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Interpersonal Communication on Sexual and Reproductive Health in COVID-19 Era: An Analysis of Adolescent Girls in Urban Village of Delhi

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Abstract: ***Adolescents are the people who are considered an important population for the development of the country. Despite this fact, youth health is one of the important public health problems in India over the period especially in the time of COVID-19. Adolescence is the most sensitive age group where the body as well as the mind goes under rapid changes which getting effected by lockdown periods deficiently. The present study will explore interpersonal communication regarding sexual and reproductive health during the lockdown. This is an important topic to be discussed because it is hardly talked by scholars in the current scenario. During this quarantine time, we have seen there is a communication gap between young ones and their parents, therefore; there is some personal health problem face by young boys and girls due to not sharing problems with anyone. Sexual and reproductive health is a very sensitive health issue in which elders should understand them at the right age. Therefore; the present study looked into the physiological changes of the body or sexual and reproductive health changes in the age of puberty during the lockdown in the urban village of Delhi. The objective of the study is to examine what is the first experience of their body changes and what kind of advice they got from their elders which help them out from difficult situations. Many times it was observed that; adolescent girls and boys feel free to share their age of puberty to their friends and peer group but at the time of lockdown the communication gap affecting the mind.***

Keywords: Interpersonal Communication, Sexual and Reproductive Health, COVID-19, Urban Village, Adolescent Girls

1. Urban Village Definition

Before going ahead we must understand the concept of the urban village, "The urban village is an area occupied by the urban community that lives and resides in the urban environment as a group or in a certain group which was formed or naturally due to urbanization. The formation of the urban village concept is based on two circumstances, which is due to the effects of urbanization and the result of the urban village formation concept brought about by the planning and strategy of redeveloping the urban area"[1]. In other words, we can say it is an urban settlement of houses in a congested form where people have to live in a surrounding which is not preferable health-wise especially in the growing age. But when the income and educational opportunity become more important people have no choice over socio-economic status even in the pandemic era. The study is based upon various sexual and reproductive health issues and challenges which need to address to strengthen the health of the adolescent during the lockdown. Urban village crowd found to be very diverse in terms of living and cultural practices, during fieldwork it was observed. Some communities have a very authoritarian rule and some are least concerned rule over the age of puberty. Especially among the South Indians families follows their cultural practices even in one-room setup. Therefore study wants to bring out the issue of sexual and reproductive health of adolescent health at the age of menarche.

The objective of the study is to examine the issues of sexual and reproductive health regarding their interpersonal communication during COVID-19. A present study has taken the WHO definition of adolescent age group between [10-19] years old. The purpose of the study is to endeavor to understand the condition of adolescent girls in terms of their sexual and reproductive health, hygiene, and lifestyle. A study conducted in the urban village Harijan Basti, Vasant Kunj, New Delhi so, "some of the pertinent issues to be looked into whether young especially unmarried girls face any difficulties in their parents' home in maintaining good health. What are the socio-cultural factors that influence sexual and reproductive health as they lived in an urban village? Both qualitative and quantitative data were used for the collection of the sample. The data source used an interview schedule, key informants schedule, and group discussion. Only 199 households selected for the semi-structured interview to understand the condition of adolescent girls in terms of their sexual and reproductive health and hygiene as well as lifestyle.

According to WHO, 1.1 million adolescents die each other with a lack of health facilities[1]. They are likely to risk health majorly due to lack of hygiene aids and no sexual and reproductive guidance. For girls, the menstrual cycle is the major part of their body change so there should be proper communication from elders regarding its care practices and hygiene practices. Lack of knowledge regarding sexual and reproductive health can lead to serious health problems for youths. It was also seen that early marriage and risk of sexual and reproductive health problems increasing day by day, especially for young girls. Evil practices of child marriage in India making youths poorer in health as well as a blockage in other development of the youth as a whole. Early marriage creates many other problems related to sexuality and reproduction such as heavy white discharge, bank pain, heavy bleeding during the menstrual cycle,

[1] https://www.who.int/health-topics/adolescent-health/#tab=tab_2

itching, and irritation around the vagina [2]. Youth mothers suffer from undernutrition, anemia, underweight, unwanted early pregnancy, postpartum hemorrhage, which leads to maternal and child death. To prevent the above serious health problems youth girls should feel free to share their age of puberty to their parents, elders, and peer group with proper medical guidance and health checkups. Care practices, proper communication from elders, and hygiene practices should start at the time of menarche. For more understanding of sexual and reproductive health problems, interpersonal communication with family members or other close friends is necessary.

