A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

A process document outlining a Zero and Low Parity Pilot (ZLPP) intervention by CARE India in partnership with the Government of Bihar in 2018-2020
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

A process document outlining a Zero and Low Parity Pilot (ZLPP) intervention by CARE India in partnership with the Government of Bihar in 2018-2020
Purpose and Organisation of this Report

The Zero and Low Parity Pilot (ZLPP) is a timely intervention modelled around findings from CARE’s exploratory studies. Key findings pointed towards how the family planning (FP) programme seems to be missing the younger age groups of married women and contraceptive use is much lower among them while unmet need is higher. The pilot seeks innovative solutions to family planning in Bihar, India, where persistent barriers include poor quality and availability of frontline health workers, lack of accurate data and limited access to services and information. It highlights several tested approaches that have potential to be taken to scale.

The report has been categorised under six main sections that capture the background of the FP programme in India and in Bihar specifically, followed by the rationale for an intervention like the ZLPP. Sections on planning for ZLPP and the intervention outline the steps and processes that were adopted in the 18-month period (2018-2020) which concluded in January, 2020. Successes achieved have been recorded with direct feedback from beneficiaries, project staff and district officials’ perspectives. The section on Challenges and Recommendations outline areas that need strengthening for any further replication.
List of Abbreviations

ASHA : Accredited Social Health Activist
ANM : Auxiliary Nurse Midwife
AWW : Anganwadi Worker
BCC : Behaviour Change Communication
BCM : Block Community Mobiliser
BHM : Block Health Manager
BMGF : Bill and Melinda Gates Foundation
BTSP : Bihar Technical Support Programme
CMWRA : Currently Married Women of Reproductive Age
DRU : District Resource Unit
DTO : District Technical Officers
EE : Entertainment Education
FLWs : Frontline Health Workers
FP : Family Planning
FP-LMIS : Family Planning Logistics Management Information System
GoB : Government of Bihar
GoI : Government of India
HIV : Human Immunodeficiency Virus
HGM : Husband Group Meeting
HSC : Health Sub-Centre Meeting
HTSP : Health Timing and Spacing
ICDS : Integrated Child Development Services
IEC : Information, Education, Communication
ILA : Incremental Learning Approach
IPC : Interpersonal Communication
ISOFI : Inner Spaces Outer Faces Initiative
JD : Job Description
LMIC : Low and Middle-Income Countries
MoHFW : Ministry of Health and Family Welfare
MoIC : Medical Officer-in-Charge
NGO : Non-Government Organisation
NLP : Nulliparous Women
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PoAICPD</td>
<td>Programme of Action of the International Conference on Population and Development</td>
</tr>
<tr>
<td>PSA</td>
<td>Public Service Announcement</td>
</tr>
<tr>
<td>RMNCH+A</td>
<td>Reproductive, Maternal, Newborn, Child, and Adolescent Health</td>
</tr>
<tr>
<td>SAA</td>
<td>Social Analysis and Action</td>
</tr>
<tr>
<td>SBCC</td>
<td>Social and Behaviour Change Communication</td>
</tr>
<tr>
<td>SC and ST</td>
<td>Scheduled Caste &amp; Scheduled Tribe</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>SoP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZLPP</td>
<td>Zero and Low Parity Pilot</td>
</tr>
</tbody>
</table>
CONTENTS

List of Abbreviations 5
Executive Summary 8

Background & Introduction
• Family planning scenario in India 11
• Barriers in accessing family planning services 12
• Family planning scenario in Bihar 12
• CARE India takes up the family planning challenge in Bihar 13

Pre-Intervention Phase and Planning for the Pilot
• Planning the Pilot 15
• Activating older, existing platforms to maximise reach 19
• Identifying new platforms to reach the last mile 20

Implementing the Pilot
• Objectives of the ZLP project 22
• The 3 pillars of the Pilot Intervention 22
• Getting teams in place and preparing for trainings 23
• Vignettes from a typical SAA training in Pakridayal, PHC/East Champaran 23
• Multiple tools and techniques to make ASHA’s presence impactful 25
• Breaking the shackles of gender stereotyping with vibrant Husband Group Meetings 27
• Reaching migrant husbands and their spouses with direct and indirect messaging 29
• Reinforcing messages and creating better lines of communication with couple counselling 29

Achievements & Innovations
• Policy level 31
• Programme level 33
• Community level 35

Challenges and Lessons Learnt
• Policy level challenges 37
• Programme level challenges 38
• Community level challenges 39

Recommendations
• At the policy level 41
• At the programme level 42
• At the community level 43

Conclusion and Next Steps 44
Glossary 45
Family planning programmes impact women’s health by providing universal access to sexual and reproductive health services and counselling information. They offer cost-effective solutions to achieve gender equality, empowering women to make informed decisions regarding contraception and childbirth. Healthy timing and spacing, fertility awareness and guidance to the young couple help them make informed choices about family planning. Access to contraceptives helps delay, space and limit pregnancies; lowers healthcare costs and ensures more girls complete their education and create gender parity at the workplace.

Increasingly, it is being acknowledged that greater investments are needed in family planning by enhancing the agency of newly married women and women with one child, besides involving men. This will improve outcomes related to not just family planning but also maternal health, immunization, education and other development indicators. It is therefore time to shift from a one-size-fits-all approach to a more accountable mechanism involving couples, health workers, communities and the local administration.

India’s family planning programme has for decades missed younger age groups of newly married women and those with one child. There are several reasons for this neglect. In many places, especially in rural areas, child marriages are still prevalent. Many traditional norms are followed within families which put pressure on the young bride to bear a male child soon after marriage. There is little dialogue between the couple about family planning. Most family decisions including when to have a child, what family planning product to use and how many children to have, are taken by husbands and mothers-in-law.

This makes it difficult to fully address sexual and reproductive needs of young people who are most in need of correct information and handholding.

Bihar accounts for 8.58% of the country’s total population (Census 2011) and is India’s third most populous state. Nearly 46% women in the state are married before the legal age of 18 and first contraceptive use is at an average age of 25 years and 90% family planning is for permanent methods (NFHS 4, 2015-16). Despite commitments from the Government of Bihar (GoB), deep-rooted cultural practices limit their ability to affect lasting change. Persistent barriers include poor quality of services, lack of availability and skills of health workers and facility staff, limited access to family planning services, lack of accurate data and inadequate public health infrastructure.

Since 2013, CARE has been a nodal Technical Support Unit (TSU) to GoB’s Health & Social Welfare Departments. As part of its mandate, it is providing support at the block, district and state levels for the Health and Integrated Child and Development Scheme (ICDS) at the facility and outreach levels. In January 2018, CARE conducted a study on the reproductive profile and associated practices among Currently

---

1 The National Family Health Survey (NFHS) is a large multi-round survey conducted in a representative sample of households across India every few years. It provides state and national information on fertility, infant and child mortality, family planning, maternal and child health etc.
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

Married Women of Reproductive Age (CMWRA), providing valuable insights in their reproductive behaviours, practices and awareness levels with data on total fertility rate, Intent of using family planning methods, unmet need, contraceptive prevalence and reasons for non-usage of methods. Findings indicated that use of contraceptives was low and unmet need for spacing methods had only marginally increased. These findings contributed to the decision to launch a first-of-its-kind intervention where CARE introduced gender and sexuality in a maternal and child health (MCH) programme focusing on zero (couples with no children) and low parity couples (couples with one child).

The 18-month pilot was launched in January 2018 for an initial period of nine months and was later extended for another nine months. It covered two districts each in East Champaran and Gaya and five blocks with a view to aid government health facilities with penetrable content modules for training CARE facilitators and the Accredited Social Health Activists (ASHA) workers. The districts were selected based on reliable supply of family planning services. The pilot adapted the tried and tested Social Analysis and Action (SAA) approach to train ASHAs and Auxiliary Nurse Midwives (ANM). The SAA approach is a community-led social change process that encourages individuals and communities to explore and challenge social norms, beliefs and practices around gender and sexuality.

The pilot focused on creating relationships and building trust between young couples and ASHAs. So far ASHAs were targeting mainly primiparous women for family planning services and not looking at newly married women and men to provide services. Utilisation of Health Sub-Centres (HSC) and Village Health and Sanitation, Nutrition Day (VHSND) platforms for family planning-related learning and counselling of beneficiaries was sub-optimal. Health department data found maximum institutional deliveries taking place in government facilities, nine months after Diwali and Chhat (popular festivals for which men usually return home for festivities), pointing towards the need for conducting special family planning drives during this time amongst migrant communities. These were opportunities that the ZLPP aimed to leverage in order to achieve state specific family planning goals.

Building capacities of ASHAs became the crux of the programme. In the preparatory phase, the TSU strategic approach was leveraging with the government to activate existing platforms like VHSNDs and HSC meetings to reach ZLP couples through outreach/home visits. Simultaneously, efforts were being intensified to strengthen new platforms like husbands’ groups, migrants’ interventions and adopting couple counselling. By the end of the pilot it was expected that the quality of interaction between ASHAs and young couples would improve. There would be better couple communication on sexual reproductive health and family planning and neglected groups like migrants and husbands would be part of the larger discussion on family planning.

Initially, ASHAs were hesitant of going into the field and talking to zero parity women about family planning. In November 2018, the SAA training for ASHAs was rolled out through nine planned sessions. The scope of the training was later expanded, and sessions added to cover additional topics on health and family planning. Through the SAA training, their critical attitudes towards gender were addressed and they were guided on how to talk to young couples and involve husbands and mothers-in-law in conversations around family planning. Improved performance of ASHAs led to target groups being better informed to adopt the most appropriate family planning product/service and ASHAs taking their learnings from the meetings to other districts. The role of CARE and ZLP male and female facilitators helped with achieving more solid outcomes, since the messaging was stronger in the combined home visits and the performance of ASHAs was also better monitored.

A total of 21 male and female ZLP facilitators were hired, following which they were called for an

CARE’s approach differed from other family planning programmes. Using a rights-based approach, it promoted dignity, social justice and equality. Instead of pushing a family planning product, it placed the decision in the hands of the couple and provided them knowledge and tools appropriate to their age and social context.
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

intense training session on the form and content of the modules, including SAA and HSC trainings. The quality and design of the trainings was instrumental in enhancing the quality of engagement that the ASHAs had at the field level. Through exercises, role play and discussion, they were guided on how to make their interactions more meaningful. Many admitted that their knowledge about family planning was greatly enhanced. They began to see themselves as powerful advocates who could influence the betterment of families, societies and their home state by contributing to tackling a problem of imminent importance.

