COMMUNITY ENGAGEMENT THROUGH WOMEN'S SELF-HELP GROUPS

Leveraging mobile technology for capacity building during **COVID-19** lockdown in India

LOK SWASTHYA SEWA TRUST

World Health Organization India

Lok Swasthya SEWA Trust and WHO India Collaboration

Community Engagement through Women's Self-Help Groups: Leveraging mobile technology for capacity building during COVID-19 lockdown in India

ISBN 978-92-9022-802-8

Suggested citation. Community Engagement through Women's Self-Help Groups: Leveraging mobile technology for capacity building during COVID-19 lockdown in India. New Delhi: World Health Organization, Country Office for India; 2021. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Printed in India

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ACKNOWLEDGEMENTS

We would like to thank all our partners on this project very sincerely. Our special thanks are due to the WHO India Office for its timely support to the Lok Swasthya SEWA Trust (LSST) in conducting the programme and for assistance in intensifying our community engagement and public health efforts during the initial phase of the COVID-19 crisis. We would especially like to convey our thanks to Dr Hilde de Graeve, Dr Chandrakant Lahariya, Dr Priya Karna and Dr Atreyi Ganguly from WHO.

It would have been impossible for us to complete this project without the leadership and active participation of the women grassroots leaders, now master trainers (MTs), from all the seven states. We would like to place on record our sincere appreciation for each of the 200 MTs who took on the responsibility of reaching out to 25,000 women and their family members with sincerity and dedication, despite the challenges of the lockdown.

We are also extremely grateful to our partner organizations and their teams:

Ms. Sanchita Mitra, of SEWA Bharat, Ms. Shikha Joshi, Ms. Kavita Malviya and the SEWA Madhya Pradesh team, Ms. Suman Verma and the SEWA Delhi team, Mr. Binoy Acharya, Ms. Swapni Shah and the UNNATI team, and Ms. Monisha Behal and Ms. Joy Grace Syiem of North-East Network (NEN) and the teams from Meghalaya, Assam and Nagaland.

Finally, we would like to thank our grassroot leaders and our health and child care teams from Ahmedabad city and district, Surat city and the SEWA Cooperative Federation for their support in reaching out to women in villages and urban neighbourhoods in Gujarat.

Mirai Chatterjee
Director
SEWA Social Security

Susan Thomas
National Health Coordinator

ABOUT LOK SWASTHYA SEWA TRUST

The Lok Swasthya SEWA Trust, supported by SEWA, was established in 2005. LSST organizes women for self-reliance, both financial and in terms of decision-making capacity and helps them obtain full employment at the household level which translates to a better socio-economic and health status. LSST focuses on promotion, prevention and curative services aimed at improving the health of poor women and their families. LSST has 15 years of experience in providing holistic and comprehensive primary health care to informal workers with a multi-pronged approach that focuses on health information and awareness, referrals, promotion of rational therapeutics, livelihoods and social security, including healthcare, childcare, insurance, pension and housing with basic amenities.

LSST has more than a decade of experience in designing and implementing health programmes, and collaborating with national and international organizations. For the implementation of this project, and in the state of emergency response, LSST partnered with organizations that participated in three regional workshops on Universal Health Care jointly undertaken by SEWA and the WHO, together with Population Foundation of India (PFI), Public Health Foundation of India (PHFI) and 3 local organizations: Unnati and Srijan in Rajasthan, SEWA MP in Madhya Pradesh and North East Network (NEN) with Indian Institute of Public Health-Shillong (IIPH-S) in the North-Eastern States. The collaboration facilitated a wider exploration of various local strategies that could be used for more effective implementation of the project.

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
COVID-19	Coronavirus Disease 2019
GBV	Gender-Based Violence
LSST	Lok Swasthya SEWA Trust
MP	Madhya Pradesh
MoHFW	Ministry of Health and Family Welfare
MT	Master Trainer
NEN	North-East Network
RCCE	Risk Communication and Community Engagement
SEWA	Self-Employed Women's Association
SRHR	Sexual and Reproductive Health and Rights

EXECUTIVE SUMMARY

COVID-19 is spreading very rapidly across India and around the globe. In India the virus infected more than 1.8 million people leading to nearly 39 thousand deaths as reported on 4 August 2020.[1] COVID-19 has spread across the country and affected all of us, particularly the informal workers, whose lives have been most seriously disturbed. Even at the best of times, their lives are characterized by insecurity of work and income, insufficient levels of food and nutrition security, and compromised access to basic health services.

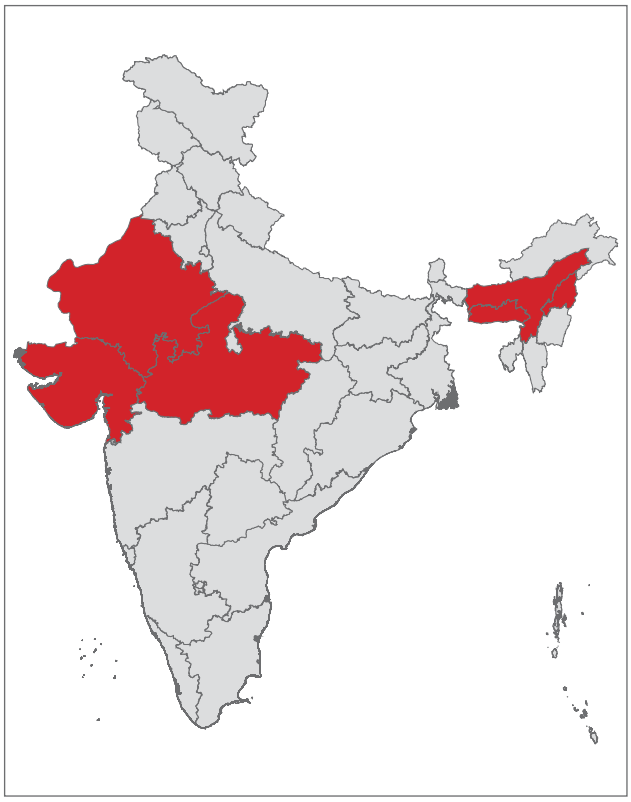
To better understand the nature and estimated impact of COVID-19, a short study was conducted by SEWA about the informal sector workers' awareness about this novel disease, their perception about the accessibility of health services during the pandemic, the impact of potential loss of livelihood, and other similar unknowns that had the potential to affect their physical, mental and social health and well-being.

The findings from this foundational work enabled LSST to undertake this capacity building activity to intensify community engagement and public health efforts through an evidence-based approach, supported by the WHO Country Office for India.

This helped to create an awareness drive about COVID-19, psycho-social health and well-being, sexual and reproductive health issues, including family planning, safe abortions, as well as domestic violence. Implementation of the project helped significantly in building the capacity of local communities, especially women.

The project was implemented in 7 states of India – Gujarat, Rajasthan, Delhi, Madhya Pradesh, Assam, Meghalaya, and Nagaland (see figure).

Figure: States covered by SEWA – WHO initiative



[1] Sewa. 2020 SEWA: Impact of Coronavirus on the Informal Economy [Website]. (https://www.wiego.org/resources/sewa-impact-coronavirus-informal-economy, accessed DATE?)

Objectives of the project

1) To develop an evidence-based community engagement framework for dissemination of accurate information on the coronavirus infection, leveraging SEWA's existing organized base of informal women workers and also the community of women belonging to partner organizations.

2) To work closely with local public health authorities on ensuring that awareness and information on COVID-19 signs and symptoms, prevention and precautionary measures, and referral care are made available at the community level in a timely manner.

3) To ensure that women have access to psycho-social support and sexual and reproductive health services particularly during the national lockdown period.

4) To develop a cadre of grassroots women leaders who are equipped and trained to lead such campaigns in health emergencies like the current pandemic.

Activities and methods

With the above objectives in mind, SEWA, together with its civil society partners working at the grassroots level, and the WHO developed a synchronised and meticulous capacity-building training and awareness programme to reach out to a large population through a cascade model of training.

Given that this was done at the very beginning of the pandemic and there was a national lockdown imposed in India from 23 March to 30 June, it was imperative that we started and adapted as we went along and as the evidence unfolded. The cascade approach helped to reach out to the women quickly, to provide accurate information about the prevention of the disease, to reduce fear and stigma associated with the unknowns and to connect people, especially women, so that additional morbidity and mortality associated with the COVID-19 and other related factors could be mitigated.

To roll out the project, activities were systematically designed and included the development of a training module and messages based on the material available from the Ministry of Health & Family Welfare (MoHFW)[2] and WHO.[3]

SEWA's practice of working through grassroots women leaders, called aagewans, was the obvious choice for taking the campaign forward. Identification of potential Master Trainers (MTs) was the next step, which was done by collaborative efforts of supervisors and the organizations, both within the SEWA family and other grassroots organizations, in each state. Thereafter, LSST trained the supervisory staff through digital platforms (WhatsApp/Zoom). This was followed by the training of master trainers who disseminated the entire training to the community members. In the span of 35 days, 25,090 women were reached across all the states.

Learnings

As an implementing partner, LSST learned that online platforms were an acceptable approach for reconnecting with local communities, the people and our own members in a short span of time. Mobile phones can empower people as

[2] MoHFW Guidance Notes and Technical Documents available at https://www.mohfw.gov.in/

[3] WHO Guidance notes available at https://www.who.int/

through them communities and families who are geographically or socially isolated from information can be reached. We also learnt that technology could be effectively used for linking people with various services and referral facilities. A simple phone could be a powerful tool!

The priority given to upgrading the skills of grassroots-level women workers as master trainers was effective and led to the identification of new uses of their skills for other work, such as counselling as "community-based counsellors"; and supporting the needs of the community. Also, institutional capacity was further strengthened in relation to effective emergency and humanitarian responses in future, especially at the community level through grassroots women leaders.

Policy recommendations

The COVID-19 pandemic has brought out new and emerging issues and needs. The most adversely affected are the poor and vulnerable groups, the informal workers of our country. Based on our experience we strongly recommend investing in frontline workers who are local leaders, preferably women, and who can reach out to vulnerable groups and address public health emergencies such as this one efficiently, with dedication and in a timely manner. The number of frontline workers in our country has to be increased. Their capacity-building for preparedness to manage public health emergencies in the future, along with training on psychosocial care during and after the COVID-19 situation are extremely important. Ongoing supportive supervision for frontline workers (FLWs) is also necessary. Both supervision and assistance are needed to refer cases that need secondary and tertiary care.

One of the most serious barriers to addressing the current crisis remains the digital divide (between genders and between rural and urban areas) and therefore, digital literacy is critical for frontline workers, local committee members and other community level leaders. Providing digital tools such as smart phones or hand-held tablets with internet connectivity, within a short time-frame, is necessary for wider outreach, which will help to prevent the spread of infections such as this one.

Sexual and Reproductive Health (SRH) issues remain neglected. There is an urgent need to build awareness about family planning and its importance, knowledge and use of contraception, evidence-based family planning messages, information on sources of contraceptive methods and increasing women's decision-making skills for their reproductive and sexual health needs.

CHAPTER 1

INTRODUCTION

New and emerging infectious diseases continue to be a serious public health issue. In the past 20 years, several epidemics such as the severe acute respiratory syndrome coronavirus (SARS-CoV), H1N1 influenza, and the Middle East respiratory syndrome coronavirus (MERS-CoV) were experienced in various parts of the world. A new virus CoV, which was highly contagious and which spread quickly across the globe, was identified in 2019. It was named "COVID-19", acronym for "coronavirus disease 2019".[4]

By 4th August 2020 the number of confirmed cases across the globe was more than 18 million with nearly 0.7 million reported deaths.[5] Whereas in India, the virus had infected more than 1.8 million people with nearly 40 thousand deaths reported. Research has suggested that vulnerable individuals, like those with comorbidities, and elderly people, are more likely to get infected and have significantly higher mortality rates. Many people especially the informal workers suffered significant loss of employment and income due to

[4] Cascella M, Rajnik M, Cuomo A, Dulebohn SC, Di Napoli R. Features, Evaluation and Treatment Coronavirus (COVID-19) [Website]. StatPearls. StatPearls Publishing; 2020 [cited 2020 Jul 20]. (http://www.ncbi.nlm.nih.gov/pubmed/32150360, accessed DATE?) AQ. What does [cited 2020 Jul 20]. Mean?

