Promoting Optimal Inter-pregnancy Interval in India Through Integrated Public Delivery systems—Differential Education Campaigns for different Stakeholders

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Project title: **Promoting Optimal Interpregnancy Interval in India Through Integrated Public Delivery systems**

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Abstract:
Early marriage and closely spaced births are important causes of high maternal mortality and neo-natal mortality in Uttar Pradesh, India. Present paper attempts to understand compulsions of young couples for early first pregnancy and reasons, despite desiring second child three years later, do not practice postpartum contraception. 20 FGDs and 30 in-depth interviews of married couples aged 15-25, providers, elderly women/community leaders were conducted to address these questions.

Findings show that young couples experience pressure from elders to demonstrate fertility at the earliest and to see their grandchildren. Strong belief prevails that contraceptive use before first child causes infertility. Despite desire to enjoy married life they do not succeed as they succumb to family pressure, lack knowledge of contraceptives and its accessibility and objection from husband to contraception. Failure of postpartum contraception is also due to misconceptions about timing of next conception—when woman becomes biologically capable for pregnancy.

Background

A large number of girls in India are married at a very young age. Approximately half of 20-24 year old girls are married by age 18 and quarter by age 15 (IIPS and ORC Macro 2000). In addition, while there has been marginal increase in the average age at marriage, there has not been parallel increase in the time elapsed between marriage and first birth (Mensch, Bruce and Green 1998). Girls aged 15-19 years, contribute 19 percent of nation's total fertility (IIPS and ORC Macro 2000).

The total fertility rate of the nation has reduced from 3.4 in 1990 to 2.7 in 2005 and contraceptive use increased from 41 percent in 1990 to 56 percent in 2005. However, maternal and infant mortality continue to be areas of concern. One of the important causes of continued high maternal mortality and infant mortality is short inter-pregnancy interval and frequent unwanted pregnancies. Not only is there risks associated with closely spaced births, the first birth itself is expected soon after marriage, thus elevating risks of adolescent motherhood. The social pressure on the young couples to have their first child soon after marriage is huge and often difficult to resist. Moreover most of the unwanted pregnancies are aborted by unsafe methods under unhygienic conditions. This often leads to serious health consequences including maternal deaths. The major groups that fall victim to these situations are rural women and the poor living in slums. The unmet need for family planning method is still high, (around 16 percent) and 21 percent of all pregnancies in India are unplanned.

The consequences of short spaced , unwanted births is well reflected in the Global Health Council study which shows that while the number of live births has stabilized at around 131 million per year worldwide, the number of women dying each year as a result of unintended pregnancy has increased. Over one fifth of the women who died during the study period died because of inability to space their births and prevent unwanted pregnancies(Daulaire, Leidl, and Mackin et al.2002). About 16 percent of maternal deaths are the result of unsafe abortion and post-abortion complications. Most of these deaths could be avoided by maintaining 3-5 years spacing between births and avoiding unwanted pregnancies.

National Family Health Survey (NFHS) data also show that low age at marriage, early age pregnancies and lack of Postnatal Check-up (PNC) contributes significantly to high maternal and neonatal mortality. In poorer and less developed states like Uttar Pradesh, the situation is even more bleak. In Uttar Pradesh, 40 percent of 15-19 year old girls are married and 29.3 percent of them are with an unmet need for contraception. Further, while the median birth interval in the state is 30 months, for young women the median birth interval is only 25 months.

Interventions like increasing age of mother at first birth and increasing inter-pregnancy interval to 3-5 years can reduce maternal and infant mortalities considerably. Available studies demonstrate that birth interval of 3-5 years could increase chance of infant and maternal survival by 2.5 times than children born at interval of 2 years or less (Whitworth and Stephenson 2002, Winikoff 1983, Setty-Venugopal and Upadhyay 2002, Rutstein 2002). The interval of 3-5 years between two births is now commonly known as Optimal Birth Spacing Interval (OBSI) and is considered as an important family planning intervention to improve maternal and child health.

Though the Indian family welfare program was successful in increasing contraceptive use among couples who have achieved their desired family size; it has failed in educating people about the importance and need of adopting contraception for spacing. According to the 3rd

All India Family Planning Survey conducted in 1990, for more than half of the couples, the first family planning method ever used was sterilization (Khan, et. al. 2000). This situation has not changed much even today. Less than 10 percent of the women receive any PNC and counseling on postpartum contraception. Not only are women unsure about Lactational Amenorrhea Method (LAM), accurate knowledge of LAM as a contraceptive method is lacking among providers too(Varkey, Mishra, and Das et.al. 2004).

To achieve millennium development goals, government of India is using RCH-II program and National Rural Health Mission to ensure ANC, safe delivery and postpartum care to all women particularly young women with parity zero and one. The concept of inter-pregnancy spacing and its advantages were never given serious attention as a program objective by the national family welfare program. However, now there is growing realization among program managers that it must be addressed seriously as an intervention to reduce maternal mortality and pregnancy complications and for mother's and child's health. The challenge is how? What programmatic interventions and educational efforts could help in achieving these goals?

