

Taking Services to the Doorstep

Providing Rural Indian Women Greater Control over Their Fertility

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Empowerment has been defined by Kabeer as the expansion of the ability to make strategic life choices. Such choices include those related to education, marriage, childbearing, and livelihood.¹ While augmenting women's empowerment has been shown to result in a decline in fertility because their choices expand,² the inverse effect of fertility control on empowerment has not been adequately explored.³ Various pathways have been theorized to explain the relationship between fertility control and subsequent empowerment. Some hypothesize that women who enjoy greater control over their fertility may experience greater gender equality because they are better able to balance and time their sexual, reproductive, and nonreproductive aspirations, thus facilitating access to emerging opportunities in the workplace and beyond.

A woman's ability to control her own fertility is likely to be crucial to her empowerment. If a woman can have control over the timing and spacing of her pregnancies, she can plan how many and which years of her life will be free from childbearing, and she may have the freedom to participate more fully and equally in economic and nonreproductive activities. Our intervention aimed to enable young women and adolescents in India to gain greater control over their fertility by improving access to pregnancy tests at the village level and linking women to quality reproductive health services. Pregnancy tests were made available to women residing in the organization's field program, which covers a rural population of about 60,800, in forty-nine villages of Udaipur and

Rajsamand districts in the state of Rajasthan, India. Women in this area have very low levels of literacy, a very early median age of marriage, and limited decision-making ability and financial autonomy.⁴ Further, while family planning programs have been recognized to play a key role in improving women's reproductive health, it is difficult to make family planning (and abortion) accessible to young women living in socially conservative societies where young women are often disempowered. Through this program, we found that using pregnancy tests as an entry point to improve reproductive health made it easier to make both contraceptive and safe abortion services more accessible for women.

CONTEXT

Rajasthan, located in the northwest of India (figures 1.1 and 1.2), is the country's largest state in terms of area (342,239 square kilometers, 10.41% of the country's total area) and is home to about 68 million people according to the 2011 national census.

Like other north Indian states, Rajasthan is marked by patrilineal, patrilocal, and patriarchal social systems. The union government counts it among India's "empowered action group" (EAG) states, which entails high governmental priority for development initiatives.⁵ Development indicators of the state are among the most adverse in the country, especially for women. Barely 46% of rural women were literate in 2011,⁶ and 62% were married before the age of 18 years.⁷ Women also have low autonomy in terms of mobility and decision making: an International Institute for Population Sciences survey revealed that only 32% of women were allowed to go to three specified places alone—the market, the health facility, and places outside the village/community; the rest could not go anywhere alone.⁸ Young women are at the bottom of social hierarchy, and the use of modern methods of family planning is still rare: only 4.6% couples in 2005–2006 used a modern method of contraception before the first child, and only 16.5% did so between their first and second child.⁹ The total fertility rate in the state is 3.1,¹⁰ while the maternal mortality ratio, at 318 per 100,000 live births, is much higher than the overall national figure (212 per 100,000 live births).¹¹ Women shoulder a heavy work burden—their days are spent fetching fuel, fodder, and water and in activities of farming, housework, and wage labor.

Action Research & Training for Health (ARTH), a private, nonprofit public health organization based in Udaipur, Rajasthan, has been work-

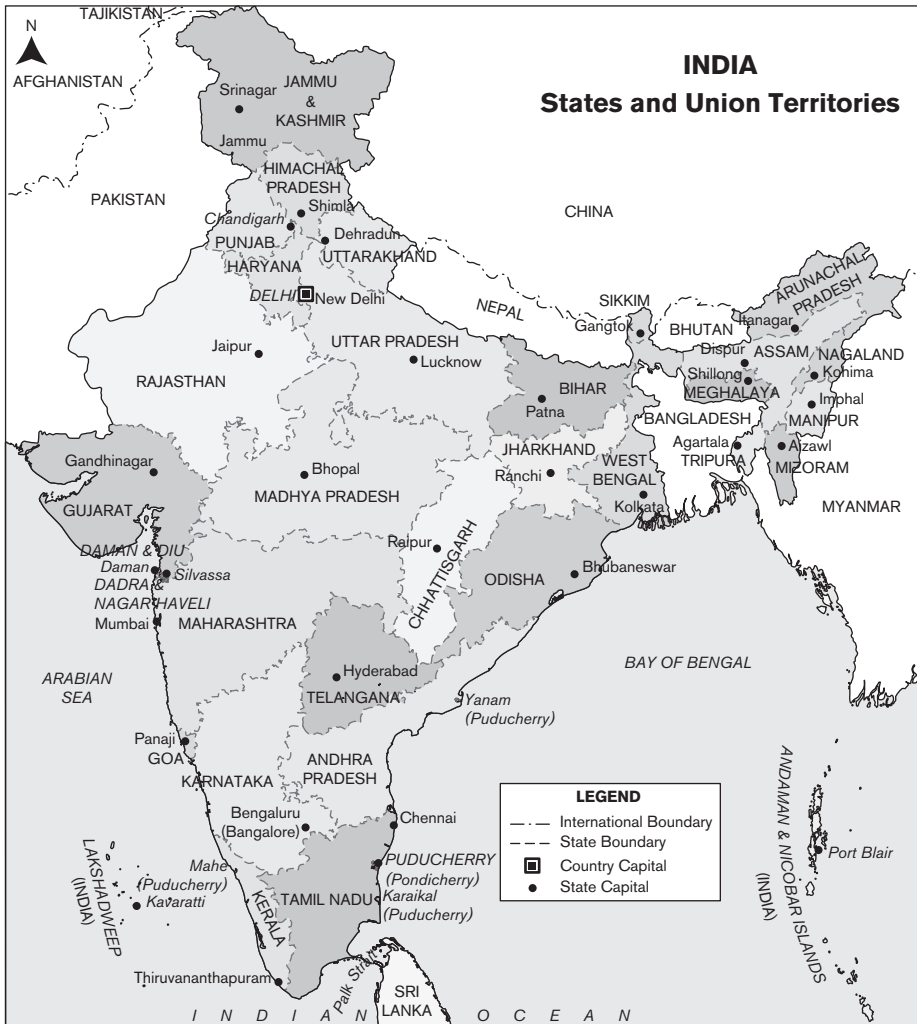


FIGURE 1.1. Map of India. Source: Indira Gandhi Conservation Monitoring Centre, WWF India.