The husband group meeting (HGM) formats were shared and to begin with, content for three months was finalised, including topics of HTSP and reproductive health. It was decided to change this content every three months before rolling out to the facilitators. The SAA trainings prepared ASHAs to conduct HSC meetings while HGMs reached ZLP men in monthly meetings (later became quarterly). To ensure sustainability, all levels of the system were involved in the programme. The Medical Officer-In-charge (MoIC), Block Community Mobiliser (BCM) and Block Health Manager (BHM) were involved closely in the planning and implementation process.

The basic tenets of the programme remained couple communication, demand generation for family planning methods, capacity building of ASHAs and encouraging healthy family planning practices among ZLP couples. Where the ZLP pilot scored was that while previous family planning interventions were largely impersonal, policy/target driven and not fully involved with the community, this connected intimately with the beneficiaries in direct, creative and sustainable ways.

In many places young couples admitted they had no idea how to broach this sensitive topic and were reconciled to whatever destiny and nature had in store for them. The ZLPP changed that mindset and they realised they could engineer their future, decide when they want to start a family or how they want to space their children and accordingly plan their finances by taking decisions in consultation with their partners. Much of the embarrassment around family planning products was eased, as men and women talked about the pros and cons of a product, initiated discussion with the ASHA and shared the information with each other. How men overcame their awkwardness and mindset was a major victory for the programme. Peer pressure and conditioning had made it very difficult for ASHAs to penetrate that barrier and get them to be genuinely interested without being judgmental or mocking in their approach. The situation changed to the extent that men even ask the ASHA if she could get them condoms or information on modern methods so that they could discuss with their wives and make an informed choice.

By the time the project ended, the seeds will have been sown to enable young couples to decide the future trajectory of their family size and choose what is best for them. By allowing them to pause, reflect, plan and act, the project has placed power in their hands, steering them to take decisions which the family planning programme urgently needs.
Family planning programmes impact women’s health by providing universal access to sexual and reproductive healthcare services and counselling information. Healthy family planning indicators have far-reaching benefits which go beyond health and these tend to impact nearly 17 Sustainable Development Goals (SDGs). Family planning offers one of the most cost-effective solutions to achieve gender equality and equity (SDG 5) empowering women with knowledge and agency to control their bodies and reproductive choices by accessing contraceptive methods. Birth spacing helps reduce malnutrition (Goal 2) and contributes to long-term good health (Goal 3) for mother and child. Access to contraceptives helps delay, space and limit pregnancies; lowers healthcare costs and ensures more girls complete their education and create gender parity at the workplace. Ultimately, these result in reduction in poverty (Goal 1) and inequalities (Goal 10) leading to achievement of SDGs through a multiplier effect.

Many women in low and middle-income countries (LMIC) would like to limit or delay their pregnancy, but lack access to consistent use and availability of modern contraceptive methods. It is now well established that improving literacy and economic conditions for individuals lowers birth rates, while low fertility plays a positive role in economic growth.

The Sustainable Development Goals (SDGs) are a collection of 17 global goals designed to be a “blueprint to achieve a better and more sustainable future for all”. Set in 2015 by the United Nations General Assembly and intended to be achieved by the year 2030, they are part of UN Resolution 70/1, the 2030 Agenda.
On Population and Development in 1994, Government of India (GoI) abandoned method specific targets and introduced standard operating procedures (SoPs) and quality assurance mechanisms.

At the London Summit on Family Planning, 2012, India committed to providing family planning services to an additional 48 million new users by 2020, committing to drive access, choice and quality of services, expanding range and reach of contraceptive options by rolling out new contraceptives and delivering the full range of family planning services. With over half of India’s population in the reproductive age group and 68.84% residing in villages, the challenge of reaching the last mile, especially women from scheduled castes and tribes (SC and ST) in distant and remote parts of the country has been immense (NHFS 4).

### Barriers in accessing family planning services

Research undertaken in recent years has clearly pointed towards how the family planning programme seems to be missing younger age groups of married women and how contraceptive use is much lower among younger age groups where unmet need is higher. Some of the barriers that have been cited include:

<table>
<thead>
<tr>
<th>Child marriage and early pregnancy</th>
<th>Insufficient male engagement</th>
<th>Unaddressed sexual and reproductive needs of youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>India has one of the highest number of girls married before the age of 18 followed by immediate childbearing.</td>
<td>A disproportionate burden for contraceptive use falls on women. Female sterilisation accounts for 75% of modern contraceptive use. The two methods of contraception available to men (vasectomy and condoms) account for 12% of overall modern contraceptive prevalence rate (mCPR) and 40.2% men assign women with the responsibility of avoiding pregnancy (NFHS-4).</td>
<td>Youth (15-34 years) account for 34.8% of India’s total population with majority having no access to contraceptives.</td>
</tr>
</tbody>
</table>

### Family planning scenario in Bihar

#### How Bihar fares on the FP scale

- Lowest mCPR in the country at **38%** and third highest overall unmet need at **21.2%**
- **21%** of currently married women in 15-49 age group have little or no access to contraception and barely **23%** women use modern methods of contraception
- Adoption of male sterilisation method is almost nil; male participation in FP is abysmally low falling over the last decade from **0.6%** to **0%** among currently married men in 15-49 age group

*Source: NFHS 4, 2015-16*

- **46%** women get married before 18 years; first contraceptive use is at 25 years on average; and **90%** FP is for permanent methods
- There is an 8-year gap between age of sexual initiation in marriage (17 years) and initiation of first contraceptive use (25 years) on average

*Source: MWRA Survey*
Bihar accounts for 8.58% of the country’s total population (Census 2011) and is India’s third most populous state. It has one of the highest rates of maternal, neonatal and infant mortality, as well as high prevalence of malnutrition, stunted growth and high fertility rates. Women bear a disproportionate burden of adopting contraception despite easier and safer methods available for male sterilisation. The dismal statistics on family planning in Bihar are due to several socio-cultural-economic factors such as:

### High unmet need
There is an unmet need for family planning among married women between 15 to 24 years, especially for spacing births. Women with no education and from poor families have the highest total unmet need at 40.1% and 40.6% (NHFS-4); also for sexually active women between 35 and 39 years the unmet need is pitched at 42.5%. Child marriages are common and contraceptive use is mostly after 2-3 child births.

### Limited exposure to modern contraceptive methods
With a population of over 104 million and 89% in rural areas, systematic interventions addressing natal health and family planning are critical. About 12.5% of total births occur among teenage women and only one in three married women have access to family planning services. A staggering 90% women’s first exposure to modern contraception is only when she visits a sterilisation procedure at a health facility.

### Spike in deliveries during festival time
Health department data found maximum institutional deliveries taking place in government facilities nine months after Diwali and Chhat pointing towards the need for conducting special family planning drives during this time as a good opportunity.

### Merit in ASHAs motivating communities to adopt better health behaviours
Capacity building of community health workers can improve family planning outcomes by strengthening information dissemination and linking beneficiaries at the last mile to health facilities to access services. So far Accredited Social Health Activist (ASHA) role in family planning has included supporting delivery of contraceptives at the doorstep of beneficiaries and counselling newly married couples to delay childbirth by at least two years after marriage and encouraging spacing of at least three years for couples with one child.

## CARE India takes up the family planning challenge in Bihar
CARE has been working in India for over 65 years, focusing on alleviating poverty and social exclusion. In 2011, CARE India launched the Bihar Technical Support Programme (BTSP) with the support of Bill and Melinda Gates Foundation (BMGF) to support GoB to increase universal coverage and quality of life-saving interventions to improve the health and survival of women, newborns, and children. CARE has been the nodal Technical Support Unit (TSU) to GoB’s Health & Social Welfare Departments since 2013, providing support at the block, district and state levels for health and Integrated Child and Development Scheme (ICDS) at public sector facility and outreach levels.
Adapting the Social Analysis and Action (SAA) approach to FP and ZLPP

The SAA is one of CARE’s models for gender transformation. A community-led social change process, it encourages individuals and communities to explore and challenge social norms, beliefs and practices around gender and sexuality. It uses participatory tools and is facilitated by experts who work closely to resolve issues that affect people most. Initiated in 2004, it has been applied in over 20 countries to CARE projects addressing diverse issues while supporting global commitment to gender equality.

In a first-of-its-kind intervention, CARE introduced gender and sexuality in a maternal and child health (MCH) programme focusing on zero and low parity couples. The pilot was launched in two districts (East Champaran and Gaya) and five blocks of rural Bihar with the aim of aiding government health facilities with penetrable content modules for training CARE facilitators and ASHA workers using the SAA approach. Government adoption and sustainability were essential to the pilot at the planning and implementation stages. Adapting the Social Analysis and Action (SAA) approach to FP and ZLPP.

The SAA is one of CARE’s models for gender transformation. A community-led social change process, it encourages individuals and communities to explore and challenge social norms, beliefs and practices around gender and sexuality. It uses participatory tools and is facilitated by experts who work closely to resolve issues that affect people most. Initiated in 2004, it has been applied in over 20 countries to CARE projects addressing diverse issues while supporting global commitment to gender equality.

In a first-of-its-kind intervention, CARE introduced gender and sexuality in a maternal and child health (MCH) programme focusing on zero and low parity couples. The pilot was launched in two districts (East Champaran and Gaya) and five blocks of rural Bihar with the aim of aiding government health facilities with penetrable content modules for training CARE facilitators and ASHA workers using the SAA approach. Government adoption and sustainability were essential to the pilot at the planning and implementation stages.
To ensure maximum proliferation of good family planning practices, the ZLP pilot was designed to reach women as soon as they got married. They were viewed as a demographic most vulnerable to misinformation and also the least mobile. The 18-month pilot was launched in January 2018 and the HSC meeting and HGM started April onwards with a plan of culminating in December 2019. The pilot focused on creating relationships and building trust between couples, newlyweds and their families on one side and the government healthcare machinery on the other.

**Planning the Pilot**

In the preparatory phase, the TSU strategic approach was leveraged with the government to activate existing platforms like VHSNDs and HSC meetings to reach ZLP couples by engaging ASHAs for outreach/home visits. New platforms like husbands’ groups meetings, migrants’ interventions and couple counselling were also adopted.

**Figure 1: Planning the pilot**
Step 1: Modelling the pilot using CARE’s experience

The pilot used the analysis-reflection-action cycle of SSA (based on the principles of the ISOFI innovation system) which was pioneered by CARE to aid community health workers, other stakeholders and project staff. It encouraged the team to critically reflect on field and personal challenges to implement the programme. As catalysts of sustainable change, the pilot was unique.

The CARE Bihar team went through a roster of material (pre-existing literature) stemming from years of its research to choreograph the pilot. In January 2018, a study was conducted on the reproductive profile and associated practices among Currently Married Women of Reproductive Age (CMWRA) providing insights in their reproductive behaviours, practices and awareness levels with data on the total fertility rate, intent of using family planning methods, unmet need, contraceptive prevalence (modern and traditional/methoMethod mix (spacing, limiting) and reasons for non-usage of methods.

