DISSERTATION
AT
DISTRICT HEALTH SOCIETY, MUNGER (BIHAR)

Dissertation Title
"Perception of ASHAs regarding factors affecting the acceptance of "Non Scalpel Vasectomy" among males in Munger district of Bihar"

by

NIKHIL RAJ
Roll No. PG/11/061

Dissertation Report submitted in partial fulfillment of the requirements for the award of

Post Graduate Programme in Hospital & Health Management

(2011-2013)

International Institute of Health Management Research

New Delhi -110075

MAY, 2013

बिहार सरकार

जिला स्वास्थ्य समिति, मुंगेर
District Health Society

Phone No. - 06344/223715
E-mail : dhsmunger@yahoomail.com

NATIONAL RURAL HEALTH MISSION

Ref..No. 456 /

Date. 27/04/13 /

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Mr. NIKHIL RAJ** *is a Second year Student of Post Graduate Diploma in Hospital and Health Management (PGDHHM) of International Institute of Health Management Research (IIHMR), New Delhi. He is working with the District Health Society, Munger (Bihar) as a* **District Community Mobilizer (ASHA)**, *headquarter at State Health Society Bihar, Patna. He has successfully completed his dissertation from* **11th Feb** *to* **27th April 2013** *as a part of the course curriculum from District Health Society, Munger (Bihar).*

He is hard working and sincere towards his work. He has completed all the assignments tasks at the District Health Society, Munger (Bihar). I wish him all the very best endeavors.

(Dr. Jawahar Singh)
Civil Surgeon cum member secretary
District Health Society, Munger

बच्चे दो ही अच्छे

Certificate of Approval

The following dissertation titled " **Perception of ASHAs regarding factors affecting the acceptance of "Non Scalpel Vasectomy" among males in Munger district of Bihar** " 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. A.M. Ichar	
Dr. Preetha GS	
Dr VINAY TRIPATHI	

Certificate from Dissertation Advisory Committee

This is to certify that Mr. Nikhil Raj, a participant of thr Post Graduate Diploma in Hospital & Health management, has worked under our guidance & supervision. He is submitting this dissertation titled **"Perception of ASHAs regarding factors affecting the acceptance of "Non Scalpel Vasectomy" among males in Munger district of Bihar"** in partial fulfillment of the requirements for the award of the Post Graduate Diploma in Hospital & Health Management.

This disseratation has the requisite standarad and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor 01/05/2013

Dr. Nitish Dogra

Designation : Assistant Professor

IIHMR, New Delhi.

Organizational Advisor 26/04/13

Md. Nasim

District Program Manager

District Health Society, Munger

FEEDBACK FORM

Name of the Student: Nikhil Raj

Dissertation Organisation: District Health Society, Munger

Area of Dissertation: Accredited Social Health Activist (ASHA)

Attendance: Complete

Objectives achieved: Completion of tasks with sincerity, Timely completion of Project assigned, Timely submission of reports & documents.

Deliverables: Perception of ASHAs regarding factors affecting the acceptance of Non Scalpel Vasectomy among males in Munger district, Bihar.

Strengths: Good managerial skills, Good communication skills, Time management, Professionalism, Multitasker

Suggestions for Improvement: Should be more initiative

26/4/13

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

जिला कार्यक्रम प्रबंधक
जिला स्वास्थ्य समिति मुंगेर

Date: 26/04/13
Place: Munger

ACKNOWLEDGEMENT

I have no adequate words to express my loyalty to God for showering his blessings over me and guiding me in my path and career.

I would like to express my gratitude to ***Dr. Jawahar Singh*** *– Civil Surgeon cum member secretary,District Health Society, Munger (Bihar), who has given opportunity to us for working with District Health Munger (Bihar).*

I would like to express my gratitude to ***Md. Nasim****, District Program Manager, District Health Society, Munger (Bihar), for his support and encouragement, kind and true guidance on my training and project whenever required and when spirits were down. He helped me by supervising my project, structuring, evaluating my report, carrying out my investigation and suggestion on the improvements.*

I would like to thank ***Dr. Nitish Dogra*** *& I would like to say thanks to all who facilitated me for the kind help they rendered during the entire course with information regarding each data and additive guidance in finding what resource is available where & report writing.*

