Attributes of ASHA workers in NSV demand generation

STUDY TO ASSESS THE EFFECTIVENESS OF ASHA IN NSV RELATED DEMAND GENERATION

Dissertation Report

Title

Study to assess effectiveness of ASHA in NSV related demand generation in Ghaziabad District (Utter Pradesh)

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at

Engender Health

By

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Under the guidance of

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Certificate of Approval

The following dissertation titled "**Study to assess effectiveness of ASHA in NSV related demand generation in Ghaziabad District (Utter Pradesh)** 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 Dissertation Examination Committee for evaluation of dissertation.

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This is to certify that **Ms. Jyotsna Sharma Roll No. PG/ 10 080,** 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 " **...**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

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Faculty Mentor	Organizational Advisor
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Acronyms and Abbreviations

ASHA	accredited social health activist (community health worker)
GoUP	Government of Uttar Pradesh
NSV	no-scalpel vasectomy
UP	Uttar Pradesh
USAID	U.S. Agency for International Development
CHC	Community health center

Abstract

Purpose of this study is to assess the effective of ASHA workers in NSV demand generation in their respective operational areas. This study was carried out in Ghaziabad District of Utter Pradesh. 20 ASHA workers from two block level rural public health facilities named; CHC Muradnagr and Dhaolana were selected for this study. They were grouped in to effective and in effective based on their performance with respect to NSV referrals. This study was undertaken with the following general and specific objectives. Qualitative Research was carried out to understand the attributes of effective ASHAs in NSV related demand generation, to understand the factors contributing to in effectiveness of ASHA with respect to NSV and to develop recommendations for enhancing capacities of ineffective ASHAs with the Specific objectives to assess the knowledge of the ASHA workers regarding NSV, to understand the field practices of effective and ineffective ASHA with respect to NSV demand generation and to develop recommendations to straighten ASHA capacity with respect to NSV. Methodology adopted for the study is, Sample of 20 ASHA workers (depend upon saturation point) from two group of ASHA workers (effective and non effective) was selected through Purposive sampling (non random sampling).A Open ended semi structured in-depth interview guide was developed, pilot tested and finalized. Analysis of the data ASHA Interviews were content analyzed using standards method. Validation of information was done through health facility records. There was no difference in the knowledge of effective and ineffective ASHA, effective ASHAs were able to put knowledge and skills in to proactive, ineffective ASHAs demonstrated increased inhibitions to practiced NSV related knowledge in the community and on field capacity building of ineffective ASHAs is suggested are the major findings of the study.

Organizations Profile

Engender Health is a leading global reproductive health organization working to improve the quality of health care in more than 20 countries around the world. In partnership with governments and communities, we train local health professionals to provide high-quality services in maternal health, family planning, and HIV and AIDS. We also work to promote gender equality and to advocate for sound practices and policies that support sexual and reproductive health. Together with our partners, we strive to ensure that every pregnancy is planned, every child is wanted, and every mother has the best chance at survival. Main works of Engender health are

A. Family Planning - Across the globe, we have proven that even in resource-poor settings, family planning services can be safe, effective and affordable. Learn about our work in contraception, informed choice, and more.

B. Maternal Health - Our approach to maternal health is holistic, addressing women's sexual and reproductive health needs throughout their lives. We work to equip health facilities with medical supplies and well-trained staff to provide high quality services.

C. HIV, AIDS, and Sexually Transmitted Infections - To help overcome the global HIV epidemic, we train health providers, improve health services, and advocate for national and international policies that respond to the needs of people living with HIV.

D. Promoting Gender Equity - Addressing gender issues is essential to improving the health of both women and men. Through our Men as Partners program and other initiatives, we mobilize men to support their partners' reproductive health, promote gender equity, and reduce gender-based violence.

E. Partnering with Youth- We believe all young people have the right to health, respect, and appropriate services that respond to their specific needs. In particular, we work to increase their access to critical sexual and reproductive health information and services.

F. Improving clinical quality - We improve the quality of health care in the world's poorest communities by training providers to be responsive and informative, preventing infection, and increasing communication among staff. Our pioneering process has been used around the world.

G. Advocacy and Policy - We work locally, globally, and in the United States to influence evidence-based policy change that will lead to lasting improvements in reproductive health care services.

H. Major Projects- Engender Health is the managing partner of several major projects—consortiums of organizations working in partnership to achieve the maximum impact on public health. These projects range from global to country-specific

Engender Health works to improve the health and well-being of people in the poorest communities of the world. We do this by sharing our expertise in sexual and reproductive health and transforming the quality of health care. We promote gender equity, advocate for sound practices and policies, and inspire people to assert their rights to better, healthier lives. Working in partnership with local organizations, we adapt our work in response to local need.

Chapter 1

Introduction

Sterilization is currently the world's most widely used contraceptive method, in developing and developed countries and it is projected to remain so over the next two decades. From all methods of family planning, Sterilization accounts nearly half of all contraceptive use. Today, one out of four couples worldwide use sterilization as their family planning method.

