Exploration of Drivers of Birth Spacing Among Rural Women: Evidence from three Blocks of Patna District, Bihar

By

Bibha Prasad

Dissertation submitted for the partial fulfillment of the

MBA Rural Management

Academic year, 2017-2019

The IIHMR University, Jaipur

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IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Bibha Prasad, student of Rural Management from The IIHMR University, Jaipur has undergone internship training at CARE India, Bihar from 25 February 2019 to 3 May 2019.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.

Dean, Academics and Student Affairs
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CERTIFICATE

The certificate is awarded to
BIBHA PRASAD

In recognition of having successfully completed her
Internship in the department of

Bihar Technical Support Programme
and has successfully completed her Project on

DRIVERS OF BIRTH SPACING AMONG RURAL WOMEN OF PATNA DISTRICT, BIHAR
25th FEB'19- 03rd MAY'19
CARE INDIA, BIHAR

She comes across as a committed, sincere & diligent person who has a strong drive
and
zeal for learning
We wish her all the best for the future endeavors

Deputy Director-Human Resources

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"An exploration of drivers of birth spacing among rural women: evidences from three blocks of Patna district"** and submitted by Bibha Prasad Enrollment No. IIHMR-U/03/2017-19/0023 under the supervision of Prof Rajiv Ranjan for award of MBA in Rural Management in Health and Hospitals of the University carried out during the period from 25 February 2019 to 3 May 2019 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Bibha Prasad.

Signature

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ABSTRACT

Background:

India accounts for 2.4% of world's total surface area, yet it supports 17.5 % of the world's population. 42 % of population increase is contributed by birth beyond two children per family. Birth spacing is defined as the time interval between two births. India has average birth spacing of 22 months, i.e. little less than two years, despite wide knowledge of contraception. Even though variety of safe and effective methods of contraception available, many women are not using any method of contraception. Objective of this study was to explore the drivers of birth spacing among rural women.

Method:

A qualitative study was employed in the three blocks of Patna district among the women of age group 15-25 years. An in-depth interview was conducted with the help of designed guidelines after getting informed consent.

Results:

Most of the women were aware about the different FP methods but the knowledge about need and benefits of spacing of child birth is inadequate, to use FP methods. Friends and family members were the key person who act as a source of awareness. There were still many misunderstandings about the practices which were not being followed up by specialist or FLWs to eradicate the misconceptions and to enhance the promotion. Awareness about the source of availability was still very limited as a result the basket of choices was being restricted as they were guided only about the very limited choices. The various factors that significantly influence family planning methods use in the study area were age, parity, migration, family pressure, incomplete knowledge, traditional factors, availability, satisfaction level, decision making power, and lack of counselling. Maternal and child health was the main concern of the respondents for spacing between the children but completion of family size at the earliest is the most adopted practice of the community.

Conclusion:

The study reveals that more efforts are required to motivate couples for contraceptive usage and educate them about their benefits, to encourage girl child education so that avoiding too many pregnancies, thus to achieve reduction in maternal and perinatal mortality and morbidity along with population stabilization. It shows that education does not act as a factor for improving awareness of need as well as benefits of child spacing.

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A. ORGANIZATIONAL PROFILE

A.1 OVERVIEW OF CARE

CARE (Cooperative for Assistance and Relief Everywhere), founded in 1945 is an international non-profit organization contributing in the field of humanitarian relief and development support. It is working in ninety-four countries addressing the need of emergency response, food security, water and sanitation, economic development, climate change, agriculture, education and health advocating at the local, national and international levels which helps in making policies helpful for the rights of poor people.

For over the time period of 65 years, CARE has been working in India focusing on alleviating poverty and social exclusion through several programmes in health, education, livelihoods, disaster preparedness and response. The primary goal of the organization is to empower the women and girls from poor and marginalized communities, enhancing their lives and livelihoods. Its main target is to identify the root causes of healthcare challenges and provide innovative solutions to help in implementing secure accessible and quality maternal and child healthcare among the vulnerable section by working in close collaboration with State and Central Governments and other partner organizations.

To address the health challenges in Bihar, CARE India launched the BTSP (Bihar Technical Support Program). BTSP has started working with CARE India's Integrated Family Health Initiative (IFHI) project in 2011 with the objective to save the lives of mother and children in Bihar. CARE stands as a pillar to support the Government of Bihar to strengthen and improve reproductive, maternal, newborn, child, adolescent, and nutrition outcomes, including the continuum during the first 1000 days-from conception to child's second birthday. Its intervention focusses on better counselling and emergency preparedness for the mother and newborn, building Basic Emergency Obstetric and Newborn Care (BEmONC) capabilities, improved management of neonatal infections, early initiation and exclusive breastfeeding, complimentary feeding, increased immunization, and expanded access to quality family planning services and birth spacing methods.

Key innovations and interventions

There are wide range of services provided by CARE in Bihar, but apart from this CARE also developed and piloted innovative solutions that address the various issues which facilitate access to high health quality services in Bihar. These innovations were made in the context of Bihar but many of them have scaled nationally. Some of these innovations are mobile health for continuum of care services, tracking and management of very low birth weight babies, Incremental learning approach, Team-based goals and incentives, Quality improvement at health facilities, Mobile nurse mentoring program.

CONCURRENT MEASUREMENT AND LEARNING UNIT-

There is a separate vertical in the organization known as CML which is responsible to generate data independently based on Logical Framework Approach (LFA), which provide a reliable mirror to program leadership of the TSU and the Government. It uses data expertise to help the other TSU team as they work with the government programs to improve data quality and use. The data generated by the CML team complements and to an extent validates the information that is available from the MIS of the two government programs as well as the data gathered are reported by DRUs and SRU. In order to implement this structure with the intended roles and responsibilities for each stakeholder, a monthly rhythm of internal data-based reviews, scheduled for a week in month as a 'home' week has helped guide the internal functioning of the TSU, and provide opportunities for ongoing internal capacity building. (CARE India, 2018).

A.2. LEARNINGS FROM ORGANIZATION

A) WORK FOR A CAUSE

Organization has a core belief of working for the development without making its separate identification. It works with the government amalgamating its identity for securing health services effectively.

B) TEAM WORK

There is a combined action of all the members working in three different tiers of state, district and block. Inputs from each level are taken into consideration while planning and implementing any project.

