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BACKGROUND

The state of Bihar in North India ranks near the bottom of the Indian states in terms of its demographic situation. The estimated infant mortality rate as of 1991 was 69 per 1000. The contraceptive prevalence rate for Bihar as of March 1990 was 26.3 per cent, compared to the national average of 43.3 per cent. Largely as a result of low contraceptive use rate, the total fertility rate of Bihar according to the latest available estimate was 4.4 (in 1991) as compared to the national average of 4.2. An estimated population of 84.7 million makes Bihar the second most populous state in India.

The state of Bihar also ranks near the bottom among other states of India in almost all indicators of social and economic development. The per capita income of Bihar was estimated to be US $ 25.3 in 1986 as compared to the national average of US $ 45. The female literacy in Bihar was only 18.6 per cent (23.1 if population aged 7 years and above is considered) in 1991. As the available studies on Bihar indicate, one of the main reasons for its low performance, not only in the field of health and family planning but also in other sectors, is weak management. Besides poverty, a poor communication network and the lack of a proper infrastructure further make the implementation of programs difficult. The family planning program is further weakened because of various deficiencies at the implementation level, such as poor training of grassroot level workers, over emphasis on achieving unrealistic targets, particularly sterilization, lack of follow-up services and almost non-existing counselling services before and after adoption of a method. The workers themselves have biases and misconceptions about various family planning methods. Similarly, educational and motivational activities are poorly designed and implemented. Because of the lack of supervision, the grassroot workers generally do not attend to their work and program outreach is mostly limited to only a few villages, like the primary health centre (PHC) village or sub-centre village. Given the situation, it is very difficult to increase the acceptance of family planning, particularly among lower parity couples unless the whole program is revamped and some innovative approaches are introduced to increase program outreach and quality of services.

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The present study monitors and documents one such innovative approach presently being implemented by the Bihar State Cooperative Milk Producers Federation (COMPFED) in collaboration with the Centre for Development and Population Activities (CEDPA), Washington, D.C. An earlier report on lessons learned on expanding contraceptive choice and access in a sample of Dairy Cooperative Societies has been published as a Working Paper by CEDPA (Kak, Roychoudhury and Weeden, 1994).

THE COMPFED MATERNAL-CHILD HEALTH (MCH) AND FAMILY PLANNING (FP) PROJECT

The aim of the COMPFED pilot project is to explore possible ways to integrate MCH/FP services within the established rural infrastructure of the dairy cooperative societies (DCS). The project was introduced in a phased manner in Samastipur district in North Bihar. In this district, COMPFED has more than 315 Dairy Cooperative Societies (DCS), representing about 15 per cent of the district's total number of villages. Each DCS consists of approximately 1.5 villages and a population of about 1,500.

In each DCS, a voluntary health worker (VHW) has been recruited to work on a part-time basis. These VHWs are females with the following qualifications: married, a current user of a family planning, and have passed at least the primary level of school. The VHWs are provided with a monthly honorarium of 130 Rupees or about US $4.00. Their training consisted of a one week program. The training was organized by COMPFED in collaboration with the district health authorities and a non-government organization (CINI) from West Bengal. In this training, the VHWs were taught about MCH and family planning methods. Subsequently, they were given periodic reorientation training.

The responsibility for monitoring the performance of the VHWs rests with the DCS management committee, a nine-member committee which has been established in each DCS unit. A key part of this monitoring takes place during the monthly meetings, during which the coordinator reviews progress and discusses field problems with VHWs. Three Health Supervisors have been recruited to assist the VHW with project supervision and management.

The responsibilities of the VHW are to provide information, education, and communication (IEC). They are also required to provide oral contraceptives, condoms, oral rehydration therapy, and follow-up of recipients of specific MCH/FP services. Other responsibilities include referrals to the government program for IUDs and sterilization, immunization, as well as preventive and curative care. Contraceptives (condoms and pills) are provided by the state government of Bihar

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to the COMPFED project free of charge. However, when pills are not available, they can be purchased from the commercial market.

SIGNIFICANCE OF THE PROJECT

The project has great potential for replication and upscaling in other districts of the state and also other parts of the country as dairy cooperatives are available all over the country. A similar experiment in Gujarat has also shown promising results. Because of the well established dairy cooperative infrastructure, at the state, district and DCS levels, the sustainability of services is possible. It also addresses two major bottlenecks of the public family welfare programme repeatedly identified in various family planning studies. These are women's lack of access to contraceptive services and poor promotional efforts to increase contraception for spacing between births.

