



Generating Evidence for Rebuilding SRH Services for Women and Girls in India

A cross-sectional study to assess
the impact of COVID-19 pandemic
on women and girls



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1.0 GENESIS

The COVID-19 pandemic and the consequent lockdown has had an unprecedented impact on young women's ability to access sexual and reproductive health (SRH) related information and services. Although many components of SRH care were declared as essential services by the Government of India, public health experts opine that access has still been significantly impacted due to various reasons, including: a) restrictions on movement of women and girls, b) repurposing of health facilities as COVID-19 treatment centres, c) redeployment of facility staff to COVID-19 services, d) suspension of transport facilities, e) disruption in the supply chain of drugs and equipment, f) federal government directives to suspend the provision of certain contraceptive methods, and g) redeployment of community outreach workers for COVID-19 duties disrupting the support channel between public health facilities and community women, particularly young women and girls.

Recent studies conducted in different parts of the world based on empirical data have not only evidenced lack of access to SRH services in the first few months since the lockdown began (Bateson et al 2020, Plan International 2020, IDF 2020, FRSHI 2020), but also highlighted significant transition in social and economic realities of women's lives (Lindberg et al 2020) in terms of social and occupational mobility, family dynamics, and financial efficacy. Women globally had lost their agency, ability, and affordability to access SRH services and information, including menstrual hygiene, RTI, STI, contraceptives, pregnancy, and abortion (IDF 2020, FRSHI 2020). Since end-March, in-person healthcare has been severely restricted, with providers necessitating to shift their priority from routine healthcare to COVID-19 management (Lindberg et al 2020). Even once lockdown restrictions are relaxed, women may not seek out needed SRH related services due to fear of getting an infection at health facilities and clinics and that may further expose their family member to COVID-19.

Healthcare providers were forced to suspend some SRH services that are not classified as essential services thus denying people this time-sensitive and potentially life-saving service (Riley 2020). Community health intermediaries were equally scared to continue to provide in-person care. This has major implications in the process of management of unfulfilled needs in the domain of SRH. It is estimated that around 47 million women in 114 low- and middle-income countries, including India, will not be able to use contraception and this would result in 7 million unintended pregnancies due to the COVID-19 pandemic and related restrictions (UNFPA 2020). As estimated by FRSHI-India, human resource issues and lack of access will lead to 26 million couples in India facing an unmet need for contraception if the current situation continues and further will result in 2.4 million unintended pregnancies; 1.45 million abortions, out of which more than half would end up being unsafe; and more than 1,700 excess maternal deaths. IDF undertook a modelling exercise to estimate the impact of COVID-19 on access to abortion services in India and estimated that 1.85 million women would not be able to access abortion services from any sources in the first few months of the COVID-19 pandemic (IDF 2020). Shifts in fertility preferences because of COVID-19 have also been identified in the United Kingdom, Germany, France, Spain, and Italy, suggesting that declines in fertility may be widespread (Luppi et al 2020). Although the COVID-19 pandemic touched all segments of the population, its ultimate impact discriminated between rich and poor, young and old. (UNDP 2020).

Over the few months, many studies have explored the medical impacts of the virus and facility-based challenges to deal with the pandemic. However, there is limited research on the social and community-

based impacts of COVID-19 and the consequences on the young women who regularly need support for SRH care and information. For girls and young women, in many countries across the world, it is a time when they are particularly at risk (Plan International 2020) as pandemic affects young women in all aspects of their life, including access to information and care, decision making, financial hardship and affordability to access basic needs. We do not know much directly from the community – their SRH needs, gaps from their perspectives, and the support they need.

With this in mind Ips Development Foundation (IDF), in line with its continuing focus on improving young women's SRH care and services, commissioned a community-based research study to assess the impact of the COVID-19 pandemic on girls and young women (15-24 years). A cross-sectional community research was implemented during November-December 2020 in three IDF program states – Assam, Jharkhand, and Madhya Pradesh to assess the ground reality in terms of accessing women's experience of accessing SRH information and services and identifying gaps and unfulfilled needs for restoration of these services.

1.1 Objectives

The broad aim of this study was to generate evidence from the community on the impact of COVID-19 on SRH services for women and develop contextual need-based community outreach strategies.

The specific objectives of the proposed study were:

- a) To assess how access to information and services was impacted due to the pandemic and the consequent lockdown
- b) To explore the unfulfilled SRH needs (information and services) of young women and girls
- c) To understand young women's experience of seeking SRH services from health facilities and how the support system impacted the access to information and services
- d) To identify immediate requirements in terms of information and services
- e) To examine challenges and good practices from the field that overcame these challenges

This study also aimed to get the broad aspects for Community Intermediaries (ASHAs) in terms of:

1. Their perspective of service utilization by the community and how it has been impacted by the pandemic
2. Have their priorities shifted towards COVID-19? Do they foresee returning to their core role?

2.0 METHODOLOGY

2.1 Study design and setting

A cross-sectional mixed methodology was adopted with a quantitative survey of interviewing girls and young women ages 15-24 years and a qualitative in-depth exploration of the perception of community intermediaries (ASHAs and chemist) along with young women ages 15-24 years. The study was conducted in the existing youth-focused intervention areas in three major states of India including, Assam, Madhya Pradesh, and Jharkhand with high, moderate, and low incidences of COVID-19 pandemic. As of February 2021, 258,574 persons were reportedly infected with COVID-19 in Madhya Pradesh followed by 217,344 and 119,477 persons in Assam and Jharkhand respectively.

2.2 Sample size and technique

This study aimed to assess two major outcomes: a) proportion of young women who explored any SRH related information and b) proportion of young women who accessed any SRH related services.

Availability of statistical information on these subjects was not very common during the COVID-19 pandemic. With a discounting factor from the pre-COVID period, we assume 35% of young women (15-24) explored any information on SRH related services, and around 30% utilized SRH related services. We estimated desired sample size for this study based on the available prevalence of these two indicators. The following formula was used to estimate the minimum sample size: $n=Z^2*p*cv^2$. Where, the coefficient of variation (cv) was fixed at 0.1 or 10% (equivalent to fixing absolute error at 20%, of true proportion and estimating at 95% confidence) and p implied the proportion of women who utilized SRH services from the formal or informal sector (30%). This suggested a total minimum sample size of 233; with a non-response of 20% the total sample needed to be covered in this study was 280 which was rounded off to 300 for the implementation. Thus, a total of 900 sample respondents (300 from each state) were targeted for this study.

A multistage systematic random sampling was used to ensure a diversity of respondents by socio-economic characteristics of the youth population. In the first stage, villages were identified using probability proportional to size (PPS) sampling technique, while in the second stage young respondents ages 15-24 years were selected using systematic random sampling. The survey utilized a probability sample and was not designed to be fully representative of the state population. However, the survey sample broadly mirrors the socio-economic profile of the youth population of the study states. For the qualitative survey, samples for the in-depth interviews were drawn purposively from six randomly selected villages of the same geography.

Table 1: Distribution of quantitative and qualitative samples by study states

| Respondents | Technique | Madhya Pradesh | Assam | Jharkhand | Total |
|---------------------------------|------------------|-----------------------|--------------|------------------|--------------|
| Young women (15-24 yrs) | Quantitative | 300 | 300 | 300 | 900 |
| Young women (15-24 yrs) | IDIs | 8 | 8 | 8 | 24 |
| Community intermediaries ASHAs) | IDIs | 4 | 4 | 4 | 12 |
| Chemist | IDIs | 1 | 2 | 1 | 4 |

2.3 Data collection and safety

900 young women and girls (300 from each state) ages 15-24 years were successfully interviewed between 2nd November and 4th December 2020. Data was collected face-to-face by 45 trained youth volunteers. Youth volunteers were exclusively trained on the personal safety and social distancing by senior doctors. Before starting any interview, the place of interview was disinfected by the trained investigators. Each study respondent was provided a safety kit, including mask, pair of gloves, disinfectant, washing soaps, and a pack of sanitary napkins. This has not only ensured the safety measures but also helped motivating them washing their hands regularly. Because of this complex precaution, a maximum of two interviews were carried out daily by each of the research investigators. For the qualitative survey-, audio- and audio-visual medium of digital interface was used for conducting in-depth interviews (IDIs). Ethical approval for this research was granted by CMS IRB a local institutional review board.

2.4 Instrument

A structured questionnaire was used to collect data from the quantitative survey in a face-to-face interview. Survey instrument gathered information about respondents' demographic and

socioeconomic status, access to SRH related information and service utilization during the COVID-19 pandemic, perceived experiences of and challenges in accessing information and services during the pandemic, and immediate needs for information and services post pandemic. The study also explored consequences of COVID-19 pandemic on their lives with respect to financial hardships, family dynamics, family support and domestic violence. The instrument for married women also included questions related to reproductive history and pregnancy management and unmet needs for different services. Study instruments were pre-tested and translated into local languages - Hindi for Madhya Pradesh and Jharkhand; and Assamese for Assam.

2.5 Analysis

Data was analysed using Stata 14.0. The state specific outcomes are presented here along with the combined results of three states. Descriptive statistics are reported for both categorical and continuous variables. Categorical variables are analysed using frequencies, and percentages; for continuous variables, means and standard deviations are reported. In order to approximate the economic status of the respondents, a standard of living (SLI) index was developed on the basis of ownership of household durables and assets. Households were assigned a score for each asset, and the scores were summed for each household. A high SLI generally implied a higher level of income and the ability to acquire other modern amenities that add to one's comfort. Overall composite mean scores were computed to describe financial hardship, transition in family dynamics, domestic violence, and perceived priority to access SRH services. The impact and consequences of COVID-19 pandemic were measured for a period of six months of COVID-19 crisis, ranging from 25th March to 30th September 2020. This study estimated multivariate logistic regression analyses to assess factors that influenced access to SRH related information and services during COVID-19 crisis after controlling socio-economic variables. All differences presented in the multivariate model were tested for statistical significance at the $p < 0.01$ and $p < 0.05$ levels.

3.0 FINDINGS

3.1 Socio-economic status of sample respondents

Table 2 presents the socio-demographic characteristics of the study participants. Around 71% of the women in the combined sample were between the ages of 20-24 years. The mean age remained 21 years, ranging from 20.1 years in Assam to 22 years in Madhya Pradesh. Most (79%) of these respondents were married. Almost half (46%) of the respondents identified as Hindu (46%) while 28% identified as Muslim, and 26% identified as Sarna. Unique variations were observed among states by religion; Madhya Pradesh was dominated by Hindu (96%) while Assam by Muslims (78%), and Jharkhand by Sarna¹ tribes (78%).

