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Authors
Shivani Singh, Ravi Prakash, Brinda Frey, Prakash Javalkar, John Anthony, Shajy K. Isac, Preeti Anand

Editors
Prapti Bhatia, Pravara Amreliya

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For additional information about the study 'Understanding Barriers and Challenges in Uptake of New Contraceptives in Uttar Pradesh, India', please contact:

India Health Action Trust (IHAT)
Uttar Pradesh Technical Support Unit (UP TSU)
No. 404, 4th Floor, Ratan Square
No. 20-A, Vidhan Sabha Marg
Lucknow – 226001, Uttar Pradesh
Telephone: 0522 4922350, 4931777
E-mail: ihat.lucknow@ihat.in
Website: http:/www.ihat.in

UNDERSTANDING BARRIERS AND CHALLENGES IN UPTAKE OF NEW CONTRACEPTIVES IN UTTAR PRADESH, INDIA

Dr. Sushma Singh
Director General

Directorate of Family Welfare
Uttar Pradesh, Lucknow

MESSAGE

The Vision 2030 document of Uttar Pradesh reiterates the state's commitment to ensure universal access to sexual and reproductive healthcare services, including family planning (Sustainable Development Goal 3.7). To achieve this, the state has laid down its family planning (FP)goals as satisfying 75% of the contraceptive demand by modern methods, attaining a modern contraceptive prevalence rate of 52% and reducing the total fertility rate to 1.9 by 2030. The Government of Uttar Pradesh (GoUP) has been making consistent efforts to meet these goals by expanding the range of contraceptive choices by introducing new contraceptives (Antara and Chhaya), enhancing community engagement, strengthening service delivery, and using innovative outreach methods.

Introducing new contraceptive methods offers additional choices to eligible couples to meet their diverse needs and preferences. The manifolds increase in users of Antara (from 1.5 lakh in 2021-22 to 4.1 lakh users in 2024-25 (till Feb, 2025)) and Chhaya (from 2.2 lakh in 2021-22 to 5.3 lakh users in 2024-25 (till Feb, 2025)) as per HMIS, also reflects the improved uptake of these new contraceptives. However, theirsustained use still remains an issue. Hence, Uttar Pradesh Technical Support Unit, in consultation with GoUPconducted a qualitative study with Antara and Chhaya users, frontline workers (FLWs) and programme personnel in Meerut and Varanasi districts, to understand the barriers and challenges in the sustained use of these contraceptives.

The findings showed that Antara (injectable) emerged as a choice with easy availability and use, however,concerns of side effects andless follow-up by FLWs hindered its sustained use. In the case of Chhaya (weekly oral pill), positive word of mouth and no sideeffects acted as enablers to its use, but lack of demarcation from daily pills, difficulty around remembering the doses in the first three months (twice a week), and adherence fatigue emerged as barriers to its sustained use.The insights from this study highlight the perceptions, preferences, and challenges faced by womenand healthcare providers regarding new contraceptives. The report also highlights evidence-based strategies to enhance service delivery, improve acceptability, and address barriers to uptake and sustained use.

I encourage the health officials at all levels across the state to use the insights from this study for making micro plans and implementation in their respective areas, focusing equally on FLWs.My sincere thanks to UP TSU for the thorough and rigorous research approach. Their commitment to amplifying the voices of diverse stakeholders, particularly women and underserved populations, underscores our shared vision to provide equitable and inclusive quality services to all.

(Dr. Sushma Singh)

John Anthony
Senior Project Director

UTTAR PRADESH TECHNICAL SUPPORT UNIT
404, 4th Floor, Ratan Square
20-A, Vidhan Sabha Marg, Lucknow-226001 Uttar Pradesh
Phone : 0522-4922351, 4931777
E-mail : john.anthony@ihat.in
www.ihat.in

MESSAGE

The Uttar Pradesh Technical Support Unit (UP TSU) provides techno-managerial support to the Government of Uttar Pradesh (GoUP) through inputs on planning, implementation and monitoring of health programs across the domains of reproductive, maternal, newborn, and child health. The UP TSU has been supporting the GoUP in its efforts to reach family planning (FP) goals of modern contraceptive prevalence rate (mCPR) of 52% and TFR of 1.92 as laid down in the state's Vision 2030 document. This involved multi-pronged approaches such as expanding the available basket of contraceptives, strengthening service delivery, enhancing community engagement, and using innovative outreach tools.

As a first step towards understanding the current FP situation in Uttar Pradesh, the UP TSU designed and implemented a unique Integrated Family Planning Survey in 2021 to provide an overview of FP use, service availability and quality of services. The insights from this study helped in identifying the key areas for program strengthening to improve the modern contraceptive uptake among the currently married women of reproductive age (CMWRA) in the state. The findings of this study highlighted that the uptake of new contraceptive methods (Antara and Chhaya) was low across the state, despite improved availability in the public health facilities.

As we work towards strengthening FP services in the state, it becomes crucial to understand the factors that influence the adoption and continued use of new contraceptives. In this regard, UP TSU conceived and executed a qualitative study in 2023 to gain deeper insights into the factors contributing to the low uptake of new methods as well as the barriers and challenges associated with their use. This exploration involved both current and former users of these new contraceptives, along with the front-line workers (FLWs), facility-based service providers and program personnel, to understand both demand and supply side perspectives.

One of the key findings from this study was that Antara, initially favored by users for its ease of availability and use, emerged as a choice with less cognitive load. However, experiences of side effects, limited knowledge among FLWs on the management of these side-effects and insufficient follow-up from FLWs made it a choice with high cognitive load, contributing to its discontinuation among users. On the other hand, Chhaya benefited from positive word-of-mouth and little to no side effects, but encountered barriers such as confusion with daily oral pills, additional cognitive effort to remember dosage in the initial months, and adherence fatigue over time.

These insights emphasize the importance of tailored communication, enhanced provider engagement, and user-centric approaches to improve the acceptability, uptake and sustained use of new contraceptives. We believe that insights from this study will help various departments and officials of the GoUP and non-governmental organizations and agencies involved in strengthening the FP program, expanding the reproductive choices for individuals and families across the state and achieving the state FP2030 goals of mCPR.

(John Anthony)

ACKNOWLEDGEMENTS

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We extend our sincere gratitude to the Department of Medical, Health and Family Welfare, Government of Uttar Pradesh (GoUP) and National Health Mission (NHM), Uttar Pradesh for extending their support and providing necessary approvals for the successful implementation of the study. We are also grateful to the Gates Foundation (GF) for their support. The GoUP and GF do not fully endorse all of the contents of this report, nor does the report necessarily represent their views or opinions. The findings, statements and recommendations contained within this report are primarily of the contributors of this report from IHAT-UP TSU.

The IHAT-UP TSU would like to thank all the partners of the Family Planning Monitoring, Learning and Evaluation (FP-MLE) consortium, namely the Population Council, CARE India Solutions for Sustainable Development (CISSD), the International Center for Research on Women (ICRW), and the Center on Gender Equity and Health (GEH), UC San Diego for their technical inputs to enhance the learning agenda of the study. The UP TSU gratefully thanks Dr. Suneeta Krishnan (Deputy Director, India Country Office, GF), Ms. Neeta Goel (former Country Lead, MLE, GF) and Ms. Priya Nanda (former Senior Program Officer, MLE, GF) for the guidance in ensuring the smooth implementation of the study.

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CONTENTS

ACRONYMS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwifery
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
CHO	Community Health Officer
CPR	Contraception Prevalence Rate
DMPA	Depot Medroxyprogesterone Acetate
DPM	District Program Manager
ECP	Emergency Contraceptive Pill
FLW	Front-Line Worker
FP	Family Planning
FP-LMIS	Family Planning Logistics Management Information System
HBNC	Home Based New-born Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDI	In-depth Interview
IEC	Information Education Communication
IFPS	Integrated Family Planning Survey
IHAT	India Health Action Trust
IUCD	Intrauterine Contraceptive Device
MCPR	Modern Contraceptive Prevalence Rate
MPV	Mission Parivar Vikas
MM	Modern Methods
NFHS	National Family Health Survey
NHM	National Health Mission
OCP	Oral Contraceptive Pills
'P' (P0, P1, P2, P3, P4)	Parity
PHC	Primary Health Centre
PPIUCD	Postpartum Intrauterine Contraceptive Device
SC	Sub Centre
TFR	Total Fertility Rate
UPTSU	Uttar Pradesh Technical Support Unit
VHND	Village Health and Nutrition Day
WOM	Word of Mouth

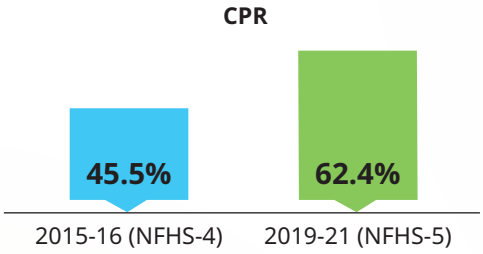
STUDY CONTEXT, DESIGN AND SCOPE

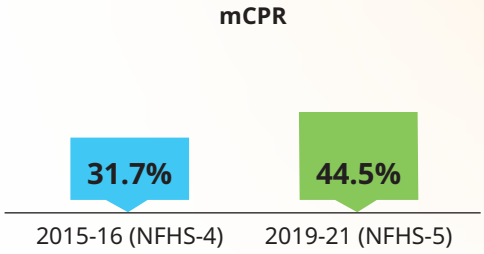
India's National Health Policy of 2017 recognizes the need for population stabilization and lays down the goal of meeting above 90 percent of family planning (FP) needs at the national and sub-national levels by 2025.

To that extent, the central government introduced Mission Parivar Vikas (MPV) in 2017 to accelerate access to contraceptives and FP services in 145 high-fertility districts that had a total fertility rate (TFR) of 3.0 or more, including 57 districts of Uttar Pradesh (U.P.).

Recognizing the need for accelerated action in FP, UP's Vision 2030 document has identified its FP milestones for 2030 as satisfying 75 percent of contraceptive demand by modern methods, modern contraceptive prevalence rate (mCPR) of 52 percent and TFR of 1.9. The state has employed approaches such as greater community engagement, expanding the available basket of contraceptives by including new methods, strengthening service delivery, and using innovative outreach tools to meet its FP goals.

The effect of concerted efforts of the Government of Uttar Pradesh is evident through the improved FP indicators, as depicted in the latest round of the National Family Health Survey (NFHS-5, 2019-21). **The state's CPR improved from 45.5 percent in 2015-16 (NFHS-4) to 62.4 percent in 2019-21 (NFHS-5), while mCPR increased from 31.7 percent to 44.5 percent in the same period.**





To address the emerging needs of couples and expand the basket of choices, the Ministry of Health and Family Welfare introduced two new contraceptives in 2017 – *Antara* (injectables), and *Chhaya* (weekly contraceptive pills).

This was coupled with the launch of Mission *Parivar Vikas* (MPV) to increase access to contraceptives and FP services in high fertility districts with TFR of 3 and above. Some initiative under MPV include *saas-bahu sammelans* (later *saas-bahu-pati*) sammelans for community interactions and outreach on FP, and *nayi pehel* or *shagun* kits for newly married couples, containing FP information pamphlets, and contraceptives including condoms, etc.

However, the uptake of new contraceptives (Antara and Chhaya) showed slow uptake among women. This was not only the case in UP, but many other MPV states viz. Bihar, Madhya Pradesh, Jharkhand and Chhattisgarh also showed similar trends (Fig 1 and 2).

Figure 1: Trends in Injectables (%) in MPV states, HMIS (2017 – 2020)

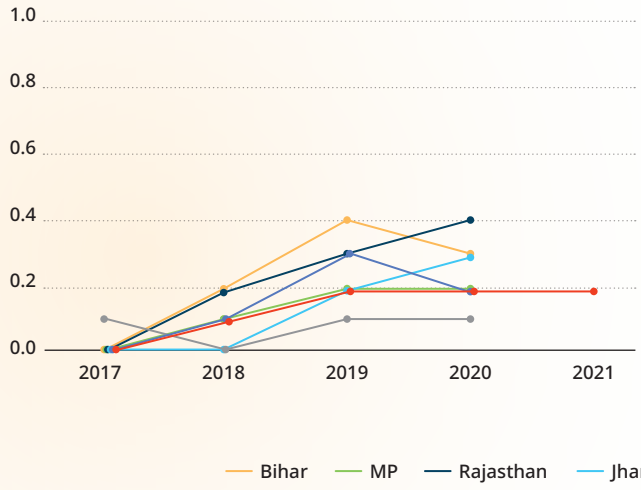
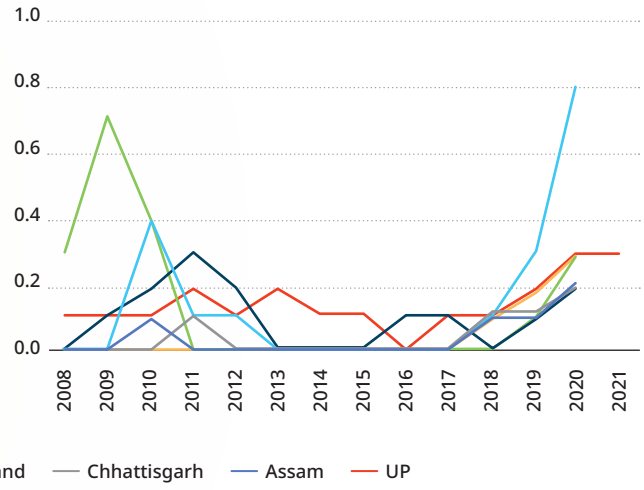
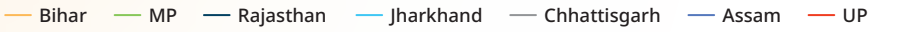


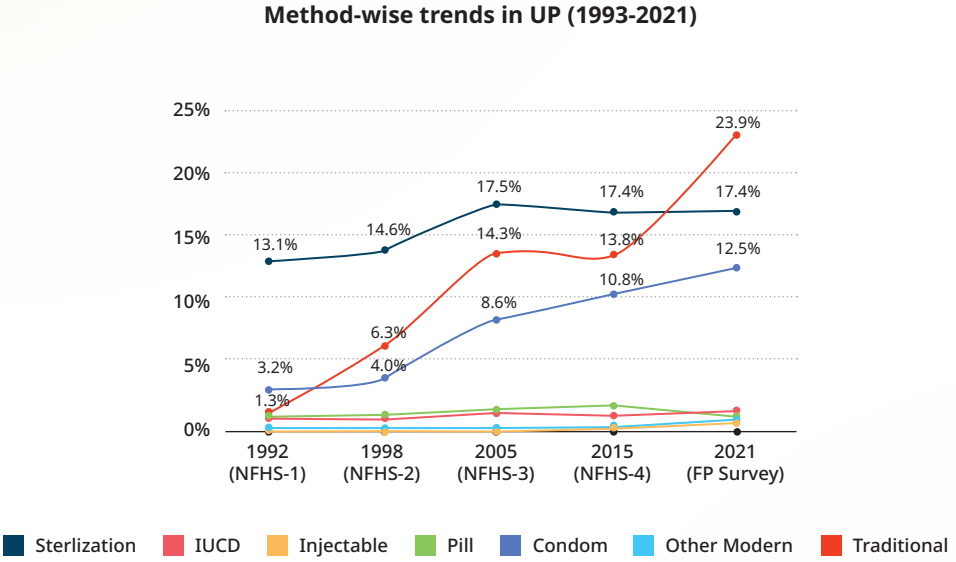
Figure 2: Trends in Chhaya (%) in MPV states, HMIS (2008 – 2020)





Note: % of injectable users were calculated by applying Couple years of protection of **0.25 per dose**

Figure 3: Method-wise trends in last three decades in Uttar Pradesh (1993-2021)



Sources:
- *National Family Health Survey (4 rounds)*
- *Integrated Family Planning Survey, UPTSU, 2021*

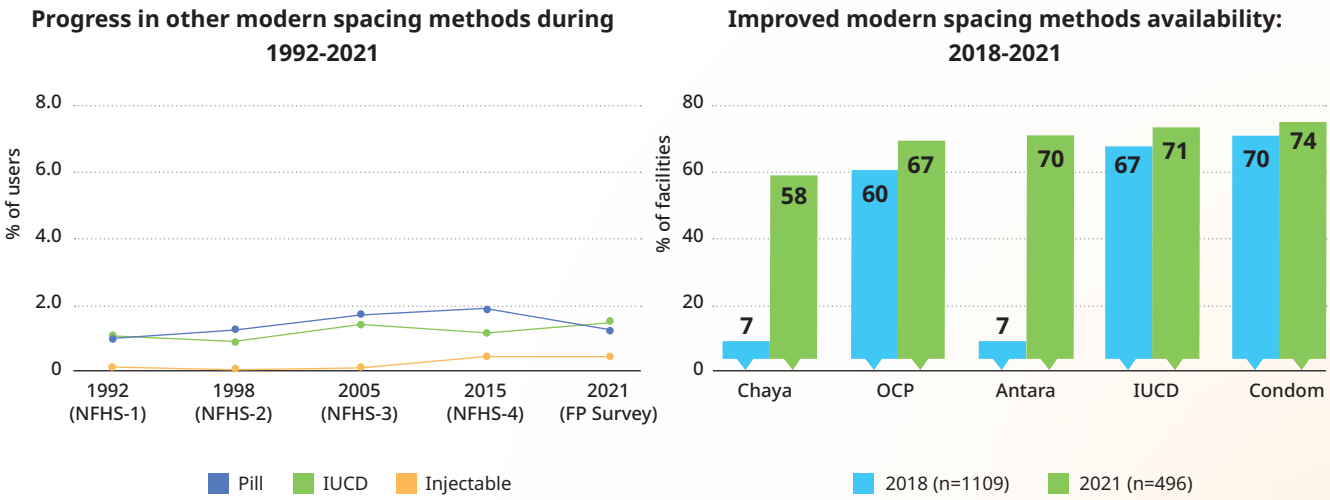
NFHS-1 and 2 represents undivided UP

	NFHS-1	NFHS-2	NFHS-3	NFHS-4	FPS-2021
Non users (%)	80.2	72.9	56.4	54.5	42.3

In UP, the uptake of new contraceptives was found to be low despite the significant improvement in the availability of FP methods at government facilities. Availability of Antara has increased from 17 percent to 78 percent and Chhaya from 16 percent to 63 percent between 2018 and 2021, according to the Integrated Family Planning Survey (IFPS)[1] conducted by UPTSU in 2021. However, end users (women) have lower knowledge about the existence of these methods as well as their usage as per the IFPS, 2021.