During past years in India, from 1952 until 1977, the government of India promoted vasectomy more heavily than any other method of contraception. During India's "Emergency Period" (1975–77), the administration took on extraordinary powers and applied many of them toward the goal of reducing India's population. Almost 7 percent of all Indian couples were sterilized during this time, many through coercive means. The Ministry of Health and Family Welfare is the government unit responsible for formulating and executing family planning related government plans in India**.** In the 1965-2009 period, contraceptive usage has more than tripled (from 13% of married women in 1970 to 48% in 2009) and the fertility rate has more than halved (from 5.7 in 1966 to 2.6 in 2009), Indira Gandhi, Prime Minister of India, had implemented a forced sterilization programme, but failed. Officially, men with two children or more had to submit to sterilization, but many unmarried young men, political opponents and ignorant, poor men were also believed to have been sterilized. This program is still remembered and criticized in India, and is blamed for creating a public aversion to family planning, which hampered Government programmes for decades. The Gandhi government in 1977, and in the ensuing years, the entire family planning programme was toned down. By the 1980s, vasectomy, which had been the dominant family planning method in India for 20 years, was almost entirely replaced by female sterilization.

Male participation in family planning has seen a very fluctuating trend in India. Vasectomy played a dominant role in India's national family planning program, from the program's inception in the 1950s through the mid-1970s, it accounted for 65% of the 32.7 million sterilizations performed between 1956 and 1980. By the late 1970s, however, vasectomy

acceptance had begun to decline drastically. This decline has been attributed to laparoscopic female sterilization becoming more widely available and popular, as well as a public backlash against the national program's high- pressured approach to vasectomy (large camps, cash incentives and reportedly coercive practices). Through the 1980s and 90s vasectomy continued to decline.

According to NFHS-2 data, among all the contraceptive methods available condom usage is only 3% and male sterilization is 2%, though by contrast, female sterilization is about 36%. In order to promote male participation in family planning, the Union Ministry of Health and Family Welfare, launched the "No Scalpel Vasectomy Project" in 1998. Though as per NFHS-3 data, male sterilization has dropped to 1%. In order to reverse this decline, the central government renewed its attention to vasectomy in hopes of revitalizing the method. Over the past decade, the number of procedures performed in the public sector doubled and vasectomy's contribution to the sterilization mix rose from 1.9 % to 5.1%. In eight states— Delhi, Haryana, Himachal Pradesh, Manipur, Punjab, Sikkim, Tripura, and West Bengal—vasectomy's contribution to the sterilization mix is greater than 10 percent

In Uttar Pradesh, vasectomy accounts for 2.3% of the sterilization mix as per 2008-09 data available in the state. A major factor contributing to vasectomy's resurgence has been the program's focus on No-Scalpel Vasectomy (NSV), commonly known as the 'no cut, no suture' (*Bina Chira-Bina Tanka*) operation. The increased uptake of vasectomy has also coincided with a revised compensation plan for vasectomy acceptors, as well as providers—80% of the procedures were performed after September 2007 when the new scheme was put in place. In Uttar Pradesh (UP) 12% of married women of reproductive age—4.1 million couples—have an unmet need for limiting. Vasectomy prevalence is 0.2%, one fourth the national rate of 0.8%. In 8 of UP's 18 divisions, vasectomy accounted for less than 1% of the sterilizations performed in 2008/09. Surveys conducted on large scale do indicate that the level of NSV acceptance continues to remain low [3]. A lot of social and economical reasons have been attributed to and the most important was that the couples do not want to take the risk on the bread earner of the family. The most common reason for the non-involvement of men is misinformation about vasectomy. Research shows that there is a wide spread belief among men and women that

vasectomy makes men physically weak, impotent and unable to enjoy sex. However, those who were aware and have adopted the method say that NSV is advantageous.

The RESPOND Project

In recent years, the governments of India and of Uttar Pradesh have taken steps to increase rates of male sterilization. In 2007, the Ministry of Health increased the amount of compensation for wages lost offered to vasectomy acceptors to Rs. 1,100 (about $20 USD) for operations performed in the public sector. Today, India is one of the leading nations in the world with regard to the use of non scalpel vasectomy (NSV), and vasectomy prevalence in the national contraceptive method mix increased from less than 1 percent in 1997 to about 3 percent in 2003.However, overall use of this method remains low. **[Expanding Contraceptive Use in Urban Uttar Pradesh][9].**

The RESPOND Project partners Engender Health and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP) are providing technical assistance to the Government of Uttar Pradesh (GoUP) to expand awareness about, acceptance of, and access to no-scalpel vasectomy (NSV) services.3 RESPOND's technical assistance is closely aligned with the State's National Rural Health Mission (NRHM) Action Plan for 2009–2010, is supportive of and synergistic with the State's planned interventions and activities, and sets the stage for expansion and scale-up of NSV interventions in 2010–2011 and beyond[9].

RESPOND's technical assistance follows a holistic Supply-Demand-Advocacy (S-D-A) Programming Model that complements the GoUP's strategic approach. On the supply side, strengthening service delivery components, NSV training, backstopping, and service site readiness will result in the increased availability of NSV service sites with skilled, motivated, well-supported NSV service providers. On the demand side, engaging communities and providing correct information about NSV will increase knowledge, improve the image of NSV services, and motivate couples to consider NSV. Advocacy is targeted at improving policies and creating a supportive environment for NSV services, with policies based on evidence, and

maximizing resources to meet the needs of demand generation while ensuring quality NSV services. Together, these components are expected to lead to a better-resourced and more productive, supported, and sustainable program, and to the improved health of the Uttar Pradesh population [10].

