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Influencers and Modifiers of Family Planning at Community, Family, and Individual -a qualitative deep dive

By

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I perceive as this opportunity as a big milestone in my career development. I will strive to usegained skills and knowledge in the best possible way, and I will continue to work on their improvement, in order to attain desired career objectives. Hope to continue cooperation with all of you in the future.
Sincerely,

Tanya Singh

Table of Content

Acronyms/Abbreviation

ASHA- Accredited Social Health Activists

ANM- Auxiliary nurse midwives

BCC-Behaviour Change Communication

CHW-Community Health Worker

IDI-In-Depth Interview

IUD-Intra Uterine Device

SDG-Sustainable Development Goals

NFHS-National Family Health Survey

FP-Family Planning

MMR-Maternal Mortality Ratio

RMNCH-Reproductive, Maternal, Newborn and Child Health

UN-United Nations

Organization Profile:

CARE INDIA is a not-for-profit organization that builds capacity of communities to ensure empowerment for marginalized women and girls. Sustainable and holistic interventions in **Health, Livelihood, Education and Disaster Relief & Resilience,** provide innovative solutions to deep-rooted development problems.

Along with access to the international confederation of expertise, integrate internal knowledge and strong network of partnerships to deliver outcomes at scale to variedstakeholders.

CARE India is a part of the CARE International Confederation, which is helping millions ofpeople in living a life of dignity and have a presence in over 100 countries.

They have been contributing to India's explosive growth for 75 years, starting from the timewhen it was a newly formed nation, till today when it is among the world's fastest developing economies.

In 2020-21, we impacted the lives of more than 52.7 million people, through 53 projects,carried across 18 states.

Core Values: -

i. **Respect**, Upholding the dignity of each individual
ii. **Integrity,** Adhering to an ethical code of conduct in all actions
iii. **Commitment,** Fulfilling our duties and social responsibilities
iv. **Excellence,** setting high performance standards and being accountable to them.

Approach:

- Gender Equality
- Knowledge, Management and Learning

Introduction

Background-

Fertility rates have declined for women of all ages in high-income nations since 1950, while fertility rates for women of all ages are continuously declining in low-income countries. Between 2021 and 2050, India is expected to have the absolute population rise of any country**.**(1)

Bihar is India's third most populous and fifth poorest state with the highest 2.9 children per woman is the total fertility rate (TFR).(2) The TFR is higher than the TFRs of the nation's most populated states, Uttar Pradesh (2.4 children per woman) and Maharashtra (1.7 children per woman). Bihar lags behind in FP use due to high fertility rate, in spite of rise in usage as recorded in NFHS-4 (2015-16) and NHFS-5 (2019-20), the use of modern contraceptives for family planning (FP) ascended from 47.8 percent to 56.5 percent..(2, 3)

Female sterilisation is adopted by 54 percent of married Indian women aged 15 to 49 years .These figures vary depending on place of residence- city or the country, the age of the woman, her parity, the number of male children, degree of education, style of living, and religion.(4)

Governments and organizations across the globe have made striding efforts to promote access to and use of FP methods. Reports on the literature Maternal mortality can be reduced by limiting the likelihood of unintended pregnancies, unsafe abortions, and the health risks associated with high parity and closely spaced pregnancies, as well as reducing the risk of child death due to shorter birth intervals.

Measures aimed at improving FP have historically resulted in better educational and job outcomes for women, as well as improved health and nutrition for children, by allowing women to better space or restrict births and thus exert control over family size.

Sustainable Development Goals (2030)-

Many of the Sustainable Development Goals (SDGs) may be achieved through FP. The important players have prioritised efforts to enhance access and supply to and use of FP techniques and to promote knowledge of FP is thus a very cost-effective way to meet the SDGs since it gives a lot of value for the funds spent. Many of the United Nations (UN)

SDGs Sustainable Development Goals for 2030 emphasise the importance of family planning:

- 3.1 - reducing global maternal mortality ratio (MMR),
- 3.7 - ensuring universal access to sexual and reproductive healthcare services, and
- 5.6 - universal access to sexual and reproductive health and reproductive rights.

Reasons of not use-

Several studies and research on drivers and challenges to FP uptake conducted in low- and middle-income countries (LMIC) may lead to an understanding of why women do not utilise family planning techniques, especially modern contraception. Women have almost no autonomy over their reproductive choices. Men have been recognised as major decision makers and action for change OR agent of change in studies. Husbands and relatives, particularly mothers-in-law, strongly influence women's reproductive decisions regarding the number of children and timing of sterilisation, while observations are also indicating a shift within young couples choosing their own contraceptive choices.

Fear of side effects, self- or others-directed opposition to contraception, infrequent sex, were recognised a few key reasons for not using contraception despite a desire to limit (not want another child) or space (not want a child soon) child bearing. In contrast, unmet contraceptive demand was seldom caused by a lack of understanding, availability, or cost.(5)

Understanding the variables that influence contraceptive usage in rural India is very critical for improving mother and child health. This requires comprehensive analysis on the 'why'—why individuals use or don't use current approaches, what affects their decisions, and who influences them.(6)

FP counselling services and efforts in behaviour change communication (BCC) are necessary to address these issues and increase demand for new approaches.

