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Women at the Center of the COVID-19 Pandemic: Insights from Rural Contexts in India

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Abstract: The Covid19 pandemic has resulted in an unprecedented health and socio-economic crisis globally and in India. Emerging discussions and evidence indicate that the impact of the pandemic is exacerbated for women and girls. In India, media articles have highlighted the challenges faced by women and girls, including increased incidents of domestic violence, limited access to support services and healthcare, challenges faced by the women frontline health workers, and those who had migrated and are travelling back long distances. This paper, based on a rapid study undertaken to understand access to health and nutrition services in rural contexts in India, highlights the impact of the pandemic on women and girls. It particularly reflects on how the pandemic and lockdown has affected access to essential health and nutrition services; the impact it is having on front-line workers, who are an entirely women workforce; increase in incidents of domestic violence, and mental health and wellbeing of women and girls. It outlines the need for the gendered approach to research and programming in the context of Covid-19.

Keywords: Pandemic, Covid-19, Front-line workers, Women and girls, Mental health.

Background and context

The United Nations in April 2020 warned that with the spread of the Covid-19 pandemic, the limited gains made in the past decades towards gender equality were at the risk of being rolled back (United Nations, 2020). Across spheres, from health, to employment and social security, the impact of Covid-19 is expected to be exacerbated for women and girls, simply by virtue of their sex. Experiences from past disease outbreaks and economic crises also suggest that women are likely to be disproportionately impacted.

However, neither in the past and nor during the Covid-19 pandemic, have policies and public health efforts addressed the gendered impact of the disease and associated crisis (Smith, 2019). There has been nearly no gender analysis of the Covid-19 outbreak by global health institutions or governments in affected countries. While initial evidence suggests that more men than women are dying, incomplete sex-disaggregated data caution against early assumptions (Wenham, Smith and Morgan, 2020). Simultaneously, data from China indicates that more than 90 percent of the health care workers in Hubei province, the most affected location in the country, are women, emphasizing the gendered nature of the health workforce and risk to female health workers (Boniol et. al., 2019). The closure of schools and workplaces to control the Covid-19 transmission in China, Hong Kong, Italy, South Korea, and other countries is likely to have a differential effect on girls and women, who provide most of the informal care within families, limiting their education, work, and economic opportunities. Further, examples from past outbreaks indicate that limited agency and decision-making authority among women, and inadequate access to healthcare and support systems, adversely impact the health and wellbeing of women during disease outbreaks (Wenham, Smith and Morgan, 2020).

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In India, media articles have highlighted the disproportionate burden of the Covid-19 pandemic on girls and women and the challenges they face–from women in migrant families, travelling long distances, without food and water, pregnant women delivering during transit, without adequate healthcare support, increased incidents of domestic violence, women having to manage the burden of increased household chores and care-provision, loss of work and pay for women, to women frontline workers providing care without adequate protective equipment and support. Yet, despite lessons from the past and emerging challenges, the relief measures and programs announced, by the central and state Governments in India lack a gendered lens. In other words, the burden of the pandemic on girls and women has not been adequately considered within these programs.

This paper, written based on a rapid study, undertaken to understand access to health and nutrition services in rural contexts in India, highlights the impact of the pandemic and lockdown on access to healthcare and nutrition for women and girls. It highlights the challenges faced by front-line workers, who are an entirely women workforce. It briefly also reflects on the increase in incidents of domestic violence, and mental health and wellbeing of women. It finally outlines the need for a gendered approach to research and program implementation in the context of Covid-19.

Research methods

The rapid study, undertaken in five states - Bihar, Jharkhand, Odisha, Rajasthan, and Uttar Pradesh, in May 2020, sought to understand access to outreach and facility-based health and nutrition services, during the Covid-19 pandemic and lockdown. Insights from the study, reflective of the gendered implications of the pandemic have been presented in this paper.

