Article

Involvement of Community Leaders in Addressing Unmet Need for Family Planning in Rural Coastal Odisha

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Abstract

Addressing unmet need for family planning is one of the major immediate objectives of India's Population Policy, 2000 (Ministry of Health and Family Welfare (MoHFW), National Population Policy, 2000. New Delhi: Department of Family Welfare, Ministry Health and Family Welfare, Government of India). The policy also advocates the involvement of elected leaders of Panchayati Raj Institutions (PRIs) in addressing unmet need for family planning. Besides, the National Rural Health Mission (NRHM) also highlights the importance of PRIs and other community leaders in addressing family planning services. The 73rd Constitutional Amendment Act, 1992, also guarantees panchayats to take responsibility of health and family welfare. To know the actual involvement of community leaders in addressing unmet need for family planning, the field survey was carried out in the coastal part of Odisha. With the help of mixed methods, the actual participation of community leaders in family planning is found negligible. The field study including surveys and in-depth interviews of health workers and community leaders reveals that lack of financial allocation for family planning activities in Gaon Kalyan Samiti (GKS), lack of funds for the village health plans, lack of inter-departmental coordination, lack of trust and confidence between the workers and leaders, lack of initiative by the workers to involve leaders and lack of incentives for community leaders are the major reasons for non-participation of community leaders in family planning activities.

Keywords

Community involvement, community participation, community leaders, non-participation of community leaders, unmet need for family planning, Panchayati Raj Institutions

Introduction

India launched the national programme on population in 1952, giving importance to family planning with the view to stabilizing the population at a level consistent with the requirement of the national economy. India adopted many population policies with different strategies as per the requirement of the time.

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The latest National Population Policy (NPP) 2000, which reiterates the voluntary and informed choices and the consent of citizens, should be taken into account while using the reproductive health care services and maintaining the target-free approach with continued family planning services. One of the major immediate objectives of Population Policy, 2000, is to address the unmet need for family planning. The empirical studies show that the usage of contraception has increased in a rapid manner both in educated and in non-educated masses, both in urban areas and in rural areas and both among poor and among rich couples due to the availability of family planning methods but simultaneously there is a visible gap between the demand and supply of contraception among women. In general parlances women are interested in using contraception but due to some circumstances they are not availing these opportunities. This demand–supply mismatch has given us a concept called the 'Unmet Need for Family Planning'. The causes of unmet needs are mainly related to poor access to services, lack of correct information and social opposition to use and concerns (whether warranted or not) about side effects (Casterline & Sinding, 2000).

The National Family and Health Surveys (NFHS) of India, which was part of the Demographic and Health Surveys, also measured the unmet need for family planning. According to the third round of the NFHS-3, the unmet need for family planning in Odisha was 14.9 per cent and the unmet need for spacing and limiting were 6.8 per cent and 8.1 per cent, respectively, in 2005–2006. The contraceptive prevalence (met need) of Odisha was 50.7 per cent (IIPS and Macro International, 2007, NFHS-3, 2005–2006, India, Mumbai; IIPS). The total demand for family planning was 65.6 per cent. A large section of currently married women were in the category of unmet need for family planning in Odisha. Satisfying unmet need would result in a substantial decline in fertility (Westoff & Bankole, 1995). The implied total fertility rate (TFR) for Odisha is 1.82 from the NFHS-3 level of 2.37, a reduction of 23 per cent (Mohapatra, 2015), after satisfying unmet need. Unmet need has a great importance in the family planning programme as it identifies the group of women who want to use contraception but are not using it.

Both demand and supply factors have an effective role in accepting the family planning methods. Besides, involvement of community leaders in the programme can have an additional and possible synergetic effect. Here community leaders are the local leaders including both elected leaders of Panchayati Raj Institutions (PRIs) and social leaders. Participation of local leaders gained momentum in the global health policy arena as the member countries of WHO accepted primary healthcare as their official policy in the Alma Ata Declaration in 1978 (Rifkin, 2014). Many social scientists such as Askew et al. (1986), Rifkin (1986, 2009, 2014), Rifkin and Pridmore (2001), Hossain et al. (2004), Bang (1986), Pal (1994, 2003), Ray (2007) and Mohapatra (2015) and so on were highlighted the importance of the community leaders and particularly the PRIs and considered it as the most appropriate and effective approach in addressing health and family welfare needs of the rural poor. The National Rural Health Mission (NRHM) called for the constitution of a Village Health and Sanitation Committee (VHSC) which is Gaon Kalyan Samiti (GKS) in Odisha to improve the participation of community leaders at the lowest level.

Need of the Study

The NRHM highlights the importance of PRIs and civil society leaders in the delivery of family planning services. The NPP of 2000 also advocates the involvement of elected leaders of PRIs in addressing family planning services. The 73rd Constitutional Amendment Act, 1992, also guarantees panchayats to take responsibility of health and family welfare, and PRI members will have the power for resource mobilization. But the question that arises here is whether these community leaders are really addressing family planning services.

Objective of the Study

The objective of the study is to examine the involvement of community leaders in addressing the unmet need for family planning in rural coastal Odisha.