Nikhil Raj

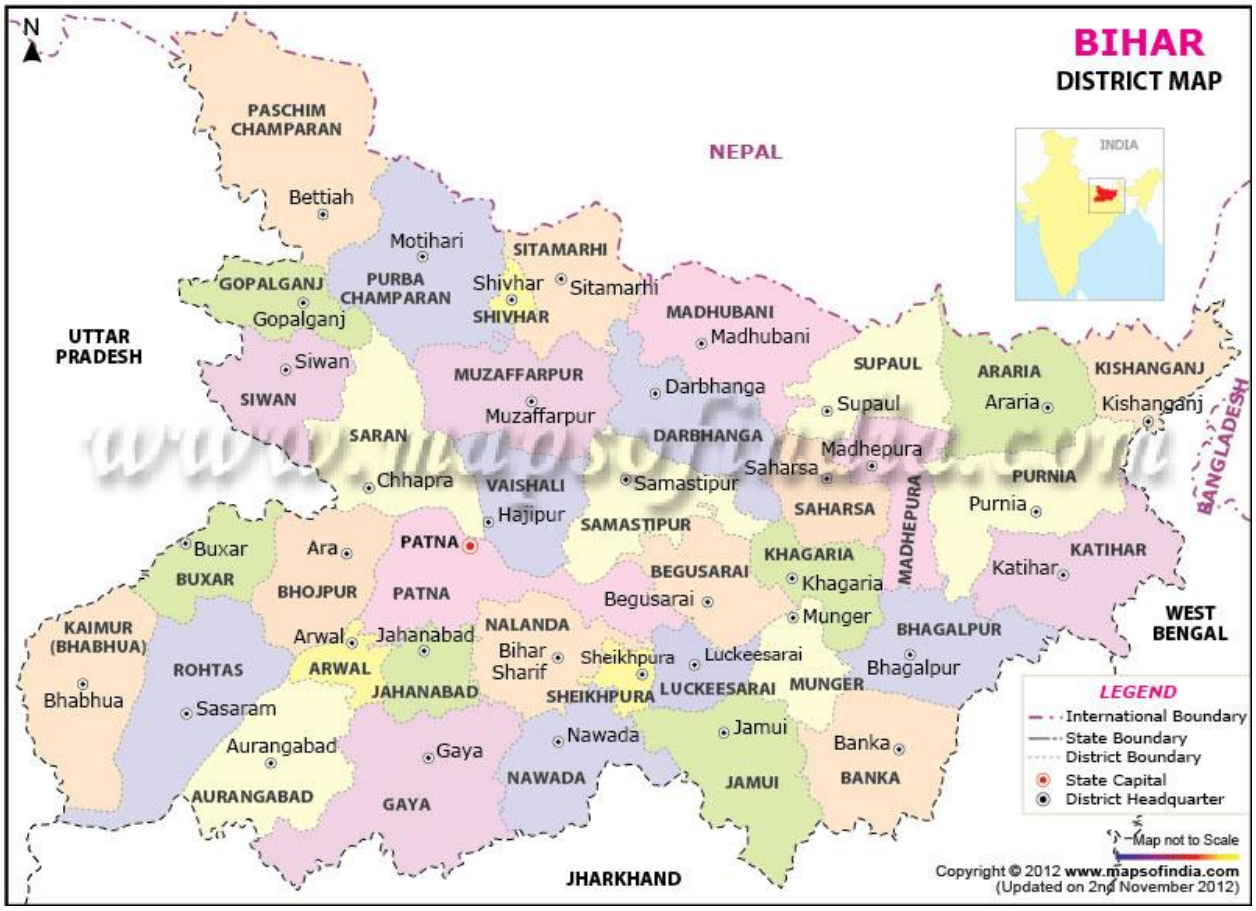
IIHMR, New Delhi, Batch "D"

Contents

Acronyms

ANM	Auxiliary Nurse Midwifery
ARSH	Adolescent Reproductive & sexual Health
ASHA	Accredited Social Health Activist
AWC	Aaganwadi Centre
AWW	Aaganwadi Worker
BCC	Behavioral change Communication
BPL	Below poverty Line
BEmOC	Basic emergency Obstetric Care
CEmOC	Comprehensive emergency Obstetric Care
CBO	Community Based Organization
CDR	Crude Death Rate
CEO	Chief Executive Officer
CMR	Crude Mortality Rate
DHS	Directorate of Heath services
DPT	Diphtheria, Pertusis & Tetanus Vaccine
DPMU	District Programme Management Unit
GNM	General Nursing & Midwifery
GO	Government Order
GOB	Government of Bihar
GOI	Government of India
HIV	Human Immunodeficiency Virus

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

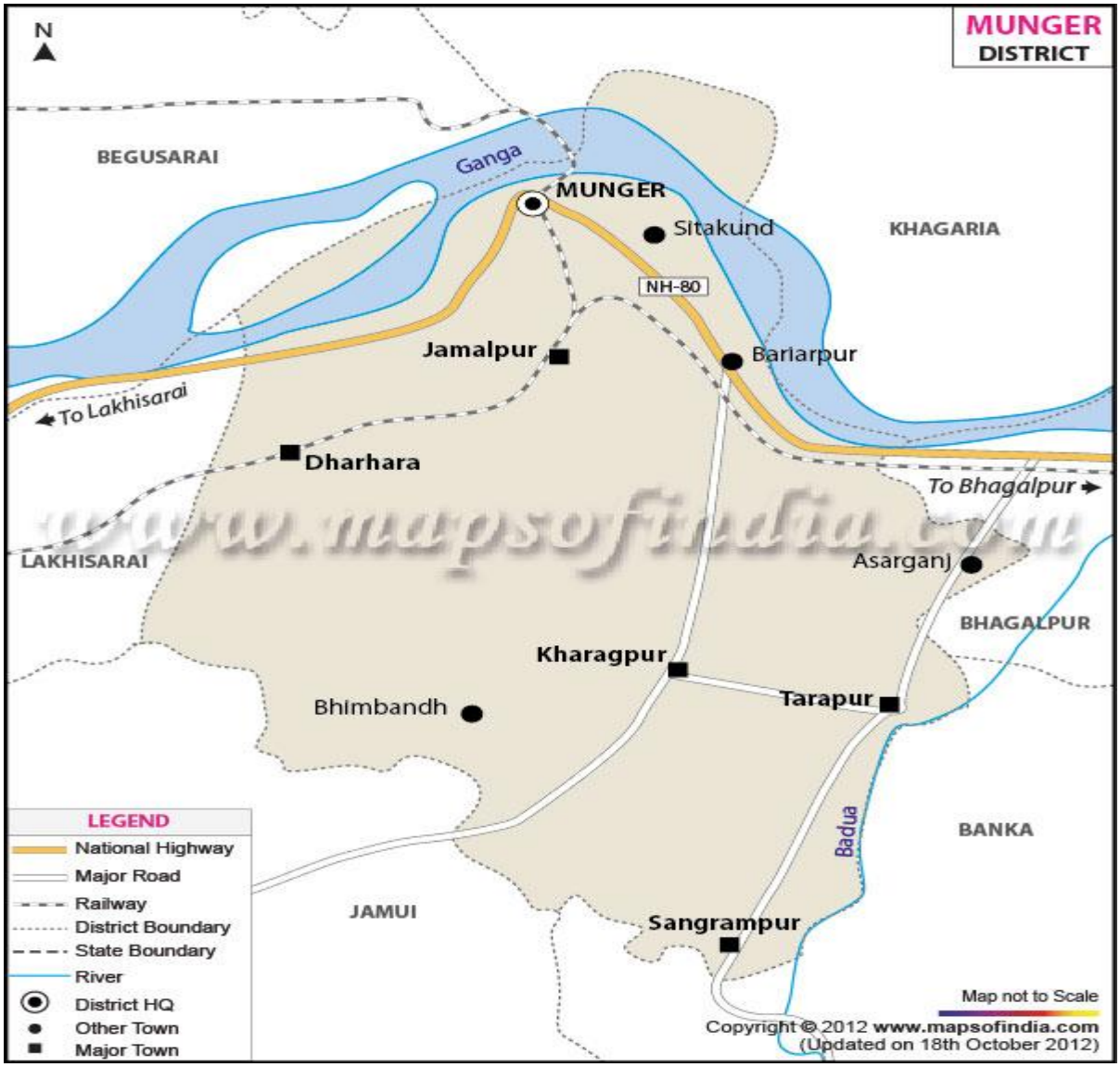
	2003	2005	2010	2011	India 2011
IMR	60	61	48	44	44
CBR	30.7	30.4	28.1	27.7	22.3
CDR	7.9	8.1	6.8	6.7	7.1
MMR		312	261		212