C) CONFLICT MANAGEMENT

The innovative ideas from each level sometimes creates a situation of conflict which is well managed by the head of the team or the senior members in the group without creating an environment of humiliation or disrespect.

D) SELF-REGULATION

Regular contact with the communities or with the different stakeholder influences the emotion and behavior which is self-regulated carefully with each member in the organization. Personal discomfort and values of each employee are kept while visiting community and the communities are treated with high respect and dignity.

E) COMMUNICATION SKILLS

Communication skill is the essential key required for involvement either within the organization or outside the organization. Learning how to adequately deliver the key messages is most important. Various methods are adopted for a mutual participation between the organization and community. Some of them are storytelling, involving the community persons with local dialects, etc.

F) PERSUADING AND INFLUENCING SKILLS

It is very important to convince the communities to work with them. Organization members create a healthy and friendly environment in the community which build the atmosphere of trust and confidentiality which collectively make a positive ecosystem to work.

G) TECHNICAL SKILLS

Organizational programmes has enhanced my knowledge on various core issues of public health sector which helped me a lot to learn and observe the ground realities. Various extra training classes organized within the organization for the learning of employees on data analysis software namely SAS and ATLAS Ti has intensified my skills.

B. RATIONALE FOR THIS STUDY

India has played a significant role towards achieving the SDGs. It has made a remarkable improvement in various health indicators. There is a decrease in infant mortality rate from 57 in the year 2005-06 to 41 in 2015-16 (NITI Aayog). Similarly, Under-5 mortality rate has declined from 74 to 50 over the same time period. Some of the goals of India in achieving SDG is to reduce poverty; to reduce stunting, maternal mortality ratio, Under-5 mortality ratio, adolescent birth rate; to secure food; providing quality primary education; clean water and sanitation; decreasing child labor; sustainable cities and communities. These all goals can somewhere be more achieved with the decreased population. Thus, a family planning-sustainable development goal model have identified family planning programs to be more cost-effective intervention to achieve SDGs effectively and efficiently. Family planning alone is a means to bring more benefits to many populations at less cost than any other single technology available now to the human race- UNICEF.

Bihar is the third most populous state, which has seen a tremendous decrease in its TFR from 4.2 in 2006 to 3.3 in 2016. Yet, Bihar has been reported as the worst TFR among the states in India at 3.3 in 2016 (Source: NITI Aayog). Except Patna and Arwal, TFR is high in all other districts of Bihar. Birth spacing is defined as the time interval between two births. On an average, India has a birth spacing of 22 months, despite having the wider knowledge of family planning methods [2]. Short birth spacing are associated with negative maternal health outcomes as well as negative perinatal, neonatal, and infant health outcomes. The spacing interval in Bihar is of two years on an average which is considered good for the rural community (CARE, MWRA survey, 2018). Yet, MMR of Bihar is 165 which is sixth highest state in the country and IMR is 38. So, this study is conducted to understand the factors contributing towards the acceptance of family planning method which can help to improve the health indicators of the state.

C. INTRODUCTION

Sustainable Development Goals (SDGs) aims at promoting universal access to sexual, and reproductive health services in which one of the main targets is to promote family planning. The population of India in 2017 as per World Bank is 1.33 billion which is approximately 17.74% of the total world population and population growth rate of India is 1.1% annual change. Bihar is third biggest state of India as far as population is concerned. As per projection, population of Bihar in 2018 is 12.57 crore (census 2011). Severe growth in population has adverse impacts such as air and water pollution,

deforestation, depletion of ozone layer, extinction of species, land/soil degradation, burden on natural resources, limited opportunities, global warming and climate change which creates health issues and collectively all influences the economic growth. Bihar is the fifth economically backward state of India due to several reasons among which one of the highest reasons is overpopulation. Factors influencing population growth are unmet needs of family planning, age at marriage and first child birth, spacing between births, and various other socio-economic factors (Annual report of Department of Health & Family Welfare, GoI, 2015-16 [15]). Population of a state influences several social parameters among which one of them is health and nutrition, such as reproductive; maternal; and sexual health issues and levels and trends in births, deaths, and migration that determine population growth and age structure (Health, Nutrition, and Population Discussion paper, World Bank, 2007 [18]). Higher fertility increases the risk of maternal and infant mortality. Some determinants of high fertility in India are early marriage which result in too early, too frequent and too many pregnancy, female illiteracy and lack of use of contraceptive methods (Sambath S et al, 2016 [1]). Bihar is the state with highest TFR i.e 3.3 in 2016(NITI Aayog). Mortality risk falls with length of birth interval (Arthur V. S., Unnati R. S, 2018 [6]). Birth interval length increases with various factors such as mother's age at the previous birth over the whole reproductive age range, mother's education level, socioeconomic status as use of family planning is more common among higher socioeconomic status groups, whereas infant death of the previous child shortens the subsequent birth interval (Arthur V. S., Unnati R. S, 2018 [6]). Birth-to-pregnancy intervals of around 18 months or shorter are associated with elevated risk of infant, neonatal and perinatal mortality, low birth weight, small size for gestational age, and pre-term delivery. There is a higher risk of neonatal death with very short BTP intervals (<nine months) compared with longer intervals (27–50 months), with risk remaining somewhat elevated for intervals 15–27 months long (WHO Report,2005 [7]). Although longer spacing is likely observed for families with the strongest son preference because they are reported using sex-selective abortions. So declining fertility is an important factor in the decision to use sex- selective abortions (Claus C Portner, 2016 [5]). Family planning ensures the birth spacing which reduces the fertility rate. The ten family planning and pregnancy related items are ranked as follows from most to least risky: sterilization; abortion; getting pregnant soon after having a baby (no birth spacing); pill, IUD, injectable; having a birth under 18 years of age (teenage motherhood), condom use, having six children; and fertility awareness methods but inadequate birth spacing was rated as more risky than all contraceptive methods and pregnancy related events except for sterilization and abortion (Hilary M. S, Joanna S, Luciana E. H, Lisa C, Abdulmumin S. and Mojisola O, 2017 [4]). The drivers of family planning usage are a set of multiple

factors range from individual and social factors, parity, age, level of education, attitudes, cultural factors, availability and access factors to factors related to the attributes of the contraceptive methods such as fear of side effects (Justin G. O, Joseph K. W, and Albino K). The most common reason for not using contraception is husband's opposition followed by opposition by other family members, fear of complications and lack of awareness (Shanthadevi S, Thangamani B, ShanthiraniI l, Mahalakshmi A, Shanthavibala S, 2016 [1]). Education is a major factor improving awareness of need as well as benefits of child spacing. Well-educated females (schooling more than 8th standard) were more likely to be practicing child spacing as well as less likely to have husband's or in-law's opposition to child spacing (Bindoo Yadav, Santvana Pandey, 2018 [2]). Family planning program substantially reduce fertility which is also associated with better schooling and child health, reduced maternal mortality and morbidity, increased percentage of women's labor force participation, and higher household earnings, which if properly managed can transform living standards permanently (Monica D Gupta, John B, and John C).