Objectives

Keeping the above mentioned points in view, FRONTIERS Program of the Population Council is testing a model to increase postpartum contraception among young women pregnant for the first or the second time. The project is divided into four phases—formative study, implementation of intervention, evaluation and creating conditions for scaling-up.

The purpose of the formative study was to understand the views of all stakeholders—young women, their husbands, elderly family and community members and the providers—about (a) the compulsions to have first child soon after marriage, (b) perceived importance of maintaining adequate spacing between pregnancies, (c) reasons why despite desiring spacing between births, the young couples are unable to delay their second pregnancy and (d) practice of Lactational Amenorrhea Method (LAM) and postpartum contraception among them. It is envisaged that the findings of the first phase of the study will be used for developing educational messages and counseling aids that will be used in second phase to educate different stakeholders (women, her husband and mother-in –law) about the need and importance of 3-5 year birth spacing. This paper discusses the findings from the formative research.

Study setting

The study was carried out in the rural area of Meerut district of Uttar Pradesh. Uttar Pradesh is the most populous state (166 million) of India with relatively poor socio-economic development and poor demographic indicators (www.censusindia.net). Meerut, the study site in Uttar Pradesh is approximately two hours drive from Delhi and has a rural population of 217 thousand. Early marriage and closely spaced births are common in Meerut like in other parts of Uttar Pradesh.

Methods

Qualitative methods were used to collect required information. A total of 20 Focus Group Discussions and 30 in-depth interviews of newly married and first time parent men and women were conducted. In addition, FGD was also conducted with mothers-in law, community leaders and family planning providers. Details of the FGD and in-depth interviews conducted are given below.

Focus Group Discussions

- Women and men who are newly married or first time parents 6 each
- Elderly women in the family 4
- Community opinion leaders 2
- Family Planning and health care providers 2

In-depth Interviews

- Newly married (six month or less) non pregnant women 5
- Newly married (six months or less) pregnant women 5
- Women with one child, delivered in last 6 months 5
- Women with one child, delivered in last 12-18 months 5
- Husband of newly married pregnant and non-pregnant women 10

Research instruments were developed drawing on the conceptual framework of the study. The guidelines for FGD and in-depth interviews included open-ended questions and probes for issues that may come up during the discussion/interview. These guidelines were written in English and then translated into local language (Hindi). The vernacular guideline was pre-tested before data collection began. The data from this pilot exercise was discarded and not included in this analysis.

The data were collected by the authors themselves in July-August 2006, with the help of three other social scientists who had experience in collecting qualitative data. The informants were identified with the help of Auxillary Nurse and Mid-wife (ANM) or Anagnawadi workers. These community level workers are generally acquainted with the families, particularly young married couples. ANMs are health and family planning providers at the village level. They are expected to list all pregnant women to see that they receive at least 3 antenatal checkups. Under the Integrated Child Development Scheme (ICDS) of Department of Social Welfare, Anganwadi centers are established in all the big villages. An anganwadi worker is appointed for a population of 1000 people. Anganwadi workers are the village level workers of the ICDS program. These workers, in addition to providing supplement nutrition to pregnant and lactating mothers and children under 6 years of age, have to visit their households to counsel them on health and nutrition.

The in-depth interviews covered informant's background, their family formation and associated attitudes and practices including spacing between births, postpartum contraception and current family planning use. In the FGDs too, the same topics were discussed but it gave a general view of the community and not personal experiences. All the FGDs were taped with the permission of the informants. Similarly all the informants in the in-depth interviews, except one woman allowed their individual interviews to be taped.

Data Analysis

The taped interviews were transcribed and translated within a week of the event. Summaries were written on the day the data was collected. After the in-depth interviews and FGDs were transcribed and translated, a code list was developed using the main themes of the study.

Data analysis was performed using a modified grounded theory approach- a process that allows researchers to discover categories, themes and patterns that emerge from the data. "Interpretations must include the perspectives and voices of the people whom we study.... Interpretations are sought for understanding the actions of individual or collective actors being studied" (Strauss and Corbin 1994).

The data were coded and analyzed using Atlas-ti, a software package for qualitative data analysis. The initial categories for the analysis were drawn from the study guide and additional themes and patterns emerged when the data was reviewed. For this article, insights from these analyses were drawn on to identify emerging trends and crosscutting themes.

Results

The analysis of the data highlights several important social constructs and compulsions that influence young couple's early reproductive life. This includes:

- Compulsion to bear first child as early as possible
- Desire of couples to have 2nd pregnancy at least 3 years after first birth but their failure to translate their desire into action
- Causes of the failure to delay 2nd pregnancy are more programmatic than cultural
- The same message or BCC to promote postpartum contraception may not convince all the stakeholders—woman, husband and mother-in-law—and hence BCC needs careful planning to address to the different stakeholders.

In the following paragraphs each of these aspects are discussed at length.

Social Compulsion for First Pregnancy

Newly married couples experience enormous pressure for pregnancy as soon as possible after marriage. This compulsion stems from the need to demonstrate their fertility and many times also to satisfy desire of in-laws to see their grandchildren. Findings from the in-depth interviews allude to the circumstances in which women put pressure on their husbands for an early pregnancy or vice versa. Opinion varied on who should decide on the timing of pregnancy. While this varied across the pregnancies, for the first pregnancy it was the newly married woman who experienced pressure to conceive soon.

