Generating Evidence for Rebuilding SRH Services for Women and Girls in India:
A Qualitative Study to assess the ground reality of COVID-19 Pandemic

INDEX

ABBREVIATIONS

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse & Midwife
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BIL	Brother-in-law
CMS	Centre for Media Studies
DIL	Daughter in-law
ECP	Emergency Contraceptive Pill
ESOMAR	European Society of Marketing Research
FIL	Father-in-law
FLW	Frontline Worker
ECP	Emergency Contraceptive Pill
IRB	Institutional Review Board
M	Moderator
MA	Medical Abortion
MIL	Mother-in-law
P	Parity
PHC	Primary Healthcare Centre
R	Respondent
RMP	Rural Medical Practitioner
SIL	Sister-in-law
SRH	Sexual & Reproductive Health
YMW	Young Married Women
YUMG	Young Unmarried Girls

CHAPTER 1

BACKGROUND AND STUDY DESIGN

1.1 Background

Over a few decades, approaches to enhance Sexual and Reproductive Health (SRH) as a human right of the citizens have gained more traction. A broader set of approaches have been adopted to address SRH within the country. However, only to offset the progress, the emergence of the COVID-19 pandemic has thwarted attempts to improve the landscape of SRH and its institutional setting across the country. The data on the impact of earlier pandemics such as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) highlights severe implications on Sexual and Reproductive Health and Rights (SRHR) at the individual, systems, and societal levels. Such outbreaks have been known to have grievously affected SRH services resulting in outcomes such as miscarriages, maternal death, and other pregnancy-related issues.[1] As stated in a formal note by UNFPA, for every three-month lockdown, in cases of high levels of disruptions, up to two million additional women may be unable to access modern contraceptives.[2] In the Indian context, it is estimated that access to as much as 1.85 million abortions might have been compromised in the first three months of the lockdown as there was an absolute shut down of many service-providing agencies despite SRH services being declared essential. Access to hospitals, chemists and pharmacies has been significantly reduced, more so, for women from rural settings.

The forced lockdowns and added stressors related to household issues and economic instabilities have been suggested to have a direct impact on the increase in the incidences of violence against women. With decrease in access to information and services to SRH, the situation is aggravated, as it disarms women to take charge of their rights.

In the given context, it is important to understand the ground realities of how the pandemic has impacted the current system's efforts to provide access to information and services of SRH to the communities and how the narratives of women, in specific, have been shaped under these pressures.

1.2 Research Objectives

The broad aim of this study was to generate evidence from the community on the impact that COVID-19 had on access to SRH-related information and services among young women and girls and develop contextual need-based community outreach strategies. The specific objectives were to:

1. Understand how access to information and services had been impacted due to the pandemic and the consequent lockdown.
2. Explore unfulfilled needs from the perspective of SRH among young women and girls.
3. Understand young women's experience of seeking SRH services from health facilities (if at all).
4. Explore how the support systems (ASHAs, ANMs and other outreach workers) impacted the access to information and services.
5. Examine challenges and good practices from the field to understand how they overcome these challenges.
6. Identify immediate requirements of young women and girls in terms of information and services.
7. Assess social resilience among young women (15-24 years) from the context of family support and support of the health system.

[1] Favre G, Pomar L, Qi X, et al. Guidelines for pregnant women with suspected SARS-CoV-2 infection. Lancet Infect Dis 2020; (published online March 3). Available from: https://www.thelancet.com/journals/laninf/article/PIIS14733099(20)30157-2/fulltext

[2] UNFPACOVID-19 Impact Brief: https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

8. Understand the perspective of community intermediaries (ASHAs) towards service utilization and how it has been impacted by the pandemic.
9. Examine the transition in priorities of ASHAs that have shifted focus towards COVID-19 and their perceived opinion on the normalization of their roles and responsibilities.

1.3 Research Approach & Methodology

1.3.1 Methodology

A qualitative study design was adopted to gather open-ended responses through in-depth interview (IDI) techniques. The interviews aimed at understanding, in details, the perception of gaps between the needs and current status of the community's access to SRH and how they were impacted due to the COVID-19 pandemic. Most critically, these in-depth interviews offered a view into anecdotal evidence surrounding SRH and the disruption of access to its services and information during the pandemic.

The study design adopted a combination of both exploratory and investigative methods depending on the stage of the project. The exploratory research design aimed to explore a problem so as to provide insights and comprehension for more precise investigation; while the investigatory approach enabled a nuanced investigation of the problem. The purpose of this approach was to triangulate the data with all stakeholders of the research problem, and to provide a holistic picture of the emerging patterns.

Using open-ended interview guides, three types of respondents were interviewed by trained and experienced research moderators. These interview guides were translated into local languages and pre-tested before canvassing for the main survey. The study protocol, tools, consent forms, and implementation design were approved by the local ethical board (CMS IRB).

1.3.2 Target Respondents

Given the context of the study, the following three types of respondents were targeted for IDIs:

- Young women and girls of age 15-24 years
- Community intermediaries like ASHA
- Pharmacists or chemists located in the rural areas

Respondents who voluntarily agreed to take part in this study and provided written consent and assent (for girls less than 18 years) were included for the IDIs.

1.3.3 The Research Implementation

The data collection was carried out in December 2020. Keeping in mind the possible spread of corona virus and consequent risks associated with it, strong measures were taken to mitigate the potential risks for research moderators and respondents. Following the standard ESOMAR (European Society of Marketing Research) advisory, data collection was initiated using a combination of online and offline interactions with all intended study participants.

In the first step, the respondents were identified and screened by a well-trained and experienced field recruiter who followed all COVID protocols to recruit eligible study respondents at the household level, and thereafter collected written consent and assent for the final IDIs. In the second stage, digital devices were installed for remote interaction with the research moderator. These recruiters acted as connectors to the online research team stationed at the capital city and study respondents located at rural areas. A mix of audio-visual interface was used as the medium, depending upon the strength of connectivity.

1.3.4 Sample Coverage

The study was conducted in selected districts of three states, including Goalpara and Nagaon districts of Assam, Chhatarpur and Satna districts of Madhya Pradesh, and West Singhbhum district of Jharkhand. A total of 40 IDIs were successfully carried out across three study states.

Table 1. Distribution of sample respondents covered through IDIs by states and respondent types

Respondent Type	Madhya Pradesh	Jharkhand	Assam	Total
Young women (15-24 years)	8	8	8	24
ASHAs	4	4	4	12
Chemists	1	2	1	4
Total	**13**	**14**	**13**	**40**

1.4 Limitations of the study

- The study was carried out in three selected states and does not represent the country as a whole. Thus, the interpretations and learning from the research cannot be generalized for all states/districts in India.

- Qualitative analysis though IDIs is limited to a small universe in terms of sampling coverage and cannot be utilized to arrive at quantitative or statistical generalizations about a target group.

CHAPTER 2

STUDY FINDINGS

2.1 Understanding the Pre-Pandemic Context

To understand the 'change' that occurred during COVID-19, with regards to SRH needs and specifically, unfulfilled SRH needs of women, it was critical to establish the initial context and state of fulfilled and unfulfilled needs, as well as prior attitude and behavior, to ascertain the quality of change that occurred. Thus, this section provides an overview of the general profile of respondents and their household to establish the pre-pandemic context across the three study states—Assam, Madhya Pradesh, and Jharkhand.

2.1.1 Profile of Respondents

- ***Joint family setup****:* Across locations, most women lived in a joint family setup with a typical size of the family being 5–6 household members, including—young woman, spouse, child (if married), MIL (mother-in-law), FIL (father-in-law) and SIL/BIL (sister-in-law/brother-in-law).

- ***The typical age of marriage and children:*** Typically, women across centers reported being married between the age of 18–23 years. While respondents were aware of the legal implications of underage marriage, it appeared that many young women had in fact, been married 2–3 years before turning 18.

- ***Husband as chief wage earner and key decision-maker****:* Husbands were reported as the chief wage earner of households, who were also eventually reported as the main decision-making agents within the household.
- ***Education profile & Occupation:*** Unmarried girls interviewed were between the ages of 17–23 years—with clearly stated intentions to continue their education for the foreseeable future. Most girls below 18 years of age were pursuing their studies and were enrolled for the secondary level. However, a few girls who were no longer studying (from Jharkhand & Madhya Pradesh) had discontinued studies due to lack of interest or financial constraints—and in the latter case were assisting the family in minor agriculture activities or in household chores.

"I really like to study so I completed my degree and am now working in a school that's why I haven't married till now because my family supported me." — YUMG, 24 years, Assam

Among married women, education levels for most of the respondents varied from grade five to secondary level and in a few cases, higher secondary level. Those who had pursued higher secondary education or above higher secondary education had pursued education post-marriage (wherein the husband and marital family were reported to be supportive of the decision). In Jharkhand, a few married women were found to be assisting in labour/agriculture work to support the income of the house.

- *"I am 24 years old… I am a higher secondary pass out." — YMW, Assam*
  "I have studied till 9th standard only." — YMW, Jharkhand

- ***Mobility limited to task-oriented needs*****:** Unmarried girls reported that custom dictates that young women must not travel, unless accompanied by a family member. Further, during teenage and young adult years, their movement outside the house was mostly for study purposes or for task-oriented activities, including going to school, purchasing personal or household items, or for any health-related need.

"I only go outside when I'm going to school or when I need to buy something from the nearby market. I go out with my Aunt mostly, she is my father's sister." — YUMG, Jharkhand

"They tell us to not go outside because there are boys who pass comments. That's why my parents ask me to be careful, girls have restrictions due to this reason" — YUMG, Madhya Pradesh

Even after marriage, the frequency of women going outside the home is mostly task-oriented, which may include purchasing personal or household items, or for any health-related need.

"After marriage, we need to keep up our mobility as per the wish of the family members and as per the husband, before marriage, a girl can fight with her parents, she can deal with her parents and can move outside with her own wish. That is not possible after marriage." — YMW, P1, Madhya Pradesh

- ***Access to smartphones:*** Most unmarried women were observed sharing smartphones with other members of the family (sister/mother/elder aunt). Women reported using the phone for basic functions, entertainment (playing games, watching videos, etc.) and occasionally, for education. *YouTube* emerged as a commonly accessed and enjoyed app for entertainment purposes (in addition to occasional usage of WhatsApp, Facebook, Tiktok). **Information sought using smartphones was typically seen to be focused on individual hobbies or interests, or to acquire vocational skills.**

  "I see blouse designs, listen to music, watch movies. I watch Hindi movies… sometimes with my sister, sometimes with my father also. I don't have personal mobile. This is my aunt's mobile"— YUMG, Madhya Pradesh

  For married women, smartphone use was found to vary between personal and shared use. The utility of features was not dependent on access alone - it varied based on their interests and abilities to explore and use functions. The most accessed and enjoyed application across centers was seen to be 'YouTube' for its both entertainment value (serials, movies, song videos) and instructional content (heena design, stitching, cooking recipes videos, etc.)

2.1.2 Pre-Pandemic SRH Needs

It was reported that SRH information and service needs of young, unmarried women across the three states were around menstrual health and hygiene, whilst for married women the needs ranged from menstrual and reproductive health, contraceptive needs, to pregnancy care and delivery, antenatal care as well as emergency contraception or abortion when dealing with an unintended pregnancy. Depending on the stages corresponding to parity (number of children) and marital status, SRH-related needs explored with the young women are highlighted in the table below.

