CONTINUITY OF CARE FOR ROUTINE HEALTHCARE SERVICES DURING THE FIRST WAVE OF COVID 19

A STUDY AMONG MARGINALISED COMMUNITIES IN THREE STATES

WITH SUPPORT FROM
WORLD HEALTH ORGANIZATION (WHO), INDIA

CENTRE FOR HEALTH AND SOCIAL JUSTICE

Continuity of Care

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CONTENTS

ACRONYMS/ABBREVIATIONS

ASHA	Accredited Social Health Activists
ANM	Auxiliary Nurse Midwives
FLWS	Frontline Workers
IUCD	Intrauterine Contraceptive Device
MCH	Maternal and Child Health Services
NRHM	National Rural Health Mission
NHM	National Health Mission
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
RMNCH+A	Reproductive, Maternal, New-born, Child and Adolescent
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
VHSNC	Village Health Sanitation and Nutrition Committee
VHSND	Village Health Sanitation and Nutrition Day

ACKNOWLEDGEMENT

Centre for Health and Social Justice, would like to acknowledge everyone who was part of this study. Especially the research teams in the three sites, who made this research possible during the time of Covid 19 pandemic. Despite the risk factors when going to the field was full of challenges and fear of catching corona, the investigators with all enthusiasm, following all protocols, made it possible to reach out to the health service users. With access to many people only over phone, especially for the qualitative interviews, the commitment by the field facilitators to ensure that respondents are well connected to the interviewer was commendable, as it required multiple attempts to schedule an interview. They have overcome the challenges faced by poor phone connections by keeping their patience and trying again and again, also scheduling the interview time as per the convenience of the interviewees.

We are extremely grateful to the communities, front line workers and Gram Panchayat members who shared with us their experiences, views and responded to our queries. Without their cooperation this study could not have been possible.

Most importantly we are thankful to the WHO-India office for their funding support to carry out this important study.

EXECUTIVE SUMMARY

The Covid-19 pandemic has affected everyone, but the hardest hit are the poor and marginalised communities. The pandemic has interrupted the dwindling health system of our country and disrupted the essential health services for millions of people. The Centre for Health and Social Justice with support from WHO conducted a study on the impact of the COVID 19 pandemic on the functioning of primary level health system. The study included the experiences of service users, of front-line functionaries, and other supportive village level mechanisms. The study used both qualitative and quantitative methods to gather data on experiences of pregnant and lactating women, parents of infants, contraceptive users, and persons requiring regular long-term treatment for chronic diseases and service providers. It covered tribal, Dalit and Muslim communities of Madhya Pradesh, Jharkhand, and Karnataka.

The study found that COVID-19 has strained the health system of the country severely, hampered and disrupted essential health services including MCH, non-communicable diseases, and services at the primary level in the study areas. Due to temporary halt of the VHSNCs women had no access to Maternal and Child Health Services at the primary level at least two to three months, and in some areas, for even more months. For other diseases like diarrhea and fever, in the absence of support from the frontline functionary, many parents sought treatment from private sources including informal providers or quacks in these three states. The experiences of the respondents also indicates that due to the limited commute options, and unavailability of public health services, they had to walk for long distances or go on a cycle with the sick child to the nearby towns to see the private doctors or village doctors. They also had to spend more money to seek treatment. Many women during the survey said that they did not receive the nutrition packets; and for routine and emergency services they had to go to private health care facilities and their out-of-pocket expenditure increased manyfold. Due to the lack of regular services for pregnant women, many women opted to have childbirth at home. The study found that in Karnataka, the MCH services started resuming in the month of May 2020 itself to some extent, but the situation was different in Jharkhand and MP. In Jharkhand the VHSND services resumed only in July 2020 and VHSNDs were not being conducted regularly even after 6 months of the lockdown.

Like other essential health services, the contraceptive supplies were also disrupted due to the lockdown and the respondents had to make their own arrangements. ANMs reported difficulty in providing contraceptive services across all three states. Supply of condoms and contraceptive pills got affected. The major difficulty was in providing IUCD or sterilisation services to women who wanted these.

Health services for other kinds of health problems like TB, diabetics diabetes, hypertension were completely ignored by the health system even though patients were prescribed regular

medicines and regular follow ups. As a result, most of the respondents went to the private health care providers in case of emergencies. ASHAs, ANMs or the PHC, played a very minor role in the treatment of hypertension and diabetes.

The experiences of the frontline health workers during pandemic are also included in this study. Most of the frontline workers were oriented and given training sessions on Covid 19 pandemic. Across the three states, the ANMs were trained at the block hospital of Community Health Centres on the features of the virus and on ways for prevention and creating community awareness. During lockdown the health workers were given new and extra responsibilities. A major challenge for them was to manage the migrants who had returned to villages for mandatory quarantine. ASHAs were encouraged to provide door-step delivery of IFA and calcium tablets. The payments and honorariums for ANMs were delayed for two to three months across the three states. Across the study states ASHAs and ANMs reported about inadequate supply of and poor quality of the safety gear (masks, hand gloves and sanitizers). After one to two supplies, health workers spent their own money to get PPE Kits and other material.

ASHAs and ANMs had to manage their family and professional responsibilities in this crisis. As health functionaries they had to go out and meet others and at the same time take measures so that the safety of their family members does not get compromised. The family support that they received to continue their work was invaluable for both ASHAs and ANMs. They also faced harassment and stigma from members of the community. Female frontline workers, notably the ASHA as well as the ANM emerged as the most important resource at the community level. In most cases they went beyond the call of duty and faced many physical as well as financial challenges to provide the services required of them. The public system expected them to perform but the support was inadequate, and reimbursements and payments were delayed.

The Village Health Sanitation and Nutrition Committee (VHSNC) is expected to be the mechanism for community engagement for the health delivery system. This committee was almost missing or very weak in all study locations.

The mass migration of migrant workers back to their villages created another level of rural health crisis in unforeseen ways and dominated Covid control efforts there. During the health emergency the local public systems had to manage food and supplies as well as livelihood and economic crisis.

Digital technology emerged as the main medium of communication and was widely used during the pandemic. This study was possible due to the digital technology as it was conducted during lockdown. However, the limitation of smart phone enabled methods with women, and other marginalised communities in remote rural areas needs to be acknowledged. Digital competencies of women and girls need to strengthen, and resources

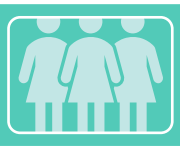
made available for them to use these in these resource constrained areas. Applications need to be developed which will allow such people to use technologies comfortably.

The study provides interesting findings on the experiences of the community during the pandemic and their health seeking behaviour and the challenges for frontline health workers and their new learnings to handle pandemic at their level. The health system response was disrupted at many levels and response priorities were also different at the community level of health services for different locations. While the closure of services and the implementation of control and prevention measures was immediate and similar, the reopening of services and the return of routine services took place slowly and at different times, in the three different states. The system in Karnataka was more responsive in these circumstances compared to that in MP or Jharkhand. This could well reflect the existing managerial and delivery capacity of the peripheral health system in the three different states.

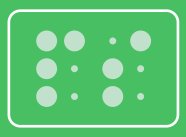
The lessons and suggestions emerging from this study will be useful for all those who are interested in strengthening the local health systems.

RECOMMENDATIONS AT A GLANCE

Empower local institutions to find timely and appropriate solutions in a crisis situation and community people to be involved in solution finding processes.



Ensure good and quality work conditions and mechanism of providing psychosocial support for Frontline Health Workers. They need to be backed up with functional health care services, effective referral transport system and adequate supplies of medicines and other essentials.



The guidelines and protocol need to be created in such a way that they can be adapted to different realities for the purpose of setting up a proper support mechanism. This mechanism can build a peripheral system which can ensure the best possible use of these guidelines in order to help communities.

Applications need to be developed which allow such people to use such technologies comfortably. Digital competencies of women and girls need to strengthened and resources made available for them to use it in resources constrained areas.

CONTEXT

The first case of the Covid 19 infection, in India, was detected towards the end of January 2020. It did not take long for the virus to rapidly spread across the country, creating a health emergency of an unprecedented nature. There was a nationwide lockdown or complete cessation of movement from 25th of March 2020 onwards. This lockdown was sudden, and it brought everything to a standstill. While tertiary care hospitals geared to tackle the pandemic, routine healthcare services came to a sudden halt. India had made considerable gains in the field of health care since the National Rural Health Mission, subsequently renamed the National Health Mission, was launched in 2005. The Ayushman Bharat scheme launched a couple of years ago has also been providing more affordable and quality curative care services. These initiatives marked a serious commitment of the country to the fulfilment of the health-related Sustainable Development Goal (SDG) of ensuring good health and well-being for all and achieving Universal Health Coverage (UHC) by 2030. The Covid pandemic was a serious setback to this path of progress.

The first wave of Covid affected urban India more than the rural areas. Metropolitan cities like Mumbai, Delhi, Bangalore, Ahmedabad were more affected and contributed nearly three fourths of the total cases in the initial months[1]. The infection was also more among the affluent, and those who had a travel history mostly from abroad. It was later when there was a massive migration from cities to the interior that the infection spread further. As the infection rates surged in the cities, hospitals were swamped with Covid patients. Private hospitals started running out of Covid beds[2] as the urban affluent preferred these in Delhi. In Mumbai there were reports of patients needing to share a bed and an oxygen cylinder[3].

The situation was also grim outside the bigger cities. Outpatient, in-patient and emergency services were all disrupted. Scheduled immunisation services for children and antenatal care for pregnant women were suspended. There were reports of hospitals not admitting women coming for childbirth and the number of institutional deliveries fell sharply. Hundreds of thousands of patients with chronic illness requiring continued treatment didn't receive their scheduled medicine. According to newspaper reports the number of cases of health emergencies treated in hospitals dropped drastically[4]. ASHAs (Accredited Social Health

[1] Gupta, D., Biswas, D. & Kabiraj, P. COVID-19 outbreak and Urban dynamics: regional variations in India. *GeoJournal* (2021). https://doi.org/10.1007/s10708-021-10394-6

[22] https://timesofindia.indiatimes.com/city/delhi/covid-beds-running-out-in-delhi-private-hospitals/articleshow/75931285.cms

[3] https://www.theguardian.com/world/2020/may/29/india-mumbai-hospitals-overwhelmed-coronavirus-cases

[4] https://www.livemint.com/news/india/how-covid-19-response-disrupted-health-services-in-rural-india-11587713155817.html

Activists) and ANMs (Auxiliary Nurse Midwives), two cadres of frontline health workers who work directly with the community, were given emergency Covid related duties and all regular services were stopped.

