Internship Training

at

NHM, HARYANA

STUDY ON USAGE OF CONTRACEPTIVES AMONG ELIGIBLE COUPLES IN PANCHKULA, (HARYANA)

by

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Enroll No-PG/13/020

Under the guidance of

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Post Graduate Diploma in Hospital and Health Management

2013-15

International Institute of Health Management Research

New Delhi

(Completion of Dissertation from respective organization)

The certificate is awarded to

Dr. Garima Bharti

In recognition of having successfully completed her

Internship in the department of

CHILD HEALTH

and has successfully completed her Project on

STUDY ON USAGE OF CONTRACEPTIVES AMONG ELIGIBLE COUPLES IN PANCHKULA, (HARYANA)

Date_____

NHM, HARYANA

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

We wish her all the best for future endeavours

Training & Development

Zonal Head-Human Resources

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Garima Bharti** 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 **NHM, HARYANA** from April 7,2015 to June 31,2105.

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

The Internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavors.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Name of the mentor
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Certificate Of Approval

The following dissertation titled **"Study on usage of contraceptives among eligible couples in Panchkula, HARYANA"** at **"NHM, HARYANA"** 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.

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Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Garima Bharti,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"STUDY ON USAGE OF CONTRACEPTIVES AMONG ELIGIBLE COUPLES IN PANCHKULA, HARYANA "** at **"NHM, HARYANA"** 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.

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Study on usage of contraceptives among eligible couples in Panchkula (Haryana)** and submitted by **Dr. Garima Bharti Enrollment No. PG/13/020** under the supervision of **Dr. Preetha GS** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **April 7, 2015 to June 31,2015** 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.

Signature

Dr. Garima Bharti
PG/13/020

FEEDBACK FORM

Name of the Student: Dr. GARIMA BHARTI

Dissertation Organisation: NHM, HARYANA

Area of Dissertation: FAMILY PLANNING

Attendance: Good

Objectives achieved: Learned the functioning & working conditions of the Organisation.

Deliverables: Monitoring the National Program of Mission Indradhanush & Sub National Immunisation Day.

Strengths: Well Organised.
Very Punctual.

Suggestions for Improvement:

(Signature of the Organisation Mentor (Dissertation)

Date:

Place:

Abstract:

Contraception has been a single most important intervention to reduce burden of unwanted pregnancy and promote healthy living among young women. An early onset of sexual activity (largely with marriage) and desperate demand on young adult to have child, such interventions would yield unmatched dividend in case of India. In socio-cultural politico setting like India, access to or promotion of contraception among young adult is very limited. Nevertheless, analysis of latest data on contraceptive use dynamics indicates wider penetration of reach and acceptability of the services.

Among married young women aged 15-24 years in India, 16% used any contraceptive method in 1992-93; a little less than half were sterilized. By the year 2005-06, 27% of them had used contraceptives; nearly one third were sterilized. During this period (1992-06), use of modern spacing methods – predominantly condom use – has doubled, and there seems to be stagnation in the use of sterilization at early stage of life. At the same time, increase in the reliance on traditional methods (periodic abstinence and withdrawal) too have increased from less than 4% to nearly 7%, this is nothing but indicative of the demand for family planning and need for making program socially accessible to young women.

In the present findings modern methods of family planning (37.33%) were more commonly practised among those who currently use family planning method. The use of traditional or natural method was 7%. And permanent method was 9%. IUDs (8%) and pills (11%) were the most common specific methods identified in current practice with the studied women.

Acknowledgement

I deem it a sacred duty to thank all those who helped me in the completion of this project It is an esteemed pleasure to present this study, and I wholeheartedly thank each and everyone who helped me in this task.

Three months internship at **NHM, Haryana** was an enriching experience. I wholeheartedly thank **NHM, Haryana** for providing me a golden opportunity for doing my internship & learning from the organization. I am grateful to my mentors at **NHM, Haryana, Dr. Suresh Dalpath (CH) & Dr. Sube Singh (MO, CH**) for their invigorating help everywhere during this period.

I express my gratitude to **Dr. A. K. Agarwal (DEAN, Academic &Students Affair)** for arranging the summer training in good schedule.

I would like to express my special appreciation and thanks to, **Dr. Preetha GS (Associate Professor, IIHMR, New Delhi)** who has been a tremendous mentor for me. I would like to thank you for encouraging my research and for allowing me to grow as a research scientist. Your advice on both research as well as on my career have been priceless.

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List of Abbreviations

NHM- National Health Mission

NRHM- National Urban Health Mission

NUHM- National Rural Health Mission

FP- Family Planning

TFR- Total Fertility Rate

FDA- Food and drug Administration Act

IUDs- Intra Uterine Devices

POPs- Progestin-only pills

COCs- Combined oral contraceptive pills

DMPA- Depo Medroxy Progesterone Acetate

ECPs- Emergency Contraceptive Pills

INTERNSHIP REPORT

INTRODUCTION

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the newly launched National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening in rural and urban areas- Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases.

Vision- The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. Specific goals for the states will be based on existing levels, capacity and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency and responsiveness. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

1. Reduce MMR to 1/1000 live births

2. Reduce IMR to 25/1000 live births

3. Reduce TFR to 2.1

4. Prevention and reduction of anaemia in women aged 15–49 years

5. Prevent and reduce mortality & morbidity from communicable, non- communicable; injuries and emerging diseases

6. Reduce household out-of-pocket expenditure on total health care expenditure

7. Reduce annual incidence and mortality from Tuberculosis by half

8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts

9. Annual Malaria Incidence to be <1/1000

10. Less than 1 per cent microfilaria prevalence in all districts

11. Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

NHM FINANCING

The NHM shall be a major instrument of financing and support to the states to strengthen public health systems and health care delivery. This financing to the state will be based on the state's Programme

NHM Finance - FMG

Financial Management Group(FMG) working under NHM Finance Division of Ministry of Health & Family Welfare is involved in planning, budgeting, accounting, financial reporting, internal controls including internal audit, external audit, procurement, disbursement of funds and monitoring the physical and financial performance of the programme, with the main aim of managing resources efficiently and achieving pre-determined objectives. Sound financial management is a critical input for decision making and programme success. Accurate and timely financial information provides a basis for informed decisions about the programme, fund release and assists in reducing delays for smooth programme implementation. FMG tries to ensure that all programmes receive their funds in a timely manner after adhering to all the GFR provisions and DoE

conditionalties. Under NHM, it is the endeavour of the Government of India to build effective financial management capabilities for managing the funds provided to the State Health Societies. The States have also been encouraged to set up Financial Management Groups (FMG) at the State and Strengthen financial management capacities at District level.

Implementation Plan (PIP). The PIP shall have following parts:

Part I : NRHM RCH Flexipool

Part II : NUHM Flexipool,

Part III : Flexible Pool for Communicable Diseases

Part IV : Flexible Pool for Non Communicable Diseases, Injury and Trauma

Part V : Infrastructure Maintenance

Within the broad national parameters and priorities, States would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.

The state PIPs would be an aggregate of the district/city health action plans, and include activities to be carried out at the state level. They would be expected to include the individual district plans particularly of High Priority Districts and City Plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state.

OGANIZATIONAL PROFILE

NRHM

National Rural Health Mission (NRHM)

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The Union Cabinet vide its decision dated 1st May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

NRHM seeks to provide equitable, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

NATIONAL URBAN HEALTH MISSION (NEW SCHEME)

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

NUHM would endeavour to achieve its goal through:-

i) Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.

ii) Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.

iii) Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.

iv) Availability of resources for providing essential primary health care to urban poor.

v) Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers.

The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10.The Programme Implementation Plans (PIPs) sent by the by the states are apprised and approved by the Ministry.

FUNCTIONS AND DUTIES OF HEALTH DEPARTMENT

Health department has manifold functions and duties which are as under :-

- Provide promotive, preventive , curative and rehabilitative services to the community through primary health care delivery system
- Provide equitable and quality health care at primary, secondary and tertiary level.
- Extension, expansion and consolidation of rural health infrastructure.
- Respond to the local community health needs and request.
- It takes many steps for population stabilization.
- Provide Reproductive and Child Health Services with the objective of reducing MMR & IMR.
- Provide immunization services against vaccine preventive diseases of childhood as well as pregnant mothers against tetanus during child birth.
- Provide Family Welfare Services.
- Provide Essential Obstetric Care.