Interpersonal communication on Sexual and Reproductive Health:

For more understanding of sexual and reproductive health problems, interpersonal communication with family members or other close friends is necessary. In *Harijan Basti*, there is a lack of functioning and regulation of Anganwadi center but sharing health problems is very necessary and it is not bad because sexual and reproductive health problems can be increased with the lack of proper treatment and this can leads to STD/ RTI. There was no such information and awareness regarding HIV [Human Immune Deficiency Virus Infection]/AIDS [Acquired Immune Deficiency Syndrome]. The majority of the respondents did not hear the name of the disease, and hearing for the first time. The question of why not sharing with anyone in the matter here which shows they are not aware of its negative symptoms. People aware of the COVID-19 pandemic since it is novel in public health subjects they know about the importance of wearing masks, gloves washing hands, and apply sanitizer for unknown things. But no one knows about the disease that has been going on for years because it is related to personal health and attached to social stigma. We are learning lots of existing gaps and disproportional impact of public health situation across the state. But one of the already marginalized areas is the urban village wherein the name of social distancing people is giving more importance to their work. In our country, people give importance to health only when it becomes serious like COVID-19 since it is a life-threatening disease so they have taken safety precautions as much as possible. But sexual and reproductive health is also one of the important topics in which we can control by just talking. Therefore issues like pregnancy, menstruation, and interpersonal hygiene can be easily solved by simple conversation within the family which helps to fill the gaps among adolescents.

The health problem of urban poor and rural village seem similar in terms of poor health outcome, people living there feel isolated from basic health care. However, "In India, research and programmatic attention to women's experience of reproductive tract infections RTIs, including STIs, has increased considerably through the 1990s and 2000s" [3]. The Study on "*Treatment Seeking for Symptoms of Reproductive Tract Infections among Young Women in India* by Shagun Sabarwal and K. G. Santhya analyze the sexual and reproductive situation of young women in India and argued that, "health care providers to develop appropriate strategies to reach younger, as well as unmarried, women". Thus, the [4] strategy needs to revisit its program and implementation for youth health in a new way with the context of COVID-19. There are many studies on young health where it was discussed that India's young population needs a health care in which it can look out other issues like economic background, cultural aspects, family responsibility, and social aspect as well as a personal problem. Many places it was observed that there are communication gaps within the family regarding the sexual and reproductive matters. Therefore, there should be an "Informal counseling services through peer educators [both male and female] enable adolescents to seek further information on issues of sexuality, safe, practices, and reproductive health"[5].

Therefore the study brings out the issue of sexual and reproductive matters and tries to correlates with the issue of interpersonal communication and how much it was relevant for the research where people practicing social distancing norms. Table 1 reveals that less than one third [26.63%] respondents are having normal pain and very few [11.56%] respondents visited doctors. They share this information while conducting an interview. It was also noticed over that time, first sign and symptoms of their menstrual cycle majority of the young girls faced isolation from a family member. Many of the respondents said they felt so sad and depressed about what is happening with them and there was nobody around to tell the exact reason for it. One respondent said that;

"*It was heavy bleeding with more than ten days; than my family took me clinic".*

We can notice here treatment is only taken when there is an emergency otherwise it was ignored by family members because according to elders menstrual cycle is a normal phenomenon why we need special attention and care we prefer home remedies rather than taking medicines. Given advice clearly shows the seriousness of treatment for adolescent they believe since it is curable by own no need for visit or counseling. It was articulated by a group discussion that;

"*This happens to every girl, when we understood ourselves, they will also understand ourselves slowly.*"

Table 1: Distribution of Respondents according to their experience of first physiological change

First Menstrual Cycle	Frequency	Percentage
Normal pain	53	26.63
Normal pain with leg cramps	48	24.12
Heavy bleeding	34	17.09
Long duration bleeding	12	6.03
Visit doctor	23	11.56
Normal	29	14.57
Total	199	100

Source: Fieldwork

Similarly in Table 2 reveals that most of them [79.40%] of respondents share their first physiological change with their mother, few [13.07%] share with elder sister. Table 3 describes the kind of advice received by respondents were less than half [49.25%] respondents received advice like "now you have grown up" and very few [19.60%] received no advice. Instead of advising proper guidance for menstrual

care and hygiene practices, elders are more concentrated on telling respondents you are grown now. Physical development is the normal process in the human being which can identify but some internal changes inside the body silents the adolescents they don't know about her own body. In this regards one key informant articulated her statement as;

"*Nobody was going to tell us because all this is done with the people confined. Whatever we learned, from ourselves with age. We got married early, we would have understood more quickly. Some things seem to be right behind in closed doors, why do you need to talk in public.*"

Table 2: Respondents first Physiological Communication with their Family Members

Sharing first physiological changes	Frequency	Percentage
Mother	158	79.40
Elder sister	26	13.07
Aunt	3	1.51
Grandmother	10	5.03
No-one	2	1.01
Total	199	100