ing in interior rural areas of two southern districts of the state since 1997. ARTH's field service program covers a population of 60,800 people within forty-nine villages, nearly half of which belong to an underprivileged tribal community. The hilly terrain of this area, coupled with the low autonomy of women in the region, makes it difficult for women to access health care services. ARTH operates two reproductive and child health centers in this area that provide a range of reproductive and



FIGURE 1.2. Map of Rajasthan. Source: Indira Gandhi Conservation Monitoring Centre, WWF India.

child health services, including twenty-four-hour delivery and maternal care services, antenatal care, first-trimester abortions, and reversible methods of contraception (including intrauterine devices [IUDs], injectable contraceptives, oral pills, condoms, and emergency contraceptive pills). ARTH also provides community-based education and services through its outreach workers.

The public health system in rural India comprises health subcenters, each staffed by an auxiliary nurse-midwife (ANM), who serves a group of villages with approximately 3,000–5,000 individuals; primary health centers staffed by one or two doctors and two nurse-midwives, serving 15–30 villages (a population of about 25,000); and community health centers (CHCs), serving 120–200 villages (a population of about 175,000). Although pregnancy test kits have been available in developed

countries since 1977 and in urban areas of developing countries since the late 1980s, they have not been available to rural women until very recently.¹² Therefore, there are few reliable mechanisms for rural women to confirm their pregnancy status. From interactions with women in our field area, we learned that ANMs procure the tests from the market and perform each test for INR 50 (approximately USD 1). Apart from the high cost to women, the ANMs irregular presence in the villages means that women are often unable to access this service when it is most needed.

AVAILABILITY OF CONTRACEPTION AND ABORTION SERVICES

India has been promoting family planning through its Family Welfare Programme (FWP) since 1951. Despite policy commitment to a target-free approach, the FWPs of many states (including Rajasthan) continue to impose targets and set local goals, now called “expected levels of achievement” (ELAs), which essentially means that health workers are expected to find a certain number of contraceptive acceptors.¹³ Thus, the program in practice continues to be heavily biased in favor of incentives and targets, with a skewed emphasis on female sterilization.¹⁴ Since frontline workers are penalized for not attaining their ELA for sterilization, they tend to avoid providing information about reversible methods (in favor of permanent methods), especially to women who have two or more children. Studies by ARTH have shown that even women who wish to limit their pregnancies may not want to use an irreversible contraceptive method because they might be afraid of the side effects of sterilization, or they might wish to maintain their fertility potential since they fear the possibility of widowhood, remarriage, or the death of a child. These women, who have achieved their desired family size but are not willing to be sterilized, have restricted access to reversible contraceptives under current family planning programs. They remain at risk for unwanted pregnancies.

A review of the National Rural Health Mission (NRHM)¹⁵ commissioned by the government of India in 2009, observed that female sterilization continued to be the most prevalent method of contraception in Rajasthan, and that the use of spacing methods needed to increase. The authors of the review observed that some Information, Education, and Communication (IEC) materials produced by the Rajasthan government promoted the two-child norm, a practice that could be

considered a violation of reproductive rights. They recommended that the IEC materials be modified to encourage the use of family planning methods in general, rather than focusing on how many children families should have.¹⁶ Another evaluation of NRHM in 2009 found that awareness of reversible methods of family planning remains low in Rajasthan—only 19% of 15- to 49-year-old currently married women were aware of IUDs, and only 12% knew about emergency contraceptive pills.¹⁷ Hence, it is not surprising that the majority of contraceptive users in India continue to choose female sterilization.¹⁸ Out of the 44.4% currently married women using modern contraceptives in Rajasthan, 34.2% adopted female sterilization.¹⁹

In 1971, the Medical Termination of Pregnancy (MTP) Act legalized abortions performed up to twenty weeks of gestation, under specific circumstances including risk to the woman's life or grave injury to her physical or mental health. The latter clause includes pregnancy resulting from rape, risk of physical or mental abnormalities in the child, and failure of contraceptive method used by a married woman or her husband. Even though the MTP Act is an enabling piece of legislation, the availability of safe abortion services, especially in rural areas of the country, remains extremely limited. In 1999, there were no health facilities that were certified to provide safe abortions in the block where ARTH worked (comprising a population of 150,000). A study of licensed facilities in Rajasthan between 2007 and 2010 revealed only 0.85 certified abortion facilities per 100,000 rural people, as compared to 3.65 facilities per 100,000 urban people. The same study revealed that the government facility in the block in which ARTH worked had reported performing no abortions over a three-year period.²⁰ Going to the city for abortion is not an option for most rural women, because of lack of familiarity with the city and the cultural expectation that a male should accompany a woman on such a journey. Male accompaniment is often not feasible, both because of the high costs of travel and the high rates of male migration. These conditions limit women's mobility, resulting in a higher incidence of women undergoing unsafe abortions or continuing with unwanted pregnancies.

Poor access to pregnancy tests has meant that rural women either wait weeks before they seek an abortion or have to travel to a block health facility located several kilometers away just to confirm a pregnancy. If they are late in approaching an abortion provider in terms of week of pregnancy, they are likely to be denied the service because most rural health facilities provide only first-trimester abortion services. On

the other hand, women's lack of knowledge of pregnancy status can be exploited by abortion providers. In the course of providing services, the ARTH team came across two women with secondary amenorrhea, due to lactation and injectable contraceptives respectively, who had been informed by private doctors that they were pregnant and hence needed an abortion. When they came to our health center to confirm their pregnancies, ARTH learned that neither woman was pregnant.

