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

By

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I perceive 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, to attain my desired career objectives. Hope to continue cooperation with all of you in the future.
Sincerely,

Aradhana 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, New-born and Child Health

UN-United Nations

Organization Profile

CARE INDIA is a nonprofit organization that builds the capacity of communities to ensureempowerment 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 a strong network of partnerships to deliver outcomes at scale to varied stakeholders.

CARE India is a part of the CARE International Confederation, which is helping millions ofpeople in living a life of dignity and has a presence in over 100 countries. They have been contributing to India's explosive growth for 75 years, starting from the time when 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 out 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

Influencers and Modifiers of Family Planning at Individual, Family, and Community level

Background

The government of India has been implementing various centrally sponsored schemes that offer financial incentives (FIs) to acceptors as well as service providers for services related to certain FP methods since 1952 when it became the first country in the world to launch a national program for family planning. It is the first country that initiated the slogan “HUM DO HMARE DO”.

Family planning has remained an important aspect of the country's national population strategy and reproductive and child health programs, which have been adopted and executed regularly. After the 1950s, a variety of programs were established to boost the use of family planning services. Due to long-term efforts, India's contraceptive prevalence rate (CPR) has increased fivefold over the last five decades, rising from 11% in 1970 to 54% in 2016, and due to the provision of a voluntary choice in family size norm, the number of births per woman has decreased from around six in 1970 to around two in recent years. (1)

India, now as we all know, is a densely populated country. Various programs, as well as healthcare staff, have undergone a shift in terms of policy and real program implementation to mitigate the problem. Permanent contraceptive methods, primarily female sterilization, are nearly responsible for the recent drop in fertility, accounting for roughly two-thirds of worldwide contraceptive use. Providing all people with access to their preferred contraceptive methods advances several human rights, including the right to life and liberty, freedom of expression and opinion, and the right to work and education, as well as providing major health and other advantages. (2)

In 2019, there are 1.9 billion women in the globe who are of reproductive age (15–49), of which 1.1 billion need family planning, of which 842 million are utilizing contraceptive methods and 270 million do not. Sustainable Development Goals (SDG) indicator 3.7.1 shows that the percentage of family planning needs to be addressed by contemporary methods has stalled at roughly 77 percent globally from 2015 to 2020 but grew from 55 to 58 percent in the African region. The human right of people to choose the number and spacing of their children is advanced by the use of contraception. India's FP 2020 commitment to provide around 48 million additional women with modern contraceptives and the anticipated population receiving contraceptive services, maintaining the quality of care (QoC) is critical both for contraceptive uptake and continuation Since Independence in 1947, the country has developed an extensive network of primary health centers (PHC) and sub-centers (SC) staffed by doctors and Auxiliary Nurse Midwives (ANMs) as well as male health workers to provide basic medical care to huge (80 %) rural population. In 1966, the Mukerjee committee suggested a target system to achieve family planning goals and the fourth-fifth plan decided to integrate family planning with the MCH program. (3)

Introduction

Providing everyone with access to their preferred forms of contraception enhances various human rights, including the rights to life and liberty, freedom of speech, employment, and education, as well as providing important health and other advantages. When births are separated by less than two years, the infant mortality rate is 45 percent higher than when births are separated by 2-3 years, and it is 60 percent higher than when births are separated by four or more years. Contraception reduces the health risks associated with pregnancy for women, especially teenage girls.

In the rural health care system, the ANM is the key field-level functionary that interacts directly with the community and has been the central focus of all the reproductive child health programs. Over the years with changes in program priorities, the role and Today's capacity of the ANM have changed substantially. Multi-purpose worker (MPW) is more involved in family planning and preventive services in contrast with ANM of the sixties who was providing delivery and basic curative services to the community. ANMs were posted in sub-centers for maternal child health besides treatment of common illnesses and were viewed as a replacement for a professional cadre of midwives in PHC. Within maternal care, the emphasis was on antenatal care (ANC) and delivery care. Most ANMs were required to stay at the sub-center village and conduct deliveries. There were few private health facilities in rural areas. An ANM needed to stay at the headquarters village. This requirement was strictly enforced by the medical officers and district health officers. (4)

