INTERNSHIP TRAINING

At

CARE India, Bihar

Title of the study: "Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District, Bihar"

Ashwanee Kumar Patel

Under the Guidance of

Dr. A. K. Khokhar

Post Graduate Diploma in Hospital and Health Management

2014-16

International Institute of Health Management Research, New Delhi

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A Report

By

Ashwanee Kumar Patel

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International Institute of Health Management Research, New Delhi

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Completion of Dissertation from Care India, Bihar

The certificate is awarded to

Ashwanee Kumar Patel

In recognition of having successfully completed his
Internship in the department of

Nutrition - Technical Support Unit

and having successfully completed his Project on

Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District, Bihar

Date: 12th May, 2016

Care India, Bihar

He comes across as a committed, sincere & diligent person, who has a strong drive & zeal for learning.

We wish him all the best for future endeavours.

CARE INDIA PATNA BIHAR

Training & Development

for

Head-Human Resources

13/5/16

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Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Ashwanee Kumar Patel,** a graduate student of the **Post-Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He is submitting this dissertation titled "**Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District, Bihar** in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.** This dissertation has the requisite standard and to the best of our knowledge. No part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. A. K. Khokhar
Director
IIHMR, Delhi

CARE INDIA PATNA BIHAR

Mr. Sharad Chaturvedi
Deputy Director, N-TSU
Care India, Bihar

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ashwanee Kumar Patel**, a student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Care India, Bihar** from **11th April, 2016** to **12th May, 2016**.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

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Dean (Academics and Student Affairs)
IIHMR, New Delhi

Dr.A. K. Khokhar
Director
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International Institute of Health Management Research, New Delhi

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District, Bihar**" and submitted by **Ashwanee Kumar Patel**, Enrolment No. **PG/14/014** under the supervision of **Dr. A. K. Khokhar** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **11th April, 2016** to **12th May, 2016** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Ashwanee Kumar Patel
PG/14/014
PGDHM (2014-16) - Health

FEEDBACK FORM

Name of the Student : Ashwanee Kumar Patel

Dissertation Organisation : Care India, Bihar

Area of Dissertation : Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District ,Bihar

Attendance : ok (100%)

Objectives achieved : Yes

Deliverables : Improve KSA of Heath workers.

Strengths : Dedicated to work, Sincere, Hard working.

Suggestions for Improvement: can be more organised.

CARE INDIA PATNA BIHAR

Date: 13/05/2016

Place:

Signature of the Officer-in-Charge
Organisation Mentor (Dissertation)

Certificate of Approval

The following dissertation titled **"Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District, Bihar"** at **"CARE INDIA, BIHAR"** 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 **Post Graduate Diploma in Health and Hospital 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.

Dissertation Examination Committee for evaluation of dissertation.

Name	**Signature**
Dr. S. B. Arora	
Dr. B. S. Singh	D S Singh
Dr. Pratibha Rai	

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Acknowledgement

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players. Likewise this project report is no exception. This has been a meticulous effort of a group of people along with me. I want to take this opportunity to thank each and every one who has been a part of this report.

To start with, I take immense pleasure to thank **Dr. A. K. Khokhar** (*Director-International Institute of Health Management Research-Delhi*) and **Dr. A. K. Aggarwal** (*Dean, International Institute of Health Management Research-Delhi*) for placing me in such an esteemed organization (Care India) to perform my dissertation and start my career with; and my mentor, **Dr. A. K. Khokhar** for her timely advice and encouragement for the successful conduction of my project.

I am highly indebted to Dr. Sunil Babu, Director, Nutrition Technical Support Unit, Care India, Bihar and Mr Sharad Chaturvedi, Deputy Director, Nutrition Technical Support Unit, Care India, Bihar, for providing me with this opportunity to be a part of Nutrition TSU team at Care India, Bihar and giving me time and space from the induction and training schedule, to perform my fieldwork.

Also, I wish to thank Smt. Indira Devi and Mr A. K. Mohan, for their continuous guidance in the training programme and arranging transport and other requirements for the completion of our desired field visit.

I then take this opportunity to thank the Front line workers, i.e. AWWs and ASHAs in Salalpur village, for being a constant source of support and guidance during the data collection in their village.

Lastly, I thank Mukhiya ji, Sarpanch ji, other dignitaries and the residents of Salalpur village, for being highly co-operative and for helping me in collecting the data for this report.

Abbreviations

ICDS	**Integrated Child Development Services**
AWC	**Anganwadi Centre**
AWW	**Anganwadi Worker**
AWH	**Anganwadi Helper**
SC and ST	**Schedule Caste and Schedule Tribe**
ASHA	**Accredited Social Health Activist**
MIS	**Management Information System**
WHO	**World Health Organization**
PRIs	**Panchayati Raj Institutions**
SNP	**Supplementary Nutrition Programme**
THR	**Take Home Ration**
SHGs	**Self Help Groups**
PHC	**Primary Health Centre**
CHC	**Community Health Centre**
FRU	**First Referral Unit**
N-TSU	**Nutrition-Technical Support Unit**
MMR	**Maternal Mortality Ratio**
M & E	**Monitoring and Evaluation**
LS	**Lady Supervisor**
LQAS	**Lots Quality Assurance Sample**
CDPO	**Child Development Programme Officer**
DPO	**District Programme Officer**
MoHFW	**Ministry of Health and Family Welfare**

MoWCD	**Ministry of Women and Child Development**
IEC	**Information Education Communication**
BCC	**Behaviour Change Communication**
IFA	**Iron Folic Acid**
MDGs	**Millennium Development Goals**
ANMs	**Auxiliary Nurse midwives**
Mos	**Medical Officers**
DRG	**District Resource Group**
BRG	**Block Resource Group**
PNC	**Post Natal Care**
ECD	**Early childhood Development**

ORGANIZATION PROFILE

❖ CARE INTERNATIONAL

CARE International is a leading humanitarian organization fighting global poverty. It places special focus on working alongside poor women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty. Women are at the heart of their community-based efforts to improve basic education, prevent the spread of diseases, and increase access to clean water and sanitation, expand economic opportunity and protect natural resources. The organization also delivers emergency aid to survivors of war and natural disasters, and help people rebuild their lives.

In the fiscal year 2015, CARE worked in 95 countries around the world, supporting 890 poverty-fighting development and humanitarian aid projects to reach more than 65 million people.

CARE International is a global confederation of 14 National Members and one Affiliate Member with the common goal of fighting global poverty. Each CARE Member is an autonomous non–governmental organization and implements program, advocacy, fundraising and communications activities in its own country and in developing countries where CARE has programs.

At the beginning, there was a package: a CARE package, aimed to reduce hunger and show solidarity with the people of war-torn Europe.

At the end of World War II in 1945, twenty-two American charities, a mixture of civic, religious, cooperative and labor organizations got together to found CARE. Originally known as the *Cooperative for American Remittances to Europe*, it began to deliver millions of CARE packages across Europe. This was basically a small shipment of food and relief supplies to hungry recipients - with a huge impact on people's lives.

During the next three decades, CARE shifted its focus from helping Europe to delivering assistance in the developing world. It started programs in the areas of education, natural resources management, nutrition, water and sanitation, and healthcare in Southern Africa, South Asia and South America. Broadening the geographic focus and expanding beyond the

original food distribution programs, CARE started to assist people affected by major emergencies – from famine in Ethiopia to hurricane recovery in Honduras.

Over the previous decades, Care has continuously developed its approach to reducing poverty. In 1945, CARE was established on the premise that poverty was mainly due to a lack of basic goods, services, and healthcare. As the organization grew, so did their understanding of poverty. CARE's scope widened to include the view that poverty is often caused by the absence of rights, opportunities and assets, largely due to social exclusion, marginalization, and discrimination. In the early 1990's, its work grew into what they call a 'rights based approach' to development.

In 1993, in an effort to reflect the wider scope of its programs, vision and impact, CARE changed the meaning of its acronym to *"Cooperative for Assistance and Relief Everywhere"*. By 2007, it started focusing on women's empowerment realizing that women are the key: by empowering women entire families can be lifted out of poverty.

Some key networks in which CARE is involved or is a signatory to are:

- Code of Conduct for the International Red Cross & Red Crescent Movement at NGOs in Disaster Relief
- The Sphere Project
- Humanitarian Accountability Partnership International (HAP)
- Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP)
- People in Aid
- INGO Accountability Charter
- CARE is a signatory to and holds itself accountable to internationally accepted humanitarian standards and codes of conduct, and works with other aid organizations and United Nations agencies to improve humanitarian action and to influence policy.

➢ CORE VALUES

Respect: Affirm the dignity, potential and contribution of participants, donors, partners and staff.

Integrity: Actions consistent with the mission. Being honest and transparent in what they do and say, and accept responsibility for their collective and individual actions.

Commitment: Work together effectively to serve the larger community.

Excellence: Constantly challenge themselves to the highest levels of learning and performance to achieve greater impact.

➢ VISION AND MISSION

Their vision is to seek a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. CARE will be a global force and partner of choice within a worldwide movement dedicated to ending poverty, and will be known everywhere for its unshakeable commitment to the dignity of people.

CARE strives to serve individuals and families in the poorest communities in the world. Drawing strength from their global diversity, resources and experience, they promote innovative solutions and are advocates for global responsibility.

❖ CARE INDIA

CARE has been working in India for over 65 years, helping alleviating poverty and social exclusion by facilitating empowerment of women and girls from poor and marginalized communities. In India, CARE focuses on the empowerment of women and girls because they are disproportionately affected by poverty and discriminations; and suffer abuse and violations in the realization of their rights, entitlements and access and control over resources. They do this through well planned and comprehensive programmes in health, education, livelihoods and disaster preparedness and response.

To be able to bring about lasting change, CARE India addresses underlying causes of poverty and social injustice. For example, they implement a gender transformative framework within their programmes to address unequal power relations at the grassroots level.

CARE in India works across 14 States and 38 projects, touching the lives of 37 million people. Some of the notable initiatives of CARE India are:

- CARE India response on Cyclone Phailin hit on the Eastern Coast of India.
- CARE India Tsunami relief programme.
- CARE India response to floods in Uttarakhand.

CARE India has been working extensively in different parts of India. They work with grassroots initiatives, state and district governments, and communities and individual from all over the country .As of now, CARE India is present in 14 states of India, with the head office being in Delhi.

Please see below for the list of the 14 states:

Fig 1. CARE in India works across 14 states & 38 Projects, touching the lives of 37 million people (Headquarter in Delhi)

❖ HISTORY OF CARE INDIA

CARE came to India in June, 1946 when one of its co-founder, Lincoln Clark, signed the CARE Basic Agreement in New Delhi at the Office of Foreign Affairs. The agreement was limited to contributions of technical books and scientific equipment for universities and research institutes. In November 1949, the first Chief of Mission, Melvin Johnson, arrived in India to establish operations. Subsequently on the invitation of the then President of India, he developed a CARE India Food Package that caused a renegotiation of the CARE Agreement to include importation of food through Indo-CARE Agreement on 6 March 1950. The CARE Office during 1950's in Delhi was a hutment (a long, thin building) located in Janpath, Connaught Place. CARE had three additional offices and warehouses in India located in Bombay, Madras, and Calcutta.

