DISSERTATION TITLE

"SOCIAL MARKETING OF ORAL CONTRACEPTIVE PILLS AND CONDOMS BY ASHA WORKERS IN SAHARSA DISTRICT OF BIHAR – "ISSUES AND CHALLENGES"

A Dissertation report for

Post graduate diploma in health & hospital management

By

Binay Ranjan

International Institute of Health Management and Research, Delhi

Dissertation at State Health Society, Patna (Bihar)

International Institute of Health Management Research

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Roll No. PG/11/004

Under the guidance of

Dr. Bhola Nath Jha

Designation: Civil Surgeon Cum Secretary

District Health Society

Saharsa (Bihar)

Dr Preetha GS

Designation: Assistant Professor

IIHMR, New Delhi

International Institute of Health Management Research, New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Mr. Binay Ranjan**, student of International Institute of Health Management and Research, Delhi has successfully completed his Dissertation w.e.f. 2th January 2013 to 30th April 2013 from **'District Health Society, Saharsa (Bihar)'.**

He undertook the research project titled, **"SOCIAL MARKETING OF ORAL CONTRACEPTIVE PILLS AND CONDOMS BY ASHA WORKERS IN SAHARSA DISTRICT OF BIHAR – "ISSUES AND CHALLENGES"** under my guidance. The project was assigned to him by District Programme Manager, DHS Saharsa.

The work done by him was outstanding. I appreciate his hard work and dedication towards the assigned project and wish his success in all her future endeavors.

Dr. Bhola Nath Jha

Designation: Civil Surgeon Cum Secretary

District Health Society

Saharsa (Bihar)

Dated: April 30, 2013

30-4-13

जिला कार्यक्रम प्रबंधक
जिला स्वा० समिति, सहरसा

Certificate of Approval

The following dissertation titled "**SOCIAL MARKETING OF OCP'S AND CONDOMS BY ASHA WORKERS IN SAHARSA DISTRICT OF BIHAR – ISSUES AND CHALLENGES"** 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

Name	Signature
Dr. Shri Singh	
Dr Preethi GS	
Dr. VINAY TRIPATHI	Vinay Tripathi

Name of Student
Binay Ranjan

Certification from Dissertation Advisory Committee

This is to certify that Mr. Binay Ranjan, a participant of the Post- Graduation Diploma in Health and Hospital Management, has worked under our guidance and supervision. He is submitting this Dissertation titled "Social marketing of oral contraceptive pills and condoms by ASHA workers in Saharsa District of Bihar- Issues and Challenges" 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.

Faculty Mentor
Dr Preetha GS
Designation: Assistant Professor
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Organizational Advisor
Mr. Prabhat Kumar
District Programme Manager
DHS, Saharsa(Bihar)

FEEDBACK FORM

Name of the student: Binay Ranjan

Summer Training Institution: District Health Society, Saharsa.

Area of Summer Internship: social marketing of oral contraceptive pills and condoms by ASHA workers in saharsa district of bihar – "issues and challenges"

Attendance: Regular and Punctual From 2nd January to 30th April, 2013

Objective met: To ascertain the issues and challenges associated with social marketing of Oral Contraceptive Pills and Condoms by ASHA workers in Saharsa District of Bihar.

Deliverables: Study will be useful for application in Public Health Delivery.

Strengths: Hard Working and sincere about his work.

Suggestion for Improvement: Needs to be more specific on your research and applications to the improvement of Health system

Signature of the Officer-in-Charge (Training)

Date:

Place:

ACKNOWLEDGEMENT

Any accomplishment requires blessings and efforts of numerous individuals and this work is no exception. I thank god Almighty for giving me this great opportunity to study and learn at this prestigious training institute

I sincerely thank Mr. Sanjay Kumar Executive Director, State Institute of Health and Family Welfare, Patna (Bihar) for giving me an opportunity to work in the esteemed institute.

I would like to thank Mr. Prabhat Kumar DPM, DHS under whose guidance my dissertation was fledged with good knowledge and skills related to Healthcare Management and who provided me with tremendous support throughout my training period and towards making my research study a complete success.

I would like to acknowledge Dr. Bhola Nath Jha (Civil Surgeon) who provided me with their intense support and guidance for conducting my Summer Internship Project.

We express our sincere thanks and gratitude to Dr.Preetha G.S for her ceaseless energy; guidance and leadership have always been a source of inspiration and support. We will forever be thankful for her encouragement and advice, which gave me strength to complete the work.

I would also like to thank all those who were a part of my research study without whose cooperation and help my study would not have been completed successfully.

Mr. Binay Ranjan
Student
IHMR, Delhi

TABLE OF CONTENTS

List of Tables

List of Figures

List of Abbreviations

ANM	Auxiliary-Nurse-Midwife
AP	Andhra Pradesh
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Worker
BTM	Bilateral Tubal Ligation
BCC	Behavior Change Communication
CHC	Community Health Centre
CMO	Chief Medical Officer
DLHS	District Level Household Survey
DH	District Hospital
FP	Family Planning
HR	Bihar
IEC	Information Education Communication
IUD	Intra Uterine Devices
JSK	Jansankhya Sthirata Kosh
LHV	Lady Health Visitors
MCH	Maternal Child Health
MO	Medical Officer
MOI/C	Medical Officer In charge
MPW	Multi Purpose Workers
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NSV	Non Scalpel Vasectomy
RMP	Registered Medical Practitioners
SC	Sub-Centre
SRS	Sample Registration System
USA	United State Of America
WHO	World Health Organization

STATE HEALTH SOCIETY (SHSB) BIHAR

The State Health Society Bihar is situated at Sheikhpura, Patna. It has been established in order to guide its functionaries towards receiving, managing, and account for the funds received from the ministry of Health & Family Welfare, Government of India.

SHSB manages NGO, PPP (Public Private Partnership), components of the NRHM in the state including execution of contracts, disbursement of funds and monitoring of performance. The Government of Bihar has decided that SHSB will function as a resource centre for the department of Health & Family Welfare in situational and policy development.

Basically SHSB strengthen the technical or management capacity of the Directorate of Medical and Health services Patna as well as districts societies by various means like recruitment of individual from open market & mobilize financial or non-financial resources for supplementing the NRHM activities in the state.

STATE'S PROFILE

Bihar has a population of 10.38 million with a decadal growth rate of 25.07% as compared to the national growth rate of 17.64%. The population density per square km is 1102 as against the national average of 382. The sex ratio is 916 per 1000 males and the literacy rate is 63.82%.

Area in sq km	94,163
Number of Divisions	9
Number of Districts	38
Number of Sun-divisions	101
Number of C.D Blocks	544
Number of Urban agglomerations	14
Most Populous District	Patna : 5,772,804
Least Populous District	Sheikhpura : 634,927

RCH indicators

	2003	2005	2010	India 2010
IMR	60	61	48	47
CBR	30.7	30.4	28.1	22.3
CDR	7.9	8.1	6.8	7.1
MMR		312	261	212

RCH indicators such as IMR & MMR are showing declining trends whereas Institutional delivery in government facility, complete ANC, contraceptive use in the state has increased. The current situation of the selected indicators based on NFHS-3, SRS and CES shows that overall the state is moving towards achieving the goals. Areas which are the main concern for Bihar are High MMR, High TFR, Poorly functional public health system, Poor accountability, Delay in payment to beneficiary, Infection management.

State's Vision, Goal and Strategy in health sector under NRHM:

- Universal access to Primary.
- Provide affordable Health Care Services.
- Decentralized Health Services.
- Community Participation in Health Care.
- Enhanced performance of Public Health System by improving quality and ensuring client Satisfaction.
- Strengthen Health Management Information System.
- Encourage participation of Civil Society Partners in health service delivery.
- Private Sector Participation in Tertiary Health Care.
- Promotion of AYUSH Services and their mainstreaming.
- Mobile Medical Services for difficult areas to improve access.
- Environment conservation (Bio-Medical Waste Management).

ORGANISATIONAL PROFILE

1. INFRASTRUCTURE

Mr. R B P Yadav (Retired IAS) - consultant of Infrastructure.

- Funding for the Infrastructure has been done by NRHM.
- As per the demands from the districts this department mentions the requirement and amount of fund in the PIP.
- It takes care of the district wise funding as needed for Hospital construction, Hospital Infrastructure etc.
- There are 76 FRUs,533 PHCs are working in Bihar.
- Currently sub-divisional hospital is 75 bedded but now it has been planned to convert it into 100 bedded.

- **Procedure for the Proposal**

  MOIC or Superintendent sends the proposal to the District health society (DHS) & then DHS further sends the proposal to the Infrastructure department at SHSB & then this department forwards this proposal to the Executive Director (ED) of SHSB & then after accepting the proposal ED allots the work to the Building Co-operate Bihar Medical Services & Infrastructure Co-operation which does the development & construction work.

2. NURSING DEPARTMENT

Dr. Y N Pathak - SPO (State Program Officer) Nursing.

Objective

The main objective of this department is to open more & more nursing school in Bihar to increase the number of ANMs (Auxillary nurse midwives), GNMs (General nurse midwives) & to strengthening the schools to come over the poor health indicators in Bihar.

- As the main motive of NRHM is to achieve the target in the limited period of time & Government of India is a Welfare so every state has equal right to get equal opportunity hence the central government has provided 26 ANM-GNM schools for Bihar as 15 in 2010 and 11 in 2011 respectively.
There is 85% funding is done by the NRHM & 15% funding is bore by the state government.

- Among 26 schools, 20 are ANMs schools from on an average 40-50 pass outs every year from each school & rest are from the GNM school.
- It has been planned to open 10 ANM & 10 GNM schools in the upcoming years.
- IGIMS (Indira Gandhi Institute for Medical Sciences), Patna & Kurji Family Hospital, Patna is planning to start B.Sc. Nursing course.
- In order to train the ANMs 4 mini skill labs each in 8 districts by the support of Care, UNICEF, Melinda Gates, SHSB etc has been running in the state.

Types of Nurses & their work

Types	Work
ANM (Auxillary Nurse Midwives)	Support the GNMs & also does the field activities like RI (Routine immunization), ANC checkup etc.
GNM (General Nurse Midwives) – A Grade	Works in the district hospitals & medical colleges, & can do IV (intra venous), Blood transfusion, can help in surgery under doctor etc.
BPHN (Block Public Health Nurse)	
PHN (Public Health Nurse)	
LHV (Lady Health Visiter)	Its work is to monitoring of the ANMs

3. HR DEPARTMENT

Jai Prakash Singh B.A.S - Senior Deputy Collecter.

- It takes care of three departments
  1. Recruitment & HR Issues
  2. Radiology & Pathology
  3. Legal Issues

I. Recruitment & HR Issues:

- It takes care of the recruitment in the State Health Society.
- Deal with the HR issues like Salary problem, CL & DL problem.
- Salaries have been funded directly by NRHM.
- At district level DHS (District health society) where Establishment cell is responsible for the recruitment.
- On every Sunday, walking interview takes place in the districts on the basis of applications received from the applicants.

II. Radiology & Pathology:

- Also see the Radiology & Pathology department in the hospitals & make the timely payment of the radiology & pathology which works on the PPP (Public Private Partnership) mode.
- In pathology department test is free in Bihar at government hospitals & the expenses have been bore by NRHM.
- Also monitor the PPP mode organization is paid timely or not.
- There are 350 hospitals and PHC which is equipped with X-rays.

III. Legal issues :

- This department resolves the legal problems like cancellation of the contract, challenges against the recruitment which is applied by the applicant who has not been selected, Payment not on time, patient not satisfied with the medication, Outsource organization which works on PPP mode etc.

- **RKS (Rogi Kalyan Samiti):**

It is a committee which has been set up at the hospital level to manage, regulate & supervise the hospital facilities & fulfill the requirements. These committees are present at PHC (Primary health centre), FRU(First referral unit), Sub divisional hospital & DHS(District hospitals) levels in Bihar.

- The concept of **RKS** came from **Madhya Pradesh.**
- Committee has of 9-11 members.
- It's almost an autonomous committee & maintains hospitals.
- There are 19500 RKS in Bihar.
- Firstly RKS has to register under Society Act then the power has been given to the RKS committee & works like NGO.
- RKS has the power to take decisions but under the government guidelines.

Committee consists of:

- Government Officials.
- People from NGOs.
- Public representatives.
- Beneficiaries.

Funding of RKS:

- Seed money of Rs 100000 has been given to the PHC for RKS annually & at the district level seed money of Rs 500000 has been given annually from NRHM.
- Untied fund goes to RKS of Rs 25000 & for annual maintenance grant of Rs 50000 is given to the RKS.

4. MONITORING & EVALUATION

Ms Jyoti Verma - Deputy Director, Monitoring & Evaluation & Quality Monitoring .

This department emphasizes on the proper working behavior of the government hospitals & does the regular monitoring to know the status of the task which has been provided to the hospitals.

- It also provides the ISO certificates to the organizations for the 46 facilities. District hospital Ara is one of the ISO certified hospital. This year a proposal for laboratory certification has been planned.
- CBPM (Community based Planning & Monitoring) has been established in the 5 districts of Bihar & the selected districts are Bhagalpur, Darbhanga, Nawada, Gaya, & Nalanda.
  Village planning monitoring committee is present at the village level.
  & Block planning monitoring committee is present at block level.
- Nigrani Samiti has been formed for the purpose of monitoring at the PRI (Panchaytiraj Institution) level.
- Two nodal officers have been allocated for each districts.
- VHC is at the Panchayat level which is a combination of PHED, PRI & IDSP.

5. FINANCE CELL

Mr. Pramod Kumar - Additional Director, Finance.

This department takes care of the distribution of the funds to the different districts on timely basis & does the regular monitoring of the utilization of the funds.

- 85% funding is from NRHM & 15% funding is from the state government.
- 90% of the fund is given to the districts.
- At district level fund has been given to the DHS (District health society) & then it transfers the required fund to the block.
- FMR (Financial management report) is send by the districts to the state on the regular basis in 19A form.
- This cell also generates Financial rules (GFR).

6. **IDSP (Integrated Disease Surveillance Program)**

Dr. A K Tiwari – SPO, IDSP

This department does the micro planning for different diseases & funds have been released to the different wings of the IDSP according to micro plan requirements.

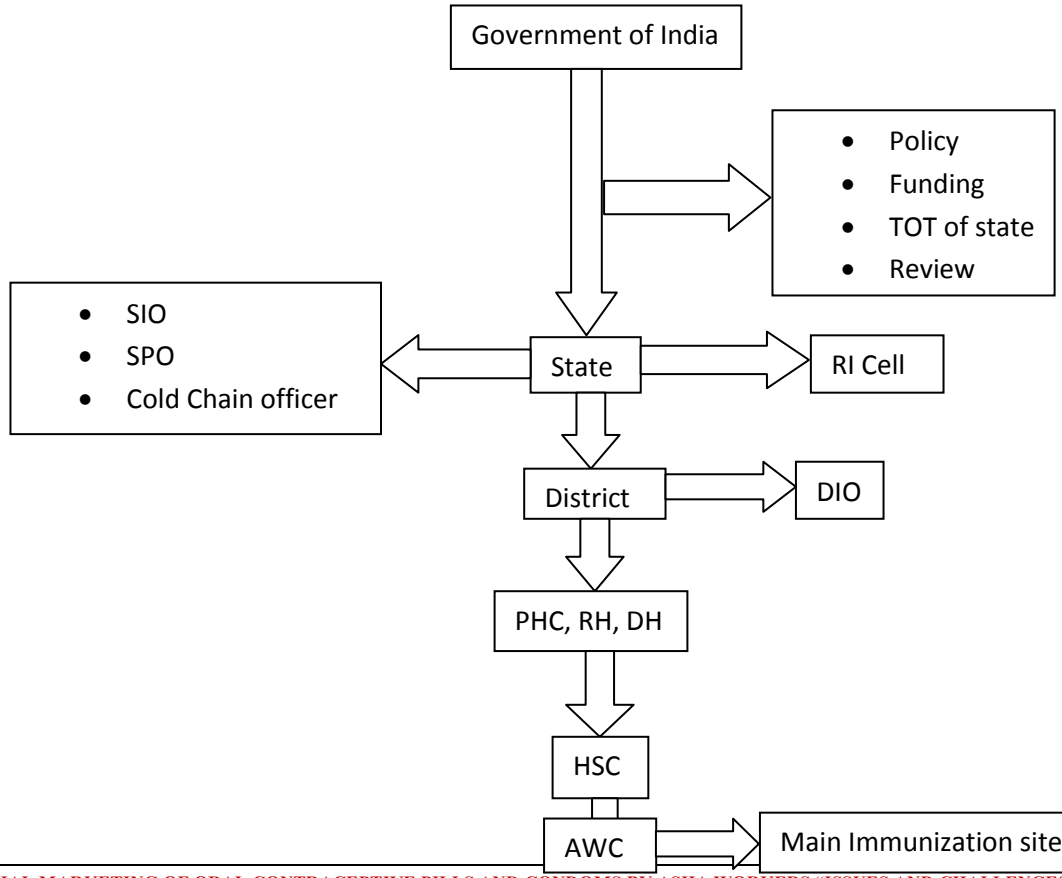
- There are 41 diseases under IDSP cell to come over the outbreak & mainly 22 focused diseases. There some of the diseases are **AFP (Acute flaccid paralysis), Measles, Chicken Pox, Diarrhea, Food Poisoning etc.**
- Reporting is on weekly basis by the districts.
- There are three forms which has been filled by the block these are
  1. P-Form (Presumptive form)
  2. L-Form (Lab form)
  3. S-Form (Synchronized form)
- P-form, L-form & S-Form respectively has been filled up by the ANMs at PHC which send the report to the District surveillance & then it further send to the State surveillance.
- EWS (Early Warning Signals) are mentioned in the every form.
- There is a target level has been decided for every disease.

7. **RI (Routine Immunization)**

Mr. Ram Ratan - SPO, RI & Polio.

- It takes care of the Immunization programmes running in the state.

Immunization Chain



- Government of India leads to the Policy making, Funding, Training of trainers (TOT) of state & does the review meeting.
- At state level SIO, SPO & cold chain officer leads the RI cell and Its monitored has by the DIO, NPSP, & the developing partners like UNICEF, Care, Nipi.

Procedure of sending the required thing for immunization

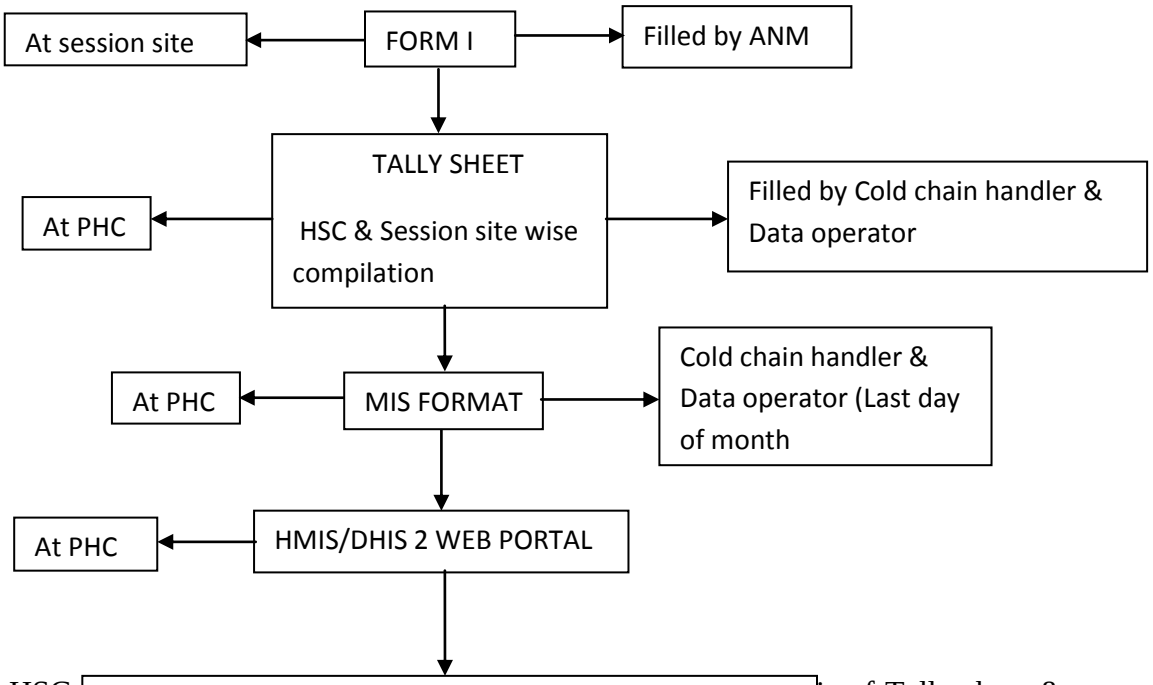
- From PHC logistics like Vaccines, Syringes, white & red bags, Hub cutter etc through courier reach to the AWC from PHC.
- The courier person get Rs 50 for per session & for hard reach area Rs 100 per session.