The following quotes from newly married men and women reflect the dynamics of pressure couples experience for first child.

A Newly married pregnant woman aged 19 reported:

> " *After marriage, I told my husband that I want first pregnancy only after 1 year. But he wanted soon. I was upset but then I thought, after all it is his parents' desire to see their grand child. So I agreed."*

Husbands had to yield to the pressure women experienced to prove their fertility.

> *" After marriage I used Nirodh (condom) for 10-12 days. But then wife started perusing me to have the first child soon. My aim was to have first child after 2 years, but I had to give in to the pressure from wife. In fact the pressure was from my grandmother who was telling her all the time that she wants to see grandchild before death".*

According to some male informants, newly married couples could delay their first child only in cases of educated couples and when the husband did not yield to the pressure of elders.

> "*Since my wife is studying, we don't want children before she completes her studies. Though this is our wish, we are being forced by my parents for a child. My wife's mother was going to take her to the doctor. Hope we will survive the pressure.*"

Another young man felt that it is easier for a man than the new bride to explain to his mother why they do not want children immediately.

"If husband supports, then women will surely do something to delay first pregnancy. It is only son who can convince his parents and reason with them why delaying first pregnancy is important and useful. But a young newly married woman can not do that."

Peer pressure among men is also a serious barrier to delaying first child among newly married men. Teasing among male friends is very common. This acts as a pressure on young men who want to prove that neither they or their wives have infertility problems.

A man, married for 4 months commented:

"*I was able to convince my mother that since I am unemployed we will have first child after 2years. My mother agreed. But the way friends tease me is too much to bear. I have managed so far.*"

Community leaders also confirmed that not only women but young men too are under tremendous pressure for demonstrating their fecundity. This pressure from friends is more overwhelming than pressure from elders.

"It is (pressure to have first pregnancy soon) more to do with friends. If the wife does not conceive within 4-6 months, they will start saying, "Nothing is happening to you, what is the matter?"

This was endorsed by young married men also.

"We don't like to hear from friends and family members that something is wrong with our wife."

Findings also illustrate the different pathways the pressure for first child takes. If the woman does not conceive within 3-4 months after marriage, pressure starts building up and if she does not conceive within 10-12 months of marriage, it becomes a matter of great concern and treatment from a doctor is initiated.

A young woman narrated:

" Though we wanted the child soon after marriage, I did not conceive for about a year. My mother-in-law was very concerned and she took me to a doctor. I took the pills he gave me, but nothing happened (did not conceive). I then contacted a person who does "Jhaad Phookh"(traditional healer who chants to remove the evil eye or such bad influence preventing conception*), still nothing happened. Then I stopped doing anything for sometime and I conceived".*

It was observed that often the treatment from doctors, traditional healers and religious leaders are sought simultaneously indicating the desperation of women (often felt more by mothers-in-law) to conceive for the first time at the earliest. These practices were emphatically mentioned in the community leader's FGD:

"Some will go to doctor. Some will show to vaidh(provider of herbal medicines*), some will go to priest, mullah and conduct special pooja* (prayers*). In some instances, they sacrifice something like chicken for conceiving. All these could be done simultaneously. "*

If a woman does not conceive, it is generally considered as woman's failing and she is subjected to treatment, mostly by general practitioners or other local indigenous healers. The women is not taken to an infertility specialist. Hence it is not surprising that very often the treatment is given without any tests. Only when doctor asks husband to undergo tests, he is taken for treatment.

Pressure to conceive early also results from the interactions with the neighbors and community members. When the neighbors frequently ask about pregnancy status of daughter-in-law; mother-in-law feels pressured to prove that her daughter-n-law is not infertile. The goodwill advise to take daughter-in-law for treatment can hurt mother-in-law and in turn she calls her daughter-in-law "banj" (infertile) and try to hurt her. This can even lead to fights at home. Many families still believe that if childless woman touch children, it can cause some harm to child, even death of child.

Threats about re-marriage begins if conception is delayed for 2 years. However, many woman believed that these are only threats and remarriage does not take place. We too believed so until we came across 3 instances of remarriage where the man remarried because wife could not conceive for 2-3 years. One of the FGD participant herself was a victim. Her husband had divorced her and married another woman after 2 years of marriage because she did not conceive.

Sometimes the problem would be with men but women suffer and is well reflected in the quote of a young women who participated in FGD:

> *"I know a family, where the man left the first wife because she did not conceive. The man remarried 3-4 years later, It is been 3 years since the 2nd marriage and wife has not yet conceived. Now she is receiving treatment to conceive."*

Many believe that contraceptive use to delay first pregnancy is harmful and it could cause infertility. Some women narrated experiences where women had to undergo treatment to conceive after the discontinuation of contraceptive pills. It is believed that reproductive "machine" gets "rusted" if not used for some time particularly soon after marriage. Hence it is a general belief, partly because of lack of program emphasis on spacing, that the best thing is to have the desired number of children quickly and get sterilized.