Source: Fieldwork

In the same context according to some group discussions by local women they stated that the menstrual cycle and other physiological changes of the body happen with every girl even we have faced the same so why it is new for now. The only difference is that we used to get married before the legal age of marriage. For them, it is a very normal occurrence of the body that should not share with anyone, and if there is any kind of emergency home remedies are the best. Regarding interpersonal communication on the health issue, Indian youth received less friendly talk and communication with their parents and elders. There is one study that shows that "India is a country where an overwhelming majority of its people, including adolescents, live in peri-urban and rural areas. In Indian society, especially in peri-urban and rural areas, reproductive and sexual health matters remain a hidden agenda and people feel uncomfortable discussing these issues openly. To develop better sexual and reproductive health, both government and non-government organizations [NGOs] have to be mindful of the needs of a large number of adolescents in peri-urban and rural areas".[6]

Table 3: Advice from the Family Member received by Respondents

Kind of advice	Frequency	Percentage
Do not go out	33	16.58
Do not play with boy	25	12.56
Do not jump and run	4	2.01
Now you have grown up	98	49.25
Not Received	39	19.60
Total	199	100

Source: Fieldwork

At some level, people believed that it is a matter of women-only and not related to men. It was found in the field that personal health considers being a women-centric and hardly father and brother take any initiatives. It was observed by the one married respondent in the field she articulated that;

"once we are dependent on in-laws family we cannot express our choices. I never complain even before my marriage and now I am with my husband family, we are so young we have to follow their instructions. Whenever I need any health emergency I have to talk to my mother in law first. I do not want a child but at the age of 19, I am a mother of one child. My husband is not doing anything, so we have to be quiet and follow them. Sometimes it is very difficult to share a toilet in a big family but we have to adjust."

Poverty, Living Condition, and Personal Health Care:

In Table 4 represented the Personal care affected by another family, where more than one third [37.69%] respondents said they are having problems with other family members. And more than half [62.31%] respondents said they never have any kind of problem with other family members. The problem of personal care is the issue related to hygiene and sanitation practice, if there is less room available in the house with more people then difficulties would be faced by young girls while taking pads/cloths [a]. Some young unmarried girls who share their one-room house with mother -father and brothers, they faced many problems during their menstrual cycle such as taking pads/cloths from cupboards, if suddenly heavy bleeding comes at night. Feeling uncomfortable to take pads/cloth immediately and staining tension on bed and clothes. In the case of married girls, they face fewer difficulties in sharing one room with their husbands. However, bathrooms are on a sharing basis it is very difficult for them to use at night sometimes they complain about electricity and water shortage. But the other hand landlords complaints that;

"Before taking the rent, they say only two people will stay, but when they start living, they call the whole relative slowly. So how we will arrange everything for their relatives as well? However, we allow and all these people live in the same room with five to six people, imagine how they would live in a small space?"

Unlike one room couples are living partners, but if something occurs during COVID-19 it is difficult for them to get home quarantine facilities. Secondly, houses are closed with each other in an urban village, with very few possibilities of fresh air and sunlight. People who live here are more dangerous in the Corona era[2], they have sharing toilets and bathrooms which can multiply the Corona cases. As per the current record of Corona cases in India, it is 1.86 million confirmed cases and in Delhi, it is 1 lakhs 38 thousand total which life is threatening[3]. According to the World Health Organisation (WHO), the majority of the people showing asymptomatic signs after infected from Coronavirus[4]. As we have seen in this paper majority of the population lives in one or two rooms accommodation thus the chances of disease transmission at a high level with asymptomatic patients. The urban village always treats as a

[2] https://www.financialexpress.com/opinion/the-coronavirus-lockdown-and-indias-urban-vulnerables/1915316/.
[3] https://www.google.com/search?client=firefox-b-d&q=latest+corona+cases+in+delhi.
[4] https://www.healthline.com/health-news/even-asymptomatic-people-can-spread-covid-19-within-a-room.

neglected area for the universal health care system in India. It was compliant by many residents in the study area that Anganwadi Centres are not functioning well. They just do the registered entry for the children's mid-day meals and medicines distributed for women. It was articulated by the married pregnant respondents during a conversation about Anganwadi center;

"*We never get any medicines from Anganwadi Centres. They only do it for the local residence we are migrated they never include us. There are three Anganwadi Centres in this locality and it was run in the home only with upper-caste ladies who have a good connection with Nigam Parshad. The monthly supply for Anganwadi Centre comes for us but we never get it. Every day they give Khichdi for kids although the weekly food menu is hanging on their wall. We never had any health counseling and friendly clinics for adolescents in the community. They never give any stationary for children and no weekly supplement given to us. They even never distributed sanitary pads and Tetanus Toxoid Injection (TTI) for pregnant mothers*."