Findings from another cross-sectional study in which household interviews were conducted across 38 districts among married women in the 15 - 49 age group in 2016 and 2018 once again pointed towards a gap between need and availability of family planning services amongst the most vulnerable population.

Important findings from these studies guided the current intervention of the ZLPP:

- Although use of contraceptives increased, it was still low. More awareness and focused drives to engage couples would push this further.
- Unmet need for spacing methods marginally increased and couples were more aware and keener to delay and space childbirth. This was more evident where ASHAs were actively engaging with couples, reducing misconceptions around family planning methods. So far ASHAs were targeting mainly primiparous women for family planning services.
- Utilisation of HSC and Village Health and Sanitation, Nutrition Days (VHSND) platforms for family planning-related learning and counselling of couples showed improvement with scope for leveraging these to achieve family planning goals.

As many as 45% husbands were part of the migrant labour force and their wives had lower mCPR and higher unmet need. This target group would benefit from a focused family planning intervention.

Husbands were major decision makers with respect to family planning. Majority but not all participants of husband groups were men who were married to ZLP women. There was scope to improve participation by members of key target groups, display family planning commodities and improve interaction amongst them.

Where the ZLP pilot scored was that while previous family planning interventions were largely impersonal or policy/target driven and not fully involved with the community, this connected intimately with newlywed couples and those with one child in direct, creative and sustainable ways.”

Padma Buggineni, Deputy Team Lead, Family Planning, Care India, Bihar

Step 2: Finalising blocks and target groups

The blocks were selected based on settings with lowest mCPR prevalence. It looked at availability of commodity supply to meet a key assumption that pertained to reliable supply of family planning methods. The ZLPP was planned as a hyper-local planned intervention. Key learnings from the baseline decided the scope and limitations with ZLP women

3Bearing a young one for the first time.
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

as target beneficiaries. Simultaneously capacity building of ASHAs was undertaken in addition to strengthening supply chain management of family planning methods.

**Pilot blocks**  
Gaya- Wajirganj & Dobhi  
East Champaran- Piprakothi, Pakridayal & Madhuban

**Step 3: Drawing guidance from exploratory studies: Baselines survey & Exploratory visits**

What made the programme unique was its multilayered bottom-to-top approach. Initial studies and baseline findings defined the scope and design of the pilot. In February 2018, a baseline was conducted, and data collected from 2257 married zero or one parity women in the age group of 15-24 years. Using the same learnings in ZLPP, major decisions were based on findings that emerged from the baseline and towards the midline. Some of the important insights from the baseline and exploratory visits that guided ZLPP are:

- **Difference of eight years between age of first sexual initiation (17 years) and first reported use of contraception (25 years).** To bridge this gap, age of women was taken between 15-24 years.
- **Awareness of family planning methods increased with age.** Young women remained high-risk category when it came to unwanted pregnancies within the perils of early conception.
- **For the 20-24 age group, many respondents were married before 20 years, resulting in early childbearing.** However, for the 15-19 age group, few were likely to be married before 15 years. Hence, median childbearing age of 17 years fell in the middle of 15-19 years.
- **Same trend was observed for all family planning methods (traditional and modern).** Extremely low use of modern contraception was found among newlywed and low parity couples.
- **Only a quarter of surveyed women reported interaction with ASHAs and only 4% talked of family planning.**
- **Since the desired number of couples were not showing up at VHSNDs, making home visits was a necessary intervention.**
- **Husbands of ZLP women were primary decision makers and not mothers-in-law as assumed earlier.** The HGM thus came about to increase communication between the couple.

**Step 4: Initial decisions that shaped the contours and nuances of the pilot**

After a two-month quantitative survey, a line list was prepared to create a list of beneficiaries which included couples with two children, only to realise that the programme’s focus should be ZLP women instead. The provider and beneficiaries were decided and adolescent health experts within CARE consulted before outlining the project. The same was implemented with few changes post midline, based on how the pilot evolved in the first few months. After recruitment of facilitators, Block Managers and District Supervisors, the team started line listing and creating list of beneficiaries and ZLP facilitators (male and female) before making combined home visits to talk to families about HTSP and family planning.

Post a series of meetings with the CARE team, it was decided that the pilot would focus on mobilising ASHAs to seed change. They would approach ZLP couples and counsel them on family planning practices while addressing key attitudes towards gender and sexuality. Local health units such as primary health centres (PHC) were identified as

**How the decision to focus on the “couple” came about**

While conducting exploratory studies, the team found that during VHSND even after training ASHAs to conduct meetings for ZLP women, they were unable to reach a sizeable number of newlyweds. The new brides were not allowed to step out of the household alone and were accompanied by mothers-in-law and/or husbands, making combined home visits a crucial intervention. Eventually the assumption that mothers-in-law were key influencers changed and husbands were acknowledged as key decisions makers. Therefore, couple counselling emerged as a priority intervention.

Komal Kumari,  
Pilot Coordinator, Patna
venues for interactions and a robust feedback loop was built to ensure maximum accountability. When it was found that only 3 of 5 blocks had a BCM in charge, CARE staff resolved the issue by coordinating with ASHAs and PHCs at the system level. The pilot was initially planned for nine months and later extended to another nine months. Expected outcomes from the pilot were to:

- Improve quality of interaction between ASHAs and couples
- Increase couple communication on sexual reproductive health & family planning
- Enhance negotiation and communication skills of beneficiaries

Step 5: Basing the pilot design on key assumptions

- ASHAs to attend HSC meetings and complete home visits with ZLP women
- Nulliparous (NLP) women to attend VHSNDs
- Husbands and mothers-in-law available for few home visits
- Reliable and regular availability of family planning methods
- Young husbands ready to attend small group sessions

Step 6: Finalising the approach

Adopting the following routes to implement the pilot:

- Training ASHA workers using the SAA model
- Involving men/spouses through exclusive HGM
- Strengthening couple-communication
- Generating demand by approaching the couple/family with information on HTSP and FP
- Training project staff to deliver content modules to ASHA workers in monthly HSC meetings
- Providing MoIC, Block Community Mobiliser (BCM), Block Health Manager (BHM) regular feedback from the field
- Strengthening supply-chain and Logistics Management Information System for FP commodities for FP cell at the State Health Society, GoB

Step 7: Identifying avenues and platforms to reach target groups

The ZLP couples were reached through home-visits, VHSND, monthly HSC and HGM meetings. The SAA trainings prepared ASHAs to conduct HSC meetings while HGMs reached ZLP men in monthly meetings (later became quarterly). They participated in discussions on reproductive health, HTSP and family planning.

Step 8: Mapping roles and responsibilities of stakeholders

To ensure sustainability, all levels of the system were involved in the programme. The MoIC, BCM and BHM were involved closely in the planning and implementation process.

Staffing for the pilot

1 pilot coordinator; 2 district supervisors for each district; 15 female facilitators 3 per block and 6 male facilitator 3 per block/2 blocks.

Why ASHAs were the soul of the programme

The incremental learning which the ASHAs received contributed immensely to achieving desired objectives. CARE followed the Incremental Learning Approach (ILA) to build the capacities of staff in Integrated Child Development Services (ICDS). It ensured sustainable change implying steady learning-action-review where ASHAs through HSC meetings were given information based on models using action points to work on the following month after reviewing work of the previous month. Constant monitoring, mentoring and reviewing led to incremental learning where ZLP facilitators built on existing knowledge of ASHAs to increase absorption, retention and dissemination of information.
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

- Encouraged spousal communication on family size and FP
- Activated FLWs to reach newly-wed and 1 parity couples with FP information/services
- Promoted/distributed FP methods
- Met during VHSND and home visits and reached newly weds and low parity women
- Provided FP counseling and link to FP services as per choice
- Helped facilitate husband group meetings
- Conducted home visits where there were 0-1 parity husbands
- Found ways to engage with newly married men on FP
- Guided men on FP methods
- Mobilised target groups at identified/finalised venues and platforms
- Supported ASHAs by encouraging them and monitoring their work
- Made combined home visits
- Checked in with ASHAs and reviewed their work
- Designed and implemented ZLPP
- Strengthened ASHAs & expanded their knowledge on FP
- Provided ASHA facilitators to streamline processes for better delivery of FP services
- Equipped 0-1 parity couples with information on FP to make informed choices on 1st child and spacing

Smooth implementation of ZLPP with well defined roles and responsibilities

- Made combined home visits with ASHAs and attended VHSNDs
- Checked with ASHAs and reviewed work done by them
- Facilitated discussion between ASHA and beneficiary without completely taking over and played a supportive role while she conducted her session independently
- Ensured overall supervision
- Was part of reviews and feedback processes
- Stepped in to find resolution to on-ground issues
- Provided guidance on linkages for specific health issues
- Kept the team informed on latest health schemes and programmes

Activating older, existing platforms to maximise reach

Using HSC meetings to build capacities of ASHAs
Monthly HSC meetings were a well-designed platform to activate AHSAs to leverage TSU model to reach ZLP couples. Using analysis-reflection-action cycle of the SAA, the BCM inspired ASHAs, monitored their work and provided feedback to district officials. Incremental learning was applied to systems and to strengthen these, each batch of ASHAs was provided SAA training averaging nine sessions. Training modules had information on HTSP and family planning, communication skills and relationship building, using exercises like role-play, and reflection. Typically, in an HSC meeting, content of the last meeting was reviewed. Female facilitators, also called ZLP facilitators, delivered the content. Based on the line list, ASHAs informed them the number of ZLP women visited. Follow-up information helped collate demand generated, methods adopted and unmet needs. It considered challenges reported by ASHAs based on which action points were drawn up.

Making the most of VHSND platforms
VHSNDs saw good turnout of women who came to get their children immunized and seek pre and post-natal advice, if pregnant. They received inputs on sanitation, hygiene, general illness, nutrition and reproductive health. ASHAs were specially primed to look out for ZLP women and reach them with information. They were also invited to attend HTSP sessions.
ASHAs conducting combined home visits to counsel women in catchment areas to reach couples directly

Even after training ASHAs to conduct meetings for ZLP women, when they could not make headway (families not allowing ZLP women to attend meetings or having ASHAs meet newlyweds alone) the project team undertook home visits. In many places ZLP women were accompanied by mothers-in-law and husbands, making it difficult to engage with them on a private matter like family planning. Combined home visits therefore became crucial and the assumption that mothers-in-law were key influencers, changed and husbands got acknowledged as main decisions makers.