The study used mixed methods for data collection. A secondary review of Government orders, advisories and media articles was undertaken to understand the pandemic response and provision of health services during the lockdown. A phone survey was undertaken with 250 Front-line workers (FLWs) - ASHAs (Accredited Social Health Activists), ANMs (Auxiliary Nurse Midwife), and AWWs (Aanganwadi workers), 50 from each state, who were purposively selected, given availability of phone numbers. In depth interviews were conducted with local NGOs (2 in each state), pregnant women (2 in each state) and adolescent girls (2 in each state).

The phone survey was undertaken using a computer aided telephone interview platform. All numbers were masked for the phone surveyors, with direct calling through the platform. Names of respondents were not collected as a part of the study. At the start of each interaction, both quantitative and qualitative, respondents were explained the purpose of the study, and use of the findings, following which, verbal consent was taken and recorded. The data gathered, was stored directly on a cloud server, with access only to the study lead and analyst. The data analyst anonymized the data set prior to cleaning and analysis.

Insights from the study – impact of the pandemic on women and girls in rural contexts

Access to health services

With the onset of the pandemic and lockdown, guidelines issued by the central and state Governments recommended deferment of community-based activities. This included outreach-based provision of antenatal care (ANC) and immunization services for pregnant women and children, provision of health commodities (such as sanitary pads, contraceptives

etc.) and information provision to adolescent girls. Consequently, provision of outreach services was reported to be suspended in all five states.

In the absence of routine outreach care provision, only 10 percent FLWs in Bihar, 24 percent in Uttar Pradesh, and 36 percent in Jharkhand reported provision of ANC services. Frontline workers reported to checking on pregnant women and those about to deliver, over phone. In Bihar, front-line workers had asked women to contact them only in case of any concerns or an emergency. The provision of ANC services was reported by a higher proportion of FLWs in Rajasthan at 71 percent. In Odisha, all FLWs reported door to door service provision, with the ANMs and ASHAs, visiting households of pregnant women. With limited provision of ANC services in four of five states, nearly 50 percent or more FLWs from these states reported that women were not accessing antenatal care. It was said that those who could afford private transportation and care were accessing Government and private health facilities, however, that this was a small proportion. Women, during qualitative interactions also mentioned waiting for the lockdown to end, to access services. In some states, it was reported that women were turning to rural medical practitioners in villages for their health needs.

> *"We have not seen the Auxilliary-Nurse-Midwife (ANM) since the start of the lockdown. I am facing some discomfort in my pregnancy. I am waiting for the lockdown to end, so I could go to a doctor or health facility"* – woman in Uttar Pradesh.

Similarly, access to health commodities was significantly affected during the lockdown. Only 5 percent FLWs in Jharkhand, Uttar Pradesh and Bihar reported to providing sanitary pads to women and girls during the lockdown. While this proportion was 77 percent in Odisha and 85 percent in Rajasthan, FLWs in these states reported to running out of stocks with limited supplies. Provision of IFA tablets to adolescent girls was reported by 40 percent FLWs in Jharkhand, Uttar Pradesh, and Bihar, and by 74 percent and 90 percent FLWs in Rajasthan and Odisha, respectively. FLWs mentioned that usually IFA (Iron Folic Acid) tablets were provided in schools; and with schools being shut, there was lack of clarity on their provision. 50 percent or more FLWs across states reported providing contraceptives. However, unlike earlier, where contraceptives were provided during the Village Health and Nutrition Day (VHND), or during home visits; these were now being provided only if beneficiaries came to the FLWs and asked for them. Limited stocks and lack of supplies was a reported to be a challenge for IFA tablets and contraceptives as well.