[5] Worldometer. Coronavirus Cases [Website]. Worldometer. 2020 [cited 2020 Aug 4]. p. 1–22. (https://www.worldometers.info/coronavirus/, accessed DATE?economy, accessed DATE?)

the lockdown measures taken by the government for containing the virus. In India most of the workers are engaged in the informal economy (more than 90%), especially women. At the best of times, their lives are characterized by insecurity of work and income, insufficient levels of food and nutrition security and even basic social security like child care and health care services are compromised.

A short study about the informal sector workers across 11 states of India was conducted by SEWA, which revealed unique challenges they were facing in combating the pandemic. The study highlighted that along with income loss being intensified; awareness deficit about the novel disease was also increasing. Most of the women were aware about preventive measures, but had less information about the signs/symptoms. Inaccessible health care services at the time of the pandemic were also a matter of concern.[6] The situation and it's complexities and consequences have led to an urgent need for psychosocial care and basic mental health services, for proper information on COVID-19 and where and when to go for referral care, as well as simple dos and don'ts. Finally, several concerns about the increasing need for SRH services and about mental health issues, including domestic violence, also surfaced as women were spending an increasing amount of time locked at home with unemployed and frustrated abusers. (3)

An intensified public health effort became an urgent need for tackling these issues and dealing more effectively with the pandemic and the other health-related concerns. Supported by WHO, LSST conducted intensified capacity building training and aggressive awareness campaigns designed to increase the knowledge of women and families on coronavirus, psychosocial/mental health, SRH services, and domestic violence, especially in the most neglected and remote areas, as well as to promote practices to minimize the risks and to develop mechanisms for dealing with the public health crisis. The campaign spanned over three months and efforts were made to ensure that the communities with SEWA members and partners in which they live, whether members or not, were reached. At that time rumours and incorrect information were creating fear, anxiety and stigma across the country so communicating scientific and technically sound information to local people had become essential.

[6] Sewa. 2020 SEWA: Impact of Coronavirus on the Informal Economy [Website]. (https://www.wiego.org/resources/sewa-impact-coronavirus-informal-economy, accessed DATE?)

About this work

LSST planned to create an awareness drive during the COVID-19 crisis for the informal women workers and their families. The project was implemented in 7 states of India, including states where partner organizations were functional. The team designed a health action strategy for effective and timely engagement with the community and dissemination of information to all members. It explored partnerships with the government for better coordination of efforts and to prevent duplication. In the view of strict lockdown measures, it was a difficult task for the team to design the plan for outreach. Hence, leveraging the use of mobile phones and digital mediums like the WhatsApp application was undertaken. For community engagement, grassroots leaders, our master trainers (MTs), were trained to conduct awareness sessions through mobile phones. A total of 200 master trainers were trained (Please refer to Annexure 1 for number of MTs and area of outreach).

Objectives

- To develop an evidence-based community engagement framework for dissemination of accurate information on the coronavirus infection, leveraging SEWA's existing organized base of informal women workers, and also the community of women connected to partner organizations.
- To work closely with local public health authorities on ensuring awareness and information on COVID-19 signs and symptoms, prevention and precautionary measures and to ensure that referral care is made available at the community level in a timely manner.
- To ensure that women have access to psycho-social support and sexual and reproductive health services particularly during the national lockdown period.
- To develop a cadre of grassroots women leaders who are equipped and trained to lead such campaigns in health emergencies like the current pandemic.

CHAPTER 2

ACTIVITIES AND METHODS ADOPTED

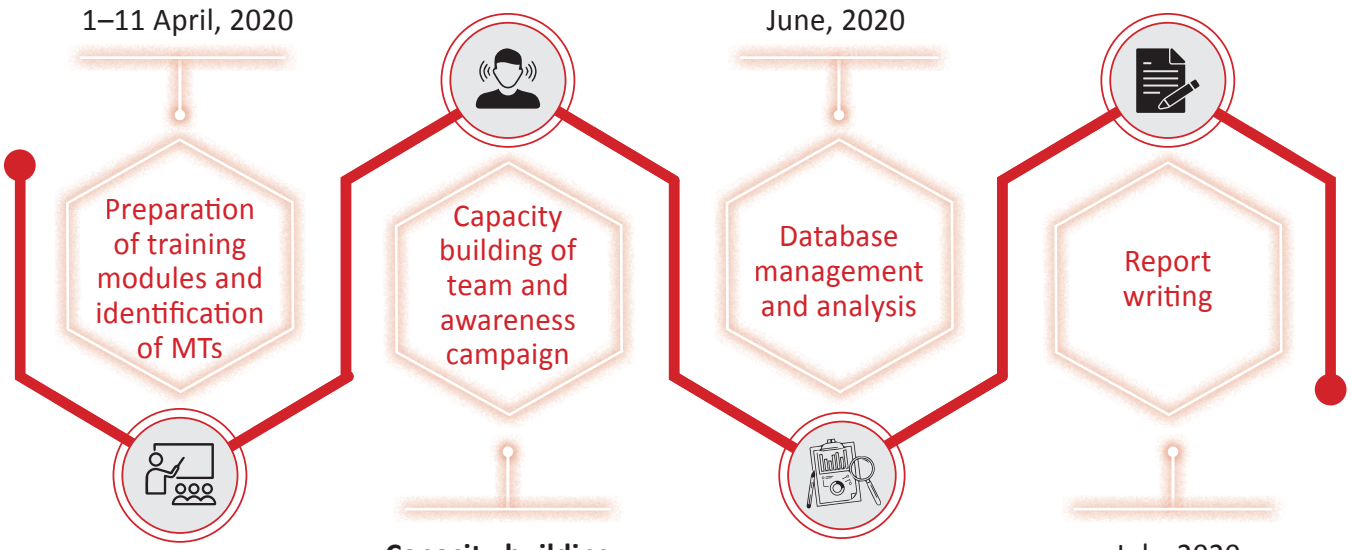
Activities undertaken to meet the objectives

- Development of training modules and messages using the awareness material developed by WHO and the Ministry of Health & Family Welfare to spread awareness regarding coronavirus, psychosocial care /mental health, sexual and reproductive health and gender-based violence.
- Identification of 200 potential MTs.
- Capacity-building of the supervisors and master trainers in each state.
- Development of a Risk Communication and Community Engagement (RCCE) plan with the 200 master trainers, who reached out to the community with information. An

implementation strategy was decided under which each Master Trainer formed 7 groups, each consisting of 20 women. The MTs conducted four sessions and a final follow-up session in five consecutive days, ensuring standard modules for training of grass-roots leaders on awareness of COVID-19. Topics connected to reproductive health, gender-based violence, as well as issues and gaps in service delivery that emerged during the lockdown period were included as part of RCCE.

- Exploration of and development of linkages with ASHAs, ANMs and AWWs, the local government health personnel for enhancing the coordination and effectiveness of the campaign.
- Coordination of master trainers with local health functionaries to achieve timely health actions and referral to health facilities.
- Creation of surveillance mechanisms by the organizations involved, with the help of supervisors and MTs, for the identification of cases (positive, suspect and contact) and informing the local health team with the aim of ensuring timely action.

Timeline

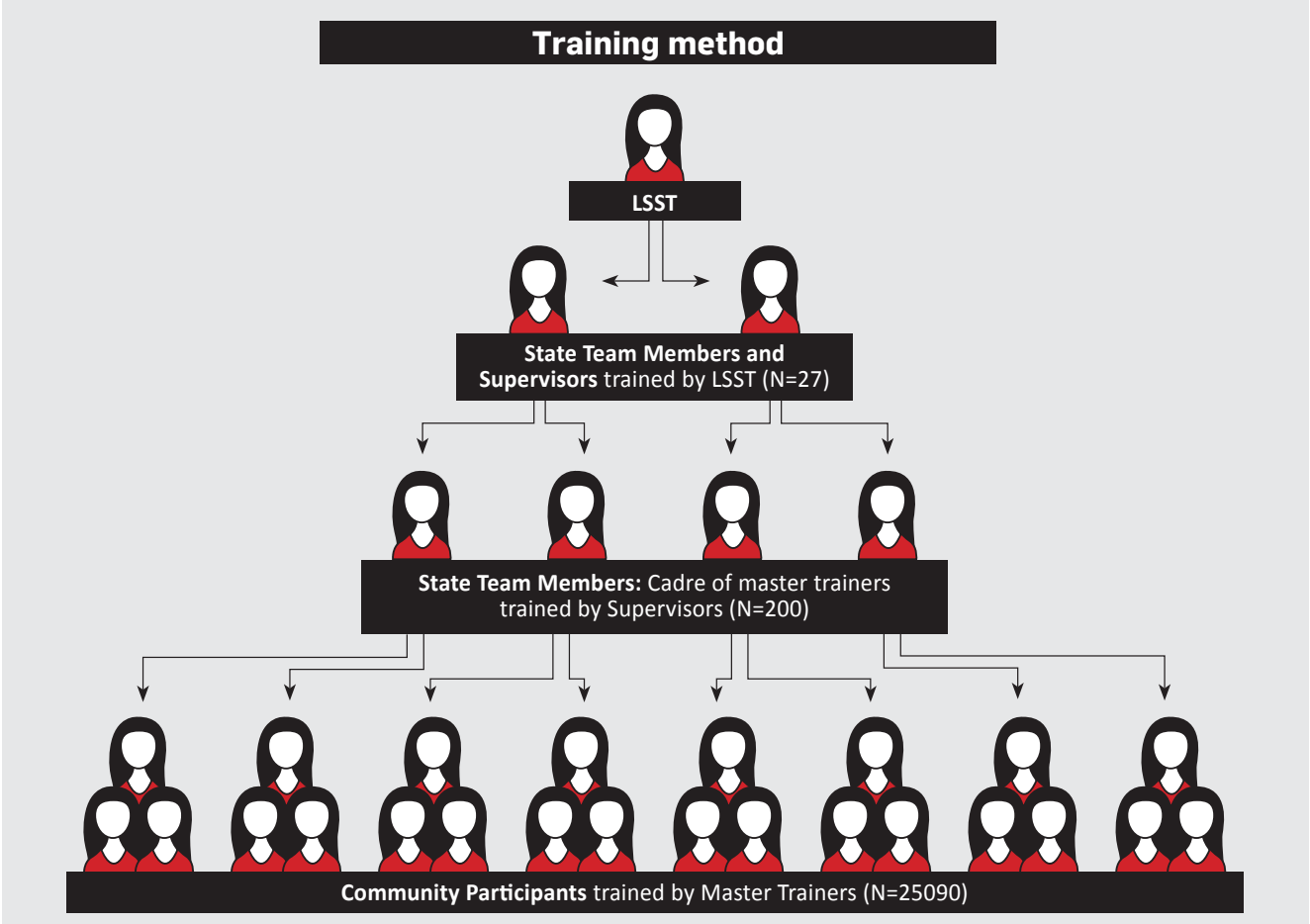


Methods adopted

The COVID-19 emergency demanded prompt delivery of messages with maximum outreach. Therefore, the cascade model was adopted which facilitated the flow of training messages from one level through several levels of team members down to the community. SEWA conducted training of master trainers (MTs) and supervisors through digital platforms (WhatsApp/Zoom) using MoHFW and WHO materials adapted to spread awareness regarding COVID-19, psychosocial care/mental health, sexual and reproductive health and gender-based violence.

Training module

The LSST team designed the four training modules and messages which were to be used to spread awareness. The training module also contained reference material for the master trainers with detailed descriptions on each topic. The modules were prepared by the material available from the Ministry of Health & Family Welfare (MoHFW) and WHO. After the training module was drafted, messages for online platforms such as WhatsApp and other social media were developed. These messages were made attractive, reader friendly and concise, while including all relevant information. The messages were primarily graphical representations with a few textual messages scripted in simple language. Training modules and messages were translated into regional languages to make them more acceptable and easier to understand for the community. The overall training was divided into four parts. (Please refer to Annexure 2 for detailed training modules).



1. Module 1 – About COVID-19

This module is an introductory session on COVID-19 and connected safe practices. It also provides information on contact and suspected cases.

2. Module 2 – Home care and precautions

The focus of this module is on the care and precautions to be taken at home, both during the lockdown and in case a family member is quarantined.

3. Module 3 – Psycho-social care

This was developed to provide essential information to informal workers on the psychosocial effects experienced during the pandemic and coping strategies for them.

4. Module 4 – Sexual and Reproductive Health and Rights (SRHR) and Gender-based Violence (GBV)

There are two parts of this module. The first part is SRH services, and the other is GBV.

