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What Makes a Family: How an Empowerment-Based Health Care Delivery Model Employs Family Planning to Positively Impact Families in Rural Maharashtra: A Study in Jamkhed, Ahmadneger

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WHAT MAKES A FAMILY: HOW AN EMPOWERMENT-BASED HEALTH
CARE DELIVERY MODEL EMPLOYS FAMILY PLANNING TO
POSITIVELY IMPACT FAMILIES IN RURAL MAHARASHTRA: A STUDY
IN JAMKHED, AHMADNEGER

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SIT Study Abroad

India: Public Health, Gender, and Community Action

Spring 2023

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Acknowledgements

I want to thank the staff at SIT for their continued support, empowerment, and education. Abidji, you are the reason I have grown to love anything related to family planning even more than I already did. Archnaji, thank you for the many hugs, laughs, and words of support – I have found a true connection in my friendship with you. Bhavnaji, from the very beginning, you have been someone who I could go to for honesty, advice, and pep talks; you always spoke your truth and I hope to embody that in the future. Goutamji, thank you for being and a constant source of laughter with your dad jokes. I have never had a language professor who cared so deeply about the learning experience over the grade, and you have set the bar for future teachers. Chrisji, thank you for always helping me talk through my thought process for my project. To Sulemanji, Babuji, and Champaji, thank you for always being smiling faces around the program center; your food kept my stomach happy and your kind nature kept my heart happy. To my host family and my home family, thank you for constantly supporting me, giving me comfort, and providing me with incredible opportunities that I have gained in this country. To my friends – both on this program and back in the States – I adore you all and love you so dearly. Thank you for always making me smile, putting up with my bad days, and being there for me as soundboards whenever I needed to talk about anything. To the team here at CRHP – especially Raviji and Surekhaji – thank you for supporting me throughout the many interviews, study sessions, brainstorming meetings, and meals. You have been there to guide me through this incredible journey, and I am truly changed because of my time in Jamkhed. Finally, to India – just when I thought I reached maximum capacity for places that made me feel at home, you proved me wrong. Thank you! <3

Abstract

The paper examines how an empowerment-based health care delivery model employs family planning services to positively impact families in rural Maharashtra. Family planning services provide those with the ability to become pregnant the option to control their own reproductive lives, whether they choose in favor of or against having children. Contraceptive use advances people's human rights to choose whether they want to bear children and how many children they want, and people should have the choice of their preferred contraceptive method. The paper examines this issue within the framework of the Comprehensive Rural Health Project's Jamkhed Model. Through the Jamkhed Model, Village Health Workers (VHWs), the Mobile Health Team (MHT), and Comprehensive Rural Health Project (CRHP) leadership work together to provide necessary primary health care in underserved village populations. The paper approaches analysis through a mix of literature review and interviews with relevant stakeholders. Around the world, healthcare has become a topic of business rather than a topic of how healthcare providers can best serve their patient populations – I hope that this paper will bring to attention the need we have as healthcare providers to help our patients feel comfortable, empowered, and supported in their healthcare experience.

Keywords: family planning, empowerment, family dynamics, health care delivery

Introduction

Family Planning and Global Health

The sustainable livelihoods of women and children help create a picture of good health around the world. Public health experts look at morbidity and mortality rates of mothers, infants, and children in order to determine the success of a country in providing essential public health

interventions. Without the protection and empowerment of current and potential mothers, society cannot grow. Effective implementation of family planning services improves rates of maternal mortality by preventing risky behaviors that lead to unsafe pregnancies or abortions. Though it varies across populations, it can be argued that family planning acts as a marker for change in sociocultural and economic status across a region because of the direct correlation between an increase in spaced out births with a decrease in infant mortality rate. This shows that effective spacing positively impacts overall health of women and children (World Health Organization, 2020).

In 2019, around 270 million women of reproductive age – between the ages of 15 and 39 – had an unmet need for contraception worldwide. In 2020, only 76.8% of reproductive-aged women felt satisfied in their need for family planning, leaving about 1 in 4 women without adequate care. While this number may seem high, it reflects a mere 3% increase compared to the previous 2 years. Reasons for this slow increase include limited access to services – especially among young, poorer, unmarried women – as well as fear or experience of side effects, poor quality of available services, gender-based barriers to accessing services, cultural and religious opposition, as well as user and provider bias against particular methods. Women increasingly desire the use of family planning and contraceptives (World Health Organization, 2020) – they must be empowered, motivated, and supported in the search for a family planning health plan that works for them so that they can regain control of their bodily autonomy and ability to choose for themselves.

The study aims to answer the following: How does an empowerment-based health care delivery model employ family planning to positively impact family dynamics? What would an ideal family planning program look like in the eyes of interviewed stakeholders?

Methodology

In order to understand the value of empowerment-based healthcare delivery's effects on family planning and those who use it, I looked to the experiences of those involved – ranging from healthcare workers to reproductive-aged village women who could have potentially used family planning services. Due to my positionality as a Western, unmarried young woman – a foreigner to India – I worked closely with the Comprehensive Rural Health Project (CRHP) to facilitate the meetings of these stakeholders. CRHP has worked in rural Maharashtra since 1970 in order to provide care for poor and marginalized groups of people. Through their Jamkhed Model, they bridge the gap between vital healthcare services and rural Indians in project villages by village outreach and providing services in-house. While they work in many aspects of health, they pay particular attention to the health of women and children. It was important for me to work with CRHP because they set the narrative for what healthcare could look like if healthcare providers focused on empowering citizens to take charge of their health and wellbeing. Additionally, because of their time and credibility of their work in Maharashtra, they had connections among many villages with people enthusiastic to participate in my study.

I conducted a total of 11 interviews with 15 people. I interviewed 2 of CRHP's village health workers (VHWs), 6 village women, the MHT, a head doctor in the Jamkhed block, and the administrative leadership of CRHP, Drs. Shobha Arole and Ravi Arole. All interviewees had been told in depth about the study and gave informed consent for the recording of the interviews.

While all 6 village women were of reproductive age, they varied greatly in caste, religion, age, and education. The youngest interviewed was 21 and the oldest 40. 2 women stopped education in 5th grade, one stopped in 6th, and one stopped in 9th. One woman received no education. The women who did not receive up to a 10th standard education cited poverty,

distance, or marriage as reasons for stopping education. One woman received 12th grade education and training in an ANM course – she was the only woman who was of a higher caste and Hindu status. The rest of the women were lower caste (*Dalit* and scheduled tribe) or Muslim. 2 women were from non-CRHP project villages while the other 4 were from CRHP project villages. Ideally, more than 2 non-project village women would have been interviewed in order to gain a diversity of experience; however, I was met with resistance and lack of interest or confidence to speak about the issue of family planning.

The VHWs ranged in age and education level – one of whom has worked with CRHP since 2013 and the other since 1972.. Both VHWs were lower caste and non-Hindu. One VHW had received no education due to the trend of non-education for girls at the time of her upbringing, while the other VHW had received an 11th standard education. Both VHWs received VHW education at CRHP. The Mobile Health Team all were 50 years of age or older. While one received no adolescent education (but instead received adult education and VHW training via CRHP), 2 received Masters in Science and Masters in Social Work, and one received an 11th standard education. The MHT members ranged in religion, but all are of middle to lower caste. The head doctor of the Jamkhed block is middle-aged, educated as an MBBS doctor, *Dalit*, and identifies as non-religious. He has worked in the block for many years and works closely with CRHP.

All interviews were conducted in a mix of English and Marathi. Surekha Sonawane of the MHT acted as the translator and facilitator for all but 2 interviews (those conducted entirely in English with the head doctor and CRHP leadership). All names are kept anonymous (referring to each as [title] [number in order of interview]) barring the interview with Drs. Shobha and Ravi Arole. From these findings, the paper seeks to contribute further to the role that different

methods in providing healthcare services can shape the experience of patients in healthcare systems.

Audience

Those interested in the family planning scheme in India, the experiences of women who use family planning, the role of NGOs such as the Comprehensive Rural Health Project in delivering healthcare services, the ways in which health care delivery impacts healthcare, and how family planning initiatives could be shaped to center empowerment and equity will find this paper insightful.

Findings

This paper discovered the following:

Gender discrimination within the communities of those interviewed show a lack of respect for the girl child as a result of historic gender norms and the history of infanticide and foeticide despite the Indian government's attempts to mitigate these inequities. Discrimination also varied with the additional considerations of caste.

Interviewees discussed economics and gender as particular factors when structuring a family. Particularly, families would consider the number of children to have based on labor resources and economic status as well as how many boy versus girl children were had. When using family planning services – inclusive of permanent and spacing – factors such as sexual behavior and intercourse, the health of the family (particularly the health of the mother and child), as well as spacing desires were considered.

Based on the findings, CRHP has a summarily positive perception in the eyes of both village communities – both project and non-project – as well as in the experiences of healthcare workers – both CRHP staff and non-CRHP staff. When asked about CRHP, interviewees saw the

organization as one that empowers communities by providing affordable, if not free, resources in addition to helping make people more knowledgeable on issues that affect their villages.