Table 2: Sociodemographic characteristics of study respondents (%)

| | Assam (n=300) | Jharkhand (n=300) | Madhya Pradesh (n=300) | Overall (N=900) |
|---------------------|------------------|----------------------|---------------------------|--------------------|
| Age of Women | | | | |
| 15-19 years | 38.3 | 35.0 | 14.3 | 29.2 |
| 20-24 years | 61.7 | 65.0 | 85.7 | 70.8 |

¹ Sarna is a traditional religion of some Scheduled Tribe groups in Jharkhand, characterized by spirit worship (Banerjee et al 2012)

| | Mean(SD) | 20.1 (2.58) | 20.3 (2.64) | 22 (2.41) | 20.8 (2.67) |
|--|--|-------------|-------------|------------|-------------|
| Marital Status | | | | | |
| | Currently Married | 80.0 | 78.3 | 80.0 | 79.4 |
| | Unmarried / Separated/Divorced | 20.0 | 21.7 | 20.0 | 20.6 |
| Religion | | | | | |
| | Hindu | 22.0 | 19.0 | 95.7 | 45.6 |
| | Muslim | 78.0 | 2.7 | 4.3 | 28.3 |
| | Sarna/other | 0.0 | 78.3 | 0.0 | 26.1 |
| Caste | | | | | |
| | Scheduled Caste | 13.0 | 5.0 | 27.3 | 15.1 |
| | Scheduled Tribe | 2.0 | 81.0 | 8.7 | 30.6 |
| | Other Backward Class | 5.3 | 11.3 | 51.3 | 22.7 |
| | General | 79.7 | 2.7 | 12.7 | 31.7 |
| Education | | | | | |
| | Never Attended School | 2.7 | 3.0 | 7.7 | 4.4 |
| | Primary | 6.0 | 9.3 | 3.0 | 6.1 |
| | Middle | 42.3 | 40.3 | 40.0 | 40.9 |
| | Secondary | 33.7 | 29.3 | 25.3 | 29.4 |
| | Senior Secondary & above | 15.3 | 17.0 | 24.0 | 19.1 |
| | Years of schooling Mean(SD) | 8.6 (2.53) | 8.4 (2.89) | 9.3 (3.17) | 8.7 (2.89) |
| Work Status (Since April 2020) | | | | | |
| | Not worked | 94.3 | 47.3 | 89.0 | 76.9 |
| | Yes, but not paid work | 3.0 | 7.7 | 7.0 | 5.9 |
| | Yes, paid work | 2.7 | 45.0 | 4.0 | 17.2 |
| Primary source of HH income | | | | | |
| | Cultivator | 14.3 | 25.7 | 39.3 | 26.4 |
| | Agricultural labourer | 4.3 | 24.0 | 33.0 | 20.4 |
| | Non-agricultural labourer - Skilled | 13.0 | 15.3 | 6.0 | 11.4 |
| | Non-agricultural labourer - Unskilled | 7.7 | 21.0 | 7.3 | 12.0 |
| | Business/ Petty trade/self employed | 42.3 | 8.7 | 4.3 | 18.4 |
| | Salaried | 2.7 | 4.7 | 4.3 | 3.9 |
| | No regular income | 15.7 | 0.7 | 5.7 | 7.3 |
| Household with BPL card | | 24.3 | 67.7 | 40.7 | 44.2 |
| Standard of Living (SLI) | | | | | |
| | Low | 76.7 | 82.7 | 57.0 | 72.1 |
| | Medium | 21.3 | 17.0 | 35.7 | 24.7 |
| | High | 2.0 | 0.3 | 7.3 | 3.2 |
| Number of living children (among married) | | | | | |
| | 0 | 32.1 | 23.3 | 15.0 | 23.5 |
| | 1 | 40.4 | 47.9 | 36.7 | 41.7 |
| | 2 & above | 27.5 | 28.8 | 48.3 | 34.8 |
| | Average number of living children (SD) | 1.0 (0.92) | 1.1 (0.88) | 1.5 (1.02) | 1.2 (0.96) |
| BPL: Below Poverty Line | | | | | |

Around 68% of the sample respondents either belonged to Scheduled Castes (15%), or Other Backward Classes (23%) or to Scheduled Tribes (31%), and half of the young women and girls completed at least secondary level of education. Almost three-fourths (72%) of the respondents fell into the low standard of living category; the main source of household income was from owning a farm (26%) or from a daily wage (44%). Little more than two-fifths (44%) reported holding BPL (Below Poverty Line) card at the

time of survey (Table 2). Reproductive history was gathered only from young married women (Table 2); 76% young women had at least one child, and 17% were pregnant at the time of the study (data not shown here). On average young married women had at least one child.

3.2 Access to SRH and COVID-19 related information during the pandemic

Young women and girls were asked whether they tried to explore any SRH or COVID-19 related information during the pandemic (March 25 – September 30). More than half (54%) of the respondents wanted some information on SRH issues like menstrual supplies and hygiene (37%), RTI (29%), antenatal care (29%), pregnancy related issues (17%), contraception and supplies (16%), postnatal care (8%) and abortion (2%). Almost half (49%) of these young women and girls tried to access information from ASHAs (Accredited Social Health Activists) followed by Anganwadi Centres (25%), youth leaders (23%), government health facilities (24%), friends or relatives (25%), and chemist shops (6%). Across all three study states, young women explored multiple options to get some SRH related information during pandemic. Almost four-fifths (81%) successfully managed to get some responses to their queries, although varied significantly by states (Table 3). While young women and girls almost uniformly (92%) managed some information in Jharkhand, these were significantly low in Assam (75%) and Madhya Pradesh (69%). Imposition of ‘stay-at-home’ at the beginning of the COVID-19 pandemic (March-May) and the numerous restrictions even after the lockdown was lifted (June-September) have been the most common reasons of failing to get desired information on SRH related issues. As depicted in Table 4, travel restriction (31%), social isolation (27%), restricted home visits by ASHAs (20%) and youth leaders² (16%), and personal fear of getting infection were the most common reasons for not getting information during the COVID-19 pandemic.

3.2.1 Who was not able to access SRH related information during the pandemic?

Global studies have highlighted that the burden of the pandemic has not been experienced equally, rather it has impacted disproportionately the most vulnerable segment of population (Gupta 2020, Ewing-Nelson 2020, Garret et al 2020, Lindberg et al 2020).

Table 3: Type of SRH information sought and sources approached by study respondents; and outcomes of attempts (%)

| | Assam (n=300) | Jharkhand (n=300) | Madhya Pradesh (n=300) | Overall (N=900) |
|--|------------------|----------------------|---------------------------|--------------------|
| Tried to access any SRH related information | 53.3 | 67.3 | 41.0 | 53.9 |
| Information sought for | | | | |
| Menstrual problem/hygiene | 26.9 | 42.6 | 41.5 | 37.1 |
| RTI /white discharge | 21.3 | 30.7 | 37.4 | 29.3 |
| Ante natal care (ANC) | 27.5 | 25.2 | 38.2 | 29.3 |
| Post-natal care (PNC) | 3.8 | 13.9 | 4.9 | 8.2 |
| Pregnancy related issues | 25.6 | 13.9 | 12.2 | 17.3 |
| Delivery care | 5.0 | 8.9 | 5.7 | 6.8 |
| Abortion related | 0.6 | 3.0 | 0.8 | 1.6 |
| Contraception related | 5.6 | 23.8 | 15.4 | 15.7 |
| COVID related | 34.4 | 31.7 | 5.7 | 26.0 |
| Other | 1.9 | 0.0 | 0.0 | 0.6 |
| Source of seeking information | | | | |

² Young community members extensively trained on communicating SRH issues and guiding young women and girls to appropriate health facilities for care and services are termed as youth leaders

| | | | | |
|--|-------------|-------------|-------------|-------------|
| Government Facility/ Doctor | 25.6 | 12.9 | 38.2 | 23.5 |
| Private hospital/ clinic/ doctor | 8.1 | 6.4 | 13.0 | 8.7 |
| Online doctor/ Tele helpline | 1.9 | 0.0 | 0.8 | 0.8 |
| ANM | 1.9 | 9.9 | 0.0 | 4.7 |
| ASHA | 48.1 | 48.0 | 52.0 | 49.1 |
| AWC | 8.8 | 36.6 | 28.5 | 25.4 |
| Youth leader/ NGO worker | 1.9 | 34.7 | 29.3 | 22.5 |
| Internet / Google search/WhatsApp/TV/Radio | 8.1 | 5.0 | 11.4 | 7.6 |
| Pharmacy/ Medicine shop | 10.6 | 3.0 | 3.3 | 5.6 |
| Peers/ friends/ neighbours/Relatives | 15.6 | 34.2 | 22.0 | 24.9 |
| RMP/Ojha/Other | 1.9 | 5.9 | 0.8 | 3.3 |
| Successfully accessed information | 75.0 | 92.1 | 69.1 | 80.6 |

Table 4: Self-reported reasons of not able to manage any information on SRH related issues during COVID-19 pandemic (%)

| Reasons for not getting desired information | Assam (n=40) | Jharkhand (n=16) | Madhya Pradesh (n=38) | Overall (N=94) |
|---|-----------------|---------------------|--------------------------|-------------------|
| Restriction on travel | 27.5 | 18.8 | 39.5 | 30.9 |
| Could not go anywhere | 20.0 | 6.3 | 42.1 | 26.6 |
| Husband/ family member did not allow to go | 2.5 | 12.5 | 2.6 | 4.3 |
| ASHAs stopped home visit | 17.5 | 6.3 | 28.9 | 20.2 |
| ANMs stopped home visit | 0.0 | 6.3 | 7.9 | 4.3 |
| Youth leaders (YL) stopped coming to us | 0.0 | 6.3 | 36.8 | 16.0 |
| No contact with ASHA/ANM/YL | 2.5 | 18.8 | 5.3 | 6.4 |
| CIs denied accompanying to facility | 2.5 | 0.0 | 15.8 | 7.4 |
| Facilities were closed for other services | 10.0 | 18.8 | 39.5 | 23.4 |
| Fear of getting infection | 17.5 | 37.5 | 34.2 | 27.7 |
| Friend couldn't provide information | 30.0 | 6.3 | 0.0 | 13.8 |
| Doctor not available | 2.5 | 0.0 | 0.0 | 1.1 |

CI: Community intermediaries include ASHA, ANM & YL

Surprisingly, in India COVID-19 pandemic affected all segments of young women and girls irrespective of their social and economic profile. As portrayed in Table 5, 19% respondents who failed to manage accessing SRH related information during the COVID-19 pandemic are equally distributed by age, marital status, living standard, individual education, and caste.

