Landscape assessment of COVID-19 response efforts among marginalized women

INTERIM REPORT

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Swasti THE HEALTH CATALYST

ADB

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List of abbreviations

COVID-19	Coronavirus Disease 2019
ICU	Intensive Care Unit
HCWs	Healthcare workers
ASHAs	Accredited Social Health Activists
WHO	World Health Organization
UNICEF	United Nations Children's Fund
GDP	Gross Domestic Product
TGNB	Transgender and Non-Binary
CoE	Centre of Excellence
FGDs	Focussed group discussions
CAC	#COVIDActionCollab
KIIs	Key Informant Interviews
MSM	Men who have sex with men
GBV	Gender Based Violence
HIV	Human immunodeficiency virus
ART	Antiretroviral Therapy
CBO	Community Based Organizations
I4We	Invest for Wellness
ESI	Employees' State Insurance
PHC	Primary health care
SRHR	Sexual and Reproductive Health and Rights
PwD	Person with disabilities
BPL	Below Poverty Line
WSW	Women in Sex Work
SMS	Swati Mahila Sanga
PDS	Patient Decision Support
ICDS	Integrated Child Development Scheme
SDG	Sustainable Development Goals
DAY-NRLM	Deendayal Antyodaya Yojana – National Rural Livelihoods Mission

Executive Summary

Low-income and marginalized communities living in urban regions are particularly at risk due to supply-side limitations, coupled with the disadvantage they face navigating the healthcare system. Access to healthcare, in general, is poor among this community due to several reasons such as distance, cost and time of travel, long wait times, lost wages, stigma, or perceived stigma by healthcare staff. We conducted a landscape assessment of COVID-19 response efforts focussed on the marginalized women where we found poor pregnant women falling under Below Poverty Line (BPL) category, frontline health workers, transgender women, women in sex work and People living with HIV (PLHIV), factory workers, women garment workers and women working in the informal sector, and women with disability to be the most marginalised due to the existing health and systemic inequties. This will serve as the foundation for elaborating three case studies on transgender women, factory laborers, and PLHIV.

Furthermore, marginalised populations are prone to historic, socio-cultural, environmental, health system/institutional, economic or political factors, individual/group perceptions shaped by one's social/peer environment, and cognitive biases relating to how a particular healthcare service, such as vaccination, is delivered. Thus, despite targeted facilitation of healthcare services towards vulnerable communities, the actual outcome of programmes may be riddled with lacunae. These communities are also at the highest risk of infectious diseases such as COVID-19 due to poor sanitation facilities and overcrowding, which makes social distancing impractical and allows for an uncontrollable spread of the virus in these communities.

Efforts made by the government and other entities to curb both the health and economic impact of COVID-19 are often not accounted for the varied realities and circumstances that negatively impact urban poor communities' ability to access services and ensure social protection. We conducted five FGDs and fifteen KIIs in September and October, 2021 through purposive sampling, and surveys from vaccination camps were used to gather insights about vaccine appropriate behaviours including the gaps and barriers faced by various groups of marginalised women. The CoE has been engaged with multiple stakeholders and the analysis framework was developed in consultation with other NGOs, CSOs and public sector engagement. The results highlighted diverse set of challenges concerning food insecurity livelihoods and enterprises, discrimination and stigma, social protection and welfare measures, vaccination hesitancy and distribution, financial services and products and health and well-being. There is an urgent need to design evidence based policies for vulnerable women in order to deliver equitable healthcare and universal health coverage. COVID-19 response efforts have been integral to peer social networks and regional political power centres, who have been pivotal in information gatekeeping and supply chain bottleneck management for supply of vaccines, availability of medicines, ambulance services and hospital beds.

A bottom-up approach to ensuring equitable healthcare access is to ensure stronger social networks within marginalised groups. The network centrality, which shows how well information travels within a network, can be improved by identifying significant actors, such as influential people, social institutions (NGOs, SHGs, Anganwadis/ICDS) that can be made credible sources and disseminators of information. Secondly, policy implementing agencies should develop innovative, gender-sensitive approaches to reach out to a maximum proportion of marginalised groups. As SDG3 sets sustainable healthcare targets for governments, in the Indian context it is important for the Government to first address the gender disparity. The impact evaluation of existing government programs is essential to ensure proper allocation of funds being received for the same and gender budgeting can enhance transparency and accountability. In conclusion, augmenting gender impact assessments and designing policies for gender appropriation within the existing programs thereby aiming towards a more robust system with human rights and social justice at its centre is the need of the hour.

Chapter 1. Introduction

The COVID-19 (Coronavirus Disease 2019) is an unprecedented global disaster whose spread, morbidity and mortality India is currently attempting to minimize. The public health crisis came at a time when India's Gross Domestic Product (GDP) growth was already stagnating and unemployment was rising (Dev & Sengupta, 2020).

The resurgence of COVID-19 across India has caused serious alarm. No single factor can be held responsible for this. Broadly lack of COVID-19 appropriate behavior, vaccine hesitancy and complacency and alterations in the genetic structure of the virus creating mutants or variants giving it presumably greater infectivity are responsible for persistence, wider dissemination and swift spread of the virus.

Moreover, healthcare facilities were facing a severe shortage of oxygen supplies, critical drugs to alleviate respiratory symptoms, and Intensive Care Unit (ICU) beds, preventing critically ill patients from receiving the care they need. The absence of adequate healthcare facilities worsened the condition of certain populations. Although all segments of populations have been affected, as in any other public health emergency, the poor, women, disabled, and other marginalized subpopulations are bearing the brunt. Lack of awareness and adherence to primary prevention (proper use of masks, social distancing, hand and respiratory hygiene) have aggravated the pandemic and resulted in a huge economic impact on the poor.

"Marginalized communities are those excluded from mainstream social, economic, educational, and/or cultural life. Examples of marginalized populations include, but are not limited to, groups excluded due to race, gender identity, sexual orientation, age, physical ability, language, and/or immigration status" (Sevelius et. al, 2020). Unequal power relationships and health inequities between social groups lead to marginalization. The pandemic also caused a surge in disproportionate hospitalizations, intensive care admissions and mortality, in marginalized communities especially among people living with chronic conditions (Singh et. al, 2020).

Some of these groups are vulnerable to potential exploitation, discrimination, and differential access to services. Marginalization excludes individuals & groups, including women, children, aged, disabled, SCs & STs, Poor migrants, HIV/AIDS-afflicted individuals, and Sexual Minorities (Ministry of Earth Sciences, Govt of India, 2011), from the "power and privilege" enjoyed by the social "cream."

Social barriers, such as casteism and ostracization exacerbate the problems of unequitable availability of medical infrastructure. Lack of education is perpetrated by socio-economic barriers that affect marginalised groups in accessing healthcare. The categories of marginalisation are never discrete but overlapping (Chatterjee and Sheoran, 2007). Women, in particular, bear a double whammy of gendered discrimination in healthcare access as well as vulnerabilities experienced as members of specific caste, class or ethnic group.

Low-income and marginalized communities living in urban regions are particularly at risk due to these supply-side limitations, coupled with the disadvantage they face navigating the healthcare system along with environmental and social determinants.

Furthermore, access to healthcare, in general, is poor among this community due to several reasons such as distance, cost and time of travel, long wait times, lost wages, stigma, or perceived stigma by healthcare staff. These communities are also at the highest risk of infectious diseases such as COVID-19 due to poor sanitation facilities and overcrowding, which makes social distancing impractical and allows for an uncontrollable spread of the virus in these communities. Efforts made by the government and other entities to curb both the health and economic impact of COVID-19 often do not account for the varied realities and circumstances that negatively impact urban poor communities' ability to access services and ensure social protection.

Preliminary insights based on secondary data

The current COVID-19 pandemic response repertory has been developed by leading global health agencies focused on "flattening the curve" and containing the pandemic, with little attention for the economic and public health consequences. We now know, almost a year into the epidemic, that a one-size-fits-all mitigation strategy may not have been the best course of action, and that in some situations, such as India, it may have been implemented too early, given the continued surge in cases, and for too long, given the economic damage (UNICEF, 2021).