Importance of CHW'S-

Over the last few decades, Community Health Worker's (CHWs) have also played an important role in lowering unmet contraceptive needs in several underdeveloped nations. While research has shown that CHWs are responsible for higher RMNCH service acceptance, their engagement with clients for FP is sporadic, particularly in India, and

studies investigating the influence of community health worker outreach on women's desire to use contraception have remained unexplored.

Community Health workers (CHWs)in India have been continually active in continuing reproductive and child healthcare initiatives, including FP yet, there is minimal information available regarding the degree of their outreach in providing FP messaging and services. Providing appropriate and high quality of FP counselling is an integral part for increasing the contraceptive prevalence rate (modern and traditional) and decreasing the unmet needs of the couple.

In India Community Health workers comprise of ASHA, ANM (Auxiliary nurse midwives) and Aanganwadi workers. Accredited Social Health Activists (ASHAs), among other aspects, who are the primary administrators of family planning services at the community level. They have been providing primary healthcare services across the world for decades, including reproductive, maternity, new- born, and child healthcare (RMNCH), and their efforts have contributed to reduce mother and child mortality. Women who received any kind of counselling on FP had increased odds of using modern contraceptives.(7)

Current Scenario-

According to National Family Health Survey(NFHS), the usage of contemporary methods of contraception has grown in most Indian states over the previous five years, with Bihar showing the biggest progress in NFHS-5. (2)The method of FP used differed depending on the socio-cultural aspects and economic state of the community. Female sterilisation, was adopted by 35.3 percent of married couples as a direct contrast to male sterilisation with less than 1% of married couples opting for it. Further, condom was the second common technique of spacing, with 4% of married couples using them. Less than 2% couples reported taking pills, while 0.8% of married women reported using an IUD.(2, 3)

Each district in Bihar saw an increase in the use of FP methods, with the exception of Purnia, which saw a 6% decrease in the previous half-decade. Contraceptive usage has grown by more than 40% in Muzaffarpur, Samastipur, Banka, Darbhanga, Gopalganj, Jamui, Kaimur, Nalanda, Paschim and Purba Champaran, Sheohar, Siwan, and Sheikhpura since NHFS-4. Adoption of FP approaches showed a clear rural-urban divide. The usage of any kind of contraception was 62.3 percent in urban areas and 54.6 percent in rural regions.(2, 3)

Understanding the variables that influence contraceptive usage in rural India is very critical for improving mother and child health. This requires comprehensive analysis on the 'why'—why individuals use or don't use current approaches, what affects their decisions, and who influences them.

Thematic approach was employed to systematically capture the influencers and modifiers of FP practises at the community, family, and individual levels in Bihar in order to generate new insights about the adoption of modern contraceptive methods which will better inform future FP interventions.

An exhaustive literature review on Influencers and modifiers in family planning was done to understand awareness, attitude, perception and practises about family planning in the community.

Review of Literature

1)A mixed method approach was used to analyse three existing quantitative data sets in order to identify trends and geographic variation in family planning adoption, gaps and contextual factors associated with family planning adoption, and to collect new qualitative data via in-depth immersion interviews in order to understand systemic and individual-level barriers to family planning use, household decision making patterns, and community level barriers. The findings suggest that interventions should focus on increasing intent to use and adopt present temporary methods, rather than enhancing awareness, through influencing underlying perceptual drivers of behaviour.(5)

2)A mixed method study was carried out to determine the relationship between the usage of contemporary contraceptives by young married women and other married women living in the same home. Even after controlling for background characteristics, the relationship between contraceptive use by an index woman and the second woman in the family remained significant, suggesting the independent effect of intrahousehold influence on contraceptive use. The findings of the study back with existing strategies employed by Indian government programmes to encourage family planning among young married women. It has been established that educating newly married, low parity women in the house through other married women is an efficient strategy for India to accomplish its FP2020 commitment.(8)

3)A qualitative study was carried out to identify determinants of discordance categories with an emphasis on women's empowerment (household and fertility decision-making, women's education, and women's contraceptive knowledge). Discordance is significant not just as a measurement issue, but also as a symbol of fundamental imbalances that exist within these couples and may restrict reproductive autonomy. Men's engagement in family planning programmes gives an important opportunity for couples to express their views and maybe negotiate reproductive decisions together.(4)

4)NFHS used a cross-sectional survey approach, with secondary data used in this study, to investigate the amount of CHWs' FP outreach and its impact on contraceptive demand among married women in India. The intention to use contraception was much greater among women who were approached by health workers than among those who were not. The intention to use contraception was 31% among women who were approached by health workers and participated in FP talks, compared to 20% among those who were not. When

women were contacted in the previous three months and ever addressed any FP, their desire to take contraception was 41 percent, compared to just 20 percent in the other case.(7)

5)A cross-sectional study to assess the number of villages having an ASHA and investigate the impact of increasing ASHA placement on healthcare trends. According to the findings, the average proportion of villages with an ASHA increased from 39.1 to 76.2 percent within 218 districts from 21 states, unmet need for family planning increased from 14.7 to 22.4 percent, institutional delivery increased from 61.6 to 82.5 percent, and full immunisation coverage decreased from 71.2 to 65.1 percent. A 1% increase in ASHA placement resulted in 0.05% fewer unmet family planning demand and 0.222% more complete vaccination, but no changes in institutional delivery. Women between the ages of 23 and 24 are present in the communities, although there are more electorates among them.(9)

Objectives

The objectives of the study are stated below:

1. To understand awareness, attitude, perception and practises about FP in the community.
2. To understand ASHAs knowledge, attitude and practises for FP related services and delivery platforms.
3. To explore the barriers and enablers faced by CHWs (particularly ASHAs) for the delivery of FP services.

