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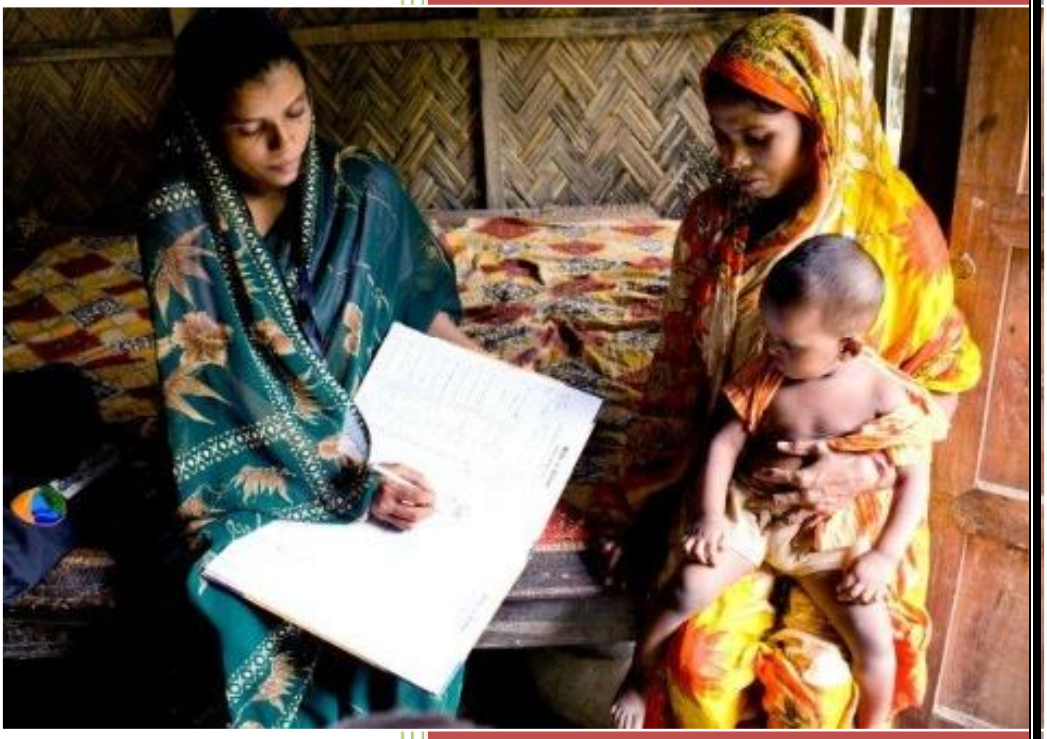
TRACKING THE PERFORMANCE OF FRONTLINE HEALTH WORKERS THROUGH BEHAVIOR CHANGE INTERVENTION PROSPECTIVE



VAISHALI TALANI

PG/10/55

5/2/2012

"TRACKING THE PERFORMANCE OF FRONTLINE HEALTH WORKERS THROUGH BEHAVIOUR CHANGE INTERVENTION PERSPECTIVE"

A dissertation submitted in partial fulfillment of the requirements

For

the award of

Post-Graduate Diploma in Health and Hospital Management with Specialization in Healthcare Information Technology

by

VAISHALI TALANI

PG/10/055

International Institute of Health Management Research

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To Whom It May Concern:

This is to certify that Ms. Vaishali Talani is working as Trainee- Research since March 1st, 2012.

During this period she has worked on the topic "**Tracking the Performance of Frontline Health Workers through Behavior Change Communication Perspective**" under the guidance of Mr. K.L Rao, Senior Manager Communication, Population Service International (PSI).

For and on behalf of Population Services International

Asit Arora
General Manager – Human Resources

Certificate from Dissertation Advisory Committee

This is to certify that **Miss VAISHALI TALANI** a participant of the **Post- Graduate Diploma in Health and Hospital Management, IIHMR , New Delhi** has worked under our guidance and supervision. She is submitting this dissertation titled "**Tracking the Performance of Frontline Health Worker through Behavior Change Intervention Perspective**" in partial fulfillment 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. Preetha G.S
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Certificate of Approval

The following dissertation titled **"VAISHALI TALANI"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory 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.

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Vaishali Talani

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ABBREVIATIONS

FP – Family Planning

GoI - Government of India

IUD- Intrauterine Device

BCC- Behavior Change Communication

IUCD – Intrauterine Contraceptive Device

WHO- World Health Organization

WHP- Women's Health Project

CPR- Contraceptive Prevalence Rate

WRA- Women of Reproductive Age

MA- Medical Abortion

WHP- Women's Health Project

MTA- Medical Termination of Pregnancy

IPC- Interpersonal Communication

IPC's- Interpersonal Communicator

WF- Willows Foundation

CBBC- Community Based Behavior Change

TG- Target Group

NFHS- National Family Health Survey

RCH- Reproductive and Child Health

NRHM-National Rural Health Mission

TFR- Total Fertility Rate

INTERNSHIP REPORT

ORGANIZATIONAL PROFILE

PSI is a global health organization dedicated to improving the health of people in the developing world by focusing on serious challenges like a lack of family planning, HIV/AIDS, barriers to maternal health, and the greatest threats to children under five, including malaria, diarrhea, pneumonia and malnutrition.

A hallmark of PSI is a commitment to the principle that health services and products are most effective when they are accompanied by robust communications and distribution efforts that help ensure wide acceptance and proper use.

In each of its platforms, PSI works in partnership with local governments, ministries of health and local organizations – creating health solutions that are built to last.

MISSION

The mission of PSI is to measurably improve the health of poor and vulnerable people in the developing world, principally through social marketing of family planning and health products and services, and health communications. Social marketing engages private sector resources and uses private sector techniques to encourage healthy behavior and make markets work for the poor.

VALUES

- Making markets work for the poor
- Measuring impact
- Speed, efficiency, and outcomes over process
- Decentralization and empowerment
- Long-term commitment to the people we serve

HISTORY

PSI was founded in 1970 to improve reproductive health using commercial marketing strategies. For its first 15 years, PSI worked mostly in family planning (hence the name Population Services International). In 1985, it started promoting oral rehydration therapy. PSI's first HIV prevention project — which promoted abstinence, fidelity and condoms — began in 1988. PSI added malaria and safe water to its portfolio in the 1990s and tuberculosis in 2004.

HEALTH IMPACT

PSI has an uncompromising focus on measurable health impact and measures its effect on disease and death much like a for-profit measures its profits. In 2010 alone, PSI helped prevent approximately 29 million malaria episodes and 300,000 malaria deaths; 4 million unintended pregnancies; 4 million cases of diarrhea; and 180,000 new HIV infections.

PROGRAM LOCATION

World headquarters in Washington, D.C., presence in 67 countries, European office in Amsterdam.

PEOPLE

More than 8,000 staff at PSI affiliates works in 67 countries. PSI's expatriate staff is about 1% of the overall workforce. Support services and advocacy are provided by staff in Washington, D.C., and Amsterdam, Netherlands.

DONORS

Major donors include the governments of the United States, United Kingdom, Germany and the Netherlands; the Global Fund to Fight AIDS, Tuberculosis and Malaria; United Nations agencies; private foundations; corporations and individuals.

PSI MAGAZINE

Impact is the quarterly magazine of PSI, sent to its donors, stakeholders, and staff in more than 60 countries around the world. *Impact* is a platform to discuss the critical issues facing the global health community. Today, 50 percent of the world's population is under 27 years old. It covers articles for health and well-being of today's tech savvy, civic-minded Millennial generation.

RESEARCH & METRICS

It is the source for PSI's evidence-based decision-making.

PSI uses primary (i.e. its own) and secondary (i.e. other people's) data to monitor and evaluate its programs; estimate the health impact of specific interventions; assess value for money and improve intervention cost-effectiveness; and evaluate the health of the markets PSI works to strengthen.

PSI WORK

PSI is a leading global health organization with programs targeting

- Malaria
- Child survival
    - Diarrheal Diseases
    - Pneumonia
    - Malnutrition
    - Neonatal
- HIV
- Reproductive health
- Non-communicable disease.

Working in partnership within the public and private sectors, and harnessing the power of the markets, PSI provides life-saving products, clinical services and behavior change communications that empower the world's most vulnerable populations to lead healthier lives. Explore specific areas of PSI's focus below.