With a total fertility rate of 3/4, Bihar has the highest fertility among Indian states. Bihar's rural areas are in a worse state than its cities. While there have been continuous discussions about how FP programmes could have been improved both inside and outside of Bihar, it is crucial to look beyond the conventional considerations taken into account when creating FP strategy. To

identify socio-cultural or demographic issues that need to be prioritised, more strategic rethinking is required. (5)

Review of literature

1) In article Migration and family planning in the state with highest total fertility rate in India. There are 38 districts in the eastern Indian state of Bihar, which has a population density of 1102/km2. Rural areas are home to around 89 percent of the population. One of India's largest migration rates occurs in this state. The state ranks among India's worst performers when it comes to family planning. Only 24%

of women aged 15 to 49 reported using a contemporary contraceptive, with female sterilisation accounting for more than 85% of this. About 21% of women had unmet family planning needs. According to author Bidhubhusan Mahapatra's, findings include 46 percent of women reported having a migrant husband. Women's profiles did not significantly change depending on their husbands' immigration status. the migratory environment, as well as husband's migration, has an impact on women's contraceptive use and access to FP services. Given that a large percentage of married men leave their home states for work, FP programs in migration-affected countries must develop and implement migration-centric FP implementation techniques. (5)

Objectives of the Study

The objectives of the study are stated below:

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

Methodology

A. STUDY DESIGN- Exploratory study.

B. STUDY SETTING- in the state of BIHAR, within 3 districts namely Patna, Arwal, and Vaishali

C. STUDY POPULATION-

ANMs of different districts of Bihar

D. SELECTION CRITERIA-

- Inclusion Criteria- it's done in 2 categories: -
    - ANMs who are available at PHCs
    - Outreach ANMs
- Exclusion criteria-
    - ANMs who don't go for field visits
    - ANM who refuses to provide consent or record their interview.

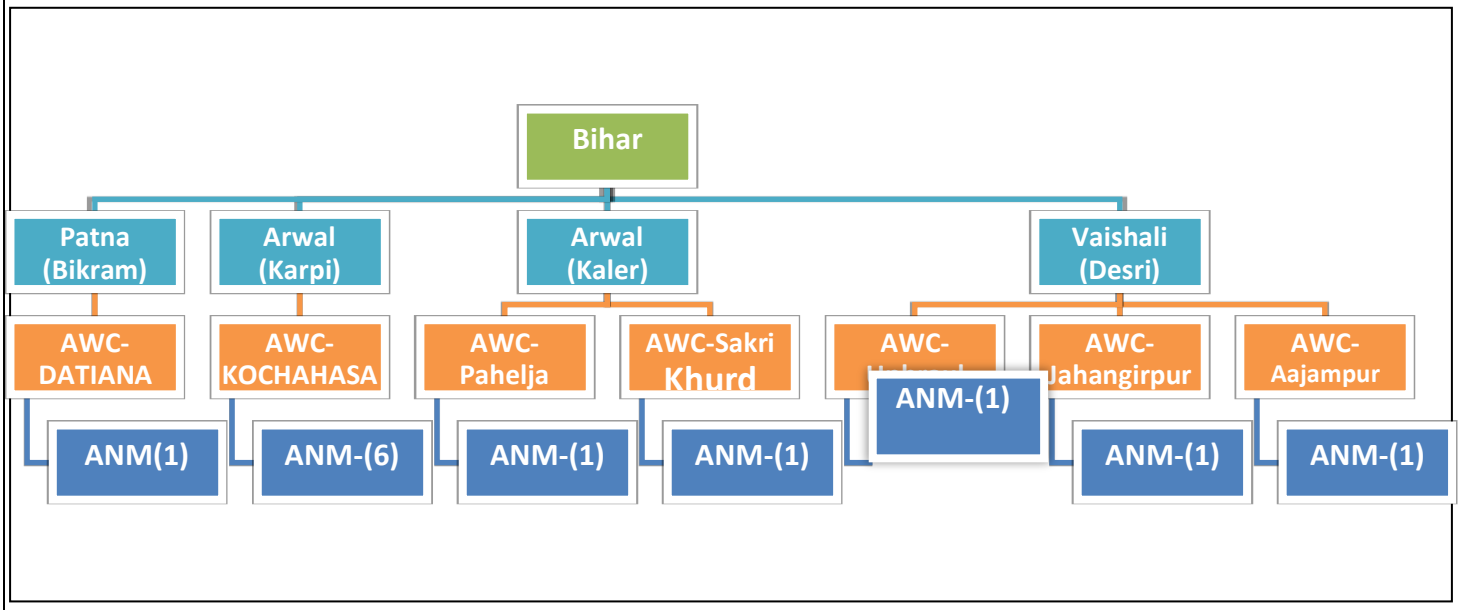
E. SAMPLE SIZE- The sample size was 12.