However, on the other hand, the Anganwadi centers say in their response when researcher cross-checked about the given information by the respondent they told;

"*They never trust us; they want to take medicines from private clinics only. We do our duty with honesty. We have every record you can check and ask to our head office in Mehrauli district. Once we went to discuss the idea of family planning and contraceptives uses they told us, they brought all family planning medicines from village Anganwadi Centres only (Home Town*). *How we will convince them they are not ready to listen?"*

Thus, these are the contradictions were found in the study area, which is challenging and differentiates them from locals and migrated populations. We can see health care inequality in the filed with the different outcomes from the locals and migrated perspective in the field. Therefore by and large the adolescent girls in the field are less exposure to health care access. However, as researcher health is not just limited to medical treatment and availability of doctors in the surrounding where we live. It is beyond medical aids were the first step of adolescent girls taken with her understanding. She must know her own body since the age of puberty. Therefore not just health but education, socio-economic flexibility, and personal freedom play an important role in adolescent girls. The first physiological changes and communication within the family are not just predetermined with how to change pad/cloth. The concept of menarche should know by her at the age of 10 only for the preparations of mental, social, and physiological transformation from childhood to adulthood. The above possibilities can be adopted by each girl when not just her family members but the community and Anganwadi Centres take to participate to aware of her at an accurate age.

Table 4: Personal Care affected by other Family Member

Presence of other members	Frequency	Percentage
Yes	75	37.69
Total	199	100

Source: Fieldwork

In the above Table 4, we can see more than 50 percent of the girls facing problems that affected her hygiene. However on the other side one-room setup houses do not have an attached bathroom, they have to share with their neighbors which becomes difficult in accessing during night time. These bathrooms and toilets shares by many neighbors therefore the situation of hygiene practice and sanitation becomes unnoticed. During the menstrual cycle young married/ unmarried girls face many difficulties during night and morning time, the problems like inadequate water in the morning time, no night bulb available in the bathroom, long queue in the morning, waiting, and therefore they have difficulties in accessing bathroom or toilets at right time.

The concept of health also talks about the health of wellbeing based on inequality and health outcome. Above description showing the health differences which are caused by the living environment. We can also see the health of each person in the study area varies thus, based on advice and guidance they have given, sexual and reproductive health depends upon that. Therefore urban village showing the almost same outcome of health care practices and these patterns varies from well-settled colonies in the cities.

Table 5: Distribution of Respondents according to their Toilet Facility

Toilet Facility within the room	Married	Unmarried	Divorce	Widow	Frequency (N=199)	Percentage
Yes	**47**	**31**	**0**	**0**	**78**	39.20

Source: Fieldwork

The above Table 5 showing how personal health care practices depends on the toilet faculties in the community, it reveals that less than half [39.20%] respondents have toilet facilities within the house and more than half [60.80%] respondents do not have toilet facilities within the house. Therefore we can easily understand the situation of the hygiene condition and sanitation situation of young girls and rightly say living conditions affecting personal health care. They are poor and low-income status respondents have to live in a place like where people live with less basic facilities without their basic demand from the governance. Low-income effects on living style as well as diet and health too. If the family is big and staying in one room it is obvious that the family faces the under nutritious or low diet which directly affecting on health. The majority of the respondents are home maids they have lots of physical activity all day but; they cannot access sufficient food every day due to low income and family size. In the group discussion, they told the researcher;

" *We have to face many difficulties like the high price of vegetables, milk, school fees, rent, health cost, rations, and other expenses, we cannot able to survive if we move here from another good place, here rent is less we can pay but other places in Delhi it is very high rent. Therefore we have*

to ignore some difficulties for living here because we are poor".

Many respondents told about their work burden and body related problems such as backache, menstrual pain, over bleeding, leg pain, dizziness, and tiredness all day. They have to go for work in the morning so cannot able to eat breakfast which is the most essential diet for the whole day. In the time of Corona which is a life-threatening disease spreading by the body to body but can end with distancing from the persons and hand wash. However, the above illness in the community is only caused by poverty, negligence of government health care, and living in the urban village.

Table 6: Distribution of Respondents according to their Menstrual Problem

Experience of Menstrual cycle-related health problem	Frequency (N=199) Yes	Percent %
Stomach Cramp	139	69.8
Stomach Ache	121	60.8
Weakness	95	47.7
Heavy Bleeding	59	29.6
Blood With Clots Thickness	40	20.1
Pain in Lower Abdomen	78	39.2
Body Pain	41	20.6
Leg Cramp	78	39.2

Source: Fieldwork

Many respondents suffer from menstrual problems in Table 6 describes the distribution of respondents according to their menstrual problems. Table 6 reveals that more than half [69.8%] respondents suffering from stomach cramps, more than half [60.8%] respondents suffering from stomach ache, less than half [47.7%] respondents suffering from weakness, less than one third [39.2%] respondents suffering from pain in the lower abdomen, less than one third [39.2%] suffering from leg cramp and few were suffering from body pain, heavy bleeding, and blood with clots thickness.
Table 6 describes the menstrual cycle-related problems but apart from this when it was observed that how many of the respondents share these problems with others? Table 7 below reveals the problems of menstrual cycle share by respondents, they share less than half [42.71%] with their husband and very few share with their no one.