Identifying new platforms to reach the last mile

It was decided that SAA training would be given to everyone involved in the project at all levels since it ensured basic tenets of the training percolating at every level. CARE staff in Patna, BMs, District Technical Officers – Outreach & Nutrition (DTO - ON) and facilitators were invited to the SAA training in Patna a day after they were brought on board. In February 2018, facilitators were called to Patna again to understand on delivering SAA training content to ASHAs.

A typical SAA training involved comprehensive exercises for participants to engage with and understand their mindsets and beliefs. Facilitators asked participants to solve problems and discuss their feelings with respect to roles played by men and women within the household and community. CARE along with experts developed a manual for facilitators/practitioners to conduct SAA and HSC meetings and trainings with FLWs, project staff and stakeholders. Training content was refined with inputs from in-house literature developed for other projects on sexual and maternal health. Training modules for HSC and HGM meetings covered benefits of HTSP, male and female reproductive system, menstrual cycle, conception, physical and psychological changes experienced by adolescents, male and female gender roles; gender and migration, safe sex and STIs, modern spacing and contraceptive methods.

Reaching men through HGMs

These meetings brought together male beneficiaries, especially ZLP men in the 15-24 age group. It included migrants and those reluctant to discuss what they perceived as female issues. Most men felt family planning was too private a subject to be taken up in a public forum and that no one had the right to ask probing questions about what transpired in a couple’s
bedroom. Here was a forum where discussions could be held on HTSP, family planning and reproductive health and human rights related topics.

A typical meeting constituted a male ZLP facilitator discussing the content module for the month. Special handouts were designed outlining the role of the facilitator and how the session needs to be conducted. If the male audience was not so forthcoming about participating in exercises and role plays, the facilitator engaged them through story telling or analysis of case stories and any other method that could catch their attention. The focus of the male ZLP facilitator was on earning the confidence of the young men/husbands. Many men wanted clarity and more information on family planning but were hesitant to make the first move. Like in the case of 20-year-old Deepak Kumar from Gaya who was a music disc jockey (DJ) by profession. He started attending HGMs before his wedding since he and his wife were both below the age of 20 and did not want to have a child immediately. When he shared this with the facilitator, it was easier to guide him on family planning methods that he and his wife could adopt to first delay and later space their children. Deepak even organised a meeting with his wife so that all three could discuss and take an informed view before his wife could approach the ASHA with clarity in her mind.

The training imparted to the male ZLP facilitators was instrumental in orienting them to the needs of young couples. Speaking in their language, understanding their concerns, allowing them to take decisions and not pushing them in any way, were taken up during mock sessions. This approach proved productive since the husbands would seek the facilitators out and ask them several questions, some related to family planning and others to general health, nutrition and social issues.

**Couple counselling, a powerful tool aimed to produce lasting results**

The very premise of holding couple counselling sessions was a breakaway from earlier information, education and communication (IEC) and behaviour change communication (BCC0 efforts. With most village meetings and interactions limited to “men only” and “women only” initiatives, the impact of couple counselling was immense. Apart from the novelty factor and high level of healthy curiosity that it created in local communities; it went down extremely well with couples. Nearly all went on record to say it was a wonderful exercise, never attempted before and guaranteed to produce desired results. With well-trained ASHAs, it was possible to steer and navigate these joint conversations in ways that were meaningful. From allaying fears to talking about some of their secrets like earlier miscarriages, difficulties in conception, unreasonable pressure and expectation from family elders to specific medical conditions, there was a great deal of openness and honesty in the sessions. Most importantly, the ASHAs could see that the relationship between the couples was improving. They were a lot more amenable to talking about family planning and to seeking her guidance on what they must do.
Implementing the Pilot

The ZLP pilot is particularly relevant for Bihar since the state has large media dark areas, illiteracy and deep-rooted patriarchal norms. The intervention model for the pilot was based on three main pillars that were critical to achieving family planning goals. By empowering women with information and tools and creating an enabling environment, it brought on board their husbands, mothers-in-laws and influencers. This approach helped ZLPP to make a natural progression to being 100% sustainable.

CARE’s approach differs from other family planning programmes. Using a rights-based approach, it promotes dignity, social justice and equality. Instead of pushing a particular family planning product, it places the decision in the hands of the couple and provides them knowledge and tools appropriate to their age and social context.

Objectives of the ZLP project

Improve quality of interaction between ASHA workers and zero and low parity couples
- Increase couple communication around sexual reproductive health & family planning
- Enhance negotiation and communication skills of young couples

The 3 pillars of the ZLPP Pilot Intervention

1. Activity 1: Monthly Health Sub-Centre (HSC) meetings
   How: Family planning and counselling services
2. Activity 2: Social Analysis and Action (SAA) meetings
   How: Critical reflections on gender attitudes
3. Activity 3: Village Health, Sanitation and Nutrition Days
   How: Weaving in FP messages at monthly platform for immunization and SRH

Figure 3: The 3 pillars of ZLPP
Getting teams in place and preparing for trainings
A total of 21 male and female ZLP facilitators were hired. This included six male (2 HGM blocks) and 15 females (3 per block); 2 District Supervisors (1 in each district) and 1 Pilot Coordinator for coordinating all activities. After the facilitators were hired, they were trained intensely on the form and content of the modules, including SAA and HSC trainings. The HGM formats were shared and to begin with, content for three months was finalised, including topics of HTSP and reproductive health. It was decided to change this content every three months before rolling out with the facilitators.

Well planned training material: Hand-outs, action points and related material were circulated with the field team who was guided on administering/sharing with ASHAs to improve quality of their interactions.

Translating training content in Hindi: The translations in Hindi helped ensure that the essence of messaging was not lost, and everyone could understand and internalise the finer points.

Simple and easy to understand content: Text was kept simple and non-technical, so ASHAs could relate to it and repackage it for dissemination, depending on who they were interacting with and where.

Strong interactive features: Training content had a combination of theoretical and practical inputs. From PPTs to printed material, participants were engaged in exercises, role plays, discussions and group work with standard and vetted exercises that were used for SAA and/HSC meetings. The SAA trainings used exercises like “Body-Mapping”, “Agree or Disagree” (Vote with your feet), “Pile-Sorting” and “Problem Tree Analysis” enhancing experience sharing and bonding amongst participants. They challenged social conditioning with respect to gender biases and preconceived notions.

Vignettes from a typical SAA training in Pakridayal, PHC/East Champaran
The SAA training started by the moderator handing ASHAs pieces of paper with a drawing, pairing them in groups of two, facing each other. They discussed their favourite actor, what they liked about their job most and what was their preferred food. They were encouraged to look each other in the eye and share details adopting a confident line of questioning.

In the second exercise, they were asked to don traditional roles of man and woman. Each partner based on the adopted gender reported what they found difficult or easy being a man/woman. “Men” reported liking playing, studying and reading and disliked not having enough disposable income. “Women” reported liking housework but resented not having a say in what they wanted to watch on television or adopting their choice of leisure activities since they were expected to toe the line of what men folk decided. When gender roles were taken up through role plays, participants were more forthcoming on what they felt regarding traditional roles being played out. Here men were expected to step out to work and women had to take care of the home and hearth. The facilitator asked them what they understood of ZLPP and if it had made them more empathetic and intuitive to the needs of their partners. Could they now have conversations around family planning and discuss what method to adopt and be aware of its pros and cons? Did they realise how important it was to willingly and without pressure follow what was right for them and their bodies? They were shown an image of a “circle of early marriage” which could be broken by adopting safe sexual practices. This meant they need not have their first child before the age of 20 and wait for three years for their second child, placing them in a more favorable financial situation. With the time and money saved, they could pursue education/other goals to improve their life condition.
Exercise: In an interactive exercise, participants were given a piece of paper with a personality attribute written on it which they were supposed to slot in either of 3 columns:

<table>
<thead>
<tr>
<th>Traits of an ideal woman/wife</th>
<th>Both</th>
<th>Traits of an ideal man/husband</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Qualities included being soft-spoken, obedient, strong and willing to experiment. After a productive round of discussion, they were asked to look for overlaps. ASHAs were shown how to speak to male beneficiaries and get their message across. At the end of the exercise, they learnt how to engage differently with men and women and return the following day with ideas on how to change their domestic and work situations.

Exercise: Participants were handed chart papers with a tree made on it and a prompt in the middle that changed from “early marriage,” “FP = sterilisation” to “early conception” and “son preference.” They were asked to write the causes (roots) and results (leaves) and take this up for discussion.

Role play and dramatic enactments
Situation 1: Mala, a newlywed lives with her in-laws and her husband is a migrant worker in Delhi. She must be persuaded to wait till she is 20 to have a child.

Situation 2: Seema, a newlywed lives with her in-laws and 8-month old daughter. She has adjusted to her husband’s infrequent visits since he is a migrant in Kerala. Now he is coming home, and she has to equip herself with knowledge/tools on family planning so she does not get pregnant or saddled with STIs.
Multiple tools and techniques to make ASHA’s presence impactful

Building capacities of ASHAs has been the crux of the programme. Initially, they were hesitant of going into the field and talking to zero parity women about family planning. In November 2018, the SAA training for ASHAs was rolled out, initially as nine planned sessions. The scope of the training was later expanded, and sessions added to cover additional topics on health and family planning through the lens of health. Following the 16-step WHO guidelines on healthy living, male and female facilitators were trained to deliver this content. A special trainer was invited to train facilitators on delivering the modules which were later fine-tuned. Each session began and concluded with a message accompanied with relevant reference material. The CARE team redesigned and simplified it so that ASHAs could absorb all the information and work on the action points. The District Resource Unit (DRU) was involved at the district level to assist facilitators in delivering content modules successfully to ASHAs and receiving the feedback which was handed over to the BCM for further modification/iteration.

Through the SAA training, ASHAs’ attitudes towards gender were addressed and they were guided on striking a rapport with young couples and on how to involve husbands and mothers-in-law in conversations about family planning. Improved performance of ASHAs led to couples being better informed to adopt the most appropriate family planning product/service and ASHAs taking learnings from the meetings to other districts.

**Grasping the essence of the trainings:** The focus was on listening and establishing deeper understanding of issues that ZLP women and men were experiencing. They were explained that ZLPP was not directly promoting any family planning method. Rather, it was approaching it in a more empowering way by allowing young couples to review their situation by focusing on benefits of HTSP and family planning. As community members developed rapport with them, ASHAs started feeling more confident about going into the field, having longer conversations with more details to report back on perceptions, attitudes and preferred choice of family planning services. The idea was for them to be welcomed into homes of newlyweds and young couples and find answers to fundamental questions related to family health.