Methodology

Study Design-

Qualitative study (exploring FP related knowledge, attitude, challenges barriers and practices among poor resource settings in Bihar by Care India).

Study Population-

For this exploratory assessment, in-depth interview (IDIs) of 12 ASHAs were interviewed in May 2022.

Selection Criteria-

Inclusion criteria-

- ASHA having upto 5 years of experience
- ASHA having more than 5 years of experience

(Were selected because of the role they play in the contraceptive use, especially in decisions related to the use of family planning methods for spacing, delaying and limiting)

Exclusion criteria-

- ASHA who are not available at AWC
- ASHA who refuses to provide consent or record their interview.

Sampling Method-

Three-stage random sampling was employed to reach the sample for interview conduction. Patna, Arwal and Vaishali districts were selected based on operational and logistic feasibility. Further 5 blocks were selected in each district, and ASHAs were selected randomly from AWCs.

Methods of Data Collection-

Before starting the interview, participants were explained the purpose of this study and verbal consent was taken for the interview as well as for audio-recording of the interview. To protect the identity of the subjects all interviews were kept anonymous conducted in the

local language using semi-structured guidelines logically arranged with open-ended questions on FP. Depending on the pace and amount of information provided, IDIs lasted between 60 to 90 minutes.

Each interview was facilitated by two interviewers-an intern and other an expert in qualitative research. While the intern primarily conducting the interview, another observed the participant and did the necessary probing. Interviewers were oriented on study guidelines for 3 days before starting the interview.

IDIs were audio-recorded and transcribed by the interviewers on the same day to minimize the loss of information. Notes were taken to capture non-verbal aspects of the communication. The transcripts before using for further exhaustive analysis were reviewed by experts in the team members for accuracy and consistency.

Data Analysis-

The data analysis was adhered to following the thematic extraction approach to inductively extract major themes through coding of text data. The coding was initiation done by interviewers then a separate batch of experts who read and reread all transcripts coded for improving and recoding as per the requirement. The codes were further refined, combined, and categorized for the analysis. A multi-stage inductive interpretative thematic process was adopted to identify recurring themes and ideas from the transcripts. All transcript coding was done using Atlas.ti 7.5 software.

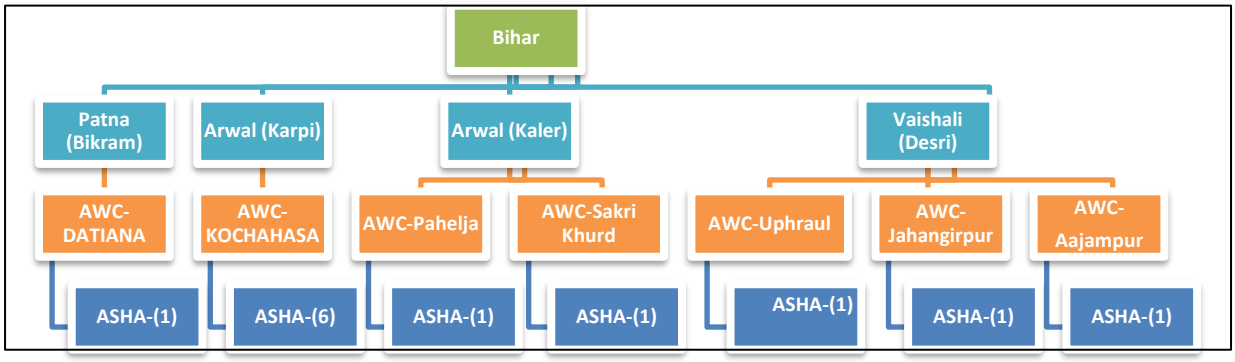

Figure-1-Sampling Frame

The study explores the following research questions:

- Who are the Key Influencers (KIs) and Modifiers? What are the perspective and contraceptive practises of community for family planning?
- What are the social strategies that they use to persuade young and low-income women?
- What family planning practises do influencers have an impact on (intention, fertility preference, method choice, method specific knowledge, decisions, contraceptive use)?
- What are social norms and social mechanisms, and how do they combine to produce demand for or opposition to current contraceptive methods?

Results

The observations of the findings are based on interactions with ASHAs-

Community Family Planning Profile and Perspective

- In the communities, there are beneficiaries of FP between the age of 18 to 24, some of them are able to understand FP while others are unable to do so due to their lack of education and knowledge.
- Communities are aware of ASHA's roles and responsibilities.
- Individuals and families perceive FLW's as being driven by their own personal and financial needs, rather than the needs of the community, and avoid procuring FP methods from them.
- Communities anticipate deliverables like information about Ante-natal check ups, and immunisation, for pregnant women and children but are less aware of family planning services.
- Home visits by CHWs in communities are largely for prenatal and postnatal care, as well as for immunizations after delivery not particularly for family planning services.
- Communities consider the ideal age of marriage to be just after a first period, no matter it being at 10,14,16 years of age and ideal age of pregnancy, just after marriage.

