COVID-19 and Female Community Health Workers

Sunita Singal,

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Presentation Overview

1. Background
2. Ground Realities and Implications
3. Our Support
4. Discussion Questions for breakout sessions

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Background: EngenderHealth in India

EngenderHealth aims to help create a world where women and girls exercise their rights to gender-equitable reproductive health resources and participate as equal members of society.

Currently we have 3 projects in India.

Projects

1. **Adolescent Health Development Program (AHDP)** in Bihar
2. **Building Institutional Capacity for Postpartum Family Planning** in Karnataka & Maharashtra
3. **Expanding Access and improving Quality of Intrauterine Device Services in India** in Gujarat & Rajasthan

We work with

~1,000	Facility healthcare providers (male & female)
~17,000	Female frontline health workers, Accredited Social Health Activists (ASHAs), who perform a range of roles as the last mile health providers

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Roles of ASHAs

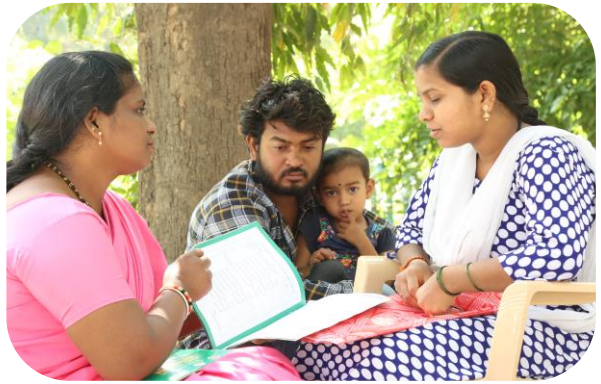
Community mobilization for health care

Awareness creation on nutrition & hygienic practices

Stock and provide ORS, IFA, Oral Pills & Condoms, etc.

Provide newborn care

Counselling on birth preparedness, safe delivery, breastfeeding, immunization, contraception etc.



Provide primary care for diarrhoea and DOTS etc.

Inform about the births and deaths

Accompany pregnant women & children → Health care facility

Promote construction of household toilets

Member of village health & sanitation Committee

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Ground Realities and Implications for Gender

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Ground Realities and the Implications…

Reality 1

Shift in priority with focus on COVID-19:

ASHAs are the last mile link in the community and the health system. Their work is considered voluntary.

All ASHAs are women. There is an unintended increased burden of responsibilities assigned to them during COVID-19.

Reality 2

Work overload:

ASHAs are overwhelmed with additional workload of door to door surveillance (traveling by foot), compounded with the routine essential reproductive and MCH work they do.

Due to patriarchal social norms, and gendered division of labour at home, ASHAs face double burden of caregiving as well as double work responsibilities.
Some of them reportedly quit their jobs.

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…Ground Realities and their Implications

Reality 3

COVID-19 stigma magnified for ASHAs:

- Struggling with their own stigma
- Community became hostile for fear of infection.
- ASHAs' spouses/family also feared of infection, resulting in strained relationships at home.

They usually do not have a strong fall back position, The gender power dynamics and emotional dependence on family/husband, adds to poor bargaining position and limited decision making abilities.
A few ASHAs reported facing GBV at home.

Reality 4

Trainings and PPE:

- Limited access to technology, (~60% own smart phones), makes it difficult for them to access information shared digitally
- PPE confusion and delay, in receiving on time.

Inequitable access to technology left many ASHAs unaware of frequently evolving guidelines, affected their competence and confidence for performing duties.
Delayed access to PPE increased their risk of exposure

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Our Support:

April to July 2020

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Capacity Building Initiatives of EngenderHealth

