Effect of COVID-19 pandemic on home delivery of contraceptives by community health workers in India: Time to (re) evaluate and innovate

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ABSTRACT

The World Health Organization (WHO) declared COVID-19 a global health emergency in January 2020, leading to a nationwide lockdown in India. Due to COVID-19-related case management, all health schemes, including FP services, have been disrupted globally regarding availability, accessibility, appropriateness of service delivery, adequacy, and continuity of care. The impact of the pandemic on FP services listed includes disruptions in supply chain management, enhanced gender inequity, communication barriers, fear of going outside and buying contraceptives, discontinuity of ASHA capacity building, increased time spent with all family members, reverse migration of workers, and increased need of contraceptive commodities. Evidence shows the consequence of non-supply of logistics, social distancing, inadequate human resources, and inability to access services might result in 26 million couples in unmet need for contraception, resulting in 2.4 million unintended pregnancies and 1.45 million abortions, which may lead to unsafe abortions. Potential solutions to these problems include telephonic service delivery, maintaining a record, using video communication and other technological solutions using a smartphone, combining routine immunization with FP services, and installing self-dispensing machines for contraceptives at accessible places. The limitation of this work is that this is wholly experienced-based work and not based on primary findings from the field level data. These findings highlight the importance of reproductive health needs during the pandemic and guide policymakers.

Keywords: ASHA, community health workers, contraceptive services, family planning service, reproductive health

Background

Worldwide, India in 1952 was the first country to start a nationwide program for family planning (FP).1 FP has been given immense importance to reduce population growth from the very beginning. India has tried for decades to create a favorable environment for FP to increase reproductive rights, make conscious decisions for contraceptive use, and get involved in the policy decision-making process. Women's reproductive health is highly impacted by FP programs, affecting all 17 sustainable development goals (SDGs), but mostly goals 1, 3, 5, 8, and 10.2 The United States Agency for International Development (USAID) states that “every dollar invested in FP saves four dollars in other health and development areas, including maternal health, immunization, malaria, education, water, and sanitation.”3 Thus, investing in FP programs is one of the most critical steps a country can take, which can help the country’s overall development. According

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Received: 26-09-2021 Revised: 16-12-2021 Accepted: 20-12-2021 Published: 14-05-2022

How to cite this article: Bharati B, Sahu KS. Effect of COVID-19 pandemic on home delivery of contraceptives by community health workers in India: Time to (re) evaluate and innovate. J Family Med Prim Care 2022;11:1598-601.
to National Family Health Survey (NFHS-4), the total fertility rate (children per woman) is 1.8 in rural, 2.4 in urban, and 2.2 in total. The prevalence of women aged 15–19 years who were already mothers or pregnant at the time of the survey (in %) is 5 in urban, 9.2 in rural, and 7.9 in total. The use of contraceptives (%) is 57.2 in urban, 51.7 in rural, and 53.5 in total. Any modern method used (%) is 51.2 in urban, 46.0 in rural, and 47.8 overall. The total unmet need (%) is 12.9, and the unmet need for spacing (%) is 5.7 overall. The statistics highlight the necessity of FP in India. FP’s areas of concern include high unmet need for contraception, quality services, inadequate attention to spacing methods, and soft focus on information and counselling. The critical challenges in FP are high rural population (68%; Census, 2011), difficult geographical terrain, poor male participation, sizeable young population entering reproductive age, and less focus on spacing method. Primary care physicians also understand the context and the challenges faced in day-to-day life by the governmental healthcare delivery systems in implementing programs and frontline workers. They are the key people who will ultimately deliver quality service.

Initiatives from the Government of India

In India, since the commencement of the national family planning program, several measures have been undertaken, such as increasing the range and reach of FP services for eligible couples, focusing on spacing methods to address unmet needs, improving quality of services, increasing the “basket of choice” to enhance acceptance and adherence to FP methods, increasing focus on male participation, and promoting informed choices. To implement these measures, the Government of India (GOI) has different schemes, namely Ensuring Spacing at Birth (ESB), Family Planning Indemnity Scheme (FPIS), Fixed Day Static Service (FDS), and Home delivery of Contraceptives by Accredited Social Health Activist (ASHA) (HDCA) at the doorstep to beneficiaries.

Choosing a contraceptive is a private affair; as such, going to the facility might be a matter of shame or shyness. Traditionally, women are not allowed to go out of the house for these services, are not educated enough to avail contraceptive services, choose the most suitable method, or be unaware of the basket of choice. Myths and misconceptions about using any form of contraceptives and family pressure of giving birth to a child after marriage ultimately compress their reproductive rights. In hard-to-reach areas, women cannot visit health centers for contraceptive methods, and access is highly impaired for various reasons.

To nullify these factors and improve access to contraceptives, the GOI utilizes ASHA to distribute them at the doorstep of an eligible couple’s house and bridge the gap of inaccessibility for which they are incentivized. ASHA is the first point-of-contact in difficult geographical areas and urban slums, playing an essential role in disseminating information and building awareness to increase the demand and create awareness regarding FP methods. ASHA, through effective counseling, helps in dealing with issues such as poor couple communication on FP commodities, breaking myths and misconception, fear of side effects of use, decreasing the low-felt-need for contraceptives, lack of availing contraceptives when in need, cultural need to prove fertility, and preference of a male child. The main aim of ASHA is to build a relationship with a family and bridge the trust gap before delivering the critical message requiring frequent visits and communication with the family. She becomes the most trustworthy person as an outsider.