DOCUMENTATION OF PROJECT

On the request of USAID Delhi, the Population Council took the responsibility of documenting the experience of using DCS network for promoting MCH and FP which included both quantitative and qualitative assessment.

Quantitative Evaluation: The quantitative evaluation component consists of a base line, mid-evaluation and end line survey of 2,500 randomly selected households spread over 40 DCSs (63 villages). This part of the evaluation was carried out by the Population Research Centre, Patna. The base line survey was carried out in June of 1992. The mid-evaluation was conducted in July of 1993, one year after the implementation of the project. End line survey was completed in September 1994. The study design and findings from the base line survey are given elsewhere (Prasad, Khan, Ram and Patel, 1993).

Qualitative Assessment: The qualitative component focused mainly on the processes involved in implementing the project. To collect the data two trained researchers lived in Samastipur (the district head quarter) and made frequent visits to the 10 selected villages. On average, they spent 20 days every month in the villages collecting relevant information through observations, informal discussions and focus group discussions. All together they spent about 15 months in the field. Before initiating the field work, the researchers were given rigorous training in qualitative methods, management and analysis.

The qualitative assessment was carried out by the Institute of Psychological Research and Service, Patna University. The Population Council staff provided regular technical assistance (TA) including organizing a six day training workshop on qualitative research and development of a guideline for qualitative data collection.

ASSESSING SUCCESS OF THE PROJECT

The following parameters are considered important for assessing the success of the project.

- Feasibility of using DCS and its village organization for bringing about planned social change.

- Increase in accessibility of non-terminal contraceptives.

- Increase in awareness, knowledge and use of contraceptives, particularly non-terminal methods.

- Increase in coverage of pregnant mothers and infants under the MCH/immunization program.

It is fully appreciated that in traditional and backward areas like Bihar, with continued public emphasis on terminal methods, increasing the use of non-terminal methods in a short span of time will be difficult. However, it is expected that the knowledge of spacing methods will significantly increase, misconception about the methods will be slowly reduced and some increases in contraceptives use particularly that of condom and pills would also take place.

FINDINGS

The present paper highlights some lessons learned from the Bihar Dairy Project. The observations made here are primarily based on qualitative data addressing to the process of implementation and possible improvements in the design while upscaling the experiment in large area or other parts of the country. However, to put the readers in proper perspective some of the findings of the base line survey, mid-evaluation and end line survey have also been presented. The surveys show:

- Women lack awareness of non-terminal methods. In the baseline survey about 50 percent women were not aware of the IUD, pills or condoms.

- Misconceptions are common, particularly related to the side effects of contraceptive methods.

- Low contraceptive use (23 percent) and very limited (4 percent) adoption of non-terminal methods.

- High level (31 percent) of unmet need. Qualitative data shows that 52 percent of all the pregnancies were unwanted - in 23 percent of cases, the birth of a child was unwanted.

- Low level of contact between clients and the public health and FP providers (only 34 percent were contacted during last three months).

- Very limited number of outlets for contraceptives through social marketing or commercial channels (only 21 percent of the villages studied had an outlet for the condom). This indicates a lack of accessibility to contraceptives, particularly to non-terminal methods.

- High dependence (75 percent) on private sources for curative services.

- The mid-evaluation conducted after one year of implementation of the project showed a substantial increase in the awareness and knowledge of spacing methods. However, no significant increase was observed in CPR.

- The end line evaluation conducted two years after implementation of the project showed a 3.6 percentage point increase in CPR (from 23 to nearly 27 percent), and a 10 percentage point increase of ever users, largely due to increased exposure to spacing methods and better referral for sterilization services.

- The ever usership increased mainly because of increased acceptance of pills. However, many dropped out soon after starting its use.

- Misconception and perceptions about side effects all the family planning methods reduced except pills where percentage reporting side effects increased by 8 percent points.