**Important role of CARE and ZLP male & female facilitators:** They made combined home visits, checked with ASHAs and reviewed work done by them. In a HSC meeting, the facilitator took stock of the work done by ASHAs in the previous month with updates on number of zero and one parity beneficiaries they met, willing beneficiaries and migrant husbands who attended and how many times the men came home in a year etc. Gradually, the facilitators began to play a supportive role while ASHAs independently conducted discussions, meeting newlywed women and talking to them about family planning. This was a breakthrough because although

> “Many of the facilitators were working for the first time. Most were passionate and vocal about what they learnt and how they wanted to use it in the field. They acquired specific skills to engage with the community. Their oration and public speaking improved and so did their ability to negotiate with ASHAs. It was heartening to see them confidently conduct meetings on their own, talking about any given topic. Some of the ASHAs who were not well educated got inspired to enroll in evening classes so that they could complete their education. Multimedia content like videos for Chaya and Antara\(^1\) contraceptive pills were well received. These were sent to ASHAs and ANMs who showed it to beneficiaries so they could make informed choices.”

---

\(^1\)The MoHFW launched two new contraceptives, an injectable contraceptive MPA (Medroxyprogesterone acetate) under ‘Antara’ programme and contraceptive pill, ‘Chhaya’, in the public health system in 2017 to expand the basket of contraceptive choices to meet emerging needs of couples.
newly married women were more in need of family planning guidance, they were not easily approachable since their family members did not always allow them to speak to strangers.

**Increasing number of days from 1 to 3 to emphasise and reiterate facilitation techniques**

The ZLP facilitators understood that their role was to facilitate discussion between the ASHA and young couples and that they must avoid monopolising the conversation. Initially, the counselling sessions were planned as one session but seeing the response, this was extended to three sessions. Extending it allowed the ASHAs to internalise the essence of the training and implement it in their own way. Storytelling and role play were tools they adapted and used in their interactions during home visits and VHSND meetings, under the observation of the facilitators with favourable impact.

**Refining content for the HSC meeting:** Initially, content of HSC meetings did not include the subject of STIs. These were later incorporated as it became clear that certain myths about sexual and reproductive health had to be debunked. The ASHAs during home visits were encouraged to talk to men and not just to the ZLP women. They reflected on their field challenges while checking personal biases regularly.

**Changes made in SAA training:** Changes were made during implementation so that the sessions could be more interactive for ASHAs, a move away from exercises that were too reading and writing heavy. This helped in better understanding and incremental retention. Critical attitudes towards gender, sexuality and power in interpersonal relationships in conjunction with social ramifications were also looked into.

The reviews took up specific instances that threw light on field behaviours and situations to see how ASHAs responded. Did their personal biases creep into their interactions? How were they helping the couple to open and talk about family planning and share their reservations and experiences? Were they encouraging them to talk about family planning products they were familiar with and which they were using/used? Were they doing “hard selling” or navigating conversations helping couples share their deepest thoughts, clarifying doubts and helping them make up their mind without pressure? During HSC meetings, ASHAs were told about the calendar rhythm method and given action points for review in the second meeting when they went in the field and calculated ‘safe and unsafe period’ for five couples/newlyweds. Next month they were told to relay their experience and clarify doubts. In action, this was done to build capacity of ASHAs to

**Self-evaluations and quarterly reviews through an instruction, action and review process:** Self-evaluation mechanisms provided ASHAs with the opportunity to pause, recapitulate, review and rank themselves on tasks they ‘seldom did, never did or always did.’ Action points were drawn and shared with BCMs at the monthly HSC meetings and quarterly reviews. Progress was reviewed on a monthly basis and structured feedback was given through the district supervisor. Team monitoring and building was undertaken by the Pilot Coordinator who gave system-level feedback involving the District Team Lead. Monthly meetings commenced from May 2019 in Gaya and East Champaran to review work done by the ASHAs helping in the decentralisation process while ensuring greater accountability.

“Our focus was not so much on instructional do’s and don’ts for ASHAs to follow in a regimented fashion. Instead, it was to get them to review their facilitation style and reorient them based on inputs received in trainings and one-on-one interactions. These were then adopted in a more permanent and sustainable way”.

Komal Kumari
Pilot Coordinator, CARE
ensure that change percolated to other aspects of their work.

“Once we got feedback from ZLP facilitators, we coordinated with BCMs to see how meetings were held. Attendance of ASHAs was recorded and information shared with the BCM on the number of people who attended the meeting; used contraceptive methods; and willingly used family planning to space children. At the monthly review meeting where MoIC, FPC, BCM and BHM were present, updated line lists got reviewed and next lot of family planning commodities were handed over. As a BM, I am a link between the field and PHC and do my best to ensure there is no break in the process.”

Vikrant Kumar, BM, Pakridayal, Champaran

Breaking the shackles of gender stereotyping with vibrant Husband Group Meetings
The HGMs and couple communication was taken up as strategic interventions to create better understanding and to bring about desired behaviour change with respect to family planning. It also gave women an equal say in decision making. Including husbands of newlyweds and low parity women helped in improving attendance of newly married women who accompanied their spouses to the meetings. Given that the initial 12 months were critical in reaching family planning information to girls of 15-16 years (despite legal age of marriage being 18) it was only prudent to reach them, even if through the husbands.

“A few months into the programme a perceptible shift was seen. Young men were openly talking about how they may want a male child but not at the cost of their wives’ health and how if there was a 2nd female child, they would not hanker after a 3rd or 4th child but instead focus their energies on being good fathers. Discussion around certain cases was particularly profound. Like when it was shared that a young couple lost their 3rd child since they didn’t practice HTSP between the 3 births and previous 2 were born prematurely and remained weak for most of their early childhood, this served as a wake-up call. Clearly, no one wanted their wives and children to be unhealthy or at risk of serious medical issues.”

Taran Kumar, Male ZLP facilitator, Gaya

Developing IEC materials to support trainings and interactions: Pamphlets and flyers with clear messaging for different target groups were developed. These were based on findings from baseline, addressing mental blocks in perceptions which communities had towards FP. Short videos were shared with ASHAs and ANMs who used and reported their usefulness. Apart from general information on gender discrimination, girl child education and health, videos on Chaya and Antara evoked interest.
How Saurabh shed preconceived notions and adopted a gender friendly view towards FP

The HGM would start with the facilitator asking them to recall what they learned in the last session. Saurabh, father of a 3-year old son had been coming to the meetings and learning from the facilitator about spacing and other modern methods of contraception. He spoke to his wife about options best suited to their needs and zeroed in on Antara. He shared his and his wife’s experience of ZLPP and how they could plan their family and space their two children. He also apprised the team that with the right kind of couple counselling they were now ensuring not to have a third pregnancy and had therefore opted for IUCD for some time. Saurabh admitted that peer pressure was a big reason why men find it hard to talk about family planning since others mock the married man for waiting long to prove his manhood. He admitted that he shed many of his own biases about masculinity and learnt about HTSP, reproductive rights and the need to respectfully engage and involve the partner in decisions related to family planning.

Baseline revealed that women usually reached out actively to seek family planning advice through ASHAs or ANMs after 3-4 years of marriage and after 1-2 deliveries. Involving men and husbands was an excellent way to give the issue due importance, reinforcing the need for the couple to take family planning decisions together.

The ASHAs faced resistance from the men because these were taboo subjects not openly discussed and certainly not by a woman (ASHA). The men either mocked ASHAs or responded cheekily, causing embarrassment to them. Few refused to get into any discussion on the subject. These issues were taken up in detail in review meetings. Through role play and dialoguing, ASHAs were shown how to navigate complex situations and emerge victorious. Things began to change, and men became more receptive, to the extent they asked the ASHAs to carry condoms for them.

Conducting exercises like ‘Rudiwadi soch’ in HSC meetings to probe and question traditional mindsets

The objective of the exercise was to point out how personal biases affect employees’ professional conduct and taking up taboo subjects for discussion can break the shackles of social conditioning. Common scenarios taken up for discussion included, not speaking to men before the training; not seeing the point in meeting a
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

Reaching migrant husbands and their spouses with direct and indirect messaging

During exploratory visits, the team found most migrant workers coming home for major festivals like Chhath Puja and Diwali. These provided an opportunity to counsel migrant men and their wives. A practical issue was that given the festive spirit and the entire family being busy, it was not easy to talk freely to the couple during the home visit.

The Bihar-wide campaign was planned to address this need. The DRU team briefed the ASHA workers during Chhath. A separate line list was prepared from the main list of beneficiaries whose husbands were away on work and now returning. ASHAs were told to visit homes of young couples where the husbands were working as migrants in another city/state. Through informal discussions they were asked to enquire when the husbands were returning and how they were going to broach the subject of HTSP and family planning with them.

Combined home visits were made to these households. This was taken up as a line item for discussion in HSC meetings a month before and ASHAs were oriented to have these conversations. Specific activities were planned to coincide with migrants’ return in different blocks and narratives planned for HGMs. The focus of the effort was to engage with these men and figure one of three things, namely whether they want a child, don’t want a child, or haven’t yet decided to have a child and start a family. Based on their response, they were explained what HTSP was and how they could avoid/plan/time the pregnancy and safeguard themselves the risk of ill timing and frequent/unwanted pregnancies.

ASHAs were given an Interpersonal Communication (IPC) card that contained talking points and virtues of HTSP. The public service announcement (PSA) messages were broadcast along with miking. Also, a toll-free number was circulated handing out a calling card asking people to speak to ASHA workers about HTSP, healthy living and family planning.

Reinforcing messages and creating better lines of communication with couple counselling

The baseline and exploratory studies had clearly brought out the nature of family planning conversations and decisions taken within the household. While the project team was more inclined towards believing that it was mothers-in-law who dominated this narrative as was seen in several other Maternal and Child Health (MCH) programmes, what emerged was that it was husbands who were the main drivers of how and what family planning decisions must be taken up between the couple. From this reality emerged the need to focus on them through both husband group meetings and couple counselling sessions.

“Within the first month of announcing a helpline number more than 300 calls were received besides seeing an increase in the turnout of ZLP couples in different meeting groups. This made it clear to ASHAs that migrants were not a group to be neglected. Excluding them from the pilot would be a major miss. Being in touch with wives of migrants not just during/immediately before/after festivals but throughout the year was important so a deeper understanding of issues could be established, and they could be guided with more information. These insights translated into themes for couple counselling. Few months into the programme, migrant couples confirmed they had been able to protect themselves from unwanted pregnancies and STIs.”

Abhinandan Anand
DTO - ON, East Champaran
“Earlier, ASHAs did not tread the sensitive ground of sex and family planning. At best they mentioned NSV or IUCD when the woman was pregnant but beyond that neither were they fully aware of the basket of choices available nor felt it was important enough to discuss. This changed after ASHAs attended SSA meetings. Most of them had so far been advising permanent methods but after ZLPP, modern temporary methods started getting adopted because ASHAs had better understanding of how to talk to young couples and what details of the product to highlight. This encouraged healthy sharing amongst husbands and wives.