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).

District's Profile

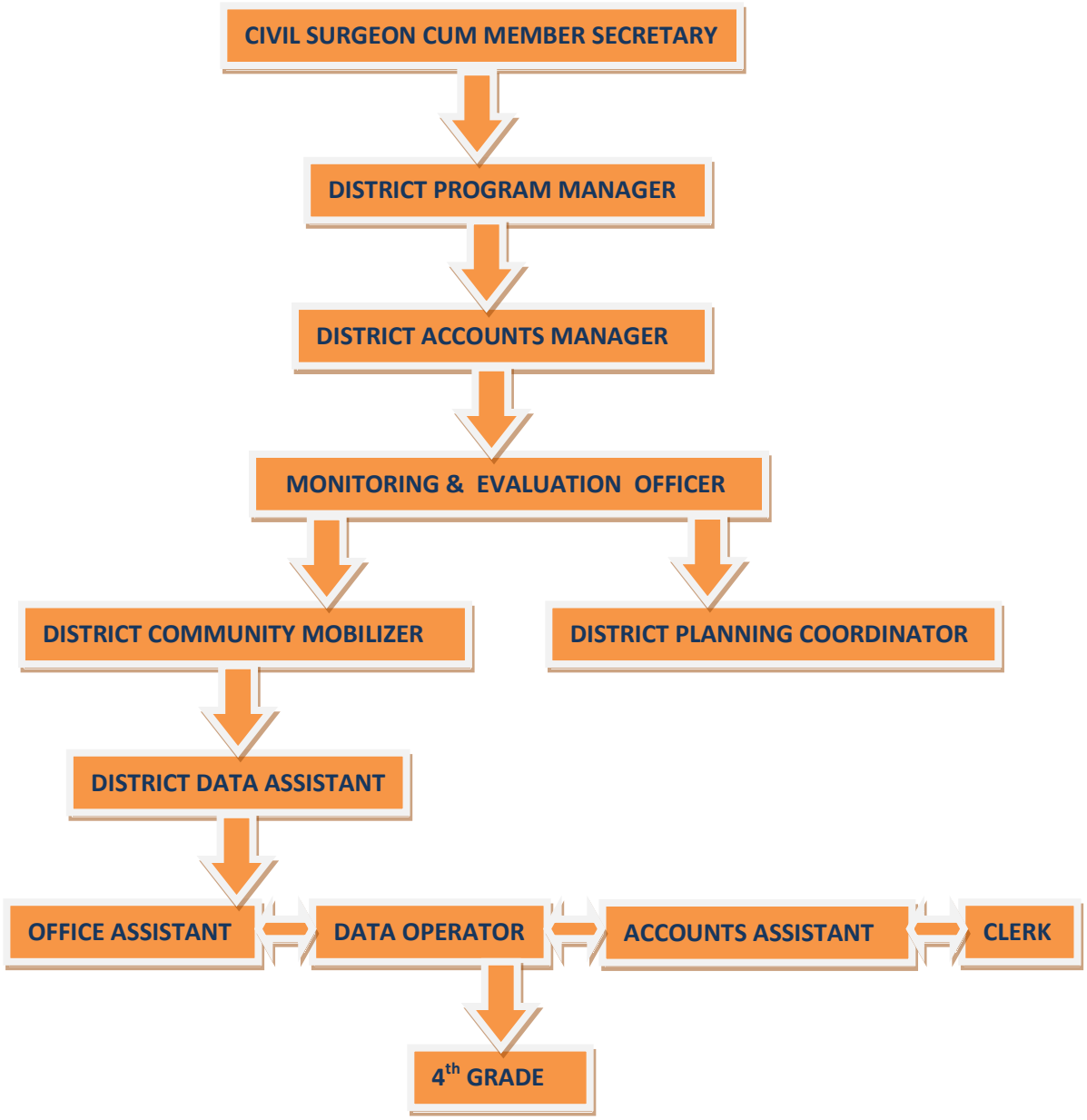


Munger is one of the 38 district of Bihar which covers an area of 1419.7 sq.km & consist of 861villages. Total population of munger is 1,359,054 out of which 723,280 are males & 635,774 are females. It comes at 33rd position according to population. Sex ratio of munger is 879 & it comes at 37th position according to sex ratio, density as per sq km is 958. It has a decadal growth rate of 19.45. Literacy rate of Munger is 73.30. **(As per 2011 census).**

District Profile :

Number of Block & PHCs	9
Number of HSC	155
Number of APHC	21

Organogram of District Health Society, Munger :



INTRODUCTION

For instant increase in the population, the Government of India formulated the national family planning programs. India was the first country in the world to formulate the national family planning program in the year 1952. Despite of implementing of different kind of efficient & effective programs in India still the high rate of increase in population is a persistent problem for India and in different states individually. Which has taken the total population to 121crore of India and 2.56 crore of Bihar. The main cause that is contributing aggressively towards it is high fertility rate and acceptance.

Men play an essential role in reproduction. They should be encouraged to involve themselves in birth control, particularly in developing countries, where contraceptive usage goals have not yet been reached. Failure to target men in reproductive health interventions has weakened the impact of reproductive health care programs. In much of the developing world individuals and couples do not have access to the full range of contraceptive options that they should have, and long-acting and permanent methods of contraception in particular remain highly underutilized.