Given the barriers to acceptance of any innovations in rural Bihar, such as poverty and illiteracy, the size of the increase is important. Secular trends in the state suggest that a one percent raise in the CPR per year would be expected in the absence of innovations. At the same time, the qualitative research provided many interesting results and the lessons learned are significant for upscaling and/or replicating the experiment in Uttar Pradesh (under the USAID supported IFPS project) and other areas. These lessons are summarized below.

IMPACT EVALUATION

How Feasible is it to Use DCS for Planned Social Change?

The study demonstrates that the DCS can be effectively used for bringing about planned social change in rural areas. It is observed that the organizational structures of COMPFED at the state, district and village level are well organized and could be used for increasing the accessibility of contraceptives through a network of village health workers who would stock and distribute

contraceptives and motivate people to plan their families. However, as we will see in the subsequent paragraphs, the project faced many bottlenecks in its implementation, which the Pilot Project was meant to explore and address through experimentation in different project strategies. This process should continue.

Has the Project Increased the Accessibility of Contraceptives?

All observations show a definite increase in the accessibility of non-terminal spacing methods in the villages. With a VHW in each village at least there is one place from which both pills and condoms can be obtained. The following quotes from the informants support the observations[1].

> *"My husband gave me pills to take every day. He told me that our daughter is only 6 months old. If you will take this pill for 6-7 months, you will not become pregnant soon. After some time we can have another child. My husband got these pills from Sakhi* (VHW) who works in the milk cooperative."*

> *"I had heard about different methods but saw them only recently. Lata Devi (VHW) showed me these methods. She showed me the condom and pills. I also learned from her about the Cu-T."*

> *"I am taking pills for the last 2 months. I have used it (the pill) earlier also. Ram Sakhi (VHW) told me to take pills and also told me that as long as I take pills, I will not become pregnant. She said that it also contained some tonic, so you would feel stronger also. After some time, Ram Sakhi went for one month to Patna for DCS Secretaries training. In the absence of Ram Sakhi, it became difficult for me to get the pills. So I could not take pills. When she came back, she gave us condoms. For 2-4 months we used condoms. After some time my husband fell ill. For some time we did not use any contraceptive as due to husbands' illness we were not sleeping together. Now my husband is all right, and I have again started using pills. I get these pills from Ram Sakhi."*

The above statements also show that the informant was totally dependent on the VHW for the availability of both condoms and pills. It was observed that easy access to contraceptives and the availability of a change agent (VHW) within the community encouraged some women to adopt family planning even without the knowledge of their husband or mother-in-law. As one informant said:

[1] The names of informants and villages have been changed to maintain their identity confidential.

"Two months back I accepted the Cu-T. I went to village Patwari with Rukmi Devi (VHW) to purchase some cloth. The ANM of that village inserts IUDs. I decided to use it. So with the help of Rukmi Devi, I got the IUD inserted. My husband does not want me to have an operation. Did you not see how his mother was shouting and getting angry with you when you came to talk with me?"

The above informant was referring to the incident when we visited her house. Her mother-in-law was sitting at the door. When she saw us, she thought we were also FP workers. She became angry and told us not to say anything about sterilization to her daughter-in-law. She told us that her daughter-in-law would not be allowed to get sterilized.

"My son will scold me. My daughter is still suffering after having an operation."

Our informant continued:

"My husband does not want me to even use the IUD. Therefore, I have not told him about the insertion of the IUD. My husband has gone out of the village for business. He is a man of hot temperament. So due to fear, I could not ask for his permission to have an operation (sterilized) or insert the IUD. I do not want to have any more children. So I have accepted the IUD without informing anyone. Rukmi Devi was very helpful."

Comments from yet another informant supported the above observation:

"I learned about pills through the VHW. I do not use the pill because I have had an operation. I did it recently with the help of Lakhi Devi (VHW) without informing my husband. He works in Calcutta. I made my own decision and had the operation with the help of Lakhi Devi (VHW). So far I have not informed him about it. "

She added:

"I knew about both the operations (vasectomy and tubectomy) before marriage through the gossip in the village and at home, but I came to know about the pill, condom and IUD only one and a half years back when Devijee started coming to the village to give medicine."

Manju, yet another informant, said:

"I came to know about pills from Behanji (VHW). I used pills for a year and then had an operation because I had complications. The pills were supplied by Behanji."

These comments also show that, although the village women knew about some methods (mainly sterilization) the project has increased their contraceptive knowledge and also provided a chance to choose a contraceptive.