METHODS

In 2007, ARTH began an intervention in its field service program to offer urine pregnancy tests to village women, counsel them about their options (depending on the result of the pregnancy test) and subsequently help them access the reproductive health services of their choice. We trained two kinds of community health workers—government-appointed Accredited Social Health Activists (ASHAs)²¹—one ASHA per 1,000 population—and ARTH-appointed village health workers (VHWs)—one VHW per 4,000–5,000 population. Both categories of health workers were mainly locally residing women who were educated at least up to class 8.

ASHAs and VHWs underwent two days of training that covered the following topics:

- Counselling skills
- Process of conception
- Methods of contraception including emergency contraception (EC)
- How to use a urine pregnancy test kit
- Importance of early antenatal check-ups
- Dangers of unsafe abortion
- Where to go for a safe abortion

At the end of training, community health workers were expected to conduct pregnancy tests, and based on the results of the test and the woman's fertility intentions, provide each woman with the desired services or referrals (figure 1.3). If the result of the pregnancy test was positive and the woman wanted to continue the pregnancy, the health worker referred her to antenatal care services. If the test was positive but she did not want to continue the pregnancy, the health worker referred her to ARTH's health centers for safe abortion services. If the

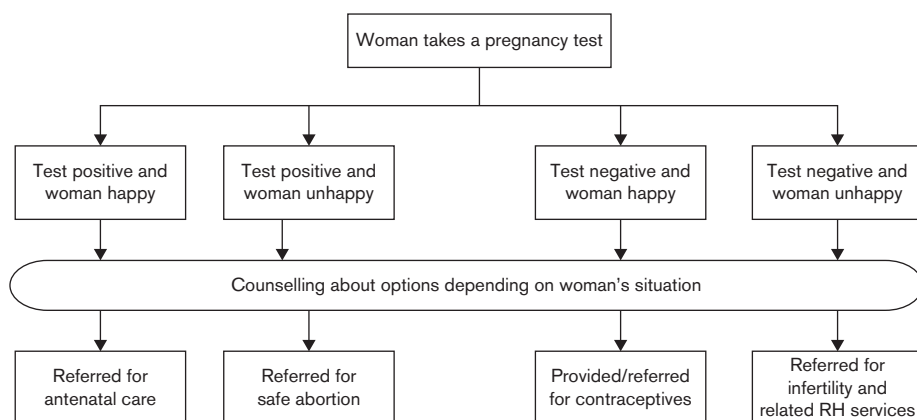


FIGURE 1.3. Conceptual framework of the intervention by ARTH.

pregnancy test was negative and the woman did not wish to become pregnant, then the health worker counseled her about contraceptives. The health worker was authorized to offer oral contraceptive pills, condoms, and emergency contraceptives; women interested in injectable contraception, IUDs, or sterilization were referred to appropriate facilities. If the pregnancy test was negative and the woman wanted to become pregnant, the health worker would subsequently refer her to services for preconception counseling, infertility, or childlessness.

Due to attrition, we trained seventy ASHAs and nineteen VHWs over the four-year period. Of the ASHAs, eighteen proved to be inactive and stopped coming to review meetings; eleven VHWs stopped working after having been trained. Overall, there was attrition of eighteen out of seventy ASHAs from this intervention and eleven out of nineteen VHWs.

Each pregnancy test strip cost around INR 5 (approximately USD 0.1). The tests were priced at INR 10 (approximately USD 0.2) for the user. Health workers reported that some women did not have money to pay for the tests. Because our organization did not want to restrict access, we advised the health workers to continue to provide the service irrespective of whether women paid or not. In the last year of the intervention, the service was provided free of cost to women after we started using the kits made available via the public health system.

Initial training was followed by a monthly refresher training-review meeting, during which we discussed and addressed problems faced by



FIGURE 1.4. Educational materials used by health workers.

health workers, refreshed their knowledge and skills, and resupplied them with pregnancy test kits and contraceptives. We provided the health workers with health education material for use during individual or group interactions in the villages. These included three illustrated educational books and small take-home booklets that could easily fit in the front shirt pocket of men interested in contributing to the planning of their families (figure 1.4).

In order to create an enabling environment for health workers to be able to provide these services, project staff initially conducted 184 orientation meetings with men and village leaders in each village to explain the intervention to them and answer any questions that might arise. We also commissioned 50 color wall paintings (figure 1.5) and conducted 132 video shows and small-group meetings with young women and men in each village. For the majority of women, one-to-one contact and word of mouth were the primary ways in which they learned about the service.

To ensure that women received the services and to confirm the tests' accuracy, we carried out regular field supervision. In the first year, a



FIGURE 1.5. Wall painting by ARTH.

supervisor verified almost half (49%) of all the tests by visiting the women's homes while maintaining confidentiality. On finding that about 97% test results were accurate and recognizing the potentially intrusive nature of such verification visits, we reduced the extent of supervision in subsequent years.

RESULTS

From 2007 onward, the popularity of pregnancy tests in the region grew steadily (figure 1.6). In the last year of the program, the numbers were reduced as ARTH started sourcing the pregnancy test kits from the NRHM to dovetail our intervention with the government program, both to achieve sustainability and to avoid duplication of resources. This reliance on the government program sometimes led to disruption of the regular supply of kits, as delays in getting them from the government did occur. Between July 2007 and June 2011, health workers conducted 4,161 pregnancy tests at the village level (figure 1.6). On average, they conducted 26 tests per 1,000 population in the third year, when the intervention was running optimally. Though ASHAs outnumbered VHWs and conducted a greater proportion of the pregnancy tests (figure 1.7), the performance of VHWs surpassed that of ASHAs. On average in year 3, each VHW conducted 87 tests while each ASHA conducted only 14 tests.

