COVID-19 and the burden of ill-health: a double crisis of disruptions and inequalities

Ramila Bisht¹ · Rajashree Saharia¹ · Jyotishmita Sarma¹

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Abstract

In this paper, we attempt to show how the novel coronavirus disease (COVID-19) has disrupted routine health services in India and has created further inequalities in the society. By taking a few examples of non-COVID diseases and conditions like immunization, maternal health services, tuberculosis and non-communicable diseases, this paper shows how these services have been disrupted by the pandemic. The paper argues that these disruptions have not emerged only as a result of the current crisis, but because of the paradigm shifts in the healthcare delivery in the country towards privatization which have disproportionately marginalized particular sections of the society. The paper concludes by stating that if adequate measures are not taken now to transform the health system and strengthen the public healthcare system, it might lead to catastrophic consequences in the future, especially for the marginalized sections.

Keywords COVID-19 · Non-COVID conditions · Health inequalities · Routine health services · India

Introduction

The globalized world of the twenty-first century has witnessed several major pandemics and epidemics such as SARS, Swine-Flu, H5N1 and Ebola Virus Disease (EVD) and has faced its profound catastrophic consequences. However, the global outbreak of COVID-19 has been unparalleled¹ in history. Given its scale of coverage, speed of spread, rate of fatality and its varied uncertainties, COVID-19 has shaken the entire world. Due to these

¹ Several parallels have been drawn between COVID-19 and the deadly Spanish Flu epidemic of 1918–1919, which had infected about a third of the global population during that period. Despite the similarities, it is important to note that the causative pathogens of both the diseases are completely different from one another (Javelle and Raoult 2020). Besides, the world that we live in has changed completely in the last 100 years and therefore the impact of COVID-19 cannot be compared with Spanish flu (Javelle and Raoult 2020; Webel and Freeman 2020).

✉ Ramila Bisht
ramila.bisht@gmail.com

¹ Centre of Social Medicine and Community Health (CSMCH), Jawaharlal Nehru University (JNU), New Delhi, India

reasons, it can be said that the unprecedented repercussions of the current crisis are not an ‘equalizer’, as initially hyped, but rather an ‘accentuator’ of the pre-existing inequalities worldwide (Bieber 2020; Mein 2020). Different testimonies from around the world have shown that COVID-19 has resulted in the creation of multi-layered disruptions and inequalities at the structural, societal and individual levels, including health inequalities. For instance, data from New York City have shown that the Hispanic and black patients make up 34% and 28% of all fatalities due to COVID-19, despite the fact that they constitute only 29% and 22% of the total population, respectively (Mein 2020). This fast spreading, potentially lethal disease struck thousands across the globe, commanded global visibility and demanded a global response to stop death and control the spread. The pandemic has placed unprecedented pressure on the health systems, impacting the delivery of health services in all countries. Responding to this pressure, the governments anticipated and made policy shifts in health delivery involving restructuring public health services, reorganizing hospital facilities and deploying existing staff to tackle COVID-19. This creates the possibility of disrupting the health services for non-COVID conditions by reducing access to preventive interventions, essential services and hospital care and interrupting the supply of medicines. Such disruptions could further lead to human suffering and loss of life, particularly in low- and middle-income countries (Hogan et al. 2020).

Health inequalities produced and reproduced by the structural inequalities are pervasive in India. The dual burden of communicable and non-communicable diseases (NCDs) along with child and maternal health issues pose a huge burden for India. From the 1940s onwards, communicable-infectious diseases were a huge contributor of morbidities and mortalities. These have been disproportionately distributed among poor and marginalized groups. However, by the end of twentieth century due to economic, demographic and epidemiological transitions, a huge burden of NCDs was also added to the pre-existing burden (Mohan et al. 2019). Since the 1990s, the Indian health sector has failed to ensure equitable, socially just and inclusive healthcare services, not only to diverse demographic groups but also to patients suffering from different various ailments.

With the outbreak of COVID-19, India, like other countries, also opted for diversification of resources and workforce to contain COVID-19—a *disease of immense visibility*. This paper intends to examine the newer forms of emerging disparities and inequalities due to prioritization of COVID-19 over routine healthcare currently rendered invisible. It underlines how our system is failing those without COVID-19. The paper argues that the neglect of unmet health needs caused by COVID-19 induced disruptions risks the accentuation and worsening of health inequalities and also creates new inequalities. In the absence of any official data on non-COVID services, this paper looks at various media sources to understand the problem under consideration.