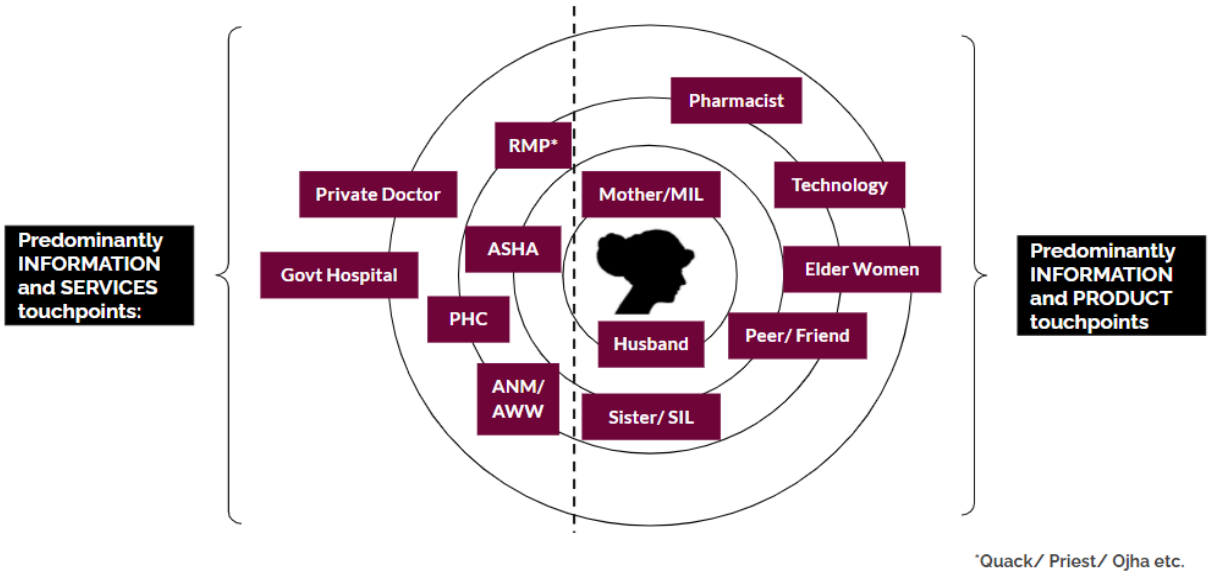
Table 2. SRH related needs of young women depending on stages of parity and marital status

Marital status/parity	Predominant SRH related needs - Information/Services/Products
Unmarried Young Women	- **Menstrual health & hygiene:** Access to *product* (pads), *services* (in case of discomfort or irregularity in menstrual health), *information* (related to hygiene practices and product use, direct/indirect mention of contraceptive use, abortion etc.)
Parity 0	- **Menstrual health & hygiene:** Access to *product* (pads), *services* (in case of discomfort or irregularity), *information* (related to hygiene practices and product use, RTI, STI) - **Pregnancy care** - **Contraceptive options** to delay pregnancy, **prevention or termination** of

	unwanted pregnancy
Parity 1 & above	- **Menstrual health & hygiene:** Access to *product* (pads), *services* (in case of discomfort or irregularity in menstrual health), *information* (related to hygiene practices, RTI, STI) - **Contraceptive options** to delay pregnancy, **prevention or termination** of unwanted pregnancy - **Pre, during, and post-pregnancy care** - **IFA supplements for self and child**, **vaccination & other nutrition support** for self & child, for both pre and post pregnancy

2.1.3 Pre-Pandemic Healthcare Behavior

SRH Ecosystem of Young Women



SRH Information

An unmarried woman is seen to have limited touch points to find information regarding her immediate SRH needs within her immediate and extended ecosystem. It is seen that comfort with discussions about sensitive matters (where judgment may occur) lies with same aged girls/women slightly older to the girl. However, when advice is sought, the experience of the woman becomes the filter.

- To access information regarding menstruation and hygiene related issues, young girls mostly reached out 'first' to their mothers. Some young girls also preferred talking to similar aged friends/elder sisters over mothers because of **discomfort and unfamiliarity with the subject.**
- When advice is sought, experience becomes the filter. Young girls will go to an 'older woman' preferably mother, elder sister, SIL or ASHA in case they have access.
- Referring to ASHA as 'sister'/ 'didi' and her being someone who lives in the vicinity (with sought after knowledge on medical needs) ultimately brings her into the immediate consideration set to seek information from.
- ASHA is seen to hold 'meetings' for unmarried girls from time-to-time to educate girls on various SRH needs whilst making the meetings a safe space for discussion and information exchange.

"I just asked my mother." — YUMG, Jharkhand
"I take help of ASHA worker" — YUMG, Assam

A married woman is seen to have multiple touch points within the immediate and extended ecosystem to find information regarding her immediate needs.

- Young woman's first point of contact was usually reported as her husband or a close '*woman confidant*' to whom she reached out without the fear of judgement. These young married women also had close relationships with a few older women to whom they could reach out to, for guidance and advice.
- ASHA by the virtue of her role and proximity was reported as the most important source of information seeking.

"I ask my mother-in-law mainly what it is and what is to be done" — YMW, P1, Assam
"According to the problem, we always take help from ASHA." — YMW, P1, Madhya Pradesh

SRH Services

- For unmarried girls, there are few (but limited) interactions at '*baithaks* (meetings)' with ASHA or ANM to access and avail SRH services especially related to menstrual health and hygiene. Apart from providing information, ASHAs were seen to provide sanitary napkins and medicines for menstrual cramps and pain, to the young girls. Interactions with doctors/nurses took place only in case of an immediate medical emergency or severe healthcare issue.
- Across the study states, unmarried women sourced sanitary napkins from pharmacy shops or general stores through a parent or an older woman. In some cases, they purchased MH products by themselves. In rare occasions when the product was unavailable, the primary point of procurement for young girls became ASHAs.

"In case I have any problem, I go to ASHA didi. She tells us everything about the problems. We used to have meetings also where all girls of my age used to go." — YUMG, Jharkhand

- The marriage of the woman usually opens the door of interaction and counselling with ASHAs as well as public and private healthcare practitioners, on SRH issues including family planning, contraceptive awareness, procurement and usage.
- The ASHA is seen providing information regarding modern contraceptive methods like condoms and pills predominantly. A woman's pregnancy puts her at the center of the ecosystem. ASHAs act as an intermediary between the woman and a public facility, ensuring appropriate measures for maternal and infant health such as supplements, immunization etc. The ASHA is often the one to ensure that delivery of the first child takes place in a healthcare facility, therefore leading to interaction of the woman (along with her husband and/or mother in-law) with the doctor, often followed by the ASHA accompanying at the time of delivery.
- Depending on the preference and affluence of the family members, young women also approach private health facilities.

2.2 Understanding the Experience of COVID-19 Pandemic

This section aims to arrive at their associations, understanding and experiences related to COVID-19 overall, followed by a detailed exploration of overall healthcare and SRH needs and experiences during lockdown and subsequent unlock phases.

2.2.1 Understanding and Awareness of the Covid-19 Pandemic

COVID-19 was well-recognized but study respondents had an incomplete understanding of it – the disease being seen as 'responsible for lockdown'. Barring one, all respondents across the three states were aware of the phenomenon COVID-19. Although what constituted the term varied from respondent to respondent, all of them could associate it with a disease that had caused a lockdown in their respective villages**.**

"Yes, all shops etc. were closed. …shops, market, everything was closed. People were not going out at that time." — YMW, P1, West Singhbhum, Jharkhand

Access to media and monitoring/campaigning by public health led to several theories and interpretations. Some of them felt that the COVID-19 pandemic had originated from China. Most of the respondents were aware of the basic norms of preventing the spread of Corona virus.

"This disease has originated from China and the whole world has been suffering due to this" — YMW, P2, Lakhimpur, Assam

"We used to stay at home. We used to wear mask and try to protect ourselves… I do not know how it spreads. But I saw some news about it on internet. There was no COVID case in our village. There But there has been a constant fear that we could catch corona. So, we used to protect ourselves by maintaining social distancing, taking care of my child, wearing mask." — YMW, P1, Satna, Madhya Pradesh

Actionable knowledge about COVID-19 was retained due to fear of severe illness and fatality. Some of the study respondents knew that the disease was contagious and spreads through air and touch and that it could be fatal. Some associated it with closing down of shops, markets, schools and colleges, restriction of transportation and movement.

"Yes! It started in January; I think in 2020. It could be fatal sometimes. I came to know through media news. We (for the) first time experienced lockdown." — YUMG, Satna, Madhya Pradesh

2.2.2 Perceived impact of COVID-19 at Community, Family, and Personal Levels

Some of the respondents mentioned that they were quite scared of the spread of the virus and consciously preferred staying indoors to take care of their families.

"COVID-19 is everywhere. I keep myself inside the house with my son and husband. I have minimized social contacts following Government's protocol. I have to take care of myself. My father might get infected, my son might get infected. So, I must take care of myself. I even learned how to make sanitizer at home. I learned it from YouTube. That is how I take care of my family." — YMW, P1, Nagaon, Assam

Two e primary changes reported by most of the respondents across the three study states were—restriction on movement or mobility, and closing of shops. Most of the shops remained closed during the lockdown which caused some problem in procuring non-essentials like clothes, etc. Public service vehicles too had stopped plying because of the restriction on movement.

"We just couldn't go out of the house. Otherwise, we would get infected with the virus. We saw news on mobile, on TV, my husband also used to tell me about these things. The shops and markets were also closed during lockdown. We all had to stay at home. — YMW, P1, Lakhipur, Assam

Suspension of commercial activity: The markets in the villages were shut and there was barricading done to restrict movement around and outside the village, one respondent from Jharkhand said. She also mentioned

that festivals were not celebrated because of the lockdown. People stopped going outside, they stopped interacting with their neighbors because of COVID-19 scare.

> *"During lockdown no festival was celebrated and even marriages could not happen. Going to market as well as going to other places were also stopped and public transport also stopped. We could not even celebrate Maghi Festival. Marriages were cancelled. There was a total ban on marriage events... No gathering was allowed, so all the marriages were postponed." — YMW, P0, West Singhbhum, Jharkhand*

Adverse impact on agriculture-dependent homes: A few respondents from Assam mentioned significant changes in their agricultural activities. They said that the farmers were unable to sell their harvest in the market during COVID-19 crisis and there was also a shortage of laborers during the lockdown, which created a setback in the farming activities, except for those who could work by themselves. This impacted the life of rural community.

> *"Lockdown has impacted a lot in agricultural activities. There was extreme shortage of laborer. So people who can do it by themselves were working." — YMW, P1, Nagaon, Assam.]*

Accessibility of healthcare services was limited, despite consistently open healthcare centres: In terms of healthcare services, one respondent from Assam mentioned that although hospitals and healthcare centres were open during the COVID crisis, people were apprehensive of visiting these facilities because of the rise in positive COVID-19 cases. One respondent from Madhya Pradesh mentioned that the local doctor was unavailable to treat general illnesses because he was asked to shut his clinic down as people in the village feared getting infected.

> *"Health facility was open but there were positive cases… And people were afraid of visiting hospitals." — YMW, P1, Nagaon, Assam*

2.2.3 SRH related Needs and Good Practices that emerged during the COVID-19 Pandemic

This section examines how the barriers resulting from the COVID-19 pandemic manifested in terms of unfulfilled SRH needs. It highlights the barriers faced by women and some of the good practices followed by young women to resolve SRH needs between March and December 2020. The table below examines in detail the SRH need gaps that emerged due to the COVID-19 pandemic, during the lockdown and initial stages of unlocking:

Menstrual Hygiene Needs

Table 3. Barriers and Good Practices in Menstrual Hygiene Needs

BARRIERS	GOOD PRACTICES
• **Unmarried girls lacked access to ASHAs amplified:** Unmarried girls had limited access to ASHA and further **compounded** due to the COVID-19 pandemic. • **Financial constraints contributed to inability to use sanitary pads:** Financial constraints led to inability to purchase sanitary pads, with women defaulting to cloth use. • **Reduced/cut-off supply of pads at point of purchase**: Supply and stock of sanitary pads was hampered, due to the COVID-19	• **Accentuated role of family members in fulfilling information needs:** Family played a critical role to fulfil information gaps created by lack of access to the provider ecosystem. • **Network of support in the community:** Social support from older women in the community was utilized in the absence of access to doctors/ASHA. • **Community support to make up for inadequate supply:** Women sought support from other women in the community to borrow sanitary pads from those who had ample stock.

lockdown, with women defaulting to cloth use. • **Limited mobility and fear of physical contact hampered information access from ASHA/Doctors.** Physical access to ASHA restricted due to limited mobility leading to lessened information access. • **Lack of care for severe reproductive issues:** In some cases, women did not receive care or treatment for RTI due to familial pressure of avoiding physical interaction with providers.	• **Habitual stockpiling protected some women from experiencing shortage of supply:** Women who were habituated of stocking sanitary pads did not face a supply issue through the course of the COVID-19 lockdowns. • **Leveraging technology to connect with FLWs:** Women with access to phones were able to maintain contact with ASHA/AWW in spite of the mobility barriers. • **Using any means possible to access PHC in close proximity:** Women chose to walk to PHCs located nearby, when they were unable to access other healthcare providers.

Discomfort, pain and irregularity in cycles are considered the 'active needs' related to menstrual health and hygiene in the minds of young women. Information and product needs are typically resolved on their own, or with the help of a family member/trusted peer. **For unmarried girls, the point of contact for information seeking was restricted to the mother/elder female family member.** Unmarried women's already limited interactions with ASHA (typically limited to group meetings), **was further restricted due to the absence of such gatherings during the COVID-19 lockdown.**

Information was sought from family members by young women on menstrual health for issues related to pain, excessive bleeding or delayed periods: Discomfort, pain and irregularity in cycles were the 'active needs' related to menstrual health and hygiene. Information needs were typically resolved with the help of a family member/trusted neighbour who could enable a solution *or access to a provider.*

I felt pain but people say it is due to winter season… But I thought I should go to doctor. However, I could not go doctor because of lack of transport facility." — YMW, P0, Madhya Pradesh

- **Some women were able to seek services related to menstrual health via telephone during the pandemic.** For young women, physical access to meet the ASHA were limited — however, they were able to find alternate means to reach out using a telephone or identify alternate sources within their ecosystem.
- Typically, minor issues were not seen as needing to be escalated. If at all, these would be shared with the mother, by unmarried girls and with the mother in-law/sister in-law/friend in case of married women. In some cases, the married women sought out the ASHA for information and small medication.
- Some of the women across centers reported issues related to their menstrual health & hygiene. Married and unmarried women both, had issues predominantly revolving around minor cramps, stomachache, backache/body ache issues, etc.

