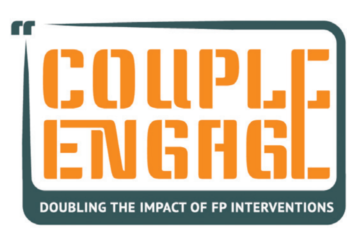
FAMILY PLANNING IN TIMES OF COVID-19

— Research Brief



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Cover Image:
A family spending time together. A scene from the film, Parwaaz (2020) produced by ICRW and directed by Mixed Media productions.

Suggested Citation
Nanda, S., Seth, K., Sharma S., Nandy, A., Sahay, A., Achyut, P. (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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Abbreviations

ASHA	Accredited Social Health Activist
ANM	Auxiliary Nursing Midwifery
AWW	Anganwadi Worker
CHC	Community Health Center
CMO	Chief Medical Officer
HCD	Human Centered Design
ICRW	International Center for Research on Women
IHAT	India Health Action Trust
IUCD	Intra-Uterine Contraceptive Device
MOHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer In-Charge
PHC	Primary Health Center
PPIUCD	Post-Partum IUCD
PFI	Population Foundation of India
PRI	Panchayati Raj Institutions
PSI	Population Services International
PSS	Parivar Seva Sansthan
RMP	Rural Medical Practitioner
SHG	Self-help Group

About the Study

The International Center for Research on Women (ICRW), in partnership with Vihara Innovation Network, undertook the Couple Engage project[1] to develop gender-equitable approaches on engagement of young men and couples in family planning. Focused on Uttar Pradesh and Bihar, India, the project used an evidence-driven approach to provide pathways and solutions to increase demand for and use of spacing methods among young men and couples. This two-year (2018-2020) project 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).[2]

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. This study was conducted in two out of five previously selected districts, one each in Uttar Pradesh and Bihar.

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?

Source: Paula Bronstein/Getty Images/Images of Empowerment

[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]The project used a human-centered design approach, which is a process that starts with the people you are designing for and ends with new solutions that are tailor made to suit their needs. Please refer to: https://www.designkit.org/human-centered-design

Methods and Framework for Analysis

We used a telephonic qualitative research method for this study. The study team identified members[3] 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. We also formed partnerships with well-known local organizations to support the process.

Profile of Community Respondents

- Eight married men aged 25–35 years. Four were migrants and four were residents, working as farmers or at small shops. Six out of the eight men had one or no child. These men usually earned between INR 7,000–15,000 per month. In most cases, they were the sole providers for their families. Resident men usually earned less than their migrant counterparts. Five out of the eight men were graduates.
- Nine community health system actors (ASHAs, AWWs, ANMs). All above 40 years of age and had served in their respective roles for over 10 years, except one ASHA who had joined in 2015.
- Four SHG members. All above 35 years of age and had a parity of three or more themselves.
- A total of four RMPs and pharmacists. All were either graduates or college dropouts with work experience at medical clinics.

We acknowledge that it would have been ideal to conduct in-depth interviews with young couples to gain deeper and personal narratives. However, reaching women during this distressing time, particularly marginalized women, was difficult and presented several ethical challenges.

Field Sites: Begusarai, Bihar and Kanpur Dehat, Uttar Pradesh

Study Duration: June 2020 – August 2020

Total Sample: 40 Key Informant Interviews

Our sample included 17 women and 23 men across various stakeholder categories

Figure 1: *Snapshot of Study Coverage*

Group	Number
Married Men in community influencer/leadership role	8
SHG members and other community influencers	4
PRI members	4
Health System Actors (ASHAs, ANMs, AWWs)	9
Pharmacists and rural medical practitioners (RMPs)	4
District Level Officers (MOIC, doctor, quarantine center in-charge)	3
Community Health Workers (NGOs)	3
Subject Matter Experts (IHAT, CARE, PFI, PSI, PSS)	5