Long-acting and permanent methods such as intrauterine devices (IUDs), implants, female sterilization (such as tubal ligation), and male sterilization, or vasectomy are by far the most effective (99% or greater) type of modern contraception and are very safe, convenient, and cost-effective in the long-run. They are all clinical methods and must be provided in health facilities by trained doctors, nurses, and or midwives. No-Scalpel Vasectomy is one of the most effective contraceptive methods available for males. It is more effective than the oral pill or the injectable contraceptive. It is an improvement on the conventional vasectomy with practically no side effects or complications. This new method is now being offered to men who have completed their families, as a special project, on a voluntary basis under Family Welfare Programme. 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 proportion 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.

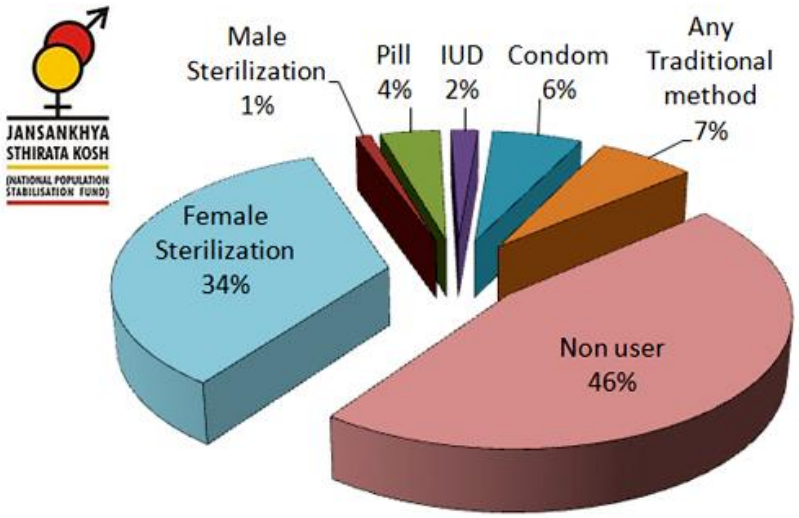
According to service report of NRHM 2008, unmet need for eligible couple (age 15-49yrs) was 12.8% in India and 8.3% for Bihar. NFHS-III also reports a similar data. The acceptance in India is low due to various factors like lack of adequate knowledge regarding contraception and its sources, limited options, preference of son, and dependence on public sector for contraceptive use. There have been various strategies adopted in India to increase the acceptance of contraception. Counseling and helpline services have been an innovative technology to provide accurate information and referrals to appropriate community based services. It is widely practiced in conditions where face to face interaction is stigmatic. Counseling and helpline services for family welfare are already in place in various western countries e.g. U.S.A, India through national interventions or at local level has been doing well through helpline services.

Principle reason for the low (or declining) use of vasectomy is the failure of health professionals to make information and services available and accessible to men. This failure has often been a result of health professionals lack of knowledge, misinformation, personal dislike of vasectomy, or untested presumptions about what men thought and wanted because men lack full access to both information and services, they can neither make informed decisions nor take the active part in family planning that their attitudes indicates they may be willing to take.

Men's perceptions, as well as the determinants of sexual behavioral change and the socioeconomic context, should be reviewed. There is a need to study and foster change to reduce or prevent poor reproductive health outcomes.

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 (1). 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 rights 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 (2). And India was the first country in the world that recognized the need for 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 (3). 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 the target-free Community Needs Assessment Approach, which involved formulating plans in consultation with communities (4). 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 citizens' consent while accessing reproductive health care, including family planning. The immediate objective is to address the unmet need for contraception (5). Despite of these efforts from the govt., acceptance of family planning methods 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.

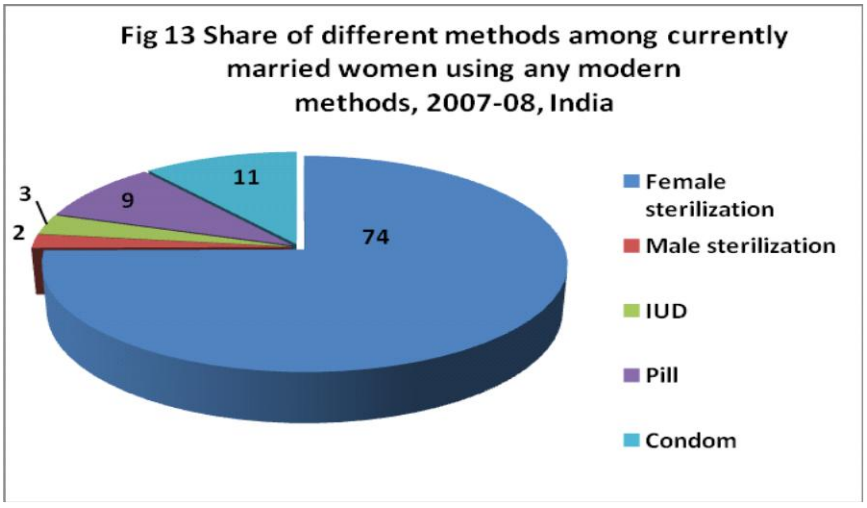


Current use of Family Planning Methods

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 DLHS – III, female sterilization is one of the mostly accepted contraceptive methods with 74% among currently married women whereas male participation is only 2%

Figure-3



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 proportion is even higher, with 70% of contraceptive users relying on female sterilization. Overall, 37% of all married Indian women of reproductive age are sterilized (6). 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 reasons for this disproportion between male and female participation in family planning are gender sensitive strategies have been neglected and, to a large extent, family planning programs have remained female oriented (7,8), some reproductive health practitioners 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 (9) and Men feel that the sterilization operation is easier to perform on women than on men