There are also long-term effects to halting the education of children and girls who drop out of school, which are difficult to assess in their entirety. There are also intriguing aspects of country-specific reactions that imply the pandemic may have been kept under control rather well and with a smaller economic cost (UNICEF, 2021).

Some groups of women and girls may be at higher risk because of poverty, poor access and lack of information and resources. Indian Nurses and midwives make up about 80 percent of Healthcare workers (HCW) (UN). Such groups are more susceptible to exposure owing to their presence as front line caregivers and workers in the health and service sectors. Frontline

caregivers and workers such as Accredited Social Health Activists (ASHAs) and women community cadres also face serious challenges in terms of being at higher risk of contracting the virus.

Moreover, ASHAs are susceptible to occupational health and safety challenges despite working long hours and still are under-incentivized monetarily. This has adversely affected their mental and physical well-being as they struggled with fatigue, burnout and psychological distress. Additionally, they also face threats of physical and verbal abuse from communities that hold them accountable for spreading the virus. All of this whilst saving lives and being exposed to the virus due to inadequate protective medical gear has worsened their situation. There has been a spiraling increase in demand for Personal protective equipment (PPE) in all states (Financial Express, 2020), but the shortage has caused concern among HCWs.

As per Rahman et. al (2021), *"institutional delivery with skilled health care professionals could reduce 16 to 33% of maternal deaths, globally."* However, the rate of institutional deliveries has been declining dramatically during this pandemic. A recent study published in The Lancet (Ashish et.al, 2020) draws a similar picture for India as Nepal where institutional childbirth has been reduced by more than half. The reasons are multifold, but mainly due to *"the lack of transport, fear among people and doctors, resulting in thousands in need of health care services being denied by hospitals"* (Rahman et. al, 2021). Moreover, based on the recent data by World Health Organization (WHO) and United Nations Children's Fund (UNICEF), India registered the largest drop in routine childhood immunization coverage in 2020 followed by Pakistan and Indonesia.

The informal sector in India employs over 80% of non-agricultural workers and is highly fragmented. Though informal work can take numerous forms, it is often defined by a lack of acceptable work. Employment insecurity (lack of protection against arbitrary dismissal), job insecurity (lack of protection against workplace-related injuries and diseases), and social insecurity are all examples of this (lack of pension, sick leave, and maternity and healthcare benefits). Moreover, only 12.1 percent of female workers are protected by social security, compared to 17.4 percent of male workers (Jagtiani, 2021).

The informal sector, which accounts for 55% of India's Gross Domestic Product (GDP) has been adversely affected and more so the women employed as domestic workers, goods carriers, street vendors etc. According to the World Bank (2021), "*women employed in the country's huge informal economy have been hit disproportionately hard as millions of livelihoods have become even more precarious or evaporated completely*." Due to COVID-19, domestic workers faced both social and economic distress adding to the burden of existing health inequities and right violations (Sumalatha et. al, 2020). Domestic workers in India are in the range from 4.2 million

(official estimates) to 50 million (unofficial estimates). Out of the two-thirds of domestic workers living in urban India, about 75% are women (Ghosh, 2013).

Sumalatha et al., (2021) argue that *"Being least organised and lacking institutional support, domestic workers are extremely vulnerable to exploitation and human rights violations, and the pandemic has aggravated the situation."* There is a clear feminisation in domestic work (Augustine & Singh, 2016) with tough working conditions and the lack of social protection measures.

The Transgender and Non-Binary (TGNB) community, have been exceptionally affected by the pandemic in several ways too. Besides having a high risk of exposure to the virus and its adverse outcomes, there were delays in access to gender-affirming care diminished access to social support, which is crucial to protecting against the effects of stigma and discrimination (Woulfe, J, and Wald, M., 2020).

Pandemics tend to disrupt social infrastructures thereby aggravating the existing conflicts and weakness and gender inequalities. Women and children are even more exposed to sexual violence and haraasment whilst procuring necesities such as food, water and firewood (Mittal and Singh, 2020). Based on an article published in The Hindu, the National Commission for Women (NCW) reported a twofold increase in cases of gender violence. Several researchers also indicate an increase in family and sexual violence during and after any disaster or crisis. During COVID-19, over 700 One-Stop-Crisis Centers remained throughout India, assisting over 300,000 women who were victims of violence and abuse (UN, 2021).

Moreover, there is worrying evidence that domestic violence increases women's hesitancy to access healthcare facilities. Additionally, childbirth bears an additional economic encumbrance on marginalised women, as their source of livelihood is cut off in absence of maternity entitlements. Migrancy leads to marginalised groups losing many benefits available to Below Poverty Line (BPL) people. They are excluded from state health programmes, facing information asymmetry, and vulnerable to sexual abuse or risky living conditions (International Organization for Migration, 2013).

Furthermore, people with disabilities (PwDs) are among the people who are more likely to become infected with COVID-19 and experience serious sickness as a result of it. Additionally, lockdowns present significant issues and have a significant influence on PwDs' ability to receive daily help (Senjam, S.S, 2021).

It is imperative to understand the barriers preventing communities from applying COVID-19 appropriate behavior and accessing and utilizing the services, especially COVID-19 vaccination that are available in public sector institutions. These barriers may pertain to awareness, *myths*

and misconceptions, socio-economic environment & compulsions, technical, logistical and health system related challenges. Fostering an understanding not only of these barriers but also of the types of strategies, practices, and innovations that can be used to circumvent them is necessary in order to be able to employ and sustain an effective and inclusive COVID-19 response.

An initial analysis of the existence and impact of these barriers followed by in-depth assessment, was of immense use in devising interventions and a strategy that strengthens public engagement in this global response to ongoing pandemic of COVID-19.

Research Questions

In light of the situation the following research questions were answered with the help of the landscape assessment:

1) What are the social barriers and facilitating factors towards effective COVID-19 response for marginalized and vulnerable women? (Vaccine hesitancy, cultural barriers, stigma, and discrimination, limited engagement, misinformation, etc.)
2) What are the COVID-19 response efforts underway in India that target vulnerable and marginalized women?
3) Who are the key community leaders, organisations, and representatives the Center of Excellence (CoE) can engage with?

Chapter 2. Research Methodology

The CoE developed the interim report using a qualitative study design with an interpretative, naturalistic approach, attempting to make sense of phenomena through comprehending meanings and moments in people's lives (Mays & Pope, 2000). The concept of thick description was relevant to the study since it implies delving deeper into the phenomenon than what appears on the surface. History and physical settings were given special consideration, as they are often crucial to delivering a detailed account (Mills, A. J et al, 2010).

Qualitative interviews and focussed group discussions were useful in elucidating societal barriers and related activities, as well as understanding the perspectives of various actors on the issues surrounding COVID-19 response efforts (Bourgeault et al., 2010).

Data collection and analysis

Data collection and analysis were aided by digital recording, which allowed for repeated viewing (Braun & Clarke, 2006). Multiple data sources, document analysis, pictures, surveys, and semi-structured interviews were used to increase the validity and reliability of the research.

The coding software Dedoos was used to aid in the analysis of the transcribed interviews with the goal of uncovering patterns (Pope & Mays, 2006). The procedure of categorizing and identifying themes and sub-themes was addressed inductively (Braun & Clarke, 2006). Interviews were analyzed as needed for qualitative research, taking into account contextual factors. Exploring the basic meaning of each individual transcript, discovering themes, classifying data bits linked to those themes, and recognising important passages that indicated the impact of the COVID-19 response efforts on marginalized women's experiences were all steps employed in data analysis.

The CoE conducted an initial screen to identify relevant marginalised women groups through three approaches:

1. **Surveys** were conducted of 658 respondents from various Indian states during January to May, 2021. The respondents' ages ranged from 20 years to 70 years and were both men and women. Some of the surveys and **Focussed group discussions (FGDs)** (n=5) were conducted specifically for marginalized groups. We also eliminated some data and focussed on certain groups based on findings on the field during vaccination surveys and workshops.
2. A **google search** using combinations of the following terms: health, global health, marginalised populations, vulnerable women, vaccination drives, primary health care, COVID-19 response efforts, and geographic terms in an effort to ensure that the most marginalized women are included;

3. **Key informant interviews (KIIs)** (n=15) and semi-structured in-depth interviews with community based organisations, NGOs, key leaders, stakeholders and field researchers were conducted in September and October, 2021.. Key informants included members of the technical advisory group convened for the Covid Action collab (CAC) and snowball from key informant interviews.