Many informants told us that they had heard of the methods before but had,

"Never seen or touched it. Now I know what these methods are and how they are used."

Has the Project Increased the Contraceptive Prevalence Rate (CPR)?

From our qualitative research it is difficult to judge how far the project has been instrumental in increasing acceptance of family methods. The end line survey indicates that the CPR did increase by 3.6 percentage points, and that the increase was largely due to adoption of female sterilization. However, the 10 percentage point increase in ever use suggests that women were willing to try oral contraceptives and condoms, but continuous use was not achieved.

Our overall impression is that wherever the VHWs were active and contacting the village women regularly, the women's acceptance of FP has increased. Many women were offered advice on spacing methods possibly for the first time, and were provided with condoms or pills by the VHWs if they wished to use a temporary method. They were also given advice and referral information if they desired longer term methods, such as IUD and sterilization. However, we have also observed that all VHWs were not active, and in some they could not work at all because of social (caste/religion) tensions. In Bihar, VHWs of one caste or religion were often not accepted in the families of another caste or religion.

How was the Quality of Services?

After training in family planning service delivery, the VHWs received condoms and oral contraceptives and began providing services using a woman-to-woman approach. VHWs also referred clients for clinical contraceptive services, which were available at the local government clinic or at the clinic operated by the Family Planning Association of India. Some of VHWs accompanied those clients who had chosen clinical methods to the service site to reassure the women..

The training called for regular follow-up of clients. VHWs were asked to visit pill clients 10-15 days after supplying the first cycle of pills for counselling and check for side effects. The client was then to be followed up every one to three months, depending on how well established her pill use was. For IUDs, VHWs were asked to follow-up clients twice in the first week, at one month, and then at intervals of three to six months.

Monthly meetings were held to monitor the activities of the VHWs and distribute commodities to them. Training plans also called for periodic refresher training to improve the quality and effectiveness of the services provided by VHWs. Despite the training, our observations show that:

Generally choice was not given: A contraceptive was prescribed depending on the number of children the couples had and their future reproductive goals. If they had three or more children, tubectomy was recommended. Interestingly, vasectomy was not recommended any time, since the workers believed that the PHC does not offer this method. It was also noticed that generally sterilization was recommended only after the couple had two sons. If the couple wanted to delay the next child or if the couple had only one or two children, generally pills or condoms were recommended.

Adverse side effects were commonly not discussed. The following comments from two VHW informants reflect the general thinking of most of the VHWs interviewed in the study area:

> *"If we tell the adverse side effects, they will not accept the method."*
>
> *"Why should we tell the side effect? Will they accept the method after that? If they face any problem after accepting the method, we will explain to them all about the problems and what measures need to be taken."*

Generally follow-up services were provided. If clients faced any problem, the workers tried to help them. Sometimes the VHWs took the clients to the PHC, or sub-centre for examination and other follow-up services.

MCH care was well integrated into the services. With the help of the Family Planning Association of India (FPAI), one of the largest non-government organizations in India, regular immunization camps and pre- and post-natal care services were provided during the period. Immunization coverage was also good. As the services provided by auxiliary nurse mid-wives were often not regular, the VHWs found it difficult to depend on them. Therefore, an arrangement was made with FPAI to provide necessary MCH support on a scheduled date and time. The collaboration between the FPAI and DCS seems to be working well.

The study thus shows that the quality of services provided by the VHWs often falls short of the desired level and to improve the services the VHWs need more regular guidance. The importance of maintaining good quality of services, measured in terms of providing more choices, detailed information about contraceptives (including possible side effects) and follow-up services needs to be emphasised regularly. During the monthly meet, more time could be dedicated for this purpose.

Has the Project Succeeded in Meeting Women's Needs for Contraception?