F. SAMPLING METHOD-

Random sampling was done to select the districts of Bihar, then blocks of Arwal and Vaishali, and then villages but convenience sampling was done to select ANMs of the District.

G. METHODS OF DATA COLLECTION-

Through self- prepared qualitative tool guide and audio recorder.



Result

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

Community Family Planning Profile and Perspectives

- some of the ANMs are aware of the traditional method but in a general form not in scientific terms.

  “hm btate hai ki jab pati-patni sath rahe toh sambhog ke dauran beej ko mahila me giraane ki jagah bahar hi nastt kar de, ya fir pati-patni ek dusre se doori banake rakkhe”(We tell that when husband and wife live together, they should prefer coitus interruptus, or maintain distance during the unsafe period)_ANM, Vaishali District
- Majority of them have no idea about the traditional method

Client provider interaction

- Most of the women prefer Antra rather than Chhaya because it’s their perception that Chhaya contains Hormones whereas Antra is free from hormones so it’ll be less harmful
- we found that one of the ANM’s own perceptions was to use contraceptives after giving birth to at least one male child

  “hum toh khud hi bolte hai ek beta ho jae uske baad operation kara lijye”(I told them, if you had given birth to a male child, then after you can get the operation done)_ANM, Arwal District
- Due to lack of knowledge they don’t understand whatever they are taught in counseling
- Parents could decide but mostly in joint family final decision was seen to be of guardians jointly or either of them in some families
- In our findings we got if a couple doesn’t have a male child then they don’t have any respect in their community

"aap nahi jaante hai yaha jiska ek bhi beta nahi hota hai uska samaaj me koi ijjat nahi rehta hai"_ANM, Vaishali District

- Majority of ANMs are not aware of the relationship between menstruation and pregnancy

  "mens hone ke 5 din baad tak garbhvati hone ka darr bana rehta hai"(Fear of getting pregnant persists for 5 days after menstruation)_ANM, Arwal district
- majority of ANMs are knowledgeable and know everything about different contraceptives
- Mother of 5 children is resistant to the use of any contraceptives or operations
- Few ANMs don't know how to use contraceptives and what is the relationship between menstruation and pregnancy
- Counselling is the main reason to influence people about using different contraceptives

  "Main sab chiz hai counselling ke upar, yadi hm acche se counselling karte hai toh log samjhte hai agr counselling sahi se nahi hoga toh sab bolega are kya bakar bakar kar rahi hai"_ANM, Vaishali District
- Beneficiaries switch contraceptives because of excessive bleeding due to use of injectables.

  "wo log islie bhi prayog nahi karna chahti hai ki kisi ka jada bleeding hone lgta hai ya jada dhadh girne lagta hai"

Male Engagement in family planning

- They feel shy in interacting with males during counselling
- Only a few men want to do sterilization. Most of them have lots of misconceptions about contraceptives and male sterilization

- Majority of males don't want to take participate in family planning

Service Provision

- "Pakhwara and VHSND" are the major source where ANMs used to talk about family planning and counsel about different types of contraceptives to beneficiaries.
- ANMs talk about all the pros and cons of every contraceptive then after if beneficiaries are interested ANMs give them that method.
- Generally ANMs handle any kind of little problems but when any major issue occurs ANMs refer beneficiaries to the higher authority or hospitals.
- ASHAs maintain their daily routine dairy and according to that ANMs check whom and when to meet again.