Activities include under Respond Project are:-

- Improving the capacity of local medical colleges to train health staff in no-scalpel vasectomy
- Developing mobile camps where services are provided on special days
- Ensuring clients receive the information and counseling they need
- Dispelling myths and misconceptions about vasectomy among both clients and health care professionals
- Developing posters and other communications media (such as puppet theater and folk drama) to inform men and women of no-scalpel vasectomy
- Training community outreach workers- ASHA/ANM/AWW
- Creating video and radio segments to run on state-wide stations to raise awareness
- Advocating for no-scalpel vasectomy to be a key part of the state's health and family planning strategy

As NSV is a very simple, safe, effective and an advanced terminal technique of contraception for males, there is definite change in the mindset of people in India towards family planning and for adopting NSV as a family planning method.

Male sterilization (vasectomy) is one of the least-used methods of contraception in urban Uttar Pradesh, with a prevalence of only 0.5 percent. Female sterilization in urban Uttar Pradesh exceeds vasectomy by a factor of 37 to 1, even though vasectomy is safer, simpler, less expensive, and equally effective.

Rationale of the study

Acceptance of NSV is increasing in India; Muradnagr block is one of the leading block for carrying out NSV operation in rural India. This study is conducted to assess knowledge and practice of effective ASHA (those who are able to make client for NSV) and compare this with ineffective ASHAs (those who are not bringing NSV cases), an attempt is made to develop the recommendation to improve the effectiveness of ineffective ASHAs.

Chapter 2

STUDY DESIGN

2.1 Research question: What are the characteristics of effective ASHA in NSV related demand generation?

2.2 Objectives: This study was undertaken with the following general and specific objectives.

A. ***General objective:-***A Qualitative Operations Research was carried out to understand the attributes of effective ASHAs in NSV related demand generation, to understand the factors contributing to in effectiveness of ASHA with respect to NSV and to develop recommendations for enhancing capacities of ineffective ASHAs

B. ***Specific objectives:-***

a) To assess the knowledge of the ASHA workers regarding NSV.

b) To understand the field practices of effective and ineffective ASHA with respect to NSV. demand generation.

c) To develop recommendations to straighten ASHA capacity with respect to NSV.