> *"FLWs are providing contraceptives from available stocks; but would run out soon. With men being at home, there is a sudden increase in demand. In some locations, even medical shops are facing a sudden shortage of condoms,"* – Grassroots organization, Uttar Pradesh

The provision of 'outreach services' at the village level, was instituted primarily to enable healthcare access to women and girls, who could not otherwise access health facilities. With the suspension of these services during the pandemic, access to healthcare for women and girls has been significantly impacted. Women are either waiting for the lockdown to end, to access services, or turning to local providers, both of which could have adverse health implications. The shortage in supply of sanitary pads, coupled with limited income during the pandemic is resulting in girls and women reverting to the use cloth (a behavior that took significant effort to change). Lack of information provision on the hygienic use of cloth as a

menstrual product, and limited opportunities for disposal, could result in prolonged and unhygienic use and concerns of reproductive tract infections. Limited supply of contraceptives could result in a possible rise in unwanted pregnancies and abortions.

In the absence of outreach service provision, Government guidelines recommend accessing health facilities for essential services such as ANC, immunization, and emergency care. However, fear of contracting the coronavirus and lack of transportation during the lockdown, deterred access to health facilities. Among those who did access care at Government facilities, the experience was reported to be disappointing, with limited care provision, and scant staff.

> *"The Government Primary Health Center (PHC) closest to my area is functioning however, the nurses available there are not helpful and are discouraging people from visiting the center. So, if someone wants to visit a doctor, instead of the Government health center I take them to a private doctor"*- Front-line worker, Jharkhand

> *"I am eight and a half months pregnant and went to the Government Community Health Center twice for routine pregnancy check-ups and sonography but returned disappointed as there were no medical staff. The village health worker suggested that I to go to a private hospital for the sonography, but we don't have the money for it, so now I don't know what to do"* – Woman, Uttar Pradesh

Access to nutrition services

The provision of Take-Home Ration (THR) to pregnant women, during the pandemic, was reported by 100 and 96 percent FLWs in Odisha and Rajasthan, respectively, followed by 73, 70 and 67 percent FLWs in Jharkhand, Bihar, and Uttar Pradesh. While in the former two states, nearly universal provision of nutrition support was reported, in the latter three states, it appears that several women were left out, owing to inadequate supplies. Interactions indicate that these women were likely those, who lived far away from the Aanganwadi center, or in remote hamlets. In other words, the differential provision, is more likely impacting women from vulnerable communities and households.

Further, NGO partners highlighted that the provision of THR does not necessarily translate to access. Concerns were raised on the distribution and consumption of food grains within households, more so, since THR was now provided one or more months in advance. NGO partners felt that, in the present situation of limited income, and access to food supplies, the ration provided to pregnant women, was probably distributed, and eaten among all family members. Prior to the pandemic, regular communication activities were reported to be undertaken by the AWWs and NGO partners, on the importance of THR being consumed by the pregnant women, which were now suspended. It was said that the in the times to come, inequitable distribution of food, adversely impacting women and girls would be a concern, coupled with limited access to IFA, could reverse the gains made in addressing anemia and malnutrition.

Challenges of front-line workers – an entirely women workforce

Across states, ASHAs, ANMs and AWWs have been engaged in the community-based response to the Covid-19 pandemic. Their roles range from undertaking community surveillance and surveys, accompanying suspect cases to health facilities, visits and follow

ups with any positive or symptomatic cases, support with establishment of local quarantine facilities, enabling information and awareness on the disease, and care provision in Covid-19 facilities, as well as routine care provision. In some states, front-line workers were also posted along with the police at check-posts to scan and identify suspect cases.

This entirely women workforce, has been entrusted with the responsibility of the primary community-based response to the Covid-19 pandemic, putting them at risk of exposure, while also expecting them to work in significantly challenging conditions. The challenges, pressures and struggles of the FLWs, as articulated by them are as follows:

- *Working in a hostile environment:* 'The pandemic has led to a state of fear and distrust among communities' said an ASHA, leading to non-cooperation and abusive behaviour. Instances of verbal abuse, refusal to share information, and non-adherence to advice were reported. In some states, FLWs said that community members were not allowing them to even enter their houses, owing to fear of virus transmission!