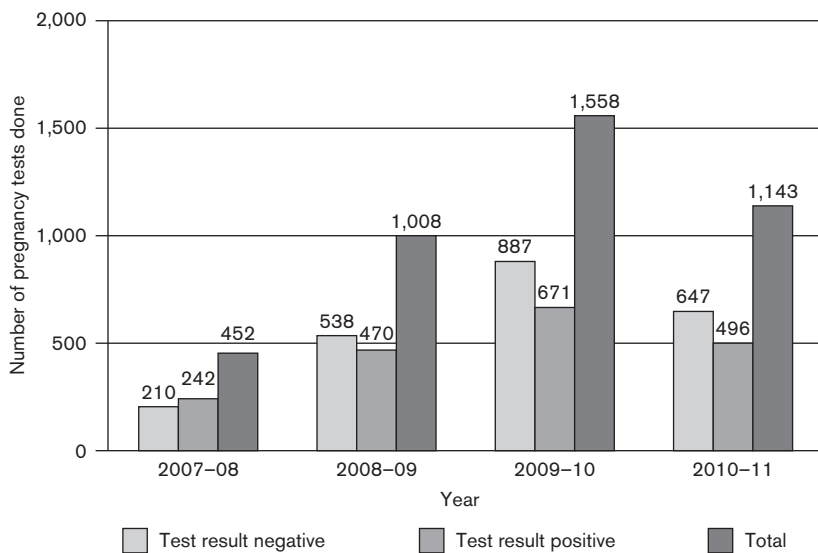


FIGURE 1.6. Number of pregnancy tests done by ARTH health workers, 2007-2011.

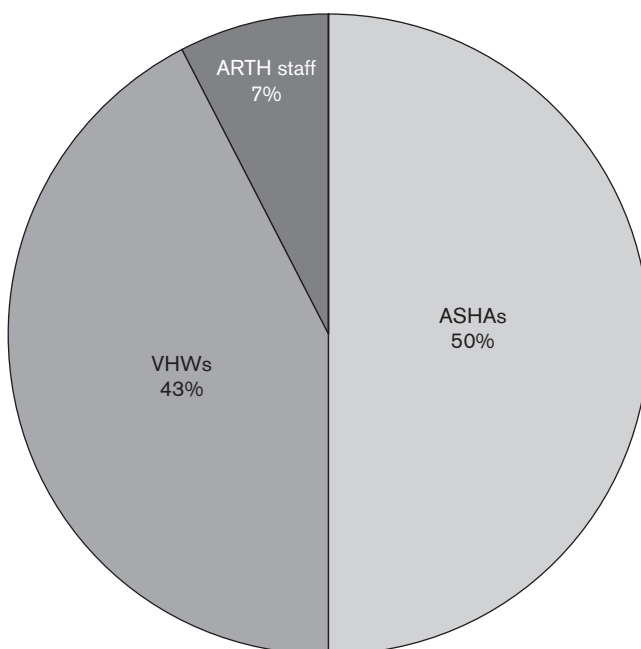


FIGURE 1.7. Who conducted the ARTH pregnancy tests?

TABLE 1.1 PROFILE OF WOMEN WHO USED THE PREGNANCY TEST SERVICE IN THE VILLAGES

Age (N = 4,161)	<20	300 (7.2%)
	20–24	1,489 (35.8%)
	25–29	1,469 (35.3%)
	30 and above	903 (21.7%)
	Mean age	25.4 years
	Range	15–48 years
Caste (N = 4,161)	Scheduled caste ²²	420 (10.1%)
	Scheduled tribe ²²	2,091 (50.2%)
	Other	1,650 (39.7%)
No. of living children (N = 4,161)	0	985 (23.7%)
	1 to 2	1,943 (46.7%)
	3 to 4	978 (23.5%)
	5 and more	253 (6.1%)
	Not recorded	2
Education (N = 3,279) (February 2009 onwards)	Illiterate	2,362 (72.0%)
	1st to 5th	428 (13.0%)
	6th to 8th	309 (9.4%)
	9th and above	180 (5.5%)
Marital status (N = 4,161)	Married	4,098 (98.5%)
	Unmarried	56 (1.3%)
	Separated/widowed	7 (0.2%)

Nearly 43% women who took the test were under 25 years of age (table 1.1). As many as 24% did not have any living children, and 47% had either one or two children, indicating that the service was accessible to women in the early phase of their reproductive cycle.

A disproportionately high number of pregnancy test users belonged to the otherwise hard-to-reach groups—60.3% women belonged to socially and economically marginalized communities, who constitute 45% of the total population in the intervention area, according to the 2001 India census.²² Nearly three-fourths of these women had never been to school. Most of the women were married, although a minority (1.5%) were single (unmarried, separated, or widowed). Married adolescents who had not yet started cohabiting with their husbands were included among the married women. As per local tradition, in the event of marriage during childhood, a girl may wait for two to five years before joining her husband's home. During this transition period, she may visit her husband's home on family occasions, where sexual

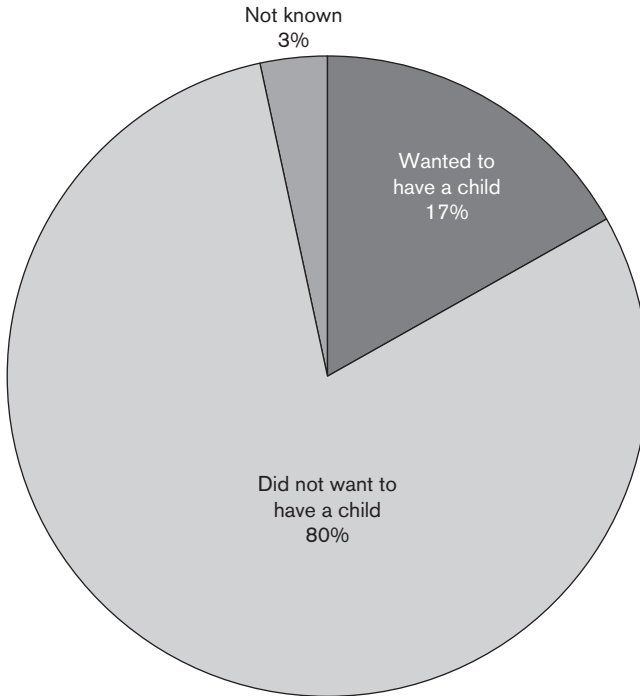


FIGURE 1.8. How many women wanted to have a child at the time of their pregnancy test?

contacts might result in pregnancy. She also might also become pregnant through intercourse with another person. However, pregnancy during this phase is considered stigmatizing; these young girls are expected to be sexually inactive, which makes it difficult for them to access reproductive health services.