Interviewees view CRHP as a reputable and trustworthy influence in Jamkhed.

When asked about government healthcare services in the scope of family planning, interviewees expressed concern of the government failures in health education frequency, resource availability, and proper counseling methods. Specifically, interviewees noted historic and current government repression of the bodily autonomy of women, especially for lower caste, poor, Muslims. Contrastingly, interviewees argued that CHRP mitigates the wrongdoings of the government through frequent, inclusive, and well-thought health knowledge distribution – CRHP works at multiple levels to provide this knowledge in order to stop gender discrimination before the birth of the girl child. Through these efforts, interviewees found that CRHP has general success in empowering and uplifting the value of the girl child. As a result, people within project villages have a comprehensive understanding of family planning and how to access it. The interviewees paint a picture of families wanting to use family planning in order to achieve a 2 child norm with adequate spacing; however, notably, some members within project village communities still struggle to reach this goal due to historical oppression within Indian society, the need to participate in agricultural labor debilitating access to health education, and a general lack of knowledge around family planning as a result.

With this in mind, the study found that both the family planning scheme in India still needs to improve upon resource availability, healthcare worker accessibility – especially to historically underserved and oppressed populations –, and counseling (especially well-rounded, inclusive, and open-minded counseling methods with focuses in adolescents and mixed gender distribution).

Limitations

While this paper highlights the experiences of some women in both CRHP project and non-project villages, it does not reflect the experiences of women in every village across Maharashtra or across India. Similar sentiment can be said of the narratives given by the various healthcare workers interviewed. Additionally, given the time limit of 28 days, the paper cannot speak to particular depths and nuances that might have been explored further with a longer time period allotted for the study project. This paper cannot make generalizations of all Indians, nor can it make generalizations about all Maharashtrians. It can only speak to the experiences of those interacted with in the interviews. Further, due to the lack of fluency in Marathi, there may be words lost in the translation between translator and interviewer, meaning that the paper cannot give a full and comprehensive understanding to the people who were interviewed in Marathi. Additionally, this paper employs language used by participants themselves; therefore, it may not reflect the experience of LGBTQ+ members or families. Finally, the paper regards what was said in interviews as expert data from primary sources – subjective rather than objective truth about firsthand experiences – due to potential bias or lack of knowledge from interviewees.

Family Planning in the Indian Context

India became the first country to have a family planning program within the national government in 1952. India's National Programme for Family Planning aimed to stabilize the rapid population growth, promote reproductive health, as well as reduce maternal, infant, and child morbidity and mortality. When evaluating why population growth continued to occur, the Programme looked to India's unmet need for family planning – specifically the nonuse of contraception despite the desire to space out or stop pregnancies – as well as very young age at

marriage and first child birth and little spacing between births. Over time, via laws that banned underage marriage as well as increase in the use of ASHAs and other healthcare delivery providers to distribute family planning services, the Programme saw improvements as total fertility rates steadily declined and the national population adopted the 2 child norm. Now, the National Programme for Family Planning provides family planning methods in a multi-faceted approach (Ministry of Health & Family Welfare):

Temporary / Spacing Methods	Permanent / Limiting Methods
IUCD 380A and Cu IUCD 375 → Provided by trained & certified ANMs, LHVs, SNs, and doctors in sub-centers or higher level care facilities	Female sterilization (either Minilap or laparoscopic tubectomy) → Provided by trained and certified MBBS doctors and specialist doctors in CHCs/PHCs or higher level care facilities
Injectable Contraceptive MPA (<i>Antara</i> program) → Provided by trained ANMs, SNs, and doctors in sub-centers or higher level care facilities	Male sterilization (conventional or no scalpel vasectomy) → Provided by trained and certified MBBS doctors and specialized doctors in PHCs or higher level care facilities
Combined Oral Contraceptives (<i>Mala-N</i>) → Provided by trained ASHAs, ANMs, LHVs, SNs, and doctors in village level sub-centers or higher level care facilities	

Centchroman (<i>Chhaya</i>)	
Condoms (<i>Nirodh</i>) → Provided by trained ASHAs, ANMs, LHV, SNs, and doctors in village level sub-centers or higher level care facilities	
Emergency contraceptive pills (<i>Ezy pills</i>) → Provided by trained ASHAs, ANMs, LHV, SNs, and doctors in village level sub-centers or higher level care facilities	

While statistical trends and resources may suggest that the history and infrastructure for family planning in India has always been about encouraging equitable access and use of family planning services, India's dark history of forced sterilizations sheds light on the ways the government uses family planning as a method of population control. In the time of the National Programme for Family Planning's creation, nongovernmental agencies and international humanitarian initiatives stressed the need for a solution to India's post-colonial 'population problem' – a term coined by those in the Western development sector as a reference to the population surge that occurred after gaining independence from Britain. The Indian government at the time not only felt the verbal pressure from international organizations but had the monetary incentive from agencies such as the World Bank to have a tangible course of action in the reduction of the Indian population surge. In 1975, Prime Minister Indira Gandhi enacted an emergency declaration and began the government-run compulsory sterilization program. The government forced women to participate in sterilization camps while also predominantly targeting poor, lower caste, rural men. In fact, over 6.2 million Indian men were sterilized in one year and thousands died from unsafe operations. In an interview with the Comprehensive Rural

Health Project's Mobile Health Team (MHT), one MHT member reflected on this time in history; he recalled how government cars would "drive around town and pick up men off the streets". Indians felt an indescribable sense of fear at the time according to the entire team. People feared for their lives and for their autonomy as individuals to have the right to choose how they treated their body (Mobile Health Team, Interview 2023). Oppressed Indians lacked full and informed consent as a part of these populations, and despite these camps supposedly being about population control, it was clear: this was just another form of eugenics to reduce the amount of minority groups in India (Biswas, 2014).

Now, those same international agencies that stressed population control in India advocate for sexual and reproductive health access as a basic tenant of human rights; however, it is hard to ignore the origins of these messages as the effects of Gandhi's sterilization camps are still prevalent. Some argue that, while the forced sterilization camps have ended, the mindset that motivated them has only continued but in a different mode (VHW 1, Interview 2023). Instead of primarily targeting minority Indian men, government health workers have shifted their targets towards minority, poor, rural women. For example, OBCs have the highest rates of female sterilization despite facing a lack of resources and knowledge surrounding other forms of family planning (Muttreja & Singh, 2018). Sterilization camps still occur at high rates, and while these camps seemingly have adopted the need for the voluntary choice principle, it begets the question of how the voluntary choice is obtained. The Indian government threatens health workers with salary cuts and dismissals should they not reach minimum target numbers for distributing permanent methods, leading them to strongarm women into getting tubectomies (VHW 1, Interview 2023). Indian women find a lack of knowledge about resource availability for temporary methods, thereby feeling that sterilization is the only method left for them should they

want to pause or stop having children. Further, due to religious and cultural superstition as well as the importance of masculinity, men do not get permanent methods because they believe they will be less of a man because of the procedure. Even when vasectomies were really pushed in the 1970s to 1980s, women faced backlash after getting pregnant from failed vasectomies – they were blamed with infidelity and severely punished in society (Ravi Arole, Interview 2023).

Unfortunately, the mix of government tactics and general Indian family planning norms have succeeded in ensuring women obtain the most permanent methods; in 2012 alone, 4.6 million Indian women had undergone sterilization, making up 37% of the world's sterilizations (Kudekallu, 2022). Additionally, where around 38% of Indian women have undergone sterilization, only about 0.3% of Indian men have had a vasectomy (Singh, 2022). Indian women of all walks of life deserve equal rights and equitable opportunities when it comes to their family planning choices. Further, they deserve a government that strives to protect its citizens, provide them the resources and access to all services, and empower them to make responsible, informed, safe decisions that they have a say in.

Maharashtra Demographic Information

Maharashtra is the third largest state by area and second largest by population in India (Patil, 2022). According to 2023 data, Maharashtra has a sex ratio of 929:1000 (while an average and healthy sex ratio stands at approximately a 1:1 range), a literacy rate of about 88.28% for men and 75.87% for women, an urban population of around 45.22%, and a total projected population of 13.16 crores (*Maharashtra population: Sex ratio: Literacy*, 2023). The 2011 Census – with further estimates by Joshua Project – states that Hindus make up a majority of the population at 79.83% followed by Muslims at 11.54%, Buddhists at 5.81%, Jains at 1.25%,

Christians at 0.96%, Sikhs at 0.2%, and other religions at 0.16%. 0.25% of the Census respondents did not state a religion. As for the caste distribution, about 32.4% identify as general caste, 34% as OBC, 11.81% as *Dalit*, 9.35% as Scheduled Tribes, 11.54% Muslim, and 0.9% as ‘other’) (Census 2011 & Joshua Project, 2023). In 2020, Maharashtra’s public health indicators were as follows: the crude birth rate was 15/1000, the crude death rate was 5.5/1000, the infant mortality rate (IMR) was 16/1000 live births, the total fertility rate (TFR) was 1.6, and there was a “significant declining trend” in maternal mortality (Patil, 2022). In 2020, India had a crude birth rate of 16.572/1000, a crude death rate of 7.35/1000, an IMR of 26.8/1000 live births, and a TFR of 2.051 (World Bank).

