Internship training

At

THE PELVIC FLOOR CLINIC

"Knowledge assessment regarding Family Planning Services among pregnant women visiting a nursing home in Kalkaji, South Delhi"

By

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PG/20/024

Under the Guidance of
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The certificate is awarded to

Khushboo Verma

In recognition of having successfully complete her dissertation in the department of

Maternal Health

and has successfully completed her Project on

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The candidate has successfully fulfilled her roles and responsibilities designated to her during internship training and approach to concerned program have been sincere, scientific, and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all the success in all her shinning future

Dr. Sumesh Kumar
Dean
(IIHMR DELHI)

Dr. Rohini Ruhil
Assistant Professor
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The following dissertation titled "**Knowledge assessment regarding family planning services among pregnant women visiting a nursing home in Kalkaji, South Delhi,** "at PELVINIC "is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of PGDM (Hospital & Health Management) for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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Dr. Rohini Ruhil
Assistant Professor
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Chapter:1

ABSTRACT

Background: To study the knowledge, attitude, and practice (KAP) of contraception among urban women in health facility at kalkaji. The Purpose of the qualitative assessment is to assess knowledge, attitude, and practices for the use of family planning methods in a community and try to identify the numerous reasons which effect the acceptance of family planning methods. The study was conducted to discover and to guide us to have remedial measures for the acceptance of family planning among urban women. The study enumerates the GAP between the knowledge of contraception and its actual practice. The present study evaluated the relation between the level of knowledge, practice and attitude towards family planning methods usage among the women and sought to explore the reasons behind the Knowledge, Attitude, and

Practice - GAP regarding contraceptive users in Delhi kalkaji

Methods: This study was done among 100 married women between the age group of 18-45 years attending a health facility and was questioned by a presented in a structured Questionnaire during a fixed period. This is a cross-sectional study; the assessment included an assessment by a present Questionnaire. The Questionnaire included details of knowledge, attitude, and practice regarding contraceptive use.

Results: Out of sample, the all women were not aware of at least one contraceptive method, 11% never used contraception. The most commonly used contraceptive was condom (55%), followed by 26 CU-T, 13% pills, 6% injectable, 5% tubectomy and 3% emergency contraception. There was a lack of knowledge of modern methods of contraception. Few of them were willing for a permanent method of sterilization. There was a KAP gap of 20% in total subjects and it was more significant among Muslim as compared to Hindu women.

Conclusions: Though every woman in the study was not aware of at least one contraceptive method the use of the contraceptive method was not 100%. Therefore, there is a strong need for motivational strategies to make people accept the methods. Furthermore, there is a need to organize more educational programs and health camps to increase awareness about the

existing contraceptive methods. Their differences in the socioeconomic and demographic factors exist, which lead to KAP GAP in the family planning (FP) usages. Therefore, in designing effective family planning programme, there is a need to understand the various factors which influence the practice of contraception.

Keywords: Contraceptives, Family Planning, Knowledge Attitude and Practice, Contraceptive methods

Chapter:2

INTRODUCTION

India's expected population will increase to 1.53 billion by the year 2050 [khan][1]. Which signifies that Every fifth birth in the world belongs to Indian, whereas the 50% of the Indian population in reproductive age category [Vaidyanathan][2]. India being the second most populous in the world whose growing population is currently growing at the pace of 16 million each year. To create a substantial reduction in population growth rate, the government of India initiate the Family planning Programme in 1952 and subsequently revised the National Population Policy by the Government of India in 2000, with the objective of bringing down the total fertility rate to the replacement level by 2010. Many Indian states achieved the replacement levels but bigger states are in race to achieve it. Despite continuous energies by the government, unmet needs still remain high among the vulnerable populations. The reasons for these unmet needs have to be analyzed to the core for better understanding of the situation and to help the government in formulation of appropriate policies but still implementation is an issue.

Family planning is a way of thinking and living that is adopted voluntarily upon the bases of knowledge, attitude, and responsible decisions by couples and individuals.[WHO][3] Family planning denotes to a cognizant struggle by a couple to limit or space the number of children through the usage of contraceptive methods.[Ethiopian Demographic and Health Survey 2016][4]Family planning deals with reproductive health of the mother, having adequate birth spacing, avoiding undesired pregnancies and abortions, preventing sexually transmitted diseases, and improving the quality of life of mother, foetus, and family as a whole.[WHO][5] Family planning is not mere birth control, but it encompasses the services, policies, information, attitudes, practices, and commodities, including contraceptives, that give women, men, couples, and adolescents the ability to avoid unintended pregnancy and choose whether and/or when to have a child [WHO]. After Independence in 1947, India partakes substantial improvement in FP-related indicators (e. g., decrease in fertility rate from 4.97% in 1980 to 2.44% in 2015) [Wang][6]. Notwithstanding this achievement, India is still distant in accomplishing the targets laid down WHO has defined family planning as a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples in order to promote the health and welfare of the family and thus contribute effectively to the social