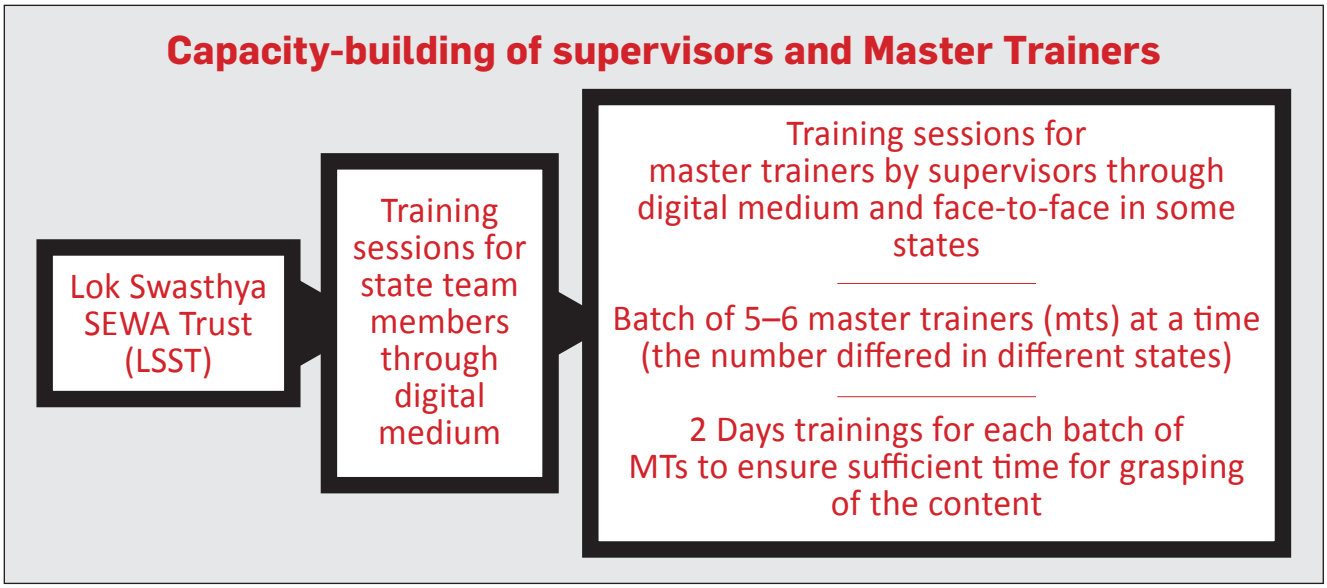
- Sexual and reproductive health and rights: The module aims to educate women about their sexual health, which includes information about Sexually Transmitted Diseases (STDs), their symptoms, ways of prevention and management at the early stages. It also includes educating women about their reproductive health, i.e., the right age for the first conception, importance of spacing between births, need for family planning, information about safe abortion if needed, and post-abortion contraception, different types of contraceptives available, and maintaining hygiene during menstruation.
- Gender-based violence: The aim of the second part of the module is to educate women about different forms of violence. It also included information about different laws against violence in India and where to seek help.

> "I was a victim of sexual harassment and had to leave my job because of it. If I had known about laws pertaining to sexual harassment of women at the workplace, I would have known what to do and would not have left the job. I learned about laws related to sexual harassment at the workplace, sexual and reproductive health in the training."
>
> **MAMTA, *Domestic worker, Delhi***

Method of identification of master trainers

The identification and selection of master trainers was carried out in all the states by partner organizations and supervisors. The selection criteria were as follows:

- The MTs were chosen from among community-based field coordinators and grassroot women leaders called aagewans. They were selected on the basis of their experience and local presence.
- Competencies such as leadership qualities and good communication skills and basic experience in taking training sessions in the community.
- Basic knowledge about the use of smart phones and delivering messages using mediums like WhatsApp.



Participants

The participants were informal workers from both rural and urban areas of 7 states (Gujarat, Delhi, Madhya Pradesh, Rajasthan, Nagaland, Assam, Meghalaya) in which SEWA and partner organizations have been working for several years. Each of the MTs was assigned the responsibility of contacting and coordinating with at least 140 members in their respective work areas, and delivering the messages to them.

Method of identification of participants-

- The participants were contacted through the references of community health workers and local health functionaries such as ASHA, AWW and ANM.
- Snowballing technique was used where each participant helped MTs to reach other participants by providing their contact details for training purposes.
- Participants' information and numbers were also collected from previous and current programmes like SEWA Shakti Kendra.

Development of risk communication and community engagement

After the training of the supervisors and master trainers was completed, MT's started awareness campaigns through the digital medium. Before starting this phase, it was made sure that MTs had the list of women to be reached along with their phone numbers. According to the design of the project, 20 women formed one group. The group was a combination of adolescents, young & middle-aged women, and the elderly (Age group 13–89 years). Each MT conducted five sessions for the same group on five consecutive days, 4 days for 4 sessions on respective modules and on the fifth day for revision and follow-up.

During the follow-up session the doubts regarding topics discussed, if any, were cleared

up, referrals arranged, and feedback taken from members. After completion of the session, the MTs also checked whether anyone in the families of the trainees were suffering from any illness or had shown any symptoms, especially related to COVID-19. Whenever required, the necessary steps were taken for further referral and treatment. Apart from this, master trainers were also able to detect a lot of apprehension among the women and their families while disclosing any symptoms they suffered and also fear of getting infected. The MTs were very supportive, but firm, and counselled the women and their families that if the disease was to be managed, there was no scope for delay or laxity. They told them that the spread of the virus and the connected stigma and fear could only be halted, or slowed down, through disciplined observance of basic precautions.

In most of the states, women were contacted via phones on an individual or on group basis, while in some cases door-to-door visits were made. Before the start of the session, an introductory brief about the organization and the objective of the training was provided to the women. It was discovered that in a few places, members had put their phone on speaker mode so that the whole family could listen to the sessions. After the session on phone, the digital pamphlets with pictorial messages were sent through WhatsApp.

> "The MT gave me very good information on COVID 19 and its precautionary measures. Also, told me about women's health issues, stress management, and violence against women. Hearing such information in this difficult time is very supportive and relieving"
>
> **ASHA, *Agriculture labourer, Madhya Pradesh***

> "One woman had heavy bleeding for 20 days. Earlier she had also suffered a miscarriage. We were able to link her with the Primary Health Centre (PHC) in Sind Hari. She is still not cured but her treatment is now underway."
>
> **SURYA, *MT, Rajasthan***

The timings of sessions were planned according to the convenience and availability of the participants so that they could attend the training without any difficulty. Training via phone calls was done through group calls with a maximum of 4 to 5 members so that all the participants would get the opportunity to interact and participate. If any participant missed the group call, the MTs made efforts to call them individually.

The average session time lasted for 30 to 40 minutes. Varied approaches were observed in different states. In Rajasthan, where the lockdown had eased, women who did not own a phone were contacted through door-to-door visits, while observing all the necessary precautions. In Delhi, where a complete lockdown was in force, MTs formed WhatsApp groups to which they would post the prepared messages before taking the sessions. This helped the women to have a little background information prior to the sessions, which made the training much more interactive.

Linkages with government frontline health workers

For community engagement, existing SEWA grassroot leaders and MTs worked in conjunction with the local government bodies, ASHA, and Anganwadi workers in both urban and rural areas. This helped in enhancing linkages with government programmes and services. In many cases the frontline health workers also found the modules and messages useful in their work.

Referrals

Referrals were made by the master trainers as and when required. The capacity building undertaken by master trainers helped in early detection of cases, related to COVID-19. As mentioned above, the master trainers ensured that they checked with all the participants about any illnesses prevailing in the family and provided them with information on next-steps, such as where to visit, whom to approach and what documents they should carry with them. In some areas, the MTs have been working in close coordination with local health functionaries (ASHA, ANM), who were already playing an active role in addressing the situation and the spread of infection. The MTs contacted them and acted as a bridge between the community and the public health system.

Monitoring and supervision

LSST established a monitoring team for daily and weekly supervision of activities and compiling of data during the project. Master trainers reported daily to their supervisors through WhatsApp. Supervisors compiled the daily data into weekly formats and sent it to the state team.

Supervisors had conference calls with their respective master trainers on a weekly basis, to get feedback and to provide any support that was required. Supervisors had conference calls with state-level monitoring teams for feedback, weekly or more often as per the need. At the state level, one person monitored the entire data on a daily basis and ensured that all formats were filled at every level. On a weekly basis, state-wise reports were submitted to LSST. Data was collected with the help of the monitoring tools mentioned below.

Monitoring tools

- Format 1: Master sheet – This format had the total number of women reached by all MTs which was updated on a weekly basis (Figure 1).
- Format 2: Data base (with phone numbers) of the total number of women to be reached.
- Format 3: Daily reporting format for MTs – record of reaching out to 20 women for the four sessions and a follow-up session on the 5th day. This format was filled on a daily basis by MTs.
- Format 4: Monitoring format for Supervisors – Supervisors randomly called 2–3 women in each group to get feedback about their sessions.
- Format 5: Referral format – The referrals (which included recording the reason for the referral and details of the institution or centre it was made to) made by master trainers were reported to the team leaders/ supervisors and documented at the state level.
- Format 6: Reporting format for Supervisors/ Team Leaders

Figure 2: Format 1 Master sheet

FORMAT-1 MASTER SHEET																															
LSST, SEWA Bharat, SEWA MP, Unnati, NEN (North East Network) & IIPH, Shillong														Starting date: dd/mm/yyyy (this will be Day 1 of Week 1)								Completion date: dd/mm/yyyy (this will be Day 35 of Week 6)									
YY	YY			YY			SESSION 1: ABOUT COVID-19										SESSION 2: HOME CARE AND PRECAUTIONS						SESSION 3: PSYCHOSOCIAL CARE				SESSION 4: SEXUAL AND REPRODUCTIVE HEAL AND GENDER-BASED VOILENCE					
Target Outreach (Total number of target women to be reached 20-25 women per day)	Week 1 (NOTE: Fill in the outreach number)					Week 2 (NOTE: Fill in the outreach number)					Week 3 (NOTE: Fill in the outreach number)					Week 4 (NOTE: Fill in the outreach number)					Week 5 (NOTE: Fill in the outreach number)					Week 5 (NOTE: Fill in the outreach number)					
	Day	Day	Day	Day	Day 5	Day	Day	Day	Day	Day 10	Day	Day	Day	Day	Day 15	Day	Day	Day	Day	Day 20	Day	Day	Day	Day	Day 25	Day	Day	Day	Day	Day 30	Day	Day	Day	Day	Day 35	Remarks
	Session 1	Session 2	Session 3	Session 4	Session 5 (Fellow up by the MT	Session 1	Session 2	Session 3	Session 4	Session 5 (Fellow up by the MT	Session 1	Session 2	Session 3	Session 4	Session 5 (Fellow up by the MT	Session 1	Session 2	Session 3	Session 4	Session 5 (Fellow up by the MT	Session 1	Session 2	Session 3	Session 4	Session 5 (Fellow up by the MT	Session 1	Session 2	Session 3	Session 4	Session 5 (Fellow up by the MT	