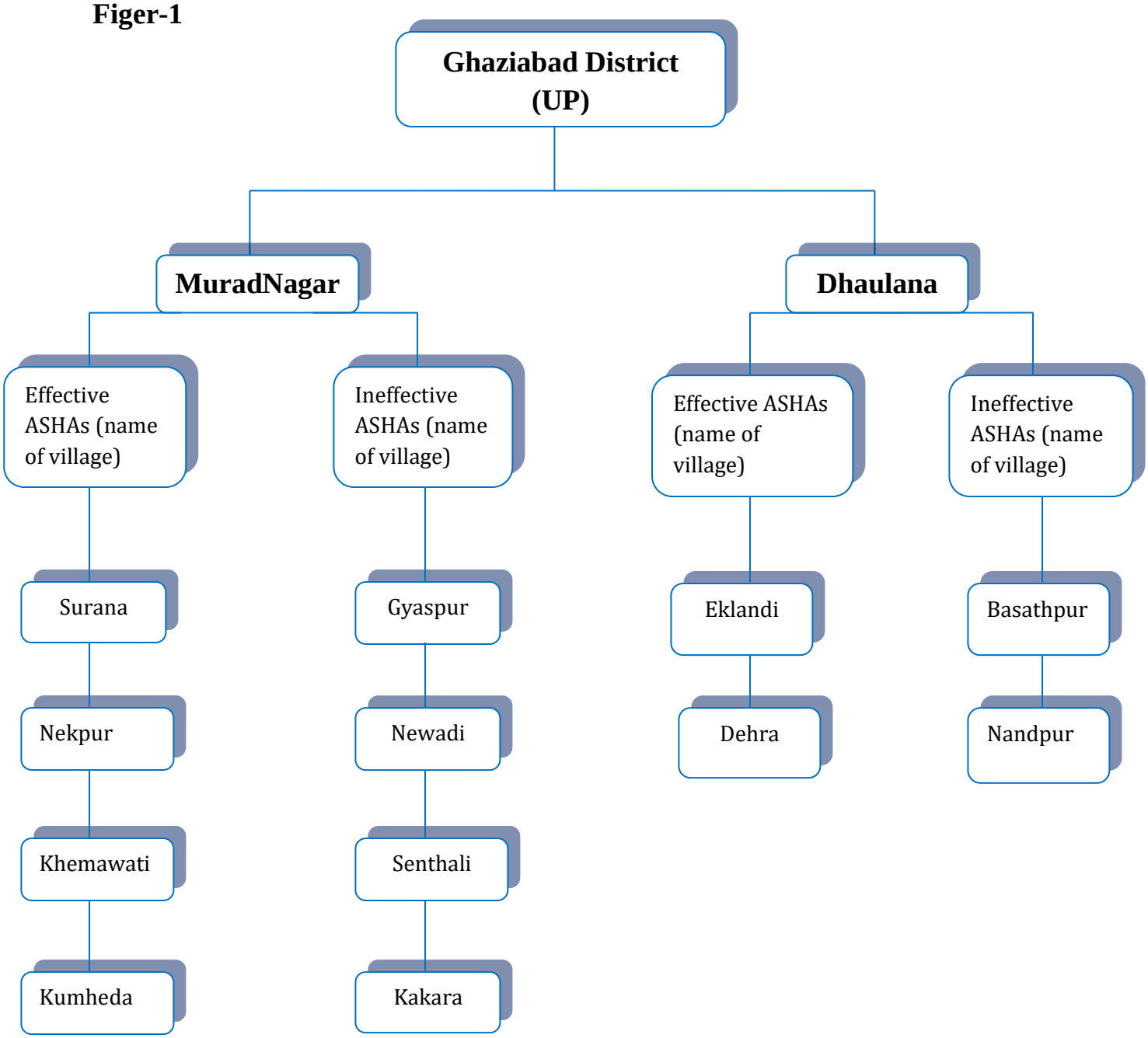
2.3 Methodology

A. **Study Area: -** This study was carried out in March 2012 in two blocks of Ghaziabad i.e. Muradnagar, and Dhoulana. Villages were selected from each block for this study by purposive sampling. The study villages selected from Muradnagar are Surana, Kakara, Gyaspur, Nekpur, Khumawati, Kumheda, Newadi, Senthali, Nekpur villages and study villages from Dhaulana are Eklendi, Dehar, Basathpur and Nandpur.

B. Study design- A Qualitative Operations Research was conducted to find out the attributes of effective ASHA workers. This study used a qualitative research approach to data collection based on in-depth Interview of AHSA. Qualitative research approach helps to understand the 'how' and 'why' of the NSV demand generation is associate with knowledge and practices of ASHA. It will also help to understand the perception of community towards adopting NSV as a family planning method, understanding of factors affecting acceptance of NSV and obstacles faced by ASHA during their work, attitudes and practices of accepting NSV by eligible couples and their family members.

C. Sample - 20 ASHA workers (depend upon saturation point) from two group of ASHA workers (effective and non effective) was selected through Purposive sampling (non random sampling). Sample size Depend upon saturation point. The Figure-1 is schematic presentation of samples based on its operation area.

Figer-1


Ghaziabad District (UP)
MuradNagar
Dhaulana
Effective ASHAs (name of village)
Ineffective ASHAs (name of village)
Effective ASHAs (name of village)
Ineffective ASHAs (name of village)
Surana
Nekpur
Khemawati
Kumheda
Gyaspur
Newadi
Senthali
Kakara
Eklandi
Dehra
Basathpur
Nandpur

D. **Study tool: -** A semi structured open ended interview guide was developed it comprised of question related to demographic, NSV related knowledge and skills. Tool also captured the practices of each ASHA under study.

a) **Process of development of tool: -** Study tool is developed keeping some facts in mind, like it should be simple and is able to generate complete information of the subjects. It should cover all the relevant information related to the NSV. Question of the study tool should be easily understandable to the subject of the study. Questions should be design in such a way they that are able to generate all the relevant information which is required to meet the objective of the study.

b) **Pilot testing of tool and finalizing:- (changes after pilot study)** after conducting pilot study the study tool were analyzed again on the basis of information obtain to fulfill the gaps in the information which was not sufficient to meet the objective of the study. Form of the tool is changed and question was reframed because some information was repeating. Knowledge and practice section were added, and tool is resized to obtain more reliable information in order to accomplish the objective of the study. Some probe for each question was also added to it. Changes were made in question number 3; point 4 has removed from this question because the information was repeating in the question number 2. Though Point number 1 and 4 of question number 4 was also repeating but it could not be avoidable. Again this was tested in the field to check the reliability of the study tool.

c) **Finalization of study tool: - Process of administration of study tool: -** Final data collection was carried out from12 march to 23 March. During this time Knowledge and practice of ASHA workers was assessed by interviewer. Knowledge part administered by the interviewer itself by asking direct knowledge based question to ASHA workers and. Practice part of ASHA worker was done by going to the field with ASHA workers. During the process of data collection interviewer were able to build up a strong rapport and relationship of trust with the (ASHA). This enabled the interviewer to probe more deeply into issues raised by an ASHA. When interviewees had not given enough in-depth information about a specific question or topic, the interviewer encouraged ASHAs to talk about what they thought and their communities felt about this or to share stories they had heard.

E. **Study Schedule:-**

Serial No.	Activities	Time duration
1	Selection of study topic	2nd February
2	Developing research question	3rd February
3	Development of study tool	4th February – 13th February
4	Pilot testing of study tool	14th February- 27th February
5	Finalization of study tool	28th February – 29th
6	Final data collection	1st March – 22nd March
7	Processing of data	23rd March – 31st March
8	Data analysis	1st April – 14th April
9	Report writing	15th April – 28th April

F. **Data collection:-**The guides were originally developed in English and then translated into the local languages for data collection. Based on the objectives of the study, the main themes of the guides include sections on Knowledge & practices of ASHAs regarding NSV fact, how they recognize eligible couples, pre NSV guidance, Post NSV precautions, how to convince client for adopting NSV and motivational factor for an ASHA to mobilize client for NSV, practices regarding NSV services in their community. Based on the information received from ASHA, questions on barriers to knowledge delivery to knowledge to the community were included. The interview guides also included many probes under each theme, aimed at determining the knowledge of ASHAs on the above mentioned topics. The discussion and interview guides were piloted in a similar community before being used for actual data collection. All the discussions and in-depth interviews with (ASHA) were conducted using the local language.