Table 5: Profile of young women and girls who could not manage SRH related information during the COVID-19 pandemic (%)

| | Managed to access SRH related information | |
|-----------------------|---|---------|
| | Yes (391) | No (94) |
| Age of Women | | |
| 15-19 Years | 80.6 | 19.4 |
| 20-24 Years | 80.6 | 19.4 |
| Marital Status | | |
| Currently Married | 82.4 | 17.6 |
| Unmarried | 72.0 | 28.0 |

| | | | |
|--|--|------|---------|
| Religion | | | |
| | Hindu | 74.3 | 25.7 |
| | Muslim | 75.9 | 24.1 |
| | Sarna/other | 91.9 | 8.1 |
| Caste | | | |
| | Scheduled Caste | 80.0 | 20.0 |
| | Scheduled Tribe | 91.5 | 8.5 |
| | Other Backward Class | 74.7 | 25.3 |
| | General | 71.8 | 28.2 |
| Education | | | |
| | Below secondary | 82.8 | 17.2 |
| | Secondary & above | 78.5 | 21.5 |
| Work Status (Since April 2020) | | | |
| | Not worked | 77.0 | 23.0 |
| | Yes, but not paid work | 89.4 | 10.6 |
| Household with BPL card | | | |
| | Yes | 84.5 | 15.5 |
| | No | 77.4 | 22.6 |
| Access smart phone | | | |
| | Yes | 79.8 | 20.2 |
| | No | 81.6 | 18.4 |
| Economic Standard | | | |
| | Low | 80.3 | 19.7 |
| | Medium-High | 81.5 | 18.5 |
| State | | | |
| | Assam | 75.0 | 25.0 |
| | Jharkhand | 92.1 | 7.9 |
| | Madhya Pradesh | 69.1 | 30.9*** |
| Sought information for | | | |
| | Menstruation/RTI | 73.6 | 26.4*** |
| | Pregnancy related (ANC/ Delivery/Abortion) | 88.5 | 11.5 |
| | PNC, Contraception, COVID | 80.0 | 20.0 |
| Tried to access information from | | | |
| | Doctor-public & private | 78.8 | 21.2 |
| | Community health intermediaries / youth leader | 84.5 | 15.5 |
| | Digital media | 76.9 | 23.1 |
| | Friend & relatives | 75.5 | 24.2 |
| <i>Multivariate logit model was tested to assess attributes influenced access to SRH information. ***: P<0.01</i> | | | |

Factors which made significant variations were types of information required by young women and girls and study states. For example, respondents who tried to access any information related to menstruation and RTI were significantly ($P<0.01$) less likely to manage those compared to their counterparts who wanted pregnancy-related information.

Similarly, young women in Madhya Pradesh that had high prevalence of COVID-19 were less likely ($P<0.01$) to access SRH related information compared to young women in Jharkhand and Assam. Thus, it was not necessarily the social vulnerability and pre-existing inequalities, but pandemic related restrictions and consequent fear that reshaped the landscape of health system.

3.3 Access to SRH services during the COVID-19 pandemic

As portrayed in Table 5, more than half of the respondents (53%) attempted accessing SRH related services during the first six months of the COVID-19 pandemic. Little more than one-third reported seeking treatment or advice for menstrual problem and supplies (38%) followed by RTI or white discharge (37%), ANC (33%), pregnancy or delivery care (22%), post-delivery care (12%), contraceptives (17%), COVID-19 (14%) and abortion related issues (2%). The frequency of utilizing SRH services increased over time. While more than half of the respondents reported accessing services in the first four months (March 25 to July 31) of the pandemic, the remaining half tried accessing services during the last two months of the reference period (August-September). Contrary to information seeking where young women and girls mostly approached community intermediaries, they mostly approached public and private sector facilities including Sub Centre (17%), Primary and Community Health Centres (24%), District or Subdistrict Hospitals (22%), private clinics and hospitals (17%) for SRH services and care. They also approached chemist shops (12%), Quacks or village doctors (13%) for the SRH services and care.

Respondents who sought SRH services during the COVID-19 pandemic were further asked whether they received the required SRH services or care. In response, around 69% reported receiving some care or services, while 31% could not manage to access desired services during the COVID-19 pandemic. Across states, variations were significant, 43% and 36% young women failed to access SRH services in Madhya Pradesh and Assam respectively. As exhibited in Table 6, women failed to access SRH services due to travel restrictions (29%), fear of getting infection (25%), inability to access preferred facility (26%), difficulties in reaching the health facility (22%), restricted mobility (20%), denial of services by health facilities (14%), fear of police actions due to COVID-19 restrictions (14%), high fees of private providers (12%), and denial to accompany women to the facility by community intermediaries (5%). Even young women and girls who could manage to access SRH services during the pandemic experienced similar challenges to avail those services (Appendix Table 1). Given these challenges, respondents reported 'taking services from village quacks or chemist shops'; 'hiring vehicles'; 'taking help of police'; 'self-medications; and 'spending extra money' (Appendix Table 2).

Table 5: Percentage of young women (15-24) tried to access any SRH or COVID-19 related services during the pandemic (March-September 2020) and its outcome (%)

| | Assam (n=300) | Jharkhand (n=300) | Madhya Pradesh (n=300) | Overall (N=900) |
|---|------------------|----------------------|---------------------------|--------------------|
| Tried to access care for SRH/COVID | 45.0 | 66.7 | 48.3 | 53.3 |
| Sought services for | (n=135) | (n=200) | (n=145) | (N=480) |
| Menstrual problem | 27.4 | 43.5 | 41.4 | 38.3 |
| RTI /white discharge | 26.7 | 37.0 | 44.8 | 36.5 |
| Ante natal care (ANC) | 40.7 | 26.5 | 35.2 | 33.1 |
| Pregnancy related issues | 28.9 | 14.0 | 7.6 | 16.3 |
| Delivery care | 3.0 | 7.5 | 6.2 | 5.8 |
| Post-natal care (PNC) | 5.9 | 17.0 | 9.7 | 11.7 |
| Abortion related | 0.7 | 3.0 | 1.4 | 1.9 |
| Contraception related | 3.0 | 26.0 | 16.6 | 16.7 |
| COVID-19 related | 10.4 | 23.5 | 5.5 | 14.4 |
| Others | 5.9 | 1.0 | 0.7 | 2.3 |

| | | | | |
|--|-------------|-------------|-------------|-------------|
| When did you seek treatment or consultancy | | | | |
| March 2020 | 3.7 | 5.5 | 8.3 | 5.8 |
| April-May 2020 | 12.6 | 22.5 | 37.9 | 24.4 |
| June-July 2020 | 28.1 | 18.0 | 29.7 | 24.4 |
| August-September 2020 | 55.6 | 54.0 | 24.1 | 45.4 |
| Recent most problem for which sought care¹ | | | | |
| Menstrual problem | 29.6 | 29.0 | 32.4 | 30.2 |
| RTI /white discharge | 10.4 | 19.5 | 25.5 | 18.8 |
| Ante natal care (ANC) | 32.6 | 14.5 | 22.8 | 22.1 |
| Post-natal care (PNC) | 3.7 | 10.0 | 5.5 | 6.3 |
| Pregnancy related issues | 9.6 | 5.5 | 4.1 | 6.3 |
| Delivery care | 2.2 | 1.5 | 4.1 | 2.5 |
| Abortion related | 0.7 | 3.0 | 1.4 | 1.9 |
| Contraception related | 2.2 | 16.0 | 4.1 | 8.5 |
| COVID-19 related | 8.1 | 1.0 | 0.0 | 2.7 |
| Other | 0.7 | 0.0 | 0.0 | 0.2 |
| Where did women go for services | | | | |
| Sub Centre (SC) | 17.0 | 19.5 | 13.1 | 16.9 |
| PHC/Doctor | 11.1 | 2.0 | 5.5 | 5.6 |
| CHC/Doctor | 15.6 | 4.0 | 41.4 | 18.5 |
| Govt. hospital (SDH/DH/MCH) | 23.7 | 22.5 | 20.0 | 22.1 |
| Private hospital/clinic/doctor | 17.0 | 9.0 | 26.9 | 16.7 |
| Online doctor/ Tele Helpline | 0.0 | 0.0 | 0.7 | 0.2 |
| Pharmacy/Medicine shop | 25.9 | 4.0 | 9.0 | 11.7 |
| Village doctor/RMP | 8.9 | 18.0 | 10.3 | 13.1 |
| AWW/ASHA/ANM | 1.5 | 22.5 | 1.4 | 10.2 |
| Went Nowhere at home | 0.7 | 12.0 | 4.8 | 6.7 |
| Received SRH services or care among women who wanted SRH services | 64.4 | 81.5 | 57.2 | 69.4 |

§1: The recent most problem during March-September 2020

Table 6: Self-reported reasons of not getting SRH services and care during the COVID-19 pandemic (%)

| Self-reported reasons of not getting care ^{§2} | Assam (n=48) | Jharkhand (n=37) | Madhya Pradesh (n=62) | Overall (N=147) |
|---|--------------|------------------|-----------------------|-----------------|
| Restriction on travel | 22.9 | 27.0 | 33.9 | 28.6 |
| Could not avail facility of my choice | 27.1 | 10.8 | 33.9 | 25.9 |
| Fear of getting infection | 20.8 | 13.5 | 35.5 | 25.2 |
| Faced difficulty to reach to the facility | 10.4 | 13.5 | 37.1 | 22.4 |
| Could not go anywhere | 6.3 | 45.9 | 16.1 | 20.4 |
| Visited facility, but turned away | 4.2 | 16.2 | 19.4 | 13.6 |
| Fear of police actions | 16.7 | 2.7 | 17.7 | 13.6 |
| High fees of private providers | 18.8 | 0.0 | 12.9 | 11.6 |
| ASHAs stopped home visit | 8.3 | 8.1 | 16.1 | 11.6 |
| Nothing was available close to our village | 0.0 | 5.4 | 19.4 | 9.5 |
| Husband/family member did not allow to go | 2.1 | 10.8 | 6.5 | 6.1 |
| ANMs stopped home visit | 6.3 | 5.4 | 4.8 | 5.4 |

| | | | | |
|---|-----|-----|-----|-----|
| CIs denied accompanying to facility | 4.2 | 2.7 | 8.1 | 5.4 |
| Facilities were closed for other services | 2.1 | 8.1 | 3.2 | 4.1 |
| Private facilities were closed | 2.1 | 2.7 | 6.5 | 4.1 |
| There was none to ask for services | 2.1 | 8.1 | 1.6 | 3.4 |
| Others | 2.1 | 5.4 | 0.0 | 2.0 |
| §2: among women who did not avail services or treatment during COVID pandemic; CI: Community intermediaries including ASHA, ANM, Youth Leader | | | | |

3.3.1 Factors influenced access to SRH services during the COVID-19 pandemic

Globally, burden of pandemic has not been experienced equally as it impacted vulnerable segments significantly. To examine that hypothesis this study carried out a multivariate logit analysis and analysed factors that influenced access to SRH services and care during the pandemic. Results however revealed that the COVID-19 pandemic impacted young women and girls uniformly irrespective of their social and economic background (see Table 7). For example, young women and girls with higher education, belonging to higher caste, better living and economic standard were not found accessing better SRH services and care during the pandemic compared to their counterparts with low socio-economic background. In contrast, factors that influenced access to SRH services and care were information and communication during the pandemic, state of residence, types of services sought, and facilities from where women sought services. For example, respondents who managed to access required information from any sources during the pandemic were almost nine times more likely to access SRH services compared to their counterparts who could not manage to get information (OR: 9.8, $p < 0.000$). Similarly, young women and girls in Jharkhand (low prevalence of COVID-19) were almost three times more likely to access SRH services (OR: 2.9, $p < 0.05$) compared to their counterparts in Madhya Pradesh (relatively higher prevalence of COVID-19). Type of services sought by young women during the pandemic also played an important role.