Because of the overriding belief that pills cause infertility, women did not use pills before the first child. A young woman during FGD authoritatively mentioned:

> *"First of all people have no information on what to eat (FP methods) to avoid pregnancy. I read in the newspaper so I know that initially one should not use family planning methods as it could cause problem in getting pregnant later. "*

Mothers-in-law also echoed the same belief:

> *"Those who take pills to delay will not conceive even after stopping its use. --- It is not a belief, that is how it happens. Once they stop pills, they have to undergo all sorts of treatments and for long time too, to conceive."*

This was reiterated during the interviews and discussions with the men too.

> *"There are many such cases. That is why it is important to have 1st child before using contraceptive methods, especially pills. Then even if she does not conceive after that, it doesn't matter. At least they have 1 child."*

Some of the providers also held similar belief. A typical quote expressing their view:

"S*ome risk is involved in delaying first pregnancy for one or two years. It may be difficult for them to conceive later*".

ANMs mentioned that the desire for first child at the earliest after marriage is so strong that investing time and energy on counseling newly married couples for contraceptive use is waste of time. Providers also informed that only those women who are facing marital conflicts soon after marriage and are not sure if the relationship will continue, are perhaps the few who would use contraceptives to prevent or delay first pregnancy.

Education and exposure to modern life however, is helping in moving beyond social restrictions and stimulating desire among young couple to spend time together and enjoy married life before the first child arrives. The quotes from newly married women exemplify their desire to enjoy married life for sometime before conceiving.

"Both my husband and I believe that this is the age for us to enjoy."

"Once child arrives, I will have to stay home. How to go out when you have to clean the child often? If child comes after 2 years one can go out together in relaxed manner."

Though number of such couples are increasing, lack of knowledge of contraceptives, difficulties in procuring condom without feeling ashamed, lack of family planning workers interest in addressing Reproductive Health (RH) needs of newly married couples and peer pressure come in the way of sticking to their desire of delaying first child.

When do couples want the second child?

The analysis of the qualitative data revealed that both men and women desired the 2nd child 3 or more years after the birth of first child. All the 16 pregnant and postpartum women informants we spoke with did not want the next child soon. They desired a gap of 3 years or more.

"I will have second child after 3-4 years".

"When 1st child starts school, only then would I like to have 2nd child."

The advantages of spacing between first and second child appealed to all including husbands and mothers-in-law. Spacing births more than 3 years is seen to have advantage to both mother and child and even husband. Women agreed that proper spacing would ensure that children are well fed and well cared. They also said that closely spaced births make women weak and in turn affect the health of the child in womb.

As one young woman mentioned:

"Everyone knows if children are closely spaced there will be problem. We know it makes women weak and children will fall sick frequently."

The advantages of 3 or more years spacing between children like proper child care and less financial burden appealed to men.

"If spacing between first and 2nd child is kept 5 years, 1st child will grow up properly and will be safe and healthy. Mother too will be healthy and it will be safe for her to conceive again without any problem. Father and family as a whole will be financially in a better position to receive the next child. But if the next child is born within 2 years,

both children will not get required attention and care. It is very important to have money for proper care of the family."

Husbands wanted their wives to be healthy as their illness can be financially draining.

"If the woman is sick, the whole house comes to a standstill. We are laborers. Money is hard to earn and we don't want anyone to fall ill." (FGD of husbands)

The community leaders reiterated how if women fell sick due to frequent pregnancies, men have to borrow money and the family remaining deeply in debt.

"If women fall sick due to frequent pregnancies, not only are men not able to take care of agricultural/business, family (husband) have to approach various sources to borrow the required money for treatment. In addition, the whole household comes to a standstill. As a consequence there are various other financial losses and burden as end result."

Causes of failure in delaying 2nd pregnancy

Despite young men and women desiring second child after a minimum of 3 years after first child, they generally fail to maintain this inter-pregnancy interval. The inferences drawn from the qualitative data point to a major draw back in the existing implementation of the family welfare program. Besides the programmatic failure to help the young couples to delay their second child, there are cultural constraints also that work as bottlenecks to realize their desired birth interval. Following paragraphs portrays each of these separately.

Programmatic: Programmatic failure in empowering the young couples to achieve their desired interval of three or more years reflects in –lack of information among young couples about return of fertility; lack of knowledge of spacing methods; no effort on the part of ANMs and other service providers to inform the pregnant women about LAM and postpartum contraception; myths about various contraceptive methods preventing its use and leading to discontinuation.

Lack of knowledge about when women would return to fertility after delivery coupled with insufficient information on contraceptive methods turned out to be the major cause for the resultant unwanted pregnancies. When women were informed about their possibility of getting pregnant as early as 4-6 weeks after delivery, they were surprised and wanted to know about when to start contraception after delivery and appropriate contraceptive methods.

*"I don't know anything. Someone will have to teach me." (*on when to start and what method to choose for spacing)

Besides lack of information, inaccurate information also were causing many unwanted pregnancies. Discussions with young women indicated that they considered return of menstruation as the only sign of return of fertility. Hence as long as woman has not started menstruation after delivery, she feels she will not become pregnant and that it is safe to have sex without contraceptives. At the same time, some women wondered how someone they know had conceived before menstruation began after delivery. Clearly they had no idea that after 40 days of delivery fecundity could return anytime. They also did not know what role breastfeeding played in delaying next child. Some believed that as long as woman is breastfeeding, menstruation will not return and she will not conceive again. Women did not know about LAM. Baseline survey findings of this study also pointed in this direction. Less than 3 percent of the women interviewed knew all the 3 conditions—women is fully breastfeeding, her menstruation has not returned and child is less than 6 months—that has to be fulfilled for breastfeeding to be effective in preventing next pregnancy for 6 months.