- Enforcement of PNDT Act to prevent Sex Determination.
- Implement and monitor various National Health Programmes.
- Provide emergency obstetric care.
- Ensure potable drinking water and basic sanitation facilities.
- Prevention and control of communicable and non-communicable diseases through active disease surveillance and timely remedial measures.
- Provide treatment for common disease and injuries including emergency medical care.
- Provide essential drugs, materials, equipments & modern medical/surgical gadgets for diagnosis and treatment of patients.
- Birth and Registration through Civil Registration System.
- Work with other sectors in promoting activities and initiatives related to health.
- Promotion of proper and balanced nutrition – To raise the health status of the community.
- Provide in service orientation training to the medical and paramedical personnel's – To update their knowledge and sharpen their skills.
- Enforcement of various Acts like Prevention of Food Adulteration Act, Drugs & Cosmetic Act, Human organ Transplant, Mental health Act, Radiation protection Act, MTP Act, Birth & Registration Act, Human Anatomy Act and implementation Of Bio Medical Waste Management & Handling rules.
- Educate community to bring about behavioral change regarding various Health and Family Welfare programmes thereby improving the quality of life – through various mass media activities.
- Conduct Medico Legal and Postmortem examination.

- Conduct Medical Examination for first entry into Govt. service, driving license, disability, medical fitness, communication of pension etc.
- Issuance of manufacturing, wholesale & retail drug license.

SERVICES

➢ Services Provided by NHM Haryana

Programmes

I. Maternal health
II. Child health
III. Family planning
IV. ASHA- Accredited Social Health Activist
V. Referral Transport
VI. BCC- Bahaviour Change Communication
VII. RBSK- Rastriya Bal Swasthya Karyakram

➢ Services provided by Child Health Department

I. HBPNC- Home based post natal care
II. CH Resource Material
III. Immunization
IV. Micro nutrient Supplementation Programme

Assigned Task & learning from the organisation

Monitored National Programme as a State Representative & acquired knowledge of various National Health Programme.

- Attended round 1st of Mission Indradhanush from Aril 9,2015 to April 19 2015 at district Palwal.
- Attended SNID round from April 26,2015 to April 28,2015 at Gurgaon.
- Attended round IInd of Mission Indradhanush from May 07,2015 to May 13,2015 at district Narnaul.

Learnings-

Knowledge of various health programme like-

- ✓ Mission Indradhanush
- ✓ IMNCI
- ✓ INAP- Indian newborn Action Plan
- ✓ Home based post natal care
- ✓ Full immunization & complete immunisation

Learned monitoring techniques of different health programmes like polio monitoring techniques, and immunisation monitoring techniques.

Also how to conduct house to house visits for taking feedback of caregivers and also way to fill the various monitoring formats.

Compilation of reports.

DISSERTATION REPORT

STUDY ON USAGE OF CONTRACEPTIVES AMONG ELIGIBLE COUPLES IN PANCHKULA, (HARYANA)

INTROUCTION

Contraception is one of the proximate determinants of fertility and the most important predictor of fertility transition.[1,2] J. Bongaarts et al reported this. according to Central according to Intelligence Agency's report 2014 Singapore and Macau has fertility rate 0.80 & 0.93 respectively which is the lowest amongst countries whereas India reported 2.5.

India was the first country in the world to adopt an official population policy and launch official family planning programme way back in 1952 which remains the mainstay of family planning efforts. During its early years, the programme focussed on the health rationale of family planning.

Family planning as a strategy for population stabilisation received attention only after 1971 population census.[3]

This strategy resulted in an increase in the proportion of couples effectively protected from12.4 percent during 1971-72 to 46.5percent during 1995-96 but remained stagnant during 1995-96 through 2003-04 and decreased to 40.4 during 2010-11. A. R. Chaurasia and R. Singh et al reported that after the launch of the National Rural Health Mission in 2005, the official family planning programme has been subsumed in the reproductive and child health component of the Mission.[4] However, universal adoption of small family norm still remains a distant dream in India. During 2007-08, only about 54 percent of the currently married women aged 15–49 years or their husbands were using

a contraceptive method to regulate their fertility [5] and the contraceptive prevalence rate appears to have stagnated after 2004[6]

The TFR of India as per NFHS III(2005-06) data is 2.7, while the TFR of the rural areas is 3.0 and that of the urban areas is 2.1

Not all contraceptive methods are appropriate for all situations, and the most appropriate method of birth control depends on a woman's overall health, age, frequency of sexual activity, number of sexual partners, desire to have children in the future, and family history of certain diseases.

The different methods of contraception include:[7,8]

- Barrier methods
- Hormonal methods
- Emergency contraception
- Intrauterine methods
- Sterilization

India suffers from the problem of overpopulation.[9][10][11] Although the fertility rate (average number of children born per woman during her lifetime) in India has been declining, it has not reached replacement rate yet. The replacement rate is defined as the total fertility rate at which newborn girls would have an average of exactly one daughter over their lifetimes. In more familiar terms, women have just enough babies to replace themselves. Factoring in infant mortality, the replacement rate is approximately 2.1 in most industrialized nations and about 2.5 in developing nations (due to higher mortality). Discounting immigration and population momentum effects, a nation that crosses below the replacement rate is on the path to population stabilization and, eventually, population reduction.

Awareness of contraception is near-universal among married women in India.[12] However, the vast majority of married Indians (76% in a 2009 study) reported significant problems in accessing a choice of contraceptive methods.[13]

In 2009, 48.3% of married women were estimated to use a contraceptive method, i.e. more than half of all married women did not.[13] About three-fourths of these were using female sterilization, which is by far the most prevalent birth-control method in India.[13] Condoms, at a mere 3% were the next most prevalent method.[13] Meghalaya, at 20%, had the lowest usage of contraception among all Indian states. Bihar and Uttar Pradesh were the other two states that reported usage below 30%.[13]

Comparative studies have indicated that increased female literacy is correlated strongly with a decline in fertility.[14] Studies have indicated that female literacy levels are an independent strong predictor of the use of contraception, even when women do not otherwise have economic independence.[14]Female literacy levels in India may be the primary factor that help in population stabilization, but they are improving relatively slowly: a 1990 study estimated that it would take until 2060 for India to achieve universal literacy at the current rate of progress.[14]

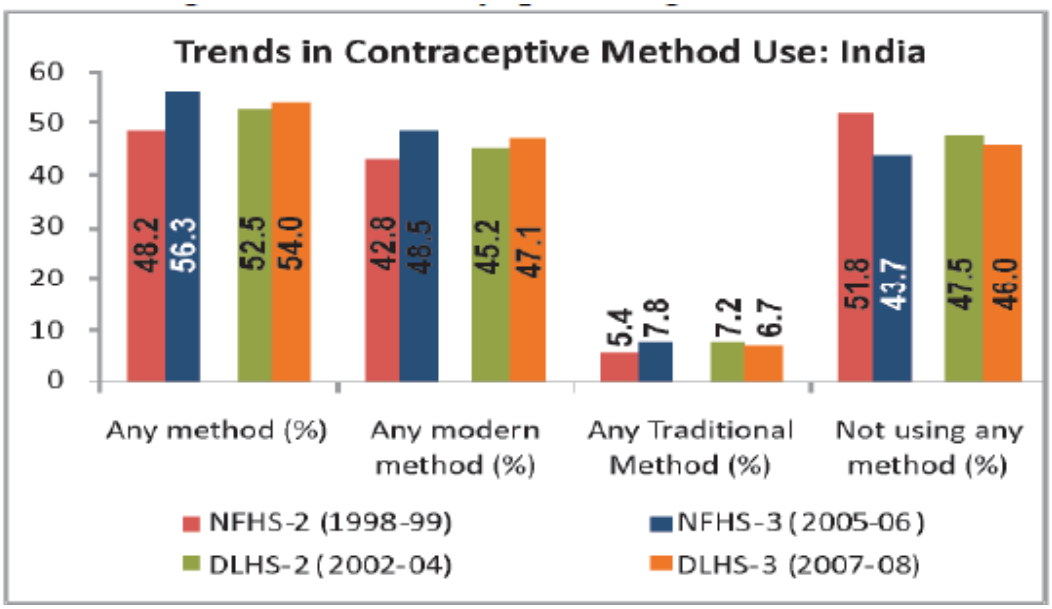

Figure 2.4.1

State and country comparisons-

Seven Indian states have dipped below the 2.1 replacement rate level and are no longer contributing to Indian population growth - Andhra Pradesh, Goa, Tamil Nadu, Himachal Pradesh, Kerala, Punjab and Sikkim.[15] Four Indian states have fertility rates above 3.5 - Bihar, Uttar Pradesh, Meghalaya and Nagaland.[15] Of these, Bihar has a fertility rate of 4.0, the highest of any Indian state. For detailed state figures and rankings, see Indian states ranking by fertility rate.