DISSERTAION

REPORT

ABSTRACT

Introduction: The contraception prevalence rate in India for IUD is lower than all other modern methods and has remained static at 2% since the first National Family Health Survey in 1992-93 (Source NFHS-3). Because of historic reasons there are strong negative perceptions as well as myths and misconception about IUD amongst potential consumer. It has been seen that behavior change communication strategy have major role in contraceptive acceptance among the community. .. Interpersonal communication is a BCC strategy through which frontline health workers establish a contact with the target group and by accessing their needs provide suitable method of contraception. Therefore this study was conducted in order to study the importance of frontline health workers in increasing acceptability and accessibility of IUCD among women through behavior change communication perspective.

Objective: To assess the performance of frontline health workers (Interpersonal communicator- IPC) in providing family planning services through behaviour change communication perspective.

Methodology: Both qualitative and quantitative technique methods were used for the data collection. The study was conducted in two reasons of Delhi ie North East and South West .30 In-depth interviews IUCD users were taken.Two focus group discussions were among the Interpersonal communicator of both the areas

Results: The major finding was that after the training of IPC on behaviour change communication their number of insertion per IPC were increased . Majority of TG had never heard before about the IUCD but they were only ready for the insertion due to perfect counselling done by frontline health workers. These health workers remove the myths and cultural beliefs about the IUCD by using various IEC materials like flash cards, uterus model, informed choice basket etc.

Conclusion: The study highlighted the untapped potential of frontline helath workers so it is recommended that in public sector also the BCC training should be provided so that performance of frontline health workers like ASHA , AWW could enhance as they are the heart of all the MOHFW health projects

CHAPTER 1 INRODUCTION

BACKGROUND:

Many couples in India never use a reversible method of contraception to delay or space births, but instead adopts sterilisation as their first and only method of Family Planning (FP). Unmet need for FP is as high as 33.8% in UP, followed by Rajasthan and Delhi at 17.9% and 13.9%, respectively.(NFHS-3)[3] . Despite the focus of Government of India (GoI) and many large international donors on FP and institutional deliveries in India, substantial programmatic gaps remain. Long-standing barriers to FP use include inadequate access and poor awareness about spacing methods, biases among medical providers against the Intra-Uterine Device (IUD) and missed opportunities for postpartum FP. The GoI recognizes that family planning can play an integral role in reducing maternal morbidity, but after more than forty years of implementing a national FP program, only about 50% of married women use a modern method of family planning. There is still limited availability of contraceptive choices and lack of emphasis on spacing

Behavior Change Communication

According to a study conducted in Gujrat (M&E, 2006), behavior change communication or BCC strategy have large share in contraceptive acceptance among the community. Many factors are responsible for the success of IUD in a community which may include providing a supportive policy environment, commitment for providing appropriate information about the method to clients, removing all myths and misconceptions about the IUCD , improving the counseling skills of providers This all can be achieved through effective BCC strategy including interpersonal communication with women, as it has been seen in India that talking about family planning in a house is a taboo. Women feel ashamed of talking about contraception with husbands and other family members. Various myths , cultural beliefs , family constraints are some reason due to which women can't even think of using contraception , in which adopting

IUCD is a very major decision of which some women can't even think due to the current prevailing situation. BCC is a process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory method**s.**

Frontline health workers are the key people through which we can change the mind set of the women. They are first and only link in some remote areas where no other facilities are available. Through behavior change these frontline health workers can remove the myths and social taboos prevailing in the community. These workers have untapped potential which can be used to foster the acceptability of IUCD among the women

FRONTLINE HELATH WORKERS

Who are Frontline Health Workers?

Frontline health workers are respected village women with basic educations who are trained to advocate for their community when they need to access the public health system. They are the backbone of effective health systems – often based in the community and come from the community they serve, they play a critical role in providing a local context for proven health solutions, and they connect families and communities to the health system. They are the first and only link to health care for millions of people, are relatively inexpensive to train and support, and are capable of providing many life-saving interventions .They are often based in the community and come from the community they serve; they play a critical role in providing local context for scientific evidence and in connecting families and communities to the health system. Examples of frontline workers include community health workers, peer counselors, shopkeepers who sell medicines, and unqualified medical practitioners. In some settings, nurse midwives and even physicians may be considered frontline workers. .Frontline healthcare workers can play a vital role in saving the lives of women and children. They may not be Hollywood stars, but they have

a huge impact on their communities. They are the first point of contact for families with the health system, and are capable of providing many life-saving interventions.

Why frontline health workers are a good investment:

1. Frontline health workers are the backbone of effective health systems and the only way to serve millions of families who live beyond the reach of hospitals and clinics;
2. Frontline health workers are relatively inexpensive to train and support. It can cost as little as $300 to train a frontline health worker in crucial lifesaving skills;
3. Frontline health workers are less likely to migrate from their communities to search for higher paying jobs;
4. Frontline health workers are trusted in their community and deliver services in synch with local needs and cultural beliefs, and can help ensure care reaches those who need it most.

These frontline health workers can play a significant role in IUCD acceptance among the community. As they are the only first direct contact with the community so they can provide supportive environment for IUCD acceptance, eliminate myths and misconceptions about IUCD by providing accurate information about the various family methods to the client and giving the best contraceptive method according to the need of the client by using various tools of behavior change communication.

PROGRAMME BACKGROUND

Population Services International India (PSI/India) is currently implementing a five year (2008-2012) integrated behaviour change program for better health of women, named ‘PEHEL’ ('an initiative' – in Hindi), in **Uttar Pradesh** (Agra, Kanpur, Lucknow, Varanasi, Bareilly, Gorakhpur, Barabanki, Mirzapur, Firozabad and Ghaziabad), **Rajasthan** (Sriganganagar, Jaipur, Alwar, Jodhpur, Ajmer, Pali, Kota, Tonk and Bharatpur) and **Delhi** (as a whole) to support the GoI efforts for improving the health and quality of life of vulnerable and poor women in India by increasing the modern contraceptive prevalence rate (CPR) from 50% to 52% (excluding

permanent methods) by 2012, increasing women of reproductive age (WRA) using an intra-uterine devices (IUDs) from 3.0% to 4.1% by 2012 and increasing access to medication abortion (MA) through the sale of 300,000 MA kits. With the goal to reduce unintended pregnancies and maternal mortality among low income women of reproductive age, the program aims to build a sustained enabling environment through advocacy efforts, harnessing the power of the private sector and using social marketing to increase the use of IUDs and Medical Abortion. The program caters to the target population of Women of Reproductive Age (WRA) in 15-49 age groups, living in urban and peri-urban areas, belonging to the B, C and D socio-economic groups, and non-sterilized couple. This Women's Health Project (WHP) PEHEL programme comprises of two components i.e. prevention of unwanted pregnancy using IUCD and increasing access of safe and legal Medical Termination of Pregnancy.

Willows Model of IPC approach being implemented by the Willows Foundation in Turkey

WILLOWS MODEL, TURKEY

Willows model (Murphy, 2008) is an integrated approach to community based model in which overall reproductive needs of the women are addressed. This model works on the interpersonal communication strategy of Behavior Change Communication. In this community health workers are selected from the community and trained on the reproductive health services. This model has helped in changing the reproductive health if the community .The life of the project is 18 months. This model aims to approach in identifying the intended beneficiaries and the hurdles they face regarding reproductive health. It was seen that many women were not in regular contact with the health system or not returned to health clinics after having had negative experiences. Then Willows provided training to health workers to improve both clinical services and the quality of interpersonal communication and counseling. The latter is critically important because the quality of client-provider interactions strongly influences health-seeking behaviors everywhere in the world.

Focus On Interpersonal Communication

PSI is providing reproductive health service by focusing on two components first is provision of

family planning services on the supply side and second is through behaviour change communication using IEC material on demand generation side. PSI followed a two fold approach; to improve access to quality IUCD product and services, by creating a large network of qualified private providers and creating demand through mass media and Inter Personal Communication (IPC) channels.

On-ground behavior change communication was the backbone of demand generation interventions. PSI's expertise on interpersonal communication (IPC) was the mainstay of the on-ground communication activities. To reach out to target group (TG), PSI recruited about 250IPCs in the program areas. PSI carved out clusters within a program area and pre identified TG (based on current FP status) and deputed a static number of TG per IPC in a given cluster. This study focuses on the importance of frontline health workers in increasing accessibility and accessibility of IUCD among women of reproductive age group through Behavior Change Communication perspective.