CHAPTER 3

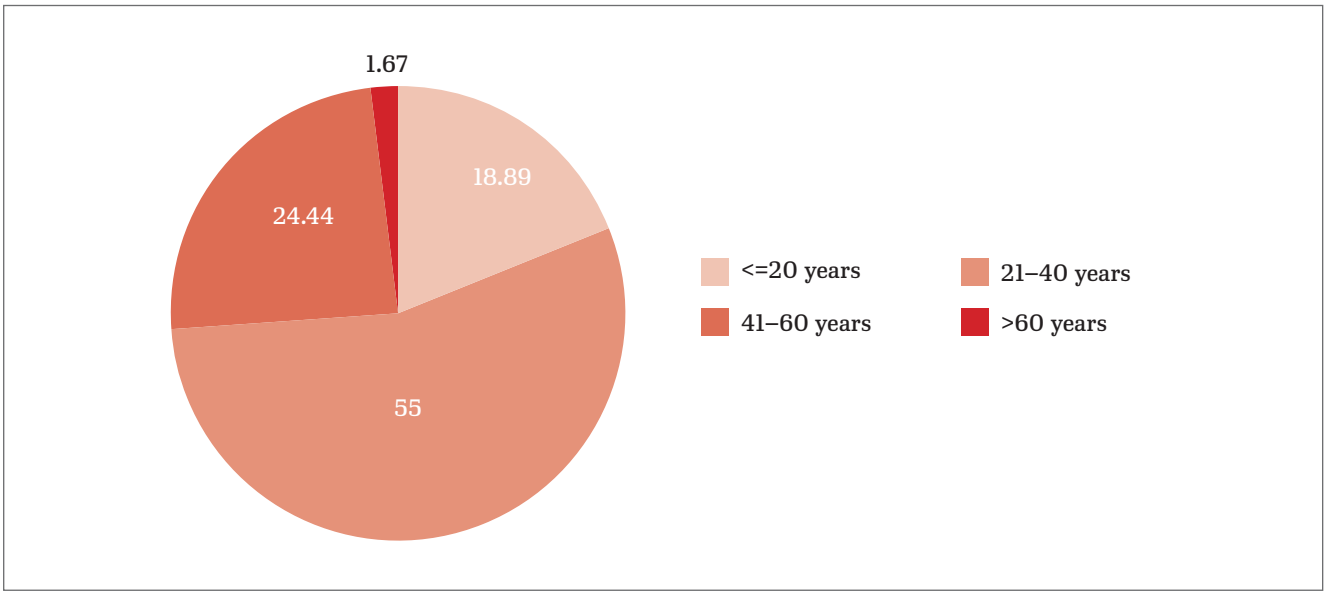
QUANTITATIVE ANALYSIS

The data received by various states were compiled in excel sheets and verified; it was then cleaned-up and an analysis plan formed for the same. Descriptive analysis was conducted in excel and Stata 10.0. The key findings from the analysis are listed below:

Profile: Master trainers

A total of 200 Master trainers were trained across 7 states of India. The average age of MTs across the states was 32 years, where the majority of the MTs were aged 21–40 years (55%). But an interesting finding from Rajasthan was observed, where over 77% of MTs were aged 20 years or less compared to Gujarat, where 62% were aged 41–60 years (Graph 1). Engaging with young women was extremely helpful as they were able to use the technology platform effectively and also act as peers. They thus enabled the dissemination of information and increased its acceptability.

Graph 1: Proportion of age of Master Trainers



Outreach

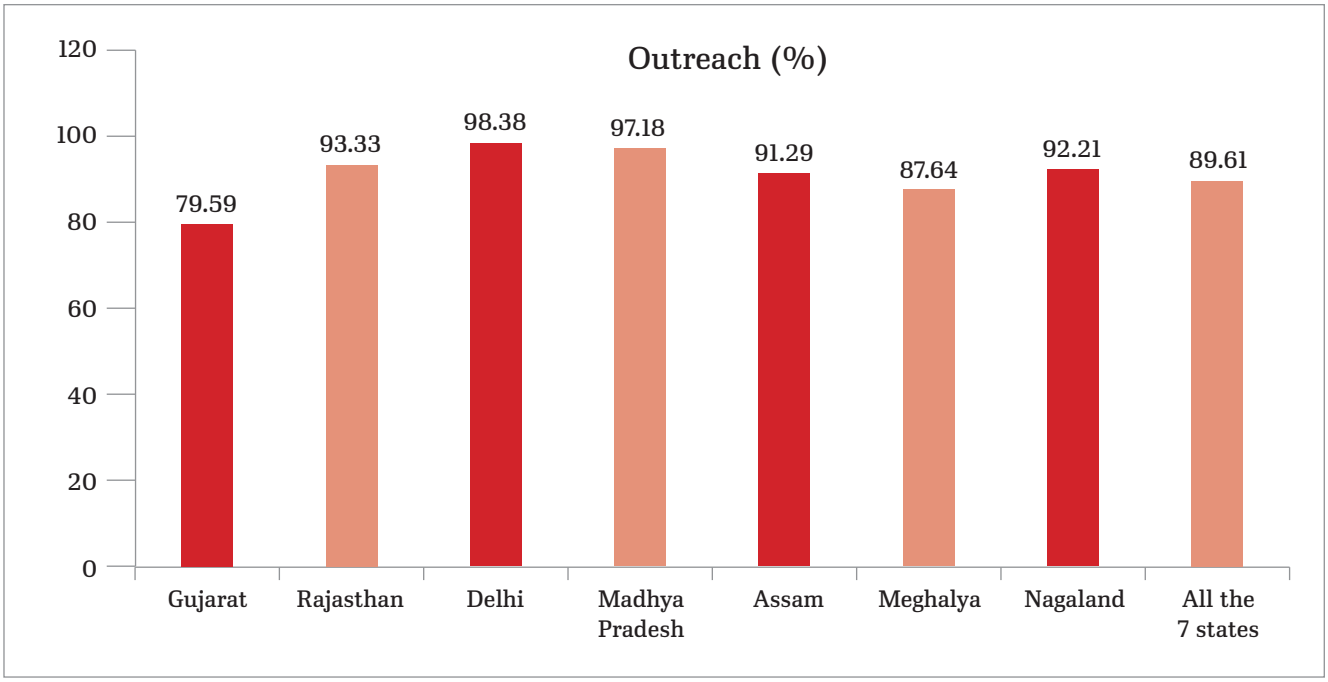
In a span of 35 days, each Master Trainer had to reach out to 140 women and provide awareness sessions. Across all seven states a total of 28,000 women were to be reached, out of which over 25,000 were actually able to be contacted and trained (89.6%). The table below shows expected and actual outcomes disaggregated by states. Compared to other states, outreach was a found to be lowest in Gujarat (80%) and highest in Delhi (97%). One of the reasons was the reverse-migration from Surat district, in Gujarat, of migrant workers, who went back to their home towns and villages resulting in the lower outreach.

Outreach

	Master trainers	Expected outreach	Actual outreach	Ratio of trainer: Women reached	Percent of goal met (%)
Gujarat	70	9800	7800	1:111	80%
Rajasthan	30	4200	3920	1:131	93%
Delhi	30	4200	4132	1:138	98%
Madhya Pradesh	40	5600	5442	1:136	97%
Assam	10	1400	1278	1:128	91%
Meghalaya	10	1400	1227	1:123	88%
Nagaland	10	1400	1291	1:129	92%
All the 7 states	200	28000	25090	1:125	90%

Even during the complete lockdown, women in all the states managed to reach at least 80% of their expected target and, on average, one MT was able to reach 125 women. The graph below shows the proportion of the actual outreach compared to what was expected (Graph 2).

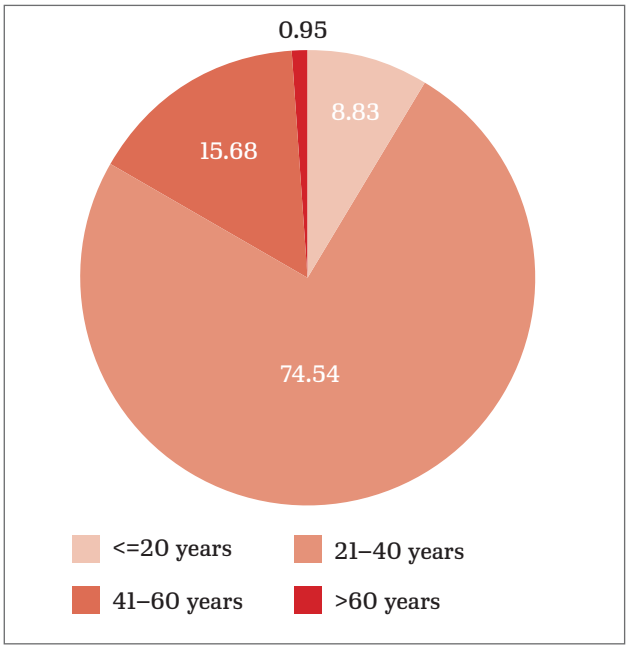
Graph 2: Proportion of actual outreach of women as compared to expected target



Profile of participants

The average age of women who attended the session was 32 years. Among them, more than 70% were aged 21–40 years (Graph 3). The majority were agricultural workers followed by home-based workers; however, women from other trades like construction, domestic work, vending, hawking, factory work, cattle rearing, small-scale production and healthcare also took part.

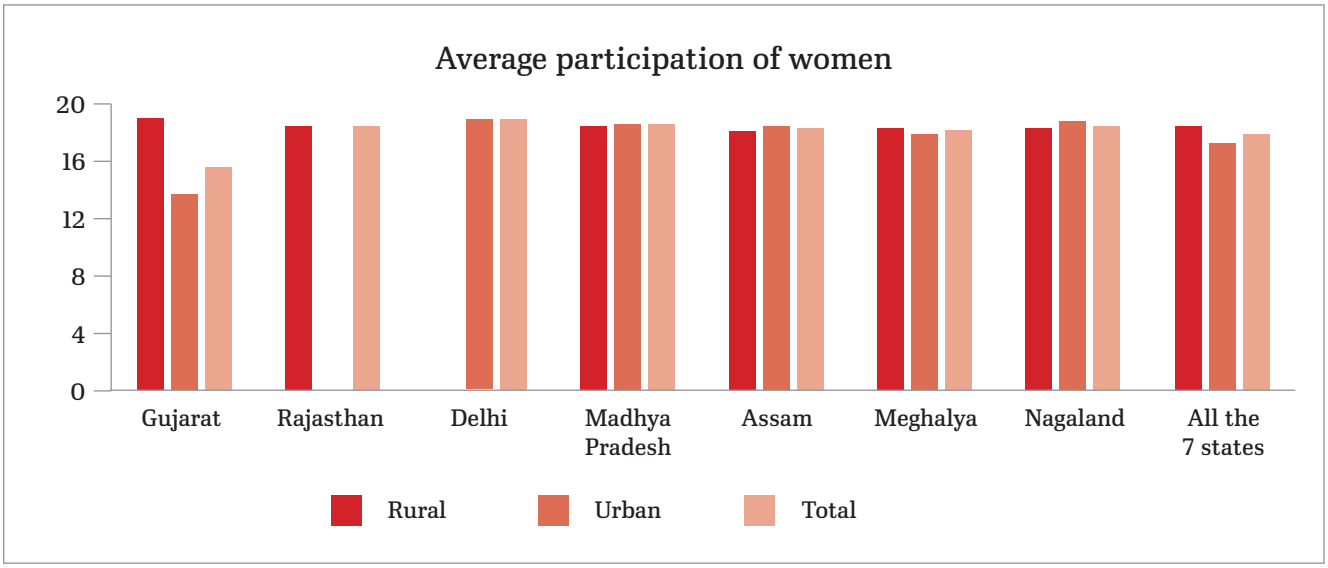
Graph 3: Proportion of age of participants



Participation of women in awareness sessions

As a part of the project design, each MT had to form a group of 20 women. Graph 4 depicts the average number of participants in the sessions, disaggregated by states, and regions, urban and rural (Please see Annexure 4 for a table depicting the session-wise average participation of the women).

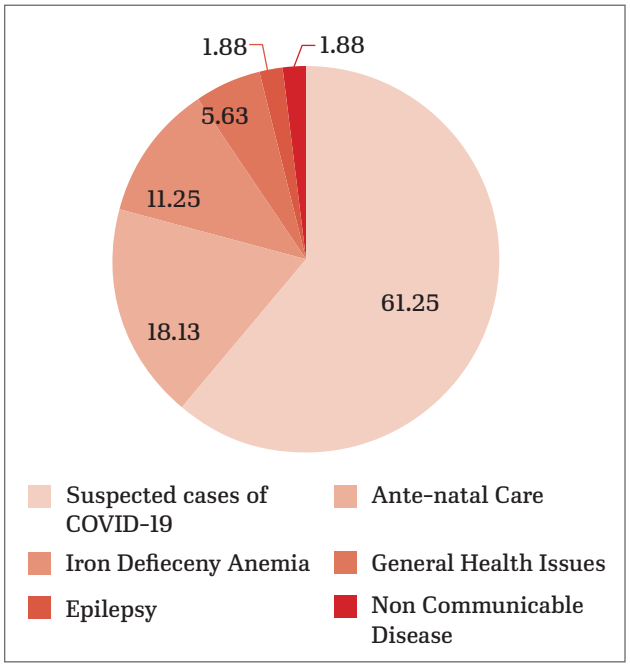
Graph 4: Mean participation of women in sessions: disaggregated by states and region (Urban and rural)



Follow-up and referrals

For the supervision of and feedback from the community members, a follow-up call was made by supervisors and the state team. Nearly a quarter (24%) of the women were contacted again by the team after the completion of the sessions. During the implementation phase of the project i.e., 35 days, a total of 161 referrals were made by the MTs across all the states. Among them, more than 60% of referrals were of suspected COVID-19 cases, followed by antenatal care (18%) (Graph 5). About 60% of referrals were from rural areas, whereas 40% were from urban areas.