Fig 2.Early days of CARE India

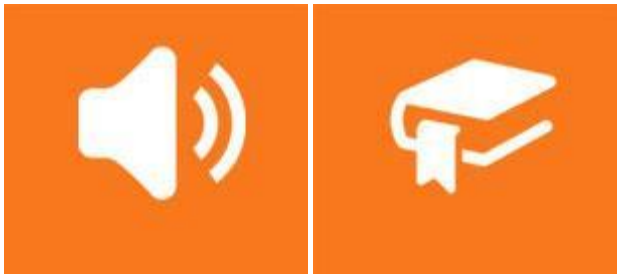
The initial programmes those days included assistance to educational institutions, relief camps and assistance to hospitals in form of books, laboratory equipments, tools supplies etc. When the Mid-Day Meal (MDM - school lunch) program started in 1960, state offices were established and the staff in Delhi and state offices increased. Since 1960's CARE has been supporting government's school feeding programs. CARE has been providing nutritious food for the beneficiaries of Integrated Child Development Services (ICDS) on the request of GOI since 1982. CARE supported the Government's ICDS in the states of Andhra Pradesh, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. As a part of support from USAID, CARE implemented a long term project named Integrated Nutrition and Health

Project (INHP) from 1996 till 2010 and reached to about 1297 blocks in nine major states of India. Recognized worldwide for its contribution in disaster response and rehabilitation operations, CARE in India has supported the efforts of Government of India and individual state governments as and when major disasters occurred in the country. CARE has provided relief to several natural disasters since 1966 with Jammu and Kashmir floods 2014 and Hud Hud in Andhra Pradesh being the most recent. Some of the efforts include response to flood relief in West Bengal in 1979, cyclone in Andhra Pradhesh in 1977 and in 1996, and earthquake relief in Latur, Maharashtra in 1993, and Odisha super cyclone in 1999.

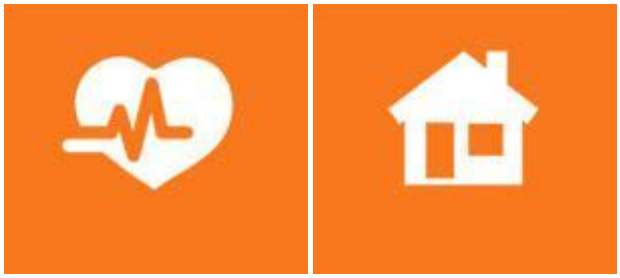
CARE India's current 'Programme' approach stems from a redrawn vision, under which, working with partners on projects has been overlapped with holistic, long term, deep impact "programmes" that work directly with key populations to ensure that the root causes of poverty and marginalisation of people, particularly poor women and girls, are tackled strategically and collaboratively.

As CARE India moves ahead, their key programming approaches will include social analysis and action, gender transformative value chain approaches, leadership and life skills strengthening, building capacities and leadership roles at multiple levels, advocacy on national and international platforms and facilitating links and dialogues between public, private and civil society.

❖ FOUR MAIN FUNCTIONAL AREAS



Disaster Preparedness Education



Health Livelihood

❖ CARE INDIA INITIATIVES IN HEALTHCARE

Delivering healthcare to over a billion people is a very complex challenge. CARE India works in close collaboration with State and Central Government and other partner organizations to secure accessible and quality maternal and child healthcare among marginalized communities. It works towards identifying the root causes of healthcare challenges, provides innovative solutions, and helps implement secure and quality healthcare services in India. CARE India believes that a healthy mother and a healthy baby is the route to a productive and a developed nation. Hence, CARE has specially focused upon providing comprehensive solutions to address public health problems. CARE India promotes essential new born care and immunization, reducing malnutrition, preventing infant and maternal deaths and protecting those affected by or susceptible to HIV/ AIDS and TB. CARE works closely with its partners to achieve good health care for everyone.

Various programmes of CARE India are:

- **EnSIGN:** Enhancing the Sustainable Farming Initiative through Gender and Nutrition. (Bankura District, West Bengal)
- **RACHNA:** Reproductive and Child Health Nutrition & Awareness. (Rajasthan)
- **HEVS extending CHCMI:** Health Education among SHG & VHSNC Members. (Puruliya, West Bengal)
- **SEHAT:** Sustainable Education and Health among Tribals. **(**Sidhi and Shahdol districts of Madhya Pradesh)
- **BRIDDHI:** Ensuring improvement in the nutritional status among severely malnourished children through growth monitoring, Behavior Change Communication, strengthening Health (including treatment) and Nutrition service delivery system. (West Bengal)
- **SWASTH:** Sector Wide Approach to Strengthen Health. (Bihar)
- **EMPHASIS:** Enhancing Mobile Populations' Access to HIV & AIDS Services, Information & Support. (Delhi NCR, West Bengal, Uttarakhand and Maharashtra)
- **OHSP:** Technical and management inputs to TMST, Government of Odisha Health Sector and Nutrition Plan. **(**15 districts of Odisha)
- **MDR-TB:** Treatment, adherence and follow up of Multidrug-resistant tuberculosis. (West Bengal)
- **SKEAP:** Strengthening Kala Azar Elimination Program. (Eight districts in Bihar)
- **Axshya:** Bridging one of the most challenging gaps in Tuberculosis control - diagnosis and treatment of DR-TB - through programmatic activities. (Madhya Pradesh, Chhattisgarh and Jharkhand)
- **BTAST:** Bihar Technical Assistance Support Team. (Bihar)
- **MPNP:** Madhya Pradesh Nutrition Project. (Tikamgarh, Panna and Chhatarpur districts of Madhya Pradesh)
- **Mother and Child Health Project**. **(**Odisha and Madhya Pradesh)
- **UHI:** Urban Health Initiative. (11 cities of Uttar Pradesh)
- **FHI:** Family Health Initiative. (Bihar)
- **N-TSU:** Nutrition Technical Support Unit. (Bihar)

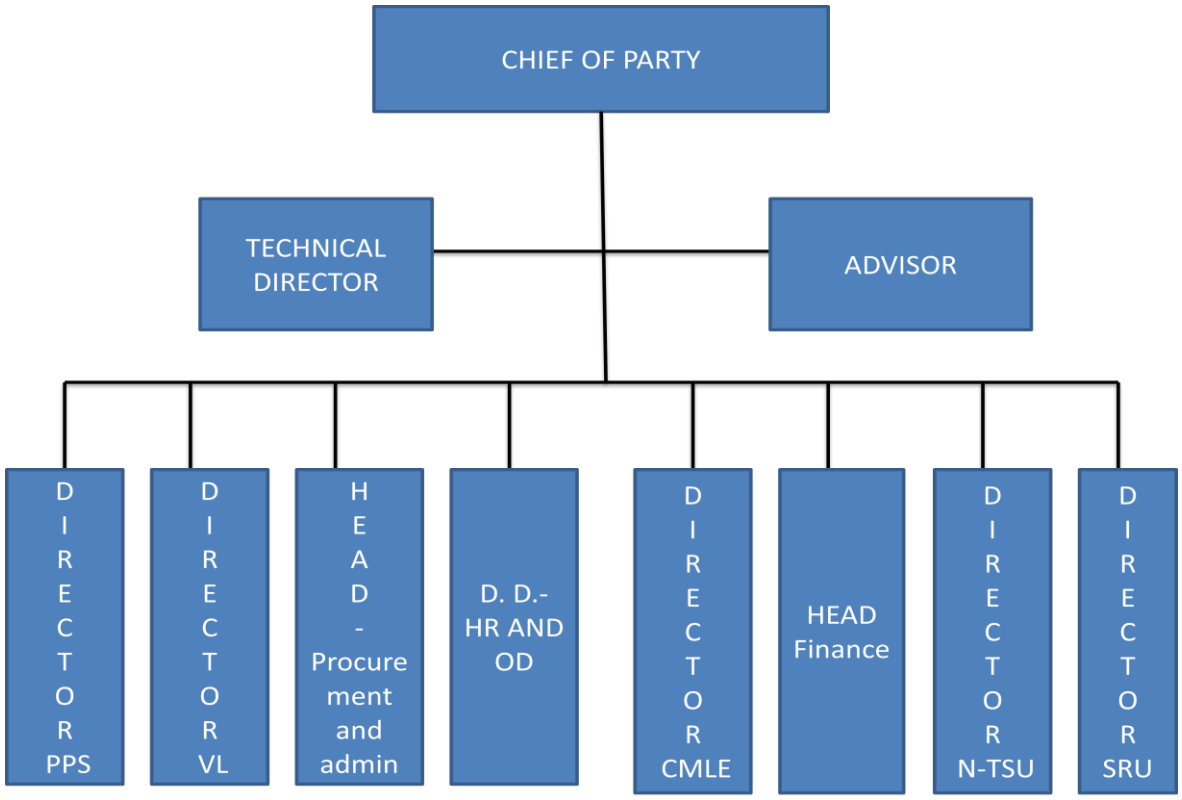
❖ NUTRITIONAL TECHNICAL SUPPORT UNIT

For CARE India, the N-TSU project offers the opportunity to provide long term support to the Bihar state government's Integrated Child Development Services (ICDS) scheme. The ICDS scheme attempts to harness human, institutional and financial resources to do more, with high quality and with increased precision and efficiency. The goal of N-TSU is to achieve greater impact on the overall development of children in the state by addressing under-nutrition, especially focusing on Young Child Feeding practices, mainly through giving vigorous Home visits by the various stakeholders to the households of beneficiaries.

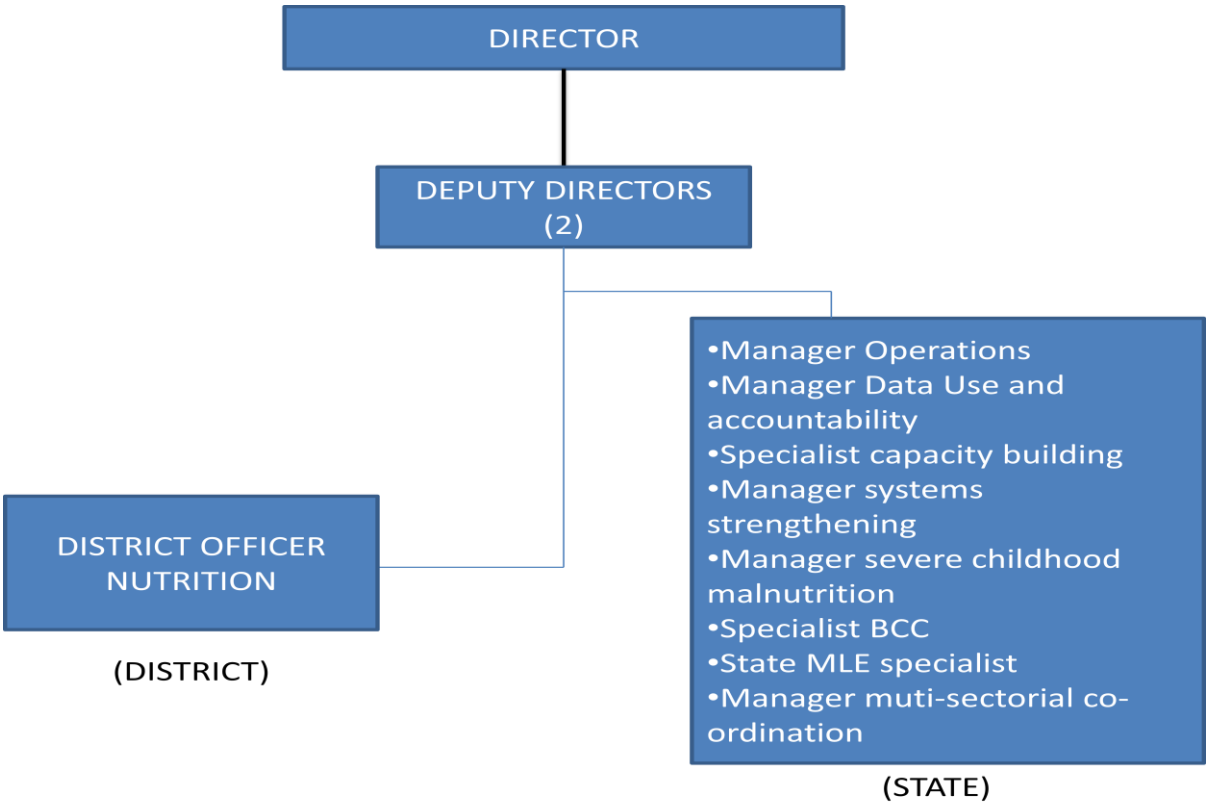
Recognizing that the Ministry of Women and Child Development alone cannot meet the needs of all children, CARE India is assisting the government to undertake convergence with other ministries and departments. CARE India is drawing from its field-tested, proven approaches to systematically create an enabling policy environment for ICDS, build trust across sectors, document models and promote convergence. Besides this, CARE India is facilitating training and capacity building of government functionaries, promoting safe drinking water, hygiene and sanitation at the household and community levels, promoting wheat fortification carrying BCC intervention, undertaking community mobilization and participatory governance. Finally, CARE India is responsible for working with block and district level ICDS personnel to improve their capabilities in data-driven management – using information to make evidence-based decisions to iteratively strengthen programs and improve outcomes.