  " *ab bolte hain MC aa gaya toh ladki jawaan ho gaya unn logoan ka kehna hain ,toh shaadi kar detein hai MC ke baad mein aur unko yeh lagta hain didi , shaadi hua jaldi bacha ho jaye ,jitna jaldi ho bacha ho jayein" _ASHA,Arwal*
- Awareness of interval between children in families of community exists but practice does not.
- Mother in law's (MIL) make decisions regarding timing and spacing of children, leaving couples no autonomy for use of FP.
- Presence of male child in a family plays an important role in decision making for family planning.

  "*voh didi jaise do ladki hain abhi tak ladka nahi hua hain,toh ladka ke chakar mein ho jaata*"*_ASHA_ Arwal*
- Family members (MILs, male members) want more children, particularly sons, to increase their status and carry on the family name.

"*samudayein yeh hi kehta hain didi ,ek go ladka huive kara toh vansh aur buniyaad chalve karega na ,agar vansh buniyaaad khatam ho gayi toh kaise kya hoyi"_ASHA,Arwal*

- More children are desired for the family's labour and income in underprivileged families, no preferences given to women health and financial condition.

"*Mochi Tha Uski Patni Abhi hi Death Kar Gai Usko 4 Bacche The Main Boli Ki Aap Opretion Karwa Lijiye Nahi Toa Mahila Karane Layak Nahi Thi Kyunki Usko damma Tha Toa Wo Kya Bola Se Nahi Kono Hum Bhumiyar Hai Ki Jo 4 Hi Baccha Rakhege Ya 5 Hi Baccha Rakhenge Humko Jitna Man Hai Hum Utna Rakhenge"_ASHA,Patna*

- CHW's have lack of knowledge and inaccurate knowledge about fertility cycle which leads to misconception in beneficiaries mind about safe and unsafe period .
- ASHA's consider primary source of information in communities for FP practises.
- VHSND, Mata Bethak, Swasthya Diwas , Pakhwada(an fortnight event consider) other sources of information for FP practises.

Community Contraceptive Perception & Practises

- Communities believe that God is responsible for providing children and family planning interferes with God's plan, implying that it cannot and should not be controlled.
- According to beneficiaries health, and advised by ANM's, ASHA'S prefer type of contraceptive methods but majority of them prefer condoms, Antara, Chhaya, Mala-D, Copper-T and female sterilization.
- Lately women have reported to show preferences for newer contraceptive methods as Antara and Chhaya.
- There is a significant fear of side effects of contraception by both men and women [Pills: Menstruation, weight gain/loss, nausea; IUD: stomach pain, and bleeding; Condoms: cause HIV, can reduce pleasure] thus deterring use of family planning

"*Antara didi ,par koi koi toh yeh bhi nahi lagana chahta hain ,kyuinki bleeding hota hain na ,phir dard hota hain,aur nirodh hain par uske liye bhi bole prabhavh hi naa padhta hain aacha nahi lagta hain toh naa lagayi purush toh manata nahi hain,toh mahila hi antara leti hain ,chhaya khati hain,"_ASHA,Arwal*

- Women receive inaccurate information about side effects from their peers, family or partner, and are directly counselled by others not to engage with or use family planning methods, consequently deterring their use.
- Women are afraid due to side effects of Antara, as its leads to absence of menstruation till 6-7 months and in some cases excessive bleeding was noticed.

  "Antara sui se bahut pareshaani hua sabko ,antara devai na 6-7 mahina bleeding nahi aaya usko ,band ho gay bleeding aana toh madam se sujhabh liye ki antara dilaya tha 6-7 mahina ho gaya hain bleeding nahi ho raha hain ,uska pura body mein sujhan aa gaya tha"_ASHA,Arwal
- The reasons for switching pattern of reversible methods are side effects of using present contraceptive methods.

  "Nahi phir nahi aapnayi ,boli ab operation karwala raha ,aur kehte hain ab goli boli nayi khayenge nirodh apna li hain,aur hum toh bole esthayi operation karwa lo ek bacha aur ek bachi hain"_ASHA,Arwal
- Women do not bring up family planning discussions, for fear of conflict with their husbands (who control usage decision) thus there is little intention to use FP.
- Women do not have adequate autonomy to decide on FP use.
- While couples want to use [traditional] FP methods, they don't have accurate information - such as understanding safe days in rhythm method - therefore family planning becomes ineffective.
- Women cannot leave the house unaccompanied or without the consent of their husbands or MILs, therefore cannot procure FP methods.
- Even if a couple ventures to use FP method, they slip back into natural methods because of ease, convenience and social acceptability.
- CHW's informed about discontinuation of pills , desire of children and inaccurate knowledge results in Unwanted pregnancy.
- Education is an essential key for Knowledge ,perception and intention of family planning practises.
- Follow-up services done through phone, at beneficiary place and at provider place.

Client Provider Interaction

- All type of contraceptives available in facility of communities.

- Women belongs to age 18-35 are the beneficiaries who seek information about contraceptive methods.
- Only women encountered issues with side effects and its consequences on their health.
- Joint counselling is preferable than individual counselling because it enables males to understand that family planning is a couple's effort rather than an individual.

  "Didi pati ke sath batayenge toh jaise mahila dawa khana bhul gayi toh pati yaad dila detein hain par jab akele baat karti hain toh kabhi mahila bhul na jaaye toh hame yaad dilwana hota hain"_ASHA,Arwal
- As information on FP methods is not translated or retained properly, couples remain unaware of key information regarding such method.
- Due to lack of information about existing FP options, couples are unable to choose a method that is best suited to their needs.
- Couples may have the intention to use contraception, but worry about being judged or stigmatized by elders because discussions around sex are considered taboo.