[1]Integrated Family Planning Survey is a state representative survey conducted by UPTSU in 2021, which covered 12,200 currently married women of reproductive age, 419 ASHAs, 370 ANMs, and 496 PHC and above facilities providing family planning services.

Figure 4: Trends in uptake and availability of modern spacing methods



Data source: UPTSU Facility Mapping, 2018 and FPS 2021

When it comes to service provision, frontline workers' (FLWs) communication about Antara increased by 6 percent and Chhaya increased by 11 percent (from 0 to 11%) between 2018 and 2021, which shows a positive shift (IFPS, 2021). However, when it comes to the knowledge about these methods - side effects, risks associated, benefits as well as eligibility criteria there seems to be varying degrees of knowledge. Additionally, ASHAs mostly discussed sterilization and condoms as contraceptive methods with the community. They also prefer speaking about condoms with low parity couples and do not focus on modern reversible methods, reasons for which are unknown (IFPS, 2021).

Although low uptake of modern contraceptives (such as IUCD, condoms, implants, pills, and injectables) has been studied in other geographical contexts viz. Kenya (R. Ochako, M. Mbondo et al, 2015), Tanzania, Pakistan (K. Hackett, S. Nausheen et al, 2021) - they explore how knowledge of the reasons for low uptake, including impact mechanisms, side effects, advantages, redressal routes, etc. may strengthen the roll out of FP programs in the respective countries. **There are very few studies that go into the nature of non-uptake, refusal and preference of non-modern methods in the Indian context.**

The existing evidence within the space of FP in India shows that couple decisions, mental models of women, their partners and families impact the decision to use contraceptives. (Char, 2011; Rimal, Sripad, Speizer, & Calhoun, 2015). Women's choice making ability is determined by couple dynamics and familial attitudes around contraceptive practices and their bodies. They are socialized into gender norms where the onus of reproduction as well as contraception is shouldered by them without any decision-making authority. Men play a crucial role in a woman's choice of contraception as notions of masculinity such as choosing the withdrawal method (one form of traditional contraceptive) over modern contraceptives, impact a woman's ability to bear a child. Lack of accurate knowledge and awareness about contraceptive methods also leads to a reduced demand for modern contraceptives, despite the government's consistent efforts on the supply side.

Additionally, the challenges outlined by the IFPS data do suggest the need to equally shift the focus to the FLWs who are mandated to make the community and eligible couples aware about the newer methods. The limitation of informing about Antara (8%) or Chhaya (4%) could perhaps also hint to their biases and perceptions leading to an underlying decision around selective counselling (IFPS, 2021). This needed further inquiry. The biases could be stemming from the fear of side-effects of these new hormonal methods which could lead to a negative impact on their image within the community. This perhaps is the reason for 85 percent of ASHAs recommending condoms to lower parity couples. In addition, further enquiry is required to understand the modus operandi of FLWs while counseling women, based on their age and parity. **This mental model of ASHAs and FLWs needs to be better understood in order to ensure we have a holistic diagnosis of the challenge and that our interventions are focused towards targeted impact.**

While there has been growing literature on challenges with the uptake of Antara and Chhaya in the community, the studies mainly focus on understanding reasons for lower uptake. However, this study attempts to explore the users' journey in terms of-

- Why do some women choose Antara/Chhaya while others do not?
- What motivates the women users to continue using Antara/Chhaya or to adopt other modern contraceptive methods?
- How the learnings from women's experience can be leveraged to guide the program strategy and thereby increasing the contribution of these two new methods to overall mCPR.

THE OBJECTIVES AND KEY INFORMATION AREAS

The primary objectives of the study are-

1

To understand women's reproductive journeys and pathways for choice making around Antara and/or Chhaya over other methods as well as factors driving continuous usage of the methods or discontinuation as well as switching between methods.

2

The study would also dive into health service providers' perspectives and lived experiences, messaging techniques, counselling tactics, provision of tailored counselling around these methods, as well as follow-up with the clients to ensure continuity of new methods.

The key information areas in focus for interviews with clients-

- What enables and motivates women to choose Antara over other available modern spacing methods?
- What enables and motivates the women to choose Chhaya over other available modern spacing methods?
- What enables Chhaya/Antara users to continue using these methods?
- What makes Chhaya/Antara users to discontinue using these methods?
- Which methods did they prefer switching to? Why?
- What can programs do better to avoid switching to other methods?
- Who are the influencers in the decision making process to take up Antara, Chhaya over other contraceptive methods?
- FLWs have different approaches and modes to counsel women who continue with Antara/Chhaya versus those who discontinue or switch to other methods. What are women's differential experiences across different methods?

The key information areas in focus for interviews with FLWs and service providers-

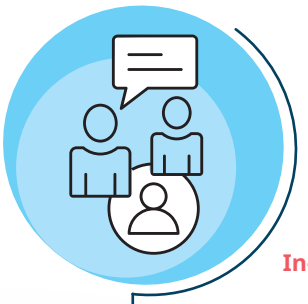
- When FLWs counsel women about contraceptives, what leads them to suggest Chhaya and Antara? Do they give information about new method to all the women or do they prioritize some women? Who are they? What are the criteria of prioritization?
- What is it that FLWs and service providers do differently from service provisioning perspective where women adopt and continue with Chhaya or Antara?
- What are FLWs communicating about Chhaya and Antara as methods when they present choices?

METHODOLOGY

For this study, a narrative account of women and their individual case studies were captured to unpack their uptake of contraceptives and factors influencing the choice of method. The approach of the interview was largely conversational aligned with a pre-defined structured interview guide. Extra measures were taken to ensure that women are not made to feel uncomfortable and a non-judgemental attitude along with empathy was utilized throughout the research phase. Areas that women found uncomfortable speaking about were not probed into, especially when it comes to abortion and miscarriages.

We used a combination of design research and qualitative methods to gain insights into the individual level and system level factors related to the Antara/Chhaya use. This was essential to understand perceptions, practices and behaviours of the selected women with respect to FP in the context of modern methods usage, and experience with FP service delivery mechanisms and modern spacing methods available at public health facilities.

Additionally, health system providers (doctors and nurses) engaged with FP service provision from PHC and/or Community Health Centre (CHC) catering to the women in the selected geographies along with district level program officials were engaged to understand programmatic challenges, bottlenecks with provision of services around Antara and Chhaya.



In-depth Interviews (IDIs) with:

Adopter end-users of Antara/Chhaya (women):
The IDIs were designed to move from a more generic/ context setting area of inquiry to a more personal and intimate area of sexual practices and use of contraceptives. This gradual movement into the probe helped build a rapport with the participant to open up about the more private topics. We organized the flow of the interview around women's life trajectories for keeping them oriented, eventually narrowing down to their use of contraceptives and factors defining their choices.

Non-adopter end-users and aware non-triers (women):
IDIs were conducted with non-adopter women who were either non-users or discontinued users and aware non-triers of Antara/Chhaya across the two districts to get an in-depth understanding of the reason behind this decision-making and the challenges they might have faced.

FLWs:
IDIs with FLWs helped in understanding their strategies of communication and spreading awareness with communities on contraceptives. Inquiries were made about their understanding of pills and injectables as contraceptive methods and the opinions/ biases they hold; and as a member of the community who have sensitive information about the community. Often, FLWs' perceptions about these methods, their fears and misconceptions feed into their interactions with community members. Tracing these through probes was crucial to strengthen the research study. FLWs were encouraged to share their knowledge around the fears and misconceptions or ability to engage with community members about their queries around contraceptives.

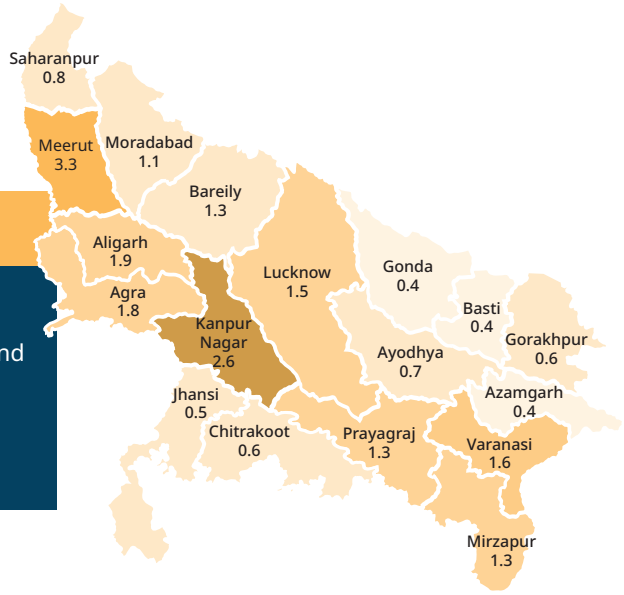
GEOGRAPHY SELECTION

Figure 5: Geographical pattern of modern contraceptive methods in UP

% USING IUCD

UP: 1.4%

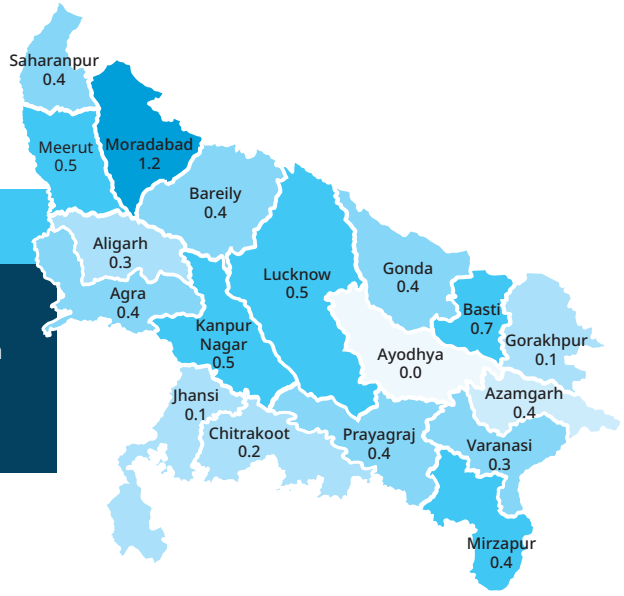
- Lowest: 0.4% in Basti, Gonda and Azamgarh Division
- Highest: 2.6% in Kanpur Nagar Division



% USING INJECTABLES

UP: 0.4%

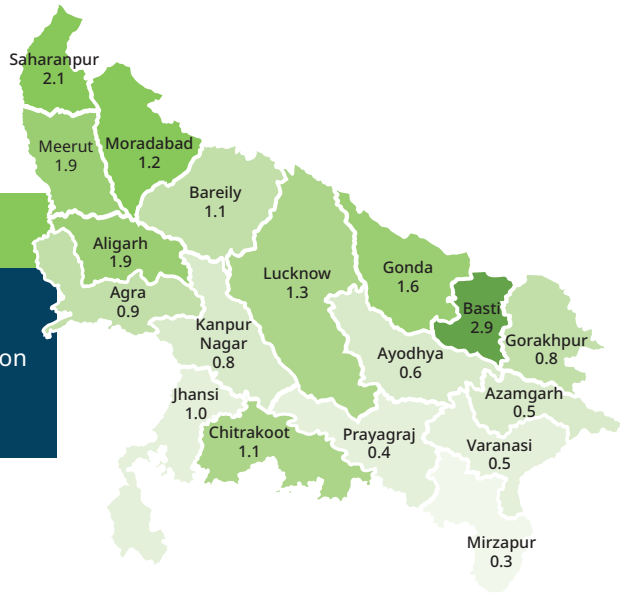
- Lowest: 0% in Ayodhya Division
- Highest: 1.2% in Moradabad Division



% USING PILLS

UP: 1.2%

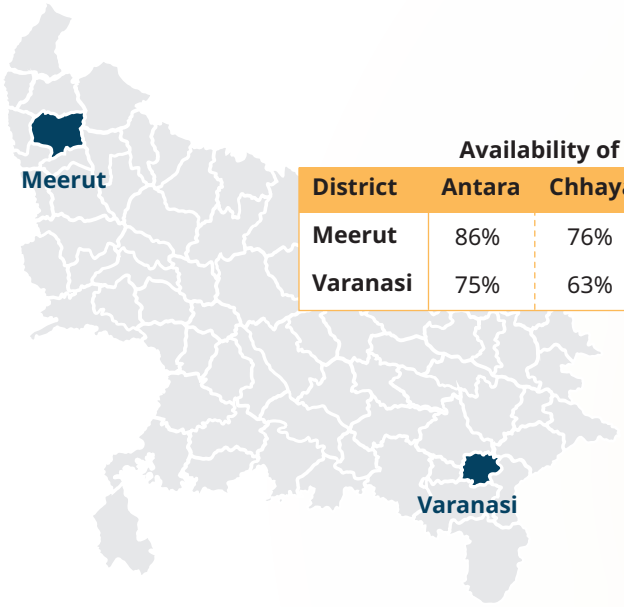
- Lowest: 0.3% in Mirzapur Division
- Highest: 2.9% in Basti Division



Study districts selected for the study were Meerut and Varanasi.

Key considerations: To overrule the general assumption that low uptake of new contraceptives might be due to low availability, two districts with higher method availability but a low uptake of new contraceptives were selected for this study (Fig 6)

Figure 6: Study district details



District	Availability of Antara	Availability of Chhaya	Uptake of Antara	Uptake of Chhaya
Meerut	86%	76%	0.54%	0.47%
Varanasi	75%	63%	0.29%	0.01%

Source: IFPS 2021

For further selection of the blocks and sub centres, a two-step process was followed -

STEP 1

Using the Health Management Information System (HMIS) data for facility-wise administration of Antara and distribution of Chhaya from July to December, 2022, the aggregate Antara and Chhaya distribution at the block level was calculated for the two districts. Further, one block with high Antara-high Chhaya[2] & one block with moderate Antara-moderate Chhaya distribution was selected from each of the two districts.

STEP 2

Within selected blocks, sub-centres with the highest administration of Antara and highest distribution of Chhaya in the last 6 months were selected to ensure the availability of adequate sample for all target groups.

Table 1: List of blocks and sub-centres selected for the study

Districts	Type of block	Blocks	Facility codes	
			Sub-centre 1	Sub-centre 2
Meerut	High Antara-High Chhaya	Saroorpur	FC15385	FC15392
Meerut	Moderate Antara-Moderate Chhaya	Jani Khurd	FC15182	FC15166
Varanasi	High Antara-High Chhaya	Harraua	FC19981	FC19999
Varanasi	Moderate Antara-Moderate Chhaya	Cholapur	FC19949	FC19964

[2]Based on the total Antara doses administered at the block level in the last six months (July-December 2022), the blocks with <300 doses were categorized as low, 300-700 as moderate, and >700 as high Antara coverage blocks. Similarly, for Chhaya blocks with distribution below 1000 were considered as low, 1000-1500 as moderate and above 1500 as high Chhaya coverage blocks.

TARGET GROUP DEFINITION

CLIENTS: WOMEN

Adopters (continued users- at least 6 months)

- Chhaya Adopters
- Antara Adopters

Non-adopters (discontinued and non-uptake)

- Chhaya users who chose to discontinue
- Antara users who chose to discontinue
- Users who used neither of the two methods and are current users of other modern spacing methods

Parity (users)

- 0-1 parity
- 2-3 parity
- 3 and above parity

SERVICE SIDE:

Front line workers

- ASHAs
- ANMs

Service providers

- Doctors
- Nurses

District Level program personnel

- DPM
- FPLMIS Manager

SAMPLING FRAMEWORK

Table 2: Details of stakeholders and study sample

Stakeholders	Sample Size
Antara adopters	15
Chhaya adopters	15
Discontinued Antara users	6
Discontinued Chhaya users	8
Aware but non-users of Antara/Chhaya	14
Frontline workers (ASHA/ASHA Sangini/ANM)	9
Service providers (Doctors/Staff Nurse)	4
District level program personnel	2
Grand Total	**73**

RECRUITMENT, DATA COLLECTION AND STUDY SETTING

Recruitment process: A two-step selection process was employed for client interviews

STEP 1
Data was gathered from ASHAs to map married women aged 18-35 years. Using this preliminary list of women, 'users' of new methods (Antara or Chhaya) and 'non-users' of new methods as per ASHA records were identified.

STEP 2
Identified women were approached (using home surveys) to gather an understanding of their FP choices and behaviour. Also, users of sterilization and IUCD (including post-abortion and post-partum) were excluded from this research. Further, none of the women were currently pregnant, and all were living with their husbands (to ensure need for contraception).

Steps were taken to avoid any anticipated recruitment bias or convenience while selecting samples for the study.

On the community side:
- Distance from the nearest PHC/ CHC/ Health touchpoint was considered to incorporate the most unreached into the sample.
- Incorporating community members from the most vulnerable sections of the society as per the dominant socio-cultural makeup of the geography were considered.

On systems-side:
- Incorporation of FLWs, doctors/staff nurses and district level health programmers who are representative from various facets of FP service provision at community, facility and system's level.

Inclusion Criteria: All consenting women clients were interviewed, which consists of-
i) current users of Antara,
ii) current users of Chhaya,
iii) women who have discontinued using Antara,
iv) women who have discontinued using Chhaya,
v) women who are current users of other modern spacing methods but have never used Antara or Chhaya.

Other consenting stakeholders were included in the study if they are-
a) ASHA and ANM serving in the PSUs selected for the study,
b) facility-based providers i.e., doctors and/or staff nurse providing FP services in the public health facility catering to or closest to the selected PSUs and
c) district level program officers working in FP Program in the selected districts.