WORKFORCE

ANM, ASHA, AWW, Courier are the workforce for the immunization.

- ANMs head the session & do the Vaccination activity.
- ASHAs do the mobilization as per the due list & also promote IEC & BCC.
- AWW take care of arrangement & the cleanness of the RI session site or AWC.

HMIS ENTRY SYSTEM FOR RI



- HSC is of Tally sheet & verified by MOIC.

- They have also started a program known as **MUSKAN EK ABHIYAN** in 2007 for the routine immunization in which around **17616 ANMs** & **83000 ASHAs** are working for this program & there is a requirement of **5633 ANMs.**

- There has been 68% immunization has been achieved & the target is to rich 85% by 2012. **Year 2012** has been announced as **YEAR OF IMMUNIZATION** in Bihar.

INCETVES GIVEN FOR RI

Number of beneficiary	Incentive for ASHA
5-10	Rs 150
11-15	Rs 100
16-20	Rs 150
>20	Rs 200

Number of beneficiary	Incentive for ANM
0-15	Rs 50
>16	Rs 100

SUPPLY CHAIN OF VACCINE

- GoI sends Vaccines & Logistics to the PHI at Patna, Bihar where it has been stored in WIC (Walk in cooler) & WIF (Walk in Freezer).
- From WIC Vaccines goes to the District cold chain storage point.
- Then it goes to the PHC & from there it goes to the RI sites or AWC.

- There are nine regional storage points in Bihar, these are **Bhagalpur, Darbhanga, Muzzaffarpur, Purnea, East Champaran, Saharsa, Aurangabad, Nalanda & Saran.**

- The vaccines which is expire after 4 hours after open the vial are BCG & Measles, & after 2 hours are JE (Japanese Encephalitis) and if the time is more than that it results to **AEFI (Adverse event following immunization).**

- On the vial of the Vaccines a **VVM** indicator is present i.e. **Vaccine Vial Monitor** which changes the color slowly and gradually it indicate the vaccines expiry.

POLIO

Path of the Vaccine to reach the ground level

- Polio vaccine comes to the state where the NPSP cell & WHO unit are present from there it goes to the district level where micro plan has been made in which

UNICEF also helps to make the micro plan. Then it comes to the Block level and then to the PHCs.

- There are more than 99% of Polio immunization coverage.

- For polio there is **SNID (State National Immunization day)** & **(NID) National Immunization day** were made.

8. MCH DEPARTMENT

Mr. Gaurav Kumar, Deputy Director, MCH

National Health Program

- RCH is a national health program.
- This project runs in the phases in which Phase I is over & currently Phase II is running.
- Its major components are Maternal Health, Child Health, FP (Family planning), ARSH (Adolescent reproductive & sexual health), Urban RCH et**c.**

- **MCH**

MCH has three component:

1. Ante natal care
2. Intra natal care
3. Post natal care

1. Ante natal care:

- In anti natal care the check up for Blood pressure, Abdominal checkup (fundal height), Hemoglobin, Blood glucose sugar, & weight is done.
- Government has suggested doing 4 ANC checkups in which 3 has to be done on a definite basis.

2. **Intra natal care**:

- In this category normal & complicated delivery is being done.
- Normal deliveries are being done at L1 level i.e. HSC & APHC & Complicated and assisted delivery at L2 level i.e. at PHC and the Caesarian section is done at L3 i.e. at DH (District hospital), Sub divisional hospital, FRUs level.
- There are 477 APHC & 76 HSC have been selected for the normal delivery in which 2 HSC & 1 APHC from each district is for normal delivery.

3. **Post natal care**:

- Checkups has been done within 48 hours after birth.
- It's 3 days, 7 days & 14 days 24 hours visit for the PHCs.

JSY (Janani Surksha Yojana)

- In this scheme Rs 1400 are given to the beneficiary, Rs 600 to the ASHA whatever it's a primary or multi gravid.
- For home delivery JSY provides Rs 500 for the beneficiaries in some terms and conditions, are:
  Beneficiaries should belong to the BPL family.
  Benefits have been provided up to 2 children
  Beneficiaries should be above than 19 years.

9. ASHA RESOURCE CENTER

Vasudha Gupta – team leader

ASHA

One of the key components of NRHM is the Accredited Social Health Activist (ASHA).ASHA must be primarily a woman resident of the village (married/widowed/divorced), preferably in the age group of 25 to 45 years. She should be literate with formal education up to class eight. ASHA is chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha. Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programs, and construction of household toilets Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programs in her village. In the state of Bihar the target population of ASHA's is 87135 against which 83000 have been already selected. Modules 5, 6 and 7 for ASHA have been rolled out in all 38 districts of Bihar. For the motivation of ASHAs they have been given the following from time to time.

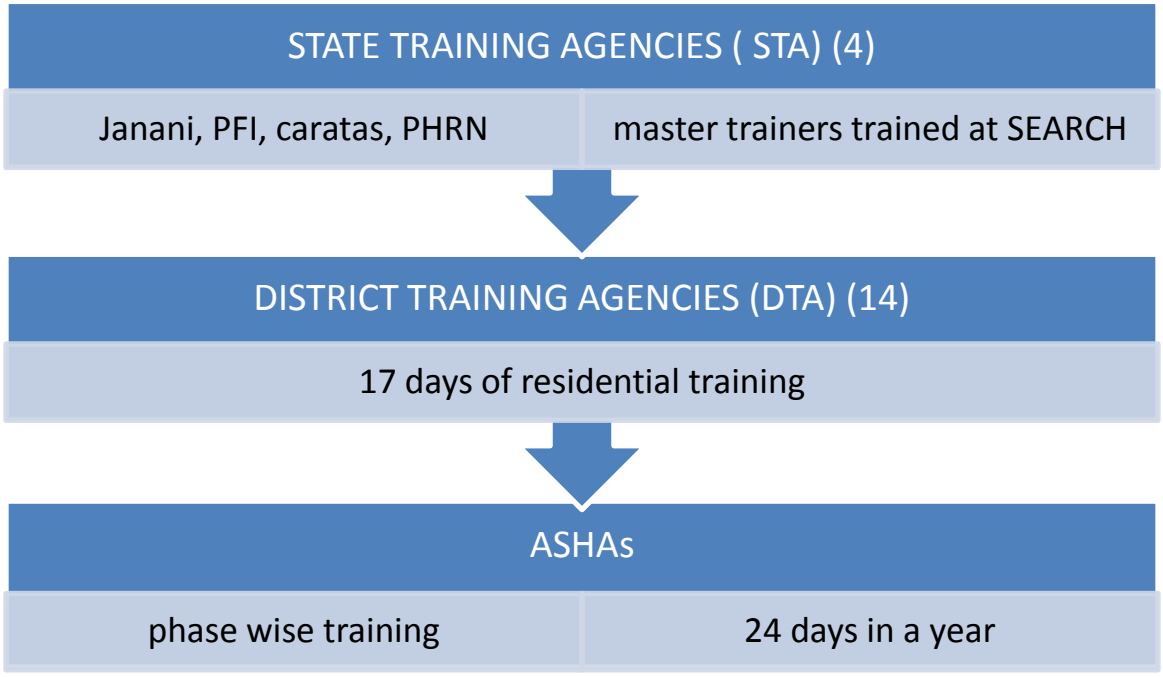
- 2009 2 sarees and 1 umbrella
- 2010 drug kits
- 2011 2 sarees and 1 torch

ASHA Resource Center, Bihar:

It is a registered body, with 11 governing board members with ED (SHSB) as the chairperson. Human resource at the state level comprises of a Team Leader, a Consultant and a Data Assistant. At the state level there are District Community Mobilizer (DCM) and District Community…… (DCA). Regional level consists of Regional ASHA Coordinator. At the block level there is Block Community Mobilizer (BCM). ASHA Facilitators each with 20

ASHAs under them constitute the human resource at the village level. About 3500 ASHA facilitators are there in the state of Bihar.

Training



10. 102,108 AMBULANCE SERVICE AND COLD CHAIN

102 and 108 AMBULANCE SERVICE

102 and 108 are toll free numbers given by the Government of India to the ambulances needed for transfer of emergency medical cases. These calls are diverted to a Central Call Center. The ambulances are well equipped with GPS, and the drivers and Emergency Medical Technicians (EMT) have mobile phones. These ambulances are run on a PPP mode.

The following sections of society receive services free of cost:

- Pregnant women from home to nearest health facility and then back home.
- Newborns from home to health facility and back home
- Accident cases
- Senior citizens
- BPL patients

For other beneficiaries 9 rupees/ km are charged from the point of pickup to the point of drop. In Bihar there are 504, 102 ambulances with Basic Life Support (BLS) which run within the

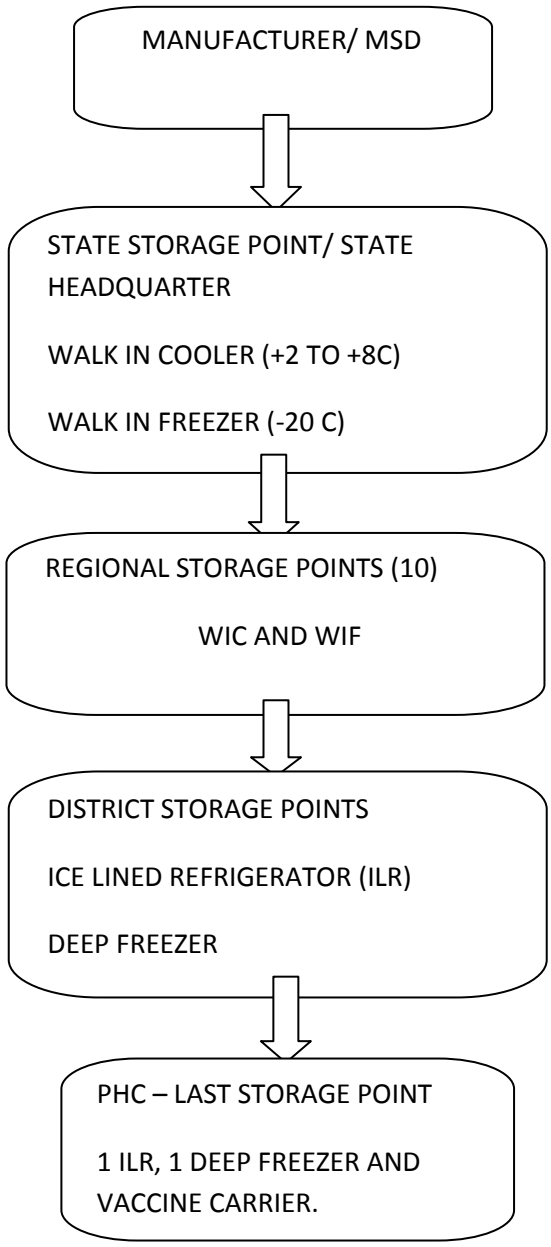
districts. 50 is the number for 108 ambulances of which 45 are BLS and 5 have Advanced Life Support (ALS), which is basically for cardiac emergencies. These 108 run between the districts.

COLD CHAIN:

Cold Chain;

Keeping the vaccine from the point of manufacture to the point of use at recommended temperature (+2 C to +8 C) is known as cold chain.

Maintenance of Cold Chain:



11. PLANNING

Ms. Rashi Jaiswal - SPM (PIP)

- Planning process for NRHM is decentralized.
- Planning is done at the following levels

    - **Village level**- 250 villages in pilot mode. Village plans are approved by VHSND.
    - **Sub centre level**- approval by ASHAs and AWW.
    - **Block level**- Medical officer in charge is the nodal officer along with Block Health Manager.
    - **District level**- District planning team, ACMO, DPM and District Planning Coordinator.
- There is consolidation of sub centre and block plans, which are sent to the district.
- Allocation of funds to district is done annually.
- Allocation is done after assessing the expenditure every 6 months by State Program Officers.
- Monitoring of the funding is done by Regional Program Managers at the district level and District Coordinator at the block level.

12. ADMINISTRATION

Mr. Ashok Kumar Singh B.A.S.- Administrative Officer

- Covers the entire establishment and administrative matters of SHSB including attendance, leaves, law and order, salaries, payments etc.
- Coordination with program officers for implementation of various programs.
- Monitoring of the programs.
- Monitoring of functions at the District level.
-

13. VHSND DEPARTMENT

Mr. Ranjeet Samaiyar, NRHM Consultant

- Focuses on the community health process.

Purpose of NRHM

- To change the approach from bottom to top, before NRHM the approach was top to bottom.

- ASHA component has been introduced along with the Flexibility, HR availability, Infrastructure, Funds, Administration, Planning & Monitoring, Convergence, PRI implementation.
    - About 2-3% of total GDP has been given for the fund for NRHM.

Health

There are four components of health:

- Preventive
- Promotive
- Curative
- Rehabilitative.

These all are interlinked with each other.

- **Community health**

- For community health NRHM works for the 3A principle i.e. Affordability, Accessibility, & Availability.
- ASHA is a community mobilizer.

VHSND (Village Health Sanitation & Nutrition Day)

- VHSND has been introduced to improve the community health of the peoples.
- It has been divided into four sectors

Category	Concerned department & the person
Sanitation	PHED
Nutrition	ICDS – AWW
Village	PRI – Community
Health	ANM, ASHA

- In VHSND ANC, PNC, Adolescent Health, Supplementary medicine, Temporary sterilization method (Condoms, ECP) etc has been taken care off.

14. FAMILY PLANNING

Mr. Subodh Kumar, Deputy Director, Family Planning

- TFR is 3.7 in Bihar.

- Hindi spoken places like UP, Bihar, Jharkhand, Rajasthan, MP are considered as the red hearted region of India as major contribution in population has been given by these states.
- Only 1% sterilization of population in Bihar can achieve a level of 2.1 of TFR.
- There are 68.2 % Child marriages in Bihar.
- 58% have a child after first year of marriage.
- A new technique **PPIUCD** has been introduced in the six medical colleges from the last year which has been planted after the delivery to maintain the gap between 2 children for 2-3 years. It has been done by the gynecologist & has been done within 48 hours of delivery.
- **JHAPAIGO** works for the **PPIUCD.**
- On population day a **World population fortnight** has been organized.
- It has been planned to introduce Family planning counselor at FRUs of which 80% counselor will be ladies.
- There is a scheme known as **Janani Suraksha Kosh (JSK)**
  Under this two programs has been done.
  1. **Prerana award:** In this if a BPL couple having first child after 2 years of marriage has been rewarded with an amount of Rs 5000.
  2. **Santhusthi:** Under this a family planning campaigning has been done during the winter season.

3. INTRODUCTION

The term, **Social Marketing** was coined in 1971 by *Philip Kotler*, a professor of management at Northwestern University. *Kotler and Gerald Zaltman* have defined Social Marketing as the 'design, implementation, and control of programs calculated to influence the acceptability of social ideas, and involving considerations of product, planning, pricing, communication, distribution and marketing research'. It is an adaptation of commercial marketing and sales concepts and techniques with promotional campaigns for attainment of beneficial social goals.

An extensive *Market Research* forms the essence of Social Marketing, which is used to inform three main intervention components:

- ✓ Branding of health service/product
- ✓ Development of logistics system
- ✓ Sustained marketing campaign

On the *supply side*, branding and logistics systems are designed to increase the availability and accessibility of desirable and affordable quality health products/services, in addition to careful choice of distributors and stockists and galvanizing community action. On the *demand side*, sustained marketing campaigns are designed to increase desire for and use of health products/services.

Since its inception, social marketing has expanded in many forms, from *social communication* to *social mobilization* to *media advocacy*. In context of **Public Health**, it seeks to make health-related information, products and services easily available, accessible and affordable to a specific targeted population (mostly low-income population and those at risk), while at the same time promoting the adoption of healthier behaviour.

One of the main aims of National Rural Health Mission (NRHM) is to provide affordable, accessible and effective primary health care and strengthening the rural healthcare delivery system through creation of a cadre of **Accredited Social Health Activist** (ASHA). Apart from creating awareness and making provision for the community on healthy living and working conditions, basic sanitation and hygiene practices, nutrition, mother and child welfare, she also has a major role in counseling women of the community in adopting Family Planning (FP) measures.

For many years, India has been putting sustained efforts towards controlling its population. India was the first nation to launch its National Family Planning Programme (NFPP) in 1952. It was changed to **National Family Welfare Programme (NFWP)** in 1980 under sixth Five Year Plan. Under NFWP, India is striving hard to achieve its envisaged aim of attaining Net Reproduction Rate of unity because of underutilization of already scarce services due to usual issues of public

myths and misperceptions; healthcare provider biases and lack of skills; and lack of availability, accessibility and affordability of FP methods.

In such scenario, Social Marketing of family planning methods, particularly Oral Contraceptive Pills and Condoms by ASHA workers can reap huge benefits in increasing and sustaining their use by the community for accelerating the pace of progress of the programme.

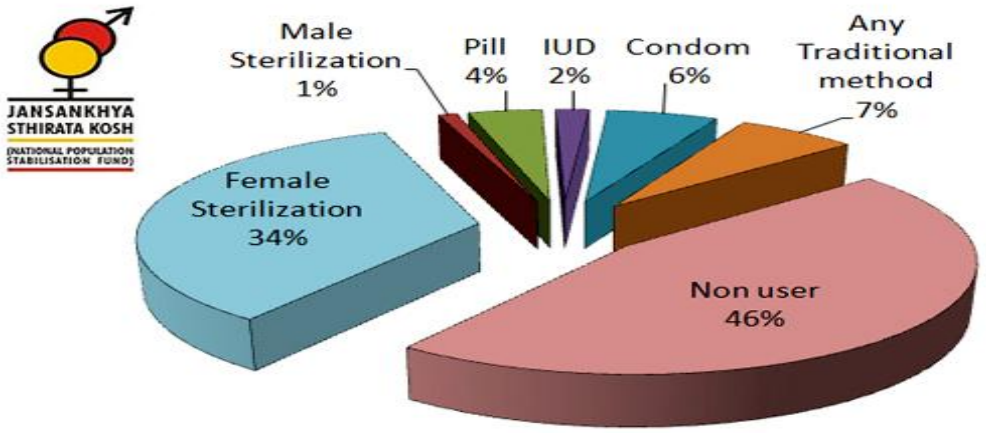
4. BACKGROUND

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

The vision of WHO/RHR is the attainment by all peoples of the highest possible level of sexual and reproductive health. It strives for a world where all women's and men's right to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved or marginalized, have access to sexual and reproductive health information and services, and India was the first country in the world that recognized the need of population stabilization in 1951 as an essential prerequisite for sustaining a good quality of life and a National Family Planning Program was launched in 1952. The approach changed from clinic to extension education approach in third fifth year plan and later on it was an integral part of MCH activities but it could not make much impact. Program suffered a setback in 1976 due to element of coercion introduced in the program and its political fallout; the political support was lost.