Similar to the Indian system of medicine, Maharashtra’s state health system acts in 3 tiers. Some key issues faced by Maharashtrians and the Maharashtrian health system include lack of uniform health structure, inability to reach populations, lack of private sector regulation, and inadequacy in women’s and maternal health. Among the urban population, about 50% of them lack a uniform health structure. Within rural populations, village and tribal populations are distributed across a large area, making it difficult to provide consistent and strong health services. Women’s and maternal health has been described as lackluster, with maternal health care either being provided very poorly much too late or in an overabundance before being needed (Patil, 2022).

Maharashtra’s diversity and size – both in population demographics and issues – as well as the work done in the state by the Comprehensive Rural Health Project made it an ideal location for this study.

The Comprehensive Rural Health Project

Background

In 1970, Doctors Rajanikant and Mabelle Arole established the Comprehensive Rural Health Project in Jamkhed, Maharashtra with the aim to provide primary healthcare services to those who have been underserved historically in the Indian healthcare system. They wanted to improve the health of those served as well as demystify the act of becoming a healthcare provider through the training of lay people to be village health workers (VHWs) or Mobile Health Team (MHT) members. Their programs have expanded since 1970 to include medical camps, farmers' groups, adolescent groups, a school, a farm, a hospital, and much more; they also host many international students and medical professionals each year to expand and trade knowledge (Perry & Rohde, 2019). Through these services, CRHP provides care close to home, integrative of all services, promotes equity and empowerment, and encourages community engagement.

A core facet of the work done at CRHP comes from their Jamkhed Model. VHWs are village-selected women who serve as health care facilitators for the village women's, adolescent's, and farmer's groups with the goal of improving health care, socio economic development, and community-empowered engagement. CRHP administrative leadership provides management, resources and training, referral services for secondary care, and village networks all from the main camp in Jamkhed. Finally, the MHT connects the VHWs and CRHP administration through their mobile health services, training, and knowledge (Arole & Arole, 1994).

The Jamkhed Model's Mobile Health Team represents a model that recently has been the center of attention in many Western research spheres, known as the community paramedicine model. Community paramedicine programs address the needs of aging, disadvantaged, and underserved populations through community assessment and referral, community paramedic-led clinics, home visit programs, monitoring services, mental health and addiction support, palliative and infectious disease care, and more. Like the Western-defined community paramedicine model, CRHP's MHT begins with a community needs assessment, provides integrated interdisciplinary collaboration, conducts general health assessments, and facilitates health promotion initiatives. While community paramedicine may be provided solely by paramedics, many programs highlight the capacity for paramedics and healthcare providers to work alongside other healthcare professionals like social workers. CRHP capitalizes on this by ensuring their MHT members are well-rounded in their ability to provide knowledge and health services regardless of the type of formal education provided (Shannon et. al, 2022). While the term 'community paramedicine' is relatively new and Western-originated, community paramedicine models have existed for decades prior to the 21st century as shown by CRHP.

CRHP demonstrates an ideal community paramedicine program that educates the providers to be flexible based on the needs of the communities served and positively impacts the community.

CRHP's Beginnings in Providing Family Planning

In her interview, Dr. Shobha Arole described the beginnings of CRHP's work in family planning based on her parents' experiences as well as her own. She stated that when CRHP first began in Jamkhed, family sizes averaged around 6 to 8 people – an extremely high number in comparison to the 2 to 3 average nowadays. Immediate acceptance of family planning did not

come; the concerns at the time came from parents not trusting that a majority of their children would survive past childhood. Indian families in Jamkhed at the time saw the struggle for children to survive and thought the only way to ensure they had a family legacy was to have more children in hopes that enough of them survived. Upon this realization, CRHP focused their efforts on helping village members understand that there were other ways to ensure the survival of the family, and that was through adequate mother and child care. CRHP began providing information on nutrition, natal care in the pre and post stages, proper sanitation and hygiene techniques, and more. They proved to families that babies could survive, so the need for a large family structure was not as high – this is the reason that CRHP emphasizes the importance of simultaneous mother and child health care in their Jamkhed Model.

Dr. Shobha Arole then described how, once family planning was accepted, it was a matter of providing a comprehensive understanding of the concept. While oral contraceptives, Copper Ts, and the permanent method were being used at positive rates, the populations CRHP served did not have a proper grasp on spacing techniques. They then began to teach that as well. According to Dr. Arole, CRHP continues to teach all of these concepts – from water and sanitation initiatives to nutrition care to spacing methods – because it is important for CRHP to care throughout multiple generational cycles. Without this, harmful beliefs that misinformed people in the past would continue to arise (Shobha Arole, Interview 2023).

Knowledge Versus Education

Dr. Ravi Arole – who runs CRHP alongside Dr. Shobha Arole and the rest of their team – emphasized the importance of knowledge over education within CRHP’s values. During his interview, Dr. Arole explained that Indians traditionally value education – the act of obtaining information – over knowledge – awareness gained through guidance and experience. Despite

this, CRHP believes that knowledge serves empowerment in ways that education cannot because knowledge encourages deeper, more personal, and independent analysis of issues affecting someone. Because of this, they aim to provide knowledge to those they serve rather than just educate on different health issues (Ravi Arole, Interview 2023). Dr. Shobha Arole supported this statement as well by citing how, from the beginning through their parents' leadership, CRHP wanted to get people thinking about the issues affecting them. Dr. Arole mentioned the Triple A Cycle of Assessment, Analysis, and Action – the action of conducting a community needs assessment, analyzing problem areas in a community, and conducting specific action steps to alleviate the issues with the resources available – in order to understand the problem, find what other factors influence the problem, and take action based on the available knowledge and resources (Shobha Arole, Interview 2023).

The Process of Structuring a Family

Many factors influence the decisions around family planning within Indian households. The Indian government's "*Hum Do, Hamaro Do*" initiative to encourage Indians to only have 2 children has greatly impacted the amount of children people have across Indian communities; however, families face multiple considerations when determining family size (BYJU'S 2022).

Money and Family Size

In an interview with Dr. Ravi Arole, he stated that "money is the great unifier and biggest decision maker" (Ravi Arole, Interview 2023). The role of economics and monetary capacity cannot be denied when considering family size.

In the conducted interviews, nearly every interviewee mentioned money as an important factor in why one might have a small or large family. Village Woman 2 highlighted how having

a small family makes affording the needs for everyone in the family much easier, whether that be on the basis of nutrition, clothes, education, financing, or potential health checkups (Woman 2, Interview 2023). Further, both village women and CRHP health workers alike cited the increase in expenditure across all parts of life as a further justification that smaller family sizes make general spending more reasonable. Canning & Shultz's analysis of the economic consequences of reproductive health and family planning highlights that in a series of controlled trials between Bangladesh and Ghana, a reduction in fertility as a result of increased access to family planning and birth spacing led to economic growth in the form of women's earnings and assets. This was because women could participate in paid labor more if there were fewer children depending on them within the household (Canning & Schultz, 2012).

All of the village women interviewed stated they had little to no time to explore their hobbies because their days started around 5-6 o'clock in the morning and ended around 10-11 o'clock in the evening. The time in between was spent caring for children, cleaning the house, cooking, or doing some form of labor. An MHT member also mentioned the idea of "if she is relaxed, no work, free", meaning that if the woman had less work or responsibilities, she had more time to herself (Mobile Health Team, Interview 2023). In this case, it could be inferred that less children meant less work load, leading to more time for themselves to work a job of their choosing, enjoy hobbies, or partake in vital self-care routines, which is vital to the overall health and wellbeing of a person.

At the same time, VHWs, the MHT, and village women alike recognised the potential benefits for a large family structure. VHWs in particular cited observing the ways that poorer, lower caste Muslim families in their villages tended to be the ones that worked the manual labor jobs in fields – whether it be their own or another farmer's field. The VHWs stated that they saw

many of these families having large family structures not just for the support system that it provided them in villages – especially when upper caste families targeted them for whatever reason – but because they would not have to outsource labor. Instead, they could employ their own family members to work on the fields, thereby ensuring that the income stayed within the family.

Overall, while the interviewees tended to agree that smaller family sizes were better for the economic status of a family, there was recognition of the value of a larger family structure, especially for lower caste, poorer community members.

Sexual Behavior and Family Planning Use

The verbage and body language displayed by village women interviewees displayed the taboo nature around discussing intercourse in particular Indian groups. According to both Dr. Ravi Arole and the Head Doctor of the Jamkhed block, women in Indian society see sex as a part of the duty to reproduce as well as the duty they have to keep their husband happy (Ravi Arole, Interview 2023) (Head Doctor, Interview 2023). This must be kept in mind when understanding the role of intercourse in family dynamics and family planning use. While the term ‘intercourse’ was explicitly asked about in only a few interviews (specifically, the interviewees were asked about the reasons people have intercourse as well as relevant follow up questions), almost all interviewees highlighted intercourse in some way.