Data collection activities were carried out in the month of May 2023 in eight PSUs across two districts – Meerut and Varanasi. Four teams with a combination of researchers and moderators (6-7), operations team (1-2) and field team (1-2) were prepared for data collection in each district. The place of interview in each village were select central venues within the villages for easy access for the participants– Ayushman Bharat Health and Wellness Centre, Panchayat Sachivalaya, Sub-centres in both the districts were chosen for fieldwork execution. Service Providers such as doctors and staff nurses were interviewed at their health facilities (CHC/PHC) catering to the women's FP needs in the selected study areas. District Level personnels were interviewed in their offices.

DATA ANALYSIS PROCESS & MODELLING

The audio recordings from the IDIs were transcribed and translated into English (since the interviews were conducted in Hindi). A detailed content analysis was carried out through the identification of codes and themes and constant brainstorming based on interview guides and field note documents. Thematic analysis of these codes resulted in larger themes, presented in this report for each cohort. Insights were then drawn out from the findings that emerged and anchored into evidence in the form of verbatims from the interviews. An action framework was then generated based on the overarching themes and need gaps identified during the study.

LIMITATIONS, SUGGESTIONS FOR FUTURE RESEARCH AND COUNTER MEASURES FOR SOCIALLY DESIRABLE RESPONSES:

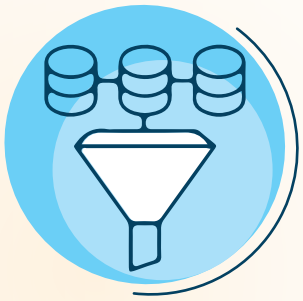
Due to limits on the scope of the research, we could not involve all stakeholders who are part of the health system in this research. Future studies can consider involvement of administrative officials (block, district, state or national level), which might provide perspective on program policies, targets, mechanisms of information dissemination and feedback for FLWs, supply side stories, etc.

Participants may have experienced the 'Hawthorne effect', that is, it is possible that the interview settings could have modified the participant's behaviour or response, especially while discussing challenges experienced within the system. **Socially desirable responses** are often noted in qualitative interviewing. This is especially true for FLW interviews, wherein ANMs and ASHAs could have felt they were being tested for their knowledge and rigour of work.

To minimize the impact of such a possibility, projective techniques (or third-person narrative association) were employed. A vignette called '*Teri Meri Kahani*' was presented to participants, made of characters with demographics similar to the participant to drive relatability and storytelling. As the discussion continued, participants were encouraged to complete the story – bringing in their own experiences, thoughts, and ideas into the interview by piggybacking on the fictional character (called *Kavita/Reshma*). Another technique used involved user imagery – a hypothetical questioning technique ('what could be...') allowing participants to express personal thoughts without fearing judgement or responsibility – again using fictional characters to piggyback on. Journey or reproductive timeline mapping was utilized to encourage participants to articulate their responses in a story-like chronological format.

The present study could be limited in scope due to a relatively small sample size, impacting its generalizability. An expansion of its scope to include other districts is a suggestion for future studies with similar objectives.

STUDY FINDINGS



The reporting of the study findings follows a funnel-like approach. It starts with understanding the social realities of the clients and the different contextual conditions within which they operate. It then moves into exploring their relationship with FP and the factors that impact their knowledge, attitudes, and practices, which gets mapped against the FLW perspective.

Next, we expand and prioritize the reasons for triggers and barriers with regards to the uptake of Antara and Chhaya. All of this culminates into our action framework (The Cognitive Load Theory) which has been generated based on the overarching themes and need gaps identified during the study.

1. THE LIFE CONTEXT OF THE CLIENTS

MACRO CONTEXT WITHIN WHICH THE CLIENTS OPERATE

Talking about geographical access and availability, most villages that we visited had **proximal access** to primary schools, bank branches, post offices, local markets with availability of basic amenities, health and wellness centres, community health centres, and subcenters.

- **Most villages were quite close to the highways**- especially Dasepur which also has proximity to the airport. Bikes, bicycles, and tractors were common for majority of the households. However, the quality of roads was not always great across villages, especially noted in Meerut.

Talking about access to health services- villages across both districts had access to the nearby health facilities (in many cases private health facilities were equally easy to access) except for Pitholker (where the nearest facility was at least 30 minutes away.

- **Key Observation**- We observed an **apparent difference in perception of service delivery quality for public vs private facilities**- in terms of access, quick redressal, and services available. Another aspect that kept coming up repeatedly in our interviews with clients was the **attitude of service providers to be relatively more empathetic in private facilities as against public facilities** which makes it a more alluring option even for people who necessarily did not have the financial means to do so.

Talking about mobility options and ease- Mobility for most clients across districts was restricted. This restriction was about both- limited options as well as social sanctions. In many cases, as expected, clients were dependent on their husbands. Other than that, in most cases, they are accompanied by their mothers-in-law/ sister-in-law or other older members of the household while going to the market, visiting relatives, doctor visits, any social functions and other occasions. This also acts as a subliminal reinforcement of the power dynamics and most of the time of the women every day is spent within the bounds of household chores, significantly restricting her mobility and access to the physical outside world.

Talking about social circles and congregation points- While men have multiple spaces to socialize outside of home and work, such spaces and opportunities are significantly limited for women. **Hence, the social touchpoints and frequency of conversation mostly remains limited to members of the family or the women living in the immediate neighbourhood.**

- **Key Observation-** *Bhabhis/* slightly older to self-women with lives, lived experiences and challenges similar to theirs in their immediate vicinity emerge as primary circles of support, information seeking, social confidence, choice making and even redressal in various situations pertaining to different aspects of life.

> ***"Hum-umar ke sath baat karne ki zyada koshish rehti hai. Unhein bhi samajh aata hai hamaari zindagi ke baare mein aur humein bhi samajh aata hai unki zindagi ke baare mein"***

- **Across districts, these social congregation points and setups are not same** and depend on the hyperlocal access- Self-Help Groups, nearby places of worship, VHND days, Anganwadi centres or in one case, the verandah in the house of the sarpanch emerged as commonly mentioned places where women met other women like them.

> ***"[Name removed] ke ghar hota hai har mangalwar ko yaa phir Anganwadi mein mil lere hain"***

Very few women were engaged with farming or working in shops or visiting college for their on-going educational/ vocational courses. For them, their peers in these places are additional circles of access and social learning.

- **Another social touchpoint that is crucial for these women is the ASHA**. Since ASHA is generally from the same locality and is also part of the health system, she represents the first formal interaction point for clients with health services. Access to ASHA is usually a 'push mechanism' through phone calls or her visits to the *mohalla/* households for VHND or any health-related surveys and outreach activities.
  - > **In a few cases,** it was observed that caste/ religion acted as a barrier from both the client side and the ASHA's side leading to limited or no exchange or involvement.

The mobile phone has established itself a perpetual-portal for accessing new information: While all couples access technology in some form or another, usage and ownership vary by gender, whereby most of the men have their own phones, and women are seen to both, own their own devices; or sometimes share phones with their husbands. Women often access phones for keeping in touch with their friends and family, entertainment purposes and learning new skills (recipes, sewing, educational information for their child). Technology hence opens a window for women to seek new information.

- Women, in all cases, have awareness about the functional aspects of smartphones such as entertainment, connecting with loved ones, and seeking information. It has been observed that in most cases, **women have hands-on-experience of using WhatsApp for audio and video calling their relatives and family members who do not live with them, using YouTube for information gathering**. A few women even **mentioned watching reels and short videos** on social media apps like Instagram.
- **Vernacular and video first content** emerge as a popular choice and there seems to be confidence in the belief that whatever they want to learn or know about, they will be able to find it online in the language of their choice and a level of complexity that they would be comfortable in.
- **YouTube emerges as the most often used app to consume a very wide range of content**- educational, informative as well as entertainment (watching movies and serials). Women tend to look for information to use it for learning to cook new dishes, stitching, or embroidery/crochet related work.

- In some cases, we have also found women use it to gather information about reproductive health and FP to understand different methods of contraception, ways to not get pregnant, etc. A limited few also recall the usage of YouTube to watch pornographic content with their partners.
- While the mobile phone and internet have emerged as an important avenue to be in contact with the outside world, mobile phone usage still remains at a nascent stage for some women. Hence, many women still do not have an access as great as others, leading to non-usage of the same for gaining information on any topic, specifically FP.

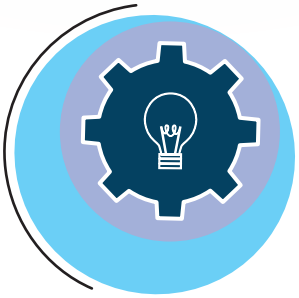
"I sometimes go out of the house; my interaction is mostly with [Name removed] bua and [Name removed] bhabhi only. They live in my neighbourhood"
- Antara User/Younger/Varanasi

"Yes, in private facilities, there are more facilities and the doctors' behaviour is also polite towards everyone."
- Antara User/Older/Varanasi

"I mostly spend my free time watching videos on my mobile phone. I learnt to make chips from there for my children, Also, I learnt about my stitching from YouTube only."
- Chhaya User/Younger/Meerut

"My friend in colony is [Name removed] Baaji. We meet2-3 times in a day where we also talk about general things only mostly."
- Antara User/Younger/Meerut

"No, we don't go anywhere. But my mother-in-law visits people in the neighbourhood. I go to hospital with my husband only. He does not allow me to go alone."
- User of other MM/Younger/Meerut



KEY LEARNING | Women and the collective phenomenon

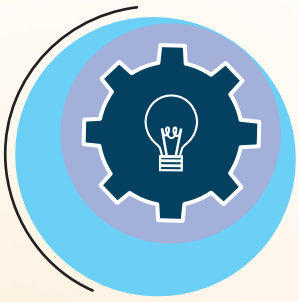
We observed that women perceived other women around them with similar lived experiences, similar contexts and challenges as a safe anchor for information seeking and choice making. There is a deep sense of trust and collectiveness that emanates from this shared context, and many times it is these women around them that become their first port of contact.

As a result, social confidence emerges as the fundamental catalyst to decision/ choice making amongst clients i.e. women mitigate risk in choices through positive or negative experiences and recommendations of other women like them (called word of mouth, which can potentially sway public opinion towards a theme/product in a negative or positive direction). Experimentation/uptake for something new is cushioned and catalysed by the validation of others in their social circle.

SOCIO CULTURAL CONTEXT

- **Patriarchy is the norm**- Across districts, the social and family structure aligns with traditional patriarchy, where men typically assume leadership roles in households, and women tend to follow their decisions. These ingrained ideas are deeply internalized by most residents of the village, making any deviation from these norms practically invisible and unacceptable within the community.
- **Women tend to assume and play the role of primary caregivers and caretakers of the household,** devoting almost all their time tending to the family members and their needs. There is minimal, and in a few cases no contribution from the male members here.
- **Therefore, family and children supersede in the value system of these women**- Most women exhibited a simplified perspective on life, centering their lives around their children and family. Their desire is to attain a happy and fulfilled life by prioritizing their children's well-being. **In all of it, the 'I' seems to be highly deprioritised**- *"Bacchon ko achhi zindagi deni hai. Unhein padhana hai...khushiyaan bacchon se hi hain"*
  - **There is a heightened onus of responsibility with limited agency for these women-** While women are deemed responsible for most everyday household chores, the responsibilities that they are endowed with and the agency that they are given for choice making is disproportionate. For example, with respect to FP, while it is deemed as a woman's responsibility, she has little/no say in taking the decision all by herself (about her sexual and reproductive health) without consulting others.

> *"I want to do many things, but it isn't in my hand like as my husband doesn't permit many things that you should not do this you should not do that you do not go here you do not go there so I am not able to do anything"*
> ***- Discontinued User/Younger/Varanasi***
>
> *"Because he has his thinking that if you want you can eat half chapati less but do not go to your maternal place not even for one hour or half an hour whoever wants to meet you should come home, I just went to my maternal place when I got married after 4 days of the same and my kids also were born here only"*
> ***- Antara Discontinued User/Younger/Varanasi***
>
> *"My children are my everything. At the end it is about my children's happiness only and nothing else. I am the woman of the household who has to be responsible. If I will not be responsible then who will be"*
> ***- Chhaya User/Younger/Meerut***



KEY LEARNING | The responsibility trap

Women often find themselves trapped in a cycle where their ability to exert agency and control over their own lives is greatly restricted. **Within a strongly patriarchal and conformist environment, their choices and actions are continuously scrutinized.** The constant fear of being judged and becoming a topic of discussion within the broader community acts as a constant barrier to their decision-making process. This perpetual cycle also keeps them disconnected from new developments, current events, and a broader understanding of the world where their choices could hold significance and influence.

Talking about the Religion and Caste Context- Religious ideologies impact the day-to-day experiences of the women. In both conservative Hindu and Muslim religious communities, there were discussions of religious teachings or cultural norms that discourage or restrict the use of contraceptives, especially when it came to external devices like IUCD, injectables and Sterilization.

- In Meerut, we found a mix of all castes and religions, except Pitholker which was dominated by the Muslim community.
- In Varanasi, caste-based division was more vivid- *Thakurs & Pandits*, and *Rajbhars* – all reside in separate colonies with little to no contact with one another. Muslim households are demarcated into separate corner. **The points of cross congregation are almost absent.**
  - While in theory, access to nearby healthcare services for all villagers remained the same, there was a lack of active conversations from ASHAs with a few communities. We observed that a few ASHAs from upper castes were a little hesitant to communicate, form rapport with lower caste/Muslim households. A lot of women within these vicinities, therefore, fall outside the immediate realm of the benefits of the public healthcare system.

Talking about the Linguistic Context- Hindi was a prevalent language across the villages where there were no language-related challenges. In Pitholker, however, women did use Urdu words which did not seem to create any barrier in communication.

- In rest of the villages across both the districts, women were able to use a few English words in their conversation, as well as Hinglish terms. For example- "by chance", mother-in-law, father-in-law, husband, sex, market, etc.

EDUCATION AND ECONOMIC CONTEXT

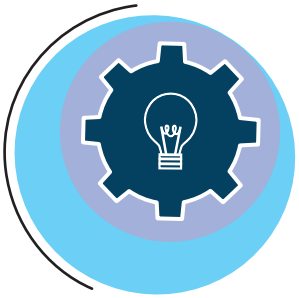
- Education levels of the women varied- All the women that we met had varying degrees of schooling and education. **Most of them had achieved schooling at least till eighth grade.**
  - A very small portion of the sample were women who were able to complete their education till 4th or 5th grade only and were married off before the legal age.
  - There were also some instances of a few women completing education till 12th grade and even graduation (mostly in the younger age cohorts). Most of these cases were observed in Varanasi. Interestingly here, women have continued to pursue and complete graduation even after marriage- These women recognized the need of education for improving their wellbeing and quality of life.

- Regarding the economic context-
  - **While education levels varied, participating in the workforce outside the domestic boundaries isn't an option for most women we met.** Staying at home, they help with tasks like taking care of the domesticated animals, milking them and other activities. A few women also assist their husbands in the field. Whenever they have time, they engage in sewing or tasks that can be done within the house and are often seen as leisure time activities and not something that they can earn money out of.
  - A few women have worked before marriage or were involved in their husband's farms to some extent, most women had limited involvement, such as starting small initiatives like beauty parlors from their own homes.
  - **Women want to do something for themselves, earn and gain financial independence.** However, this desire is curtailed by the family members, especially husbands and mothers-in-law.
  - A few young women, especially those who had completed education till 12th displayed the desire to work- either in an Anganwadi or a play school as a nanny/support for the teachers in the classroom. They even talked about how they actively seek and look for employment opportunities in the newspaper and even YouTube.
  - Talking about the occupation of the husbands- In Meerut- most were working in the fields or engaged in daily-wage occupations (ice-cream factories such as that in Pitholker in Meerut), owning a personal/family business (such as garment shops, grocery shops, etc.), or desk/permanent jobs.
  - In Varanasi- husbands were engaged in vegetable farming (and had bigger land holdings), worked in power loom industry for designing Banarasi sarees and suits- widely called as the "computer job" by the villagers, skilled labor, such as painting, driving, running small businesses, tailoring, assisting in shops, or working as property dealers.

"I want to work. You know these classroom helper kind of jobs. I have also seen it on YouTube. I keep regularly checking for these vacancies in the newspaper also. If my husband agrees then I will see if we can do it or not. See, if I will work, we will get some money, I will be able to help my husband also."
- User of other MM/Younger/Varanasi

"I have completed by education till 12th. After that I used to work also in a computer shop in Lajpat Nagar, Delhi. But after coming here, I stopped."
- Antara User/Younger/Meerut

"I teach my children. They study in a private school. I only asked my husband to get them admission in a private school. After they come back from school, I help them in studying. I can help them cover basics."
- Chhaya User/Older/Varanasi



KEY LEARNING | The emergence of a 'relatively' more educated and more 'intrinsically' aspirational young woman than the generations before her

Majority of the clients (compared to their predecessors) have-

1. Greater levels of education;
2. Greater levels of aspiration;
3. Greater access to tech and information (many times visual, audio) for decision making with regards to different aspects of their lives leading to an amplified ability for sense making.

There is a need for the health system to acknowledge the emergence of the young and educated client of today and differentiate it from the ones before them and adjust its language with them accordingly. This would mean that the health system delivers the information in a manner that is elaborate and detailed. Detailed information on health behaviours and their related outcomes, nuanced knowledge on contraception and FP would work in favour of the client of today for making better and informed decisions.

FAMILIAL CONTEXT

The general age of marriage was observed to be **between 17 and 21 years** for most couples- Most of the women got married at the age of 17-18 years barring a few women in Varanasi who got married around 21-24 years of age.

Family size and composition- We have observed that the household structure of the women that we met was **a mix of both nuclear and joint family structure.** In most cases, the women had a big family size comprising of 12-15 members.