Graph 5: Proportionate break-up of referrals



Assisting the government in mobilizing returning migrants to go to healthcare facilities

A family from Dasai village of Dhar district, Madhya Pradesh that had been working and living in Gujarat, returned to their village having lost their work and income because of the lockdown. Upon their return, the family members were requested by the local ASHA worker to visit the hospital for check-ups as per the health department guidelines. They resisted and did not go for tests and insisted that they were in good health. They had heard that they would be locked-up inside a room indefinitely. The ASHA worker could not convince them to go and finally she requested the master trainer to talk to the family as she knew that SEWA MP had been working for more than 35 years in the area and had built a sense of trust among their members. As a part of their training, MTs had learnt to detect contact cases, and suspect cases. With this knowledge the MT tried to clear the misconceptions of the family concerned. She explained why it was necessary to go to the health centre and also what would be done there. She explained that, "As you have come from a different state where COVID-19 cases are very high, you need to go for the check-up. You won't be admitted to the hospital unless the test results are positive. Just home quarantine measures will be taken."

The family members again asked: "Why should we visit the healthcare facilities if we are feeling fine?" The MT explained about the asymptomatic cases and also about them spreading the infection to others in the family and neighbourhood. She also assured them that they would not be left alone or unattended. Finally, the family agreed to visit the facility. The test results were negative and the family was advised to remain in home quarantine for 14 days. The counselling approach for resolving crises, a mitigating strategy, acquired over the years, along with the COVID-19 awareness training, enabled the MT to educate the family about appropriate conduct during an epidemic. The panchayat was so impressed by the services rendered by the MT, that they requested all MTs in the area to inform the panchayat about the migrants and to provide assistance in referring them to the healthcare facilities. Thus, an emergency situation was handled effectively through collaborative effort.

CHAPTER 4

CHALLENGES AND LEARNINGS

Challenges

With its core strength of well-trained and enthusiastic grassroots leaders, LSST has many years of experience in carrying out awareness projects for its members, who are informal women workers. But a new method for this campaign to successfully reach all our members during the lockdown and curfews was needed. The project mostly achieved its targets in terms of outreach and response from the community, but there were issues that we had to face at different stages of the project.

Project level issues

- The project was implemented in diverse geographical areas and various cultural settings. Awareness material was generic and common for all the states. Therefore, some contextual differences had to be addressed based on the feedback of MTs and understanding about the local situation. Some parts of the content regarding gender-based violence and sexual and reproductive health were not relevant to the North-Eastern states. Hence, necessary changes were made adapting to the local context.

- In the remote areas, most of the information was given verbally as tribal women from different groups spoke different dialects and it was difficult to translate all the information. In some cases, limitations with regard to digital messages were observed, as women who did not have access to smartphones couldn't be provided with messages through WhatsApp.

Issues during training of community members

- **Lack of access to phone numbers of women from remote areas:** It was difficult to reach out to women from remote areas as their contact numbers could not be obtained. Hence, sessions were conducted through door-to-door visits.
- **Irregular internet connectivity:** One of the challenges of the campaign, in some areas, was irregular internet connectivity. In these areas the MTs had to struggle to fix the training schedule with the participants. The MTs also expressed concern about the difficulty in having uninterrupted conversations, either due to internet issues or the participants re-scheduling the time, which delayed the trainings and made it difficult to complete sessions within the stipulated timeline.
- **Lack of mobile phones:** In Nagaland, Meghalaya and Rajasthan, most of the MTs based in rural settings opted for door-to-door visits and group meetings (following all the norms related to precautionary measures) as many of the women did not have mobile phones. However, this engagement required the MTs to make extra efforts to reach out to the villages as they had to walk long distances to meet participants, which was physically and mentally stressful.
- **Lack of spare time:** Many of the participants were already burdened with extra household chores and care work and found it difficult to spare time on all five days and sometimes dropped out of sessions or missed some of the sessions. However, the MTs made efforts to reconnect with them wherever possible.
- **Participants engaged in agricultural work during the day:** In Gujarat, Rajasthan, Madhya Pradesh, and Nagaland it was difficult to get the participants during the day as most of the women in rural areas were involved in agricultural work. Many MTs had to meet participants either in the early hours or late evenings.
- **Awkwardness resulting from presence of men at home:** We also observed that some women were not comfortable listening to the sessions on sexual and reproductive health and rights and gender-based violence when male members of their family were nearby. This pattern was mainly observed in Delhi, Gujarat and Rajasthan. However, women would reach out to MTs later with questions and concerns on SRH and GBV related issues.
- **Confusion and myths about preventive measures:** MTs and supervisors in Gujarat observed that multiple communication channels with information on COVID-19 had created a lot of confusion and myths about preventive measures. Hence, some discussions around this issue were needed to make them understand the correct and effective practices to be followed.
- **Government helpline numbers not functional:** In Delhi and MP, it was observed that government helpline numbers for COVID-19 weren't functional. To address this problem, MTs in Delhi found out the district-wise helpline numbers and shared them with the participants. In MP, in addition to providing alternate numbers, MTs also contacted the police department to provide ambulance services for COVID-19 patients.

- **Digital divide and lack of digital literacy:** The digital divide and lack of digital literacy among many women were a challenge. Many women were using the phones of family members and needed their cooperation to use them efficiently; they also had to abide by the needs and timings of the phone owners. In these circumstances, schedules had to be adjusted in many cases. But, in a few places we found that men were very supportive. When they came back from work, they would call the MTs and ask them to speak with their wives/daughters/sisters. They also supported women in accessing the messages.

Monitoring and supervision related issues

- **Women in remote areas without phones:** In remote areas, where women did not have phones, door- to-door visits were the only way to deliver the sessions. In such cases follow-up through calls was quite difficult and due to the lockdown, direct visits were not possible, either for supervisors or anyone else, other than MTs residing in the same locality.
- **Demanding workload of supervisors:** Monitoring and parallel reporting became hectic at some points as, in some cases, supervisors had to fill up the daily reporting formats of MT and complete the follow-up too.

Learnings

This project facilitated the strengthening of local communities and grassroots leadership and developed a cadre of women leaders who are prepared to respond to crisis situations such as the COVID-19 epidemic and similar emergencies in the future.

> "When I was told to close our field operations, I assumed that I couldn't work anymore. We would just have to sit at home. Later, when I was told that I would have to conduct education sessions using a mobile phone, I was scared. But, our SEWA sisters taught me how to use smart phones. Within a week, I learnt the use of smart phones, and became confident. SEWA has always been a source of courage and in making me self-reliant in whatever we do."
>
> **VARSHABEN, *MT, Gujarat***

A few of the learnings are summarised below:

1. **The potential of grassroots leadership:** This project enabled us to train and develop 200 master trainers / women leaders across seven states. This project gave us the opportunity to build grassroots leadership and prepare them to respond to the current crisis and any similar emergencies in the future. It is important to invest in these leaders and develop frontline workers in addition to the ASHAs, ANMs and AWWs in order to address a pandemic of this level and intensity.
2. **Wider outreach and timely measures:** The cascade model and mobile-based platforms adopted were found to be very effective in reaching out to many women in a short span of time. At the first level a total of 20 supervisors were trained, who then trained 200 master trainers. The MTs reached out to over 25,000 women and through them a population of 100,000 people across the

seven states were trained on four modules. In emergency situations such as this where timely measures have to be taken, it is critical to use methods and tools that can bring about quick results and reach out to a large number of families in a short span of time.

3. **Mobile-based platforms can create a family cascade in emergency situations:** The mobile-based approach helped in reaching out to the entire family of the official participant. We saw that many members of a family could be connected when the phones were put on speaker mode and so they could also participate in the training sessions. In our trainings prior to the COVID-19 lockdown we were only reaching out to women. Disseminating the messages to whole families is crucial for effectively curbing the spread of the infection.
The speaker-mode on phones helped in conveying information to men on topics that are usually considered sensitive and treated as women specific, such as gender-based violence and sexual and reproductive health related issues. Although, the responses were mixed, there was some positive feedback and a few women even suggested that in future trainings such topics should be actively discussed with men.

4. **Effective learning through textual and graphic digital messages:** This was the first time health training was conducted online or on a virtual platform by SEWA and other partners. We learned that we could reach out to many people across geographies, through crisp, short and to the point WhatsApp messages. The messages were very effective, and women could read them again and again whenever they wanted to. We also saw that they forwarded messages to their families and friends. Thus, a large number of people beyond the communities we usually work with could be reached.

5. **Digital literacy and effective use of technology by grassroot leaders:** The project helped the master trainers by providing them opportunities to sharpen their skills in such areas as:

   a) Digital literacy – use of technology, how to use android phones, how to make group / conference calls, how to make WhatsApp groups, how to send messages to many participants.

   b) Learning to convey messages in an effective way through brief phone calls. Formulating simple messages in the local language and keeping them relevant for the current situation.

   c) Overcoming initial difficulties and challenges – Working out how to reach out to many women and their families and talk to them, despite numerous limitations that included scheduling problems due to internet connectivity issues. Ultimately, each MT reached out to roughly 125 families.

   d) Building a sense of general self- confidence – We witnessed in the course of a short period, the increasing self-confidence of the master trainers in speaking and communicating messages in an effective and positive manner.

Their growing competencies helped build the self-esteem and self-reliance of the MTs. They learned new ways of reaching out to the communities they repr-esented and worked with, which also helped them to think differently and use the learnings from other programmes as well.

6. **Technology can reach the last mile:** We realized that online platforms and social media are very good ways to reach out to informal workers, who are otherwise busy with work throughout the day, as well as to remote villages, and convey critical messages in a very short time and also at

a time convenient to the recipient. This experience has helped us understand the significance of using online and virtual platforms. We have learned a new and effective way of using technology in other projects as well. However, we realize that in the coming days a lot of investment in digital literacy will be essential and needs to be made a priority. We also know from this experience that women from all sectors and geographies can learn and can be trained to use technology.

7. **Accepting innovative methods:** We also experienced that WhatsApp and other online platforms were appreciated by informal workers (because of the short time frame involved in the engagement). Rural women were very excited about learning this method and many of them specifically downloaded and used WhatsApp for this activity. They reported the application as being empowering for them. Since then, they have been continuing to use the mobile-based app. The benefit of the training was that they started using technology and became confident about it, and about being able to reach out to large groups of people.

8. **Adopting communication tools to the local context:** It is important to develop simple messages. Graphic communication with less text and colourful messages that we sent to all participants were appreciated, were easy to understand and easy to translate into local languages. Our focus should always be to convey the relevant messages only, as too much information and too many messages create a lot of confusion, myths, fear and ultimately prevent appropriate action.

9. **Online referral networks for timely action:** We were able to build a strong referral network through phones, where we linked community members and their families to ASHAs and ANMs and to Mohalla Clinics and PHCs to address their health needs. Follow-ups were carried out to ensure that proper care was given to them. The women were also able to reach out to the MTs for any kind of health needs, for ANCs, GBV, COVID-19 and other related problems. Local level referral networks have to be strengthened and that too through online platforms. Information on telemedicine and other services should be readily available at the local level and made functional.

10. **Online monitoring to ensure quality and efficiency:** We learned and developed online monitoring mechanisms. Telephonic participation allowed the monitoring which was effective in ensuring quality and in identifying gaps. All formats were done online. The MTs also sent lists of participants to the supervisors through screen shots and WhatsApp on a daily basis. The supervisors were in turn able to convert these data into excel sheets and reports. The supervisors also called a few of the participants (selected randomly) daily to get their feedback and to ensure that the quality of training was maintained by all master trainers.

11. **Upgrade the skills of grassroot women leaders to address emerging issues:** Now that we have a cadre of trained MTs we will involve them in other programmes and upgrade their skills further. For example, we hope to train them as "community-based counsellors" who can be a support to their communities during health emergencies and even in normal situations. These women should remain connected and be provided regular trainings to upgrade their skills and kept involved at the local level so that they may remain motivated and prepared for any public health emergency in the future.