CHAPTER 2.LITERATURE REVIEW

India was the first country in the world to start a National Family Planning Programme in 1956. The programme remained centred around adopting permanent methods, with very little adoption of spacing methods. In 1997, the Government of India adopted the Reproductive and Child Health (RCH) Programme which advocates a client-centered, demand-driven and target-free approach with emphasis on spacing methods for quality reproductive life and promotes responsible and Planned Parenthood. In 2005, the Government of India launched the National Rural Health Mission (NRHM), which subsumes the second phase of RCH Programme, advocating the same approach for achieving quality reproductive life. The National Population Policy 2000 has recognized as its immediate objective the task of addressing the unmet need for contraception to achieve the medium term objective of bringing the Total Fertility Rate (TFR) to replacement level of 2.1 by 2010 so as to achieve the long-term goal of population stabilization by 2045. As per National Family Health Survey (NFHS-3), the contraceptive prevalence rate in India is 56.3%, which varies widely between different States. The unmet need for family planning is high at 13%, with unmet need in spacing methods at 6%. The current approach in family planning emphasizes on offering high quality contraceptive services among eligible clients on a voluntary basis with spacing methods as an important component. However, the acceptance of spacing methods still remains low in the country. It is an established fact that use of spacing methods can effectively reduce Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). Studies indicate that children born less than two years after a previous birth are nearly three times at greater risk of death than children whose mothers waited three years between births (NFHS-3). Hence, promotion of spacing methods would not only contribute towards reduction in TFR but also in reduction of MMR and IMR.

A study conducted by FHI 360 reveals that the IUD is a highly effective contraceptive method (pregnancy rate < 1%) and does not require constant attention. It does not interfere with

intercourse and there is a quick return of fertility once woman stops using the method. As the IUD can be used for at least 10 years, its use will be less expensive than most temporary methods. This is an important consideration for countries where contraceptive security is an issue, such as with the Ministry of Health and Family Welfare (MOHFW). The evidence from various projects trying to increase use of the IUD suggests several factors as conditions for success. They include providing a supportive policy environment for the repositioning of the IUD, a commitment to provide accurate information about the method to clients, eliminating myths and misconceptions about the IUD using appropriate behavior change communication (BCC), upgrading of the technical and counseling skills of health care providers, mechanisms for follow-up and resolving supply constraints to meet the emerging demand.

A study conducted in Gujarat on the user experience of IUD users showed that there are various myths and misconception prevailed in the community, counseling by HCP or health care provider was found to be the major reason through which we can eliminate the cultural beliefs. It was found that their was less removal of IUD among the IUD users if the client was properly counseled.

Results of FHI based study on the reposition of IUCD 375 revealed that majority of healthcare providers favored the no touch technique if IUCD 375 and agreed that it is easy to insert cultural beliefs and taboos are the major barrier for non acceptance of IUD. () Acceptance of IUD in the community requires its high demand, ensure supply, supportive environment for provider. Various studies in India have shown lack of accessibility to these modern contraceptive methods in rural areas compounded with myths and misconceptions about the method, limited educational about the method , provider bias against the IUD are serious barriers to IUD use (Santhya 2003, Mishra and Retherford 1999, Khan et al 1999, NFHS 2006, Gandotra and Das 1996. It is shocking to see that temporary use of contraceptive prevalence in India is 10.2% but of modern methods like IUD is only 2%. (NFHS, 2006) Supports of Government of India in launching a national program for emphasizing on IUD adoption have given importance to this method. Various studies conducted in the past have shown high rates of discontinuation of IUCD especially in rural areas but very few studies have been conducted for determining the responsible contributing factor for the same. It has been emphasized that there is an urgent need to increase its use for which we have to plan for providing quality service to the client by

eliminating the myths and misconception prevailing in the community through effective BCC strategies.

CHAPTER 3 RATIONALE OF THE STUDY:

The contraception prevalence rate in India for IUCD is lower than all other modern methods and has remained static at 2% since the first National Family Health Survey in 1992-93 (Source NFHS-3). Because of historic reasons there are strong negative perceptions as well as myths and misconception about IUCD amongst potential consumer. It has been seen that behavior change communication or BCC strategy have major role in contraceptive acceptance among the community. Hence IUCD use and demand can be increased through major tool of behavior change communication ie interpersonal communication. Interpersonal communication is a BCC strategy through which frontline health workers establish a contact with the target group and by accessing their needs provide suitable method of contraception these frontline health workers can play a significant role in IUCD acceptance among the community. As they are the only first direct contact with the community so they can provide supportive environment for IUCD acceptance, eliminate myths and misconceptions about IUCD by providing accurate information about the various family methods to the client and giving the best contraceptive method according to the need of the client by using various tools of behavior change communication.

Hence, there was a need to highlight the untapped potential of frontline health workers through which they can create a suitable environment for acceptance of IUCD in a community. Therefore in order to study the importance of frontline health workers in increasing acceptability and accessibility of IUCD among women through behavior change communication perspective.

CHAPTER 4 OBJECTIVES OF THE STUDY

The main objective of the study is:

"To assess the performance of frontline health workers (Interpersonal communicator-IPC) in providing family planning services through behaviour change communication perspective"

Specific Objectives:

- ✓ To assess the performance of frontline health workers (IPC's) in providing family planning services to the target group women after the behaviour change communication training.
- ✓ To study the user experience satisfaction , acceptability and accessibility of IUCD with respect to behaviour change communication
- ✓ To seek the opinion of frontline health workers on the effect of behaviour change communication training in improving their interpersonal communication with the target group.

CHAPTER 5 DATA SOURCE & METHODOLOGY

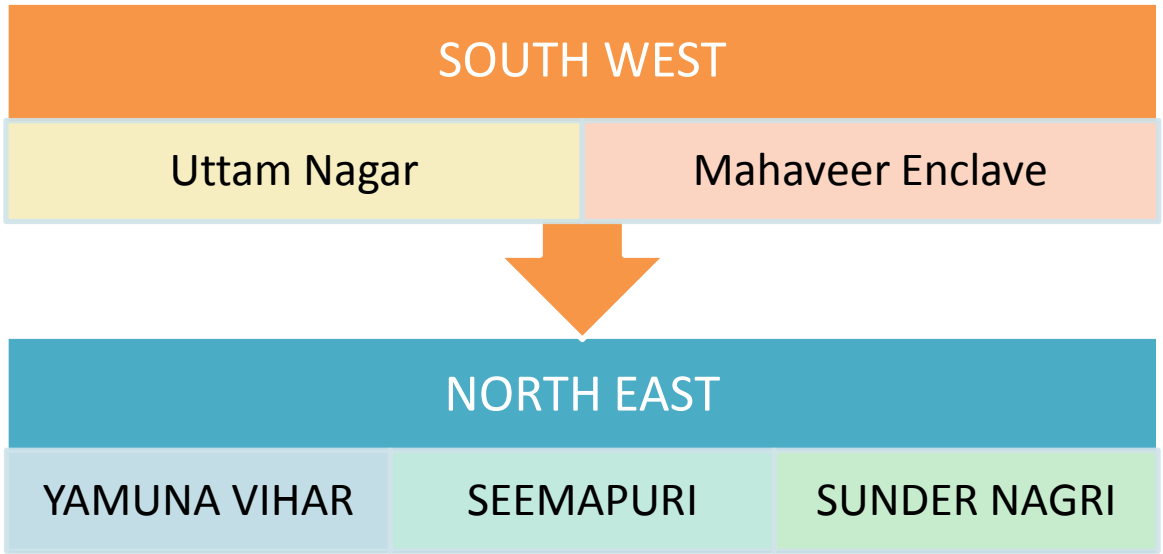
The methodology adopted includes both qualitative and quantitative technique of data collection. All the frontline health workers are termed as IPC ie. Interpersonal communicator (IPC), every cluster has coordinating IPCC (Interpersonal Communication Coordinator). In Pehel Project, Delhi region total no of IPC working was 30. So in this study we have tracked the performance of all the 30 IPC's. These IPC were trained for on the behavior change community based model for improving the reproductive health in the community.