The context of COVID-19 and new policy regime in India

In India, the first case of COVID-19 was reported from Kerala on 30th January 2020 and the first death on 12th March, 2020. By the end of March, cases and deaths went up to 1000 and 35, respectively (Duggal 2020). During this critical period, the central government was swamped by other political preoccupations.² These developments

² Political preoccupations with events such as Delhi Assembly elections, Donald Trump’s visit and managing the repercussions of the Citizenship Amendment Act led to nationwide protests, most tragically ending in communal conflagration in Delhi.

delayed the state response to the pandemic. It realized the enormity of the challenge only towards the end of March 2020 after witnessing the explosion of the pandemic and rapid escalation in fatalities in major developed countries of the Western world like the USA, Italy and Spain. As against an expert driven policy, engaging epidemiologists, public health experts and social scientists to suit the contextual realities of the country, the Government of India (GOI) resorted to bureaucratically motivated idea of importing dominant readymade measures such as putting the country's unwieldy demographics under a 'draconian lockdown' from the midnight of March 24th 2020 (Khan 2020).

With the call for lockdown, the health systems started to rationalize and prioritise services only for COVID-19 over other pressing health issues. Human and material resources and physical infrastructures like hospitals, beds, intensive care units and ventilators were diverted for mitigation and management of COVID-19 (Singh 2020). During the initial week of lockdown, the diversification and lack of preparedness strategies to deal with the disease resulted in all the other preventive, curative and services requiring continuum of care coming to a halt in the public sector. This led to unprecedented hardships and sufferings for everyone requiring access to health services, particularly pregnant women and NCD (non-communicable disease) patients in need of immediate medical interventions. After several media reports, statements from civil society organizations and most importantly the WHO mandate for continuation of essential services, the Ministry of Health and Family Welfare (MOHFW), GOI, issued a guideline on 15th April 2020. The guideline is well laid out; however, it is based on a 'utopian' view of the public health system of India. It completely disregards the inherent issues like lack of resources, workforce, non-functioning referral system, broken supply chain of medicines to name a few, that have plagued the health system since the last few decades. As per the guideline, the states are directed to convert well-functioning hospitals into COVID-19 centres. In most states, already overburdened public health facilities like medical colleges and district hospitals are transformed into COVID-19 facilities, leaving the remaining Community Health Centres (CHCs) and Primary Health Centres (PHCs) as alternative arrangements for non-COVID patients. Given the systematic neglect of the public sector over decades, the fate of non-COVID patients stand endangered (Singh 2020).

Along with the shifts in hospitals, suspension of transportation facilities and sudden closure of interstate borders led to much suffering for critically ill patients like cancer patients availing chemotherapy, patients requiring dialysis services and cardiovascular surgeries, maternal care and abortions. The situation was more precarious for patients in rural and hard-to-reach areas, as compared to the urban areas, due to unavailability of services in the vicinity, lack of transportation facilities and police brutality (Onmanorama Staff 2020; Bedi and Yadavar 2020; Chakraborty 2020).

The guideline assured uninterrupted supply of essential drugs. However, field reports even from well-functioning states like Kerala brought to the fore a gap in drugs for NCD, tuberculosis and HIV, contraceptives and other essential services (Onmanorama Staff 2020). Even the most ambitious and farsighted telemedicine intervention did not incur the expected result as it was totally disconnected with the ground reality of non-availability of mobile phones and the pre-existing power relations between the health personnel and the patients, owing to the latter's class status and language barriers. In other words, it can be claimed that the ill-planned lockdown and the subsequent process of unlocking has transformed a public health crisis into a humanitarian catastrophe (Duggal 2020) and has resulted in suffering and 'distress deaths' of desperate non-COVID patients (Rawal et al. 2020).

The 10-week-long strict lockdown was not able to contain the spread of the virus. Following ‘Unlock’, there has been a surge in the number of COVID-19 cases and fatality rates across India. The fatality rate was explained to be a result of co-morbidities among both the younger and older population. With the COVID-19 cases and deaths updated hourly, the visibility of COVID-19 became huge. On the other hand, the cited reason for fatalities, that is, comorbidities, was left unaddressed.