Through monthly convergence meetings, N-TSU plans to re- establish the importance of convergence and coordination amongst the different government departments and other stake holders that contribute in reduction of malnutrition.

Bihar Management Team:-



N-TSU Project Team:-



❖ KEY LEARNINGS

- An entire set of programmes are running under the MoHFW and MoWCD in the state of Bihar, but the ground level implementation and performance is in a miserable state.
- There is a huge communication gap and too much overlap and confusions in the work profiles of FLWs of ICDS and Health Department.
- Work profiles of government officials, i.e. DPOs, CDPOs and LSs in the Department of Social Work, Government of Bihar, is heavily loaded with add-on responsibilities like election duties, land issue resolutions, etc; which often results in a compromise with their actual job-specific work.
- The agony of cultural taboos is still widely prevalent in Bihar. Also, the caste system affects the functioning of the AWCs at large. There are a few communities like Mushahar and Passi, the presence of which is not acceptable to higher caste groups like Rajputs and Yadavs, which often results in preventing their children from going to AWCs if AWW or AWH belong to any other community or other caste groups are also benefitted at the same AWC.
- The physical state of AWCs is miserable, with unmaintained dust-filled registers, unreadable IEC on walls, no electricity and an acute shortage of space for the conduction of AWC functions, especially on VHSNDs.
- AWCs are equipped with Nutritional and Health education kits and materials, to be used by the FLWs on VHSNDs for educating women; but they are mostly unaware of the proper message to be communicated or the way to deliver it.
- People tend to look at an AWC as a spot to merely provide them ration and vaccinations, and thus are widely uninterested in the other services provided, and consider it to be a waste of time.
- There is a severe shortage of home visits by the FLWs, and this result in an improper knowledge of women on topics like exclusive breast feeding, complimentary feeding, family planning and birth preparedness.

- Since long, the entire focus in the field of healthcare in Bihar has been on immunization and institutional deliveries only, and thus the nutrition component was missed heavily, which has resulted in very high malnutrition rates in Bihar.
- There are huge gaps in the logistics or supplies of the essential materials like registers, growth charts, IFA tablets, THR, etc at the AWCs, which majorly affect their day to day functioning.
- A lot of meetings like ANM Tuesday meetings, HSC meetings, Sector meetings, DRG meetings, BRG meetings, etc are a part of general operations of the various stakeholders of health, but their regular conduction is a matter of question and a major challenge for the development partners like CARE.

PROJECT REPORT

Title of the study: "Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna District, Bihar"

❖ INTRODUCTION

Family planning (FP) is one of the major components of reproductive health and its goal is to prevent unwanted pregnancies and regulate wanted pregnancies, thereby ensuring the health of mothers and children. It also aims at regulating the population in order to maintain the vital balance between development and the environment. Ideally, FP depends on the efforts of a couple where the man and woman are equally responsible and accountable. In reality, however, this is not the case. It is in this background that the present study aims at examining the nature and level of male participation in preventing unwanted pregnancies and the factors that influence male participation in FP.

With its historic initiation in 1952, the family planning programme has undergone transformation in terms of policy and actual programme implementation. There occurred a gradual shift from clinical approach to the reproductive child health approach and further the National Population Policy (NPP) 2000 brought a holistic and a target free approach which helped in reduction of fertility. Over the years, the programme has been expanded to reach every nook and corner of the country and has penetrated into PHCs and SCs in rural areas, Urban Family Welfare Centres and Postpartum Centres in the urban areas. Technological advances, improved quality and coverage for health care have resulted in a rapid fall in the Crude Birth Rate (CBR) and Growth Rate (2011Census showed the steepest decline in the decadal growth rate.)

The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002 and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals, FP 2020 Summit and others).

- **Factors that influence population growth:** Factors influencing population growth can be grouped into following 3 categories :-

a) **<u>Unmet need of Family Planning:</u>** -This includes the currently married women, who wish to stop child bearing or wait for next two or more years for the next child birth, but not using any contraceptive method. Total unmet need of Family Planning is 21.3% (DLHSIII) in our country.

b) **Age at Marriage and first childbirth:-** In India 22.1%of the girls get married below the age of 18 years and out of the total deliveries 5.6% are among teenagers i.e. 1519 years. The situation regarding age of girls at marriage is more alarming in few states like, Bihar (46.2%), Rajasthan (41%), Jharkhand (36%), UP (33%), and MP (29.2%). Delaying the age at marriage and first child birth could reduce the impact of Population Momentum on population growth.

c) **Spacing between Births:** -Healthy spacing of 3 years improves the chances of survival of infants and also helps in reducing the impact of population momentum on population growth. SRS 2013 data shows that In India, spacing between two childbirths is less than the recommended period of 3 years in 59.3% of births.

➢ Current Family Planning Efforts (Contraceptive services under the National Family Welfare Programme) :-

The methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (Emergency Contraceptive Pill) to be used in cases of emergency.

1. **Spacing Methods:** These are the reversible methods of contraception to be used by couples who wish to have children in future. These include:-

A) Oral Contraceptive Pills

- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. The strip also contains additional placebo/iron pills to be consumed during the hormonal pill free days. The method may be used by majority of women after screening by a trained provider.
- At present, there is a scheme for delivery of OCPs at the doorstep of beneficiaries by ASHA with a minimal charge. The brand "MALA-N" is available free of cost at all public healthcare facilities**.**

B) Condoms

- Which offer the dual protection of preventing unwanted pregnancies as well as transmission of RTI/STI including HIV. The brand "Nirodh" is available free

of cost at government health facilities and supplied at doorstep by ASHAs for minimal cost**.**

C) Intra-Uterine Contraceptive Devices (IUCD)

- Copper containing IUCDs are a highly effective method for long term birth spacing.
- Should not be used by women with uterine anomalies or women with active PID or those who are at increased risk of STI/RTI (women with multiple partners).
- The acceptor needs to return for follow up visit after 1, 3 and 6 months of IUCD insertion as the expulsion rate is highest in this duration.
- **Two types:**
    - Cu IUCD 380A (10 yrs)
    - Cu IUCD 375 (5 yrs)
- New approach of method delivery- postpartum IUCD insertion by specially trained providers to tap the opportunities offered by institutional deliveries.

2. Permanent Methods: These methods may be adopted by any member of the couple and are generally considered irreversible.

A) Female Sterilisation-

- **Minilap:** Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.
- **Laparoscopic:** Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen. Can be done only by trained and certified gynaecologist/ surgeon.

B) Male Sterilisation-

- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carries sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery). The

procedure is performed by MBBS doctors trained in these**.** However, the couple needs to use an alternative method of contraception for first three months after sterilization till no sperms are detected in semen. Two techniques being used in India:

- Conventional
- Non- Scalpel Vasectomy – no incision, only puncture and hence no stitches.

3. Emergency Contraceptive Pill (ECP) :

- To be consumed in cases of emergency arising out of unplanned/unprotected intercourse.
- The pill should be consumed within 72 hours of the sexual act and should never be considered a replacement for a regular contraceptive.[(2)]

- **Different Kinds Of Family Planning Method and There Service Provider :-**

Family Planning Method	Service Provider	Service Location
Spacing Methods		
IUD 380 A/IUCD 375	Trained & certified ANMs, LHVs, SNs and Doctors	Sub-centre & higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and Doctors	Village level ,Sub-centre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and Doctors	Village level ,Sub-centre & higher levels
Limiting Methods		
Minilap	Trained & certified MBBS Doctors & Specialist Doctors	PHC & higher levels
Laparoscopic Sterilization	Trained & certified Specialist Doctors (OBG & General Surgeons)	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS Doctors & Specialist Doctors	PHC & higher levels
Emergency Contraception		
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level, Sub-centre & higher levels

❖ Natural Family Planning during Breastfeeding(*LAM - the Lactational Amenorrhea Method)*

"This is a temporary contraceptive method that relies on exclusive breast feeding (No other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for 6 months of life, but allows the infant to receive ORS, drops and syrups (vitamins, minerals and medicines)). It can be used from birth up to six months afterwards. Producing milk is called lactating and not having a period is called amenorrhea, hence this method of birth control is called lactational amenorrhea (or LAM)". Studies have confirmed that women who exclusively breastfeed their baby around-the-clock and who have not started menstruating are very unlikely to get pregnant during the first six months after they give birth. Breast feeding in a certain way, following certain rules, did work as a method of child spacing, as effectively as the mini-pill, yet with no side effects either for the woman, for her baby or for the quality of her milk supply. Woman wanting to breast feed her baby and benefit from its child spacing effect, is that the early weeks are critical for setting the regulator. If a mother is able to:

- Fully breast feed from birth, with no bottles being slipped in to "top up" a feed
- With no long time intervals between **day feeds** (every 2 hours at first, increasing to 3 hours, then **4 hours maximum between feeds in the day time**)
- Maintain night feeds for as long as possible
- Give a full early morning breastfeed

This will ensure that ***her baby has the best supply of breast milk, the best food possible for health and growth, and for herself the beginnings of the best and most natural means of postponing pregnancy.***

As the baby gets bigger and does not need /or want a night feed, it is important to

- Maintain the late evening and early morning breastfeeds and
- Allow a gap of **no more than 7 hours overnight** between these feeds in order to continue to enjoy the above benefits.