development of a country [WHO] by the Sustainable Development Goals (SDG) (i.e., sustaining 75% of the total demand by practice of modern FP methods). The unmet FP needs among lower socio-economic strata are high.[Singh][7] About 54% married and 44% all women (15–49 years) do not use any type of contraceptive, and Only 48% married and 38% all women (15–49 years) use modern contraceptive methods. Amongst these women, the discontinuation rate of contraceptives was high, which are related to multiple factors. (Singh) female sterilisation (accounting to 37% of women between 15 and 49 years of age), is the most preferred approaches of limiting the family size as compared to male sterilisation and modern contraceptives, The number of female sterilisations carried out per annum is higher as compared to other countries apart from India. [Singh][8] In 2015, the accidental pregnancy frequency in India was 70.1 per 1000 women (15– 49 years); where one-third of all the pregnancies ended in induced abortions. Furthermore, the health facility survey conducted in six Indian states reported that there were 15 .6 million abortions happened in India among reproductive age group [Pareskar][9]

Why there is a need for Family Planning: The population explosion will only result in the depletion of scarce natural resources. Hence, the adoption of contraception becomes imperative. In 1951 India was the first country in the world to launch a family planning programme to decrease population growth in the country. Reproductive health, therefore, implies that people are able to have a responsible satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if when and how often to do so. This definition puts emphasis on right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples, with the best chance of having a healthy infant. A good family planning program not only helps in improves the economic condition of the nation as a whole but also in enhances the health of the women and children at the family level. Hence there is a great need to address this key problem by knowing the level of awareness of the women regarding contraception. [Kashyap, et al. Int J Med Res Health Sci 2018, 7(10): 150-154] The present study was done to study the knowledge, attitude, and practice of semiurban women towards family planning.

By addressing FP needs, more than 90% of low- and middle-income country's child deaths and morbidity connected with abortion and pregnancy could be evaded. [Chola][10] Seeing this, the government of India is dedicated to upsurge the demand for modern reversible contraceptives use to 54.3% among married women (15–49 years) (2010). To highlight harmonies (or dissimilarities), it is noteworthy to establish and summarise the belief and standpoints of people fitting to a broader group or background on a multifaceted phenomenon. To the best of our

knowledge, there are limited reviews conducted on the resident Indian population that studied perceptions of FP. Previous qualitative systematic reviews conducted elsewhere were focused on a subset of population such as age group, provider or country. [Pareskar][11]Therefore, the present study was designed to explore personal experiences and perceptions of and on women about FP in India. The study would try to fulfill the gap by accounting for the knowledges, prospects, sentiments, requirements, opinions, and spirits of resident Indian women on the FP, which will add to help guide policies and frame FP interventions in India.

The present study was conducted among the Urban females of reproductive age group seeking treatment at Health Centre (PHC) Kalkaji. These females are residing in slum and poor areas of kalkaji of south district in Delhi state. The present study is an effort to assess knowledge, attitude and practice (KAP) of family planning among them. Despite the provision of safe and affordable family planning services, 120 million couples worldwide are not using any contraception to limit or space their family, and many who use one or the other method, conceive.

Chapter:3

AIM

Aim: To evaluate the knowledge, attitude and practices of pregnant women regarding family planning services in a nursing home in Kalkaji, South Delhi.

Chapter:4

OBBJECTIVE

I. To assess the knowledge, and attitude of family planning among pregnant women visiting the nursing home in Kalkaji, South Delhi.
II. To evaluate the family planning practices among pregnant woman visiting the nursing home in Kalkaji, Delhi.

Chapter:5

LITRATURE REVIEW

The family planning services is an ability to decide freely the quantity, arrangement and effectiveness of one's children as a basic human right, recognized at the International Conference on Population and Development in 1994 (United Nations Population Fund, 1994). Family planning programmes are linked with lower fertility and lower maternal mortality in any country (Cleland et al., 2006). Through family planning interventions, women increased access to contraceptives, which in turn create a desired family size. Yet, notwithstanding the well-documented profits of family planning, an estimated 40% of pregnancies are unintended (Sedgh et al., 2014) and unmet need for contraception remains high notwithstanding augmented availability of methods (Cleland et al., 2014). Persistent barriers to contraceptive use and related behaviours underscore the need to expand the understanding of, and improve efforts to address, structural drivers of contraceptive use, such as women's empowerment.

5.1 Family planning and women Empowerment: Preceding exploration on women's empowerment points to its fundamental part in persuading reproductive health behaviours, (Abadian, 1996; Blanc, 2001; Malhotra et al., 2002; Kishor & Subaiya, 2008). A current appraisal of women's empowerment and fertility shows that women's empowerment is associated with lower fertility, lengthier birth recesses and minor rates of unintended pregnancy (Upadhyay et al., 2014).