Like when a 25-year old woman shared that her husband had failed to notice her failing health due to repeated miscarriages or another 28-year old woman talked of how hurt and angry she was at being blamed for not conceiving and was thereafter made to undertake endless tests, while her husband refused to see a specialist. Talking about these pent-up feelings was a positive trend. ASHAs were equipped to handle these situations maturely. ASHAs became trusted confidantes of men and women with many looking forward to their next interaction with her. Couple relationships improved and there was more happiness all around.”

Bipin Bihari
Block Manager, Dobhi PHC, Gaya

“Earlier, I did not consider talking to newlyweds important, but through the course of my engagement with ZLPP, I got convinced this was exactly the demographic we should be reaching since newlywed women and their husbands must know what options they have in terms of family planning products and which one will be most suitable for them, their lives, bodies, future and finances.”

Ranju Kumari
ASHA, Tarwan, Gaya
The response of all stakeholders clearly pointed towards the timeliness and relevance of the ZLPP with broad consensus on the need to continue with the efforts. While impact of the pilot will take time in becoming evident, many achievements were there for all to see.

**Policy level**

*Sustainability, a prime focus of the project’s collaboration with the government:* The focus was on sustainability and effective government adoption. Involvement of local PHCs and government officials and making them responsible was a major achievement. There is a clear change in government attitudes with Bihar government taking the lead in prioritising and pushing several family planning initiatives including printing of IEC material and planning of district specific campaigns. There is commitment and consensus across departments to spearhead a movement to space children and empower people especially young couples with information, tools and services.

**Strengthening government health facilities:**
Since CARE serves as a TSU, it manages to reach interiors of the state with the goal of strengthening government healthcare facilities. With increase in demand for family planning services through ASHAs and ANMs, the public health system has become more responsive to needs of ZLP women and their husbands. The HSC and SAA trainings benefited cadres of the district and block administrations which are now activated to serve goals of the pilot, especially with respect to family planning counselling and ensuring smoother, more efficient supply chain management.

“ZLP couples are looking anew at family planning and related health issues. Couples are talking more freely to ASHAs. A more collaborative approach is seen with joint decisions being taken on what family planning method to adopt with the woman’s voice and concerns duly factored in.”

Dr. Bina Das
MoIC, Pakridayal PHC, East Champaran

The pilot recorded many successes and achievements. Not all achievements are measurable since the change is more in terms of behaviours and attitudes of frontline health workers, government service delivery and the couple in question – how they approach family planning, what product they adopt, how they jointly take and own that decision and ways in which the health system responds.
**Change in attitude of health workers and government functionaries:** The trainings oriented government health functionaries on family planning on the four pillars of the pilot. Engaging with them at the state, district and block levels and encouraging them to participate was a breakthrough. While East Champaran faced more challenges, change in attitude was observed in how ASHAs operated before and after receiving SAA training. Similarly, MoICs, BCMs and BHMs in PHCs showed interest and positive engagement translating in over 80% attendance of ASHAs and BCMs post trainings.

"I did not speak to men before but after being part of the ZLPP, I feel at ease and talk to them in a way they listen. This is a new phenomenon in our village where most women, including me, did not talk directly to men. Ours was a passive role but now we actively talk of family planning engaging with men, their wives and family elders on sexual and reproductive health and using these as entry points to more focused discussions on family planning."

**Sanju Kumari,**
ASHA Facilitator, East Champaran

"We are seeing change across levels. There is consensus on having an ongoing family planning discourse and keeping the subject in the forefront of health and community welfare interventions. At HSC level, ASHAs are putting their training to good use by challenging traditional mindsets and bringing couples on a common platform. Shift in attitudes of ASHAs is palpable and their energy infectious. Young people are stepping forward to ask questions and ASHAs are taking their role as change marker/influencer seriously."

**Dr. S. K. Prasad,**
MoIC, Dobhi, Gaya

**Difference in how ASHAs are perceived:** No longer are ASHAs seen as just health workers. People had earlier stopped establishing relationship with them and even mocked them for talking about sexual health. But now they command respect for their knowledge of family planning and dedication to improving lives of couples and families. With greater trust in their abilities, they were sought out for information on other issues as well, like HIV testing and seeking protection from frequent urinary tract infections (ASHAs heard these cases and made referrals, often following up to ensure recovery).

**Receiving steady and comprehensive feedback and crucial data:** The data that emerged from reviews and feedback from the project staff helped validate the need to take ZLP to the next level. ASHAs were so motivated that in many places they were competing to bring in beneficiaries. There were cases where zero parity women insisted on taking Antara that was pitched only to one parity women. Couples with no children stepped forward and requested ASHA for family planning advice since they wanted to wait for few years before having a child. The ASHAs were able to carry out conversations on emergency contraception, delay and spacing of pregnancy and in many cases take forward conversations initiated by couples. A district-wide trend of proactivity and accountability is growing and creating a ripple effect.

**Programme level**

**Enhancing capacities of ASHA workers:** Excellent training platforms were created to motivate ASHAs and resolve field challenges. The SAA trainings were well received and the rigorous conversations that ensued around gender translated into checks and
balances and mini interventions. Not only did their knowledge of good sexual and reproductive health practices improved through SAA training and regular HSC meetings, but they also got to play a role in creating a more equitable social order.

“Unmet need in family planning was not being fulfilled due to gaps in supply chain. We could never mention words like condom and IUCD. With elders living in the same household these were taboo subjects. Once the programme got underway and women were counselled by ASHAs and men at HGMs, we could have these uncomfortable conversations. Young women themselves initiate dialogue on family planning because they want to receive correct information and adopt family planning methods most suitable to their needs.”

Abhay Kumar, DRU Team lead, Champaran

“Training and mentoring received from our ZLP facilitator encouraged us to take up education. Had it not been for her, we would not have understood the importance of the written word. We want to learn more and are determined to take up education. Nothing feels better than being able to write your own name and be literate.”

Urparmila Devi
Dhanmati Devi and Sreekanti Devi, ASHAs from Piprakothi, East Champaran

Demand generated for family planning methods: In ZLPP blocks, number of male NSVs improved and demand was generated for family planning methods by ASHAs who used SAA training and HSC meetings to advantage. Myths and misconceptions around usage were dispelled and visibility to an entire range of family planning products created. They were no longer seen as ‘woman only’ or ‘male only’ devices but as responsible actions taken by couples to further their life goals in respectful, dignified and gender friendly ways.

Block-level reviews of ASHAs, a good thing: Block-level reviews helped in improving the quality of monitoring and gave the MoIC a chance to assess how ASHAs were performing in the field. Those who had been active and had recorded success were encouraged and appreciated and their incentives were released on time. Based on data collected from the field, HSC meetings, information was shared with the BCM and progress in the field assessed. This helped to see where issues persisted and what further interventions were needed.

Complementary approaches of ILA and SAA having positive impact: Impact of the combined approach is ensuring change percolates every level of the system. The SAA training combined with monthly HSC meeting is creating a generation of ASHAs who are taking on leadership roles in the local community, informing them of good health practices, linking them to services, allaying their fears and doubts and connecting them to other beneficiaries so they can exchange notes and interact on the issue. Many ASHAs are turning into social activists and even enrolling in higher studies.
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

**Using existing platforms to promote family planning:**
On VHSND, the ASHAs did not just meet the mothers-in-law, but also met the ZLP women. Information on family planning was shared with them so they could avail services and return for repeat doses, counselling, reporting back side effects and clarifying doubts. Earlier, ASHAs were not making conscious efforts in this direction but attended only to queries. Now they spoke up on the subject, sought inputs from ZLP couples and personalised their interactions.

**Migrant campaigns reached most vulnerable communities with much-needed family planning services:** By having a dedicated campaign around the time of the Chhath festival, households with migrants were reached. Special posters, banners, hoardings and IEC materials were printed and displayed at public places, PHCs and CHCs. Miking activity was undertaken. Stalls were put up and volunteers deputed at local festivals, fairs and exhibitions. Every effort was made to emphasise the merit of talking about family planning and making informed choices to ensure a better future for the couple and the family.

**Positive role of facilitators in training ASHAs:** A major success of the pilot has been the role played by ZLP facilitators in training ASHAs.

Many newlyweds admitted if they had right information soon after marriage, they would have delayed their first child and spaced their first two children.

“This was trained on family planning, menstruation, female reproductive system and natal health. During SAA training, I was provided correct training making it easier to build a relationship with the beneficiary and family. If someone gets married before 18, I talk to them about family planning, STIs and delay and spacing in pregnancy. I encourage women with two children to opt for permanent methods. I don’t suggest every method to everyone. I assess the situation and suggest methods on a case-to-case basis.”

**Kumkum Sinha,**
ASHA, Pusa, PHC Dobhi, Gaya

“I emerged from my shell and learnt on the job. Speaking to ASHAs was a challenge since we needed to understand their interest and level of comprehension before broaching sensitive topics. I was oriented on new ways of engaging informally with them and gauging their thoughts before framing my dialogue. Mutual respect was the cornerstone for facilitation and I am glad we could make breakthroughs which translated into ASHAs working far more effectively. As a single mother, this journey has been nothing but empowering, I now have a different vision for my future. Going forward my daughter and I will not settle for anything less than a world where women have a voice and the freedom to pursue their goals.”

**Rani Kumari,**
ZLP Facilitator, Piprakothi, East Champaran
facilitators in bridging the gap between ASHAs and target groups. They were instrumental in getting key messages across, orienting the ASHA cadre, monitoring them and reporting back to the project team. Together they had a marked impact on the lives of young couples and uptake of family planning services.

Successes manifold on account of couple counselling and HGMs: Apart from bringing respect, dignity and equity into the relationship between the husband and wife, the couple counselling sessions were seen as a major vehicle through which a collaborative and consensual approach could be adopted with respect to family planning choices that the couple was likely to make. The HGMs filled a major gap in health communication especially that is related to reproductive and sexual health and family planning. Drawing in young married men into conversations on these issues was a first-time effort that was refined with each sessions/meeting and the results were extremely positive and impactful with high potential to change mindsets, behaviours and the course of the marital and familial relationships.

Community level

Wide reach with inroads in near forbidden areas: Traditional barriers existed especially in Muslim communities where health workers treaded carefully, not wanting to upset anyone or create any controversy. But the trained ASHAs could get the messages across having learnt how to break the ice and draw the young women into a meaningful discussion. They succeeded in motivating many women in these settings to go for institutional delivery, seek treatment for anemia, malnutrition and STIs besides having far more open discussions on family planning. If they had reservations about NSV, they were pointed towards alternatives and connected to health workers who further engaged with them on the subject.