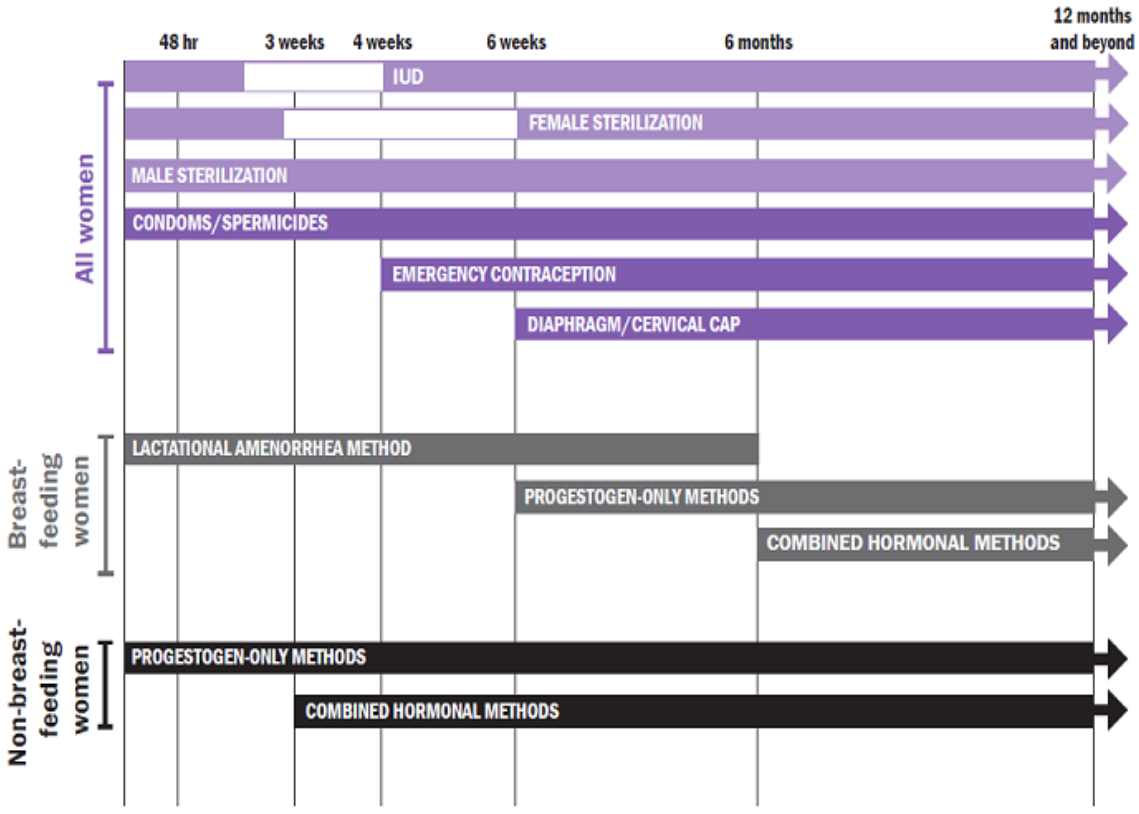
- **Here's why it works: -**

Breastfeeding interferes with the release of the hormones needed to trigger ovulation. So the more you nurse your baby, the less likely you are to ovulate.

- **How effective is LAM? :-**

If you use LAM perfectly, fulfilling all of its conditions, your chances of getting pregnant during the first six months after giving birth are less than 2 percent. For most women, however, a 1 in 50 chance of an unintended pregnancy is more of a risk than they want to take (particularly with a new baby), so many combine LAM with another contraceptive method.

Timing of method initiation and breastfeeding considerations:-



- **Key Indicators**

Current Use of Family Planning Methods (currently married women age 15–49 years)

- **World -In 2013-1834 millions And Expected 2025-1960 millions**
- **Asia- In 2013-1134 millions And Expected 2025-1166 millions**
- **India- In 2013-323.6 millions And Expected 2025-365.4 millions**
- **Bihar- In Annual health Survey (2011-12)-568.917 millions**

Current Use of Family Planning Methods (currently married women age 15–49 years)						
Indicators	**Bihar NFHS-4 (2015-16)**			**India**	**Asia**	**Word**
	Urban	**Rural**	**Total**			
1. Any method (%)	**34.6**	**22.6**	**24.1**	**54.8**	**66**	**63**
2. Any modern method (%)	**32.1**	**22.0**	**23.3**	**48.2**	**61**	**2**
3. Female sterilization (%)	**26.8**	**19.8**	**20.7**	**35.8**	**22**	**18**
4. Male sterilization (%)	**0.1**	**0.0**	**0.0**	**1.1**	**2**	**3**
5. IUD/PPIUD (%)	**1.3**	**0.4**	**0.5**	**1.8**	**17**	**13**
6. Pill (%)	**1.1**	**0.7**	**0.8**	**3.6**	**6**	**8**
7. Condom (%)	**2.3**	**0.8**	**1.0**	**5.5**	**7**	**8**

(Sources-Population Reference Bureau & NFHS- 4, 2015-16)

- **Bihar-Key Indicators**

Unmet Need for Family Planning (currently married women age 15–49 years)				
Indicators	**NFHS-4 (2015-16)**			**NFHS-3 (2005-06)**
	Urban	**Rural**	**Total**	**Total**
1. Total unmet need (%)	**19.1**	**21.5**	**21.2**	**23.9**
2. Unmet need for spacing (%)	**8.1**	**9.6**	**9.4**	**10.4**
Quality of Family Planning Services				
Indicators	**NFHS-4 (2015-16)**			**NFHS-3 (2005-06)**
	Urban	**Rural**	**Total**	**Total**
1. Health worker ever talked to female non-users about family planning (%)	**15.2**	**11.6**	**12.0**	**5.8**
2. Current users ever told about side effects of current method6 (%)	**36.9**	**34.1**	**34.4**	**11.7**

❖ PROBLEM STATEMENTS

170 million women have no access to safe and effective methods of family planning in developing countries.1/3 of population growth is due to unplanned pregnancies .Of the 210 million pregnancies occurring each year, nearly **80 million** are unintended. Each year, modern contraceptives help women prevent **215,000 pregnancy-related deaths** (including 66,000 from unsafe abortions), **2.7 million infant deaths** and the loss of **60 million years of healthy life**. Demand for modern contraception is expected to increase by about **50% to 75%** by the year 2020 in countries still reliant on donor assistance for implementing their programs. **21.6 million** Unsafe abortions occurred worldwide in 2008. The reasons why women do not use contraceptives most commonly include **concerns about possible health and side effects and the belief that they are not at risk of getting pregnant** .Each dollar spent on family planning can save governments up to $31 in health care, water, education, housing and sewers and other waste disposal .Expanding the number of women in the workforce by investing in their education could increase per capita income in some countries by as much as **14% by 2020**, and **20% by 2030** in many developing countries.

➢ International Conferences

✓ International Conference on Family Planning 2009

"*Family planning is to maternal health what immunization is to child health*." These words from Dr. Khama Rogo, then of the World Bank, encouraged more than 1,300 conference participants from 61 countries to take up the challenge to share and apply family planning research discoveries and best practices for family health and family wealth.

✓ International Conference on Family Planning 2011

Family planning remains out of reach for many couples in low-income settings; more than 200 million couples in the developing world are unable to control the number and spacing of births. Among the many technologies available to improve the human condition, family planning is one of the most cost-effective interventions, with enduring health and welfare benefits for women, families and nations.

- **Current Scenario of Population and Family Planning in India**

- **Expected increase of population of 15.7% in fifteen years:-**From 1210 million in 2011 to 1400 million in 2026.

- **Socio-demographic and health indicators of India and Bihar**

Indicators	India	Bihar
Population in millions (2011 census)	1210.19	103.80
TFR (average number of children born to a woman during her lifetime), 2011 SRS	2.4	3.6
Women giving birth by age 20 years (%)	45.2	59.6
Current use of modern FP among married women age 15-49 years (%)	55.8	41.3
Unmet need for contraception among currently married women (2007-08)	21.3	37.2
Level (%) of unintended pregnancy (including mistimed and unwanted)(2005-06)	24.3	25.4

(Note: 2011 data is based on the provisional population figures published by census of India.)

❖ RATIONALE

- ✓ Bihar is one amongst the three highest populated state in India (Census 2011) after Maharashtra & UP and population is increasing 25.42% as compared to last Census Year 2001.Its highly necessary to control the population by using different method of Family planning.
- ✓ There is evidence from studies conducted in different parts of the world that promoting the different Family Planning Methods especially after 6months of delivery, improves preventive behaviour & knowledge of mothers about Family Planning. This eventually leads to improvement in Exclusive Breast Feeding which is Natural Family Planning method (LAM).
- ✓ Various such studies are focused on states like Jharkhand, Maharashtra & Lucknow, but no major evidence could be gathered in the context of Bihar. Thus, this study is being proposed, with the objective of assessing the status of Post natal contraception & Family Planning trends amongst the women in Salalpur village of Barh Bock of Patna, Bihar.

❖ REVIEW OF LITERATURES

1. A research article titled "The influence of contraception, abortion, and natural family planning on divorce rates as found in the 2006-2010 National Survey of Family Growth" by Fehring RJ (Linacre Quarterly. 2015 Aug; 82(3):273-82) The purpose of this study was to determine the influence of contraception, abortion, and natural family planning (NFP) on divorce rates of US women of reproductive age. The variables of importance of religion and frequency of church attendance were also included in the analysis. The study involved 5,530 reproductive age women in the (2006-2010) National Survey of Family Growth who indicate that they were ever married. Among the women who ever used NFP only 9.6 percent were currently divorced compared with the 14.4 percent who were currently divorced among the women who never used NFP ($x (2) = 5.34$, $P < 0.21$). Odds ratio analysis indicated that ever having an abortion, sterilization, and/or methods of contraception increased the likelihood of divorce - up to two times. Frequency of church attendance decreased the risk of divorce. Although there is less divorce

among NFP users the reason might be due to their religiosity. Lay summary: Providers of natural family planning (NFP) frequently mention that couples who practice NFP have fewer divorces compared to couples who use contraception. Evidence for this comment is weak. This study utilized a large data set of 5,530 reproductive age women to determine the influence that contraception, sterilization, abortion, and NFP has on divorce rates. Among the women participants who ever used NFP only 9.6 percent were currently divorced compared with the 14.4 percent who used methods of contraception, sterilization or abortion as a family planning method. Frequency of church attendance also reduced the likelihood of divorce.

2. An article on "Lactational Amenorrhea Method as a Contraceptive Strategy in Niger" published in Matern Child Health J by Heather L. Sipsma, Elizabeth H. Bradley, Peggy G. Chen If used properly, the lactational amenorrhea method (LAM) can be a valuable family planning tool, particularly in low-income countries; however, the degree to which LAM is used correctly and characteristics associated with its use have not been well documented. We therefore sought to use nationally representative data from Niger, where fertility rates are high and women may have limited access to alternative contraceptive methods, to describe the proportion of women who use LAM correctly and the characteristics associated with LAM use. We utilized cross-sectional data from the 2006 Niger Demographic Health Survey. Our sample included all sexually active, non-pregnant, breastfeeding women using some form of contraception (N = 673, weighted). We used weighted frequencies to describe the correct use of LAM and logistic regression models to describe women who chose LAM for contraception. Among our sample, 52 % reported LAM as their primary method of contraception, but only 21 % of the women who reported using LAM used it correctly. Women who reported using LAM were more likely to live in certain regions of the country, to have no formal education, and to have delivered their most recent baby at home. They were also less likely to have discussed family planning at a health facility or with their husband/ partner in the past year. Results indicated that few women in Niger who reported using LAM used it correctly. Our findings reinforce the need to address this knowledge gap, especially given Niger's high fertility rate, and may inform efforts to improve family planning in Niger and in other low-income countries.