A substantial proportion of Indians depend on private institutions for healthcare. But the role of the private health sector in this unprecedented crisis has been unclear and ambiguous. The private sector in India is not a homogeneous entity,³ and state governments have been pursuing different policies vis-à-vis the private sector. There is little information about it (Indranil and Bose 2020). Even though GOI has powers under the National Disaster Management Act, 2005, to requisition required services to handle emergencies such as the present crisis, it has failed to engage the private sector to supplement the public sector (Baru and Bisht 2020). Review of media reports show that soon after the pandemic, many private hospitals of varying sizes had either down-sized or had completely shut down their services, due to ‘playing it safe’ attitude, lack of PPEs, fear of losing their non-COVID in-patients and thereby their revenues (Contractor and Kakar 2020; Raghavan et al. 2020). Another reason for the absence of the private sector soon after the lockdown was the government’s restrictions and motive to trace the spread of COVID-19 under its ambit (Raghavan et al. 2020). However, as the surge of cases overwhelmed the public sector post lockdown, the intervention of the private sector was called for. In spite of repetitive circulars to resume services for both COVID-19 and non-COVID patients, the highly subsidized private sector which constitutes two-thirds of hospital beds and 80% of ventilators did not step in until April, except one-tenth of the private hospitals (Contractor and Kakar 2020; Raghavan et al. 2020).

By mid-May and early June, the private sector resumed their services, but regulating cost became a contentious issue. With no central government move towards nationalization or cost regulation guideline (Baru and Bisht 2020), some states managed to provide free treatment through requisition (West Bengal), some managed to regulate the cost (Maharashtra), whereas some states left it unregulated (Delhi)⁴ (Asthana and Bisht 2020; Contractor and Kakar 2020). Despite such regulations, many corporate hospitals continued to profiteer by charging exorbitant prices for both COVID-19 and non-COVID patients, which was found to be beyond the reach of even India’s upper middle class. With most public sector hospitals pushing out non-COVID patients, the poor who were dependent on these services for critical care were left with no other alternative but to forgo care. Even under the ‘flagship’ insurance scheme Ayushman Bharat, the Prime Minister’s Jan Arogya Yojana (AB-PMJAY) which claims ‘to mitigate the adverse impact of this catastrophic illness on the poor’ could not ensure free of cost critical care in the private sector (Contractor and Kakar 2020).

³ The private health sector in India is plural in character, which has both formal and informal providers and for-profit and not-for-profit entities under it (Indranil and Bose 2020).

⁴ After several complaints from patients and health activists about exorbitant service fee charged in hospitals like Apollo, a committee was formed to cap private hospitals charges in Delhi (Kohli 2020).

Non-COVID experiences of disruptions in health services and emergent inequalities

This section describes how the disruption has adversely affected non-COVID health delivery and access with respect to a range of communicable and non-communicable diseases and the multiple kinds of suffering caused to patients even ending in death. The singular focus on COVID-19 has also negatively affected maternal health services. Thirdly it has also had many repercussions on preventive programmes such as immunization. The section provides accounts of difficulties encountered by those availing /in need of these services in the course of the 4 months (March -June) of the pandemic.

Tuberculosis

India's battle against tuberculosis (TB) has been a long and protracted one, and it continues to be one of the country's major killer diseases. According to available data, India bears approximately one-third of the world's TB burden, killing more than 1400 people in the country every day. In the year 2019, India reported over 2.4 million TB cases and notified more than 79,000 deaths. India also has one-fourth of the global burden of multi-drug resistant (MDR) TB, which is the highest in the world (Das et al. 2020).

In 2020, a dedicated National Tuberculosis Elimination Programme (NTEP) was adopted in a mission mode. The 'End TB' strategy aims at adopting concrete preventive, diagnostic and treatment measures to eliminate the disease by 2025. Thus identification, diagnostic and speedy treatment is vital to the success of the programme (Das et al. 2020).

The pandemic has put a brake on effective implementation of TB elimination. A massive decline of 69% in detection of TB cases was observed between February and April 2020 (Das et al. 2020). In April 2020, according to Central Tuberculosis Division Nikshay portal the number of new cases detected in government-run health care centres shows a massive decrease of 78% (Iyenger and Jain 2020). According to Union Health Ministry, the drop in Tuberculosis notification between January and June, 2020 is around 26% as compared to the previous year (Ray 2020). In the private sector the decrease in notified cases increased to 89%. TB detection had drastically gone down in major cities. Municipal Corporation-run Sewri TB hospital in Mumbai which caters to the slum population of Malad, Dadar, Govandi, Sion, Bandra and Andheri (East), known as TB hotspot areas, reported a drop of about 87.09% in newly diagnosed cases from January to March 2020. New Case notification plunged by 70% in private hospitals in the same period (Chakraborty 2020).