Table 7: Problems of Menstrual Cycle share by Respondents

Whom do you share	Frequency	Percentage
Husband	85	42.71
Mother in law	13	6.53
Mother	56	28.14
Sister	13	6.53
Aunt	4	2.01
No one	28	14.07
Total	199	100

Source: Fieldwork

Table 6 proved that menstrual cycle-related problems are more among respondents but they share their problems very less according to Table 7 There are some reasons behind this first; is extreme poverty, second; is ignoring tendencies because menstrual cycle and its related problems are common phenomena in girls, third; is they more trust on home remedies or self-medication. Few respondents are suffering from heavy white discharge and menstrual cycle problems, which affect their health badly. Now they are used to their kind of problems and getting more and more ill, weak, and underweight.

In this scenario, there is a need for quality of health services for adolescents with their surroundings at the community level. It can be run by the school, Anganwadi centers, Self Help Groups (SHG), Some Mahila Mandal for *Kishori Swathya* [d], youth-friendly clinics, and parents groups for both boys and girls. They can aware of the adolescent girls about the onset of puberty is begins from the menstrual cycle and how much it is necessary for the body and future reproduction. There is no need of feeling shame and shy about the menstrual cycle always feel free and discuss the problems faces by them. They can also give them knowledge about sexual education does not limit to physical relationships and making babies. Why at this age only hormones changes and pubic hair came to these things they need to know in a friendly manner than only they can share about their first menstrual experience and its related issues. After Sexual and reproductive health there is a need to understand the body of its emotions, physiological and psychological changes which play a very important role in this transformation period from childhood to adulthood. Living in an urban village on how to keep them hygienic during each menstrual cycle is necessary and disposal methods can ease their anxiety.

Socio-Cultural Practices Among Adolescents Girls

Some cultural and religious practices in India have to follow during the menstrual cycle and it is continuing in practice for years. According to group discussions from key informants infield area, they discussed;

"*There are some rules and regulations during menstrual hygiene which is followed by every women and girl, such as for Hindus no worship allowed for four days, avoid temple visit, for Muslims no praying Namaz* [e] *for four days, and sleeping separate, in some religion, there is no entry in kitchen. And after completed four days girls or women have to take bath from top to toe than only they can allow doing their previous work without any restrictions*".

Scientifically if we see women need rest during her menstrual cycle and it should come out from her wish. But socio-cultural norms pushing her to follow these practices without her choice in Table 8 we can see all the religious taboo by married and unmarried girls. The current debate on menstrual leave policy of women in Zomato (Is an Indian restaurant aggregator and food delivery[5]) has to have struggled for their health. Once again menstrual hygiene is waged over the personal issue of women versus patriarchy thought. Many believed that menstrual pain depends upon the body to body and others think women are fragile she cannot compete with men. Menstrual pain is not a normal pain-body needs some rest as well as hygiene, it is not possible to take medicine every time to control pain[6]. At the

[5] https://en.wikipedia.org/wiki/Zomato.
[6] https://timesofindia.indiatimes.com/life-style/relationships/work/Do-women-really-need-period-leave-policy/articleshow/51288163.cms.

workplace there is some discomfort while accessing toilets and changing pads, women might face body shame and discrimination. However, some people connecting it to kitchen entry during the menstrual cycle which is not progressive and biased thoughts for women at the workplace.

Table 8: Socio-Cultural Practice behind Menstrual cycle

Religious Taboo	Married	Unmarried	Widow	Divorce	Frequency (N=199)	Percentage
No worship and Temple Entry	**34**	**29**	**0**	**0**	**63**	31.66
No Namaz/ Kuran Touch	**75**	**29**	**2**	**1**	**107**	53.77
Sleeping Separate	**2**	**1**	**0**	**0**	**3**	1.51
Sitting and Sleeping Separate	**13**	**7**	**0**	**0**	**20**	10.05
Not Cooking	**1**	**3**	**0**	**0**	**4**	2.01
Not answered	**1**	**1**	**0**	**0**	**2**	1.01

Source: Fieldwork

Similarly, the same kind of discrimination and stigma related to menstrual cycle girls facing at her home is more disrespectful. Some respondents explained that

"*We feel ashamed to follow this protocol in front of `younger brothers because they laugh and ask us several questions. Why do we girls have to face all this?"*

Above Table 8 reveals that socio-cultural practices behind menstrual cycle more than one third [31.66%] Hindu respondents did not allow to do worship and temple entry during her menstrual cycle, more than half [53.77%] Muslim respondents do not allow praying Namaz or Kuran touch during their menstrual cycle and very few [10.05%] respondents sitting and sleep separately. Another issue related to the menstrual cycle is diet or food which they eat during this period. Few [14.57%] respondents have some kind of diet regime during these periods and the majority [85.43%] respondents have no specific diet regime during their menstrual cycle.