Women Who Tested Negative ($n = 2,282$)

A high proportion of the total tests conducted resulted in a negative pregnancy outcome (54.8%). Of those women, 79.8% (1,821) did not want to have a child at the time (figure 1.8), and 64.7% (1,178) of them either had no children or one or two children. Of the women who did not want to have a child, 50.8% (925) initiated a reversible contraceptive soon after the test was performed, with oral contraceptives pills

being the most popular among the users (46.8%), followed by condoms (30.9%), emergency contraceptive (EC) pills (8.1%), and injectable contraceptives (7.1%). The health worker who conducted the test gave the women the choice of all contraceptive options and informed the women where to access each option. The health worker was also able to provide oral pills, condoms, and ECs immediately following the test in the village; for clinic-based methods of contraception, the woman was referred to an appropriate health facility.

In the event that a woman who desired pregnancy was not pregnant (16.8%, 383), the health workers referred her to an obstetrician/gynecologist at ARTH's health center (see example 1.1). The gynecologist would examine the patient and advise on a first round of tests before making a referral to an infertility center when needed. We do not have information about how many of these women sought further medical advice for infertility.

Women Who Tested Positive (n = 1,879)

A total of 45.1% of women tested positive for pregnancy. Of these, 61% wanted to continue the pregnancy, and 39% did not (figure 1.9).

Example 1.1. Pemli Gameti's Story

Pemli Gameti, an illiterate 35-year-old woman belonging to the tribal community, missed her period. She lived in a village about 35 kilometers from the nearest town where she could access reproductive health services. When the village health worker (VHW) was on one of her regular visits to Pemli's village, Pemli saw her and called her. Pemli informed the VHW that she had not had her period for the last two months and was concerned that she might be pregnant. The VHW conducted a urine pregnancy test for Pemli, which revealed that she was not pregnant. Pemli was relieved as she already had five children and did not want any more. The VHW counselled her and told her that her amenorrhea could be due to lactation. The VHW advised her to come to the clinic and also told her about the various contraceptive options. After a visit to the clinic and meeting with the physician, Pemli decided to start oral contraceptive pills. Subsequently, she took her supply of pills from the VHW whenever she visited the village.

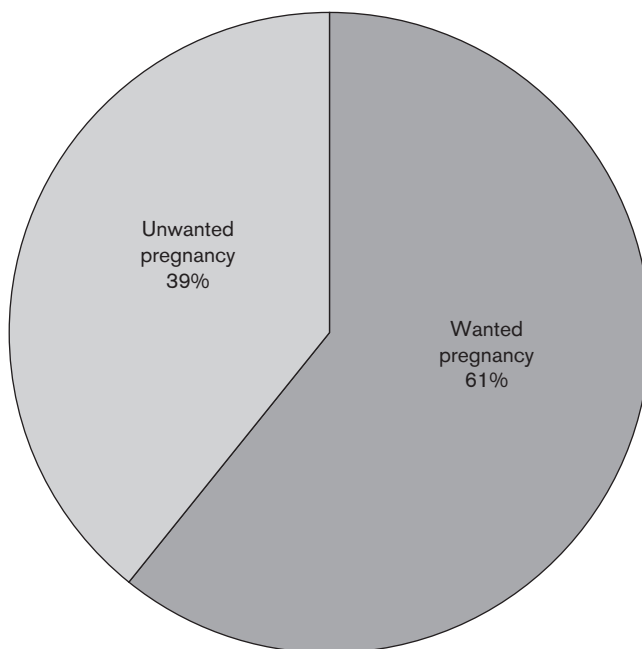


FIGURE 1.9. How many women wanted to continue their pregnancy?

The women who reported that they wanted to continue the pregnancy were referred for early antenatal checkups to either the ARTH health centers or to the government ANM.

A follow-up of the 735 women who did not wish to continue the pregnancy revealed that the majority (72%) reported having an induced abortion, and 9% reported spontaneous abortions. However, 18% women who expressed that the pregnancy was unwanted subsequently continued their pregnancies (figure 1.10). We did not record the reasons for carrying unwanted pregnancies to term. However, discussions with women in the villages revealed that financial constraints or inability to go out of the home to seek abortion services were among the reasons for continuing unwanted pregnancies. The team was unable to follow 1% of women who migrated out of their village, usually to be with their husband who worked in a city.

Among the women who reported induced abortions, 70.4% (371) underwent safe abortions at certified facilities (figure 1.11). Such a high proportion of safe abortions is not a reality for many Rajasthani women.

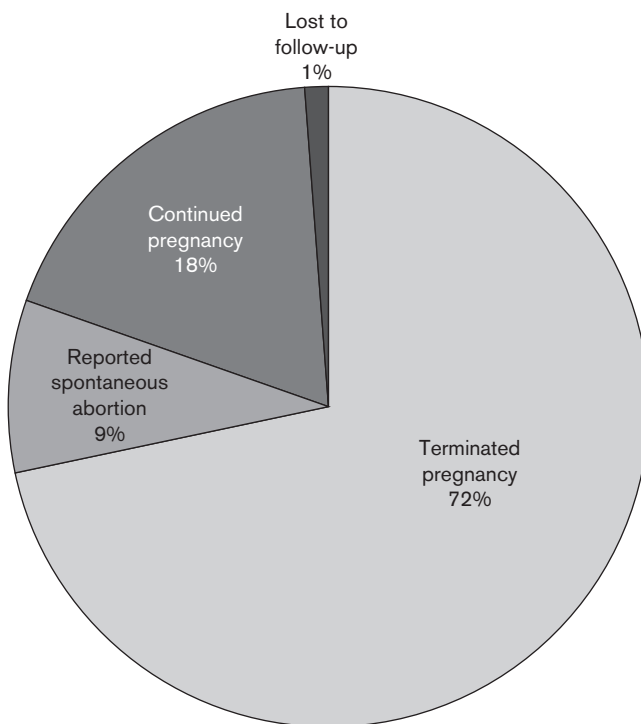


FIGURE 1.10. What did women do in case of an unwanted pregnancy?