  " usko jaise nahi chahiye bacha toh hume chupke se bolegi toh hum de detein hain na usko condom ,yaha aayegi toh sabko pata chal jayega ,agar ladka bhi rahega toh bolega chachi yeh hain samnva toh hum log de detein hain"_ASHA,Arwal
- Women and men are not available at the same time for counselling, therefore deterring overall impact of the session, and follow up action or use.
- CHW's do not provide FP counselling to young men and couples, as they believe it is not required, therefore couples are not aware of FP methods.
- Maintenance of register done by ANM's.
- If beneficiaries are satisfied, they will continue with that method; otherwise, they will switch to some other methods.

Male Engagement

- Couples (particularly men) do not seek information on FP on their own as they do not see it as a priority compared to income generation, thus remain unaware of both need and methods of FP.

  " *Nahi didi mahila hi aati hain tikakaran mein bhi ,pakhwada mein bhi,purush ka yogdaan na ke barabar hain,jaise maan lijiye 100 hua ya 50 go operation hua hain usme se mushkil se 5 go purush karayein hain ,nahi toh mahila hi karati hain"_ASHA,Arwal*

- FP is made available to women and not men who feel ashamed to ask about it from female CHW's. Male feel uncomfortable speaking to a female provider regarding FP.
- CHW's focus their attention on counselling women (adhering to social norms), leaving men unaware of FP methods.
- Condoms can reduce sexual pleasure for men, so they avoid using them. Vasectomy is considered a loss of masculinity, so men decide against it.

" *Kehte hain Bhabhi hum use karte hain par santhusthi nahi milti"*

" *didi jitna joh sahe voh sab mahila sehti hain ,Boltein hain na didi hum toh humse bolte hain hume kaam karna hain,bora uthana hain ,baahar jaana hain,ikko kya karana hain ghar par baithkar khana hi toh banana hain aur khana hain"_ASHA,Arwal*

- The majority of them are aware of male specific training for family planning practises, however half of them have never received such training.

Social Analysis and Action

Social Analysis and Action (SAA) refers to a methodology designed and introduced by CARE. SAA is one of CARE's models for gender transformation. It is a community-led social change process, (mediated through ASHAs) through which individuals and communities explore and challenge social norms, beliefs and practices around gender and sexuality that shape their lives.

The approach was executed through ASHAs who were capacitated on content and communication to reach out the zero and low parity couples with relevant messages on family planning.

- The ASHAs confessed that they now comfortably and freely introduce and explain FP to women and face less inhibitions as compared to earlier times. (reference period 2-3 years back when first sensitised through SAA)
- Women now seek FP related advice to the ASHAs, even on phones, if they are unable to meet physically.

" *Parivartan hai na didi pahale hamko ye sab chij ke bare me kya pata tha pata jaise yahan par aye meeting hota hai "*

"To usme me didi log batati hai""PCM Sir hai ye sab batate hai "ASHA,Arwal

Service Provision-

- ASHA served as a mobiliser in community outreach event as VHSND and facility based Fortnight termed locally as *Pakhwada* (an event in which FP services are delivered in a campaign mode at the healthcare facility)

- Able to provide counselling for management for side-effects of contraceptive methods by if explained by ANM.
- Counselling is provided on determining family size, spacing, methods of FP etc. "*didi jinka baccha ho gaya hain aur unko baccha nahi chahiye toh kehte hain esthayi operation karane ko,aur jiska baccha 6 mahine ya 8 mahine baad teher jaa raha hain usko batatein hain ,Antara ,Copper-t,jab bacha hua usse turant copper-t lagwa diye ,aur nahi lagwatein hain toh nirodh ka salah detein hain,baccha thoda bada ho jayega deh vikas ho jayega ,phir toh waise bhi hum teen shaal ke baad ki salah detein hain"_ASHA,Arwal*

- Provider provide follow up services at beneficiary place and on phone. Sometime respondent also visited ASHA's

Barriers to family planning and contraceptive use

- Provider first seek permission from MIL's to talk to beneficiaries about family planning to avoid future violence.
- Individuals perceive CHW's as being driven by their own personal and financial needs, rather than the needs of the community, and avoid procuring FP from them.
- Women adopting any FP method (despite opposition from their husbands) are seen as violating gender norms, and do not feel supported.
- FP is made available to women and not men, and men do not take any conscious action to procure it regularly.
- Couples choose "self-control" or abstinence over modern FP methods as it is considered personal virtue.
- Family planning is perceived as a means to limit family size, not spacing birth.