The population policy 1977 clearly underscored that "compulsion in the area of family welfare must be ruled out for all times to come," and emphasized the need for an educational and motivational approach to make acceptance of family planning completely voluntary. In 1996, the government initiated to target-free Community Needs Assessment Approach, which involved formulating plans in consultation with communities. In 2000, the National Population Policy was reformulated to achieve long-term population stabilization by 2045 and replacement level of fertility by 2010. The policy reiterates the commitment to voluntary and informed choice, and to citizen's consent while accessing reproductive health care, including family planning. The immediate objective is to addressing reproductive health care,

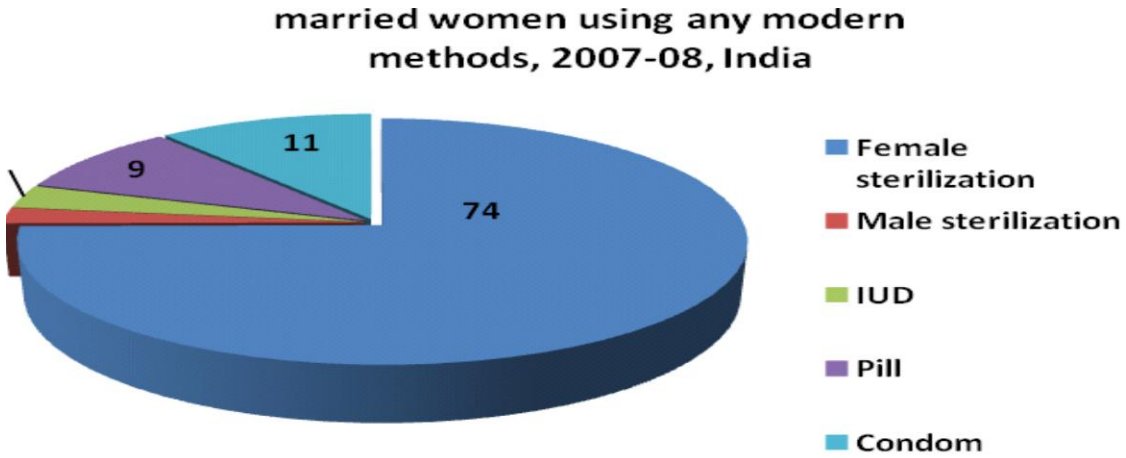
including family planning. The immediate objective is to address the unmet need for contraception.Despite of these efforts from the government, acceptance of family planning method is very low. According to JSK report only 54% are using any of the family planning methods out of which male participation is only 7% i.e. 1% male sterilization and 6% condom use.



Current use of Family Planning Methods

According to JSK Report 2008

Rest of the methods are female oriented i.e. 34% female sterilization, 4% oral contraceptive pills and 2% IUD. Remaining 7% uses any traditional method of contraception for limiting their family size. According to DLHS- III, female sterilization is one of the mostly accepted contraceptive methods with 74% among currently married women where as male participation is only 2%.



Source: District Level Household Surveys, 2007-08

According to the latest National Family Health Survey (NFHS-3), two out of three married Indian women aged 15-49 who practice contraception still use female sterilization. In rural areas, the population is even higher, with 70% of contraceptive users relying on female sterilization. Overall, 37% of all married Indian women of reproductive age are sterilized. Now this is clear that male participation in family planning is very poor. They thought that family planning is the whole sole responsibility of female. Some of the main reason for this disproportion between male and female participation in family are gender sensitive strategies have been neglected and, to a large extent, family planning programs have remained female oriented(7.8), some reproductive health practitioner have recognized that the failure to target men has weakened the impact of family planning programs, because men can significantly influence their partners reproductive health decisions and use of health services especially in societies where women do not possess the same decision-making powers as men and Men feel that the sterilization operation is easier to perform on women than on men.

5. RATIONALE

Social Marketing of Family Planning measures, particularly Oral Contraceptive Pills (OCPs) and Condoms is a fresh perspective that challenges health strategists to pay more attention to the target population and create/render a more responsive product/service, with appropriate utilization of resources and time. Keeping in mind the Indian population, there is an immense scope to address their unmet needs with the help of community participation. This ownership can be productive if ASHAs are employed to market and/or distribute contraceptives to the female population of their community who are belonging to the reproductive age-group (15-45 years).

Despite the voluminous amounts of efforts of healthcare delivery system, Saharsa district of Bihar has not been able to establish an effective step in improving its demographic and health indicators, so this research pertains to study about the various aspects of Social Marketing of OCPs and condoms by ASHAs, challenges it poses and how it can be an effective tool for increasing and sustaining the usage of such family planning methods by the female population in Saharsa.

6. OBJECTIVES

- **General Objective:**
  To ascertain the issues and challenges associated with social marketing of Oral Contraceptive Pills and Condoms by ASHA workers in Saharsa District of Bihar.

- **Specific Objectives:**
  - ★ To assess the level of awareness of ASHA workers regarding various factors associated with the usage of Oral Contraceptive Pills (OCPs) and Condoms and benefits related to health.
  - ★ To assess the training needs of ASHA workers in Information, Education and Communication (IEC) activities to promote family planning measures in the community.
  - ★ To assess the health seeking behaviour of the community w.r.t. family planning, particularly females of reproductive age group (15-45 years), in response to social marketing by ASHA workers.
  - ★ To find out an association between literacy level of women of reproductive age group (15-45 years) and use of OCPs and Condoms.

7. METHODOLOGY

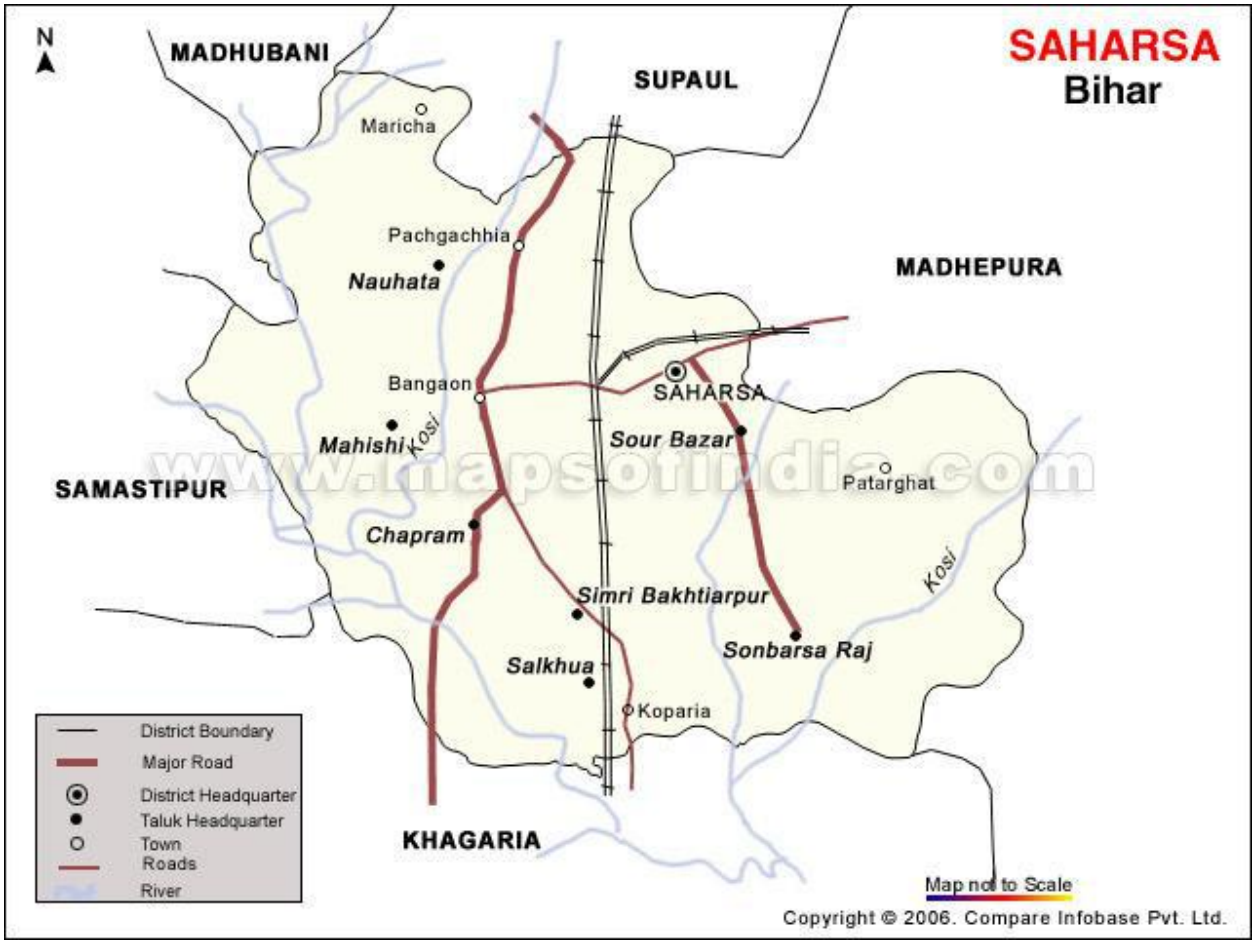
- Multi stage sampling is used.
- **Study Area:** Saharsa District Of Bihar State, India
- **Study design:** Cross-Sectional Exploratory Study
- **Study Sample:** 35 ASHA workers and 175 community females (5 females per ASHA)
- **Tool and Technique:** Interview Schedule (Semi structured Questionnaire)
- **Sampling:** (42 villages chosen in total under 4 CHCs: Sadar, Simri Bhaktiyarpur, Nauhata, Pattarghat)

- Four CHC'S were selected on the basis of their previous year performance according to high and low in Family planning respectively from the district.
- Four PHC'S were selected randomly from each CHC'S and again four sub-centers were selected from each PHC'S respectively through lottery method. Systematic random sampling was done in the sub centre level and one female for every third house was selected as a sample till 175 samples are selected.

About Study area: Saharsa

Map 1: Map of Bihar showing the study area i.e. Saharsa

Map 2: Map of district Saharsa of Bihar



As per 2001 India censusGRIndia the current population of Saharsa district is 1854618 which constitute 2% population of the state . The district has a population density of 885 person per sq. km., which is high compared to 881 of the state. The annual exponential growth rate of the district as per 2001 census is 2.8%, which is higher then that of the state average 2.5%. About 8% of the total population lives in urban area in contrast to 11% of the state. The sex ratio of the district is 910 females per 1000 males. Males constitute 54% of the population and females 46%. Saharsa has an average literacy rate of 58%, lower than the national average of 64.4%: male literacy is 66%(national average:75.6%), and female literacy is 48%(national average:54.2%). In Saharsa, 17% of the population is under 6 years of age.

Table 1: Administration set-up of Saharsa district of Bihar

Block	*Gram Panchayat*
Sadar	25
Panchgachia	12
Saurbazar	13
Patarghat	11
Sonbarsa	18
Salkhua	14
Banma-Itahri	18
Simri bakhtiyarpur	11
Mahisi	16
Nahutta	14

Division	*Number*	*Name*
Sub Divisions	2	
Tehsils	2	
Sub Tehsils	2	
Blocks	10	Sadar, Panchgachia, Saurbazar, Patarghat, Sonbarsa, Salkhua, Banma-Itahri, Simri bakhtiyarpur, Mahisi, Nahutta
Municipal Committees	3	
PHCs	10	Sadar, Panchgachia, Saurbazar, Patarghat, Sonbarsa, Salkhua, Banma-Itahri, Simri bakhtiyarpur, Mahisi, Nahutta
APHCs	15 including 4 Block PHCs	
SCs	152	
PRIs	3 tier set-up	
Villages	611	

Table 2: Gram Panchayats of Saharsa district of Bihar according to blocks

(Source: District Action Plan, 2006)

Table 3: Couple Protection Rate of Saharsa district of Bihar

CPR per 1000 Eligible Couples of Saharsa is 26 percent i.e. 47186 out of 1853283 Eligible Couples. CPR per 1000 EC block-wise is given below:

Block	*Rate*
Sadar	24.24
Panchgachia	21.8
Saurbazar	26.3
Patarghat	45.0
Sonbarsa	30.8
Salkhua	23.4
Banma-Itahri	31.9
Simri bakhtiyarpur	24.5
Mahisi	26.1
Nahutta	23.5
Total	30.8

(Source: Civil Surgeon's Office)

Table 4: Status of National Family Welfare Programme in Saharsa district of Bihar

Method	*Population Target (up to Jan' 2007)*	*Total Achievement (up to Jan' 2007)*	*Percentage*
Sterilization	708	144	20.3
IUCD	2917	2590	88.78
OCP	1083	2074	191.5
CC	10000	10076	100.8

(Source: Civil Surgeon's Office)

Table 5: Age-wise breakup of Contraception Usage in Saharsa district of Bihar:

Rural (age-group in years)	***No. of EC***	***CC users***	***OCP users***	***% using any method***
15-19	26284	1032	240	6.45
20-24	31118	1916	1344	19.84
25-29	30963	5147	2309	34.98
30-34	31749	2260	2242	33.43
35-39	28958	2525	917	30.52
40-44	27357	1204	341	20.84
Total	176429	14084	7393	24.86
Urban (age-group in years)	***No. of EC***	***CC users***	***OCP users***	***% using any method***
15-19	1422	50	0	3.5
20-24	1694	151	92	25.74
25-29	1689	181	91	41.39
30-34	1525	187	69	54.3
35-39	1367	200	47	56.69
40-44	1371	254	35	39.75
Total	*9068*	*1023*	*334*	*36.76*

(Source: Civil Surgeon's Office)

Table 6: Contraception usage by number of living children in Saharsa district of Bihar:

Age of living children	*No. of EC*	*CC users*	*OCP users*
0	25811	166	181
1	29700	1437	2770
2	33315	2338	3150
3	32145	2301	1303
4	29497	2802	751
5+	35029	2153	780
Total	185497	11197	8937

(Source: Civil Surgeon's Office)

8. DATA ANALYSIS AND RESULTS

Data collected through field visits was finally analyzed using Statistical Package for Social Sciences (SPSS), version 16.0. Statistical Significance was proved in some cases using ***Chi-Square test*** showing association between two factors (independent and dependent).

9. A. ANALYSIS OF ASHA WORKERS:

The sample of 35 ASHA workers in the study was found to have the following characteristics in the district of Saharsa in Bihar.

Demographics:

Figure 1:

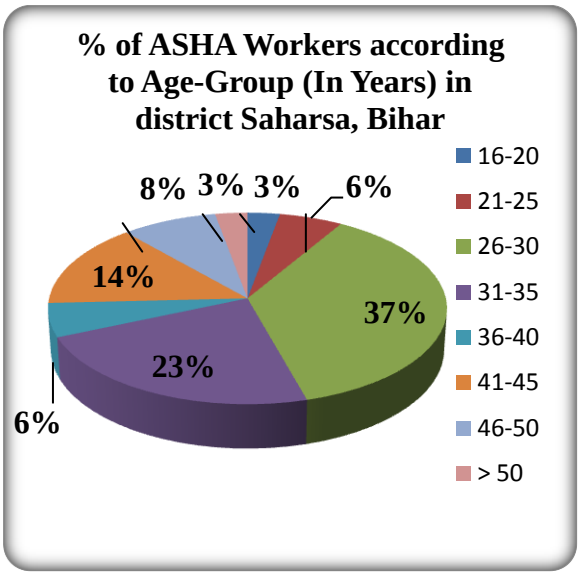


Figure 2:

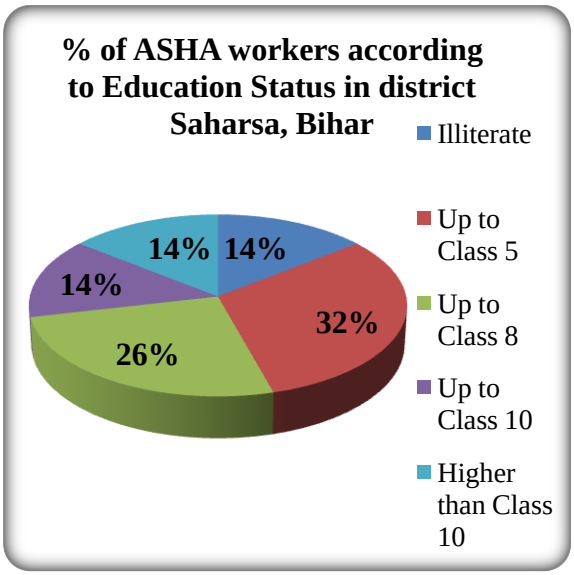


Figure 3:

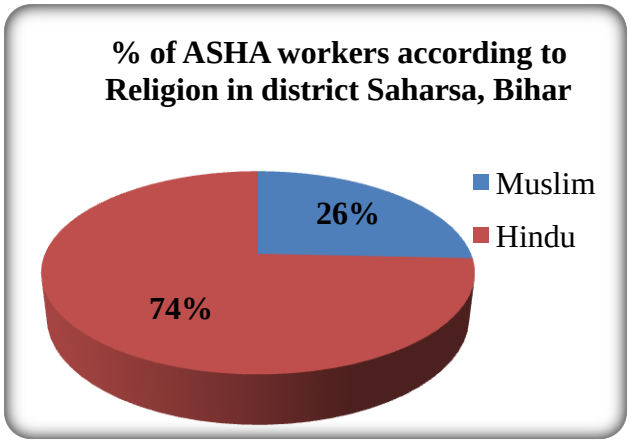
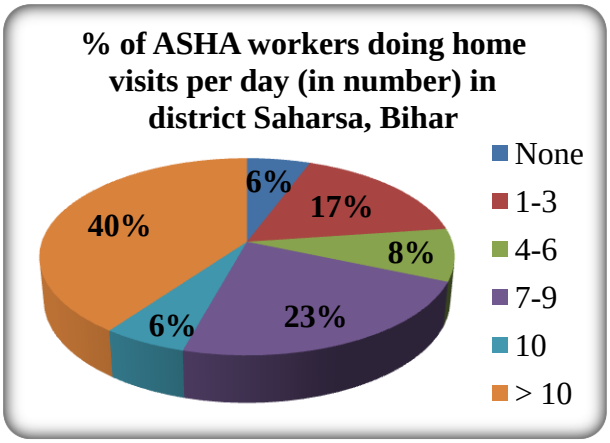


Figure 4:



Services provided by ASHA workers:

97% of ASHA workers reported to be involved in escorting the delivery cases, 88.6% provided services like increasing service utilization and 83% created health awareness and counselled the women of their villages on health-related matters. While, only 40% of them were involved in any primary treatment of disease like diarrhoea, fever, etc. and 28.6% knew about timely identification of diseases and their timely referral. Only 8.6% of them were involved in facilitating the village health plans.

Awareness about Family Planning Methods:

- There was 100 % awareness about the Family Planning (FP) measures, but ASHA workers in Saharsa knew less about the various methods available for family planning.
- The study sample showed differences in the awareness about FP according to Education Status and Religion.

Table 7: Awareness levels of ASHA workers about methods available for family planning in district Saharsa, Bihar.

METHODS			NUMBER	PERCENT
Reversible (Temporary) Methods	Natural Methods	Abstinence	6	17.1
		Rhythm method	1	2.9
		Coitus Interruptus	4	11.4
	Barrier Methods	Male condoms	34	97.1
	Hormonal methods	Oral contraceptive pills (OCPs)	35	100.0
		Emergency contraceptive pills (ECPs)	3	8.6
		Injectables	2	5.7
	Intra-Uterine Devices	Intrauterine contraceptive devices (IUCDs)	29	82.9
Irreversible (Permanent) Methods	Sterilization	Vasectomy	9	25.7
		Tubectomy	31	88.6

Table 7 shows that there was a little awareness about natural methods and maximum about barrier methods (male condoms), IUCDs and OCPs. However, there was no awareness regarding other barrier methods like cervical cap and female condoms, spermicidal methods and other hormonal methods like Trans-dermal patches.