Blanc family planning conceptualization formulated by Kabeer and prevailing assumptions about gender dynamics and reproductive health (Kabeer, 1999, 2001b; Blanc, 2001), it is sensible to conjecture that women's empowerment would be connected with various family planning conclusions. Indeed, it might be predictable that as women are extra able to make planned life choices, they might want to plan for the future and expand their lives role elsewhere being a wife and a mother since using family planning would permit them to postponement, spacing or limiting the pregnancies, liberating their time for other pursuits. Nevertheless, it is indispensable to intermittently examine the signs concerning such popular expectations and concepts and polish the perceptions elaborated before continuing to develop new interventions

and programmes in any country, particularly with scarce resources for reproductive health improvement.

5.2 Family Planning a Voluntary thinking: An Expert Committee (1971) of the WHO defined family planning as "a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decision by individuals & couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of the country". Family planning services have the potential to improve the quality of the lives of people and also their economic welfare. Increasing population growth is a worldwide problem today and India is no exception.

"Family planning refers to practice that help individuals or couples to attain certain objectives:

a) To avoid unwanted births
b) To bring about wanted births
c) To regulate the intervals between the pregnancies
d) To control the time at which birth occurs in relation to the ages of the parent
e) To determine the number of children in the family".

An assortment of diverse methods of contraception are accessible to population, which are enormously benign associated with the dangers accompanying with pregnancy and childbirth. Not all methods are suitable for everyone needs. Expanding the number of family planning options available to women is a critical part of increasing contraceptive coverage, lessening unintentional pregnancies and dropping maternal morbidity and mortality around the country. [WHO] Family planning through contraception attempts to accomplish two main objectives; firstly, to have the anticipated number of children and secondly, to have appropriate spacing of pregnancies. [MOHFW] A deficiency of familiarity of contraceptive methods or a source of supply, cost and poor availability are the fences that happen in developing countries. Side effects perceived as major factors for the leaving of modern methods. Mass media also plays a significant part in upgrade and suitability of contraception. [Ghule][12]

According to Bongaarts the knowledge, attitude, practice surveys revealed no complete relationship between knowledge and attitudes and between attitude and practice of family planning methods. (Bongaarts) Fawcett has also described that respondents usually display substantial knowledge and attitude change over time, but they do not always display equivalent deviations in contraceptive practice usage.

The family planning programme operating in India for more than five decades and there is considerable increase in the governmental and non-governmental actions for encouraging the acceptance of family planning through extensive and strengthened efforts and clinical services

being made available to the primary user at primary healthcare centers. Unmet needs are conceptually identified as a separate category within family planning services in order to focus on such married women whose attitudes resemble those of contraceptive users but practices do not. The factors responsible for such behavior can be: lack of information or of services, inconvenient or unsatisfactory services, poor design and management of service delivery systems; fears about contraceptive side effects, opposition from the husband and relatives are other contributory factors. [Bongarts][13]

Around the world, governments and partners have prioritized investments to increase access to and uptake of family planning methods. There is a wealth of evidence linking family planning (FP) to reductions in maternal mortality by reducing the likelihood of unplanned pregnancies, unsafe abortions, and the potential health risks of high parity and closely spaced pregnancies.

a) These successes are also well documented for children: rapider birth intervals are associated with upsurges in kid mortality danger
b) By allowing women to improved space or limit childbearing and therefore exercise governance of bigger family size, family planning intervention positive consequences are better educational and employment outcomes for women as well as improved health and nutrition for children
c) The standing of family planning is apprehended in many of the United Nations Sustainable Development Goals' targets for 2030: where target 3.1 suggests reducing the global maternal mortality ratio, target 3.7 ensures universal access to sexual and reproductive healthcare services, and 5.6 universal access to sexual and reproductive health and reproductive rights
d) Its position is correspondingly replicated in the Family Planning 2020 initiative (FP2020), launched in 2012, which united governments, donors, the private sector, and other organizations to set go-getting FP targets with a definitive goal of allowing 120 million extra women and girls to practice voluntary modern contraception by 2020
e) Prevailing exploration of drivers and barriers of family planning acceptance might enlighten the reasons why women do not use family planning methods, predominantly modern contraceptives. Analysis of Demographic and Health Surveys in 52 countries between 2005 and 2014 discovered that the utmost common motives for not using contraception despite wanting to limit (not wanting another child) or space (not wanting a child soon) child bearing were fear of side effects, infrequent sex, and opposition to contraception from self or others. In contrast, lack of awareness, lack of access, and cost were rarely reasons for unmet contraceptive need. Several additional studies across low- and middle-income countries also found that fear of side effects, particularly infertility, is a significant barrier to modern contraceptive use. Therefore, family planning services and investments in behavior change

communication campaigns will be critical to address these apprehensions and produce mandate for modern methods usage. Women have limited autonomy over their reproductive decisions. Research has identified men as key decision makers and targets for messaging. Husbands and relatives, in particular mothers-in-law, heavily influence the fertility decisions made by women in regard to number of sons and timing of sterilization, though norms have begun to shift with young couples making their own contraceptive choices [11]. Some of these findings hold across multiple geographies, suggesting that drivers and barriers of family planning use are Understanding drivers of family planning in rural northern India