Among those asked about the purpose of intercourse, all of the village women talked about the need for reproduction. Woman 1, for example, stated that intercourse was only meant to be had for having children and for no other reason. However, when asked if she had intercourse after having a permanent method or when taking spacing methods such as condom or the oral pill, she stated that she and her husband did have sex (Woman 1, Interview 2023). When

questioned further, she could not verbalize why she had sex when she could not reproduce. VHWs and the MHT had a clearer understanding that women knew they could have sex for pleasure even if they did not explicitly state it in an interview. The Indian women interviewed clearly understood that intercourse could be for pleasure and satisfaction. One of the MHT members highlighted how intercourse could also be a vessel for connection between family members – when elaborating, she stated that it was an opportunity for trust and “strong bonding between the couple...also it helps to avoid conflict”, stress, or fighting (Mobile Health Team, Interview 2023). When another MHT member elaborated, they mentioned that “if there is no intercourse, no nice relationship between wife and husband, then there is a possibility of infection like HIV, other STIs” because both men and women might seek sexual pleasure outside of the home. However, with this comes the risk of “high risk to the whole family” by exposing themselves to STIs – one of the MHT members shared an example from a village they work in where this happened (Mobile Health Team, Interview 2023).

Regular, consensual intercourse between couples can be beneficial to family health both physically and mentally. With the use of family planning – whether it be permanent or temporary – a couple can have sex for pleasure without fear of another child. While having people participate in family planning might not address the lack of language or comfort discussing sex for pleasure, it does allow people to circumvent the cultural norms indirectly in order to safely participate in a pleasurable activity without fear of severe consequences.

Health and Family Planning Use

Many health issues arise as a result of large family structures or poor spacing in between births.

Multiple village women and the health workers interviewed stated that cases of anemia can be seen in many of the women in the village who do not properly space out births. Some village women, for example, stated that they did not menstruate for 1 and 2 years respectively after giving birth to their first child because of lack of blood in the body (Woman 2, Interview 2023) (Woman 1, Interview 2023). In some extreme cases, a VHW reported uterine collapse occurring to a mother who lacked proper family planning and became severely anemic (VHW 2, Interview 2023). Another woman mentioned the need for family planning and spacing because a mother's anemia could cause larger issues within the family. She'd mentioned, as an example, that if a woman was not healthy, they would be too tired to take care of the family. So, if the mother was unable to cook or care for the rest of the family. "Who will take care of [them]? If we are healthy, then the family is healthy and kids are healthy" (Woman 4, Interview 2023). Multiple women mentioned how smaller families allowed for everyone in the family to have an adequate amount of food to eat, which would prevent further health issues related to malnutrition. One VHW mentioned how a healthy mother has a healthy child, so when mothers can eat a nutritious meal – both during and after pregnancy – they can take care of their child better (VHW 2, Interview 2023). Studies have supported this sentiment as increases in family planning use to improve birth space can positively impact the Body Mass Index of both the child and the mother (Canning & Schultz, 2012).

Family size directly affects the health of the entire family – particularly the mother and children's health.

Gender and Family Planning Use

When understanding what goes into the process of family planning in India, gender must be considered as one of the most predominant influences due to the systemic and historic discrimination against the girl child.

A qualitative study conducted in 2015 examined the reasons behind contraceptive method non-use among rural young married couples in Maharashtra – one of the most pressing reasons for spacing contraception avoidance came from the need to have multiple sons (Ghule et. a, 2015). One VHW supported this claim in her interview as she recalled certain families in her village waiting on using a permanent method because they wanted a boy child. When a family would get a boy child, sometimes they would try again in hopes of a second or third son (VHW 2, Interview 2023). When asked why people in their villages would want a boy child, both healthcare workers and village women alike stated the need for a boy child for reasons that fall under the following categories: status, economic, and legacy. First, in Indian culture and society, the status of the man is highly respected and revered over the status of a woman. One woman cited how there “is some social status” and “social pressure” to have boys (Woman 4, Interview 2023). The reason being tied into the need for a boy child for economic and legacy reasons. Economically, a boy child can help with labor, own agricultural land or other properties, and give “good economical status of the family” (VHW 1, Interview 2023). Finally, boy children seem to be valued for their purpose in taking care of family members in their old age (Woman 3, Interview 2023) and are able to partake in particular religious customs for passed family members when girls cannot (Woman 1, Interview 2023). Additionally, another legacy that those interviewed stated was a value of having a boy child was their ability to carry the last name of the family in order to ensure the family “hereditary” continues – when probed further regarding

this statement, women recognized that both girl and boy children could carry the “hereditary” / genes, but boys could carry the father’s last name forward, ensuring the continuation of the family name (Woman 2, Interview 2023).

Concurrently, interviewees were asked to name the reasons people in their village would want a girl child. Some women mentioned the girl child helping around the house through cooking and cleaning as well as constant connection to the parents even after marriage or moving to a different area. All women used a form of the phrase ‘taking care’ in reference to the fact that, if the boy child were to neglect the parent after marriage, the girl child would be there to provide for the parents.

“She is taking care of the parents when the parents are sick... if the sons are not taking care, she is taking care of the parents” (Woman 1, Interview 2023). “The girl child... for two or three days she is coming, looking after, taking care” (Woman 2, Interview 2023). “So even if the girl child got married and went to another village, still she is visiting and taking care” (Woman 3, Interview 2023). “Even if the parents are giving all the property to the son, still he’s not looking after them. The girl child will” (Woman 4, Interview 2023). “She shows empathy, also whenever there is any health issue, she is coming to take care of the parents” (Woman 5, Interview 2023). “If the son is not taking care, then definitely the girl will take care. The parents are sick, then they will visit them and support by giving money” (Woman 6, Interview 2023).

Whereas the boy child has value for social status, women value the girl child for the unconditional love and support they show to their parents and family.

Gender-Based Discrimination

While some Indians find more value in having a boy child, this paper suggests that the issue stems more so from the low status and disrespect for women and the girl child. The earliest forms of discrimination against girls in India come from female foeticide – sex-selective abortion – and infanticide – murder of the girl child after birth. The Medical Termination of Pregnancy Act of 1971 – with a 2014 amendment – allows for safe and easily accessible abortion services to women with unwanted pregnancies on approval of a medical practitioner prior to 20 weeks of gestation, prior to 24 weeks of gestation if the pregnancy involved risk to mother or child or was caused by rape, or with the special approval from a court of law. With this, the Indian government aimed to stop routine, unsafe abortions performed by unregistered medical practitioners or by self-medication as well as expand the types of medical practitioners who could perform medical abortions (Muttreja & Singh, 2018). Where legal abortions in India should be an act of empowerment for women, it instead acts as a vessel to discriminate against the basis of sex. Further, many find ways to misuse sex diagnostic techniques in the prenatal stage. In 1994, India passed the Pre-Conception and Pre-Natal Diagnostic Techniques Act – with an amendment in 2003 – banning the act of revealing the sex of a fetus prior to birth in an act to stop female foeticide. Further, the Indian government has made multiple attempts via legal action and social campaigns to stop illegal sex discrimination and block sex selection advertisements online (BYJUS Admin, 2022). In spite of this, female foeticide and infanticide continue to occur and go wildly underreported; those seeking to commit foeticide and infanticide find healthcare providers willing to illegally perform the sex diagnostics or even withhold food from a girl child

so that when she dies it can be from causes other than traditional physical violence (Head Doctor, Interview 2023).

CRHP Addressing Family Planning

Via a multi-faceted approach to around-the-clock and inclusive practices, CRHP addresses the failures of the government system and uplifts historically oppressed Indians through empowerment-based health care.

Perceptions of CRHP

When asked about their knowledge and perception of CRHP, the interviewees responded with broad yet positive answers. Village Woman 1, while she did not utilize CRHP's resources as frequently as other village women, stated that she had heard about the programs that the VHW and MHT did in the village; from her understanding, the village trusted CRHP and saw the work they do as vital and "doing well" (Woman 1, Interview 2023). Village Woman 3 also discussed the work that the VHW was doing in the village with providing family planning services. Village Woman 2 and 4 stated how CRHP "provides all the facilities" at a low cost, go "house to house" for health education, were vital during COVID times, and have many facilities that attracts international visitors such as American students (Woman 2, Interview 2023) (Woman 4, Interview 2023). Village Woman 5 was not from a project village; however, she had stated that she worked in the CRHP during COVID and saw how vital the work that they did was. She stated that she believed her village would "be better with" the work of CRHP and the MHT; she also highlighted how "all the staff members are good, dedicated, and they are working [hard]" to serve the community (Woman 5, Interview 2023).