Method of selection (sampling)

Purposive sampling was used for selecting respondents and focus groups. Certain groups of individuals especially knowledgeable about or experienced with marginalised women (Cresswell & Plano Clark, 2011) were identified and selected. Additionally, the availability, ability to communicate opinions and experiences, and the willingness to participate in a reflection process provide insights was an additional criterion for selecting experts and field researchers for key informant interviews and focussed group discussions (Palinkas et. al, 2015). Community members that possessed in-depth knowledge were therefore selected to gain an understanding of the problems faced by these marginalized groups. Based on the data collected, the following groups were identified to be the most vulnerable:

1. Poor pregnant women falling under Below Poverty Line (BPL) category
2. Frontline health workers
3. Transgender women and women in sex work and People living with HIV (PLHIV)
4. Factory workers,women garment workers and women working in the Informal sector
5. Women with disability

Figure 1 - Analysis Framework developed by CAC as a comprehensive response to the pandemic

**Initial insights from landscape study , will be finalised later*

Chapter 3. Results

Gaps and barriers

Operational and logistic issues:
The Co-Win App, although meant to ease access to vaccinations, has proved to be challenging for the digitally disadvantaged populations. There have been issues related to ID discrepancies for migrant women who do not necessarily have the right documents to get access to health services. Another observation was that the vaccination utilisation rates were very poor due to operational and logistic constraints. For instance, the name and photo mismatch for transgender women which created registration delays and further reduced access to the vaccination.

Quarantine centers were a result of a significant policy action during the lockdown to isolate Covid-19 patients and prevent the sickness from spreading. According to the first part of the study from Bundelkhand (2021) almost 60% of CHWs reported that quarantine centers in their communities were located in government schools. Furthermore, they discovered that women and girls, in particular, were uncomfortable visiting these quarantine facilities. The lack of separate facilities for women and men has been a major source of concern in all regions. The centers do not rectify women's various hygiene, sanitation, and safety needs and concerns. (Bhatia S., Saha D. & Pal S.,2021).

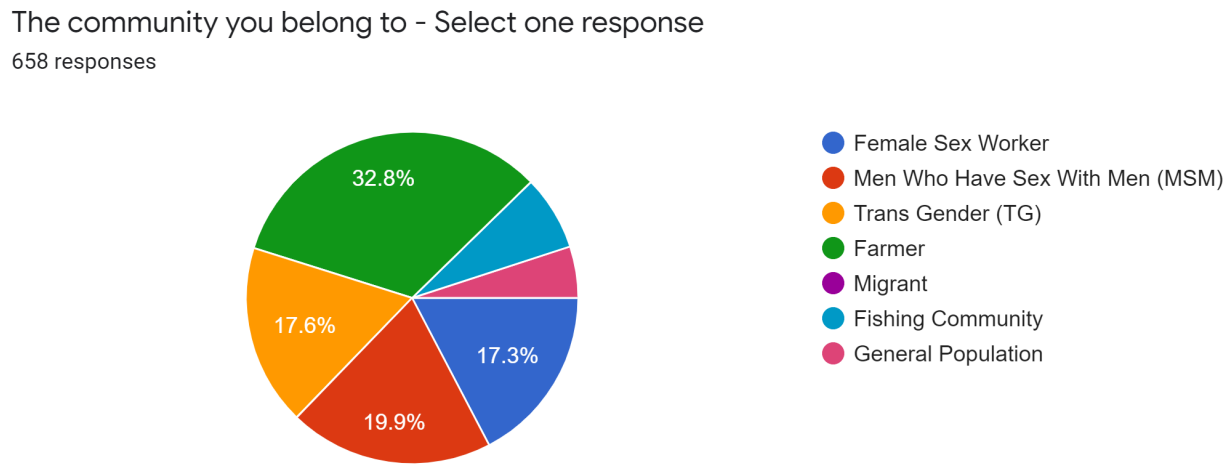
Gender-based digital divide:
The majority of women were discovered to rely on their boyfriends or male relatives for phone access, further limiting access. The digital gap, as well as a lack of affordability for smartphones, has only exacerbated the situation, resulting in less access for vulnerable communities. The large gender gap, along with a lack of agency, has resulted in limited autonomy in making the proper medical decisions for women as primary caregivers in families.

Widening gender gap:
A clear gender gap was observed during vaccination drives. Men were prioritised over women as they have to travel for work. Moreover, there were misconceptions about vaccines affecting fertility, which prevented women adding to their delayed responses. Women were also unable to travel to hospitals or health facilities to get vaccinated due to their roles as sole care providers in the family.

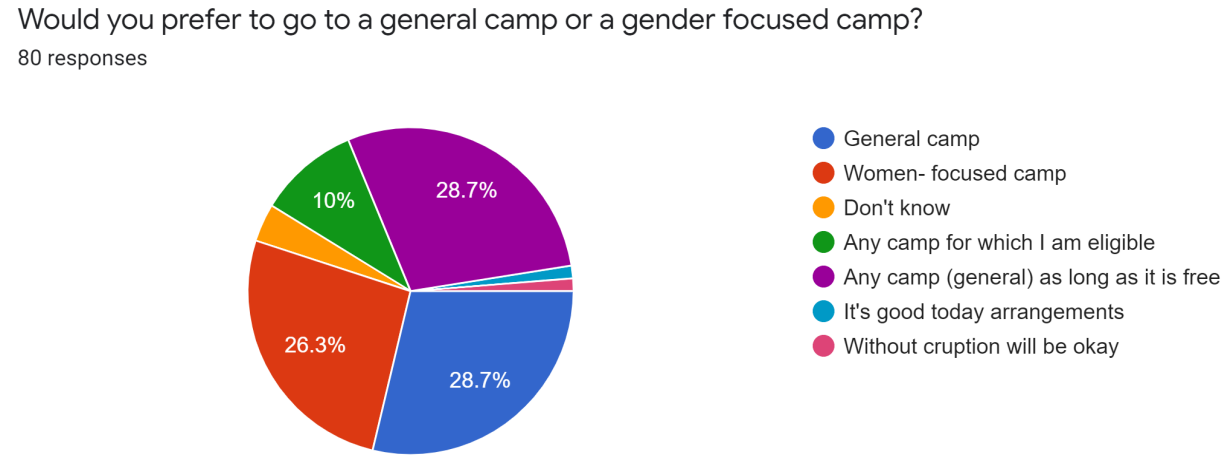
Urban-Rural divide
Richer cities procured more vaccine doses compared to rural districts adding to the growing vaccine hesitancy and skepticism around vaccines.

Class divide
Poor participation from lower - middle class sections of society;
lack of knowledge and awareness;
unaffordability of vaccines at private hospitals

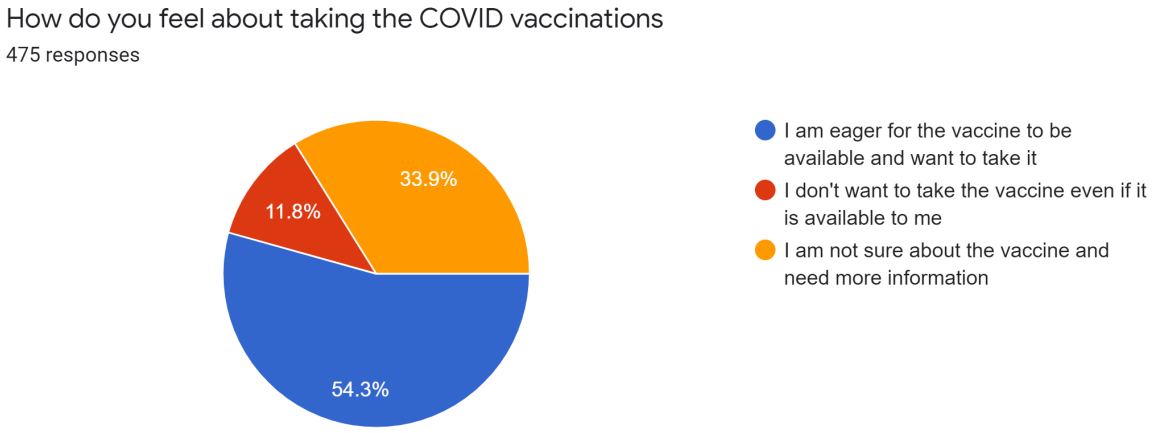
Digital divide
Vulnerable, poor and digitally illiterate left out widening the vaccine divide;
complexity of registration process;
zero access to technology



Based on the COVID vaccination sentiments survey (n=568), the majority of the respondents (33%) belonged to the farmer category followed by Men who have sex with men (MSM) (20%). The marginalised groups were Female sex workers and Transgender populations. This data was from various states in India such as J&K, Himachal Pradesh, Punjab, Chandigarh, Uttaranchal, Haryana, Delhi and Rajasthan.