While some women went to government or private health facilities in the city (20–65 kilometers away), most of them (64.4%, 239 women) obtained safe abortion services from one of ARTH's two health centers in their immediate vicinity. (See examples 1.2 and 1.3.) Thus, the availability of good-quality, subsidized services at ARTH's health centers, close to women's villages, provided an important follow-up service to the field level service being provided by the health workers. Over a quarter of the women (27%, 145) underwent unsafe abortion—either by consuming tablets for medical abortion (bought over the counter from pharmacy shops) or by seeking services from unauthorized providers or by consuming a traditional herbal concoction on their own. Two percent of the women (11) did not reveal the provider of their abortion. Nearly half of the women (49.6%, 365) who did not want to continue the pregnancy (735) had either none, one or two children already.

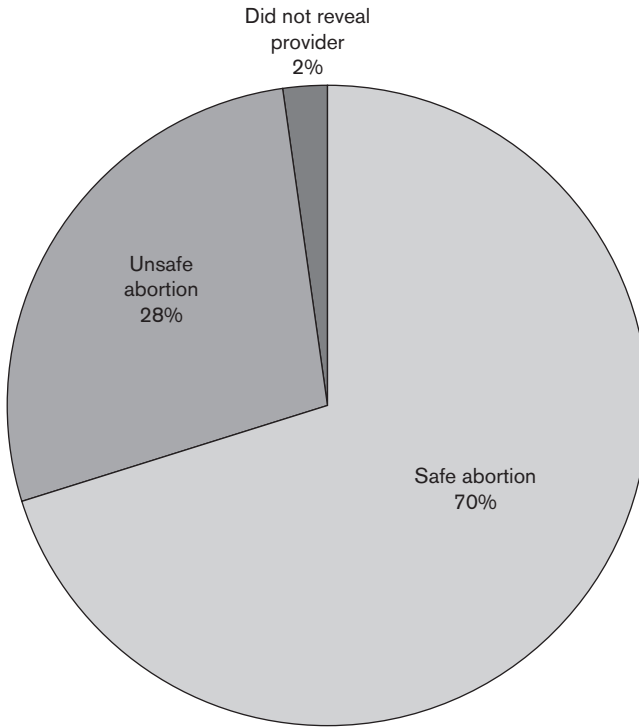


FIGURE 1.11. How many women underwent safe abortions?

Example 1.2. Pushpa Singh's Story

Pushpa Singh, an illiterate 35-year-old mother of four children, belonging to one of the higher castes, had missed her period. She saw the VHW in her village when the VHW had come to make a postpartum visit to another woman. Pushpa called the VHW to her house and asked her what materials she could share. Along with other demonstrations, the VHW showed her the urine pregnancy test kit. Pushpa then told the VHW that she had not had her period for the last two months and asked her to do the test. The test was positive. Pushpa did not want to continue the pregnancy and asked the VHW for some tablets to abort. The VHW referred her to ARTH's health center for abortion services, which was located 8 kilometers from her village. Pushpa obtained a safe abortion from ARTH and subsequently chose to use an IUD to prevent further unwanted pregnancies.

Example 1.3. Mohini Gameti's Story

Mohini Gameti was an illiterate woman belonging to a tribal community and lived in a village 25 kilometers from the city. Mohini became a mother at the age of 16. At the age of 18, when her daughter was one-and-a-half years old, she missed her period again. When a village health worker (VHW) visited her village, Mohini obtained a pregnancy test and learned that she was pregnant. She did not want to have another baby so soon. However, she could not tell her husband or in-laws, who would pressure her to carry the pregnancy to term. Mohini managed to take money from her husband on the pretext that she had to return it to someone from whom she had borrowed. Mohini went with the VHW and had a safe abortion. Thereafter, she continued to take oral contraceptive pills from the village health worker.

DISCUSSION

The decision to reproduce, paired with the freedom to regulate one's own fertility, has been identified as one of the mainstays of reproductive health. Reproductive health is affected by a variety of sociocultural and biological factors on one hand and by the quality and responsiveness of the health-care delivery system on the other.²³ Women's ability to control their fertility is also fundamental to their empowerment: if a woman can plan her family, it will be easier for her to plan her nonreproductive choices as well. Prevention of unwanted fertility protects a woman's health, and when a woman is healthy, she becomes more productive and better able to care for her existing children. When her reproductive rights are protected, she has the freedom to participate more fully and equally in society. Our experience shows that training community health workers to provide pregnancy tests at the village level is an important step to empowering rural women in India to take charge of their reproductive health.

In our intervention, the pregnancy test served as an entry point to talk to women about broader aspects of their reproductive and sexual health. The service made it possible for women to know their pregnancy status at an early stage without having to leave their village. Seventy percent of the users of the pregnancy test service were women with no children or with one or two children. Given that younger women in rural Rajasthan have very limited autonomy and mobility, this doorstep service was crucial for them. The majority of these women did not want to have a child (or more children) at that point in their lives, and thus knowing their

pregnancy status and subsequently having access to contraceptives or abortion was a direct pathway to make an informed choice.

In southern Rajasthan, where this intervention was carried out, there is a considerable social distance between health care providers (mostly urban, well-educated, and of higher socioeconomic status) and women (mostly rural, illiterate, and socioeconomically disadvantaged). This social distance makes women hesitate to approach or talk frankly with trained health providers. Unscrupulous providers who come to know about a woman's pregnancy status before she herself knows that she is pregnant have at times exploited this asymmetry of power and information. Providing the pregnancy test service through a woman-to-woman outreach program has changed this dynamic, enabling women to *gain important information about their own health and bodies in time to make informed decisions*. Women were excited to be able to see the strip and to learn how it could tell them if they are pregnant or not. Furthermore, the convenience of being able to get this information without leaving the village saved them a lot of time and effort.