The CRHP healthcare workers interviewed expressed similar sentiments – uplifting the work of CRHP and stating the value they found in the mission. The first VHW interviewed has worked with CRHP since 1972 and has lived on the camp for the past 20 years. When asked about what she liked about CRHP and why she joined, she stated that CRHP gives all “the information, trying to motivate” and trying to help others “understand the facts” (VHW 1, Interview 2023). The second VHW expressed similar sentiments, saying she wanted to work as a VHW with CRHP to provide knowledge and be a part of the “counseling, giving information to the people” that she saw previous CRHP members do. She also recognized the trust of the village members in CRHP as “when we are there, the people gather around us” and listen to what the VHWs and MHT have to say (VHW 2, Interview 2023). Among the MHT, while one member was born into CRHP due to his parents being social workers with the team, the other members joined after seeing the work done and hearing about the impacts that CRHP had on community members. To quote one of the MHT’s members, “they were serving the people really dedicatedly... so that motivates me” (Mobile Health Team, Interview 2023).

Many of the village women and the CRHP healthcare workers acknowledged the trust and respect that village community members hold for CRHP staff – because of this, village members seem to gravitate towards CRHP staff for their health needs rather than the government healthcare workers.

CRHP’s Actions and Addressing Government Failures

In order to understand how CRHP operates, one must examine where the government healthcare workers fail and where CRHP bridges gaps to improve care.

The frequency with which CRHP provides care greatly outweighs that of the government workers. The MHT visits villages approximately every 15 days, and the VHW – a woman

chosen by her community – lives within the community, making her available daily (Ravi Arole, Interview 2023). Meanwhile, multiple women described the frequency of the ASHA and other government healthcare workers to be extremely ineffective. One woman described that, while she may have many resources for her community, the ASHA educated at inopportune times, choosing to arrive when many village members go to work in the fields (Woman 5, Interview 2023). Meanwhile, when CRHP comes to villages, they provide knowledge to members at convenient times for the populations they serve. For example, MHT members might go to farms with the farmers groups and deliver healthcare education there (Mobile Health Team, Interview 2023), while VHWs might host sewing sessions with women and talk about health problems being faced in the community (VHW 2, Interview 2023). The government system does not reach all Indian populations when raising awareness for health issues; scheduled tribes, namely, have the lowest contraceptive use of the Indian population (Muttreja & Singh, 2018). When asked why this might be the case, the MHT explained that tribal groups work long hours and sometimes live on the outskirts of villages, meaning that in the rare cases they know about health education occurring in Anganwadi centers, they do not have the time to go (Mobile Health Team, Interview 2023). Therefore, by going house-to-house and explaining to everyone in the family – both individually and as a group, inclusive of factors like age and gender – the issues at hand and solutions to them, CRHP reached a greater audience than the government can.

The type of care and counseling provided by CRHP also signals the ways in which they tackle major societal norms that negatively impact family planning efforts. When describing health problems, CRHP's team cites anonymous, real examples from families within project villages. For example, if describing the benefits of a 2 child or small family norm, they point to project villagers with small family structures and describe how that family has a comfortable

economic situation, can afford basic needs with ease, and much more. This empowers families to think long-term of their household's physical and economic health, which encourages them to embody the structure of smaller households around them (VHW 2, Interview 2023).

Additionally, the MHT and VHWs address certain beliefs around family planning within particular groups in order to dispel myths. For example, certain religious groups might believe that they cannot use family planning – in his interview, Dr. Ravi Arole mentioned how some Hindu men do not use a permanent method because Hindu scriptures imply that being unable to produce viable sperm makes them less of a man (Ravi Arole, Interview 2023). Moreover, CRHP also talks to in-laws involved in the decision-making process. Women 1 and 5, for example, both stated that their in-laws (such as the mother or sister) had a say in the decision-making process; thankfully, both women stated they found the say of all parties involved were equally important and taken seriously rather than the husband or in-laws having a greater say than the woman (Woman 1, Interview 2023) (Woman 5, Interview 2023). However, not all Indian women have this same decision-making power. Some Indian women find their voices subdued and silenced by their husbands and in-laws. While this paper does not mean to speak to who should have decision-making power in choosing family planning methods, it does emphasize that a woman's agency and status should be at least equal to those involved in the family planning decision-making power (Shradha et. al, 2021). CRHP works to combat these greater social issues affecting family planning efforts.

Finally, CRHP acts as the facilitators of resources and conflict mediators between the government and Indians in project villages. While CRHP does not typically provide family planning services directly – as they make use of the government resources – they hold the government accountable to having the necessary provisions as well as host government camps in

the hospital. Through this, they close the gap between the government and the communities they serve by making people aware of what they have at their disposal and ensure that they understand what rights they have (Ravi Arole, Interview 2023). Equally important, they help act as advocates for their community members in times when the government fails to uplift the autonomy of women. The following are examples from VHWs in which in-laws, husbands, and government healthcare workers did not properly support women in their choices around family planning – or, in extreme cases, committed human rights violations:

“So [one lower caste] woman - they had one male child, one female child... she was too much anemic and then I was motivated her to do family planning. She use method but the husband's in-laws was not ready. She was ready... to do the permanent method, but no one was [assisting] her. And then the third time she was pregnant and she gave birth to a girl child. [But] they were expected that the male child will be there... [the family members] were not happy [with her]... So when the Mobile Clinic team was there in the village, that time Jayrosakhta (nurse) I took that woman to her for counseling. And then the family members said that “you are not ready to have a permanent method. Then at least use some spacing method”. So, only the couple was ready to do family planning - not the in-laws. Then, her mother's village, they give that [operation and counseling] from the other village side and they motivate her to do the family planning. So then the surgery - the permanent method was done” (VHW 1, Interview 2023).

“One case, 3 days old baby. The nurse was with the baby in the hospital and the mom was at house. And then ultimately when the baby is in the hospital that mother came to be with the baby and they did all the forms all that thing. [The nurse tried to withhold the child from the mother unless the mother got the permanent method. The woman brought

this to the attention of the VHW.] She explain the story, all the registration, the things was done by the nurse. “I’m not ready to have the family planning but she was with my baby in the hospital”. So then I counseled and stopped that thing. So the people, they are afraid of the government. “Like when we do this thing they will beat us!” These people, community, when we are doing anything positive the government they are not doing that. We are thinking of their whole, like the whole thing... about the family, their attitudes, their thinking, their problems” (VHW 1, Interview 2023).

“So the womens they were afraid of their husband because if the woman asked her husband to use condom... so they are like scared because big issues. Husbands are not agreeing. So instead of that, for us give some remedy some thing that we will use that. So oral pills it was the best to pay. And with the help of the government nurse free supplies was there. The ASHA was also distributing so they started using oral pills... The educated [women] use condoms and some of the womens who their husbands are not listening, they secretly using oral pills. Some of them did the help of doctor’s advice, they are taking the injectables” (VHW 2, Interview 2023).

From these examples, CRHP proves themselves to be an organization that supports women’s choices in all aspects rather than promoting population control at the expense of bodily autonomy.

Has CRHP Uplifted the Value of the Girl Child in Project Villages?

“We want to get people to realize just how much the girl child – and women as a whole – does for the parents and the family rather than thinking of the girl as a liability due to societal expectations and the practice of the dowry” (Shobha Arole, Interview 2023). Both VHWs stated that over time, they saw the women be able to have either sole or joint and equal decision-

making capacity with their husbands. All of the project village women also stated that they felt they had an equal say to their husband and felt comfortable with the amount of children that they had. CRHP's adolescents and self-help group programs seek to instill behaviors that promote gender equity; during the MHT interview, members said that they had felt the adolescent groups in particular were of great value in starting gender equity work early so that the change can be seen long-term. One member recollected on how CRHP's work has positively impacted the status of the girl child over time when, in her village, "3 young guys got permanent method even only with 2 young girls. They had that award like prize in the program for that to motivate others". Follow up included being asked the hypothetical of "if project village families had family members in non-project villages, how did those family members react to hearing that they had a permanent method without having boy children?". The MHT collectively responded with the fact that family members had confusion and disappointment as a response (Mobile Health Team, Interview 2023). While there are many – both in project and non-project villages – who still want boy children over girl children, this can be attributed to outside factors mentioned previously, such as labor needs and the effects of the caste system. Regardless, non-project villages see an increased number of children being had in hopes for boy children and a lack in care for the girl child (Head Doctor, Interview 2023). CRHP continuously combats gender discrimination in their project villages by ensuring an recognized and deep-seeded value of the girl child at all ages.

How to Reach Empowerment

This paper does not aim to define empowerment or how to measure it, but rather to understand how empowerment can be reached. Empowerment can range from an internal, subjective experience of self-realization to an external experience of understanding what

structural factors prevent this realization as well as assessing how to overcome them (Oladipo, 2008). In order to reach full empowerment, one must be able to gain complete autonomy, independence, power in resource use and decision-making, as well as the ability to overcome systemic obstacles in all areas of life (Ibrahim & Alkire, 2007). Throughout this study period, CRHP would point out examples of empowerment in project villages. For example, if a woman spoke loudly without fear of retribution from the men around her, she had empowerment. If a woman felt that she had an equal say in decision-making and could advocate for herself, she had empowerment. If a woman had up to a 10th standard education or drove cars and motorcycles, she had empowerment. While these examples may not reflect what Western literature would define as empowerment for women, empowerment cannot always equate to what the Western standard is. Empowerment must work within a scale of cultural awareness and understanding.