"I got blood discharge and had pain. I tried contacting the ASHA. Then she told Anganwadi madam and asked for medicine. Anganwadi madam gave me medicine. I had bleeding for 15 days. She asked me to eat vegetables, fruits and drink milk… We were contacting them from distance. ASHA sister came to my house but Anganwadi madam was not able to come to my house because of lockdown." — Married Woman, P1, Assam

Since information about hygiene practices and product use is typically received and assimilated through multiple sources (like ASHA's counseling, monthly meetings at Anganwadi centres, multiple SRH programs etc.) there is limited ability for women to recognize and escalate issues or seek information in the absence of these influences, making information a critical needs gap. As reported in their pre-lockdown behavior, most of the

women and young girls gained information about menstruation and hygiene passively while growing up through immediate ecosystem i.e., any woman member of the family or friend or through the meetings arranged by ANM/ASHA at the anganwadi center.

- **The change due to the pandemic, has been the sudden cessation of active engagement with ASHA & ANM:** Due to the lockdown and restriction in mobility there were no meetings held in the anganwadi center. In case a woman/young girl needed immediate assistance they either approached ASHA while she took rounds in the neighborhood or used a phone to make contact and discuss the issue at hand. It is to be noted that ASHAs themselves reported women tried to contact them using phones especially during the lockdown period.
- **The information cutoff (due to the pandemic) acted as threat to MHH behavior:** Typically, information on menstruation and hygiene and following the best practices was actively imparted during the meetings organized by ASHA. Because of this information cut off young women were compelled to start using traditional cloths instead of sanitary napkins.
- **Community support to access sanitary napkins:** Women generally procure sanitary napkins themselves (or in some cases ask their husband to bring them) from a general store or a pharmacy. During the lockdown, few women managed to stock big packs of napkins, while those who failed to procure them, approached and borrowed napkins from their friends and neighbors. In Jharkhand, it was reported that during the lockdown shops had established a 'backdoor' system which was used by the locals to buy different products.
- **Hesitation in asking male family member to procure products due to shame:** Unmarried girls reported shifting their preference from sanitary napkins to cloth as only one male member of the household was going out of the house to make purchases. Given that the male member was the brother, some young girls of Jharkhand decided to go back to traditional cloth.
- **Shifting preference due to financial reasons:** It was also inferred after probing that due to financial constraints it was difficult for young women to bear the cost of napkins and they consequently shifted to traditional cloth.

> *"I generally didn't get the napkins during lockdown. Everything was closed and pharmacy was also far from our place."* — YMW, P1, Assam

> *"But as now the situation is normal, and everything has started to open we are still not going to buy napkins due to lack of money… I faced problem to buy it. It was not available at that time and used to get finished quickly. Finally, I approached my neighbors if someone has more quantity."* — YMW, P0, Madhya Pradesh

Pregnancy & ANC Care

Table 4. Barriers and Good Practices in Pregnancy & ANC

CHALLENGES & BARRIERS	GOOD PRACTICES

ANC: • **Limited physical access to ASHA and PHC compromised quality and frequency of ANC:** Due to the lockdown and persisting fear of exposure (felt by either ASHA or the woman herself) there was limited interaction with ASHAs/public health system. • ASHAs not prioritizing early pregnancy, leading to ANC being concentrated in the last few months.	**ANC:** • **Community maximizing available resources**: In cases where the PHC was close, pregnant women visited the PHC in the last few months. In case facilities were not in the proximity, ASHAs became the only choice for ANC support. • Community's dependence on ASHA as a catalyst to public health became amplified. Even where ASHAs were not visiting PHC, some were able to navigate lockdowns to facilitate check-ups for pregnant women in the last couple of months.

- **Economic constraints led to compromised diet, nutrition and treatment:** It was inferred by talking to a few mothers that the economic situation of the less affluent households compromised the access to nutritious diet during the lockdown. In Jharkhand, a nurse from the facility used to visit the anganwadi center instead of women going to public or private hospital.

> *"I couldn't have a proper diet. I could not get a nutritious diet during my pregnancy because of lockdown. We had to make use of what was easily available at home." — YMW, P1, Jharkhand*

- **Restricted mobility & ANC**: With limitations in mobility due to lockdown young women were restricted to their household with no or negligible access to both public and private healthcare facilities. Further, the regular meetings and checkups held at the Anganwadi center through the course of pregnancy became limited. The limitation happened both due the pandemic as well the young women (and their family) restricting their movement.

- **Limited access to services and providers.** In cases where women were able to seek ANC at a facility, they experienced limited availability of doctors, and those who were present were not conducting any examination. It was reported by women that they were required to engage the doctor at government facilities from a distance, undergo some tests and then had to leave the facility quickly.

> *"Yes, there were few challenges. We had challenges of getting transport facility. I was facing difficulty in commuting via two-wheelers… Doctors were there. But they were treating us from a distance and were not touching us because of (fear of) getting infection… There was no facility to test our COVID status. They did not touch me. They checked my weight, urine, and BP."*
> *— YMW, P2, Madhya Pradesh*

In some cases, ANMs, Anganwadi and ASHA workers have continued to deliver immunization services to pregnant women during the pandemic.

> *"Yes, I got a few of the immunizations; ANM madam used to come and call us to Anganwadi Centre. She used to wear a mask and gloves. I got my first injection in the 3rd and then 6th month of pregnancy. — YMW, P2, Madhya Pradesh*

Delivery Care & Post-pregnancy Care

Table 5. Barriers and Good Practices in Delivery Care & PPC

CHALLENGES & BARRIERS	GOOD PRACTICES
DELIVERY • Familial pressure and fear of exposure of child to COVID-19 led to decision of home deliveries (particularly in Jharkhand) — family members insisted on home deliveries. **PPC & IMMUNIZATION** • Permissible duration at facility after delivery was strictly limited, leading to very minimal post pregnancy maternal and infant care.	**DELIVERY** • **ASHA's sense of accountability led to circumventing structural barrier:** ASHAs utilized their contacts with facility to ensure that transport was available to ferry women in labour to facilities for institutional delivery. • **Community support emerged as a supplement for public health infrastructure:** Solidarity within the community led to support from other members, to offer help and transport to facilitate delivery. • **Optimizing accessibility to available public health infrastructure:** In the absence of access to district facility, young women used the block facility or PHC as a proxy to ensure an institutional delivery.

- **Extreme fear of contracting the virus compromised pregnant women's care:** For most pregnant women, their mobility during the lockdown became more restricted owing to the fact that there was fear of catching the virus outdoors that will in turn put their and the child's life at risk. This restriction was seen to be monitored by the mother-in-law. The family of the pregnant women was seen to be more involved in providing them the necessary healthcare needs and any decision regarding the mother or child's health was taken by an elder member/husband.

- **With limited or no access to healthcare facilities the delivery experience route was altered – deliveries took place at home, in places where the hospital was too far to access in the lockdown; whilst in places with some scope for local mobility, deliveries occurred at sub-centre or PHC.**

  In Jharkhand, the fear of contracting the virus led to home delivery (family restricted to go to the hospital) instead of going to a PHC/private facility. In this case, a nearby child summoned the ASHA and explained the procedure to the MIL who performed the delivery at home. Even though ASHA insisted on visiting a facility for delivery, the MIL insisted to do it herself and at the home.

  In MP, considering the affluence level of the population there was no alteration in delivery experience wherein the woman delivered at sub health center or PHC.

"We didn't go to any hospital. I didn't face any issue as such. We called ASHA home. She asked my mother-in-law to let me go to the facility but she (M-I-L) said no. ASHA told her how to do everything and my child was born at home. I was not happy with the experience. There was pain."
— YMW, P1, Jharkhand

"I didn't feel satisfied. If it was at hospital, I and my baby would have had better health. We would have gotten some injections. I heard that you get shots for TB and all. That couldn't happen."
— YMW, P1, Jharkhand

"Because it was my husband's decision, we didn't want to take any risk, because private hospitals take much better care, government hospitals have many patients so they cannot take good care of all the patients. My son also had jaundice, after admitting him it was found out that he had oxygen deficiency also. So, he was treated there and he was released the next day after completing the treatment."
— YMW, P1, Assam

"It did not happen in the health centre. It happened in a centre at Block level, health centre. Everyone was going there... It is safe to have delivery there rather than at home. In case there is some problem then it could be taken care of there. And treatment was also free there.
— YMW, P1, Jharkhand

- **In cases where the ASHA took the onus of ensuring a facility delivery,** she coordinated with the facility to send a vehicle for a woman in labour, leading to a guaranteed delivery at a facility. **In this case, the delivery experience was comfortable as reported by women. In some cases, where government transport was not available,** transport was offered by fellow community members.

- **Post pregnancy care was compromised during the pandemic because of low awareness and access to immunization care:** In Assam, ASHA provided Mosquito net and iron tablets post childbirth, but there was no immunization. In Jharkhand, the children were not vaccinated during the pandemic.

"I delivered a baby during the covid pandemic. I didn't go to Sadhar (district) hospital because there was high chance of getting COVID infection. That was the reason I delivered baby at home. I couldn't get an injection, or medicine that I had to get after delivery. The same thing goes for my newborn baby." — YMW, P1, West Singhbhum, Jharkhand

Contraceptive Need and Information:

Table 6. Barriers and Good Practices in Contraception

BARRIERS & CHALLENGES	GOOD PRACTICES
• **Shifted priority of the health system:** Pharmacies were closed, facilities switched focus to COVID-19, initially ASHAs were unavailable, later they started focusing on pregnant women. Therefore, the unfulfilled need for information & product became amplified. • **Fear of exposure and restricted mobility:** Reduced accessibility to facilities, where long-term methods like IUCD, injectables could be administered, lead to lapsing from use of current method. • **Restricted mobility and financial constraints hindered ability to purchase short term contraceptive methods:** Stock shortage of condoms/OCPs primarily due to inability of young women (and men) to access pharmacies. In some cases, due to	• **Community played significant role as source of information:** In the absence of contraceptive methods, women sought advice from others in the family/community to learn about traditional methods • **Replacement of long-term contraceptive methods:** Short-term spacing methods were used depending on affordability and ability of women • **Stockpiling of condoms:** This ensured that couples had adequate stock of condoms available. • Young women attempted to manage contraceptive needs by replacing use of modern methods with traditional methods like calendar and withdrawal methods. • **ASHA as alternate source of procuring contraceptives:** Attempting to source OCP/condoms from ASHA when pharmacies were not accessible.

intense financial constraints, this purchase was considered as non-priority.	

- **At zero parity (P0),** there was generally a **mix of condom and traditional method users and lapsers**.
  - The reason for avoiding any long-term contraceptives at P0 was the family pressure to prove the fertility. The onus of decision making (to use the contraceptive) was in the hands of the husband.
  - In cases (across parity), where procurement of condoms became an obstacle there was an easy switch found in traditional methods like the calendar and withdrawal method.

"Since March we are using Condom... However, we don't use every time. If we use it once we won't use it next time." — YMW, P0, User, Jharkhand

- **At parity one and more** users seemed to interchange between multiple modern contraceptive methods (like condoms, pills and in some cases, injectables) and traditional methods, whilst lapsers had stopped usage entirely and were relying solely on traditional methods or no method at all. A woman was seen to be more involved in deciding the contraceptive method after having one child (P1 stage). Considering the lack of active counselling by ASHA, women who used methods interchangeably, showed behaviour of lapsing or complete dependence on calendar methods.

"I have not used my pills during lockdown… In fact, we stopped using any method." — YMW, P1, Lapser, Assam

"I couldn't get the injection; everything was closed so we didn't use anything." — YMW, P1, Assam
"I don't have sex for 15 days… Otherwise, I used a condom." — YMW, P1, Madhya Pradesh

Seeking Information:

- **The role of family members and spouse as primary sources of information with regards to usage of contraceptives intensified significantly due to lack of access to sources like ASHA, ANM, and doctors.** Consistent and immediate sources of information for topics of family planning seem to be leveraged as the primary information sources within the woman's home/familial ecosystem — such as Mother-in-law, Sister-in-law, elder women in the community or a friend.
- **Connect with ASHA and women in community led to adequate information.** The spouse, ASHA and other elder women continued to be in contact in-person or through phones during the pandemic. In case a woman was at P0/P1, private and the public health sector in most cases remained inaccessible (where a doctor/nurse can act as an information source).

"Sister "Asha" told me and explained to me about the Pill. I take pill after having my dinner before sleeping, one pill every night. I had it during lockdown so there was no problem." — YMW, P1, Assam

- **Women who did not have adequate information (and who are accustomed to interchanging between methods) lapsed from the usage of modern contraceptives, to using traditional methods, when stock ran out.** This was due to them not finding alternatives for the products they were utilizing**.**

"I got pregnant, while I was using condom… We did have sex without condom when there was no stock… Then I got pregnant". — YMW, P0

- **Lack of active information access made women (who used to interchange between methods) non-users of modern contraceptives.**

Service Utilization during Pandemic

With no alternate route to access healthcare facilities owing to restricted mobility, the role of ASHA was seen to have increased multifold and also seems to have replaced the load of health facilities. Restriction on mobility compelled young women to look for alternatives in their proximity. Visiting healthcare facilities like district hospitals or CHCs and PHCs or even the village healthcare facility became a concern. Government run vehicles like "Mamta-Vans" or “Ambulance-108” also were not functional which led to hassles like hiring private modes of transportation which were not cost effective. In exigency, few respondents mentioned that they travelled to the facilities on foot and some borrowed two-wheelers from either neighbors or relatives as the last resort. Keeping the mobility considerations in mind, ASHA’s role became more prominent where she was seen replacing public or private healthcare facilities.