5.1 Study area

Study was conducted among the two clusters of DELHI ie south west and north east.

Both the clusters were divided into further small clusters:

Fig 1.1



5.2 Sample size and Respondent groups

Table1.1

DELHI				Eligible women	Target Group		
DISTRICTS	**Locality**	**Area Name**	**Population**	**women in rep age group (15-49)**	**Non Users of Any FP**	**Women using IUD as a method of Contraception**	**Number of IPC appointed**
South West	Uttam nagar	Binadapur , Mohan Garden , Milap Nagar, J.J colony	2,66000	53,400	23,229		10
	Mahaveer Enclave	Vijay Enclave	1,45,000	26,463	11,511		7
North East	Yamuna Vuhar	Brijpuri	80,000	10,220	4,446		3
	Seema puri	New Seema puri	1,07,000	19,528	8,494		5
	Sunder Nagri	5/6 blocks	1,00,000	18,250	7,939		5
TOTAL			6,98,000		55,619	15,898	30
Total Sample Taken						30	30

- ✓ **From the total IUD users we selected 30 women who are currently using IUCD as contraceptive method**
- ✓ **We selected all the 30 IPC's present in the programme to track their performance**
- ✓ **2 Focus group discussion in two clusters (North East and South West) with both 10 respondents in each area.**

5.3 Sampling Design

From the total population in each cluster currently married women from the age of 15-45 were identified and among them we targeted the women who are currently using the IUCD as method of family planning or are in a need of any method of contraception.

This information about the background of the women was taken from the house listing data bank with the Interpersonal Communication Coordinator, PSI.

To assess the performance of IPC's secondary data was collected on the pre and post training performance of IPC's from Area Communication Manager and MIS department (PEHEL), PSI, India

To seek the knowledge, user satisfaction and behavior of IUCD users' in-depth interviews of the currently married women who have adopted IUCD were taken.

To seek the opinion of Interpersonal Communicator (IPC 's) on the effect of behavior change communication in improving their interpersonal communication skills with the target group two focus group discussion were done in both the areas South West and North East.

5.4 Study Instruments

Three type of study instruments were used which include:

- Qualitative In-depth Interview Guide to seek the knowledge, user satisfaction and behavior of IUCD users' in-depth interviews of the currently married women
- Focus group discussion Guide for seeking the opinion of IPC's on effect of behavior change communication in improving their interpersonal communication skills with the target group (TG)

CHAPTER 6 KEY FINDINGS AND RESULTS

6.1 OBJECTIVE 1.

To assess the interpersonal communication skills of frontline health workers (IPC's) in providing family planning services to the target group women after the behaviour change communication training.

Secondary data on area wise number of insertion done per IPC before 45 days of training and after 45 days of training was collected from Area Communication Manager, PSI India.

Total number of IPC in Delhi- 30.

Table 1.2

S. No	IPC Name	Pre Training Phase (Before 45days)	Post-Training Phase(After 45days)	Growth	% Growth	Area	No of IPC's
1	Savita Srivastava	24	28	4	17	New Seemapuri	7
2	Godambari	21	29	8	38	New Seemapuri	
3	Urmila	24	29	5	21	New Seemapuri	

4	Ain Mary	26	31	5	19	New Seemapuri	
5	Shilpi Vajpai	28	29	1	4	New Seemapuri	
6	Anita Sharma	27	29	2	7	New Seemapuri	
7	Shashi Bala	20	27	7	35	New Seemapuri	
8	Suman devi	18	25	7	39	Uttam Nagar	9
9	Vaishali	18	28	10	56	Uttam Nagar	
10	Rekha	30	38	8	27	Uttam Nagar	
11	Surrender	21	21	0	0	Uttam Nagar	
12	Pushpalata	23	30	7	30	Uttam Nagar	
13	Sharmila	16	31	15	94	Uttam Nagar	
14	Seema	21	25	4	19	Uttam Nagar	
S. no	**IPC Name**	**Pre Training Phase (Before 45days)**	**Post-Training Phase(After 45days)**	**Growth**	**% Growth**	**Area**	
15	Sangeeta	23	24	1	4	Uttam Nagar	
16	Manju	21	24	3	14	Uttam Nagar	
17	Sonu	21	30	9	43	Mahaveer Enclave	6

18	Nirmala	17	22	5	29	Mahaveer Enclave	
19	Sharda	16	23	7	44	Mahaveer Enclave	
20	Sumitra	20	22	2	10	Mahaveer Enclave	
21	Santosh devi	18	21	3	17	Mahaveer Enclave	
22	Santosh	14	20	6	43	Mahaveer Enclave	
23	Madhu lata	22	33	11	50	Yamuna Vihar	8
24	Nirmala	13	19	6	46	Yamuna Vihar	
25	Priyanka	12	18	6	50	Yamuna Vihar	
26	Sheetal	13	21	8	62	Yamuna Vihar	
27	Aarti	13	22	9	69	Yamuna Vihar	
28	Jasveer	9	9	0	0	Yamuna Vihar	
29	Puspa	12	19	7	58	Yamuna Vihar	
30	Urmila Tiwari	9	9	0	0	Yamuna Vihar	
	TOTAL	570	736	166	29		