- While some of the women lived together with all these family members in the same house, others lived in a smaller family size with their husbands, kids, and in-laws.
- If the other family members such as *jeth-jethanis* or *devar-devranis* lived in the same house, their *chulha/rasoi* was different.
- It has also been observed that when not living in the same house, jeth-jethani, devar-devrani would live in the vicinity of the women's house, or sometimes in close by villages/towns.
- The decision of the number of children is influenced by a variety of factors, including economic considerations, sex-composition of children, cultural beliefs, and access to FP resources.

Relationship between the women and their family members- Women, in most cases, had a neutral relationship with all their family members.

- ***Nanads, Jethanis, Devranis* as the go-to persons**- In the majority of cases, women that we met shared a positive relationship with the other women in the family. **Since they are immediate/proximal points of contact, they have also been observed to be women's go-to persons ranging from normal day-to-day conversation to even critical things like contraception and family-planning related choices.**
  - In many cases, the nanads, jethanis, and devranis have been sources of influence and information for making a choice of contraception.
  - **Mother-in-laws are perceived as a hegemonic but a reliable figure who is also seen to shape and control the beliefs, values, norms, and behaviours in the household** - While there is a very visible power distance between the women and their mothers-in-law who tend to dictate most things in the household, with women even having disagreements/conflicts with them, they are also seen to be the figures that women turn to for advice. In most cases, women share a cordial relationship with their mothers-in-law as well, where they are seen having open conversations about almost everything even FP and contraception.
- Talking about **women's relationship with their husbands-** Inter-spousal communication in all cases is dominated by conversations about monetary stability, their children's education, and future.
  - In a nuclear family space, where it is only the woman and her husband living together (mostly in younger age groups), women share a relatively open relationship with their husbands where they can express themselves with lesser filters- ***"Ab pati hi toh apna hain, jo bhi bolna hota hain unhi ko bolti hoon"*** They openly discuss their happiness, concerns, pleasures, and discomfort with one another.
  - However, **a power imbalance between the husband and the wife is prevalent mostly when it comes to topics such as sexual and reproductive health of the women**. Most women talked about how it was their **husband's choice to decide on issues such as when to have intercourse and what contraceptive method to use**. Even though women did talk about their discussions with their husbands about family size, they would still have no major say once their husbands had already decided about sexual intercourse.

Decision making in the household- As has been observed, the family set-up is hierarchical in nature where the women that we met lack the agency and autonomy to make decisions in the household.

- This is largely a result of the prevailing patriarchal structure within these communities. In these village settings, the primary source of income is typically derived from male members. Women, on the other hand, often have limited or no financial contributions to the household, which leads to male members (who are bread-earners for the family), such as **husbands, fathers-in-law, and uncles, assuming the role of key decision-makers**.
- This contributes to the women being at the lower end of the decision-making spectrum where they are dependent on the family members for all the decisions that they make.
  - Older women in the household, mostly the mother-in-law, also enjoy a status of privilege when it comes to taking/leading decisions in the household. However, the **ultimate decision-making power predominantly rests with the male members** only.
  - While most of them have a say in their child's education such as which school to send them to, **the husband, mother-in-law, father-in-law remain the dominant and authoritative figures of the family** who would be taking most decisions of the household ranging from decisions such as shopping for the groceries, meals to be cooked in the house, ccontrolling expenses in the household for child's education, to big decision related to women's health- what contraception method would they adopt are all a family affair- with limited say of the women in the same.

"My father-in-law takes most decisions in the household- like everyone is scared of him, even my husband only listens to him. If we do anything new- for example- my children's admission in a school was decided by him only."
- User of other MM/Younger/Meerut

"My sister-in-law visits us during the vacation. I am close to her. She sometimes even scolds my husband when he does not listen to me"
- Discontinued Chhaya User/Older/Meerut

"My jethani used to have Chhaya and she told me about this. We had a full discussion and she told me about the entire thing."
- Chhaya User/Older/Varanasi

KEY TAKEAWAYS

Who is this young client that the health system must watch out for?
The young clients are relatively more **educated, more intrinsically aspirational and tech exposed** young women than the generation before them. However, most of them are trapped in a cycle where their ability to exert agency and control over their own lives is greatly restricted. **Within a strongly patriarchal and conformist environment, their choices and actions are continuously scrutinized.**

The constant fear of being judged and becoming a topic of discussion within the broader community acts as a constant barrier to their decision-making process. **This perpetual cycle also keeps them disconnected from new developments, current events, and a broader understanding of the world where their choices could hold significance and influence.**

As a result, most of them lean strongly on the women around them with similar lived experiences, similar contexts and challenges as a safe anchor for information seeking and choice making. There is a deep sense of trust and collectiveness that emanates from this shared context, and many times it is these women around them that become their first port of contact. Social confidence emerges as the fundamental catalyst to decision/ choice making.

2. RELATIONSHIP WITH FP | KNOWLEDGE, ATTITUDES AND PRACTICES

APPROACH TO SEX

- Different point of views were observed when it comes to sex as a topic both at a collective as well as individual level

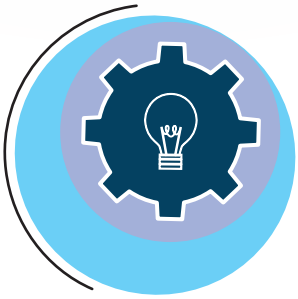
At a collective level- Most women during the interviews did not appear to be too uncomfortable while talking on the topic or with the vocabulary around intimacy/ sex/ sexual intercourse. Most of them used the following words to describe the act- *'sex', 'pati ke paas jaana' ,'sambandh banana' and 'pati se milna', 'sambhog', 'enjoy karna'*

- All of them report clear and technically accurate knowledge about the mechanism of fertility, pregnancy, and risk in intercourse. **The biological understanding that a sperm ('paani', 'shukranu/sperms', 'bacche daani mein shukranu jana') must meet the egg by way of entering a woman's body is clear.**
- Regardless of their age, education, and parity, conversations around sex and contraception are approached with openness by them. Even with other women around them, women had **a great sense of ease and comfort** with discussing the topic of sex openly with each other, discuss experiences with contraceptives and so on. **There were many instances during interviews where women shared that they knew about the experiences (pertaining to contraceptives) of other women around them.**

At an individual level-

- **Sexual intimacy is seen as holding positive** value for both men and women, albeit cited as being of greater interest to men. Mostly **women cite it as being an act that they sometimes seek and sometimes do not.**
- It is notable here that while both the parties express desire and consent for intercourse, it **is often the husbands who initiate the act.** While some women are able to say no when they do not wish to engage in intercourse (mostly young married), most report that they "give in" to their partners' wishes to make their partner happy and satisfied.

As we go higher in terms of parity and older in terms of age, there seems to be a growing power distance between the males and females pertaining to the instances and frequency of sexual intercourse.

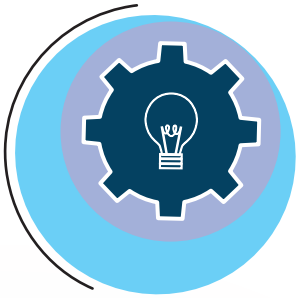


KEY LEARNING | The ease with which women talk to other women about sex and their own experiences with sex and contraception seems to be a lot more than when they are talking to their own husbands

This is a reiteration of what we spoke about in the earlier sections about other women (like them) in their social groups becoming the first port of contact for information seeking/ building trust for choice making. When it comes to sexual/ reproductive/ contraceptive discussions, in most cases, we observed the other women in the community preceding the health system representatives. **This existing and thriving grapevine must be leveraged by the health system and interventions must also be designed from a 'collective' standpoint in addition to individual.**

APPROACH TO FP

- **In most cases, women stated the very strong desire to not have the first child immediately after the marriage.** They want to *"Delay and savour the first 1-2 years of their marriage without having to cater to the responsibilities of a child"* (this was stated even more strongly within the younger age cohort). **However, this was not how it played out in most cases.**
  - Some women across districts stated that while they tried to express their desires to their partner about delaying the first pregnancy, most of them gave in to the familial pressures and had the first child early in their marriage. In some cases, where women did not have a child immediately after the marriage **involved miscarriages, or other complications** such as difficulty getting pregnant.
  - In Varanasi, we observed a few instances where negative experience of another woman in the family or around them who chose to delay her first child, later had difficulties in conceiving a child influenced the women. Hence, this fear led them to plan their kids immediately after marriage.
  - We have also observed that there is great amount of implicit and explicit pressure that the younger women, who are newly married and zero parity, have to go through. Hence, this negatively influences their use of contraception (s). **In many cases, husband and mothers-in-law ask them to plan their child immediately after.**



KEY LEARNING | It can be hypothesised that a conducive context to enter a 'planned' mindset pertaining to FP gets hampered at step- 0 of the marriage itself for most clients. This is to say that, since the act of intercourse itself is not planned, the planning of contraception takes a backseat.

Identifying a need for information related to sexual and reproductive health, seeking that information, getting access and information dissemination at the initial stage starts inconsistently and without a focus on building fundamental depth of knowledge. **This inconsistency, as we establish later in the report does not change as they progress in their reproductive journeys.**

- **Women understand the risks associated with pregnancies** and exhibit awareness (read fear) to use contraception and FP. Most mentioned in some way or the other that their husbands are always pushing for 'not compromising on their own pleasure' and hence **the onus of ensuring protection from pregnancies lay largely with the women-** A dominant fear amongst women was the risks and challenges related to random, recurrent, or too many pregnancies.
  - They understand that having frequent intercourse without using any contraceptive methods would lead to unwanted/ unplanned pregnancies (and in many cases unwanted abortions). Hence, they try to emphasize the use of contraception.
  - **Most women displayed varying degrees of depth and breadth of knowledge of both traditional as well as modern methods.**
    - Most commonly mentioned modern methods included condoms, sterilization, IUCD, and ECP's stating sources of information as women in the family and neighbourhood, and ASHA/ANM or their husbands. Mentions of oral pills were relatively lesser and all oral pills were talked about as one nebulous set.
    - **For Chhaya and Antara,** the majority had either heard about it via a family member who had an experience with it- Nanad/ Bhabhi/ Jethani/ Devrani; OR a neighbourhood Bhabhi, Didi, or bua; OR ASHAs were observed to be points of awareness and information. In very few cases it was the husband.
    - **Traditional methods such as pull-out/ withdrawal method and the calendar method were also reported to be used by a majority of women in combination with the modern methods.** While these methods are perceived as having no side effects, most women displayed a lack of trust and assurance in these methods as they might lead to **'by-chance'** pregnancies. Women use ***'baahar nikalne ka tareeka', 'periods ke baad pati ke paas nahin jaana'*** for describing these two methods.

"Her relationship with her husband would be good. They will discuss about unwanted kids while having sex."
- Chhaya User/Older/Varanasi

"According to me she should use a condom, Chhaya pill and should also use home remedies, if she is getting intimate with her husband, she should remove his husband's genitals before any sperm is released, in that way there would be no kids and there would be no fear. If you have not got operated on like me then there would be fear but if the husband pulls out then there would be no fear nothing will happen."
- Chhaya Discontinued User/Older/Varanasi

"Yes, because we do not want children right after our marriage. I got pregnant after one year; my mother-in-law insisted we have kids, but I don't like it. When you are newly married, it takes time to adjust in a new house. If anyone got pregnant then it invites many problems. So, we did not use any precautions during intimacy because my husband wanted a child, he did not use any precautions. But I did not want a child in the early days of marriage. I had to give in."
- Chhaya User/Younger/Meerut

"There is only one fear that we should not have kids so early, usually women think like this and now men also think that they are too young to have kids. Many people try to avoid that as there is a fear of having kids early. So, we will use home remedies or pills or injection. This is what I know."
- Antara Discontinued User/Younger/Varanasi

INFLUENCE OF CHILD PARITY AND GENDER COMPOSITION ON FAMILY PLANNING DECISIONS

- **Most women emphasise their socio-economic realities of limited resources for raising children** and keep these considerations in mind when speaking about their idea of an 'ideal' or complete family.
  - With men typically having erratic source of income, all women are aware of the financial burden of having too many kids can lead to making it desirable to seek financial stability before making child-planning decisions.
  - **Most women ideally prefer to have two children, one male and one female.** Such an ideal perspective is also drawn from the systemic language that promotes ***hum do and humare do.*** **Due to the prevailing cultural and patriarchal norms, at least one male child is mostly thought to be mandatory for the family to be complete.** Limiting methods are sought after a complete family is achieved. A complete family here implies achievement of a desired family size which is 2-3 children in most cases and having at least one male child.
  - The Number of children a woman bears is also influenced by religious considerations in some cases. In Pitholker, for example, we observed that women belonging to the Muslim community tended to have larger families, with an average of 4-6 children.

- **Most women express a belief that the ideal spacing between children should be around 1 to 2 years-**
  - Women strongly **emphasize the need for spacing so that older children can be self-sufficient before the woman shifts her attention to a new child.** They are also aware of the health benefits that spacing can provide, such as ensuring that each child receives an adequate amount of the mother's milk without having to share it with a younger sibling, and the woman's body also gets a chance to recuperate physically.
  - This perspective stems from the fact that mothers/women bear the sole responsibility for childcare while also managing household duties, providing food, and caring for themselves and their children.
  - Spacing enables them to better manage their households and care for all their children without feeling overwhelmed. The common sentiment is that if one child becomes older, they will be able to take care of themselves to some extent. ***"Agar ek bachcha bada ho jaaye to who khud apna sambhal lega."***

> *Two children are sufficient; I don't want more. I was in tension when I got late periods. Some pills are available on the market, but no one buys them. Also, there are some injections to take to not get pregnant."*
> ***- User of other MM/Younger/Meerut***
>
> *"My mother-in-law speaks with my sister-in-law, and she asked her if there is any procedure or cure so that at least she doesn't get another pregnancy for 2 to 3 years because she is not healthy and if you could have a gap of around 2 to 3 years because everyone wanted another child."*
> ***- Antara Discontinued User/Younger/Varanasi***
>
> *"Two boys and one girl, this should look like a complete family because a boy is must in the family, then only it is considered as a complete family."*
> ***- Chhaya User/Younger/Meerut***
>
> *"In this time, it is not only about giving birth to children but giving them good education. When I see poor people, low caste people, they have 4-6 children but are not able to give them education, even if they are going to study, parents are not able to satisfy their needs. I feel 2 children are enough and a maximum 3 children."*
> ***- Antara User/Younger/Varanasi***

INTERSPOUSAL COMMUNICATION WITH REGARDS TO FP AND AGENCY

We observed multiple perspectives when it came to inter-spousal communication.

- **We observed rare instances of active conversations between the woman and her husband about her reproductive wellbeing.** Women's reproductive wellbeing is not viewed as a primary concern by their husbands. In fact, it is also not something that women themselves understand very well- if she is healthy enough to deliver children, there aren't any concerns observed. Only extreme cases of miscarriages and difficulty in conception trigger the need to have these conversations since any perceived hindrance to reproductive health or fertility is concerning for the family members.
  - While women get the opportunity to express their thoughts and feelings about contraception, discuss their experiences, beliefs, and expectations regarding FP, reproductive goals, and desired family size, the key-decision making is managed by the husband in many cases.
  - **The woman's role in these cases is to get the information firsthand and pass it on to her husband who helps her decide the method she would opt for.** This often accounts for being the **final decision-maker for the method of contraception that the couple would use.**

- **On the other end, amongst some young couples- the clients we interviewed talked about greater ease in conversations around FP and a relatively greater sense of partnership and negotiation with their partners.** The factors impacting the same were-
  1. Contextual factors such as both partners being young and having more instances of exposure to the opposite gender growing up;
  2. Higher level of education and access to technology & content in different aspects of their lives;
  3. Exposure to metro city 'nuclear couple counterparts' either from their extended social circles/ people who have moved to cities around them, or on social platforms.
     - Younger couples especially talk about their pleasure, and time for enjoyment, whereby sex is seen as a medium of expression/ coming together and couples express their aspiration of wanting to raise their children with the facilities of education, nutrition, etc.
     - **Negotiation but within bounds- despite substantial references made by women to indicate attempts to negotiate; the final choice about sexual activities remains with the husband.** This, as mentioned above, also reflected in the socio-cultural & familial context of the participants where their mobility and technology usage is often moderated by family members and husband in the name of 'safety'

> *"In my mind I had that I wanted an operation after the second child but my husband did not listen to me. I cried so much and my mother-in-law was there with me but my husband did not listen to any thing. If I don't get the operation done this time again, he will have in mind that he wants a boy. I was sure that now I don't want kids and after the kids grew again, he started saying that I want a child."*
> ***- Antara Discontinued User/Older/Meerut***
>
> *"And after my first daughter I asked her for an injection, she said yes, come let me get you injected, but when I asked my husband, he said no so then I ignored and when I got two children, then I went myself and got myself injected."*
> ***- Chhaya Discontinued User/Younger/Varanasi***

KNOWLEDGE, AWARENESS AND PERCEPTIONS ABOUT MODERN METHODS AND DECISION MAKING AND FACTORS GOVERNING CONTRACEPTIVE CHOICES

- **Inflections for contraceptive methods are varied.** As discussed above, women do not have complete agency to control the number of children they plan to have. **Contraception has a 'staying safe' and 'protecting oneself' connotation attached to it.** Hence women tend to use it as a means to solve problems and not as a lifestyle choice/ enabler of physical and mental wellness.
- **Information-seeking regarding FP methods is not always an active process and is largely need based.** The way information is sought by the client at different parities and the way in which the information about contraceptive choices are disseminated by the health system at various parities- there is rarely a situation when a client is truly exposed to all choices that they have at their disposal.
- **Women are rarely exposed to information on FP before marriage.** The realization and the need to seek information normally arise after the birth of the first child. The system plays little role in ensuring that women can start their sexual and reproductive journey with adequate information about contraceptive methods and their importance prior to a pregnancy situation.
  - Information access is context-dependent and was not consistent across clients-
    - In a majority of cases- **a lot of the information regarding the variety of methods happens passively-** overhearing conversations around the household or the conversations with ASHA. Women are often subjected to word of mouth regarding contraceptive methods both positive and negative. So, by the time, active information seeking of FP methods happens the woman has started absorbing the preconceived notions which ultimately affect the adoption/ non-adoption of the methods.
    - **In most cases, women start with seeking information about contraceptives and financial planning from other women around them- in many cases this precedes their interaction with the FLWs.**
      - » Strong negative word-of-mouth about any given method acts as a counter-force to the health system and automatically leads to intense questioning or elimination of a particular method from their consideration set.
      - » Women not only learn about these methods but also learn about their usage- **incorrect ways (in many cases) therefore are also absorbed in the process which tends to stay there without systemic intervention to consciously correct them.** The stamp of approval on any given method at this stage is a key factor that motivates the adoption of that method- which is mostly sought from the husband.
      - » In some cases, active information seeking normally starts with the husband. **Women try and get any information they can from their spouse.** In this process, a **handful also seek technological help- to get a grasp on the basics of the method.**
    - **Information seeking from ASHA-** In cases where P0 women are familiar with a certain method, they themselves mostly reach out to ASHA for more information. Some women might further visit an ANM or another service provider to get more information. Adoption of a contraceptive method normally happens at this stage. It has been observed that FLWs and service providers' personal attitudes and opinions also influence women's choice of contraception.
    - ASHA provides information about both modern and traditional methods. There are two tendencies observed in this process-
      - » ASHA tends to promote methods that are incentivized- for instance **sterilization and Antara**.
      - » They give information about traditional methods wherever they identify the hesitation towards any modern method. **They help ensure some sort of planning in the process.**
      - » **It has also been observed that ASHAs themselves have limited correct knowledge** which hinders her motivation and confidence to pass on that information to the clients.
- **Limiting methods are sought after a complete family is achieved.** The realistic ideal family must have an assurance of a male child with little to no aspirations for a girl child. If this is not the case, then family members such as the mother-in-law tend to influence the women for not getting sterilized, especially when they are young and physically healthy to bear children.
  - Limiting is sought only after this ideal perspective is assured. **Female Sterilization is the most discussed method when it comes to limiting the pregnancy (after the ideal family size is achieved).** It is heavily promoted by the ASHAs, ANMs, bound within government targets, and is widely adopted.