5.2 KAP Study in family planning in India: India became the forerunner nation in the world to unveil a countrywide family planning programme in the year 1952, with an intention to decrease fertility and thereby to calm the population growth in the near future. The family planning programme was introduced with a very careful approach in India, after the independence (1952) natural method of family planning was considered to be the most appropriate technique for preventive births but a main discovery in contraceptive technology happened, when the 'Lippes Loop' was accepted in India in 1965, the government started encouraging the device through concentrated operations.

In 1977 the programme was renamed as Family Welfare Programme. The Family Welfare Programme has relaxed its compulsive approaches in the modification of family planning at various nodes so as to make the programme more educational and wholly voluntary. Desired family size and timing of births are two primary objectives that are fulfilled by the family planning through contraception.

Although the family planning programme was not as successful as was expected, it was success in generating universal knowledge of family planning methods among the masses but, even with this high awareness of contraception there occurs a great break between the knowledge and Practice of these methods due to the existing variations in the socioeconomic and geographical characteristics within its territory

There has been a substantial upsurge in the governmental and non-governmental activities for promoting the adoption of family planning through widespread and intensified efforts as well as clinical services being made available to the users of family planning methods. KAP studies are highly focused evaluations that measure changes in human knowledge, attitudes and practices in response to a specific intervention, usually outreach, demonstration or education. **KAP studies** have been extensively used and appreciated around the world n public health, water supply and sanitation, family planning, education and other programs. National governments, nongovernmental groups, United Nations agencies and the World Bank use KAP assessment approaches. KAP studies are cost-effective and finance conserving than other social research

methods because they are highly focused and limited in scope. KAP studies tell us what people know about certain things, how they feel, and how they behave. Each KAP study is exclusive to a specific background and considered for a specific issue. However social surveys may cover a wide range of social values and activities, KAP studies focus precisely on the knowledge, attitudes and practices (behaviours) for a certain topic.

5.3 KAP Survey: "KAP survey is a representative study of a specific population to collect information on what is known, believed and done in relation to a particular topic. In most KAP surveys, data are collected orally by an interviewer using a structured, standardized questionnaire. These data then can be analysed quantitatively or qualitatively depending on the objectives and design of the study. A KAP survey can be designed specifically to gather information about related topics, but it may also include questions about general health practices and beliefs".

5.4 Family Planning and KAP study: Specific Literature Review:

The studies completed in past on the topic of family planning were restricted in nature. Majority of the studies focused only on quantitative aspects, moreover, the bulk of research done in recent past for this topic was conducted by medical or para medical branches. The field was restricted to rural areas in most of the studies and family planning has always been looked as something that needs to be studied in rural communities and major respondents for most studies were "women"; As pointedout.by Arna Seal, in her study, the topic of family planning is usually confined to rural areas with very few researchers focusing on urban areas, (Seal, 2000) in Negotiating Intimacies: Sexualities, Birth Control, and Poor Households, the researcher chose to study this process in the context of urban working class women. The issue of birth control is often viewed as a raging "problem" in rural India. problems of the rural and urban in terms of residence? Policy planners often fail to consider these complexities while implementing their strategies. For instance, the KAP survey showed that on the average, the number of children born by I desired family size. (Seal, A. 2000).

Rule makers attributed this difference between of admittance to active contraceptive. On the basis of this understanding, the markets in developing countries were flooded with contraceptives for women's use. However, the fertility rates remained high because, in fact, there was and is more issue than mere access only. (Seal, A. 2000)

5.5 Awareness about family planning methods in rural areas

5.5.1 the Nepal study suggest that Majority of women had heard about family planning methods. However, few had practiced them, which results in high unmet need among married Tharu women of Dang district in Nepal. In this context, this study concerns the need for the policy maker, government officials, and program managers to focus on strategic behavior communication

program regarding reproductive health including family planning among tribal communities like Tharus. (Bhattarai, 2018)

5.5.2 Indian Perspective: Reproduction is always instantaneously a physiological as well as a social act. The gap between society and biology is what enabled reproduction to be such a potent site for reformist efforts. Antiquities of fertility and contraception have principally been made to serve as the pre-modern antithesis to a fully "modern" future, agents of backwardness and as wrongdoers in the pursuit to responsibility for national poverty. (Hodges, 2016)