G. **Analysis Procedure: -** Following protocol in content analysis of in-depth interview of ASHA workers was used.

a) Preparation of transcript:- The Hindi form of in-depth interviews were transcript in to English transcript

b) Arranging the data for content analysis- All the data of in-depth interview was arranged block wise for analysis.

c) Deciding coding units – example – word, concept, sentence, paragraph, and theme, entire. We used in-depth interview text as coding unit.

d) Deciding Categories- The categories that immerged from intensive reading were – Knowledge regarding General Facts of NSV, Recognition of eligible couples Pre

NSV Guidance, and Post NSV Guidance Convince Client for NSV Motivational factors for an ASHA Each category was further coded with Nodes as shown in the following table.

Category	Node
Knowledge regarding General Facts of NSV	Permanent method
	Less time taking
	bleeding
	Weakness
	pain
	Start working in few days(2 days)
	sexual relationship
	contraceptives
	Honorium of 1100
Recognition of eligible couples	Age <60
	no desire for more children
	Wife should be alive
	Wife and client have not gone any sterilization method
	Have child at least one year of age
Pre NSV Guidance	Part preparation
	Consent
	eligibility
Post NSV Guidance	Avoid hard work
	Avoid bath
	Avoid cycles
	contraceptives
	5 days medicine
	Follow-up-Semen analysis

Convince Client for NSV	Directly talk to client
	Talk to his wife
	Talk to both
	Refer them to doctors
	Use any IEC
	Successful client
Motivational factors for an ASHA	Money
	Associated fame
	Responsibility of an ASHA

e) Coding the text - All the selected sample text (20 In-depth interviews, Period March 2 Blocks x 1 district), were coded as per the above table. Test coding was done and the same method was followed for the entire sample size.

f) Checking coding consistency – for the time being the codes were limited in number so coding instructions and rules were listed in one page. Human coders are subject to fatigue and are likely to make more mistakes as the coding proceeds. However, in the current study the sample size being very small these challenges were not seen.

g) Drawing conclusion from coded data - involved exploring properties and dimensions of categories, identifying relationships between categories, uncovering patterns and testing categories against full range of data.

Data analysis was mainly done based on the thematic approach that involves organizing from the collected information into meaningful category. Some quotes that could explain the perceptions of ASHA and their community in context of NSV were identified and presented in their own words to give more insight into the perceptions and practices of the ASHAs and community.

Demographic information was arranged in a table with the frequencies of all respondents

Chapter 3

Results

In this study, a total of 20 ASHAs participated, from two Block Muradnagar, and Dhaulana of Ghaziabad District of Utter Pradesh. Information gathered from ASHA was summarized by thematic area and is presented below. Overall discussions about male sterilization (NSV) With ASHA workers, ASHA workers are tend to speak more freely and give more information about NSV to wives than directly talk to her client, they also shared their opinion about NSV and difficulties faced by them during their work for NSV demand generation. Many more stories and examples were shared by them explaining the reason that why they are/are not able to communicate their knowledge with community. Their greater knowledge of NSV related facts indicated that they have enough information. But practice part of study which is assessed by the interviewer by going to field with ASHA's shows that some of them are not able to share this information to their community Because of some reason i.e. shyness, they are daughter in lows of village, wives of clients don't allow to their husbands to undergo sterilization procedure etc. ASHA discuss abut NSV much more frequently and freely with wives as comparison to clients. This information was supported by the information available in facility records.

Socio-demographic characteristics of the 20 ASHA workers interviewed, such as current age, level of education, No of years as an ASHA are presented in Table 1.

Table 1. Socio-demographic characteristics of the study population

Characteristics	N=20	
Current age (In years)	Effective	No effective
20- 25	0	2
26-30	3	3
31-35	4	3
36-40	2	2
41-45	1	0
Level of education		
Illiterate	0	0
1-5	2	1
6-10	7	7
11-12	1	1
Graduate	0	1
Postgraduate		
No of years as an ASHA		
1-6	10	10

Q1:-Knowledge and practice about NSV fact:-

Table -1

Knowledge level						
Answers	**Effective No=10**		**%**	**No effective No=10**		**%**
	K	**P**		**K**	**P**	
1. Permanent method of family Planning for mails.	10	10		10	10	
2. Less time taking.	10	10		10	10	
3. No bleeding.	10	10		10	10	
4. Weakness.	10	10		10	10	
5. No pain during procedure.	8	7		10	10	
6. Can get back to their work in few days.	10	8		6	3	
7. No effect on sexual relationship.	9	6		5	2	
8. Use of contraceptives for 3 months.	9	9		4	3	
9. Compensation of 1100.	10	10		8	8	
10. Rs/- 200 for motivators	10	10		9	9	
11. Any other point	0	0		0	0	

1. All the ASHAs (Both the group effective and ineffective) had the knowledge and were able to practice on field- that NSV is a permanent family planning method, it takes less time involves no bleeding and no pain and does not cause any weakness. When probed ineffective ASHAs were not able to explain the NSV related benefits in detail. Example

2. ASHA in the effective pool had the knowledge about the time period after which the NVS client can get back to their work; NSV does not affect their sexual life and mandatory use of contraceptives for 3 months. Effective ASHAs were able to put this knowledge in the practice as well. However ASHAs in the ineffective group lagged in knowledge as well as in practice in these information related NSV.