Table 7: Profile of young women who successfully accessed SRH related services during the pandemic: A multivariate logistic regression analysis

| | Accessed SRH Services (Unadjusted %) | beta co-efficient | Odds Ratio (OR) | Significance level (p) |
|------------------------|--------------------------------------|-------------------|-----------------|------------------------|
| Age of women | | | | |
| 15-19 Years (R) | 68.3 | | 1 | |
| 20-24 Years | 69.8 | -0.23 | 0.8 | NS |
| Marital Status | | | | |
| Unmarried (R) | 49.3 | | 1 | |
| Married | 72.7 | 0.47 | 1.6 | NS |
| Caste | | | | |
| ST (R) | 80.0 | | 1 | |
| SC-OBC | 61.4 | -0.17 | 0.8 | NS |
| General | 64.9 | 0.23 | 1.2 | NS |
| Education | | | | |
| Below Secondary (R) | 70.3 | | 1 | |
| Secondary & above | 68.4 | -0.29 | 0.8 | NS |
| Hold a BPL card | | | | |

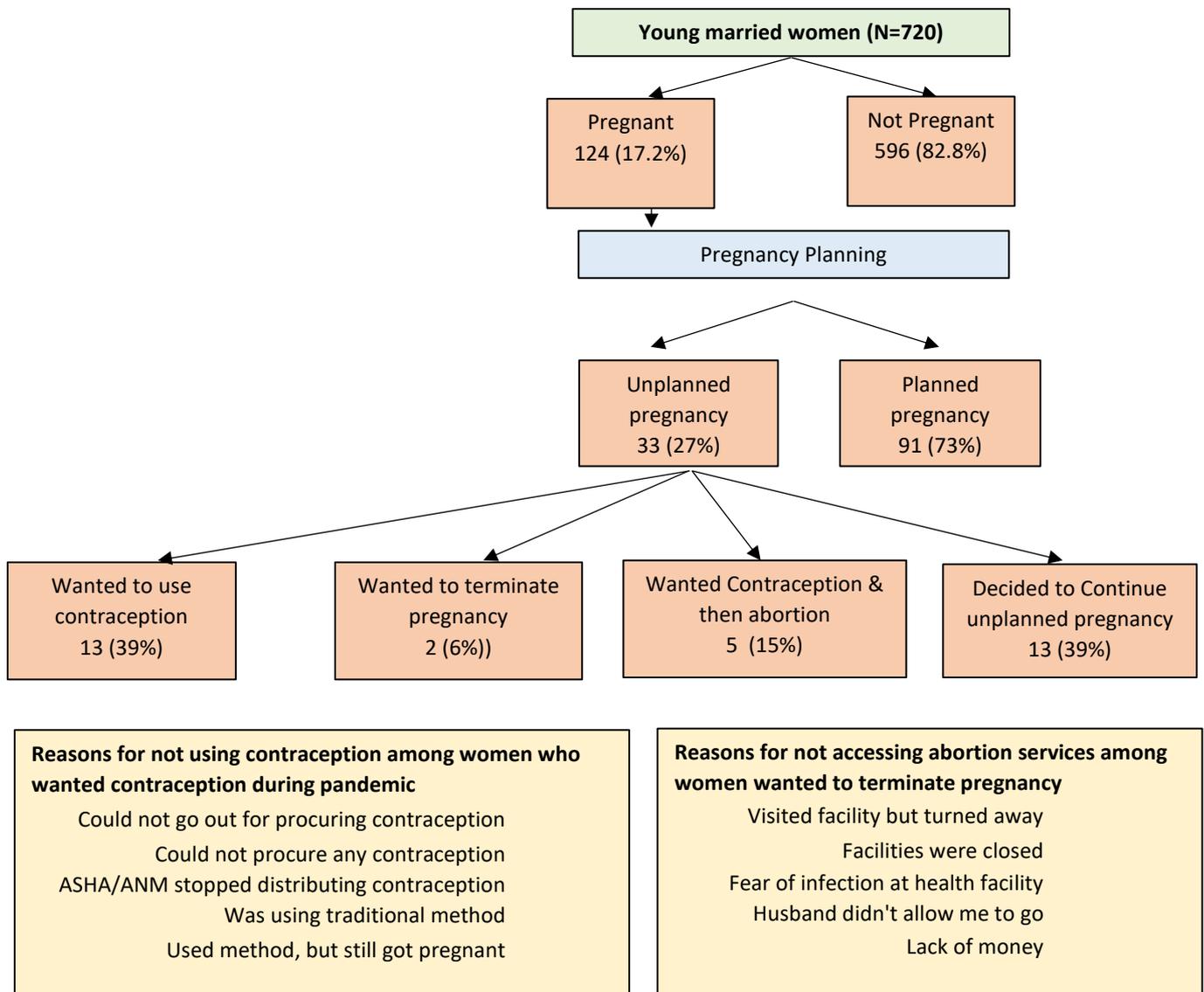
| | | | | |
|---|------|-------|-----|-----|
| <i>Have BPL Card (R)</i> | 72.5 | | 1 | |
| No BPL Card | 66.5 | 0.27 | 1.3 | NS |
| SLI | | | | |
| <i>Low (R)</i> | 68.2 | | 1 | |
| Medium-High | 72.5 | 0.43 | 1.5 | NS |
| Time of seeking service | | | | |
| <i>Mar-May20 (R)</i> | 62.8 | | 1 | |
| Jun-Jul 20 | 64.1 | -0.02 | 0.9 | NS |
| Aug-Sep 20 | 76.6 | 0.50 | 1.6 | NS |
| State | | | | |
| <i>Madhya Pradesh (R)</i> | 57.2 | | 1 | |
| Assam | 64.4 | -0.16 | 0.9 | NS |
| Jharkhand | 81.5 | 1.07 | 2.9 | ** |
| Accessed desired information | | | | |
| <i>No (R)</i> | 28.9 | | 1 | |
| Yes | 83.0 | 2.28 | 9.8 | *** |
| Sought service for | | | | |
| <i>Menstruation/RTI/STI (R)</i> | 57.1 | | 1 | |
| Pregnancy, delivery & abortion | 80.7 | 0.76 | 2.1 | * |
| PNC & Contraception & COV | 71.3 | 0.37 | 1.5 | NS |
| Sources of service | | | | |
| <i>Other Informal providers (R)</i> | 52.9 | | 1 | |
| Private facility | 78.6 | 1.25 | 3.5 | ** |
| Public facility | 76.1 | 0.90 | 2.4 | *** |
| OR: Odd Ratio; R: Reference category, ***: p<0.01, **: p<0.05, *:p<0.10, NS: Not significant; Other informal providers include chemists, village doctor, and health workers | | | | |

Young women who sought pregnancy and delivery related services were significantly more likely to access these services (OR: 2.1 p<0.10) compared to women who sought services and care for menstrual problems, RTI & STI. Further young women who reached public or private health facilities reported receiving services compared to women who approached quacks, chemist shops and other health workers.

3.4 Pregnancy Management during the COVID-19 pandemic

Although of the Central Government guidelines on “essential health care,” services included contraception and abortion as essential and time-sensitive health services during the COVID-19 crisis, their utilization remained restricted during the pandemic. Restricted mobility coupled with the individual fear of getting infected with COVID-19 created new barriers to accessing contraception and abortion services. These may result in an increase in births from unintended pregnancies (MSI 2020, IDF 2020, Lindberg et al 2020). In this cross-sectional observation 17% (124 of 720) young women reported pregnancy at the time of survey.

Figure 1: Retrospective insights of pregnancy management during COVID-19 pandemic among married women



Pregnant women were further asked whether they wanted this pregnancy then or they wanted to delay or they didn't want this pregnancy at all. As portrayed in Figure 1, more than one-fourth (27%) of these pregnancies were reported as unplanned during the COVID-19 pandemic. Those 33 women who reported unplanned pregnancies during pandemic were also asked whether they intended to use any contraceptive method to delay or avoid pregnancy or terminate those unwanted pregnancies. In response, 13 of 33 women wanted to delay these pregnancies by using contraception and two women wanted to terminate these unwanted pregnancies and five women wanted both contraceptives as well as pregnancy termination (see Figure 1). As reasons of not using any contraceptive method majority of young women reported pandemic-related challenges. A similar trend is observed for abortion services where women were either denied services by the health facility or women avoided accessing services because of fear that they or family members might contract the COVID-19 infection.

3.5 Access to contraception during the COVID-19 pandemic

The COVID-19 pandemic restricted women’s ability to access and pay for contraception. . All young married women who were not pregnant at the time of survey were asked whether they were using any contraceptive methods. Around two-fifths (41%) reported using any contraceptive method at the time of survey. These proportions varied significantly from 36% in Assam to 46% in Jharkhand. However, across states, there was no significant variation in the use of modern contraceptive methods (Assam:35.2%, Jharkhand: 36.8%, Madhya Pradesh: 39.5%).

Table 8: Current use of contraception among young married women during the pandemic (%)

| Currently married and not pregnant at the time of survey | Assam (n=182) | Jharkhand (n=209) | Madhya Pradesh (n=205) | Overall (N=596) |
|--|---------------|-------------------|------------------------|-----------------|
| Currently using any contraception | | | | |
| Yes | 35.7 | 46.4 | 41.0 | 41.3 |
| No | 58.8 | 50.2 | 47.8 | 52.0 |
| No, stopped using | 5.5 | 3.3 | 11.2 | 6.7 |
| Method of contraception | | | | |
| Oral Contraceptive Pill | 29.1 | 8.6 | 4.9 | 13.6 |
| Weekly pills (Chhaya) | 1.6 | 1.0 | 4.4 | 2.3 |
| Male condom | 2.2 | 9.6 | 12.2 | 8.2 |
| Female sterilization | 0.5 | 1.4 | 14.1 | 5.5 |
| IUCD | 1.6 | 11.0 | 2.0 | 5.0 |
| Injectables | 0.0 | 5.3 | 2.0 | 2.5 |
| Traditional method | 0.5 | 9.6 | 1.5 | 4.0 |
| Not using any contraception | 64.3 | 53.6 | 59.0 | 58.7 |

Majority reported using oral pill and condom (24%) followed by IUCD and injectables (8%) and female sterilization (5%). However, almost all of those who reported permanent and LARC methods received them prior to the onset of the pandemic (mean duration of use of sterilization and IUCD were 16 months and 18 months respectively). Almost 59% young women reported using no contraceptive method at the time of survey primarily because of fertility (wanted a child), spousal preference (husband didn’t like) and COVID-19 related reasons - travel restrictions (5%), lost contact with community health workers (5%), stock out (3%), closure of shops & facilities (3%). Similar challenges were shared by women who were using any method at the time of survey (Appendix Table 3). Few women reported that the pandemic had compelled them to shift to traditional methods since other effective methods were available or accessible.

3.6 Access to abortion services

This study also tried to explore women’s ability to access abortion services during the COVID-19 pandemic. This has been assessed at two different levels. In the first level, all young married women were asked whether they were aware of any woman in their community who tried to terminate an unwanted pregnancy during the pandemic, while in the second level, respondents were further asked whether they themselves needed an abortion during the pandemic. As portrayed in Table 9, 66 (9%) young married women reported knowing at least one woman who needed pregnancy termination during the COVID-19 pandemic (March-September 2020), 29% of them bought MA tablets from medicine shops and 21% managed their abortion from village doctors or quacks and 18% sought services from public and private facilities.