Implication of any public policy largely depends on the conceptual model of the policy, as it passes through diverse socio-economic and enlightening context. In February 2000, the government of India adopted the National Population Policy 2000. as population is not integrated with health, it has population stabilisation rather than the health and wellbeing of the population as a goal, and so on. Yet a optimistic feature of the policy is that it definitely confirms the "assurance of the government for citizens while availing of reproductive health care services, and continuation of the target free approach in administration (Rao M., Population Policies family: States Approve Coercive Measures, 2001)

India understandings a lot of constraints in implementing policies, owing to the complexities arising out of the heterogeneity and diversity of the population, this pose a major challenge to the process of development in India, especially in the field of social change. Thus, it is unjust to compare India with a country like China which has a one-party communist rule and can impose on its people one child policy and achieve considerable success without much popular revolt, which is highly unlikely in India as the policy makers have to keep in mind the complexity and diversity of the Indian population and the imposition of the political philosophy which operates in India.

Population of India witnessed a very slow growth till 1920 owing to the huge number of fatalities from famines, wars and epidemics. The population began to increase from 1921, mostly because of improvement in health and sanitation condition which was taken care of by then provincial governments. Population increased by more than 10 percent in a decade with 1931 census enumerating a population of 279 million.

Chapter:6

METHADOLOGY

Study Design: Cross-sectional Descriptive Study Design

Study Population: Pregnant Women aged between 18 to 49 years visiting a particular nursing home in Kalkaji, South Delhi.

Source of Participants / Data

(a) Eligibility Criteria: The eligible participants should be pregnant and between 15- 49 years.

(b) Sample Size Calculation: In order to calculate the sample size we assume that adoptions is 15% decrease, incidence population is 77%, alpha is 0.05% and power is 88%. Hence, our sample size is 113. (By clincalc calculator)

Tools-A self-administered structured questionnaire will be used which is attached at the end of the synopsis.

Study Duration: April- June 2022

Sampling Method: Non-probability sampling method- Convenience sampling

Data Analysis Method: Descriptive Statistics, Chi- Square

Ethical Considerations: This study does not involve any invasive procedure or sample study; I will follow all the photocells and will do at the time of the administration of the questioner. I will follow informed consent from the subject.

Inclusion Criteria Women in the reproductive age group residing in that area were included in the study.

Exclusion Criteria Women who refused to participate in the study were excluded. The data was collected after gathering information from predesigned and pretested proforma. A verbal consent was obtained from all women. The interview was administered to all participants explaining them the aim of the study and objectives. After making rapport with the subjects and maintaining confidentiality, the proforma was collected. Information was taken with respect to age, parity, religion, socio-economic status, knowledge about various contraceptive methods and their usage.

Reason for not using and the source of information was also collected. After the interview, the participants were given information about the various contraceptive methods and their usage and thanked for their cooperation.

Descriptive statistics was used for data analysis. All the collected data were analyzed with regard to the information given by the subjects in the set questionnaire.

Chapter:7

RESULT

Indicators:

Socio Demographic Indicators:

Among, the 100 women in the study group more than 84% were married. Divorced and refusal consist of 12% of the total sample. Majority were Hindus (84%) followed by Muslims (13%). Sikh Buddhist and Christians formed a minority. Eighty two percent of females were passed the Matriculation followed by graduate, post graduate and Higher studies. In terms of occupation 45% working in services sector followed by self-employment 12%, Homemaker 29% and others 14% respectively. Almost all (95.7%) were married and majority (80.1%) of were housewives. (Table 1)

Table 1: Socio-Demographic indicators

S.no	Marital Status	Percentage
1)	Married	84%
2)	Unmarried	02%
3)	Separated	01%
4)	Divorced	05%
5)	Never Married	01%
6)	Refused	07%
S.no	**Education Status**	**Percentage**
1)	High School	82%
2)	Graduate	15%
3)	Post Graduate	03%
4)	Higher studies	01%
S.no	**Employment Status**	**Percentage**
1)	Service	45%
2)	Self-employed	12%
3)	Homemaker	29%
4)	Others	14%
S.no	**Religion**	**Percentage**
1)	Hindu	84%
2)	Islam	13%
3)	Christian	01%
4)	Sikh	03%
5)	Buddhism	00%

Knowledge:

The fundamental area manages the strategies, the wellspring of data and wellspring of administrations benefited by the respondents in Health centres in kalkaji area of Delhi. The data on contraceptives implies the number of prophylactic methods known to the women, wellsprings of information for family orchestrating known, and the wellsprings of family organizing organizations known by respondents. 67% of the women had found out about family orchestrating systems and (33%) of women were unaware of term family planning. About 61% of women got information about contraceptives at the age of 16-25 followed by age group 2535. According to most of the women family planning information received from Healthcare workers (54%) followed by school 35% parents 10% and others 01% respectively. Almost all (89%) of them had heard about oral contraceptive pills and 11% still have no information about contraception. 42 % of the them had heard about Oral contraceptives and 23 % were aware about Male condoms and only (9%) of them had heard about Vasectomy. Most of them avail contraceptive were available in Government Hospital and Health centres (Table 2).