C.1. FAMILY PLANNING

Family planning is defined as set of activities which enable one including minors to plan freely about the number and spacing of their children and to choose the means through which this can be achieved (WHO Guidelines). It helps couple in making decision of number of children they are wishing to have including the choice to have no children keeping age in consideration. While achievement of this depends upon many other factors such as marital situation, career growth, financial stability, and many more.

Family planning services provides various health benefits especially to the mother and children. It was therefore promoted with an objective to secure the well-being of women, which will support the health and overall development of the community. It prevents health risks in women related to pregnancy by allowing delay and spacing especially in young women. It also reduces the rates of unintended pregnancies, which overall reduces the need for unsafe abortion. Short interval birth often causes problem to child health and may even result in infant mortality, family planning plays a major role in reducing infant mortality. Its use helps in preventing sexually transmitted infections including HIV/AIDS, and thus reduced risk of unintended pregnancies among HIV infected women results in fewer infected babies and orphans. Early marriage and childbirth acts as a barrier for education among women, thus by making informed choices trough family planning provides an opportunity for women to pursue higher education and build their career. Additionally, small family size helps in the good

nurture of the children. This is very beneficial to the adolescents as adolescent mothers more tend to have preterm or low birth-weight babies which increases the rate of neonatal mortality. Most important, family planning acts as a key to slow down unsustainable population growth and its negative impact on the economy, climate, environment, regional and national development.

C.2. FAMILY PLANNING IN CONTEXT OF INDIA

India was the first country to launch a National Programme for Family Planning in 1952. From then, the programme has undergone various transformation in terms of policy and implementation. A gradual shift has occurred from clinical approach to the reproductive child health approach, and further in 2000, the National Population Policy has brought a holistic and target free approach to help in the reduction of fertility.

Over the years, various efforts have been made to expand the programme and make it accessible to every corner of the country. It has penetrated the primary health centers and sub centers in rural areas and Urban family welfare centers and post-partum centers in the urban areas. It is made easily available to a sexually active individual through midwives and other trained health workers. The 2011 census showed the steepest decline in the decadal growth rate as the advancement in technologies, improved access to quality healthcare have resulted in a rapid fall in the Crude Birth Rate, total Fertility rate, and Growth rate.

C.3. FAMILY PLANNING SERVICES

Family planning methods currently available in India may be broadly divided into two categories, spacing methods and limiting methods. Third category of the method is emergency contraceptive pills which are to be used in case of emergency.

C.3.1. Spacing methods-

These are the reversible methods adopted by the couples who wish to have intervals between their children. These methods are broadly categorized into two groups, modern and traditional methods.

C.3.1.1. Modern method generally includes:

i) Oral Contraceptive Pills (OCPs)

These are hormonal pills taken by a woman daily preferably at a fixed time. At present, ASHA provides the OCPs at the doorstep of beneficiaries with a minimal charge under the scheme of home

delivery of contraceptives. The brand popularly known as “MALA-D” is available at all public health centers free of cost.

ii)Condoms

This is mainly the barrier methods of contraception which provides the dual protection from unwanted pregnancies as well as transmission of sexually transmitted infections including HIV/AIDS. Condoms are available for female as well as male, but male condoms are widely popular. The brand “Nirodh” is available at government health facilities at free of cost and by the ASHA at the doorstep for minimal cost.

iii)Intra-Uterine Contraceptive Devices (IUCD)

For long term birth spacing, Copper containing IUCDs are highly effective methods. It is popularly known as Copper-T. Two types of IUCDs are available, known as Cu IUCD 375 which is effective for five years and Cu IUCD 380A effective for ten years. The user needs to follow up visit after 1,3 and 6 months of IUCD insertion as during this time period, the expulsion rate is the highest. Or anytime if the following symptoms are observed,

- P: Period-related problems or pregnancy symptoms
- A: Abdominal pain or pain during intercourse
- I: Infections or unusual vaginal discharge
- N: Not feeling well, fever, chills
- S: String problems

iv)Injectables

It is given intramuscular at the interval of every three months. First shot is given by an MBBS doctor after screening and subsequent shots by any other trained provider.

v)Lactational Amenorrhea Method (LAM)

It is temporary family planning method for new mothers whose menstrual cycle has not returned after the delivery. It requires exclusive breastfeeding at day times at the interval of four hours and at night for the interval of six hours of an infant less than six months old.

vi)Standard Days Method (SDM)

It is a method used to identify the fertile days of a woman by tracking the fertile periods using beads, calendar or other aids and unprotected vaginal sex are avoided during the most fertile days.

B.3.1.2. Traditional methods include:

i)Rhythm Method

It is a similar method to SDM, but the difference is women usually track their fertile days without using any aids and avoid vaginal sex for the time period which may result in the failure.

ii)Withdrawal Method

It is one of the riskiest methods in which man withdraws his penis away from his partners genital and ejaculates outside, but the estimation of proper timing of withdrawal is difficult which can lead to the unwanted pregnancy.

B.3.2. Limiting Method-

These are irreversible methods which can be adopted by any member of the couple. There are generally of two types-

i)Female Sterilization (Tubectomy)

There are two techniques used for female sterilization-

Minilaparotomy involves making a small incision in the abdomen by a trained MBBS doctor.

