Medicus Mundi Switzerland

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Lessons learned from nimble adaptations to organisations' responses to the sexual and reproductive health (SRH) needs of adolescents in the context of the COVID-19 crisis.

Country: India

MAMTA Health Institute for Mother and Child

MAMTA Health Institute for Mother and Child is a not-for-profit organization with its head office in Delhi. Its interventions are spread across 19 states of India and the neighboring countries of Bangladesh and Nepal. It has touched over 5 million lives across 100 districts of India through 150 projects in the last 30 years. MAMTA works in the fields of maternal and child health and nutrition, youth sexual and reproductive health and rights, communicable diseases, such as HIV and tuberculosis, as well as non-communicable diseases. Project Jagriti , a community-based project, is spread across 13 districts of India and is committed to improving maternal, adolescent, and young women's health, nutrition, and hygiene status. The project implements health education and promotion approaches that are tailored to reach marginalized populations, strengthen and empower communities, and transform lives through sustained behavior change.

Were you delivering services to young people before the COVID-19 crisis?

Before the COVID-19 crisis, our staff partnered with frontline workers for door-to-door visits to provide contraceptives and counseling. But after COVID-19, frontline workers were forced to reduce physical contact. Also, most frontline workers were occupied with the management of COVID-19 operations. However, due to lockdown, there was a perceived notion that pregnancy rates might increase. As a result, Jagriti staff thought of new ways to help disseminate contraceptive-related information to young married couples.

What new approaches did you use to respond to the barriers created by the COVID-19 pandemic to reach young people?

Jagriti pivoted its existing strategies and launched new initiatives across 11 districts of India. Here are some of the key approaches:

Positive gossiping by "Chugal Chachi": "Chugal" stands for gossip and "Chachi" for aunt. In Indian culture, especially in rural areas, it is rather common to find older women gossiping with each other, during evening tea time. Mothers-in-law typically have a great influence on their daughters-in-law and can advise them on issues such as nutrition and family planning methods, pregnancy care, and post-pregnancy care. Based on widely available survey data, 70-80% of women in India are well educated about contraception. Since the 1950s, mass media programs have done well in spreading the information widely.

However, the issue really lies in young women's low decision-making power. Husbands generally hold a lot of influence, but mothers-in-law hold even more. Thus, identifying some older women, who are likely mothers-in-law, to move across villages and 'gossip' about the positive impact of adopting family planning methods, was a strategy we adopted since 2019, at a large scale. These women would speak about the importance of delaying pregnancies after marriage and the positive impact of a 3-year gap between two pregnancies. The gossip may look like this: *"So and so's daughter-in-law used X contraceptive method and it was positive. Her older son is 3 years older than her little one."*

When COVID-19 hit, the "Chugal Chachi" program was able to continue at a smaller scale in rural areas, where restrictions were less strict. During the pandemic, we continued our intervention across 5 districts, which covered 20-30 villages.

Kiosks: When COVID-19 hit, it made a lot of sense to employ a passive approach with required minimal human contact. We installed kiosks next or close to the Outpatient Department (OPD) of hospitals, where there is high foot traffic. The kiosks were usually staffed by female health workers who had the responsibility to disseminate information about family planning methods, provide infection prevention and control, and distribute contraceptives to those interested. Those requiring other services would be referred to doctors or midwives. People were coming in for their usual appointment at the OPD, and so, we used the opportunity to share information about contraception. It was especially important to counsel couples about the financial ramifications of having a child during the pandemic.

Condom boxes: Condom boxes were placed in the hospitals. This was specially designed for men who are usually hesitant to approach female health workers. There was no need to interact with anyone to get condoms. It served as a place for a quick grab-and-go.

Online training of accredited social health activists' supervisors (ASHA supervisors): A one-day, 4-hour training was organized for ASHA supervisors on three topics– technical details of contraceptives, interpersonal communication, and the importance of supportive supervision.

ASHAs are the first level of contact with people living in rural areas. They are frontline workers, who are skilled in giving a range of advice about a range of contraceptive products and methods. However, clients find themselves unable to translate the knowledge they get into practice. Usually, the problem is that the health system is really overburdened.

ASHA supervisors manage the frontline workers, making rosters as well as troubleshooting daily issues. Our approach was to train the supervisors so that they can in turn train the ASHAs they supervise through a cascade model. Our hope is that helping supervisors improve their management skills would help improve the efficiency and ability of ASHAs to spend more quality time advising clients.

Why did you decide to use these approaches?

These approaches were essential to motivate and counsel young couples to adopt family planning methods as per their needs, especially when the risk of pregnancy was high due to lockdown and unavailability of routine health services. These approaches were, in a way, an adaptation to the routine door-to-door delivery of services, which limited the contact of frontline workers with the community.

Problem identification– increased risk of pregnancy, less access to routine services, limited contact with health workers– was followed by discussions with the field teams and state leads to invite approaches to address these problems. This was followed by virtual pre-event planning discussions, such as how to craft the condom boxes, the content of pamphlets, and the development of the content of the trainings.

How are you working to find out if these approaches are having the desired impact?

We did a survey to find out if we were able to increase the uptake of contraceptives through the installation of kiosks and condom boxes. A total of 19 condom boxes were installed across health facilities in the state of Uttar Pradesh and around 125 condoms can be kept in the boxes at a time. A total of 14 kiosks were placed across facilities that reached up to 4763 couples. We were interested in identifying if there were any changes in outcomes, beyond people's knowledge about contraceptive methods improving. In the short survey 3-months after the activities, we noted a 28% increase in the uptake of contraceptives.

Thus far we have had 81 "Chugal Chachis" involved in positive gossiping, who reached over 6500 women across 5 districts of Uttar Pradesh, 2 in Rajasthan, and one each in Delhi and Nagpur. We managed to complete the online training of 35 ASHA supervisors which focused on interpersonal communication and a client-based approach for improving the uptake of contraceptives among young couples.

All data collected will further be supplemented with routine sub-district-level Health Management Information System (HMIS) data.

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