- For those who adopt the method are aware that the method has lasting impacts on the body with mandated rest immediately after the procedure. Women therefore delay the procedure till they have sufficient support and have achieved the desired family size and composition. They also perceive that a child must be grown up before limiting as an option is even on their radar.
- **Other methods discussed by ASHAs with the women for limiting include IUCD, and in some cases Antara.**

- **For women from the Muslim community, sterilization is not a preferred choice.** They believe that it is *haram* and against the teachings of their religious scriptures.

Table 3: The associations with different contraceptive methods, perceived benefits and risks and socio-cultural context associated with it (gleaned from the client responses during the course of the study)

METHOD	HOW THE METHOD WORKS- Client recall	PERCEIVED BENEFITS	PERCEIVED RISKS	SOCIO-CULTURAL CONTEXT
ANTARA (Generally suggested to P2+)	An injection that is given once every three months is effective for this time period to avoid pregnancies.	Helpful in avoiding unwanted pregnancies. For adopters- there is a lesser cognitive load for this method- ***"ek baar lagwao aur teen mahine ki chutti"***. *There is no hassle of remembering the doses*	Bodily problems such as excessive bleeding or amenorrhea, weight gain, or weight loss.	**Negative word of mouth is prevalent** based on the experiences of other women around them. Negative attitude towards the method is also passed down by the husband who has seen a friend's wife getting problems due to the injection.
CHHAYA (Generally suggested to P1 onwards)	Oral medicine that is eaten once a week. As soon as you stop eating it, you get pregnant. Not aware about the name in most cases- *"Ek goli hoti hai"* Many women lack depth of knowledge about the method- do not know how and when to take it i.e. two days in a week for the first three months and then one day in a week after three months.	Helpful in avoiding unwanted pregnancies. **Not a single client at an unaided or aided level recalled the non-hormonal aspects of the method**	*Goli Khaani padhti hai*- there is a belief that one might forget to eat this. Hence, the attached cognitive load. (Only one case) Bleeding and problems- this is a perception that the women form on the basis of the negative experience of someone in the family.	There are no negative perceptions around the method. However, there is no proper dissemination of information around the method.

METHOD	HOW THE METHOD WORKS- Client recall	PERCEIVED BENEFITS	PERCEIVED RISKS	SOCIO-CULTURAL CONTEXT
CONDOM (Generally suggested to P1 onwards)	Husband wears it during the time of sex- the onus many times is on the husband to procure the same.	One of the most commonly known methods of contraception- easy to access, easy to use	While there are no technical negatives around this method of contraception, most women stated perceived reduction in sexual pleasure as a recurrent reason for their partners to not prefer the method	Widely available in the medical shops in the vicinity. Openly discussed in the household by *saas and chaachi-saas,* there are no conversational barriers around condoms- see it in a playful light. However, ONUS AND AGENCY to use condoms lies with the husband. The husband remains the key decision maker when it comes to the decision-making around condoms- ***"Pati ki zimmedari hai, who laaenge toh hi use kar sakte hain"***
STERILIZATION (Generally suggested to P2/3 onwards or on completion of the desired/ ideal family size)	Woman is operated and the pregnancies are limited once and for all.	Usually adopted as a method of limiting pregnancies only after the desired family size is achieved	Changes in the body that are not well received by everyone- Body *phool jaati hai* Negative perception that it would lead to some side-effects on the body. There is also fear around this method- *"operation se darr lagta hai"*	Most women get the operation done after a minimum two kids. This is a prevalent idea in the community, also a suggestion made by the doctor who gives Antara injection as an alternative to the same.

METHOD	HOW THE METHOD WORKS- Client recall	PERCEIVED BENEFITS	PERCEIVED RISKS	SOCIO-CULTURAL CONTEXT
IUCD (Generally suggested to P1/P2)	A device is inserted inside the body. Know it by the name of 3 *saal* aur 5 *saal wala* injection/ Copper T.	Usually adopted as a method of limiting pregnancies/ spacing amongst P1 and P2 cohorts.	**Very high instances of negative word of mouth** Constant negative experiences on the body; excessive bleeding; "*upar chadd jaegi*"- women have a flawed perception that Copper-T might get pulled up and cause problems in one's body An invasive procedure that might affect the body- something is implanted inside your body. Usually, negative experiences of someone in the family- nanad, bhabhi, mummy, saas- *baccha kharaab ho gaya tha*	Many in the community and women's family have a negative idea about this method- leads to bleeding, might get stuck in the body are all ideas that are disseminated by the women in the family especially saas, and mother who themselves have used it sometime in the past This method however is widely promoted by service providers, and a lot of women are recommended this method right after childbirth. The promotion can be widely attributed to the systemic push.
TRADITIONAL METHODS- WITHDRAWAL AND CALENDAR METHOD	Withdrawal Method- The husband pulls out before ejaculation during the sexual intercourse. Calendar Method- Couple should not have sexual intercourse after women's monthly cycle gets over	There are no overall positives, however, the use of these two methods tends to be free of any side-effects. The methods also leave scope for immediate conceptions- what if the couple wants to have a child- they can conceive it immediately.	There is no guarantee that the method would fully protect against unwanted pregnancies. Usually used in combination with modern contraceptive methods- **especially condoms.**	Mostly regarded as the *gharelu tareeke* that are most prevalent in the community. However, it is also observed that these are less talked about or there is "hush-hush" around these methods.

Note: No other traditional methods were talked about during the course of the study

- Interactions with the FLWs, especially ASHA, happen on a regular basis (in a few cases such as with the newly married women and the zero parity women, FLWs interaction is limited). Since the ASHAs are part of the women's social communities only, and live in their proximities, women can meet them on a frequent basis, especially for ante-natal care, or on immunization days after their child's birth. Hence, establishing contact with the ASHAs is far removed from the picture. ASHAs even escort the women to the ANM when they have questions or when they choose injectables as a method of contraception.
- ASHAs have been observed to be an active source of information and provision of FP methods at the community level.

KEY TAKEAWAYS

Different methods of contraceptives have been put on a 'parity spectrum'

Different methods/ combinations of methods have come to be perceived as suitable for different parities/ stages of the reproductive journey. Amongst the clients we met, in most cases, Antara was suggested and nudged as a contraceptive method to P2 and above only. This is an outcome of three contextual factors working in tandem-

1. Expected level of achievement (targets- which are set at the systemic level) against various modern methods;
2. Socially accepted norm of a 'complete family';
3. Perceived levels of intrusion and efficacy of the method.

Chhaya, on the other hand, is suggested from P1 onwards. However, due to the greater association of cognitive load (both for the FLW as well as the clients), the method tends to be on the bottom end of the contraceptive choice spectrum. High cognitive load, absence of a differentiated point of reference, and less seriousness around the method makes it less lucrative/appealing to use.

3. THE SERVICE SIDE PERSPECTIVE- THEIR CONTEXT, ROLE AND IMPACT ON FP CHOICES

GENERAL CONTEXT TO WORK

- FLWs have a wide range of responsibilities and are often overwhelmed with their workload. Their primary tasks are as follows:
  - **Care for pregnant women:** FLWs are responsible for ensuring the well-being of pregnant women in their respective areas. This includes conducting **regular checkups, monitoring their health during pregnancy, facilitating timely antenatal care (ANC) visits, and providing necessary support and guidance.** FLWs play a crucial role in promoting safe deliveries and ensuring that pregnant women receive appropriate healthcare services.
  - **Service provision for child health:** Another important task for FLWs is to focus on child health services. This involves **immunization and vaccination** programs to protect children against various preventable diseases. FLWs are responsible for organizing immunization drives, tracking immunization schedules, and ensuring that children in their community receive the necessary vaccines. This helps in reducing child mortality and improving overall child health.
  - **Community involvement in spreading awareness about FP:** FLWs also play a significant role in promoting FP and contraception methods within their communities. They engage with community members to raise awareness about the importance of FP, educate them about different contraceptive options, and provide information on where to access these services. By involving the community, FLWs aim to enable individuals and families to make informed choices regarding their reproductive health and FP.

> *"In this ASHA Diary, we maintain the list of kids from 0 to 2 years, 2 to 5 years, eligible couple's list, list of people who are taking services of family planning, whole village survey list, list of pregnant women, list of all deaths in village, list of newborn babies, list of death of newborn babies."*
> ***- ASHA Sangini/Meerut***
>
> *"It is most of ASHA's responsibility, they explain to ladies about family planning, if having a small child then tell them about FP - what all benefits are there from that injection. If they are ready for delivery then they will take them to Govt hospital and get their child delivered properly, then visit children."*
> ***- ANM/Varanasi***
>
> *"We cover all points like HBNC, underweight children etc. Also, new topics keep coming up, like few days back, SANCHARI ROG PAKHWARA was going on, there was one signature campaign also, or PMMY pakhwara before that. So they tell us the issues to focus on, and explain us how to work on them."*
> ***- ASHA Sangini/Meerut***
>
> *"We check the place where we sit, where we provide proper information to the beneficiaries, as well as check whether check-ups are proper there or not, we can do vaccination, etc. Among other tasks, we have logistics in which we have a Blood pressure check-up machine, haemoglobin machine, Pregnancy test kit, HIV kit, tablets, syrup, etc. We maintain all these records in registers. And, we also have a family planning kit."*
> ***- ANM/Meerut***

RELATIONSHIP WITH CLIENTS AND COMMUNITY & FP - THE ASHA IS THE FIRST AND THE MOST SCRUTINIZED POINT OF CONTACT WITH THE HEALTH SYSTEM

ASHA is the first and most accessible touchpoint- From the point of view of most clients that we interviewed, the ASHA is the first, most easily accessible, most recurrent touchpoint of the health system (especially given the extremely limited mobility of women/ occasions of stepping out). They expect them to have all the answers. If the ASHAs do not seem to have all the answers, most of them do not reach out to the ANM or other players within the health system necessarily.

- **It has been observed that greater cohesiveness between the ASHA and the clients makes them an influential source in the lives of the women.** There was a constant dialogue between the two on FP and contraception- it is important to note that the ASHA is also sometimes the **only person in the health system** that they would go to for any and every health-related advice. Hence, the way in which they deliver the information, the accuracy of the same would impact the decision that women make with respect to their health- especially FP and contraception.
  - Despite the limited mobility that the women have outside their homes, the FLWs remain accessible to these women and are also parts of their social groups and congregation points. However, it is important to note that women who are newly married, and those with zero parity do not have as great access to the FLWs as others.
  - Across the villages that we visited (more so in Meerut)- it was observed that the FLW and client network was very cohesive, specifically ASHA and the clients who were closely knit with most families in their designated areas. It was apparent from how the women were conversing with the ASHA- the nature of their discussions and the camaraderie shared between the two. ANMs too have recurrent conversations with the women during the VHND, their visits to the healthcare facility, etc. In Munari (Varanasi), specifically, we found that ANM was even called in for intervention to resolve conflicts in families of the community.
  - **It is worth noting that FLWs acknowledge the fact that the people in the villages are evolving (especially younger)–** in terms of greater awareness around health and FP education and tech access. They display greater openness to learn about health and FP.

> *"Earlier, people not used to listen at all, it was very difficult to convince them, but still some people like 8 to 10 are those who do not listen and feel that these are not good things, but most of the people now listen and have become aware about these things."*
> ***- ASHA/Varanasi***

APPROACH TO FP PROGRAM

- The FLWs acknowledge the need for a FP program in the face of the increasing population. The FLWs talk about how living expenditures have increased so much in the past decade that it is not sustainable to have more than two children, they feel that **couples should have two kids and focus on giving them a good lifestyle** where the education, life, future of the kids and family are secured. Further, they believe that once a couple's ideal family size is achieved (most cases in P2), the couple (especially women) should start adopting limiting methods like sterilization. Hence, for younger women, or those up till P2, spacing is focused. At P2 stage, sterilisation becomes the program focus.
- Further, FLW also talk about the need for a focus on maternal and child healthcare, closely related to FP. They emphasise the need for spacing between children so that the women are healthy and does not face health issues of malnutrition, anaemia, etc. With reduced unwanted pregnancies, the risk to women's health can be tackled.

  The conversations around FP and contraceptive methods typically begins after the women have delivered their first child. Women with parity zero are not approached for any FP related information dissemination. Basically, there is no contact between the parity zero women or newly married women and the healthcare providers. **The FLWs refrain from suggesting anything to these women mostly because they are fearful- what if any method, especially Antara and Chhaya negatively impacts the woman's reproductive cycle or leads to difficulties in conception or any other side-effects?** The fear majorly emanates from the fact that the community members might reject or outcast them or behave negatively towards them.
- **For women with** parity 2 or more, FLWs promote permanent or long-term methods such as sterilization, IUCD; for women with parity 0-1, spacing methods are promoted.
- Since their roles focus around advising, counselling, and recommending ways, they can help increase the use of FP services and make the FP program more effective. Being a part of and working in the same community for years, FLWs have a thorough awareness of the regional context, cultural values, and social norms in their communities.
  - According to ASHAs, they have **built personal connections with their clients – seen as a friend or family member.** Participants shared anecdotes about how ASHA provided support during times of stress and health-related issues.
- **Congregation points such as the VHND** (Village Health and Nutrition Day) **and Health Awareness Camps serve as important platforms for interaction between the FLWs and the clients, particularly women.**
  - During the VHND, FLWs, including ASHAs and ANMs play a significant role. They gather and discuss various options and services available to the women, presenting them with a "basket of choices." This interaction allows FLWs to educate the clients about different healthcare interventions, FP methods, immunization, nutrition, and other related topics. The VHND serves as a comprehensive platform for FLWs to engage with clients and address their health-related concerns.
  - In the context of the VHND, the ANMs lead the discussions and provide information to the clients. They are likely to spend more time interacting with the women, answering questions, and addressing their needs. ASHA's role is to mobilize women and children to the VHND venues. Typically, the discussions around contraception happen during ASHA's visits to the client's homes.
  - Apart from the VHND, the ANM in Varanasi discussed that there are Health Stalls (happen at the level of CHC, or during the VHND) which are another venue where they can present choices and information to women. These camps focus on raising awareness about specific health issues, such as reproductive health, maternal and child health, or communicable diseases. FLWs use these opportunities to provide education, counselling, and guidance to the clients, empowering them to make informed decisions about their health.
- While ANMs and ASHAs play a crucial role in promoting FP services to women in communities in all four districts, they acknowledge that competing priorities like immunization drives, and antenatal care take precedence over FP. **FP is largely discussed only when they visit the homes of women during the 42 days of postnatal care (starting from P1 stage, called HBNC visits), and they rarely find time to counsel women on FP otherwise.**
- The FLWs' role in spreading awareness about FP methods, their advantages and disadvantages, and the significance of delaying and spacing pregnancies is crucial for maternal and child health. **However, with the amount of work they have to do, FP sometimes becomes a secondary priority.**

"After children are born then tell them about family planning, if their child is small, then give them knowledge of Antara, Chhaya. If they do not want more children, then go for their nasbandi."
- ANM/Varanasi

"We are also mostly giving them information on family planning on Mata Baithak Day. There are health camps also, there we keep different choices of Family Planning in front of them. On VHND also, we meet them and talk about the methods."
- ANM/Varanasi

"For women with one kid, we suggest temporary methods. For women with two kids, we suggest permanent method."
- ANM/Varanasi

APPROACH TO MODERN METHODS (DIFFERENCES OBSERVED ACROSS DISTRICTS)