6.1.1 IPC WISE INSERTION IN SOUTH WEST AREA

. **Fig: 1.2**

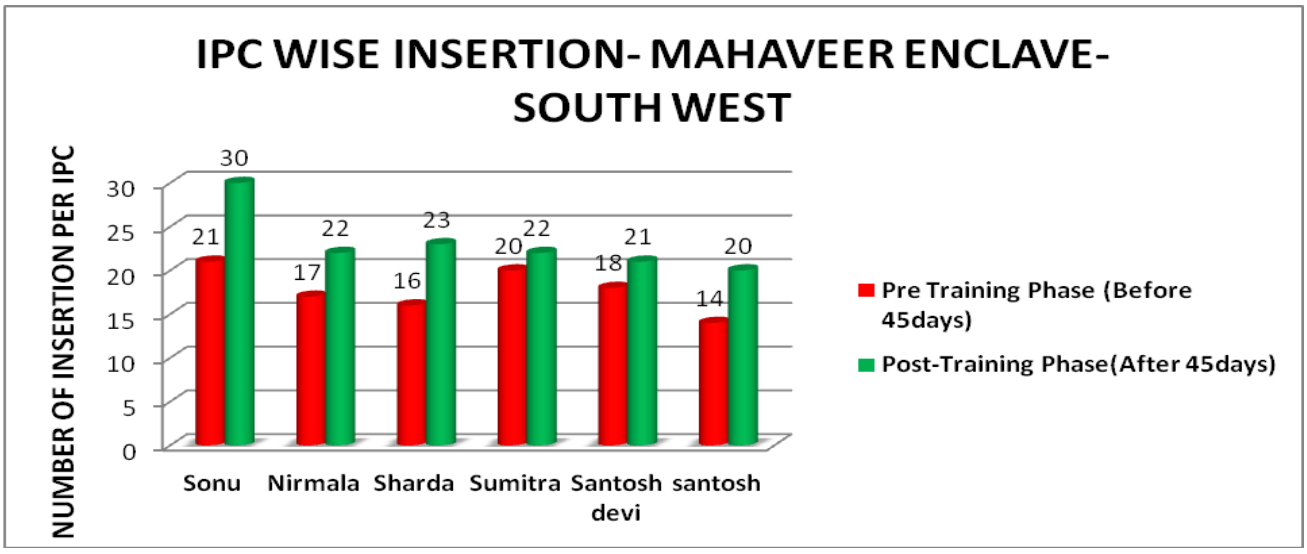


Fig: 1.3

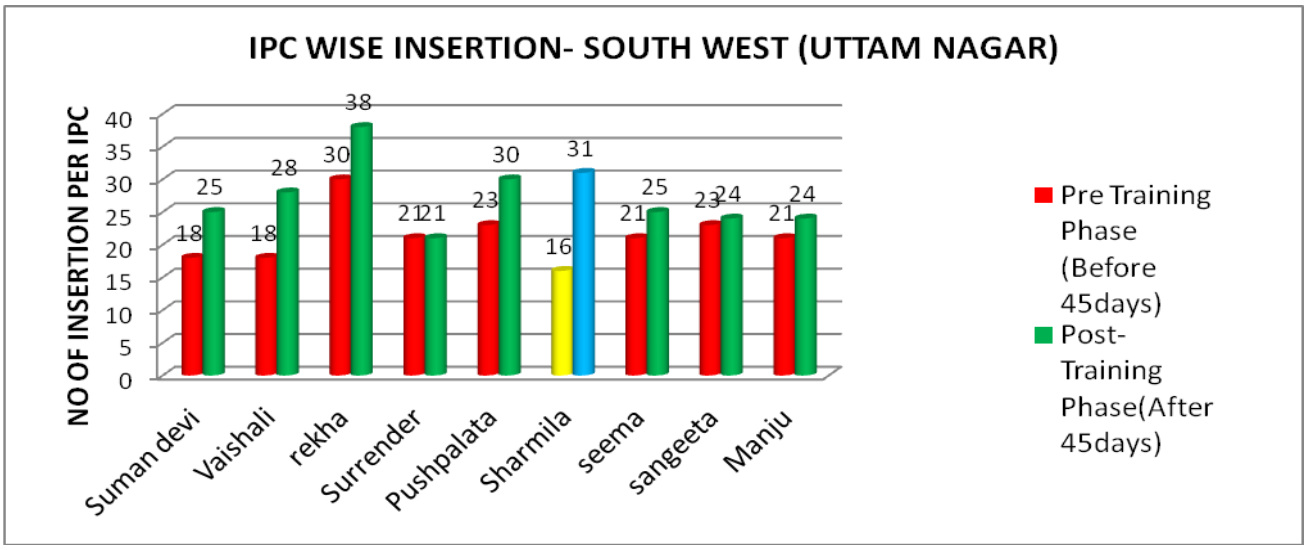


Fig: 1.2 and Fig 1. 3 show the insertion record of the IPC in two south west zones i.e. Uttam Nagar and Mahaveer Enclave. Almost all the IPC showed increased in number of insertion after the training. Only one IPC shows growth of 48% after the insertion. Average growth rate observed was 10.5%.

6.1.2IPC WISE INSERTION IN NORTH EAST AREA

Fig: 1.4

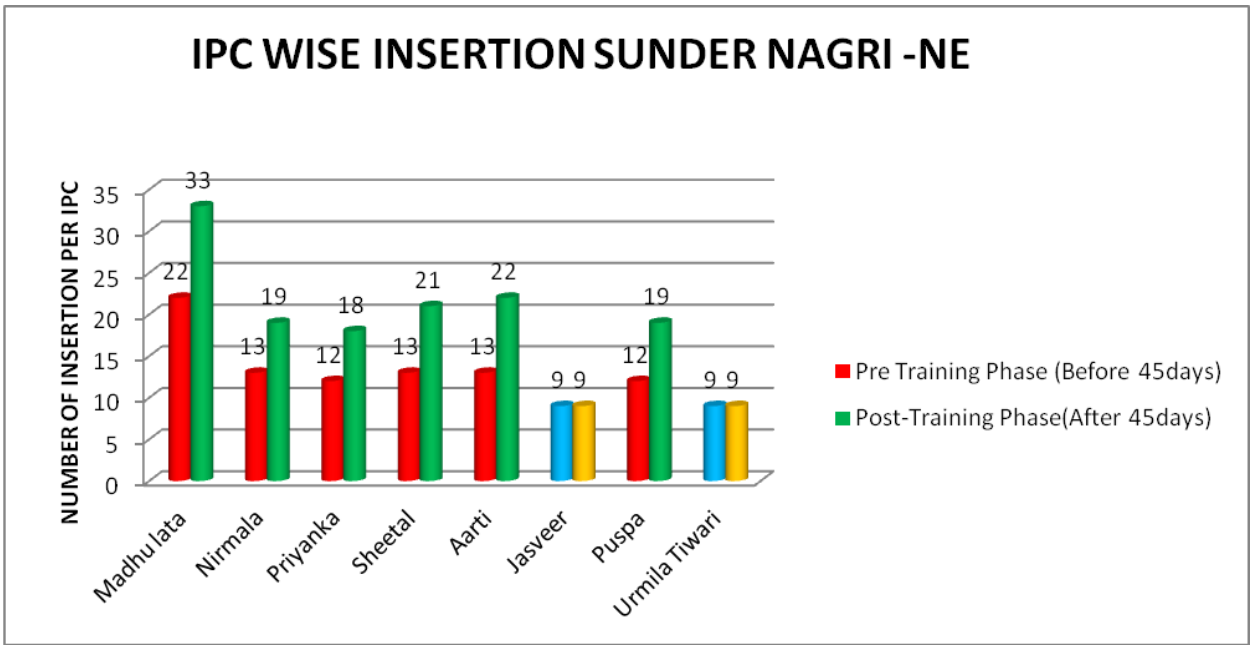


Fig: 1.5

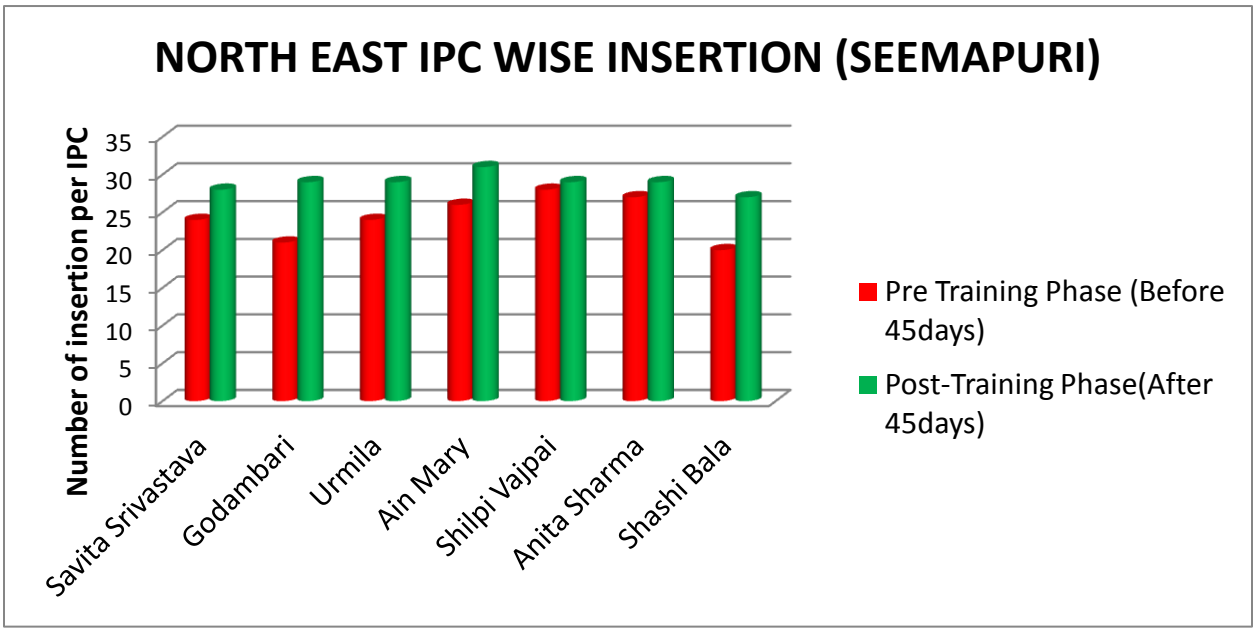


Fig: 1.6

In North East area increase in insertion was seen after training, average growth rate observed was

5%. In this area two IPC showed zero growth as there were no increase in their insertion after the training.