Table 8: Cross-tabulation between education status and level of awareness about family planning methods among ASHA workers in district Saharsa, Bihar (in %).

FP METHODS	EDUCATION STATUS				
	Illiterate	Up to class 5	Up to class 8	Up to class 10	Higher than class 10
Abstinence	20	18	11	40	0
Rhythm method	0	0	0	0	20
C. Interruptus	0	9	11	40	0
Male condoms	100	100	100	80	100
OCPs	100	100	100	100	100
IUCDs	60	82	88	80	100
Vasectomy	0	36	0	60	40
Tubectomy	100	90	66	100	100
Injectables	0	18	0	0	0
ECPs	0	9	0	20	20

Table 8 shows that better education females had better awareness about natural methods of FP, IUCDs, Sterilization and ECPs.

Figure 5: Cross-tabulation between religion and level of awareness about various family planning methods among ASHA workers in district Saharsa, Bihar (in %).

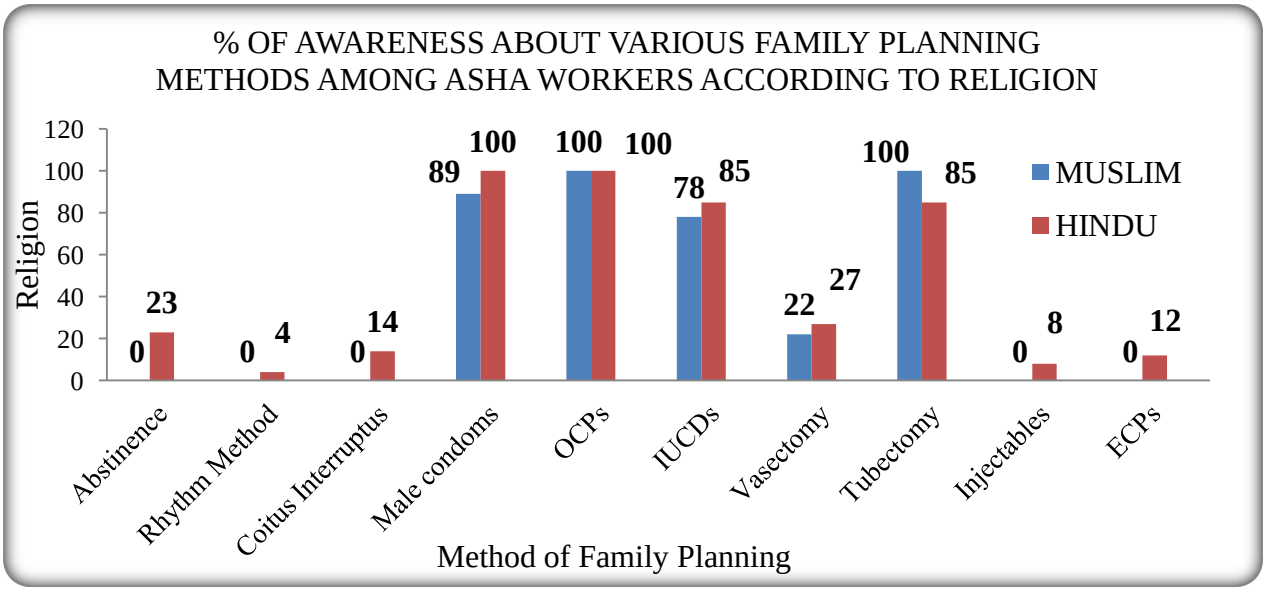


Figure 5 shows that Hindu ASHAs were more aware of FP methods, except OCPs where the percentage was equal among both Hindu and Muslim ASHAs.

Figure 6: Level of awareness about Health Outcomes of family planning among ASHA workers in district Saharsa, Bihar (in %).

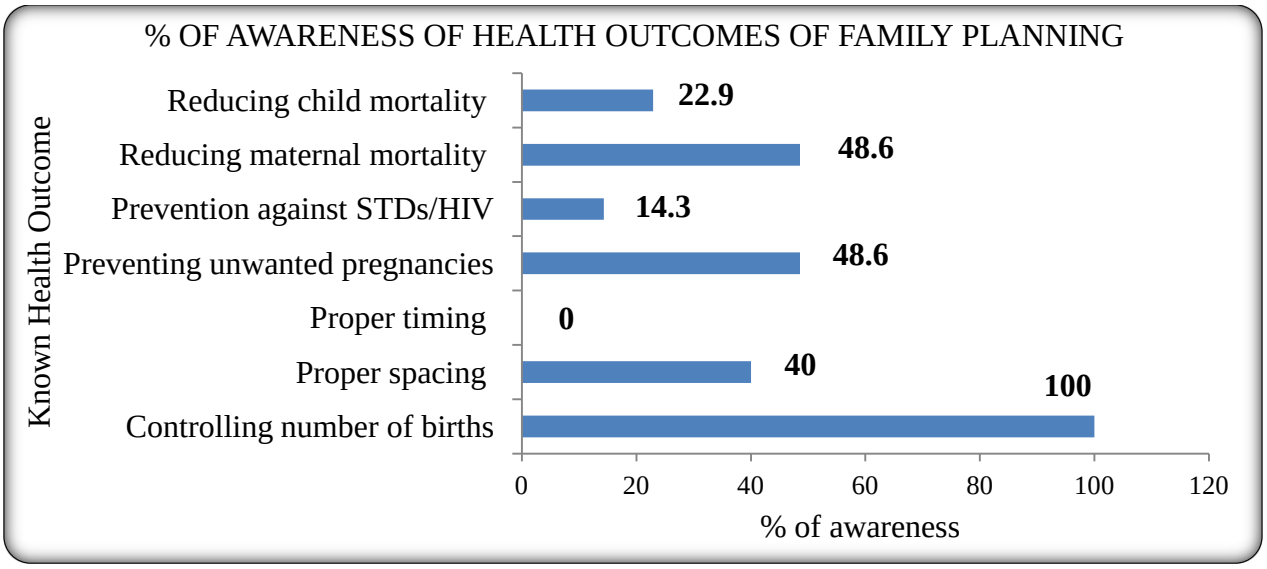


Figure 6 shows that ASHAs were less aware of health outcomes of FP, except that it controls number of births. Few knew about other outcomes, while none knew that FP is helpful in establishing proper timing of births.

Table 9: Cross-tabulation between education status and level of awareness about health outcomes of family planning among ASHA workers in district Saharsa, Bihar (in %).

HEALTH OUTCOME	EDUCATION STATUS				
	ILLITERATE	UPTO CLASS 5	UPTO CLASS 8	UPTO CLASS 10	HIGHER THAN CLASS 10
Controlling no. of pregnancies	100	100	100	100	100
Proper spacing between children	60	36	56	0	40
Proper timing of births	0	0	0	0	0
Preventing unwanted pregnancies	40	45	33	60	80
Prevention against STDs/HIV	0	27	0	0	40
Reducing maternal mortality	40	55	44	40	60
Reducing child mortality	40	18	0	60	20

Table 9 shows that more educated ASHAs were still more aware of other health outcomes of Family Planning.

Figure 7: Cross-tabulation between religion and level of awareness about health outcomes of family planning among ASHA workers in district Saharsa, Bihar (in %).

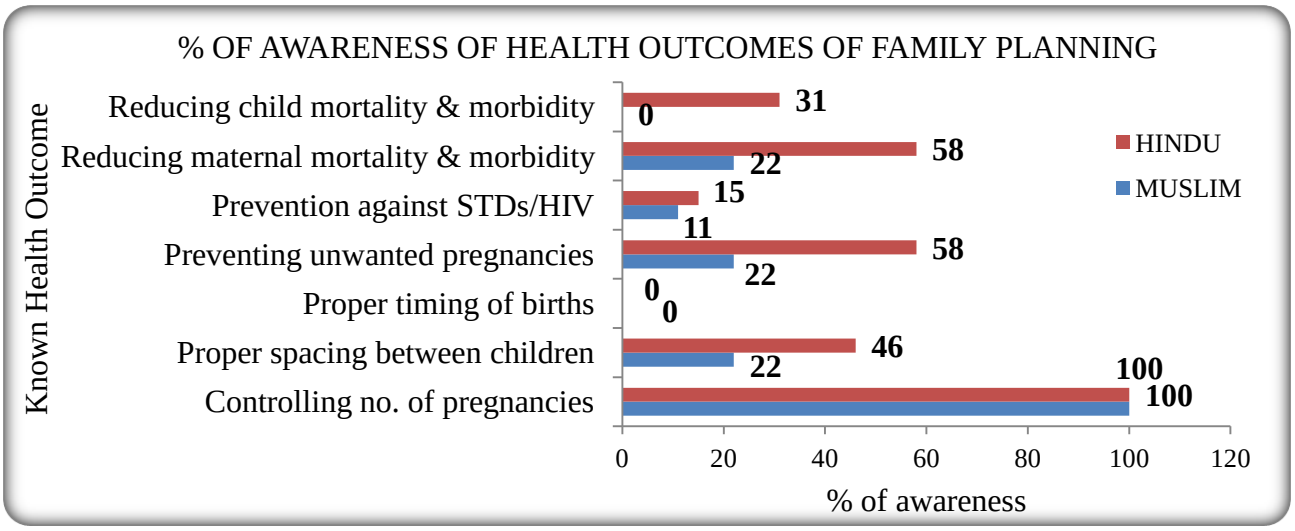


Figure 7 depicts that Hindu ASHAs were more aware of health outcomes of FP, except controlling number of births. However, none knew about proper timing of births and Muslim ASHAs were not aware of reduction in child morbidity and mortality as a health outcome of Family Planning.

Figure 8: Level of awareness about Benefits of family planning among ASHA workers in district Saharsa, Bihar (in %).

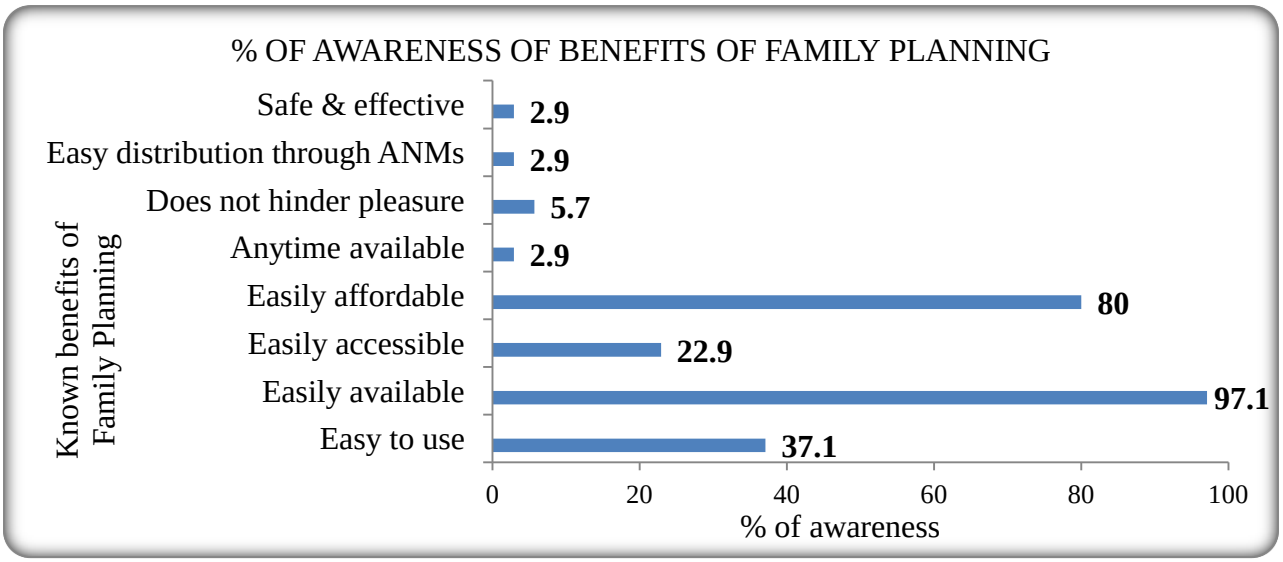


Figure 8 depicts that majority knew that being easily available and affordable are one of the best benefits of using FP methods, especially OCPs and Condoms. A *striking feature* to note was that an ASHA worker of a village reported that she was distributing the OCPs and Condoms to

ANMs of her village and that, she was herself not involved in any of the social marketing campaigns.

Table 10: Cross-tabulation between education status and the level of awareness of ASHA workers about the benefits of family planning, especially OCPs and Condoms in district Saharsa, Bihar (in %).

BENEFITS	EDUCATION STATUS				
	ILLITERATE	UPTO CLASS 5	UPTO CLASS 8	UPTO CLASS 10	HIGHER THAN CLASS 10
Easy to use	0	55	44	40	20
Easily available	90	100	100	100	100
Easily accessible	20	27	0	20	60
Easily affordable	80	90	67	90	90
Anytime available	0	0	0	20	0
Does not hinder pleasure	0	0	11	0	20
Distributions to ANMs	0	0	11	0	0
Safe & effective	0	0	0	0	20

As per Table 10, it was noted that many ASHA workers believed that condoms are less used by the females of the community as their use tends to hinder pleasure. Higher levels of education showed better results as per the benefits of using OCPs and condoms known to the ASHAs.

Social Marketing of Family Planning and Its Measures By ASHA Workers To The Community Females

- A good percentage of ASHAs reported that they were able to make females aware of family planning, however, the table 5 below depicts that the number went down when their communication strategies to make females adopt FP were judged.

- Also, only 71.4 percent of them were aware of the intention of the females to continue the use of OCPs/Condoms who were already using these measures.

- Educated ASHAs were able to demonstrate the use of Condoms to other females in a much better way than uneducated or less educated ones.

Table 11: Ability of ASHA workers to provide information regarding family planning and its measures to the beneficiaries in district Saharsa, Bihar.

COMMUNICATION ABILITY		Yes	No	Can't say	Total
Able to make females aware of FP methods	Number	32	1	2	35
	Percent	91.4	2.9	5.7	100.0
Able to make females understand about the benefits of FP	Number	30	5	0	35
	Percent	85.7	14.3	0.0	100.0
Able to convince females to adopt use of OCPs & Condoms as FP measures	Number	20	5	10	35
	Percent	57.1	14.3	28.6	100.0

Table 11 suggests that ASHAs reported that majority of them were capable enough to make females aware of FP, but the percentage dropped by 5 points in being able to make them understand about the benefits of FP, which further dropped by around 30 points (only 57 percent) in being able to convince them to adopt using OCPs and Condoms as FP measures.

Table 12: Cross-tabulation between religion and ability of ASHA workers to provide information regarding family planning measures in district Saharsa, Bihar (in %).

COMMUNICATION ABILITY	RELIGION	
	MUSLIM	HINDU
Able to make females aware of FP measures	78	96
Able to make females understand about benefits of using FP methods	78	89
Able to convince females to adopt use of OCP & condoms	44	62
Aware of the intention to continue the use of OCP & condoms in future by couples who are already using them	44	81
Demonstrate the use of condoms	22	77

Table 12 clearly shows that ability to communicate about the increasing the usage of FP methods was more among Hindu ASHAs than Muslim ASHAs.

Figure 9:

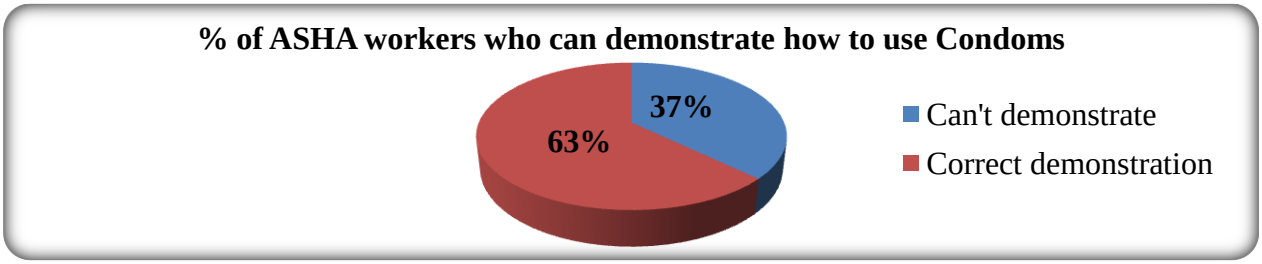


Figure 9 shows that around 1/3rd of ASHAs were able to correctly demonstrate the use of condoms to the community females.

Figure 10:

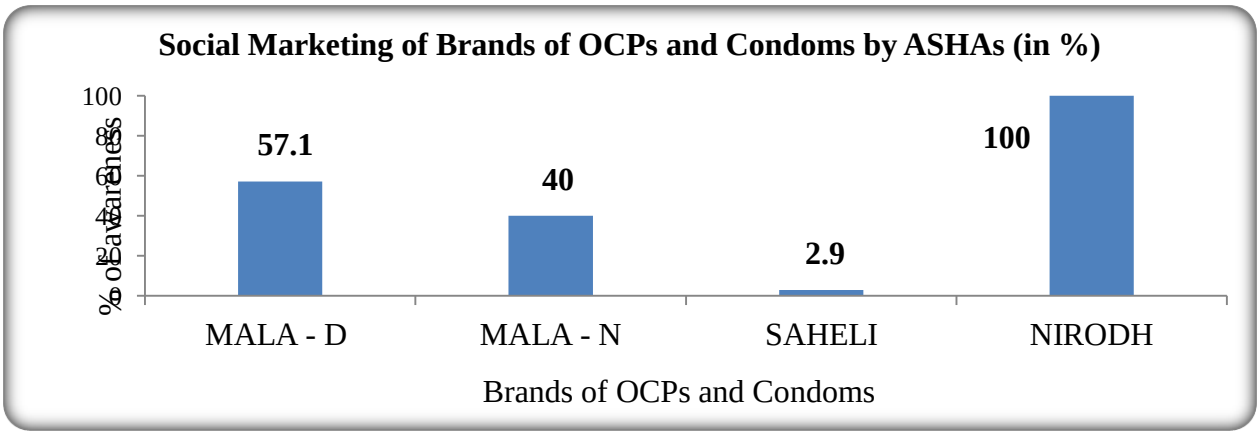


Figure 10 shows that ASHAs were able to do 100 percent social marketing of condoms w.r.t. their brand names, however, only half of them did the branding of OCPs. Majority were involved in social marketing of Mala-D than Mala-N and Saheli as per their brand names.

Table 13: Social Marketing of family planning methods by ASHA workers as per age group in district Saharsa, Bihar (numbers represent the no. of ASHA workers selecting an option out of 35).

AGE-GROUP	FAMILY PLANNING METHOD TO BE USED			
	OCP	Condoms	IUCD	Sterilization
18-25 years	✓ 1			
18-30 years	✓ 8	✓ 8	✓ 3	
18-35 years	✓ 2	✓ 2	✓ 3	
18-45 years	✓ 1	✓ 1	✓ 1	✓ 1
More than 25 years				✓ 1
More than 30 years			✓ 2	✓ 3
More than 35 years			✓ 2	✓ 3

More than 40 years				✓ 2
Don't know	✓ 20	✓ 20	✓ 20	✓ 20
Any method at any age	✓ 1	✓ 1	✓ 1	✓ 1

Table 13 depicts the social marketing of FP methods according to age-group. Around 57 percent ASHAs did not know the correct age of recommending specific FP methods. Only 29 percent knew the correct age of recommending OCPs or Condoms (18-30 or 35 years). Less percentage knew about IUCD use as per age, while Sterilization was suggested mostly to those above 30 years of age.