Table 2: Knowledge about Family Planning and its methods

Knowledge

S.no	Have you received any family planning education (sex education)?	Percentage
1)	Yes	67%
2)	No	33%

S.no	In which age did you know about family planning education?	Percentage
1)	10-15	05%
2)	16-25	61%
3)	26-35	23%
4)	36-49	11%

S.no	From where you have received family planning education?	Percentage
1)	School	35%
2)	Parents	10%
3)	Healthcare Provider	54%
4)	Other	01%

S.no	Are you aware about the family planning / contraceptive methods available?	Percentage
5)	Yes	89%
6)	No	11%

S.no	If yes to Q. 8, what kind of family planning / contraceptive methods have you heard of? (Please tick all that apply)	Percentage
1)	Oral Contraceptive (pills)	42%
2)	Vaginal ring	00%
3)	IUD	18%
4)	Implant	00%
5)	Male condom	23%
6)	Female condom	00%
7)	Vasectomy	09%
8)	Tube Ligation (tube tied)	01%
9)	Hysterectomy (removal of womb)	02%
10)	Abstinence (no sex)	05%

Practice of Family Planning methods:

Around (45%) of the review members rehearsed one or other strategy for family arranging. Around 49% respondents imagine that reception of family arranging strategy prompts Preventing undesirable pregnancy.35% of the respondents were motivated by a Health professional for adoption of a family planning method and 5% used family planning methods to overcome problem of Sexually transmitted disease. Among participants who were married around (67%)of respondents were currently have access to the family planning method but still 27% were unaware of Family Planning methods. The Problem lies with 7% of population who do not have any access to Family Planning methods. Around two-fifth of respondents were involving condoms as a family arranging technique. (Table 3)

Table 3: Practice

1. Have you ever used birth control method?

S.no	Have you ever used birth control method?	Percentage
1)	Yes	49%
2)	No	51%

2. What are the reasons to use birth control / contraceptives? (Can choose more than one Answer)

S.no	What are the reasons to use birth control / contraceptives?	Percentage
1)	Want to improve my own health	10%
2)	Preventing unwanted pregnancy	45%
3)	Prevent (STDs)	05%
4)	It is recommended by health professionals (doctor, nurse, Counsellor)	35%
5)	What are the reasons to use birth control / contraceptives? (Can choose more than one)	05%

3. Do you find family planning services ease to access?

S.no	Do you find family planning services ease to access?	Percentage
1)	Yes	67%
2)	No	07%
3)	Do not know	26%

Attitude:

The 56% of the respondents had an ideal demeanor toward family arranging and have no issues towards the entrance of family arranging strategies. Out of the wedded participants,57.4%hadfavorableattitudefromtheirhusbands toward family arranging. Around 80% of the respondents had talked about reception of family arranging technique and among them 49% started practicing family planning methods after the birth of first child and still 51% is either not using or nor aware about it. About 69% of the respondents opined that using birth control / contraception profitable and get encouragement from health professionals for having appropriate gap between child birth. Around 77% urged loved ones to utilize anti-conception medication/contraception for utilizing family arranging strategies. Around two third of

respondents believed that knowing the prophylactic Knowledge for better life and health important. (Table 4).

Table 4: Attitude

4. I find it difficult to get family planning services / contraception?

S.no	I find it difficult to get family planning services / contraception?	Percentage
	Yes	24%
	No	56%
	Do not know	30%

5. After my delivery, I want to use birth control / contraception?

S.no	After my delivery, I want to use birth control / contraception?	Percentage
1)	Yes	49%
2)	No	34%
3)	Do not know	17%

6. In my opinion, using birth control / contraception profitable?

S.no	In my opinion, using birth control / contraception profitable?	Percentage
1)	Yes	69%
2)	No	09%
3)	Do not know	22%

7. I will support the family and friends to use birth control / contraception?

S.no	I will support the family and friends to use birth control / contraception?	Percentage
1)	Yes	77%
2)	No	13%
3)	Do not know	10%

8. What do you think is it necessary to know the contraceptive Knowledge?

S.no	What do you think is it necessary to know the contraceptive Knowledge?	Percentage
1)	Necessary	81.2%
2)	Not Necessary	18.8%

Chapter:8

DISCUSSION

Although India introduced its National Family planning program in 1952 at the primary care level and productive energies have been engaged from time to time to expand its exposure and approachability by involving the primary care level workers, but increasing program coverage is not enough unless all eligible women have passable awareness as well as satisfactory attitude and a correct and consistent practicing of family planning methods as per their need. Upsurge of awareness, knowledge, and favorable attitude for family planning activities of eligible women are strongly recommended and it is essential that the healthcare workers especially the primary care physicians themselves have sound knowledge, favorable attitude, and practice family planning. The results of this study showed that all of respondents had ever heard of family planning and their major source of information were Healthcare providers and the majority (67%) of the respondents had a favorable attitude toward family planning and around (45%) of study participants practiced one or other method of family planning. This finding was lower than a study conducted in Rohtak district, India. Preceding studies documented strong modifications in family planning care provided by Primary health centers and other primary care providers compared with specialized family planning organizations.