The 'missing cases' could be attributed to a number of factors, viz. non-availability of services for non-COVID patients due to staff reallocation, prioritization of COVID testing over TB testing in the diagnostic laboratories and fear of venturing out due to risk of contracting COVID and police brutality in the streets amidst lockdown. Prime Minister's appeal to the nation on combating COVID-19 on 19th March also created confusion. They didn't know whether to consider TB diagnosis as 'essential' or 'non-essential'. Moreover, people with TB symptoms were aware of delays in consultation and non-availability of services and, therefore, felt compelled to forgo detection, registration and treatment (Iyenger and Jain 2020; Dutta 2020). Women who attempted to access diagnostic services in Sewri hospital, risking COVID infection and being penalized for breaking lockdown rules, experienced refusals or delay (Chakraborty 2020). Undiagnosed TB patients reported refusals and stigmatization when accessing diagnostic services. Those with cough and fever were compelled to get tested

for COVID-19 as TB symptoms are similar to COVID-19. People from containment areas were perceived as ‘potential carriers’ of coronavirus and thus refused diagnosis (Chakraborty 2020).

Regular medication for diagnosed TB patients is an unavoidable necessity. However, amidst this crisis, the care regime got interrupted as local DOTS centres and TB hospitals were converted into COVID-19 centres, and TB workforce was assigned COVID duties. This rearrangement led to disruption in delivery of services, monitoring of treatment regime and acute shortage of essential drugs like Clofazimine tablets (Chakraborty 2020; Iyenger and Jain 2020). Majority of the TB patients in India are poor and disadvantaged. As such, due to the disruption in delivery of free medicines these patients with compromised lungs had to remain without medicine. Interrupted medication caused them immense side-effects, but due to lack of money to buy medicines, they had to suffer (Chakraborty 2020). MDR-TB patients also had to encounter nightmares either due to lack of essential medicines and injections, or lack of doctors or nurses to administer Mikacin and Streptomycin injection—which needs to be done under strict supervision (Iyenger and Jain 2020; Chakraborty 2020). Non-functioning of private sector at its normal capacity and its reluctance to treat people with cough and fever has just added to the plight of the people seeking care for tuberculosis (Vijayan and Pai 2020).

Reports from TB patients in Rajasthan, Mumbai and Delhi revealed that during lockdown permanent residents eventually in a week’s time managed to arrange medicines through their social networks. But the patients from other regions, who got stranded were not brought under the radar of supervision and ensured medication, thereby leaving them to suffer (Chakraborty 2020; Bedi and Yadavar 2020; Jain 2020).

Lockdown and the sudden economic hardship that it generated led to a mass exodus of migrant workers, including the existing TB patients. While the plight of the home-bound migrants got media visibility, the pain and suffering of TB patients among them went unnoticed. On reaching their destinations frontline workers checked them for COVID-19, but no care was taken to look into other health problems and hence continuity of TB treatment for them has not been maintained (Das et al. 2020). The 145 TB deaths reported within the initial 54 days of the COVID crisis in Agra is a shocking example of the disbanding of TB services due to the overwhelming demands of the pandemic response (Qureshi 2020).

Given this urban-centric scenario of disruptions, it is not hard to imagine the scale of health care deprivation among patients in rural areas. Contrary to the government directives of converting PHCs and CHCs into non-COVID hospitals, the staff of these centres were deployed for COVID duty. Reports reveal that CHCs have been turned into COVID hospitals and the more distant district hospitals are reserved for Non-COVID (Shukla 2020). In Chhattisgarh, PHCs were open but due to shortages in medical supply, absence of doctors and lack of transportation, access to TB services remains low (Bedi and Yadavar 2020). Banda district of Uttar Pradesh saw many TB related deaths as it failed to recommence TB services for its TB patients. Deaths occurred among the returning migrants who walked back 1200 kms from Morbi in Gujarat and also permanent residents who in pre-COVID times took treatment from nearby private or public hospitals, due to lockdown, absence of health personnel, lack of medicines and police barricades. In Chhattisgarh, the lockdown led to a complete breakdown in transportation, police barricades, service disruptions with grave consequences for severely ill TB patients causing the untimely death (Bedi and Yadavar 2020).