Laparoscopy is performed either by a specialist or an MBBS doctor by inserting a long thin tube with a lens in it into the abdomen by making a small incision.

ii)Male sterilization (Vasectomy)

It is performed by an MBBS doctor by making small incision or puncture in the scrotum. However, the couples are restricted to make unsafe sex for the first three months till no sperms are detected in the semen.

C.3.3. Emergency Contraceptive Pill (ECP)

These are hormonal pills consumed by woman within 72 hours after unprotected sexual intercourse.

C.4. STATUS OF FAMILY PLANNING IN INDIA

The data available from NFHS-4(2015-16) and DLHS-4 (2012-13) shows that the small family norm is widely accepted as the wanted fertility rate for India is 1.9 and the general awareness about family planning methods is almost universal. The data of NFHS-4 shows the decrease in unmet needs (from 13.9, NFHS-3 to 12.9, NFHS-4). The use of family planning method among married women of age 15-49 years is 53.5 percent in NFHS-4 whereas 56.3 percent in NFHS-3. This show a decrease in the usage pattern. It is observed that 46.6 percent of current users in NFHS-4 have told about the side effects of current method in comparison to 34.4 percent only in NFHS-3. Service of delivery by the health workers has increased from 10.1 percent in NFHS-3 to 17.7 percent in NFHS-4.

C.5. STATUS OF FAMILY PLANNING IN BIHAR

The data from NFHS-4 shows the decrease in total fertility rate of the state from 4 (NFHS-3) to 3.4 (NFHS-4). Total unmet need of the couple has decreased from 23.9 percent in NFHS-3 to 21.2 percent in NFHS-4. There is a huge decrease in the usage of family planning method as it has decrease from 34.1 percent in NFHS-3 to 24.1 percent in NFHS-4. The complains from the current user for the side effects of adopted method is very high as it has increase from 11.7 percent in NFHS-3 to 34.4 percent in NFHS-4. Whereas the service of delivery by the health workers has a steep increase from 5.8 percent in NFHS-3 to 12 percent in NFHS-4.

D. RESEARCH QUESTIONS

There are different indicators playing role for the usage of family planning method such as socio-economic and geographical factors, level of awareness and knowledge about the benefits of family planning methods, source of availability which arises a central research question:

- What are the factors affecting the acceptance and decision making of family planning methods?

E. OBJECTIVES

To have a basic understanding about the perception of rural women towards the family planning method through assessment of following:

- To find out the different drivers of birth spacing among rural women of Bihar.

F. METHODS

F.1. Study settings

The study was conducted in Patna district of Bihar. The district was selected as it has the lowest TFR in Bihar (NFHS-4) and birth spacing was also found to be appropriate. Thus, it was assumed that information collected from Patna was likely to provide best estimates of family planning method usage in Bihar and can also guide us regarding the program implementation strategy in other districts having poorer family planning indicators such as high TFR or low modern contraceptive prevalence rate (mCPR).

F.2. Study design

The study employed a qualitative design. It is explorative cum descriptive in nature, conducted over the time period from 25 February 2019 to 3 May 2019.

F.3. Participant profile and data collection

The study respondents were currently married women of age 15-25 years having 0 – 1 living children. The respondents were identified from three blocks from which one village was sampled purposively based on operational feasibility. In the selected villages, eligible respondents were identified with the help of Anganwadi workers. In-depth interviews were conducted with four eligible women in Fatwah block, four in Daniyawan block and three in Naubatpur block of Patna district.

F.4. Data collection instruments and procedures

An interview guideline, designed with inputs from family planning experts working for Bihar Technical Support Program (BTSP), was used for the in-depth interviews. The principal domains of inquiry were awareness about different family planning methods and their usage. Additionally, the study guideline also explored socio-demographic characteristic of the respondents, factors influencing adoption of family planning among the respondents, source of family planning related knowledge and beneficiary perceived role of FLWs in imparting behavior change. At the time of data collection, participants were assured of confidentiality of the information they shared.

F.5. Ethical approval and consent to participate

Ethical approval was taken from the organization to conduct the study. Eligible participants were explained about the procedure and informed verbal consent was taken from all of them. Participants could object their participation anytime at the interview.

F.6. Data Analysis

The interviews conducted were audio tapped with the consent of participants, and the recordings were transcribed. The transcriptions were then coded using pre-formed codes identified from literature and some in-vivo codes were generated from the unique quotations. Using a grounded theory approach the codes were then grouped (using a result matrix) and relevant themes were identified. The analysis was conducted manually by a single investigator.

G. KEY FINDINGS

The socio-demographic profile of the respondent observed are demonstrated in the table below:

Table 1: Percentage distribution of observed respondents based on their socio-demographic profile in Patna districts of Bihar

Indicators	Percentage distribution (N-11)
Distribution of respondent based on their age	
15-20 years	54 Percent
20-25 years	46 Percent
Distribution of respondent based on their education	
Primary	27 Percent
Secondary	10 Percent
Senior secondary	36 Percent
Higher education (Pursuing Graduation)	27 Percent

Distribution of respondent based on their occupation	
Unemployed	100 Percent
Employed	0 Percent
Distribution of respondent based on their husband occupation	
Skilled labor	45 Percent
Unskilled labor	27 Percent
Farmer	18 Percent
Unemployed	10 Percent
Distribution of respondent based on their husband migration status	
Migrant	19 Percent
Non-migrant	81 Percent

The findings observed are discussed based on different thematic areas of family planning method.

G.1. AWARENESS AND KNOWLEDGE OF FAMILY PLANNING AND ITS METHODS

G.1.a) Common knowledge of Family Planning

Most of the respondents observed were aware of family planning. They were however, unaware of the term “FAMILY PLANNING” but most of them were having the concept that one can plan for delay of first child or spacing between two children. Majority of them have heard about the traditional and modern family planning methods.

G.1.b) Impact of education on awareness and knowledge

Education doesn’t play a crucial role with awareness about FP methods as it was observed that women from illiterate to higher educated group (up to Graduation) were aware about most of the traditional and modern FP methods namely withdrawal, injectables, condom, copper-T, Rhythm method, Pills,

Sterilization. Maximum numbers of women observed have heard about different FP methods but most of them were not having any detail knowledge about the effectiveness of them.