Table 9: Utilization of abortion services among community women during the COVID-19 pandemic (%)

| Utilization of abortion services by community women | n | % |
|--|---------------|------|
| Aware of any woman who sought abortion services during the pandemic | | |
| Yes | 66 | 9.2 |
| No | 654 | 90.8 |
| Places where community women sought services | | |
| | (n=66) | |
| Village doctor/quacks | 14 | 21.2 |
| Private Facility/clinic | 7 | 10.6 |
| Government facilities | 5 | 7.6 |
| Bought abortion tablets from medicine shop | 19 | 28.8 |
| Didn't get services & continued pregnancy | 12 | 18.2 |
| Don't know | 9 | 13.6 |
| Is this a usual source of abortion service | | |
| | (n=66) | |
| Yes, it is a regular practice | 11 | 16.7 |
| No, women had no other option during COVID crisis | 55 | 83.3 |

Almost one-fourth (18%) did not receive any abortion services and continued with unplanned pregnancies. Thus, the COVID-19 crisis appears to have compelled women to either opt for alternative pathways for abortion services or continue with unplanned pregnancies as 83% respondents stated, “women had no other option during the COVID-19 crisis” (Table 9). Study respondents who terminated pregnancies during the pandemic also echoed similar responses. Five of 10 women conducted abortion by self at home– the remaining five received services from nurses (2) and medical doctors (3). Thus, face-to-face contact between women and providers was reduced and abortion self-care using medical abortion drugs emerged as an alternative option during the pandemic.

Table 10: Study respondents utilized abortion services during the COVID-19 pandemic (Number)

| Abortion experience | Number# |
|---|-----------|
| Number of women utilized abortion services during the pandemic | 10 |
| Sources of abortion services | |
| Conducted at home | 2 |
| Chemist /Quack | 3 |
| Public facilities | 3 |
| Private clinic | 2 |
| Who conducted abortion | |
| Doctor | 3 |
| Nurse | 2 |
| Self-use | 5 |
| Abortion method | |
| Surgical method | 4 |
| Medical Abortion | 4 |
| Not mentioned | 2 |
| How did you manage to get services | |
| No Challenges | 2 |
| Took abortion tablets at home | 4 |
| Took help from ASHA | 2 |
| No Response/Blank | 2 |

#: Because of low sample size results are not presented in percentages

3.7 Menstrual health and hygiene (MHH) during pandemic

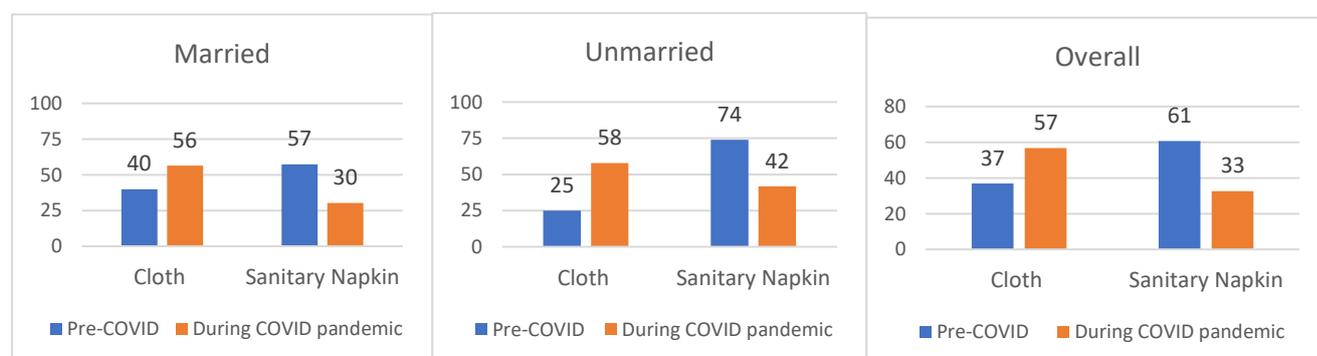
During the pandemic, young women and girls in rural communities faced increased challenges in accessing services, supplies and information that are critical to MHH. Respondents were asked about their menstrual hygiene practices before and during COVID-19 pandemic. As portrayed in Table 11, most (61%) were using sanitary napkins prior to the COVID-19 pandemic.

Table 11: Type of protection used by young women during their menstrual period before and during the COVID-19 pandemic (%)

| | Assam (n=300) | Jharkhand (n=300) | Madhya Pradesh (n=300) | Overall (N=900) |
|------------------------------|------------------|----------------------|---------------------------|--------------------|
| Pre pandemic | | | | |
| Used Cloth | 47.7 | 22.7 | 40.7 | 37.0 |
| Locally prepared napkins | 1.7 | 1.7 | 2.7 | 2.0 |
| Sanitary napkins | 48.3 | 72.7 | 55.0 | 58.7 |
| Nothing | 1.7 | 2.7 | 1.7 | 2.0 |
| No response | 0.7 | 0.3 | 0.0 | 0.3 |
| During COVID pandemic | | | | |
| Used Cloth | 67.7 | 26.0 | 76.7 | 56.8 |
| Locally prepared napkins | 0.7 | 1.0 | 0.7 | 0.8 |
| Sanitary napkins | 25.0 | 55.7 | 14.7 | 31.8 |
| Nothing | 4.7 | 15.7 | 7.3 | 9.2 |
| No response | 2.0 | 1.7 | 0.7 | 1.4 |

This MHH behaviour changed significantly during the pandemic, around 57% young women and girls reported using traditional clothes and 9% used nothing during their menstrual period. During pandemic use of sanitary napkins declined significantly from 61% to 33% and these variations were more pronounced among young unmarried girls (see Figure 2). For married women use of sanitary napkins declined from 57% to 30% (47% decline), while the same declined from 74% to 42% (44% decline) among unmarried girls.

Figure 2: Menstrual health and hygiene before and during pandemic



Those who shifted to a traditional method from sanitary napkins reported multiple COVID-19 related reasons (Table 12) including, financial reasons (married: 41%, unmarried 52%), restricted mobility

(married: 24%, unmarried 40%), shops remained closed (married: 18%, unmarried 20%), perceived low priority with current financial crisis (married: 8%, unmarried 13%), had no supplies (married: 6%, unmarried 10%), and non-availability of free supplies (married: 5%, unmarried 12%).

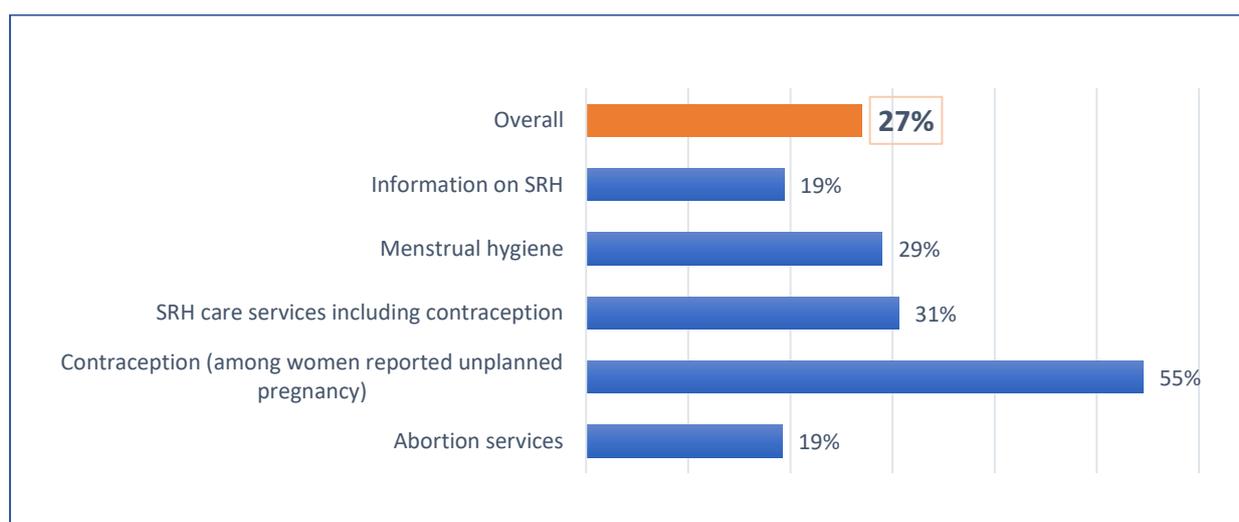
Table 12: Reasons for discontinuation of sanitary napkins during COVID-19 pandemic among young women and girls who were using them before pandemic (%)

| Self-reported reasons | Married women (n=201) | Unmarried girls (n=60) |
|---|-----------------------|------------------------|
| Could not afford to buy napkin during pandemic | 41.3 | 51.7 |
| Couldn't go out for purchasing sanitary napkins | 23.9 | 40.0 |
| Chemist shops of my locality were closed | 18.4 | 20.0 |
| With current economic crisis, it is not a priority | 8.0 | 13.3 |
| Not available at shops /stock out | 6.0 | 10.0 |
| No free supply of napkins that we used to get earlier | 4.5 | 11.7 |
| Schools were closed | -- | 1.7 |
| No menstruation | 3.0 | -- |
| Pregnant | 8.5 | -- |
| Not required | 10.0 | -- |

3.8 Unfulfilled Needs

Experiences of young women and girls accessing SRH information and services that was presented in the earlier sections paint a grim picture – the COVID-19 pandemic has clearly negatively impacted the SRH outcomes among young women and girls. This study estimated overall and issue specific unfulfilled needs as a ratio of unfulfilled needs and actual needs during the pandemic. As portrayed in Figure 5, more than one-fourth (27%) of young women and girls shared unfulfilled needs for any SRH related information and services. This proportion varied from information (19%) to menstrual health and hygiene and supplies (29%) and further to SRH services including contraception (29%).