So the various responses on this topic were not surprising.

"It is all about menstruation. When you get menstruation after delivery, you can get pregnant."

A first time pregnant woman said:

"People say, as long as mother is breastfeeding, she will not conceive. Is this right, what I said?"

A currently pregnant woman who conceived 4 months postpartum said, when asked about 'conditions required to prevent pregnancy by breastfeeding'*:*

"No conditions. Just breastfeeding is enough.--- For me it worked for 4 months. (she had got menstruation after 1 month)

One of the men whose wife had a 3 month old baby was able to mention the 3 conditions of LAM. He learnt these from radio. During different ANC visits, he or his wife were not advised on need of postnatal check-up or postpartum contraception. This discussion also revealed that advise on postnatal check-up or postpartum contraception is totally neglected during ANC.

"Nobody came for postpartum check-up or counseled us about family planning. No one visited us when she (wife) was pregnant, nor after she delivered. Only once the ANM came to check if we had taken the child for pulse polio."

As a practice, most of the ANMs (paramedics) do not counsel women on postpartum contraception or LAM during their ANC visit. Discussion on postpartum care or visit to women during first week after delivery is rare. The baseline survey data of young pregnant women showed that only less than 10 percent of women surveyed were educated about LAM or postpartum contraception by the health providers or anganwadi workers.

A 3 month postpartum woman said :

"It's 2 years since we are living here on rent. No one has come for counseling.--- During pregnancy, Anganwadi worker told me to go to ANM and get my TT injection. I got injection and ANM gave me some pills to eat.----Nothing was told about contraceptive methods, breastfeeding or any other care."

Contraceptive counseling was greatly lacking among young women going through different phases of pregnancy and postpartum. After miscarriage, the only advise one women received was:

"Don't try for next pregnancy soon. Wait for 2-4 months at least before getting pregnant again. Nothing was told about how to avoid pregnancy for 4 months."

Despite the availability of modern contraceptives, its use is not very popular among young couples. We tried to find out myths and misconception that may be causing this impasse. Our enquiry showed that due to lack of correct knowledge, many misconceptions and myths are attached to each spacing method. For example, in case of condom, apart from the general complaint of lack of sexual pleasure, many (particularly women) believe that condom could cause infection leading to stoppage of menstrual cycle.

Although some of the young informants had seen information about contraceptive methods on TV, correct knowledge was lacking. One of the informants who had seen the AIDS awareness poster promoting use of condoms to protect from infection, misunderstood the message and believed that condoms will cause infection. In her words:

"*My husband has said that we will use condom after the baby is born. I have refused it point blank. I don't want to get any infection".*

When asked how she misunderstood the message, she said that as she did not discuss the messages with any one, she thought that condoms spread infection.

While men learnt about contraceptive methods from TV and radio, for women the main source of information were their neighbors and friends. Hence in the absence of correct knowledge, myths, rumors and wrong information spread among the network of friends.

"She(friend) said, he (husband) uses condom, and as a result now she has stopped getting menses."

Table 1: Myths and Misconceptions around Spacing Methods

Methods	Myths and misconceptions
Condom	Causes infection Stopped menses Itches No sexual pleasure
IUD	Can't be used if woman had caesarean Women can die Goes to throat
Pills	Feels very hot Causes swelling in stomach Bad for health Causes burning in stomach Menses 3-4 times a month Before 1st can cause infertility

In case of pills, in addition to the discomfort caused by pills, which is making it unpopular the list went on increasing as we spoke to more women. Women complained of getting swelling in the stomach, feeling "hot", getting menses many times and the like. These problems either discouraged them to adopt pills or they discontinued pills soon after adoption. It is generally believed that pills did not suit them. Probing showed that the reason for getting menses many times during the month was "withdrawal bleeding" as women were not regular in their pill intake. We also discovered that reported "swelling in the stomach" was the explanation provided by providers as the cause for any of the gynecological problems of the women. Women mentioned swelling in the stomach as the cause of infertility, not getting menstruation, or adverse result of pill use. This also may be an indication of the limited knowledge of ANM or their perceived problem with pill use.

Various myths surrounding copper-T like it will go to the throat, cause death or that it can not be used by women who have delivered by cesarean were mentioned by women.
Mother of 18 month old child said:

*"Doctor said "**no"** to copper T since I had both children by operation. She said I can't use that method."*

The beliefs among doctors is not helping its promotion either. Many providers mentioned during FGD that copper-T is not suitable for women who had child through cesarean section and for women with many children. These various myths are given in Table 1.