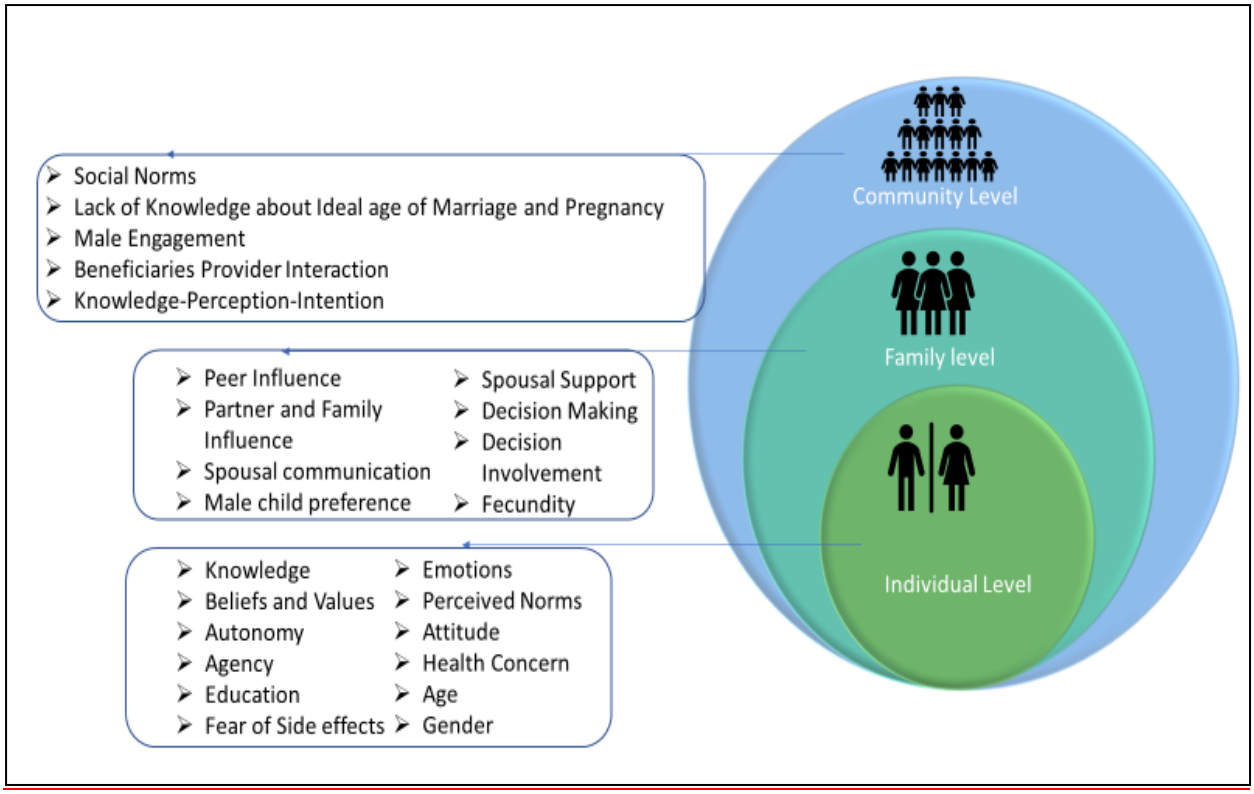

Figure -2-Barriers to family planning and contraceptive use at different levels

- In above figure barriers are depicted at individual level, family level and community level.
- All types of contraception methods are available at facilities.
- The community is less willing to invest money on contraceptive methods.
- Beneficiaries prefer public facilities over private facilities for access to contraceptive techniques.
- CHW's encourage women in their communities to use contraceptive methods by providing their example.

Provider motivation/Improvement

- Lack of supportive supervision & timely incentives leads to de-motivation and lack of accountability.

  " *ASHA ban ke didi aacha lag raha hain samaj ka seva kar rahe hain khush hain ,lekin ek hi baat se naraz hain sarkar joh hain toh hum jono hisab se kaam kar rahe hai uss hisab se vetan nahi mil raha hain"_ASHA,Vaishali*
- Training on FP is clearly lacking and is required to instil confidence to increase awareness about FP.

- Training on digital literacy was relatively low with training preceding provisioning of Android phones for FPLMIS usage.

Support for ongoing work

- The ANMs were identified as constant source of support as they provide hand-holding support in day-to-day activities.

  "*ANM didi se ,raam raam didi yeh ANM didi hain hamare liye baghwaan hain yeh hi hamara register maintain karti hain" _ASHA,Arwal*

- There was a lack of formal feed-back and constructive support or feedback from senior public health professionals.

  " *hum sarkaar ka kaam karte hain online ka apne paise se,karja managate hain ,ek mahina mein kitna ASHA diwas hua hain,kitna tikaran hua,sab hame online paise dena hota hain,ASHA facilitator kyuin banayein hain unlgoan ko hamari madad karni chahiye na ,100 rupayein dena hota hain,ASHA facilitator kuch nahi sunati" _ASHA,Arwal*

Discussion

In this study, we used qualitative approaches to investigate a wide range of Influencers and modifiers of FP practises at Community level, family level and individual level in State of Bihar, India. To understand the causes for the slow progress, we first looked at where CHW and contribution for their pathway from planning to execution.

While awareness and desire to space or restrict childbirth were both substantial, willingness to utilise modern contraception was negligible (for temporary methods). Demographic factors as access, age, education and others were used to determine what was driving this low intention to use. We also discovered numerous distinct contextual variables that led to the gap between intention and action. The qualitative data from interviews provide additional insights about the community, family, and individual factors for poor intents and adoption that the quantitative data could not.

First, it indicated that various ideas and emotions had a significant impact on uptake. Social norms influenced usage and exacerbated the shame associated with obtaining modern contraceptives.