- In Varanasi, sterilization cases have been reported by the FLWs. While there is no communal bias towards sterilization, there are prevailing misconceptions regarding sterilization emanating from negative word of mouth, such as- *"nasbandi ho gayi toh sex nahin kar paaege, aurat ke shareer ki taakat khatam ho jaaegi, pati se dur rehna padega"*
  - The suggestion of a FP method happens because of systemic push. The FLWs suggest sterilization as a method when the woman who has three or more than three children approaches them, typically to aid limiting the family size.
- **However, it has been observed in Meerut (specific to the Muslim community in Pitholllker)**- sterilization is viewed against the *mazhab*- something that would make them impure and is forbidden in their religious scriptures.
- **It was also noted that there is a systemic push for the use of PPIUCD in Varanasi.** Women are usually convinced by the ANM, or the service providers during or post the delivery of their child. Women usually understand PPIUCD through the terminology of Copper-T. However, as the ANM suggested, there are negative perceptions around the method which are usually disseminated by private healthcare facilities- "*private mein bhi lagti hai toh woh phaila dete hain negativity*".
- **As has been reported by the ANM in Munari-** daily pill (MALA-N) enjoys more superiority as compared to Chhaya. The way it is marketed and promoted is interesting to note.
  - An old method that is used by the women more than other comparatively newer methods- "*Logon ko zyada pata hai*"
  - Marketed as a method of contraception that has **added benefits for one's menstrual and sexual health as well.** *"Period regular kar deta hai", "Uterus Cancer se bachav kar deta hai"*
  - **More social proof and validation-** In one case, MALA-N was consumed by saas and bahu together-the client selected it because the highest source of authority in the family had chosen this method of contraception.
- **Emergency Contraceptive Pills are mostly used by women whose husbands stay away from home.** In these cases, the frequency of sexual intercourse is lesser.
- **Use of abortion pills is also recurrent (more so in Meerut),** and health facilities generally receive two-three cases of women (every month) who have used these pills to abort their child. It is interesting to note as reported by the service providers- husband usually gets these abortion pills for the women from the nearby medical store and the level of knowledge- what repercussions it might have on their physical health are not known to these women or their husbands completely and the casual consumption keeps happening

"For example, if some have three girl children, then we suggest temporary method of family planning, and if some think that they are satisfied with their children then sure we suggest sterilization."
- ANM/Meerut

"In Muslims, we have seen that they have issues with barrier methods. Sterilization, we suggest, but they do not like it. Also, we do not suggest any method for women who are having their first child."
- ASHA/Meerut

"Before they used to provide Mala D, now they give Mala N, they have already taken that medicine, so they have experience and I have noticed myself too, that whoever have irregular periods, it gets regular. At first, when we met them also, we discussed that if you took this medicine, you would be saved from uterus cancer and all. So, they mostly take Mala N."
- ANM/Varanasi

"If she says that now we do not want a child, then I tell her about the permanent method, that is getting a vasectomy. When they say that we don't want a baby right now or they do not want to get vasectomy now, then we use to tell them about the temporary method. In the temporary methods there are Chhaya, Antara, Mala-N, Saheli, taken by them in private"
- ASHA/Varanasi

"At the time of delivery, PPIUCD has been given there in Cholapur, so there is no need for Chhaya and Antara. Now it is different here, I have to give it to everyone. Mothers who have given birth to a child have to ask their families about it and if they agree then she gets it. It has been 5-6 months since it started here, or even more than that."
- ASHA/Varanasi

ANTARA & CHHAYA: THEIR OWN KNOWLEDGE, ATTITUDES, PRACTICES AND CHALLENGES

ASHA's role in the implementation of Antara and Chhaya remains the most vital at the ground level. The FLWs perceive Antara to be an easier method to promote in terms of the cognitive load which is very less as compared to Chhaya. *"Ek baar teeka aur phir teen mahine ke chutti"* (It is a one-time process to be followed once in three months, hence devoid of any complexity in promotion or suggestion)

Chhaya's promotion and distribution (within the health system) is mostly managed by the ASHA. However, we can see that she does not have a consistent or clear understanding of how to suggest the method to the clients due to its difficult to remember dosage schedule; no standardized simple way to suggest the same to the women, **making the method high on the cognitive load for the FLWs to explain as well.** Different methods such as the yo-yo method creatively designed by IHAT UPTSU to memorize and communicate the days when Chhaya is to be consumed may help in offering a counter to the load.

The following challenges got recurrently mentioned pertaining to the promotion of Antara and Chhaya:

FOR ANTARA

- According to the FLWs, **Antara has very recurrent instances of side effects**- but how are they communicating this to the clients and countering the same is unclear. An increased number of women report bodily issues after getting the Antara injection but there are no standardized ways of countering the problems- **the FLWs are not equipped with any strong counters or solutions for the problems that these women report.**
- **There are also much higher instances of negative cases of Antara in the community-** with the clients forming a negative perception on the basis of third-party accounts of someone in the community or family- *"meri Jethani ko thyroid ho gaya tha, antara lagwaya tha"*. So, we can infer that myth formation is strongly taking place and **the FLWs lack mechanisms and ways to convince/course correct these women.**
- While **ANMs possess greater technical knowledge** on both these methods as well as their side-effects, **their direct contact with the women tends to be much lesser.** While 1-2 ANMs reported that they sometimes explain these side-effects to the ASHA and even their Sangini, ASHA's mechanisms of disseminating this information amongst the women are unclear.
- The FLWs report that with a **greater number of doses, the fallout tends to be less along with lesser** side effects of the Antara injection, **however they are not equipped to make women stick to these methods**- *"side effects 5th dose tak khatam ho jaate hain, par wahan tak koi pahunchta hi nahin hai"*- **ANM/Poothri/Meerut**
- It is also very critical to note that if the woman complains of recurrent problems due to uptake of Antara, ASHA tends to present them with other alternatives which are usually Chhaya, Copper-T, condom, or sterilization, instead of taking the onus and seeing the problem through with them. **Providing alternatives is easier than course correcting.** This is because providing alternatives takes lesser cognitive effort than providing detailed explanations on the side-effects of a method.
- In fact, it was also noted that intensity around promotion of Chhaya is relatively less than Antara (owing to a lack of incentives, relatively lesser systemic push behind the method as per the FLWs and doctors). **There is more implicit systemic pressure to promote Antara which is not the case with Chhaya.** So, it tends to make the FLWs inundated and aimless as to which method to promote more and how. In addition, Antara's promotion and adoption is incentivized, thus making it a greater priority.

FOR CHHAYA

- Chhaya is commonly recommended as an oral contraceptive tablet, or *'goli'*, to be taken bi-weekly. Its dosage pattern is critical: initially, it is to be consumed twice a week for the first three months, and then once a week thereafter. The successful initiation of Chhaya's regimen is typically well communicated by ASHAs, with the first dose to be taken on the first day of a woman's menstrual cycle. However, the guidance becomes less clear for the crucial second dose, which is to be taken on the third day after the first. This lapse in detailed communication by ASHAs concerning the second dose timing is a significant concern. While they often correctly advise the frequency of intake, they frequently omit or incorrectly convey the specific timing for the follow-up dose. **This inconsistency in guidance leads to a lack of a standardized, universally understood protocol for Chhaya's use, potentially complicating its effective adoption.** The key issue thus centre on whether ASHAs are sufficiently informed and whether they are effectively communicating the complete dosing schedule, especially the timing of the second dose in relation to the menstrual cycle.
- **We can also see that there is no point of differentiation for Chhaya.** The myths around Mala-N tablets in general are very prevalent which also extends to Chhaya, including patterns of differential dosage based on menstrual cycle for instance, and makes its promotion very difficult. The FLWs are aware that Chhaya is different from other pills, however, they do not actively or vehemently communicate any standards of differentiation, hence, women tend to take it less seriously and more like *"any other goli"*
- Similar to Antara, with regards to Chhaya the FLWs lack the resources or ways to counter the instances related to side effects of Chhaya- while we did not come across any case as such in the sample we covered. But on enquiry, the ASHAs were not able to respond to this clearly.
- **Further, remembering when to take the doses puts a lot of cognitive load on the women-** They find it difficult to remember. We observed a few cases where ASHA/ANM gives them in writing sometimes about how and on what days of the week one has to take the tablet in the form of a *parchi* (which is a simple *kagaz* with dates and dosage written on it)- women still do not remember the same or misplace the *parchi*.
  - We must also acknowledge that **most women lack psychological resources such as motivation and knowledge to keep track of the dates**- the health system does not adequately acknowledge the same and therefore, there are no proper provisions of counselling people on Chhaya.
  - The ASHA and the ANM make the clients remember the doses of Chhaya by making them mark on their calendars. However, whether or not the clients are doing it is not known. **There is no regulated mechanism for follow-ups.**

"I have got training on family planning. Like how to give Antara although we do not give Antara to them, they can only be given by ANM and CHO and how to give Chhaya to them and how to explain them about it. But I don't remember what exactly they trained us on. They do not give us training on how to inject it, they only tell us about it. They have told us about its side effects. Like after taking Antara woman can face heavy bleeding or no bleeding at all."
- ASHA Sangini/Meerut

"Like they are giving 100rs in Antara so if they would give this type of incentive in Chaya also then maybe it would also become more popular."
- ANM/Meerut

"Some women have seizure or bad period; they should not take Antara. Because if anything happens, they blame Antara only."
- ASHA/Meerut

"To newly married women also, we tell them to not have children for 2-3 years. But they come here rarely."
- ANM/Varanasi

"Asha notes it in the diary and then she tells the beneficiary that if you have eaten it today then you need to take the next one on this day and after that you need to take it on this day so they help them to memorize it. They show them to count on hands."
- ASHA Sangini/Meerut

"I told them that Antara is a good option for three months."
- ASHA/Meerut

"Like beneficiary comes to me that I am very much worried, please tell me some method so that I should not get pregnant, they need to take Mala Daily whereas in the case of Chhaya it needs to be taken only twice a week."
- ASHA/Varanasi

"We tell women about all these methods. They used to say that they have a problem with getting an injection, and if they take a pill, they might forget to take it regularly. Everyone tells me that blood flow increases, there is a problem in getting periods, or there is pus coming out of the uterus, such misconceptions have spread. Still, for those who have got their periods, they are going on for 15 days."
- ASHA/Varanasi

Table 4: The associations with Antara and Chhaya, perceived benefits and risks and socio-cultural context associated with it (gleaned from the FLW responses during the course of the study)

METHOD	PERCEIVED BENEFITS	PERCEIVED RISKS	SOCIO-CULTURAL CONTEXT
ANTARA (Generally suggested to P2+)	Long term acting method- effective for people who are looking at a long term method and have more or less attained their desired family size; or for women who are looking at a discreet method of contraception	Bodily problems such as excessive bleeding or amenorrhea, weight gain, weight loss. Unsure about the exact long term impact; hence not suggested to P0, P1 clients	Negative word of mouth is prevalent (based on the experiences of multiple clients in the community.)
CHHAYA (Generally suggested to P1 onwards)	Simple method which can be administered at home	There is a belief that one might forget to eat this or might eat this in a wrong pattern	There are no negative perceptions around the method. However, there is no proper or systemic dissemination of information around the method.

- **Limited contact between the service providers and the clients –** It has been clearly established that the doctors and nurses, by systemic design, do not have direct communication with the clients in the community. The ASHA and in some cases even the ANM remain the point of contact between both the parties, therefore, bridging the gap between the health system and the clients. However, this sometimes acts as a filter of information – the clients tend to get primed with the information that the FLWs gives them.
  - **CRITICAL CALLOUT** – With newly-weds and P0, the service side has zero contact.
- Conversations around FP and basket of choices only happen during/after delivery of the women – Post-delivery conversations are the only time when doctors and staff nurses can hold conversations with the women about FP.
  - Implications that this has – Absence of regular contact with the service providers leads to heightened reliance on the ASHA only. This tends to make the clients devoid of the "proper" knowledge on FP methods.
  - Since the clients do not have up to date information on various contraceptive methods, they tend to make uninformed choices having negative implications on their reproductive journey and goals.
- While the service providers (doctors and staff nurses) possess a high level of knowledge about various FP methods, **due to systemic push, PPIUCD and Antara tend to be the most promoted methods of contraception** by the service providers across all districts (at the time of the study).
  - They promote Antara generally to women with P2 and higher parity. However, they do not recommend Antara to women who have heavy bleeding.
  - While service providers, in a few instances, have provided Chhaya tablets to the women immediately after childbirth, Chhaya (as aforementioned) tends to be the onus of ASHA. The service providers acknowledge that they too have limited knowledge on Chhaya.
  - There are also sterilization cases that happen at the CHC, where ANM and ASHA's role is important, because they convince and mobilize the clients for the same.
    - Implications for this – ASHA and ANMs have the primary role of convincing and mobilizing women to avail FP methods. This reinstates the fact that service providers remain at the bottom end of the information-seeking spectrum for the women. Women's easy access and comfort with the FLWs makes them reach out to them only.
    - **Even when women face issues with any FP method – they tend to be reliant on the FLWs only, who themselves seem to be unequipped to course correct or disseminate the "right" information.** In the absence of regular interactions with service providers who have proper knowledge, clients rely on myths,

or misinformation which results in the avoidance of certain methods due to misconceptions, leading to suboptimal FP choices.

- Even from the perspective of the service providers, Chhaya is a method that is less prevalent among the women due to the high cognitive load pertaining to remembering the number and pattern of doses. **The women have access only to the ASHA when it comes to Chhaya who many times herself does not have correct information on the dosage.**
  - Antara, even though leads to bodily changes, is used by the women. Women continue till the 3rd dose even after facing issues such as excessive bleeding, or clotting. This is because, in a few instances, women have access to the service providers who provide them with medicines for treating these bodily issues.
  - **There were also instances where ASHA's own biases towards some FP methods negatively influenced her counselling to the in-laws or husband** - their biases towards the method could easily influence their communication with the family as they are a constant presence around these people compared to a nurse or doctor at the block/district level.
- **Within the service side, the staff nurses are the primary contact for the clients who administer Antara, as well as some other FP methods.** They are also responsible for maintaining records of Antara dosage but their role is limited to administration and provision of services only.
- **Due to a limited number of FP counsellors within the system, the doctor assumes the role and provides counselling to the women on various methods.** They sensitize women and in a few instances their husbands as well (who come to them on their own). **However, they lack consistent follow-up and involvement in the process which creates a disconnect from the side of the clients.**
  - The paucity of designated counsellors, who are intended to play a pivotal role in sensitizing women on FP methods and aiding their choice making process functionally and emotionally, has created a gap in ensuring accurate information dissemination to clients regarding FP. This has contributed to the absorption of misinformation by the client. As a result of this situation, discontinuation of temporary FP methods becomes more likely due to the lack of proper guidance.
  - In addition, the **service providers also acknowledge that there is a lack of an institutionalized mechanism for follow-up or reminders** that makes discontinuation more frequent for the clients
- One regular scope for intervention for the service providers is during pre-natal care and post-natal care period of the women's reproductive journey. They use this time to talk about different contraceptive choices available to the women. Although, targeted towards both the husband and wife, the communication is more focused towards the women missing out on important scope to bring the husband as an equally important focus for the FP program.

In sum – despite a gap in the 'latest' training and on-ground implementation of new methods, where the last training for the new methods happened in pre-pandemic period, service providers have accurate and technical knowledge on Antara and Chhaya. They do not display any preference for a method, it is more driven by the systemic push as well as the preference of the women. The preference of women is mostly influenced by their husband's/mother-in-law's beliefs or the FLWs.

> *"We only maintain records and administer Antara, counselling and everything is done by doctor ma'am. We don't have counsellors so doctor only takes up this role."*
> ***– Staff Nurse/Meerut***
>
> *"Because people don't take it regularly, they forget about it and take it when they remember so they have to just repeat it, so it won't be that effective. Even if we mark on the calendar then also, they forget to take pills."*
> ***- Doctor/Varanasi***

KEY TAKEAWAYS

A. The basket of choices is becoming an enabler of method discontinuation amongst clients- *"yeh nahin chal raha. koi baat nahin toh yeh le lo..."*

When faced with an issue, redirecting the client to a new method is very common modus operandi amongst FLWs. It is perceived to be an easier and safer option rather than convincing them and providing them with depth of knowledge or reasons to remain committed to their choice(s).

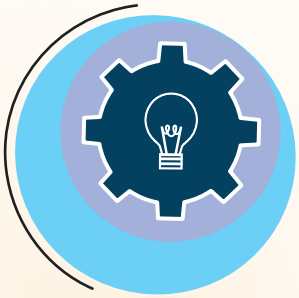
A very critical reason for this is that the ASHAs, who in most cases are the primary interfaced touchpoint(s) of the health system, do not feel fully equipped themselves or feel a sense of authority and confidence to take any kind of risk against a potential client/ community backlash.

Clients expect the ASHA to be able to give answers to/ resolve their problems and in most cases do not go beyond her to seek assistance from the health system.

B. There seems to be a lack of consistent, singular, and correct source of information for addressing misconceptions and misinformation about contraceptives among clients and their immediate ecosystem.

There are two forces that work in tandem:

- While ASHAs are accepted as catalysts for access to the health system, they have inconsistent (and in many cases, very little) authority amongst clients.
- There is a thriving grapevine amongst clients- Information (and in many cases myths and misinformation) on various aspects is exchanged very frequently. In addition to that, there is a high degree of trust on the lived experiences of 'others like us' amongst clients.
- It is also interesting to note that while clients (have to) actively seek information pertaining to contraceptive options after they attain a particular parity, myths and misinformation reach them organically much earlier and without active seeking.



KEY OBSERVATION | ASHA training faces a lack of consistency, had been erratic (especially since Covid) – and FP takes a backseat in such discussions

There is a lack of standard information on modern methods for ASHAs to refer to while counselling clients. Further, tools like IEC posters, medical eligibility criteria wheel, etc. have not yet reached to many ASHAs, and if they have, they have a limited use-case by them.

They often make notes in their diaries during trainings but have limited chances to refer back to them. Through time, ASHAs knowledge also starts building on hearsay from the community – noted in their focus on side-effects of modern methods (such as OCP's, Chhaya, Antara, and PPIUCD) while speaking about them with clients.

Dissemination of knowledge is also based on a fear of rejection from the community upon strong advocacy of modern methods. A number of gaps in the knowledge of ASHAs are hence noted – for instance, the mechanical and medical difference between OCP and Chhaya (hormonal v/s non-hormonal) is not known by FLWs.