In 2009, India had a lower estimated fertility rate than Pakistan and Bangladesh, but a higher fertility rate than China, Iran, Burma and Sri Lanka.[16]

Rationale of the study:

- Study is related to awareness and usage of contraception and also determinants of contraceptives in panchkula district of Haryana and such study has not yet been conducted in panchkula so far but similar studies have been carried out in other countries.

Objectives:

General Objective: To determine the usage of contraception and determinants of contraception among the women of age group 15-49 years residing in Panchkula District of Haryana state.

Specific Objective:

- To determine the prevalence of usage of contraception.
- To determine awareness level regarding contraception.
- To determine the factors associated with contraception usage.
- To determine determinants of contraception.
- To determine the reasons for using contraception.
- To determine which method is using most among the population.

Review of Literature:

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.
Decline in Total Fertility Rate(TFR)	Helps to stabilize India's population growth which in turn spurs the economic and social progress
Greater investments in family planning	Helps to mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies Reduce maternal mortality by 35% Reduce infant mortality and abortions significantly
Govt. of India's commitment by 2015	Maternal Mortality Ratio (MMR) to 100/100,000 Infant Mortality Rate (IMR) to 30/1000 live births Total Fertility Rate (TFR) to 2.1

Annual Report 12-13

Table 2.5.1

Factors that Influence Population Growth

Unmet need of Family Planning	1.3% as per DLHS-III (2007-08)
Age at Marriage and first childbirth	22.1% of the girls get married below the age of 18 years Out of the total deliveries 5.6% are among teenagers i.e. 15-19 years Marriages below legal age is more alarming in few states Bihar (46.2%), Rajasthan (41%), Jharkhand (36%), UP (33%), and MP (29.2%)
Spacing between Births	spacing between two childbirths is less than the recommended period of 3 years in 61% of births (NFHS-3)

Table 2.5.2

Current Demographic Scenario in the Country (CENSUS 2011)

2.4% of world's land mass	17.5% of the world's population
1.21 billion	India's population as per Census-2011
200 million	**Population of Uttar Pradesh** –more than the population of Brazil

Table 2.5.3

Progress in TFR

TFR decline	• From 2.9 in 2005 to 2.5 in 2010. • Decline more significant in High Focus States.
TFR of 2.1 or less	• 21 States and Union Territories
TFR 2.1-3.0	• **7 States** – Odisha-2.3, Haryana-2.3, Gujarat-2.5, Assam-2.5, Uttarakhand-2.6, Arunachal Pradesh-2.7 and Chhattisgarh-2.8.
TFR above 3.0	• **7 States** - Bihar-3.7, Uttar Pradesh-3.5, Dadara & Nagar Haveli-3.3, Rajasthan-3.1, Madhya Pradesh-3.2, Meghalaya-3.1 and Jharkhand-3

Table 2.5.4

Impact of High Focus Approach of the Government of India:

Government of India has categorized states as per the TFR level as very high-focus (more than or equal to 3.0), high-focus (more than 2.1 and less than 3.0) and non-high focus (less than or equal to 2.1)

Decline in TFR

All the 6 very high focus states except MP have shown a decline of 0.2 points Except Gujarat, rest of the high focus states has shown a decline of 0.1 point; Haryana has shown a decline of 0.2 points.

Very High Focus States for FP

State	SRS-2009	SRS-2010	Point change
Bihar	3.9	3.7	-0.2
Uttar Pradesh	3.7	3.5	-0.2
Madhya Pradesh	3.3	3.2	-0.1
Rajasthan	3.3	3.1	-0.2
Jharkhand	3.2	3.0	-0.2
Chhattisgarh	3.0	2.8	-0.2

Table 2.5.5(a)

High Focus States for FP

State	SRS-2009	SRS-2010	Point change
Assam	2.6	2.5	-0.1
Gujarat	2.5	2.5	-0.0
Haryana	2.5	2.3	-0.2
Odisha	2.4	2.3	-0.1

Other Non- High Focus States for FP

State	SRS-2009	SRS-2010	Point change
Karnataka	2.0	2.0	0.0
Andhra Pradesh	1.9	1.8	-0.1
Kerala	1.7	1.8	+0.1
Tamil Nadu	1.7	1.7	0.0

Table 2.5.5(b)

Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9 (NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure).

Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). The proximate determinants of fertility like, age at marriage and age at first childbirth (which are societal preferences) are also showing good improvement at the national level. The adjoining figure indicates the current position of social determinants of fertility in the country. AHS survey has been conducted in 9 states (8 EAG states + Assam) which indicates that:

- ✓ All the states except Uttarakhand has shown an increase in use of any modern contraceptive method.
- ✓ The increase has mainly been on account of increase of female sterilisation, which means there has not been much improvement in other methods of family planning.

CURRENT FAMILY PLANNING EFFORTS

National Policies recognize that lowering Total Fertility Rate would help to stabilize India's population growth, which in turn spurs the economic and social progress.

Greater investments in family planning can help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. It has been estimated that meeting unmet needs for family planning can avert around 50 lakhs child deaths over 8 years in India. Especially in areas with poor health infrastructure, family planning is a cost-effective and feasible way to reduce maternal deaths, as it does not rely on complex technology. It is estimated that if the current unmet need for family planning could be fulfilled over the next 5 years, we can:

- Avert 35,000 maternal deaths
- Avert 1.2 million infant deaths

- Save more than Rs. 4450 crores
- Saving of Rs. 6500 crores, if safe abortion services are coupled with increased family planning services.

Considering the above, a new strategic direction has been developed for family planning programme wherein, it has been repositioned to not only achieve population stabilization but also to reduce maternal mortality as well as infant and child mortality. This strategic direction would be the guiding principle in implementation of family planning programme in future. Government of India has redesigned its family planning programme to have more focus on spacing methods, especially, IUCD (both post-partum and interval). To strengthen the spacing services, it is envisaged that states would ensure the fixed day service delivery up to the SHC level for IUCD insertions so as to enable clients to avail the services in close vicinity of their community. Services of ASHAs would also be utilized for counselling clients to promote delay in first child birth and healthy spacing between 1st and 2nd child birth.

FAMILY PLANNING METHODS

The different methods of contraception include:[1,2]

- Barrier methods
- Hormonal methods
- Emergency contraception
- Intrauterine methods
- Sterilization

Barrier Methods

Designed to prevent sperm from entering the uterus, barrier methods are removable and may be an option for women who cannot use hormonal methods of contraception. Types of barrier methods include:

- M**ale condoms.** This condom is a thin sheath that covers the penis to collect sperm and prevent it from entering the woman's body. Male condoms are generally made of latex or polyurethane, but a natural alternative is lambskin (made from the intestinal membrane of lambs). Latex or polyurethane condoms reduce the risk of spreading sexually transmitted diseases (STDs). Lambskin condoms do not prevent STDs. Male condoms are disposable after a single use.
- **Female condoms.** These are thin, flexible plastic pouches. A portion of the condom is inserted into a woman's vagina before intercourse to prevent sperm from entering the uterus. The female condom also reduces the risk of STDs. Female condoms are disposed of after a single use.
- **Diaphragms.** Each diaphragm is a shallow, flexible cup made of latex or soft rubber that is inserted into the vagina before intercourse, blocking sperm from entering the uterus. Spermicidal cream or jelly should be used with a diaphragm. The diaphragm should remain in place for 6 to 8 hours after intercourse to prevent pregnancy, but it should be removed within 24 hours. Traditional latex diaphragms must be the correct size to work properly, and a health care provider can determine the proper fit.

  A diaphragm should be replaced after 1 or 2 years. Women also need to be measured again for a diaphragm after giving birth, having pelvic surgery, or gaining or losing more than 15 pounds.[3] Newer diaphragms, such as the Silcs diaphragm, are designed to fit most women and do not require fitting by a health care provider. The Silcs

diaphragm is currently in clinical trials for approval by the U.S. Food and Drug Administration (FDA) and other regulatory agencies.