3. A Study by Kishore S; Garg BS; Deshmukh PR; Aggarwal P (Indian Journal of Community Health. 2010 Jun; 22(1):4-7) entitled "Role of lactation in family planning" Objectives: 1. To evaluate the role of Lactational Amenorrhea Method (LAM) as a spacing method. 2. To assess knowledge attitude and practices regarding breastfeeding. 3. To bring awareness regarding importance of breastfeeding on child health and as a method of family planning so that exclusive breast feeding is promoted. Study Design: Cross sectional study. Setting: In rural village of district Wardha. Study Universe: All the lactating mothers who had2 children (one of which was less than 3 years). Study Variables: Duration of Breast Feeding, LAM, Importance of Breast Feeding. Knowledge of Colostrum, Awareness of Breast Feeding, etc. Statistical analysis used: Percentages and proportions. Result: A total 42 families were included in the survey of which 26 (61.9%) belongs to nuclear families with majority of the women 19(45.2%) in the age group of 20-25 yrs, 20 (47.6%) were illiterate and 18(42.8%) families were of lower Socio Economic Status. A directly proportional relationship was found between duration of Breastfeeding & LAM and period of LAM & age of youngest child when the mother delivered again. Only 31% knew about the importance of breastfeeding. 16.6% of woman initiated Breast Feeding within 1/2 hr.
4. A Study by Rizvi A; Mohan U; Singh SK; Singh VK (Indian Journal of Community Health. 2013Jan-Mar; 25(1):6-11) entitled "Assessment of knowledge of contraceptives and its practice among married women in urban slums of Lucknow District. Not many studies have been conducted regarding contraceptive practices in the slums of Lucknow. This study will be helpful in the assessing the current scenario of prevalence of contraceptive use and various bio-social characteristics that can affect the contraceptive use by the women residing in urban slums of Lucknow. Objectives: To assess the knowledge of contraceptives and its practices among married women in urban slums of Lucknow district. Methodology: This was a descriptive cross-sectional study. Based on thirty cluster sampling technique, thirty urban slums were selected. Total 600 married women of reproductive age group (15-49 years) were interviewed in the period of one year from August 2010 to August 2011. Data was collected through preformed and pretested schedule and analysis was done using chi squared test and multiple logistic regression through SPSS 17.0 software. Results: It was found that 99.2 percent married women had the knowledge of contraceptives but its use was only

46.7 percent. Most commonly used contraceptive was condom. Among women who had ever used contraceptives, about 56.3 percent women were current users. Fear of side effects/ health concern was the main reason for discontinuing contraceptive use. Conclusions: Though knowledge of contraceptives among women residing in urban slums of Lucknow was good but contraceptive use was far lagging behind.

5. A Study by Chhugani M; Jha P; Caine KL (Indian Journal of Community Health. 2013 Jan-Mar; 25(1):82-85) All couples should have the ability to decide how many children to have and when to have them. Nurses represent the critical link between the health system and communities, sharing family planning methods and information that can help women time and space their pregnancies. This information is often a matter of life and death for women and children. The World Health Organization (WHO) recommends an interval of 24 months between childbirth and subsequent pregnancy in order to reduce the risk of adverse maternal, perinatal, and infant outcomes. In spite of the importance of birth spacing for maternal and child health, spacing methods are underutilized in India. While 38% of married women of reproductive age use sterilization, only 10% use a modern birth spacing method. Eight percent use a traditional method such as rhythm, and 44% use no method. Meanwhile, 13% of women have an unmet need for family planning, half of which is for birth spacing. These data suggest a potential demand for additional birth spacing choices.

❖ SPECIFIC OBJECTIVES

- To assess the status of Post Natal Contraception & Family Planning Trend in Salalpur Village of Barh Block of Patna.
- To cite recommendations with respect to the findings of the study, to bridge the identified gap.

❖ METHODOLOGY

- ✓ **Study Design:-**Cross-sectional study
- ✓ **Study Period**:-One Month
- ✓ **Study area & group:** The study has been conducted in Salalpur village of Barh block of Patna district, Bihar. All the mothers having 6-8 month baby who were present in the village at the time of visit were covered in the study.
- ✓ **Tools and techniques:-**The data collection technique would be survey-based, using the 'Post Natal Contraception and Family Planning' section of pre-tested and standard questionnaire, by the Bihar TSU, Care India; specifically designed to target the mothers of children aged 6 to 8 months.
- ✓ **Data Collection: -** Visiting households of eligible respondents and conducting personal interactions, after receiving proper consent.
- ✓ **Plan of data analysis:-**The collected data will be compiled and analysed using various functions in Microsoft Office Excel software. Bar Charts and Pie Graphs will be used to represent the findings of this study, as and when required.

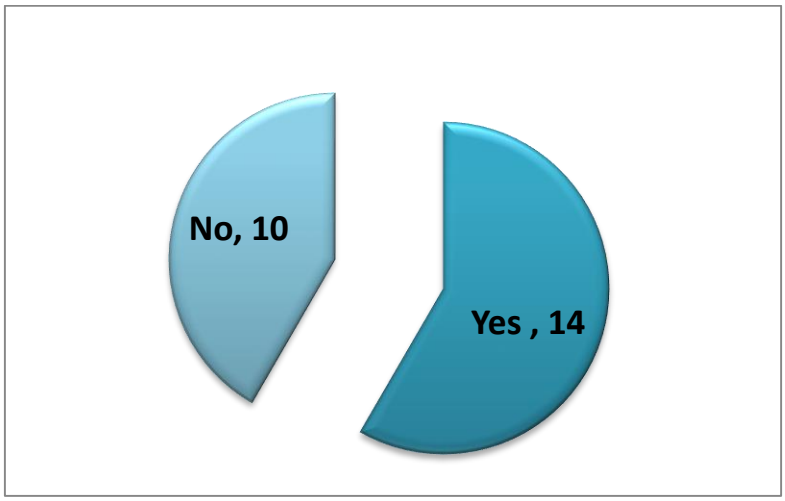
❖ LIMITATIONS

- ✓ The sample size for this study is small because there were very few no. of families with 6-8 months year old child in the Salalpur Village.
- ✓ Time was a major constraint in the study.
- ✓ Some house were closed during the survey, therefore data could not be collected from those households.
- ✓ The study was limited to a confined area (Salalpur village) only

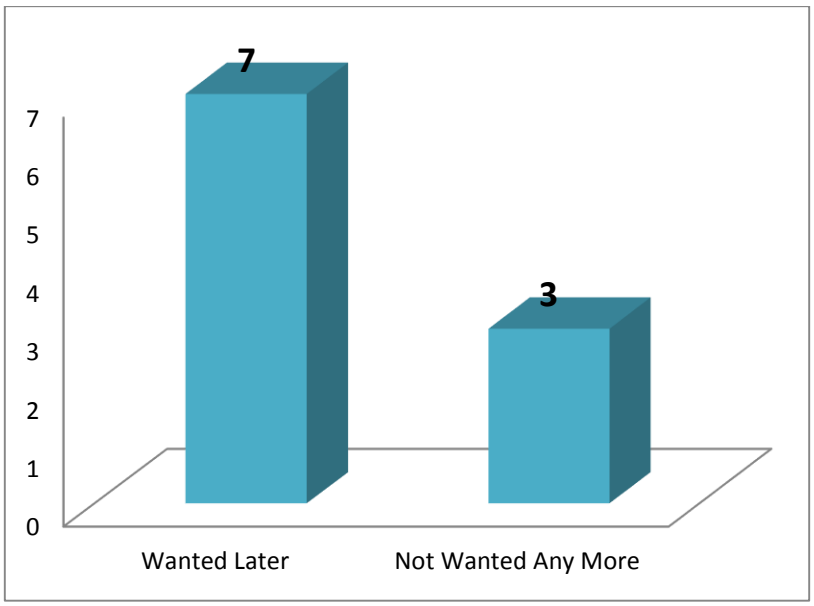
❖ FINDINGS

Ask to all respondents

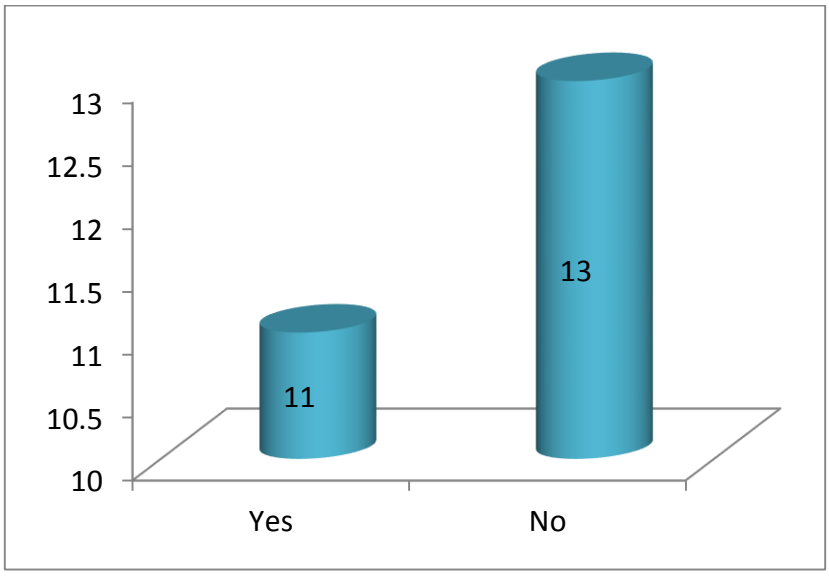
1. **When you got pregnant with Baby, did you want to get pregnant at that time?**



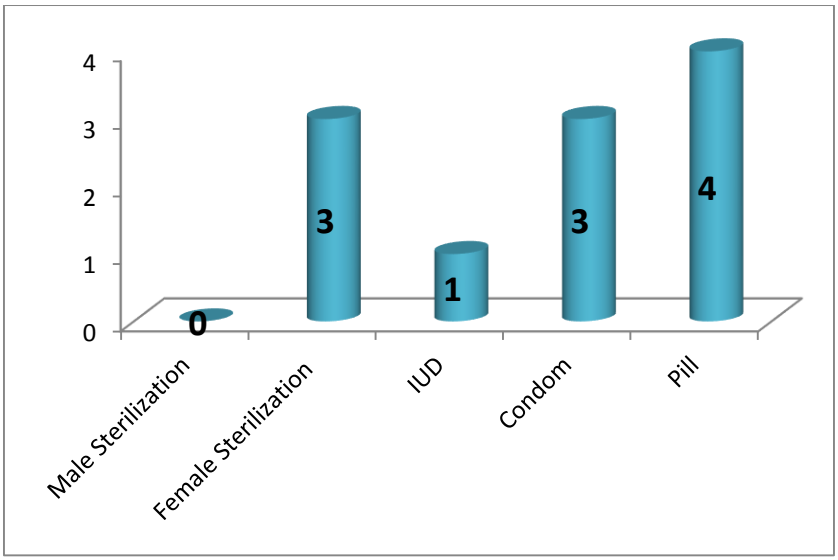
2. **Did you want to have a baby later on, or did you not want any children?**