Figure 11:

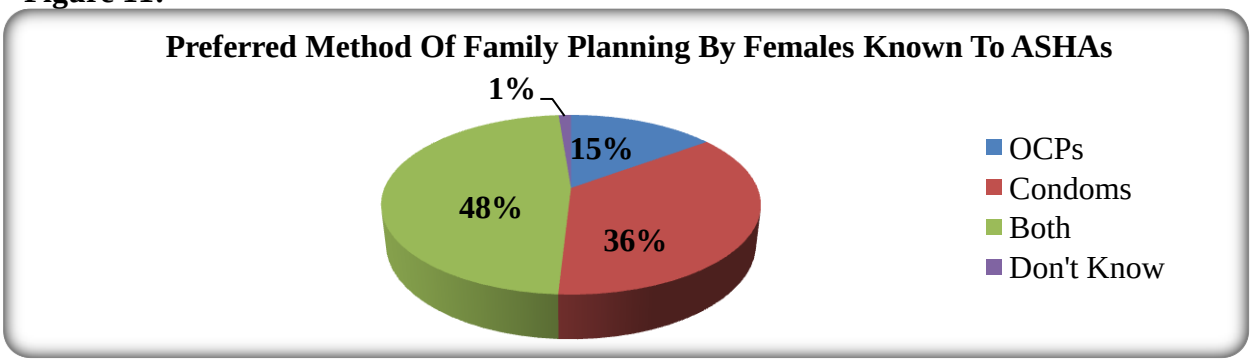


Figure 11 depicts that majority of ASHAs reported that both OCPs and Condoms were the preferred methods of FP by the females of their villages as known to them, and still Condoms were the next preferred measure than OCPs.

Knowledge of ASHA workers about Use of OCPs in district Saharsa, Bihar:

- Regarding *options* available, 51 percent ASHAs were aware of 28 pills pack and nine percent knew about 21 pills pack, while 26 percent reported that there are 30 pills in a pack and 14 percent had no knowledge at all.
- 3 out of 35 ASHAs did not know the *criteria* of taking OCPs i.e. the daily uptake of a pill.
- 94 percent ASHAs knew about the correct *timing* of taking OCPs i.e. at night after meals and that, every pill has to be taken at the same time of the day.
- Only about 69 percent ASHAs were able to communicate correctly as what to do if a female *forgets to take a pill* on a particular day, while 14 percent gave incorrect knowledge and 17 percent were unaware regarding the same.
- Six percent ASHAs reported that OCPs can be taken during *breastfeeding*; however none knew which type of OCPs (combination pills) can be taken. Among the rest, 83 percent denied their use while breastfeeding and 11 percent had no knowledge regarding the same.

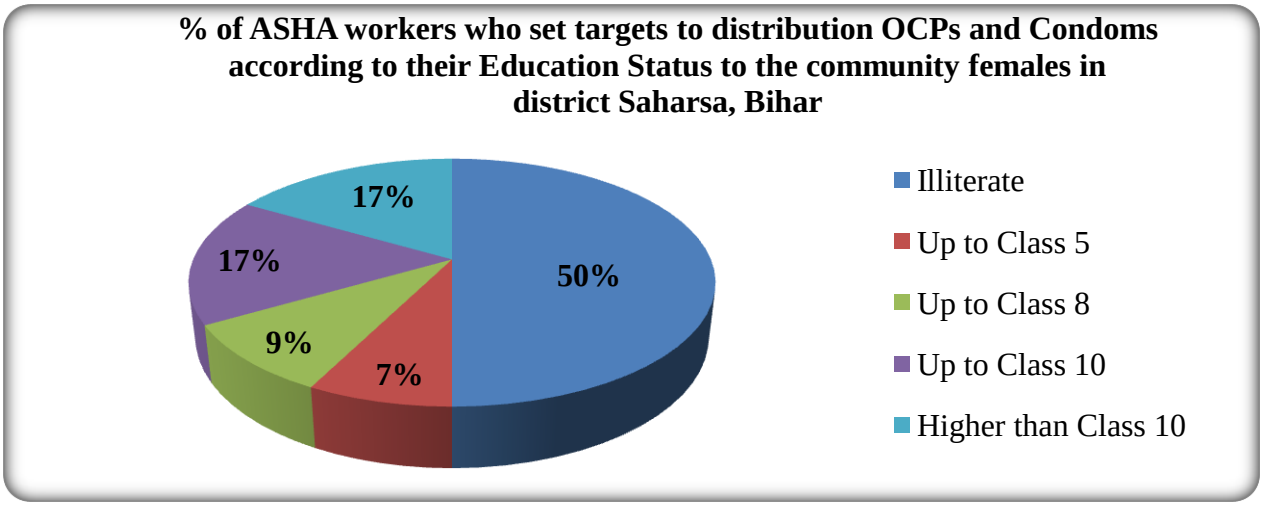
- Regarding awareness about *side-effects* of using OCPs. Only 37 percent knew about bleeding disturbances that can occur as a result of OCP use or their wrong use, while few know about other side-effects like nausea (23 percent); headache and migraine (14 percent); weight gain and white discharge from vagina (11 percent); cardiovascular effects like DVT and general malaise (6 percent); breast tenderness, fullness and discomfort, anaemia because of excessive bleeding, allergy on body and blisters in mouth and stomach (3 percent). However, none knew about mood changes and cancers (cervical/breast) as one of the major side-effects.
- *Contraindications* of OCP use known to ASHAs were mainly lactating mothers for first 6 months (46 percent); undiagnosed abnormal bleeding, age more than 40 years (17 percent); cardiac abnormalities (14 percent); pregnancy, smoking, diabetes mellitus (6 percent); cancers (cervical/breast), hyperthyroidism, tuberculosis and epilepsy (3 percent). None knew about contraindications like gall bladder and renal diseases, Thromboembolism, etc.

It was seen that knowledge of using OCPs and their side-effects and contraindications was higher among ASHAs who were better educated and amongst Hindu ASHAs than Muslim ASHAs.

Training Needs Assessment of ASHA Workers

- 20 percent of ASHA workers had set targets of distribution of OCPs and Condoms so as to increase their usage and adoption by the females of their respective villages. Rest 80 percent relied less on social marketing and had less awareness and motivation to act as perfect distribution channels of OCPs and Condoms in the villages.

- All ASHA workers agreed that they are able to listen attentively, without interruption to somebody with whom they disagree. However, 14 percent of them reported that they are not able to handle conflict situations and defend their state.**Figure 12:**



As per Figure 12, there is no direct relation between better education status and number of ASHAs who set targets to distribute OCPs and Condoms. Most of the illiterate ASHAs were able to set good targets like 5-10 OCPs and 3-5 packets of Condoms per month for distribution for which they get **financial incentives** as Re. 1 per Condom packet containing 3 condoms, Rs. 2 per OCP packet containing 28 pills and Rs. 3 per ECP.

Figure 13: Grading of their communication strategies adopted by ASHA workers regarding increasing the usage of family planning methods by community females, especially OCPs and Condoms in district Saharsa, Bihar (in %).

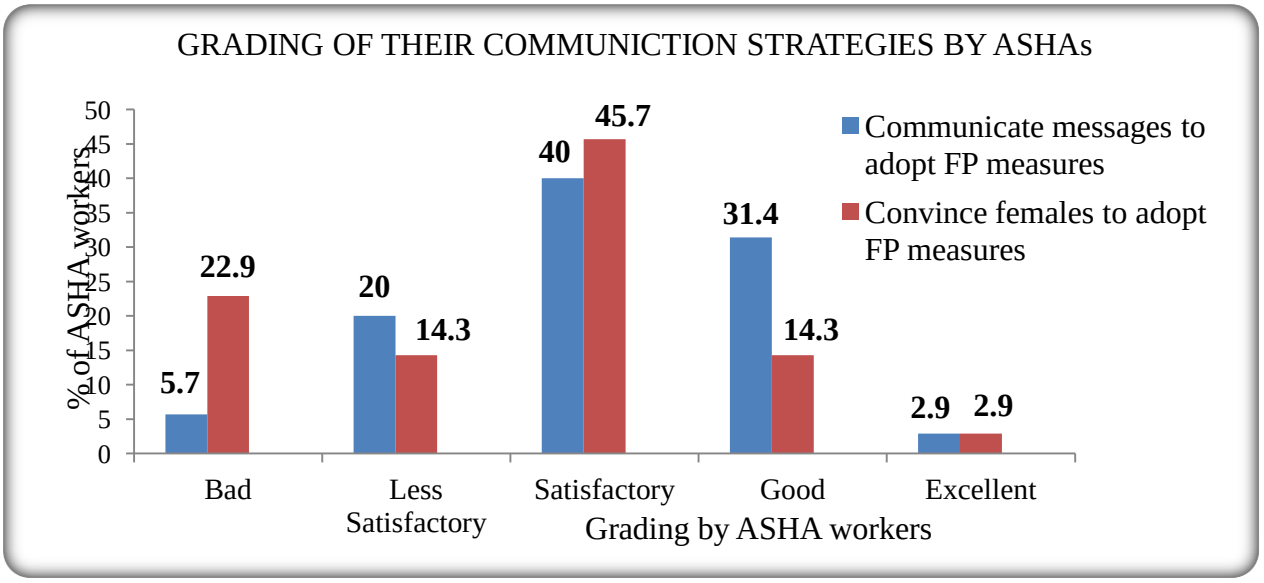


Figure 13 shows that majority of ASHAs graded their communication strategies as satisfactory.

Figure 14: Rating of their training sessions by ASHA workers related to family planning in district Saharsa, Bihar (in %).

Figure 14 shows that majority of ASHAs rated their trainings as good; however those who received trainings on family planning and its measures were such 74 percent.

Table 14: Cross-tabulation between education status & grading of their communication strategies adopted by ASHAs regarding increasing the usage of family planning methods by community females, especially OCPs and Condoms in district Saharsa, Bihar (in %).

EDUCATION STATUS	ABILITY TO COMMUNICATE ABOUT OCPs & CONDOMS				
	Bad	Less satisfactory	Satisfactory	Good	Excellent
Illiterate	25	25	25	40	0
Up to Class 5	0	9	55	36	0
Up to Class 8	11	33	33	22	0
Up to Class 10	0	20	40	40	0
Higher Than Class 10	0	20	40	20	20

EDUCATION STATUS	ABILITY TO CONVINCE ABOUT USAGE OF OCPs AND CONDOMS				
	Bad	Less satisfactory	Satisfactory	Good	Excellent
Illiterate	20	20	40	20	0
Up to Class 5	0	27	55	18	0
Up to Class 8	33	11	44	11	0
Up to Class 10	60	0	20	20	0
Higher Than Class 10	20	0	60	0	20

Table 14 depicts that ASHAs with better education status were able to communicate the females in their villages in a better way about use and adoption of OCPs and Condoms.

Amongst those who received trainings, they reported that they mainly taught about the usage and benefits of family planning (71 percent), increasing the adoption of OCPs and condoms through distributions (nine percent), communication strategies and education about population control (six percent) and proper diet and provision of IFA tablets during OCP use (three percent).

Table 15: Cross-tabulation between trainings received by 27 ASHAs and services provided by them related to family planning and its measures in district Saharsa, Bihar (in number).

TRAININGS RECEIVED	SERVICES PROVIDED BY ASHA WORKERS					
	Creating awareness about FP		Counselling about FP methods		Increasing utilization of OCPs and condoms	
	Yes	No	Yes	No	Yes	No
Yes	22	5	23	4	24	3
No	7	1	6	2	7	1
Total	29	6	29	6	31	4

Table 15 shows that those ASHAs who received trainings about family planning were able to better provide with information about adoption of family planning methods to the community females.

Table 16: Cross-tabulation between number of home visits per day and services provided by ASHA workers related to family planning in district Saharsa, Bihar (in number).

HOME VISITS PER DAY	SERVICES PROVIDED BY ASHA WORKERS					
	Creating awareness about FP		Counselling about FP methods		Increasing utilization of OCPs and condoms	
	Yes	No	Yes	No	Yes	No
None	1	1	2	0	1	1
1-3	6	0	6	0	6	0
4-6	2	1	2	1	2	1
7-9	5	3	5	3	7	1
10	2	0	2	0	2	0
>10	13	1	12	2	13	1

Table 16 shows that those ASHAs who did more home visits per day to the homes of beneficiaries, they were able to provide with more information about family planning to them and increase the usage of OCPs and Condoms among them.

Table 17: Cross-tabulation between education status and training sessions rated by ASHA workers related to family planning in district Saharsa, Bihar (in %).

EDUCATION STATUS	RATE TRAINING		
	Satisfactory	Good	Excellent
Illiterate	50	25	25
Up to Class 5	11	56	33
Up to Class 8	25	50	25
Up to Class 10	25	50	25
Higher Than Class 10	0	80	20

Table 17 shows that ASHAs with better education status were able to better rate their training sessions received on family planning, mostly as good.

Feedback on trainings received by ASHA workers:

- **Positive Aspects:** 44 percent of ASHA workers (out of 74 percent who received training) reported to have competent trainers to solve and explain the issues regarding family planning and also received good arrangements and refreshments, 24 percent reported that they received adequate information on family planning, 16 percent reported that their doubts were readily clarified, 12 percent had sufficient practical training and 4 percent received compensation.

- **Negative Aspects:** 60 percent of ASHA workers (out of 74 percent who received training) reported of no negative aspects of trainings held, however, 28 percent reported of not getting any compensation, 12 percent felt that the sessions were overcrowded, 20 percent talked about less retention while 4 percent of them reported to have received less training on family planning, less practical sessions, no reporting skills taught, no revision lessons and low ability to understand the sessions owing to their low education status.

Table 18: Opinion of ASHA workers on the quality of training material provided to them in district Saharsa, Bihar (in %).

	THEORETICAL TRAINING				PRACTICAL TRAINING			
	Incomplete	Optimum	Too much	Need to repeat	Incomplete	Optimum	Too much	Need to repeat
Number	0	18	7	1	2	22	0	2
Percent	0.0	69.2	26.9	3.9	7.7	84.6	0.0	7.7

Table 18 depicts that majority of ASHAs regarded their training material (both theoretical and practical) as optimum, while some believed that theory material was too much and others believed that practical sessions were incomplete or they needed repetitions.

Other key findings regarding trainings of ASHAs workers:

- All ASHA workers wished to have more sessions to be included in their training sessions on FP measures so as to perform better. Most of them reported that the *duration* of such sessions should be 3-5 hours (51 percent), while 31 percent believed that the sessions should long for 5-7 hours and 6 percent each wished sessions to be of 1-3 hours or 7-9 hours or 9-11 hours durations.

- When asked about the *problems* they might face in attending trainings, around 71 percent of them complained of conveyance problems as the trainings were held mostly at far-off places and 14 percent complained of lack of motivation, while few raised issues of culture and language problems, less frequency of sessions and insufficient time to attend the sessions.

- They *suggested some methods* to teach the females of their respective villages according to their education levels. 40 percent wished to learn better oral communication skills especially while dealing with Muslim community females; 26 percent wanted better IEC materials; 17 percent suggested methods like practical demonstrations, sessions addressing local beliefs and in local language; 14 percent thought street plays can be a good option, while around 6 percent suggested that Muslim community ASHAs should be appointed, more and newer information along with fear messages should be provided; and 3 percent opted for measures like teaching retention skills, conducting Focused Group Discussions and using Sarpanch as a mediator between ASHA and community females.

- Data also reveals that low level of *education and religion* were major factors in contributing to *lack of motivation* among ASHA workers. Majority of them believed that financial incentives, addressing religious beliefs, improving conditions in their villages apart from gaining social prestige, knowledge enhancement, for better exposure in village, volunteerism, receiving more respect from Muslim community females and work as Dai from past many years were the motivating factors that encouraged them to involve in such training sessions.

A. ANALYSIS OF BENEFICIARIES: The study sample of 175 females showed following results in the district of Saharsa, Bihar.

Demographics

Figure 15:

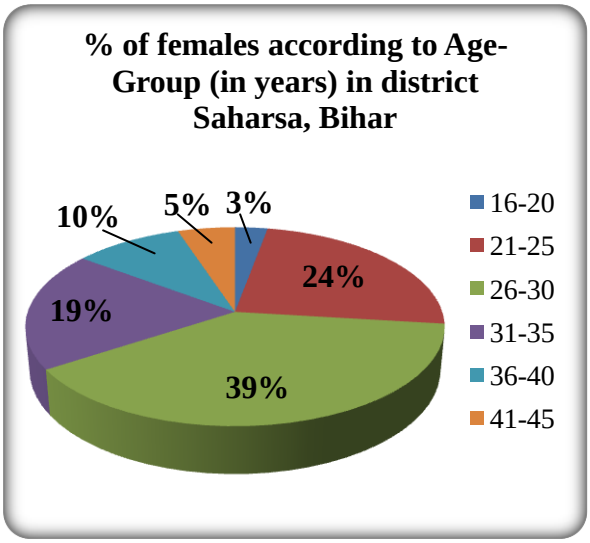


Figure 16:

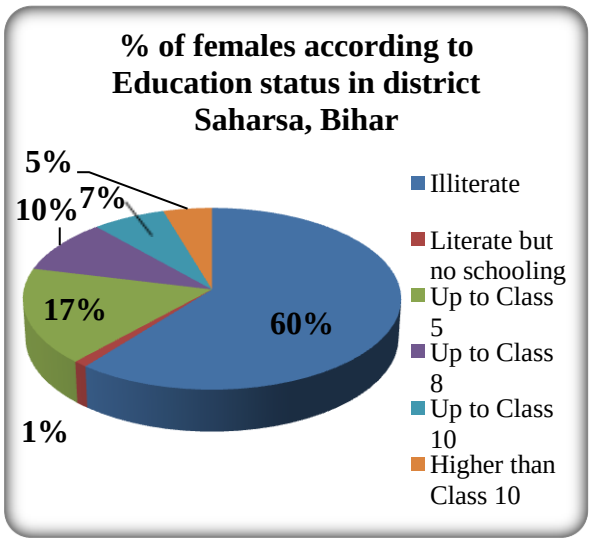


Figure 17:

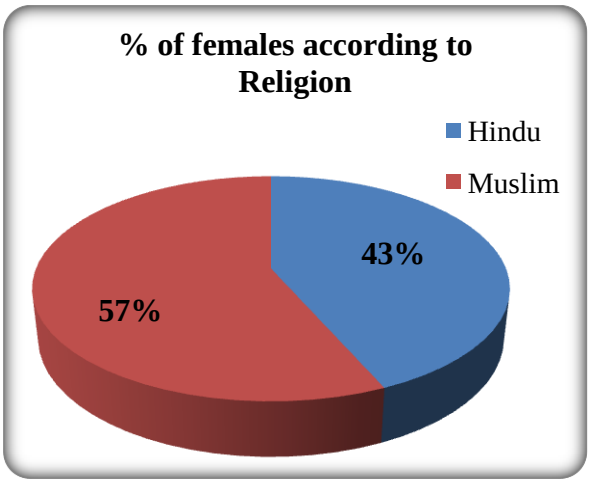


Figure 18:

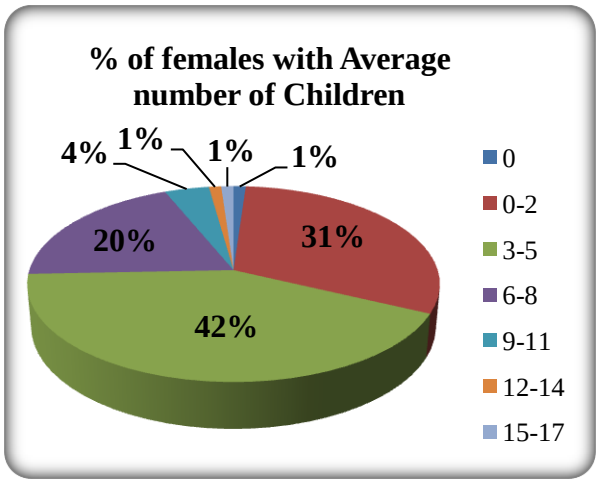


Table 19: Education status of sample community females according to their religion in district Saharsa, Bihar (in %).