There have been efforts in other parts of India to provide pregnancy tests at the village level, primarily through non-governmental organizations. One program provided urine pregnancy tests in the villages, followed by registering new pregnancies and providing family planning services at the field level.²⁴ Another program offered a urine pregnancy test kit as one of the items in the reproductive health tool kit of its village health workers.²⁵ However, we did not find any published information about a program that linked the urine pregnancy test with other reproductive health services. A small study conducted in the central Indian state of Madhya Pradesh among two hundred newly married women who used the pregnancy test kit followed their pregnancy outcomes until their delivery.²⁶ The study found an increase in early registration of pregnancies and an increase in deliveries performed at health-care facilities among women who used the pregnancy test kit. However, our data shows that a higher proportion of women who underwent the pregnancy test did not want to be pregnant at that time. Thus, while early pregnancy registration and increased institutional delivery are potential advantages of the home-based pregnancy test, our experience suggests that the service also holds a high potential to address the needs of those women who do not want to be pregnant. This is further validated by the findings of a retrospective cross-sectional study conducted in Cape Town, South Africa, that found that women who had obtained a urine pregnancy test of their own accord presented 3.6 weeks and 1.4

weeks earlier for antenatal care and abortion services respectively, independent of all other factors.²⁷ Thus, easy access to pregnancy confirmation seems to be associated with earlier care seeking for antenatal care and abortion.

Access to a service may be promoted or hindered by the provider's attitude, as was found in the South Africa study.²⁸ Half of the seventy-eight public health-care providers interviewed thought that they should not perform tests on young teenagers because "they should not be sexually active or using contraception anyway." Reasons given for not promoting the pregnancy test service were "irresponsible client behavior," "decreased contraceptive use," and the "possibility of clients abusing the service."²⁹ Thus, access to technology, especially among more vulnerable groups, may be restricted by providers' own values. Our findings reveal that some women as young as 15 years old were sexually active. These young women utilized the pregnancy test service when it was provided in a nonjudgmental and adolescent-friendly manner. Other studies in India have shown that compared to married women, single women face a more complex process when deciding to undergo an abortion, with others often deciding on their behalf. As a result, single women are more likely to approach informal providers who are perceived to be better at maintaining confidentiality.³⁰ Hence, if the service is to be scaled up in a large program, it would be crucial that service providers are trained and guided to respect the reproductive health needs of adolescents, young people, and single women, irrespective of their own values and perceptions.

One feature of our intervention was that the performance of health workers was not consistent. The performance of ASHAs, appointed by the government, varied widely. Some ASHAs conducted only two pregnancy tests over a one-year period, while others conducted up to twenty tests in the same time frame. On average, the village health workers conducted more pregnancy tests than did the ASHAs. While ARTH staff provided similar supervisory support to both ASHAs and VHWs, encouraging both groups to offer the service in the villages, pregnancy testing was not the government's priority at the time.³¹ We suspect that since pregnancy testing was not a priority for the government, ASHAs did not focus much attention on this activity. In 2009 (two years after we started this intervention), the government of India started providing urine pregnancy tests (*nishchay* kits) at the village level through ASHAs, in a phased manner.³² Although the government intended the pregnancy

test kit to act as an entry point to reproductive health and family planning services, there were problems with the supply chain and with the supervision of ASHAs. As a result, the test kits have not become easily accessible to a majority of the women who are its intended beneficiaries. The third review of NRHM observed that the nishchay pregnancy kits were not being used to rule out pregnancy and provide contraceptives to women.³³ Additionally, an evaluation of the ASHA program in Rajasthan revealed low levels of counseling being offered by ASHAs, and in terms of referral for services, female sterilization has remained the central focus.

A qualitative study done with ASHAs provides more evidence of the government's promotion of sterilization over reversible contraceptive methods. ASHAs report facing pressure to meet sterilization targets and being penalized by their supervisors for not meeting the targets. It may be the case that our intervention has the potential to enable women to fulfill their reproductive rights by gaining access to a full range of health services. However, this will be possible only when the performance monitoring of frontline workers in the public health system changes from "ELAs" to meeting the actual reproductive needs of women.

LESSONS LEARNED

We found that this intervention was an important step to help women make decisions about their sexual and reproductive health at critical junctures in their lives. It also contributed to their health by preventing unwanted pregnancies and unsafe abortions. Those with a negative pregnancy test who did not want children at that point in their lives were able to start a contraceptive in time, whereas those whose test was positive but who did not want to continue the pregnancy were counselled and helped to access safe abortion services. Women who wanted to continue their pregnancies were able to start antenatal checkups in time. This intervention also allowed us to reach hard-to-reach groups such as adolescents and young women.

Developing a suitable workforce of community health workers was a challenge. While ASHAs had limited and highly variable effectiveness, village health workers had a high turnover rate, largely because they were young (unmarried or newly married) women who did not have the autonomy to decide about their jobs. Some of them moved from paternal homes to husband's homes and were asked to quit their jobs, while

others had to leave within a few months of training either because their families were not happy that they had to “roam around in villages” or because their families needed them to attend to household chores.

Our experience suggests that systematic, effective referral links to clinic-based services such as long-term family planning methods or safe abortion are essential for the effectiveness of community-based services. We linked the compensation for village health workers to the services they provided, which we believe contributed to higher performance. In order to take the intervention to scale, it would be crucial to develop a robust resupply system for getting test strips, oral pills, condoms, and emergency contraceptive pills to health workers. In a large government system, it will be equally important to orient village volunteers (e.g., ASHAs) to provide nonjudgmental services to unmarried and newly married adolescents and women and to women who might be seen as “candidates for sterilization.” Further, a system of monitoring and supervision will be important to avoid misreporting and to ensure that even women living in remote villages receive services.

CONCLUSION

In rural Rajasthan, very few women have genuine control over their fertility decisions, which reflects and compounds their social disempowerment. Our organization views the relationship between fertility and empowerment to be synergistic: by bringing fertility management under women’s control, this can be one small step towards empowering women in other aspects of their health and well-being. Our project’s door-to-door pregnancy testing service marked the first step of this process.