G.1.c) Source of awareness

The major source of awareness in the community were the neighbors and family members who played the role of key messengers. Few numbers of women observed confessed that they have heard about it after her marriage from her husband only. As stated by one of the respondents,

"वो तो हम को भी पेहले ना पता था, ये तो मेरे हस्बैंड जी बताये थे"

("I didn't know about it earlier, my husband told me"-1 parity women, Patna)

Hospitals were also found to be another major source of awareness either through medical staff (doctor or ANMs) or IEC material. As stated by some of the respondents,

"जहाँ बाबु हुई थी वही डॉक्टर बताया था"

("Doctor told me in the hospital at the time of delivery"-one parity woman, Patna)

"फ़ोटो सटा रहता है हॉस्पिटल में"

("Posters are displayed in the hospitals"-one parity women, Patna block)

"किताब में जब बउवा हुआ था न त दिया था हॉस्पिटल में वोहू में लिखल था"

("It was written on the book kept in the hospital during my delivery"-one parity woman, Patna)

G.1.d) Knowledge about availability

Maximum number of women observed were unaware about the source of availability of different FP methods. As said by one of the respondents,

"तो इ सब नही पता था कि कहा मिलता है नही मिलता है"

("I was not aware of the place from where I can get it"-zero parity woman, Patna)

G.1.e) Counselling by Frontline Workers

It was observed that there was no counselling done by the FLWs in the community. Some of the newly married women observed were even unable to identify ASHA or Aganwadi worker of her village. As stated by a newly married woman,

"नही हम नही जानते है यहाँ का आशा कौन है"

("I don't know who the ASHA of this village"-one parity woman, Patna)

G.2. FAMILY PLANNING ADOPTION PRACTICES

G.2.a) Impact of education on FP practices

Education does not influence the FP practices as among each educational group, maximum number of women observed were found to be non-users. Most of them were aware of limiting methods only i.e vasectomy (female sterilization) and only a few numbers of women knew tubectomy (male sterilization) too.

G.2.b) Most widely used FP method

Female sterilization is the most common method practiced in the community. Most of the women observed believe that any spacing method adopted may delay the second childbirth due to the infertility caused by using it. This belief prevails as the women assert that there are many examples of women in the community who have suffered a lot due to the infertility and had to visit temples, perform superstitious customs, undergo regular checkups and many more. So, they think one should give birth to number of children they want and then they should do sterilization.

Despite of having awareness about different modern spacing methods, few women observed have adopted it while most of the women who uses spacing method were found to be practicing traditional method mainly withdrawal.

G.2.c) Perceptions about traditional method

It has been observed that women observed in the community are influenced towards the wrong but strongly ingrained traditional practices, irrespective of their educational level. As stated by one of the graduate women in the community,

"माथा धो लेंगे तो, बाल धो लेंगे तब "

("After washing my hairs", (after her menstrual cycle)-one parity woman, Patna)

Whereas one of the women with primary education claimed that one can eat sewing needle for spacing method.

"सलैया वाला कटिया"

(Sewing needle, zero parity woman, Patna)

G.2.d) Taboos associated with the use of contraception

There are still some taboos which stop women from using contraception as women in the community still believe that there should be no discussion on the topics like family planning with the family members. It is being also observed that newly married women are restricted from going out of the house and the elder members didn't interact with them on this topic either in their paternal home or in their in-law's house. As stated by one of the women,

"सोच भी नहीं सकती है ये सब करना पति भी नहीं बोलते है"

("I cannot even think about doing it, even my husband also doesn't talk about it"-one parity woman, Patna)

G.3. EFFECT OF DIFFERENT FACTORS ON SPACING PRACTICES OF FAMILY PLANNING

G.3.a) Effect of wrong or incomplete knowledge of family planning method on FP practices

It was found that observed women who were using any of the FP methods either traditional or modern were having an incomplete knowledge about the effectiveness i.e about the duration, consumption pattern, days to be calculated for spacing, etc whereas the women who haven't practiced any method were having no knowledge about any of the FP methods. As stated by one of the women wrongly practicing the Rhythm method stated that,

"10 दिन एम.सी. होने के बाद करे तो बच्चा नहीं ठहरेगा"

("Intimacy after 10 days of menstrual cycle will not lead to pregnancy"- one parity woman, Patna)

G.3.b) Effect of parity on birth spacing

Parity influences the usage pattern of FP methods as maximum number of observed women practicing spacing methods were of two parity in comparison to one parity women or the woman who wanted to delay her first pregnancy.

G.3.c) Effect of migration on birth spacing

Respondent whose partner doesn't migrate were found to be practicing the spacing methods whereas the women whose husband migrate were not practicing any of the family planning method as they count it as a reason of natural spacing.

G.4. UNMET NEEDS DURING FIRST CHILD BIRTH

Nearly half of the women observed have confessed about the unmet needs at the time of their first childbirth either due to family pressure or due to the lack of awareness or availability. Few of them have reported the failure of traditional FP method (withdrawal) resulting in early pregnancy.

G.5. REASONS AND PERCEPTIONS REGARDING FP CHOICE AND PRACTISE

G.5.a) Reasons for spacing between two children

Some of the reason's women think for spacing are adverse effect on maternal and child health, completion of self-education, shyness of becoming mother at an early age resulting in mocking jokes by community members. As stated by a young-women,

"ऐसे अच्छा नही लगता है..... देखता है हँसता है लोग देखके कि इतना जल्दि बच्चा हो गया"

("People laugh and make fun of pregnancy in smaller age"-zero parity woman, Patna)

G.5.b) Prevailing myths about family planning method

Different perceptions were found regarding the side effects of modern FP methods. But the most common method for which maximum number of observed women have expressed their perception was copper-T and injectables and some for condom. Some of the statement are:

"सुई तो दिक्कत करता, वो ही देह हाथ फूलता है का जो है, मोटापा बढ़ जाता है"

("Injections are harmful, it swells body and also increases weight"-one parity woman, Patna)

"कॉपर-टी अक्सेरा-वुक्सेरा करवाएं तो उस में निकलवे नहीं किया कॉपर-टी लगवाएं, वो ही दिक्कत होए, पेट में दर्द रहता था"

("Copper-T lost in the body after insertion and was not found in the x-ray also, so it causes discomfort and stomach aches"-one parity woman, Patna)

"ऐसाही केतना कहता है की कोंडोम से रोग हो जाता है एड्स कौची कहता है"

("Some people say that condom causes AIDS"-one parity woman, Patna)

The main source behind developing these perceptions were either through the stories in the community or through self or others bad experiences.