RELIGION	EDUCATION STATUS					
	Illiterate	Literate but no schooling	Up to class 5	Up to class 8	Up to class 10	Higher than class 10
Muslim	85.86	0.0	8.08	2.02	1.01	3.03
Hindu	27.63	2.63	28.95	19.74	14.47	6.58

Table 19 depicts that most of the Muslims were illiterate and most of the Hindus were educated up to class 5 and some were educated up to class 10.

Table 20: Cross-tabulation between education status and average number of children born by each woman in district Saharsa, Bihar (in %).

NO. OF CHILDREN	EDUCATION STATUS					
	Illiterate	Literate but no schooling	Up to class 5	Up to class 8	Up to class 10	Higher than class 10
0-2	18.9	50.0	43.3	52.9	66.7	62.5
3-5	40.6	50.0	56.7	41.2	33.3	25
6-8	31.1	0.0	0.0	5.9	0.0	0.0
9-11	5.7	0.0	0.0	0.0	0.0	12.5
12-14	1.9	0.0	0.0	0.0	0.0	0.0
15-17	1.9	0.0	0.0	0.0	0.0	0.0

Table 20 shows that on an average, more number of children were born by the illiterate population. However, highly educated females were taking up the family norm of two children, preferably when the first child was a son.

Table 21: Cross-tabulation between religion and average number of children born by each woman in district Saharsa, Bihar (in %).

RELIGION	NUMBER OF CHIDREN					
	0-2	3-5	6-8	9-11	12-14	15-17
Muslim	21.21	37.38	30.3	7.07	2.02	2.02
Hindu	46.06	48.68	5.26	0.0	0.0	0.0

Table 21 shows that majority of the study population on an average had 3-5 children. However, number sharply increased among the Muslims who even had 6-8 children. Family norm of two children was also born by many Hindu females.

★ 44 percent females of the study sample reported that they *plan to have more number* of children

Figure 19: Cross-tabulation between religion and women who plan to have more number of children in district Saharsa, Bihar.

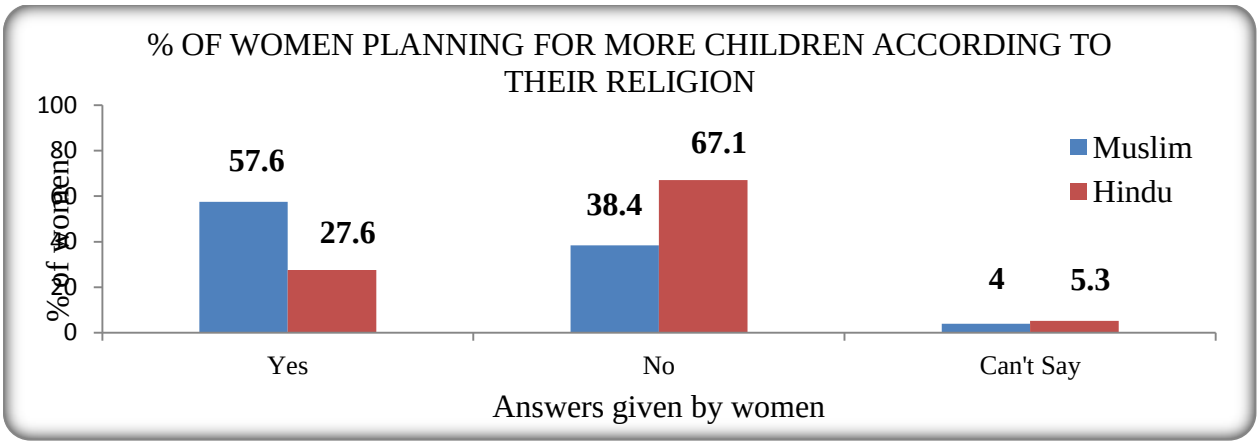


Figure 19 clearly shows that Muslim women were planning for more children with their existing status than Hindu women.

Table 22: Cross-tabulation between education status and average number of women who plan to have more children in district Saharsa, Bihar (in %).

PLAN FOR MORE CHILDREN	EDUCATION STATUS					
	Illiterate	Literate but no schooling	Up to class 5	Up to class 8	Up to class 10	Higher than class 10
Yes	70.5	0.0	10.3	9.0	5.1	5.1
No	49.4	2.2	24.7	11.2	8.0	4.5
Can't say	87.5	0.0	0.0	0.0	12.5	0.0

Table 22 shows that those women who were planning to have more children were mainly from the less educated or illiterate groups.

Table 23: Reasons given by women who plan to have more children in district Saharsa, Bihar.

REASONS	YES		NO		TOTAL	RATIO
	Number	Percent	Number	Percent		
Support to the family	64	36.6	111	63.4	175	0.6 : 1
More working hands	43	24.6	132	75.4	175	0.33 : 1
More income	45	25.7	130	74.3	175	0.35 : 1

Family tradition	72	41.1	103	58.9	175	0.7 : 1
Religious values else a sin	55	31.4	120	68.6	175	0.46 : 1
Son preference	47	26.9	128	73.1	175	0.37 : 1
Family norm of two	2	1.1	173	98.9	175	0.01 : 1

Table 24: Cross-tabulation between religion and reasons given by women who plan to have more children in district Saharsa, Bihar (in %).

RELIGION	REASONS						
	Support to the family	More working hands	More income	Family tradition	Religious values else a sin	Son preference	Family norm of two
Muslim	47.5%	31.3%	33.3%	55.6%	53.5%	35.4%	2%
Hindu	22.37%	15.79%	15.79%	22.37%	2.63%	15.79%	0%

Table 24 shows that Muslim women planned for more children especially because of religious values and family tradition, also, a large number also believed that more children means more support, more working hands and income, and son preference was rampant among them. However, as the analysis shows, the percentage dropped among Hindu women. And the reasons given by them were mainly family tradition, support to family, more working hands and income and son preference in decreasing order of their preference.

Table 25: Cross-tabulation between education status and reasons given by women who plan to have more children in district Saharsa, Bihar (in %).

EDUCATION STATUS	REASONS						
	Support to the family	More working hands	More income	Family tradition	Religious values else a sin	Son preference	Family norm of two
Illiterate	42.5%	27.4%	30.2%	51.9%	49.1%	31.1%	0%
Up to class 5	20%	13.3%	13.3%	20%	3.3%	16.7%	3.33%
Up to class 8	35.3%	29.4%	29.4%	23.5%	5.9%	29.4%	5.9%
Up to class 10	25%	16.7%	25%	25%	0%	8.3%	0%
Higher than class 10	50%	37.5%	12.5%	50%	12.5%	37.5%	0%

Table 25 clearly suggests that illiterate population was more exposed to reasons for planning more children like religious values, family traditions and support to family. As education status

improved, still half of the females support to the family, more working hands and income and family tradition as a major factor for having more children, especially sons.

Level of Awareness and Health Seeking Behavior of Beneficiaries Regarding Family Planning And Its Measures

- On an average, 83 percent of total study sample of beneficiaries and religion-wise, 93 percent Hindu and 75 percent Muslim females were aware of family planning measures.

- Muslim community females were found to be more aware of family planning methods like OCPs (67 percent), tubectomy (52 percent), male condoms (40 percent) and IUCDs (20 percent), while only few knew about methods like abstinence, rhythm method, coitus interruptus and injectables.

- Whereas, awareness was seen to be more among Hindu community females like OCPs (84 percent), tubectomy (72 percent), male condoms (72 percent) and IUCDs (38 percent), abstinence (16 percent) and other methods like rhythm method, coitus interruptus, vasectomy and injectables.

- None had knowledge regarding use of other barrier methods like female condoms and cervical cap, spermicidal methods, and other hormonal methods like Transdermal patches.

Table 26: Cross-tabulation between education status and level of awareness of family planning among the beneficiaries in district Saharsa, Bihar (in %).

EDUCATION STATUS	AWARENESS OF FAMILY PLANNING	
	Yes	No
Illiterate	75.5	24.5
Literate but no schooling	50.0	50.0
Up to class 5	93.3	6.7
Up to class 8	100.0	0.0
Up to class 10	91.7	8.3
Higher than class 10	100.0	0.0

It is clearly suggested from table 26 that more educated females were aware of methods like abstinence, rhythm method, coitus interruptus, male condoms, OCPs, IUCDs and male as well as female sterilizations. Less educated females were found to be aware of methods like injectables.

Table 27: Sources of information about family planning methods to the beneficiaries in district Saharsa, Bihar (in %).

SOURCE	ASHA	AWW	ANM/ GNM/SN	Doctor	Media	Traditional Healer	Peers	Family
Percent	97.9	3.5	64.2	16.6	26.9	0.7	49.7	4.8

Table 27 suggests the very less females visited doctors for information, so social marketing of Family Planning methods has been taken up by ASHAs and ANMs in the villages for the necessary guidance.

Figure 20:

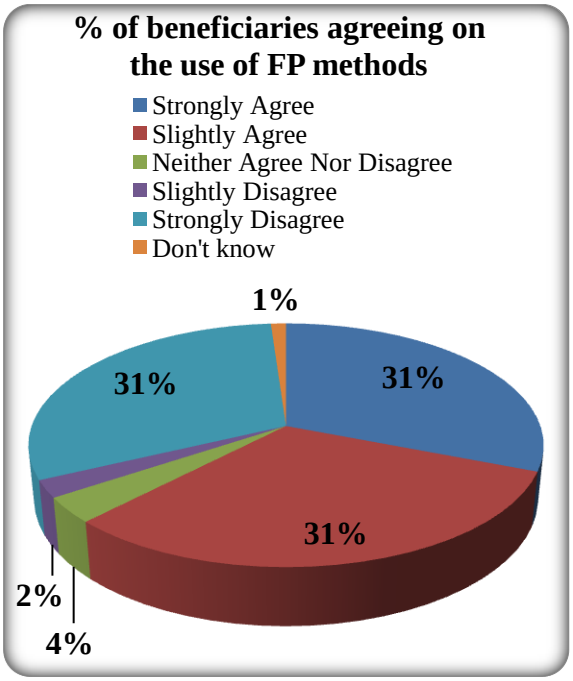


Figure 21:

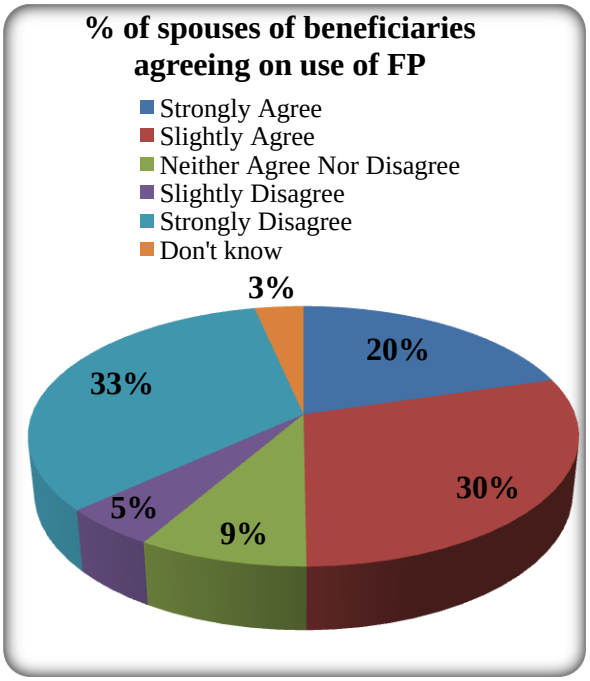


Figure 20 shows that an equal percentage of females strongly and slightly agreed on the use of FP methods, however the percentage was quite less (only 31 percent). Surprisingly, another 31 percent females strongly disagreed on the use of FP methods.

Figure 21 shows that 38 percent spouses of females in total disagreed using FP methods as reported by them. Those agreeing on the use were 50 percent in total. Nine percent even responded that their husbands neither agree nor disagree showing their lack of knowledge about their husbands' will and awareness to use FP methods.

Figure 22: Cross-tabulation between religion and agreement on use of FP methods by females and their spouses in district Saharsa, Bihar (in %).

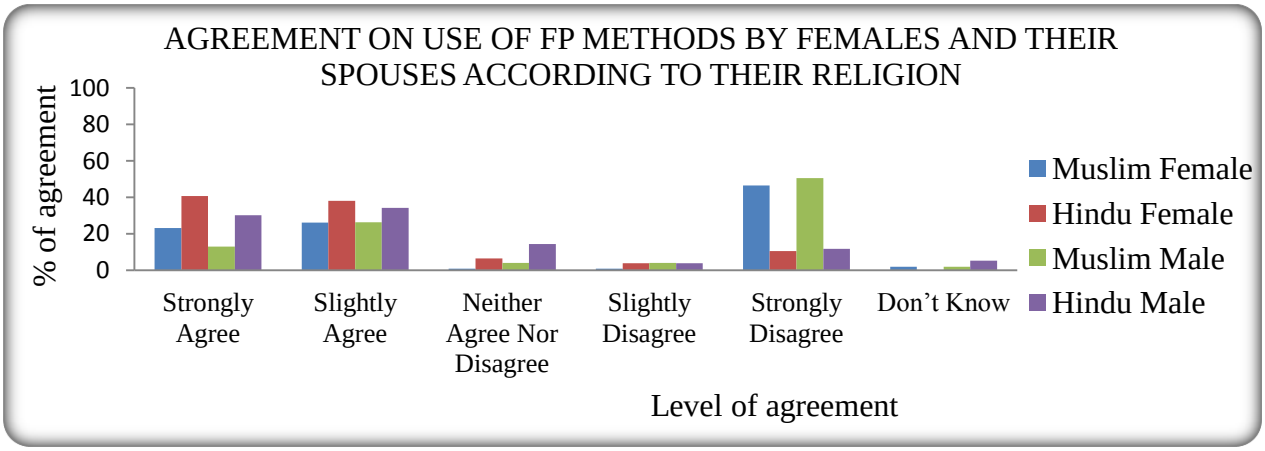


Figure 22 depicts that Hindu women were more willing to adopt family planning methods than Muslims and, spouses of women were more unlikely to agree for adoption of any FP method as compared to their counter-parts, which was more among Muslims than Hindus.

Table 28: Cross-tabulation between education status and level of agreement of the beneficiaries on the use of family planning methods in district Saharsa, Bihar (in %).

AGREEMENT ON USE OF FP METHODS	Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree	Don't know
Illiterate	37	0	22	15	17	9
Literate but no schooling	51	43	22	16	4	4
Up to class 5	33	0	67	0	0	0
Up to class 8	50	0	50	0	0	0
Up to class 10	96	0	0	0	2	2
Higher than class 10	100	0	0	0	0	0

Table 28 shows that more educated females strongly agreed on adopting family planning. Majority of illiterates and literates without any schooling agreed on the use of FP, but some females disagreed with the idea of adopting FP. Females educated up to Class 5 and Class 8 females also showed varying responses shoeing that education had nothing to do with agreeing using FP methods.

Table 29: Cross-tabulation between education status and level of awareness about health outcomes of family planning among the beneficiaries in district Saharsa, Bihar (in %).

HEALTH OUTCOME	AWARENESS	EDUCATION STATUS				
		Illiterate	Up to class 5	Up to class 8	Up to class 10	Higher than class 10
Controlling no. of pregnancies	92.6	90.6	93.3	100.0	100.0	100.0
Proper spacing between children	18.9	10.4	25.0	47.1	16.7	75.0
Proper timing of births	2.9	0.9	0.0	5.9	8.3	25.0
Preventing unwanted pregnancies	21.7	19.8	23.3	17.6	33.3	37.5
Prevention against STDs/HIV	0.0	0.0	0.0	0.0	0.0	0.0
Reducing maternal mortality & morbidity	5.1	1.9	10.0	0.0	0.0	50.0
Reducing child mortality & morbidity	2.3	0.9	3.3	0.0	0.0	25.0

Table 29 shows the average level of awareness of females about the health outcomes of Family Planning was very low. They mainly reported that controlling the number of pregnancies was the major outcome of FP. Some knew about proper spacing and preventing unwanted pregnancies, but a very less percentage knew that FP is helpful in reducing maternal and child mortality and morbidity, and none knew that FP is a major tool to combat against STDs/HIV. The analysis also shows that more educated females were more aware of various other health outcomes of family planning.

Table 30: Level of awareness of beneficiaries about the benefits of using OCPs and Condoms in district Saharsa, Bihar.

BENEFITS	OCPs		CONDOMS	
	NUMBER	PERCENT	NUMBER	PERCENT
Easy to use	35	20.0	21	12.0
Easily available	64	36.6	66	37.7
Easily accessible	15	8.6	17	9.7
Easily affordable	27	15.4	41	23.4
Anytime available	2	1.1	11	6.3
Does not hinder pleasure	12	6.9	8	4.6

Safe	22	12.6	25	14.3
Effective	3	1.7	12	6.9
Good compliance	2	1.1	1	0.6

Table 30 suggests that majority of the females reported easy availability, easy usage, easy affordability and safety as the major benefits of using OCPs and Condoms.

Table 31: Beneficiaries as 'Ever Users' of family planning methods in district Saharsa, Bihar.

EVER USED ANY FP METHOD	RELIGION	
	Muslim	Hindu
(111 out of 175 i.e. 63.4 percent)	48 (48.5 percent)	63 (82.9 percent)

- **Method:** Majority had used barrier methods like male condoms (30 percent), hormonal methods like OCPs (25 percent), permanent method of tubectomy (9 percent) and IUCDs (7 percent), while lesser percentage of women had used natural methods like abstinence (six percent), coitus interruptus (three percent) and rhythm method (one percent).
- **Method as per Religion:** Muslim community females lagged behind Hindu community females in the usage of family planning methods, for which statistical significance was proved at $p<0.0001$. Abstinence was used by Hindu beneficiaries almost twice more than used by Muslim beneficiaries. Use of male condoms, OCPs, IUCDs and undergone Tubectomies were used more by Hindu beneficiaries (41, 28, 9, and 15 percents respectively) than Muslim beneficiaries (21, 22, 6 and 4 percents respectively). Rhythm method and coitus interruptus were used equally by the beneficiaries of both religions.
- **Method as per Age-Group:** Abstinence was seen to have been used more by the beneficiaries of age more than 35 years, rhythm method in 21-25 years age-group, coitus interruptus by females over 35 years age, IUCDs in 30-40 years age-group and Tubectomies by females over 30 year of age. However, male condoms and OCPs were reported to be used by the females of all age-groups (16-45 years).
- **Method as per Education status:** Better educated females were found to have used even once natural methods in some cases and more variations in FP methods than the illiterates or lesser educated ones. Statistical significance was seen in methods like rhythm method, coitus interruptus, male condoms and IUCDs at $p<0.1$, $p<0.01$, $p<0.01$, $p<0.0001$ and $p<0.01$ respectively showing an association between their use and better education status. However, no statistical significance was seen for OCPs used ever as FP method.

Table 32: Beneficiaries as 'Current Users' of family planning methods in district Saharsa, Bihar.