The qualitative research clearly revealed that just by making contraceptives available within the community with the help of VHWs, people may not adopt family planning "automatically." Similarly, effective access to contraception may not be improved because of other social and cultural constraints. According to our observations there are several social and programmatic bottlenecks that do not allow couples to take advantage of the availability of contraceptives within the village boundaries. Some of these are discussed below:

1. Lack of knowledge and misconceptions about FP methods: Women do not have detailed information about various contraceptives. They do not know how the methods are used, what the possible side effects are, whether the side effects are common and lasting or less frequent, temporary and not serious. Because of these reasons, a majority of the women have concerns and hold many misconceptions about the methods. Some of the concerns of women are reflected in the following comments of the informants:

> *"I know about pills, but, I am afraid to take them. If I take pills and something happens to me what will I do then?"*
>
> *"After the operation (sterilization), at least six months' rest is required. One should not do hard work (like carrying buckets of water, cutting grass for the animals). If I take rest who will cook? Who will take care of family work?"*
>
> *"After an operation, women need good quality food. We are poor people. From where will we get the money to eat good food? The money we get from the hospital (incentive money) is not sufficient. Besides operation, one has to spend money on medicine also. We cannot afford it."*
>
> *"The pill causes gas and heat in the stomach. I suffer from asthma. If use of pill increases my breathing problem, I will die."*
>
> *"The IUD goes up into the stomach. I know in one case, it went up to the heart and she died."*

Subsequent probing showed that she heard it from someone else in the village:

> *"The IUD causes heavy bleeding, pain in the stomach and even cancer".*

There is no evidence that VHWs were successful in dispelling all these strongly held misconceptions. For this, it is necessary that along with the CBD program, an aggressive

educational campaign should also be launched.

2. Opposition from husbands and mothers-in-law. Opposition from husbands and in-laws are often a serious obstacle to the adoption of contraception. Their opposition to family planning stems from the following three concerns:

Fear of loss of labour: Many of them actually share the same misconceptions about various family planning methods (though for a majority of them family planning is still only sterilization). They are afraid that if the woman, either as wife or daughter-in-law, adopts a contraceptive and "something" happens to her, then no one will be there to do the household tasks or work on the farm. For them the free labour of a woman is too valuable an asset to take any risk with adopting FP methods that could have side effects.

> *"I know why my husband does not want me to use any contraceptive or allow me to have an operation. If something happens to me, who will look after household work."*

Yet another informant expressed almost the same feeling.

> *"I had requested my mother-in-law to allow me to get an operation. She had agreed, but my father-in-law advised her not to do that. He did not say anything but I know why he did not agree. It is only because of work, the same reason my husband also does not support me. They all are afraid that after operation I will not remain as strong or useful as today. They are also worried that during my rest days no one will attend household chores or take care of animals."*

Strong son preference: The strong desire of husbands and in-laws for sons also forces women to continue child bearing, although personally the women do not want any more children. An informant with six children commented:

> *"I delivered five daughters to get a son. But for my husband one son is not sufficient. He wants more. I am again pregnant. I tried to persuade him not to try for more sons, but he did not agree. I had to give it up. Had I still tried to avoid pregnancy, I would have gotten abuse and been even beaten. I have to obey him."*

When the informant was telling this to us, her husband was hearing our conversation from another room. He called Ram Devi (informant) and ordered her not to talk with us. She came back and whispered to us to come another day when her husband is not at home.

Rukhia, yet another informant expressed similar helplessness and lack of control of her sexuality and reproductive choice.

"I do not want any more children. I want to have an operation but my husband wants one more son (they have one son and two daughters). Obviously whatever he wants will be done."

Fear of adultery: Some of the opposition to contraception expressed by husbands is imbedded in their fear of adultery. They fear that after the operation or accepting the IUD or pills, their wife may feel safe enough to indulge in extra-marital sex.

Social and religious tension: Social, religious and opposition from the husband and in-laws often make accessibility to contraceptive illusionary for women. Caste and religious tension among community members is a serious obstacle to the free and easy accessibility of contraceptives. Availability of VHW within villages does not ensure that VHWs can easily go to all the houses for motivational work or that women could easily approach VHWs to obtain a supply of contraceptives. Informal discussions with various VHWs revealed some of these difficulties.

If the worker belongs to an upper caste, she has no difficulty in working with the lower caste women or with the upper caste woman. This is mainly because traditionally higher castes have dominated lower castes.

If the worker belongs to a lower caste and she has to work with the upper caste women, she feels it is difficult and her suggestions are often not accepted.

"I do not go to Puroshottampur because they are Rajput's tola. Those persons hate us and they look down on us (worker is a yadav backward caste lady, and Puroshottampur tola is predominantly Rajput, upper caste).