In another vaccination camp survey conducted in July and August, when asked in if respondents (N=80) would go to a general camp or gender focussed camp, the majority (28.7%) of respondents said that they were okay to go to any camp as long as it was free and were also willing to go to the gender specific camp like we arranged, and 26.3% of respondents were willing to go to women focused camps.



Vaccine hesitancy:

When asked respondents (N=475) about their perception about the COVID vaccinations, a majority of the respondents (54.3%) expressed eagerness to take the vaccine and 34% were unsure and needed more information to make the right decision.

In another set of vaccination camp surveys (n=402) conducted from June to August (2021), in various sites in Bangalore, vaccine hesitancy was observed owing to these top 3 reasons:

1. fear of vaccine side effects
2. rumors and misconceptions from family or close acquaintances
3. fear of vaccines or injection

Demand and supply barriers:

Moreover, some region-specific data highlighted more demand and supply-side barriers. For instance, the infection rate was much higher in certain areas and the issues related to critical services such as no supply of oxygen, crunch of beds in hospitals was observed. Moreover, due to restrictive mobility, people with limited or no technology access were affected the most. As they could not adequately access services and critical information, dramatically affecting the poor and marginalised.

Social protection:

Based on our field data, women accessed more home care services and men availed more social protection services; vaccination, COVID awareness, relief in terms of nutrition, medical equipment (hospitals and homes/community), vaccination information, and a few people used social protection which supplemented income source. Moreover, the transgender population also used the Social protection schemes as supplements in absence of employment and severe loss to

livelihood.

Gender based violence:
Gender-based violence increased dramatically in South Asia as a result of the epidemic, as it does in most crises and survivors were unable to obtain fast and high-quality response assistance. Many NGOs reported violence from women, children and girls. There was limited help available in hospitals and clinics due to which the access to Sexual and Reproductive Health and Rights (SRHR) facilities worsened. Abortion, miscarriage, unwanted pregnancies rose but there were no proper facilities to handle such cases.

Findings specific to target groups

Specific populations faced certain set of challenges:

People living with HIV (PLHIV):
A few consultative meetings and focus group discussions with Key leaders from Key vulnerable population groups were conducted earlier this year. Discussions were focussed on sentiments around COVID vaccination. Most people were excited to take the vaccine and highlighted strong reasons for the same. However, the feeling that their community will not get access to the vaccine at all and it will mostly be available for the rich and the powerful was strongly palpable. Apprehensions that are specific to the community's fears about side effects were also highlighted, especially in relation to how the vaccine interacts with Human immunodeficiency virus (HIV) Antiretroviral Therapy (ART) and other comorbidities and medications used to manage these conditions.

A huge gap in awareness, or nuanced awareness was observed to be absent about protection offered by vaccines, transmission prevention and the side effects. People believed that vaccines prevent transmission, which is currently unproven. Discussion about what side effects have been seen in trial, how comorbidities interact with the vaccine and data on the same etc. was missing. Community members had a lot of doubts and questions that were still unanswered. Learning from whatsapp is also a key problem and more credible sources of information are needed.

Based on a recent study on People living with HIV (PLHIV), there was a strict restriction on mobility and a stoppage of transportation services due to the lockdown. A major reliance on family member, friends was observed in order to procure medicines and travel to health care facilities. Respondents who used private vehicles also faced harassment from the police authorities in terms of fines, verbal and physical restraints. At times, there were reports of abuse, torture and vilification despite showing records to receive ART, thereby reducing access and showing gaps in service delivery mechanisms.

Furthermore, PLHIV respondents faced difficulties in procurement of medical supplies and condoms. However, some NGOs and CBOs and ART centres came to rescue and delivered

supplies at their doorstep. The reasons stated by PLHIV concerning the eagerness to get vaccinated and the fear apprehensions around vaccination were as follows:

Reasons stated for being eager to access the vaccine:

- All community members have witnessed a significant loss of livelihood - vaccination will allow them to go back to work. They believe if their clients know they have been vaccinated the client load might be higher once they give them the information about being vaccinated
- Will protect themselves from their clients
- Their families will be safe once they are vaccinated
- The rest of the community will also be safe
- Prevention is better than cure "*To protect ourselves from HIV we use condoms, to protect from COVID we can take vaccine"*

Apprehensions/fears around taking the vaccine:

- The main fears centered around the lack of information about what some of the side effects of taking the vaccine could be and how these will be managed
- A large number of people in the community live with existing comorbidities. Within the PLHIV group there were questions about how the vaccine would interact with their existing condition and medications, and if there is potential for worse side effects. They had some recent experience from people being shifted from their old ART medication to TLD. The community perceived that this shift has caused some side effects in people and worried how introducing a vaccine to the mix could cause issues.
- Majority of people also have comorbidities like diabetes and hypertension amongst others. They had concerns that vaccine interference with their medications will cause more side effects.

Migrant women and factory workers:

According to Jackson et. al (2020), the majority of garment workers in the Asia-Pacific region are women (3.5 crore), and the garment sector employs 5.2 percent of all working women in the region, or 27.9 percent of all women working in the manufacturing sector (Singh, 2021).

As a part of the Invest for Wellness (**I4We program)**, the CoE has been engaged with 30,000 workers from over 30 factories since the last two years. In our field surveys, migrant workers were marginalized due to gender based discrimination and inadequate sensitivity to migrant needs.

Factory workers (women) faced challenges such as :

- Lack of sanitation measures
- Gender inequity
- Gender based exploitation since the management positions are mostly occupied by men
- Lack of grievance mechanisms
- Poor facilities for women in the reproductive age
- Inadequate investment in women's well-being: The management was found to be more reactive than responsive in handling issues related to providing support when women faced emotional turmoil.
- Poor fabrication around women workers and well-being- social stigma around migrant workers, perceptions about sex work and treating them as second line citizens.
- Lack of basic necessities: In some facilities there was no soap/hand wash provided for hand wash, apart from toilet and sanitary pad supplies and safe places to feed babies:

"The leftover cloth is easily available to workers. The workers use this to make sanitary pads for themselves. With little or no knowledge about the adverse effects of using such cloth during menstruation, more than 80% of workers use the waste cloth regularly."
- A garment worker

Factory workers face occupational health problems, poor leave structures and lack legal rights and protection (Sumalatha et. al, 2021). The labor unions function in many factories in India, but there is a clear exploitation taking place, especially for female workers. There's a great deal of gender inequity observed in many small and big factories in terms of providing the right facilities and treating them respectfully. The exploitative nature of governance adds to the burden. Path dependency seen in the governance mechanisms, administrative policies and labour management. The governance appears to be lackadaisical, labor unions are functioning, but they are also exploitative in their own systems. While in most factories, most workers approach their supervisor for support, in a few factories workers are unaware of who the welfare officer or HR officer is. Moreover, in most factories, workers reported that supervisors do not have adequate capacity to manage and deal with women workers (lack understanding of women problems - issues related to menstruation, pregnancy, taking care of their children etc).