Objective

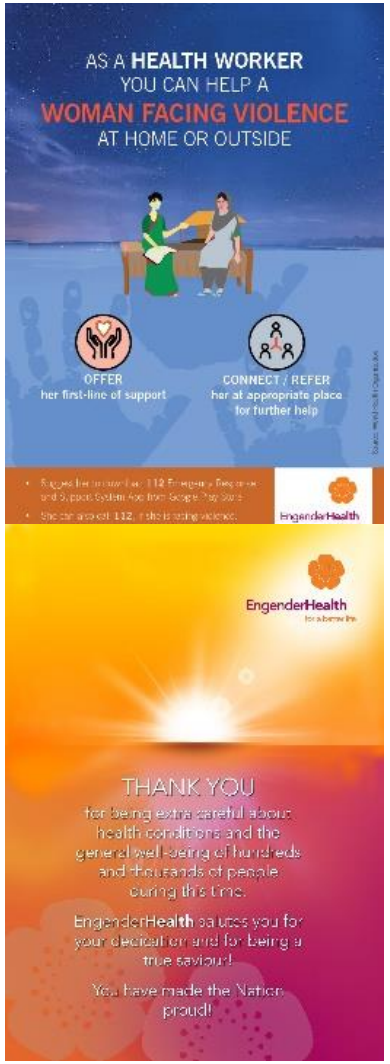
Engaging with ASHAs to provide up-to-date standardized information on COVID-19 & FP, as well as provide psycho-social support amidst the Pandemic.

Processes

	Interpersonal	Digital	
Media	Phone calls [1:1]	WhatsApp	Zoom + Others
Plan	Call 5 health workers daily [Total CHWs = 12,985]	Send two personalized messages every week [Total CHWs = 12,985]	Organize virtual trainings for community health workers based on a agreed roster.
Content	•Guided discussion based on empathy principles •Initiate discussion on COVID-19, family planning and GBV	•Self-care during COVID-19 (8) •COVID-19 myths vs facts (3), FAQs (2) •Motivational messages (2) •Myths vs. facts on contraceptives (10) •World Population Day (1) •GBV (1)	Orientation: COVID-19; self care; dealing with stigma; GBV and mental health

Advocacy with Gov't. counterparts at all levels in-person and over phone

Ongoing SBC approach = Train-Assist-Graduate [TAG]



Accomplishments

Reached
12,589
ASHAs
between April
and July 2020

- In April, 1.4% of the ASHAs requested additional information on COVID-19; that number increased to 46% in June 2020.*
- 16 ASHAs reported providing GBV referral services to clients in their locality.*

"The trainings conducted by EngenderHealth has helped us a lot while conducting household surveys during COVID-19; we learned how to take care of self, family, and community. This also has built our capacities [confidence] to provide guidance to the community on the COVID-19 situation."

---- Sarika Chavan, PHC Kurunda

Advocacy efforts helped resolve PPE availability and FP restocking issues

In April, 47% of ASHAs reported FP stock-outs; that decreased to 29.9% in June.*

"Due to the situation of COVID-19 pandemic from last two months, the FP commodity stocks were not available, because of which we were unable to provide the FP services to clients. However, because of the guidance and support EngenderHealth has provided, we received FP commodity from PHC …."

----Ms. Vanita Bari, PHC, Bhadali, Jalgaon

*** Source:** Project MIS

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Lessons Learned & Opportunities

Lessons Learned

- Building self-efficacy of ASHAs requires a close follow up and information sharing which is crucial to the continuation of caregiving. This empowers and enables ASHAs to deal with stigma.
- Individual empathetic support strengthens negotiation abilities and encourages job continuation among ASHAs.
- Reducing the digital divide and providing learning opportunities to ASHAs can contribute to resilient health systems.

Opportunities

- Engage with decision-makers to better understand gendered barriers related to COVID-19 and to design customized solutions to address these barriers.
- Meaningfully engage men, religious leaders, and other key influencers in the community.
- Strengthen Gender training curriculum of ASHAs.

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Discussion Questions for Breakout sessions

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Discussion Questions for Breakout sessions

Question 1

What more can we do to work with health systems and governments to support frontline female health workers continue to provide RH and other health services safely during pandemic?

Question 2

How can we more effectively address the digital divide to reach women and girls without access to the digital technologies that we are using to provide virtual/remote support and outreach?

Question 3

What other innovative social behaviour change communication strategies can we use during pandemic or other disaster situations to support health workers for improving their performance?

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Thank you!

www.engenderhealth.org
sunitasingal@engenderhealth.org