However, the ASHA’s role as a central pillar in enabling service access for women appears to have intensified. Some women said that in general, ASHAs were well informed about SRH and other health issues and they even prescribed medicines to them. This had been true when a woman was faced with a general illness. In some cases, the ASHA even advised on the course of action when someone in the household would be faced with a minor illness. Some respondents said that for general illnesses, they visited the nearby private doctors. Some preferred the government hospital and some preferred private hospitals in order to avoid long queues at the government facility. The overall reliance on the ASHA for help, assistance, facilitation of mobility and access to the doctor appeared to have intensified during the pandemic.

> *“I went to the government doctor along with ASHA because I had fever, stomach pain and leg pain. When I went there the situation was quite different, because I had to first get myself tested for covin, and only when I got the test as negative, then I could meet the doctor.”— YMW, P2, Lakhimpur, Assam*

Accessing information and care for abortion-related services

It is known from previous experience that delivery of information and services related to emergency contraception and abortion care in particular are typically impacted by moral judgment from the provider (Doctor, Pharmacist, ANM/ASHA/AWW). In a pre-pandemic context, young women would attempt to identify pathways to abortion care that would be private, discrete and judgment-free. With a limited sample size, this study failed to capture the experience of women who accessed abortion services during the pandemic. However, this study captured their opinion on the access to abortion-related information and services during the pandemic.

The COVID-19 pandemic was seen to further limit the information as well as service options available due to structural barriers in terms of physical accessibility of doctors, pharmacists, and facilities along with limited mobility and pressing financial constraints. Since providers were mostly involved in the management of COVID-related activities, there was significant gaps in access to abortion-related information and services. As perceived by the respondents, to overcome this scenario young women probably attempted home remedies to manage unintended pregnancies or continued with an unintended pregnancy.

One study respondent from Madhya Pradesh spoke about her pre-pandemic experience with abortion. She mentioned that she would adopt other traditional methods of abortion first if a need arises during the pandemic. And she would only talk to a health provider if the abortion was not successful in her first attempt.

> *“I use to have tablet with water, 3 times a day and continued for 3-4 days. I didn’t know of these tablets earlier, madam told me. After having a tablet, I faced heavy bleeding... I don’t know much about abortion tablets. I know that if you take black tea with ginger, it prevents pregnancy.”*

"Some women don't believe in tablets. They get the cleaning done from the hospital. Some young girls do sex and get pregnant mistakenly. They get it cleaned in hospital. I have heard about them. If I require any abortion, I will drink black tea with ginger."
— YMW, P1, Satna, Madhya Pradesh

Utilization of abortion services during the pandemic as reported by ASHAs

ASHAs could not report many cases of abortion during the pandemic as they often remained unaware of the incidences of self-use of medical abortion. ASHAs could share just one side of the story as they were consulted only when women faced complications after taking tablets (MA drugs). As community health workers, ASHAs were not aware of the successful episodes of medical abortion. This often compelled ASHAs to not recommend tablets for abortion (without the guidance of a doctor), even during the pandemic, when the community faced difficulties to access a medical doctor. As narrated by an ASHA in Assam:

"We do not want women to take any chance and ask them to go for a surgical abortion at any health facility." — ASHA, Lakhimpur, Assam

A similar thought has been shared by one of the ASHAs of Jharkhand who felt **MA self-use in absence of access to complete information lead to complications,** and narrated a recent incident that she experienced during the lockdown.

"One of my friends took pills during the COVID crisis. It didn't work and caused bleeding. So, she had to rush for surgical abortion. She should have directly consulted the doctor in the hospital because pills could cause bleeding. I think surgical abortion is a better option because pills can have side effects on physical health." — ASHA, Jharkhand

ASHAs across the three study states reported their experience with MA. One ASHA from Assam mentioned how abortion with medicines is not as effective and therefore, patients are referred to the hospital for "surgical abortion".

"...Even this month I had one case. It was an incomplete abortion. So, we referred her to the hospital where the doctor did an abortion... The doctor also scolded me... As ASHAs, we are questioned, and I told the doctor that she did not consult me earlier. When excessive bleeding happens then they contact ASHA." — ASHA, Lakhimpur, Assam

Another ASHA from Jharkhand described a similar incident that she managed during the COVID crisis.

"...The couple didn't inform us and went to Sadar Hospital for treating complications. Sadar hospital did not take admission without ultrasound. The couple also visited private hospitals and were turned away. Finally, they returned back home and called me to inform me about the situation... I agreed to go with them, but we were delayed as the vehicle was not available. The couple had a shortage of money as well, so we arranged vehicle and money. I took her to Sadar and Arun, both didn't admit her. We took her to 3-4 hospitals, and finally admitted her in a private hospital. They admitted her at night and in the morning around 4-5 AM, they asked us to take her to another hospital. She took medicine without guidance of anyone... Her husband mixed the medicine with tea and she consumed it. She didn't take her meal and consumed medicine, this was the result for this entire problem... She is slowly improving now." — ASHA, West Singhbhum, Jharkhand

Thus, lack of access to safe providers during the pandemic not only impacted the utilization of SRH services, rather it aggravated the financial burden in case of treating post abortion complications.

Utilization of Emergency Contraceptive Pill (ECP) during the pandemic

Young women were predominantly lacking information about ECP as an option*:* Young women's knowledge and access to ECP appears to be dictated by the ASHA's proclivity towards recommending and supplying the same. Across the three states, there seemed to have a low level of awareness of ECP as a secondary option for women who had unprotected sex. In Assam, there was considerably higher awareness about ECP amongst users of modern contraceptive methods with a case of previous use experience. The women who followed traditional methods of contraception to prevent pregnancy were seen to have no awareness about ECP. Few women reported continuing unintended pregnancy due to the lack of any options during the pandemic.

Further, the provider bias or knowledge seems to determine information available to the young woman. With limited options available during the COVID pandemic, ECP was further amplified as an immediate need for young women. In Madhya Pradesh and Jharkhand**,** women expressed limited or no awareness of ECP which could have been a great support during the pandemic.

"Yes, the tablet is there. I don't know much as I never required that, but my neighbor needed it. My husband got that for her, so I know little about it. He got that and told, if it will be taken within 48 hours, then things get in control." — YMW, P1, Sarna, Madhya Pradesh

"I heard about it, but I don't know the name of the medicine. I heard of it while I was talking to other women. It is taken in an emergency."— YMW, P1, West Singhbhum, Jharkhand

"I used it twice to avoid unwanted pregnancy. ASHA gave me the tablets. I wanted to avoid pregnancy during the pandemic." — YMW, P0, Assam

Procurement of ECP has been a common concern as ASHAs in Madhya Pradesh and Jharkhand claim they do not stock ECP. However, ASHAs in Assam reported cases of ECP use. They reported women requested and asked them during the COVID pandemic and shared reasons for using it as well. In other centres, ASHAs reported that in case unplanned pregnancies occurred, women did go ahead and either procure MA on their own (that is, she was not involved) or she would advise them to continue her pregnancy. Thus, lack of access to ECP and related information has been a miss opportunity for young women who compelled to continue unwanted pregnancy during the COVID crisis.

2.3 Unfulfilled SRH needs during the COVID pandemic

This study also analyzed the SRH needs and gaps during the pandemic that were highlighted by study the study respondents:

	Needs	Unfulfilled Needs during pandemic
Young Married Women & Unmarried Girls	**Menstrual/Reproductive health:** Delayed periods, painful menstrual experience, supply of sanitary napkins, RTI/STI	1. Information regarding menstrual hygiene and care not available 2. Unable to access to ASHA for information 3. Supply of sanitary napkins hampered due to lockdown 4. No access to facility treatment of RTI 5. Lack of funds to procure sanitary pads
Young Married Women	**Contraceptive needs:** Unavailability of condoms or OCP; need for long-term methods	1. Supply of short-term contraceptive methods (condoms/OCP) 2. No/low access to health facility for long-term methods 3. Defocusing of ASHA on contraceptive counselling

	Emergency Contraception or Abortion: Management of unintended pregnancy	1. Unfulfilled need for contraceptive methods 2. Information about abortion due to provider bias 3. Supply of MA due to amplification of provider bias 4. Facility level access to facility for EC/Abortion
	ANC: Check-ups, supplements and immunization	Monitoring & care during early pregnancy/check-ups due to denial of care at facility or by ASHA
	Institutional Delivery: Timely and safe delivery at a facility	1. Delivery by doctor due to unavailability of personnel 2. Delivery at facility not possible in some cases 3. Duration of care provided at facility was hampered
	PPC: Post pregnancy care and immunization	1. PPC post-delivery not received 2. Immunization and nutrition support for infant

2.4 Barriers to Availability & Accessibility of SRH Information and Services

Given the unfulfilled needs to access to SRH related information and services, this study analysed multiple barriers that limited women's ability and affordability to seek information, care and products/services during the lockdown and subsequent unlock phases. The barriers are segmented into three broad categories, including social barrier, structural and financial barrier, and supply side barrier:

Social Barriers

- ➔ Subjective prioritization of healthcare needs in the household, with lesser emphasis on SRH needs
- ➔ Limited mobility compounded by confinement of woman to home due to fear of exposure to COVID-19
- ➔ Inability of young woman to seek help without assistance of a family member
- ➔ Inability of woman to identify severity of SRH concern to seek help

Structural & Financial Barriers

- ➔ Stringent mobility restrictions on population leading to reduced access to healthcare personnel & facilities
- ➔ Lack of availability of public transport to access facilities/pharmacies
- ➔ Inability to physically access healthcare centres or hospitals due to long distance
- ➔ Financial constraints due to loss of work leading to inability to purchase pads, contraceptives etc.
- ➔ Closing down of commerce leading to limited supply of products like sanitary pads, contraceptives etc.

Supply Side Barriers

- ➔ Lack of availability of doctors and staff at facility led to halting of standard services
- ➔ No physical access to ASHAs due to lockdown
- ➔ Fully or partly closed pharmacies due to pandemic and consequent lockdown
- ➔ Dedicated use of government facilities as COVID-19 centres
- ➔ Limited access to routine care (no physical check-ups)
- ➔ Limited duration access to facilities (quick discharge of women delivered at facility to prevent exposure)
- ➔ Delay in routine IPC or service delivery schedule of ASHA (of group engagement/immunization etc.)
- ➔ No or limited counselling for SRH issues

2.5 Overview of Good Practices

This section encapsulates the resilience and good practices adopted by young women and girls to navigate unfulfilled SRH Needs:

- Amplified role of family and community in providing information and support.
- Proactive support from trusted network of women within and outside the household.
- Persisting financial crisis and limited transport resulting in identifying alternative touchpoints for care seeking for SRH, including Rural Medical Practitioners (RMPs), ASHAs and private doctors.
- Amplified role of the ASHAs as the enabler for young women to seek information and services within available means.
- Leveraging technologies like phone and search engines to connect with healthcare providers and ASHAs for information and SRH support.
- Role of ASHA as back-up source of products like sanitary pads, condoms, OCPs, and ECPs.
- Exchanging essential MHH products like sanitary pads among friends and neighbours.
- Extended efforts by ASHA to ensure pregnant women receive adequate delivery support and care by establishing contacts between provider, ambulance, and pregnant women.
- Leveraging lower-level facility as proxy for district and sub-district level facilities for services like treatment of RTI, ANC, and delivery etc.
- Identifying alternative methods of contraceptives when LARC methods were not available: Clear shifting of long-term methods to short term spacing methods and traditional methods.
- Stock-piling of hygiene and contraceptive products at home to ensure adequate supply.

2.6 Immediate SRH Needs of Young Women and Girls

Stage/Need	Information	Services
Menstrual & Reproductive Hygiene and Health	Ability to identify and articulate the need for information & care with respect to menstrual health & hygiene and reproductive care.	Proactive communication from ASHAs or other providers on menstrual hygiene and prevention of RTI/STI.
Contraceptive	Access to information and supply of short-term and long-term methods of contraception.	Safe and convenient access to administration of long-term methods in a facility (village/block/district level).
ANC/Pregnancy & Delivery/ PPC	Information on maternal health, preparation for delivery, and critical milestones for seeking ANC. Information on improving maternal health post-delivery, with access to limited care post COVID-19.	Consistent and complete ANC & facility deliveries at a village/block level, in the face of apprehensions and restrictions in accessing distant facilities which may not be accessible due to a variety of barriers.