In most factories, workers reported that the mechanism for prevention of sexual harassment is inadequate. In all the factories, workers did not have a clear idea of how to deal with / resolve sexual harassment (POSH) at workplace owing to the lack of knowledge on procedures/ systems. All factories reported that there were no cases of sexual harassment filed. It was perceived that workers lack awareness and existing systems are inadequate in identifying such harassment.

In most factories , there were some special facilities like salary advance, production incentives and small loans, but they reached only very few workers owing to a lack of awareness about these facilities. There were some migrant workers in all factories, who had not received Employees' State Insurance (ESI) cards due to inadequate facilitation from the factory. Due to this, they visited private hospitals, and had to pay for health care services out of their own pockets, despite paying the ESI premium every month. In all factories, most workers used informal sources / institutions for financial transactions (e.g. sending money home through friends), and making risky investment choices (e.g.chit funds for saving/loan from informal sources), owing to inadequate financial literacy and poor access to formal sources.

When asked about any changes field researchers might have encountered in the last five years, and if there's been any change through Swasti's interventions, Shankar (Swasti) insightfully pointed out:

"*Yes. I think that's an important question. You know, there are several changes. If you ask me whether those changes are enough, no they are not enough. If you ask me whether it is because of our efforts or there are other factors in play.. I say yes, along with our efforts, other concomitant efforts have been made. The focus of brands on ethical and responsible business practices has increased exponentially. there are efforts to enforce international standards and guidelines. Apart from these, there is a positive push from the labor unions and from worker representation as well. . What I'm saying is that, there are changes, however many more things need to be changed, and long way to go..This require collaborative efforts and actions to make* it happen"

Transgender population:

Trans community members generally avoid Primary health care facilities (PHCs), as they are subjected to vilification and rude remarks by PHC staff. They could not access camps organized early in the mornings owing to their late night shifts. This, along with unanswered questions led to decreased access to vaccination. The vaccine uptake was less and many questions were still unanswered. Most frequently asked questions pertained to the choice and the efficacy of vaccines (Covishield vs Covaxin).

During the lockdown, the lack of government documents such as Aadhar card and BPL card eliminated the Transgender population from receiving social protection benefits like food security and financial aid from the government. Although there is a clear need and demand to provide gender-affirmative psychological services and continuing supply of hormonal therapy, there was a lack of sensitivity observed with respect to gender affirming procedures for the transgender populations in various vaccination camps.

As Pandya and Redcay (2021) argue, *"the concern is not just about the lack of healthcare facilities but also the lack of dialogue about the needs and inclusion of transgender individuals in the healthcare system."*

Most people who don't work with the community don't think about the fact that either the IDs are not available or there is a lot of sensitivity towards *deadnaming*. The visual and name difference between IDs was also found to be a deterrent in accessing services. Ensuring that individuals know that this would be a friendly place both during mobilisation and that all volunteers and health care providers are sensitised was key.

Stakeholder mapping

We performed a stakeholder mapping exercise to gain a better understanding of the key community leaders, organizations, and representatives with whom the CoE has worked and will work in the future. However, this list is in the works and will be expanded later.

Themes

Corroborated with literature review, the following themes emerged based on the findings, focussed on the challenges faced by marginalised women:

1. Food insecurity
2. Livelihoods and enterprises
3. Discrimination and stigma
4. Social protection and welfare measures
5. Vaccination hesitancy and distribution
6. Financial services and products
7. Health and well-being

COVID-19 Response efforts with Partners

The CoE is a knowledge management and learning platform that connects and collaborates with partners working to bridge the gap between communities and health systems and services, particularly for vulnerable and marginalized women, to combat COVID-19. The Center of Excellence worked to generate learnings and best practices from COVID-19 response efforts implemented through communities, civil society partners, government organisations, and local leaders. The CoE also collaborated with a range of partners to generate learnings, knowledge management, and knowledge dissemination from COVID-19 response efforts in India related to livelihoods, telecare and access to human rights and government schemes:

Saving the livelihoods of garment workers in Kalburgi district

Across the 3 villages of Kalburgi district, Sedam taluk and Mudhol, there are approximately 100 SHGs, most of whom rely on tailoring as their primary form of livelihood. Vrutti and Mudhol trained 40 tailors on sewing face masks. L&T construction placed an order of 10,000 face masks in April 2020. SHG members earned on an average of INR 4,000 from this project.

Telecare

In 2021, Swasti created some employment opportunities for the trans community members wherein some members took up roles as remote tele-callers and Nurse aid callers. EIM Kota is one of the implementation partners and the telecare service via Call4Svasth was initiated during the start of the second wave of COVID-19 in the peri-urban areas of Kota. The exposure methods included community health workers going to the areas and filling out surveillance forms and posters and printed materials being used as a means of spreading the information about the programme. The services offered included:

- COVID-19 screening for symptoms and management

- Connect with a nurse/doctor
- Information on government social protection schemes
- Information regarding vaccination
- Depression, trauma, anxiety management

The intent of the programme was to cover everyone in the area, however the programme was able to reach out to only 58% i.e 250 people out of 429. Among the people treated, 213 benefited out of 250, which is a very high number and a good indicator for telecare use and need. The network effect of the programme was negligible as approximately 13% people were aware about the programme and a negligible amount used the helpline. This pattern was observed in other parts of the country as well. For instance, Jagori, a Delhi based NGO reported a drop in calls on helpline numbers by 50%. Jaya Velankar, Director of Jagori argues that this could be attributed to the pre-existing fear of getting exposed and discovered by their offenders at home (Mittal and Singh, 2020).

However, among all the healthcare services being offered in the area, telecare was ranked the lowest as compared to other services offered. The government hospitals were ranked highest among all the service providers. The service providers included: government hospitals, private hospitals, family doctors and telecare. Possible reasons for the low ranking were :

- Government hospitals offer other facilities like free medicines etc.
- The telecare programme was not free of cost
- The timing was a deterrent since the telecare programme was not an emergency service and functioned only from 8 am to 8pm

Access to human rights and government schemes

68 CBOs from Taaras who were engaged with the CoE were instrumental in ensuring health and security of women in sex work, many of whom are PLHIV during the pandemic.
The following 7 services were facilitated to community members to tackle this situation:

1. Free food distribution
2. Grocery distribution and facilitating access for Patient Decision Support (PDS)
3. Direct Bank Transfers- Govt schemes, Private institutions and individual donors
4. Cash benefits- Govt schemes, Private institutions and individual donors
5. Distribution of ART medicines
6. Screening/testing and treatment- referrals to PHCs and local clinics
7. Free gas cylinder under Ujjwala scheme
8. Distribution of masks and sanitizers.

Fundraising and support mobilization from individual donors including leaders, elected members (Ministers, MLAs), businessmen etc. helped in distributing cooked food, grocery kits, sanitizers and masks.

Furthermore, the women and child welfare department, police department, and authorized officials from district administration supported the community by issuing permission letters and ID cards to carry on with their field work. Taaras and Swasti secretariat helped community members (1.2 lakh) in accessing support worth close to Rs. 68 crore.

An important aspect of these efforts was also strengthening the mental and emotional support during this uncertain and deeply troubling time. *"This experience has given community leaders the confidence that they can take up responsibility and deliver too. We want to use this platform as an example to show the government the importance of bringing the community to the forefront"* says Kallan Gowda, National Coordinator of Taaras.

The CoE was also engaged in the following activities:

1. Orchestrating safe quarantine measures for women. Types of quarantine measures included quarantine centers or other local housing options, aimed at caring for and housing positive but asymptomatic or symptomatic but non-serious cases, adhering to the highest standards of dignity, respect, and privacy, and provide medical (including referral linkages with hospitals) and psycho-social support to those observing quarantine in such facilities. Swasti provided ration kits and camps focussed on the needs and expectations of the trans community. Sensitivity training of healthcare professionals and counselling was provided so as to instil a sense of confidence and trust in the communities. 250 members were vaccinated and several camps were conducted successfully thereafter.

2. Awareness building and education activities in the community surrounding vaccine awareness, COVID-19 symptoms, hand hygiene and safe practices (mask-wearing, social distancing, etc.), respiratory etiquette, etc. These activities were conducted through a combination of home visits and outreach activities, such as WhatsApp campaigns, social media, signage, etc. A webinar for TGNB was arranged by means of a whatsapp chatbot to access PHCs from network providers and we reached out to more than 800 Transgenders and Women in Sex Work (WSW) for primary care support.