The primary care organizations in this study were first-time recipients of family planning contracts reported numerous operational challenges in launching a family planning program in kalkaji area due to poverty and poor hygiene conditions, whereas the nearby established primary care providers experienced difficulties expanding reproductive health services due to limited usage of family planning methods. The administrators have to reorganize the delivery of care and develop strategies that would facilitate the provision of family planning services. While many respondents incorporated these challenges and received the prospect to provide holistic care to women, the reasons they cited, such as women's perceived lack of need for contraception, competing service priorities, and reliance on patients to initiate discussions about contraception, correspond to other reports of primary care providers' barriers to contraceptive care. These findings suggest that even when funding is specifically tied to the provision of family planning, some community health centers and public health agencies may not be able to offer these services immediately and others

may not readily adopt family planning at all into their model of care especially due to lack of commitment by the primary care physicians.

Neighborhood centers, as well as broad prosperity divisions including fundamental thought specialists, can be significant accessories in expanding the ongoing work of family orchestrating providers and ensuring women get the regenerative clinical consideration they need.
The concentrate additionally showed that information and demeanor of the review members were connected with family arranging use albeit powerless on the relationship. The demeanor and practice likewise showed a relationship albeit powerless, this may be because of the way that disposition impacts practice for explicit exercises.

Although primary care organizations experiences expanding family planning services in the region are unique to the recent policy history and constellation of programs in Delhi state, the challenges identified in this study foreshadow the already available services at primary care level. Because the fundamental shifts in practices that would be required to provide the same evidence-based care at many primary care organizations may not take place immediately, low-income women wanting to prevent pregnancy may be unlikely to obtain services when they need them. Therefore, to fulfill the goal that all low-income women have access to comprehensive reproductive health care, publicly funded family planning programs should continue to support a robust and diverse network of providers, including specialized family planning organizations.

Chapter:9

CONCLUSION

Conclusion and Recommendation On the basis of results of our study, it was concluded that knowledge and attitude of family planning methods were directly related to practice of family planning methods usage and due to unavailability of the methods the uptake of family planning is limited. The level of knowledge and attitude toward family planning was relatively low and the level of family planning utilization was quite low in comparison with many studies of the past. Study participant's age group, marital status, length of married life, family type, number of children, associated with practice scores is low. Health workers should teach the community participants on family planning practices in a comprehensive manner so as to increase the awareness and develop a favorable attitude so that family planning utilization will be enhanced. Further, more studies are needed in exploring reasons affecting the non-utilization of family planning and how it can be addressed.

Limitation of the Study

Since the data were collected using a self-administered questionnaires, some of the participants would have been unable to understand the questionnaire completely and the reported KAP might be overestimated or underestimated.

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Annexure I

Analysis chart for Study

Socio Demographic

1. Marital status

S.no	Marital Status	Percentage
7)	Married	84%
8)	Unmarried	02%
9)	Separated	01%
10)	Divorced	05%
11)	Never Married	01%
12)	Refused	07%

2. Highest level of Education completed

S.no	Education Status	Percentage
5)	High School	82%
6)	Graduate	15%
7)	Post Graduate	03%
8)	Higher studies	01%

3. Employment status

S.no	Employment Status	Percentage
5)	Service	45%
6)	Self-employed	12%
7)	Homemaker	29%
8)	Others	14%

4. What religion do you practice?

S.no	Religion	Percentage
6)	Hindu	84%
7)	Islam	13%
8)	Christian	01%
9)	Sikh	03%

10)	Buddhism	00%

Knowledge

5. Have you received any family planning education (sex education)?

S.no	Have you received any family planning education (sex education)?	Percentage
3)	Yes	67%
4)	No	33%

6. In which age did you know about family planning education?

S.no	In which age did you know about family planning education?	Percentage
5)	10-15	05%
6)	16-25	11%
7)	26-35	61%
8)	36-49	23%

7. From where you have received family planning education?

S.no	From where you have received family planning education?	Percentage
7)	School	35%
8)	Parents	10%
9)	Healthcare Provider	54%
10)	Other	01%

8. Are you aware about the family planning / contraceptive methods available?

S.no	Are you aware about the family planning / contraceptive methods available?	Percentage
11)	Yes	89%
12)	No	11%

9. what kind of family planning / contraceptive methods have you heard of?