REVIEW OF LITERATURE

In order to determine the factors influencing the acceptance of vasectomy, a multi-stage stratified random sampling method and a 3-year reference period was used covering 900 subjects residing in 6 districts of Andhra Pradesh. In order to determine the factors influencing the acceptance of vasectomy, a multi-stage stratified random sampling method and a 3-year reference period was used covering 900 subjects residing in 6 districts of Andhra Pradesh. The study revealed that literacy was not a pre-requisite for undergoing vasectomy. Majority of the acceptors were poor and engaged in labour-oriented jobs. However, 50 percent of the subjects underwent operation only after 3 or more children.(2003) 10

The study has identified important factors like political and bureaucratic commitments, motivational strategies involving multi sectoral and social mobilisation approaches, patronizing well-executed vasectomy camps popularising NSV operation, schemes with innovative incentives, counseling and follow up services rendering client satisfaction, etc which were probably responsible for high acceptance of vasectomy in Karimnagar and Warangal districts in Andhra Pradesh.(1996) 11

Though males are the prime decision-makers in reproductive matters, their acceptance of No-Scaplpel Vasectomy (NSV) as a family planning method has not been satisfactory so *far. The study undertaken in the NSV'clinic of Safdarjang Hospital, New Delhi, during the year 2003-2004* that almost 50 per cent of the NSV acceptors were, in the age group of 36-40 years and most of them were Hindus (95.2%). 46 per cent of the respondents had high school level of education while 23.4 per cent and 13.7 per cent had senior secondary level and post graduate and above respectively. By and large, most of the NSV acceptors were educated and only 1.6 per cent had no education.

To popularize the acceptance of NSV among men and to involve them to actively participate in family planning, there is a need for rigorous mass media campaign to highlight the advantages of NSV and the places of its availability. The mass media campaigns should highlight the advantages of NSV viz. (i) how it is a painless operation and (ii) benefits of the post-NSV sexual life of the acceptor 12Getting men involved in FP, the study recommended the importance, not only of motivation, but that efforts should be made to create a male-friendly service delivery system at the existing service delivery centers (H & FWCs). A series of orientation meetings were held at the various phases of the project, at which all officers and fieldworkers were in attendance. These regular monthly meetings with all of the than a level FP workers were an excellent opportunity for in-depth discussions. 13

Barriers to male involvement in FP programs are also caused by service providers who assume that men have no interest in reproductive health (Alexis, 1996). Men are reluctant to seek medical treatment for conditions associated with social stigma (such as impotence and infertility). The author suggested that to promote male involvement, it should be understood that men make decisions about sex based on power, trust, and pleasure. Thus, programs should help men, understand the power which can come from promoting reproductive health. Also, programs must work towards overcoming the perception among males that acceptance of contraceptive methods is a threat to their status. Programs should also emphasize the pleasure to be derived from sexual intercourse. Outreach programs for men should use men as educators, promoters, and providers and should address a variety of topics. 14

Green et al. reviewed male involvement programs in more than 20 developing countries and recommend the following strategies to promote positive male involvement: i) changing the social norms which govern male behavior in sexual relations and parenthood; ii) incorporating male involvement in the overall planning of reproductive health programs; and iii) making service delivery programs more male friendly specifically, they recommended the development of policies for making condoms and vasectomy more accessible; encouraging private-sector initiatives such as condom sales and workplace programs; giving more attention to specific male audiences -- especially youth; and promoting greater spousal communication (Greenet al., Unpublished. 1996). 15

To a large extent, clients have expressed their satisfaction with the use of NSV method. Main reason for their satisfaction includes ‘it is a successful method’ and there are no side effects’. Satisfaction with the NSV method has motivated the clients to talk about the method with other possible beneficiaries. Emergence of post-operative health problems if not addressed adequately could lead to dissatisfaction among the clients. This in turn would have a negative influence on the program as users are also effective promoters of the method in the community. 16

RATIONALE OF THE STUDY

Vasectomy is safer, simpler, less expensive and equally as effective as female sterilization . . Yet, in India female sterilization prevalence exceeds vasectomy prevalence by a factor of 37 to 1.

Though equally easy, non-scalpel vasectomy is not being preferred due to various myths and misconceptions. Fear of loss of libido and strength, method failure, and an attitude that makes birth control as the responsibility of the woman explain in large part the poor acceptance of the method.

Changes in both men's and women's knowledge, attitudes and behavior are necessary conditions for achieving the harmonious partnership of men and women. Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life .

Apart from increasing access to male sterilization services by making them available on a regular basis at the level of the primary health centre, there is a need to strengthen communication support to the program at the field level. Community based health worker ASHAs provide the first level care in public health sector.

ASHAs are closely working with the community and they better understand the factors affecting for low acceptability of No scalped vasectomy. Factors are related to both the side provider and acceptors. It is very important to understand these factors so the related solutions can be introduced.

GENERAL OBJECTIVE

To identify the Perception of ASHA s regarding factors affecting the acceptance of 'No scalpel Vasectomy' among males

Specific Objective

- ✓ To identify the myths and misconceptions of the community regarding NSV as per the perception of the ASHAs
- ✓ To gain an understanding of the social factors related with NSV usage in community according to ASHAS
- ✓ To assess the views of ASHAs regarding service related factors for NSV usage
- ✓ To make recommendations for improved acceptance of NSV

METHODOLOGY

- ✓ The study was carried out in Munger district of BIHAR.
- ✓ Quantitative questionnaire was developed for the study groups.
- ✓ Analysis was done with percentage.

Population

The study population consists of Community based health workers (ASHA).

Sampling

- ✓ The Total Sample size is 60

Selection of blocks :

- ✓ There are 9 Blocks in the district. Among this blocks first of all 6 blocks were taken on the base of their previous year performance in NSV
- ✓ Three blocks are high performing and three are poor performing blocks selected.

Selection of study population(Community based health workers) :

After selection of the blocks,actual study group selected from these blocks. There are Total 60 Community based health workers(ASHAs) were selected.

10 ASHAs from each block. This is done on the base of the performance of ASHAs in NSV client referred. Study of previous record of ASHAs helped in this process. These all ASHAs are highly active motivators in that block.