3. Supporting marginalized women through the prevention, screening, and addressing of cases of COVID-19. Support included guiding women to register for vaccinations, conducting symptom screening, referring community members to vaccination centers (particularly elderly women), health care facilities, and quarantine centers, and delivering support packages that may include food, medicine, PPE, sanitation supplies, etc. depending on the need identified. More than 3Cr ration and health kits were distributed by NGOS- Swati Mahila Sanga (SMS) and Arogya Deepa as a means to render support to families.

Additionally, two trainings were conducted and around 43 participants from Transgender community took part in these workshops.

4. Testing and screening of the population for noncommunicable diseases that increase susceptibility to complications from COVID-19, including diabetes, hypertension, anemia, and lung health, through the simple point of care tests. Provision of advisory support to individuals who test positive for non-communicable diseases, including information on follow-up care, COVID-19 vaccination, and decision-making to improve their health. In these camps, health kits were provided for Covid Positive cases and 22000 Non-Communicable Disease (NCD) screenings were successfully conducted.

5. Provision of support to the local PHC for improving COVID-19 vaccine demand generation and service delivery. The initial survey provided insights on the needs of PHCs which informed partners' work. We are currently working in more than 60 wards and PHCs across Bangalore urban.

6. Social protection and telecare support. In many households, rents were not paid due to lack of employment due to the economic crisis. Swasti offered Co-operative top-up loans to these families along with telecare support and community surveillance. Swasti also facilitated the access to Government schemes that were available and educated the communities about Social protection schemes.

Other COVID-19 Response efforts

- The Indian government put COVID reaction activities into "mission mode." The *Jan Andolan*, a popular campaign led by India's Prime Minister, Narendra Modi, emphasized the importance of making India's reaction a "people or community-led movement." Every Indian was inspired by his clarion call to confront the pandemic head-on. The first narrative is about a group of teenage volunteers who realized that in order to save their neighborhood from the pandemic, they needed to raise community awareness. In a race against the clock, these volunteers devised creative ways to convey the necessity of the COVID-19 vaccine. One of the most important components of the pandemic was getting accurate information to people in real time. Given the country's tremendous geographical diversity, this was exceptionally difficult. At a time when people were primarily confined to their houses, Community Radio Stations performed an important role in getting accurate information to them (MoHFW).

- Focusing on high-burden districts for the elimination of mother-to-child transmission of HIV, based on the most recent ANC survey data, which showed a prevalence of 0.2 percent, and intensifying prevention programs, including targeted interventions for key populations such as female sex workers (1.56 percent HIV prevalence), prison populations (2.04 percent), transgender (3.14 percent), and people who inject drugs, were used as examples of ways to speed up the AIDS response.

- People living with HIV (PLHIV) receive antiretroviral therapy (ART) in two ways: it slows disease progression and helps PLHIVs live productive lives, and it lowers viral load to reduce disease transmission and prevent new infection. "When Covid-19 was first reported in India, we got together with NACO, civil society, and PLHIVs to plan for contingencies like the Wuhan lockdown, to mitigate the impact on critical HIV services like ART delivery and harm reduction," said Dr Bilali Camara, Unaids Country Director for India and a trained medical epidemiologist. The Joint United Nations Programme on HIV and AIDS (UNAIDS) is the acronym for the United Nations Joint Programme on HIV and AIDS. By March, all states had switched to a three- to six-month supply of ART medications instead of a monthly supply. Instead of monthly supplies, we started giving them six-month supplies so they wouldn't have to return to a facility and risk exposure to Covid-19, or spend money on transportation and other expenses" says Dr. Camara. State Aids Control Societies swiftly implemented this across India (The Hindustan times).
- The Government of India's Ministry of Rural Development is implementing the Deendayal Antyodaya Yojana – National Rural Livelihoods Mission (DAY-NRLM), a flagship anti-poverty program aimed at bringing a minimum of one woman member of each rural poor household into the Self Help Group (SHG) network, ensuring their financial inclusion and support in livelihoods generation activities. DAY-NRLM has formed around 66 lakh women SHGs with 7.14 crore women members as of July 2020.

- The Indian government has announced a number of steps to solve the crisis, ranging from food security to additional cash for hospitals and state governments, as well as sector-specific incentives and tax deadline extensions. On March 26, a series of economic relief measures for the poor totaling over 170,000 crore (US$23 billion) were launched. The Reserve Bank of India launched a series of actions the next day, making accessible a total of Rs 374,000 crore (US$50 billion) to the country's financial sector. The World Bank and the Asian Development Bank have agreed to provide assistance to India in the fight against the coronavirus pandemic (WorldBank, 2020).

- **Rapid Rural Community Response (RCRC)**, a network of more than 60 organizations, focuses on rural livelihood projects, giving assistance and support to rural communities and distant villages affected by the pandemic. Major delays in the transmission of blood samples were noted by the RCRC, as well as a fair amount of resistance in communities to follow quarantine regulations. Fear of contracting Covid-19 was evident among the general public, as was a shortage of diagnostic facilities and critical treatments, resulting in additional transmission. Furthermore, communities were concerned about being locked down and losing their sources of revenue and livelihood.
    - Vaccine hesitancy was observed as was inadequate vaccination infrastructure and the lack of hospital facilities to accommodate patients. Moreover, they observed a trend in reverse migration coupled with limited monitoring and testing systems. Based on these findings

and observations, they recommended mitigation as the primary strategy to contain the virus and prevent it from spreading further.
    - RCRC also works with other organizations and NGOs. Shrishti, for example, works in Odisha to help marginalized people through health, education, livelihoods, technology transfer, and policy advocacy.
    - Srishti field teams have been conducting awareness campaigns as part of their COVID-19 response activity, emphasizing the necessity of maintaining a safe distance and frequent hand washing with water and soap as the first line of defense against the coronavirus disease. With its #RCRC partners Centre for Youth and Social Development (CYSD), Gram Vikas, and Harsha Trust, the Srishti team use WhatsApp to spread information on new rules and updates from the government about COVID-19 on a regular basis.

- **Covid-19 Resource Collaborative** is a collaborative that intends to bring together resources from across the social sector on how we are all responding to the Covid-19 crisis. They conducted a Crisis management conference various important topics such as:
    - Financial Management for Covid-19 response (Aria Advisory)
    - Team management during the crisis (Arthan Careers)
    - Examples of what other NGOs are doing to tackle challenges through three kinds of responses: *mitigate, adapt* and *pivot* (Sattva consulting)
    - The possible challenges that NGOs will face during the crisis and the aftermath; and how NGOs pivoted their programs to provide support and relief to their beneficiaries (Acumen)
    - Resilience & Funder Management (Dasra)

- Moreover, there have been efforts to augment healthcare delivery with the help of home care. For instance, Deloitte has piloted an idea with the Government of Haryana state in India that could be a solution to under-investment in public health facilities – and a silver lining to the pandemic. A uniquely Indian approach was developed in collaboration with the Haryana government, Dr Srinath Reddy of the Public Health Foundation of India, and Dr Dhruva Chaudhry of the Post-Graduate Institute of Medical Sciences to provide support and home care to those in the Karnal district with mild to moderate COVID-19. This concept freed up local hospitals to focus on the sickest patients.

- **Private sector engagement**: Shadowfax, an IFC investee in India that began as a logistics platform for quick, last-mile delivery service six years ago, has expanded its mission to include ground services support for vaccine shipment. Shadowfax's on-the-ground cold-chain readiness with refrigerated vehicles for vaccine delivery, as well as a partnership with SpiceXPress for rapid cargo movement, can help with this. Moreover, PickMe driver partners like Deepthi were able to keep their jobs once the company switched to an emergency delivery fleet, which was a huge relief for her because she is the sole provider for four family members. Deepthi and other PickMe driver partners have provided cooking gas to consumers in addition to hospital drop-offs.