Abortion and ECP	Information on **sources and options** for seeking emergency contraception/ abortion services post COVID-19.	Destigmatized access to channels for accessing **timely EC or abortion** (medical or surgical) at multiple touchpoints such as **ASHA/Pharmacy**

"After having a baby, the body became very weak. The body was no more like what I had before..." — YMW, Assam

"...We have regular episodes like headache, irregular periods, white discharge for which we need support and care." — YMW, P0, Assam

"There are many problems, but the main problem is the monthly menstrual periods and cramps." — YMW, P1, Madhya Pradesh

"Sometimes I feel pain. I do hot water fomentation. I don't take medicines." — YUMG, Madhya Pradesh

"I don't know why I am getting this pain, but I get this when I am on periods. I can do nothing. I have to suffer what else can I do." — YMW, P0, Madhya Pradesh

"White discharge problem is there. We face issues because of not maintaining proper hygiene. We try to share with ASHA didi..." — YMW, P1, Assam

"Some women were not able to reach to any health facility at the right time during delivery and they happened to deliver baby at home. However, if we informed ASHA didi that I am experiencing labor pain, they can send vehicle from Sadar hospital. If ASHA didi has gone somewhere for some other work, we have no choice other than to deliver baby at home." — YMW, P1, Jharkhand

"For me, the condoms and 'Whisper' must be always available, that's all. Some women take contraceptive pills so maybe pills should also be available all the time." — YMW, P1, Assam

2.7 Provider's Experience and Opinion

2.7.1 Experience of ASHA during the COVID-19 Crisis

The prices of general commodities and food items had increased during the pandemic and it became unaffordable for majority of rural population relying on agricultural activities and daily wage earnings. Additionally, the restriction on vehicles and mobility added major threats and concerns for the utilization of SRH care and services. Along with financial distress, social distancing and restriction on gathering and interactions had made ASHA's work difficult. In fact, people wanted things to return to normalcy as soon as possible like, opening of markets, resumption of work.

"People were using their own savings to run the family. Rural population mostly relies on farming and they kept their grains and vegetables which luckily were the main source of livelihood during the pandemic". — ASHA, Chhatarpur, MP

ASHAs also shared about their own financial crisis during the pandemic which not only impacted their personal lives, but also restricted their ability to ensure all out support to villagers. One ASHA from Assam spoke about the financial crisis she faced because of irregularity in payments and people of her community helped by donating food and other provisions.

"During lockdown our personal life changed a lot. We faced troubles as we didn't receive money from the Government, but still, we helped the society. Some people helped me by donating food… We faced many problems as there were many cases during the lockdown. We get 3000 rupees every month which is very little to run a family..." — ASHA, Assam

A few other respondents too reported that they had to deal with financial instability and uncertainty and had to sustain their households with whatever was available with them in terms of provisions and savings. Despite doing their designated jobs, they were not being paid regularly after the onset of the pandemic. This transition also impacted their personal life and consequently their routine jobs.

2.7.2 Perspective of ASHAs on their own role during the First Three Months of Pandemic

- **Spike in workload immediately after the lockdown:** Some ASHAs reported that the workload and accountability increased immediately after the lockdown, particularly in April and May 2020. Post-lockdown a normalization process started gradually, although it was very slow.
- **Reaching out to beneficiaries:** Due to closer monitoring for COVID-19 related work, ASHAs were compelled to reach out to young women in spite of the fear of getting the infection through personal contact. As reported, their interaction with young women was greater than usual, given that they had to undertake door-to-door surveys to monitor COVID-19 symptoms and to spread awareness about hygiene and social distancing protocols.
- **The transition of work from non-COVID to COVID:** ASHAs across the three states reported that they were spreading awareness regarding the pandemic, the symptoms, the sources and how it could spread. They were also advising people to constantly wash hands, wear masks, socially distance themselves and stay indoors, and maintain proper hygiene and sanitation.
- **Used technology in place of face-to-face contact:** Some ASHAs however, had restricted the frequency of their visits to young women's houses in the **first three months of the COVID-19 pandemic** due to fear of contracting the virus and thus **interacted with young women over phone calls.** In some cases, the ASHA chose to visit the households after maintaining all protocols of social distancing.

"During the lockdown, as people contacted me, we talked through phones." — ASHA, West Singhbhum, Jharkhand

- **Increased workload led to increased stress:** Keeping a track of all ongoing health situations along with the pandemic and lockdown was reported to be hectic. A respondent from Assam mentioned that everyone faced problems during the lockdown because there was a setback in providing healthcare facilities while facilities were closed, and transporting patients using maternity vehicles known as *Mamta Vans*.

"During lockdown, we were doing a survey of people aged more than 40 years. We recorded people with critical diseases, including diabetes, cancer and TB etc. This has happened in the lockdown." — ASHA, West Singhbhum, Jharkhand

- **Workload had relatively increased because they had to assess COVID status** along with their previous allotted roles and responsibilities such as assisting pregnant ladies, advising them, accompanying them to health facilities. They also had to monitor the status and number of COVID infections, check who was coming in and going out of the village along with their medical status. ASHAs had to do all these works taking full precautions like sanitizing and wearing masks and amidst their own personal fear of contracting the virus.

"We had to check the people who would come to the village from outside. We also had to provide reports of every single day. I had to monitor who is going out of the village and who is coming inside

the village and when and at what times. If someone would come from outside, then we had to check his medical status and symptoms." — ASHA, Chhatarpur, MP

2.7.2 Perspective of ASHAs on their own role during the unlock phase of pandemic

- **ASHAs were the backbone of community:** In the pre-pandemic context, ASHAs believed that while their core role has been focused on the health and well-being of women of reproductive age and they focused on pregnant and new mothers; the community approached them for all kinds of healthcare needs. With transition in needs during COVID-19, ASHAs subjectively prioritized their roles. Even though, the core focus remained pregnant women, and new mothers (and their infants), followed by married women of reproductive age.

"For one month ASHAs were not supposed to work but we were told that if someone is facing problem and not going to hospital like pregnant women, then we can go with her if the car comes from hospital. I sent two women to the hospital. But one refused to go without me. Finally, I had to go. This happened in the month of April 2020."
ASHA, Satna, MP

- **Resumption of ASHAs core role:** As lockdown lifted and restrictions were slowly removed, the resumption of ASHAs' work has begun with a focus on pregnant and new mothers (and infants) followed by resuming interaction with women who have contraceptive needs. At the time of this study (December 2020), the ASHAs started conducting group meeting while keeping social distance at the Anganwadi centres. However, the attendance continued to be lower, primarily for pregnant women coming for the check-ups and new mothers for supplements and vaccination of infants.

"Even in my area few beneficiaries came forward to do laparoscopy. We also started our routine immunization for the children and mothers, and we guided them to follow a healthy diet according to their health situation".

- **ASHAs started offering information and products:** ASHAs reported that they stock a variety of items like OCPs, Condoms, Pads, Zinc/Iron/Folic Acid supplements. In some cases, these are provided by the ANM, and in some cases they have purchased and stocked these items because of the needs of their young women. They were able to utilize these stocks during the pandemic, ensuring provision of basic items even as shops and pharmacies were either closed or inaccessible due to restrictions on mobility.

- **Little or no attention paid to unmarried girls:** It was worth noting that ASHAs rarely mentioned about the SRH needs of unmarried girls as their target stakeholder. They refer to pre-COVID efforts related to counselling on hygiene, but none of them included this in their work description during COVID-19.

2.7.3 Barriers and challenges faced by ASHAs and sustained impact of COVID-19 on their Roles & Responsibilities

Barriers and Challenges to ensure Routine Activities

➔ **Complete lockdown for initial two months with** no physical access to community.
➔ **Their own fear of life to visit facility for deliveries** led ASHAs to use their contacts and influences to arrange transport, but avoid traveling with beneficiaries.
➔ **Facilities functioning as COVID-19 centres**, discouraged ASHAs from bringing in women for any procedure.
➔ **Over dependence of community on ASHAs** causing stress and physical exposure.
➔ **Myths and misconceptions of community members** with the worry that the ASHA would be the major source of COVID-19 given her wider social interactions and engagement with different patients.

- ➔ **Assisting home deliveries** at the insistence of the women's families has been a new domain for ASHAs.
- ➔ **Lack of transport support** appeared to be a barrier for ASHAs to establish contact with health facilities.

Sustained impact

- ➔ **Resumption of physical community engagement by ASHA has been largely focused on pregnant and new mothers.** Focus on the whole domain of SRH for young women and girls, was not considered as an urgent need. It will take time to restore the complete support system.
- ➔ **As lockdown lifted, ASHAs began to accompany women to facilities for delivery.** Owing to their role in facilitating delivery ASHAs have either began to accompany women to facilities, or have enabled delivery at PHC with the help of the ANM.
- ➔ **ASHAs continue to interact with young (married) women over the phone** as a result of momentum gained during COVID-19.
- ➔ **Social distancing and sanitation protocols are now part of regular group meetings and IPC.** A lesser number of women are being aggregated by ASHAs to ensure social distancing and to combat spread of infection.

"Mamta Van (ambulance) was stopped in the lockdown. It has started again in November. When patient experienced pain, we called the Van immediately." — ASHA, West Singhbhum, Jharkhand

"We are organizing meetings to advise women of all ages about pregnancy and how to take care of their health." — ASHA, Nagaon, Assam

"All the private hospitals were closed; treatments were not happening. Only the Sadar hospital was operational. However, those whose Corona test was not done, were not allowed to get admitted." — ASHA, West Singhbum, Jharkhand

2.7.4 ASHA'S Perspective on Information Seeking and Service Utilization of Young Women

- ➔ **Restricted utilization**: ASHAs reported that hospitals were far off and were providing limited services. Due to COVID-19 management, patients were not being examined physically, or being permitted to stay. This proved to be a challenge. Further, according to them, young women were also hesitant to reach out to facilities due to the fear of getting infected and were feeling that they would be quarantined if COVID-19 was suspected. This fear impacted service utilization significantly.

"Suppose if someone had labor pain, we needed a vehicle to take her to the hospital. So, at such times we had to wait to take the patient to hospital. Also, there was no scope of staying in hospital. So immediate after delivery patients were dropped back to home." Because there were COVID-19 patients in the hospital. So, it was safer to ask the women to go back home." — ASHA, West Singhbhum, Jharkhand

- ➔ **Nurses and ASHAs emerged as proxies for doctors:** Nurses and ASHAs stepped in during lockdown to facilitate institutional deliveries. In some cases, ASHAs were unable to arrange for pregnant women being taken to hospitals so they took them to PHCs for deliveries. Here, the ANMs stepped in to conduct deliveries in facilities. Meanwhile, other young women found access to private vehicles and visited the hospital without the support of the ASHA as well.

"We always could not take pregnant women to the urban hospitals. We took them to the health centers where they delivered babies under the supervision of ANM. So I arranged the car anyhow and took them to the health centre."

"Transport was big issue. So, I told them that if you want your delivery in the hospital then you have to pay your own money for the vehicle. So, some of them arranged for vehicles to reach the hospital. I didn't let anyone's delivery happen at home." — ASHA, West Singhbhum, Jharkhand]

➔ **RMPs & Quacks played important roles to fill the gaps:** In case facilities and pharmacies were inaccessible for young women, ASHAs report that there was an increased dependence on alternative providers like RMPs and *quacks* for basic healthcare for all family members, especially women. This was compounded by the fear of the community to step outside their homes. Quacks visited homes and provided basic medicines—as per ASHAs, they have gained the most from COVID-19. In some cases, young women sought the assistance of RMPs for menstrual issues, as well as for RTI. **Although, ASHAs were not very positive towards their role during the pandemic.**

"They (Jhholachhap & quacks) are the ones who have earned the real money during this lockdown. In the beginning people were refusing to leave their homes and go to see the doctors, because they were afraid. These guys started visiting homes and gave medicines and when something went wrong people came to us." — ASHA, Satna, Madhya Pradesh

➔ In cases where the PHC was located close to homes, young women have consistently been able to visit centres to seek medical assistance between May to December (with March-April being months of total lockdown). Here, they were able to interact with the ANM or the ASHA and resolve urgent healthcare needs.

2.7.5 ASHA'S perspective on unfulfilled SRH needs for young women and girls

COVID-19 has compounded young women's and girl's abilities to seek SRH related information and services:

- A critical point made by ASHAs across centres is the increased apprehension in the community, and therefore women's hesitation in addressing issues with ASHAs, to avoid visiting facilities or PHC.
- They now have to work harder with young women to build comfort and understanding, to get them to talk about their concerns especially about contraceptive and family planning needs.
- This is further exacerbated by the fact that women only felt comfortable talking to ASHA but did not feel the same with other healthcare providers.
- **Increasing unfulfilled needs for contraceptives:** In Jharkhand and Assam**,** ASHAs revealed that they witnessed greater instances of women visiting them to enquire about abortions, emergency contraception, and contraception, respectively.
    - In Assam, ASHAs were aware and were able to provide ECPs to young women and reported that there was a greater incidence of them having to give ECPs during lockdown.
    - In Jharkhand however, ASHAs did not report knowing about or stocking of ECPs, and were proactively discouraging abortions, claiming that they did not have access to MA kits either. They stated that in typical situations they would be referring young women to a facility for an abortion, **but since this was not possible, women either procured MA through their own means or had continued to carry the pregnancy to term.**

"In this lockdown? More of lovers, women who wanted to control pregnancy and wanted abortion had come more but as there weren't such facilities available at that time we could not provide them with such facilities. We got more women coming for abortion." — ASHA, West Singhbhum, Jharkhand]

"During COVID crisis, more of women who wanted to control pregnancy and wanted pregnancy termination had come. However, we couldn't help them all because of lack of functional health facility… They also

mentioned that their husbands did not understand the risk of unwanted pregnancy. Women wanted to maintain a separation as their children were young." — ASHA, West Singhbhum, Jharkhand"

"When they got pregnant, they were afraid to ask for abortion. Some newly married women didn't know when they got pregnant." — ASHA, West Singhbhum, Jharkhand

"There were problems. When the things were available, like condom, Mala N, they were given to those who needed. If not available then there was problem, because there was no supply." — ASHA, Satna, Madhya Pradesh

"People mainly came looking for condoms or napkins during the lockdown". — ASHA, Nagaon, Assam

2.7.6 Current Scenario, Future Role, Expectations and ASHA's Suggestions

ASHAs across the three states mentioned that the services they provided before pandemic have returned back. And facilities have resumed functioning the way they did before the pandemic. This has restored some semblance of normalcy in the minds of the young women as well.