The cessation of services did not mean people stopped having health care needs. While there were many reports, especially from urban areas, where people reached out to support each other in different ways, there is little information on how rural communities addressed their health care needs. The Centre for Health and Social Justice conducted a short study to understand how communities were managing their routine healthcare needs which would otherwise be part of the various National Health Programmes. The study was conducted in 54 villages under 18 PHC areas in 3 districts each of Madhya Pradesh, Jharkhand, and Karnataka. Financial support for the study was received from the WHO, India office.

INTRODUCTION TO THE STUDY

OBJECTIVES AND METHODOLOGY

The study explored the impact of the COVID 19 pandemic on the functioning of primary level health system including the experience of service users, of front-line functionaries, and other supportive mechanisms like the VHSNCs and PRIs. In order to understand the experience of users the study included the experience of a diverse range of users who require health care services regularly like pregnant and lactating women, small children, contraceptive users, and persons requiring regular long-term treatment including infectious diseases like tuberculosis, and non-communicable diseases like hypertension, and diabetes.

The study covered 18 PHC clusters of 3 villages each, in 9 districts in the states of Jharkhand, Karnataka and Madhya Pradesh. It included both quantitative and qualitative components. The total population covered in these 54 villages was estimated to be a little over one lakh. To understand the experience of health service users a survey was conducted among a sample of women who had their delivery between April and September 2020, mothers of children between 3 and 24 months of age, women who were using pills, condoms or IUCDs and those with health conditions either TB, diabetes or hypertension. The qualitative component included in-depth interviews with ASHAs, Anganwadi Workers, ANMs and members of the Village Health Nutrition and Sanitation Committees from the same villages.

For the quantitative survey, a sample was drawn using population proportionate to size based on the prevalence of each category of the health service users as given in the NFHS 4. The total number of respondents for the survey were as follows: 331 persons requiring regular long-term treatment, 327 users of child health services, 287 lactating women and 254 users of contraceptive services. For identifying potential respondents, lists of users were first collected from the ASHAs or ANMs and the respondents were randomly chosen based on the population size each village.

For the in-depth interviews with service providers a list of all ASHAs and ANMs serving in the study villages was prepared. For PRI members, the Panchayat President (Sarpanch/ Mukhiya/ Pradhan) were interviewed. Where the Panchayat President could not be reached then the Vice President, or any other panchayat member was interviewed. For VHSNCs, while making a list of members it was realized the VHSNC's were not active and as the AWW is an ex-officio member, she was interviewed. A total of 44 ASHAs, 17 ANMs, 37 AWWs and 21 PRI members were interviewed in the study.

The data collected during the study pertained to the six-month period between April 2020 and September 2020.

CHSJ works closely with field level partners in each of these areas and the interviews with health service users were conducted by fieldworkers of these partner organisations using the Kobo collect app on a mobile phone. Prior to data collection the field workers were provided a two-day online training on data collection methods as well as the use of the app. Continuous telephonic support was provided to the field surveyors during the survey. The in-depth interviews were conducted by members of the CHSJ research team over telephone along with the field surveyor who was with the respondent.

The partner organisations for the study were Prerna Bharati in Jharkhand, People's Forum for Justice and Health in Karnataka and Satyakam Jankalyan Samiti, Manav Foundation and Srijan Sewa in Madhya Pradesh. All these organisations are based in the districts where the study was conducted, and the field surveyors were all normally resident of the study areas.

All Covid related precautions were taken during the interviews. The data collection took place between October- December 2020. The quantitative data was analysed on SPSS and the qualitative data was analysed using Atlas ti.

An ethics committee comprising of eminent public health researchers and ethics experts was constituted and they reviewed the study design.

CHALLENGES IN DATA COLLECTION

The field team faced several challenges in collecting data. Due to their engagement in Covid related activities records were not updated by the ASHAs. Data on chronic illnesses was not updated in their records. The lists given by the frontline workers were not exhaustive especially for those with chronic conditions. Several contraceptive users denied using the method of contraceptive mentioned in the lists provided. Some tribal hamlets were not included in the lists provided but were later included after consultation with the community. In some cases, women contraceptive users denied using any contraceptive method due to the fear of disclosure within the family. A few TB patients refused to give an interview as they didn't want other people to know about their health status. These raise issues related to over-reporting possibly due to the pressure of meeting contraceptive targets, as well as exclusion of marginalized communities and persistent stigma.

Due to the declaration of PRI elections in Karnataka the team faced some difficulty in interviewing PRI members. In case of a few women Gram Panchayat Presidents in Jharkhand and Madhya Pradesh the husband or brother-in-law responded on behalf of the woman who was in position.

LIMITATIONS OF THE STUDY

This study is limited only to exploration of the impact of the pandemic and pandemic response on other health system and did not explore the magnitude of the actual cases in the

community. Hence the findings are not able to make any conclusions on impact of the management of exact case burden of frontline workers on the health system.

INTRODUCTION TO THE STUDY POPULATION

The study was conducted in the states of Jharkhand, Karnataka and Madhya Pradesh. These three states have very dissimilar public health profiles, but the study areas chosen in each of the states were somewhat similar as the population in these areas were from the marginalised sections of the society.

In Jharkhand, the study covered three tribal districts of Deogarh, Lohardaga and Giridih with a large population from the Santhal, Oraon, Lohra, Munda and Mahali tribes and also have a large proportion of Dalits and Muslims.

In Karnataka the study was conducted in the districts of Raichur, Haveri and Tumkur and in villages with Dalit communities like the Madiga, Vadaru and Valmikis as well as tribals and Muslims.

In Madhya Pradesh the three districts were Chhindwada, Rewa and Sheopur. Sheopur district has a predominantly Sahariya tribals who are one of the most marginalised tribal communities in the state. In Chhindwada the study focussed on villages with Dalit communities such as Katiya and Mehr castes and Gond tribals. In Rewa, there was a mixed population of Dalits, tribals and others.

TABLE 1: CASTE CATEGORY OF THE RESPONDENTS (%)

Caste	Persons on Long Term Treatment	Children	MH service users	Contraceptive Users
ST	111 (31.0)	123(37.6)	94(32.8)	79(40)
SC	94(25.0)	96(29.4)	88(30.7)	61(23.9)
OBC (Mostly Muslim)	89(24.9)	81(24.8)	71(24.7)	83(32.6)
General	63(17.6)	27(8.3)	31(10.8)	32(12.6)
Total	331	327	287	254

Most of the respondents were from farming families or worked as daily wage labourers. Most respondent families had irregular and uncertain source of income, which worsened during the pandemic and lockdown period. In Jharkhand and Karnataka, most of them belonged to the BPL category. In Madhya Pradesh and Jharkhand, several respondents did not have a ration card which entitles poor families to subsidised rations. Respondents in Karnataka had BPL ration cards.

ROUTINE HEALTHCARE SERVICE DELIVERY AND THE COVID 19 PANDEMIC

ROUTINE HEALTH SERVICES DELIVERY MECHANISM IN INDIA

Public health care services in India are delivered both through the national as well as the state governments. Most curative services and hospitals services are delivered by the state governments while the national government provides guidance and financial support through the National Health Mission (NHM). The NHM includes maternal and child health programmes, immunisation, family planning, control of communicable diseases as well as management of epidemics. The NHM started as the National Rural Health Mission in 2005 to ensure accessible, affordable, and quality health services at the primary level in the rural especially for the marginalised sections of the society. Later health issues of the urban poor were also included and the programme was renamed NHM. Community engagement is an important component of the NHM and is facilitated through the ASHA (Accredited Social Health Activist), a community level part time worker, the Village Health Sanitation and Nutrition Committees (VHSNC) and linkages with the Panchayati Raj Institutions. A monthly health day called the Village Health, Sanitation and Nutrition Day (VHSND) is the main mechanism for delivery of health services to the community.

The key components[5] of NHM include the Reproductive, Maternal, New-born, Child and Adolescent (RMNCH+A), as well as programmes aimed at control of communicable and non-communicable diseases and measures for the strengthening of health systems. The RMNCH+A[6] programme is built upon the continuum of care concept and includes a range of interventions under one broad umbrella. The Revised National Tuberculosis Control Programme (RNTCP[7]) is also part of the NHM and includes a community based, DOTS, where field level health workers ensure that medicines are taken timely and regularly.

The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)[8] was launched in 2010 as a pilot programme with focus on strengthening infrastructure, human resource development, health promotion, early diagnosis, management, and referral. This programme also focuses on early diagnosis through population-based surveys and management of the disease through regular treatment and follow up and referral as necessary.

[5] https://nhm.gov.in/index4.php?lang=1&level=0&linkid=353&lid=444
[6] https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168
[7] https://www.nhp.gov.in/revised-national-tuberculosis-control-programme_pg
[8] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1048&lid=604

The NHM has been a positive step to improve services and crucial to achieving Universal Health Coverage and the Sustainable Development Goals related to health.

HEALTH SERVICES AND THE COVID -19 PANDEMIC

On 24th March 2020, the National Disaster Management Authority[9] on being 'satisfied that the country is threatened by the spread of the Covid 19 epidemic' announced 'a series of effective measures to prevent its spread across the country' starting a nation-wide lockdown from the next day. All medical establishments, both in the public and private sector were to remain functional and transportation of all medical personnel was permitted. The Epidemic Diseases Act which had been enacted in 1897, to respond to the plague epidemic by the colonial government was amended through an ordinance in April 2020. The amendments were mainly aimed at protecting health workers against violence.

The Ministry of Health and Family Welfare issued guidelines on clinical management of Covid 19 which were updated regularly as more information about the disease and its treatment became available. For the health department the areas of major concern were treatment of those with Covid -19 and preventing the spread of infection. Guidelines, advisories and standard operating procedures (SOPs) were issued about quarantine, isolation, travel and transportation, testing, treatment and several other concerns [10]. State Governments arranged for the adaptation of these for their own requirements.

Within a month the Ministry of Health and Family Welfare, Government of India had made several provisions for the training and upgradation of skills and safety of health professionals and frontline workers[11] . Guidance notes had been issued for timely payments to front line workers. A dedicated toll-free line had been set up to provide psychosocial support. An Integrated Government Online Training (iGOT) – Diksha platform had been established uniform training of health professionals across the country and life insurance cover was provided for all categories of health workers.