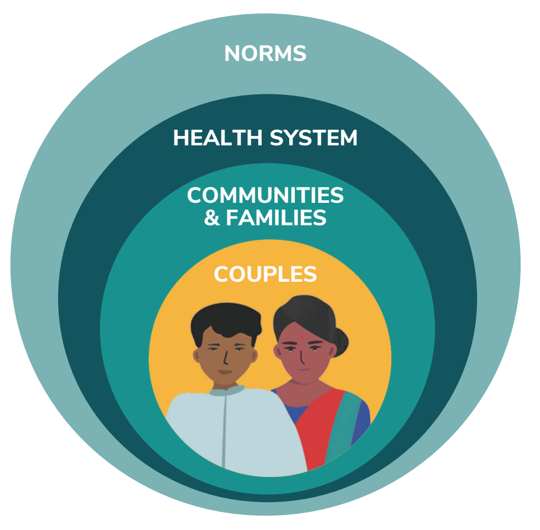
Figure 2: *Sample and Profiles of Selected Groups*

To analyze our findings, we utilized the overarching analytical framework used under the Couple Engage project throughout. The framework adopts an ecosystem approach[4] to analyze how various factors influence a couple's contraceptive journey. To learn more about this framework, please refer to the evidence review document.[5]

[3] 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.

[4] The social ecological model helps to understand factors affecting behavior and provides guidance for developing successful programs through social environments. Social ecological models emphasize multiple levels of influence and the idea that behaviors both shape and are shaped by the social environment. The principles of social ecological models are consistent with social cognitive theory concepts which suggest that creating an environment conducive to change is important to making it easier to adopt healthy behaviors (Richard et al., 2011).

[5] Seth, K., Nanda, S., Sahay, A., Verma, R. & Achyut, P. (2020). "It's on Him Too" – Pathways to Engage Men in Family Planning: Evidence Review. New Delhi: International Center for Research on Women.



Family planning is fraught with interplay of social and gender norms at various levels; the intimate space, the family and, the community spaces, and at the policy and structural levels. Norms work within and across these levels, perpetuating predetermined behaviors of male dominance.

The health system does not position family planning as a right, but as a population control method and thus, has an instrumentalist approach to it. Gendered family planning programs and fragmented engagement of providers, driven by their own normative perspective, pose real challenges to equitable quality of care. Further, supply side factors to access and availability limit and shape family planning demand.

Most often, norms perpetuated by society and gendered policies are further reinforced at the level of the community. When individual action is performed collectively, norms are reinforced, reinstated and re-emphasized and form a life of their own. Thus, community engagement on family planning is stigmatized and lacks meaningful avenues for participation.

Young couples are under immense pressure to perform their gender roles, extending to their fertility performance through the established community norms. The intimate space of the couple is influenced heavily by the interplay of these deeply entrenched norms.

***Figure 3:** Analytical Framework adopted in the Couple Engage Project*

Key Findings

As documented during other pandemic situations, the influence of a health crisis in the form of COVID-19, ensued an intensification of the existing economic crisis and exacerbated several ongoing issues in a variety of ways. The overarching social and gendered impacts of COVID-19 in India emerge from the complete lockdown implemented across the country in March 2020. The lockdown advisory did not include any specific guidelines around many problems that ensued thereafter. Existing power hierarchies and ongoing violence worsened due to COVID-19 as prolonged quarantine and economic stressors increased conflict in the household.[6] This was exacerbated with loss of incomes and employment, restricted access to markets and resources, loss of access to sexual and reproductive health services,[7] increase in early and child marriages, increase in sexual and gender-based violence,[8] mental health issues[9] and so on.

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, and the same ecosystem actor (or influencer, in this case) operates in different capacities across. For instance, a frontline worker in the community, while being a direct and trusted source of information from the health system, was subjected to stigma during this time for the same reason.

[6] Kumar, Arjun, Mehta, Balwant Singh & Mehta, Simi. (2020). *The link between lockdown, COVID-19, and domestic violence. India Development Review. Retrieved from: https://idronline.org/the-link-between-lockdown-covid-19-and-domestic-violence/*

[7] Motihar (2020). *The impact of COVID-19 on reproductive health services. Retrieved from: https://idronline.org/the-impact-of-covid-19-on-reproductive-health-services/*

[8] Vranda, M. N., & Febna, M. (2020). *Response to sexual and gender-based violence against women during CoViD-19. Indian journal of psychological medicine, 42(6), 582-584.*

[9] Roy, A., Singh, A. K., Mishra, S., Chinnadurai, A., Mitra, A., & Bakshi, O. (2020). *Mental health implications of COVID-19 pandemic and its response in India. The International journal of social psychiatry.*