"There is everything alright now in this month of December. The shops have opened now. The Mamta Van also started running. It has been running for the last two months. We can see that our core role has returned back." — ASHA, Nagaon, Assam

- In Assam, one respondent mentioned that the workload would increase in future and they will be allotted more tasks of assessing the status of various other illnesses along with routine jobs. Another respondent hoped not to be unnecessarily burdened by the government in the future.

Moderator: "What do you think your future role will be?"
Respondent:" I just hope the government doesn't give us an unnecessary burden - we already have enough on our plate. It's really hard to manage." [ASHA, Lakhimpur, Assam]

Moderator: "Do you think future duties of an ASHA will change?"

Respondent: "Yes, it will. In the future we will have to do more tasks, we might even have to look after other diseases after the normalization of pandemic. Maybe in the future, the whole village will be dependent on the ASHA." [ASHA, Nagaon, Assam]

- In Madhya Pradesh and Jharkhand, most of the respondents said that there would not be any stark difference in their workload or role. They would be dealing with similar young women that they were dealing earlier. Some of them also mentioned that since the world is progressing towards all out development, young women would also be more informed.
    - One of the respondents also mentioned that if the women applying for an ASHA job are more educated, they might get the role of a supervisor in future

- One of the major suggestions provided by ASHA was that the medical practitioners and providers should recognize and understand the specific needs of women and listen to their problems.
    - One ASHA from Assam suggested that we must collectively unfollow a few cultural practices that could sabotage the health of pregnant ladies. As per her opinion, health is more important than religious and cultural practices. Others said that ANMs and AHSAs should organize meetings and clarify the need specific doubts of young women in an easy and comprehensive manner and create a safe space for them so that they can talk about issues like abortion freely, frankly and clearly.

- Few also felt we should have some long-term thoughts and training to cope up with any unexpected exposure of pandemic.

2.8 Perspective of Pharmacists on their own role during COVID-19 Pandemic

Profile of respondents

- **The pharmacists interviewed have been in business of selling drugs for between 10-20 years.** One of the pharmacists interviewed in Jharkhand **turned out to be a quack who also had set up a small chemist-like shop**. He opened his shop once or twice a week, and mostly conducted home visits in around 6-7 villages during the pandemic. In addition to supplying medicines, he diagnosed and prescribed medicines for young women and administered injections and performed minor surgical procedures (such as pus excision) as required.

"I also travel 8 km to check up people, some people call up and ask me for things like stomach pain, child not feeling well. Sometimes people do not have any things to travel. So, I visit them... Today morning I visited a young woman whose menstrual bleeding was not stopping. I gave her a medicine and gave her an injection as she was feeling weak." — Quack, West Singhbhum, Jharkhand

- The other pharmacist interviewed in Jharkhand had informal connection with a gynecologist who works at the government hospital. This gynecologist visits his shop for a fixed duration (1-2 hours) on a daily basis to consult with woman patients. This draws his woman customers to make purchases whilst they visit to consult the doctor.
- They all stock items related to women's SRH needs including sanitary pads, pregnancy testing kits, condoms, and OCPs.

2.8.1 Experience of the Pharmacist and Challenges perceived during the Pandemic

- **Business was first closed, then limited, and then resumed as the lockdown progressed.** In the initial **two months of lockdown,** pharmacists across the states were either completely closed or were operating for two hours at a time (depending on the mandate of the local guideline).

"*Yes I've faced a lot of financial problems and I am still going through those. I am unable to make the same amount of money as I did earlier. The situation is yet to be fully normal. Now it's like 80 percent normal. I could not open the pharmacy for 3 months so then I didn't have any income."*
— Pharmacist, Goalpara, Assam

- **Life as usual has resumed for young women according to the pharmacists in Madhya Pradesh and Jharkhand, but the reduced demand during the lockdown has led to reduction in business for the pharmacists.** Though medicines continue to sell, especially for young women who consume medicines for chronic illnesses and have regular subscriptions, sale of items like condoms (which can be bought from general stores and are distributed free by ASHAs) and cosmetics has seen a reduction.

"Yes, it affected the sales a lot. It reduced out sales by almost 50%. Young women and girls, who stayed nearby stopped coming to medicine shops, which impacted sales."
— Pharmacist, West Singhbhum, Jharkhand

- For the quack interviewed in Jharkhand, business not only sustained, but thrived as more people were wary of visiting facilities and getting forcibly quarantined even if they had symptoms of a regular cough or cold. For him, business has continued to grow through the pandemic.

"Almost 5-6 calls come daily. They call me daily, as such no impact at all."

- According to pharmacists, their operating hours have resumed to normal, and it has been the case since July 2020.

"After July, I kept my pharmacy open full time from morning 8 am to evening 6. Now my pharmacy is always open. I open at 7am and close it at 9 or 9.30 pm."

2.8.2 Interactions with young women during pandemic

- **Across the states, pharmacists claimed they are visited mostly by men and a smaller proportion of women.** The pharmacists feel that women 'go to the ASHA' for their healthcare needs, so they would not require visiting the pharmacy for any reason other than purchase of a certain medicine. **An exception to this is the pharmacist in Jharkhand** who has tied up with a government hospital doctor to conduct OPDs from his shop, which he refers to as a clinic. He claimed that his clientele was predominantly women who purchase medical and general items when they visit the doctor.

- **During the lockdown, women were able to navigate mobility restrictions with greater ease than men. In Assam, the interaction between pharmacists and women actually increased.** In Goalpara, police were being very stringent about movement across towns, so women procured items like birth control pills, pads etc.

"Mostly males used to come to my shop. Females however came to my shop during the pandemic. They mostly came to buy birth control pills; females didn't face any difficulty to come to my pharmacy because the police won't stop them."

- It was reported that women from adjacent villages were no longer visiting the pharmacy as actively as before. That reduced a significant portion of the young women leading to reduction in footfall.

"Village women were not coming during lockdown. We lost around 40% of our customers. So less number of people are coming even after unlocking phase."

2.8.2 Perspective on information seeking & service utilization

- Pharmacists in Madhya Pradesh & Jharkhand reported that government healthcare facilities had limited services available, with lesser doctors available and those present not spending time with patients due to the fear of COVID-19 exposure.

M: "Do you find a difference after the pandemic?"
R: "Here doctors have reduced. Where there should be 11 doctors there are just 2."
M: "Okay so that's why people are not getting treated properly due to less doctors."
[Pharmacist, Chattarpur, MP]

- According to the pharmacists interviewed, the husband is the primary source of providing access to information, SRH services and products. **The only thing women purchased themselves from pharmacists was sanitary napkins,** which have not fallen short in supply through the course of the pandemic. Further, the needs that the husband cannot fulfill are taken care of by the ASHA, who, according to them, is stationed in the villages for the benefit of the young women.

2.8.4 Perspective on unfulfilled needs

- **Following from the points made in the previous section,** along with the fact that pharmacies remained open through the majority of the COVID-19 period (except for the initial lockdown); pharmacists did not perceive any unfulfilled needs among young women and girls in terms getting access to information, care

and products. Pharmacists however, recognized the reduced capacity of health facilities to ensure support and quality of care for young women and girls.

"…This is an interior area, most women don't come, and go for home remedies. If they come to the hospital, then they come here with a prescription. Usually, men take things on behalf of the women." [Pharmacist, Chhatarpur, Madhya Pradesh]

- **As for unintended pregnancies,** all pharmacists stated that they do not stock medical abortion kits. They were quick to point out that medical abortion requires a doctor to prescribe and administer, and that they could not do so as they were unqualified. Further, the pharmacist in Madhya Pradesh stated that in case women approached him with the need to tackle an unintended pregnancy, he would first ask for her husband's consent, and advise her **against abortion as it is seen as a crime against an unborn child.** Further, he stated that in case the woman was desperate, he would direct her to visit a healthcare facility for her requirement.

"No, apart from abortion, I have all kinds of medicines in my pharmacy that would be required by people in this area. I tell them please don't mind, I am not allowed to do abortions in my pharmacy, you should go to the hospital and consult a doctor for this."

- In Assam, the pharmacist has a tie-up with the ASHA to procure and stock condoms free of cost, in case young women are unable to procure them from her.

"They come for birth control pills because now people do not want to have more than one or two children, so they take birth control very seriously now. The ASHA workers also give me condoms and ask me to give to people free of cost who cannot afford it. So, I give it for free and then I write it down on a register which is provided to me by ASHAs themselves to keep a record of how many free condoms have been distributed. So, through me the poor people who cannot afford can get free condoms or other medicines." — Pharmacist, Goalpara, Assam

CHAPTER 3

DISCUSSION & RECOMMENDATIONS

3.1 Discussion: Capturing Key Shifts post COVI-19 in the lives of Young Women

This section captures key shifts and changes experienced by young women as described above. These are meant to serve as thought starters for ideation when it comes to the next phase of the program.

Need gaps emerging from discontinuation of positive SRH behaviour rather than infrastructural gaps: Except for hesitation in visiting healthcare facilities, need gaps that emerge across SRH **information, products and services** are results of behavioral changes caused due to the lack of mobility and interaction with healthcare touchpoints during the pandemic. In terms of programming, it is necessary to encourage beneficiaries to resume all pre-COVID programming with rigour to ensure resumption of communication and sustenance of positive SRH behaviours that may have discontinued due to lockdown and unlocks, as normalcy resumes in all other aspects of life.

Information Access:

- **Overall, the information need gap appeared to have widened for issues of menstrual hygiene, especially for unmarried girls; and contraceptive usage, especially for P0 or P1 women**. This is based on the fact that women, though they are not seeking information proactively, are impacted by proactive communication by the ASHA, which stopped during the early stages of lockdown.
- Though this access is reported to be resuming, ASHAs' focus on pregnant women and new mothers seems to have remained even as normalcy is resumed in everyday life. For example, in meetings being conducted with social distance, their focus remains on bringing pregnant and new mothers to attend, and not necessarily pushing the rest to join.
- This is a critical area of concern in terms of inclusion of other young women like newly married women and unmarried women.

Product Access

- In cases where the dependence was on ASHA for stocking SRH products, stocks running out had been a concern for young women. Whereas, for women who have made purchases directly from stores/pharmacies (or whose husbands have procured sanitary pads, condoms or OCPs), item stock has not been a need gap.
- Especially amongst mixed method users (traditional + modern contraceptive use), the availability of an alternative has discouraged them from making the effort to **procure condoms or OCPs; or renewing injectable doses at facilities,** with them defaulting to using traditional methods of contraception. This is certainly a cause for concern, in that it would reverse adoption of modern methods, and would require programming to encourage positive disposition towards modern over traditional methods of contraception.

Service Utilization

- In terms of healthcare facility access, the lockdown and following paranoia about COVID-19 exposure has reduced the overall propensity of men and women to access government healthcare facilities. This led to one of three outcomes:
  - i) Preference for a locally available private (formal) doctor on-call
  - ii) Reaching out to alternate routes of healthcare services like quacks, traditional/naturopathic doctors, village priests etc.
  - iii) Avoiding access to healthcare facilities

ASHAs & Pharmacists — Role of Alternate Touchpoints

- **Evolving role of ASHA:** The ASHA's role has become multi-fold and dynamic. ASHA is seen by women, men, pharmacists and ASHAs themslelf as the primary and most consistent touchpoint for a woman's information and product needs.
- **Virtual ASHA - Leveraging the availability of phone calls:** It appears that young women have established not only physical but virtual connections with ASHA. The ASHA has continued to engage with the community through the course of the pandemic and has facilitated institutional deliveries for women.
- **Pharmacists have served as information sources and as interface for ASHAs and medical practitioners, and are resuming their business with pre-pandemic frequency and intensity:** This is an opportunity to leverage pharmacists as standardized information source as well as a medium to direct young women to ASHAs or doctors, as required in order to maintain the information-service continuum when it comes to SRH needs and behaviour.

3.2 Recommendations

As restrictions imposed during the lockdown are slowly being relaxed and providers also reportedly resuming their normal health care services, it is critical to attempt to bring supply-side efforts at par with pre-COVID levels. It is equally important to encourage young women and girls to seek SRH healthcare without fear or hesitation. Specific areas merit further attention to build SRH services for young women and girls in particular.

The recommendations to cater to young women's SRH needs, need to be rooted through ground reality. That is, they must be rooted in their context, and must actively account for pre-existing vulnerabilities that have been exacerbated due to the prolonged COVID-19 pandemic**,** by way of curbs on mobility and social interaction, financial limitations etc. Programs that cater to the needs of these women, in our view, must factor in the value of good practices already adopted in the community, and find a way to formalize, legitimize and support these practices.