Further, ASHAs are often not informed about follow-up and redressal mechanisms – that is, management of side effects. Since they form a part of client's immediate ecosystem, and represent the health system at large for the clients, this lack in their training misses out on the opportunity of carefully attending to bodily changes a woman faces upon choosing to intake Antara injections or Chhaya pills. Resolution and management of these bodily changes are critical to containing the spread of negative word of mouth around these methods, and around modern contraceptives in general.

Hence, training of FLWs need to be technical in nature, but also beyond that to ensure quality of care:

- Training on community mobilisation (*Saas-Bahu-Pati Sammelans*, under MPV)
- Counselling techniques for contraceptives (for instance, how to remember days of Chhaya pills, differentiating between the mechanism of Chhaya and OCP for clients, etc.)
- Addressing myths and misconceptions (especially on-going health and quality related fears attached to modern methods)
- Consistency in technical knowledge through refresher trainings using alternative means of information dissemination for ASHAs
- Plan of action in case of reports/complaints about side effects from method uptake – change in body weight, untimely menstrual bleeding, etc.

4. UPTAKE OF NEW CONTRACEPTIVES- ANTARA | KNOWLEDGE, ATTITUDES AND PRACTICES; LIVED EXPERIENCES; TRIGGERS, BARRIERS AND NEED GAPS

KEY CONSIDERATIONS IMPACTING ANTARA ADOPTION

- **Most clients who opted for Antara had already exhausted multiple options in their basket of choice.** Many of them had experiences with pills, condoms, traditional method, and in a few cases even IUCD.
- **The need for adoption was initiated by a 'compelling need/ problem' and Antara was suggested as a solution to the problem-** *"Pati nahin maante...who toh rukne nahin waale aur mujhse aur nahin hota", "Koi aisa tareeka jo kisi ko pata na chale", "Humaare dharam mein isko phir bhi maan lete hain", "Mere shareer ki aur himmat nahin hai", "Koi aisa tareeka jahaan baar baar khud dhyaan na rakhna pade"*
- **In many cases, Antara adoption was done in continuation with traditional methods like withdrawal and the calendar method**
- **Information regarding Antara is actively disseminated by both users, discontinued users, and ASHAs.** As a heavily incentivized method, ASHA tends to promote Antara among clients over most other methods. Users of the method strongly replay the efficacy of the method (if only it suited you)- ***"Jisko suit kar jaaye uske liye bohot acha hota hai"***
- **Correctness of knowledge of the method-**
  - With regard to Antara- both clients and ASHA' are aware of its usage. They are sure about the gap (3 months) between each dosage and how the first ever dosage is to be injected on the 4th or 5th day of the period cycle. The underlying tag of the method that has emerged with its colloquial interaction - *3 mahine ke liye chutkara* helps with absorption of a proper methodology for Antara uptake.

ANTARA ADOPTERS- KEY REASONS FOR ADOPTION

- **The most common and effective trigger for adoption in both districts- *"3 mahine ki chutti".*** An effective, cognitive-load-free that does not require the client to remember, to travel frequently or make any arrangements.
  - **Unlike other methods, the initial induction of the clients happened under the direct supervision of a staff nurse or a doctor or even an ANM**- someone viewed as an authority figure and more formal expertise compared to ASHA.
- We came across multiple clients who were able to adopt Antara without informing their spouses or other family members. **The easy concealability of the method provides a greater sense of agency and control around FP to the women.**
- **Negative experience with past methods-** Shift to Antara, especially for women who have more than two children happens from a position of distrust/disappointing experience with other FP methods. Complaints of pain/ bad experiences with IUCD, condom perceived as non-pleasurable/gross/ not preferred by husbands, unsurety around the efficacy and dependence on the husband for traditional methods. Antara is presented as a promising option that **has greater efficacy, no management and a promise of pleasure for the husband and self.**
- **Better option than sterilization-** Compared to permanent procedures like sterilization, Antara is- a) perceived as an option where women can opt out of the method and plan more children when they want; b) Thought of as a more palatable choice. Especially amongst Muslim clients- Antara is a desirable option for women who want to uphold their religious practices while yet attaining effective contraception because their religious beliefs forbid sterilization.
- **For women who do not like taking pills-** A lot of women across centres have talked about how they are inherently skeptical of taking pills, they give examples of how usually any pill has side effects and with the numerous stories they had heard of women facing consequences after taking the everyday pill, they were wary of it and preferred taking an injection once in three months.

- **Problems faced with Antara gradually decrease with an increase in dosages (reported by women with 3+ doses)**
  - **Clients in Varanasi** have been provided with over-the-counter medicines that helped with irregular blood flow during periods– one of the most common side effects recalled for Antara.
  - Similarly, clients recall how they had faced side effects during the first or second dosage which has since lessened or completely disappeared.
- **Easy availability and usage**- Antara is easily available to the client in their nearby sub-centres or PHCs. The ASHA in most cases takes responsibility for tracking the dosages and accompanying the respondents to get the injection.

"After having a third child, I asked ASHA to tell me some solution so that I don't get pregnant because I don't want to have any other child. She told me to get an operation done. I told her I don't want to have an operation. She told me, you get an Antara Injection given every 3 months."
- Antara User/Younger/Varanasi

"So, there is an Aunty next door, she said what will you do by going every 3 months and injecting. There is medicine, you come to me and take it. If you eat that then you will not be pregnant for 6 months. She was given medicine for 1000 rupees. I got pregnant even after taking the medicine. Then I had to abort the child after consuming the medicine."
- Antara User/Younger/Varanasi

"My aunt's daughter had done sterilization, so she told me that there will be a lot of pain for one day, then after a few days, there will be relief. But I am fearful of pain. My mother also asked me to come to her place and get the operation done."
- Antara User/Older/Varanasi

"ASHA has told us about the Antara injection that the government hospital gives us, so we have to take it once every 3 months."
- Antara User/Older/Varanasi

"First ASHA didi told me about the operation, so my family and I didn't agree with that, then she told me about Antara. Then, I thought let me try this method. Its benefit is like we don't have to take any precautions and we can have sex without a condom."
- Antara User/Older/Meerut

"Because nothing works if you don't get pregnant. I tried some medicines and pills, but nothing worked. I don't know the name. I don't like anything, and it doesn't work. So, I think it's better to use injection."
- Antara User/Older/Meerut

"Yes, like when my husband comes and says that he wants to do something, I always tell him to take precautions and if he doesn't take precaution, I take some precaution, like Antara and I tell him for pull out method. Because he also doesn't want a child and my daughter is so small, she's of 10 months only, I am also weak. ASHA told me that get Antara and there will be gap of 3 months. Then after 3 months, only you will have to think about it."
– Antara User/Younger/Meerut

"When my husband first got condom, nothing happened, he didn't have fun so we stopped using that. After that I said I won't get operated now because my younger one got delivered by C-section and the elder one was a normal delivery. Multiload (IUCD) might cause harm so I used Antara, my husband helped me in this, he said Antara is the best, he completely refused to use Condom and if you miss pills for a day then you'll get pregnant so injection is better, get tension free."
- Antara User/Older/Meerut

ANTARA DISCONTINUED USERS- KEY REASONS FOR DISCONTINUATION

- **Recurrent and high intensity health concerns without having the means to understand to tackle them-** Inconsistent menstrual cycle and bleeding sometimes lasting up to multiple months'; constant weight loss, fatigue and health deterioration. The clients in most cases are left only with *'Aisa hota hai/ Aisa hoga'* but are not explained why what happens in greater detail for them to be able to navigate these physical issues. **It must also be noted that most clients have a high threshold for pain and physical suffering and generally do not go to the health system when these issues are at a nascent stage.**
- There is relatively greater access and constant reiteration of negative experiences/ stories of other women with Antara within their immediate ecosystem. **Access to success stories is EXTREMELY RARE.**
- **Only in a couple of cases-** clients talk about discomfort with recurrently going to the doctor, ANM with their health problems in the fear of being ridiculed or not being talked properly to
- **Little to no support from the family.** Husbands and/or mother-in- law advise them to leave the method and choose traditional or other methods over it when issues emerge. Medical issues are met with a 'shutdown' response.

"I started when doctor told me that if you don't want children then you can go without it, get the injection of Antara. But I got it and my periods did not come for 4 months. They stopped and when I told my husband about it. He told me that if this does not suit you then leave it. ASHA also did not tell anything what to do. So, I stopped."
- Antara Discontinued User/Older/Meerut

"I started feeling dizzy and had problems in periods. I started having a fever. I told her and she said it is normal. I even went for third injection after that, I think after 2-3 months, I don't remember much. ASHA did come to my home and reminded me. In this village I got these two injections. I faced some problems in the first injection. Then when I went for second time, I told the doctor about the problems that came after the first injection. He said that you are quite weak, that's why you are facing this problem. Again, in the third injection ASHA didi called me and then I again went for injection but after the third injection got heavier periods than before, then I stopped taking these injections."
- Antara Discontinued User/Younger/Meerut

"Yes, I used to get heavy blood flow and it used to last for a week and then it used to stop, and then again after 2-3 days same used to happen."
- Antara Discontinued User/Younger/Varanasi

"After I got an injection of Antara, I faced problem with that, so I stopped taking it and now we have adopted the method of ejaculating out. When I faced problem with injection, I stopped taking it and now we take precaution during periods. And no one told me if anything else can be done."
- Antara Discontinued User/Younger/Varanasi

AWARE NON-TRIERS- KEY REASONS FOR NON TRIAL

- **The problem-solving association with Antara amongst FLWs-** Antara seems to be positioned as a P2+ option by community service providers; in most cases it is **not pushed by the system as a general preventive method of contraception that can be utilized by women at all reproductive stages.** Instances of FLWs pushing it to newly married women were non-existent and to P1 clients was also relatively far and few
- **Comfortable with already used methods and lack of a pressing need to look for an alternative-** these clients are settled with the methods they are already using. The functional (avoid pregnancy) and emotional needs (pleasurable and safe sexual experience) of FP are taken care of by the method already used.
- There is relatively greater access and constant reiteration of negative experiences/ stories of other women with Antara within their immediate ecosystem. **Access to success stories is extremely rare.**

KEY TAKEAWAYS

Antara starts as a very promising, cognitive load free choice but ends up becoming a high cognitive load led lapse.
Antara adoption is strongly entrenched in an easily understood and easily describable adoption anchor- *"3 Mahine ki chutti"*. It makes for a cognitive-load-free choice.
However, the clients feel ill-equipped with regards to redressal of physical symptoms and issues that follow- 1) The ASHA in many cases is the first, and the only touchpoint in case of negative experiences. They, in many cases themselves, do not have enough depth of information and generally leave the client only with 'Aisa hota hai'; 2) Most clients mentioned not being fully explained what exactly happens and why- even by other health providers (ANM, doctors, nurses, etc.), wherein, reaching other representatives than ASHAs for redressal is slim in the first place; 3) Add to that the rampant myth formation and easy access to negative experiences of other clients...**what starts as a very promising, cognitive load free choice ends up becoming a high cognitive load led lapse.**

Another interesting finding has been the perception about the Antara 'course being over' after 4-5 dosages- was heard across districts. While this instruction has not been made part of their trainings on the new contraceptive, this perception has emerged through time. It can be assumed that this could be a cooling off period that is aimed at giving rest to the bodies of the clients (to address the effects of Antara on their bone density, but they don't share this with clients)- it is being widely perceived and communicated as course completion. The communication with the clients are being left at '*Ab aap ko nahin lagegi*'. Even the ASHAs in most cases echoed the same.

5. UPTAKE OF NEW CONTRACEPTIVES- CHHAYA | KNOWLEDGE, ATTITUDES AND PRACTICES; LIVED EXPERIENCES; TRIGGERS, BARRIERS AND NEED GAPS

KEY CONSIDERATIONS IMPACTING CHHAYA ADOPTION

- **Chhaya's adoption in most cases was rooted more strongly in the positive experiences of other women around the client INSTEAD of it being pushed as a method by the ASHA.**
- **Most older clients who opted for Chhaya had already exhausted multiple options** in their basket of choice. Many of them had experiences with other pills, condoms, traditional method. Adoption of Chhaya for them is heavily motivated by the promise of the absence of side effects.
- **Interestingly, it is amongst the younger, recently married cohort that we saw women for whom Chhaya was the first-ever contraceptive method.** In a majority of these instances, they had other women within their family or social circles who told them about their positive experiences with the method or they had found about it/ looked it up online on platforms like YouTube and then went to the ASHA themselves to ask for it.
- **The correct self-administering of the second dosage (weekly) in the first three months of adoption seems to be the most commonly observed failing** amongst adopters. Most adopters seem to be getting it wrong either in terms of day or dosage.
  - > In many cases, Chhaya adoption was done in continuation with traditional methods like withdrawal and the calendar method.

"Her name is Pinky, and she is a neighbour, only once you sit along you become friends, she is very close. We talk all about household and if my husband fights with me and if her husband fights with her, all these things. She only told me to use Chhaya."
- Chhaya User/Older/Meerut

"But I do not like Copper T and injections. I am fearful of injections, that is why I am using Chhaya."
- Chhaya User/Younger/Meerut

"People said that Copper-T is not good. Uterus might come out if heavy lifting is done. And for the surgical procedure, my husband did not agree. For injection, you have to come and go again and again. Therefore, I went for Chhaya. My sister-in-law told me about it that you will not have kids."
- Chhaya User/Older/Varanasi

"Sometimes we used condom, sometimes, we kept distance like after some days of periods there is no problem as such. We did that. After 21 days of periods are safe days, but I was afraid from those safe days also. Then, I started using this pill."
- Chhaya User/Older/Varanasi

CORRECTNESS OF KNOWLEDGE OF THE METHOD

- Clients are able to sort out the pattern in which they are supposed to have the pill and are of the opinion that even if they forget they can easily continue from the next scheduled day. They are not aware of the maximum number of pills they can have or of the specific age till which they can continue with Chhaya.
  - Clients start taking the pill correctly. But the mistake they make is the gap between the pills.
- **Knowledge around the method tends to be inconsistent across districts-**
  - In Dasepur, Ateshua, and Munari women tend to be confused about the number of gap days between each consecutive pill. We have come across women who give a gap of 2 days which is ideal but others who have opted for a gap of 3 or 4 days.
  - In Danganj, the methodology recalled was twice a week for one month and once a month afterward. This information was passed on by ASHA and was found to be the same for a few respondents.
  - **The misinformation is often maintained because of the systemic gaps-** ASHAs give out the information but never recheck if the information is absorbed correctly. In other cases, ASHA themselves do not have the correct knowledge. But women show no concern or doubt as the method seems to work for them to prevent pregnancy.
  - **They remember the respective days by connecting with recurring family events-** *Bachoo ke school ka uniform, jeth ji ki pooja ke din, etc.*
  - **In Meerut,** most respondents were aware about the *'hafte me 2 baar khane vali goli'* for the first three months, but across districts, it was also observed that a lot of unclarity on it was also noted. A woman in Mainaputhi, took the pill, twice a week for six months and then started taking it once a week, this she said was the way ASHA had told her about it.
  - **We also noted that a few women were only taking the Chhaya pill when at the time of intercourse,** confusing its consumption with emergency contraceptive methods.
  - There were also respondents who talked about forgetting to take it and then just taking it whenever they remembered it, they said that ASHA had told them to do so.

> *"ASHA told me to take the medicine on the third day of the periods, after I wash my hair. Yes, we take one pill only in a month."*
> ***- Chhaya User/Older/Meerut***
>
> *"For example, on every Sunday is a holiday and I talk to my parents also, so I remember like this. Then second pill, I know that on every Wednesday, my son's uniform changes so I ate it on that day."*
> ***- Chhaya User/Younger/Meerut***
>
> *"After my period, I started taking the pill from second day, it was Monday. After Monday, I took the tablet on Thursday. So twice a week, and after 4th month, I have to take one tablet after dinner, so yes, after that, one tablet once a month."*
> ***- Chhaya User/Younger/Varanasi***

CHHAYA ADOPTERS- KEY REASONS FOR ADOPTION

- **Positive WOM-** Respondents come across mostly positive stories but incidentally- Bhabhi's and Jethani's who adopted the method seem to swear by it. The preconceived notion regarding the pill is wholly positive, making it easy for the respondent to adopt.
- **Control over method with the respondent-** With methods like Chhaya, clients still have a sense of control on what goes into their body. Multiple women have repeatedly mentioned how they always have the option to not have the pill in case they observe any side effects.
- **Independent usage-** For women where the question of mobility is an overbearing issue, the ability to adopt the method within the bounds of the home is a trigger that helps with the adoption of Chhaya. Unlike other methods the client need not step out of their home, ASHAs help with sourcing the method and delivering it to their houses, and they can have it within their own set routines without having to be dependent on another person.
- **Easy approval from family members-** It is observed that family members especially husbands, mothers-in-law, or any other patriarch are easily convinced about Chhaya. Pills or medicines are very common within the health ecosystem and the imagery associated with edibles is mostly positive. For the client, it is very easy to convince these decision-makers/influencers for the adoption this method.
- **Amongst some older clients (P2 and above) they wanted a contraceptive method which they could successfully use without having any side effects in their body...**Chhaya became their saviour. After taking the first few doses, they did not see many changes to their body and assumed it to be working on them.
- **Negligible side effects-** Women across cohorts hardly recall any negative side effects for Chhaya. For clients who have already been through terrible pain with methods like IUCD and discomfort and limited pleasure with Condoms, Chhaya seems to work like magic.
- **Habit formation-** When taken consistently, Chhaya has proved to be highly effective in avoiding unwanted pregnancies. So, when they saw the pill working for them, they decided to stick with it for a longer duration and all respondents had taken at least for 6 months to up to 1.5 years. Over a point of time the pill becomes a part of the client's daily routine. Initial doubts of not being able to take it on time, and forgetting about it are washed away as they get habituated with the method and have to take it once a week.
- **Familiarity with taking a pill is much more common among women as everyone at some point in time in their lives have taken it for one or the other reason** and taking it consistently increased their trust in the pill that it was working for them.