CURRENT USER OF ANY FP METHOD (102 out of 175 i.e. 58.3 percent)	RELIGION	
	Muslim	Hindu
	46 (46.5 percent)	56 (73.7 percent)

- **Method:** Majority are current users of barrier methods like male condoms (25 percent), hormonal methods like OCPs (17 percent), permanent method of tubectomy (nine percent) and IUCDs (six percent), while lesser percentage of women are using natural methods like abstinence (two percent), coitus interruptus (one percent) and rhythm method (0.6 percent).
- **Method as per Religion:** Muslim community females lagged behind Hindu community females in the usage of family planning methods, for which statistical significance was proved at $p<0.0001$. Methods like abstinence, rhythm method and coitus interruptus was being currently used by only Hindu beneficiaries but in very low percentage. Use of Male Condoms and undergone Tubectomies were used more by Hindu beneficiaries (32 and 15 percents respectively) than Muslim beneficiaries (19 and 4 percents respectively). OCPs and IUCDs are being used equally by the beneficiaries of both religions (17 and 6 percents respectively).
- **Method as per Age-Group:** Current use of family planning methods was seen to be high among females of the age-group 21-25 years (63 percent) and 26-30 years (62 percent), moderate among 36-40 years (59 percent) and 31-35 years (53 percent) and low among 16-20 years (40 percent) and 41-45 years (33 percent). Male condoms and OCPs are being used among all age-groups, while other methods are known to be used by females above the age 30-35 years.
- **Method as per Education:** Use of male condoms, OCPs, IUCDs and undergone Tubectomies was reported to be higher among more educated females (preferably after class 8) and some of those above class 10 used methods like abstinence and rhythm method. Some illiterate women used coitus interruptus too. Values were found to be statistically significant for rhythm method, male condoms and OCPs at $p<0.01$, $p<0.01$ and $p<0.1$ respectively showing an association between use of these methods and better education status of females.

Table 33: Cross-tabulation between education status and use of family planning methods by the beneficiaries in district Saharsa, Bihar (in number).

EDUCATION STATUS	USERS OF FP METHODS	
	EVER USERS	CURRENT USERS
Illiterate	49	46
Literate but no schooling	1	0

Up to class 5	26	23
Up to class 8	17	17
Up to class 10	11	10
Higher than class 10	7	6
Total	111	102

Table 33 depicts the *drop outs* among the users of family planning methods. Not only lesser educated females had withdrawn from using family planning methods, especially OCPs and Condoms, some of the females with better education status had also stopped the use of family planning method owing to many reasons, however, the number was less in the latter.

There was perfect statistical significance at $p<0.001$ for both ever users and current users using *Chi-Square test* showing an **association** between higher education status and use of Family Planning methods by both ever users and current users.

Other key findings about consistent use of OCPs and Condoms by beneficiaries:

- Also, there was a reported *inconsistency* in the use of OCPs and Condoms by their current users in Saharsa. Out of 175 females, 30 were current users of OCPs, amongst which 27 reported of consistent use, but only 21 intended to continue with their consistent use.
- And, out of 175 females, 43 were current users of Condoms, amongst which 25 reported of consistent use, but only 23 intended to continue with their consistent use.
- Consistent current users of OCPs and Condoms belonged mainly to the age-group of 20-40 years and 20-30 years respectively.
- Both Muslim as well as Hindu population equally used OCPs on a consistent basis (15 percent), while Hindu community females used Condoms more consistently (18 percent) than Muslim community females (11 percent). However, they were statistically significant only for Condoms at $p<0.1$ and $p<0.01$ showing association between religion & consistent use and religion & intention to continue with the use of condoms respectively.

Table 34: Cross-tabulation between education status and consistent use of OCPs and Condoms in district Saharsa, Bihar (in number).

EDUCATION STATUS	OCPs		CONDOMS	
	Consistent use	Intention to use consistently	Consistent use	Intention to use consistently
Illiterate	12	10	11	6
Up to class 5	5	5	4	6
Up to class 8	5	4	5	4
Up to class 10	1	0	3	4
Higher than class 10	4	2	2	3

Table 34 shows that consistent use of OCPs was more among educated females, but intention to use OCPs consistently dropped among all. Similarly, consistent use of Condoms was more among educated females, but intention to continue with use of Condoms dropped among illiterates and those educated up to class 8, however, it increased among those educated up to class 5, class 10 and higher than class 10.

Statistical significance was however, proved only among consistent users of OCPs at $p<0.1$ and those who were intended to continue with use of condoms at $p<0.1$ showing an association between consistent use and intention to consistent use of these methods of FP with higher education status of beneficiaries.

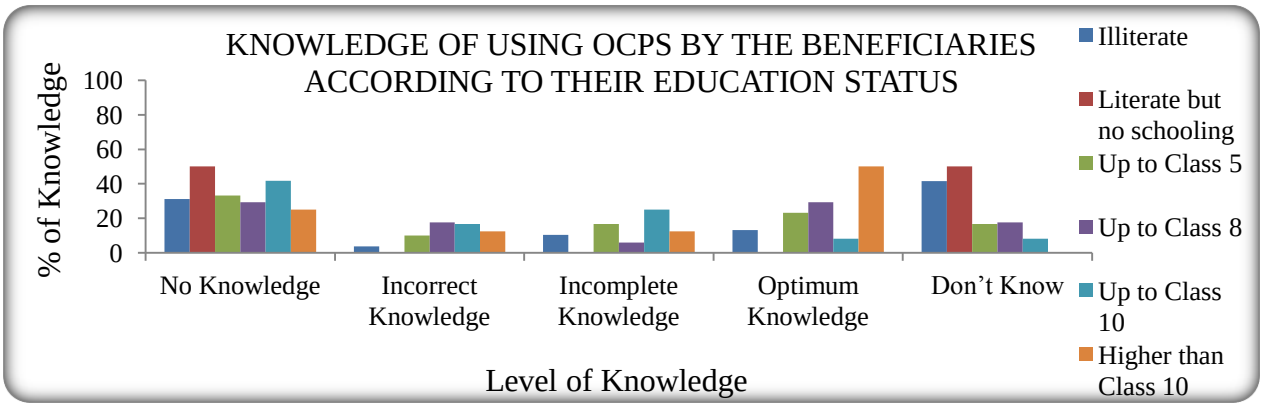
Table 35: Reasons for inconsistent use of OCPs and Condoms by the ever or current users in district Saharsa, Bihar (in % out of total females).

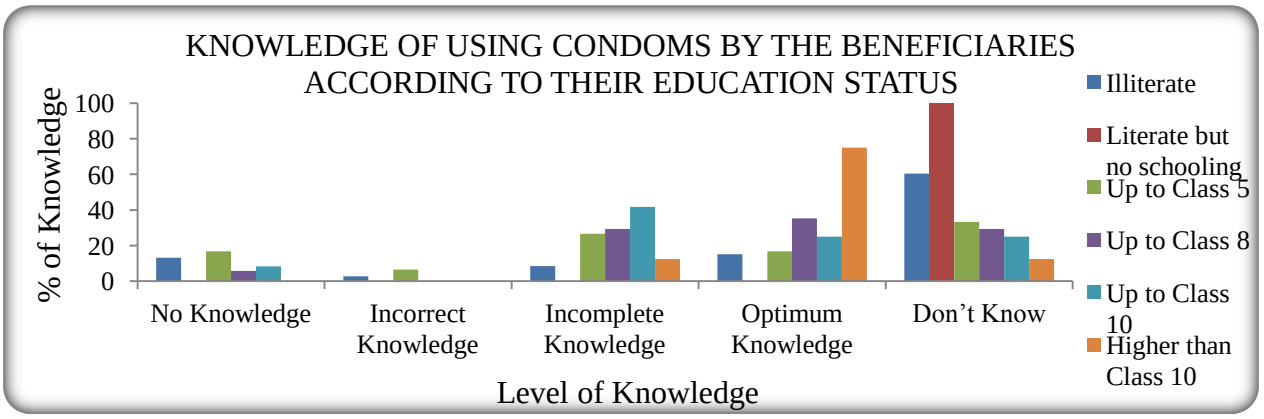
REASONS FOR INCONSISTENT USE OF OCPs AND CONDOMS BY EVER OR CURRENT USERS		
	OCPs	CONDOMS
Religious restrictions	34.3	34.9
Unavailable	0.0	3.4
Unaffordable	0.6	0.6
Inaccessible	0.6	2.9
Lack of knowledge	29.7	50.9
Low quality	1.1	8.0
Family pressure	12.6	10.9
Husband doesn't approve	8.6	32.6
Developed side effects after use	3.0	0.0
Fear of side effects	40.6	8.0
Doubt on effectiveness	7.4	9.1
Topic of mockery & laughter in society	0.6	6.3
Problems with storage in house or away from children	2.9	5.7
Problems with disposal	0.0	4.0
Hinders pleasure	0.0	12.6
Problems with usage	0.0	2.9
Sterilized now	6.9	6.9
Forgetfulness	4.6	0.0
IUCD inserted now	5.7	5.7
Ought to be taken daily	1.1	1.1
Willing for tubectomy or IUCD	3.4	3.4
Willing for pregnancy	1.1	1.1
Unwilling to use any external means	3.5	3.5

Feel shy to ask repeatedly from ASHA/ANM	0.0	1.7
Has to be taken in secrecy	0.0	0.6

Knowledge of Using OCPs and Condoms:
Only 17 percent females knew how to use OCPs correctly and 21 percent females knew how to use condoms correctly.

Figure 23, 24: Cross-tabulation between education and knowledge of using OCPs and Condoms by the females in district Saharsa, Bihar (in %).





Figures 23 and 24 depict that knowledge of using condoms was better among higher educated females. Majority of females did not know anything about OCPs or Condoms and those who had heard about them from various sources had no knowledge how to use them. Educated females also reported incorrect and incomplete knowledge how to use OCPs. Better educated females had better knowledge of using OCPs. Around 50 percent of those educated higher than class 10 had optimum knowledge. Some reported incorrect knowledge while major proportion had an incomplete knowledge of using condoms. Around 75 percent of study sample beneficiaries had optimum knowledge of using condoms.

Statistical significance was also proved among those having knowledge how to use OCPs and Condoms at $p<0.1$ and $p<0.001$ respectively showing an association between knowledge of using these methods with higher education status using Chi-Square test.

Tables 36, 37: Cross-tabulation between religion and knowledge of using OCPs and Condoms by the beneficiaries in district Saharsa, Bihar (in number).

RELIGION	KNOWLEDGE OF USING OCPs				
	No knowledge	Incorrect knowledge	Incomplete knowledge	Optimum knowledge	Don't know
Muslim	28	4	9	16	42
Hindu	28	9	12	15	12
RELIGION	KNOWLEDGE OF USING CONDOMS				
	No knowledge	Incorrect knowledge	Incomplete knowledge	Optimum knowledge	Don't know
Muslim	9	2	8	18	62
Hindu	12	3	20	18	23

Tables 36 shows that majority of Muslim women had not even heard of OCPs (42 percent) and many had no knowledge of using them even if they had heard about them (28 percent). Only 16 percent had optimum knowledge of using OCPs, while four percent reported of incorrect knowledge and nine percent of incomplete knowledge. Majority of Hindu females also had no knowledge of using OCPs (37 percent), while an equal percentage had incomplete knowledge and not heard about using OCPs (16 percent). Rest 12 percent had incorrect knowledge of using OCPs. Statistical significance was proved showing association between Religion and those having knowledge how to use OCPs at $p<0.01$.

Table 37 shows similar results. Majority of Muslims and Hindus had not even heard how to use Condoms; however, the percentage was almost double in Muslims than the latter. Only 18 percent of Muslims and 24 percent of Hindus had optimum knowledge of using condoms. A high percentage of Hindu females reported of having an incomplete knowledge how to use them (26 percent). Statistical significance was proved showing association between Religion and those having knowledge how to use Condoms at $p<0.001$.

Only 37 percent beneficiaries reported that there can be some *side effects* of using OCPs while 42 percent of them did not respond at all.

Table 38: Side effects of OCPs known to beneficiaries in district Saharsa, Bihar.

SIDE EFFECT	PERCENT	SIDE EFFECT	PERCENT
Nausea	3.4	Cardiovascular effects like DVT, PE, MI, stroke	4.6
Headache & migraine	0.6	**User dies and goes to hell after that**	2.9
Breast tenderness, fullness & discomfort	1.1	White discharge from vagina	2.9
Bleeding disturbances and anaemia because of excessive bleeding	25.7	Blisters in mouth & stomach of lactating mother	3.4
Weight gain	8.0	Blisters in mouth & stomach of breastfed child	1.7
General body weakness	2.8	Ability to conceive reduces	1.1

Table 38 shows the knowledge of beneficiaries about possible side-effects of using OCPs. Around 26 percent knew that OCPs can cause bleeding disturbances. Low percentage of them knew about other side-effects. A striking feature to note was around 3 percent of them believed that using OCPs is life-threatening and after using them, the user goes to hell.

Table 39: Cross-tabulation between education status and side effects of OCPs known to the beneficiaries in district Saharsa, Bihar (in %).

EDUCATION STATUS	SIDE EFFECTS OF OCPs KNOWN				
	Yes	No	Can't Say	Don't Know	Total
Illiterate	31	12	8	55	106
Literate but no schooling	1	0	0	1	2
Up to Class 5	12	6	3	9	30
Up to Class 8	10	4	0	3	17
Up to Class 10	7	0	0	5	12
Higher Than Class 10	3	5	0	0	8
Total	64	27	11	73	175

Table 39 shows that majority of females did not about any side-effects of using OCPs (55 percent). Those educated up to class 8 had best knowledge than the rest of the lot.

Very few females reported correctly about the *contraindications* of using OCPs. They only knew about contraindications like lactating mothers in first 6 months (five percent), abnormal bleeding (five percent), already pregnant (two percent), excessive vaginal discharge (one percent), age more than 40 years (one percent), cardiac abnormalities (0.6 percent) and smoking (0.6 percent).

Branding of OCPs and Condoms:
OCPs and Condoms called by brand names were less known to the beneficiaries. OCPs like *Mala-D, Mala-N and Saheli* were known to only 20 percent, 11 percent and 0.6 percent of the total sample females, while Condom known most-commonly by the name of *Nirodh* was known to half of the study sample only.

Figure 25: Cross-tabulation between education and knowledge about various brands of OCPs and Condoms to the beneficiaries in district Saharsa, Bihar.

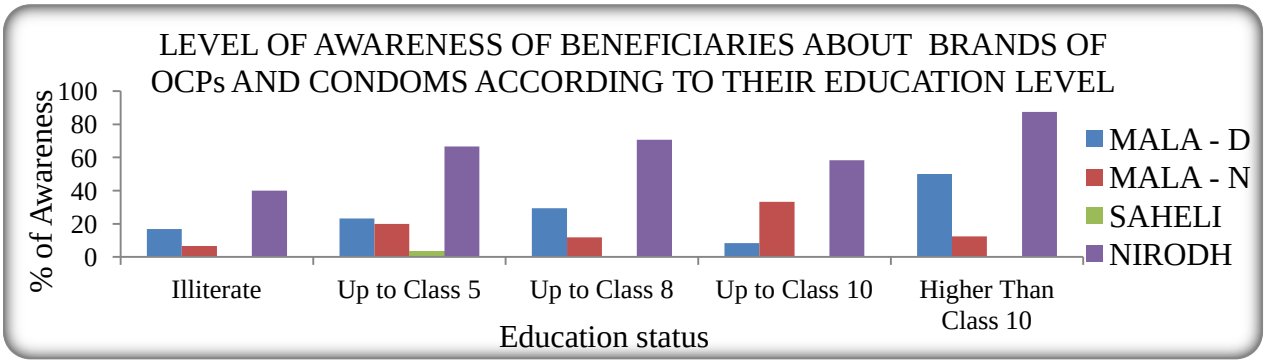


Figure 25 depicts that knowledge of brands of OCPs and Condoms as marketed by various sources was better among better educated females. Condom was known by its brand name (Nirodh) by majority of them among all groups, and the awareness was known to increase as the education status improved. Mala-D showed varying results and Mala –N was known better by better educated females. However, Saheli brand was known to only three percent of those educated up to class 5.

Preferred Method By Females:
None (35 percent) > male condoms (25 percent) > OCPs (17 percent) > tubectomy (14 percent) > IUCD (7 percent) > Abstinence (1 percent) > coitus interruptus (0.6 percent)

- **Reasons for use of various methods in order of their preference:**
  Condoms: easily available, easily accessible, affordable, safe, effective, does not hinder pleasure and available anytime.
  OCPs: easy to use, easily available, affordable, does not hinder pleasure, easily accessible, anytime available, safe and effective.
  IUCDs: proper spacing is available.
  Tubectomy: permanent measure can be done after adequate numbers of children are born.

Preferred FP Method By Spouse:
None (36 percent) > male condoms (23 percent) > OCPs (14 percent) > tubectomy (19 percent) > IUCD (7 percent) > Abstinence (1 percent) > coitus interruptus (0.6 percent)

- **Reasons for use of various methods in order of their preference:**
  Condoms: easily available, affordable, safe, effective, does not hinder pleasure, easily accessible and available anytime.
  OCPs: easily available, anytime available, does not hinder pleasure, easily accessible, affordable, effective, has to be used by wife and safe.
  IUCDs: proper spacing is available.
  Tubectomy: permanent measure can be done after adequate numbers of children are born.

Role of ASHA Workers in Social Marketing of Family Planning and its Measures to the Beneficiaries

- 74.3 percent females reported that there were regular home visits by ASHA workers to provide them with various health services, whereas 64.6 percent females reported that they provided them with information regarding adoption of family planning methods, especially OCPs and condoms.

Table 40: Rating by the beneficiaries on the ability of ASHA workers to guide and inform them regarding various health services and social marketing of OCPs and condoms (in %).

RATING BY FEMALES	ABILITY OF ASHA WORKERS TO GUIDE BENEFICIARIES	
	Counselling about health services	Social marketing of OCPs and Condoms
Bad	25.7	36.6
Less Satisfactory	8.0	16.0
Satisfactory	33.1	23.4
Good	28.0	18.9
Excellent	5.1	5.1

Table 40 reports the rating of ASHAs by beneficiaries on their ability to counsel them about health services and social marketing of OCPs and Condoms. Majority of them reported the counselling to be satisfactory (33 percent). But, around 26 percent even reported the counselling ability to be bad, amongst which were those who did not want to take any services from ASHAs. Despite all this, majority reported that SM ability of ASHAs was bad (37 percent), while others believed it to be satisfactory (23 percent) or good (19 percent).

10. Conclusion and Discussion.

- Only 14 percent females reported that ASHA workers instructed on the use of condoms through *demonstrations* while doing social marketing of condoms to increase their adoption by the community females.

- However, 61 percent females believed that ASHAs can be a *good source of information* regarding family planning measures.

- They *suggested some methods* by which ASHAs can advise them and other community females on the use of OCPs and Condoms. Around 28 percent believed that oral communication and demonstrations are the best sources of information, some believed that telling more about usage and benefits, convincing other family members to reduce family pressure, more prompt distribution patterns & more accessible ASHA, posters, pictures, books, availability of safer & better quality of OCPs and condoms, street plays, same religion ASHA for guidance, self training in front of ASHA and fear messages can prove to be fruitful as well.

- However, 28 percent females *did not want any ASHA to guide them* as they considered use of OCPs and Condoms as a religious sin and her money as evil money, and some believed that they are more involved in earning money rather than social welfare and that, they disliked other religion ASHA workers, some had family pressures that prevented them using any family planning method, while many of them were unwilling to use any external means for family planning, few were willing to get sterilized than use OCPs or Condoms and the rest were clueless as they did not have any knowledge about family planning and its various methods.

2.6 CONCLUSION

The results support that there is a huge shortage of skilled ASHA workers in terms of Social Marketing of OCPs and Condoms in Saharsa district of Bihar. There is an immense need to focus on their education status, while appointing them for the work of ASHA. Religious hindrances play a major role towards adoption of OCPs and Condoms by the females of the community added with huge disapproval of adoption of any methods especially Condoms. ASHA workers can thus prove to be a major line of extension to outreach the females to adopt such methods.

11.Recommendation

Many IEC/BCC activities need to be carried out so that the community is motivated to use family planning methods especially temporary methods like OCPs and Condoms.