Risk perception was very high for method side effects, particularly fear of infertility from temporary methods, but low for the consequences of not using FP for an unplanned or mistimed pregnancy. The data suggests three distinct decision-making paths for how various communities, families, and individuals handle the FP pathway: those who completely ignore it, those who use temporary methods but eventually abandon them, and those who use temporary methods but eventually switch to permanent methods.

Previous research has revealed that a novel approach in which families use permanent contraception without using any other type of contraception may emerge..(5) In addition, even when contact was made, the amount of time spent addressing FP throughout the conversation was constrained. The data also suggested that FP outreach by health workers had a positive shift on contraceptive intention, which was not the case in this study's findings. The findings of this study are comparable to other research conducted in India, which revealed that FP exposure and advice between outreach health workers and users was comparatively low when compared to prenatal and delivery care counselling, indicating a lack of FP outreach by outreach health workers. This could be attributed to Indian health initiatives over the last two decades focusing on maternal and child healthcare rather than FP. For example, after 2000, India launched two ambitious health initiatives under the flagship projects Janani Suraksha Yojana (JSY) and National Rural Health

Mission (NHRM) of the Ministry of Health and Family Welfare (MOHFW) of the Government of India (GoI). Through improved institutional delivery, prenatal care, and postnatal checks, these programmes attempted to reduce the vulnerability of maternal, neonatal, and infant mortality. As a result, the emphasis on enhancing maternity and child health (MCH) services may have influenced CHWs' engagement in family planning. As a result, the emphasis on enhancing MCH services may have influenced CHWs' engagement in FP.

Another reason for limited FP outreach and discussion is that monetary incentives for FP, particularly for ASHA's staff, are lower than for MCH-related duties, as per the findings of this study. With the exception of female sterilisation, CHWs, particularly ASHA;s, were paid and rewarded less for FP outreach than for pregnancy, delivery, and postnatal healthcare services..

The findings also revealed that understanding for FP was greater among educated and wealthy women than illiterate and underprivileged women.(7)

Women were found to be more likely than men to report talking about contraception with their partners. This might be because conventional family planning campaigns have mostly targeted women for family planning education. As a result, women maybe pre-disposed to face the burden of initiating family planning discussions.

We identified no predictors of variances in preferred family size, which maybe attributed to small real difference between the majority of couples who did react discordantly. The empowerment of women was shown to be significantly associated to spousal communication regarding contraceptive use as well as contraceptive use reporting. Women who have more literacy and autonomy believe they have equal decision-making power and are more aware of contraception are more likely to have discussed contraception with their spouses. These factors predicted both jointly reported conversations and instances in which women reported communication but their husbands did not. (4) Our findings indicate that discordance is important not only as a measurement issue, but also as a representation of fundamental disparities that exist among these couples, which may impede their reproductive autonomy.

Limitations-Responses from the interviewed ASHA's may present a distorted view of reality due to social desirability bias. Since she herself is a member of the same community in which she works, her perception driven by the same social norms and cultural ethos which (in the absence of regular capacity building) impedes her job responsibilities and strongly also directs her work approach and deliverables, eventually diluting her role as an

influencer Future research should address the same questions of respective respondents - women from the same community - to better understand their knowledge, perception, and intention about family planning practises.

Major Concern/ Critical analysis & Observation

As the Indian society is extremely divided, with urban, slum, and rural populations all having their own distinct identities. In their attitudes about sex, sexuality, and contraception, rural communities in particular are neither assertive nor inclusive. Because family planning is often seen as a personal concern, public understanding of the advantages of contraception is limited. As a result, it is critical that ASHAs receive sufficient training in order to break down social & communication barriers surrounding contraception and promote family planning information.

ASHAs are active female community members who are chosen via a competitive procedure to give assistance for a variety of health issues that are unique to the rural and urban regions they serve. She is not a medical professional, although it is normally expected that she be qualified to a level of 10 standard

Even though they bridge the gap between the community and the public health system, ASHAs are critical components of the NHM and the Ministry of Health and Welfare. Despite their critical role in promoting health practices in the community, the ASHA workers interviewed have been subjected to significant stress and have been denied primary access to a decent living. ASHAs reported that they do not get a fixed income and that their incentive is erratic and inconsistent. Incentives are largely oriented toward permanent and long-acting contraceptive techniques; training is inadequate and lacks in-depth instruction on spacing choices. There is a dearth of education on FP as a concept, the reproductive cycle, and its relationship to pregnancy.

Furthermore, ASHAs are unfamiliar with the concepts of reproductive rights and reproductive self-determination; and finally, ASHAs' work is frequently hampered by social and cultural factors.(10)

Conclusion

Given the importance of the family planning services they provide, they require comprehensive, ongoing training and support to ensure that they are providing accurate information about FP methods to their clients so that they can make an informed choice. An ASHA's advice to a single person or a couple could mean the difference between an unwanted pregnancy and a successful birth spacing.

Way Forward

1)ASHA are highly dissatisfied with their remuneration and feel that they should be paid a set remuneration on a monthly basis.

2) Institutionalising acknowledgment ASHAs work and performance for exceptional field work or service delivery.

3) Periodic trainings on counselling strategies to enable ASHAs to break down socio-cultural communication barriers in the community, in addition to the technical components.

4) State-level development partners to be made responsible for supportive supervision, execution, and assessment and capacity building of the ASHA.

5) The distribution of smartphones and digital literacy to ASHAs in order to facilitate effective communication and counselling.