Sterilization is well-accepted and popular. Young women think that sterilization is better and is easier than using pills daily, asking husband to use condom or adopting other methods like copper-T or injection. Among the elderly women too, sterilization is well-accepted, but not the various spacing methods. Our discussion revealed that while the younger couples are ready to delay the first child and definitely space the second child, the elderly women are more interested in completing the child bearing quickly and the couple's adoption of sterilization. As one of the elderly woman said during FGD:

"*In the village, no one is ready to understand all these (why to use spacing method). They say "if child is born, let it be so. We shall get sterilization done after that. Earlier we had 12,13 children. Now it is just a matter of 2-3 children. Let them have2-3 children and then go for sterilization."*

Such thinking suits the ANMs also who feel that motivating young couples for spacing and making them continue using the methods is much more difficult than motivating couples for sterilization once they have achieved their desired family size. In the discussions with the providers, however, they did not agree that they give undue emphasis on sterilization. They exhorted that they are educating couples on the need to space, but are not taken seriously. When any complications arise as a result of a closely spaced pregnancy, women are at their door step requesting them to help.

During FGD ANMs asserted:

"If 2nd child is conceived soon after 1st they say, let that child be born, then we will go for operation. Some will say let the children become big, then we will go for operation. And in between if they become pregnant, they say let it continue. But they won't use any contraceptives (spacing method)."

However, some questioning and thinking is going on in the community about the merits of sterilization. So proper information dissemination can promote spacing methods. Elderly women did add that:

"*If the man is right (ready to allow FP use and knows need for spacing), there is no need for operation. They can use FP method and prevent pregnancy. With operation also one can become weak. As though operation is better than the spacing methods.*"

Cultural: During the discussion a few cultural barriers were also mentioned as the cause for short birth interval. For example, the elderly women reported that at their time, women were maintaining a much longer period of abstinence after delivery, both voluntarily and involuntarily. Involuntarily because women used to go (in fact still do) to their parents home to deliver their first child and then stayed there for a long period. In some cases for more than one year. Even when they came back to in-laws, husband was maintaining some abstinence voluntarily particularly if the women was still breastfeeding. There is a belief that sex when women is breastfeeding can spoil milk and thus affect the health of baby. These traditional practices are vanishing fast. Women do not go to natal home for delivery. Postpartum abstinence has reduced to few weeks and most become sexually active after about 40 days.

During FGD, elderly women mentioned:

> *"Earlier by itself the gap was 2-3 years between children. After childbirth, for 2-2 years mother-in-law would ask them to remain at natal home. These days, no husbands want to abstain. Now they say, once married this is your house. So you stay here only."*

A woman with 2 kids mentioned:

> *"We did not have sex after my delivery for some time, but when he (husband) saw that I have started doing household chores, he started having sex."*

In the absence of proper educational campaign, such changes contribute to frequent and short spaced pregnancies.

Certain traditional values, though disappearing fast are still blocking the access to correct information about contraceptives and family formation. For example, in rural areas, though the young men have much easier access to radio and TV news and programs, the young woman has very limited access to these facilities. Family values do not allow young women to join the group, particularly sit at par with elderly men and women to listen to radio/see TV program. They are also not allowed to go out alone to market or clinics from where they could obtain information on contraception or supply. This is typically reflected in what a young woman said:

> *"I got TV during marriage, but I don't watch TV at all. I feel shy to sit and watch program on TV with elders because they show advertisements on FP methods during breaks."*

Another woman mentioned:

> *"My mother-in-law tells me always to watch program when I am free. But I don't watch TV at all. I will go to my room and sit if there is no work. So I haven't seen any information on contraceptives."*

If husband is not supportive to family planning or he perceive that the existing spacing methods are not good for wife's health, the possibility of wife using any contraceptive method becomes very difficult—because of lack of access to supplies as well as lack of permission from husband. These problems are well reflected in the quote of young married woman:

> *"He(husband) did get it (pills)for me, but when he realized that I will actually take it, he threw away the strip.----He just said they are bad for health.----I can not go and buy it alone."*

One of the mothers-in-law put the reason for low contraceptive prevalence as the opposition from husbands.

> *"Knowledge is there. But will the husband listen? Now a days girl is not kept in the mother's house after marriage. -- if husband and wife stay together without using contraceptive method, how is spacing possible?"*

Though not reported in the in-depth interviews, continued son preference is an important cause for not adopting postpartum contraception, if the first child is a girl. Birth of a boy raises status of the women in the in-law's family and also reduces pressure for next child. But if the first child is a girl, all including the women want the second pregnancy soon for son.

Educational messages for woman, husband and mother-in-law

During the formative study an attempt was also undertaken to assess what arguments will work best to convince different stakeholders (woman, husband and mother-in-law) about the benefits of maintaining healthy interval between births. A discussion at district level with health officials revealed that not only is there dearth of BCC materials to promote spacing, existing materials are not addressed to the specific thinking of the different stakeholders. The data indicated that one of the key issues is their lack of knowledge about the timing of return of fertility, correct knowledge about non-permanent methods and myth associated with different non permanent methods .Unless these issues are seriously addressed in educational campaigns, unwanted closely spaced pregnancy will continue to occur. Further, it was also observed that some aspect/arguments for maintaining longer birth interval between births or delaying first birth appeal to one group more than the others. Concern for child's health impress everyone—mother, father and grandparents equally. So none of them wanted anything to compromise child care and a healthy child was desired by all.