Figure 3: Study respondents reporting unfulfilled needs for SRH during COVID-19 pandemic (%)



3.9 Immediate SRH needs at the time of the survey

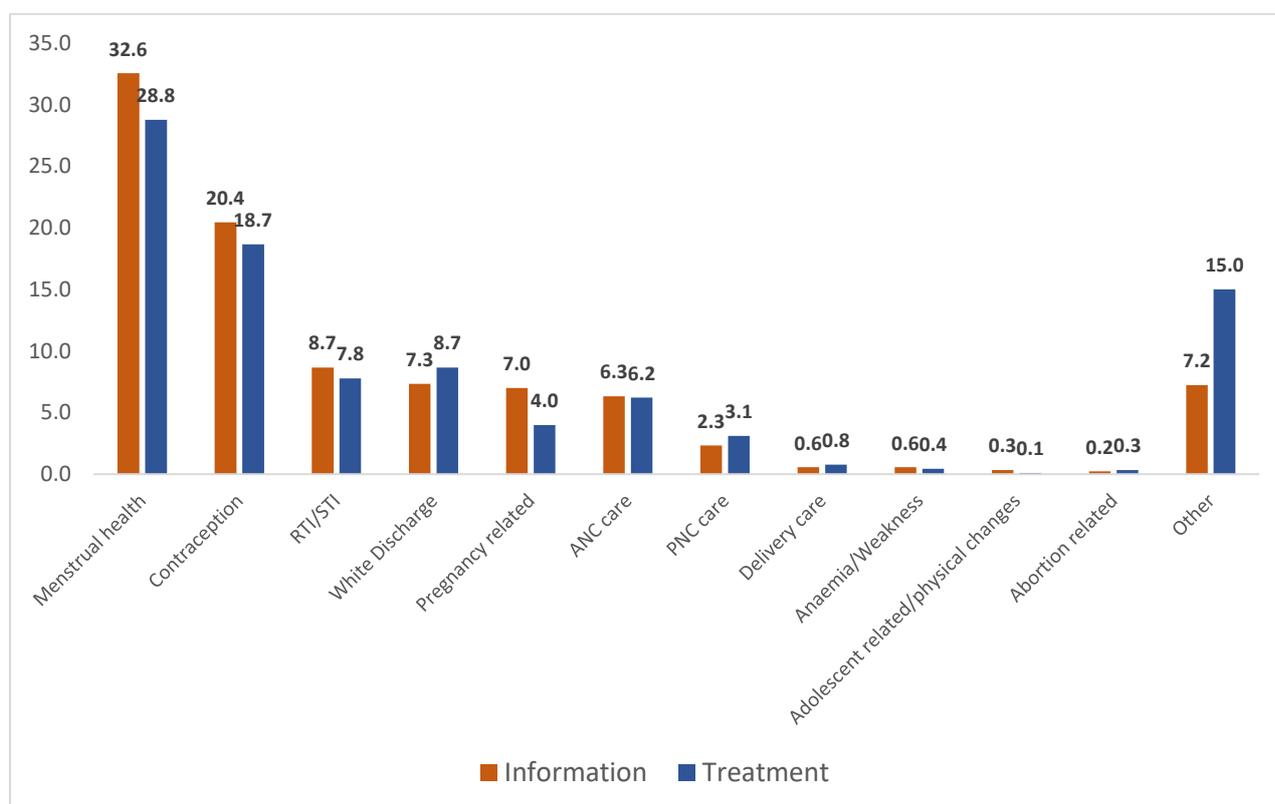
With these unfulfilled needs young women and girls were also asked to prioritize their immediate needs at the time of the survey (December 2020). Surprisingly, study respondents expressed their

immediate requirements for information and services almost in line with their needs during the pandemic (March-September 2020). Almost one-third of young women and girls expressed immediate needs for information (33%) and services (29%) on menstrual health and hygiene, followed by information (20%) and services (19%) on contraception, RTI / STI (9%-8%), white discharge (7%-9%), pregnancy related (7%-4%), and ante natal care (6%).

3.10 Perceived sources of information in the future

Based on the negative experience of COVID-19 pandemic study respondents were further asked about sources of information and support for SRH care that they would like to use in future.

Figure 4: Percentage of young women and girls expressed their immediate needs for SRH care and information at the time of survey (N=900)



Once again young women and girls have shown strong keenness to rely on community health workers for SRH related information post pandemic. Young women and girls uniformly mentioned ASHAs or youth leaders as their preferred sources of support after the pandemic.

Table 13: Percentage of young women and girls shared their future plan for accessing information

| How do you plan to seek information on SRH issues in near future | Assam (n=300) | Jharkhand (n=300) | Madhya Pradesh (n=300) | Overall (N=900) |
|--|---------------|-------------------|------------------------|-----------------|
| Will contact ASHA | 62.0 | 68.0 | 73.0 | 67.7 |
| contact youth leaders/ NGO workers | 8.0 | 45.0 | 57.0 | 36.7 |
| Husband / Family member | 9.7 | 50.3 | 36.3 | 32.1 |
| Peers /friends/neighbours | 1.3 | 29.3 | 27.7 | 19.4 |
| Pharmacy/Medicine shop | 11.3 | 2.0 | 4.3 | 5.9 |
| Doctor/Govt hospital/RMP | 16.3 | 1.3 | 0.0 | 5.9 |
| Explore internet / Google search | 0.3 | 2.0 | 9.3 | 3.9 |

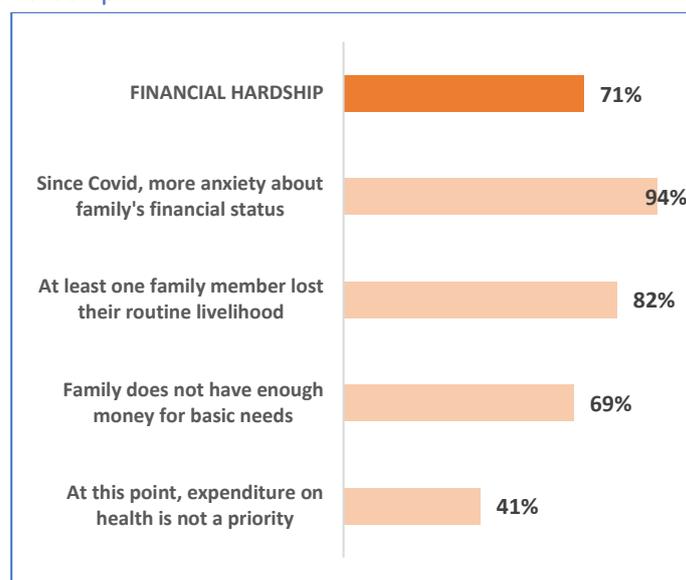
| | | | | | |
|--|-----------------------------------|-----|-----|-----|-----|
| | AWW / ANM | 3.3 | 8.0 | 0.3 | 3.9 |
| | Explore through WhatsApp messages | 0.0 | 1.0 | 6.7 | 2.6 |
| | Online doctor/ Tele helpline | 0.0 | 0.3 | 0.7 | 0.3 |

Respondents also mentioned the support of husbands, family members and peers for collecting information. Notably, 8% rural young women and girls intended to take help of new digital technology, including Google search (4%), WhatsApp Chatbot (3%), and tele medicine (<1%).

3.11 Impact of COVID-19 pandemic on household economy and family dynamics

Lockdown, social distancing, and various disruptions caused by the pandemic have narrowed the scope of economic opportunities for all segments of population, which indirectly impacted the ability of young women to afford SRH services. As portrayed in Figure 5, because of COVID-19, many (71%) respondents found themselves facing financial difficulties. Ninety-four percent of study respondents agreed with the statement, “I feel since COVID-19, I am more anxious about my family’s financial status”. Almost 82% of them reported loss of livelihood of at least one family member. This impacted expenditure on basic needs and SRH. Around 69% felt that they did not have enough money for the basic needs, while 41% perceived expenditure on health is not a priority need after the pandemic.

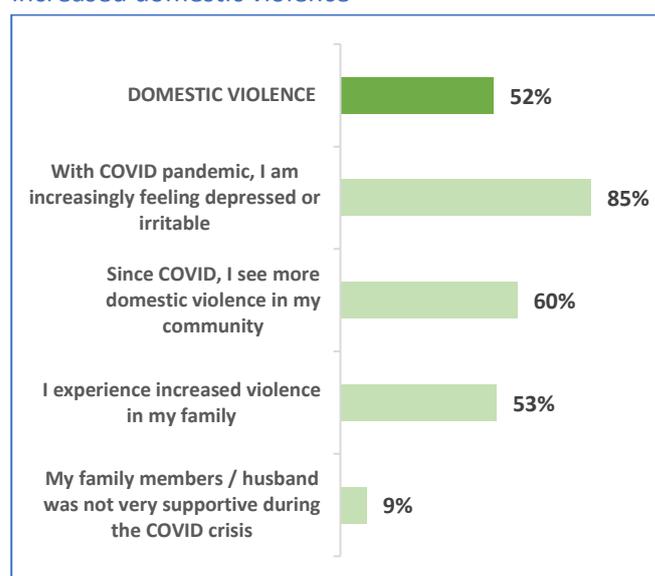
Figure 5: % of respondents reporting financial hardship.



3.11.1 Increased domestic violence

Increased financial crisis, stress, uncertainty, and new family dynamics (stay-at-home) have led to increase in domestic violence during the COVID-19 pandemic. Half of the study respondents (52%) reported increased violence and depression during the pandemic. Three-fifths (60%) of respondents reported increased domestic violence in their community during the COVID-19 pandemic. While 53% experience increased violence in their family”. While 9% experience increased violence in their family”.

Figure 6: % of respondents reporting increased domestic violence



3.11.2 Workload and agency

Universal imposition of social distancing during the pandemic compelled majority of the family members to stay-at-home. This probably has changed the family dynamics, particularly role and agency of women at home. Almost three-fourths of respondents (73%) felt that their workload and role changed adversely during the pandemic. Two-thirds of young women and girls (68%) also agreed with the statement, “the family dynamics has changed since all members stay at home”. These new dynamics have impacted mobility as well as agency of young women. Around 64% study respondents felt that their routine mobility has been restricted during the pandemic as they were not allowed to go out for routine purchases, while 44% perceived loss of agency as new family dynamics allowed male members to interfere in all household decisions.

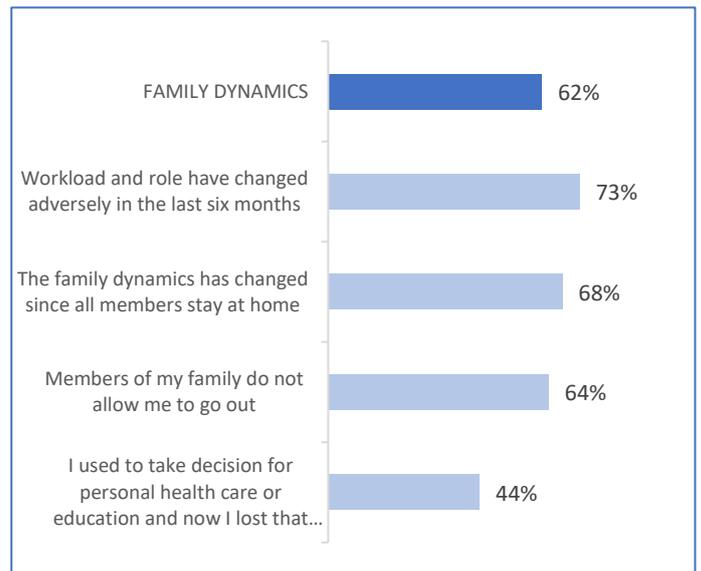
3.11.3 Access to Health Services

Access to general health services has been universally restricted directly because of COVID-19 pandemic and indirectly because of financial crisis. More than half of the study respondents felt some barriers in accessing health care and services. Most (62%) young women and girls were scared to visit any health facility for information or treatment. Almost half (48%) were not happy with the quality of services being offered by the public health facilities. Respondents (54%) also felt that community women were scared to deliver at hospitals during pandemic, while same proportion of women agreed with the statement, “During COVID crisis, I will prefer to use home remedies rather than visiting a doctor”.