3. Majority of the ASHA have the knowledge about the compensation packages associated with NSV.

4. The only difference between effective and non effective was observed that effective ASHAs were having much more knowledge regarding procedure as comparison to Non effective ASHAs. Some of them especially effective ASHA of their area prudently explained the procedure of an NSV operation with the help of handouts to support that why there is no pain and weakness after getting NSV done as comparison to non effective ASHA.

5. Observation during field visits with ASHA shows that majority of ASHA were form Effective pool those who bring cases of NSV were able to explain much more frequently and freely to their client as comparison to those who do not bring cases (non effective ASHA).

6. Majority of respondents (ASHA) from both group of sample effective non effective considered that they are not able to talk about sexual relationship with the male because they are the daughter-in-lows of their village and clients themselves do not feel free to talk them rather than they preferred to go and talk with facility Doctors and other staff who can council them.

   "Nhi me Adamiyon se baat nhi ker sakti saram ati hai unse baat karane kyunki me bahu hun yaha ki or jyadatar log mere bade hai or pariwar k hote hai"

Q2:- How do you recognize eligible couples?

Table-2

Knowledge level						
Answers	**Effective No=10**		**%**	**No effective No=10**		**%**
	K	**P**		**K**	**P**	
1. Age <60.	10	10		7	3	
2. Have completed their family and do not desire more children.	10	10		7	7	
3. Wife should be alive.	10	10		10	10	
4. Wife and client have not gone any sterilization method.	10	10		10	10	
5. Have child at least one year of age.	0	0		0	0	

1. All the ASHAs in the effective group have the knowledge of most of the eligibility criteria for NSV and were able to share this knowledge to the community. However ineffective ASHAs group showed variation in the knowledge related to eligibility criteria.

2. All the ASHAs (Effective and ineffective group) were lacking the important knowledge about eligibility criteria-that age of youngest child should be one year.

3. ASHAs from ineffective group lacked information about the requirement of the family size and the age. A lot of ASHAs were unsure of the age bar for NSV and the reasons for the same.

4. Majority of respondent were aware of lower age of client but they were not having enough knowledge about maximum age of a client's eligible for NSV even ASHAs from effective pool were also not having exact knowledge of age of a client who is eligible for NSV, Same in case of non effective ASHA they were also not having proper knowledge of age of a client. Most of the responses were coming by probing them like.

   "Kam se kam 30 saal se to upper hi hone chahiye or 45 se kam hone chahiye"

5. That was the most common answer came from almost all ASHAs. The most common factor they consider to find their client is that couples do not desire more children than that. While discussion during field visit with ASHA and community the fact which came

out is- people are not ready to use any permanent method of family planning till at least they have a boy as well as girl in their family.

6. The religion is also a reason for not accepting NSV as a permanent family planning method in some members of Muslims community. They said that after getting NSV done, their religion will not allow them to read Kuran; one member from their community said that

Q3:- What is the main pre NSV guidance for a client?

Table -3

Knowledge level						
Answers	**Effective No=10**		**%**	**No effective No=10**		**%**
	K	**P**		**K**	**P**	
1. Part preparation.	7	0		3	0	
2. Consent of client	8	8		6	6	
3. Consent of his wife and his family/members	9	9		6	2	

1. ASHAs in both the groups (effective and ineffective) varied in knowledge related to pre NSV guidance. However none of the ASHAs were able practice information related to part preparation.

2. Knowledge about consent of client as mandatory pre NSV guidance was not recognized by many ASHAs under the study.

Q4:- What are the main post NSV measures /precautions should keep in mind?

Table -4

``Knowledge level						
Answers	**Effective No=10**		**%**	**No effective No=10**		**%**
	K	**P**		**K**	**P**	
1. Avoid hard work for 48 hours.	10	10		6	3	
2. Avoid bath for 2 days.	3	1		0	0	
3. Avoid cycles for 7 days.	7	7		5	2	
4. Use of contraceptives for 3 months.	10	7		5	3	
5. 5days medicine.	3	0		0	0	
6. Follow-up-Semen analysis for three months	8	6		1	0	

1. ASHAs in the effective groups scored high on both knowledge the practice related to post NSV pre cautions as compared to ASHAs in the ineffective group.

2. In both study groups (effective and ineffective ASHA), instructions for 5 days medicine, were not observed. However some ASHAs in the effective group had the knowledge about the course of medicine to follow the post NSV procedure.

3. ASHAs in the effective groups had the knowledge about the follow up semen analysis and were able to practice the same in the field whereas ASHAs in the ineffective lacked knowledge about the same.

4. In case of post NSV care majority of respondent were aware of the fact that, client has to avoid any kind of hard work for two days after getting NSV done to avoid any kind of failure in operation.