Analysis showed that for young women perceived advantages like "more time to spend with husband" and "better for own health" are some attractive messages for delaying the first child or maintaining 3 years interval between births. Similarly in case of men apart from child's health, finances and enjoying married life are some convincing arguments for healthy timing of pregnancy and spacing at least 3 years between births. Table 2 gives the messages/arguments which were found more attractive to different stakeholders in the order of priority. Based on these observations various BCC materials have been developed, field tested and printed.

Table 2: Appropriate Messages for Young Woman, Husband and Mother-in-law

Woman	Husband	Mother-in-law
Health of the young child Own health Time to spend with husband Finances Proper care of child	Health of the young child Finances for child care Finances for delivery Togetherness and enjoyment of marital life Beauty and health of wife	Health of the young child Household expenses Education of children, especially boys

Discussion

The main findings from the study suggest that both men and women are aware of the disadvantages of closely spaced births and desire to have 2nd child after 3-5 years of first birth. However, they fail to translate their desire into practice, largely because of lack of knowledge about return of fertility, LAM, and contraceptive methods. Return of menstruation

is considered as the only indicator of return of women's fertility after delivery. They also believe that if women is breastfeeding she will not get menstruation and hence can prevent conception. Thus even women who are not exclusively breastfeeding believe that it can delay return of fertility. Empirical evidence indicates that breastfeeding can work as a contraceptive if the 3 conditions of lactational amenorrhea are fulfilled (Jain et al, 1970; Chen et al. 1974; Jain and Bongaarts 1981; Shamil T. et.al 2004). Not only women, but providers also need to be educated on the correct knowledge of LAM. Providers too inform women that they only need to use contraceptives after menstruation returns.

If women have succeeded in spacing 2 years without using modern contraceptives, it may have been a result of postpartum amenorrhea and abstinence. The belief among both elderly women and young women that 2nd pregnancy will be delayed by itself without using contraceptives has stemmed from the observations emanating from this experience. A combination of postpartum amenorrhea and abstinence can result in birth spacing of 2 years (Setty-Venugopal and Upadhyay 2002). Women need to be educated that healthy interval between births can not be achieved naturally and post partum contraception need to be practiced. They should also need to be educated when and how to shift form LAM to modern contraceptive method.

Indian Family welfare program has various mechanisms and strategies for promoting ANC and PNC. ANMs are supposed to counsel women about postpartum contraception during ANC and house visits. However, ANMs and other community level workers fail to do so. The study clearly indicates that during ANC visit women particularly of lower parity are given no advise on postpartum contraception. The ANC is largely limited to TT injection, provision of iron and folic acid tablets and some check-up. During mother's visit for immunization of children, no question is asked on breastfeeding or postpartum contraception. Postpartum care are almost non-existing. These points to improving ANC and PNC services, particularly to younger women. The poor counselling and negligence of postpartum care and contraception are not new findings (Koenig et al 200; Bhatia 1999; ICMR 1986; Khan and Gupta 1988). This could be addressed only by strengthening supportive supervision and building indicators in their monthly reporting system related to postpartum check-up, use of LAM and postpartum contraception. Providers also need educational materials and counselling aids. The BCC campaign are required to educate all the stakeholders about healthy birth interval. Delaying first birth will require some time to bring about the required social change, the interval between first and 2nd child could be easily increased by improving focus of the health and family planning delivery system including attitudes of the key providers—ANM, LHV—who primarily look for sterilization cases.

To address women's information needs and contraceptive services, inter-sectoral collaboration among the community level workers is critically important. Aganwadi workers are the key community level workers under Department of Social Welfare. Their target population consists of children under three years, adolescents girls and pregnant women Their key activities include provision of supplement food to children and pregnant women and educating women on child and pregnancy care. The program stipulates that the Anganwadi workers have to visit daily 5 pregnant or postpartum women at their home to educate them about health and nutrition.. The program also stipulates close linkage ANM nad anganwadi workers to achieve the common goal of ensuring welfare of pregnant women and children. Dissemination of correct us of LAM and post partum contraception could be far more easily done if the work of ANM and Anganwadi workers are properly coordinated and within their monitoring system also , LAM and post partum contraception are included.

Recently under National Rural Health Mission (NRHM) a new volunteer ASHA (Accredited Social Health Activists) has been added. In this coordinated effort she could be another effective link to make community and all the stakeholders aware of LAM and postpartum contraception along with ANC, PNC and nutritional care. If all the workers under different programs try to integrate their effort and work strategically, achieving common program objectives will not be difficult.

Uttar Pradesh is the state with the highest fertility in India. Among women aged 20-24 years, 81 percent had never used a contraceptive method and 9 percent used a method after first child and 4 percent after second child. Only 12 percent received postpartum check-up (IIPS and ORC Macro 2001). Findings from the FGDs and in-depth interviews with young couples are pointing to the lacuna in the existing service provision. A review of the quality of care within the Indian family welfare programme highlighted restricted method choice, limited information provision and low levels of follow-up (Koenig, Foo and Joshi 2000). Unless women are informed about the need for postpartum contraception and choice of contraceptive methods, short spaced pregnancies and risks associated with short spaced pregnancies will continue.