Non-communicable diseases

Non-communicable diseases (NCDs) contribute 61.8% of all deaths in Indian. Among the five major causes of deaths, three are due to NCDs (ischemic heart disease, chronic obstructive pulmonary diseases and cardiovascular diseases) (Mohan et al. 2019). As against the myth that NCDs primarily ail elderly people, most of these deaths were premature (30–70 years) and occurred in the most productive years of life. India has 257 million people with hypertension and 77 million diabetics—accounting for two million annual cardiovascular disease-related deaths (Arora 2020). India also detects more than 1 million new cancer patients every year (Sharma 2020). Before the 1990s, NCDs remained restricted to the privileged class and caste groups, whereas the poor largely struggled with communicable diseases. However, as the benefits of economic development trickled down, the poorer sections were also afflicted by NCDs. The gradually increasing burden of NCDs among all sections of the population, irrespective of class and age, alongside the load of communicable diseases emerged as a ‘dual challenge’ to the perennially under-resourced health sector of India (Arora 2020).

The outbreak of COVID-19 brought NCDs into prominence worldwide as a leading cause of death for those infected with COVID-19. India's statistics on COVID-19-related deaths and infected cases had revealed that among the 500,000 COVID-19 cases reported till the end of June 2020, more than 70% were linked to co-morbidities like diabetes, hypertension and heart disease (Arora 2020). In spite of the huge health risk to NCD patients, the government opted for an isolationist approach to COVID-19. Reorienting the already overburdened health system to the exclusive needs of coronavirus treatment created severe disruptions and uncertainties with regard to the delivery of routine chronic care. These disruptions include potential blockages in supplies of essential medicines and technologies, screening and diagnosis procedures, limited access to resource availability including health workers and support services that are critical for ongoing management of NCDs (Arora 2020). The MOHFW guideline which had clearly mandated uninterrupted services for NCD patients was set aside. Much like TB services listed above, unavailability of public transportation and closure under lockdown and the absence of services further disrupted the continuum of care (Chalasani et al. 2020).

The small section of people who managed to avail services or access medicine owed it to their class position, geographical advantage, social network or economic capital. However, they had to avail it at a price much higher than the original price. For instance, patients accessing dialysis, chemotherapy and blood transfusion services in Apollo hospital, Delhi, had to pay an additional charge of Rs. 4500 for COVID-19 test alongside the exorbitant service fees. In contrast, middle class patients dropped the idea of accessing care due to the high fees (Kaur 2020). The pain and suffering of the critically ill patients remained out of the public gaze.

The government directed registered physicians to provide healthcare through telemedicine to ensure some measure of equitable access, as well as to cut down unnecessary crowding of non-essential visits to the hospital. The advantageous section could afford private consultations, while the disadvantaged, constrained by absence of mobile phones, lack of personal contact with physicians and language barriers, failed to avail the facility. Those who availed teleconsultations were prescribed medicines in lieu of important surgeries, chemotherapy sessions and urgent medical interventions. Although it seems like a beneficial intervention during crisis time, in reality many patients were actually pushed into a ‘gray zone of medical risk’. Delayed or postponed surgeries by

transforming their condition from curative stage to palliative stage have endangered patients' lives and their chances of long-term survival (Sharma 2020; Chalasani et al. 2020).

In the absence of adequate tertiary care centres, movement of NCD patients from villages and small towns to medicities in metropolitan areas like Delhi, Mumbai and Chennai is a common phenomenon in India. A complete silence in the guideline on this issue was tantamount to complete disregard for the concerns of these patients. Lack of regulation and the sudden lockdown left many stranded in inhospitable cities with no clarity on their return. Similarly those who needed urgent attention in cities could not continue with receiving treatment in metropolitan centres of healthcare (Sharma 2020).

Regular government-run, medical travel services like the famous "Cancer Train" in Punjab were also brought to a halt depriving thousands of cancer patients from continuing treatment in Jaipur (Vasudeva 2020). Similar cases have also been reported from Kasargod district of Kerala where cardiovascular and renal disease patients were stopped from travelling to Mangalore, Karnataka, to avail regular treatment. This state action resulted in the death of many patients (Emmanuel 2020). Patients requiring blood transmission for leukaemia and thalassemia, and childhood cancers, suffered immense hardship as the blood banks ran dry in Kolkata, Orissa, Delhi, Mumbai and Uttar Pradesh. Shortage of blood in these states had led to putting all the surgeries on hold and delays in blood transfusion process of critically ill patients with low haemoglobin and platelets levels (Salve 2020).