  "*Even people who know us well, do not let us come into their homes. How do we provide them information on the virus and how to we monitor their behaviors, when we can't even talk to them properly*" – ASHA, Bihar

  "We have to sanitize ourselves somewhere far from home. The people in the neighborhood abuse us, saying that we would bring the virus and tell us to stay away from the village."- ANM, Bihar

  While the FLWs have been assigned tasks and responsibilities in the pandemic response, they lack guidance and support on managing the new and challenging environment. Other than community hostility, several FLWs reported to facing hostility from their families as well. Not all families were comfortable with the tasks they were undertaking and the risk at which they were putting themselves and the family.

- *Lack of safety and personal protective equipment (PPE):* Activities being conducted by the community health workers, are categorized as low risk activities in the Government guidelines; with recommended PPE that includes triple layer masks and gloves. On an average, approximately 50 percent frontline workers surveyed in five states reported receiving PPE. Those who had received PPE, reported insufficient quantity and irregular supplies as a challenge. Across states, front-line workers said that they had begun using homemade masks or using dupatta's/ scarves/ handkerchiefs for protection, to cover their face.

  "We were given masks once earlier; now we have our own home-made masks. We don't have any gloves or sanitizer" - ASHA, Odisha

  "*We have been given soaps and not sanitizers. How are we expected to use soap after every house visit, when people don't even let us come in?"* - ASHA, Uttar Pradesh

  "We are working in the field without any safety gears, or masks. We have bought sanitizer for our own safety. The least the government can do is provide us with such basic amenities."- ASHA, Bihar

- *Workload management:* FLWs reported to feeling overworked, having to manage the Covid-19 response, along with regular care provision. It was also said that the multitude of orders issued by Governments, with changes and revisions every few days, led to confusion and non-clarity on the roles to be undertaken and the services to be provided. FLWs also had to ensure that they manage and balance their domestic responsibilities.

- *Delayed receipt of incentives and financial support:* 58 percent FLWs in Jharkhand, 27 percent in Uttar Pradesh, 39 percent in Rajasthan and 46 percent in Bihar reported not having received their salary/ incentive for the month preceding the study (April 2020). While delays in receipt of payments were reported to be common, FLWs said that during the pandemic they had to spend more money on PPE and transport. Further, that in several households, earning members had lost their employment, making the money earned by the FLWs critical for household expenses.

Many of the above-mentioned concerns are routine for the FLWs – they manage communities and their expectations, also that of their families, work in difficult conditions without support and social security, manage multiple tasks and responsibility and are often not paid on time. However, in a situation such as the Covid-19 pandemic, where the FLWs have been entrusted with a critical role, the lack of support systems and payment delays become a glaring reality.

Domestic violence

While not a primary area of enquiry of the study, during qualitative interactions, FLWs and women reported increasing incidents of domestic violence. ANMs in some states reported incidents where women suffering from violence had come to access first aid or had needed stitches. Despite hearing about cases, FLWs were apprehensive to record, report or even intervene in the present circumstances of hostility among communities. Women mentioned that with the perpetrators of violence being in the same physical space, indefinitely; opportunities for privacy and to make any complaints were limited. Further that during the lockdown, opportunities, to even to speak to other women in the community were scant. NGO partners felt that the economic crisis in the times to come would lead to a further increase in instances of violence and sexual abuse.

Mental Health and Wellbeing

Facing several concerns and challenges - not being able to access health services, concerns from risks of unwanted pregnancies, not being able to engage with neighbors, friends and peers, lack of privacy within and outside homes, and increased workload within households, women reported to be tense and anxious. They were also concerned about the future, availability of income and employment and adequate resources for the households. Adolescent girls, reported to be concerned about the future of their education, and if they would be able to go back to schools and colleges. They were also concerned about the increasing tension and disagreements within households between family members.

Frontline workers also reported to be suffering from significant stress, anxiety, and mental duress, stemming from the role they are undertaking during the pandemic, with limited resources and support. They were concerned of the risk they were putting themselves, their families and especially their children in. While dealing with their own anxieties and that of their families, they also had to engage with and manage hostile communities; without necessarily knowing how to do so. They had to ensure that they discharged their duties to the

health system, while not being assured timely payment or health/ social security. Many said that they felt a sense of loss of dignity and respect!