Given that the use of reversible methods of contraception in the country is low and there is a high unmet need for contraceptives for spacing,³⁴ conducting a pregnancy test provides an opportunity to meet the reproductive health needs of women and couples, as has been shown by this pilot intervention. The intervention has potential to be scaled up because it involves a safe, low-cost, low-technology service that can be provided by low-literate health workers who lack formal medical training. The components of the intervention are easy to use at the community level and can therefore be integrated with other community-based distribution (CBD) programs.³⁵ In communities where women have difficulty accessing contraceptives, safe abortion, and timely antenatal care, a community-based pregnancy testing service could provide the

much needed “pull” for uptake of other reproductive health services (as against the current “push” by the public health system for women to choose sterilization).

Although we have not systematically evaluated the impact of this intervention on reproductive outcomes and women’s ability to control their fertility, we believe it offers promise for scale-up and integration into the government’s current family planning programs. The results may also be relevant for program planning in other countries where women have limited reproductive autonomy. Because this intervention has excellent potential to reach adolescents and younger women in need of birth spacing, it could be a viable strategy to promote reproductive rights and health among hard-to-reach populations.³⁶

Box 1.1. Summary

Geographic area: Rural population of about 60,800 people living in forty-nine villages across Udaipur and Rajsamand districts in the northwestern state of Rajasthan, India.

Global importance of the health condition: Limited mobility and autonomy of rural women in low-income countries makes it difficult for them to access reproductive health care services, often leading to adverse health consequences.

Intervention or program: Action Research & Training for Health (ARTH) trained community health workers to provide a door-step urine pregnancy test service at a minimal cost followed by counseling and referrals to help women make their own reproductive health decisions and obtain the required products and services (condoms, oral pills, emergency contraceptive pills, or a safe abortion) at the village level or at a health facility.

Impact: Large numbers of illiterate young women belonging to socioeconomically disadvantaged communities learned their pregnancy status at a minimal cost within their village and sought follow-up services of their choice—particularly contraception and safe abortion.

Lessons learned: This low-cost, door-to-door pregnancy test service provided an entry point to address the broader reproductive health needs of women. It was greatly appreciated by rural women, especially the younger ones. Nonjudgmental delivery of such services, coupled with a robust system of supervision, resupply, and effective referrals were important factors in the success of this community-based intervention.

Link between empowerment and health: The decision to reproduce, when paired with the freedom to regulate one's own fertility, has been identified as one of the mainstays of reproductive health. Empowerment has been defined as the expansion of the ability to make strategic life choices—choices that are critical for people to live the lives they want. These choices include those related to education, marriage, childbearing, and livelihood. Prevention of unwanted pregnancy is directly linked to women's health and also enables them to balance and time their reproductive and nonreproductive aspirations, thus facilitating their access to emerging opportunities. When women's reproductive rights are promoted and protected, they have the freedom to participate more fully and equally in society.

For a video about Action Research and Training for Health (ARTH), see <https://youtu.be/mObfWwc6Gmk>.

Box 1.2. Factors behind the Success of Village-Based Reproductive Health Services in India

- The intervention demonstrated that a safe, low cost, low technology intervention designed to support women's fertility preferences can be provided by *community-based health workers* with low levels of literacy and no formal medical training.
- *Young community health volunteers, trained to provide services* in a nonjudgmental and confidential manner, were able to reach large numbers of adolescents and young women.
- *Orientation meetings* with village leaders, video shows, wall paintings, and small group meetings with young women and men helped health workers establish an enabling environment and enabled them to provide effective services.
- *A robust system of supervision, resupply, and referrals*, backed by an accessible clinic-based service, contributed greatly to the intervention's success.
- The intervention can be *easily integrated with other community-based distribution programs* as an entry point to begin a conversation with women (especially adolescents and young women) about reproductive health issues.

NOTES

1. Kabeer 2001, 19.
2. Larsen and Hollos 2003, 1111–1112.
3. Malhotra 2012, 3; Ansara et al. 2011.
4. IIPS 2010a, 2010b.
5. Planning Commission 2006, 8.
6. Registrar General and Census Commissioner 2011.
7. IIPS 2010a, 6.
8. IIPS and Macro International 2007, 1:473.
9. IIPS and Macro International 2008, 48.
10. Registrar General of India 2012, 48.
11. Registrar General of India 2011, 3.
12. Leavitt 2003.
13. Demography and Evaluation Cell 2012.
14. Jejeebhoy 1997, 5; Santhya 2003, 2–5.
15. NRHM is a flagship program of the government of India, launched in 2005, to improve the health status in rural parts of the country.
16. NRHM 2009, 29.
17. IIPS 2010c, 174.
18. Pachauri 2004, 16–17; Mookim 2006, 4–7.
19. IIPS and Macro International 2008, 48.
20. ARTH n.d.
21. Asha is a commonly used name for girls, it means “hope” in Hindi and several other Indian languages.
22. Taking note of the fact that certain communities in the country suffer from extreme social, educational, and economic deprivation, the first schedule of the Constitution of India has identified them as Scheduled Castes and Scheduled Tribes as per provisions contained in Clause 1 of Articles 341 and 342 of the Constitution (<http://lawmin.nic.in/ld/subord/rule3a.htm>, <http://ncst.nic.in/index.asp?langid=1>).
23. Jejeebhoy 1997, 2.
24. “Tribhuvandas Foundation” 2016.
25. Jan Swasthya Sahyog 2006, 9.
26. Saroshe, Mehta, and Dixit 2012, 46.
27. Morroni and Moodley 2006.
28. Ibid.
29. Ibid.
30. Visaria et al. 2004.
31. NHSRC, 2011, 103.
32. HLFPT n.d.
33. NRHM 2009, 29–30.
34. IIPS and Macro International 2007, 1: 121, 159–160.
35. Price n.d., 2–3.
36. Youth Health and Rights Coalition 2011, 3.

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