

FAMILY PLANNING IN TIMES OF COVID: WHAT DOES IT MEAN?
REMOTE QUALITATIVE RESEARCH IN UTTAR PRADESH AND BIHAR, INDIA

Introduction

The Couple Engage project¹ (2018-2020) aimed to understand the pathways and opportunities for male engagement in the contraceptive journey of couples and underlying processes of spousal communication and decision-making through literature review and human-centered design (HCD).

While the ethnographic and HCD research was completed earlier, the onset of COVID-19 presented an opportunity to re-examine some learnings. During June and July 2020, ICRW undertook a rapid remote qualitative study to assess the effect of COVID-19 on family planning demand and choices, and its implications on engagement of young men and couples in family planning. The study aimed to explore the following research questions:

- Q. How has COVID-19 influenced couples' contraceptive choices? What does it mean for young men and couples and developing solutions for them?
- Q. What are some considerations from communities that have a bearing on the family planning choices of young men and women in the context of COVID-19?
- Q. How has COVID-19 shaped the use of technology in the health space, especially in family planning service delivery, demand generation and access?

Research Methods

The study used telephonic qualitative research method for this study in one district each of Uttar Pradesh and Bihar. The study team identified members² of the local governance system, representatives of civil society organizations, members of women's collectives, frontline workers (Accredited Social Health Activists [ASHAs], Auxiliary Nursing Midwifery [ANMs] and Anganwadi Workers [AWWs]), youth leaders, pharmacists and informal health providers for telephonic key informant interviews were conducted with 40 respondents.

We also formed partnerships with well-known local organizations to support the process. These partners provided real time, district-specific information; guided the planning process and supported in identifying eligible respondents, building trust with the respondents. They also supported in managing intra community dynamics in case there were questions or concerns related to the research.

¹ Couple Engage was a two-year project (2018-2020) led by ICRW in partnership with Vihara Innovation Network. Please refer to: <https://www.icrw.org/research-programs/couple-engage-doubling-the-impact-of-family-planning-interventions/>

² Earlier research under the Couple Engage project highlighted that owing to their affiliations and roles, these community members engage with men and women on a range of issues, including reproductive health and usually have wider knowledge about the situation in their community.

Findings

COVID-19 was not just a health crisis, but also a social crisis in the context of India, owing to its peculiar economic, demographic, and social structures. Our study findings reflect this complexity, where implications of the pandemic are articulated across the layers of the ecosystem, beginning from health systems, communities and families and the couple space encompassed by norms.

Crises led to a greater bias in the health system

In early April 2020, facilities continued with only providing services for institutional deliveries. Several reports, articles and commentaries emerged anticipating an increase in unplanned pregnancies and abortions.³ This led to several experts pushing the government to release guidelines for continuing family planning services as an essential need. In India, the Ministry of Health and Family Welfare released guidelines to provide eligible couples with contraceptives (except IUCD and sterilization) through public health facilities and ASHAs/ ANMs⁴.

While ASHAs were at the forefront of COVID-19 response, they were tasked with rapid COVID-19 screening, information sharing on protective measures, maintenance of health records of their catchment population, and ensuring migrants are quarantined — over and above their regular duties. Hence, the burden of work on frontline workers led to the need to make trade-offs on time. For instance, not spending time on engaging with men or, at times, certain communities altogether to save time on convincing them and focusing on groups where they saw greater chances of acceptance.

“Our work has been affected a lot because of COVID-19. We have been doing so many surveys, we must give a record of whosoever has come back from the city. Then we did household survey. Then we were told to do wall markings and paintings with details of the family size and pregnant women in the house. They have given us all this to do.” — ASHA, 46 YEARS

Further, accounts of some health actors indicated that certain groups of people were marked as more likely to be non-compliant with respect to family planning guidelines. This othering was based on socio-economic markers of class, caste, educational status or religious identity and were associated with lack of or reckless family planning. ASHAs, ANMs and PRI members pointed to the resistance of certain marginalized groups toward family planning.

“During an economic crisis, it is [people of certain religion] who think how to feed their families, provide for their children, educate them and hence they do it less. But [people of another religion] do not think like this, I do not know why they do not think and keep having children.” — ASHA, 40 YEARS

Other aspects noted were increased distance between men and the health system. Men’s engagement with FLWs was already restricted in pre-pandemic days and it was further intensified during the pandemic. All these factors had a collective influence on family planning uptake.