[10] Menon, V., Padhy, S. K., & Pattnaik, J. I. (2020). *Stigma and aggression against health care workers in India amidst COVID-19 times: Possible drivers and mitigation strategies. Indian journal of psychological medicine, 42(4), 400-401.*

Crises led to a greater bias in the health system

Burden of work on frontline workers and the need to make trade-offs on time

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. Given such an extensive amount of work, they adapted to minimizing their load, which could have often resulted in biased decision-making. 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. To be most effective, it is likely that frontline workers resorted to a path of least resistance and implicitly cater to groups of people who they perceive to be most receptive for specific services.

> *"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, Begusarai*

Distance between men and the health system

Concurrent with the above, men reported no or minimal engagement with ASHAs and AWWs; even during pre-pandemic days. They saw ASHAs as a system of support and information for women. This implication has been further intensified during the pandemic. For instance, certain condom users believed that frontline workers do not supply condoms and shared their hesitation in talking to them about it because they are women.

> *"ASHA does not give anything, neither to me nor my wife. We did not know the government also distributed these things (condoms); we would take it from there. It is not that I like condoms sold in the market. I only use condoms for protection."*
>
> *— Man, 31, Parity 1, Kanpur Dehat*

> *"We talk less to men due to their unavailability — all of them are generally busy at their work, they are not at home. So,we talk to women only. If some men are home, we talk to them a little but cannot talk to them about everything. Even in lockdown, men are still not home all the time — they go out to the field to work to earn and also go to the center. Purush ghar mein baitha rahega toh kahan se khayega (if men stay at the house how will they eat)."*
>
> *— AWW, Begusarai*

Further, people had to serve the mandatory 14-day quarantine based on the report made by ASHAs. This made men (especially migrants) evade and dislike ASHAs. The impression of the ASHA as a self-serving mouthpiece of the government added another layer of distance between men in the communities and ASHAs.

> *"People fight a lot with me when I visit the community. They tell me you will do nothing, you are only making money, what will you and your government do for us. They complain to me in various ways and say that they will not get food and other things in the quarantine center and ask me to go away. So, I am also running around."*
>
> *— ASHA, Begusarai*

Othering and discrimination

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.

The collective perception on ground also indicated that a section of population had larger, unplanned families despite their financial inabilities. Condom use was also seen as the choice of the "ignorant" male laborer, who resorts to it as the most easily accessible and affordable means of family planning without much awareness.

> *"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 donot think and keep having children."*
>
> *— ASHA, Begusarai*

> *"The use of condoms has increased a bit since migrants have returned. Laborers use it more because it is cheap and they do not have a lot of money or knowledge. They hear about condoms and use that."*
>
> *— Pharmacist, Begusarai*

The prevailing presumption is that the archetype of a *samajhdaar* (aware) person is a male, often educated, and therefore seen as a "responsible family planner" — the one with a small family who uses contraceptives and/or practices abstinence.

However, as per an anecdote, educated women (especially those more educated than their husbands) were *badtameez* (ill-mannered) because they are more vocal and express their opinions freely.

> **Some men are irresponsible maybe due to their economic problems, some women who are more educated than the men tend to be more confident in talking back (badtameez hoti hain), which leads to problems with the men. If they are equally educated, they tend to have fewer issues.**

— ASHA, Kanpur Dehat

Influence on family planning

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.[11] 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/ ANMs.[12] However, things were still difficult, as reported by community stakeholders.

> **In the households where there were pregnant women people would say you are visiting every household and meeting people, you cannot come and conduct check-ups. So, we had to make them understand that we have masks, we wear gloves and sanitize, there is no need to fear us.**

— AWW, 49 years, Kanpur Dehat

> **The ASHA did not visit during the lockdown. The medical stores are 15km away from here, but I went to get pills for my sister in-law. Around 20-25 women could not visit the medical store and most women rely on pills only. I am 100 percent confident that the population will rise due to this.**

— Panchayat Member, 32 years, Begusarai

Existing vulnerabilities in communities were exacerbated

Increased economic distress

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.