5. ASHA from effective pool were not having much difficulties to communicate their knowledge regarding use of contraception for three months and they also explained the

reason that why it is important to use condoms for three months to avoid any kind of failure after getting NSV done. Explanations of all these facts were much more practiced by effective ASHA during their field work as comparison to non effective ASHAs.The reason for not practicing and communicating all NSV related facts to the community were,

a) Shyness of ASHAs

b) Male members of village do not allow them to talk about NVS,

c) They their self do not feel comfortable to talk to them because ASHA are the daughter-in –laws of their village.

6. Response of ASHAs from both effective and non effective were very low regarding avoid use of bicycle for 7 days, avoid bathe for two days was very low even after probing them for both point the response was very low. In case of cycles Most of them were aware that client has to avoid cycles but they don't know exact no. of days. Most of them were also not aware about medicine given to the facility and also response was very low for examination of semen.

Q5:- How do you convince client for adopting NSV?

Table -5

Knowledge level					
Answers	**Effective No=10**		**%**	**No effective No=10**		**%**
	K	**P**		**K**	**P**	
1. Directly talk to client.	3	3		0	0	
2. Talk to his wife.	10	10		10	10	
3. Talk to both	5	0		2	0	
4. Informed them about the benefit of the NSV	0	0		0	0	
5. Refer them to ANM	0	0		0	0	
6. Refer them to doctors	5	0		8	0	
7. Use any IEC material	9	7		4	2	
8. Some ASHA husband has got NSV done (Link Workers).	0	0		0	0	
9. Successful client of the village helps	4	4		0	0	

1. Bothe effective and ineffective ASHAs showed preference for communicating with the wives of potential client as the first step for demand generation.

2. Effective ASHAs had better the knowledge of IEC as compared to ineffective ASHAs. Some ASHAs in both the group were using IEC material in the community.

3. Some of the ASHAs in the effective group teamed with NSV accepters in the village to increase the NSV demand.

Q6:- What are the motivational factors for an ASHA to mobilize Client for NSV?

Table -2

Knowledge level						
Answers	**Effective No=10**		**%**	**No effective No=10**		**%**
	K	**P**		**K**	**P**	
1. Money.	10	10		7	7	
2. Take it as a responsibility of an ASHA.	4	4		6	0	
3. Influence by others such as ANM, service providers, any other	0	0		0	0	
4. Associated Fame.	8	0		5	0	
5. Others	0	0		0	0	

1. Most of the ASHAs said the money and associated fame were the major motivational factors for ASHAs to mobilized client for NSV.

Discussion

This report tries to summarize some of the most important information regarding NVS demand generation and attributes of ASHAs for demand generation, problem faced by an ASHA during their work in field, perception of community for acceptance of NSV, perception of family members of an ASHA, views of people where she lives, support of community and the attitudes of staff of health care facility. Based on that, this research attempted to broaden our understanding of an ASHA that why some of them are effective in the same community whereas others are not as effective and also try to understand the community's support to an ASHA for her work of demand generation, knowledge, perception and behaviors of ASHAs and village people.

In addition, attempt was made to gather relevant information about perception of facility member for the work done by ASHA of their area. What they feel as attributes of effective and ineffective ASHA vis-à-vis NSV. The findings can help to develop effective communication messages and strategies to develop skill to enhance effectiveness of ASHAs to work for NSV demand generation.

Study is qualitative in nature which is the main strength of this study. Data which is used for the study is collected through primary source of data collection. Data validation is done through information available in the facility records. Sampling technique used for selection of ASHAs is non random purposive sampling which helps to select the respondent those are beneficial to get the more reliable information for the study .One thing which is come up as a major strength of the is capacity building of the ASHAs during the assessment of their practice part.

The main loophole is the low sample size resulting from availability of effective ASHA, and short duration of the study.

Major leanings from this study are

A. **Attributes of effective ASHAs: - Talk to wives of the clients**, **Use IEC material** and **successful clients of the village were the major strategies used by ASHAs who were successful in NSV demand generation.** ASHA workers spoke more freely and give more information about NSV to wives than directly to the potential clients. Effective ASHA also used IEC to start their conversation with the clients. Successful client of village also helped ASHA to make their client.

B. Ineffectiveness of ASHAs: - Result shows that there is a little difference in the knowledge of effective and ineffective ASHA. The only difference is in their practice part. Effective ASHAs are practicing their knowledge in their respective fields while ineffective ASHAs are not doing the same because of shyness, cultural inhibition and social factors like family support. Ineffective ASHA needs hand holding during the practice in the field at least 3 to 4 times. This will help them to develop the confidence and communication skill to practice their knowledge in their respective fields.

C. **Cultural context: -** It was observed that some cultural and religious factors were also the reason for not accepting NSV as a permanent family planning method, for some members of Muslims community. They said that after getting NSV done, their religion will not allow them to read Kuran; one member from their community said that

"Hamare dharm me likha hai k Allah ne jaisa bana k bheja hai vaise hi marane per jannat naseeb hoti hai"

D. **Facility support: -** Result shows that ASHAs who are getting good support from their respective facility for NSV are more effective in comparison to those who are not having support.

E. **NSV Champions: - ASHAs** who are effectively working for NSV demand generation can became a role model for those who are not effective in NSV demand generation.