Thus, the following recommendations are based on three critical pillars that constitute the young woman's SRH experiences:

Individual level

1. It has been seen that women's articulation of their problems and their narrative description of their SRH issues differ vastly. This leads to the understanding that unless there is a substantial degree of severity, SRH problem identification and knowledge of the right time and place to seek care are barriers to information and service seeking amongst young women.
2. At present, the efforts to ensure **access to information and services** focus on imparting best practices and solutioning for SRH issues, but it is our belief that there is a need, now more than ever, to **take a step back** and enable young women to **acknowledge, recognize and report** issues **in order for them to receive appropriate care.**
3. This may be achieved by **dedicated individual or collective outreach to young women,** starting with early adolescence up to late stages of parity, after marriage.
4. Based on the experience of pandemic we should encourage young women and girls to establish contact with providers, particularly ASHAs, over phone. In future, mobile phone can replace the need of face-to-face contacts for majority of normal SRH related issues.

Family & Community

This study has reiterated what we learned in previous studies—that young women communicate with experienced women within the family and community. Here information exchange occurs in a **comfortable, safe and reliable** environment. This merits programmatic attention, given that such conversations currently occur in pockets and would need collective attention in order for them to be **of value to young women.** This includes:

1. **Paving the way — Amplifying interactions between women in the community:** Communication campaign at a community level to **encourage judgment-free communication between older and younger women** building upon existing networks of older (P2+) women.
2. **Platform Building — Legitimizing interactions between women:** The next step would be to utilize these informal networks as active information channels, and encourage older, experienced women to be touchpoints for younger women to assist with SRH information/ resources. This legitimacy may be brought in by creating **platforms similar to SHGs, focused not on finance, but on sexual and reproductive health as a critical component of a woman's life.**
3. **Formalizing the platform:** If feasible, it is recommended to institute **a community-based cadre of older, more educated, and experienced women** to formalize imparting of SRH information to young women (married and unmarried) to ensure adequate support and the ability of young women to gain access to SRH services.

Community Intermediaries (ASHAs)

It is clear that the ASHA is a respected and trusted source of healthcare related information for young women as well as other younger and older members of the community. During COVID pandemic**,** ASHAs have been seen to spread themselves thin and extended their role to support women and other members in multiple ways, leveraging their **contact with the healthcare system.** The below recommendations are focused on recalibrating the workload of ASHAs as well as recognizing **human effort** to motivate delivery and **ensure that their work reinstates focus across stages of SRH needs:**

1. Social and emotional recognition and acknowledgment of the role of the ASHAs in the community to **motivate consistent delivery of information and services. During the pandemic, they were the only health care cohorts who remained active throughout the pandemic.**
2. Connecting young girls and women with ASHA for their SRH needs. ASHAs accountability is overwhelmed with pregnancy related issues and institutional delivery and immunization. With this work pressure, ASHAs often got disconnected with the SRH needs of young women and girls.
3. **Build upon the accessibility of ASHAs** as the custodian of healthcare in the community and her ability to connect with beneficiaries via technology **(contact through phone).**
4. Encouraging outreach by **unmarried** girls and young married women to engage with the ASHAs.
5. Systematizing **stocking of SRH products** (sanitary pads, OCPs, Condoms, ECP) given the community's dependence on ASHA as has emerged during the COVID-19 pandemic.
6. Providing for **physical support** to **ease the burden** on the ASHA by introducing a provision for the older, experienced ASHAs to train and build capacity of younger, less experienced ASHAs at a village level.

APPENDIX

APPENDIX 1: Observations about Geographical Locations

A few key observations about the locations were gathered via our local field team representatives and interactions in the three centres i.e. Assam, Madhya Pradesh & Jharkhand.

A. Assam

District: Goalpara, Block: Lakhipur, Villages: Folimari & Manaspara

a) In the villages selected, the livelihood of people mostly depends on cultivation, rest are skilled workers and petty traders, and small shop owners.
b) In Folimari, there is a dominance of Muslim population and some of the people belong to different communities. Manaspara has a more affluent population of residents with a mixed population of Hindus & Muslims.
c) There is a PHC situated in each village. However, in case of serious ailments the inhabitants visit the 'Goalpara Rural Hospital'.
d) There is a mix of population who has access to personal vehicles or use public transportation system like auto, toto and other private vehicles.
e) Most of the children go to 'Folimari village primary School.' Since Manaspara village has no high school students attend the high school located at Folimari— 'Folimari High School.

District: Nagaon, Block: Bagiagaon, Villages: Samaguri, Baghborali

a) In the Samaguri village, most of the inhabitants are Hindu and remaining belong to Muslim and other communities. Most of the population of this village is seen to be engaged in small businesses (some men posted outside for work).
b) In this village, there are five government lower primary schools and private primary schools. The village is famous for organising Cultural programmes on every occasion with special focus towards Bihu.
c) BPHC is situated right next in the Samaguri village. Ambulance facility is available in this health centre. There are five famous medical stores situated opposite the hospital. Beside these stores, there are 2 medical stores located at the Samaguri Auto stand. The transport system to and from the village is satisfactory.
d) 'Baghborali' is the last village of the Samaguri GP with an approximate population of 1500. It is the highest populated village in Samaguri GP. The village is situated 8kms away from the 'Samaguri' Auto stand.
e) The village is dominated by the Hindu community. The Muslim and Christian population live in the eastern part of the village. Most people of the village depend on farming as a source of livelihood, while some villagers leave the village to take up outside work.
f) With only one lower primary school in the village most of the students receive their education from 'Samaguri' village school. After passing the LP school they continue with their education from middle school which are situated in the corner of the village.
g) There is one sub health center in this village. If the villagers want to go outside the village for health treatment, they visit 'Samaguri Block Primary Health Centre'.
h) Transport facilities are below satisfactory and accessing transport post sunset is an ordeal.

B. Madhya Pradesh

District: Chattarpur, Block: Bijawar, Villages: Panagar, Ragauli

a) Both the villages covered are dominated by Hindu population. In the village Panagar, majority are from the Chaurasia sect within the Hindu population.
b) The population resides in pukka houses across villages (closely attached to each other) with small shops scattered across the villages. The main source of income is from agriculture or labour related work. The market located in Bijawar and Mati Gaon market (approximately 28kms away from Chatarpur) are the main markets where the inhabitants of different villages go for shopping and other needs.

c) Panagar village is approximately 48kms away from the center Bijawar and there is no fixed tempo/auto stand outside the village. The timings of buses, autos, etc are fixed and the access to the same stays limited along the day. There is a prevalence of 4-5 quacks across the village; but no healthcare sub-center.
d) Unlike Panagar, Radoli village has an auto/tempo stand and better transport connectivity till the main center. The youth population of the village regularly travels to Chattarpur for daily wage and skill-based work. There is also a small health sub center located in the village where the population access healthcare needs.

District: Satna, Block: Maihar, Villages: Dolni, Pipri Kalan

a) The villages have mostly 'pukka houses' (the houses are not attached to each other) and a good supply of electricity, water and other amenities. The population is dominated by the OBC and SC category wherein the predominant source of livelihood is agriculture, small shops (of tyres, general stores, etc.), and labour work.
b) Both the villages are approximately 10-12 kilometers away from the center and the locals usually travel by 3 wheelers (local conveyance) between 8:30 in the morning to 5:30 in the evening. Post evening, the public transport facilities are limited and not easily accessible.
c) The locals mostly travel to Maihar's health center to avail medical facilities. However, there are small medical shops and quacks available in the villages.

C. Jharkhand

District: West Singhbhum, Block: Sadar Chaibasa: Villages- Khunta, Teka Sai, Dobro Sai, DiliyaMarcha, Nakhasa, Kapar Sai

a) The district West Singhbhum is an Odisha bordering district with Chaibasa being the headquarter block. The district is an underdeveloped area dominated by tribal population (with penetration of naxals in a few areas). The commonly spoken language across the region is *Ho.*
b) Most of the men earn their livelihoods working as manual laborers in nearby mines. Agriculture activities are limited due to barren lands and forest surrounding the region. However, some women were seen to be active and involved in small and limited agriculture activities.
c) The houses across the villages are not very close to each other and each village is at average distance of at least 4-12 kilometers from the headquarter center.
d) For healthcare needs, locals are solely dependent on Sadar Chaibasa Hospital (PHC). The hospital caters to all healthcare needs, considerably at a minimum cost.
e) ***'JharPhoonkh'*** is considered as one of the sources of medical treatment by the local population.

APPENDIX 2: Behaviour towards Family Needs during Covid-19

Any formal healthcare provider like a government/private doctor is the most desired for family members' healthcare needs. For women's health concerns, information and services are typically sought from informal providers like ASHA, traditional health practitioner and ANM before deciding to visit a formal provider (doctor). Women's healthcare needs appear to be lower in priority over child's health and that of the family's in the minds of both the family and women. There is a belief that a woman's ill health affects the smooth functioning of the household, making it crucial to address her healthcare needs.

M: Who takes the decision regarding financial expenditure and all?
R: Father takes. — Unmarried girl, Assam

M- Who pays the money for the health related expenditures in your family?
R- My husband. — Married, P2, Assam

M- Who takes the decision to go to the doctor in the family?

R- All of us have the same option, we always consult a Doctor when any of us face any health issue. My husband mostly takes us to the hospital and sometimes we go by ourselves too. — Married, P1, Assam

M: Who decides the money to be spent on someone's health in your family?
R: Father in law. — Married, P1, Madhya Pradesh

M: So, first you go to Asha. You go to the doctor only after her suggestion?
R: Yes.
M.: If Asha says, take medicine from pharmacy then what do you do?
R: Not pharmacy, she also keeps some medicines. She gives that to us. — Unmarried girl, Assam

After 2.1

Note to the reader: *The report documents a base level understanding of the lives, information touchpoints and behaviours of young women prior to the pandemic induced lockdowns and subsequently captures SRH-related experiences during the COVID-19 Pandemic (between March 2020 and December 2020).*

Geographical Coverage

The study was undertaken in three different states of India—Assam, Madhya Pradesh and Jharkhand. Different districts and blocks (within districts) were chosen in each state, based on accessibility during the pandemic and geographically dispersed population. In the absence of block-level data on SRH indicators, the selection of villages was carried out to attempt appropriate representation across the selected districts.

- In Assam, the districts and blocks were: *Goalpara (Block-Lakhipur) and Nagaon (Block- Bajiagaon)*
- In Madhya Pradesh, the districts and blocks chosen were: *Chattarpur (Block- Bijawar) and Satna (Blocks- Maihar)*
- In Jharkhand, *the chosen district was West Singhbhum (Block- Sadar &Chaibasa)*

Use of Smart Phone

In Assam, most of the married women have ownership and access to personal smartphones. Apart from calling, they use the phone for entertainment purposes (at rare occasions when they get free time from household chores) i.e. watching videos on YouTube, spending time on social media apps like Facebook/WhatsApp. The video calling feature was mostly used to contact members at 'maternal home' to exchange a few words and heartwarming smiles.

In Jharkhand and MP, there was a mix between personal and shared ownership of smartphones i.e. women using their own phone and sharing the phone with another family member. In case the woman was married, the phone was shared with the husband and accessed mostly to watch videos, serials and for other entertainment purposes.

M: Do you have your personal mobile or is it your house mobile?
R: It is personal mobile; my husband has given to me.
M: Do you only use this mobile or others also use it?
R: I use it, my mother-in-law and my husband also use it.
M: When you go out, do you take your mobile along with you?
R: If I feel necessary, then I take it, if not then I don't take it along with me.
— Married, P1, Madhya Pradesh

M: As you were telling me that you don't have a mobile phone with you?
R: Yes I don't have.
M: As you said your husband is having a phone, do you use it?
R: Sometimes when he gives me so I see films
— Married, P0, Jharkhand

Pre-Pandemic Healthcare behavior:

For a woman's health ASHA is considered to be most accessible while doctor is the most desirable. For minor to moderate treatments, the provider preference is based on proximity to the household.

- In case of minor health issues most women stated that they first resort to home remedies recommended by the elder members of the family. Home remedies are perceived as natural, easy, quick and free. It is to be noted here, when we asked women about the subject of abortion few stated natural remedies as the first immediate cure to terminate pregnancy or their moral conscience interfered with subject regarding abortion.

- If the problem persists, the woman reaches out to an immediate confidant in the family (preferably an older woman) and later ASHA keeping in mind she is readily easily accessible and considered to be 'one of their own' from the community.

- **Menstruation Health & Hygiene**: The information regarding menstruation and hygiene is sought passively across various touchpoints. Most of the respondents, across centers use sanitary napkins for hygiene and procure them from pharmacies and general stores nearby. They either procure them themselves or ask their husbands fetch it when necessary. Unmarried girls are seen to be dependent on an older woman in the household to procure the sanitary napkins from them or in case of emergency procure the same directly from the ASHA. Any information regarding irregular menses, severe bleeding, cramps, etc is directly sought after from the ASHA (across parity). In Assam, an unmarried girl also reported that the quality of sanitary napkins provided by the ASHA were thin and poor in quality which made her to start the procurement of sanitary napkins from a shop. These 'good quality' pharmacy/general store sourced pads were used only when she travelled far from her house (to avoid the fear of leakage and spotting).
    - ***Few women in Madhya Pradesh generally interchange use b/w cloth & sanitary napkins:*** A few women expressed interchanging the usage between cloth and sanitary napkins based on the ready availability at home. If pads were available, that was the first preference and if not they would end up using cloth only. It is to note, this is their general behaviour and not changed owing to the pandemic. Clearly, there is a sense of adjustment towards needs related to themselves.
    - ***In Jharkhand, financial constraint and issue of disposal restricts a few women to use cloth:*** A few women in Jharkhand prefer to use cloth over sanitary napkins due to financial constraints in the household. Due to continual usage they find no discomfort to use cloth—it is easy to wash, dry and change. There was an issue of disposal reported which required the women to travel to a far off well to dispose pads, making her prefer cloth over sanitary napkins. It was also stated by a young woman that ASHA only provides free sanitary napkins to unmarried girls and not to married women (costs around Rs 35/- per pack).