The MoHFW also released a guidance note for Enabling Delivery of Essential Health Services during the COVID 19 Outbreak[12]. The note started with the acknowledgement that during the Ebola outbreak of 2014 -15, there were more deaths due to measles, malaria, TB, and HIV/AIDS than from Ebola due to health system failures. To avoid this during the Covid pandemic it emphasised that 'particular attention needs to be paid to the delivery of essential health care for specific population sub-groups'. States were encouraged to maintain continuity of non-Covid services. For ensuring optimum care delivery it advised mapping of

[9] Letter No 40-3/2020-DM-1(A), dated 24th March 2020, Ministry of Home Affairs, Government of India
[10] For a extended list of government Advisories and Guidelines see - https://www.mygov.in/covid-19-advisory
[11] For an extended list of early support mechanisms see – Measures Undertaken To Ensure Safety of Health Workers Drafted for Covid 19 Services - https://www.mohfw.gov.in/pdf/MeasuresUndertakenToEnsureSafetyOfHealthWorkersDraftedForCOVID19Services.pdf
[12] See - https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf

all facilities, delivering services for minor ailments by frontline workers by tele-consultation and continuing service delivery through non-Covid facilities through protocols that had been established. Alternative arrangements for outreach services for immunisation or antenatal were encouraged through decentralising service delivery at the ward/village level and having multiple smaller batches. Follow up, including optimised home visits were encouraged for high-risk pregnant women, new-borns, those with tuberculosis, leprosy, diabetes, hypertension, and so on. Details on how each of these conditions could be managed during the pandemic were also elaborated in this note.

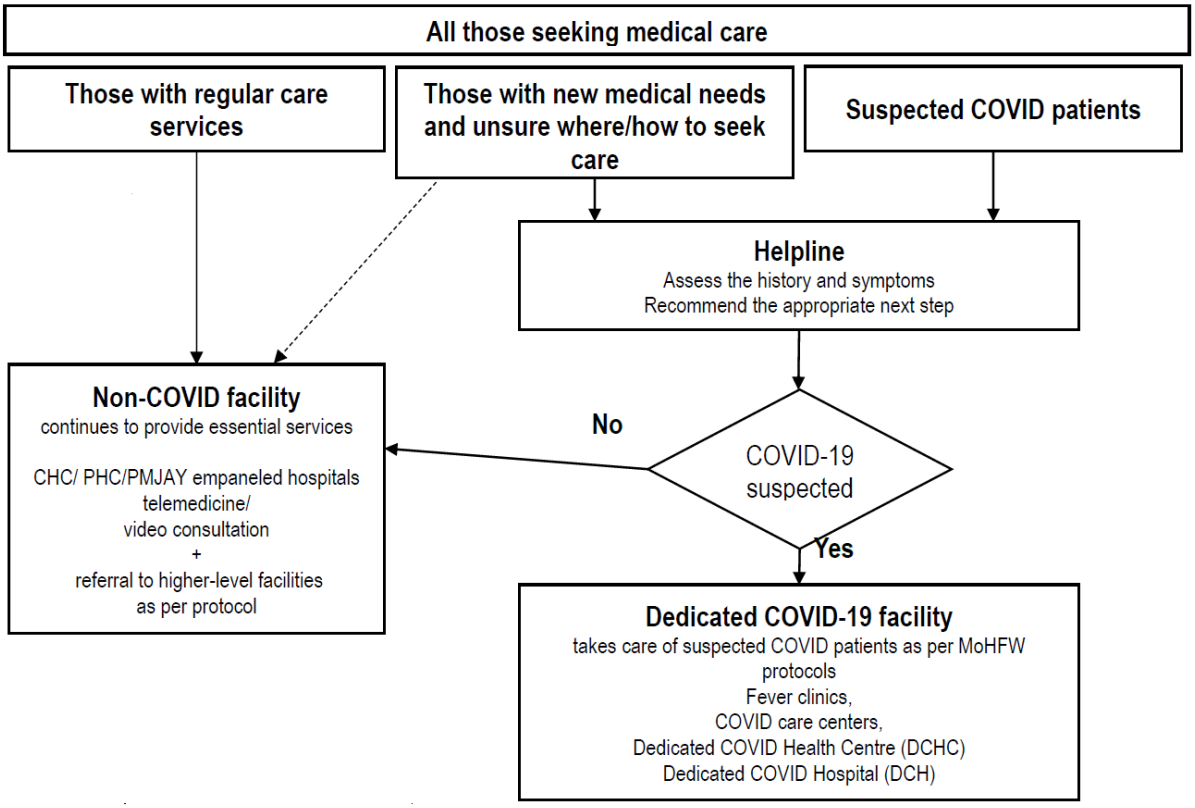


Figure 1: Protocol for providing essential medical services during Covid 19 (MoHFW)

STUDY FINDINGS 1: EXPERIENCE OF USERS

ACCESS TO MATERNAL AND CHILD HEALTH SERVICES

MoHFW Guideline

- Village Health, Sanitation and Nutrition Day (VHSND) activities could be suspended but ANC services are to be provided on walk in basis as per standard protocols at the SHC level following physical distancing norms.
- Availability of TD/ IFA/ Calcium during ANC period to be ensured
- Ensuring safe institutional delivery. Each pregnant woman to be linked with the appropriate health facility for delivery
- Ensure availability of IFA and calcium tablets during PNC period. In case of home deliveries, immediate visits to be made by ANM or CHO
- Immunization services are to be provided at facilities wherever feasible, for walk-in beneficiaries.
- Delivery of immunization services though outreach must be assessed in local context and should be undertaken only if safety of health workers and community is not compromised.
- Catch-up vaccination should be conducted as soon as the restriction is eased.

SERVICES FOR CHILDREN

A total of 327 parents were interviewed. Before the pandemic over 90% of the respondents with small children who needed immunisation services, across the three states, reported that immunisation services were being held monthly on the Village Health Nutrition and Sanitation Days at the Anganwadi Centre. In a slight variation between states, 96% of the respondents from Jharkhand and 94% of those from MP reported a monthly regularity, while it was a little less at 85% for Karnataka. With the onset of lockdown, the VHSND services were suspended. ASHAs and ANMs reported that they were asked not to conduct the VHSNDs for 2 or 3 months. Families could not access the MCH services at the village level. In Karnataka most of the respondents noted that the services started resuming in the month of May itself and by July all the respondents noted that the VHSND had started functioning. The situation was different in Jharkhand and MP. In MP the respondents noted that the VHSND services resumed in a graded manner over the months of May, June and July, while in Jharkhand most respondents noted that the VHSND services resumed only in July. In Jharkhand, the respondents reported that VHSNDs were not being conducted regularly even after 6 months of the lockdown, and several noted that they were asked to come to the health subcentre, which was some distance away, instead of at the AWCs which was in the village. This increased their difficulty in accessing immunisation services, especially since travel was restricted due to lockdown. One ASHA from Jharkhand described the situation in her village thus. '*It could be resumed only in July and that too at the sub centre level. As sub centres are located far*

from the villages, most people could not come there. Also, there was fear of getting infected by corona among community and that's why pregnant women and mothers with small children were not ready to come out."

Due to the differing pattern of resumption of VHSND services in the three states, the immunisation of children was affected more significantly in Jharkhand and Madhya Pradesh compared to Karnataka. In Karnataka at the end of the 6-month period the immunisation of 7 children out of the 100 children covered in the survey remained incomplete, whereas in MP and Jharkhand 77 out of 125 children and 47 out of 102 children had incomplete immunisation. In Karnataka 11 parents had to take their children elsewhere, including to private clinics for getting them immunised, while in Jharkhand 18 parents did the same. In MP only 1 parent took their child to the district hospital for getting them immunised.

Around 30% of the respondents reported the child having some health problems during the lockdown period, most of them suffering from diarrhoea and fever. Of the 28 children who had fever or diarrhoea in Jharkhand only 5 were attended to by the ASHA. In MP it was 16 out of 46 children while in Karnataka it was 11 out of 24 children. In the absence of support from the frontline functionary many parents sought treatment from private sources including informal providers or quacks. In Jharkhand 13 out of the 24 parents, who were not supported by the public system, sought the treatment from informal providers. A very small proportion of parents, depended on home remedies, while a few did not take recourse to any form of treatment for their child's illness.

TABLE 2 : CHILD HEALTH PROBLEMS AND THEIR MANAGEMENT DURING THE LOCKDOWN

	JH (102)	MP (125)	KR (100)	Total (327)
Diarrhoea	5	31	5	41
Very High fever	19	23	4	46
Pneumonia	0	4	1	5
Jaundice	0	0	1	1
Other (cough/fever/tumour, bites)	7	2	8	17
Total*	28	46	24	98
Treatment support provided by ASHA	5	16	11	32
Treatment from private or informal provider	21	30	7	58

(Total includes children with more than one condition)

The experiences of the respondents also indicate that due to the limited commute options, unavailability of public health services, they had to walk for long distances or go on a cycle with the sick child to the nearby towns to see the private doctors or village doctors. They also had to spend more money to seek treatment. Some of them have reported paying as high as Rs1000/- just consultation, injections and medicines. Some of the respondents in JH and MP managed to reach the public hospital, however providers refused to treat the child. In one such instance where the respondent (from MP, whose baby had diarrhoea) shared their experience, "*First we went to the Primary Health Centre, there the nurse madam told us that our baby was very small and could not be treated in the hospital and should be taken to a private hospital, I rushed to the private hospital, my child got the treatment."*

MATERNAL HEALTH SERVICES

A total of 287 women who had a childbirth in the last six months and were currently lactating were covered by the survey. Before the lockdown 262 out of these 287 women reported attending the VHSND. However, with the lockdown VHSND services were affected and many women in Jharkhand and MP did not receive the required services during the period under review. In Karnataka as the VHSND services had resumed soon very few women were affected. Nutrition supplementation, which is a key component of the maternal health programme was affected due to the lockdown. Many women in Jharkhand (86%) and Karnataka (50%) did not receive their nutritional packs on a regular basis. Surprisingly only 11% of women in MP said that did not receive nutrition packets on a regular basis. The respondents were informed that packets were not being supplied due to the lockdown.