Chapter 4. Discussion and conclusion

Inadvertently, the COVID-19 pandemic has exacerbated existing systemic socioeconomic and gender disparities. The public health measures have had a significant impact on the urban poor, resulting in job losses, driving individuals to consider returning to their original lands despite the hazards, and causing a deep hunger crisis and uncertainty for thousands of others who choose to stay. In the previous few days, the federal, state, and municipal governments have taken a number of steps to ameliorate some of these effects, including food relief, cash transfers, and the establishment of camps for migrants and the homeless, among other things. However, the situation faced by many kinds of urban poor is multifaceted, and these interventions can only help to a limited extent. The consequences of failing to include the urban poor in pandemic preparedness measures could be far too costly for the country, thus it is critical to recognize and respond to the approaching humanitarian disaster as well as the health crisis.

The crisis experienced by the diverse categories of urban poor is however multidimensional and is only partly mitigated by these measures. The implications of a failure to take the urban poor along in the measures to deal with the pandemic may be far too costly for the nation and hence, it is necessary to recognize and respond to the impending humanitarian crisis as much as the health crisis. Research suggests that measures of containment drawn from developed and high- income countries based on an isolated health- centric perspective are possible to sustain only for a

limited period in countries with large proportions of migrants and urban poor. These strategies also demand a very high capacity of the state to deliver on the ground on multiple fronts ranging from public health to services including vaccines to welfare and coordinated action between multiple units.

The 'urban' areas in India are found to be grossly wanting in this area, especially in relation to the urban poor located in informal settlements or otherwise. All indications suggest that the dense, informal settlements are vulnerable to the fast, uncontrollable spread of the pandemic which may then also be drawn out for a much longer period with significant devastation in terms of lives. Further, accessibility to vaccination and any hesitancy issues or demand-side constraints need to be better understood to scale up vaccine drive and ensure equity.

Another area that can illuminate unique considerations for healthcare delivery and encouraging utilisation is to critically analyse the impact of COVID-19 on communicable and Non-communicable diseases (NCDs), which has an indirect impact on the women apart from men and children. Besides this, there is a dearth of qualitative research around the psychosocial well-being of frontline workers following the pandemic. WHO has stressed upon the need to investigate the impact of mental and physical health of healthcare workers and further research in this field will be fruitful.

Reflections and limitations

The strength of this research lies in the amount and quality of the interviews, FGDs and surveys, and the calibrated response efforts of the CoE aimed at providing high impact services directly to communities through collaborative partners. The data was collated from various partner institutions through robust knowledge management targeted towards marginalized women. However, the information around trafficked women and other informal workers was difficult to find due to the difficulty to reach out to informal workers, and investigating the access of health services including vaccination. Moreover, there is paucity of reliable data available, and the data available remains to be largely inferential and anecdotal.

Policy recommendations

1) Even Though the supply of mental health services increased to match the demand quite evidently in the second wave, the utilisation and uptake has still been considerably low. In order to address the bottlenecks in mental health management and to combat the increase in incidents of gender based violence, there needs to be a more robust Technitisation of mental health whilst empowering women to use the services. It is imperative that non-verbal clues are identified and community health workers are trained to recognize signs of gender based violence and offer additional support to the victims and their families.
2) Segmenting populations and providing group based counselling can improve access and further funding to the sector can increase the utilisation of telecare services. The lack of

accountability and transparency in governance can lead to poor health outcomes, and should be combated with results based financing and appropriate grievance and redressal mechanisms. Further a review of labour laws and legal frameworks within India should be done to recommend systemic changes, given the changing scenarios and challenges related to labour rights and welfare.

3) Mazza et al. (2020) emphasize that there is an urgent need to mobilise efforts for further prevention of domestic violence using a trained multidisciplinary staff including psychiatrists, psychologists and social and legal services. Moreover, ensuring an accurate assessment of diverse domains of abuse is an urgent need along with ensuring engagement of men with women to understand both perspectives. We strongly recommend utilising the Nirbhaya funds in order to mobilise legal resources, shelter, counselling and developing protocols to strengthen support to trans women, migrant women, disabled women and ensure sustainable recovery. We recommend a bottom-up approach, actively engaging with grassroot organisations, NGOs, SHGs, Anganwadis/ICDS to mobilise and further help in dissemination of information. Additionally, legal advice should be accessible and available to marginalised women in order to empower them.

4) Another area of focus should be integration of gender impact assessment processes and tools in emergency response management which cannot be done in the absence of a proper system of gender mainstreaming. A robust gender and intersectional analysis involving women in decision making can further aid in prevention and response to COVID-19 (Ramos, G., 2020). The LGBTQ+ community faces discrimination and has been excluded from the Indian healthcare system. They also face a higher prevalence of mental ill health in comparison to the rest of the population. Targeted interventions to promote mental health and resilience can go a long way improving uptake and de-stigmatisation. A moral enquiry of gender based inequalities and health inequities can bring light to ethical issues related to SRHR and social justice to amend reproductive behaviours and revamp systemic challenges.

5) There are a lot of missed opportunities related to educating the medical community for humanising people with disabilities. Institutionalisation for women with disabilities has been associated with abuse and violation of human rights. We need to encourage people to work with disabilities and involve PwDs in a professional manner. Sensitising the medical community and training frontline workers so they have appropriate knowledge is critical and more research into intersectionality can provide fruitful insights to creating enabling environments. Inclusive systems should include social protection schemes with better approaches to health insurance, larger system coordination, and disability allowance.

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Annexure

Glossary

S.No	Term	Definition
1.	Gender-affirming care	The processes through which a health care system cares for and supports an individual, while recognizing and acknowledging their gender identity and expression
2.	Naturalistic	An approach to sociological research that assumes that there are multiple views of reality influenced by the social context and environment in which a situation is viewed.
3.	Social Protection	(A) set of policies and programmes aimed at preventing or protecting all people against poverty, vulnerability and social exclusion throughout their life-course, with a particular emphasis towards vulnerable groups - UNICEF
4.	Deadnaming	Deadnaming is the use of the birth or other former name (i.e., a name that is "dead") of a transgender or non-binary person without the person's consent.
5.	#COVIDActionCollab	COVID Action Collaborative has united over 300 partners to provide relief, recovery and build resilience among the most vulnerable communities. The collaborative consists of organizations and networks working together to support these communities during the period of crisis and enable them to secure their future
6.	Invest for Wellness	Invest for Wellness (i4We) is a system innovation in primary healthcare, which combines health and wealth interventions, and focuses on wellness for the poor in an affordable, quality assured and scalable way.
7.	Covid-19 Resource Collaborative	This is a collaborative initiative to bring together resources from across the social sector on how we are all responding to the Covid-19 crisis.

8.	Rapid Rural Community Response to COVID-19	Rapid Rural Community Response to COVID-19 (RCRC) is a coalition of more than 60 organisations. RCRC member organisations serve over 1.6 crore people in over 110 districts of 15 states. The Working Committee (WC) is the leadership team of 10 senior CSO leaders
9.	Taaras	Taaras Coalition is a national platform in India for marginalized women and their community organizations. With 107 CBOs and a presence across 12 states in India, Taaras aims to ensure access to rights for women in sex work.
10.	Call4Svasth	Swasti and partners of the COVID Action Collaborative have built an integrated digital platform, with hyper-localized, community-led, cost-effective helplines run by trained nurses, nurse-aide-callers, front-line counselors, and social protection officers.
11.	ICDS	Integrated Child Development Services is a government program in India which provides nutritional meals, preschool education, primary healthcare, immunization, health check-up and referral services to children under 6 years of age and their mothers
12.	TLD	Tenofovir (TDF), lamivudine (3TC) and dolutegravir (DTG) is a fixed-dose combination antiretroviral medication used to treat HIV/AIDS.

