or individuals may decide against stepping out during the lockdown to access care to avoid scrutiny and questioning (and potentially violence) from police personnel. This may result in them being further along in their pregnancy and/or needing second-trimester abortion care. Research shows that only a minority of abortion providers in the public and private sectors provide abortion beyond the first trimester, and even among these facilities only very few provide abortion services up to the legal limit (Singh, et al. 2018). This could make access to abortion extremely challenging in pandemic situations. Third, service providers may be adopting measures to mitigate the spread of the virus such as spacing out appointments and managing client flow differently. For instance, in the internal survey administered by IPPF, the India affiliate reported switched from a walk-in to an appointment system—such changes may result in potential delays in accessing care.

Reduced mobility, lack of clarity about abortion as an essential service and as a service permitted by telemedicine, shortages in raw material, limited inter- and intra- state transport of drugs, and additional delays to care are factors that may lead to reduced access to abortion services and drugs. It is estimated that 1.85 million women will be unable to access abortion services as a near-term impact of COVID-19 (Ipas Development Foundation 2020).

CHANGING DEMAND FOR ABORTION AS A RESULT OF COVID-19

Several factors may intersect to create additional barriers, result in subsequent unplanned pregnancies, and lead to a greater demand for safe abortion services, including abortion after the first trimester, during and after the pandemic.

The provision of long-acting and permanent methods (LAPM) of contraception such as intrauterine contraceptive devices and sterilization was suspended a week before the lockdown, with the Ministry of Health and Family Welfare providing guidance to the states that LAPM services should not be resumed until further notice (Ministry of Health and Family Welfare, Government of India 2020). LAPM contributes to 80 percent of the modern method mix in India (International Institute for Population Sciences and ICF 2017)—lack of availability of these methods could lead to increased risk of unplanned pregnancies and increased need for abortion services.

Decisions around parenting and birthing may also shift for couples due to the pandemic. Reports of complaints of domestic violence to the National Commission for Women and civil society organizations have more than doubled since the lockdown began (Chandra 2020). Intimate partner violence can result in unintended pregnancies, leading to an increased need to access abortion. Coupled with limited mobility, accessing abortion could be especially challenging when fertility preferences of the male partner differ from that of the woman seeking to terminate a pregnancy and/or when cohabiting with an abusive partner—all of which may result in increased risk of unacceptable/forced pregnancies, unsafe abortions, or infanticides.

Sixty-six percent of India's population is rural (The World Bank 2018). Due to COVID-19, thousands of migrants are returning to their native villages (Pandey 2020b), leading to potential changes in patterns of cohabitation, and thereby a shift in the need and method

preference for contraception. However, some of those who reach their villages face additional discrimination, due to fear of transmitting the virus (Hindustan Times 2020), which may impact how soon they may be able to receive the care they deserve.

Preliminary data from an online survey led by one of the coauthors confirm many of scenarios raised in this commentary. Over 6,000 Facebook users in India (men and women), identifying as aged 18 years or above, at different stages of their reproductive lives participated in an online survey shared through Facebook ads in April 2020. Preliminary data show that about three weeks into the lockdown, 32 percent of current family planning users ($n = 2,488$) reported facing barriers in obtaining their preferred method because of COVID-19; about 7 percent of women pregnant with gestational age less than 20 weeks (number pregnant = 203) said they were considering terminating, with another 7 percent unsure; and 72 percent of those considering abortion reported facing barriers to access it. Of those who had had an abortion in the last month ($n = 59$), 30 percent faced some barrier, with the greatest proportion reporting that it was harder to get their abortion because they were scared to go to the clinic/facility/pharmacy due to COVID-19. The second greatest barrier reported was less time to access services due to childcare/elderly care responsibilities, followed by facilities being closed, or the lockdown in general. These preliminary results, although not representative, provide some insight into shifting fertility intentions and highlight the need for abortion access.

STRATEGIES TO ADDRESS AN INCREASED DEMAND FOR ABORTION

The majority of abortions in India already happen outside of health facilities (Singh et al. 2018). Due to the factors outlined above, abortion seekers may now overwhelmingly prefer—or be forced—to manage one's abortion at home with limited information or support from a facility/certified medical provider. For vulnerable populations (including adolescents and unmarried young women, people living with disabilities, people identifying as LGBTQ+, those from rural or tribal communities, and people living with HIV, among others), the pandemic could result in even greater barriers in accessing the care they deserve. To ensure that abortions are safe and people feel supported through the process, there is a heightened need for unencumbered access to medication abortion and to evidence-based information and support while self-managing one's abortion.

Availability and access to public health and health care facilities is a core component of the right to health (World Health Organization 2017). The pandemic brings to the fore many issues which civil society groups have long been advocating for, including universal access to health care and the need to invest in and transform public sector health services. Proven strategies that have worked in other contexts, such as telemedicine, could help mitigate the potentially disastrous aftermath of the pandemic on abortion access. The use of communication technology for counselling, assessment, and clinical guidance through the abortion process and/or during follow-up has been shown to be safe and effective across several contexts, including in settings where access to abortion is legally restricted (Endler et al. 2019). Guidelines that allow for abortion seekers to access timely abortion care through a range of

technologies will provide clarity and a framework for providers as well as the Indian health system to offer timely, supported, safe abortion care.

The current telemedicine guidelines allow clients to consult only with registered medical providers; the role of health workers is restricted to facilitating these consultations (Indian Medical Council 2020). Global evidence—from Nepal (Warriner et al. 2011; Tamang et al. 2018) and Bangladesh (Akhter 2001), among other countries (Berer 2009)—of the safety of abortion care provided by nurses, midwives, clinical officers, and other cadres of health workers is well established. This is further supported by research in India that shows that nurses and allopathic and ayurvedic physicians can assess medical eligibility, perform manual vacuum aspiration, and assess completeness of abortion effectively (Jejeebhoy et al. 2012, 2011). Hence, safe abortion provision, including telemedicine provision of abortion, should be expanded to include the cadre of health workers. This could result in dramatically increasing access to safe abortion, especially in rural areas.

The World Health Organization's guidelines recommend that medical management of induced abortion can be used safely and effectively up to and beyond 12 weeks gestation and that abortion up to 12 weeks can be self-managed with access to accurate information and access to a health care provider, in case one may be needed or wanted at any stage of the process (World Health Organization 2018). Evidence from Indonesia and Argentina show the safety of self-use of mifepristone and misoprostol for inducing abortion up to 24 weeks (Gerds et al. 2018; Zurbriggen, Keefe-Oates, and Gerds 2018). Self-managed abortion can be a safe and viable option for women seeking abortion at and beyond the first trimester in India as well, if systems are put in place that ensure their safety and access to healthcare systems/providers in case of any emergency or complications. In addition to strengthening second-trimester provision of abortion care, efforts should be made to ensure that access to evidence-based information and care are within reach for anyone who might seek an abortion, irrespective of their gestational age.

The actions that Indian policymakers take to ensure access to safe abortion services can set an example for the rest of the world, both in this current crisis as well as more broadly. Revolutionary changes to abortion access that India makes today to center the rights and health of women in this unprecedented time can and will have a long lasting impact on making safe abortion access a reality to all.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Conflict of Interest Disclosure

The authors have no conflicts of interest to declare.

Ethics Approval Statement

The study led by a coauthor cited in the commentary has received ethics approval from the University of California, San Francisco.

Permission to Reproduce Material from Other Sources

Sources for any data cited in the commentary have been included.

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