Some women also faced some other health issues like anaemia, back pain and white discharge during the lockdown. Most of them went to the private hospitals for treatment. Some who were able to reach the government health centres, also shifted to the private hospitals because government doctors didn't attend to them. This raised cost of care and one respondent mentioned spending Rs.3000 for check-ups and tests.

The ASHAs said during their interviews that ambulance services were disturbed and they couldn't take women for institutional deliveries. In Karnataka the families managed to reach institutions by hiring private vehicles but in Jharkhand and MP, many women ended up having childbirth at home with the help of the Dai or family member or on their own. One ASHA from MP shared "*Around seven child births took place during lock down. Two cases were managed at the district hospital. 5-6 childbirth took place at home. They were scared to visit the hospital due to the corona pandemic. Childbirth was done by midwives and mother and child are fine.*

In some places, families took women to the private clinics who charged high fees. In the initial phase of the lockdown, ASHAs were asked not to do home visits. Benefits under maternity programs (JSY /PMMVY) got delayed in reaching women; especially affected were those who had their first baby as they did not have a bank account and couldn't open one. Later when the services were resumed, the ASHAs reported that everyone including the doctor maintained a distance while talking to a pregnant woman or to a woman who just had had childbirth and avoided touching the new born. An ASHA from MP shared *"Doctors maintained distance during clinical check-up of pregnant women. Earlier they used to touch and do the check-up but are not doing so now. They were asking for sonography. Sonography is done in private laboratory in … (name of town). It charges 1000. Sonography facility is available in …(name of district HQ) but there you have to go twice, once to take appointment and then later for the actual sonography."*

CONTRACEPTIVE SERVICE DELIVERY

MoHFW Guideline

- Contraceptives (Condoms/ Oral Contraceptive Pills MALA/Chhaya, Injectable Contraceptive Antara /Emergency Contraceptives) are to be provided to eligible couples / others needing them through all Public Health Facilities, including through ASHA/SHC and PHC for easier access.
- Medical and surgical abortion services should be ensured at appropriate facility level, with appropriate infection prevention measures including counselling for post abortion care and provision of contraception.

A total of 254 contraceptive users were surveyed across the three states. The details of the contraceptives used by them are given in Table 3. A total of 170 of the 254 used contraceptives which required regular supplies.

TABLE 3: TYPES OF CONTRACEPTION USED BY RESPONDENTS

	Jharkhand	MP	Karnataka	Total
Injectable	6	10	8	24
Copper T/PPIUCD	32	34	18	84
Pills	40	36	18	94
Condom	27	16	9	52
	105	**95**	**54**	**254**

The majority had started using contraceptives one year before the lockdown. Before the lockdown 152 of the 170 users (90%) received their contraceptive supplies from government sources and only around 10% each got it from private sources. A third of all supplies were received from the ASHA.

Pills were the most commonly used contraceptives and the ASHAs shared that the most common pill was the Mala –N (Combined Oral Contraceptives (COCs). The ASHAs also shared that Muslim woman preferred condoms and took Chhaaya tablets (Centchroman a non-hormonal pill) or IUCDs. A*divasi* women on the other had preferred sterilization but also used injectables and pills.

Four women in MP said that they had their PPIUCD inserted without any information or consent. The ASHAs confirmed that this would happen in some cases. One woman who was noted as a PPIUCD user in the lists received from the ASHA shared her experience. "*After my delivery, without any information or consent, they put a Copper T for me, which I was told only after the procedure was over. After 4-5 days, I got pain in my abdomen, I suspected it must*

be because of the Copper T. After a week, without informing the ASHA, I went to the hospital and got the Copper T removed and after that I was feeling better."

With the lockdown around a fourth of all respondents reported facing some problems in accessing pills, injectables or condoms. With the health system preoccupied with Covid 19 related duties the respondents had to make their own arrangements. A third of the 170 users of pills, condoms and injectables bought their own supplies while a fifth (21%) said they had sex only on safe days. Another third (34%) said they had sex without using contraceptives. One major hurdle in getting contraceptives was that the markets were closed and travelling to the town to get them was also difficult.

One woman from MP reported that she became pregnant because she couldn't access contraceptives and carried the pregnancy. Two ASHAs from Jharkhand shared that they were approached by women who were earlier contraceptive users, to obtain an abortion. Several contraceptive users also had health problems like heavy bleeding during menstruation, nausea/ vomiting, pain in abdomen, irregular menstruation, white discharge, and back pain. Some of these women sought help from the ASHA.

ACCESS TO SERVICES FOR LONG TERM TREATMENT NEEDS

MoHFW Guideline

- List of all TB patients should be maintained at the PHC/ SHC level.
- Delivery of DOTS to TB patients through ASHAs/ ANM/ volunteers to be ensured, closer to the community, with minimum or no travel
- Hypertension, Diabetes and other NCDs like COPDs- All known/ diagnosed patients of Hypertension, Diabetes, COPD and mental health to receive regular supply of medicines for upto three months through ASHAs or SHCs on prescription.

A total of 331 persons requiring long term treatment were surveyed from the three states. Before the lockdown a majority of those with diabetes or hypertension sought treatment from private providers. In the case of tuberculosis only 10 of the 91 respondents with TB sought treatment from private providers. In Jharkhand the peripheral health system, comprising the ASHA, ANM or the PHC, played a very minor role in the treatment of hypertension or diabetes. In MP the peripheral system played some role in the case of hypertension, but it was of not much use to those with diabetes. This was because some Health and Wellness Centres had started here and the Community Health Officer was treating patients with hypertension. In Jharkhand and Madhya Pradesh some ASHAs did not know whether they have any role to play in the treatment of diabetes or hypertension. In Karnataka the situation was different and the peripheral system was of much greater help to those with hypertension and diabetes. For their TB treatment most patients in Jharkhand and MP had to go to the CHC or the District hospital whereas in Karnataka many TB patients got their

medicine closer to home from the ASHA, ANM or PHC. In MP a new cadre of volunteers called Senior Treatment Supervisor/ ICMR Volunteer were providing the treatment. Further details of where patients received their regular medicines before lockdown is provided in Table 4.

TABLE 4: SOURCE OF HEALTH SERVICES FOR LONG TERM TREATMENT									
Service Provider	***Hypertension***			***Diabetes***			***Tuberculosis***		
	Jknd	**MP**	**Kntk**	**Jknd**	**MP**	**Kntk**	**Jknd**	**MP**	**Kntk**
Total Cases	23	38	62	44	25	45	37	41	13
ASHA/ANM/PHC/	1	21	24	4	3	19	10	28	11
CHC/ DH/ Govt Hospital/ ICMR Vol	0	8	15	7	12	15	27	35	2
Pvt Doctor/ Hospital	15	21	29	25	15	20	3	3	4
Jhola-chaap/ Home remedies/Other	3	2	0	5	0	0	0	0	0

In addition to medicines, persons with diabetes, hypertension and tuberculosis are expected to receive regular check-up and counselling according to the prescribed norms. In Jharkhand and Karnataka, less than 50% of the respondents with hypertension received counselling, in MP it was a little higher at 55.3%. Among diabetes patients, less than 40% received any counselling services, only in MP it was around 56%. With regard to TB patients, 62% received counselling services in Jharkhand and, in Karnataka 42.9% and in MP only 18.6% were counselled. Patients with tuberculosis are also supposed to receive a monthly stipend of Rs 500 for nutrition support. Of the total TB patients, only 32.4% in Jharkhand, 14% in Madhya Pradesh and 7% in Karnataka received this monthly support, before the lockdown.

With the onset of lockdown many respondents had difficulty getting their regular medicines from the government facilities, especially the TB patients. In Jharkhand 34 of the 67 respondents with hypertension or diabetes faced a problem in getting their medicines and treatment. In MP 33 out of 63 respondents faced the same problem and in Karnataka the problem of getting medicines was faced by 51 out of 99 respondents.

Around 21% of hypertension respondents, 25% of those who had diabetes and 16% of TB patients were unable to get their regular medicines. Around 10% of respondents requiring long term treatment could not contact any health provider, around 20% of hypertension respondents, 14% of those with diabetes, and 13.8% of TB patients could not go to the health care centres. For respondents with tuberculosis where the services were primarily provided by the government, 22 out of 37 respondents in Jharkhand and 19 out of 41 respondents faced problems in getting their medicines. In Karnataka only one respondent out of the 13 with tuberculosis was unable to get their anti TB medicines. This person had reached the PHC but was told there was a shortage in the drugs in the hospitals.

Some of the respondents reported that they were getting anxious due to unavailability of medicines and, reported increase in cough, nausea, palpitations, blood sugar level and so on.

Some respondents visited informal providers or quacks. One of them explained their experience. *During the lockdown, I was out of breath, I went to the government hospital, no one paid attention to me. Then I went to the nearby quack, he gave me one injection, put me on a drip. I went to him ten times, each time spent Rs 500/- and the total expense as of now is Rs. 5000/-.*

STUDY FINDINGS 2: EXPERIENCE OF FRONTLINE WORKERS

The health system responded to the lockdown by preparing front line workers. Orientation sessions were organized where they were provided information about how to manage the situation and about the safety measures. In Karnataka, the health department did this orientation very systematically, but it was not the case in Jharkhand and MP. Across the three states, the mobile phone was used extensively for sharing of information with FLWs. However, access to smart phones was limited and these were also needed for children's online classes. There were also challenges with internet connectivity. The experience of ASHA's and ANMs is summarised below.

Accredited Social Health Activists (ASHAs)

During the lockdown, the frontline workers became key actors in the roll out of various pandemic related community outreach activities. The ASHAs are often the face of the public health system at the village level. They are part-time community health workers who are paid a performance-based incentive for the various tasks that they are expected to perform. A total of 44 ASHAs, 11 from Jharkhand, 15 from Karnataka and 16 from MP were interviewed as part of the study. In Jharkhand the ASHAs are known as Sahiyas.

COVID 19: PREPAREDNESS OF THE ASHAs

In all the study sites the ASHAs said that the health department had oriented them about the novel Corona virus, the preventive measures and what their role would be in the addressing the challenges. ASHAs from Karnataka reported that these trainings were systematic and, in some places, they also had weekly meetings with the Panchayats. The other source of information were the news channels on TV. The health department had suspended all the regular meetings and started communicating with its staff through phone, WhatsApp or doing virtual meetings.