Maternal health services

Historically the situation of maternal health in India has been a matter of grave concern. Till as recently as 2007–2009, maternal mortality ratio (MMR) was a staggering 212 (SRS 2011). According to NFHS-3 data (2005–2006), 77% women had accessed ANC services⁵ [iii] at least once and 39% had institutional deliveries. However, since then we have seen marked improvements. The maternal mortality ratio (MMR) has decreased to 130 in 2014–2016. During this period, women accessing ANC services at least once have increased to 84% and 79% have had institutional deliveries (NFHS-4, 2015–16). Some of the reasons for this improvement are improved access to maternal health services (including institutionalization of deliveries), state sponsored financial incentives such as Janani Shishu Suraksha Karyakram (JSSK), improved social determinants of maternal health like literacy and increased age at marriage and positive engagement between public and private health care providers, that have allowed women access to ANC check-ups, obstetric gynaecologists and to track high risk pregnancies (Singh 2018). Additionally, provision of ASHAs (under NRHM) at the village level to motivate women to avail services provided by the government health facilities has also improved access to maternal health services (Roy et al. 2013).

In the context of COVID-19, pregnant women, in general, are no more susceptible to this pathogen than the general population, even though there are vulnerable groups within the pregnant population. Pregnant women are considered to be a high-risk group for severe respiratory complications (Karami-Zarchi et al. 2020). A recently published study

⁵ Antenatal care (ANC) interventions are considered to improve maternal and infant outcomes. GOI guidelines on maternal health recommend every pregnant woman to avail at least three ANC visits (with the first one preferably in the first trimester), to consume 90 iron folic acid tablets and must receive at least two Tetanus Toxoid (TT) injections (Singh et al. 2014).

confirmed that vertical transmission from the mother to the foetus is possible (Prasad 2020) and that it might lead to preterm deliveries (Browne et al. 2020). However, the proportion of such pregnancies and significance to the neonate is yet to be determined. The morbid fear of exposure, however, is not unfounded. In previous coronavirus outbreaks such as SARS and MERs, adverse pregnancy outcomes such as miscarriage, prematurity, foetal growth restriction and maternal death have been observed (Hussein 2020). In the EVD outbreak in Sierra Leone, resources demarcated for sexual and reproductive services were given away to deal with the outbreak. This eventually resulted in the rise of maternal mortality in the region (Wenham et al. 2020).

A similar response has been witnessed during COVID-19 pandemic in India. Essential services for women's reproductive healthcare have been curbed raising several important questions about ensuring safe, timely and quality maternal care. Many states have curtailed outreach services citing the importance of taking precautionary measures against COVID-19 infection. Even tertiary level public facilities are mainly available for COVID-19 patients. In the face of increasing infection among health providers, private hospitals too have stopped functioning. Undoubtedly under-provision of services has exacerbated the potential threat to pregnant women's lives.

While most pregnant women endure physical suffering and mental anxiety due to non-availability of satisfactory services, their concerns vary depending upon their social class. The better-off are anxious that they will not be able to visit their hospitals for regular check-ups. Reports have cited that women are anxious about contracting COVID-19 infection at the hospitals. Due to the current situation, several hospitals across the country have decided to provide emergency services through telemedicine making it easier for the women to remain in contact with their doctors (Bisht et al. 2020). However, immunization services and administration of TT injections cannot be done through telemedicine and require personal visits. This essentially means that these women in the absence of vaccination are now at risk of contracting vaccine-preventable diseases (VPDs). Hence the overall burden of mental stress is also very high.

Poor women, on the other hand, have encountered a different set of problems. With most of the ambulance services diverted for COVID-19-related activities and suspension of transportation facilities, women in labour confront the grave possibility of failure to avail maternal health services on time. Media reports have captured the trauma of having no health facility to access or lack of necessary infrastructure in small hospitals and clinics to deal with pregnancy-related complications and sometimes even the absence of adequate and timely transportation facilities. The health facilities that they were registered at are either closed down or are denying care (Bisht et al. 2020).