4.0 DISCUSSION

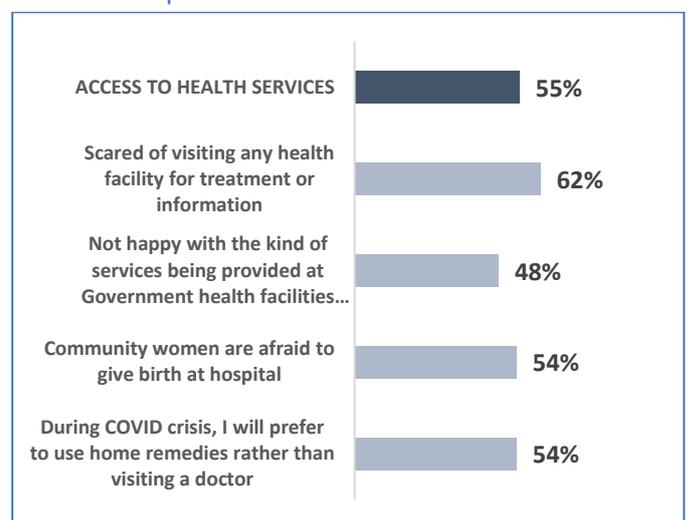
This study clearly reveals that the COVID-19 pandemic had a broad impact on young women’s sexual and reproductive health experiences. Since end-March when India entered into the first phase of lockdown, in-person health care consultation and visits have been severely limited. Numerous

Figure 7: % of respondents reporting changes



in workload and agency

Figure 8: % of respondents reporting SRH effects from pandemic



disruptions of this pandemic have created health system level, community level, and household level barriers to accessing SRH information and services and has impelled significant changes in young women's and girls' attitude and behaviour to deal with SRH issues, including menstrual health and hygiene, fertility and contraceptive preferences and management.

In the first six months of COVID-19 pandemic (March 25 to September 30), access to information on SRH services and care has been limited, with numerous administrative restrictions, personal fear of contracting the virus, and shifted priority of the health system. More than half (54%) of young women and girls reported exploring SRH related information during the pandemic and 81% of them could manage to have some information to their queries, primarily from outreach workers, including ASHAs, AWWs, and Youth Leaders. Thus, community support acted as the primary source of contact during the pandemic. Even with this community support mechanism, around one-fifth (19%) could not manage to access any information to their questions. However, those who failed to access their desired information were not from any disadvantaged groups – this study reveals that access was impacted by marital status (unmarried women were less likely to be able to access information); subject of inquiry (information of topics of menstrual health and hygiene was least available); and prevalence of COVID-19 (young women and girls in Madhya Pradesh were less likely to access information compared to their counterparts in other states due to higher prevalence of the virus in the state).

The situation was found to be similar for utilization of SRH care and services. Little more than half of the study respondents (53%) tried to access some SRH related services and care during the pandemic. However, prevalence and ease of service utilizations was not uniform across the first six months of the pandemic. Even after all lockdown restrictions were lifted young women and girls were scared to seek services from health facilities. For example, service utilization reported during August-September (45%) was almost twice than the first four months (April-July) of the pandemic (24%). Study respondents tried to access services and care for multiple reasons, including MHH, RTI/STI, ANC, delivery care, PNC, contraception, abortion, and COVID related issues. However, only 69% of service seekers successfully managed to get SRH services during the pandemic. Travel restrictions, denial of services, fear of contracting the virus and exposing other family members, disruption of non-COVID related service provision at health facilities, and disruption of accompaniment visits by the community health workers like ASHAs were reported as the reasons for not getting desired services among 31% of young women and girls. Global studies highlighted that the pandemic compounded existing inequalities by disproportionately affecting poorer and vulnerable women (Lindberg et al 2020). However, this study found no such variations in access to SRH services by their socio-economic profile. The bivariate as well multivariate analyses revealed that the COVID-19 pandemic impacted all segments of population irrespective of their affordability and ability to access services. In contrast, attributes which adversely impacted the access to services in rural India were communication and information during the pandemic, types of services sought, types of service providers approached for desired services, and state of residence. Interestingly majority of young women who managed to access needed information from any sources during the pandemic or women belonged to state Jharkhand or women who sought services for essential services like delivery care and pregnancy related issues, or who approached public and private health facilities were significantly more likely to get such services compared to their counterparts. Thus, information (mostly from community health workers) played an important role to ensure access to SRH services, particularly on the most essential services. Further, people's perception on the severity of the pandemic influenced the decision of women to go out for the SRH services. Young

tribal women and girls of Jharkhand had experienced relatively less impact of the COVID-19 pandemic compared to their counterparts from the other two study states Madhya Pradesh and Assam.

Pandemic has also created physical and economic barriers to contraception and abortion services which further impacted people's ability to manage pregnancy and fertility preferences. This study has accounted 27% of unintended pregnancies among young married women who became pregnant after the onset of the pandemic in India. This rate of unintended pregnancy seems very high for young women ages 15-24 years. Other cross-sectional studies (Banerjee et. al 2015 and IDF 2020) conducted before the COVID-19 pandemic among young women of the same study areas accounted significantly lower incidence of unintended pregnancies (17% in Assam and Madhya Pradesh and 16% in Jharkhand). Majority of these women (18 of 33) failed to access contraception before pregnancy and further few of them (7 of 33) also failed to access abortion services because of several restrictions during the pandemic. These disruptions in access to essential SRH services like contraception and abortion services may have some impact on the incidence of unintended pregnancy and overall fertility (UNFPA 2020, FRSHI 2020).

Access to modern contraception among young married women who were not pregnant at the time of the survey was also restricted with few modern spacing methods, including oral pill and condom. Almost uniformly women had no access to sterilization and IUCD and those who reported using long-term methods at the time of survey accepted those methods before the COVID-19 pandemic. Reported challenges and barriers to access contraceptive services were travel restrictions, affordability, infrequent visits of community health intermediaries, and supplies of methods by community health workers, stock out of spacing methods at chemist and other shops.

This prevalence of unintended pregnancies, combined with challenges to access modern contraceptive methods, reveals that the need for abortion services may increase. Around one-tenth of study respondents reported knowing a woman who was seeking abortion services during the COVID-19 pandemic. These women (29%) either opted self-care through medical abortion or approached quacks (21%) for abortion or continued pregnancy due to lack of access to abortion services (18%). Ten study respondents who themselves accessed abortion services during the COVID-19 pandemic also shared similar experiences. Although the Government of India declared comprehensive abortion care as an essential service, many COVID-19 related restrictions, coupled with service provision and financial challenges created new barriers to access. This eventually may lead to increase in unintended pregnancies and levels of fertility. Although contrasting trends of fertility preferences during the pandemic have been portrayed for developed countries including France, Spain, United Kingdom, and Germany (Luppi et al 2020). This study in developed countries projected a probable decline of fertility due to widespread crisis of COVID pandemic.

Access to menstrual health and hygiene, including supplies of sanitary napkins, is a key component of sexual and reproductive health care and autonomy. This study however, observed a steady decline in hygienic practices as use of sanitary napkins reduced significantly from 61% to 33% before and during the COVID-19 pandemic, respectively. This difference was surprising among unmarried girls who reported a transition in hygienic practice from 74% to 42%. Pandemic-related economic changes, restricted mobility, and stock out of products were cited as the main reasons for stopped using sanitary napkins and started using old cloths during their menstrual period. Thus, COVID pandemic has thrown several challenges on SRH outcomes and left young women and girls with several unfulfilled needs. More than one-fourth (27%) didn't receive SRH care that they wanted during pandemic, one-fifth (19%)

failed to collect SRH related information, while another one-fifth (19%) reported unfulfilled need for abortion services and one-third experienced unfulfilled needs for menstrual hygiene. All these unfulfilled needs were echoed in the voice of respondents when they explained their immediate needs after the normalization of COVID-pandemic. However, even after these adverse experiences of the pandemic young women and girls from the rural areas want to rely heavily on community health workers, including ASHAs, ANMs, Youth Volunteers for SRH related information and care. Along with community health support, young women and girls also mentioned about digital support, including, Whatsapp chat, and other search engines like google, and tele-medicine for SRH related information. For rural India, this seems to be a new emerging opportunity to serve millions of young women who often face several challenges to access information and services on time.

This study also assessed pandemic related economic challenges and how these challenges intersect with their family life and access to sexual reproductive health services. Findings of this study clearly reveal that the COVID-19 pandemic has changed the social and economic landscape of people's lives. Pandemic-related financial worries were almost universal (94%) because of job loss and instability (82%). This impacted their decision to spend money on SRH related services and basic needs. Financial crisis is recognized as an influencing attribute to instigate the psychological stress and intimate partner violence (Schneider 2016). This study also marked pandemic-related stress, increased domestic violence during pandemic, aggravated workload, loss of agency and decision making within family, and increased worries to visit health facilities for accessing SRH related information and services.

5.0 WAY FORWARD

While significant progress has been made in recent times to ensure access to sexual and reproductive health information and services among young women and girls, community and health system level disruptions during the COVID-19 pandemic pose some threats to these gains. The immediate and short-term impacts analysed in this study have gathered enough evidence of disruptions during the first six months of the pandemic. Although the long-term impact is still not clear, we need to take some steps to minimize the adverse impact on SRH needs and rebuilding the support system. It is obvious that young women need support for accessing menstrual health and hygiene, STIs and RTIs, contraception, ANC, labor and delivery related, and safe abortion services. Policymakers must recognize that SRH care is essential and cannot be delayed or deprioritized. Global learnings from pandemics like Ebola and COVID-19 demand a long-term strategy and preparation to mitigate the sudden unexpected shortages of human resources, and logistics issues. The outcome of this study suggests some potential actions for rebuilding the accessibility and ability of young women and girls to access SRH service even in crisis:

- **Strengthen information and communication systems within community**

This study evidenced a strong association between access to information and service utilization. During the COVID-19 pandemic women who could manage to access information were more likely to access SRH services. Interestingly, young women mostly tried to access that information from community health workers and youth leaders who were available to share information even during the lockdown and social restrictions.

- **Re-emphasize community-based care**

In India, community health intermediaries including, ASHAs, ANMs, AWWs, Youth Volunteers, already ensure the support for primary health care and help women in reaching to a provider for essential services. This study also has evidenced the significant role of frontline health workers and reliance of young women and girls for accessing information from them. To improve the capacity of existing reservoir of frontline workers, we further need to strengthen their skill to facilitate home-based support outside the healthcare facilities. This probably needs appropriate training and technology to provide support and refer women for higher level services.

- **Digital solutions, including mHealth, WhatsApp Chat, and Tele Medicine**

The use of digital technology seems to be the most emerging opportunity to improve SRH related information and services. With increasing penetration of mobile phones, mHealth solutions not only help in ensuring information, but helps getting immediate solutions and referral linkages for any health concerns. This technology probably will reduce the over reliance on health facilities and will also help in reducing the out-of-pocket expenditures in terms transportation and food. Given the adverse experience of COVID-19 pandemic there is a need to explore the new space and opportunities for tele-medicine. However, the major limitations of this digital solution are to reach the most vulnerable segments of population who do not have access to mobile handset or smartphone or networks. Community health intermediaries can play an important role to connect those vulnerable populations through innovative approaches.