- C**ervical caps.** These are similar to diaphragms, but smaller, more rigid, and less noticeable. The cervical cap is a thin silicone cup that is inserted into the vagina before intercourse to block sperm from entering the uterus. As with a diaphragm, the cervical cap should be used with spermicidal cream or jelly. The cap must remain in place for 6 to 8 hours after intercourse to prevent pregnancy, but it should be removed within 48 hours. Cervical caps come in different sizes, and a health care provider determines the proper fit.[4] With proper care, a cervical cap can be used for 2 years before replacement.2 Currently, Fem Cap is the only cervical cap approved by the FDA.
- C**ontraceptive sponges.** These are soft, disposable, spermicide-filled foam sponges. One is inserted into the vagina before intercourse.[5] The sponge blocks sperm from entering the uterus, and the spermicide also kills the sperm cells. The sponge should be left in place for at least 6 hours after intercourse and then removed within 30 hours after intercourse. Currently, the Today® Vaginal Contraceptive Sponge is the only sponge approved by the FDA.
- **Spermicides.** A spermicide destroys sperm. A spermicide can be used alone or in combination with a diaphragm or cervical cap. The most common spermicidal agent is a chemical called nonoxynol-9 (N-9). It is available in several concentrations and forms, including foam, jelly, cream, suppository, and film. A spermicide should be inserted into the vagina close to the uterus no more than 30 minutes prior to intercourse and left in place 6 to 8 hours after intercourse to prevent pregnancy. Spermicides do not prevent the transmission of STDs and may cause allergic reactions or vaginitis (pronounced *vaj-uh-NAHY-tis*).[6]

Hormonal Methods

Hormonal methods of birth control use hormones to regulate or stop ovulation and prevent pregnancy. Ovulation is the biological process in which the ovary releases an egg, making it available for fertilization. Hormones can be introduced into the body through various methods, including pills, injections, skin patches, transdermal gels, vaginal rings, intrauterine systems, and implantable rods. Depending on the types of hormones that are used, these pills can prevent ovulation; thicken cervical mucus, which helps block sperm from reaching the egg; or thin the lining of the uterus. Health care providers prescribe, monitor, and administer hormonal contraceptives.

- **Combined oral contraceptives ("the pill").** Combined oral contraceptive pills (COCs) contain different combinations of the synthetic estrogens (pronounced *ES-truh-juhns)* and progestins (*proh-JES-tins*) and are given to interfere with ovulation. A woman takes one pill daily, preferably at the same time each day. Many types of oral contraceptives are available, and a health care provider helps to determine which type best meets a woman's needs. Use of COC pills is not recommended for women who smoke tobacco and are more than 35 years old or for any woman who has high blood pressure, a history of blood clots, or a history of breast, liver, or endometrial cancer.
- **Progestin-only pills (POPs).** A woman takes one pill daily, preferably at the same time each day. Progestin-only pills may interfere with ovulation or with sperm function. POPs thicken cervical mucus, making it difficult for sperm to swim into the uterus or to enter the fallopian tube. POPs alter the normal cyclical changes in the uterine lining and may result in unscheduled or breakthrough bleeding. These hormones do not appear to be associated with an increased risk of blood clots.

- **Contraceptive patch.** This is a thin, plastic patch that sticks to the skin and releases hormones through the skin into the bloodstream. The patch is placed on the lower abdomen, buttocks, outer arm, or upper body. A new patch is applied once a week for 3 weeks, and no patch is used on the fourth week to enable menstruation.[4] Currently, Ortho Evra® is the only patch that is FDA approved.
- **Injectable birth control.** This method involves injection of a progestin, Depo-Provera® (DMPA—depo medroxyprogesterone acetate), given in the arm or buttocks once every 3 months.[7]This method of birth control can cause a temporary loss of bone density, particularly in adolescents. However, this bone loss is generally regained after discontinuing use of DMPA. Most patients using injectable birth control should eat a diet rich in calcium and vitamin D or take vitamin supplements while using this medication.
- **Vaginal rings.** The ring is thin, flexible, and approximately 2 inches in diameter. It delivers a combination of a synthetic oestrogen (ethinyl estradiol) and a progestin. The ring is inserted into the vagina, where it continually releases hormones for 3 weeks. The woman removes it for the fourth week and reinserts a new ring 7 days later. Risks for this method of contraception are similar to those for the combined oral contraceptive pills, and a vaginal ring is not recommended for any woman with a history of blot clots, stroke, or heart attack, or with certain types of cancer.[4] Currently, the NuvaRing® is the only FDA-approved vaginal ring. A new contraceptive vaginal ring that can be used for 13 cycles is under clinical development.
- **Implantable rods.** Each rod is matchstick-sized, flexible, and plastic. A physician surgically inserts the rod under the skin of the woman's upper arm. The rods release a progestin and can remain implanted for up to 5 years.[4] Currently, Implanon®, which releases etonorgestrel, is the only implantable rod available in the United States. A two-

rod method, Jadelle®, which releases levonorgestrel, is FDA approved but not currently distributed in America. A new levonorgestrel-releasing, two-rod method, Sino Implant, is in clinical development.

- **Emergency Contraceptive Pills (ECPs).** ECPs are hormonal pills, taken either as a single dose or two doses 12 hours apart, that are intended for use in the event of unprotected intercourse. If taken prior to ovulation, the pills can delay or inhibit ovulation for at least 5 days to allow the sperm to become inactive. They also cause thickening of cervical mucus and may interfere with sperm function. ECPs should be taken as soon as possible after semen exposure and should not be used as a regular contraceptive method. Pregnancy can occur if the pills are taken after ovulation or if there is subsequent semen exposure in the same cycle.

Intrauterine Methods

An IUD is a small, T-shaped device that is inserted into the uterus to prevent pregnancy. A health care provider inserts the device. An IUD can remain and function effectively for many years at a time. After the recommended length of time, or when the woman no longer needs or desires contraception, a health care provider removes or replaces the device.

- A **copper IUD** releases a small amount of copper into the uterus, causing an inflammatory reaction that generally prevents sperm from reaching and fertilizing the egg.[4] If fertilization of the egg does occur, the physical presence of the device prevents the fertilized egg from implanting into the lining of the uterus. Copper IUDs may remain in the body for 12 years. A copper IUD is not recommended for women who may be pregnant, have pelvic infections, or had uterine perforations during previous IUD insertions. It also is not recommended for women who have cervical cancer or

cancer of the uterus, unexplained vaginal bleeding, or pelvic tuberculosis. Currently, ParaGard® is the only FDA-approved copper IUD.

- A **hormonal IUD** releases a progestin hormone into the uterus.4 The released hormone causes thickening of the cervical mucus, inhibits sperm from reaching or fertilizing the egg, thins the uterine lining, and also may prevent the ovaries from releasing eggs. Hormonal IUDs can be used for up to 5 years. Currently, Mirena®, a levonorgestrel-releasing IUD, is the only FDA approved hormonal IUD that is available.

Sterilization

Sterilization is a permanent form of birth control that either prevents a woman from getting pregnant or prevents a man from releasing sperm. A health care provider must perform the sterilization procedure, which usually involves surgery. These procedures usually are not reversible.

- A **sterilization implant** is a nonsurgical method for permanently blocking the fallopian (pronounced *fuh*-LOH-*pee-uhn*) tubes.[8] A health care provider threads a thin tube through the vagina and into the uterus to place a soft, flexible insert into each fallopian tube. No incisions are necessary. During the next 3 months, scar tissue forms around the inserts and blocks the fallopian tubes so that sperm cannot reach an egg. After 3 months, a health care provider conducts tests to ensure that scar tissue has fully blocked the fallopian tubes. A backup method of contraception is used until the tests show that the tubes are fully blocked.
- **Tubal ligation** (pronounced *TOO-buhl lahy-GEY-shuhn*) is a surgical procedure in which a doctor cuts, ties, or seals the fallopian tubes. This procedure blocks the path

between the ovaries and the uterus. The sperm cannot reach the egg to fertilize it, and the egg cannot reach the uterus.[9]

- **Vasectomy** (*va-SEK-tuh-mee*) is a surgical procedure that cuts, closes, or blocks the vas deferens (pronounced *vas DEF-uh-renz*). This procedure blocks the path between the testes and the urethra (*yoo-REE-thruh*).[10] The sperm cannot leave the testes and cannot reach the egg. It can take as long as 3 months for the procedure to be fully effective. A backup method of contraception is used until tests confirm that there is no sperm in the semen.

Methodology

Research Questions:

The research questions are-

1. Do females using more contraception than males?
2. What are the reasons for using contraception?
3. What are different factors which affects the contraceptive usage?

Study Area: study has done in district Panchkula (HARYANA**)**

Study Design: This was a descriptive cross-sectional study. The survey was conducted only among married women aged 18–49 years old who had not reached menopause.

Sampling Technique: The women were selected by non probability purposive sampling among married women aged 18–49 years of age.

Sample Size: 75 married women aged 18–49 years of age.