Faced with multiple denials from the public sector and the unaffordability of the private hospitals, poor women have ended up delivering on roadsides or in the ambulances, and at times without the help of any trained personnel risking their own and their babies' health and lives. It is important to note that many such instances have been reported from urban areas including major metropolitan cities. The situation of rural women has been found to be even worse (Bisht et al. 2020). There has also been a play of communal prejudices against women post the Tablighi Jamaat incident as they were perceived as potential carriers of the virus (Alam 2020; Sarkar 2020; Wadhawan 2020).

The situation of pregnant women living in urban containment zones, where entry and exit are severely restricted, is even more precarious. With multiple factors such as tight police control, absence of readily available ambulance services, or helpline numbers to assist or facilitate transport services, difficulty in arranging vehicle passes and police harassment, there is hardly any assistance or facilitation of transport services. This makes it

extremely difficult for women from the containment zones to access ‘time-bound’ maternal health care (Bisht et al. 2020).

To make matters worse, the Indian Council of Medical Research (ICMR) guidelines of 21st April 2020 required all pregnant women from containment zones presenting signs of labour, or delivery in the next 5 days to test for COVID-19 even if asymptomatic. This led to a lot of chaos and additional trauma for many such women as they were sent back from the hospital facilities if they did not have test results. After several such negative reports, the ICMR issued a fresh guideline on May 18th. It directed that emergency procedures, including deliveries, should not be delayed for asymptomatic patients for lack of test. In spite of the clarification, however, due to initial miscommunication, many pregnant women in different regions of the country continued to face hardships in accessing services (Bisht et al. 2020).

A retrospective study in western India revealed a 43.2% reduction in hospitalization among pregnant women during the 10 weeks of lockdown compared to 10 weeks prior to the lockdown. When compared to the same period in 2019, reduction increased to 49.8%. While admissions for obstetric emergencies reduced by 66.4%, the death of pregnant women in hospitals increased (0.20 vs. 0.13%). There has also been a high number of late intrauterine foetal deaths and stillbirths (3.15 vs. 2.25%) (Kumari et al. 2020).

Ironically in a country where for past 15 years the state has proclaimed improved maternal outcomes for women with institutional delivery, pregnant women today are struggling to find a health facility for delivery. It is feared that the hard-won gains in MMR could now be lost (Dasgupta 2020).

Immunization

Immunization is one of the most cost-effective public health interventions that help in preventing two to three million deaths of children every year worldwide (Varughese and Shah 2020). Since 1978, GOI has been providing free of cost vaccination against VPDs such as polio, measles, tetanus and diphtheria, among other diseases. Auxiliary Nurse Midwives (ANMs), Anganwadi workers and ASHAs are responsible for the task of ensuring immunization coverage among children and pregnant women. These efforts from GOI⁶ have significantly improved child health indicators. Despite this, even today only 65% of children are fully immunized in the first year of life, and nearly one million children fall victim to VPDs before their fifth birthdays (UNICEF n.d.). Some of the challenges that are faced in ensuring universal immunization include difficulty in reaching the targeted beneficiaries in remote areas, community mobilization for acceptance of vaccination and maintaining the cold chain of the vaccines in extreme weather conditions (Banerjee 2020).

It is feared that this delay in immunization can lead to a build-up of unimmunized or partially immunized children, rendering them vulnerable in potential outbreaks of life threatening VPDs (Routray 2020). The situation can be particularly grave for those with compromised immune systems such as children of the urban and rural poor and migrant workers (Banerjee and Athar 2020). In fact, it has been said that VPDs pose a much higher

⁶ In December 2014, GOI introduced Mission Indradhanush that aimed to strengthen and energize the existing immunization programme and achieve full coverage for all children up to 2 years of age and pregnant women at a rapid pace. It is considered to be the largest immunization drive in the world in terms of the number of beneficiaries (27 million newborns and 29 million pregnant women every year), the geographical coverage and quantities of vaccine used (9 million courses of immunization).

risk of mortality and morbidity than COVID-19, for children of under-five age group (Routray 2020; WHO 2020). Such a pattern was also observed during the peak of EVD in West African countries when a simultaneous measles outbreak killed almost double the unimmunized children (Sun et al. 2017; Ranganathan and Khan 2020). Due to these reasons, the WHO and UNICEF have stressed on the importance of maintaining essential health services during emergency situations and have asked the concerned nations to facilitate ‘catch-up immunizations’⁷ in places where services have been disrupted.