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APPENDIX TABLES

Appendix Table 1: Challenges faced seeking SRH services during COVID pandemic (%)

| Challenges faced ^{§1} during COVID pandemic | Assam (n=87) | Jharkhand (n=163) | Madhya Pradesh (n=83) | Overall (N=333) |
|--|-----------------|----------------------|--------------------------|--------------------|
| No challenges | 54.0 | 74.8 | 16.9 | 55.0 |
| After multiple visits I got the treatment | 14.9 | 14.1 | 50.6 | 23.4 |
| Faced difficulty to reach to the facility | 11.5 | 8.6 | 33.7 | 15.6 |
| Got from a private doctor with high fees | 8.0 | 4.9 | 26.5 | 11.1 |
| Restriction on travel | 16.1 | 7.4 | 6.0 | 9.3 |
| Could not avail facility of my choice | 2.3 | 8.0 | 13.3 | 7.8 |
| Got treatment, but not from a doctor | 3.4 | 6.7 | 13.3 | 7.5 |
| Fear of getting infection | 6.9 | 8.0 | 7.2 | 7.5 |
| Cl's stopped home visit / denied accompanying to the facility | 3.4 | 8.6 | 3.6 | 6.0 |
| Visited facility, but turned away | 2.3 | 4.9 | 10.8 | 5.7 |
| Nothing was available close to our village | 1.1 | 1.8 | 8.4 | 3.3 |
| Police actions | 2.3 | 2.5 | 4.8 | 3.0 |
| Had to bear more money for treatment | 0.0 | 1.2 | 7.2 | 2.4 |
| There was none to ask for services | 0.0 | 0.0 | 4.8 | 1.2 |
| Private facilities were closed | 0.0 | 0.0 | 3.6 | 0.9 |
| Could not go anywhere | 0.0 | 1.2 | 0.0 | 0.6 |
| Husband/family member did not allow to go | 1.1 | 0.6 | 0.0 | 0.6 |
| Facilities were closed for other services | 0.0 | 0.0 | 1.2 | 0.3 |
| <i>§1: among women availed services or treatment during COVID pandemic</i> | | | | |
| <i>§2: among women who did not avail services or treatment during COVID pandemic</i> | | | | |

Appendix Table 2: How did young women overcome COVID-related challenges (%)

| | Assam (n=300) | Jharkhand (n=300) | Madhya Pradesh (n=300) | Overall (N=900) |
|--|------------------|----------------------|---------------------------|--------------------|
| Went by own vehicle/walking | 2.2 | 6.5 | 47.6 | 17.7 |
| Took help from police | 0.7 | 1.5 | 13.8 | 5.0 |
| Called 108 ambulance | 0.0 | 1.0 | 1.4 | 0.8 |
| Contacted ASHA/ANM/AWC | 9.6 | 9.5 | 6.9 | 8.8 |
| Got treatment from Subcentre | 0.0 | 2.0 | 0.0 | 0.8 |
| Got treatment from Village doctor | 9.6 | 18.0 | 34.5 | 20.6 |
| Took medicine from shop | 9.6 | 2.5 | 4.1 | 5.0 |
| Went many times/waited longer time | 4.4 | 1.5 | 17.2 | 7.1 |
| Online Doctor/over phone | 0.0 | 0.0 | 2.8 | 0.8 |
| Tried home remedies | 5.9 | 0.0 | 5.5 | 3.3 |
| Spent more money | 17.8 | 4.5 | 0.0 | 6.9 |
| Couldn't get treatment due to restrictions | 2.2 | 4.0 | 7.6 | 4.6 |
| No treatment-lack of money, hospitals closed | 1.5 | 11.0 | 6.2 | 6.9 |

Appendix Table 3: Challenges faced in procuring contraceptives during COVID pandemic (%)

| Challenges in procuring contraceptive method among current users | Assam (n=65) | Jharkhand (n=97) | Madhya Pradesh (n=84) | Overall (N=246) |
|--|--------------|------------------|-----------------------|-----------------|
| Faced no challenges | 66.2 | 85.6 | 66.7 | 74.0 |
| ASHAs/ANMs had no product/ Stock out | 20.0 | 4.1 | 3.6 | 8.1 |
| Using contraceptive methods | 0.0 | 0.0 | 10.7 | 3.7 |
| Not able to procure due to travel restriction | 4.6 | 0.0 | 4.8 | 2.8 |
| No contact with ASHA/ ANM | 1.5 | 4.1 | 1.2 | 2.4 |
| Used traditional methods when method was not available | 1.5 | 3.1 | 1.2 | 2.0 |
| Govt. facilities remained closed | 0.0 | 3.1 | 2.4 | 2.0 |
| Could not go for the next dose of injectables | 0.0 | 3.1 | 2.4 | 2.0 |
| No idea if methods were available in facilities | 1.5 | 0.0 | 3.6 | 1.6 |
| Had no home supplies of contraceptives | 3.1 | 0.0 | 2.4 | 1.6 |
| Not able to buy contraception at this time | 1.5 | 0.0 | 2.4 | 1.2 |
| Other | 3.1 | 3.1 | 2.4 | 2.8 |
| No reason mentioned | 1.5 | 3.1 | 0.0 | 1.6 |

Other includes- Husband doesn't stay at home, menstruation not started/low age, fear of side effects etc.

Appendix Table 4: Reasons for not using any contraceptive methods during COVID pandemic among non-users (%)

| Reasons for not using contraceptive method | Assam (n=107) | Jharkhand (n=105) | Madhya Pradesh (n=98) | Overall (N=310) |
|--|---------------|-------------------|-----------------------|-----------------|
| Fertility related | | | | |
| Wanted a child | 26.2 | 20.0 | 27.6 | 24.5 |
| Husband doesn't like | 13.1 | 11.4 | 12.2 | 12.3 |
| Husband doesn't stay at home/not required | 2.8 | 18.1 | 7.1 | 9.4 |
| Family opposed | 3.7 | 1.0 | 2.0 | 2.3 |
| Method Related | | | | |
| Experienced side effects | 5.6 | 1.0 | 3.1 | 3.2 |
| Fear of side effect | 3.7 | 1.9 | 1.0 | 2.3 |
| COVID related | | | | |
| Not able to procure due to travel restriction | 0.9 | 0.0 | 15.3 | 5.2 |
| Not able to buy contraception at this time | 0.0 | 0.0 | 15.3 | 4.8 |
| No contact with ASHA/ ANM | 6.5 | 1.9 | 5.1 | 4.5 |
| Menstruation not happened/low age | 3.7 | 4.8 | 1.0 | 3.2 |
| ASHAs/ANM couldn't be able to provide/ Stock out | 1.9 | 2.9 | 4.1 | 2.9 |
| No idea if methods were available in facilities | 3.7 | 1.0 | 2.0 | 2.3 |
| Pharmacy/Shops closed | 0.9 | 0.0 | 3.1 | 1.3 |
| Govt. facilities closed | 1.9 | 0.0 | 1.0 | 1.0 |
| Used to get methods at home, now all stopped | 0.0 | 1.0 | 1.0 | 0.6 |
| Private facilities closed | 0.0 | 0.0 | 2.0 | 0.6 |
| Could not go for the next dose of injectables | 0.0 | 0.0 | 1.0 | 0.3 |

Appendix Table 5: Reasons for stopped using contraceptive methods during COVID pandemic (%)

| Reasons for stopping use of contraceptive method | Assam (n=10) | Jharkhand (n=7) | Madhya Pradesh (n=23) | Overall (N=40) |
|--|--------------|-----------------|-----------------------|----------------|
| Fertility related | | | | |
| Wanted a child | 30.0 | 28.6 | 56.5 | 45.0 |
| Husband doesn't like | 20.0 | 28.6 | 4.3 | 12.5 |
| Husband doesn't stay at home/not required | 0.0 | 28.6 | 0.0 | 5.0 |
| Family opposed | 0.0 | 14.3 | 0.0 | 2.5 |
| Method related | | | | |
| Experienced side effects | 30.0 | 0.0 | 0.0 | 7.5 |
| COVID related | | | | |
| Not able to buy contraception at this time | 0.0 | 0.0 | 17.4 | 10.0 |
| No idea if methods were available in facilities | 0.0 | 14.3 | 4.3 | 5.0 |
| Used to get methods at home, now all stopped | 0.0 | 0.0 | 8.7 | 5.0 |
| No contact with ASHA/ ANM | 0.0 | 0.0 | 8.7 | 5.0 |
| ASHAs/ANM couldn't able to provide/ Stock out | 0.0 | 0.0 | 8.7 | 5.0 |
| Not able to procure due to travel restriction | 0.0 | 0.0 | 4.3 | 2.5 |
| Govt. facilities closed | 0.0 | 0.0 | 4.3 | 2.5 |
| Private facilities closed | 0.0 | 0.0 | 4.3 | 2.5 |
| Could not go for the next dose of injectables | 0.0 | 14.3 | 0.0 | 2.5 |

Appendix Table 6: Reasons for stopped using sanitary napkins during COVID pandemic among young women and girls who were using sanitary napkin before pandemic (%)

| | Assam (n=73) | Jharkhand (n=60) | Madhya Pradesh (n=128) | Overall (N=261) |
|--|---------------|------------------|------------------------|-----------------|
| Married | (n=53) | (n=54) | (n=94) | (n=201) |
| Could not afford to buy napkin | 39.6 | 33.3 | 46.8 | 41.3 |
| Couldn't go out for purchasing napkins | 22.6 | 1.9 | 37.2 | 23.9 |
| Chemist shops were closed | 30.2 | 0.0 | 22.3 | 18.4 |
| With current economic crisis, it is not a priority | 11.3 | 1.9 | 9.6 | 8.0 |
| Not available /stock out | 0.0 | 1.9 | 11.7 | 6.0 |
| No free supply of napkins | 11.3 | 0.0 | 3.2 | 4.5 |
| No menstruation | 0.0 | 11.1 | 0.0 | 3.0 |
| Pregnant | 11.3 | 13.0 | 4.3 | 8.5 |
| Not required / Not applicable | 0.0 | 18.5 | 10.6 | 10.0 |
| No response | 1.9 | 20.4 | 0.0 | 6.0 |
| | | | | |
| Unmarried | (n=20) | (n=6) | (n=34) | (n=60) |
| Could not afford to purchase napkin | 50.0 | 100 | 44.1 | 51.7 |
| Couldn't go out for purchasing napkins | 20.0 | 0 | 58.8 | 40.0 |
| Chemist shops were closed | 25.0 | 0 | 20.6 | 20.0 |
| With current economic crisis, it is not a priority | 25.0 | 0 | 8.8 | 13.3 |
| No free supply of napkins | 15.0 | 0 | 11.8 | 11.7 |

| | | | | |
|--------------------------|-----|---|------|------|
| Not available /stock out | 5.0 | 0 | 14.7 | 10.0 |
| Schools were closes | 0.0 | 0 | 2.9 | 1.7 |
| | | | | |