Respondent: The respondents are married women aged 18–49 years of age.

Variables:

i. Age of women
ii. Education of women
iii. Family size
iv. Family income

Questionnaire and interview

The instruments used for data collection was designed in English. The questionnaire included socio-demographic characteristics of the participant and her husband, followed by items related to socioeconomic status, pregnancy history, knowledge of contraception, attitude towards contraception and current use of contraception. The questionnaire also included some items to determine the causes for use and reasons for avoiding contraception. Breastfeeding, withdrawal, safe period and isolation were defined as natural family planning methods. Intrauterine device (IUD) (the loop) is classified as medical methods. Vaginal cream/supplement, pills, injectable contraceptives, tubal ligation, condoms and emergency contraceptive were defined as modern methods of family planning.

Result-

A total of 100 women were approached and 75 consented to participate in this study, giving a response rate of 75%. Of these, 25 women were excluded, either due to incomplete questionnaires or they excused themselves before completing the questionnaire due to lack of time.The majority of the women (75, 86.67%) reported that they had heard about contraceptives and mentioned one or more.

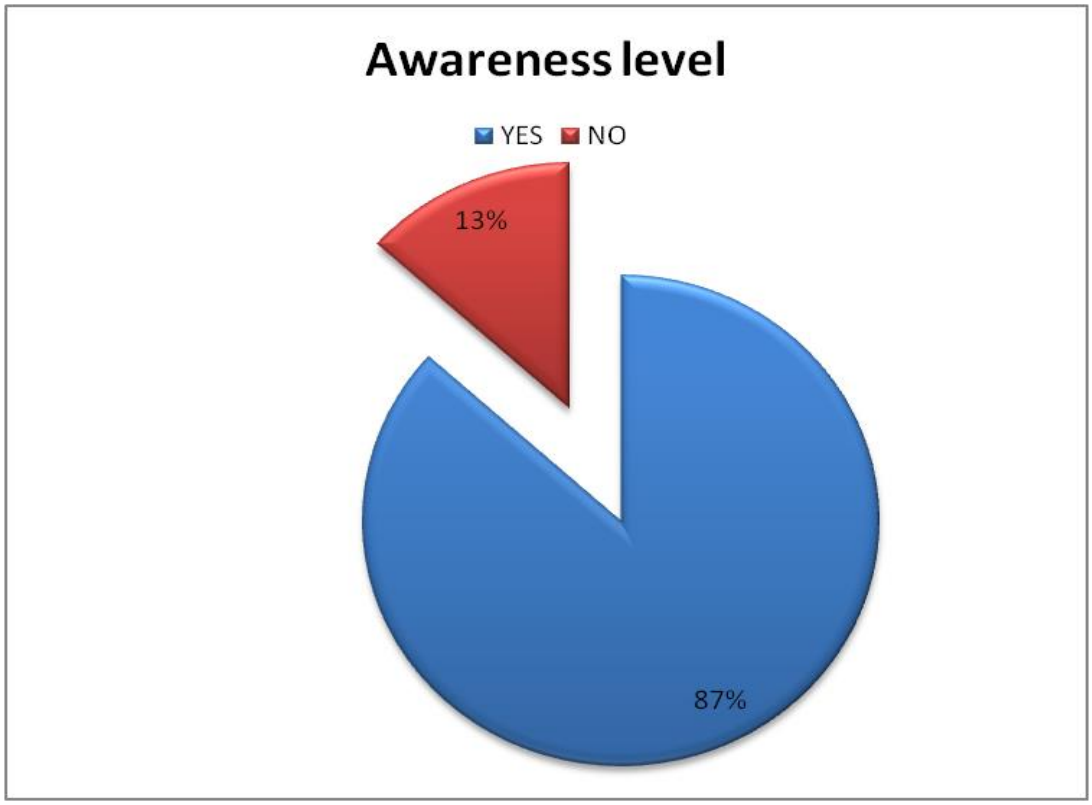

Figure 2.7.1

The current usage of family planning methods among 75 married women are 53.33%.

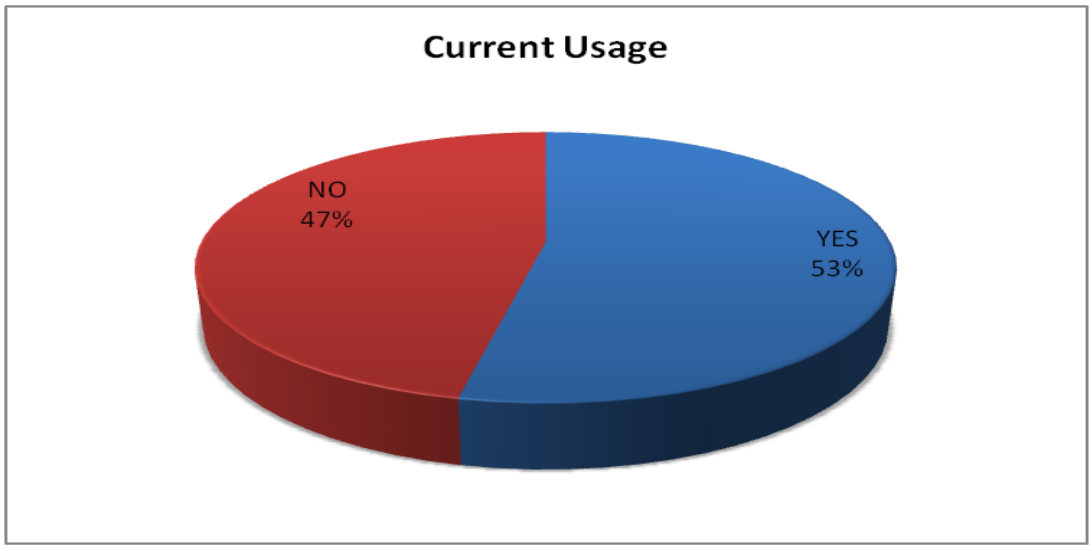

Figure 2.7.2

Modern methods of family planning (37.33%) were more commonly practised among those who currently use family planning method. The use of traditional or natural method was 7%. And permanent method was 9%. IUDs (24%) and pills (11%) condoms (18.33%)were the most common specific methods identified in current practice with the studied women. And individually modern method of family planning for men is (13.33%) and permanently method is (1%).

Most of the women who currently use contraceptives (49%) mentioned child spacing and, (49%) women did not want have more children as the most common reason for using them. In addition, 2% of the women used contraception as easy to use..

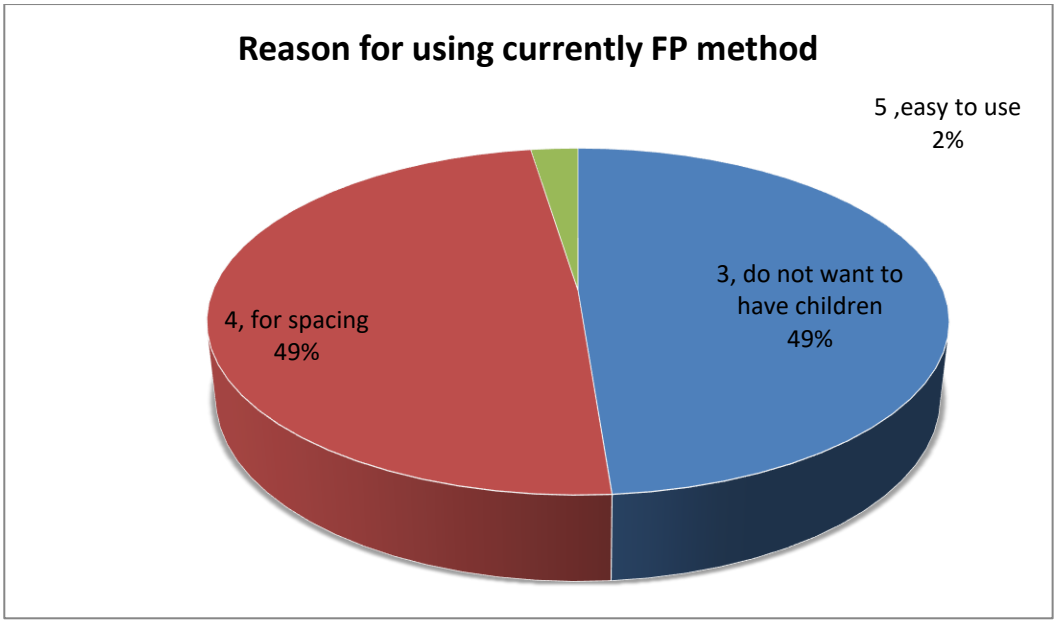

Figure 2.7.4

The most common complications identified by the women were bleeding, severe headache, abdominal pain, vaginal discharge and irregular menses.