Barriers to family planning and contraceptives

- ANMs are threatened and abused as they talk about family planning to beneficiaries

  "ek aurat ko 6 baccha tha, usko family planning ke baare mei btane gye toh gaali dene lagi"(A woman had 6 children when ANM went to tell her about family planning, she started abusing her)_ANM, Arwal District
- When ANMs visit upper-caste beneficiary's homes they are not treated properly

  "ucha caste wale ke ghar gaye the toh paani niche rakh ke pair se ghaska kar ke dia wahi agar Chhota logo ke ghar jaate hai toh ijjat se jo rehta hai wahi deta hai"(When I had gone to the house of the upper caste, they put the water down and dragged it from their leg while when I visit the house of lower caste people, they offer whatever they have with respect)_ANM, Arwal District
- Lack of providers of Contraceptives

"Vidhi ki kami nahi hai lekin dene wale ki kami hai"_ANM,Arwal District

Provider motivation / Improvement

Changes can be made in the use of contraceptives if we give proper counselling to village people, Due to a lack of knowledge about contraceptives they avoid using it

Support for Ongoing Work

- Locals and the head of the village (mukhiya ji) cooperate with ANMs to influence people about Family planning and the use of different contraceptives
- Seniors provide different types of training according to need
- Few ANMs gets appreciation for their work by the head of a health facility

Myths and misconception

- Women avoid contraceptives because their perception is that, contraceptives can be harmful and can cause death also.
- They think that teenagers are not allowed to know about family planning and different contraceptives because it can deviate their minds in the wrong direction
- If a woman washes her hair after menstruation and then comes in contact with her husband, she gets pregnant

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 low (and especially low for temporary methods). From intention to actual usage, there was a further decrease. We investigated access, age, education, and other demographic factors to determine what was driving this low intention to use. While these factors predicted usage intention in part, their influence varied depending on the strategy. 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 in influencing uptake. Social norms against usage and shame associated with obtaining modern contraceptives were widespread, while risk perception was high regarding method side effects–particularly fear of infertility from temporary methods–but low regarding the consequences of not using FP for having an unplanned additional or inadequately spaced child. The data implies three distinct decision-making routes for how various communities, families and individuals handle the FP pathway: those who ignore it entirely, those who use temporary ways but eventually abandon it, and those who use temporary methods but eventually switch to permanent methods.

Previous study has revealed that another approach might emerge in which families utilise permanent contraception without using any other type of contraception.(6) 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 and significant effect on contraceptive intention, which was not the case in this study's findings. This study's findings are comparable with other research conducted in India, which revealed that contact and advise on FP between clinicians and clients was comparatively low when

compared to counselling on prenatal and delivery care, indicating a lack of FP outreach by health workers. This might be because Indian health initiatives have focused heavily on maternal and child healthcare rather than FP over the last two decades. For example, after 2000, India started two ambitious health initiatives under the flagship projects Janani Suraksha Yojana (JSY) and National Rural Health Mission (NHRM) of the Government of India's (GoI) Ministry of Health and Family Welfare (MOHFW). 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.

The findings also revealed that understanding for FP was greater among educated and wealthy women than illiterate and underprivileged women. The FP outreach of health personnel did not differ depending on social class, such as caste or religion of women, and the trend remained consistent over time.

Women were 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 may face the burden of initiating family planning discussions, predisposing them to recall their interactions.

We identified no predictors of variances in preferred family size, which might be due to the 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. When women are more educated, have more autonomy, believe they have equality in decision making, and are more aware about contraception, they are more likely to have discussed contraception with their spouses. These characteristics predicted jointly reported talks as well as instances in which women reported communication but their husbands did not. Our findings suggest that discordance is essential not just as a measuring issue, but also as a depiction of fundamental disparities that exist among these couples, which may impede their reproductive autonomy, as per the study men involvement in family planning programmes provides couples with a significant chance to articulate their preferences and maybe negotiate reproductive decisions jointly.

Limitations-Responses from the interviewed ANMs may include partial view of the reality due to social desirability bias. As she herself is the member of the same community where is works, her perception influenced by the same social norms and cultural activities. They are affected by the same perception as they see in their community. As some of them are educated and try to educate people but due to lack of knowledge and education they deny to follow.(7)

Conclusion

Given the importance of the family planning services they provide, they require comprehensive, continuous training and hand-holding support to ensure that they are delivering

accurate information about FP methods for their clients to make an informed choice. An ANMs counselling to a single person or a couple might make a crucial difference between an undesired pregnancy and a successful birth spacing.

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