Dr. Ravi Arole pointed out that many times – especially among those in the development sector – people would say that empowerment for women meant that every woman had a Masters degree and worked in a high paying corporate job; however, this does not reflect the situation and resources within rural Maharashtra. In order to empower women in project villages successfully, empowerment work has to be done within the Indian – specifically the Maharashtrian – context (Ravi Arole, Interview 2023). In a study conducted at CRHP in 2016, interviewees were asked to describe what an empowered woman looked like. They responded by saying, in their perspective, an empowered woman “is able to solve her own problems, no matter what the challenges she faces... their ‘aim is to live life for [their] kids and husband, give them a happy environment and life’” (Madhusudan, 2016). Women in project villages at the time felt that empowered women could fulfill their chosen responsibilities, earn money, and meet the needs of their loved ones because of the support and positive environment created by CRHP.

Village Knowledge, Attitudes, and Practices

Knowledge, attitudes, and practices surrounding family planning varied between the project and non-project village, thereby signaling the impacts had by CRHP.

All interviewees explained their understanding of family planning and how to access the methods. Both project and non-project village women could give a basic overview of different methods – both temporary and permanent. All 6 village women highlighted the Copper T, oral pill, condoms, and sterilizations for women. Women mentioned accessing these resources via medical shops, CRHP, their local VHW or ASHA, as well as government facilities such as a hospital, Anganwadi, or sub center. On top of the more well-known methods, one of the non-project village women mentioned that other wives in her village as well as the “Anganwadi” told her of “giving papaya and banana” as a way to conduct a medical termination of pregnancy early on in the first term as well as to avoid intercourse around certain stages of the menstrual cycle to increase spacing (Woman 6, Interview 2023). Due to the limitations of this paper, the validity, popularity, and knowledge around these methods cannot be verified; however, this speaks to data collected about the ways in which women receive family planning knowledge inclusive of more scientifically-verified information as well as more colloquial ways. When further probed about the methods mentioned, the project village women could give a more comprehensive explanation of the differences between methods and had more open body language when discussing them in comparison to non-project village women – particularly Woman 6 as Woman 5 practices as an ANM. Overall, while knowledge did not vary greatly across the board, comfort in discussion as well as depth of knowledge did.

The interviewees paint a picture of families in their communities wanting to achieve a 2 child norm; however, while those households may use family planning, non-project village

women did not elaborate on why (Woman 6, Interview 2023). Contrastingly, the non-project village women with ANM training as well as all 4 project village women interviewed mentioned the importance of spacing for various reasons. For example, Women 1, 2, and 4 highlighted cost and economics, while Women 1-5 mentioned health of those within the family. While Woman 6 mentioned spacing, she stated that her mother-in-law did not want them to have spacing, so she could not space between her nearly 2 year-old son and her current 6-months-along pregnancy (Woman 6, Interview 2023). Concurrently, project village women had more points of criticism for family planning in India – they wanted to see men be more involved in family planning as well as government health workers properly explaining all the different methods prior to use or conception of the first child (Woman 2, Interview 2023) (Woman 4, Interview 2023). This summary insight reflects on the interviews conducted; as previously mentioned, it would have been beneficial to conduct more non-project village woman interviews. However, many women refused to be interviewed. One woman even went as far to say that she would only talk about family planning if the study team gathered every woman in the village to do it. Meanwhile, multiple project village women eagerly volunteered to discuss family planning and had comfortable body language throughout the entire interview.

VHWs and the MHT spoke to the nuances within village practices around CRHP. These health workers have seen a shift overall in favor of having 2 child norms in place, with both the husband and wife being equally involved in the family planning decision-making process. In project villages specifically, community members increasingly speak to one another about family planning – for example, multiple members discussed how husbands and young women would talk within their individual circles regarding family planning concerns in order to spread accurate knowledge and motivate others to use spacing methods (Woman 2, Interview 2023) (VHW 2,

Interview 2023). One interviewee recalled how village members “were not listening previously. They were saying that they have the land, [and were handling the responsibilities]... So 1 or 2 kids nowadays, they are enough... Nowadays, even one girl child is there, they are having permanent method. They are really for 1 child girl child is there” (VHW 1, Interview 2023). The MHT also observed similar sentiments of the ways in which people talk about family planning with others now while they did not previously: “So during those days it was the many kids, no discussion, no spacing, nothing. And nowadays they are discussing in the group also. Asking their problems then sharing their experience and taking the help... So now they have that trust and guarantee that even if they have one child whatever gender they are doing the permanent method” (Mobile Health Team, Interview 2023).

While the general trend has shown positive practices around family planning, CRHP health workers still see rare outlier instances within project village communities – particularly scheduled tribe, lower caste, and poor Muslim households – struggling to maintain a 2 child goal. Reasons for this include historical oppression within Indian society, the need to participate in agricultural labor making it difficult to access or increase desire of family planning use, and general lack of knowledge or empowerment around family planning (VHW 1, Interview 2023) (VHW 2, Interview 2023) (Mobile Health Team, Interview 2023). Additionally, as previously mentioned, men still need to improve their involvement in the family planning process as some men are not involved at all, not knowledgeable on family planning methods, have misinformed information, or simply “do not care and are only focused on their own pleasure rather than the implications of having unprotected sex” (Ravi Arole, Interview 2023) (Head Doctor, Interview 2023). During their interviews, all 6 village women mentioned the increased need for male participation in family planning. Women 1-5 discussed how their husbands acted as ‘outliers’ in

their communities because they wanted only 2 children, participated in family planning by using condoms, and encouraged their wives to use methods right for them; in spite of this, they noted how very few men in the village acted in this manner. While CRHP has worked greatly to improve the status of family planning in project villages, the onus still greatly falls on the wife to use temporary and permanent methods.

In light of this, CRHP's work proves that the type and quality of care provided can positively impact communities served. Within project villages, it can be argued that when community members feel that they are valued, respected, and properly cared for by their health workers, they use family planning efficiently and in a greater frequency regardless of understanding or formal education on the subject. The biggest difference – when asked – between CRHP and the government came from the treatment of patients in family planning. The way that government healthcare workers conduct patient care and have a “time limit” makes interviewees and their constituents feel like a number to be counted rather than a human being seen holistically (Woman 5, Interview 2023). Women – and CRHP healthcare workers – value that CRHP emphasizes the need to counsel around the clock on various yet intersecting issues because CRHP sees how multiple issues can impact a person's health and wellbeing all at once (VHW 1, Interview 2023) (Woman 4, Interview 2023). By CRHP being empathetic, passionate, and inclusive in their care, they ensure that village members can lean on them and use all the available family planning services as they choose. If community members do not gain knowledge, resources, and empowerment from healthcare workers because of the family planning infrastructure put in place by the government, it begs the question: how can people that have more than 2 kids be blamed for the situation thrust upon them by a flawed system? The government must take responsibility for accommodating the needs of all populations in India.

Recommendations for Improving India's Family Planning Programmes

While CRHP makes great strides in improving empowerment around family planning in their project villages, both CRHP and the Indian government must work to constantly re-evaluate and improve their family planning programs in order to support empowerment-based health care delivery for all. The following are a culmination of suggestions by the interviewees on how both the government and CRHP can work to improve their family planning delivery.

Availability of Resources

One study highlights how limited access to “modern” spacing contraceptives can be one of the biggest barriers to the use of spacing contraception among young, married couples in rural Maharashtra (Ghule et. al, 2015) as well as the need to increase resource procurement (Muttreja & Singh, 2018). In interviews, both healthcare workers and village women criticize the lack of family planning resources at their disposal.

For the village women, they struggle to maintain consistent access to contraceptives. Women 5 stated that, in non-project villages like hers, sometimes women will finish their oral pills and go to the ASHA for another packet; however, at times, the ASHA does not have any supplies to be able to accommodate for the need, which could lead to the possibility of pregnancy for that woman if she does not continue with her family planning method (Woman 5, Interview 2023). Woman 4 expressed her concerns with similar shortages as women in her village would get family planning methods from medical shops if the sub center did not have supplies; she stated that, many times, “[the sub center] themselves are distributing to use but [are] not available” (Woman 4, Interview 2023). She also stated that, while she liked the facilities available at CRHP because she does not have to pay money for the same resources at

other facilities, some people may not have the same ability. She argued that, when stocks of condoms are finished at sub centers, sometimes people cannot access them for long periods of time – this leads them to have to pay more out-of-pocket, go to other areas further away, or potentially even wait and return later for them. All of these have the potential to cause households to spend unnecessary funds or even get pregnant if they attempt to have sex through other, less reliable methods such as withdrawal or ovulation tracking (Head Doctor, Interview 2023).

