

ALIENATION OF MEN BY THE HEALTH SYSTEM

The existing health system fails to recognize the role of men in family planning and is not equipped to engage them

CONTEXT

The health system needs to contemplate its strategy from various facets. The health system has failed to recruit men even as clients, let alone engage with them as equal partners when it comes to family planning. This is made evident by the number of men accepting male-centric methods, which is miniscule. The health system does not view family planning as men's domain and is heavily influenced by community norms and perspectives, adding to their inability of looking at men as equal stakeholders and equal partners.

This thematic brief provides evidence from global literature and our primary research in Uttar Pradesh and Bihar on how the health system perceives men when it comes to family planning. It situates the health system's capacity to address the needs of men on family planning and also touches on models that can better engage men and thereby couples. This will enable researchers and programmers in the family planning landscape to have a layered understanding and a detailed perspective of the system and provide potential pathways to engage men in a sustained manner.

HOW THIS THEME WAS EXPLORED

The study participants for this theme were frontline health workers (FLWs), mostly accredited social health activists (ASHAs) at each of the study sites. In addition, women and men were also asked about their experiences of interactions with ASHAs or other health providers they felt comfortable with.

We explored the information ASHAs shared with married women and men on contraceptives and family planning, particularly to understand if details around specific methods and side-effects were shared and what these were. We also inquired about the level of comprehension and knowledge that ASHAs themselves had on various contraceptives and family planning to understand the comfort and ease with which they could discuss family planning with men.



KEY INSIGHTS

The health system is not gender neutral; gender norms shape and influence the perspectives of all systemic actors.

Literature indicates that the health system is not gender neutral and gender functions as a key determinant (Morgan et al., 2016) of how policies are shaped and implemented. The language in policy documents, which serve as the guiding tools for implementation of policies, is gendered and limits the possibility of a gender inclusive approach (Daniels et al., 2012) (Theobald et al., 2005).

The underlying issues of harmful gender norms significantly influence the perspectives of all systemic actors from

There is no need for a newly married woman to use a family planning method, it is important that they have their first child and get it out of the way. They can think of family planning later. Hence, we do not approach newly married women.

ASHA, GORAKHPUR (RURAL)

(Working as an ASHA for the last five years)

We live in a rural setting and here women do not talk to men of other households, and I also hesitate. Usually, we talk to the women in the households and give condoms to them, men are not allowed in my house, they do not come to my doorstep.

ASHA, KANPUR


(Working as an ASHA for the last fourteen years)

policymakers to last mile service delivery functionaries (Ved et al., 2019). FLWs play a dual role as system functionaries and community stakeholders, thereby, influencing and influenced by both systemic thinking and community perceptions. They also function as the “invisible gatekeepers” who shape the contexts in which gender and health inequities are embedded; the evidence is even more substantial in the case of low-and-middle income countries (LMICs) (Morgan et al., 2018).

Nested in these normative and systemic contexts, the health system’s reach with respect to all women is limited and is negligible with respect to men. The system does not reach out to unmarried women or newly married women. It is not trained on gender and lacks a gender perspective. As in many LMICs such as Ethiopia, Pakistan and India, the cadre of the community health workers is all-female by design (Ved et al., 2019). Although successful in many ways, India’s ASHAs

(nearly one-million workers) are faced with challenges when it comes to reaching out to men in the community, especially on the contentious issue of family planning. Further, following community norms, community health workers believe that childbearing, child rearing and thus family planning is a woman's responsibility (Kabagenyi et al., 2014).


Findings from our primary research corroborate the literature available and emphasize the influence of norms that exist in the ecosystem on health system actors and their perspectives. Women respondents mentioned that ASHAs came to them only after they had conceived their first child and never before. Anganwadi workers (AWWs) and auxiliary nurse midwives (ANMs) do not have any interactions with newly-married women; they are connected by ASHAs usually after the birth of the first child. Male respondents stated that they were not comfortable with speaking to ASHAs and vice-versa. In cases where the ASHAs were middle-aged women, the hesitation levels were found to be lower as they spoke to men freely and confidently.



We have not come across anyone who will give us any information. The ASHA never gives us any information, she comes to give polio and all but not this.

WOMAN, PARITY 3, GORAKHPUR (URBAN)
(Married for 11 years with three children, one son and two daughters)


Another significant reason for the limited engagement of ASHAs on family planning was the backlash they face from men and families, which further derails their attempts to engage men.



Men don't listen to us as it is, so we tell women only to get sterilization done.

ASHA, KANPUR
(Working as an ASHA for the last two years)

It was found that men would accuse the community health workers of ruining their families, of putting wrong ideas in their wives' minds and promoting contraceptives without their approval. This was most heightened when the women faced extreme side-effects of methods or when they could not conceive, in case of mismatched fertility desires of partners. This also hinder ASHAs from effectively carrying out their duties.



We don't tell these women anything, their husbands abuse us. If tomorrow there is an issue in their home, they will ruin my home and cause trouble.

ASHA, GORAKHPUR
(Working as an ASHA for the last nine years)

The health system perceives men as clients and does not engage them as partners.

Evidence suggests that the health system and policies, by being gender unequal, have alienated men to a large extent (Ved et al., 2019) (Theobald et al., 2005). So far, men have been only engaged as clients for no-scalpel vasectomy (NSV), popularly known as male sterilization. Men have hardly been engaged as supportive partners to their wives or as influencers in both research and policy, and these roles for them are least understood. Men also perceive that family planning services are designed and reserved for women, thus are embarrassed to find themselves involved in a “female domain” (Vouking et al., 2014).