Data Sources and Selection of the Sample

A field study of the sample villages of Odisha is carried out because there is no required survey data on the involvement of the community leaders in addressing family planning services. This involved visits to villages, scrutiny of records of auxiliary nurse midwives (ANM), Accredited Social Health Activist (ASHA), VHSCs and observations of activities and interviews with community leaders and service providers. Details on family planning services were collected from the ANM's register and concerned members. A total of 39 villages are selected by the method of stratified sampling, the strata formed by village size, with a probability proportionally to size selection within the strata, from the 2001 census.

Study Area

The overall socio-economic and demographic characteristics of Odisha are not good compared to India (Registrar General of India [RGI], 2013). The share of rural population is 83.32 per cent which is very high. To study the involvement of community leaders in the addressing unmet need for family planning, the rural part of coastal Odisha is chosen. The scope of the study is restricted to rural coastal areas of Odisha as the nature of the involvement in tribal areas is different. Baleswar, Bhadrak, Kendrapara, Jagatsinghpur, Cuttack, Khurda, Puri and Ganjam are the eight districts of the coastal Odisha.

Methodology

A qualitative study was conducted in the rural coastal Odisha. In-depth interviews were conducted for health workers and community leaders. Besides, two focused group discussions were held with adult men other than leaders. The data were transcribed, systematically coded and analyzed.

Results and Discussion

The family planning programme is implemented by service centres and service providers of the department of health and family welfare. The workers of the programme at the village level have the responsibility of implementing the programme including addressing the unmet need and have to work with the community to ensure the involvement of community leaders. The service centres of rural areas are sub-centres, primary health centres and community health centres, and the service providers are female health workers/ANMs, male health workers, anganwadi workers (AWW) and ASHAs. The ANM is the principal functionary at the peripheral level for the family welfare programme. The ASHA is not an employee but a locally identified social activist. The AWW is part of the Integrated Child Development Services and does not have the responsibility for family planning in a formal sense. Besides, private

Table 1. Numbers of Health Workers and Community Leaders Selected from the Sample Villages, Rural Coastal Odisha, 2013–2014

Districts	ANM	ASHA	AWW	Total Health Workers	PRIs Members	SHG Leaders	Other Leaders	Total Community Leaders
	N	N	N		N	N	N	
Baleswar	7	8	8	23	8	9	7	24
Bhadrak	2	2	2	6	2	2	2	6
Puri	2	3	3	8	3	3	3	9
Jagatsinghpur	4	4	4	12	4	3	5	12
Khurda	5	5	5	15	5	5	5	15
Cuttack	5	5	5	15	5	5	5	15
Kendrapara	4	4	4	12	4	4	4	12
Ganjam	8	8	8	24	8	7	9	24
Total (*N*)	37	39	39	115	39	38	40	117

Source: Primary Survey.

providers also play a role in providing family planning services and addressing unmet need for family planning but they are mostly in urban areas. According to the 73rd Amendment Act 1992, community leaders from different fields of the community will have the power to mobilize resources and also take part in addressing family planning issues. Besides, the guidelines of GKS also highlight the importance of community leaders in addressing family planning issues.

During the field survey, health workers including ASHA, AWW and ANM and many community leaders such as sarpanch, panchayat nominee, ward member, self-help group (SHG) leader, youth club member, secretary, *pani panchayat*, village head, president, village school, *janch* committee member, ex-serviceman, NGO member and GKS member were interviewed. For the analysis three categories such as PRI members, SHGs and other leaders are formed. The total health workers and community leaders in selected villages are 115 and 117 (Table 1).

The field survey responses are uniform in nature. The results show that health workers are addressing family planning issues. Both the training manuals and guidelines of GKS clearly mention one of the roles of community leaders to address family planning programmes. Still these leaders are not addressing family planning issues. The author tries to know the reasons for the non-participation of community leaders in addressing family planning services through in-depth interviews which are conducted for both health workers and community leaders. The workers and officers of Health and Family Welfare, Women and Child Development and Panchayati Raj Departments and community leaders from the bottom to the top levels were interviewed.

Result Based on Views of Health Workers and Officers

The in-depth interviews covered various aspects of perception and experiences of health workers and officials of concerned departments. The health workers are not strictly communicated to involve the leaders. The insufficient incentive for leaders is another challenge of the non-participation of leaders.

Though the provision of GKS is kept in the Department of Health and Family Welfare AWW is assigned as the head of the GKS, whereas AWW is from the Department of Women and Child Development. The already overburdened AWW and the officials of the department are not serious about the functioning of the GKS. There is a lack of coordination between the Department of Health and Family Welfare and Women and Child Development which obstructs the proper functioning of the GKS. The health officials are not serious about the inclusion of leaders due to their perceived authoritative behaviour and money-oriented nature. The officials have no trust in the leaders. The health officials, especially doctors, are totally against the involvement of the community leaders whereas the officials of NRHM are to some extent ready to get involved with the leaders. There is a difference in the attitude within the department. The training programme is not adequate. There is no follow-up system for the involvement of leaders. The system has no accountability on the leaders. These are the major reasons for the non-participation of leaders in addressing family planning issues.