S.no	If yes to Q. 8, what kind of family planning / contraceptive methods have you heard of? (Please tick all that apply)	Percentage
11)	Oral Contraceptive (pills)	42%
12)	Vaginal ring	00%

13)	IUD	18%
14)	Implant	00%
15)	Male condom	23%
16)	Female condom	00%
17)	Vasectomy	09%
18)	Tube Ligation (tube tied)	01%
19)	Hysterectomy (removal of womb)	02%
20)	Abstinence (no sex)	05%

Practice

10. Have you ever used birth control method?

S.no	Have you ever used birth control method?	Percentage
1)	Yes	45%
2)	No	55%

11. What are the reasons to use birth control / contraceptives? (Can choose more than one Answer)

S.no	What are the reasons to use birth control / contraceptives?	Percentage
1)	Want to improve my own health	10%
2)	Preventing unwanted pregnancy	45%
3)	Prevent (STDs)	05%
4)	It is recommended by health professionals (doctor, nurse, Counsellor)	35%
5)	What are the reasons to use birth control / contraceptives? (Can choose more than one)	05%

12. Do you find family planning services ease to access?

S.no	Do you find family planning services ease to access?	Percentage
1)	Yes	67%
2)	No	07%
3)	Do not know	26%

Attitude

13. I find it difficult to get family planning services / contraception?

S.no	I find it difficult to get family planning services / contraception?	Percentage

	1Yes	24%
	2No	56%
	3Do not know	30%

14. After my delivery, I want to use birth control / contraception?

S.no	After my delivery, I want to use birth control / contraception?	Percentage
1)	Yes	49%
2)	No	34%
3)	Do not know	17%

15. In my opinion, using birth control / contraception profitable?

S.no	In my opinion, using birth control / contraception profitable?	Percentage
1)	Yes	49%
2)	No	19%
3)	Do not know	32%

16. I will support the family and friends to use birth control / contraception?

S.no	I will support the family and friends to use birth control / contraception?	Percentage
1)	Yes	67%
2)	No	23%
3)	Do not know	20%

17. What do you think is it necessary to know the contraceptive Knowledge?

S.no	What do you think is it necessary to know the contraceptive Knowledge?	Percentage
1)	Necessary	68%
2)	Not Necessary	32%

Annexure II

Questionnaire

	Name : _____
	Age : _____years
	Socio Demographic
1.	**Marital Status (Please tick one)** Married ☐ Widowed ☐ Separated ☐ Never Married ☐ Divorced ☐ Refused ☐
2.	**Highest level of education completed (Please tick one)** High School ☐ Graduate ☐ Post-graduate ☐ Higher studies ☐
3.	**Employment Status (Please tick one)** Service ☐ Self-employed ☐ Homemaker ☐ Others ☐
4.	**What religion do you practice?** Islam ☐ Christian ☐ Hindu ☐ Sikh ☐ Buddha ☐
	KNOWLEDGE
5.	**Have you received any family planning education (sex education)?** Yes ☐ No ☐

6.	**If yes to Q. 5, In which age did you know about family planning education?** 10-15 ☐ 16-25 ☐ 26-35 ☐ 36-49 ☐

7.	**From where you have received family planning education?** School ☐ Parents ☐ Healthcare Provider ☐ Other ☐
8.	**Are you aware about the family planning / contraceptive methods available?** Yes ☐ No ☐
9.	**If yes to Q. 8, what kind of family planning / contraceptive methods have you heard of? (Please tick all that apply)** Oral Contraceptive (pills) ☐ Vaginal ring ☐ IUD ☐ Implant ☐ Male condom ☐ Female condom ☐ Vasectomy ☐ Tube Ligation (tube tied) ☐ Hysterectomy (removal of womb) ☐ Abstinence (no sex) ☐
	PRACTICE
10.	**Have you ever used birth control method?** Yes ☐ No ☐

11.	**What are the reasons to use birth control / contraceptives? (Can choose more than one Answer)** Want to improve my own health ☐ Preventing unwanted pregnancy ☐ Prevent (STDs) ☐ It is recommended by health professionals ☐ (doctor, nurse, Counsellor)
12.	**Do you find family planning services ease to access?** Yes ☐ No ☐ Do not know ☐
	ATTITUDE
13.	**I find it difficult to get family planning services / contraception?** Yes ☐ No ☐ Do not know ☐
14.	**After my delivery, I want to use birth control / contraception?** Yes ☐ No ☐ Do not know ☐
15.	**In my opinion, using birth control / contraception profitable?** Yes ☐ No ☐ Do not know ☐
16.	**I will support the family and friends to use birth control / contraception?** Yes ☐ No ☐ Do not know ☐
17.	**What do you think is it necessary to know the contraceptive Knowledge?** Necessary ☐ Unnecessary ☐