The ASHAs were instructed not to touch any surface, especially during childbirth and if did so, wash their hands immediately or use sanitizers. They were also asked not to use registers but keep a list of people who attended their meeting and sit at a two arms distance from each other. They were given formats to do surveys to list people with symptoms of cold, cough or fever; to make list of people who had come from outside and send them for quarantine; to create awareness in the community about the pandemic and about preventive measures like wearing masks, maintaining safe distance, and not to attend the public functions or large gatherings.

In all the study sites ASHAs reported that they were given Safety kits (masks, bottles of sanitizers and gloves), but often had to spend out of pocket for Personal Protective Equipment (PPE). In MP, when ASHAs didn't get masks, they learnt how to make these.

PERCEPTION ABOUT THE PANDEMIC AMONG ASHAs AND THEIR FAMILY

There was a sense of fear among ASHAs. They were scared to go out of their homes as one ASHA said, *"We were told that the virus stays on clothes for 9-10 hours and on hands for 2-3 hours. Since we had no choice and we had to save others' lives, we took extra precautions."* Many ASHAs had small children at home or aged family members. "*After returning from the field we would first take a bath, wash our clothes and only after that we would enter in the house."* One ASHA said, *"I raised my fear in my department, but I was told that you were given work and you have to do it…"* ASHAs felt that it was their responsibility to save people. They also handled their family's fear and made them understand about their roles and responsibilities. They said they had to balance between their responsibility of serving people and at the same time keep their families safe.

ASHAs said that their families supported them in performing their duties. *"There was fear and courage both. (Bhayanu ittu, dhairyanu ittu). We were using sanitizer; we were wearing mask. when we had to go inside district hospital there was some fear."* said an ASHA from Karnataka. When they would return from the field or from the hospital others in the family would keep hot water ready to take a bath, would take care of the children and sometimes, especially during the night, their husband would accompany them to the field. *"My husband understood soon and stood by me and supported me. After reaching home, I would go straight to the Washroom to take a bath and only after ensuring proper sanitization I would let my children and family come near me. I have a young child 3 years old, my husband would take care of him"* said an ASHA from MP.

DEALING WITH FEAR IN THE COMMUNITIES

Community members faced many challenges during lockdown. Everyone was scared *("sabhi ko bhay lag gaya tha"*), everything was closed, people who had jobs or businesses lost their livelihood. The ASHAs were busy providing health education, clarifying doubts, stopping rumours, teaching protective behaviours and explaining why quarantine is needed. When ASHAs conducted door-to-door surveys asking people about any kind of illness, people hid illnesses since they were scared they would test positive and would be put in quarantine centres. People would not even offer them water. In some places, members of the community argued with the ASHAs. One ASHA from MP recounted *" The people had come to beat me even. One boy had come from Gujarat during that time. I had asked him about the screening at Sheopur. I told him that you are fine but still the check-up is needed. People of the village thought that if he would be sent for screening then he would be killed at the hospital. They were angry with me. Then I called ANM didi."*. Despite all the hard work and challenges, ASHAs

were happy that people started recognizing them and started understanding their role and responsibilities.

CHANGE IN ASHAs' RESPONSIBILITIES AND REIMBURSEMENT FOR ADDITIONAL SERVICES

During the lockdown many new responsibilities were given to the ASHAs. They had to do surveys for Non-Communicable Diseases (NCDs) and make lists of children, adults, and elderly people. They also had to do daily checking for any health problem and submit updated lists daily. They also needed to make lists of migrants coming from other places enquire about their health and then take them to PHC for testing. In MP the ASHAs shared that they also needed to do surveys for malaria and tuberculosis during the lockdown.

They had to often go to the PHC or CHC. Sometimes they were provided ambulance not always. While returning from the hospitals they had to often arrange for their own transport. Since public transport was restricted, they had to ask their family members to take them on two wheelers or hire a vehicle.

ASHAs are given a small, fixed honorarium and performance-based incentives for providing maternal health or family planning or other services. During lockdown routine services were disrupted and for the Covid related additional work they were given Rs.1000 / per month for first couple of months. Then this payment was stopped. ASHAs mentioned that payments are usually delayed and released in tranches. During lockdown income of other family members was affected and the delayed disbursements from the health department affected them. Many expressed their frustration over the tiny amount paid to them in comparison to the workload they were carrying and that too was not given on time. They were told if any ASHA gets infected by Covid 19 she would be covered by an insurance, but this was verbal assurance and nothing was given in writing.

ASHAs AND THEIR ROLE IN MONITORING RETURNING MIGRANTS

In several study villages in Jharkhand and MP people who had migrated to other places for livelihood started returning in large numbers during the early months of lockdown. Villages were full of such returnees and a majority were men. ASHAs had to keep list of all such people and report daily. Initially it was chaotic but soon they would receive advance information and prepare the families for home quarantine for 14 days. Later quarantine centres were set up in the villages in community halls, schools, panchayat bhawans. In some villages the quarantine centres were in separate villages and the families or the returnees' faced difficulties in giving them cooked meal from a distance. In other quarantine centres migrants were provided dry rations and they cooked their own food. While the responsibility of running these quarantine centres were with the Panchayats, the ASHAs had their own responsibilities and had to coordinate. On their arrival the ASHA had to take them to the nearby hospital for testing and this was repeated after 14 days. When home quarantine was started the ASHAs needed to coordinate with the family for making the necessary arrangements.

COORDINATION WITH OTHER FUNCTIONARIES

ASHAs in MP and Jharkhand had to coordinate with the Panchayat and the Anganwadi Worker. In Karnataka, Male health workers were engaged to support ASHAs in discharging their Covid related responsibilities. ANMs were posted in hospitals and would come only on vaccination day (VHND) or when Covid tests were to be done in village camps. They supported the AWW in distributing Take Home Rations when supply was resumed. ASHAs also supported the Panchayats in identifying people who did not have ration card so that they could be given rations and supplies.

While ASHAs supported the Panchayats in their work, they did not receive much support from Panchayats for their work. In MP the ASHAs felt that although panchayats members helped when asked, they did not extend support on their own. They were mostly useful when some villager would not cooperate or created problems for the ASHA to do her job. In Karnataka the Panchayats made arrangements for spreading information about preventive and protective measures through *dangra saridru* which included beating a drum to get people's attention and then making announcements.

In Jharkhand supplies like masks and sanitisers and rations were also received from an NGO. In one location the adolescent girls group helped in distributing these and also in communicating health information. In another location the local women's group provided food to people. In another village the local SHG group served cooked food and arranged for a public distribution for those who needed it.

When asked whether the Village Health Nutrition and Sanitation Committees provided them with any support, ASHAs in all locations said that no support was received.

PROVIDING ROUTINE SERVICES

All routine services were suspended in the first couple of months of lockdown. Services resumed the earliest in Karnataka. ASHAs said that they had to put other maternal health related work on hold as conducting meetings was prohibited. Immunization was not done also because people were not ready to take any injections. The situation was better in Karnataka compared to the two other states.

There was no clear guideline about what to do with women who were about to have childbirth and, in some cases, ASHAs lost touch with them. In the initial phase of the lockdown, ASHAs were asked not to do home visits. Women were scared to go to the hospital for fear of catching the infection. Ambulance services were severely affected. Those who went were often ignored by doctors busy with pandemic related duties. In Jharkhand and MP there were many home deliveries. Later when services were resumed, ASHAs said that they maintained a distance while talking to pregnant or to a woman who just had given birth and avoided touching the newborn.

Contraceptive supplies were not provided to ASHAs of MP and Jharkhand for the first three months of the lockdown. In Karnataka ASHAs carried condoms and contraceptive pills with them and gave them to whoever asked for it. No sterilization camps were held in either of the three states.

Over time the ASHAs started resuming home visits and some women started coming out for the immunization. ANMs and doctors started examining women properly as earlier they were avoiding any contact with the women. ASHAs called women in small groups for vaccination so that safe distancing could be maintained. They asked women to come wearing masks and kept sanitizer or soap for hand wash. Ambulances services become more regular. The incentives under the Janani Suraksha Yojana and, Pradhan Mantri Matritwa Vandana Yojana which were suspended for the first 2 months were resumed.

Auxiliary Nurse Midwives (ANM)

Auxiliary Nurse Midwives (ANMs) are the lynchpins of healthcare in rural areas in India. On one side they manage the link between the health care system and communities by managing the Sub Health Center and coordinating with the ASHAs. Seventeen ANMs were interviewed to understand their experience during the Covid lockdown.

SUPPORT FROM THE HEALTH DEPARTMENT

As the lockdown was announced, ANMs across the three states were instructed that they suspend all daily, and monthly activities for some time. They were trained at the block hospital of Community Health Centres on the features of the virus and on ways for prevention and creating community awareness. In Karnataka Zoom meetings were organised. In Jharkhand the ANMs also received messages on WhatsApp. They also received thermal screening device. In MP physical meetings were cancelled and all instructions were virtually provided.

Although the information given was comprehensive, the supplies given were not adequate. Most of the ANMs reported having received the supplies for masks, gloves and sanitizers only for a limited period, after which they had to spend their own money to buy them. Only limited number of PPE kits were given in Jharkhand and Madhya Pradesh which were to be used only while conducting childbirth or while dealing with a COVID positive patient.

SUPPORT FROM THE FAMILIES

The ANMs reported that even though there was fear and anxiety in the community and among their family members, they continued their work with a sense of duty. ANMs across the districts shared the anxieties they faced in doing their daily work and returning home to their children or their older parents. One ANM from MP shared her fears. *"I was scared for my family, for once I thought to leave my children at home and work from the CHC itself but my child is very small so it was not possible. Whenever I came back from the job I took bath, washed my clothes and then only entered the house."* Some of the ANMs had very supportive

family members who encouraged them to continue their work, however, some ANMs said their partners and in laws were unhappy.

There were also instances of husbands continuously boosting the morale of the ANM. *"My husband used to come with me, because the roads would be empty and I would have to travel 16 kms and I felt scared to go alone. He used to say you have worked all these days, but it is important that you work now and he would come with me."*

One ANM from Karnataka shared how she constantly had to reassure her family. *"I had to reassure my family members that I am fine, family members worried all the time, they were scared and angry. I was not afraid because I was doing everything with safety. It was my duty. If we feel scared and sit at home, who will make them aware. They kept getting angry with me, but I kept reassuring them."*

NEW RESPONSIBILITIES OF THE ANM

Across all the 3 states the ANMs reported being given new responsibilities. These included

- being present at the assigned check posts or in the village for screening of all migrants
- reporting of incoming number of migrants,
- ensuring that migrants are quarantined with adequate care in the quarantine centres.
- conducting village level surveys for identification of people with comorbidities,
- visiting all the villages to provide preventive information regarding COVID.