The COVID-19 pandemic

The World Health Organization (WHO) declared COVID-19 a global health emergency on January 30, 2020, leading to nationwide lockdown. In India, due to the pandemic, lockdown started from midnight on March 25, 2020. The country’s healthcare delivery system managed the pandemic situation with high priority and provided minimal importance to other areas. It has been seen in previous public health emergencies that reproductive health remains neglected; it has been hypothesized that a 10% reduction in sexual and reproductive health leads to a decline of up to 80%.

Due to COVID-19-related case management, all health schemes, including FP services, have been disrupted globally regarding availability, accessibility, appropriateness of service delivery, adequacy, and continuity of care. Some of the critical problems for the HDCA in India are listed as follows:

1. There is a huge gap in service delivery and supply chain management by disrupting the manufacturing of contraceptive methods and by delaying transportation, leading to the unavailability of contraceptives. The GOI supplies contraceptives such as oral pills, condoms, and emergency contraceptive pills to hospitals for free, but the accessibility and availability of supplies is a question in this pandemic.
2. Apart from the pandemic in general, there is a considerable gap in the reproductive health perspective between men and women, for instance, women not having the autonomy to decide on their reproductive and sexual health and inadequate financial resources leading to insufficient access to a health care facility. In this outbreak, women have less power in decision-making than men, and their needs remain unmet for reproductive health. These problems are increased to multifold in the pandemic.
3. There have been certain limitations in the COVID-19 pandemic to limit transmission and maintain overall health, appropriateness of service delivery, adequacy, and continuity of care. Due to COVID-19, people have developed a fear of going outside their house.
4. Moreover, a particular group of women take birth control pills without the knowledge of their husbands. When ASHA visit their home to distribute the pills in the pandemic time,
the situation worsens. The communication is broken due to fear of transmission. As ASHA visits many homes in the village, people now hesitate and have an unwelcome attitude toward ASHA. The receiver and communicator here may both be uncomfortable in the communication process. The communicator might also be hesitant to travel house to deliver essentials.

5. There has been an impact on the distribution of contraceptives due to lockdown limiting further access to contraceptives. ASHA can refuse to deliver services as she might consider the working environment unsafe. Service delivery must be restructured and reorganized in this pandemic, and people’s trust must be regained in availing services.

6. Not the service delivery side alone, but the capacity building of ASHA is also highly impacted. Field-level training is now not in the limelight and is going unnoticed. The ongoing capacity building has been highly impaired. All the staff at the district level are indulged in the pandemic, which is the point of concern.

7. Increased time spent at home by all the members during the pandemic and reverse migration of thousands of workers to the home state might have increased the demand for contraceptives by manifolds.

Non-supply of logistics, social distancing, inadequate human resources, and inability to access services will land 26 million couples in unmet need for contraception, resulting in 2.4 million unintended pregnancies and 1.45 million abortions, which may lead to unsafe abortions, according to a policy brief by a renowned NGO.[12][13]

Potential suggestions for a solution

In this scenario, the GOI should strengthen supply chains by identifying alternative methods to make reproductive health commodities available during the lockdown.[11]

To ensure continuity of FP in the pandemic, we can adopt the following strategies:

1. Frontline workers can ensure delivery and continuous use of contraceptives through phone calls.
2. They can keep a logbook of their beneficiaries, type of contraceptive delivery, amount delivered in numbers, and next delivery date.
3. Sending contraceptive-related videos to beneficiaries can help overcome myths, misconceptions, and usage.
4. Combining counseling for contraceptives with routine immunization programs.
5. Mounting self-dispensing machines for contraceptives at readily accessible places such as the nearest pharmacy, community center at village or panchayat label for rural areas and Anganwadi centers for urban slums.

Advantages and challenges for primary care physician

India is a country where FP is considered the sole responsibility of women in most areas, including the urban poor, unreached rural areas, and section of people who are less educated.[7] As discussed earlier, proactively discussing FP needs is culturally taboo.[8] Here ASHA plays an essential role in bridging this gap by proper communication strategies. Due to COVID-19, ASHA interaction has been hampered, and there have been many changes.

ASHA counsels females and connects them with primary care physicians (PCPs) for FP services; if the process is broken in any step, the service will change. ASHA plays a vital role in counseling; she gives a lot of time to understand the different types of FP services, their use, advantages, and disadvantages. If ASHA does not do this, then PCPs have to spend a lot of time explaining the basket of choice and explaining reproductive rights. This is an extra workload for them. They have to spend a lot of time counseling and explaining the different products available for an informed choice. PCPs can miss opportunities as they have multiple responsibilities in a health center. We are now targeting to decrease the unmet need and maintain reproductive rights.

Moreover, the point of contact of a client with the PCP is only for a few minutes, and it is difficult to convince and make them understand the value and necessity of a contraceptive. When ASHA reach is obstructed in COVID-19, there are chances of irregular supply of FP pills, proper use, leading to unwanted pregnancy, late detection, or abortion, which also leads to patient load in health centers, and ultimately, PCPs are overstressed. ASHA plays a pivotal role for FP activities in early pregnancy detection, counseling clients for FP services, informed choice, discussing basket of choice, decreasing unwanted pregnancies, continuing FP product supplies, and maintaining a healthy lifestyle. This reduces a lot of stress on PCPs by reducing unnecessary patient load and saving time in counseling services.

Conclusion

Multiple lockdowns, inefficient supply chains, and pandemic restrictions have made low-socioeconomic women more vulnerable. ASHAs are considered the grassroots health advocates who help mobilize a community, facilitate critical thinking, and address barriers. Outbreaks are unavoidable, but the disastrous losses in reproductive health are not. World Population Day's theme for 2020 was “how to safeguard the health and rights of women and girls now” amid the pandemic. Our suggested innovative solutions might work as a small step to understand HDCA and help maintain overall FP indicators.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.
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