On the other hand women never using any contraception believed that contraceptives have major side effects (12%), also not aware of family planning method are (12%) and having misconceptions 76%

Among men the most common method is condoms(97%) and very less percentage men having permanent method(3%).

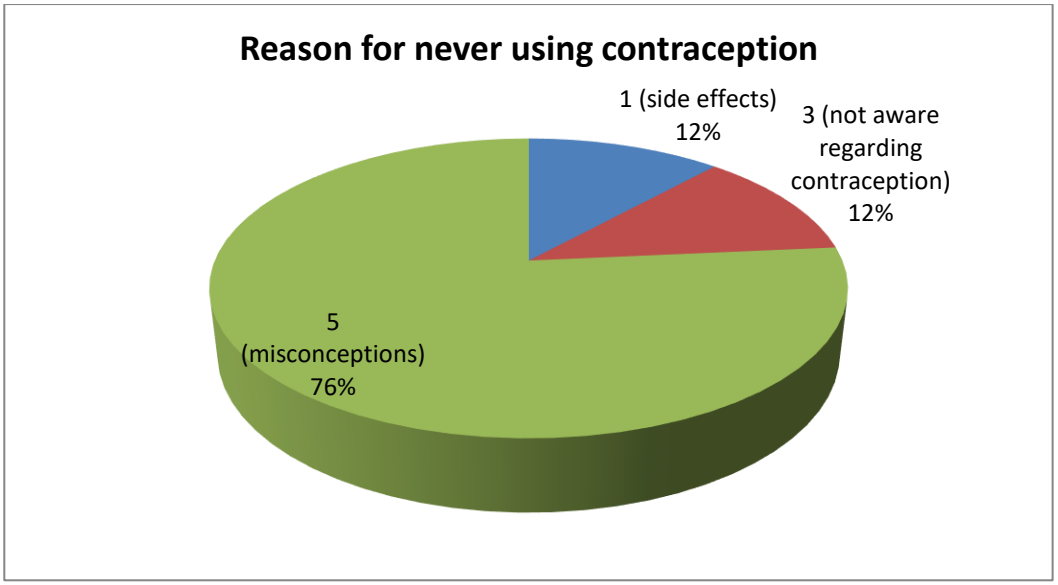

Figure 2.7.5

Among men the most common method is condoms (97%) and very less percentage men having permanent method (3%).

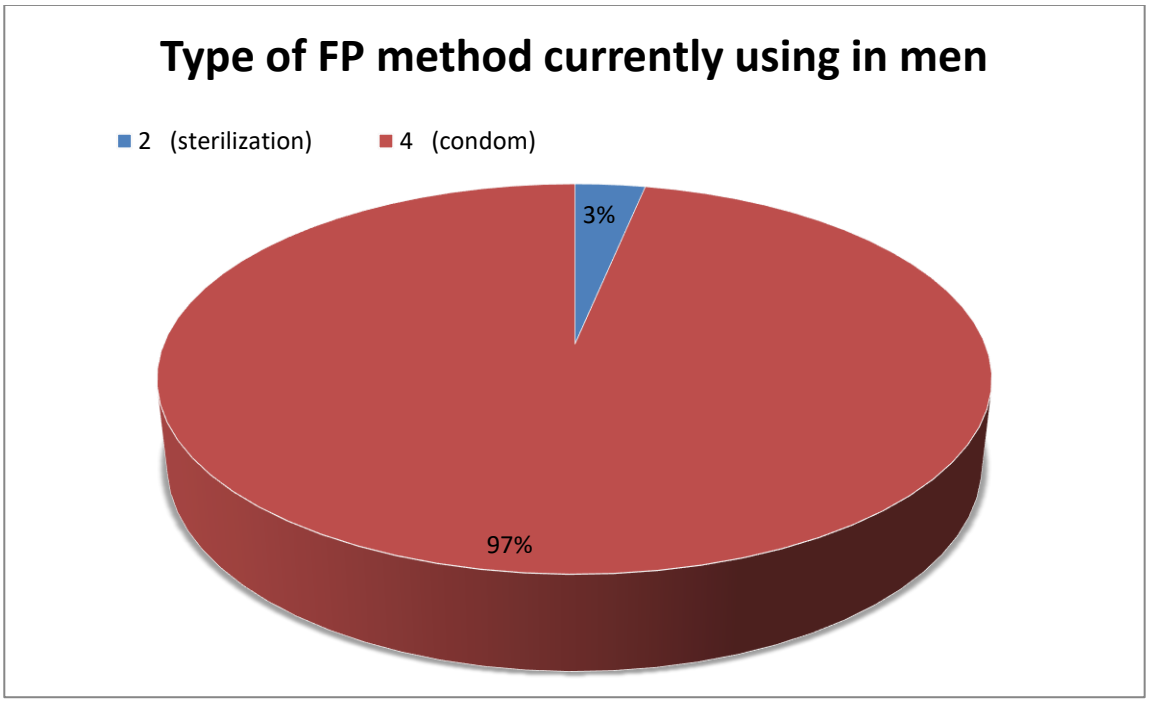

Figure 2.7.6

Determinants of contraceptives

- ✓ Education of respondents is directly proportional to the contraceptive awareness level. As education level is increasing percentage of awareness level is also increasing.

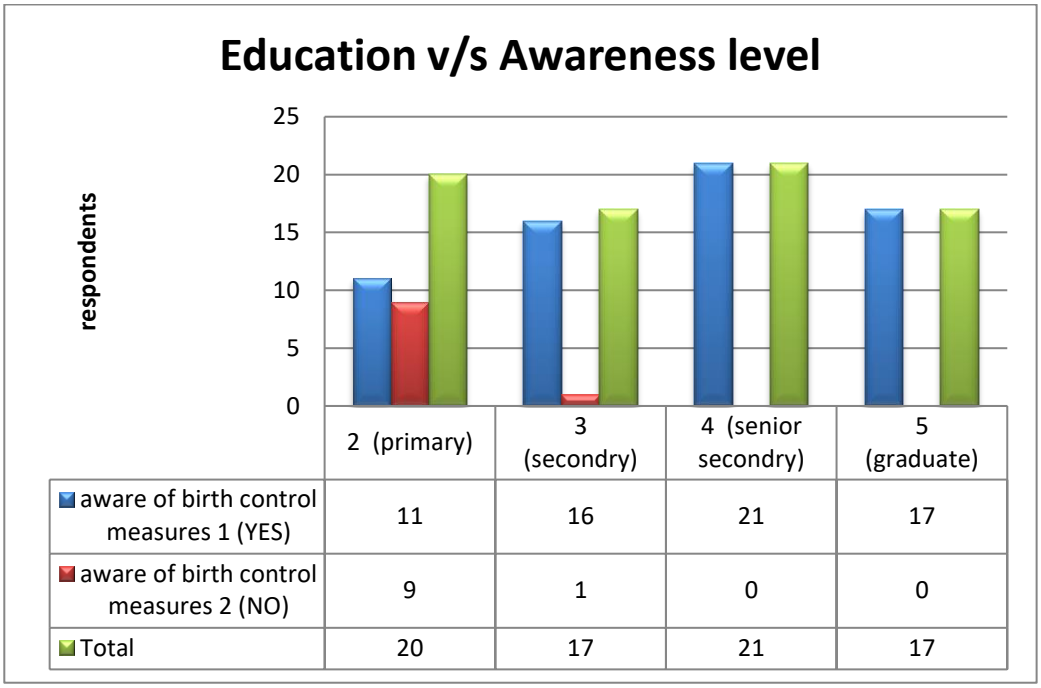

Figure 2.7.7

Education level	**Awareness (%)**
Primary-	**55%**
Secondry	**94%**
Senior secondry	**100%**
Graduate	**100%**

- ✓ Among women as age is increasing the awareness level is also increasing. All women are aware regarding contraception who belongs to age group 30-34 and 40-44.