G.5.c) Reasons for not using family planning method

Some of the reasons for not using any of the FP methods were family pressure, lack of awareness, infertility, myths to be prone to some disease, incomplete knowledge as some of the observed women reported that as they are menstruating for a time period of more than one and half years after the child birth so they are not practicing any of the family planning method or either they do not intimate with their partner after the childbirth and goes to her paternal house and thus considers no need for spacing method. But the major reason for not using spacing method is family constraint, as stated by one of the respondents,

"घरवाले बोहोत बोलते थे, वो करते थे फिर सोचे की जाने दीजिये
अभी नहीं होगा तो भी अच्छा है होगा हो जाएगा तो भी अच्छा है"

("We make sexual relationships, there was a constant pressure of the family members, so after a while we thought that if we conceive it is good or else also it is good"-zero parity woman, Patna)

Case Presentation:

Participant 1, a lady of 22 years old was a resident of Fatwah block, Patna district. She has completed her studies up to 4th standard. She was married at an age of 20 years and now she is living with her one child, husband and maternal laws. Her child was 11 months old. She was not much happy in her in-law's house as compared to her paternal home as her mobility was restricted, she was not allowed to go out of the house even when she has work. She gave birth to her child within one year of her marriage. She believed that one should marry at an age of 18 years, and then should conceive her child after that as an early childbirth may damage maternal health. She was aware of most of the family planning methods either through IEC materials in hospitals or by her neighbors. She wants a birth spacing of minimum 2 years for her next child but was not practicing any of the Family planning methods despite having awareness about all the traditional and modern methods. She was not willing to adopt any methods as till now after her child birth she was not menstruating and after some days her husband will migrate to Chennai and will return after 1 year which she considers as a factor of natural birth spacing. She also has an option to go to her paternal house if her husband doesn't migrate or if her husband doesn't agree to stop physical intimacy for one more year. She was even afraid of condom as she has listened somewhere that one can have AIDS using condoms. She was a very courageous lady who wants to do sterilization after her third child birth even if someone doesn't allow her. As she was being said by her husband that he wants a girl child, but she replied him that if among three children they will have a girl child it is good or else she will not wait for any more children.

The case shows that women are bounded by the society against her wish. Their mobility affects the source of information as most of the times woman receive information on such topics by their neighbor and restriction to go out can result in lack of awareness. The most common reason which was also observed in this case for not using any of the family planning method is the migration status of her husband. As migration of husband is considered as a natural spacing in the community as a result of which seasonal delivery capacity for a particular time period is increased on the district. There are still some misconceptions existing in the society as contraceptives such as condoms are used for the prevention of sexually transmitted diseases, but it was observed that woman thinks that she will be affected by AIDS by using condoms.

G.6. DECISION MAKING

G.6.a) Decision maker for spacing methods

It was being observed that maximum numbers of women observed were not free to make self-decision or with their husband together, but the in-laws play the major role in decision making for adoption of spacing method and in most of the cases in-laws deny for the practice of family planning.

Case Presentation:

Participant 2, 22 years old was a resident of a remote village of Daniyawan block, Patna district. The natural environment and the occupation of the Household gives an option to survive in the location very precisely and is cutting out of the development even now. She was married at an age of 21 years and now she is living with her one child, husband and maternal laws. Her child was 28 days old. She has requested her parents to let her complete her studies before getting married but as she stated that as "society considers unmarried girl as burden", so she was married regardless of her wish. Her laughing statement shows the inclination of girl towards the decision of their parents. Every young woman is full of hopes and desires to achieve success in life and she too was appearing for various competitive examination for her bright future. She is a graduate but was not exposed to the developed society and still express her conservative scenario. Family planning is not a new issue to her although she is not spoken the issues very loudly in front anybody. She conceived the first child after a gap of one and half month after her marriage. She said that she was willing to conceive at so early age but as her husband was very eager, so she was being asked to deliver first baby as early as possible and then could take the decision for their second child. She was aware of most of the family planning methods and the main source of her awareness was her husband only. But due to the pressure from her husband she could not meet her unmet needs. As now she is free to take the decision, so she has decided to go for the option of taking injectables to space the next birth for 5 years. She was interested in taking injectables method as she had heard about the side effects from Copper-T and think that it can affect her health. She has not thought of the timing to go for the option as she has delivered the baby just once a month before, so she will take a concern from her husband and family members and will decide further.

The case shows the socio-demographic conditions still prevailing in the community which reflects the dependency of the woman on her husband and family members for at least to take first step her decision even after being educated which shows the moral incapability among woman which has been built in her due to the societal constraints. It reflects the imposition of decision even on educated girls and the girl happily accepts it bounded of social relationship. It also reflects that educational background does not influence the traditional or cultural values as some of the health topics such as family planning are still not discussed considering it as a taboo or a character identifying indicator especially among the unmarried girls. Family planning is a concept about which every woman is aware of but are not practicing because of several reasons but the most common reason found was hesitation of woman to talk openly on such topics as a result of which either they are not having complete knowledge about it or else they considered it as bad practice. Education of husband acts as an important factor for influencing the decision pattern of a woman. As his support to her builds up the confidence and make her self-assured to take the mutual final decision. It was observed that there was a very minimal role

of Frontline Line Workers for creating awareness especially to the newly married woman due to the societal barriers.

G.6.b) Decision maker for limiting methods

Few of the couples collectively make decisions for limiting and the roles of in-laws were not much involved in making decision.

It has been observed that few of the women were courageous to step forward and take self-decision for limiting the childbirth as they consider that it can affect both maternal and child health.

"पति के भी 3 बच्चा चाहिए पर उसको एगो बेटी चाहिए जे
तीन गो में जो होना है होतइ न त हम ऑपरेशन कराम न केगो जनमैते रहते"

("My husband wants 3 children but one girl child, if a girl child is among the three child it is good or else, I will do sterilization, how many children will I give birth to?"-one parity woman, Patna)

G.7. PREFERENCE METHOD FOR FAMILY PLANNING

There was a mixed response on method preference among the users. Some of the women observed preferred to consume injectables because it can be remembered easily while they reported that they forget to take pills timely.