6.1.3 AREA WISE INSERTION PER IPC

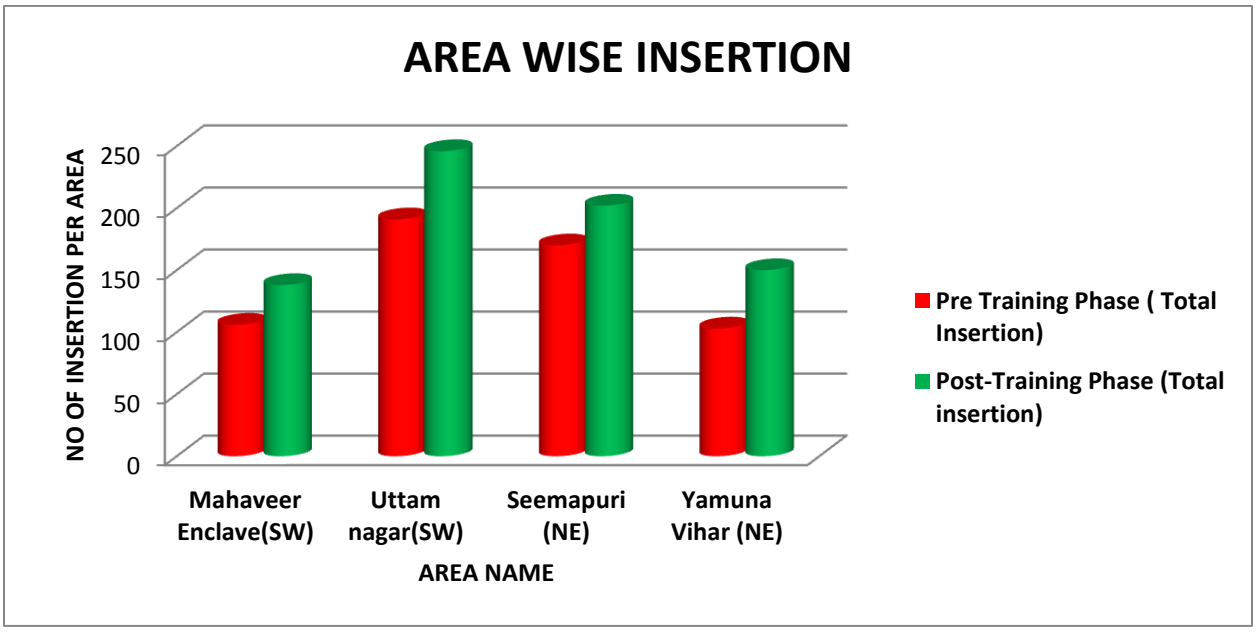
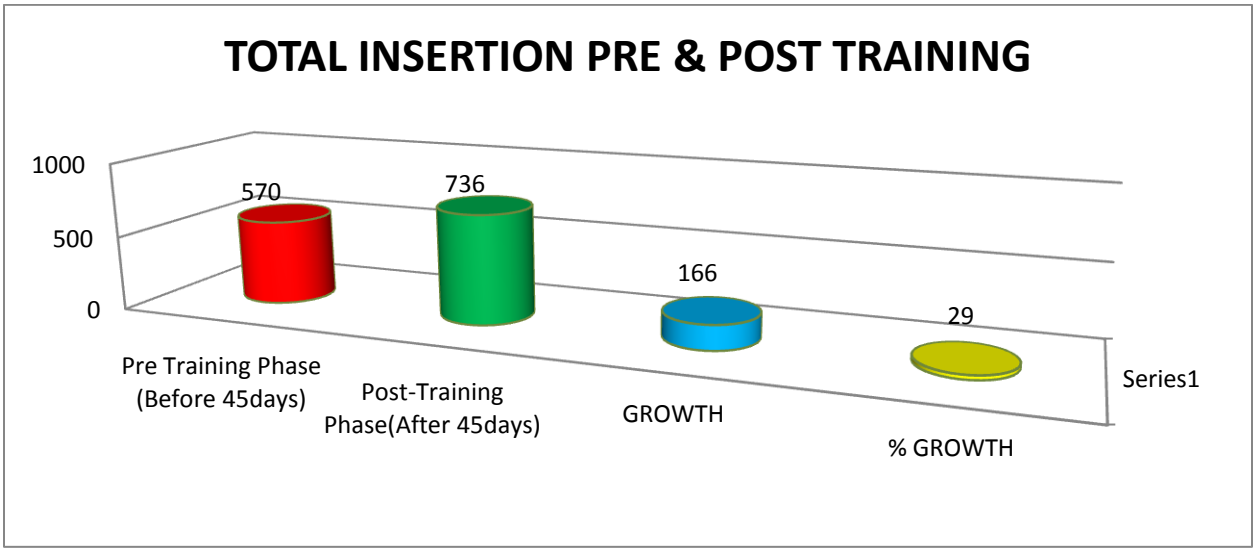


Fig: 1.7



The fig 1.6 reveals that maximum insertion were done in Uttam nagar(growth – 22%) – South West but the growth of insertion were maximum in Yamuna Vihar (31%) area North east . Hence north east was having average growth of 23% and south West with 22%. In this figure

overall growth of IPC'S after the training is shown. There was about the total growth of 22% of new insertion than number of insertion before training.

6.2 OBJECTIVE 2

To study the user experience, acceptability and accessibility of IUCD with respect to behaviour change communication

6.2.1 Knowledge about IUCD

During in-depth interview with the women who have adopted IUD, it was found that most of the women earlier were not aware of the IUCD as a method of contraception, they got to know about it through IPC's .

Women with four children told that -
"I was only aware about pills and condom didi (IPC) told me about the IUCD which can control births for five years."

27 year old women said -

I was only aware of the tablets , I got to know about IUD from the nukkad natak organized in our community , then I consulted with didi and she suggested me IUD as I want space of for least five years between next child

For women who have adopted IUCD, major source of information about the IUCD was IPC. Mid media was found to be the one of the source through which women got to know about the IUCD.

6.2.2 CHOICE OF IUCD OVER ALL OTHER METHODS

It was found that majority of the women who have adopted IUCD were having 3-4 children, hence they were in need of permanent method of contraception. Some of them

My fifth child was an unwanted pregnancy, I wanted some permanent method which should be

have also faced unwanted pregnancy due to use of temporary methods like pills, condom or injectables

6.2.3 ROLE OF COUNSELLING IN REDUCING IMPACT OF SIDE EFFECTS

The major findings from the interview conducted from IUCD user women was that the role of counseling in eliminating the myths related to side effects of IUCD.S It was found that side effects after the IUCD adoption ere most common but if women are properly counseled about these side effects then there is least chance of removal of IUCD . Interview findings revealed that IPC's were appropriately doing their counseling jobs as many of TG consulted doctor during occurrence of any warning symptoms as told by IPC's to them

A Women from Yamuna Vihar area said – "I was having white discharge continuously after the insertion but these all symptoms were told by didi and doctor both. So I took tablets given by doctor and white discharge problem was cured in one month.".

29 Year old women said-"Till six months I was having two days extra of periods but as didi and doctor both told me that it is normal and will cure in few months so I took it normally, now I am absolutely fine".

A mother of three children reported that- "Didi told me about the warning signs (Khatre ke

6.2.4 MYTHS ABOUT COPPER T

Almost all the women interviewed had some or the other myths regarding Cu T. The myths were generally heard through someone or were prevailing due to lack of correct knowledge about methods of contraception.

6.2.5 USE OF IEC MATERIAL

It was found that women were having many myths and misconception, but IPC was found to be major source through which their myths were eliminated. Use if IEC (Information, Education and Communication) tool was an effective tool used by IPC to counsel the women. Many women were refraining in adopting IUCD but when IPC counseled them with the help of various IEC material like informed choice basket, uterus model etc , most of their myths were eliminated.

Women from Seemapuri area reported that- "I was afraid of using IUD as many women say that it gets dislocated but didi explained me with help of uterus model that it can't be dislocated and will not go in any organ"

A mother of three children said-"I was told that IUD gets dislocated and its string also interrupts while doing sex but didi explained with help of uterus model that thread does not disturb during the intercourse"

A women from Uttam Nagar told that –"My husband said that IUD string can harm his penis so

\\

6.2.6 AWARENESS ABOUT HELPLINE NUMBER

It was found that women were using help line services for any consultation with doctor.

I always call on helpline number given by didi for any problem; I keep the bindi packet safely on which the number is written

6.2.8 EFFECTIVENESS ABOUT IUD

It was found that women had develop faith for IUCD, according to them IUCD was best method to adopt as its best method as compared to all other contraceptive methods like condom, pills etc. Most of the women said they feel free for five years after IUCD adoption; it's a better long lasting option.