Some of the ANMs were trained to do the tests for COVID 19 and were given test kits. In JH ANMs were given targets to do to tests of the people in the village. In MP, the fieldwork started within 15 days to one month of the lockdown, the ANMS served as informers of those who were probably positive. They sent the suspected patients to the doctors, who later screened them and tested them. A few ANMs said that they had to work away from their homes for 3 months, if they were working near the state borders like the Madhya Pradesh border. In Karnataka they also had to do door to door thermal screening of all community members.

The ANMs were supported by the other people from the department as well as the AWW, ASHA, Sarpanch and Panchayat Secretary. In Jharkhand they complained that most of the responsibilities were given to the ANMs, and the male workers were not given any work. ANMs were full of praise of AWWs and ASHAs for the support they provided. In Karnataka the ANMs also got support from the local police. In many places the community was also very supportive and in one place the community took an oath to follow all the precautions.

MANAGEMENT OF ROUTINE RESPONSIBILITIES

In the first two months all routine services were suspended. Women who went to the hospital for childbirth would be tested for COVID before admission. Once services resumed, they had to do their routine responsibilities with the new ones. In Karnataka they had difficulty in doing

immunisations as AWCs were not open and they had to find alternative spaces, sometimes it would be under a tree. They could not do urine and blood tests during the first few months of lockdown. Pregnant women were advised against routine services and told only to seek help in cases of emergencies. ASHAs were encouraged to provide door-step delivery of IFA and Calcium tablets. Deliveries were conducted at home in all three states. In Karnataka it was reported that there was a shortage of ambulances because these were being used for COVID patients.

ANMs reported difficulty in providing contraceptive services across all three states and within the states. The major difficulty was in providing IUCD or sterilisation services to women who wanted these.

Even when regular services resumed some problems continued. In Jharkhand ultrasound for pregnant women was difficult to access both in public and private hospitals. In some places in MP and Jharkhand SHCs were closed. In other places the CHCs buildings would only open for emergency services and child birth services. OPD and other services were being given from outside and doctors would not touch the patients. In Karnataka, no health facilities closed at any level.

CHALLENGES FACED BY THE ANMs

Some of the challenges faced by the health workers are described below.

AVAILABILITY OF SAFETY GEAR AND EQUIPMENT

Almost all the ANMs across the district reported having to buy their own gloves and masks, as they had not received adequate materials. In Jharkhand there were some concerns with the quality of the masks. Some ANMs from Karnataka faced challenges in using PPE kits for extended periods of time.

EXTENDED WORK HOURS

Some ANMS felt that there should have been some time for rest as they had to work for 7 days a week for a very long period.

SETTING TARGETS

An important issue raised by ANMs from Karnataka related to targets for doing COVID tests. Doing tests to fulfil targets when people didn't have symptoms, they felt was a waste of time. The new App through which they had to connect the patients and the doctor was time consuming and delayed their daily work schedule.

HONORARIA AND PAYMENTS

Almost all the ANMs across the states had grievances regarding payment of salaries and honoraria which they said was always delayed by 2 months to 6 months and this continued

during the lockdown. They were unsure whether they would receive any additional payments for the additional work they were doing. They had heard about it but till the time of the interview they had not received it. They were also not sure whether they were insured as they had not received any documents confirming what they had heard. The insurance scheme only covered the permanent ANMs but some who were interviewed were temporary and felt that their exclusion was unfair. The temporary ANMs also mentioned that due to the difficulties in travelling they would end up spending more money in travelling than their honorarium during this period. Some felt it was okay to be feted as Corona Warriors, but they should also be compensated.

CHALLENGES FACED IN THE COMMUNITY

With fear and anxiety that had spread in the community, response from each village to the Covid lockdown related restrictions varied. On one hand, ANMs appreciated the support provided by the Panchayats but also felt that there were other people in the community who were not adhering to the prescribed norms, and some were rude to or harassed health workers. In one case an ANM reported of being attacked. In other cases, they were stigmatized and asked to vacate their rented premises. Others asked ANMs to stay away from their homes fearing that they would carry the infection.

STUDY FINDINGS 3: LOCAL SUPPORT MECHANISMS

Early in the pandemic, even before the lockdown was announced, the Ministry of Panchayati Raj, in an advisory to all State Government's on 13th of March 2020, had advised that the Gram Panchayats, Panchayat Samitis and Village Health and Sanitation Committees should spread awareness and facilitate environmental sanitation in the villages. In a further advisory on 15th of May 2020, an advisory on community preparedness was issued to all states. It advised among other things promoting solidarity and preventing 'social stigma', identification of needy families and arranging for help and ensuring continued provision of essential health services in addition to quarantine, testing and environmental sanitation related responsibilities. These institutions were also asked to coordinate with the health authorities and functionaries. A checklist on community preparedness developed by the Mahatma Gandhi Institute of Medical Sciences, Wardha was also attached with this advisory.

The study tried to understand of role of such agencies and the support they provided to frontline workers and those requiring essential health care services. In-depth interviews were also conducted with 21 PRI members and 37 VHSC members.

VILLAGE HEALTH, SANITATION AND NUTRITION COMMITTEE (VHSNC)

The VHSNC[13] is a community level committee that is expected to support the implementation of health programmes, facilitate community engagement and also help in community-based planning and monitoring. It includes members of the Panchayat other members from the community as well as the ASHA and the AWW. More than one-third of ASHAs, ANMs and AWWs interviewed were either ignorant of VHSNC or said that the committee has been non-functional for quite some years now. Those who knew about it, said that it was mainly known for the untied fund of Rs 10,000 which was used to buy furniture and equipment for the AWCs or for cleaning and disinfecting the village. Many said that the untied fund had not been received for many years. In some places however VHSNC members helped the ASHAs in spreading awareness or talking to people who came from outside. An ASHA from Karnataka said, *"They have helped us a lot. They have helped us in giving information to people in home quarantine, spreading awareness about COVID, they have given us masks and sanitizers as we are 'Setuve Sibbandi' means bridge crew"*. On the other hand an ANM from MP said "*I don't have idea which committee you are asking about. There is one committee where we receive 6000-10000 annually. That committee didn't contribute during lock down."*

The various service users were also asked about any support they may have received from VHSNC members. There was a marked difference in the role played by the VHSNCs in

[13] https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=149&lid=225

Karnataka compared to Jharkhand and MP. In Jharkhand and MP most had not heard or did not know that a such a committee existed. In Karnataka on the other hand nearly 25% of those having requiring long term treatment and more than 50 % of parents of infants said that they had received some support from the VHSNC members.

TABLE 5: SUPPORT BY VHSNC TO HEALTH SERVICE USERS						
	Persons needing LTT			Parents of Children		
VHSNC Support	JH	MP	KR	JH	MP	KR
Helped in availing health services	1	6	17	0	9	26
Helped in availing ration	1	3	1	0	3	3
Gave information regarding protection from Corona	4	6	17	3	8	24
Other	0	0	4	0	0	1
No Support Provided	119	108	87	99	107	48
Total	124	116	117	102	126	100

GRAM PANCHAYAT

During pandemic lockdown Gram Panchayat members were expected to maintain law and order at the village level, provide support to the FLWs and arrange for the quarantine of returning migrants. Among the 21 GP members interviewed 10 were women and of these in the case of 5 the roles of the GP member were being done by their husband or male family member.

They made arrangements to prohibit direct entry of the people returning from cities by putting barricades at the main entry points of the villages. Those coming back home were sent for Covid tests and then quarantined for fourteen days. Panchayats managed these quarantine centres. In MP and Jharkhand many migrants returned as they lost their livelihood in cities. Initially the Panchayats distributed ration and later supported the Public Distribution System (PDS). Jobs were created under MNREGA but many migrants did not come forward as wages were lower and did not want to do earthwork that was being offered. One Panchayat President from Jharkhand shared that *"Lockdown did not affect health services as much as it had affected livelihood of people; they were unemployed, not able to earn livelihood anywhere. We worked hard and provided jobs to them in MNREGA scheme. We did every effort so that people can earn and eat two times meal respectfully".* Another Panchayat President from MP shared that as people faced getting rations from the market *"we came up with a solution, as some shops in the village were open, so we printed pamphlets and gave to each household and if anyone needed any material, they could call in the shops or give lists to the shopkeeper. The shopkeeper then packed and kept it ready and then ration went to people in a systematic manner."* Another shared that *"This was done once because during first lockdown people were unaware and confused."*

Panchayat members also said that they distributed masks, soap, sanitiser and arranged for disinfection of the village. A Panchayat President from MP said that from the MNREGA funds they got 2000 masks stitched and distributed theses to every resident of the village. They also made arrangements for public announcements for Covid related awareness in the village. In many cases they made arrangements for sending people to hospitals when needed.

Some Panchayat members shared that the panchayats had not received any budget from the govt because the lockdown had been declared in March and release of funds was delayed. This hampered relief works. Some Panchayat members said that because the government health system was overwhelmed by the pandemic many had to visit private doctors for their health problems, and they charged a lot of money. A woman Panchayat President shared her own experience "There was no alternate arrangement. The hospital staff referred patients to private clinics. I had an accident while going to the field visit to N village to observe VHND. I was on bike with my brother and suddenly a dog came in front of us. I was taken to K CHC for treatment but they did not take me in, I was then taken to the private clinic where I got treated. I had to spend Rs. 6000 on my treatment. Private clinics were taking so much money from people."

TABLE 6: SUPPORT BY THE PRI MEMBERS TO PERSONS NEEDING LONG TERM TREATMENT AND PARENTS OF INFANTS

	Jharkhand		MP		Karnataka		Total	
	LTT	Inf	LTT	Inf	LTT	Inf	LTT	Inf
Helped in availing health services	0	0	3	3	7	14	10	17
Helped in availing ration	0	2	14	13	2	2	16	17
Gave information regarding protection from Corona	9	7	7	3	20	16	36	26
Other	2	-	1	-	5	-	8	-
No Support Provided	115	91	99	95	90	71	304	257
Total	124	102	116	125	117	100	357	327

(LTT= Persons needing Long Term Treatment, Inf = Parents with Infants)

Many Panchayat members said that they are usually not involved in health-related work and thus were not prepared for managing a health-related crisis. Panchayat members said that they helped ASHAs and AWWs when they faced problems in convincing to people follow the lockdown protocols. However, a majority of ASHAs said that although panchayats distributed masks and soaps and ration to the poor, they did not help the ASHAs. Also, Panchayats were active only in the village where the panchayat president's house was, other villages did not

receive such benefits. In many instances ASHAs and AWWs were unable agree with what panchayat president claimed.