Engaging with men, a major plus: Advancing goals of the pilot intervention by involving not only young women but also their partners through HGMs and migrants’ sessions was much needed since these were ignored platforms. Response received reinforced the team’s line of approach in checking gaps in knowledge of the local community on family planning.

Giving options to young couples: The entire approach towards family planning counselling has undergone sea change among health workers. They embraced the ZLP approach where respect and choice was at the centre of every couple’s family planning decision. With unbiased information at their disposal they began to view family planning products, not as a physical object but something that had deeper conceptual value with potential to empower and instill in them a sense of responsibility towards each other.

“It was good to see transformative change amongst young fathers and to-be fathers. I could see men taking decisions of delaying fatherhood, giving a gap of 2-3 years between first two kids and saying no to the third child. They understood that by doing so they could have a happy married life with responsibilities that were manageable, and which did not cripple their household economy.”

Tarun Kumar, ZLP Facilitator, Gaya

Improved awareness amongst FLWs and community members: Earlier family planning was a stigmatised topic riddled with preconceived notions not just amongst users but also health workers in general. Almost all ASHAs and ZLP facilitators admitted improving their knowledge on modern, efficacious and flexible family planning products. By learning how to initiate dialogue, share information and encourage young couples to decide for themselves what was best suited for them, helped change ground realities too. The ZLP couples now approach them with questions on new contraceptive choices and even bring other young couples who are considering spacing childbirth and delaying pregnancy.
“Earlier, I did not pay much attention to newlywed couples and even if they asked me, I just casually suggested sterilisation and permanent methods. Now I think of what is healthy and appropriate for them, given their socio-economic-cultural reality. Young brides are shown options and encouraged to exercise them rather than prove to their husbands and in-laws their fertility when they are not ready for it.”

Kumari Suchitra, ASHA, East Champaran

“I got married six months ago at the age of 17. My mother-in-law wanted me to have a baby right away. ASHA didi advised us to wait till I was 21 because according to her I was anemic and ran the risk of a miscarriage. I spoke to my husband and we decided to use condoms and explained to my mother-in-law that we will definitely start a family but when we were ready to shoulder the responsibility.”

Jyoti Kumari, 17-year old, Etwa village, Wazirganz, Gaya

“I was 16 when I was visited by ASHA who enquired if I was planning to have a child. She explained me the possible health issues from an early pregnancy and asked me to wait till I was 21 years old. I explained this to my husband and mother-in-law, but they were insistent that we have a child. I ended up conceiving at 16 but to my good fortune, they agreed to let me go in for a temporary spacing method so that I could delay the second child. I now felt more in control of my body and life.”

Munni Devi, 18-year old, Badka Village, Gaya

16-year old Suman and 15-year old Baiju, residents of Piprakoti in East Champaran were married at the behest of Baiju’s ailing grandmother who was desperate to see them settled before she died. The couple realised they were too young to shoulder the responsibility of marriage and regretted tying the knot so early. It was a relief to find family planning advice at their doorstep because being saddled with a newborn was not a welcome thought at this stage. When they were approached by their ASHA within the first week of marriage with information on family planning choices, they were relieved. Ensuing discussions with the ASHA helped them to take a joint decision. They were not coerced into adopting any specific method but encouraged to make an informed choice that considered Suman’s age, reproductive health, menstrual cycle and the couple’s overall financial situation.
Despite having a national family planning programme for over five decades, family planning is still misunderstood by government officials and service providers. While the focus of the pilot was to delay and space childbirth, government programmes have historically ignored this aspect, since their focus has been to get people to either use permanent/chosen family planning methods. There has been little understanding of why ZLP women must adopt modern temporary family planning methods and not be brought in for sterilisation. This section looks at key challenges encountered at the policy, programme and community level.

Policy level challenges

Supply chain management issues: The family planning supply chain showed different levels of performance. CARE India staff including District Team Leads in East Champaran and Gaya reported supply side issues where it was not always possible to have real-time updates on demand generation and adoption. Chayo tablet, for instance, was in demand among young couples but the supply side did not quite keep pace. While the Family Planning Logistics Management Information System (FP-LMIS) was launched by the government to ensure smooth flow of contraceptive supplies and did not eliminate chances of stock-outs and overstocks, impacting the family planning programme’s effectiveness and contraceptive security. Many places did not have enough stocks to ensure steady flow of family planning commodities, leading to interruption in making modern spacing methods available and increasing risk of unwanted pregnancies.

Drop in attendance of ASHAs: Mid-way into the pilot, it was observed that ASHAs were not coming to the SSA trainings very regularly. The BCMs were asked to take regular attendance and discuss the same in review meetings. In few places, BCMs began grading ASHAs in A, B, and C categories (efficient to not efficient) mirroring an ideal system which the pilot did achieve. The performance of ASHAs was under observation by the BCM.

Delay in remunerating ASHAs: ASHAs were incentivised for getting young couples to select family planning services. While some payments were disbursed immediately others took time. Since ASHAs spent money on commuting, making phone calls and investing time, they resented delay in reimbursement. Payment of incentives is smooth for Tube Ligation whereas for other incentives, ASHAs will have to wait for longer time resulting in their getting resentful. As a result, in many places, they did not make a pitch for it when talking to couples about family planning options.
“There was a time somewhere during the pilot when ASHAs were not coming in good numbers. We had to then tell BCMs about it and were told to start taking regular attendance, followed by a review meeting. We also identified ASHAs who were not going actively into the field or were getting someone else to do their work. The new BCM suggested grading them into three categories of A, B and C. We started monitoring them closely. If in the past three months, an ASHA did not bring in any child for immunization or did not get any pregnant women registered/babies delivered in the PHC or failed to hand over any family planning commodities to young couples and also did not attend any meetings or made home visits, we made note of that. This compiled data was shared with the BCM In-charge who passed it on to the PHC staff. Additionally, all cash claims for reimbursements and incentives were duly verified from the field, HSC meetings and qualitative forms filled by ZLP facilitators and shared with the BCM. This increased accountability and attendance. Now over 80% ASHAs are talking about emergency contraception, delay and spacing and are a lot more regular in their attendance.”

Vikrant Kumar, BM, CARE, Pakridayal, East Champaran

“Programme level challenges
The challenge was to run this smoothly given the fact that ground realities in Gaya and East Champaran were different. East Champaran posed more bottlenecks at the block level since Piprakoti and Madhuban did not have a BCM in-charge. This pushed the BMs to go out of their way to coordinate with PHC staff to make sure the supply-chain was maintained and the programme ran smoothly.

Provider bias and poor mentoring approach: When the pilot began, it was evident there was barely any mentoring or clarity around how family planning related guidance would be provided to young couples. Sensitivities of both newly married men and women were not always factored in like in the case of under age women or women who had several miscarriages or who were having problems with conception. A standard one size fits all approach was used. Sterilisation was the most common method and this was thrust upon the woman who came to deliver her 2nd or 3rd child. The family usually expected the woman to manage family planning at her end. Apart from the social conditioning, provision of services was found lacking and there was a lot of embarrassment and hesitation, both on the part of the young women and the men that stopped them from finding out more about what was available and what could be best suited to their needs. Moreover, there was no dedicated staff that could guide them at the health facility with patience, sensitivity and compassion.

“We found the incentive approach created more problems than solutions. We must understand cultural issues that run deeper. These should be encouraged with respect to family planning and if incentives have been announced, a speedy and hassle-free way of disbursing them must be ensured.”

Komal Kumari
Pilot Coordinator, ZLPP

“Only Pakridayal in East Champaran had facilities for NSVs. The other two blocks did not have doctors who could perform NSVs, showing a strong provider bias with lack of mentoring and counselling. Madhuban and Piprakoti did not have a gynecologist on call and not all PHCs had enough trained doctors and nurses to perform family planning procedures and handle complications. ASHAs were performing their role and sharing relevant information to bring about systematic change in behaviours but were not medically trained. In the absence of dedicated family planning counsellors in these blocks, ASHAs were unfairly burdened.”

Abhay Kumar, DRU Team Lead, East Champaran

A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices
Human resource and coordination issues in few blocks: Some of the blocks had challenges related to human resources. In Madhuban and Piprakoti in East Champaran for example, there were no BCMs and without their presence, it was difficult to supervise ASHAs. There were some problems with coordination amongst ASHAs in these two blocks and a lot more leg work was required. In some places, ASHAs were living in far off places and could not spend the entire day to reach the intervention site. For example, ASHA’s living in Motihari found it difficult to visit Sadar and adjoining areas of Pakridayal, Madhuban and Piprakoti, affecting attendance in these HSCs.

Not all HSC meetings were held: Due to festivals, some HSC meetings could not be held. These were challenges that could not be overcome easily since during major festivals, things came to a halt and there was not much that could be done, besides adjusting the curriculum of the meetings.

Community level challenges

Getting ASHA workers to check personal biases: ASHAs, as frontline workers were the nucleus of the pilot. They were trained to do their job with efficiency and at the same time reflect on personal biases. Initially they were not receptive to the curriculum that was adopted for the SSA trainings and had reservations regarding talking openly about family planning in households that were very rigid and traditional. While trainings and meetings helped eliminate some of these hiccups, few ASHAs remain inactive to this day, unable to break the barriers of societal conditioning and resistance.

Discomfort about talking on issues related to family planning: In HGMs, people were apprehensive of finding other male family members from the community with whom they were uncomfortable talking of family planning, contraception and child spacing. These were topics that were considered private and to be shared only within families. Young men in such cases skipped attending HGMs to avoid running into other men who could possibly make fun of them or call them henpecked etc.

Initial reluctance of men to become part of the programme: Men were not very receptive initially to discuss family planning though they were okay to discuss and learn about health and risk factors related to pregnancy and childbirth. These were good entry points to draw them into the conversation. Another challenge was getting men to participate fully in the process. The ZLP facilitator had to put in a lot more effort to engage and enthuse the menfolk to be interested and committed to the subject.

Difficult to get newlyweds to attend meetings: Reaching newlywed girls was not easy. Many came from different villages and were not allowed to intermingle without another family member accompanying them. Getting them to attend meetings regularly was therefore not an easy ask. One ASHA reported that ZLP women found it hard to leave their homes till they had given birth which was when the family pressure on them eased up. Even during VHSND, their mothers-in-law were seen hovering around them, taking decisions on their behalf and not letting them exercise their free will. The ZLP facilitators and ASHAs were trained to build rapport with the mothers-in-law and newlyweds during home visits, establishing a line of communication with focus on trust building.