Drawing from our primary research — field immersion in UP and Bihar — we find that men do not feel connected with the health system. Further, community health workers, ASHAs in the Indian context, are usually older women who feel removed from the world men inhabit and feel uncomfortable engaging with men on an already stigmatized issue. ASHAs also opined that it is the mother-in-law who has a say and takes an interest in the daughters-in-law’s fertility choices.

I watch the news, ASHA and AWW also come and tell, I have also read about it that ‘chhota parivaar, sukhi parivaar’.

MAN, PARITY 2, PURNEA

(Married for six years, with a three-year-old son; wife has been pregnant for a month)

I am ready to speak to men but it is their wives only who stop men from undergoing NSV, they stop us as they fear that their husband will lose his virility and that they would rather get a sterilized than their husbands.

ASHA, DARBHANGA


(Working as an ASHA for the last seven years)

ASHAs shared extensively about their own limitations and experiences when interacting with the community on family planning. As community women themselves, they need to think of their own survival. Some ASHAs also face ostracization from their own communities, if they promote family planning methods or if there are side-effects faced by women. In the absence of direct engagement between the health system and men, in many cases, ASHAs end up pushing women to adopt family planning methods. The women in the community often find ASHAs to be their confidantes as they seek both methods and advice, also encouraging them not to disclose the use to their family members, to save them both from backlash from families. Married women are in a precarious position and are susceptible to violence within the marriage and family.

The most common method voiced by ASHAs is sterilization, particularly after a couple has had two children. Female sterilization also keeps everyone in the family satisfied, be it the mother-in-law or husband, as it is performed on the woman’s body and, that too, after the ideal family size has been achieved.

Men feel alienated by the health system; they seek male peers and other informal channels of engagement.

There is little but significant evidence which informs us that men are more comfortable while conversing with male health workers about family planning and contraception, particularly when they are peers from within the community (Khadivzadeh et al., 2013) or sources they perceive as reliable and have a rapport with. Primary research suggests that there were instances where men reached out to the local pharmacists who they referred to as their “dost” (friends) to understand how condoms are used or the dosage pattern of oral pills to be taken by their wives and their side-effects. Another concern for men, highlighted across evidence and primary research, was quality of care. Evidence suggests that quality of care, with respect to levels of privacy, confidentiality and a respectful client-provider interaction in most cases, is not adequate (Jejeebhoy, 2007).



There is a pharmacist dost on the main road from where I get condoms and also a pill once for my wife. I ask him everything, what is good, what should I do if my wife gets pregnant by mistake. I also recommend him to other peers in the community.

MAN, PARITY 1, PURNEA

(Married for four years, with a two-and-a-half-year-old daughter)

Findings from our primary research suggest that men do interact with the rural medical practitioners, but not for family planning or contraceptive use. With other system actors, men's interaction is limited to maternal or neo-natal health services and does not broach family planning. The health system's failure to recognize men as equal partners presents these windows of engagement as missed opportunities. Further, the ASHAs' husbands came across as key influencers at both urban and rural sites. We observed that men were comfortable speaking to them about issues related to contraceptive use and if there were any side-effects that their wives were facing. Similar age range of the men in the community helped in establishing this rapport further.

SPECTRUM OF RESPONSES

We noted a striking imbalance with respect to ASHAs from rural and urban areas. ASHAs in rural areas have now been present for over a decade; however, in urban areas, recruitment and placement of ASHAs has been a recent process. This imbalance was visible during our immersion visit. While ASHAs in rural areas still had a reach and a system of functioning, ASHAs at urban sites were either not allotted to the respective wards or if allotted, their husbands were the point-persons for all aspects. The outreach was also lopsided as the dynamics of caste and religion were as significant at urban sites as they were in rural areas.

PATHWAYS TO ADDRESS THE BARRIER

- A robust review of all policies on family planning relating at the center, state and district levels through a gender lens and providing actionable suggestions which are then incorporated into the language of policy documents.
- Provision a forum or a “safe space” for the frontline health workers so that they may seek redressal on any backlash that they may face from families of women for promoting contraceptive use and family planning
- Provide gender training to all the health system actors at various levels and ensure frequent and timely refreshers
- Undertake advocacy for gender-transformative systemic practices to engage men by involving all stakeholders at the community level – from Panchayati Raj Institution members to community health workers and NGO community workers as well as other influencers that emerge organically in communities. This will ensure that the efforts undertaken are sustained.
- Understand the evolving aspirations of community health workers for their careers and enhancing their capacities, given the voluntary and incentive-driven nature of work. Thereby, putting in a clear career trajectory for them.
- Initiate “systems thinking” which percolates to the last mile functionary and provides tailored and suitable approaches for unmarried men and women, newly married women, couples with one child, among others.
- Understand and provide training to FLWs to better address men’s and couples’ reproductive health needs and issues.

COVID-19 IMPACT

In light of the COVID-19 pandemic, these challenges shall be further intensified as the entire health system is engaged in COVID-19 response and the immediate needs of women and girls, men and boys stand compromised. There shall be new challenges for young couples planning a family or a child considering the stretched functioning of the health sector, lack of contraceptive access and other services.

Given the large presence of men in the community due to reverse migration, this might be an opportunity to engage with them in a meaningful and sustained manner. The health system must prepare to maximize this opportunity. To this effect, ICRW has conducted a rapid research¹ to understand the changes that COVID-19 has brought to the family planning landscape.



ENDNOTES :

- i ICRW conducted a rapid qualitative study to understand the impact of COVID on family planning needs of women and men and its implications on engaging young men and couples in family planning in Uttar Pradesh and Bihar. Please refer to Nanda, S. et al. (2020). Family Planning in Times of COVID-19 — A Remote Qualitative Study in Uttar Pradesh and Bihar. Research Brief. New Delhi: International Center for Research on Women.

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