As per the Ministry of Home Affairs and MOHFW guidelines, birth dose vaccination (BCG, OPV-0 and hepatitis B) was to be continued in all zones, while health facility based and outreach immunization were to be carried out only in areas beyond the buffer zone⁸ and green zone,⁹ and not in containment¹⁰ and buffer zones.¹¹ Following these orders, many states in India have resumed immunization activities from the month of May, which had been suspended after the lockdown. Immunization is to be carried out in different health facilities such as PHCs, district hospitals and medical colleges by following national and state guidelines on preventive measures (MOHFW guidelines 2020). In spite of this, due to lack of parental awareness, fear of exposure to the virus, lack of transport, long queues, limited staff in the healthcare facilities and reengagement of a majority of ASHA workers from community mobilization to COVID-19-related work, families are demotivated to take their children for immunization (Johari 2020; Iftikhar and Shrangi 2020; Banerjee and Athar 2020). Rising temperatures in cities like Delhi have also added to the woes of the people which makes standing in the hot sun unbearable (Iftikhar and Shrangi 2020). The private sector, which is an important provider of immunization services in India, has also stopped functioning due to lack of PPEs for clinic staff, unavailability of vaccines and parent’s inability to travel during the lockdown (Kinikar and Kulkarni 2020). Additionally, infants of women who were unable to access hospitals and gave birth at home invariably missed their first dose of the BCG vaccine which is usually administered at the maternal health facility (Iftikhar and Shrangi 2020).

The mounting backlog of unimmunized children is a huge challenge for the already strained health system as a VPD outbreak will leave it in complete disarray. Many paediatricians and other experts are worried that this disruption in immunization services might lead to a long-term consequence for child survival in the country (Banerjee 2020; Ranganathan and Khan 2020; Yewale 2020).

Conclusion

The COVID-19 pandemic’s disruption of the healthcare delivery system has been particularly challenging in India. This is primarily because of a major focus on COVID-19 and an incoherent non-COVID policy. COVID-19 outbreak has pulled essential medical resources away from critical prevention activities and regular healthcare services through

⁷ ‘Catch-up immunization’ involves tracking mother–child pairs, listing of children due for immunization, administration of all primary and secondary vaccine doses using the updated lists and targeted social mobilization (Routray 2020).

⁸ Areas beyond the buffer zone are those areas that are beyond the buffer zone.

⁹ Green zones are areas with no active COVID-19 cases.

¹⁰ Containment zones are those areas from where COVID-19 cases are reported.

¹¹ Buffer zones are areas surrounding the containment zones that have the risk of COVID-19 spread.

restructuring of public health services, reorganization of hospital facilities and redeployment of existing staff, leading to cancellations, delays and disrupted treatment. These developments also impacted OPD and other services of the private hospitals, nursing homes and private clinics with negative consequences for non-COVID patients in India. As the COVID-19 caseload increases, the adverse impact on regular healthcare services gets bigger.

Prior to the pandemic, India already had a high burden of communicable and non-communicable diseases, and need for regular, day-to-day services for RCH and vaccination was huge. It is precisely these conditions whose treatment is now massively neglected. Many of these patients are at a higher risk of even severe complications from COVID-19. On the one hand, people's fear of COVID-19 makes them refrain from going to medical centres, which significantly impacts their access to medical care, while they require acute treatment. On the other hand, this has caused complications for patients who need treatment for medical conditions that require timely and appropriate care. For those who managed to get healthcare, we find the pandemic has distorted healthcare costs with costs increasing in complex ways for treatment, drugs and indirect costs.

From the limited information available in the public domain, in the last 4 months, services have become increasingly disrupted leading to a lot of human suffering in the form of additional death and years of life lost. These effects are likely to persist into the longer run as many studies project a steep rise in caseload and mortality as an indirect consequence of the pandemic potentially exacerbating pre-existing health inequalities.

In conclusion, the paper underlines how our system is failing those without COVID-19. By prioritizing prevention of spread of COVID-19 or its control, we are leaving behind those on brink of life and death, those requiring routine treatment. We cannot deem only the COVID-19 response as 'essential' and treatment for people living with other diseases as 'non-essential'. These significant inequities in access to treatment and preventive measures for non-COVID conditions risk not only accentuating and worsening health inequalities but also creating newer forms of health disparities. Future studies must focus on systematically capturing the experiences of the hardships that patients had faced in the wake of the COVID-19 crisis.

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