F. **Gender: -**India is a male dominating country. In rural India it is see that most of the decisions of a family take by the male members of the house. This is also one factor for not accepting NSV as a family planning method. Weaker role of female gender in the decision making has come across as major barrier to NSV uptake in the rural areas.

"Agar mere haath me unka operation karana hota to me kab ka karawa chuki hoti per ab unhe kon samjhayega Jo aapne mujhe samjhaya hai NSV k bare me. Mujhe to unse es baat k baareme baat karane me dar lagat ka khin wo mujhe marane na lage esk bare me sunkar"

(Kakara village community woman)

She was a pregnant lady and wants to limit her family after this child; But She was afraid that how she will talk to her husband. That why some women don't allow even to ASHA to Talked to her husband because of his arrogant nature.

Chapter 4

Recommendations

1. ASHA in the ineffective group should be coached at least three times on field.

2. To overcome the cultural barriers that faced by ASHA NSV related sensitization of the important stake holder in the village and the facility will be useful.

3. Capacity building of ASHAs in the areas of sexual and reproductive health will help to overcome the communication barriers.

4. A NSV specific visual job aid will help to increase the effectiveness of ASHAs

5. It is recommended to motivate eligible husband of a ASHA to accept NSV as permanent family planning method this kind of modeling can bring a lot of fane to an ASHA in the village as fame one of the motivation for ASHA in NSV client mobilization.

6. Makin a team of ASHA and successful client in the village will strengthen the support system of ASHA with respect to NSV at the village level

7. Positive attitude of facility staff and ASHA family members will enhance ASHA performance in the field.

Conclusion

ASHAs are one of the important stake holders of health system in rural India. Knowledge, skills and attitude of ASHAs are responsible for NSV uptake in the community.. ASHAs in effective and ineffective pool match with respect to knowledge but differ in practices. It is important to build capacities of ASHAs with respect to NSV demand generation to improve NSV uptake in the rural areas. To help address cultural and gender factors, advocacy with gram pradhans and senior citizens in the village will give immediate results with continuing efforts at district and state level.

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Annexure

Questionnaire

Demographic detail

Q1.Name-……..

Q2.Age-…….....

Q3.Education-……

Q4 No of years as an ASHA-……

Each Point of every Answer will be asked with the reason, why they respond for it.

S.No	Question	Knowledge	Practice
1	What do you think about NSV please share your views? Ans:- 1. Permanent method of family planning for mails. 2. Less time taking. 3. No bleeding. 4. Weakness. **(Probe them to explain the reason of no bleeding**) 5. No pain during procedure**.(Ask them about the procedure and)** 6. Can get back to their work in few days**.(Why)** 7. No effect on sexual relationship**.(why)** 8. Use of contraceptives for 3 months**. (Why)** 9. Honorium of 1100. 10.Rs/- 200 for motivators 11. Any other point.	1…… 2…… 3…….... 4…… 5…… 6…… 7…… 8…… 9……... 10…….. 11……..	1…….. 2……..... 3…….. 4……. 5……. 6……. 7…….. 8…….. 9…….. 10…….... 11…….....

S.No	Question	Knowledge	Practice
2	How do you recognize eligible couples? Ans:- 1. Age <60. 2. Have completed their family and do not desire more children. 3. Wife should be alive. 4. Wife and client have not gone any sterilization method. 5. Have child at least one year of age**.(Why)**	1……... 2……... 3…….. 4…….. 5…….	1……... 2……... 3…….. 4…….. 5……..
3	What are the main pre NSV guidance for a client? Ans:- 1. Part preparation**.(what is part preparation and why it is essential)** 2.Consent of client.**(what it is mandatory)** 3. Consent of his wife and his family/members .**(what it is mandatory)** 4. eligibility of client	1……. 2…… 3…… 4……	1…… 2…… 3…… 4……..
4	What are the main post NSV measures /precautions should keep in mind? Ans:- 1. Avoid hard work for 48 hours. 2. Avoid bath for 2 days. 3. Avoid cycles for 7 days.**(Why)** 4. Use of contraceptives for 3 months.**(Why)** 5. 5 days medicine. 6. Followup-Semen	1…….. 2……... 3…… 4……... 5……...	1…… 2…….... 3……... 4…… 5……

	analysis for three months. **(Why)**	6……	6……
5	How do you convince client for adopting NSV? Ans:- 1. Directly talk to client.**(if yes than how and if no then why**) 2. Talk to his wife.**(Why)** 3.Talk to both 4.informed them about the benefit of the NSV 5. Refer them to ANM **(Why)** 6. refer them to doctors**(Why)** 7. Use any IEC material**(How please explain)** 8. Some ASHA husband has got NSV done (Link Workers).**(How they help in your work)** 9. Succesful client of the village helps.**(How they help in your work)**	1……. 2……. 3……. 4……. 5…….... 6…… 7…… 8……... 9……	1……. 2……. 3……. 4…… 5…… 6…… 7…… 8…… 9…….....
6	What are the motivational factors for an ASHA to mobilize Client for NSV? Ans:- 1. Money. 2Take it as a responsibility of an ASHA. 3.influence by others such as ANM, service providers, any other 4. Associated fam. 5. Others.	1…… 2…… 3……. 4…….. 5……..	1…… 2……. 3……... 4……. 5…….