6) Male community health workers, like ASHAs, are required in the community to involve and engage men as partners and beneficiaries in Family Planning services.

7) Joint counselling (spousal counselling) should be promoted more to develop better understanding about family planning practises among couples.

8) A day or platform should be set aside for couples (especially recipients of *Adarsh Dampati Yojna*) to discuss their experiences with contraception and family planning techniques with other couples.

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Annexure 1

S.NO	Documents
1.	Evidence Table
2.	Themes and Sub-themes
3.	Guideline/Tool
4.	Comprehensive Thematic Mapping
5.	Code Dictionary

Tanya Singh report

ORIGINALITY REPORT

12%	8%	7%	3%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	www.ncbi.nlm.nih.gov Internet Source	3%
2	Abhishek Kumar, Anrudh K. Jain, Faujdar Ram, Rajib Acharya, Ankita Shukla, Arupendra Mozumdar, Niranjan Saggurti. "Health workers' outreach and intention to use contraceptives among married women in India", BMC Public Health, 2020 Publication	2%
3	Submitted to Trinity College Dublin Student Paper	1%
4	stodd-art.com Internet Source	1%
5	insights.careinternational.org.uk Internet Source	1%

CARE India Solutions for Sustainable Development

Date: 24/06/2022

Internship completion certificate

This is to certify that **Tanya Singh** pursuing **Post-Graduate Diploma in Hospital and Health Management (PGDM)** at the **International Institute of Health Management Research (IIHMR), Delhi** has completed her internship with **CARE India Solutions for Sustainable Development (CISSD)** from **11/04/2022 to 24/06/2022**.

As a part of this internship, she successfully delivered the following assignments:

1. Literature review, themes and sub themes, comprehensive thematic mapping, tool development, data collection, data management and analysis of study topic: **Influencers and Modifiers of family planning (with a special emphasis on role of ASHAs)-at Community, Family and Individual level-a qualitative deep dive.**
2. Conducting In-Depth Interviews (IDIs) among the eligible participants regarding the mentioned topic of interest and allied factors in three districts of Bihar (Arwal, Vaishali & Patna). Transcribing the In-Depth Interviews (IDIs) within 24 hours of interview maintaining accuracy and sanctity as well as cross-checking other colleagues' transcriptions against the audio recording. Coding of In-depth Interviews done through Atlas-Ti software. Got exposed to Data management, Data cleaning and analysis Using SAS and MS-Excel. Learnt the Basics of & worked on MS-word/Power-point/Excel, and EndNote.
3. Writing the comprehensive Internship report and made a Power-Point presentation by contextualization of the analytical findings with the summary of the literature review.
4. Presentation editing and compilation of district stories depicting the progression of health and nutrition related indicators in Bihar from 2014-2021.
5. Presentation editing for Health and Nutritional Situation Assessment (HANSA) project.

During this period, she displayed very good adherence to protocols, punctuality, clarity of understanding, writing skill, teamwork, commitment, sincerity and diligence with analytical progress. Based on her learning abilities and efforts, it appears that, given the level of effort and aptitude she has, if given chance she can become a very important contributor in public health research and implementation sector of India.

Wishing her the best for the future,

Dr Tanmay Mahapatra
Team Lead, CML Unit

Regards
Dr. Anup Gopalakrishnan Nair
Deputy Director HR & OD

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Certification of Approval

The Summer Internship Project Titled **"Influencers and Modifiers of Family Planning at Community, Family, and Individual Level-a qualitative deep dive "** at **CARE India Solutions for Sustainable Development (CISSD),Bihar Technical Support Program (BTSP),** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn there in but approve the report only for the it is submitted

Dr. Sidharth Sekhar Mishra

MBBS, MD Community Medicine (AIIMS), DNB (PSM)

Assistant Professor

IIHMR-Delhi

CARE India Solutions for Sustainable Development

FEEDBACK FORM

(ORGANIZATION SUPERVISOR)

Name of the student: Tanya Singh

Summer Internship Institution: CARE India Solutions for Sustainable Development

Area of Summer Internship: Influencers and Modifiers in family planning(with a special emphasis on role of ASHAs)-at community, family and Individual level-a qualitative deep dive

Attendance: Perfect adherence to internship norms

Objectives Met: The student understood the details of the concept, theoretical underpinning, worked on the literature review, guideline development, study implementation and participated in the analysis and interpretation

Deliverables:
Literature review, Evidence Table, Themes and Sub-themes, tool development, Comprehensive thematic mapping, prepared exhaustive code dictionary, data collection, data management and analysis by thematic extraction for study topic: Influencers and Modifiers in family planning -at community, family and Individual level-a qualitative deep dive. Supported in presentation of slide decks and compilation of district stories depicting the progression of health and nutrition related indicators in Bihar for 2014-2021. Supported in presentation of slide decks for HANSA project, DMT Outreach project. Literature review for Methods of Spacing. Prepared the above deliverables using PowerPoint, ATLAS.TI, SAS, EXCEL, Endnote.

Strengths: Sincerity, attention span, concentration, hard work, diligence, detail-oriented ness and proactiveness

Suggestions for improvement: Communication skill, scientific writing, subject and programmatic knowledge, analytical thinking and skills

Signature of the Officer-in-charge

Date: 17.06.2022
Place: Patna, Bihar

Local Mentor: Dr Tanmay Mahapatra

Deputy Director HR: Dr Anup G Nair

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