District Hospital selects 12 ASHAs from each blocks for their ASHA Help Desk concept.These ASHAs are also very active and they select through the cluster sampling method.Some of the study population also consist these ASHAs.

	Name of 9 Blocks		Selected 6 Blocks
1.	Asarganj		High Performing Blocks
2.	Bariyarpur	1.	Jamalpur
3.	Dharhara	2.	Sadar Block
4.	Haweli kharagpur	3.	Tarapur
5.	Jamalpur		
6.	Sadar Block		Poor Performing Blocks
7.	Sangrampur	1.	Dharahra
8.	Tarapur	2.	Sangrampur
9.	Tetiabamber	3.	Tetiabamber

Data Collection :

- ✓ Qualitative questionnaire was distributed to the study population. Before distribution of the questionnaire there is brief orientation was given about the importance of the study and the details of the questionnaire. Quarries were resolved and than enough time were given to the groups.

- ✓ There are Ten questions in each questionnaire .

RESULTS

Table – 2, Qualification of Participants

Qualification	Frequency
Up to Primary	2
Primary to Middle	11
Middle to Secondary	17
Secondary to Higher secondary	26
Higher secondary to graduate	4
Total	60

- ✓ There is a less acceptance of NSV among males because they think once NSV done then they will be physically weak .32 among 60 strongly agree on this point where 23 agree .2 of them thinks this is not a reason for less acceptance, 1 strongly disagree and 2 didn't have any idea about this particular point.

- ✓ There is a less acceptance of NSV among males because they think after NSV they will be unable to make sexual relations with their wife. Again 29 strongly agreed and 21 agreed on this reason and this perception of the community. 6 of the ASHAs don't think this is reason where 2 strongly not think for this reason.2 didn't have any idea.

- ✓ Males didn't accept NSV because they are suffering from some other disease like Hydrocel, Hernia etc.7 ASHAs strongly agreed on this point where 13 agreed on this reason.27 were disagreed and 6 were strongly disagreed.7 out of 60 didn't have any idea about this question.

- ✓ People think that more children and big family is better than small family and this might be the reason why they are not willing to go for NSV. On this point only 3 ASHAs gave their opinion as a strongly agreed where 8 agreed on this point.33 were disagreed and 14 were strongly disagreed.2 of them didn't have idea.

- ✓ Males more preferred to go for female sterilization of their wife so they don't accept NSV.41 out of 60 strongly agreed on this point where 16 agreed for this point. Only 3 of them disagreed .

- ✓ Wife of male didn't allow them for NSV.8 ASHAs strongly agreed on this point 10 agreed where 28 didn't agreed.9 strongly disagreed .5 of them didn't have any idea.

- ✓ Beneficiary and Motivators not getting the 1100 Rs and 200 Rs respectively, provided by Gov.Facility so there is less acceptance of NSV. 29 strongly disagreed were 23 disagreed were only 6 were agreed and 1 strongly agreed.1 didn't respond

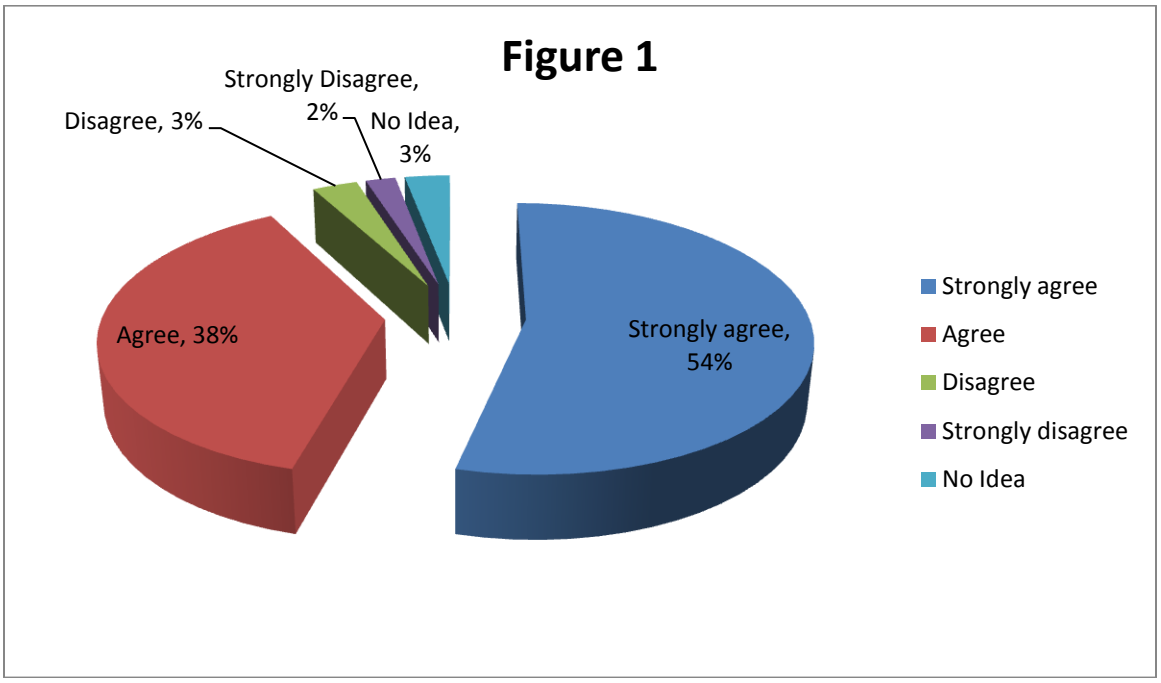
- ✓ There is no facility for NSV at nearby Hospital this might be the reason of less acceptance of NSV.22 Strongly agreed where 14 agreed on this point. 16 were disagreed where 8 were strongly disagreed

- ✓ The attitude of doctor and other staff towards client is not well so males didn't go for NSV in the hospital. Only 4 of the 60 strongly agreed where 8 agreed.28 didn't agreed ,16 strongly not agreed .4 of them didn't have any idea.