- ★ Spirit of Volunteerism among ASHA workers to be enhanced, apart from increasing their financial incentives on the basis of monthly sales of OCPs and Condoms.
- ★ Educated ASHA workers- better communication and provision of services.
- ★ Training of ASHA workers- Revision sessions, Retention skills, Communication strategies, developing goals and strategies, increasing their Motivation.
- ★ Monitoring of ASHA workers on social marketing and distribution of OCPs and Condoms directly to the community females.
- ★ Evening Education sessions of community females, especially Muslims- Oral communication and teaching through demonstrations, holding Focussed Group Discussions (FGDs), Street Plays, Posters outside health facilities.
- ★ Communicating Positive Deviants from the community itself.
- ★ Communicating the importance and benefits of family planning along with adequate information about use of OCPs and their side-effects and contraindications, while addressing their local beliefs, misconceptions and myths.
- ★ Practical sessions: Demonstrating the use of Condoms, encouraging self training.
- ★ Branding of OCPs and Condoms so as to reduce the stigma associated with these things and rural people are freer to ask for OCPs and Condoms from ASHAs.
- ★ Sustained Marketing Campaigns need to be carried out to increase the desire for use of condoms and OCPs by the community.
- ★ Community Mobilizer can be appointed in every village who guides the community at adopt healthy Family Planning behavior at the time any couple marries and delivers their first child and he/she can be appointed from within the community.
- ★ Special sessions can be held by ASHAs and ANMs or SMS groups of the villages for adolescent girls to tech about family planning and encourage education among them.

12. LIMITATIONS OF THE STUDY

- ★ Low education status of the respondents might have been an obstacle in making the study population understand about certain questions related to the prepared questionnaire by the interviewer.
- ★ Socio-cultural issues might have affected the true picture of communicating the family planning methods adopted by the females of the community to the ASHA workers as well as the interviewer.
- ★ Study sample might not have been adequate to reflect true and concrete statistical significance about various issues related to the study.

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14. APPENDICES

Confidential, For research purpose only

INFORMED CONSENT FORM FOR ASHA WORKERS

Interview Schedule Identification Number	
State Name:	District Name:
Block name:	Village name:
Name of ASHA:	
Phone number of ASHA:	

Introduction:

Namaste. My name is _____ and I am from State Health Society, Patna. I am conducting a survey about the adoption of family planning methods and your role in facilitating the adoption of these methods by women of this village. Your participation in the study would be highly appreciated.

The intent of this study is to assess your level of awareness about family planning measures and your training needs for the same. There is no or minimal risk involved. This survey would usually take between 20 and 30 minutes to complete. Whatever information you provide will be strictly kept confidential and anonymous to the extent allowed by law.

Participation in this survey is voluntary and if you choose not to participate, you may withdraw at any time you wish. However, we hope that you will take part in the survey since your participation is important.

May I begin the interview now?

- Respondent agrees to be interviewed…… 1
- Respondent does not agree to be interviewed…….. 2

Interviewer's Name: Date:
Interviewer's Signature:

ASHA's Name:
ASHA's Signature:

INTERVIEW SCHEDULE FOR ASHA WORKERS

SECTION: A

Questions pertaining to General Information of ASHA workers			
S. No.	**Question**	**Response**	**Skip to**
1.	What is your name and age?	_____ ☐☐ Years	
2.	What is the name of your village?	_____	
3.	What is your religion?	1. Muslim 2. Hindu 3. Sikh 4. Jain 5. Christian 6. Others (Specify)_____ 99. Don't know	
4.	What is the highest level of education that you have attained?	1. Illiterate 2. Literate but no schooling 3. Up to class 5 4. Up to class 10 5. Higher than class 10 99. Don't know	
5.	Do you stay in this village?	1. Yes 2. No	**} Q. 7**
6.	If no, where do you come from and how far is it from this place?	_____ ☐☐ Km.	
7.	For how long, have you been working as ASHA in this village?	_____ Months/ Years	
8.	What is the population of this village?	_____	
9.	What all trainings have you received so far?	Training / Days	
10.	Name the services provided by ASHA.	1. Create health awareness 2. Counselling 3. Increasing service utilization 4. Timely identification of diseases 5. Primary medical healthcare of diseases like diarrhoea, fever, etc.	

		6. Timely referral 7. Facilitate village health plan 8. Escort/accompany the sick and delivery cases 9. Others (please specify) _____	
11.	How many homes do you visit every day?	1. None 2. 1-3 3. 4-6 4. 7-9 5. 10 6. More than 10	

SECTION: B

Question pertaining to Measures of Family Planning known to ASHA workers			
S. No.	**Question**	**Response**	**Skip to**
12.	Are you aware of the family planning measures that can be adopted by an individual?	1. Yes 2. No	**} Q14.**
13.	Name the family planning measures that you are aware of?	1. Abstinence 2. Rhythm Method 3. Coitus Interruptus 4. Male Condoms 5. Female Condoms 6. Cervical Cap 7. Oral Contraceptive Pills 8. Spermicidal Methods 9. IUCDs 10. Male Sterilization (Vasectomy) 11. Female Sterilization (Tubectomy) 12. Injectables 13. Transdermal Patches 14. Others (Specify) _____	
14.	What are the possible health outcomes of family planning?	1. Controlling the number of pregnancies 2. Proper spacing between children 3. Proper timing of births 4. Preventing the unwanted pregnancies 5. Prevention against STDs/HIV 6. Reducing maternal mortality & morbidity 7. Reducing child mortality & morbidity 8. Others (Specify) _____	
15.	What are the benefits of using family planning measures, particularly OCPs and Condoms?	1. Easy to use 2. Easily available 3. Easily accessible 4. Affordable 5. Anytime available	

		6. Does not hinder pleasure 7. Others (Specify) _____	
16.	Are you able to make the females of this village aware of family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
17.	Are you able to make the females understand about the benefits of using family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
18.	Are you able to convince females regarding the use of OCPs and condoms as family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
19.	Can you tell the names of brands of OCPs and Condoms that you might/might not have in stock?	OCPs / Condoms	
20.	Which method do you suggest the females to use according to different age groups?	Age-Group (years) / Method	
21.	Do you know which method is preferred by the females of this village amongst OCPs and Condoms?	1. OCPs 2. Condom 3. Both 4. None	
22.	Are you aware of the intention to continue with the use of OCPs and condoms in future by the couples who are already using them?	1. Yes 2. No 98. Can't say 99. Don't know	
23.	Can you demonstrate how to use the condoms?	1. Can't demonstrate 2. Incorrect demonstration 3. Correct demonstration	
24.	What are the options available in prescribing or using OCPs?	1. 21 pills pack 2. 28 pills pack 3. Every alternate day 4. Others (Specify) _____ 99. Don't know	
25.	What is the criterion of using OCPs?	1. Day-wise pill 2. Any pill any day 3. Others (Specify) _____ 99. Don't know	

26.	Is there any difference if OCPs are taken at any time of the day during the entire day?	1. Yes 2. No 98. Can't say 99. Don't know	
27.	What do you suggest if a woman forgets to take a pill on a particular day?	1. Take the pill as soon as u remember and next pill at the same time of day 2. Take two pills the next day at any time of day 3. It doesn't matter, take the next pill at the same time of day 99. Don't know	
28.	Can OCPs be taken during breastfeeding?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 30**
29.	If yes, which OCPs can be taken during breastfeeding?	1. Mini pills 2. Combination pills 3. Any pill 98. Can't say 99. Don't know	
30.	What are the side effects of using OCPs?	1. Nausea 2. Headache and Migraine 3. Breast tenderness, fullness and/or discomfort 4. Mood changes 5. Bleeding Disturbances 6. Weight gain 7. Hypertension 8. Cardiovascular effects like DVT, MI, Stoke, PE, etc 9. Cancers (Cervical/Breast) 10. Others (Specify) _____ 99. Don't know	
31.	In what medical or biological or social conditions, you should not take OCPs?	1. Cancers (Breast/ Genitals) 2. History of Thromboembolism 3. Cardiac abnormalities 4. Undiagnosed abnormal bleeding 5. Congenital hyperlipidaemia 6. Smoking 7. Age over 40 years 8. Lactating mothers in first 6 months 9. Diabetes Mellitus 10. Gall bladder disease 11. Chronic Renal disease 12. Epilepsy 13. Migraine 14. Amenorrhoea 15. Others (Specify) _____ 99. Don't know	

SECTION: C

Questions pertaining to Training Needs Assessment of ASHA workers			
S. No.	**Question**	**Response**	**Skip to**
32.	Do you have any set targets to increase the usage of OCPs and condoms in your community?	1. Yes 2. No	
33.	How do you grade your ability to communicate the messages regarding use and benefits of OCPs and condoms to the females of your village?	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
34.	How do you grade your ability to convince the females regarding use of OCPs and condoms on a consistent basis?	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
35.	Are you able to listen attentively, without interruption to somebody with whom you disagree?	1. Yes 2. No	
36.	When in a conflict situation, are you able to handle the situation without offending the other person?	1. Yes 2. No	
37.	Have you ever had any training related to communication and adoption of family planning measures to the community?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 46**
38.	If yes, what information did it convey to you?	_____ _____ _____	
39.	Rate your training session on a scale of 5.	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
40.	Give a feedback on your training session regarding promoting the use of OCPs and condoms?	1. Overcrowded sessions 2. Trainers didn't explain the material clearly 3. Trainers weren't able to clarify the doubts 4. Trainers weren't competent enough to solve problems 5. Unsatisfactory provision for food & accommodation 6. No compensation received 7. Others (Specify) _____	
41.	What were the positive aspects of your training	_____	

	session?	_____ _____	
42.	What were the negative aspects of your training session?	_____ _____ _____	
43.	In your opinion, how was the quality of theoretical training being provided to you?	1. Incomplete 2. Optimum 3. Too much 4. Need to repeat	
44.	In your opinion, how was the quality of practical training being provided to you?	1. Incomplete 2. Optimum 3. Too much 4. Need to repeat	
45.	Do you think sessions should be incorporated in your training modules to teach about adoption of family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 49**
46.	If yes, can you suggest some methods w.r.t. education level of the females in your village?	_____ _____	
47.	Do you think you will be able to perform better if additional trainings about family planning are provided to you?	1. Yes 2. No 98. Can't say 99. Don't know	
48.	In your opinion, what should be the duration of these training sessions per day?	_____ Hours	
49.	Would you face any problems if such trainings are provided to you?	1. Place of training too far 2. Family doesn't approve 3. Insufficient time 4. Lack of motivation 5. Others (Specify) _____	
50.	In your opinion, what are the motivating factors that encourage you to involve yourself in such training programs?	1. Financial Incentives 2. To get more exposure in village 3. To improve conditions in your village 4. Social prestige 5. Peer pressure 6. Others (Specify) _____	

Thanks, End of Survey!

Confidential, For research purpose only

INFORMED CONSENT FORM FOR COMMUNITY FEMALES

Interview Schedule Identification Number		
State Name:	District Name:	
Block name:	Village name:	
Name of the Respondent:		
Phone number of the Respondent:		

Introduction:

Namaste. My name is _____ and I am from State Health Society, Patna. I am conducting a survey about the level of awareness and adoption of family planning methods and your perception about the working of ASHA in your village as a family planning method motivator.

Your participation in the study is highly appreciated. There is no or minimal risk involved. This survey would usually take between 20 and 30 minutes to complete. Whatever information you provide will be strictly kept confidential and anonymous to the extent allowed by law.

Participation in this survey is voluntary and if you choose not to participate, you may withdraw at any time you wish. However, we hope that you will take part in the survey since your participation is important.

May I begin the interview now?

- Respondent agrees to be interviewed…… 1
- Respondent does not agree to be interviewed…….... 2

Interviewer's Name: Date:

Interviewer's Signature:

Respondent's Name:

Respondent's Signature:

INTERVIEW SCHEDULE FOR COMMUNITY FEMALES

SECTION: A

Questions pertaining to General Information of community females			
S. No.	**Question**	**Response**	**Skip to**
1.	What is your name and age?	_____ ☐☐ Years	
2.	What is the name of your village?	_____	
3.	What is your religion?	1. Muslim 2. Hindu 3. Sikh 4. Jain 5. Christian 6. Others (Specify) _____ 99. Don't know	
4.	What are your educational qualifications?	1. Illiterate 2. Literate but no schooling 3. Up to class 5 4. Up to class 10 5. Higher than class 10 99. Don't know	
5.	How many people are there in your family?	☐☐	
6.	What is the occupation of your husband?	1. Agriculture 2. Animal husbandry 3. Artisan 4. Manual Labour 5. Business 6. Industrial Worker 7. NREGA 8. Service 9. Self employed 10. Domestic Help 11. Others (Specify) _____	
7.	How many children do you have?	☐☐	
8.	Do you plan to have more children?	1. Yes 2. No 98. Can't say	} **Q. 10**
9.	If yes, why?	1. Support to the family 2. More working hands 3. More income 4. Family tradition 5. Others (Specify) _____	

SECTION: B

Questions pertaining to Health Seeking Behaviour on Family Planning			
S. No.	**Question**	**Response**	**Skip to**
10.	Are you aware of any family planning measures?	1. Yes 2. No	**} Q. 13**
11.	Name the family planning measures that you are aware of?	1. Abstinence 2. Rhythm Method 3. Coitus Interruptus 4. Male Condoms 5. Female Condoms 6. Cervical Cap 7. Oral Contraceptive Pills 8. Spermicidal Methods 9. IUCDs 10. Male Sterilization (Vasectomy) 11. Female Sterilization (Tubectomy) 12. Injectables 13. Transdermal Patches 14. Others (Specify) _____	
12.	From where did you get information regarding family planning methods?	1. ASHA 2. AWW 3. ANM/GNM/Nurse 4. Doctor 5. Media (Posters, Plays, Newspaper, TV, Radio, etc.) 6. Traditional healer 7. Others (Specify) _____	
13.	Do you agree on the use of family planning measures?	1. Strongly agree 2. Slightly agree 3. Neither agree nor disagree 4. Slightly disagree 5. Strongly disagree 99. Don't know	
14.	How do you perceive your spouse's attitude towards use of family planning measures?	1. Strongly favourable 2. Quite favourable 3. Neither favourable nor unfavourable 4. Quite unfavourable 5. Strongly unfavourable 99. Don't know	
15.	What are the health outcomes of family planning?	1. Controlling number of pregnancies 2. Proper spacing between children 3. Proper timing of births	

		4. Prevent unwanted pregnancies 5. Prevention against STDs/HIV 6. Reducing maternal mortality & morbidity 7. Reducing child mortality & morbidity 8. Others (Specify) _____ 99. Don't know	
16.	What are the benefits of using OCPs?	1. Easy to use 2. Easily available 3. Easily accessible 4. Affordable 5. Anytime available 6. Does not hinder pleasure 7. Others (Specify) _____	
17.	What are the benefits of using Condoms?	1. Easy to use 2. Easily available 3. Easily accessible 4. Affordable 5. Anytime available 6. Does not hinder pleasure 7. Others (Specify) _____	
18.	Have you ever used any family planning method?	1. Yes 2. No	**} Q. 28**
19.	If yes, which family planning method have you ever used?	1. Abstinence 2. Rhythm Method 3. Coitus Interruptus 4. Male Condoms 5. Female Condoms 6. Cervical Cap 7. Oral Contraceptive Pills 8. Spermicidal Methods 9. IUCDs 10. Male Sterilization (Vasectomy) 11. Female Sterilization (Tubectomy) 12. Injectables 13. Transdermal Patches 14. Others (Specify) _____	
20.	Are you a current user of any family planning method?	1. Yes 2. No	**} Q. 28**
21.	Which family planning method are you using now?	1. Abstinence 2. Rhythm Method 3. Coitus Interruptus 4. Male Condoms 5. Female Condoms 6. Cervical Cap	

		7. Oral Contraceptive Pills 8. Spermicidal Methods 9. IUCDs 10. Male Sterilization (Vasectomy) 11. Female Sterilization (Tubectomy) 12. Injectables 13. Transdermal Patches 14. Others (Specify) _____	
22.	Do you use OCPs on a consistent basis?	1. Yes 2. No	**} Q. 23**
23.	If no, what is the reason?	1. Unavailable 2. Unaffordable 3. Inaccessible 4. Lack of knowledge 5. Low quality 6. Family pressure 7. Husband doesn't approve 8. Fear of side effects 9. Doubt on effectiveness 10. Topic of mockery and laughter among society 11. Problems with storage in house, away from children 12. Others (Specify) _____	
24.	Do you intend to continue with the use of OCPs on a consistent basis in future?	1. Yes 2. No 98. Can't say	
25.	Do you use condoms on a consistent basis?	1. Yes 2. No	**} Q. 27**
26.	If no, what is the reason?	1. Unavailable 2. Unaffordable 3. Inaccessible 4. Lack of knowledge 5. Problems with disposal 6. Low Quality 7. Family pressure 8. Husband doesn't approve 9. Hinders pleasure 10. Fear of side effects 11. Doubt on effectiveness 12. Topic of mockery and laughter among society 13. Problems with storage in house, away from children 14. Others (Specify) _____	
27.	Do you intend to continue with the use of condoms on a consistent basis in future?	1. Yes 2. No	

		98. Can't say	
28.	Do you know how and when to use OCPs?	1. No knowledge 2. Incorrect knowledge 3. Incomplete knowledge 4. Optimum knowledge 99. Don't know	
29.	Do you know how and when to use Condoms?	1. No knowledge 2. Incorrect knowledge 3. Incomplete knowledge 4. Optimum knowledge 99. Don't know	
30.	Are there any side effects of using OCPs?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 32**
31.	What are the side effects of using OCPs?	1. Nausea 2. Headache and Migraine 3. Breast tenderness, fullness and/or discomfort 4. Mood changes 5. Bleeding Disturbances 6. Weight gain 7. Hypertension 8. Cardiovascular effects like DVT, MI, Stoke, PE, etc 9. Cancers (Cervical/Breast) 10. Others (Specify) _____ 99. Don't know	
32.	In what medical or environmental conditions, should you not take OCPs?	1. Cancers (Breast/ Genitals) 2. History of Thromboembolism 3. Cardiac abnormalities 4. Undiagnosed abnormal bleeding 5. Congenital hyperlipidaemia 6. Smoking 7. Age over 40 years 8. Lactating mothers in first 6 months 9. Diabetes Mellitus 10. Gall bladder disease 11. Chronic Renal disease 12. Epilepsy 13. Migraine 14. Amenorrhoea 15. Others (Specify) _____ 99. Don't know	
33.	Name some brands of OCPs that you are aware of?	_____ _____ _____	

34.	Name some brands of Condoms that you are aware of?	_____ _____	
35.	Is there any method of family planning that is preferred by you? Any specific reason for the same?	_____ _____ _____	
36.	Is there any method of family planning that is preferred by your spouse? Any specific reason for the same?	_____ _____ _____	

SECTION: C

Questions pertaining to Social Marketing of OCPs and Condoms by ASHA workers			
S. No.	**Question**	**Response**	**Skip to**
37.	Does ASHA visit your home regularly?	1. Yes 2. No 99. Don't know	} **Q. 42**
38.	How do you grade the ability of ASHA of your village to guide you and inform you regarding various health services?	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
39.	Does she provide you with any information regarding use and adoption of OCPs and condoms?	1. Yes 2. No	
40.	What is your opinion regarding her communication with you regarding use and adoption of OCPs and condoms?	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
41.	Did ASHA instruct you on the use of OCPs and condoms by demonstrations?	1. Yes 2. No	
42.	Do you think ASHA worker of your village can be a good source of information regarding family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
43.	Can you suggest any means by which ASHA can advise you on the use of OCPs and Condoms?	_____ _____ _____	

Thanks, End of Survey!