> *"I stay and sleep away from my husband, children and family, in a separate space. While it is difficult to do so, I do not want to risk them"* – ANM, Jharkhand'

Discussion

The study, while undertaken to understand access to health and nutrition services, has enabled insights on the challenges and concerns that women and girls face with respect to their health and wellbeing, during the Covid-19 pandemic. Women and girls are unable to adequately access health and nutrition services, are victims of growing domestic violence, are forced to face the increased burden of household chores and care provision, as front-line workers, are at risk of exposure to the disease, and work in significantly challenging conditions, and suffer from stress and anxiety. Women and girls are also likely to be affected in many other ways, such as – in their education, employment, they may be forced to seek employment, there may be threats to their safety and security, among other aspects, which, while are beyond the purview of this paper, are also consequences of the pandemic and lockdown.

Thus, in crisis situations, the challenges that women and girls face are manifold. The pre-existing inequalities, and socio-economic vulnerabilities, exacerbate these challenges for women and girls. Women are often expected to cope with these challenges, with limited support and suffer adverse consequences. Experiences from the Ebola outbreak indicate increased maternal deaths during the epidemic. Initial reports from across countries, indicate that millions of women would lose access to regular contraception owing to irregular supplies, during the Covid-19 pandemic (Morse and Anderson, 2020). In India, an analysis by the Foundation of Reproductive Health Services in India, estimates an additional 1743 maternal deaths, owing to the pandemic and lockdown. It also indicates an additional 2.38 million pregnancies and 679,864 child births and 1.45 million abortions, including 834,042 unsafe abortions (FRHSI, 2020).

With the increasing Covid-19 infection rate, and experts predicting repeated infection surges, there is an urgent need for policy makers to recognize the gender dynamic of the pandemic and look at the response beyond just a technical and structural lens. There is a need for gender segregated data analysis and rapid studies to understand and quantify the impact of the ongoing pandemic and lockdown on women and girls in different socio-economic contexts. Relief and ongoing programs must have a gender lens; gender planning and budgeting must be integrated into program implementation. Critically, to ensure equitable relief and support to overcome the pandemic and its impact, it is important to recognize the distinct interests and needs of men and women, girls, and boys as equal, so women and girls do not continue to face the burden of the pandemic in the long run.

Limitations of the study

The primary objective of the study was to understand access to health and nutrition services; emerging insights on the gendered impact of the pandemic have been presented in the paper. Given the purposive sample, the study, while enables an understanding of the current situation; is not generalizable. Unlike FLWs and adolescent girls, it was noted that

some women were hesitant to speak over phone and were not very forthcoming with their responses.

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References

United Nations, 2020, Impact of Covid-19 on women, Policy brief, retrived from https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406.

Smith, J., 2019, Overcoming the "tyranny of the urgent": integrating gender into disease outbreak preparedness and response; *Gender Develop*, 27: 355-369

Wenham, C., Smith J. and Morgan R., 2020, Covid 19: the gendered impacts of the outbreak, *The Lancet*, 395(10227): 846-848

Boniol, M., McIsaac M., Xu L., Wuliji T., Diallo K. and Campbell J., 2019, Gender equity in the health workforce: analysis of 104 countries, Health Workforce Working Paper 1, World Health Organization (WHO/HIS/HWF/Gender/WP1/2019.1)

Novel Coronavirus Disease 2019: Guideline on rational use of Personal protective Equipment; issued on March 24, 2020; Ministry of Health and Family Welfare, Government of India

Morse, M. and Anderson G., 2020, The shadow pandemic: how Covid-19 crisis is exacerbating gender inequality; United Nations Foundation Blog, published on April 14, 2020

Impact of COVID 19 on India's Family Planning Program, 2020, Foundation of Reproductive Health Services in India, Policy brief.