The Mobile Health Team also expressed the need for more resource availability as a way to increase family planning effectiveness – in their interview, one MHT member expressed how they wished that men would take advantage of being able to easily stop pregnancies with condoms rather than have the wife go through potentially painful procedures or risk missing an oral pill (Mobile Health Team, Interview 2023). The Head Doctor boosted this sentiment by arguing that both male and female contraceptive methods should be used among Indian populations (Head Doctor, Interview 2023).

Interviewees hope that in time, the government and other agencies addressing family planning will not only create contraceptive supply surplus stocks but a plethora of types of family methods for people to choose from.

Accessibility of Healthcare Workers

Literature suggests the need for better coordination in family planning programs, monitoring, and training initiatives in order to improve the overall quality of family planning programs in India (Muttreja & Singh, 2018). Interviewees across the study period have expressed the need for a holistic improvement in the healthcare workers providing these resources.

Among village women, many believe that ASHAs and other healthcare workers should improve the timing of their health education sessions. Woman 1's mother, for example, holds a VHW position with CRHP; however, Woman 1 herself did not express a great deal of understanding around family planning knowledge (Woman 1, Interview 2023). In a later interview, a MHT member from the same village revealed that that woman lives in the outskirts of the village, making it difficult to reach her and other members in the area, which include scheduled tribe and lower caste households. While the MHT and VHWs attempt to reach everyone in their care, it cannot always be possible – they expressed the need for government healthcare workers to also help in this knowledge distribution (Mobile Health Team, Interview 2023). The MHT connected this to a larger issue seen in the fact that family planning knowledge could not be accessed by people who need it the most. In Woman 5's interview, she addressed the criticism many ASHAs and other government health workers face with regards to their availability. She stated that they would come around “1-1:30” when the women from scheduled tribe or lower caste households would be at the farm for work – sometimes, the work would extend from early hours in the morning to late at night depending on the season and harvest. At that time, ASHAs would go to houses or hold education sessions at the Anganwadi. Woman 5 argued that the “problem is the timing, [sometimes] no visit... no one waits for them... for the women, [ASHAs] should come before 10 before their work. Then it will make a difference” (Woman 5, Interview 2023). The time that healthcare workers provide knowledge around family planning – as well as other vital health topics – must be at times where everyone can access education.

Healthcare workers at CRHP expressed a different priority concern when it comes to healthcare worker accessibility. In her interview, VHW 1 expressed symptoms of tiredness and

burnout because she acts as the only VHW for a population of almost 1000 people. She understood the need for people to gain frequent knowledge and counseling around family planning as new topics arose; however, at times, she had no time to think about her family because she had to serve her community. She argued that there should be more dedicated, effective healthcare workers helping serve the community so the burden does not fall on a select few people (VHW 1, Interview 2023). VHW 2 spoke similarly; however, she argued that there should be more ASHAs, and they should act in the capacity that CRHP does. VHW 2 made aware the fact that ASHAs conduct their outreach independently – because of this and a number of other factors, the ASHA treats community members like numbers and lacks emotional accessibility. However, CRHP comes in large groups, can distribute responsibilities equitably, and can take the time to consider the person as a whole in order to address any issues occurring. She believes that ASHAs should work as a unit rather than the individual (VHW 2, Interview 2023). If the government improves quality of care and healthcare worker accessibility – both physical and emotional – then quality of life as well as family planning use has the potential to improve greatly.

The diversity of healthcare workers providing the services as well as the knowledge provided during counseling must be increased as well. While there are over 900,000 ASHAs in India, Indians do not feel confident or trusting in the quality of care they receive from them or the Indian healthcare system – women frequently complain about mistreatment by healthcare workers, lack of universal access to contraceptives, and generally poor family planning investment by the government (Muttreja & Singh, 2018). CRHP proves that community mobilization as well as all-encompassing counseling that addresses myths and misconceptions can increase the positive health behavior as well as receptiveness of health knowledge in project

villages without the need for cash incentives or handouts. Further, what makes the healthcare workers at CRHP so unique is that they are the friends, peers, and loved ones of those they serve; village members see themselves represented in religion, caste, and economic status. By seeing someone like them be able to provide such vital services, it not only allows for a trusted person to go to to seek guidance, but it empowers them to do more than what is expected of them in society.

Counseling Methods

When asked what an area of improvement in family planning was, healthcare workers and village women alike cited the need for better counseling methods.

Across the board, those interviewed recognized the need for mixed gender family planning counseling. Some barriers to spacing contraceptive use include the husband's lack of involvement on family planning issues as well as general misconceptions (Ghule et. al, 2015). Multiple women in their interviews discussed the importance of counseling – both for men and women – in order to share knowledge across a diverse group of community members (Woman 3, Interview 2023) (Woman 6, Interview 2023). A member of the MHT stated that she “[likes] to say to the mens it is very important to counsel all the things to the pregnancy. The things – complication, risk, health problems – are all there to the woman. So his responsibility should be there, use condom... it is the easier method” (Mobile Health Team, Interview 2023). Multiple interviewees also mentioned the importance of men being educated in family planning because they can go to their social circles and share their experiences. One of the women, for example, stated that men “definitely will share” information about family planning with one another; “in our friend circle, the mens – the discussion – is there. So the mens, he is also sharing his experience and the information” (Woman 5, Interview 2023). Both VHW 1 and the Mobile

Health Team alluded to this same phenomena, and how such discussions among men help alleviate potential stigma around the conversation of family planning as well as the burden upon women, making it easier to discuss and ask questions to healthcare professionals (Mobile Health Team, Interview 2023) (VHW 1, Interview 2023).

In an initial trial in rural India called the CHARM (Counseling Husbands and wives to Achieve Reproductive Health and Marital equity) trial, researchers investigated how men engaging with other men in gender equity and family planning counseling would impact use, understanding, and marital relationships. The trial revealed that this counselling method increased pill and condom use and reduced marital sexual violence; however, the CHARM trial had a limited reach for women (Dixit et, al, 2019). In an expanded trial with adjusted methods to add a female provider delivering counseling to women and to the couple together, called the CHARM2 trial, the new method showed high couple retention in the program, increase in intra-couple communication and agency for women's choice, and a decrease in the unintended pregnancy rate among women with expressed fertility ambivalence at the baseline (Raj et. al, 2022). This trial supports the idea that, when men are more involved in aspects of sexual and reproductive health and family planning, women feel more empowered to seek family planning care (Muttreja & Singh, 2018). With more mixed gender and male-oriented family planning programs, couples will be empowered both as individuals and as a family unit to achieve needed health delivery and equity for those in the family.

While the healthcare workers and village women mentioned the need for mixed gender counseling, the head doctor argued that the Indian government should make more of an effort to educate adolescents on sexual health behavior. India has the largest youth population in the world, but a large amount of Indian youth lack the access, knowledge, and vocabulary needed to

safely and effectively use contraceptives (Muttreja & Singh, 2018). In his interview, the head doctor argued that India lacks a comprehensive sexual health education curriculum for adolescents – he acknowledged that, while it may be occurring in schools, teachers may not be delivering the education and knowledge in an effective manner due to their own internal biases and perception of the stigma around the subject. In his opinion, if adolescent sexual health education with an emphasis on open dialogue and comprehensive knowledge became a priority, then Indians would be more likely to benefit positively long-term (Head Doctor, Interview 2023). Healthcare knowledge should not just be obtained in adulthood or after marriage – tackling major health needs early can lead to knowledgeable, motivated, and safe youth long-term.

Conclusion

This paper sought to understand the ways in which the Comprehensive Rural Health Project's Jamkhed Model empowers families in rural Maharashtrian project villages to utilize family planning services effectively. Gender discrimination continues to be at the core of many decision-making processes around family planning in certain households; however, the work of the Village Health Workers and Mobile Health Team motivates communities to uplift women and the girl child.

Findings revealed that, while government healthcare services do not create an inclusive and supportive environment, CRHP intentionally utilizes government resources as well as knowledge employment to enact real and positive change in households. Despite this, some families still face difficulties in reaching empowerment due to systemic constraints on identity-specific populations. In order to improve the family planning scheme in India, the government –

and other relevant organizations – must improve resource availability, healthcare worker accessibility and inclusivity, as well as counseling methods, according to the interviewees.

We must work together to empower women such that they can control their own reproductive lives and have the resources to carry out family planning intentions. Contraceptive use, bodily autonomy, and reproductive health are human rights – governments and healthcare providers should be boosting these ideas rather than suppressing them like many have for centuries.

Recommendations for Further Study

As stated in the limitations, the time constraint posed a serious barrier to fully exploring the various nuances of family planning in India. During my study project period, the following topics were presented but not explored further due to the scope:

1. The role of healthcare workers in family planning delivery
2. Private versus public healthcare delivery of family planning services
3. Perception of different family planning methods
4. The explicit role of the ASHA in family planning
5. Family planning surgery / medical camps
6. The role of religion and tradition in family planning
7. Stigma of sexual intercourse
8. Sexual health education in Indian schools
9. Allopathic versus Homeopathic family planning techniques

If interested in expanding on a topic related to this study project and would like to discuss further, you may contact me at sezinsakmar@gwu.edu. If interested in exploring topics related to

the Comprehensive Rural Health Project, CRHP hosts interns twice a year who contribute to CRHP operations as well as have the opportunity to conduct a study project of their choice. Ravi Arole can be contacted via email to discuss: ravi@jamkhed.org.