12. **Work from home at all levels is possible:** We have learned that a lot can be done from home. The development of modules,

the posters, the monitoring formats and implementation was done during the lockdown period. The team worked from different locations and effectively completed the project. Through virtual platforms, the area and scope of work can be expanded. Moreover, use of digital media reduced travel time, costs of travel, meetings, and administrative expenses. In future, we can use a combination of working from home and office as per the need and requirement.

13. **Online education can bring alternate livelihood for grassroots women:** This project became an alternate livelihood opportunity for informal women workers who had lost their livelihood during the lockdown situation. The incentives given to them for the training helped them and their families to manage some of their day-to-day expenses. We learned from this experience that grassroots women can provide a wide range of services, and earn a living too, if we give them the necessary training.

14. **Virtual platforms effective for expansion of emergency work:** Through virtual platforms the area of work can be expanded. We started with 7 states and 200 MTs under this project and in less than three months we have expanded to 11 states and trained nearly 800 master trainers. In a short time and with limited staff the project outreach could be expanded. Today, we have an outreach of over 300,000 women workers and their families, a total of 15,00,000 people in a span of four months.

15. **Women leaders can adapt easily to new and modern methods of working:** We saw that some of the women leaders who have been working with us for the past several years were used to engaging with the communities, being with the people, meeting them and talking to them. They learned to reach the same communities by sitting in their homes. Initially, it was a difficult task to convince them to do the same work through phones, make group / conference calls, make WhatsApp groups, send messages to a large number of participants, but with the help of training they tried, became confident and worked effectively. This has helped them to improve their communication skills also.

16. **Need to address other important health concerns of women:** We can focus on topics other than COVID-19, such as SRHR, GBV, and psychosocial care. There weren't many organizations that have talked about these issues during this time. Not even the government or ASHAs. The participants appreciated this aspect of the programme, as we were sensitive to the issues of women. Many of them wanted us to continue to take up similar issues. They also felt comfortable sharing their problems with us.

17. **Community-based organizations can learn to reconnect and work through virtual platforms:** SEWA and other organizations that function at the grassroots level, work closely with people, are in constant touch with them and connected at all times. It was difficult to function in this way during the lockdown. However, this project helped us reconnect with the communities, with the people, and with our members. The database, the phone numbers, we have today will help us continue to connect with them in the future and use technology to establish linkages with various services and referral facilities. Most importantly, the women now have a phone number they can call during emergencies or whenever they need to talk.

18. **Availability on phone builds trust and connection with women:** We found that SRH issues remain a taboo and knowledge related to family planning, birth spacing and contraception especially among women remains limited. Women were often unaware about contraception and

were undergoing stress and anxiety related to SRH. They were also uncomfortable discussing the issues and/or listening to the sessions when male family members were present. However, using WhatsApp messages and being available through phone was an important step in building trust and connecting women with SRH services even during the lockdown.

19. **Importance of digital media in building partnerships:** This project helped us build partnerships with local organizations. It was easy to expand our work and outreach. We worked with partners in areas where SEWA has not worked earlier. This experience taught us how we could reach out to more and more women across the country. In pandemic situations such as the current one, it is important to build partnerships, alliances and networks to reach out across the length and breadth of a massive country like India.

20. **A simple phone is a powerful tool:** Finally, we have learned that health action can be undertaken by women at the grassroots using technology.

POLICY RECOMMENDATIONS

1. **Increase investment in public health especially for the frontline health workers.** The number of frontline workers in addition to ASHAs should be at least 1:100 to 150 households in case of a pandemic situation and these numbers should be increased as per the need. Ongoing supportive supervision for frontline workers (FLWs) will be necessary and a layer of HR with higher skills should be appointed, both for supervision and support with cases that need secondary and tertiary care.
2. **Raise digital literacy levels especially for frontline workers, local committee members and other community level leaders.** Providing digital tools such as smart phones or hand-held tablets with internet connectivity is important. A data base of phone numbers of all households should be maintained electronically and be available to the health department and authorities for timely action.
3. **The cadre of frontline workers developed for emergency response should be recognized by the public health system,** and their health and wellbeing should not be ignored. The frontline workers trained for emergency response should be sustained even after the pandemic. This can be done by integrating them with other activities (non-health activities) and their incentives continued. The emergency response team should be an integral part of the public health system.
4. **Online platforms to reach women in rural areas should be developed, especially on psychosocial care.** The technology implemented should be more gender responsive. Digitalization of local governance bodies like Panchayati Raj Institutes (PRIs) should be done in order to increase women's access to the internet.
5. **Raise awareness about SRH issues.** There is an urgent need to build awareness about family planning and its importance, knowledge about the use of contraceptives, evidence-based family planning messages, information on sources of contraceptive methods and increasing women's decision-making skills for their reproductive health needs.

ANNEXURE 1

State-wise integration of master trainers with areas covered

Name of the state	Name of the organization	Total number of master trainers	Areas covered	
Madhya Pradesh	SEWA M.P	40	18 Villages	4 District
Rajasthan	Unnati	30	40 Villages	1 District
Gujarat	Lok Swasthya SEWA Trust (LSST)	70	96 Villages	3 Districts
Delhi	SEWA Bharat	30	-	3 Districts
Assam	North East Network (NEN)	10	6 Villages	3 Districts
Meghalaya		10	4 Villages	1 District
Nagaland		10	37 Villages	4 Districts
Total		200	201 Villages	19 Districts

ANNEXURE 2

Training modules

Module 1: About COVID-19

1.1 What should i know about COVID-19?

- It is a disease called Coronavirus Disease-2019 caused by a Coronavirus named SARS-CoV-2
- The symptoms of COVID-19 are fever, cough and difficulty in breathing
- If you have the symptoms of fever, cough or difficulty in breathing or any kind of respiratory issue
- You are a contact of a laboratory confirmed positive case
- You must immediately call the State Helpline Number or Ministry of Health & Family Welfare, GoI 24x7 helpline 011-2397 8046, 1075 or your ASHA/ANM.

1.2 What are the safe practices to be promoted?

Maintain a physical distance from people

- Maintain at least 1 to 2 metres distance between yourself and others.
- Avoid going to crowded places.
- Avoid organizing and attending events with a lot of people, like parties, religious gatherings etc.

Frequent hand washing

- Wash your hands with soap and water regularly and thoroughly for 40 secs (you can relate the time to saying a prayer or singing a song) or 70% alcohol-based hand rub.

Using a mask

- A mask should be used at all times (can use a handkerchief, any cloth, dupatta or homemade mask).
- The handkerchief, any cloth, dupatta or homemade mask should be cleaned frequently with water and soap and dried under the sun.

Avoid touching eyes, nose and mouth

- Contaminated hands can transfer the virus to your eyes, nose or mouth.

Practice good respiratory hygiene

- Cover your mouth and nose with a handkerchief when you cough or sneeze.

- If you have to dispose of the used cloth/napkin it should be thrown in a closed dustbin.
- Wash your hands with soap and water for 40 secs or rub hands with 70% alcohol-based hand sanitiser

Stay informed, take care and follow advice of ANM / ASHA/AWW

- Stay informed about the latest developments regarding COVID-19 by checking with the ASHA/ ANM/AWW or PHC. Direct any queries you have on how to protect yourself to them.

1.3 Who is a suspect case?

- Anyone with any kind of respiratory illness (fever and at least one sign/symptom of respiratory disease, such as cough or difficulty in breathing),

AND

- A history of travel to or residence in a country/area or territory reporting local transmission of COVID-19 disease during the 14 days prior to symptom onset,

OR

- Anyone with any acute respiratory illness AND who has had contact with a confirmed COVID-19 case in the last 14 days prior to onset of symptoms;

OR

- Anyone with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease cough, difficulty in breathing) AND requiring hospitalization;

OR

- A case for which testing for COVID-19 is inconclusive.

1.4 Who is a contact case?

- Staying in the same close environment as a COVID-19 patient (including a house, workplace, classroom, household, gatherings)
- Travelling together in close proximity (less than 1 m) with a symptomatic person who later tested positive for COVID-19
- Person providing direct care to a COVID-19 patient
- The infection may have been transferred within a 14-day period before the onset of illness

Module 2: Safe practices at home

2.1 What safe practices can you practice at home?

Stay away from others

- Stay in a specific room and away from other people in your home. Maintain distance of at least 1 to 2 meters. Restrict all movement so that others in the house stay safe from infection
- If available, use a separate bathroom

Seek healthcare and notify local health authorities

- If suffering from fever, cough, or having difficulty in breathing, wear a mask to protect others and immediately get in touch with your nearest health facility or ASHA or ANM.

Wear a mask

- Wear a mask at all times.
- When you are around other people and when you enter a healthcare provider's clinic do not remove the mask.
- If a sick person is unable to wear a mask, then family members and others should wear it when they enter the patient's room.

Avoid going to public areas

- Do not go to work (office, factory, shop etc.), school, or public areas or religious gatherings.
- If you are infected, you could transmit the infection to others.

Avoid visitors or support staff coming to the house

- You may pass on or contract the infection unknowingly.
- Support staff like maids, drivers, etc should be asked to stay away as you have to protect them from getting infected.

2.2 How to support home quarantine?

Support: Assign one family member to take care of a bed-ridden patient. While helping him or her, follow the doctor's instructions regarding medication(s) and care.

Monitor symptoms: Fever and breathing must be monitored regularly and reported immediately, in case there is breathing difficulty or very high fever.

Protective hygiene:

- Avoid sharing household items like dishes, drinking glasses, cups, eating utensils, towels, bedding with the patient. Throw used masks/cloths in a closed trash can.
- Wash and disinfect linen in water and soap; dry it in the sun.
- Place all used disposable gloves, face masks, and other contaminated items in a closable container before disposing them of with other household waste.

Clean and disinfect: All "high-touch" surfaces, such as counters, table tops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables should be wiped clean every day. Also, clean any surfaces that may have blood, stool, or body fluids on them

Wash hands: with soap and water for at least 40 seconds or, if soap and water are not available, clean your hands with a 70% alcohol-based hand sanitizer. Wash often and especially after touching face.

How can you support family members in home quarantine?

- Wash hands often and thoroughly with soap and water for 40 secs or rub with 70% alcohol-based hand sanitizer.

- Keep away from the elderly. Household members should stay in another room or be separated from the quarantined person as much as possible. Members of the household should use a separate bedroom and bathroom, if available.
- Avoid sharing their daily use/household items e.g. dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with other people at home.
- Wear a triple layered mask at all times when in contact with an infected person.
- Disposable masks are never to be reused. (Used mask should be considered as potentially infected).
- Masks must be disposed of safely.
- If the quarantined person experiences any symptoms (fever/cough /difficulty in breathing) the nearest health centre should be informed immediately. Or you should call your local phone number/ help line.

Module 3: Psychosocial effects on informal workers and their families and coping strategies

3.1 Stress – symptoms and factors responsible

What is stress?

Stress is our body's response to unexpected and frightening or anxiety inducing incidents and situations.

Symptoms of stress

- Eating too much or too little
- Sleeping too much or too little
- Aches and pains
- Memory problems
- Feeling upset
- Loneliness and isolation
- Negative thoughts

Factors increasing stress:

- In any epidemic, it is common for individuals to feel stressed and worried. But there are certain **factors** which increase the stress in such situations.
- Fear of **being infected and infecting others,** especially if the route of transmission of the virus is not clearly understood.
- The appearance of common symptoms of other minor health problems (e.g. cold and fever), leading to fear that one is infected, even though there has been no consultation with a doctor
- **Inadequate information and rumours** leading to stress
- Feelings of helplessness, boredom, loneliness and depression due to **physical distancing** (For example: not being able to go out of the house, having to maintain a physical distance from friends and family)

- Fear of losing livelihood, not being able to work and sitting at home due to **physical distancing,** constant worrying about effect of distancing measures leading to economic crisis
- Increasing worry about the **elderly, people with disabilities, children and pregnant woman** in the house, if other care and support is not in place

3.2 Measures for staying stress free

- If you **experience suspicious symptoms, immediately contact a doctor or local public/SEWA health worker,** and discuss your symptoms with them.
- Stay away from news and discussions related to Corona virus, if they increase your stress level and make you more anxious
- **Avoid** taking updates from social media platforms such as **Facebook, WhatsApp groups, and television (TV).** Adhere strictly to information provided by **World Health Organization (WHO) or follow local public health departments in your neighbourhood** for correct information.
- **Avoid getting into arguments and discussions** after listening to new information or news related to Corona virus.
- Physical exercises like **yoga, stretching,** and relaxation exercises like **deep breathing** help reduce stress
- **Drink plenty of water and eat a nutritious diet.**
- **Do not use tobacco and alcohol** in the hope of coping with your emotions.
- Maintain **physical distance** (a minimum of one meter distance) from others and greet them with "Namaste" – by joining both hands.