" सुई लगवाएगे, दवाई में याद पड़ेगा तो खाऐगे नहीं खाऐगे भूल हो जाएँगे "

("I will prefer injectables, as if I will remember pills I will take or else I will miss it"-one parity woman, Patna)

While some of them preferred to pill as it is easily available and can be consumed without the permission of in-laws.

" गोली आसानी से मिल जाता है इसीलिए "

("Pills are easily available"-zero parity woman, Patna)

Some of them preferred to use condom whereas some of them denied as it causes dissatisfaction to her partner.

" कंडोम से उनका कम मिलता है आनंद "

("He is less satisfied by using condom"-one parity woman, Patna)

H. CONCLUSION

The present study reveals that most of the women were aware about the different FP methods but the knowledge about need and benefits of spacing of child birth is inadequate, to use FP methods. Friends and family members were the key person who act as a source of awareness. There were still many misunderstandings about the practices which were not being followed up by specialist or FLWs to eradicate the misconceptions and to enhance the promotion. Awareness about the source of availability was still very limited as a result the basket of choices was being restricted as they were guided only about the very limited choices. The various factors that significantly influence family planning methods use in the study area were age, parity, migration, family pressure, incomplete knowledge, traditional factors, availability, satisfaction level, decision making power, and lack of counselling. Maternal and child health was the main concern of the respondents for spacing between the children but completion of family size at the earliest is the most adopted practice of the community.

I. SUGGESTIONS

For the acceptance of family planning methods in rural India, there is a need to motivate the people as in rural parts residents hold on to old beliefs, traditions and values. So special programs of expert counselling should be aired on radio at each Aganwadi Centers where the women of reproductive age should be invited by the FLWs along with their mother-in-law and a separate program should be conducted for both, which will not act as a barrier for married women to come out of the house. Then the eligible woman along with FLWs should be guided on basket of choices of FP methods including all the benefits and side effects of different methods to create an environment of trust and acceptance for the product.

ANMs should conduct couple counselling especially to the newly married couple to break their discomfort about the topic so that they can talk and decide collectively which will enhance the delay and spacing practices effectively.

Special programs with incentivization should be launched at the season of high migration in the specific blocks having higher migration rate so that the couples are attracted towards it.

Voluntary agencies including youth clubs, women organizations, labor union (mainly focusing for men), religious societies, para-medical workers in health centers and interns working in the public health should be involved through non-formal programs for educating the eligible couples towards the importance of birth spacing so that sterilization of women of early reproductive age can be delayed.

Services should be made easily available, affordable and accessible through a variety of delivery points, such as clinics, community-based channels, retail outlets etc. Technologies such as condom vending machine should be advanced for the availability of services.

J. LIMITATIONS

The sample size and time duration of the study was very limited, due to which the findings cannot be generalized for the whole district of the state. Language plays an important role while communicating in such a sensible topic. Interviews conducted in a language different from respondents sometimes breaks the communication which has acted as a barrier for receiving information accurately.

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ANNEXURE-1

Interview guide for MWRA

Interview No:

District: Block:

Introduction

नमस्ते दीदी मेरा नाम बिभा प्रसादहै और मैं केयर इंडिया से आई हूँ। केयर इंडिया महिलाओं एवं शिशुओं के स्वास्थ्य के उपर काम करती है, इसी सिलसिले में मै आपसे आपके विचारों को जानने आई हूँ। क्या आप मुझे थोड़ा समय देंगी बात करने के लिए ?

(Hello my name is Bibha prasad. I've come from CARE India. Care India works on the health issues for women and children. I have come to know your thoughts regarding this. Will you be able to spare some time for this?)

Confidentiality

सबसे पहले तो आपका बहुत बहुत धन्यवाद कि आप अपने काम से समय निकालकर बातचित करने का अवसर मुझे दे रही हैं |शुरू करने से पहले मैं ये बताना चाहती हूँ कि इस बातचीत में हम आपके विचारों को समझना चाहते हैं। आपकी और हमारी बातचीत पूरी तरह से गोपनीय रखी जाएगी।

(First of all, thank you so much for taking time out of your work to talk to me. Before beginning, I want to assure you that we would like to understand your thoughts in this conversation and this conversation will be kept confidential.)

Consent

ये बातचीत सिर्फ हम दोनों के बीच ही रहेगी, इसलिए आपसे विनती है कि आप खुल कर मुझसे बात करें, कोई भी सवाल आपके मन मे आए तो आप बेझिझक पूछें। क्या हम रिकॉर्ड कर सकते है और कॉपी में लिख सकते हैं? (These conversations will only stay between the two of us, so you can open up and talk to me and ask any questions that come to your mind. Can we record and take notes?)

Consent given for interview (As declared by the Interviewer):

This is to declare that the interviewee was told the purpose and objective of the in-depth interview and s/he has provided the information voluntarily. S/he was also apprised about the confidentiality measure and has willingly consented to provide (Kindly tick the appropriate options)-

a. Verbal information ☐

b. Check Documents ☐

c. Take photos ☐

d. Record Interview ☐

e. Take Notes ☐

Signature of the Interviewer

A. Icebreaker:

i) दीदी ये आपका ससुराल है या मायका है? आपके परिवार में कौन-कौन लोग रहते है?

ii) आप घर से बाहर कहाँ -कहाँ जाती है (जैसे कि पड़ोस में, बाज़ार,मेला, मंदिर या अस्पताल)|

iii) **दीदी आप कुछ अपने बारे में बताईए :(जैसे – नाम, उम्र, शिक्षा, पेशा)**

B. Bridging Topic:

i) **अपनी शादी के बारे में कुछ बताइये। (जैसे – कितने दिन पहले शादी हुई, शादी के समय कितनी उम्र थी)**

ii) दीदी आपके कितने बच्चे है और आप कितने बार गर्भवती हुई है? (कुल संख्या)

iii) दीदी आपके पति क्या काम करते हैं और कहाँ करते हैं?