While the Panchayats played a crucial role in managing the Covid related crisis, across the three states, the survey clearly indicates that the GP members played a limited role in supporting those families with routine health needs.

SUPPORT FROM OTHER ORGANISATIONS

Apart from VHSNCs and Panchayats, several other community-based organizations, adolescent groups, women collectives also came forward to help people during the Covid and lockdown, in some areas. These groups helped in different ways such as creating awareness among community members, distributing masks and sanitizers to people, making cooked food arrangements for the migrants and for the needy people and so on. One ASHA from Jharkhand said "*I received help from adolescent girls group. They distributed masks in the village. They got these supplies from an organization. The girls also assisted in my work, they used to come along and learn about the work I do in the field."* Another ASHA from Jharkhand said *"there is a (women's) SHG group in the village. They were providing cooked rice and daal for Rs. 10 to its members and their families. Very poor people who did not have any source of income also went there to eat. They provided food for almost a month."*

Local community members also pitched in support. A Panchayat President said *"if 50 people were coming at one time, we needed people to make arrangements for them. Community volunteers helped to look after quarantine centres, Sarpanch and panchayat secretary along with these volunteers took turns to make sure that all arrangements were proper in these quarantine centres."*

From the survey with the service users, it emerged that in Karnataka around 30% of service users received support from the local women's groups, mostly about preventive care. Lactating women were also supported for availing health services and getting nutritional supplements.

SUMMARY DISCUSSION AND RECOMMENDATIONS

During the first wave of the pandemic the main stories were about the spreading of the infection in large urban areas, emerging treatment protocols and their effectiveness, vaccine possibilities and the reverse migration of millions of people away from the cities. Many studies were published about the potential extent of spread and there was widespread fear among the population about this hitherto unknown condition. This study provides some light on people's experiences far from the where the main theatre of action was during the first wave. The unique advantage of this review is that it focusses on the experiences of communities and frontline health care delivery mechanisms among the most marginalised in diverse states. Despite the similarity of community level realities, the response from the public machinery in the three states was different and thus the experiences at the community level also had some diversities.

SUMMARY OF FINDINGS

HEALTH SYSTEM RESPONSE AT THE COMMUNITY LEVEL

The health department at the central level responded to the growing evidence of the Covid pandemic by releasing several protocols and advisories. Health care, notably the provision of curative services through hospitals is a mandate of the state governments, while the prevention of contagious diseases which can spread between states, like the Covid pandemic, are a joint responsibility of the central and state governments. Managing the health measures, including screening and quarantine at ports or points of entry into the country and interstate quarantine are the exclusive responsibility of the central government. Besides this constitutional division of responsibility, the management of the pandemic was also determined by the provisions of the National Disaster Management Act (NDMA) of 2005. Several states also invoked the Epidemic Diseases Act a 123-year-old law which was amended in April 2020 after the pandemic was announced.

There were many regulatory frameworks and different levels of jurisdiction that influenced the way health care services were delivered at the community level. The central government released several detailed advisories and SOPs. The three states covered in this review, followed through with their own state level advisories, and these were different according to local priorities. This meant that at the community level the delivery of health services, had some similarities but several differences as well. While the closure of services and the implementation of control and prevention measures was immediate and similar, the reopening of services and the return of routine services took place slowly and at different times, in the three different states. The system in Karnataka was more responsive in these

circumstances compared to that in MP or Jharkhand. This could well reflect the existing managerial and delivery capacity of the peripheral health system in the three different states.

DELIVERING SERVICES AT THE GROUND LEVEL: EXPERIENCE OF FRONTLINE PROVIDERS

The SOPs and Guidelines issued by the health department at the central government level were very detailed and included several facilitative elements. However, the capacity of the peripheral health system to address the emerging crisis and at the same time adapt its routine services to the changing circumstances was limited. This meant that managing the crisis took priority and routine services were affected.

The ASHAs, who are essentially community volunteers expected to perform part-time worker roles, were the most crucial link between the health system and the community during the crisis. The evidence from this review shows that they were right in the frontlines working tirelessly while confronting several concerns. They were provided some training for managing the crisis, but the support provided was inadequate to manage the different roles that she was expected to deliver. Despite the many challenges they were able to provide the pandemic prevention and control related services with some level of success. Routine services suffered, not so much due to lack of interest or effort but more because there was not enough guidance, support, or time for these. There was some difference in the experience of ASHAs in the three different states, and this was a result of the system support and guidance that was different in the three states.

The ANMs who are formal functionaries of the health department had several Covid related responsibilities. The prevention and control of the pandemic was their primary responsibility, and, in some cases, they were deputed to manage quarantine centres and manage incoming migrants into the region. The SHC through which ANMs are expected to provide routine services were closed in the first couple of months and reopening of these centres took place at different times in the three states.

Both the ASHAs and ANMs are women workers, and they had to manage their family and professional responsibilities in this crisis. As health functionaries they had to go out and meet others, when staying at home and avoiding contact with others was crucial for personal and family safety. The family support that they received to continue their work was invaluable for both ASHAs and ANMs. They also faced harassment and stigma from members of the community. A practical dilemma, especially for the ASHA was access to the mobile phone, which would be needed by children for their online classes as well as by her for her work.

One major challenge faced by ASHAs and ANMs in these lockdown times was continued delay in payment of salary and honoraria. Lockdown was a time when other members of the family had lost their livelihoods. In many situations they had to make out of pocket payments to fulfil their duties and delay in payments and reimbursements was a serious challenge.

EXPERIENCE OF EVERYDAY USERS OF HEALTH CARE SERVICES

Despite guidelines for provision of routine services being issued in the month of April 2020, the delivery of routine services was disrupted at the community level. These services resumed the earliest in Karnataka and the latest in Jharkhand among these three states. Since government health facilities were busy in handling Covid patients, people requiring regular services went to the private sector providers, informal providers or did nothing. Immunisation of small children was disrupted, most severely in the Jharkhand areas under review. Children having other illnesses were not attended to. Antenatal care of pregnant women stopped, and home births increased after consistent efforts over the last fifteen years or so had improved the quality of maternal health care and institutional delivery. Contraceptive commodities like pills and condoms were no longer available regularly from government sources and while some couples made private arrangements, others tried to adopt a safe-days approach. Some couples also had unintended pregnancies. The treatment regimen of those requiring long term treatment was disrupted. Because of lockdown, arranging for services from private sources was difficult because markets were closed and transportation unavailable. In some cases, persons who had approached public hospitals, which should have had provisions for managing cases according to the guidelines, were turned away. No evidence was available in this review of tele-consultation or any similar mechanism of support for those requiring routine services.

COMMUNITY SUPPORT MECHANISMS

The Village Health Sanitation and Nutrition Committee is expected to be the mechanism for community engagement for the health delivery system. This mechanism was weak in all study locations. There was often little evidence of even its membership beyond the official members mainly the AWW, who are more involved in the deployment of the little resources that are made available to this mechanism through the annual untied grants. The Panchayat on the other hand played several important roles, particularly in the control and prevention of infection, ration support to the needy and in the regulation of entry and support of returning migrants. Since the participation of the panchayats in health-related activities was less to start with, their support for users of health services during the lockdown was also less.

One of guidelines from the Ministry of Panchayati Raj pertained to developing community preparedness including solidarity at the community and to deal with stigma. It was advised that Gram Panchayat should coordinate with volunteers and SHG members at the community level. In this review, there was no evidence that the PRI members were familiar with this advisory. There was some evidence of support from adolescent girls groups and SHG groups in Jharkhand but this was probably the result of the initiative of a local voluntary organisation.

DISCUSSIONS

MANAGING MULTIPLE CRISES WITH WEAK SYSTEMS

The first wave of the pandemic affected the affluent in urban India first. This was unlike many other public health emergencies which often affect the poor or rural populations disproportionately. One possible consequence of this difference was that the pandemic and possible management mechanisms were interpreted through the urban middle class experience. Since the pandemic was due to a fast-spreading contagion, restriction of movement and activities was the first response. The urban middle class may have comparatively more resources to manage such restrictions, but these had a cascading and multi-dimensional impact in faraway rural areas. The livelihood and economic security of the urban poor are more tenuous, and thus there was unprecedented mass in-migration into rural India. This added to the rural health crisis in unforeseen ways and dominated Covid control efforts there. Thus, without much evidence of infection in rural areas, the weak public health system was overwhelmed. Routine services were disrupted, and frontline health workers were overwhelmed. In the best of times the bureaucratic machinery moves slowly. The National Rural Health Mission, envisaged in 2005 for a seven-year period, continues in a slightly different name fifteen years later with many early aspirations still not achieved. If the senior functionaries had expected that this same machinery would deliver Covid control and prevention services while maintaining routine services, it was an unrealistic expectation. While managing the health emergency the local public systems had to manage food and supplies as well as livelihood and economic crisis. Overall, the local systems managed credibly, but this was probably more due to the resilience of marginalised communities and features related to virus and its infectivity which changed dramatically during the second or delta wave.

CRISIS MANAGEMENT: BALANCING CONTROL AND COOPERATION

India announced complete lockdown on 24th March 2020. At that time India had very few ‘cases’, and even fewer deaths due to Covid 19, compared to countries in Europe that had announced lockdown a few days earlier. While identification and treatment of those with the disease was one focus, controlling the spread of infection was a more ‘visible’ concern. The coercive elements of such control were soon visible as news items carried images and reports of police lathi-charging people who had come out on the streets, barricades isolating areas and and posters marking houses where infections had been detected, crowds being doused with bleaching powder solution to disinfect them and so on. Fear of infection spread rapidly and even doctors and nurses who were working overtime were stigmatised and even beaten up. The more facilitative elements of support like organising trains and busses of stranded migrants came much later. There were more stories of citizens reaching out to migrants who wanted to return home in the early months than of government support.