Plan a schedule for indoor activities such as learning new recipes, participating in fun activities with children, spending more time with family members and engaging in long discussions with them, praying and meditating, etc. Stay connected with friends and relatives through phone.

Module 4: Sexual and reproductive health and rights and gender-based violence

Sexual and Reproductive Health

Sexually transmitted diseases are those diseases which are mostly spread through sexual contact. HIV, Leucorrhoea / white discharge are some forms of sexually transmitted diseases.

Common symptoms:

- Itching and swelling on the outer part of the vagina
- Lesion on vaginal tract or opening of uterus (Cervix)
- Burning sensation and discomfort during micturition
- Green or yellow, smelly, watery discharge
- Bleeding or scar after sexual intercourse

- Irregular menstrual bleeding
- Discomfort in lower abdomen and back pain

RISK FACTORS

- Unsafe Sexual relations and without protection
- Lack of hygienic practices

How to prevent sexually transmitted diseases

- Keep private parts clean and dry especially during menstruation
- Clean private parts after sexual intercourse
- Use condoms during sexual intercourse
- If you notice any symptoms, consult a doctor immediately or contact ASHA/ANM or health service provider.

Family planning methods/contraceptives

When focussing on sexual health, women also need to be aware of when they are ready to conceive, be able to talk to their partners openly about this topic and to go to the health centre to consult a doctor or ASHA or ANM. Women should make sure that they follow healthy practices such as keeping themselves clean (washing with water) after sexual intercourse, so that there is no risk of infection.

Ways of confirming pregnancy

- Missing menstrual period
- Using a pregnancy test kit. You can take this kit from ASHA, ANM or from the sub-centre. You can also contact the local SEWA health worker and she will help you.

Information on family planning

- According to the law, the right age of marriage is 21 years for boys and 18 years for girls.
- The first conception after marriage should be delayed.
- Pregnancy at the right age ensures the health of the baby and mother
- Maintain a gap of at least 3 years between the first and second child
- There are many types of affordable and safe contraceptive methods (condoms, Mala-D), through which couples can delay having their first child and ensure spacing before having the second. You can consult ASHA, ANM or visit the subcentre for information about methods of family planning

Why is it important to have the right birth spacing?

- The mother stays healthy and can properly nurture and breastfeed her baby
- The baby is nurtured correctly after spacing and the womb is fully prepared for the birth of the second child
- Economic burden on the family is reduced

Menstrual health and hygiene management

- If sanitation is not maintained during menstruation, the chances of infection increase, so it is very important to take special care of hygiene and sanitation during this period.
- Special care should also be taken of the diet and nutrition during menstruation

Menstruation and health

- The onset of menstruation usually occurs anytime between the ages of 12–15 years and stops permanently between the ages of 45–55. There can be a variation in these ages however. So, the total number of years menstruation happens can be different for individual women.
- During menstruation, the blood flow usually lasts for 4–5 days. For some women it may last for more or fewer days.
- During menstruation, 40 mm of blood (as much as half a cup) is lost.

Cleanliness and hygiene to be followed during menstruation

- Use clean, cotton, soft cloth / pads.
- Keep changing the pads from time to time (3–4 times a day). Do not use dirty, infected pads
- Wash genitals thoroughly with clean water
- If cloth is used, it must be washed thoroughly and dried under direct sunlight to make it germ free.
- In order to avoid possible infections, the same cloth should not be used for more than 3 months.
- If pain occurs, take proper rest and use hot pads
- Eat a nutritious diet to compensate for menstrual blood loss

Live a normal life during menstruation, play in the normal way, continue the daily routine of household chores and do not interrupt your normal day-to-day activities.

Myths and facts on abortion in India

	
All abortions are illegal	All abortions are not illegal and MP Act defines clear indications for legal abortions.
Sex selection can be ground for terminating pregnancy	Sex selection is not a legal ground for terminating pregnancy and its illegality should be emphasised.
If the girl does not want any legal action, the provider should not report sexual abuse	Under the law it is mandatory to report sexual abuse and failure to do so can lead to punishment by imprisonment of up to six months, with or without fine.
Consent for MTP of a minor girl can be given only by her parents	Guardian can be any adult (> 18 years) who is taking care of the minor girl.
A medical provider must wait for a medico-legal documentation before performing abortion	Providers can inform the authorities about a pregnant minor after performing the abortion. Any legal or magisterial requisition or other documentation is not a mandatory pre-requisite to rendering such care.
No one should be present when the examination of a minor girl is being performed.	Section 27 of the POCSO Act, 2012, specifically requires that the examination be conducted in the presence of the child's parents/guardian or other person in whom the child has trust and confidence.
Abortion leads to infertility	Abortion does not affect the fertility if performed with reasonable care.
There is no need for contraception after an abortion	Contraceptive advice must be offered after both first trimester and second trimester abortion.
Emergency pill is the same as abortion pill	Emergency pill is given after unprotected intercourse to avoid pregnancy is not the same as abortion pill which is given to medically induce abortion.
PC & PNDT Act regulates access to safe abortion services	PC & PNDT Act has been implemented to prohibit sex selection. It does not in any manner restrict access to safe abortion services.
MTP can be denied if the woman refuses any method of contraception at the same time	MTP should not be denied irrespective of the woman's decision to refuse concurrent contraception.

Gender-based violence

Issues

There are many types of violence, such as physical, mental, economic and social violence.

Some examples are given below:

Shouting in anger, slapping, shaming and humiliating someone, not letting someone go out for work, sexual harassment, denying safe sex, disrespecting a person, gender selective abortion, rape, unwanted sexual relations, ignoring pain, using abusive language, not allowing a person to go out of the house, etc.

- **Violence can occur anywhere, for example, at home, on the way somewhere or on the road, at a place of business, and in any public transport, any public place.**
- **The victims of violence are mostly women, teenagers and children, because they are considered to be socially and financially weaker**

Patriarchy is still seen in most parts of our country, due to which women are deprived of their rights and their place in society leading to several types of violence against women. Even today women do not have the right to take decisions in economic and social matters. To emerge from the problems, they face on a day to day basis currently, it is necessary that women become aware of the laws that ensure their safety, and protect their rights. They can take the help of these laws when in need.

Acts of violence and tolerating them are both legal offenses; there are several laws against violence in India. Lack of awareness about them and not being able to access legal help remains one of the critical causes for increasing violence against women and girls.

If you face any kind of violence reach out to a friend, a relative, ASHA, ANM or SEWA aagewan.

ANNEXURE 3

Training schedule

S.NO.	State	Organization	Date of training (Supervisors)	Date of training (MTs)
1	Madhya Pradesh	SEWA MP	14.4.2020	17.4.2020 – 18.4.2020
			15.4.2020	
2	Rajasthan	Unnati	15.4.2020	22.4.2020– 25.04.2020
			22.4.2020	
3	Gujarat (Rural)	SEWA (Health)	16.4.2020	17.04.2020 – 18.04.020
4	Gujarat (Urban)	SEWA (Health and Child Care)	17.4.2020	18.4.2020 – 22.04.2020
			18.4.2020	
5	Delhi	SEWA Bharat	17.4.2020	19.04.2020– 20.04.2020
			18.4.2020	
6	Assam	North East Network (NEN)	20.4.2020	23.04.2020–28.04.2020
			21.4.2020	
	Meghalaya		20.4.2020	22.04.2020–24.04.2020
			21.4.2020	
	Nagaland		20.4.2020	25.04.2020–26.04.2020
			21.4.2020	
7	Tapi, Gujarat	SEWA Federation	20.4.2020	21.4.2020 – 22.04.2020
			21.4.2020	

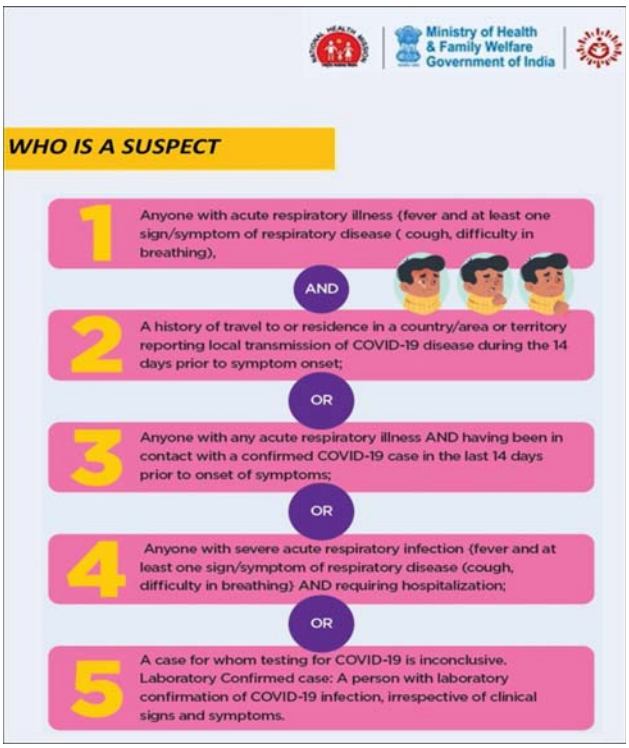
ANNEXURE 4

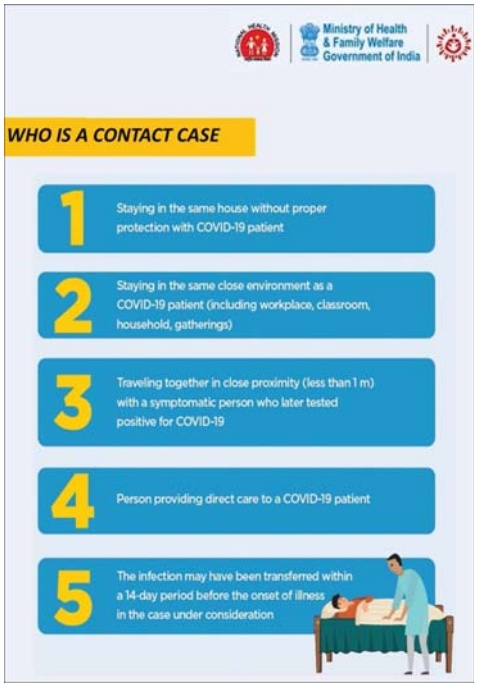
Session-wise average participation of women

AVERAGE PARTICIPATION OF WOMEN															
States	Session 1			Session 2			Session 3			Session 4			Follow up Session		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Gujarat	19.02	14.15	16.35	19.00	13.94	16.23	18.89	13.69	16.04	18.90	13.57	15.97	18.83	13.25	15.76
Rajasthan	18.28	NA	18.28	18.37	NA	18.37	18.33	NA	18.33	18.43	NA	18.43	18.96	NA	18.96
Delhi	NA	19.06	19.06	NA	18.96	18.96	NA	18.92	18.92	NA	18.98	18.98	NA	19.11	19.11
MP	18.84	18.93	18.88	18.66	18.64	18.65	18.48	18.54	18.51	18.32	18.54	18.43	18.52	18.89	18.70
Assam	18.31	18.59	18.42	18.19	18.41	18.28	17.95	18.48	18.16	18.09	18.29	18.17	18.21	18.44	18.30
Meghalaya	18.48	17.93	18.24	18.48	17.90	18.23	18.50	17.97	18.27	18.45	17.93	18.23	17.78	17.93	17.84
Nagaland	18.30	18.74	18.44	18.30	18.74	18.44	18.30	18.74	18.44	18.30	18.74	18.44	18.30	18.74	18.44
All the states	18.60	17.41	18.01	18.58	17.24	17.92	18.49	17.13	17.82	18.49	17.10	17.80	18.66	17.13	17.90