> **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, Kanpur Dehat

> **I will not go back to the city. I will teach children at my friend's coaching center.**

— Man, 29 years, Daily wager turned tuition teacher, Parity 1, Begusarai

As rural areas of Bihar and Uttar Pradesh were placed under lockdown, self-employed men such as small shopkeepers, daily wage workers and those working for local businesses became jobless and faced relentless difficulties in securing cash for months on end. The pressure of providing for the family was most acutely felt by men, often the sole and/or primary breadwinners in their families.

> **The kids trouble us. They say things like, 'Papa, I want to eat this'. For the sake of the children, men are driven to even go far to find work. On days when it rains less, we leave for work. Here we do whatever work we find.**

— Man, 35 years, Parity 3,Begusarai

> **I have stocked up food grains so that the family has something to eat soon. I fear that it could be hunger and not the pandemic that may kill people.**

— Man, 25 years, Parity 1, Begusarai

In some rare cases, unemployment and loss of jobs led some men to take loans from friends, get things on credit and rely on the market for loans based on their past loans and creditworthiness. Essential purchases— such as salt and oil — were also made on credit from local shops. The *khaata* (account) ran for months, adding stress to already strained lives.

Rampant psychological distress

All key respondents emphasized the 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

[11] 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

[12] 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

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. Representatives of local government bodies stated that families and couples experienced unprecedented mental and emotional strain leading to conflicts in the household.

"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, Kanpur Dehat

Spousal relations and contraceptive use suffered severely

Tense spousal relations and pronounced gender roles

Monetary constraints added to the conflicts between partners and affected domestic life more than usual. 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.

Despite denial of their rights, women in their roles as wives were expected provide succor to their husbands facing financial crisis by being passive and gentle during altercations. Community stakeholders such as the AWWs, ASHAs, and SHG members also recommended such an approach to women in the community.

"When men live and work in the city, they cook for themselves, do the dishes and wash their clothes. When they come home, the wife must serve them, she will do it all. They should not think like this. But what can one do? You know that men in the village are like this...women at home also know that men are not getting jobs right now so they also deal with them accordingly.I also tell them that in case of some argument, they should remain silent. Women will have to be understanding during this time."

— SHG member, Begusarai

Physical, but not sexual distancing

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. "*Mood ban jaata, aur kya kariyega?*" (what else can we do when we feel the mood for it?) were some of the phrases used by men.

"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, Kanpur Dehat

As reported by a male respondent, sex was also a method for stress release and a brief distraction from their ongoing crisis. SHG members mentioned how women were frustrated because of the constant demand for sex from their husbands.

"People can stay away from each other for 15-20 days or a month, but cannot stay apart for three-four months. That is a long duration for anyone to maintain control and not have sex. So, then there are unintended pregnancies. People will have sex even if services are not available. Population must have increased during this time."

— SHG Leader, 40 years, Parity 4, Kanpur Dehat

Shifting ideas on "early first birth" and deferring the second child

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, Kanpur Dehat

"My wife and I do not want to have children for the next one-two years, until this child is not a little older and it becomes easier for my wife to manage the second child."

— Man, 31 years, Parity 1, Kanpur Dehat

Contraceptive access and use

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. RMPsand pharmacists also assumed the role of men's family advisors during this time.

"I talk to men about family planning, make them understand if they do not use such methods,they will face financial problems if they are not ready to have kids. It could also be physically and mentally distressing."

— RMP, Begusarai

Women avoided oral pills due to a common perception about their ill-effects on their health; men from the community also advocated against the use of oral pills for health reasons. Pharmacists and RMPs, however, maintained that the high sale of condoms was followed by the sale of pills, but not to the same extent. Use of methods such as Post-Partum IUCD (PPIUCD) and Antra injections were sparsely reported, presumably due to the unavailability of services. Pre-existing consumption patterns and method mix also had implications for disruption and changes in contraceptive behavior due to COVID-19, including factors such as use of short-term versus long-term methods, self-use versus provider-centric methods, among others.

Technology has the potential to aid health outreach in crises

Interviews with frontline workers highlighted the increased use of phone and apps (such as WhatsApp) for their work, which included reporting their attendance to their supervisors, sharing reports of tasks, sharing photos from their worksites, engaging with other frontline workers in digitally enabled groups and receiving guidelines to discharge their duties.