The balance between control and support was tilted in favour of control in the areas that were covered in this study. In areas where infections were not so widespread, fear of the infection was stronger than any form of community support. Where state systems are weak, especially in the more remote areas and among marginalised communities, people have many mechanisms to support each other. The public systems failed to build upon the existing community support mechanisms. The guidelines for community preparedness remained unimplemented in letter and in spirit.

INADEQUATE APPRECIATION OF DIVERSE GROUND-REALITIES

The guidelines for maintaining routine services issued by the central government were very detailed and very facilitative. But despite the best intentions of these guidelines, they were not 'implementable'. This was primarily so because they did not consider the ground realities of the areas in which they were expected to be implemented. India is a country of multiple realities. The areas which were included in this study were from different states, but the population groups were similarly marginalised. The evidence shows that even in the state with better functioning systems, the demands of running emergency support and doing routine services was not easy. The communities suffered and workers were stretched. It may have been better if the guidelines were graded according to the different realities. But this would mean greater flexibility to local authorities to adapt according to their specific needs. This may also have been counter-productive because Indian public systems are run on top-down orders and instructions rather than on a bottom-up needs-based approach. Lower rung functionaries are expected to faithfully follow guidelines rather than innovate. Facilitative supervision is not a strength of lower bureaucracies and community action, including community planning remains one of the most ignored aspects of the NHM. The non-functional VHSNCs that were evident in the study are a testimony to this.

RECONCILING DIGITAL ASPIRATIONS AND REALITIES

With cessation of physical movement, the internet became a crucial medium for communication during the lockdown. While the digital footprint is reasonably widespread in India, access to the internet is not universal, and ability to use the internet varies among different population groups especially among marginalised communities residing in remote rural areas. The training and communication related to Covid management was done by the health department through online means and it was also assumed in the guidelines that teleconsultation would emerge as a major medium for routine health care related support. However, there was little evidence of the use of teleconsultations, though frontline health workers mentioned that the use of social media was useful for their work. The frontline workers also faced some constraints in the use of digital media as they often did not have exclusive use of an internet enabled smartphone. While there are tremendous possibilities in using social media and other internet enabled technologies for addressing communication and training and for extending information and other forms of support to remote rural communities, it is necessary to anticipate the ability of the intended beneficiaries of such

support to use these technologies optimally. It is true that digital technology and user capacities have vastly improved during the pandemic, but there remains a great digital divide which needs to be identified and addressed as we move forward.

ADDRESSING THE WEAK LINKS AND STRENGTHENING THE KEY RESOURCES

Female frontline workers, notably the ASHA as well as the ANM emerged as the most important resource at the community level. In most cases they went beyond the call of duty and faced many physical as well as financial challenges to provide the services required of them. What the guidelines expected of them in terms of delivering routine as well as pandemic services, concomitantly, was unrealistic. The support provided to them was insufficient. While they received training and commodity related support for covid prevention, they did not receive any emotional or psychosocial support beyond being feted as Covid warriors on rare occasions. They lived with the same fear of infection as everyone in the community, often with little personal protective equipment to call on. They had the fear of carrying the infection back to their families. They faced stigma and harassment from the community they served because the fear of the disease was so widespread. The public system expected them to perform but the support was inadequate, and reimbursements and payments were delayed. According to government guidelines a telephonic helpline was established to provide psychosocial support to frontline workers, but none of the front-line workers were aware of such a helpline.

Over the years several community levels groups have been established at the community level. These include SHGs, Nehru Yuva Clubs, Mahila Mandals (women's groups) among others. These are potential platforms for collaborative community action in times of emergencies. Notionally these mechanisms were acknowledged in the guidelines, but in practical terms they were ignored in the study area. There seems to be little trust in the district and sub-district bureaucracy in either community mechanisms or the communities' abilities to take coordinated action. This is a probably a big weakness of public systems to effectively deliver public services in remote rural communities. The health system itself demonstrated little faith in the VHSNCs that have been established as a part of its own programmes.

RECOMMENDATIONS

The Covid pandemic is an important reminder of human frailty and limitations, but also of the need to remain prepared for unknown and known challenges. Experts warn that there is a likelihood of more epidemics in coming years because of increasing global travel, urbanisation, climate change, increased human-animal conflict, and health worker shortages. Insights from this study may be useful as we prepare ourselves for managing such situation in resource poor settings. Such preparation will also be crucial for achieving the SDGs and UHC.

EMPOWERING LOCAL INSTITUTIONS

Despite a long-standing rhetoric of decentralisation of governance, public systems in India continue to be top-down administrative and authority driven. The NHM has mechanisms for communitisation, but they are secondary to technico-managerial solutions. The PRI has been limited to delivering public works and employment generation programmes at the village level. Various community level groups serve as extension agencies for government programmes rather than platforms for meaningful community participation and planning. When disasters happen, external resources are very important for overcoming them. However, the people within the community are best aware of their problems and have to be involved in finding appropriate solutions. This needs trust in the communities' ability to find solutions that will help their lives and helping them to build their capacities to do so. This also strengthens local resilience.

This requires moving the focus of community involvement in public programmes from nominal participation to meaningful participation. There is no lack of community level groups in villages in India as each new public programme has often come with its own specific community platform. In most cases these remain non-functional as the study found about the VHSNCs. These groups may need to be consolidated and given more responsibilities and resources. They need to be trusted, trained, monitored, and supported. Government officials may not be the best agencies to empower these groups, because they have little experience of autonomy within the government system. Social inclusion must be prioritised while building capacity so that marginalised communities can participate and benefit. Partnerships with NGOs and civil society organisations may be considered as has been done in many programmes including for Community Action for Health in several states. PRIs are constitutionally established local bodies and must be included within this framework.

STRENGTHENING FLWS

The immense value of female frontline workers in managing local problems, including crises, has been reinforced by this study. The fact that these female frontline workers often remain the most ignored and unsupported has also been underlined. There has often been mention of the team of the ANM, ASHA and the AWW as being crucial to the health and well-being of women, girls, and children in villages. However, the position of the ASHA remains the weakest

link in this triad as their position is uncertain. Is she an activist, a worker, or a volunteer? Does she represent the interest of the community, or does she represent the last link in the chain of the public health system?

Over the years an elaborate training and support mechanism has been developed for the ASHA, but their reimbursement and honoraria, remain uncertain. ASHAs have often agitated for better work conditions and have repeatedly demanded that they be treated as workers. As women they need to negotiate both with the system and their family and often have double responsibilities. This study shows that in times of crisis, even when they are not considered as workers, and their support is weak and there are several ground level challenges, they have performed to the best of their ability. This needs to be recognised not only through better work conditions but also through mechanisms which provide psychosocial support. The need for such support is acknowledged but the mechanisms proposed are notional and need to be made operational. FLWs also need to be backed up with functional health care services, effective referral transport system and adequate supplies of medicines and other essentials.

REALISTIC EXPECTATIONS AND PRACTICAL GUIDELINES

The Covid pandemic has created a large resource pool of guidelines and advisories. This study shows that despite best intentions, these guidelines could not be implemented for several reasons. One set of reasons remains that issue dissemination down the chain of functionaries into the forms and language appropriate for the field workers. Another set of reasons relate to the appropriateness of these guidelines in different contexts and situations and the space and encouragement for innovation and local adaptation. To be helpful and empowering these guidelines need to be developed so that they can be adapted to different realities and there is a support mechanism which helps the peripheral system to use these to the best of their capacity and help communities.

APPROPRIATE DIGITAL TECHNOLOGIES

During the pandemic digital technology emerged as the main medium for remaining connected. Even in the remote study sites the phone was widely used. This study was possible due to the digital technology as it was conducted during partial lockdown. However, the limitation of smart phone enabled methods with women, other marginalised communities in remote rural areas need to be acknowledged. Ways need to found where those who are more adept in the use of such technologies like younger people can be involved as local supporters and facilitators. Digital competencies of women and girls need to strengthened and resources made available for them to use these in these resources constrained areas. Applications need to be developed which allow such people to use such technologies comfortably.

We do hope the lessons and suggestions emerging from this study will be useful for all those who are interested in strengthening the local health systems. We believe these will not only be helpful facing up to emergencies and crises but also strengthen routine practices.

ANNEXURES

STUDY TEAM

FIELD INVESTIGATORS

- Purba, Ramswarath, Ribika, Santoshi, Shankar, Simoti, Sukhmani, Vishnu (Prerna Bharati, Jharkhand)
- Amarnath, Lakhichand, Sanket (Satyakam Jankalyan Samiti, MP)
- Meenakshi, Sadhana ()
- Geetanjali, Jameel, Pramod (Manav Foundation, MP)
- Devaputra, Gangaraju, Karibasappa, Latha, Salma, Shruthi (Peoples Forum of Justice and Health, Karnataka)

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- Sandhya Gautam
- Abhijit Das

GUIDANCE AND REPORT REVIEW

- Leila Caleb
- Imrana Qadeer
- Jyotsna Sivaramayya
- Nibedita Phukan

ETHICAL REVIEW COMMITTEE

- Nidhi Shukla
- Ritu Priya Mehrotra
- Sunita Sheel Bandewar

ABOUT CENTRE FOR HEALT AND SOCIAL JUSTICE

The Centre for Health and Social Justice (CHSJ) promotes meaningful change in the lives of the most marginal communities in our society. CHSJ empowers communities by strengthening individual capacity, agency and leadership through solidarity, and collective actions. CHSJ has been working to promote Gender Equality and improve SRH services since 2005 and the leadership has more than thirty years' experience in community development. For the last couple of years, CHSJ has been in the process of institutional rebuilding and created a path for the new leadership. CHSJ is registered as a Charitable Trust with its headquarters in New Delhi and field interventions and partnerships in more than 10 states of India.

CHSJ works with disempowered and marginalised communities like women, single women, domestic workers, manual scavengers, Dalits, tribals, minorities, urban poor and others on issues like health, gender equality, violence against women and governance. CHSJ works with a gender synchronized approach and works with men and boys to make them partners in initiatives on social justice.

CHSJ works directly with the community and provides technical support to other organisations who are working with similar objectives. Linking research with action and evidence with advocacy for policy action are other strategies of CHSJ.

CHSJ implements its activities through its field units based in New Delhi, Kolkata (WB), Jabalpur (MP) and Bundelkhand (UP).

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