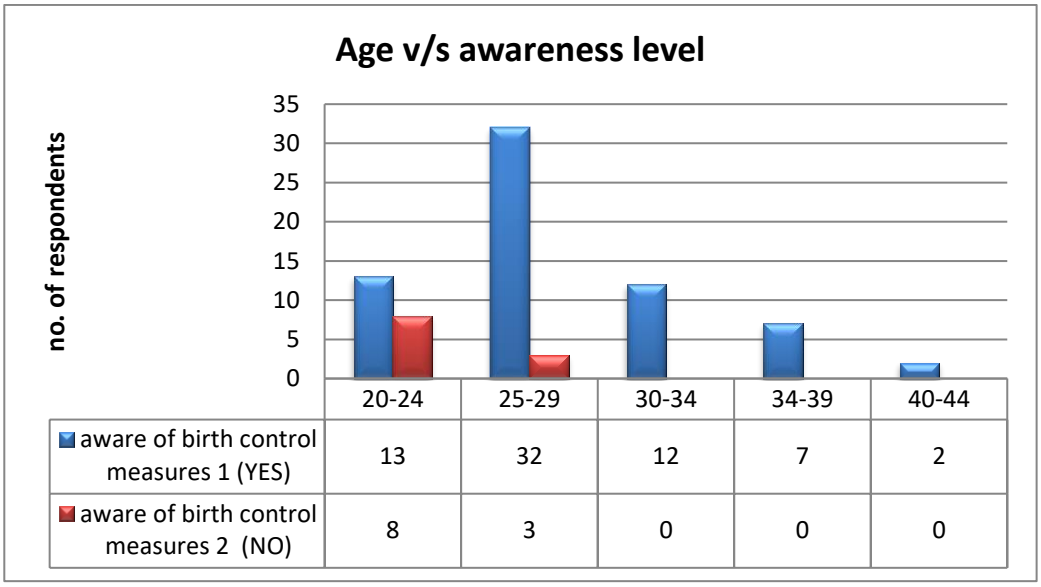

Figure 2.7.8

Age	**Awareness level (%)**
Age group (20-24)	**61%**
Age group (25-29)	**91%**
Age group (30-34)	**100%**
Age group (35-39)	**100%**
Age group (40-44)	**100%**

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- ✓ Women who delivered either at government institution or private they are aware regarding contraception in comparison to home delivery

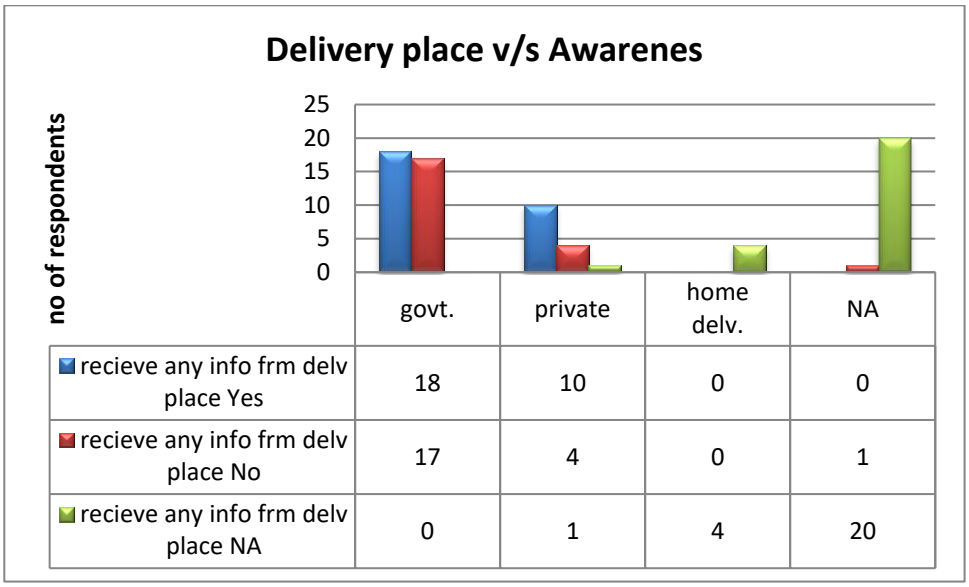

Figure 2.7.9

Delivery place	Awareness level (%)
Government	51%
Private	71%
Home delivery	0%

Women who got married in age group 15-19 more unaware than those women who got married in age group 20-24 and those women who got married in age group 25-30 none of them unaware regarding contraception.

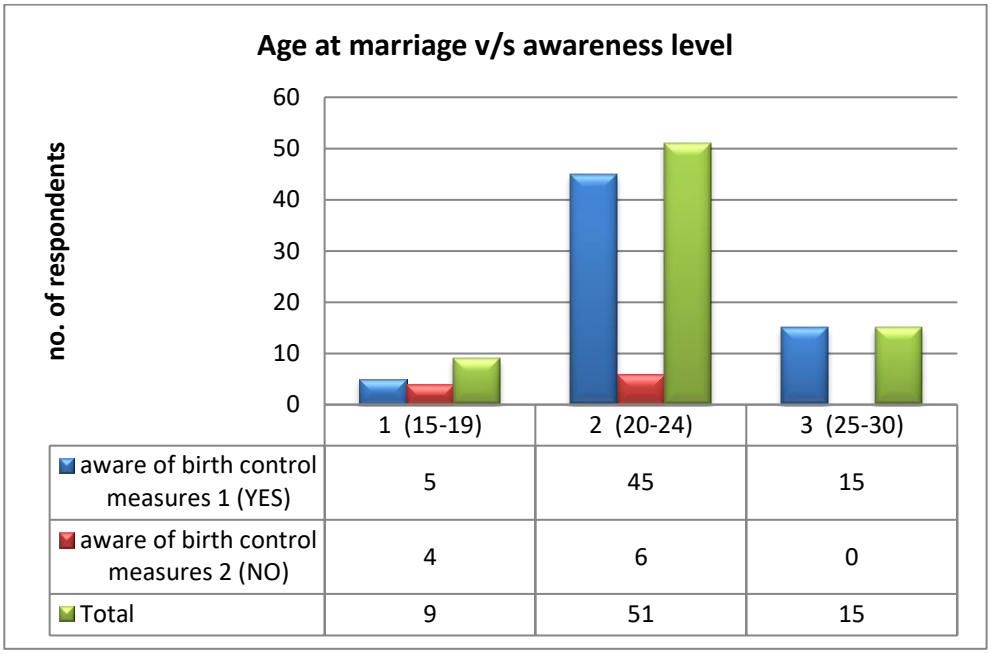

Figure 2.7.10

Married age group	**Awareness level**
Age group 15-19	55%
Age group 20-24	88%
Age group 25-30	100%

Internet (40%), Television/ radio (34%) and Friends (29%) government doctors (24%)were the most common also source of knowledge about family planning methods.

And other sources are like NGO/field workers (1.33%) and private doctors(5.33%) were uncommon sources of knowledge about family planning.

Discussion

This study examines the reasons for not using any method of contraception as well as reasons for not using any family planning methods now among participants who previously used contraceptives, and factors associated with the future intention to types of contraceptive use in the styudy area Panchkula, Haryana.

It has been widely perceived and accepted that the use of contraception is a matter of mutual agreement between the spouses, but there may possible opposition from the respondent or the husband or others or some religious prohibition as mentioned in the analysis.

In 2009, 48.3% of married women were estimated to use a contraceptive method, i.e. more than half of all married women did not. And the current usage of family planning method is 53.33%.

Studies have indicated that female literacy levels are an independent strong predictor of the use of contraception. And also in current study literacy is the strong predictor of use of contraception.

Fear of side effects also may cause of not using any contraceptives.

Reason for never using any contraception believed that contraceptives have major side effects (12%), also not aware of family planning method are (12%) but if we will compare to the previous study reason for side effects was (21.6%) and among men the most common method is condoms(97%) and very less percentage men having permanent method(3%).

A comprehensive measure to improve the use of contraceptives is to make women aware of the source and availability of contraceptives and how to choose the method effectively. Only lack of knowledge could not be the reason for non-use as evident from this study. Those who were exposed to family planning messages through mass media have a higher chance of contraceptive use in comparison to those who are not exposed.

Motivation and counseling for future use of contraception play an important role in change of attitude towards the use of family planning

According to the study, there is a tendency among the respondents to agree to use any method of contraception with increasing number of living children. The indication is positive in a way that women wish to control their fertility by adopting the use of contraception to attain the desired family size. This study also suggests that women advised to use contraceptives (any method or traditional methods of contraception) were more likely to comply with future contraceptive use. This indicates that if proper counseling is administered in a community, the likelihood of adoption of contraception will increase.

In conclusion, this study documented varying degrees of concerns related to reasons behind the apprehension and future intention to use contraceptives. As previous studies have documented, the challenge becomes significant when opposition to use, unawareness, and low education are the prime barriers to the use of contraceptives.

Conclusion

The conventional approach of analysing determinants of contraceptive use has been exploring the effect of a given characteristic of women on the use of different contraceptive methods using a number of statistical procedure. In this study, we have compared contraceptive use among groups of women with distinct demographic, economic, cultural, and social characteristics.