If the VHW belongs to higher caste, generally she can be accepted both among higher and lower caste Hindus. The lower and backward caste Hindus may accept her advice and do not feel uncomfortable in learning or receiving new information from them. However, the reverse is certainly not true. Workers belonging to the lower caste groups are not easily accepted among higher castes and the workers also feel uncomfortable in advising higher caste people on contraception or MCH care.

A Hindu worker from Rain village says

"When I went to Kedarchak and Pathan tola, their women said that she (the VOW) had come to make them sterile. These women looked down on me. Once I gave pills to a woman of Pathan tola, but the next day the client's husband came to me and gave the pills back and said you could throw them somewhere else.

Similarly, the rapport of Hindu VHWs with Muslim families was poor. Generally VHWs

avoided visits to Muslim localities for motivational and educational activities. They were afraid that their visits to Muslim families would not be welcomed by the Muslim community members. This perceived fear never allowed them to seriously approach and motivate the Muslim families to adopt family planning. The following comments from the VHWs present some of the experiences they have encountered. It should be noted that religious feelings cannot be changed so easily, especially in rural areas.

> *"I do not go to Chakfazil where Muslims live. Once or twice I went to that side but they abused me. They asked "Are you feeding us. Many old women said that even after 14-16 children they did not eat any medicine (pills). We do not use it and you go and get chirwa (sterilization) done for yourself."*

Another worker's comment,

> *"I do not go to Chakfazil (a Muslim village area). Once or twice I have visited Chakfazil but they talk rudely, so I skip going there."*

Yet another VHW said,

> *"I know Muslims would not accept family planning and abuse me if I go to them. Hence I never got the courage to go to their villages or community."*

As we saw earlier, opposition from the husband and other family members also significantly reduces women's accessibility to contraceptive.

A woman informant said,

> *"I cannot go to the VHWs house. She belongs to a low caste. My mother-in-law does not want me to use family planning. Who will bring pills for me? I cannot talk with my husband about the condom. It will be a shameful act. What will he think of me?"*

A VHW pointing out this difficulty said,

> *"I avoid those families where husband or mother-in-law does not want the woman (wife or daughter-in-law) to use family planning. If I go there I will be unnecessarily abused. Who likes to be abused unnecessarily."*

Yet another VHW said,

"Because the family members (mother-in-law) are against use of contraceptive, I am not supplying pills to Rama Devi. Because of this opposition, neither the woman could come to me nor could I go to her home to supply contraceptives."

LESSONS FROM THE IMPLEMENTATION PROCESS

The Bihar Dairy Family Planning project has demonstrated that it is quite feasible to involve dairy cooperatives in bringing about planned social change in the area of family formation and promotion of family planning. The lessons learned from this project may help in strengthening the replication of this model and its expansion in other dairy cooperatives, particularly in Uttar Pradesh as part of the IFPS project, and in improving performance and scaling up project implementation in the Bihar project itself.

Lesson 1

Expanded method choice increased ever use of temporary methods and had a synergistic effect on the number of permanent method users, but is not sufficient.

Prior to project implementation, the reliance on sterilization contrasted with the extremely low use of temporary methods. With the project, ever use of temporary methods and use of sterilization increased. The project demonstrated that a program that offers expanded method choice can increase adoption of methods for spacing as well as limiting births. Continuation of use of temporary methods remains an important challenge for community health programs.

At the same time, the list of social and cultural obstacles identified in the project clearly indicates that improving accessibility and choice alone may not be sufficient for increasing the CPR or reducing unmet need. For example, strong son preference and continued desire for two sons demand broader social and economic change and cannot be easily addressed by this project. Other initiatives need to be taken simultaneously to complement the VHWs' efforts. For example, the project clearly indicates need for strong educational efforts to remove the misconception about various family planning methods. And efforts should be made to educate couples, particularly husbands, about the importance of quality versus quantity of children and the significant role that daughters can also play in the household, if they are given an equal opportunity. This cannot be done by the VHWs alone; additional educational and motivational inputs are required to support the VHWs, work.

Lesson 2

Quality training of VHWs is insufficient, if a problem solving approach to supervision is

lacking.