3. **Are you or husband currently using any family Planning Method?**

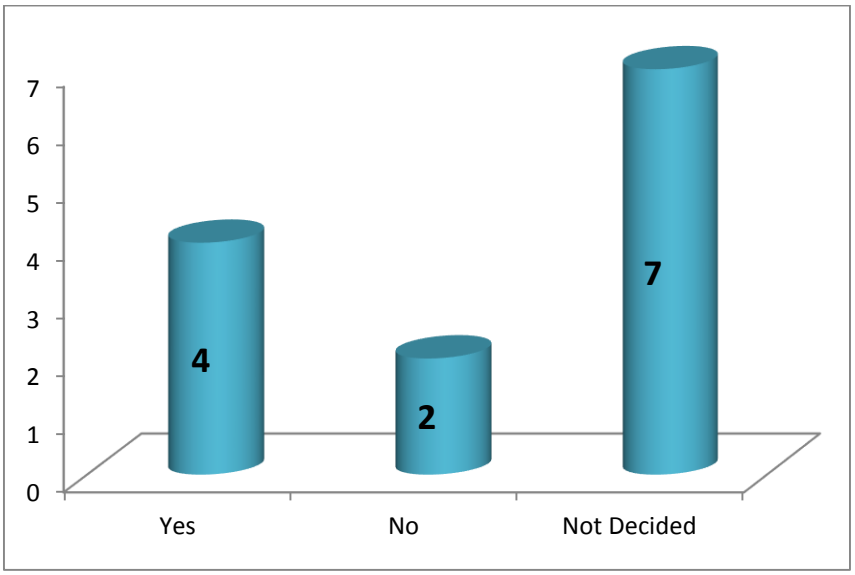


4. **Which method are you using currently?**

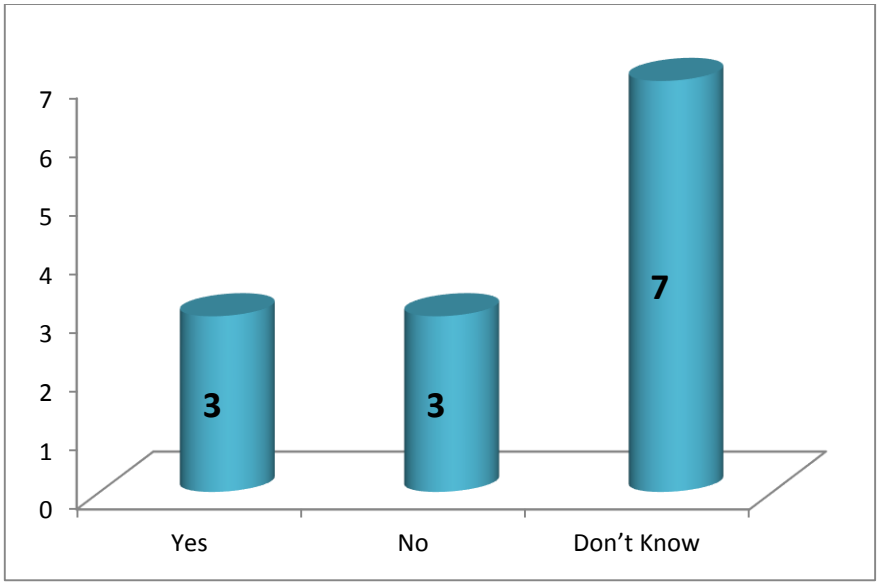


Ask those who are not using any methods

5. **Would you like to have another child?**

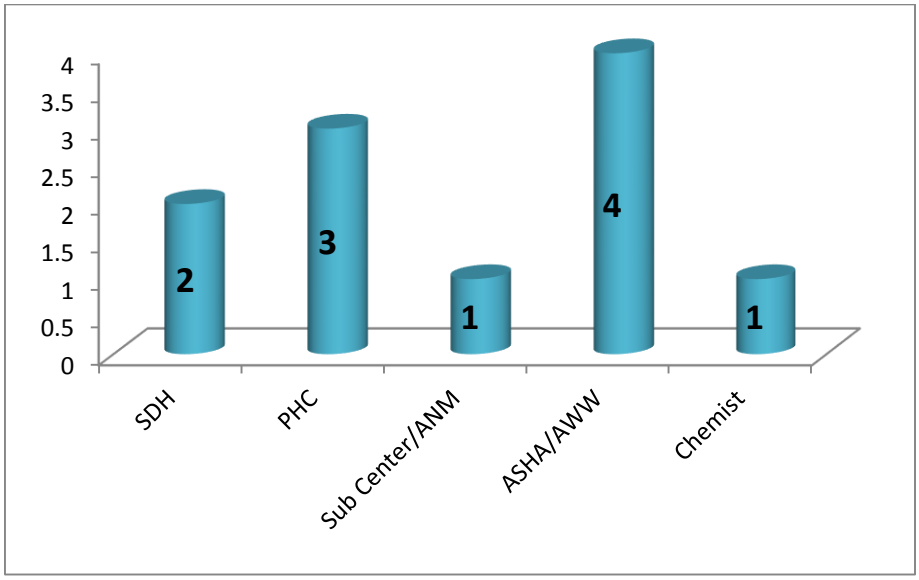


6. **Do you intend to use any method of family planning to delay or prevent the next pregnancy?**

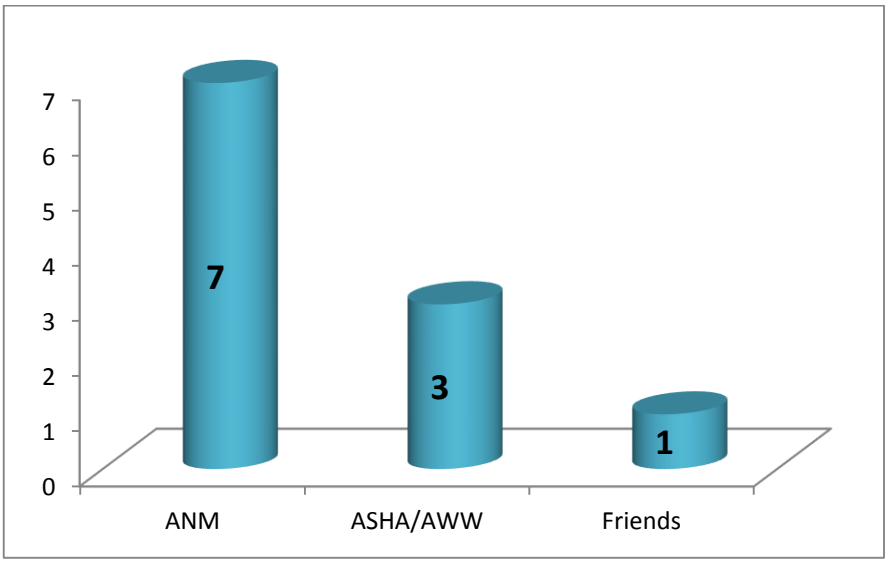


Ask those who are using any methods

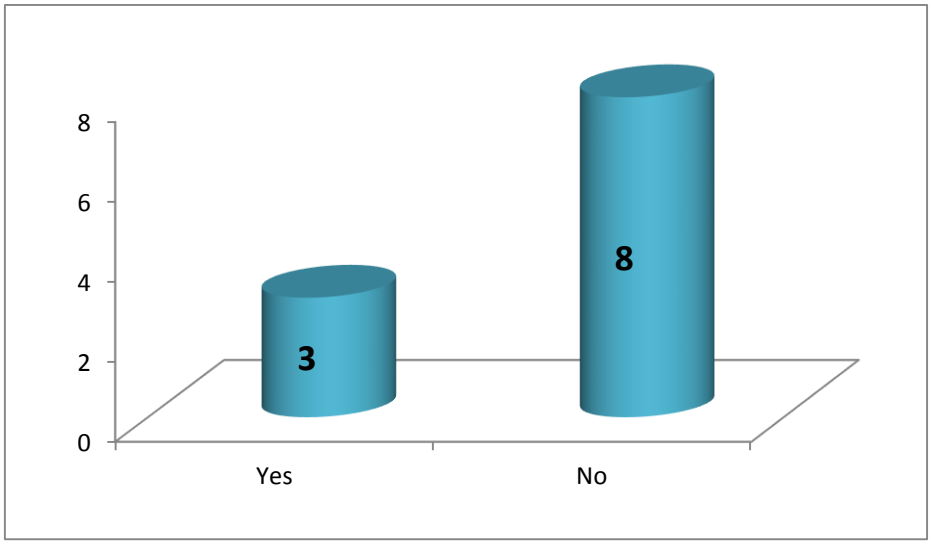
7. **Where did you get this method?**



8. **Who advised you to adopt this method?**

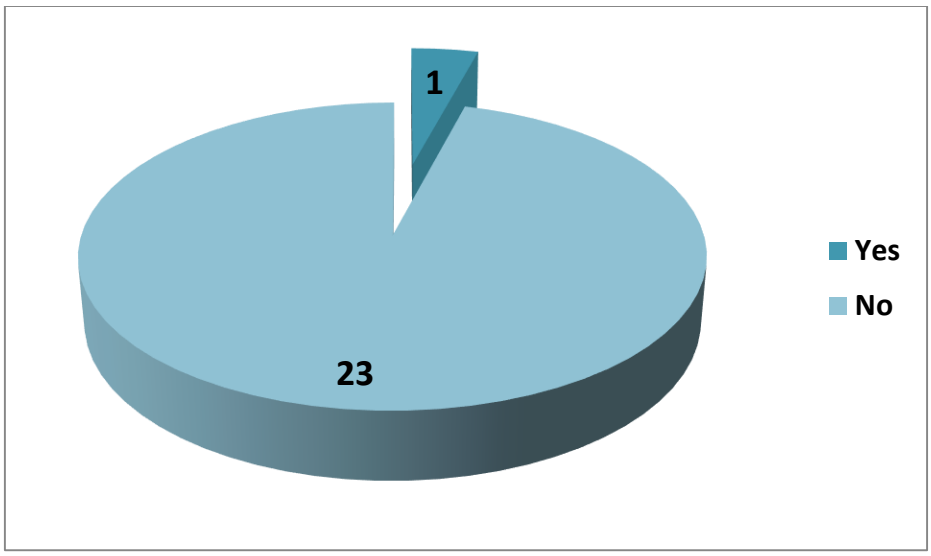


9. **After you started using the method of contraception did an ASHA/AWW/ANM ever visit you to enquire about any problem regarding the method?**