Table 9: Distributions of Respondents According to their Specific Diet Regime

Diet Regime	Married	Unmarried	Widow	Divorce	Frequency (N=199)	Percentage
Yes	18	11	0	0	29	14.57

Source: Fieldwork

A rich and healthy diet of young girls is necessary during the menstrual cycle because the menstrual cycle and care are necessary for future pregnancy. As we know the menstrual cycle first experienced in a girl's adolescent age some respondents face long and painful periods and some faced fever, sadness, anxiety, weakness, leg cramps, and stomach cramps because of undernutrition and insufficient diet on time. Few girls can maintain their good diet on time but there are many girls which unable to have adequate food on time because of the low income of the family. While taking an interview it was observed that respondents are unaware of the menstrual cycle and unaware of how it is related to their reproductive value even they never ask anyone regarding these matters due to shy and hesitation. They discussed;

"*We have to eat late when everyone eats. If we eat the first, then how will serve them food? And we have seen this since childhood, we do not mind. We do not get to eat sour during the menstrual cycle, we even do not eat chicken and fish our mother says it is not good for your body. When do we ask why? They never give a proper satisfying answer*".

Girls always face discrimination being girls but mostly they feel disturbed when family restricts them during menstrual cycles. The majority of the girls struggles with their duties at the household and kitchen level. During this COVID-19 time when moving out is strict and staying home for good health making them more vulnerable. The post lockdown period in an urban village is very unusual. Staying in a small room and wearing a mask while going out and follow COVID-19 guidelines making them more miserable. They have sharing toilets which makes them more uncomfortable while wearing masks and cleanliness issues causing fear of coronavirus.

Government Policy and Programme for Reproductive and Sexual Health

Much earlier in 1994 "when the International Conference on Population and Development [ICPD] took place, it changed the world's population and development related priorities and emphasized social inclusion, human rights and the importance of addressing the needs and developing the capacities of the young [7]" For the first time youth health became the international issue and putting the strength on compulsory education for adolescents as well as the early marriage issue. Much later in India when the RCH-2 ARSH strategy when came in 2005, it considered adolescent and youth health problems and looking at the issue of health of youth in India. Some problems such as male-female ratio, female literacy, and sexual and reproductive health problems of youth were the major challenge of it. In 2014 National Youth Policy [8] also looking at the issue of youth health and its development issue. According to Union Budget 2011-2012 "Government of India invests more than Rs 90,000 Corers per annum on youth development programs or approximately Rs 2,710 per young individual per year, through youth-targeted [higher education, skill development, healthcare and non-targeted [food subsidies, employment programs[Ibid]". NYP also suggested a healthy lifestyle of youth is necessary for the overall development of youth, especially developing county like India where "Of the total adolescent population 12 percent belong to the 10-14 years age group and nearly 10 percent are in the 15-19 years, age group. Females comprise almost 47 percent and male 53 percent of the total adolescent population. More than half of the currently married illiterate females married below the legal age of marriage. Nearly 20 percent of the 1.5 million girls married under the age of 15 are already mothers [9]".

Even the ill health situation of a young girl in *Harijan Basti* very poor, no government clinics or NGOs are working here to look at the issue of the poor health of young girls. Anganwadi centers run by local females who are working in their homes or some small rooms, there is no emergency facility available for local people, even there was confusion regarding programs and functioning behavior. There was no place for storing material like food, stationeries, medicines, and others that require things for Anganwadi. There is no doubt that these Anganwadi centers are only established for polio and mid-day meal schemes other than there is no such kind of facility available for adolescents, youth, or adult women. According to NRHM [National Rural Health Mission], "to achieve population stabilization and to encourage healthy married life, contraceptive use voluntarily through a comprehensive package of improved accessibility and incentive program. There is near-universal awareness of sterilization for limiting and IUD, Pills, and Condom for the spacing of children among the ever married and currently married women in Delhi. Even similar patterns of knowledge and in awareness of different contraceptives are also found in all the districts of Delhi [10]". Even the ARSH strategy seems nonfunction here; there were no adolescent or youth clinics available in this area even the Anganwadi centers have no registered maintained for adolescent or youth health.