The initial training of VHWs by the Child-in-Need-Institute (CINI) was quite good. The challenge is sustaining the work of the VHWs. The monthly meeting of VHWs that was meant for reviewing the work of VHWs, and help in solving their field problems was generally used for payment of honorarium, distributing supplies and for admonishing the workers who were not doing well. A problem solving attitude among supervisory staff was missing. Because of this the VHWs were hesitant to ask any question in the meeting, and important topics such as the management of side effect of orals or dealing with obstacles to women's access to services was not sufficiently dealt with. Maintaining and improving the skills of VHWs over time is just as important as good initial training.

Lesson 3

Even when field workers are provided with job descriptions, additional briefings may need to be provided to the VHWs at the time of selection on the nature and amount of collaboration required.

At the time of the selection of VHWs, detailed information should be provided to them about the nature and amount of work they are expected to do. Not all field workers are able to read and understand the complex tasks they are being asked to do. It is therefore necessary for them to fully comprehend what is expected of them and for them to agree to the terms before they accept a voluntary position as VHW. There may be family pressures to take the position and competing demands on the volunteer's time that must be understood before a decision can be made. The following comments illustrate how some workers misunderstood their role as volunteers and became disillusioned.

> *"I only knew that I would get some medicine and I would have to distribute it to the village households. I was not told any of the details before training."*

> *"I did not know that I would have to arrange and accompany clients for sterilization. Once when I went there, (at the camps/PHCs), they (doctors/ANM) asked me to hold the client's hands and feet during the operation. I was very afraid and it was so repulsive to watch all those things happening to women. On that day I came back at 9.00 p.m. with my client. It was so difficult to get a rickshaw at such a late hour. Due to these problems, now I do not want to arrange any operations."*

> *"The amount of work is much more than the money given as an honorarium."*

Mother-in-law of a worker commented:

"My daughter-in-law is working as a VHW with our permission. But then, we did not know that she would have to do this type of work (family planning work, motivate women operations, distribute pills and condoms) and she has to work like other members of the milk centre do. Had I known these, I would not have allowed her (to accept the work of VHWs). Now she cannot stop because she is being persuaded to continue. They say now the project is only for six more months."

One way to avoid such situations is to call a meeting of all potential candidates for VHW position before their selection and give them details about the project and explain what is expected from them as VHW. Perhaps speaking with other VHWs would be even more helpful. They should be encouraged to participate in the discussion and clarify their doubts. It is also important that they should not be overloaded with work, subsequently.

Lesson 4

The target approach among staff is persistent and counter productive, even in systems were it had been officially abolished by program managers.

Assigning targets to VHWs for recruiting family planning acceptors should be avoided at all cost. Our observations showed that local supervisors' reliance on traditional management through targets led to inflation in reported figures of acceptors. Although the project did not include targets in the implementation of the project, slowly a target approach to local management evolved. In the monthly meetings each worker was regularly asked to register at least five new acceptors. Often the workers were told that their payments would be withheld if they were not able to recruit new acceptors. *However, except in one case whose payment was held for two months, no such action was taken.*

The workers, however, felt the pressure from the setting of target and this often led to poor reporting. Generally the target was not method-specific. However, if the VHW had not motivated any woman to use the IUD, she was pressured to motivate at least one women for the IUD. The following quotation suggests the type of pressure under which the workers had to work.

"(the supervisor) pushes us to get clients for operations and IUDs. She puts more stress on the IUD. Is it a thing to be forced? I can ask only those women who are willing to accept the method."

During field visits we often noticed the names of women on the users' list who were actually non-users. For example, a woman who was actually given iron tablets was listed as a pill user for several months.

Similarly, in Rampur after a few visits we learned that the worker was not visiting the village and there was no Cu-T client. However, in a monthly meeting, when the worker showed four IUD clients, we returned to the village. A woman named Rani Devi saw us again, she invited us to her home and voluntarily informed us that she was using an IUD. Subsequently, we talked with her on two different occasions. Each time she said that she was using an IUD. However, we could not tell us where she received the service or where the IUD was inserted. During our third visit she finally said: "In fact I have not taken the Cu-T." On detailed probing, she said that she was requested by the VHWs to do so.

The study thus indicates that targets for recruiting family planning acceptors should not be fixed as a measure of performance of the VHWs. Instead of setting recruiting targets for the VHWs as the measurement of FP success, increasing choice, improving continuation rates and overall helping clients achieve their reproductive intentions are better parameters of success. Having these as performance indicators requires more work by the project staff in the development measurement procedures, but in the end the client's ability to make an informed choice is not compromised by the field worker.