"It was not about like or dislike, I was in search of some easy and effective method, so we have to do something. For three months only I have to take it twice a week, after that it is one pill only, very easy to manage and also without any tension."
- Chhaya User/Older/Varanasi

"It is not such a big tablet; anybody can use it. You do not know of condom if your husband will like it or not. So, you can consume it easily because you are in-charge here."
- Chhaya User/Younger/Varanasi

"I am taking Chhaya. After I took it, there was little bit of sleepiness. But I did not feel very bad. It is sleepiness only."
- Chhaya User/Younger/Meerut

"There are no side effects from the pill. Some women have white discharge, and I heard that Saheli has many side effects. One of my relatives said to me that she doesn't take any pills because her husband uses condoms."
- Chhaya User/Younger/Meerut

"I was using condom. I feel a little unhygienic because first you have to use it, then keep it and put it somewhere. But having pills is a very easy method to use."
- Chhaya User/Younger/Meerut

CHHAYA DISCONTINUED USERS- KEY REASONS FOR DISCONTINUATION

- **Across both districts, the reasons for the discontinuation of Chhaya were very trivial** which indicates the fact that in some cases it does not get registered with the association of a 'serious' contraceptive or 'fatigue with continuous adherence' sets in.
- **Casual behaviour around having medicine-** Typical Indian attitude and behaviours towards consumption of medicine in general – *thoda saa khaya, theek laga phir chod diya!...*"I did not feel like eating the medicine anymore..."
- **One of the common reasons cited for discontinuing the use of Chhaya is that women do not like to have the medicine.** In a few of these cases, withdrawal method is used- the effectiveness of which is validated by the husband- *"hum protection use kar toh rahe hain"*. Discontinuation is also encouraged by the husband- *chod do, hum milkar kuch nikal lenge* solution.
- **Additional mental labour-** To remember the doses, when to take it, hence, lapse is easier. it is more convenient for them to lapse than to remember the intake of the medicine.
- **Does not get registered as a serious method-** Among the range of contraceptives in the basket of choice, Chhaya gets lesser attention owing to its small and insignificant size and look; it is also notably not pushed very strongly by the health system itself.

> *"After one year when I started getting periods, I consumed this Chhaya, I also used to forget to eat it, as it is consumed twice in a month."*
> ***- Chhaya Discontinued User/Older/Varanasi***
>
> *"I started feeling dizziness and weakness in the eyes. I discussed this with ASHA and then I left it. After that I did not feel like having it and asked the ASHA and my bhabhi to suggest an alternate option."*
> ***- Chhaya Discontinued User/Older/Meerut***
>
> *"The problem was that periods were coming late and when it was coming, there was heavy bleeding. So, I left eating the medicine."*
> ***- Chhaya Discontinued User/Older/Meerut***

AWARE NON-TRIERS- KEY REASONS FOR NON TRIAL

The most common and consistent reason for non-adoption was an all-pervasive lack of depth of information on the method or a clear distinction being set compared to 'other pills'. No other reasons for non-trial emerged.

KEY TAKEAWAYS

Chhaya is 'deprioritized by design' within the health system. This negatively impacts all aspects- knowledge, perception and uptake.

'Chhaya is non-incentivised, not clearly segregated in the minds of the clients from other OCPs, and generally not nudged as the first preferred option. It is a reluctant suggestion in many cases highly dependent on other (incidental) positive use cases.

The majority of the adopters had been on Chhaya for a long time but had been having incorrect dosages. Once information is exchanged and usage is initiated, any incorrect patterns do not have a way to reach the health system and get rectified. There is a need for an intervention to build a depth of knowledge about the method and to anchor correct usage days against a constant social (or religious) calendar anchor.

A good practice amongst some women from the Muslim community was remembering dosage on either side of *Jumma Namaaz*. Many Hindu clients used their period date as the anchor for the first dosage but it was the second dosage that became missed or remained inconsistent.

KEY LEARNING FOR BOTH ANTARA AND CHHAYA | There is great pressure and dependence on human intervention with no perceptible sanctions on misses

The process of follow ups and control with regards to Antara & Chhaya adoption, follow-ups and continuation is manual and human-dependent.
Misses occur frequently. There were multiple cases where women had themselves taken the decision to delay their Antara dosage more than three months or delaying their Chhaya dosage without an intervention by the health system

IMPLICATIONS:
At an overall level, **there is a need to build complementary interventions for health information dissemination, tracking progress and providing effective behavioural nudges** in addition to human intervention. It is very natural for a perpetually overworked frontline worker to not be in control of all of these aspects.

CONCLUSION & ACTION RECOMMENDATION

KEY TAKEAWAYS

Role of cognitive load in choice making and what can we learn from it to design effective interventions

THE COGNITIVE LOAD THEORY states that the **inherent level of difficulty** (Intrinsic load) associated with a given subject matter, **the amount of effort required** (Extraneous load) to access the correct information in an effective form and process it in the intended manner and **using it for creation and modification of existing knowledge and schemas** (Germane load) affects cognitive performance which has a direct correlation with choice making.

Cognitive load seems to play a role in deterring clients from adopting/ correctly adopting/ adhering/ continuing usage of modern methods of contraception. There are multiple points in the client pathway where cognitive load impacts or plays a role in the decision-making journey.

Cognitive Load Theory could be a key contributor in defining modern method(s) strategies in the future:

- The program could map action against multiple inflection points to create a greater positive impact for MM.
- The objective should be to eventually create a sustainable system where the use of MM will not solely depend on creating client conviction through human interactions with FLWs or other stakeholders of the health system.

Through this study, an attempt has been made to deconstruct the entire progression of Antara and Chhaya users and understand the positive or negative impact that cognitive load has on choice making at each stage. Broadly the progression has been segregated into three stages- AWARENESS, ADOPTION and CONTINUATION. **The key question to answer at each stage-**

1. **AWARENESS-** In what circumstances and form do people get exposed to information about modern contraceptives.
2. **ADOPTION-** What is the process and experience of sense making?
3. **CONTINUATION-** What leads to the creation of conviction and memory anchors for choice making and continued action?

HIGH-IMPACT CONTEXTUAL FACTORS GOVERNING CHOICE MAKING IN DIFFERENT ASPECTS OF LIFE

FACTORS	IMPACT	OUTCOMES
HIGHLY RESTRICTED MOBILITY	***Lives lived within the confines of the community.*** *Instances of stepping out are rare. High dependence on husband and other elder members of the family*	**COMPLIANCE AND THE INTENSE NEED FOR A SUPPORT SYSTEM**
HIGHER LEVELS OF EDUCATION AND TECH ACCESS	***Mobile phones and visual + vernacular content provide a window to the world outside the community.*** *Shared, therefore, unregulated and unsanctioned*	**GREATER SENSE OF ASPIRATION AND ENABLEMENT FOR SENSE MAKING**
TRADITIONAL, PATRIARCHAL FAMILIAL POWER DYNAMIC	***Women at the lower-end of the decision-making spectrum;*** *older women have greater say with time; men of the house have the final word*	**CONSTANT SCRUTINY OF CHOICES; COMPROMISED AGENCY**
EVOLVING RELATIONSHIP & NEGOTIATION WITH PARTNER (OR NOT)	***Younger couples have a 'relatively' better sense of partnership-*** *greater instances of exposure to opposite gender growing up + greater levels of education _ tech access; exposure to metro city couple counterparts* ***But most key decisions still need husband's sign off.***	**GREATER SPACE TO EXPRESS (ESP AMONG YOUNGER COUPLES) BUT POWER LIES WITH THE HUSBAND**
THRIVING GRAPEVINE OF OTHERS LIKE THEM AROUND THEM	***Women in similar age groups or slightly older around them with lives, lived experiences and challenges similar to theirs in their immediate vicinity emerge as primary circles of support,*** *information seeking, choice making and even redressal*	**SOCIAL CONFIDENCE AND POWER OF THE COLLECTIVE**

PRIMARY TRIGGERS AND BARRIERS AT EACH STAGE AT A GLANCE

	ANTARA	CHHAYA
AWARENESS 	Strong push by the health system and a zero cognitive load choice- **"3 mahine ki chutti"** At the same time, a thriving grapevine and negative WOM emanating from **access to more negative experiences than positive**	High dependence on positive experience of others- making it a **predominantly emotional choice** Lower **natural** push within the health system as an efficacious choice **of contraception makes it sporadically adopted**
ADOPTION 	**Recurrent health issues without the enablement** to understand or tackle the same.	**Inconsistent understanding of the method being non-hormonal;** or what is non hormonal? **High instances of incorrect/ inconsistent dosage** within the first three months
CONTINUATON 	**Lack of support** from within the context x sub optimal depth of knowledge x own **personal bad experiences** x constant reiteration of **negative experiences around them** VS Efficacy of the method.	**The cognitive load reduces with the switching from 2 times a week to one time a week-** adherence improves

Reiterating the top learnings and programmatic implications & action suggestions that have emerged from the study and plotting it against **the three stages of- exposure, experience and adherence** within our cognitive load theory framework. It is critical to note that these three stages are interdependent. Therefore, interventions and solutions cannot be elemental or isolated.

AWARENESS: IN WHAT CIRCUMSTANCES AND FORM DO PEOPLE GET EXPOSED TO INFORMATION ABOUT MODERN CONTRACEPTIVES.
AND
ADOPTION: WHAT IS THE PROCESS AND EXPERIENCE OF SENSE MAKING?

1. Different modern contraceptives have been put on a 'parity spectrum'

- Different methods/combinations of methods have come to be perceived as suitable for different parities/ stages of reproductive journey. Amongst the clients we met, in most cases, Antara was suggested and nudged as a contraceptive method to P2 and above only. This is an outcome of three contextual factors working in tandem
  - Expected Level of Achievement (targets) against various modern methods
  - Socially accepted norm of a 'complete family'. For instance, after this stage, service providers feel confident in dealing with the potential effect of contraceptives on overall fertility
  - Perceived levels of intrusion and efficacy of the method

IMPLICATIONS AND ACTIONS

- Clients, in most cases, never truly have access to the entire basket of choices
- **The health system has a 'problem first' approach (instead of a lifestyle approach) to contraceptive recommendations** similar to medicines i.e. different kinds of contraceptives are supposed to solve different kinds of problems
- **The onus of 'demand generation' for different kinds of contraceptives seems to lie with the health system ONLY**
- **THEREFORE, there is a need to** shift from a problem solving mindset to a lifestyle based mindset and with a view of building **depth of knowledge** and tangibilizing the basket of choices for the clients both at an individual as well as at a collective level at step 0 of their reproductive journeys. All existing and potential clients must therefore have access to easily understood and describable information and assets (individual or shared) that can be constantly revisited or serve as reminder for the various options and a complete breakdown of everything that is needed to be known about them without human dependence, **and can be served as an opportunity for social interaction, exchange and dialogue.**

2. There seems to be a lack of consistent, singular, and correct source of information for addressing misconceptions and misinformation about contraceptives among clients and their immediate ecosystem.

- There are two aspects that work in tandem:
  - While ASHAs are accepted as catalysts for access to the health system, they have inconsistent (and in many cases, very little) authority amongst clients.
  - **There is a thriving grapevine amongst clients-** Information (and in many cases myths and misinformation) on various aspects is exchanged very frequently. In addition to that, there is a high degree of trust on the lived experiences of 'others like us' amongst clients.
- It is also interesting to note that while clients (have to) actively seek information pertaining to contraceptive options after they attain a particular parity. However, myths and misinformation reach them organically much earlier and without active seeking.

IMPLICATIONS AND ACTIONS

- **Myth formation, misinformation is given a chance to find deeper roots** and there is an absence of a designated (and consistent) place/ person/ system from the health. The clients themselves, in a way, become health information disseminators and start imparting incomplete, and in many cases incorrect knowledge to other clients and enabling lapse- '*Yeh nahin theek chal raha toh yeh le le. Maine bhi yeh hi kara tha*'
- **There is a need to make 'positive stories/ case studies and lived experiences' with various modern methods much more visible and accessible to the clients within their daily contexts** without it being dependent on actively seeking that information only when a need arises.

3. The health system does not seem to fully acknowledge the improved sense making and intelligence of the clients

- Majority of the clients (compared to their predecessors) have-1) Greater levels of education; 2) Greater levels of aspiration; 3) Greater access to tech and information (many times visual, audio) for decision making with regards to different aspects of their lives.
- However, the communication with, manner of handling the clients or their grievances seems to be a little too dumbed down. In most cases, they are not provided with depth of knowledge to make a choice for themselves *"Haan yeh hota hai. Koi Nahin theek ho jayega"... instead of "Yeh Isliye hota hai... aur tumhaare shareer mein yeh aise kaam karta hai"*

IMPLICATIONS AND ACTIONS

- There is a **need to completely overhaul** the approach of health related communication with existing and future clients.
  - Need for a **greater use of visuals/ visual reinforcement;** and in new-age formats like short videos/ use of micro-influencers
  - Focus on **building depth of knowledge and not just ensuring easy access to information**
  - Some potential ideas for the same could be to use shared common walls to create social communication that can be constantly revisited; vernacular videos describing the methods that can be accessed through individual mobile phones on online platforms; pushing situation-based visual content (on reproductive health and contraceptive choices) through micro influencers to make the topic 'more everyday'.
- This would result in a shift from- **a push-dependent strategy to a pull strategy of demand generation for contraception and continuation with contraceptive choices**

4. The basket of choices is becoming an enabler of lapse amongst clients- *"Yeh nahin chal raha. Koi baat nahin toh yeh le lo..."*

- When faced with an issue, redirecting the client to a new method is a very common modus operandi amongst FLWs. It is perceived to be an easier and safer option rather than convincing them and providing them with depth of knowledge or reasons to remain committed to their choice(s).
- A very critical reason for this is that the ASHAs, who in most cases are the most often interfaced touchpoint(s) of the health system, **do not feel fully equipped themselves or feel a sense of authority and confidence to take any kind of risk against a potential client/ community backlash.**
- Clients expect the ASHA to be able to give answers to/ resolve their problems and in most cases do not go beyond her to seek assistance from the health system

IMPLICATIONS AND ACTIONS

- There is a strong need to **empower the front-line workers with tech interventions and tools (perhaps 24 x7 helpline) to help them counter the inadequacies** they feel with regards to- **Technical knowledge** about more complex methods; The **social challenge** of a backlash from the community that they live in; The reality that the client has **a very strong mobility handicap and they rarely leave the village premises to seek solutions unless a problem is perceived to be 'big enough' by them**
- **There is a need to review the competency of ASHAs on the subject and to conduct more method-focused trainings on the various methods of FP.**
- **At a systemic level, there is a need to relook at the approach to setting targets for modern contraceptives –** The system of targets often leads to discouragement of basket of choice, incentivizing front line workers to focus on the more rewarding contraceptives during counseling.

Continuation- what leads to the creation of conviction and memory anchors for choice making and continued action?

5. Antara starts as a very promising, cognitive load free choice BUT ends up becoming a high cognitive load led lapse

- **Antara adoption is strongly entrenched in an easily understood and easily describable adoption anchor-**
- ***"3 Mahine ki chutti"*. It makes for a cognitive-load-free choice.**
- However, the clients feel ill equipped with regards to redressal of physical symptoms and issues that follow- 1)The ASHA in many cases is the first, and the only touchpoint in case of negative experiences. They, in many cases themselves, do not have enough depth of information and generally leave the client only with *'Aisa hota hai'*; 2) Most clients mentioned not being fully explained what exactly happens and why- even by other health reps (ANM, doctor); 3) Add to that the rampant myth formation and easy access to negative experiences of other clients...**what starts as a very promising, cognitive load free choice ends up becoming a high cognitive load led lapse.**
- Another interesting observation has been the perception about the Antara 'course being over' after 4-5 dosages- heard across districts. While it could be a cooling off period that is aimed at giving rest to the bodies of the clients (to address the effects of Antara on their bone density, but they don't share this with clients)- it is being widely perceived and communicated as course completion. The communication with the clients are being left at *'Ab aap ko nahin lagegi'*. Even the ASHAs in most cases echoed the same.

IMPLICATIONS AND ACTIONS

- There is a need to build a depth of knowledge about possible health issues and the reasons for them to occur within the body at step-0 of the adoption of the method. This would lead to a rebranding of 'adverse' health impacts as 'bodily changes' and make clients feel more equipped to navigate the challenges

- Establishment of redressal mechanisms in case of 'complaints' of adverse health effects, through education of ASHAs on counselling about effects at the time of method introduction OR **the creation of a community-based-social-groups comprising of experienced clients who have had lived experiences with the method and can be trained to become dedicated community resources for information access and dissemination or helpline 24X 7**
- Focused efforts on community mobilisation– for both women and men to initiate conversations on social forums

6. Chhaya is 'Deprioritized by Design' within the health system. This negatively impacts all aspects- knowledge, perception and uptake

- 'Chhaya is non-incentivised, not clearly segregated in the minds of the clients from other OCPs, and generally not nudged as the first preferred option. It is a reluctant suggestion, in many cases, highly dependent on other (incidental) positive use cases.
- Majority of the adopters had been on Chhaya for a long time but had been having incorrect dosages. Once information is exchanged and usage is initiated, any incorrect patterns do not have a way to reach the health system and get rectified. There is a need for an intervention to build a depth of knowledge about the method and to anchor correct usage days against a constant social (or religious) calendar anchor.

IMPLICATIONS AND ACTIONS

Chhaya seems to be a big opportunity missed till now in terms of-

- **Being a non-hormonal and therefore having the best chance of leading to the least physical complications** amongst clients who, in many cases, are undernourished and have inconsistent nutritional intake
- **Infusing a sense of pride being a 'made in India'/ India's contribution to the world**

India Health Action Trust
Bharathi Enclave, 2nd Floor
No. 197, 10th Cross, CBI Road, Ganganagar
Bengaluru - 560032
Karnataka
Phone: +91 80 2340 9698
Email: contactus@ihat.in
Website: www.ihat.in

Uttar Pradesh Technical Support Unit
India Health Action Trust 404, 4th Floor
Ratan Square No. 20-A Vidhan Sabha Marg
Lucknow-226001
Uttar Pradesh, India
Phone: +91-522-4922350 / 4931777