People were aware of the Corona Virus but they do not know about the basic health rights in the urban village. Very few girls know about Ladli scheme and other government health programs such as DISHA [Delhi Initiative for Safe Guarding health of Adolescent] clinic, Kishori Shakti Yojna, RGSAG [Rajiv Gandhi Scheme for Adolescent Girls or Sabla], Balika Samridhi Yojna, girl's child protection scheme, a nutrition program for adolescent girls and supplementary nutrition program. Very few girls admitted that when they were in school they heard about Ladli schemes from their teacher but they said, "we are unable to get the idea about what is the eligible age for filling this form and what is the time when it comes when we can fill the forms, we always had confusion regarding these matters and nobody is there who has correct knowledge of this. On the other side young migrated girls said," Ladli schemes are only for local school girls not for migrated school girls", so, there is this kind of misconception regarding the health care service barrier. Presently three Anganwadi centers are running but helpers of the Anganwadi Centres never encourage local as well as migrated school girls regarding government health programs.

Access and Barriers of Reproductive and Sexual Health:
As we already discussed, except three Anganwadi centers in *Harijan Basti* there is no government clinic or dispensary available for free health care service delivery. There are very few private clinics and local *Bengali Baba* [f] for residence health needs. This is the first reason of ignoring health need on time; second migrated people are new for the city they follow where others go, there are no weekly health check-up camps available for youth, these three Anganwadi centers working in a small congested area they even do not have proper materials like medicines, rations, stationeries and information and knowledge about reproductive and sexual health. Helpers of Anganwadi centers never visit door to door to provide information regarding sexual and reproductive health. They never tell residence about the use of condoms or pills or any contraceptives methods. Less than half of young married suffering from severs white discharge but they never consult any doctors because of the high fees of doctors and government hospitals are very far from their reach. The case study below describes the health care access and barriers of young girls.

2. Major Qualitative observation in the Field

Case Study of the Key Informant: General Profile
Pushpa housemaid 15 years unmarried girl she completed her primary school and daughter of Arjun [40 years] and Bimlesh [53 years] old. She has two sisters and two brothers. Sushma is an elder sister of Pushpa she is 18 years old housemaid earns 7,000/month, she able to complete her high school and after that, she is working as a housemaid. Vishnu is the younger brother of Pushpa he is 14 years old and right now he is not doing anything. Karan is also the younger brother of Pushpa, he is 8 years old and studying in the second standard. The youngest one is Sapna, she is 4 years old and studying in the 1st class. They belong from Hindu [Schedule Caste] and migrated from [Uttar Pradesh] staying in Delhi for four years. The purpose of the migration was income and having a better life for the family. Her father is just a high school pass and her mother is primary school pass. Her mother is also a housemaid and earns 3,000/ month and father is a sweeper and able to earns 7,000/month.

House Hold Details:
They belong from the BPL [g] family, the house was pucca it was one room set up and the kitchen is in the same room. Total house rent is 5,000/months, there is no attached bathroom in the house they have sharing bathroom facilities from other neighbors. The room was very small and congested with no ventilation. There is no water availability so; they have to fill water in the morning and evening. They don't have any kind of vehicle in their house they have a very big family and manage to live altogether in the same room. Earning is less compare to the size of the family. Pushpa and her sisters facing other kinds of problems like difficulties of sharing public latrines, it was always full and queue outside the bathroom and toilet there is no light at night many times they wanted to complain to the landlord but they never listen.

Low Economic Status and Health:
Low economic status responsible for poor health, including Pushpa they are seven family members in the house, they are surviving on 23thausand income per month. Due to low-income status and family size less nutritious food, diet, and standard of living affecting on health which makes poor health status. Pushpa and her daily struggling life make her health poor. She is suffering from severe white discharge and irregular period's problems; she is also underweight, as we know irregular periods, white discharge and underweight can create risk for ill reproductive health for future childbirth. This is the condition of Pushpa. She belongs from a poor family she cannot access health care any time because her poverty becoming a barrier to her ill health. She

also has a problem where she lives, its one-room house which affects her privacy and personal health care.

Access and Barriers of Health Care:
First, she cannot access good health care treatment because of poverty; she cannot take leave from her work again and again because of the fear of being jobless. She cannot take long rest and leave for her health check-up because she said," it all time taking and my mother has some knowledge of home remedies regarding white discharge and irregular menstrual cycle. So the barrier is her poverty and she cannot access health care treatment because there is the unavailability of government health care despite having Anganwadi center at surroundings.

She also mentioned at last, "all we have to manage here on our own, there is neither government health care treatments available nor any NGOs. For bigger health care needs we all have to go far for government hospital? Because we are migrated people nobody cares for us our condition is very poor nobody wants this kind of life.