³ FRHS India. (2020). Impact of COVID-19 on India’s Family Planning Program – Policy Brief. New Delhi: FRHS India. Retrieved from <http://www.frhsi.org.in/images/impact-of-covid-19-on-indias-family-planning-program-policy-brief.pdf>

⁴ Ministry of Health and Family Welfare (MoHFW) (2020). Enabling Delivery of Essential Health Services during the COVID-19 Outbreak: Guidance Note. New Delhi: MoHFW. Retrieved from <https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf>

Existing vulnerabilities in communities were exacerbated

For migrant men, shortage of both food and money was real, unlike local farmers with at least a short supply of food that they grew themselves. Unable to find any or suitable employment in their native places (including those with graduate and postgraduate degrees), certain migrant workers were driven to irregular jobs that paid them less than their former jobs. This led to acute anxieties and fear experienced by the rural poor after the lockdown ended their sources of livelihood. Men as sole providers for the family, especially nuclear families, were particularly affected by the relentless responsibilities they had to shoulder amid the looming crisis. “*Maansik tanaav*” (emotional distress) and “depression” were words used by locals to describe what men experienced as they grappled with their present and the imminent future. While narratives of men being affected by the pandemic were out there, it was interesting to note the omission of women’s struggles. Women, has increased caregiving responsibilities in the household, with no mobility and fulfilling the needs of the household in a decreasing budget.

“I did not find any work till after four months of returning to the village. Then, few days back I purchased a vegetable cart. There is no other work here.” — Man, 27 years, Ice cream vendor turned vegetable seller, Parity 1

“About 99 percent people here are under distress. There is no work here, no earnings and unemployment...people are slipping into depression, they are anxious about what the future will bring, how will their families survive...they are all living somehow.” — Pradhan, 52 years

Further, monetary constraints added to the conflicts between partners and affected domestic life more than usual. The aggression and violence exhibited by men in the intimate space was a manifestation of their compromised masculinity, in light of economic scarcity. The greater the economic distress, the higher the incidence of conflict among couples. Men coped with their anxieties and agitation with alcohol, which added to the already tense domestic situation. All forms of violence and abuse against women were reported by different actors: from verbal, physical and emotional to sexual violence or non-consensual sex. Women and men from the community agreed that there had been a considerable increase in sexual activity, especially with the return of migrants and their prolonged presence at home. Respondents shared the difficulties and impossibilities of abstinence while being within the same physical space.

“Sexual relations have increased now. Even women are distressed. They say neither can we go to our natal home, nor to our marital home. We are sitting at home and all day and 24 hours only this (sex) happens.” — SHG member

Although, the pandemic seems to have made an impact on the notion of “early first birth”. Young (mostly educated) couples who were already users of modern and/or traditional contraception found an alibi in the pandemic to strengthen their arguments against the social pressures for an early first child. Livelihood, financial and health related uncertainties triggered by the pandemic offered a persuasive context to such non-normative decisions.

“Till the time the pandemic is there, we do not want children. After one-two years, we will have the next one. Money and savings are required to have a child.” — Man, 27 years, Dehat, Parity 1

Informants — men, pharmacists and ASHAs — from both the districts reported a marked increase in the demand for and use of condoms. Although the use of condoms did not increase exponentially, condoms did emerge as the most preferred modern method. Men’s use of condoms could be

attributed to risk-aversion during a rather difficult period. RMPs and pharmacists also assumed the role of men's family advisors during this time.

Way Forward

As we learned from a range of findings, the pandemic enhanced certain structural (including gendered) barriers and further deepened the existing biases and gaps in the relationship between demand and supply with respect to family planning.

Men and women faced separate crises while navigating through the pandemic and state-imposed vulnerabilities due to lockdowns and containment efforts. While men dealt with the pressure of earning through an economic slump and loss of jobs, women struggled with increased burden of housework, loss of livelihood and vulnerability to violence and coercion. In this context, contraceptive dynamics of couples also shifted, but this needs to be viewed in conjunction with heightened work burden on frontline workers, narrowing of biases on who prefers what kind of contraception, and restricted availability and access to family planning services.

Family planning and sexual and reproductive health services were deprioritized by the system during COVID. The pandemic induced crisis also had a pronounced effect on gender roles within the household by increasing caregiving responsibilities of women, diminishing their ability to negotiate bodily autonomy and thus compromising their family planning choices. It was met by an equally disrupted supply as issues of access and availability got intensified. Family planning programs will need to recognize the skewed gender dynamics within households and couples, intensified as a result of the pandemic and work with it. It will enable women to have equitable access to quality contraceptives and services of their choice in a timely manner.