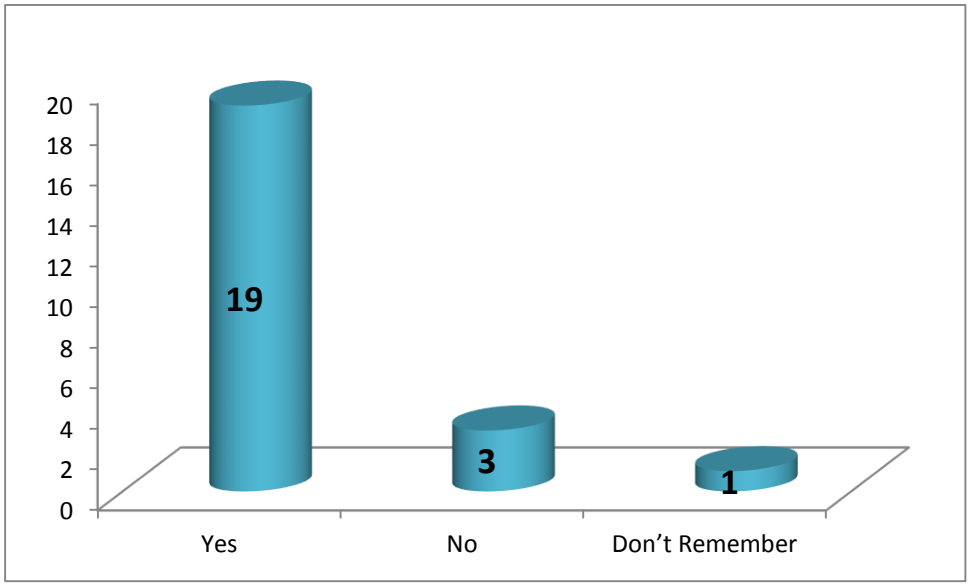


Ask to all respondents

10. **Have you ever used IUCD/PPIUCD?**

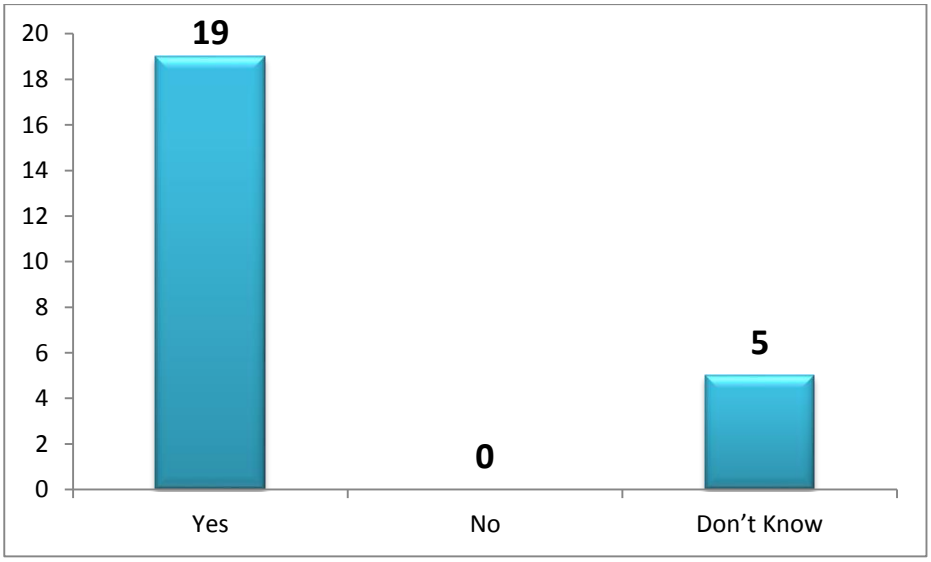


11. **Did ASHA/AWW/ANM advise you about the risk of becoming pregnant soon after delivery if you didn't use a method to avoid becoming pregnant, after your last pregnancy?**

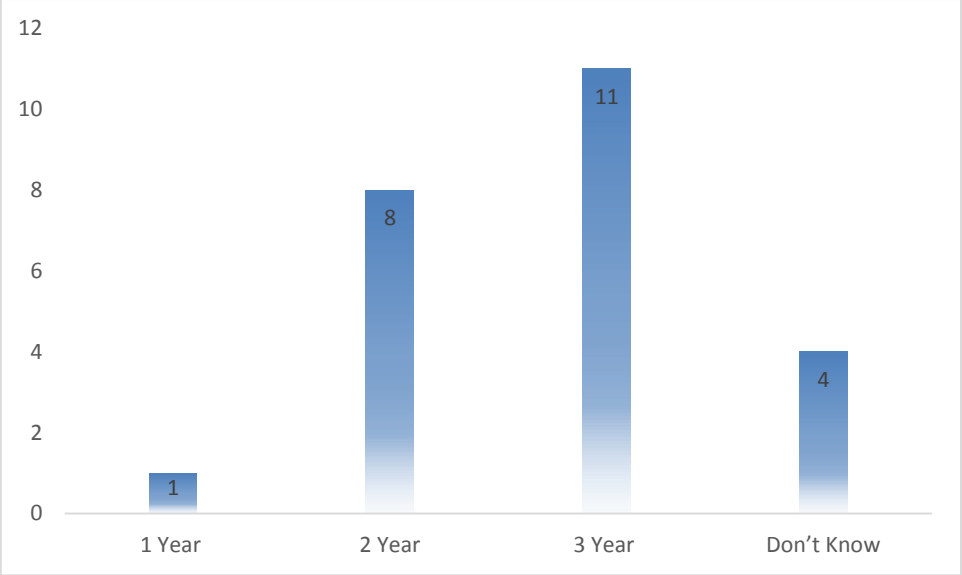


Knowledge Question

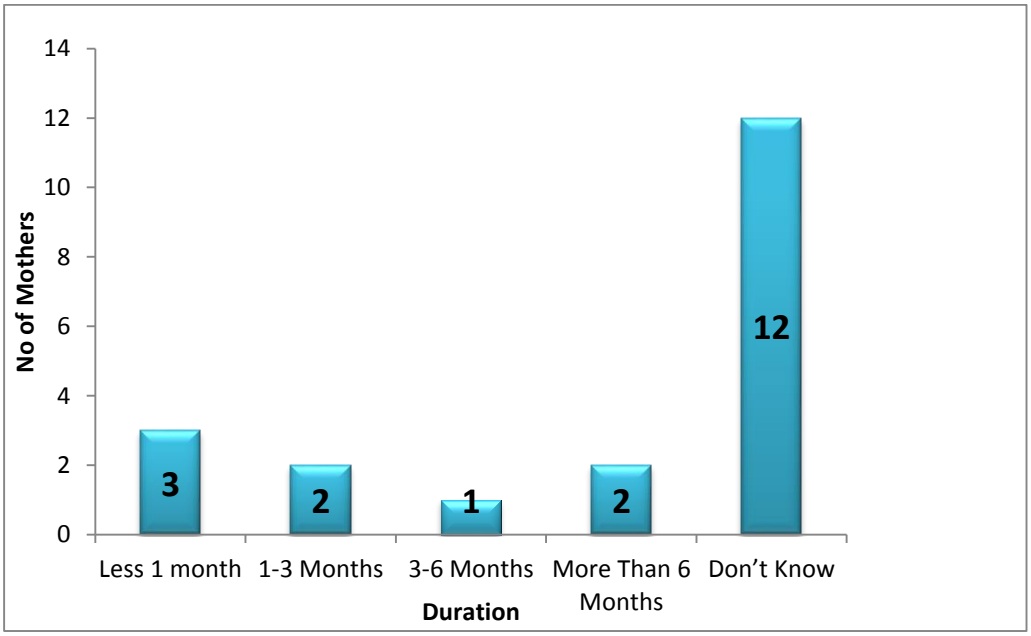
12. **Does Family planning methods prevent the unwanted pregnancy & helps birth spacing?**



13. How long should one wait between two children?



14. How long after birth family planning method can be started?



➢ RESULTS AND INTERPRETATION: –

- ✓ When we met to pregnant woman we found that 14 women want to get pregnant because of culture believe but 10 women did want to get pregnant that time out of 24 women and out of these 10 women maximum women want to pregnant later & few are didn't want to pregnant.
- ✓ Maximum women/husbands are not using use family planning and only 11 women/husbands are using FP method out of 24 women/husband because of they are not aware about FP method as well as they think it may be cause of any diseases like Cancer by using of IUD and only 1 women use IUD method out off 24.
- ✓ When we ask to women those are not using any FP method for another Child then we found that 7 women not decided, 4 women said yes and only 2 Women said No out of it means those 7 women get may be not get pregnant once again.
- ✓ According to the data those are using FP method we can say that maximum Women/husband using Pill and Condom which is got from ASHA/AWW and some women got PHC for Sterilization.
- ✓ When we ask about advice to adopt the FP method and visit of ANM/ASHA/AWW after using these method we found that maximum ANM give advice but they didn't go to home of Women for enquiry about any problem regarding method.
- ✓ Maximum women said that ANM/ASHA/AWW give advice Regarding FP method that you can avoid your pregnancy by using these method.
- ✓ Maximum women aware about FP method that its help birth spacing but 12 women don't know that "How long after birth FP method can be started?"

❖ RECOMMENDATIONS

- ✓ According to these study found that peoples are don't want use PF method because of their culture believe & said that *"Bachche Bhagwan ka den hai"* and it may cause Cancer like by using IUCD so we need aware about FP that what is advantage of FP.
- ✓ Use IEC material and activity like street play to increase awareness about FP.
- ✓ Effective home visit of ANM/ASHA/AWW and ask about any problem regarding the method.
- ✓ Effective training of all health worker regarding FP method and organized proper FP Camp under the supervision of higher authority to avoid any mishap.
- ✓ Improve the Health services and facility as well as make friendly environment in all health center so that they can easily share there thought & problem regarding FP.
- ✓ Regular feedback from beneficiary by higher authority to avoid gap and to know the ground reality so they can improve the services according to need.

❖ CONCLUSION

Study indicate that women don't want to pregnant but due to their family member want at least four to five child because they wait for Baby Boy and if Baby Boy is there then they wait for Baby Girls and they have mentality FP like IUCD may Cause Cancer or other Diseases so we need to aware about FP by different method like IEC etc. we also give information about ***Lactational Amenorrhea Method*** which is most cost effective method for FP and it does not produce any diseases to beneficiary. ANM/ASHA/AWW don't want to go to Home Visit and if they are going which not effective so effective Home Visit should be there and there are casteism is one of the biggest problem in the village so it can be solved so that everybody can get the benefit of Family Planning.

❖ REFERENCES

1. Joshi LR, Male Participation in Family Planning: Human Behaviour Perspective, Centre of Social Medicine and Community Health, School of Social Science, Jawaharlal Nehru University, New Delhi, India, J Nepal Health Res Counc. 2015 Sep;13(31):18895 Available from: http://www.ncbi.nlm.nih.gov/pubmed/27005710[accessed on 2 May 2016].
2. Annual Report 2014-15 Family Planning Available from:http://www.mohfw.nic.in/WriteReadData/l892s/5632145789632456.pdf[accessed on 2 May 2016].
3. Available from: http://www.nfpta.org.uk/pdfs/How-NFP-Works-in-Breastfeeding.pdf[accessed on 2 May 2016].
4. Family Planning Improving the Lives of Women and Their Families Around the World 2011 REPORT[accessed on 2 May 2016].
5. Fact Sheet **National Family Health Survey-4,2015 -16.** Available from:http://rchiips.org/nfhs/pdf/nfhs4/br_factsheet.pdf[accessed on 2 May 2016].
6. Population reference bureau 2013 Data Sheet Family Planning Worldwide Available from: www. p r b.org, [accessed on 2 May 2016].
7. Kishore S; Garg BS; Deshmukh PR; Aggarwal P, entitled "Role of lactation in family planning" (Indian Journal of Community Health. 2010 Jun; 22(1):4-7) [accessed on 6 May 2016].
8. Fehring RJ "The influence of contraception, abortion, and natural family planning on divorce rates as found in the 2006-2010 National Survey of Family Growth" (Linacre Quarterly. 2015 Aug; 82(3):273-82) [accessed on 6 May 2016].