The above case study describes not just the story of Pushpa but also why her health is poor and she is not able to recover? There is no health care accessibility facility according to population size and household size in this area. The living condition of migrated people are worst neither they can say anything nor move out from anywhere else.

This field was conducted at the time MCD election campaign [Municipal Corporation of Delhi] was going on. Most of the people had misconceptions regarding this interview process; they thought that; this is also a part of the election campaign and the main aim of this interview is vote gain for the particular party. Many people said that they do neither want to give their interviews because of our situation nobody can change nor any new political party. All political party is making false promises to us, it's being a year our health, low living situation, water shortage, and unavailability of basic amenities are same.

Even the Nigam Parsad Smt. Omvati in this area was saying that people living here have no problem regarding health and sanitation, according to her except migrated people all landlords are in good condition. Because she mentioned migrated people first come up with one or two people but after taking room they call their relative and increase their numbers, which cause inconvenience for them as well as for landlords too. She further mentioned that there is no Non-Governmental Organization [NGO] working here right now, everyone is living here is safe and healthy. But actually, the real situation is different by different people; the problem regarding sexual and reproductive health seems neglected here. There is a need to increase awareness regarding sexual and reproductive health issues because they require the quality of health care and health service delivery is missing out by the majority of the people.

3. Conclusion

In India young girls only get medical attention, proper diet, and health care guidance once she becoming a mother. At one side after the age of puberty mothers says to daughter; "*now you are grown.*"

But never guide her about the care and safe practices during menstrual cycle like; how to use and dispose of pads, how to care during menstruation cycle, specific diet for your future reproduction, the importance of menstrual cycle in your life. Some women from the field discussed;
"*Having a menstrual cycle is a common natural occurrence which happens with every girl. How we understood they will also understand one day*".

In reality, there was no talk over reproduction and sexual health care by elders to their young girls. We believe this kind of talk only discusses when they marry someone and understanding will come naturally. Talk about a living condition that also plays an important role in personal hygiene care and sanitation practices. The low-income group in Harijan Basti shares their bathrooms with many families, during the menstrual cycle; it creates a hurdle for young girls to access toilets at night time. Some time they found there is no light and water at night time therefore they feel uncomfortable while changing or disposing of pads. They found themselves hesitant and makes them culprit if mothers found a stain on the bed or their dress. Similarly, in the morning time, there is an issue of the long queue which creates difficulties in accessing bathrooms on time. Hence low-income effects on living standards, diet, and health care too as well as low communication skills. Mothers always guide their young girls not to worship or enter into kitchen and temple but can never advise them on how to care and what should you eat during your menstrual cycle overall development of the body. During fieldwork, researchers did not found any girls saying that I have a specific diet during the menstrual cycle except a few girls who belong from good income landlord's families. Is interpersonal communication depends upon income and education only? If young girls did not know about her body and reproductive and sexual health care value which is happening with her body how she becomes a mother of a healthy child in the future? Even the Anganwadi Center only focusing on polio and mid-day meals for children, there are no emergency facilities available in the communities for locals. Even for COVID-19 care medical emergency numbers reaching us very late. More than half of the respondents did not know about the government program for them and how they can approach it. Some key informants say;

"*We often feel that these government facilities only exist for locals, not for migrants*".

Therefore there is huge confusion about utilizing the government facilities and no hope for additional health care availability in the community. When researchers told them it is for migrants as well as locals too they wondered. Another respondent says that;

"*Once we went Anganwadi centers to inquired something related to maternal health they tell us to go therefore we started going-private clinics*."

Most of the married young girls did not know about contraceptives and their proper use for their reproductive and sexual health. The young couple living alone they are

having limited knowledge about family planning methods. They even did not know about government schemes and policies by which they can make their better health and healthy children.

As we moving towards the urban village we have seen the access to basic amenities lesser. Those basic amenities affected girl's mobility and functioning capacity at a larger level. At the time of COVID-19 water, availability is necessary to follow the hand wash protocol. But access to water all day is unavailable, storing water sometimes creates a hygienic issue, especially during menstrual days. Toilets are made up of a matchbox with no ventilation and tap water facilities. The urban village was ignored by the state, they always listed down from the priority. There is a diversity of issues and it should be solved at the universal level. It is the responsibility of the state to examine the issue very carefully especially at pandemic alert for longer perspective in the public health subject.

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Key Term

a) Cloths- During menstrual cycle girls and women use spare cloths instead of pads because they cannot buy it. Once use they wash and resue it, if it is ripped out they buried it in the soil.
b) Nigam Parshan- Municipal Councillor.
c) Khichdi- Polenta, mush or cereal with mix vegetables, salt and turmeric cook with water.
d) Kishori Swashtya- Adolescent Health
e) Namaz- Pray to God in Muslim community.
f) Bengali Baba- Local Quack
g) BPL- Below Poverty Line.