- ✓ Transport facility is one of the reason for less acceptance of NSV.22 strongly agreed and 21 agreed. 11 disagreed where 4 strongly disagreed where 2 didn't respond.

STUDY FINDINGS

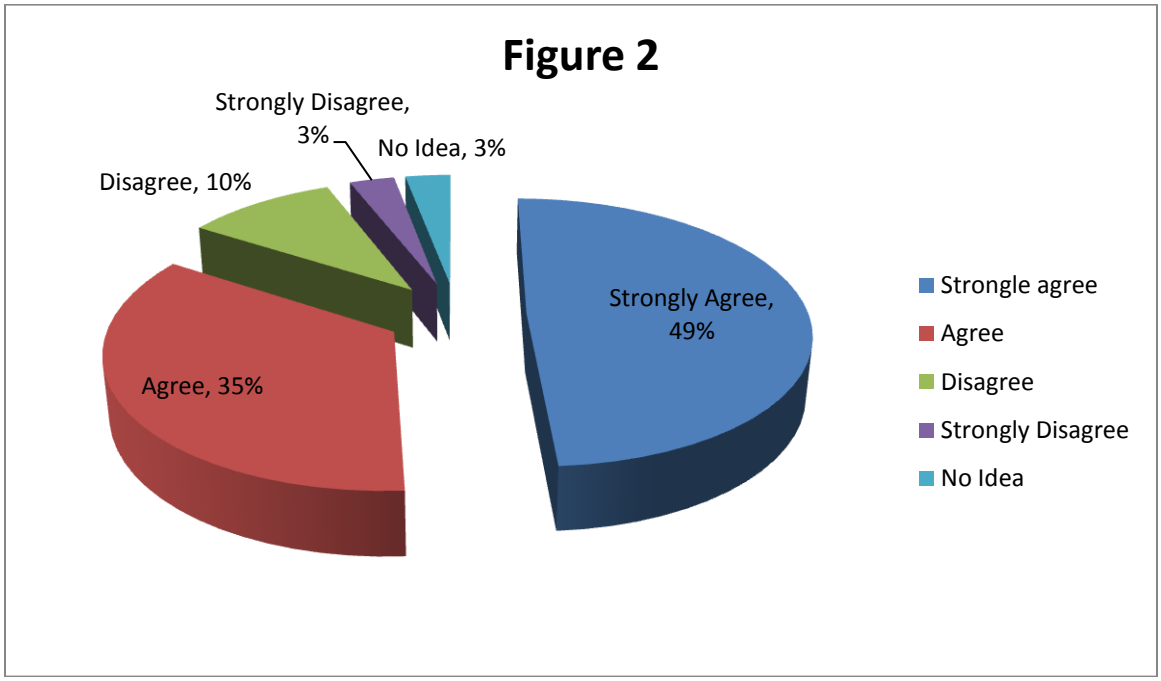
- ✓ People have myth about NSV and think it will create physical weakness.



54% ASHAs strongly agreed and 38% agreed on this matter which shows the strongest myth about NSV in community.

Maximum population in the district is from low economic group and laborers. They all working on the base of daily wages and doing physically heavy work so they have myth about their physical weakness after NSV.

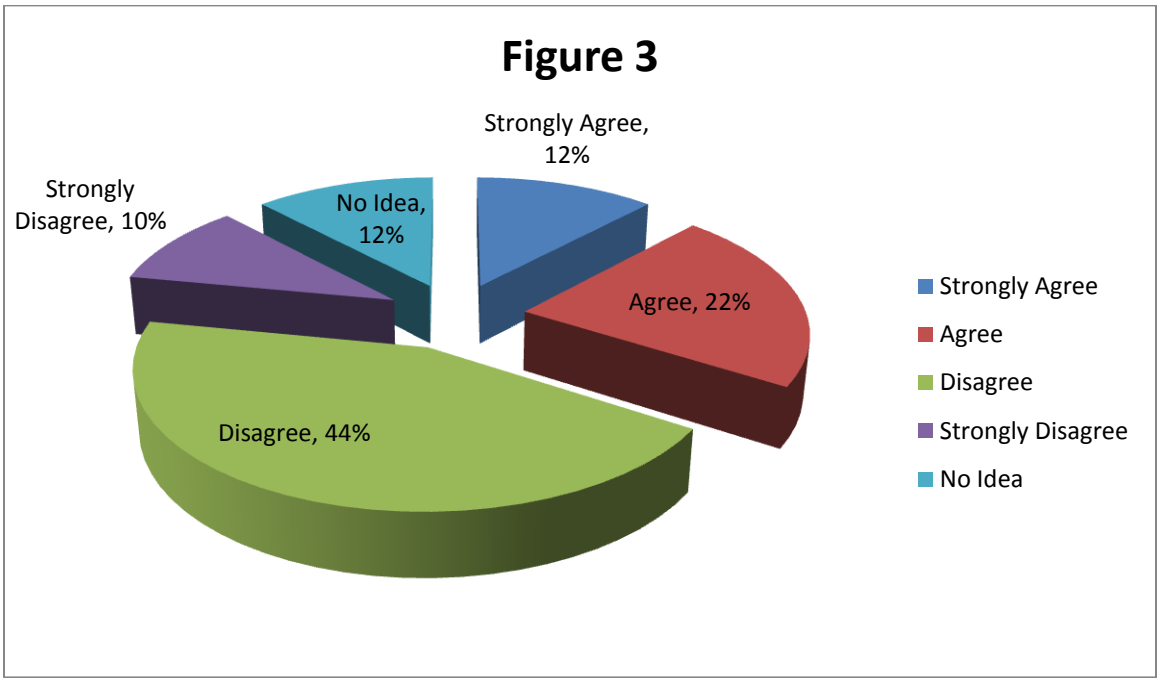
✓ People have myth about NSV and think it will create sexual weakness.



49% ASHAs strongly agreed and 35% agreed on this myth of community and give opinion that this is another strong reason why people are less willing to accept NSV.

Here Sexual weakness normally related with myth that after NSV they will unable to produce semen during the inter course.

✓ People can't accept NSV because they are suffering from some diseases like Hydrocel, Hernia etc.