Despite the current family welfare program promoting a quality of care framework (Bruce 1990) with the client's perspective in focus, it is not reaching the vast majority. Although follow-up post contraceptive acceptance has received much attention in research and the reasons for discontinuation of contraceptive methods are pointing to the problems with follow-up, it remains to be tackled at the program level. Public health and social interventions have an association with differences in rate of maternal death even under conditions of restricted material resources (Shiffman 2000). Clearly the long term objective of reducing maternal mortality is possible if the interventions required to be carried out by the various community level workers are happening the way it should be. Proper monitoring and guidance is the key to achieving this. Despite removing target based approach from the family welfare program, even today supervisors are not able to guide the workers under them in proper contraceptive counseling during ANC or house visits.

The findings reveal that exchange of ideas on FP operates differently by sex. Recently as part of awareness raising, NRHM is airing good video and audio with information on the various contraceptive methods on TV and Radio. This may have benefited men, but not women. Women feel shy to pay attention to information coming in TV or radio. They also do not sit along with elders to watch TV. Hence it is important that community level workers explain about need of spacing between births and adoption of postpartum contraception to women as stipulated in the FP program.

Since contraceptive use is largely controlled by women (even when the decision about whether to use a method is made by husband), and because women experience the problems arising from closely spaced births and also because they have limited opportunities to gain information on FP, they discuss about FP with their friends and neighbors. This also becomes a major source of passing on of myths. However, their friends suggestion on FP use would lead to its use more than the providers advise. Social interactions among network members or friends result in diffusion of fertility ideas (Bongarts and Watkins1996). Hence it is important to capitalize on these networks to pass on correct and accurate information to the young women. Counseling by the network members can help to remove the psycho social barriers which is one of the major barriers to contraceptive acceptance (Luck et. al. 2000)

The lack of knowledge about contraceptive methods coupled with the lack of decision making ability make women resort to prayer or take consolation from believing that it is their fate if they have too many children or closely spaced births. Husbands control even fertility and contraceptive use decisions. Mothers-in-law also play a dominant role. In a study conducted in Uttar Pradesh, 56 percent of the women of reproductive age deferred health care decisions to their mothers-in-law and 15 percent to their husbands (Singh, Bloom, and Ong Tsui 1998). Active involvement of men and elderly women in the intervention activities will go a long way in promoting contraceptive use.

Lessons Learned and programmatic implications

Several lessons can be learned from this study that have programmatic and policy implications. Briefly the following points stand out.

- There is pressure on newly married women to become pregnant soon after marriage, mostly from mother-in-law. If they do not become pregnant within an year treatment will be initiated for the same. For men the pressure is the teasing from friends and more than they themselves being labeled infertile it is their wife being labeled infertile that prompts them to procreate soon. Given the social construct that puts equal pressure both on young married men and women to have the first child at the earliest after marriage, a broader societal change and supportive environment is required to encourage young couples to delay first child. This demands a relatively longer time and sustained programmatic effort to bring about the desired social change.

- Education has broadened the horizons. Newly married couples want to enjoy at least one year without children. They are more and more willing to use family planning to delay first pregnancy. Condom is the most acceptable method. There is still belief that using oral contraceptive pills before first delivery can lead to infertility. Young couples' lack of awareness of fertile time in a woman's monthly cycle has far reaching consequences when they use safe period as contraception. A little bit of effort in this direction to re-educate with the correct facts, discuss the side-effects of the various contraceptive methods and explain why the myths surrounding the methods are inaccurate can go a long way in contraceptive acceptance and reduce discontinuation.

- Elderly women compare with their generation and say that they had 13-14 children and still are keeping good health. They say that it is because this generation are not used to hard work that they fall ill with the slightest exertion. Hence explaining about the importance of spacing births 3-5 years and the risks involved in closely spaced births is crucial.

- Beliefs like breast feeding woman will not conceive, woman will conceive only after menstruation has returned after delivery, second pregnancy will happen only after women has regained strength after delivery (say after 2 years) and the like leads to closely spaced children. Educating about LAM and conditions for breastfeeding to act like a contraceptive method is easy to implement. It is important that providers have correct knowledge of LAM and teach about correct use of LAM.

- Mothers-in-law are also willing to allow women to use contraceptive methods to delay second pregnancy. However, they said that couples discuss such things among themselves and mothers-in-law will not get to know whether couples are using any method. On the other hand, women are accompanied by elderly women when they go

for ante-natal check-ups and delivery. Mother-in-law takes care of the mother and child after delivery. Involving them in the education about need of ante-natal and post-natal check-ups, importance of postpartum contraception and correct use of LAM can ensure proper care of mother and child. This will also be a step in promoting correct contraceptive information and attitudes favoring its use in the community.

- While men do not discuss about FP among their peers, for women direct interaction with their friends or neighbors is the source of information. Women are likely to adopt a method that their friend suggests. This is also a source of passing down myths and so very difficult to erase. Hence group meetings where members can raise doubts and openly question the myths can prove useful as an intervention for both men and women. For men, these meetings will be educative in providing information. For women these meetings will be a forum to discuss myths and doubts. Moreover knowing about others' contraceptive use can promote their own.

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