Women in India is to produce the desired number of children quickly with little spacing between successive births and then opt for terminal methods of contraception to stop childbearing.

Right since its inception in 1952, the programme has focused on birth limitation rather than birth planning. The programme preoccupation with birth limitation also appears to be an important factor in its inability to engage young married women- women in the process of building their family— and enable them to realise their family planning intentions. It has also resulted in highly skewed contraceptive method mix and Hindu-Muslim divide in the contraceptive use pattern. This approach of meeting the family planning needs of women appears to be reaching its limit. Future increases in contraceptive prevalence in India will be contingent upon meeting family planning needs of young married women who are in the process of building their family and not the family planning needs of women who have completed their family building process.

Recent studies suggest that the demand for family planning in these women is quite substantial. Family planning services delivery system must meet this demand. From the

policy and programme perspective, the findings of the analysis are significant. In the context of universal access to family planning services, there is a need to enhance the needs effectiveness and increase the capacity efficiency of organised family planning efforts so that these efforts can address specific family planning needs of women with distinct social, economic, and personal characteristics as revealed in the present analysis The reach of family planning efforts in the country is quite substantial but this reach is virtually confined to specific groups of women.

It is the need of the time that family planning efforts in India explore the determinants of different contraceptive preferences and choices across different women groups and reinvigorate themselves to address these preferences and choices in an efficient yet cost effective manner.

USAGE OF CONTRACEPTIVES AMONG ELIGIBLE COUPLES IN PANCHKULA, HARYANA
INTERVIEW SCHEDULE

Section 1: General	
1. Name	……..
2. Age	……
3. Gender	Male----------1 ( ) Female----------2 ( )
4. Religion	Hindu----------1 ( ) Muslim----------2 ( ) Sikh----------3 ( ) Christian----------4 ( ) Others----------5 ( )
5. Education	Illiterate----------1 ( ) Primary----------2 ( ) Secondary----------3 ( ) Senior Secondary----4 ( ) Graduate----------5 ( ) Post Graduate and above----6 ( )
6. Monthly Family Income	<5000……1 ( ) 5000-8000……2 ( ) >8000……3 ( ) No……..4 ( )
7. Age at the time of Marriage	…… 15-19……..1 20-24……..2 25-30……..3 >30.....4
8. Age at first delivery	…… 15-19……..1 20-24……..2 25-30……..3 >30.....4
9 a) No. Of pregnancies b) No of deliveries c) No of abortion d) No of living children	 NA.....11 .NA.....11 .NA.....11, No abortion.....12 NA.....11
10. Are you currently pregnant?	Yes----------1 ( ) No---------- 2 ( )
11. Have you recently delivered?	Yes----------1 ( ) No----------2 ( )
12. Where did your last delivery take place?	Government Facility----------1 ( ) Private Clinic----------2 ( ) Home Delivery ----------3 ( ) Others (Please Specify)……4 ( ) NA.....5 ( )
13. Are you aware of any birth control measure?	Yes---------1 No----------2 **(Skip to Section 2**
14.Did you receive any information on contraception from place of delivery	Yes .....1 ( ) No.....2 ( )

15 .Did you receive any contraceptive from place of delivery?	Yes---------1 No----------2 NA.....3
15.a- if yes which contraceptive?	Condoms (male/female)---------- 1 IUCD/Copper T----------2 OCPs----------3 Emergency pills----------4 Injectables----------5 Sterilization (male/female)----------6 Safe period method----------7 Lactational Amenorrhea (LAM)---------8 Withdrawal----------9 NA.....10 Others(please specify)----------
15.b-how many days after delivery?	Within five days after delivery.....1 After five days of after delivery.....2 NA.....3
15.c- still continuing with that contraceptive or switched to any other?	Still Continuing with that.....1 Switched to other.....2 Currently Not using any.....3 NA.....4
15.d-if switched then which one?	Condoms male)---------- 1 Condoms female----------2 IUCD/Copper T----------3 OCPs----------4 Emergency pills----------5 Tubal ligation----------6 Male sterilization.....7 Lactational Amenorrhea (LAM)---------8 Others(please specify)----------9 NA.....10
SECTION-2	
16. From which source did you get information on birth control measures? *(Multiple responses can be recorded)*	Government Workers (ANM/ ASHA/ AWW)----------1 Medical Officers ----------2 Private Doctors----------3 NGO field workers------ ----------4 Friends/Family/Relatives----------5 TV/Radio ----------6 Newspaper/ Magazine/Handouts------7 Street play/Folk media ----------8 Others(please Specify)----------9 Internet.....10 NA.....11
17. Which methods of family planning are you aware of? *(Multiple responses can be recorded)*	Condoms (male/female)---------- 1 IUCD/Copper T----------2 OCPs----------3 Emergency pills----------4 Injectables----------5 Sterilization (male/female)----------6 Safe period method----------7

	Lactational Amenorrhea (LAM)---------8 Withdrawal----------9 Others(please specify)----------10 NA.....11
SECTION-3 Current contraceptive usage	**Type of family planning (FP) method used, reasons for use, complications faced among women who practise**
18. Do you or your husband currently use any family planning method?	Yes----------1 No ----------2 **(Skip Question 24)**
19. For how long have you been using current contraception method?	…… <6months……1 6months-1year……..2 >1year……..3 NA.....4
20. Who out of the couple using contraception method?	Husband only ----------1 **(Skip Question 22)** Wife----------2 Both ----------3 No one.....4 NA.....5
21. Type of family planning method being currently using among women *(Multiple responses can be recorded)*	Abstinence ……1 Vaginal cream……2 Tubal ligation……3 Breast feeding……..4 Safe period……5 Withdrawal……6 Condom……7 Pills……8 Injectables……9 loop (IUD)……10 NA.....11
22. Type of family planning method being currently using among men?	Abstinence ……1 Sterilization.....2 Withdrawal……3 Condom……4 NA.....5 No one.....6
23. Reasons for using current FP method	Economic ……1 Physician's advice……2 Do not want to have children……3 For child spacing……4 Any other, please specify.....5 NA.....6
Section D Previous Contraceptive Methods (EVER USED)	
24. Have you used any contraceptive in the past?	Yes.....1 No.....2 **(Skip to 29)** Never used.....3
25. If yes, then describe for women	Name used Duration a) abstinence.....1 b) Vaginal cream.....2 c) Tubal ligation.....3

(Multiple responses can be recorded)	d) Breast feeding……..4 e) Safe period……5 f) Withdrawal……6 g) Pills……..7 h) loop (IUD)…….8 i) female condoms.....9 …… <6months……1 6months-1year……2 >1year……..3
26. for men	a) Male condoms.....1 b) Vasectomy.....2 c) Others.....
26a. Duration of using condoms	…… <6months……1 6months-1year……2 >1year……..3
26b.duration of vasectomy	…… <6months……1 6months-1year……2 >1year……..3
HISTORY & REASONS OF DISCONTINUATION	
27.Reasons for discontinuation	Side effects.....1 Contraceptive failure.....2 Medical conditions.....3 Wanted pregnancy.....4 Want to switch other methods.....5 Any other.....6 NA.....7
28. History of side-effects (*Multiple responses can be recorded)*	Reduced breast milk……1 Back pain……..2 Irregular period/absence of period……3 High blood pressure……4 Anxiety……5 Intrauterine device rejection……6 Nervous/heart palpitation……7 Got pregnant ……8 Nausea and vomiting……9 Obesity……10 Vaginal discharge……11 Abdominal pain ……12 Severe headache ……13 Bleeding ……14 Any side-effect……15 NA.....16 No side effects.....17

29.Reasons for never using contraceptives	Side effects.....1 Menstrual irregularities.....2 Not aware regarding contraceptives.....3 Not aware of its uses .....4 Misconceptions.....5 Improper guidance by health providers.....6 B,coz husband is using.....7 NA.....8
30. Reasons for not using any family planning method now among participants who previously used contraceptives? (multiple responses can be recorded)	Currently Pregnant……1 Want a child……2 Fear of side effects ……3 Opposition from family members ……4 Religious taboo ……5 Unavailability of family planning methods….6 Lack of knowledge about FP methods……7 Economic reasons……8 Infrequent sex……9 Hysterectomy……10 Menopause……11 not reliable……12 husband objection……13 cause major side effects……14 want to more children……15 medical reason……16 Others(Please Specify)……17 NA.....18
31. Any other experience do you want to share regarding contraception?	

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