I *have heard that after insertion of Copper T women's can gain weight so I didn't adopted it, I have never heard anything like that five year IUD, I think it's more reliable"28 year old women said*

"After using IUD I really feel that I have a lock and its key which can be opened whenever we want"- 26 year old women said

6.2.9FUTURE PLANNING

When asked that what they will do after five years as the time for IUCD 375 is five years , then it was shocking to hear from some women that they will again go for IUCD as it's a better option. . A large number were also in favor of going for sterilization/. These statements reveal that women had a faith in IUCD and they are willing to adopt it again.

A 25 year old mother of three kids said "I will go for IUCD 375 again most probably"

A 34 year old mother told "I will go for sterilization after five years"

Women of South Delhi said that-
"After five years I will again go for IUCD375 but will not insert Cu T as IUD is more reliable than Copper T."

6.3 OBJECTIVE 3.

OBJECTIVE 3. To seek the opinion of frontline health workers on the effect of behaviour change communication training \in improving their interpersonal communication with the target group.

All the IPC's shared various experiences and talked about the improvement in their skills before and after the training.

COUNSELLING

According to IPC's counselling was an important tool due to which a TG can be explained about advantages and disadvantages of any method . Counselling helps them to choose suitable contraception and also is a boon in providing satisfaction to women that they are choosing correct method

"Counseling is the most important thing before the insertion as the provider (doctor) has so many clients that she doesn't have time to properly explain all the advantages and side effects , so if the TG is pre informed about the complication and side effects then she can automatically raise question in front of doctor and remove all the queries"- 23 year old IPC said

"In first visit most of the women are afraid or shy in talking about contraception, for perfect behavior change we have to meet a particular TG 4-5 times"- IPC from Uttam nagar said.

SIDE EFFECTS

Common side effects seen after IUCD adoption were – irregular periods, spotting , cramps in abdomen , white discharge etc

"Generally women complain of heavy bleeding or missed periods , spotting , cramps in abdomen etc ,but if all these symptoms are told before the insertion , then nearly very few TG complain of extreme complications"
Statement of 32 year old IPC from Seemapuri.

BEHAVIOR OF HUSBAND AND MOTHER IN-LAW

IPC's face major challenge in explain the effectiveness of IUCD to TG's mother in law or husband. They both usually refuse in allowing the for the use of IUCD. Religion was also seen as barrier in some regions as there are some cultural beliefs associated which are very difficult to remove

Once I was interrupted by the husband in between while talking to the TG , he expelled me out of their house and advised to never come again, after few days that particular TG contacted me and presented her need of IUD adoption as she was having 7 children, I took her to doctor and till now confidentiality of TG is maintained ."

"In Muslim community husbands don't allow their wife to adopt IUCD as according to them in their religion if we die with any contraceptive method inside then Allah doesn't Kabul the ending namaz, hence we always tell them that this IUCD 375 is effective for five years , after five years you can expel it."

Convincing the Mother in law and husband are the most difficult job, we generally show the flashcards of the real users of IUCD 375 and try to organize a group meeting for mother in-laws where users can meet and share their experience and remove the myths of others"

PROVIDING INFORMED CHOICE

"In training we were told that its is mandatory to inform each client about the informed choice of contraception and advantages about each method, its solely depend on TG's choice which contraception method she is willing to use"

Protection from RTI / STI

"Now we always inform the client that IUCD doesn't protect from RTI and STI , this is the major knowledge I have gained from the training, now I can easily answer all the queries related to STI and RTI's"

Use of IEC material

"Generally husbands are conscious of their health and always enquire that can IUCD 375 harm them during the intercourse, and then explaining with the help of uterus model is the best method"

"When the TG sees all the contraceptive choices available, then she can decide what she is using and what she should use"

Informed choice basket

"Its easier to explain with the help of informed choice basket to explain about various contraceptive choices as some women use some brands but they are never aware of the name"

"I think the informed choice basket is the major tool which works during the interaction with TG"

CHAPTER 7 DISCUSSIONS & CONCLUSION

IUCD as a method of contraception is underutilized in family planning programme of India It is seen that. The contraception prevalence rate in India for IUCD is lower than all other modern methods and has remained static at 2% since the first National Family Health Survey in 1992-93 (Source NFHS-3). Because of historic reasons there are strong negative perceptions as well as myths and misconception about IUCD amongst potential consumer. It has been seen that behavior change communication or BCC strategy have major role in contraceptive acceptance among the community. The present study highlights the role of frontline health workers in increasing the accessibility and acceptability of IUCD through behavior change intervention perspective. It was observed that after the training of frontline health workers on the behavior change communication with major focus on interpersonal relationship with target group it was seen that performance level of all the frontline health workers in the project increased. The study findings highlight that number clients motivated per IPC for insertion were more after the behavior change training. Both the clusters were having approx same growth rate with South West Delhi (29%) and North East Delhi (31%). Only two IPC's in the north east area were having zero growth as there was no growth in their number of insertion before and after the training.

During assessing the IUD user experience it was found that there was major role of IPC in motivated the TG for the insertion ,, with point of accessibility of IUCD , it was found that most of Target group women were not aware of IUCD as a method of contraception , they were newly introduced by IPC to this method . Many studies have revealed that myths and cultural beliefs play a major role in non acceptance of IUCD among the community. In this study it was found that IEC material used by IPC played a major role in removing the myths of women. Uterus model , flash cards , informed choice basket were key tools through which IPC can engage TG and can explain TG about the facts to counter the myths prevailing in the society. Almost all the women were having myths about the Copper T, so they were resisting the usages of IUCD but IPC played major role in removing their myths and motivating them for IUCD usage.

It was seen that IEC material played a major impact on TG as now TG can feel the IUD and observe it , they can choose their choice of contraception according to need from the informed choice basket. Many TG feel shy to talk about the contraception but seeing them and choosing

their own makes them more comfortable. It was revealed that counseling plays a mojor in motivating TG for IUCD, they already have myths related to IUCD with all these if we counsel the women pre and post insertion then there would be less chance of IUCD removal. Many studies have shown that if proper counseling is done then TG rarely goes for IUCD removal. Almost all women were facing one of the problem of irregular periods , white discharge , abdominal pain but as they were counseled about these side effects earlier only so most of the women consulted doctor and were cured within six months.

IPC were playing key role in changing the perception of mother-in-law and husband. They usually cleared all the myths prevailing in the minds of the husbands, some of the women were shocked how IPC convinced their husband for IUCD adoption. Confidentiality was the main issue maintained by IPC, as many TG said their husband and mother in law are still not aware of the insertion after so many months and all this is because of confidentiality. Almost all users were satisfied after the insertion; major issues seen were the sudden spotting or heavy bleeding in some women, which could some time make them week. Focus group discussion among IPC's in two areas revealed that IPC were much more active and performing well after the behaviors change training. According to them after training they are able to interact with the TG in better way, now the TG feels interacted all the time does not lose interest. Earlier IPC were more focusing on the motivating TG for IUCD but after the training they are providing informed choice according to the need of the TG. Most if the TG felt that after the training they are working on the need based approach of the TG.

Hence we can conclude that by use of behavior change communication strategy we can enhance the performance of frontline health workers. As these frontline health workers are the key role players of any project so increasing their performance will automatically enhance the productivity of the project. These frontline health workers can assess the need of the community more suitable then others. In India NRHM is running on the innovation of ASHA and AWW but their potential is not being utilized. In many districts ASHA not even talk about contraception in the community. Family planning is the issue which is usually not given preference and these frontline health workers majorly work for maternal and child care but as family planning is a part of maternal and child care still nobody tries to talk about them in the community. The major

results shows that if all the frontline health workers are trained in BCC aspects then they can surely contribute in increasing the contraceptive prevalence rate of the country

RECOMMENDATIONS

- **Similar Behavior change training can be given to ASHA and AWW as they are the heart of national level program like NRHM**

  Government of INDIA is providing free contraceptive services to women still the accessibility to these services is very slow , hence if frontline health workers would be targeted on changing their interpersonal communication skills then we can surely cha ge the behavior of our target group.

- **Introduce IUCD tracking cards**

  Introduce IUCD tracking cards as an integral part of all IUCD services. This will help providers schedule follow-up visits and care, by reminding them when women should return to the facility or when a community health worker should visit their homes. The cards also help facilities track all IUCD insertions and maintain a reliable supply.

- **Providing separate space for counseling about family planning in clinics**

  Improve the infrastructure of facilities. Sufficient private space is needed for counseling clients and inserting IUCDs, particularly in facilities with high client loads. Postpartum units and labor rooms can be utilized for postpartum provision of IUCD 375s, but additional space is required for women who have not recently given birth.