9. Heather L. Sipsma, Elizabeth H. Bradley, Peggy G. Chen "Lactational Amenorrhea Method as a Contraceptive Strategy in Niger" published in Matern Child Health J, Publised online on 2012,[accessed on 6 May 2016].
10. Rizvi A; Mohan U; Singh SK; Singh VK "Assessment of knowledge of contraceptives and its practice among married women in urban slums of Lucknow District" (Indian Journal of Community Health. 2013Jan-Mar; 25(1):6-11).
11. Chhugani M; Jha P; Caine KL "Nurses bring new family planning methods to communities: Standard Days Method and Lactational Amenorrhea Method"(Indian Journal of Community Health. 2013 Jan-Mar; 25(1):82-85)

Annexure

भाग–4 / SECTION-4

प्रसव पश्चात् गर्भनिरोधक और परिवार नियोजन / POST NATAL CONTRACEPTION AND FAMILY PLANNING

Q NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
अगर प्र0 सं0**113=77** (पति जीवित नहीं) तो अगले भाग–**5** में जाए / IF RESPONSE TO 113 IS '77' THAT IS "HUSBAND NOT ALIVE THAN GO TO SECTION 5			
अब मैं आपसे परिवार नियोजन के विभिन्न विधियों जिससे गर्भ को रोका या टाला जा सकता है के बारे में बात करना चाहूँगा / गी। Now, I would like to talk about family planning, the various ways or methods that a couple can use to delay or avoid pregnancy.			
401	जब (नाम) आपके गर्भ में आया तो क्या आप उस समय गर्भवती होना चाहती थी? When you got pregnant with (NAME), did you want to get pregnant at that time?	हाँ / YES ..... 1 → नहीं / NO 2	Q403
402	क्या आप बाद में बच्चा चाहती थी, या आप और बच्चा नहीं चाहती थी? Did you want to have a baby later on, or did you not want any (more) children?	बाद में चाहती थी / WANTED LATER ..... 1 और बच्चा नहीं चाहती थी / NOT WANTED ANYMORE 2	
403	क्या आप या आपके पति (नाम) के जन्म के बाद किसी विधि का उपयोग चालू किया था जिससे बच्चा होने में देरी हो या और बच्चा नहीं हो ? Did you or your husband start using any method to delay or prevent pregnancy after birth of (NAME)?	हाँ / YES ..... 1 नहीं / NO 2	
404 S21	क्या आप या आपके पति वर्त्तमान में किसी विधि का उपयोग कर रहे है जिससे बच्चा होने में देरी हो या और बच्चा नहीं हो? Are you or your husband currently using any method to delay or prevent pregnancy?	हाँ / YES ..... 1 नहीं / NO ..... 2 →	Q406
405	वर्त्तमान में आप किस विधि का उपयोग कर रहे हैं? Which method are you using currently?	पुरूष नसबंदी / MALE STERILIZATION ..... 1 महिला नलबंदी / FEMALE STETILIZATION (TL) ..... 2 आई.यू.डी / (गर्भ निरोधक)अंकुडी / IUD / LOOP ..... 3 इंजेक्टबल / INJECTABLES ..... 4 कंडोम / निरोध / CONDOM/ NIRODH ..... 5 गर्भनिरोधक गोलियाँ / CONTRACEPTIVE PILLS ..... 6 अन्य / OTHER _____ 88 (स्पष्ट करें / SPECIFY)	Q410
4A: उनसे पूछे जो किसी भी विधि का उपयोग नहीं करते हैं / Ask those who are not using any method			
406	क्या आप एक और बच्चा चाहेंगी? Would you like to have another child?	हाँ / YES ..... 1 नहीं / NO ..... 2 फैसला नहीं किया / NOT DECIDED ..... 7 →	Q408
407	आपने कब अपने अगले बच्चे का इरादा किया है? When do you intend to have your next child? आप अगला बच्चा कब चाहती है?	वर्ष / YEAR ☐☐ माह / MONTH ☐☐ अभी गर्भवती है / CURRENTLY PREGNANT ..... 98 → पता नहीं / DON'T KNOW 99	Q417
408	क्या आप अपने अगले गर्भ में देरी या रोकने के लिए किसी भी परिवार नियोजन विधि का उपयोग करना चाहती है? Do you intend to use any method of family planning to delay or prevent the next pregnancy?	हाँ / YES ..... 1 नहीं / NO ..... 2 पता नहीं / DON'T KNOW ..... 99 →	Q417
409	आप भविष्य में कौन सी विधि का उपयोग करना चाहती है? What method do you intend to use in the future?	पुरूष नसबंदी / MALE STERILIZATION ..... 1 महिला नलबंदी / FEMALE STERILIZATION (TL) ..... 2 आई.यू.डी / (गर्भ निरोधक)अंकुडी / IUD / LOOP ..... 3 इंजेक्टबल / INJECTABLES ..... 4 कॉन्डॉम / निरोध / CONDOM/ NIRODH ..... 5 गर्भनिरोधक गोलियाँ / CONTRACEPTIVE PILLS ..... 6 तय नहीं किया / NOT DECIDED ..... 7 अन्य / OTHER _____ 88 (स्पष्ट करें / SPECIFY)	Q417
4B: उनसे पूछे जो किसी विधि का उपयोग करते हैं / Ask those who are using any method			

Q NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
410	प्रसव के कितने दिन / महीने के बाद इस विधि को अपनाया? After how many days/ months after delivery you adopted this method? **[यदि 30 दिन से कम हो तो दिन में दर्ज करें]** [RECORD IN DAYS IF LESS THAN 30 DAYS]	महीने / MONTH ..... ☐☐ दिन / DAY ..... ☐☐	
411	आपने इस विधि को कहाँ करवाया / प्राप्त किया? Where did you get this method?	जिला अस्पताल / DISTRICT HOSPITAL / SDH ..... 1 प्राथमिक स्वास्थ केन्द्र / PHC ..... 2 सामुदायि स्वास्थ्य केन्द्र / CHC ..... 3 स्वास्थ्य उपकेन्द्र / ए.एन.एम SUB-CENTRE/ANM ..... 4 आशा / आँगवाड़ी कार्यकर्त्ता ASHA / AWW ..... 5 निजी अस्पताल / क्लीनिक PRIVATE HOSPITAL / CLINIC ..... 6 केमिस्ट / फार्मेशी / CHEMIST/ PHARMACY ..... 7 अन्य / OTHERS _____ 88 (स्पष्ट करें / SPECIFY)	
412	आपको इस विधि को अपनाने के लिए किसने सलाह दिया?Who advised you to adopt this method?	चिकित्सक / DOCTOR ..... A ए.एन.एम. / नर्स / ANM/NURSE ..... B ममता / MAMTA ..... C आशा / ASHA ..... D आँगनवाड़ी कार्यकर्त्ता / AWW ..... E रिश्तेदार / पड़ोसी / दोस्त / RELATIVES / NEIGHBOURS / FRIENDS ..... F अन्य / OTHERS _____ 88 (स्पष्ट करें / SPECIFY)	
413	**निर्देश : प्रश्न संख्या 413 उन्हीं से पूछे जो कंडोम या गर्भ निरोधक गोली का उपयोग करते है (इसकी जांच प्र0 सं0.405 से करें) अन्यथा प्रश्न संख्या 414 को उनसे पूछे जो किसी भी विधि का उपयोग करते है?** **INSTRUCTION: Ask Q 413 to those using Condom or Contraceptive Pills (Check this from Q.No. 405). Skip to Q414 for those using any other methods** क्या आप नियमित कंडोम या गर्भ निरोधक गोली का उपयोग करते है? Are you using condom or contraceptive pill regularly?	हाँ / YES ..... 1 नहीं / NO 2	
414	आप / आपके पति ने जब इस पद्धति का उपयोग करना शुरू कर दिया तो क्या उसके बाद आप / आपके पति को किसी प्रकार की समस्या हुई थी? Have you/your husband had any health problem after you/your husband started using this method?	हाँ / YES ..... 1 नहीं / NO 2	
415 S 22	परिवार नियोजन के विधि को शुरू करने के बाद आशा / आँगनवाड़ी कार्यकर्त्ता द्वारा उससे होने वाले समस्या के बारे में कभी आकर पूछताछ किया? After you started using the method of contraception did an ASHA/AWW/ANM ever visit you to enquire about any problem regarding the method?	हाँ / YES ..... 1 नहीं / NO ..... 2 →	Q417
416	परिवार नियोजन विधि अपनाने के कितने समय के बाद आशा / आँगनवाड़ी कार्यकर्त्ता / एएनएम पहली बार देखने आई? How many days after the procedure, the ASHA/AWW/ANM first came for follow up?	महीने / MONTH ..... ☐☐ दिन / DAY ..... ☐☐	
	सभी उत्तरदाता से पूछे / ASK TO ALL RESPONDENTS		
417	क्या आपने कभी आई.यू.सी.डी. / पी.पी.आई.यू.सी.डी. का इस्तेमाल किया है? Have you ever used IUCD/PPIUCD?	हाँ / YES ..... 1 नहीं / NO ..... 2 →	Q418

Q NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
417a	आई.यू.सी.डी. लगाने, निकलने या हटवाने की तिथि क्या थी? What was the date of incertion, expulsion, removal of IUCD? **अगर अब तक नहीं "हटाया" या "निकाला" गया तो 999 लिखें।** **Write 999 if not removed yet or expulsion not done.**	लगाने की तिथि / DATE OF INCERTION..... DD MM YYYY निकलने की तिथि / DATE OF EXPULSION..... DD MM YYYY हटाने की तिथि / DATE OF REMOVAL:..... DD MM YYYY अभी तक नहीं हटाया / NOT REMOVED YET.....999	
418	क्या आशा / आँगनबाड़ी कार्यकर्त्ता / ए.एन.एम. ने आपसे या आपके पति से पूछा कि आपको या आपके पति को और बच्चा चाहिए? Did the ASHA/AWW/ANM enquire from you or your husband whether you intend to have more children, after your last delivery?	हाँ / YES.....1 नहीं / NO.....2 पता नहीं / DON'T KNOW.....99	
419	क्या आशा / आँगनवाड़ी कार्यकर्त्ता / ए.एन.एम. ने आपको बताया कि अगर आप परिवार नियोजन के किसी भी विधि का उपयोग नहीं करते हैं तो प्रसव के बाद जल्द ही फिर से गर्भवती होने का खतरा हो सकता है? Did ASHA/AWW/ANM advise you about the risk of becoming pregnant soon after delivery if you did not use a method to avoid becoming pregnant, after your last delivery?	हाँ / YES.....1 नहीं / NO.....2 याद नहीं / DON'T REMEMBER.....99	
419a	क्या आशा / आँगनवाड़ी कार्यकर्त्ता / ए.एन.एम. ने गर्भावस्था से बचने के इन तरीकों को बताया था? Did ASHA/AWW /ANM inform you about these methods to avoid pregnancy after your last delivery?	हाँ / Yes .. नही / No पुरूष नसबंदी / MALE STERILIZATION.....1 2 महिला नलबंदी / FEMALE STETILIZATION (TL).....1 2 आई.यू.डी / (गर्भ निरोधक)अंकुडी / IUD / LOOP...1 2 इंजेक्टेबल / INJECTABLES.....1 2 कॉनडॉम / निरोध / CONDOM/ NIRODH.....1 2 गर्भनिरोधक गोलियाँ / COUNTERCEPTIVE PILLS....1 2 अन्य / OTHER_____ 88 (स्पष्ट करें / SPECIFY)	
	जानकारी संबंधि सवाल / KNOWLEDGE QUESTION		
420	क्या परिवार नियोजन विधि अनचाहे गर्भ एव दो बच्चों के बीच अंतराल रखने में मदद करता है? Does family planning methods prevent unwanted pregnany and helps birth spacing?	हाँ / YES.....1 नहीं / NO.....2 पता नहीं / DON'T KNOW.....99	
420a	दो बच्चों के जन्म के बीच कितना अंतराल होना चाहिए? How long should one wait between two child?	वर्ष / YEAR..... ☐☐ पता नहीं / DON'T KNOW.....99	
420b	प्रसव के कितने दिनों के बाद परिवार नियोजन की विधि की शुरूआत करनी चाहिए? How long after birth, family planning method can be started?	एक माह से कम / LESS THAN 1 MONTH.....1 एक से तीन माह / 1-3 MONTHS.....2 तीन से छः माह / 3-6 MONTHS.....3 छः माह से अधिक / MORE THAN 6 MONTHS.....4 अन्य / OTHER _____ 88 (स्पष्ट करें / SPECIFY) पता नहीं / DON'T KNOW.....99	