ANNEXURE 5

Module 1






COVID-19
10 WHAT ARE THE SAFE PRACTICES AT HOME
1
Stay away from others
a. Stay in a specific room and away from other people in your home. Maintain distance of at least 1 meter. Restrict all movement so that others in the house stay safe from infection
b. If available, use a separate bathroom
2
Seek health care and notify
a. If su ering from fever, cough, or having di culty in breathing, wear a mask to protect others and immediately get in touch with your nearest health facility or ASHA or ANM.
3
Wear a mask
a. When you are around other people and before you enter a healthcare provider's clinic
b. If sick person is unable to wear it, then other family members should wear it when they enter the sick person's room
4
Avoid going to public areas
a. Do not go to work, school, or public areas
b. If you are infected, you could transmit infection to others
5
Avoid visitors or support sta coming to the house
a. You may likely pass infection unknowingly
b. Support sta like maids, drivers, etc should be asked to stay away
Ministry of Health & Family Welfare Government of India
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COVID-19
12 HOW TO SUPPORT HOME QUARANTINE FOR FAMILY MEMBERS
1
Wash hand often thoroughly with soap and water for 40 secs or rub with 70% alcohol-based hand sanitizer
2
Keep away from elderly. Household members should stay in another room or be separated from the person as much as possible. Household members should use a separate bedroom and bathroom, if available.
3
Avoid sharing household items e.g. dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with other people at home.
4
Wear a triple layered mask at all the time when in contact with infected person. Disposable masks are never to be reused. (Used mask should be considered as potentially infected). Mask to be disposed safely.
5
If symptoms appear (fever/cough /difficulty in breathing) he/she should immediately inform the nearest health centre or call your local phone number
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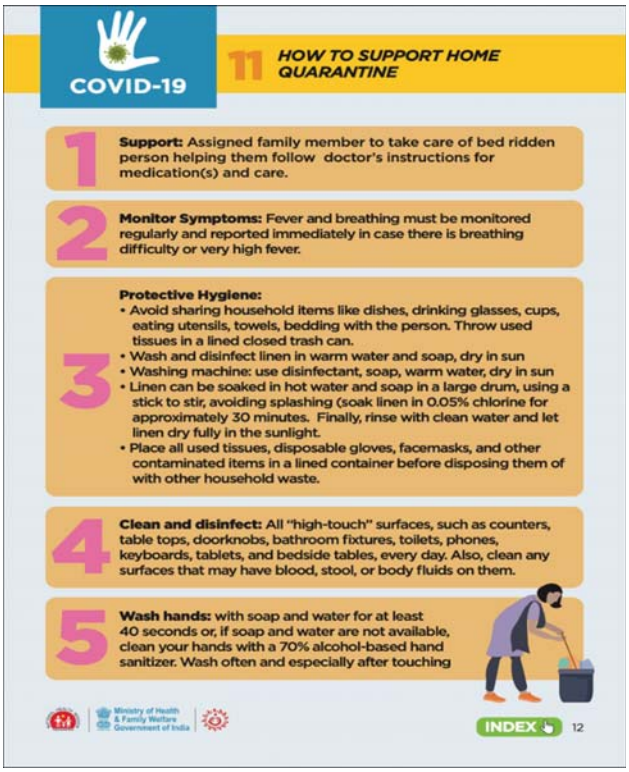
COVID-19
11 HOW TO SUPPORT HOME QUARANTINE
1
Support: Assigned family member to take care of bed ridden person helping them follow doctor's instructions for medication(s) and care.
2
Monitor Symptoms: Fever and breathing must be monitored regularly and reported immediately in case there is breathing difficulty or very high fever.
3
Protective Hygiene:
• Avoid sharing household items like dishes, drinking glasses, cups, eating utensils, towels, bedding with the person. Throw used tissues in a lined closed trash can.
• Wash and disinfect linen in warm water and soap, dry in sun
• Washing machine: use disinfectant, soap, warm water, dry in sun
• Linen can be soaked in hot water and soap in a large drum, using a stick to stir, avoiding splashing (soak linen in 0.05% chlorine for approximately 30 minutes. Finally, rinse with clean water and let linen dry fully in the sunlight.
• Place all used tissues, disposable gloves, facemasks, and other contaminated items in a lined container before disposing them of with other household waste.
4
Clean and disinfect: All "high-touch" surfaces, such as counters, table tops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables, every day. Also, clean any surfaces that may have blood, stool, or body fluids on them.
5
Wash hands: with soap and water for at least 40 seconds or, if soap and water are not available, clean your hands with a 70% alcohol-based hand sanitizer. Wash often and especially after touching
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Stress, factors and measures to stay stress- free during Corona virus infection epidemic

Symptoms of stress

- Eating more or less
- Sleeping too much or too little
- Aches and pains
- Memory problems
- Feeling upset
- Loneliness and isolation
- Negative thoughts

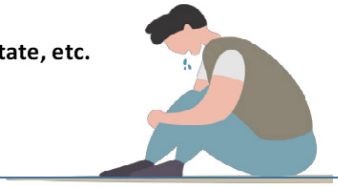
Factors increasing stress

- Lack of information
- Spread of rumours
- Fear of becoming infected and infecting others
- Fear of being socially excluded
- Fear of losing an income
- Constant worry for elderly, children and pregnant women in the house

For more information: Contact toll- free helpline number 104

Measures to stay stress- free

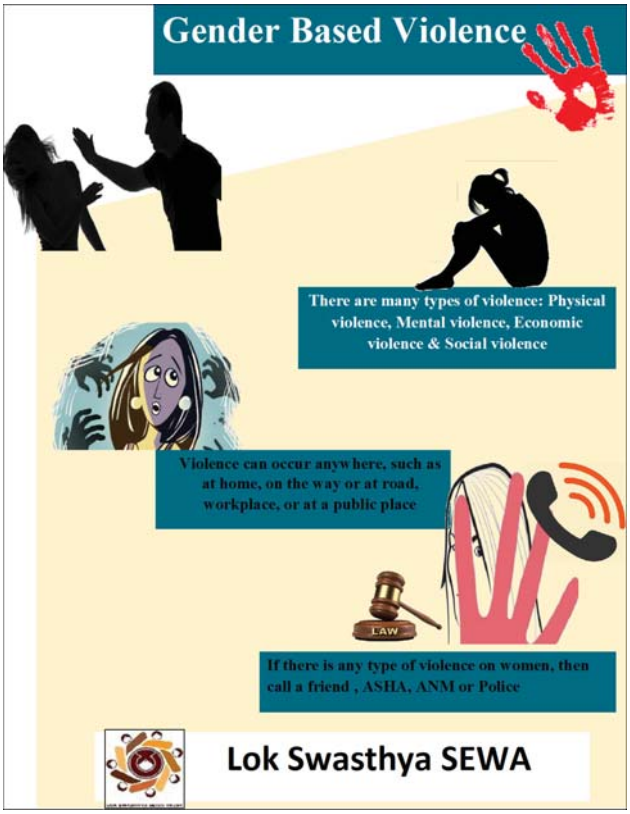
- Stay away from news and discussion related to Corona virus
- Drink plenty of water and take nutritious diet, regularly
- Do not use tobacco and alcohol
- Make home- activity schedule. For example, talk with family members, learn new recipe, participate in playful activities with children, pray and meditate, etc.
- Stay connected with friends and relatives through phone

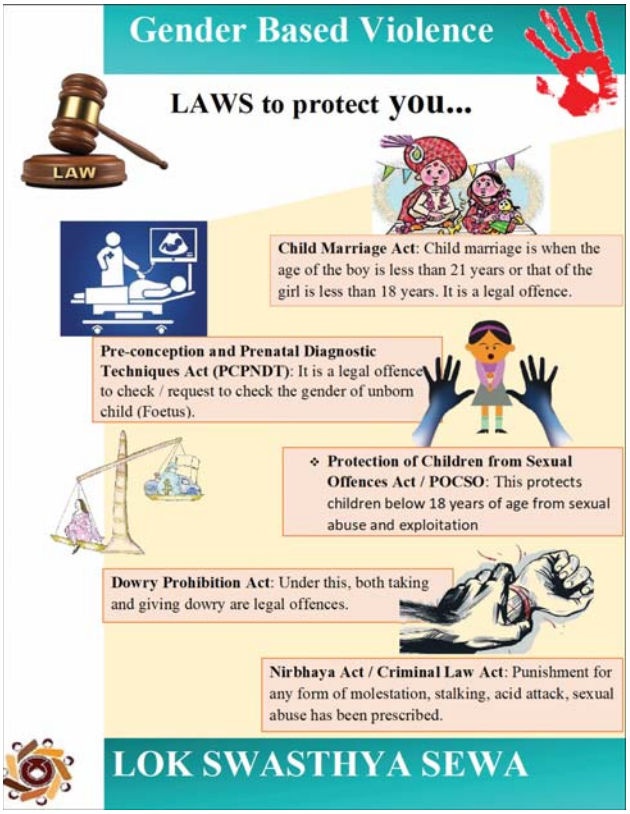


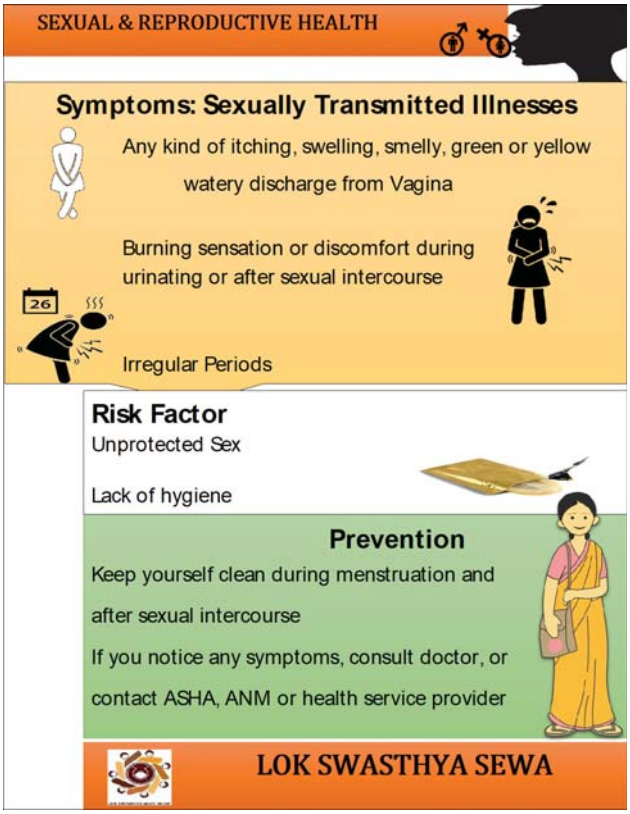
LOK SWASTHYA SEWA TRUST

Lok Swasthya SEWA


SEXUAL & REPRODUCTIVE HEALTH
Family Planning
Delay first conception
Maintain a gap of at least 3 years
between first and second pregnancy
For different contraceptive methods, please contact
Doctor/ ASHA/ ANM
How to find out about Pregnancy?
Missing Menstrual Periods
Using Pregnancy test kit, also available from ASHA/ANM or Sub centre
LOK SWASTHYA SEWA


Gender Based Violence
There are many types of violence: Physical violence, Mental violence, Economic violence & Social violence
Violence can occur anywhere, such as at home, on the way or at road, workplace, or at a public place
LAW
If there is any type of violence on women, then call a friend , ASHA, ANM or Police
Lok Swasthya SEWA


Gender Based Violence
LAWS to protect you...
LAW
Child Marriage Act: Child marriage is when the age of the boy is less than 21 years or that of the girl is less than 18 years. It is a legal offence.
Pre-conception and Prenatal Diagnostic Techniques Act (PCPNDT): It is a legal offence to check / request to check the gender of unborn child (Foetus).
Protection of Children from Sexual Offences Act / POCSO: This protects children below 18 years of age from sexual abuse and exploitation
Dowry Prohibition Act: Under this, both taking and giving dowry are legal offences.
Nirbhaya Act / Criminal Law Act: Punishment for any form of molestation, stalking, acid attack, sexual abuse has been prescribed.
LOK SWASTHYA SEWA


SEXUAL & REPRODUCTIVE HEALTH
Symptoms: Sexually Transmitted Illnesses
Any kind of itching, swelling, smelly, green or yellow watery discharge from Vagina
Burning sensation or discomfort during urinating or after sexual intercourse
26
Irregular Periods
Risk Factor
Unprotected Sex
Lack of hygiene
Prevention
Keep yourself clean during menstruation and after sexual intercourse
If you notice any symptoms, consult doctor, or contact ASHA, ANM or health service provider
LOK SWASTHYA SEWA

Maps in this document are for design purposes only and not reflective of accurate territorial boundaries.

Lok Swasthya SEWA Trust and
WHO India Collaboration