"We have a WhatsApp group called ICPS-Anganwadi, we are in contact with mukhiya sevika and other officers. We have another group the mukhiya sevika and the ANM where we they send 'kachii reports' (raw reports) over WhatsApp regarding nutrition, immunization. Secretary gave instructions and guidelines on social distancing, our new role, we got information from the health division through phone and WhatsApp, reporting for this was to the health division, and khandvikas adhikari (block development officer)."

— AWW, 49 years, Kanpur Dehat

There is little evidence of frontline workers engaging with women on the phone for provisioning of their regular services. However, since frontline workers are part of the same community as women users of contraceptive commodities, there are opportunities to engage with each other regularly and advise on health emergencies.

Source: Florian Lang/ICRW

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 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.

Key Recommendations

- The pandemic has exposed the uneven power dynamics in spousal relationships more than before; policy and program designers to consider it seriously.
- Women's agency and men's engagement with respect to family planning has been affected negatively during this crisis.
- Heightened aspirations of young people to achieve economic stability, particularly during COVID-19, provides an opportunity to position family planning as a means to achieve those aspirations.
- Family planning programming and implementation continues to be mired by overwhelming biases, narrow messaging, and skewed counselling in favor of certain methods (depending on context, comfort, and supply in a particular location).
- Frontline workers' own understanding of dynamics between spouses, and ability to interpret and work with it remains limited by the struggle they face while tackling various responsibilities and fear of community backlash.
- When providers are stretched, an already neglected area such as male engagement gets further sidelined. However, reiteration of the role of private players (pharmacists and RMPs) during the pandemic provides us an opportunity to leverage on their existing connections with men in communities.
- There has been an increase in access and acceptance of technology, for instance, digital platforms used by ANMs, use of mobiles and apps to collect information and communicate within the system by ASHAs; and Zoom calls used to train ASHAs and achieve last-mile connectivity. This presents opportunities to use technology for capacity building of frontline workers, provide supportive supervision, and real-time data collection and feedback. Greater reliance on helplines for tele-counselling and guidance to reduce the footfall in clinics was also observed.
- There is a felt need for the creation of a common sexual and reproductive health and family planning helpline that acts as a go-to source for latest information. This could have prevented confusion for clients while determiningaccessibility, availability and understanding rules during the various phases of lockdown and unlock.
- There is a need for provision of psychosocial support (including violence redressal) to men and women as well as frontline workers in communities for them to be able to share their distress.
- As we learn to live with the pandemic, greater and timely access to information is crucial as is access to the entire basket of choices for contraceptives.
- While policies and programs realign to COVID-19 and prepare for future pandemics and do so in the context of a larger socio-economic marginalization of the disadvantaged, there is a need to gather data on newer and more relevant questions—to understand how men and women are negotiating crises, the ways couples are meeting their contraceptive needs despite the existing barriers, how women are negotiating gender and power relations in the new circumstances and so on.
- Similarly, it is important to examine vulnerabilities experienced by frontline workers in domestic and public spaces and during interactions amid the pandemic. It is also crucial to understand the support or facilitation required by them to perform their roles and responsibilities effectively.

Acknowledgements

This research brief is a product of collective effort, study, and research. We would like to thank everyone who supported us conceptualizing and executing the research during the pandemic in difficult situations. We are especially indebted to our onsite research partners — Shramik Bharti in Kanpur, Uttar Pradesh, and Gram Praudyogik Vikas Sansthan (GPVS) in Begusarai, Bihar — for enabling this remote qualitative research. We acknowledge Rakesh Kumar Pandey and Amitabh Singh at Shramik Bharti, and Ripudaman and Sunil Kumar Singh at GPVS for their efforts. We appreciate the participants and experts who gave us their time and spoke with us over the phone patiently for fulfilling the needs of this research.

We would also like to thank Abhijeet Arun Pathak from the Bill & Melinda Gates Foundation for supporting us in this endeavor. We thank Rai Ganguly and Tarini Gupta, for their support in secondary analysis and interviews. We thank our colleagues at ICRW Asia, Falak Raza for support on research ethics and approvals, Sakshi Garg for operations support and Ketaki Nagaraju for her editorial inputs. We also acknowledge the insights from our partner organization, Vihara Innovation Network.

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