List of partners (engaged/ in pipeline)

S.N.	Partner Name	Brief description
1	**Swathi Mahila Sangha**	Swathi Mahila Sangha is a women led community based organization which has a 13,000 member base in Bangalore Urban District. The mission of the organization is to build capacities of women in sex work by enhancing their knowledge, skills, and attitudes in order to safeguard their lives and livelihood.
2	**Arogya Deepa Swasthya Samiti**	Arogyadeepa Swasthya Samiti is a collective/federation of Swasthya Groups (Self Help Groups) of women in Bangalore district of Karnataka. SHGs and its women members of Arogyadeepa Swasthya Samiti require a variety of support and continued services for improving their health and wellbeing.
3	**Janadhanya**	GREEN Foundation initiated the formation of Janadhanya, an association of farming community members who are empowered to work collectively to conserve agro biodiversity, provide market linkage for farmer produce and promote organic farming, among many other objectives.
4	**Sanjeevani Kalyan Samiti**	Sanjeevani Kalyan Samiti is a registered women's organization with a current reach of over 700 families in Gurugram. SKS works towards improving the health & well-being of the commodities and its members.
5	**Jagriti Mahila Sangha**	Aids Jagruthi Mahila Sangha is a non-profit organisation, established in 2000 that works primarily in the domain of Education, Right to Information & Advocacy, Food & Nutrition, Business & Finance, Minority, Employment, Legal, Technology, Human Rights and Health. Its primary office is in Vijaypur, Karnataka.
6	**Taaras Network**	Taaras Coalition is a national platform in India for marginalized women and their community organizations. With 107 CBOs and a presence across 12 states in India, Taaras aims to ensure

		access to rights for women in sex work.
7	**EIM Kota**	EIM works with multiple partners pan India on multiple projects such as preventing blindness amongst children, holistic health care, prenatal vitamins to disadvantaged mothers.
8	**National Coalition of People Living with HIV**	NCPI focuses on health activists to strengthen care, support, treatment, and prevention response of the country by improving the quality of life of individuals and families to control HIV.
9	**Gujarat State Network of People living with HIV/AIDS**	Gujarat State Network of People Living with HIV/AIDS (GSNP+) is a community based non-profit making organization formed by & for people living with HIV/AIDS. GSNP+ strives to improve the quality of life of people living with HIV/AIDS through various activities.
10	**Love Life society**	Love Life Society works for the health rights and empowerment of marginalized groups by providing HIV related facilities to the TG/MSM who suffer from HIV/AIDS by linking them with health and social protection services.
11	**Uttar Pradesh Welfare for People Living with HIV/AIDS Society (UPNPplus)**	Uttar Pradesh Welfare for People Living with HIV/AIDS Society (UPNPplus) is a community based, non-profit organization representing the needs of people living with HIV/AIDS (PLHIV). UPNPplus promotes holistic and participatory approach for community empowerment and gives priority to PLHIV especially women and children.
12	**BENGAL NETWORK OF PEOPLE LIVING WITH HIV/AIDS (BNPL)**	Bengal Network of People Living with HIV/AIDS (BNPL) is a non-governmental organization based in Kolkata that focuses on advocacy. This state-level network spreads awareness of the disease for better understanding and less ostracism so that those infected can receive treatment.
13	**Network of Maharashtra People (NMP+)**	Network of Maharashtra by People Living with HIV/AIDS (NMP+) is a community based organization formed by people with HIV to improve conditions for positive people.
14	**All India Artisans and Craftworkers Welfare Association (AIACA)**	The All India Artisans and Craftworkers Welfare Association (AIACA) mobilizes multi stakeholder collaboration for promoting handicrafts in India and empowers marginalized women communities through hand skills. Key initiatives include: a) Policy Advocacy

		b) Enterprise Support Programme c) Sustainable Livelihood Development
15	**LabourNet Services India Pvt. Ltd**	LabourNet is an enterprise that enables sustainable livelihoods for disadvantaged men, women and youth in urban and rural areas. The three-pronged engine integrates social and business impact by bridging the gaps in Education, Employment and Entrepreneurship.
16	**Traidcraft Services India**	Traidcraft is a mission-based social enterprise working towards trade justice and climate justice, supporting businesses looking to establish sustainable, fair and inclusive supply chains. They offer a range of strategic consulting and advisory services backed by organisational capacity to support on-ground execution.
17	**Creative Dignity**	Creative Dignity is a movement that has brought together diverse creative producers, practitioners, and professionals to energize the ecosystem that Indian artisans need in this time of COVID-19 and post-COVID-19 impact. The focus is to provide relief, and rejuvenation to the artisans in a bid to ensure their sustained prosperity.
18	**Thamate - S3IDF Collaboration**	Thamate (literally a Dalit Drum) is a CBO working in Karnataka with the *madiga* community and other most marginalized communities for the eradication of manual scavenging practice and comprehensive development of the community.
19	**Federation of Rickshaw Pullers Association**	Federation of Rickshaw Pullers Association (of India) fondly known earlier as FoRPI, is a movement, a registered federation, set in action by the like minded trade unions, social and cooperative organizations to lend a hand to decision-makers and the civic structure.
20	**Maharashtra Hawkers Federation**	MHF is a Street Vendor Association with an overall reach of 2 lakhs under the National Hawkers Federation.
21	**Head Held High Foundation**	The Head Held High Foundation works to tackle the most persistent problem of poverty. Poverty alleviation efforts in these communities include assessment, social protection, financial inclusion, training, skill building, livelihood creation and more.
22	**PHIA Foundation**	PHIA Foundation works to tackle poverty across India across multiple themes such as reducing inequality, humanitarian and climate change, sustainable livelihood, essential services.

23	**UDYAMA**	Udyama primarily aims towards strengthening and building capacities of local communities towards rejuvenating human, ecological and economical capital and making best use of available resources, working directly with the community and also with partner Development Organisations.
24	**Sara Seva Sansthan Samiti**	To preserve natural systems, strengthen the communities for positive social changes by delivering information, services and advocacy. Holistic development of community with people's participation.
25	**Centre for Migration and Inclusive Development (CMID)**	CMID is an independent non-profit that advocates for and promotes social inclusion of migrants in India. Our priorities include designing, piloting and implementing programmes for mainstreaming as well as improving the quality of life of migrants. CMID's work also includes technical support in the formulation, refinement and implementation of strategies, policies and programmes that promote inclusive and sustainable development, in collaboration with diverse state and non-state actors.
26	**RubanBridge Pvt. Ltd. (1Bridge)**	1Bridge is a village commerce network present in 6000+ villages of 60 districts across 6 states through a 7000+ network of 1Bridge Advisor(1BAs) who are our local trusted entrepreneurs. By enabling their integration into the digital world through our tech platform, building social capital in their village communities, and creating opportunities to generate additional incomes consistently, we make it compelling for the 1BAs to stay & grow as part of the 1 Bridge network.
27	**Ankur Yuva Chetna Shivir**	AYCS work spans across the following thematic areas: Child Rights Community organization Education Environmental Health HIV/AIDS Health Housing & Tenure Rights

		Micro finance & Credit Reproductive & Child Health Water & Sanitation
28	**People's Action in Development**	PAD is a non-profit making and socio-economic development society involved with the tea garden workers and Adivasis/Tribals for enhancement of the working class who are in penury, social exclusion and experiencing countless discrimination every moment, everywhere.
29	**Institute of Social Responsibility and Accountability (ISRA)**	ISRA's primary objective of empowering the marginalized citizens by creating awareness about the various welfare schemes formulated by the Govt. to enhance their living conditions.
30	**Association for Advocacy and Legal Initiatives (AALI)**	AALI is a feminist legal advocacy and resource group addressing women's issues through a rights-based perspective. AALI addresses these issues through Advocacy and Networking programme, casework and legal support, women's leadership program and resource centre.
31	**Bullock cart Workers Development Association**	BWDA works for a poverty free, equitable, prosperous and sustainable society across thematic areas such as women empowerment, education, financial inclusion, WASH, Child Welfare, Health and Well being etc.
32	**Voluntary Health Association of Tripura**	Voluntary Health Association of Tripura(VHAT) was formed as a state level net work NOGs and CBOs, with the aim to promote the Health, Elementary Education & Environment status of the state through policy level advocacy and conceptual level intervention by capacity building. Voluntary Health Association of India, New Delhi, was one of the main inspirations to form this organization as State federation of Voluntary Health Association of India for the state of Tripura.
33	**Jai Odisha**	Jai Odisha works across multiple thematic areas such as women empowerment, access to health, food, service for the elderly amongst others.