Impact of COVID-19 on family planning services in India

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The COVID-19 pandemic has tested the health systems of all countries and some of the supposedly “strong” health systems in European and North American nations have buckled under the pressure. The focus is now on low- and middle-income countries such as India to see how they fare in handling the pandemic. Conventionally, these health systems are considered weaker and the additional load of pandemic management makes it impossible to ensure routine services. In the rush to ensure containment of the pandemic and in preparing health systems to handle the pressures of pandemic related emergencies, routine but essential healthcare is neglected.

Globally, reproductive health services such as contraception and abortion services are either shut down or not accessible.1 On their website, the International Planned Parenthood Federation reported anticipated shortages of contraception as lockdown and measures put in to curtail the pandemic lead to a reduction in the manufacturing of contraceptives. A UNFPA technical note estimated that due to measures taken for COVID-19 containment, about 47 million women in 114 low- and middle-income countries, including India, will not be able to use contraception and this would result in 7 million unintended pregnancies.2 A Lancet publication stated that “only when public health responses to COVID-19 leverage intersectional, human rights centred frameworks, transdisciplinary science-driven theories and methods, and community-driven approaches, will they sufficiently prevent complex health and social adversities for women, girls, and vulnerable populations”.3 Pandemics such as Ebola and COVID-19 further weaken the health systems that are performing at suboptimal level due to constraints such as shortages of skilled human resources, logistics issues and infrastructure issues.4,5

Measures implemented to contain the epidemic such as lockdown and suspension of public transportation have affected access to healthcare in the public and private sectors in India. Guidelines released by the Ministry of Health recommend continuation of routine reproductive health services, including walk-ins for family planning services.6 However, the almost non-existence of available transport to reach the facility and limited capacity for decision making related to contraception and abortion, translates into few walk-ins. We present data to demonstrate the impact of the COVID-19 pandemic on family planning service provision.7,8

A fundamental consideration underlying the data available is that the number of public sector facilities reporting routine health management information system (HMIS) data fell between December 2019 and March 2020 all over India: by 32% from district hospitals that provide secondary health care and specialist services; and by 14% from primary level health facilities near the community. These disruptions to healthcare service data reporting may be due to these facilities having to provide COVID-related care; and field workers being deployed to community health facilities. Nevertheless, the HMIS data that are available show that provision of preventive services such as family planning is reduced. For example, the numbers of injectable contraception-first doses given have decreased by 36% (66,112 doses given in December 2019 and 42,639 given in March 2020), while IUD insertion has shown a 21% decrease (260,615 in December and 205,395 in March) in the same period. Distribution of combined oral pill cycles and condom pieces were similarly reduced by 15% and 23%, respectively.
The reduction in abortions performed is about 28%. These figures, although somewhat unrefined, paint a grim picture of limited family planning service provision and increase in unmet need for family planning.

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. If not for the pandemic, in these six months more than 0.7 million tubal ligations would have been performed, about 1 million IUDs would have been inserted and about 0.6 million injectable contraceptives would have been administered.

Lockdown has also resulted in a loss of distribution for social marketing organisations and private providers, leading to further reductions in access to family planning and abortion services. The private sector all over India is grappling with a lack of human resources and significant reduction in the clientele. There is a dearth of personal protective equipment, resulting in refusal to provide services and an unsafe working environment. Limited resources and fear of contracting infection have led to significant reduction in tubal ligations and IUD insertions in the private sector. A renowned gynaecologist (personal communication, anonymous, verbal phone call, 12 May 2020) indicated that even in six weeks of lockdown, many abortions that could have been carried out with medicines have been converted to surgical abortions due to lack of access and avoidance of attending a facility because of fears of contracting infection. Surgical abortion can cause complications and increases the chances of morbidity and mortality for the woman as pregnancy is more advanced. The gynaecologist also indicated that at times, providers insisted on a test for COVID-19 before carrying out the surgical procedure, which increases the financial burden on the patient and leads to further delay.

Pandemics such as COVID-19 require the health system to restructure and reorganise service delivery. Responsive health systems should focus on the pandemic but also ensure people’s faith in the system is maintained by continuing to provide routine health services to avoid excess morbidity and mortality from other health conditions.

Health system responses should include delivery of essential services while maintaining physical distancing, use of technology such as telemedicine, virtual appointments, and involvement of the private sector, including for-profit and not-for-profit entities for service provision. Alternate models for outreach services can be tried out, such as home visits by frontline workers to provide family planning services, while also protecting healthcare providers with adequate personal protective equipment and testing. Ensuring staff safety with regard to infection and security measures for the prevention of violence against health providers are important.

The unmet need for family planning and abortion services is already high in India. COVID-19 has exacerbated the situation by reducing access. A comprehensive, rights-based health system response to address family planning services provision during pandemics is the need of the hour for India to avoid unwanted pregnancies and prevent additional mortality and morbidity of women.

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