Lesson 5

In selecting both numbers and types of VHWs, caste and religious composition of the community to be served should be considered carefully.

Caste and religious tension have a significant bearing on the functioning of VHWs and hence should be given careful thought during the selection procedure. Attempts should be made to select VHW belonging to the same community or religious groups that are to be served by the project. This is particularly important for minority groups in Bihar like the Muslims. If necessary, in larger villages, more than one VHW should be selected to cover dominant caste/religious groups. However, as has been the experience in organizing the dairy cooperative societies with milk producers of all castes, regions and economic levels, undue stress on differences can be at times counterproductive. It is important for all developmental activities that preference is not given to all community groups.

Lesson 6

If the catchment area for field workers is too large, distant hamlets and households will not be served, and it may be necessary to have more than one field worker in a catchment area.

In the Bihar project, each VHW was supposed to cover one DCS that may include more than one village. If households to be visited by fieldworkers are more than two kilometers away from the fieldworkers home, they may not be visited as frequently. Discussions with those

households indicated that VHWs rarely visited them. VHWs confessed that they did not visit hamlets not only because of the distance but also at times for lack of security. In such cases, it is important that distant hamlets are considered as a separate village and a woman from the same locality should be identified to work as an VHW.

Attempts should be made to select VHW, belonging to the same caste/community or religious group that are to be served by the project. This is particularly important in the case of minority groups such as Muslims in the project area. If necessary, in some of the big villages, more than one VHW should be selected to cover at least two dominant caste/religious groups.

Lesson 7

Involvement of male community members needs more attention in all family planning and health programmes.

The study highlights the urgent need for involvement of male members of the community in family planning and health. Unless a focused attempt is made to educate men about contraceptive methods and involve them in this planned social change, husbands' opposition to contraceptives will remain a major obstacle for the program. Many of the unmet need cases were due to opposition from the husband. The possibility of training couples as VHWs could be explored. There is an urgent need for systematically educating males about contraceptives, allaying their misconception about the existing family planning methods, consequences of continuous child bearing on women's health, reproductive health issues and need for sharing responsibilities in family formation. Unless males are sensitised to these issues, women will continue to have unwanted pregnancies. Obviously the proposed male VHWs cannot achieve all these goals alone, but a good beginning could be made.

Lesson 8

Economic sustainability of the project is difficult unless the Dairy Cooperative contributes to the program.

At least at the initial stage of the project, cost recovery from the community is difficult. While most of them spend money for curative needs and almost three-fourths exclusively depend on private sources for treatment, they do not like to spend money on preventive services. According to one informant, which typically presents the general thinking of most of the poor families:

> *"When we are sick we have to spend money for treatment. We depend on our daily earnings. If we do not work, we do not get money. How will we eat then? Even if we*

have to take loan for treatment, we will do it. However, it is not true for family planning. You people think in terms of tomorrow. For us, it is today which matters."

It is possible that once people start realizing the importance of FP, or immunization and pre-post natal care, they may agree to pay for the preventive services also. However, until that time, these projects need to be subsidized. Alternatively, the dairy cooperatives could ask for a marginal increase in milk prices for sustaining such projects.

Commitment to economic sustainability or planning at least partial cost recovery should be taken up at the planning stage of the project itself. It is difficult to inject these ideas when the project implementation has already started. Cost recovery in form of charge for services from community members may, however, be difficult during the initial stage of the project.

LINKAGE OF THE BIHAR DAIRY PROJECT WITH THE CURRENT INITIATIVE IN UTTAR PRADESH

Now that the Dairy Project is being expanded in Uttar Pradesh, the findings of this project become much more significant and should be carefully examined in the context of UP initiative. Given the social and cultural similarities between the two states, most of the observations made here will also be applicable in case of Uttar Pradesh. As a model, the Buhar project should be extended by two to three years, so that the DCSs continue to learn how to modify and improve the functioning of the project and make it sustainable. The lessons learned from Bihar could be directly transferred to the UP project, which will take the next one to two years to become fully functional. With the insight gained from the Bihar project, it is likely that the UP Diary Cooperative Societies could implement the model more quickly and have greater expected impact.

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