THEMES:

C. Views on marriage & Family Planning:

i) दीदी आपके गाँव में लड़कियों की शादी किस उम्र में हो जाती है और कब माँ बन जाती है? |

ii) दीदी यदि किसी लड़की की शादी जल्दी हो जाती है या माँ जल्दी बन जाती है तो उसके और उसके बच्चे के स्वास्थ्य पर कुछ असर पड़ता है?

iii) दीदी आप और आपके पति ने कभी कुछ बातचीत किया था कि अपलोगों को कितने बच्चे चाहिए ?

D. Knowledge on contraceptive methods & Spacing:

i) दीदी आप, बच्चे की रोकथाम (पहले बच्चे मे देरी, बच्चो के बीच में अंतराल या और बच्चा न हो-परिवार नियोजन) से आप क्या समझती है थोड़ा बताईये ना?

(आधुनिक एवम पारम्परिक तरीका, एस.डी.एम, एल.ए.एम, वीर्य बाहर निकाल देना,गोली,कंडोम,सुई,कॉपर-टी,ऑपरेशन(महिला एवं पुरुष)

ii) अच्छा दीदी इन गर्भ निरोधक तरीको के बारे में आपने कहां से सुना या जाना और ये कहां-कहां उपलब्ध हो सकता है|(दोस्त/रिश्तेदार, अस्पताल, आशा/आँगनवाड़ी कार्यकर्ता/एएनएम ,टी वी, रेडियो अखबार)

iii) दीदी ये गर्भ निरोधक विधिया कितने समय के लिए काम करती है,कुछ बताईए इस बारे में| (जैसे की सुई कितने दिन के लिए काम करती है, दवाई कब-कब लेनी पड़ती है, कॉपर-टी कितने समय के लिए होती है

iv) दीदी आपके अनुसार दो बच्चो के बीच में कुछ सालों का अंतर होना चाहिए क्या? यदि हाँ तो कितना, क्यों और कैसे ?

E. Contraceptive practices & Reasons for not using contraception:

i) दीदी शादी के कितने दिन के बाद आप गर्भवती हुई? (अगर महिला को पहले बच्चे में/गर्भावस्था में देरी हुई है तो कारण जानिए)

OR/या

i) दीदी अगर आप शादी के तुरंत बाद गर्भवती हुई है तो क्या ये उनका सोचा समझा निर्णय था?(probe: परिवार नियोजन का आधुनिक/पारम्परिक कोई भी तरीका अपनाया था)

ii) यदि कभी भी महिला ने आधुनिक/पारम्परिक तरीकों को अपनाया हो तो इसके कारणों को जाने |**(प्रोब: अगर आधुनिक आपनाया तो पारम्परिक क्यों नहीं/ अगर पारम्परिक आपनाया तो आधुनिक क्यों नहीं?**

OR/या

ii) महिला से जाने की कभी भी परिवार नियोजन नहीं अपनाने का कारण (पहले बच्चे में देरी के लिए, दो बच्चो में अंतराल के लिए, या और बच्चा नहीं चाहिये **)(प्रोव :ससुराल या पति का अस्वीकार करना, पति का प्रवास, उपलब्धता, बेचैनी, भ्रम/भ्रांतियाँ)**

iii) बच्चो में अंतराल के बारे में जानें (प्रोब : कोई विधि का उपयोग किया अगर नहीं तो किन कारणों की वजह से) (प्रोब 2 : यदि महिला बताती है कि 'माहवारी नहीं आया तो बच्चा कैसे होगा' तो पूछे कि ये जानकारी आपको कैसे मिला)

iv) परिवार नियोजन की वो कौन सी विधि थी जो अपने पहली बार इस्तेमाल की थी और आपकी क्या उम्र थी|

v) किसके कहने पर आपने ये विधि का इस्तेमाल किया था और किस लिए और इसे इस्तेमाल करने के बाद आपका अनुभव क्या था, कुछ बताएगी |

vi) दीदी आप या आपके पति हाल-फ़िलहाल में परिवार नियोजन की कौन सी विधि इस्तेमाल कर रही है?यदि ये पहले विधि से अलग है तो क्यो बदला?नयी विधि के क्या फायदे आपको पता चला/बताया गया? अगर नहीं तो क्यों कोई विधि का इस्तेमाल क्यो नहीं कर रही है?

vii) कुछ बताईये दीदी किन कारणों के चलते अपने परिवार नियोजन की विधि को इस्तेमाल करते हुए भी बीच में बंद कर दिया?

viii) इसका निर्णय कौन लेता है कि आप कोई विधि या कौन सा विधि उपयोग करेंगी या नहीं और इसमें आपकी क्या भूमिका होती है |(पति, सास)

ix)परिवार नियोजन के किसी साधनों को अपनाने के लिए आपको कभी कोई समस्याओं का सामना करना पड़ा या पड़ रहा है? (प्रोव: यदि हाँ तो क्या क्या, और आपने क्या किया ?)

Closing:

आपका बहुत बहुत धन्यवाद, अगर आपको कोई सवाल पूछना है तो आप स्वतंत्रता से पूछ सकती है में आपके सारे सवालों का जवाब ध्यानपूर्वक दूंगी|

)Thank you so much, if you have any questions about this interview, feel free to ask me and I will reply to all your questions carefully.(

ANNEXURE-2

IDI DEBRIEFING FORMAT FOR WOMEN

Bridging topic:

Number of children and total number of pregnancies:

Mobility to go out of the house:

THEME: Views on marriage

Thoughts on age of marriage and age at first child:

Consequences of early marriage and early childbirth:

THEMES: Knowledge on contraceptive methods

Understanding of family planning methods (Traditional/modern:

Source of information on FP:

Reflections on the effectiveness on duration of method:

THEME: Contraceptive practices

- Timing of first pregnancy(if the child was delayed reasons for the delay):

- Reasons for conceiving immediately after the marriage:

- Reasons for using modern methodsin preference of traditional methods:

- Reasons for using traditional methods in preference of modern methods:

- Interest in spacing between children/Reasons for not spacing the child:

- Method which was used by the women for the first time and age at that time:

- Source of information of particular method and reasons:

- Current use of any methods (traditional/modern), list all:

- Experience about the method used by her:

THEME: Reasons for not using contraception

- If she is not using anything, detailed reason for non-use:

- Reasons for stopping any tried method:

- Main decision maker on which method to be used:

- Difficulties faced by women in using different contraceptive methods: