ABSTRACT

Background
It is well known that in Rajasthan there is a predominance of irreversible contraceptive methods, limited use of male/couple dependent methods, high levels of discontinuation, and negligible use among both married and unmarried adolescents. To better understand the underlying causes of these gaps, it is crucial investigate the functioning of ASHAs, the frontline community-based workers responsible for providing and promoting family planning services, particularly reversible methods. Each provider has a confluence of factors – beliefs about contraception, personal reproductive intentions, experience using family planning services, method bias – that affect their willingness and/or capacity to promote the full range of contraceptive methods and prioritize client satisfaction. Exploring these factors may shed light on barriers to ASHAs enabling women and men to choose to use the contraceptive method they prefer. As a result, ARTH can design programmatic and advocacy strategies to reconcile these issues and thus increase adoption of the full range of contraceptive methods among the most marginalized populations.

Methods
Structured interview with 39 ASHAs in eight blocks throughout southern Rajasthan.

Findings
ASHAs’ approach to counseling on family planning is influenced by the pressure to fulfill sterilization targets.

Conclusions
The findings of this study reveal that the sterilization target is undermining ASHAs’ ability and/or willingness to provide comprehensive family planning services centered around women’s fertility preferences.

Introduction
This study examines the knowledge, attitudes, and practices regarding family planning services among 39 ASHAs across eight blocks in rural southern Rajasthan. The intention was to explore how the provision of sterilization targets well as ASHAs’ personal experiences using contraception affect how ASHAs deliver family planning services.

In Rajasthan, only 12% women of reproductive age use any reversible method of contraceptive, while 42% use a terminal method.¹ The emphasis on terminal methods has been articulated through unofficial yearly female sterilization targets, which community-based government health providers, Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activitists (ASHAs), and Anganwadi Workers (AWWs), have to fulfill. For example, on April 29, 2011 a representative from ARTH attended a meeting of the District Health Society, an organization run by the government, and reported that sterilization targets were one of the primary topics on the agenda. The representative shared that the collector reported to the Chief Medical Officer that he had suspended six ANMs (four from Kotra and 2 from Salumberg), stopped salary increments for 19 ANMs, and gave notice to 140 ANMs that they must achieve the target or face similar consequences. The Collector agreed to issue new letters to 16 ANMs who had demonstrated poor performance in reaching achieve the targets.

Pressure for government outreach workers to fulfill sterilization targets may shape their understanding of reproductive rights and delivery of family planning services since the emphasis is no longer on informed choice. Furthermore, targets for terminal methods are particularly problematic because they are not appropriate for meeting the needs of a large cohort of women, including those who have not completed their families or are not interested in a terminal method.

The purpose of my research was motivated by the assumption that effective counseling and interpersonal contact can be the difference between contraceptive method adoption, return/follow-up, and behavior change, or method rejection, discontinuance, and adverse health-seeking behavior, and that each provider has a confluence of factors that inhibit their willingness and/or capacity to promote contraception. This study has important implications on how Rajasthan’s family planning services and policies support its frontline health workers in increasing contraceptive uptake among marginalized populations.

Objectives:
1) To determine whether operation targets are negatively affecting ASHAs’ willingness to promote contraception based on informed choice.
2) To understand ASHAs’ personal experience using contraception and if that correlates to how they provide family planning services.

Importance of Study
In 2002, the international development community amended the Fifth Millennium Development Goal (to reduce maternal mortality by 75 percent) by adding a secondary target: universal access to reproductive health. This decision was a testimony to the fact that reproductive health services, as defined by unmet need for family planning, contraceptive prevalence rate, adolescent birthrate, and antenatal care coverage, are vital to achieving a reduction in maternal mortality, and have far-reaching implications on the progress towards all other Millennium Development Goals.

Despite greater commitment to delivering reproductive and maternal health services, 550,000 women continue to die from pregnancy-related causes; 215 million women who want to avoid a pregnancy are not using an effective method of contraception; about 20 million women have unsafe abortions each year, and three million of the estimated 8.5 million who need care for subsequent health complications do not receive it. Many of these unacceptable deaths and poor health outcomes could be curtailed if there were greater investments in comprehensive family planning programs. According to the WHO, family planning has the potential to reduce 32% of maternal deaths, 10% of newborn, infant and child deaths, 71% unwanted pregnancies, and avert 80% HIV sexual transmission with consistent and correct condom use. In 2009, UNFPA and Guttmacher Institute released a publication which revealed the significant health benefits from modern contraceptive use among women who want to avoid a pregnancy, according to contraceptive use scenario, 2008.

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benefits of meeting the need for family planning services; each year, there would be:

- 640,000 fewer newborn deaths;
- 150,000 fewer maternal deaths (more than 50,000 fewer from unsafe abortion and more than 90,000 fewer from other pregnancy-related causes);
- 600,000 fewer children who lose their mother; and
- 36 million fewer healthy years of life lost (12 million fewer among women and 24 million fewer among newborns).

By empowering women and men to access and choose the contraceptive method that best suits their needs, the number of unintended pregnancies would drop by more than two-thirds from 75 million in 2008 to 22 million per year. This would be particularly beneficial for adolescents in that it would improve educational and employment opportunities for women, which would in turn contribute to improving the status of women, increasing family savings, reducing poverty and spurring economic growth.

Investments in family planning services would have dramatic positive implications for health outcomes in India, which currently contributes one-quarter of all newborn and pregnancy and delivery-related maternal deaths in the world. As of 2008, India achieved a maternal mortality rate of 230, a decline of more than half its level in 1990 (570). However, India’s efforts to reduce the rate of maternal mortality – which contributes the largest number of maternal deaths of any single country (63,000) – remain insufficient; between 1990 and 2005, the level of maternal deaths decreased by 1.8% per annum, far below the 5 percent needed to achieve MDG 5. A study conducted in 2010 by Goldie et al identified family planning as the most effective individual intervention to reduce pregnancy-related mortality in India. It postulated that if the unmet need for spacing and limiting births was met over the next five years, more than 150,000 maternal deaths would be prevented; more than US$1 billion saved; and at least one of every two abortion-related deaths would be averted.

**Background: Family Planning Policy in India**

India’s national family planning policy, the Family Welfare Programme, dates back to the early fifties when it was the first country to establish a population stabilization program. During the 1970s and 1980s, family planning was primarily seen as a means towards controlling population growth and thus relied on the institutionalization of method-specific targets for contraceptive use. This came to a disastrous climax during the state of emergency in 1975 when Indira and Sanjay Gandhi imposed a forced sterilization campaign targeting men who had had two children; 7.8 million men and women were sterilized between April 1976 and January 1977. Intense national backlash and international scrutiny against these coercive measures compelled the government to pass the Population Policy 1977, which explicitly stated that “compulsion in the areas of family welfare must be ruled out for all times to come.” Although this tried to engender a commitment to

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7 [http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000264](http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000264)


[http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000264](http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000264)
voluntary family planning, by the 1980s the target-oriented approach was revived and incentive payments were actively promoted, leading to violations of women’s rights in some cases.\(^{10}\)

In 1994, the International Conference on Population and Development (ICPD) established reproductive rights as human rights, recognized sexual health as a component of reproductive health and called for universal access to reproductive health care by 2015. India was among 179 countries to pledge to promote a policy grounded in informed choice, ensuring that women and men would be provided with comprehensive counseling and services that supported them in determining what method (if any) befit their needs. Two years later, the government formally abandoned method-specific targets and the established the Community Needs Assessment Approach, which focused on identifying contraceptive needs at the community level in consultation with community members and leaders, instead of being centrally-assigned. The measurement of need was coined “Expected Levels of Achievement,” which became the new benchmark for gauging health providers performance and overall progress in family planning. The advent of the Reproductive and Child Health Programme in 1997 confirmed the paradigm shift towards voluntary family planning, and placed reproductive rights and women’s empowerment as centerpieces of India’s population and development concerns. As a result, there was a steady increase in the use of modern contraceptive methods across income-levels over the next decade.\(^{11}\)

In February 2000, the National Family Planning Policy was adopted with the dual objective of population stabilization and promoting reproductive health within the wider context of sustainable development.\(^{12}\) The trend towards decentralized democracy placed family planning programs within the purview of state-level bodies, including the Panchayati Raj. As a result, Rajasthan, which had not made much headway on reducing fertility rates, informally reverted back to target-based approach, rendering the Estimated Levels Achievement as a mere euphemism. It has been proven that availability of a more diverse range of family planning methods is associated with better quality services and higher levels of contraceptive use, thus this regression threatens to undermine the progress that has been achieved to date.\(^{13}\)

**Rajasthan**

Access to contraception remains extremely limited among young women in Rajasthan. This stems, in part, from the bias in the government health system towards sterilization as a strategy for reducing the state’s total fertility rate (TFR), which remains higher (3.3) than the national average (2.7).\(^{14}\) The emphasis on terminal

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\(^{14}\) NFHS III
methods is evident by the DLHS (2007-08) results,\textsuperscript{15} which reveal that only 12% women of reproductive age use any reversible method of contraceptive, while 42% use a terminal method.

Pressure for government outreach workers (ANMs, ASHAs and Anganwadi Workers) to fulfill sterilization targets has been expressed anecdotally but is not well documented. Indeed, the current use of modern contraceptives by women who have one child and two children is 16.5% and 50.5%, respectively. Hence, more than 80% of women with one child do not use any contraceptives.\textsuperscript{16}

Sterilization was not always the priority of the state’s health policymakers and functionaries. In 1992, the Government of Rajasthan was the only state to launch an innovative community-based distribution program through a husband and wife team, known as the Janmangal Couple (JC). The objective of the Janmangal Couple initiative was to promote the health of mother and child through proper spacing between births. Based on the spirit of volunteerism, JCs were selected to distribute oral pills and condoms and given monthly honorarium of Rs. 200. As of December 2007, Udaipur district had selected 2,356 JC couples who distributed 3,279 oral pills and 2,206 nirod and motivated 323 and 245 women for a sterilization and C-T, respectively.

With the establishment of the National Rural Health Mission in 2005, an ASHA was introduced as another community level worker who, in addition to other job responsibilities, was tasked with promoting contraception. In December 2007, the SIHFW conducted a study\textsuperscript{17} of the JC program to evaluate the status and effectiveness of the program in Rajasthan after the introduction of ASHA-Sahyoginis. The study revealed that JCs were very popular in the villages – more then 90% of users have good rapport with them – and were the primary resource person for information on contraception. In addition, users reported receiving regular supply of contraceptives; one JC provided oral pills and nirod to an average of 4.87 and 7.25 couples, respectively.

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\textsuperscript{15} http://www.jsk.gov.in/dlhs3/rajasthan.pdf

\textsuperscript{16} NFHS III

Despite the popularity and efficacy of the program, the government has not invested in maintaining it, perhaps due to perceptions that it is duplicating the efforts of ASHA. As a result, training and monitoring of existing couples and recruitment of new couples have subsided as medical officers and ANMs have shifted focus to building the capacity of and interfacing with ASHAs. Of the remaining active JCs, many are now outside of the optimal age range to be able to relate to young couples interested in spacing. As a result, ASHAs and ANMs are now the primary community-based contacts for distribution of contraception. This is concerning for several reasons: ASHAs and ANMs have an extensive portfolio of job responsibilities and therefore have less time to dedicate to promoting contraception; ASHAs operate on incentive-based compensation, so more lucrative tasks such as motivating for institutional delivery may take priority over distribution of reversible contraception, which is not incentivized. ANMs and ASHAs both face significant pressure to meet sterilization targets, which may affect their willingness to promote reversible methods.

The true unmet need for contraception is misleading, because it does not take into account unmarried youth. The National Adolescent Reproductive and Sexual Health strategy of the RCH programme articulates the importance of addressing the sexual health needs of unmarried individuals, however, this has not translated into action on the ground in Rajasthan. This may be attributed to the state’s conservative culture, which has led policy makers to ignore this vulnerable population despite the fact that by 19, 36% of women have begun childbearing (NFHS III). In the past, there has been a dearth of data elucidating the sexual and reproductive behavior and service needs among youth in India. However, data from the recent study, Youth in India: Situation and Needs, revealed that, in Rajasthan, 15% of young men (15-24) and 2% of young women reported having pre-marital sex. Consistent condom use was almost nonexistent; among young who had experienced pre-marital sex, only 13% of young men and 3% of young women reported that they had always used a condom. Large numbers of youth report discomfort seeking contraceptives, including condoms, from a health care provider or pharmacy.

Although state-level calculations of the impact of expanded access to family planning services have not been conducted, it is easy to extrapolate the potential benefit. For example, evidence shows that birth intervals less than three years predisposes both mother and child to higher risk of death. In Rajasthan, 12% of births occur within 18 months of the previous birth and 29% occur within 24 months. Almost two-thirds (65%) of births occur within three years, the minimum recommended time to wait before having another child. The risk of death in the first year of life is more than five times as high for infants born less than two years after a previous birth than for children whose mothers waited four or more years between births. Therefore, there is a critical window between six months and two years post delivery when it is particularly important – for both the mother and future children – to provide reversible contraceptive services, which is not a

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18 The Youth in India Study comprised of a survey conducted in six states, including Rajasthan, between January 2006 and April 2008, during which a total of 50,848 married and unmarried young men and women were interviewed.
20 NFHS III
reality for many Rajasthani women. Despite the fact that among couples who want another child 41 percent of women and 47 percent of men want to wait at least two years.

Methodology:
Over a period of 2 months, structured interviews were conducted in Hindi with 39 ASHAs from 8 blocks. I decided to focus primarily on ASHAs outside of ARTH’s field area to collect information more representative of frontline workers than those in ARTH’s field area who have received supportive supervision and training from the organization. The interviews followed a questionnaire (see annexure II) designed for the study. Before each interview, participants were asked to sign a consent form, which highlighted the purpose and benefit of the study, and ensured that their confidentiality would be upheld.

In addition, I developed a questionnaire outside of the parameters of this study to explore attitudes and practices regarding contraception among ASHAs, AWWs, and ANMs, VHWs in ARTH’s field area in coordination with a translator or ARTH staff member. Some anecdotes from these interviews are included in this report to substantiate the trends revealed from the data collected in this study, however, the information was not included in any of the quantitative analysis. My participation in adolescent women’s group meetings, VHW trainings, and informal conversations during field visits have informed some of my conclusions and recommendations.

Limitations of Research:
Several phenomena may have impacted the rigor of data collection process and quality of results, including: 1) a recall bias among interviewees, leading them to inaccurately report the number of contraceptives they distributed; 2) the questionnaire was changed to omit one question and rephrase another which women had trouble understanding. One question was added21 midway, so that information from 20 interviewees was collected; 3) the interviewer was inexperienced and, despite training inputs, she had difficulty building a relationship with the interviewees, knowing when to probe further, and understanding questions #15 and #27. Therefore, some of the data she collected was incomplete or very limited in depth.

Results:
Profile of ASHAs

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21 What type of contraception do you spend the majority of your time talking to women about?
Knowledge

Although one of the primary responsibilities of ASHAs is to meet the family planning needs of women and men in their community, the vast majority of ASHAs reported caring for pregnant women, promoting institutional delivery and immunization, and conducting household visits as their main activities. Only two mentioned anything related to family planning; both reported motivating women to have an operation, and one added that she raises awareness about contraception among women who have one child. This is unsurprising, however, because ASHAs receive compensation for bringing women for an institutional delivery and women and children for immunization. Women also receive compensation for motivating women to get an operation, but ASHAs most frequently reported that this task was the biggest challenge to their work (10), while the community largely values their role in bringing women for institutional delivery and promoting immunization.

When asked about their specific tasks in family planning,
ASHAs reported the following reasons for why they think operation targets are the biggest challenge to their job:

“Women do not talk to us nicely [when we counsel them on operation]. They talk so badly that we don’t want to go to their houses again.”

“Women are not interested. Some women say that they will get an operation if they are paid a lot of money or given land.”

“Men do not like it because it ‘causes weakness’.”

Despite the lack of popularity among women and the negative impact it has on their job, the policy has shaped their perception over which methods are beneficial; of all methods, operation was the only method to be recognized unanimously as a beneficial method. Nearly a quarter of respondents shared this opinion, explaining that operations do not cause any problems, weakness, or have any complications.

**Attitudes**

ASHAs almost unanimously report that one of the purposes of family planning is to space child birth.

ASHAs’ perceptions of which methods are beneficial or harmful reflect considerable bias against copper-Ts and favorability of nirodh. Only one ASHA believed that all methods were beneficial while only one thought that no methods were harmful.
Table One: Reasons Given for Why Contraceptives Methods are Harmful

<table>
<thead>
<tr>
<th>Reason</th>
<th>Mala-n</th>
<th>Nirodh</th>
<th>Copper-T</th>
<th>EC</th>
<th>DMPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause nausea</td>
<td>cause nausea (5)</td>
<td>weaknees</td>
<td>excessive bleeding (9)</td>
<td>harmful if taken more than once</td>
<td>irregular menses</td>
</tr>
<tr>
<td>Problems from regular or excessive use</td>
<td>problems from regular or excessive use (5)</td>
<td>risk of accidental pregnancy from tearing</td>
<td>raises up in the body “upper chad jata hai” (5)</td>
<td>back (4), stomach (3), and general body pain</td>
<td></td>
</tr>
<tr>
<td>Excessive bleeding</td>
<td>excessive bleeding (2)</td>
<td></td>
<td>back (4), stomach (3), and general body pain</td>
<td></td>
<td>gets stuck in uterus and causing problems</td>
</tr>
<tr>
<td>Swelling</td>
<td>swelling (2)</td>
<td></td>
<td></td>
<td></td>
<td>gets removed on its own</td>
</tr>
<tr>
<td>Giddiness</td>
<td>giddiness (3)</td>
<td></td>
<td></td>
<td></td>
<td>not able to be kept for a long period</td>
</tr>
<tr>
<td>Frequent periods (10-15 days)</td>
<td>frequent periods (10-15 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>headache</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pimples</td>
<td>pimples</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can be forgotten</td>
<td>can be forgotten</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Copper-T was overwhelmingly perceived as harmful, and Mala-n was a close second. However, mala-n was almost just as frequently described as beneficial because it causes regular menses and does not hurt the body or have any side effects. Nirodh was mentioned as beneficial most frequently, primarily because of its ability to prevent infection and diseases, like HIV/AIDS (11), and also because it can be used and thrown away (2), does not cause any problems, stomachache, or excessive bleeding, and doesn’t interrupt a woman’s menstrual cycle. DMPA and EC were rarely mentioned, yet both perceived as harmful.

ASHAs’ perceptions of the most and least popular methods among women largely mirror their opinion of which methods are beneficial and harmful. The main difference is that there are 5 ASHAs who acknowledge that operation is not a popular method among women, versus 3 who say that is popular. They explain that women do not understand operations, prefer to use other methods offered by the government, and find it unnecessary since they can use other methods which last for five years.
ASHAs reported that women are averse to copper-Ts (n=21) because it causes excessive bleeding, stomach, back, and general body pain, damages uterus, nausea, body swelling, weight loss, rises up in and gets stuck in uterus and body, and they think it is much more complicated and expensive than operation; mala-n (n=9) because it causes excessive bleeding, body swelling, nausea, giddiness, white discharge, husband disapproval, overuse leads to heat in body and harms uterus, and chance of forgetting to take one pill; EC (n=5) because it is expensive, causes a burning sensation in the body; and only works for 72 hours; DMPA (n=2) because they are afraid of it and think it causes nausea; and nirodh (n=2) because it causes illness and miscarriage and should not be taken in the summer.

Practices
Over the past three months, ASHAs reported higher rates of distribution of mala-n and nirodh than any other method; 28 distributed an average of 11.8 packets of mala-n, 28 distributed an average of 8.7 packets of nirodh, 3 distributed an average of 2.6 packets of emergency contraception, 1 motivated 1 woman to get DMPA, 11 motivated an average of 1.7 women to get
a copper-T, and 5 providers motivated an average of 1.8 women to have an operation. None reported distribution of pregnancy tests.

The distribution and completed referral of methods shown above does not capture the extent to which ASHAs are spending time advocating for certain methods; nearly fifty percent said that the majority of the time they spend on family planning is oriented towards promoting operation. This likely stems from the fact that all but two ASHAs reported yearly operation targets varying from 2-14 that they are unofficially mandated to achieve. This is not a formal policy, as explained by an ASHA: there is “no written notice or any order that they are supposed to do [operation targets]. They have to only because staff say so.” Based on the Community Needs Assessment approach articulated by the National Family Planning Policy, the number of operations “required” for each ASHA depends on the demographic profile of her community. Despite greater investments of time given to promoting operation, only 22% of providers who reported having a target (n = 36) had fulfilled it during the previous year.

When asked how they were able to achieve their target, responses indicated that timing, positive deviance, and monetary incentives were the keys to success. One ASHA said that the women she motivated had the procedure immediately following delivery, another said that after she convinced one woman, 3-4 easily agreed to have one as well, and a third explained that she told women that they would get paid Rs. 600, which she confirmed had been allocated to them.
following their operation. Discussions revealed that some ASHAs had been given incentives to promote strong performance; one said that she received a trophy for motivating 7 women to have an operation, while another said “staff say if you motivate 5-6 than you can be trained to be an ANM.”

Over three-fourths of ASHAs were unable to complete their targets. This was largely attributed to disinterest in or fear about having an operation, difficulties making people understand the benefits of a terminal method, disapproval from husband and family members, and competition with the ANM. The following statements capture these themes:

“Women do not want to go for operations and speak badly to ASHAs [when we try to convince them].”

“If we have an operation after only one child, and if the child dies in the future, than what will you do for us?”

“When I counsel women on having an operation, they say that they are afraid of the procedure. They ask what can the ASHA do if anything bad happens? The family members say bad words to me.”

“Women don't take the [type of] contraceptives what I give, they take what they want. They don't get operation because they want more children.”

“People will make excuses to avoid an operation. They say they want a girl if they have a boy, or they want a boy if they have a girl, so they don’t get an operation.”

“When we make women understand, she agrees, but her husband does not agree. Family members say that if she takes rest than who will do the household chores?”

“Women say we have to get permission from our husband and in the end they go with the ANM.”

Reservations about family planning in general were also mentioned: “People are not comfortable speaking about family planning. They do not like to share much about it, therefore it becomes
difficult to make them understand.” “People are not ready for operation, nor do they use other methods.” When asked how they would suggest increasing contraceptive uptake if they were given the freedom to decide, it was common for ASHAs to suggest home visits to explain advantages (i.e. prevention of unwanted pregnancy, and weakness and complications, delay and space childbirth, reduce financial burden of big family, prevent infection) of different methods of contraception, and allocating additional time outside of regular job hours. Counseling on and promoting operation was mentioned by 4 ASHAs, and nirodh, mala, and copper-Ts by 2 ASHAs each. One specifically said that she would conduct home visits to counsel on methods other than operation, while another suggested that operations should be promoted and other methods should be reduced.

When asked what ASHAs would do differently to meet their target in the coming year, the most common response was that "we will go to houses regularly to make women understand the advantages." Specific messages for the benefits of an operation include: "you will not have any more children;" "you don't have to use any other method again and again. All problems will be solved by operation;" and "if more children are delivered than they will not get enough food to eat." One ASHA said that she plans to motivate women by telling them not "to get carried away by others in the community who say misleading things about operation. Come with us we will also care for you."

Despite the fact that the vast majority said they were given an operation target, more than half (55%) said that they did not experience pressure to promote any method, while 42% reported that they felt pressure to achieve a certain quota of operations per year. Analysis does not find a correlation between successfully achieving sterilization target and reporting pressure to fulfill it.

Although the majority of ASHAs said that their work was not affected by the pressure to fulfill operation targets, further probing revealed contradicting trends. Several mentioned that it “creates

Case Study: Pressure to Fulfill Operation Target
In ARTH’s Kuncholi field area, an ASHA shared that she receives a lot of pressure from her supervisor to fulfill her sterilization target of two per year. She described how her supervisor, who has a target of one per year, tells her that the most important thing for her to focus on is meeting the target, and will reprimand her if she doesn't fulfill it. “Unfortunately,” she said, “I didn’t fulfill my target because the ANM took credit for my work. Unless I help the ANM fulfill her target, which is 30 per year (supervisor expects 50% to be completed), the ANM refuses to sign PNC and ANC forms so I don’t get my honorarium. After I motivated two people to have an operation, the ANM took their names so that she could achieve her target and avoid a salary freeze. As compensation, she began signing the [PNC and ANC] forms again.” At the PHC sector meeting, all ASHAs are asked how many cases they have achieved to date.
Case Study: Affect of Operation Pressure

In Dula waton ka gurad, Buri (husband Devila) took mala-n from one of ARTH’s VHWs (Mohini gamethi) for two months. The VHW said that Buri told her that she no longer wanted to take mala-n because an ASHA (Shanta Gurr) said that it caused problems and she shouldn’t take it. The ASHA asked her to have an operation instead, but Buri was not interested. Instead, she decided to take DMPA at ARTH’s clinic. She has not told the ASHA that she is taking DMPA (she has taken three injections), so the ASHA continues to ask her to have an operation.

When this ASHA was asked how the pressure to have an operation affects women, she said that it causes them to reject all contraception. “ASHAs were given warning that if we don't bring operation cases than we will be terminated from job. Pressure for sterilization is more than deliveries.”

Three said that it interferes with their work relationship with the ANM who they have disputes with about who gets credit for the operation.

“There is no bonding between ASHA and ANM.”

“If women understand family planning, than they go with the ANM to get an operation, instead of with the ASHA.”

Three ASHAs mentioned that when they counsel women to have an operation, women and family members will demand more money and, in two separate cases, land and food were also requested.

“What is the use of operation? How much money will you give us?”

Analysis (n=21) did not identify a significant association between pressure to conduct an operation and spending the most time on promoting an operation (OR = 0.2499; CI = 0.0394 – 1.5224). However, six ASHAs shared that efforts to meet their operation target consume significant amounts of time, including daily meetings and “[spending] the whole month meet[ing] women for operations, and affects how they manage their job time. For instance, “we have to do 10 visits each day to tell women and families about operation. This affects our ability to do our other work, like immunization of pregnant women and children.” “When we go for home visits than our work at the Anganwadi stops. We mainly focus on operation during our [home] visits.” One of these ASHAs explained that because “women are not ready to get sterilized, it is hard to motivate them. I meet women 5-6 times but they still are uninterested.” Another reported making 1-2 visits in the family to provide information regarding operation.

When asked how the operation pressure affects women, the most frequent response was that women cannot make the decision to have an operation by themselves because they must take permission from their husband, mother-in-law and/or other family members. Those who reported husbands and family members refusing to allow the procedure attribute their lack of support to apprehension that women will not be able to do household chores and take care of the children and will have a “damaged uterus.” Some women share the belief that operations will affect their daily responsibilities, and also fear negative physiological effects.

“Women fear that they have to take permission from their husbands, that there is not enough food in the house to help them with their recovery, and weakness occurs after sterilization.”
To investigate ASHAs’ approach to family planning counseling, interviewees were asked to explain how they would talk to four hypothetical women about family planning. The trends reveal that ASHAs tell women with 0-1 children to use mala-n, nirodh, and Cu-T, women with two children to use mala-n, nirodh or have an operation, and women with three or more children to have an operation.

Seventy-one percent of ASHAs said that they would counsel a woman who recently delivered her second child to have an operation, while 100 percent suggested that they would counsel a woman with three or more children on operation. Operation was most frequently suggested first and without alternative, as show by the following chart.
Statements from two ASHAs further corroborated this trend, one explaining that she advises women who already have two children to have an operation, while the other said "I place more stress for sterilization to women who already have three to four children. I tell them that your body will be fit and you will not face any problems and you can run your family smoothly." An ANM in ARTH’s Kuncholi field area said that she will only talk about reversible methods with women who have one child, and will talk about sterilization and side effects of mala-n with women who have two or more children.

**Personal use of contraception**
Twenty-three ASHAs (60%) had ever-used one or more reversible methods (only two had used more than one method: one had used both mala-n and nirodh before having an operation, and one had used both mala-n and EC). Subsequently, ten opted to have an operation, so, at the time of the survey, operations were the most common method followed by nirodh. About one quarter of ASHAs were not using any method; three were pregnant, one was divorce, and one was a widow, while five did not want any more children but were not doing anything to protect themselves from pregnancy.
Discussion

There is evidence that ASHAs’ attempts to meet the sterilization target is affecting both their work and the women whom they are responsible for serving.

Denying women contraceptive preference

ASHAs are pushing for sterilizations instead of responding to women's contraceptive preference. It appears that ASHAs are not following a counseling methodology grounded in informed choice; instead of first offering full range of methods, ASHAs will promote a specific method(s) based on where a woman is in her reproductive cycle and biases about method suitability. This is captured by one ASHA’s statement, “women don't take what contraceptives ASHAs give, they take what they want. They don't get operation because they want more children,” which seems to reveal that some ASHAs are not asking families about their fertility preferences before suggesting contraception. Particularly with sterilizations, ASHAs seem to follow a formula of initially suggesting this method to women who have two or more children, than offering another method if the woman is not interested. Although this is not overtly coercive, it certainly steers the decision in favor of operation for women who do not have previous knowledge about other methods.

Distort counseling agenda

It may motivate government workers to deliberately distort the information presented during their counseling sessions. At the community-level, there are widespread myths and misconceptions about short-term methods ANMs and ASHAs the primary means for dispelling misconceptions about negative symptoms that may occur. One of ARTH’s VHWs, said that she learned that an ASHA was telling women not to take mala-n because it causes tumors. Although this seems like an extreme case, exacerbates confusion over what are the actual benefits and associated risks of each method, leading to reductions in contraceptive uptake and overall health-seeking behavior.

Commodifies Reproductive Health

The government-sponsored incentives for operations (and perhaps institutional delivery) appears to have generated a culture of expectation for compensation for health-seeking behavior. Marie Stopes is paying women Rps. 500 when they opt for a sterilization and giving ASHAs Rps. 150 for motivating them. Attaching a price tag to one specific family planning method has doubly negative implications; it diminishes the understanding of the inherent benefit of using...
contraception, while directing providers’ towards promoting a method that may not best suit or be applicable to all women.

Undermines provider relations and service delivery

It is undermining collaboration both among and between public and private service delivery systems to the detriment of poor, marginalized, women who have no other health information and service outlets. One of ARTH’s senior field staff (Rheka) disclosed that ANMs are hostile towards ARTH's community-health workers because they perceive ARTH as competing to reach women with contraception. Because ANMs are under such intense pressure to promote operation, many see ARTH’s efforts as directly undermining their work. This tension has deterred ARTH staff from interacting with ANMs, and, likewise, may affect ANM’s willingness to interface and/or promote ARTH’s services.

In some cases, the relationship between ASHAs and ANMs is strained as both see the other as competition for achieving their operation target. This goes directly against the NRHM’s policy which envisions ANMS, ASHAs, and AWWs working together towards a shared goal of healthy women and children (reference). These providers are typically the only source of information that women have about contraception, and therefore a lack of coordination and even hostility between them will likely detract from their objective to the detriment of women and children.

In addition, when ASHAs advocate for a method that does not match the preference of women, it creates a strain on their relationship, which may deter women from seeking any health services.

This study did not capture sufficient data to determine a correlation between ASHAs’ personal experience using family planning services and how they, in turn, offer family services.

Recommendations

Abandon Operation Target

The operation target is not serving the demands and needs of either ASHAs or the women they are supposed to serve.

Values Clarification

One of the biggest revelations in this study is that ASHAs are counseling women on which family planning method to use based on their assumptions, preconceived notions about women’s fertility desires, and desire to meet their operation target. Therefore, it is essential to incorporate rights-based language into family planning counseling trainings for ASHAs so that. It appears that their problems with the operation targets stem from the inconvenience of trying to convince women to do something they are not interested in or from the competition with ANMs. It does not seem that they associate sterilization targets as an infringement on women’s reproductive choice.

Some have internalized the target system, citing that no work will be done without pressure and that instead of getting rid of the target, it should be given either to ASHA or ANM to prevent disputes.

only then can they be leaders and role models in the field, become proactive citizens who are conscious of their rights.

Reposition Family Planning and Integrate Services

It is unclear whether ASHAs’ recognize the critical contribution that family planning makes towards reductions in maternal and neonatal mortality, which two mention is the overall goal of
their job. On the one hand, they nearly unanimously agree that family planning’s major purpose is to promote spacing. On the other hand, the consistency of reports that ASHAs’ primary tasks are promoting immunization and institutional delivery, it appears that ASHAs may not consider family planning as a key intervention towards these goals. Most likely, the incentives they receive for immunization and institutional delivery are driving them to invest more time in these activities, instead of the less lucrative and more challenging task of promoting contraception. Regardless, ASHAs report that they feel most valued by their role in promoting immunization and institutional delivery, which can be leveraged by integrating family planning services. Both of these areas provide an opportunity for initiating discussions about fertility preferences, particularly during the Maternal, Nutrition, and Child Health Days, when women congregate at the Anganwandi center to receive supplementary nutrition and health check ups.

Resurrect Janmangal couple scheme
A large literature documents that engaging men in discussions about family planning enhances women’s ability to use contraceptives. In areas covered by the study, there is a need to strengthen men’s understanding of the importance of contraception, considering women frequently mentioned that they had to ask permission from their husbands to have an operation, and often husbands do not approve. it would behoove community-based distribution program Janmangal Couples would be appropriate complement to ASHAs who have significant job responsibilities other than family planning and also do not have a mandate to engage men. When the Janmanagal Couple Scheme was active, men were.

Weaknesses in the program included: absenteeism in Milan meetings due to inconsistent payment of honorarium, poor management and investment in the program by MOs and ANMs, gaps in training of JCs (20% untrained), 20% couples either are not aware of responsibility to distribute contraceptives and counsel eligible couples or are performing other activities which they are not responsible for (motivating for ANC, JSY, MCHN, immunization). These challenges can be overcome with political will.

Address Myths and Misconceptions
The prevalence and breadth of misconceptions and myths about contraceptive method is striking. ASHAs require a refresher training during which each misunderstanding needs to be addressed and corrected. Because of the lack of popularity among women about operations, copper-Ts are a fitting alternative for women who have completed their families. Thus, the overwhelming perception that copper-Ts are harmful both among ASHAs and women needs to be resolved. More serious investments in disseminating accurate information about copper-Ts is required, perhaps through positive deviance. For example, four ASHAs had used copper-Ts themselves, so they could speak about their personal experience using this method so as to attenuate some of the skepticism and debunk some of the myths. ASHAs should be provided with tools, such as a uterus model, to use when they counsel women on each method.

More research
More qualitative studies are needed to explore women’s experience engaging with ASHAs and other frontline health workers in areas governed by the operation policy. Because ASHAs may not be fully aware of the impact of operation target or hesitant to divulge the extent of its affect, this study may not capture as many dimensions about women’s experience availing their preferred method of family planning. A comparison between Rajasthan’s target-based approach and another state which has achieved replacement level fertility through providing comprehensive services would also be useful to better understand how each of these approaches contributes and/or detracts from the dual goals of population stabilization and upholding reproductive rights.
Furthermore, more research needs to be conducted on women's experience using IUD to gauge whether the problem lies in the quality of services (problem with method itself, counseling on symptoms, follow-up to make women feel confident that they have support if they experience complications) or exaggerated myths and misconceptions.

Conclusions
Over the past decade, maternal and neonatal mortality reduction have emerged as clear priorities in the Indian national political agenda, with family planning listed as a key strategy. Unfortunately, the policy rhetoric on family planning based on informed choice has not translated into on the ground action. The findings of this study reveal that the sterilization target is undermining ASHAs’ ability and/or willingness to provide comprehensive family planning services centered around women’s fertility preferences. The emphasis on sterilization targets contradicts the principles of equity and equality that India’s Family Planning Policy articulates.

Rajasthan's family planning services must no longer pay lip-service to women’s reproductive rights. The operation targets are denying women and men their reproductive rights, as it distorts ASHAs ability to promote the contraceptive method that best fits individuals’ and family’s needs. This is only serving to undermine progress towards reducing the TFR, especially as India’s population is now comprised of 30 percent young people aged 10-24 (315 million) who are less likely to be interested in a terminal method.

As 2015 approaches, the deadline for the Millennium Development Goals, India’s commitment to fulfilling MDG 5b remains tenuous. Granted there have been improvements facilitated by the first and second phases of the Reproductive and Child Health scheme and the National Rural Health Mission – total fertility rate fell from 4s in 1990 to 2.7 in 2009 while the contraceptive prevalence rate increased from 35% in 1997 to 54% in 2009 (although three fourths are from sterilization) – the overwhelming focus on limiting family size through sterilization, as stipulated through the target policy, needs to be abandoned. Many countries have demonstrated that family planning programs modeled on reproductive choice instead of advocating one method does lead to reductions in fertility and maternal mortality rates, as well as myriad other positive economic and social outcomes. As I have learned, providers are poised to take this approach, just as long as the government stops dragging its feet and begins to trust the judgment of its own people.
Study Proposal: ASHA Contraception Knowledge, Attitude, and Practices

It is well known that in Rajasthan there is a predominance of irreversible contraceptive methods, limited use of male/couple dependent methods, high levels of discontinuation, and negligible use among both married and unmarried adolescents. To better understand the underlying causes of these gaps, it is crucial to investigate the functioning of ASHAs, the frontline community-based workers responsible for providing and promoting family planning services, particularly reversible methods. Each provider has a confluence of factors – beliefs about contraception, personal reproductive intentions, experience using family planning services, method bias – that affect their willingness and/or capacity to promote the full range of contraceptive methods and prioritize client satisfaction. Effective counseling and interpersonal contact can be the difference between method adoption, consistent use, and behavior change, or discontinuance and dropping-out. Exploring these factors may shed light on barriers to ASHAs enabling women and men to choose to use the contraceptive method they prefer. As a result, ARTH can design strategies to reconcile these issues and thus increase adoption of the full range of contraceptive methods.

Objective of study: Identify ASHA behaviors and attitudes – and their underlying cause – that may inhibit or limit them from offering and delivering quality family planning services based on informed choice.

I want to interview the following:
1) 20 ASHAs: 10 from ARTH’s field are (5 in both Kadiya and Kuncholi) and 10 from outside ARTH’s field area.

In addition, I will interview women on an ad hoc basis, particularly those who have interfaced with the ASHAs interviewed, to provide the client’s perspective about ASHAs’ performance.

Consent Form

Namaste,

My name is (person conducting interview) and I am from ARTH, an organization based in Udaipur working on health. We are conducting a small study to learn about ASHAs’ roles in their community, and wanted to invite you to participate. Your participation will provide important information about how to improve women’s health in rural areas.

If you agree to participate, you will be asked a series of questions about your job responsibilities and experience using health services. This will take about half an hour. Your name will be kept strictly confidential and not be shared with any government officials. Your name will appear only on this consent form, and then a number will be assigned to you for use in other documents.

Your participation is voluntary and you are free to refuse to answer any questions or withdraw after you start. You can also ask any questions about this study at any time.

The signature below indicates that this consent form has been read and explained to you, you have been given the chance to ask any questions, and you agree to join the study.

Print Name of Subject:
ASHA Survey

**Personal Background:**

1. What is your name? ____________________________________________

2. How old are you? ____________________________________________

3. Where do you live? ____________________________________________

4. How many years of school did you attend? __________

5. Are you married? Y / N

6. If yes, how many children do you have? 1 2 3 4 5

7. What are their sex (m/f) and age? ____________________________

**Working Conditions:**

8. How long have you been an ASHA?

9. What do you spend the most of your time doing?

10. What do you find most challenging about your work?

**Contraception Service Delivery:**

11. What are your tasks in the area of family planning?

12. Why is it important for women and men to use contraception?

   Limit family size / space childbirth / prevent unwanted pregnancy / prevent abortion
   increase women’s welfare / other ________________________________

13. What types of contraception are beneficial? Why?
14. What types of contraception are harmful? Why?

15. If you were given the freedom to decide, what could you do differently to increase contraception usage?

16. How would you talk to each of the following women about family planning?
   a. A recently married 17 year old woman without children
   b. A twenty year old woman with a nine month old child
   c. A twenty three year old woman who recently had her second child
   d. A twenty five year old woman with three or more children

17. What contraceptives (and amount) did you provide or offer referral for over past 3 months?
   Mala-n_____ nirod______ EC______ DMPA_IUD______ Sterilization_______

18. What method(s) do you spend the majority of your time talking to women about?
   Mala-n_/ nirod_/ EC_/ DMPA_/ IUD_/ Sterilization

19. What are the most popular methods among women in your community?
   Mala-n_/ nirod_/ EC_/ DMPA_/ IUD_/ Sterilization

20. What are the least popular methods among women in your community?
   Mala-n_/ nirod_/ EC_/ DMPA_/ IUD_/ Sterilization

21. Why do women dislike these methods?

Attitude Towards Family Planning:

22. What do you find most challenging about your work in family planning?

If she mentions sterilization pressure, proceed to question # 25. If NO mention of sterilization pressure, than ask question #24.

23. Do you feel pressure to promote a specific method(s)?   Y   /   N   type(s):__________________

24. What was your sterilization target for last year?

25. Did you achieve it?   Y   /   N
DRAFT

26. How does the sterilization targets affect your work?

27. How does the sterilization targets affect women?

Personal Experience with Family Planning Services:

28. In the past, have you ever done anything to prevent pregnancy? Y / N

If she responds “no” go to TRACK A

If yes, what did you do? Mala-n / nirod / EC / DMPA / Cu-T / Sterilization / other__________

a. Where did you obtain it?____________________________

b. When did you start using it?____________________________

c. How long did you use it?____________________________ / still using it

If she responds “still using it,” go to TRACK B.

d. Why did you stop?

TRACK A

29. Are you planning to have another child? Y / N

a. If yes, when?

b. If no, are you currently protecting yourself from pregnancy? Y / N

  c. If yes, how are you protecting yourself? Mala-n / nirod / EC / DMPA / Cu-T / Sterilization / other__________

     i. When did you start taking it?

     ii. Where do you get it?

     iii. Are you satisfied with method? Y / N

  d. If no, why not?

  e. If no, do you plan on using contraception at any point? Y / N
DRAFT

f. If yes, what type? Mala-n / nirod / EC / DMPA / Cu-T / Sterilization

TRACK B

30. Are you planning to have another child? Y / N
   a. If yes, when?