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Woman 3. Interview. Conducted by Sezin Sakmar. Translations by Surekha Sonawane. 17 April 2023.

Woman 4. Interview. Conducted by Sezin Sakmar. Translations by Surekha Sonawane. 17 April 2023.

Woman 5. Interview. Conducted by Sezin Sakmar. Translations by Surekha Sonawane. 18 April 2023.

Woman 6. Interview. Conducted by Sezin Sakmar. Translations by Surekha Sonawane. 18 April 2023.

Appendices

Interview Questions for Village Women

1. What is your name?
2. How old are you?
3. Were you educated? What level of education did you receive? Why did you stop education?
4. What is the name of the village you live in currently? What is the name of your mother's village?
5. Who all are in your family? Who lives in your household?
6. How many kids do you have? How many boys? How many girls? How old are they all?
 - a. Are all of your children in school?
7. How many brothers and sisters do you have?
8. What is your occupation? How long have you been in this occupation?
9. Are you a part of a self help group?
10. What is your daily routine?
11. Are you giving time for yourself, your hobbies, etc.?
12. Why would some people in your village want a boy child?
 - a. Why would some people in your village want a girl child?
13. What do you know about family planning?
14. What are the different methods of family planning, and what do you know about them?
15. Where do you get your family planning education / information from?
16. Have you used family planning services?
 - a. What type of family planning did you get? → Temporary v Permanent Method
 - b. Who do you prefer to go to to get your family planning services?
 - c. How did you choose to use family planning?
 - d. Who helped you make that decision?
 - e. Are you comfortable with that decision?

17. What is the general perception of family planning services in your village?
18. What is the women's perception of family planning services in your village?
19. What is your husband's opinion when it comes to family planning?
20. What do you think a man's role should be in family planning?
21. Do you want more kids / are you thinking about having another kid?
22. Do you think it is important to use contraceptives and family planning? Why or why not?
23. Do you think it is important to have family planning? Why, or why not?
24. What is the purpose of intercourse?
25. What is the role of CRHP in your village when it comes to family planning?
26. What is an area of improvement when it comes to family planning delivery? (Ex: health education, access, cost, type, distance from home to get services, facilities, etc.)
27. Is there anything else you want to share?

Interview Questions for Mobile Health Team

1. What is everyone's name?
2. What is each of your education levels?
3. How long have you worked with CRHP?
4. What are each of your individual roles on the MHT - both at village and at CRHP?
5. What are all of your daily routines?
6. In the village, how are you educating people on family planning services? (ex: method use, how to access, health behavior, etc.)
7. What are the most common reasons people use family planning?
8. What are the most common reasons people don't use family planning?
9. What questions do you get asked by people about family planning when in villages?
10. How do you counsel families or couples on family planning?
11. How are you motivating the women to use family planning services?
12. How do you see the use of family planning affect family dynamics?
13. What is the importance of family planning?
14. What are the benefits and disadvantages of having a small family?
15. What are the benefits and disadvantages of having a big family?
16. Can you share an example of what it's been like delivering family planning services on the MHT?
17. How does religion impact family planning?
18. How does caste impact family planning?
19. How does money and the economy impact family planning?
20. How have you seen the way you provide family planning services change over time?
21. How have you seen the way the government provides family planning services change over time?
22. What are the good parts of the way you provide family planning services? What parts would you like to change to make it more effective?

23. What do you think the difference in providing family planning services is between the government and CRHP?
24. In what ways does CRHP work with the local government to deliver family planning?
25. If you could, how would you change the way the government provides family planning services?
26. What is the purpose of intercourse?
27. Is there anything else you want to share?

Interview Questions for CRHP Leadership

1. What is your name?
2. What is your education level / type of education?
3. What is your daily routine?
4. How long have you worked with CRHP in an official capacity?
5. How would you define your role at CRHP?
6. Describe the mission and values of CRHP.
7. What are the priorities of CRHP? How would you rank these priorities - importance?
8. Describe the populations you serve.
9. What are the priorities of the population you serve? Ranked - importance?
10. How have you seen shifts in the community over time since working with CRHP?
11. What are the different ways in which CRHP provides family planning services?
12. When did CRHP begin providing family planning services, and what were the reasons behind this?
13. What are the biggest challenges when providing family planning services?
14. How do ideas like caste, religion, and the economy affect family planning?
15. How have you seen the way you provide family planning services change over time?
16. What is the importance of family planning?
17. What do you think is the purpose of intercourse?
18. What's the relationship between intercourse and family planning?
19. The government has a system in place for family planning. How do you see CRHP fitting into that system or working alongside it?
20. How have you seen the way the government provides family planning services change over time?
21. How successful would you say your family planning service delivery has been?
22. What are the good parts of the way you provide family planning services?
23. What parts would you like to change about the way you provide family planning services?
24. What do you think the difference in providing family planning services is between the government and CRHP?
25. Do you have any suggestions to make the way CRHP provides family planning services more effective?

26. Do you have any suggestions to make the way the government provides family planning services more effective?
27. How do you measure success of delivery for any of your programming?
28. Where do you see CRHP in 5-10 years?
29. Is there anything else you want to share?

Interview Questions for Village Health Workers

1. What is your name?
2. How old are you?
3. What is the name of your village?
4. Who all are in your family? Who lives in your household?
5. How many kids do you have? How many boys? How many girls? How old are they all?
6. How many brothers and sisters do you have?
7. How many years have you worked as a VHW/ASHA? What village do you work in?
8. What level of education did you receive? Why did you stop education?
9. What is your village population demographics?
10. Right now, what do you think are the top priorities of the community you serve?
11. What is your daily routine?
12. When was the first time you learned about family planning? Where did you learn about it? Who did you learn about it from?
13. Have you ever used family planning?
 - a. What type of family planning did you get? → Temporary v Permanent Method
 - b. Who do you prefer to go to to get your family planning services?
 - c. How did you choose to use family planning?
 - d. Who helped you make that decision?
 - e. Are you comfortable with that decision?
14. What are the different methods that women in your village like to use the most for family planning? Why do they like this method the most?
15. Right now, what is the general perception of family planning services in your village? What was the perception when you started working in your village?
16. How do you educate women on family planning?
17. Who in the family makes the decisions about family planning for women?
18. What is the women's perception of family planning services in your village?
19. What education do men in the village receive about family planning? By whom do they receive this education? How did they respond to this education?
20. What is the men's perception of family planning services in your village?
21. What is your husband's opinion on family planning?
22. How does religion impact family planning?
23. How does caste impact family planning?

24. What are the good parts of the way you provide family planning services? What parts would you change if you could?
25. What do you think the difference in providing family planning services is between the government and CRHP?
26. If you could, how would you change the way the government provides family planning services?
27. What is the importance of family planning?
28. Is there anything else you want to share?

Interview Questions for Head Doctor

1. What is your name?
2. What is your occupation? How many years have you worked as this? Where do you work?
3. What level of education did you receive?
4. What is your daily routine?
5. Who all are in your family? Who lives in your household?
6. How many kids do you have? How many boys? How many girls? How old are they all?
7. How many brothers and sisters do you have?
8. What is your patient population demographics?
 - a. How many patients are you responsible for providing services to?
9. What are the health-seeking behaviors of your patient population when it comes to FP services?
10. Right now, what do you think are the top priorities of the community you serve?
11. When was the first time you learned about family planning? Where did you learn about it? Who did you learn about it from?
12. What are the different methods that women in your community like to use the most for family planning?
 - a. Why do you think they are used the most?
 - b. Which do women in your community like the most?
13. Who in their family makes the decisions about family planning for women?
14. What is the general perception of temporary v permanent methods in your community?
15. What is the women's perception of temporary v permanent methods in your community?
16. What is the men's perception of temporary v permanent methods in your community?
17. What are common misunderstandings of family planning?
18. How do people get referred to the doctor for family planning?
19. What is the importance of family planning?
20. What is the biggest struggle in delivering family planning services?
21. How do you counsel people on family planning?
22. How do you motivate people to use family planning? Why do you motivate them in this way? Is it working?

23. What are the different ways to give information on family planning methods? What method do you like the most to provide? Is it working?
24. What are the good parts of the way you provide family planning services?
25. What parts would you like to change about the way you provide family planning services?
26. What do you think the difference in providing family planning services is between the government and CRHP?
27. Do you have any suggestions to make the way CRHP provides family planning services more effective?
28. Do you have any suggestions to make the way the government provides family planning services more effective?
29. Can you share an example of what it's been like delivering family planning services as a doctor?
30. Is there anything else you want to share?