Negative news spreads like wildfire: Source of information for young men was mostly the internet and friends. Even if one person had a bad experience with family planning, it spread like wildfire having negative consequences for the programme. Being small communities, any negative feedback could slow down progress and dampen morale of people, negatively affected the uptake of family planning services. Local community influencers had to be roped in to diffuse some situations.
Reaching migrant workers: Some of the young married men could only be spoken to in a brief time between Diwali and Chhath puja. Those who could not be met through a combined visit, had to be approached in this short time, which was difficult. To address this gap, the state-wide family planning campaign targeting migrant workers was planned.

“I was turned away from meeting a newlywed who I wanted to invite for a meeting. Her in-laws told me she would not meet me or anyone. I felt dejected but returned the following week on the pretext of sharing information on government schemes. The situation thawed and her in-laws realised I was being helpful. I continued to make regular trips and after 5-6 visits, found an opportunity to talk to the young bride. Initially her mother-in-law would sit through the interactions but after few sessions left us alone, giving me the chance, I was looking for. I realised that earning the trust of the mother-in-law was important before I could be seen as someone who was well meaning.”

Kumari Suchitra, ASHA, Dobhi, Gaya
Based on the field visits and engagement with multiple stakeholders, a list of recommendations has been proposed to make any future scale-up impactful. These have been categorised under the broad heads of policy, programme and community.

**At the policy level**

*Promote dissemination of information on family planning with services:* With greater awareness around family planning, the government must partner stakeholders to create more platforms to share accurate information. This must be backed with availability of family planning services and products through the public health system to willing young couples (fulfilling unmet needs) to reduce chances of conception due to delay in procurement.

*Ongoing training for healthcare personnel:* For newlywed and low parity couples, accurate knowledge about fertility can be used as a starting point to make them aware of risks of early and frequent pregnancy, regulation of fertility and awareness of different modern family planning methods. Start training staff and counsellors so that they can forge relationships of trust with couples. The trainings were both unique and relevant. The role-plays made it simple for ASHAs to understand what they had to do. Even those who were not educationally sound and adept at comprehending the written word, could easily grasp the essence of the programme and drive home messages succinctly in their interactions with young couples.

*Adopt the approach tested by ZLP:* Promote healthy living based on WHO guidelines and reach target groups with ‘healthy living guidelines’ generating demand in consultation with young couples. Encourage new ways of looking at family planning and seek collaborative ways of getting couples to make family planning choices rather than have health centres pushing NSVs and other permanent methods of family planning.

*Encourage a shared vision that is owned by key stakeholders and led by the government:* The success of India’s family planning programme is shouldered by researchers, policymakers, service providers and users, who must ensure equitable access to quality services. The praxis of family planning is simple and availability of a basket of contraceptive choices will play a crucial role in stabilising population growth. Greater male participation as active partners will increase use of contraception. The time to act is now and everyone must do their bit to empower couples, expand contraceptive choices and pave the way for greater gender equality.

*Promote male engagement approach:* The project has given healthy weightage to involving men by changing their mindset and encouraging them to take joint decisions with their wives and respect her thoughts on the subject.

*Continuing to focus on migrant population:* The work initiated by the pilot in drawing in migrant
populations and their spouses must continue, especially during festivals when they return home. Some effort to measure the impact of the campaign and the home visits to migrant households will throw light on issues that need to be addressed more emphatically and how much have the efforts during the ZLPP benefitted in terms of changing behaviours and actions related to family planning.

**At the programme level**

**Upgrade review mechanisms:** District-level reviews followed by Block-level reviews served as good monitoring and feedback mechanism. In many places male and female facilitators shared experiences and observations directly with the project team without routing it through DRU or block. A well-integrated review system that involves block managers, family planning coordinators and male/female facilitators with proper documentation will further smoothen operational efficiency of any family planning intervention.

**While demand for NSV has increased there is need to discuss other family planning options:** ZLP saw a spurt in demand for NSV. This was a natural outcome of discussions which male family planning facilitators had with young men in the community. However, focus of any future family planning intervention must be to encourage broader discussions and provide wider basket of options, so that the couple can make joint decisions best suited to their age, family size, income and health.

**Monitoring of ASHAs’ attendance and performance:** Attendance of ASHAs was monitored more systematically once this was found to be irregular. A more streamlined way of measuring their impact should be finalised and integrated in the feedback-review-reward cycle.

**Using data to guide programmatic interventions including how to engage with ASHAs:** Making ASHAs understand and imbibe core elements of ZLPP was a major achievement. Going forward, with more data and evidence from the field, community interactions of ASHAs can be further refined.

**More frequent trainings with shorter intervals needed:** Both SAA and HSC trainings were well received and need to be conducted more regularly. The winning features of these trainings, the interactivity, use of role play and exercises and other tools can be used in other programmes too.
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

“HTSP has been historically ignored and couples were not really asked if they were practicing HTSP by their local health provider. Frontline workers must be encouraged to adopt the ZLP approach that runs deeper since it promotes overall family health and good family planning practices.”

Shashi Ranjan, DRU Team Lead, Gaya

More strategic investments in social and behaviour change communication needed: Although family planning programmes in India have made significant progress, budgetary spending and allocation is still skewed towards terminal methods, without adequate emphasis on training of service providers and investment in BCC/IPC. Issues surrounding family planning and sexual and reproductive health emerge from deep-seated social norms, which cannot be uprooted overnight. In addition to SBCC, interpersonal/spousal communication can be strengthened to improve family planning use and continuation, reaching far-flung and media dark areas.

At the community level

Generate more information through multimedia platforms: Given that young people have smart phones, having family planning messages beamed through short videos will be an impactful IEC intervention. Using WhatsApp groups for husbands, adolescents and newly-weds will provide a platform for sharing, celebrating success and creating avenues for support. Educational videos and messages from influencers on harms of early marriage and childbearing, financial drain of repeated miscarriages and health impact of ill-planned pregnancies along with details on Chaya and Antara can be disseminated,

Normalising conversations on family planning: More discussion around sex and gender and how to talk about sex and sexuality with each other and their families will help destigmatise and demystify the issue. With more sharing, misunderstandings will be fewer.

Involving local community influencers: Positioning family planning in a way that it becomes a shared concern of not just ZLP couples, but society will make the different tenets of the family planning programme a success. Breaking down policy interventions to suit state, district, block, village and gram panchayats, a freshness in approach will augur well for the country’s plans for the youth demographic. Local champions and opinion makers must be encouraged to pick up the mantle of family planning and advocate for the same.

“Having both male and female ZLP facilitators proved to be a good move since both women and men needed to be talked to. Through these combined home visits, HGMs and couple counselling sessions, the men were getting increasingly updated on information and involved in the larger family planning discourse. They now had access to reliable information and not mere nuggets gleaned from half-baked and biased messages received via interactions with their male friends. The way ASHAs struck rapport with them and shared facts helped in the men-folk getting better understanding of the merits of HTSP and to consider adoption of permanent methods. ASHAs on their part were less embarrassed and more forthcoming talking about family planning and about the different family planning products.”

Dilip Kumar, BHM, Dobhi PHC, Gaya
Conclusion and Next Steps

Through the course of the ZLP pilot, many socio-cultural and programmatic bottlenecks in utilisation of family planning services were overcome by building robust feedback loops. The cycle of action and reflection created positive behavioural changes and addressed gender attitudes. The pilot worked well since it was based on initial data that emerged from baseline studies showing family planning as a limiting factor with little to no knowledge of spacing among ZLP couples who had been neglected with respect to family planning interventions.

The focus of the programme was not so much on encouraging a particular family planning product but on providing all the information in a gentle and nuanced manner. Through a participatory and proactive approach, it talked to couples (both men and women) in ways that made them realise the price they were paying for ignorance, being misinformed and most importantly for delayed action.

Greater accountability of ASHAs will be a constructive step forward in giving family planning efforts more teeth. The ASHAs trained under the SAA-HSC model helped enhance their involvement and overcome personal biases as they reached young couples with family planning services that were most relevant and needed. All these factors contributed to the pilot being extremely well received, making a strong case for its state-wide scale-up.

According to Padma Buggineni, Deputy Team Lead, Family Planning for Care India in Bihar, “We found success in implementing the approach of giving ZLP couples guidance to make informed family planning choices. As more young couples become part of a voluntary movement, we look forward to the government owning it and to receiving support of donors and external stakeholders. We are confident of scaling it by leveraging our large presence in the state (over 2000 staff working in health) and a growing relationship of trust, which we share with the state government. Together we will address one of Bihar’s most pressing development problems of population stabilisation.”
A Refreshing Approach Adopted in Bihar to Encourage Sustainable Family Planning Practices

**Glossary**

**Accredited Social Health Activists:** ASHAs are community health workers instituted by the Government of India’s Ministry of Health and Family Welfare, as part of the National Rural Health Mission. They serve as key communication mechanism between healthcare system and rural population, motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning, treating basic illness and injury with first aid, keeping demographic records and improving village sanitation.

**Contraceptive prevalence rate (CPR):** The percentage of women of reproductive age (15-49) who are practicing, or whose sexual partners are practicing, any form of contraception.

**Family Planning 2020 (FP2020):** By building partnerships and enhancing existing efforts, Family Planning 2020 is working to reach 120 million more women and girls in the world’s poorest countries with access to voluntary family planning information, tools and services by 2020.

**Health Sub-centre:** The HSC covers a population of 5000 in plain areas and 3000 in hilly and difficult terrains and aims to provide primary health care services to the local population.

**Line List:** Information that goes into a line list is generally collected on a questionnaire or standard case form. The critical components of these questionnaires are then used to create a line listing that provides specific insights that guide the project/programme/initiative.

**Modern method use:** Proportion of women in the 15-49 age group who are using or whose partners are using a modern method of contraception that includes hormonal and barrier methods, sterilisation, emergency contraception, lactational amenorrhea method (LAM) and the standard days/cycle beads method.

**Nulliparous women:** Nulliparous is the medical term for a woman who has never given birth either by choice or for any other reason. This term also applies to women who have given birth to a stillborn baby, or a baby who was otherwise not able to survive outside the womb.

**Primiparous women:** A primiparous woman is one who is pregnant for the first time and/or has given birth for the first time to an infant or infants, alive or stillborn.

**Technical Support Unit:** TSUs were established as decentralised structures regionally across the country providing technical support to different government ministries and departments with the aim of enhancing effectiveness, efficiency and strategic support to sector players.

**Unmet need:** Unmet need reveals the gap between a woman’s reproductive intentions and contraceptive behaviour. The gap could be due to limited access to contraceptives, but also reflect cultural, social and religious beliefs that forbid contraception or forbid women from taking decisions about FP.

**Village Health Sanitation and Nutrition Day:** The VHSND is a Government initiative to improve access to maternal newborn and child health, nutrition and sanitation services at village level. They are scheduled to take place in every village, across the country, once a month.