- **Contraceptives**: After a woman is married, it was stated that ASHAs across centers contact women by going to their households or in anganwadi centers to educate them about family planning and methods to prevent pregnancy. There is seen to be high awareness amongst women about modern contraceptives methods like condom and pills. Few women were aware of long term contraceptive methods like Copper T and injectables (only one user across centers).
    - At P0, there is high awareness about methods but the pressure to prove fertility often leads to not using no contraceptive methods. The onus of deciding the method of contraception lies in the hands of the husband.
    - At P1, there is a greater tendency to fluctuate between methods as per choice and convenience. There were young women who were solely dependent on condoms or pills and then others who switched between condoms and traditional methods. For women consuming pills, there is irregularity in consumption (based on need i.e. when making sexual relations)
    - At P2, men and women start to consider long-term methods such as PPIUCD or injectables as the desired duration for contraception is longer and these methods are seen as a transition before opting for sterilization.

  Across centers, it was observed that women mostly used condoms, oral pills or traditional methods (calendar method) as contraceptives.

"We should use condoms if we want to avoid unwanted pregnancy. Earlier I didn't use any contraceptives before my children were born. After my daughter was born I took contraceptive pills. Now I discontinued it because people say that it's not good so I don't take it."
— Married, P2, Madhya Pradesh

M: So you don't use condoms?
R: No
M: Why do you only prefer oral pills not condom?
R: Because this Asha worker has given me the options, so I have chosen pills. I have it when my husband is in town.
— Married, P1, Assam

M: Like if any woman doesn't like to have a baby now, there are many women who don't want a baby now, what can be the reason? What will she do?
R: There are many things available, there is a tablet for that. Copper T is there, which one can fix. For protection they can use condoms. I don't do much, we use condoms. In that everything was normal.
— Married, P1, Madhya Pradesh

M: Your baby is 8 months old. Are you doing something for pregnancy control?
R: Yes.
M: What are you doing?
R: I am not doing anything for now. We would not do it for 15 days after periods. I would use it before the baby is born.
M: Have you not had intercourse with your husband after the baby is born?
R: We do it but we avoid it for 15 days after the menstrual cycle.
M: So you have intercourse on safe days.
R: Yes.
M: That works for you.
R: Yes.
— Married, P1, Jharkhand

- **Pregnancy, Delivery, ANC:** In case of pregnancy, delivery and ANC the entire family of the woman is involved in decision making. The elder women of the household, ASHA and ANM are the primary point of contact who start engaging with pregnant women from the second trimester onwards. This outreach is primarily restricted to the woman and not to her husband. Women reported that the ASHA visiting the household talked to them directly and not the man in most cases. Most of the P2 women across centers reported having made visits to ASHA, ANM center or a public/private healthcare facility to avail ANC facilities. In most of the cases, where the woman preferred to go to a public or private health facility, she preferred ASHA's company (for ASHA knows people around the facility and acts as mediator between the woman and the staff).
  The delivery of the woman is often carried out with consultation of ASHA, but ultimately the place of delivery depends on the family's preference, affluence and the proximity of a healthcare facility from the household. 'Mamtavahans' (small mini ambulances) in Jharkhand are seen to be called upon by the ASHA for the young women in case of urgent needs.

- **Emergency Contraceptive Needs and Abortion (MA):** Most of the women correlated abortion to a 'surgical operation' that needs to be performed by an experienced healthcare practitioner like a doctor/surgeon. In case of MA, the women across states reported no usage of MA in the past, and that if needed (in future) they would seek out ASHA for details and information. In few instances, there was a moral dilemma attached with abortion wherein women expressed it to be bad or not needed.

M: Do you know how is abortion done?
R: No.
M: Have you talked to anyone about it?
R: No.
M: I have heard that there is a pill by which you can do abortion.
R: I haven't heard of such pill.
M: How do you think abortion should be done?
R: One shouldn't do abortion.
— Married, P0, Madhya Pradesh

Present day scenario: Normalization of Phase-1 Pandemic [December 20-January 21]

Shift in Family Dynamics, Familial Interaction, Decision-Making and Impact on the Lives of young women

- **Increased time spent with household members:** Many respondents said that the imposition of lockdown helped them spend more time with their family members. Under normal circumstances, their husbands did not get to spend much time with them or their families but because of the lockdown they could spend quality time together. One respondent however said that as a housewife, things remained the same for her. Only her movement got curtailed due to the lockdown. Unmarried respondents from Assam said that they started doing household chores like cleaning, drying out clothes, etc.
  M- Was there any change in your daily routine during lockdown?
  R- No.
  M- Did you have any financial difficulties during lockdown?
  R- No, my husband had some savings; we managed our expenses through that only.
  M- So during lockdown your husband was at home?
  R- Yes all of us were at home we got to spend quality time together. My husband usually doesn't get much time with the family when he's working.
  — Married Woman, P1, Lakhipur, Assam

- **Switching to online education:** One unmarried respondent from Jharkhand said that she had to purchase a mobile phone for her online classes while another unmarried respondent from Jharkhand mentioned that there was a great loss in terms of education.
  "R- Previously we were did not have a mobile.
  M- So you had to buy it?
  R- Yes
  M- This you have purchased within 8-9 months for doing your class?
  R- Yes
  M- But you said it is a phone of aunt?
  R- Yes bought by her for me.
  M- So, your aunt bought it for you for doing class?
  R-Yes
  — Unmarried Woman, West Singhbhum, Jharkhand

- **Acute financial distress triggered by lack of physical access to commerce centres, and due to lack of jobs, especially for contract workers:** Both married and unmarried respondents mentioned a decline in their financial situations. Respondents from Jharkhand said that their husbands or fathers were not getting jobs (labour and agricultural) which led to monetary problems. Only their bare minimum needs were being fulfilled. One respondent also mentioned a loss in their poultry businesses because their chickens had died.
  Most respondents from Assam did not mention any financial issues.
  R: Yes, I have faced challenges, my parents were not going to work, not earning and they are the only earner, so all the expenses are at halt.
  — Unmarried Woman, Chhatterpur, MP

- **Paucity of physical resources:** Because of the imposition of lockdown and the subsequent closing of shops, procurement of some necessities, clothes, etc was also a problem.
- Women mentioned that they were also indoors and were mostly engaged in doing household chores. One respondent from Assam mentioned that she got time to experiment on her culinary skills and cook new food for her kids.
  M: Didn't it affect your daily routine? What did you do in the morning, in the day, in the evening before lockdown and in the lockdown what have you been started doing in this time?
  R: There was little effect on our routine.
  M: How did it affect you?
  R: We didn't get time to go out. We had only one option and that was, doing my all work and then going back to my room and then again doing my all work and then again going back to my room. That was only thing to do.
  — Married Woman, P2, Chhatterpur, MP

- **Business as usual: The pandemic was over for this audience soon after lockdown lifted. They view the pandemic in two phases—lockdown and post-lockdown life.** Most of the respondents reported that the current situation is better than the initial months of lockdown. The betterment was described in terms of the lifting in restrictions. The respondents reported that the shops that were closed during the lockdown are now open, vehicles are plying regularly and they can commute easily as they could before the pandemic.
  M: When did everything open?
  R: When lockdown ended, everything started opening up.
  — Married Woman, P1, Satna, Madhya Pradesh

- Unmarried respondents who are students and married respondents both mentioned that schools had re-opened. It was reported that schools reopening for older students, at least—**was seen as a sign of normalcy returning.**
  Similarly older, married young women reported that wedding functions had resumed in their localities—seen as being indicative of the resumption of 'life as usual.'
  M: In your village also, was everything closed?
  R: Yes.
  M: Everything was closed, now is it open or is it still closed?
  R: Yes now it's open.
  M: So things have changed now. Now is everything open?
  R: Yes its open like before.
  M: So now it's like before right?
  R: Yes.
  M: Have schools opened?
  R: Yes open.
  M: So do you go to school now?
  R: Yes but I did not go today.
  M: So today you have not gone? On other days you go to school?
  R: yes
  — Unmarried Woman, Lakhipur, Assam

- Apart from trains for intercity or interstate transport, almost everything was functioning as before. One respondent even mentioned that weddings were banned during lockdown but in recent times, even that resumed in their village.
  M: For that what are the changes you have noticed? In your neighbourhood, or in your locality?
  R: I have seen people who have come from outside, they were kept in the schools.
  M: What are the other things you have noticed?
  R: Vehicles were stopped, we have faced lots of difficulties in travelling, and shops were also closed.
  M: All was closed, but is it closed now or they are open now?
  R: They are open now.

M: All are open or some are closed?
R: Half are closed and half are open.
M: What all is closed?
R: All are open only trains are closed."
— Married Woman, P2, West Singhbhum, Jharkhand

- **Sense of loss of mobility felt the least by the woman, due to limited mobility prior to the pandemic as well:** Some women mentioned that they did not register any stark change in their personal mobility/freedom or routine with respect to the lockdown or unlock phases, because they anyway used to remain indoors and not move around too often.
  M: Do you feel any changes during lockdown?
  R: As a housewife, things were same only for us. But we couldn't go out frequently during lockdown.
  — Married Woman, P1, Nagaon, Assam

Other Needs and Response for Family Healthcare Needs During COVID-19 Pandemic

Following differential stated levels of severity attributed to different family members' healthcare needs, the utilization of services seems to follow a similar pattern in terms of both **pathways to access healthcare services (typically more long-drawn for women)** and in terms of urgency of service utilization.

- **This difference in prioritization of recipients of healthcare services appeared to intensify during the pandemic—placing even greater emphasis on healthcare needs of others—whilst seemingly delaying service access for women in the household further due to infrastructural challenges in accessing healthcare facilities.**

A respondent from Jharkhand said that she performed some "*puja"* to cure the pain in her legs and body. This puja was performed by a village *pujaari*, a naturopathic who is one trustworthy source of solutions to medical issues around the village.
"I was having pain in my legs and head; I have done some puja for that which happens in our village."
— Married Woman, P2, West Singhbhum, Jharkhand

FOR ELDERLY FAMILY MEMBERS & CHILDREN: It was observed that for elders (especially male members) and children, the pathway for service utilization decision-making is:

Detection of symptoms → Escalation of symptoms → Consultation with known/trusted source → Government/Private Facility → Pharmacist

FOR THE WOMAN: Meanwhile, for the woman, pathway to seek healthcare services seemed to follow a more prolonged route:

Detection of symptoms → Longer duration before detecting cause for concern → Growing discomfort → Sharing with parent/MIL/husband → Consulting ASHA → Consulting neighbour/trusted friend → (Sometimes) Consulting ALTERNATE source of healthcare resolution (Quack/Pujari/Ojha/Traditional Doctor etc.) → Consulting ANM/PHC personnel → Visiting government facility

Preference for Service Utilization (Representative of shifts)

Individual*	**Pre-Pandemic**	**During COVID-19**
Child (acute illness)	Doctors at PHC/Hospital	Doctor (if possible)/Pharmacist
FIL/MIL (chronic illness)	Government/Private Doctor	Pharmacist/Private Doctor

Husband (acute illness)	Private Doctor	Private Doctor
Woman (SRH needs & other health concerns)	ASHA/Government Doctor	ASHA/ANM /Nurse and Govt. Doctor in case of pregnancy/delivery

- Restrictions on travelling and movement posed problems in accessing healthcare services, one respondent from Jharkhand reported. This led to them seeking healthcare advice from people living around and resorting to home remedies.

  M: Okay, have you ever felt that the advice of a doctor should also be taken or the advice of people around you is enough?
  R: I did not take the advice of the doctor, only consulted the people around me.
  M: If all the hospitals were open eight to ten months prior to covid-19, then would you have taken the advice of the doctor?
  R: Yes, I would have gone.
  M: So why didn't you go at that time?
  R: Because at that time there were no facilities to travel and everything was closed.
  — Married Woman, P0, West Singhbhum, Jharkhand

  Another respondent from Madhya Pradesh reported a similar issue in which her ailing father living in her natal home could not access healthcare services because the doctor lived far away from their home. Her family tried home remedies which worked out positively for her father.

  M: Did anyone you know got ill and couldn't get any health related help?
  R: My father got ill at parent's house. He couldn't get medical help. He is old, so gets ill once in a while.
  M: Then how did your family manage?
  R: We tried home remedies. Now he is alright. Doctor is very far from home.
  — Married Woman, P1, Satna, Madhya Pradesh

_____XXXXXX_____