Result Based on Views of Community Leaders

The in-depth interviews covered various aspects of perception and experiences of community leaders from the bottom to the top level. Though leaders think population growth is a major problem for the development of the family and the nation, still, the leaders are not addressing family planning issues. Motivating couples for family planning is not a serious issue now as people are convinced it is. The leaders are not aware of population policy, GKS guidelines and their role. Political parties are not discussing family planning issues in their party as it is not a serious matter nowadays. Health workers are not inviting them for involvement in family planning activities. The training session is not motivational and there is no follow-up after the training of the leaders. Some leaders are not in favour of interfering in personal matters like acceptance of family planning methods as it will affect their vote politics, and also the family planning issue is dominated by women. The insufficient incentive in family planning is also a major reason for the non-participation of leaders. The GKS is not involving all the ward members of the village which demotivates the other ward members. The devolution of power to panchayats is still not effective in Odisha which prohibits the actual power of PRI members. The selection of the healthy village award is also debatable. The chance of manipulation is more in developmental schemes rather than in family planning and hence there is little interest among the leaders for involvement in family planning activities. The state leaders are also not interested in family planning programmes which demotivates the panchayat leaders.

Result Based on Views of Adult Men other than Leaders

In addition to the health workers, officials from the Health and Family Welfare and the Panchayati Raj Departments and leaders from the panchayat to the state, adult men other than the leaders of the panchayat, were interviewed on the issue of non-participation of leaders in addressing family planning. The in-depth interviews covered the perception of other members on population growth and contribution of leaders on the issue of family planning. These members are serious about population growth and its negative impact on the family and society but according to them people are aware of different family planning methods, and it is not a serious issue now. Leaders are not interested in getting involved in the personal issue.

Conclusion

It is clear from the NPP of 2000 that the involvement of community leaders in the population programme is part of its strategy and is expected to support the programme including addressing unmet need for family planning. Given the constitutional provision for PRIs, formalizing involvement of community leaders is feasible. The structure of GKS ensures the involvement of both the health workers and community representatives including at least elected members of the panchayat. The GKS has some resources at its disposal and guidelines have been formed for its functioning.

However, as the field survey revealed, the actual involvement of community leaders in family planning is negligible. There is no doubt that the health workers of the public health system and in particular the ANMs are engaged in family planning activities as it is their formal role. ASHA is a community-based social health activist and primarily engaged in maternal and child health but also assists the ANM in family planning. However, the non-official members of the GKS and other community leaders seem to be hardly involved in family planning. The field study and in-depth interviews including a survey of health workers and community leaders revealed a number of reasons for the lack of involvement of community leaders in family planning activities.

First, though the GKS which is a formal committee has family planning listed as among these activities, there is no financial allocation for this budget. The village health plan provides only a small amount. The impression which the committees get is that family planning is not a priority matter for GKS. The lack of coordination between the departments of Health and Family Planning and Women and Child Welfare obstructs the real purpose of the GKS. Second, there is lack of trust and confidence between the health workers including the ASHA on one side and the community representatives on the other. On the other hand, community leaders are not happy with the meagre fees they get and complain of the lack of initiative by the workers to involve the leaders. Similar feelings are expressed by officials and leaders at higher levels. In fact, officers at a higher level considered the community leaders as less educated, greedy and do not see much advantage in their involvement.

But an important finding that has emerged is that population growth is no longer seen as an alarming issue. The general feeling among the leaders at different levels is that now there is a wide acceptance of the small family norm. Therefore though population growth is an issue, family planning campaigns of the earlier kind are not required. Thus, family planning is now a matter of providing contraceptive services to those who need this rather than motivating couples to accept the small family. Therefore, there is no role seen for community representatives as the Health and Family Welfare Department has to provide services. This seems to be the feeling of the workers in the health department since they too are not keen to engage with the community leaders.

However, since then, the small family norm seems to have become very pervasive and the TFR is below the replacement level in all the Southern states and some Western states, Northern states and West Bengal. There is evidence from various field studies of the consensus on the small family planning norm in these states. This seems to have happened in Odisha where the TFR is now close to the replacement level. But an important point is that unmet need can coexist with low fertility. While at macro-level the fertility is near the replacement level, there could be couples with unmet need. A satisfaction at the macro-level should not lead to the neglect of the individual needs. Addressing unmet need for family planning is important even in conditions of low fertility.

The government programme has to address these needs and in particular the needs for spacing. The government departments and community need to work together in this task. The structure and formal mechanisms for the involvement of community leaders can be fine-tuned and the coordination between the departments should be strengthened. The coordination among health workers and between health

workers and community leaders should be emphasized. Emphasizing the importance of the involvement of community leaders in the training programmes for all health workers and organizing the orientation programme for all community leaders and follow-up programmes will go a long way in ensuring the involvement of community leaders in programmes. But more important is to eliminate prejudices of the department on community leaders and have a deeper understanding of each other's capabilities and perceptions.

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