REFERENCES

1. Alam ME, Kabir MA and Rahman MM. Overwhelming Reasons for High IUD discontinuation in Bangladesh. JUJS, 2009; Vol. 32(1): p.127-128
2. Conde-Agudelo A, Bermúdez AL, et al. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA, 2006; 295: p.1809-1823.
3. Fallon JBO, Speizer IS, Cálix J, and Rodriguez F. Contraceptive Discontinuation among Honduran Women Who Use Reversible Methods. Studies in Family Planning, Mar 2011; 42(1): p.11
4. Fallon BO, Speizer IS, et al. Contraceptive discontinuation: A one year follow-up study of female reversible method users in urban Honduras. Chapel Hill, NC, MEASURE Evaluation and PRODIM (Tegucigalpa, Honduras): 2008.
5. FHI 360, M. (2012). *Introduction of the intrauterine Contraceptive Device 375 in India : Positive Assessement Findings.* FHI 360.
6. Gandotra, M. M. and N.P. Das. 1996. "Factors influencing choice of contraceptive and the reasons for its discontinuation," in Spacing as An Alternative Strategy: India's Family Welfare Programme, edited by M.E. Khan and G. Cernada. New Delhi. B.R. Publishing Corporation, pp. 95- 114.
7. International Institute for Population Sciences (IIPS) and Macro International. *National Family Health Survey, 2005-2006: India*. Mumbai, India: International Institute for Population Sciences, 2007.
8. Iyengar K, Iyengar SD. The Copper T 380A IUD: A ten-year alternative to female sterilisation in India. *Reproductive Health Matters*. 2000;8(16)125-33.
9. Khan M, Patel B, Gupta R. The quality of family planning services in Uttar Pradesh from the perspective of service providers. In: Koenig MA, Khan ME, eds. *Improving Quality of Care in India's Family Welfare Programme.* New Delhi, India: Population Council, 1999.
10. Khan, M.E., Bella C. Patel and R.B. Gupta. 1999. "The quality of family planning services in Uttar Pradesh from the perspective of service providers". In Improving Quality of Care in India's Family Welfare Programme edited by Michael A. Koenig and M.E. Khan. Population Council. New Delhi. pp. 238-269.

11. Marston C and Cleland J. Do unintended pregnancies carried to term lead to adverse outcomes for mother and child? An assesment in five developing countries. Population Studies (Camb). 2003; 57(1): p.77-93

12. ME Khan, S. S. (2008). *Increasing IUD accessibility , Accetability and Use of IUD in Gujrat* . May 2008: USAID.

13. Murphy, E. M. (2008). *The Willows Reproductive Health Project.* Washington: Population reference Beureau

14. Ministry of Health and Family Welfare Government of India. Repositioning IUCD. In: *The Family Welfare Programme: Strategy, Operational Plan and Achievements*. New Delhi, India: Family Planning Division, Ministry of Health and Family Welfare, 2008.

15. Mishra, Vinod K., Robert D. Retherford, P.S. Nair and Griffith Feeney. 1999. "Reasons for discontinuing and not intending to use contraception in India." National Family Health Survey Subject Report Number 13. International Institute for Population Sciences, Mumbai, India.

16. Santhya K. Contraceptive use dynamics. In: *Looking Back, Looking Forward: A Profile of Sexual and Reproductive Health in India*. New Delhi, India: Population Council, 2004.

17. Santhya, KG. 2003. "Changing family planning scenario in India: An overview of recent evidence". Regional Working Paper No. 17. Population Council, New Delhi.

18. Seiber EE, Bertrand JT, Sullivan TM. Changes in contraceptive method mix in developing countries. *Int Fam Plan Perspect* 2007;33(3):117-23. devices for contraception. Contraception 2007;75

19. Alam ME, Bradley J and Shabnam F. IUD use and discontinuation in BD. E&R Study No-8; New York: Engender Health / The ACQUIRE Project: Nov- 2007.

20. Tripathi V, Nandan D and Salhan S. Determinants of early discontinuation of IUCD use in rural northern district of India: a multivariate analysis and its validation. J Biosoc Sci. 2005 May; 37(3): p-319

ANNEXURE

ANNEXURE 1.

INDEPTH INTERVIEW GUIDE FOR IUD USERS

Informed consent:

My name is …… I am from PSI, India. I would like to talk to you about your experiences regarding IUD insertion. Specifically I would like to talk you about your experience and thought on IUD insertions, any benefited or discomforts you might have felt, how IUD impacted your daily life and you're thought on recommending IUD to others.

The interview would take half an hour to 45 min. All responses would be kept confidential. Your interview response will only be shared for research purpose only.

I would like to begin by asking you some brief question about yourself before moving on to the discussion point

Date of the interview Signature of the interviewer

A Participant Identification Number: …….

B. Date of the interview: ……

C Interview Site : ……..…

DEMOGRAPHIC PROFILE

1. Name:
2. Address:
3. How old are you in complete years?
4. Age at marriage
5. Relationship status
   a) Married
   b) Married but separated
   c) Widowed
   d) single
6. How many live children's do you have?
   a) 1
   b) 2
   c) 3
   d) 4
   e) >4

7.	IUD adopted for which reason	a) Spacing b) Don't want any child now
8.	No of family members :	
9.	What is your religion?	a) Hinduism b) Buddhism c) Islam d) Christianity e) None
10.	Your Occupation	a) House Wife b) Government worker c) Skilled labor d) Unskilled labor e) Private job f) Others ……..
11.	Husband's occupation	a) Government worker b) Skilled labor c) Unskilled labor d) Private job e) Others ……..
12.	Highest level of education of yours	a) Illiterate b) Primary fail c) Primary pass d) Secondary fail e) Secondary pass f) Post Secondary g) Graduation h) Post Graduation
13.	Highest level of education of your husband	a) Illiterate b) Primary fail c) Primary pass d) Secondary fail e) Secondary pass f) Post Secondary g) Graduation

h) Post Graduation

14. IUD insertion time:
    i) <6 months
    j) >6 months
    k) 1 year
    l) > 1 year
    m) > 2 year

1. How did you got to know about this IUD?
2. Have you met any IPC before? If yes what did she talked about you in first meet?
3. What other methods of contraception you are aware of?
4. What were you using before the IUD adoption?
5. Have faced any side effects after the insertion?
6. Did IPC explained you about s some side effetcs which can occur after insertion? If yes tell me few?
7. Could you tell me about which methods of contraception did IPC talked ? Did she told you any other method of contraception except IUD
8. Is your husband and other family members aware about your decision. Did they supported you
9. Do you think IPC have maintained confidentiality of your insertion
10. Did IPC told you about the warning signs which should be kept in mind after the insertion
11. Did IPC showed you some IEC material like flip charts, uterus model, various contraception etc. , were they helpful in choosing the contraceptive method.
12. Have you asked any queries related to IUD? Were your all queries solved by IPC
13. Have you recommend any other for IUD usage?Or Will you recommend in future Why Are you satisfied with your decision?

ANNEXURE 2.

FOCUS GROUP DISCUSSION GUIDELINES

PLACE- NO OF PARTICIPANTS

TARGET AUDIENCE – IPC'S working for PEHEL project

ATTENDENCE OF Presented participants

MODERATOR GUIDE

Good Morning all of you , thank you for all for coming for participation in the FGD

The goal of this session is to obtain your feedback on the training given to all IPC' s for quality enhancement. I like to know what challenges you were facing earlier and now how training has helped you in improving your interpersonal skills with the TG

DIRECTIONS

In next two sessions we would be noting your sessions .I would like if every body could contribute in the study and also gives others chance of speaking

TOPICS TO BE COVERED

- What have you learned training?
- Which aspect did you liked the most in the training session
- What differences you have observed before and after the training
- What is the major issue in handling with target grou?
- How do you tackle it?
- Do you think IUCD is effective method of contraception.
- What were difficulties you were observing while interacting withTG before training
- According to you what are the changes you have observed iin your workstyle / anything after the training
- .Can you compare the behavior of TG before and after training
- What are the myths prevailing with IUCD. What difficulties do you face while motivating the TG, how do you tackle all these situations