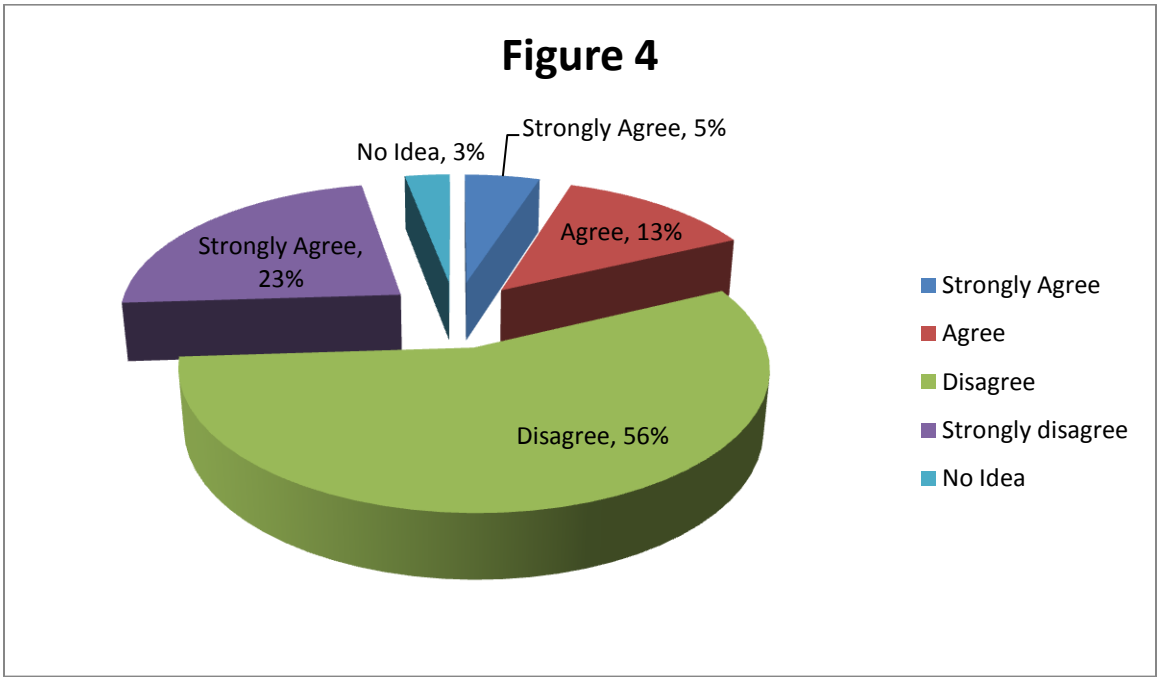
44% ASHAs disagreed and 10% strongly disagreed with this reason of less NSV acceptance

Though 22% agreed and 12% strongly agreed on this point.

Munger is highly affected with the Hydrocele. In hydrocele patients before conducting NSV need to operate the patient for hydrocele and than conventional vasectomy can possible.

Surgeons charged for this operation and after operation patients need to take rest for few days that's why people with hydrocele don't want to go for NSV.

✓ People thinks that large family is better than small family and want more no children.

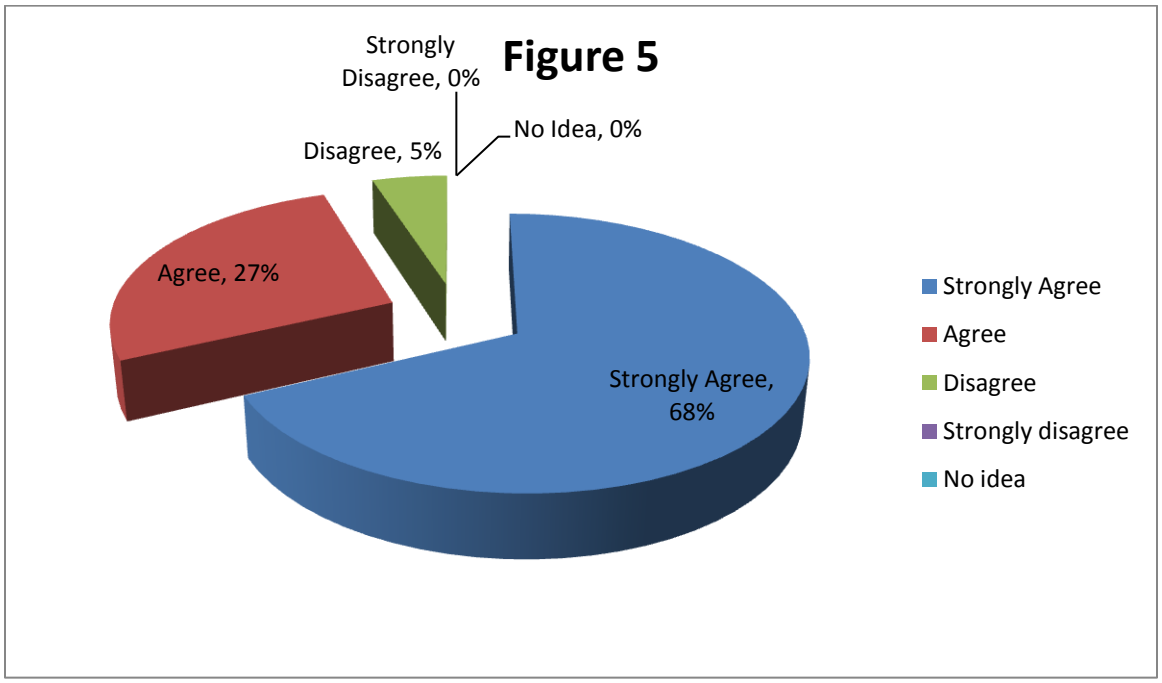


Only 13% ASHAs agreed and 5% strongly agreed for this perception of community.

Maximum ASHAs don't agreed and don't think this is the reason of less acceptance of NSV.

These shows today maximum public is aware about the benefits of less children and they understood the small family is better for the future of their children.

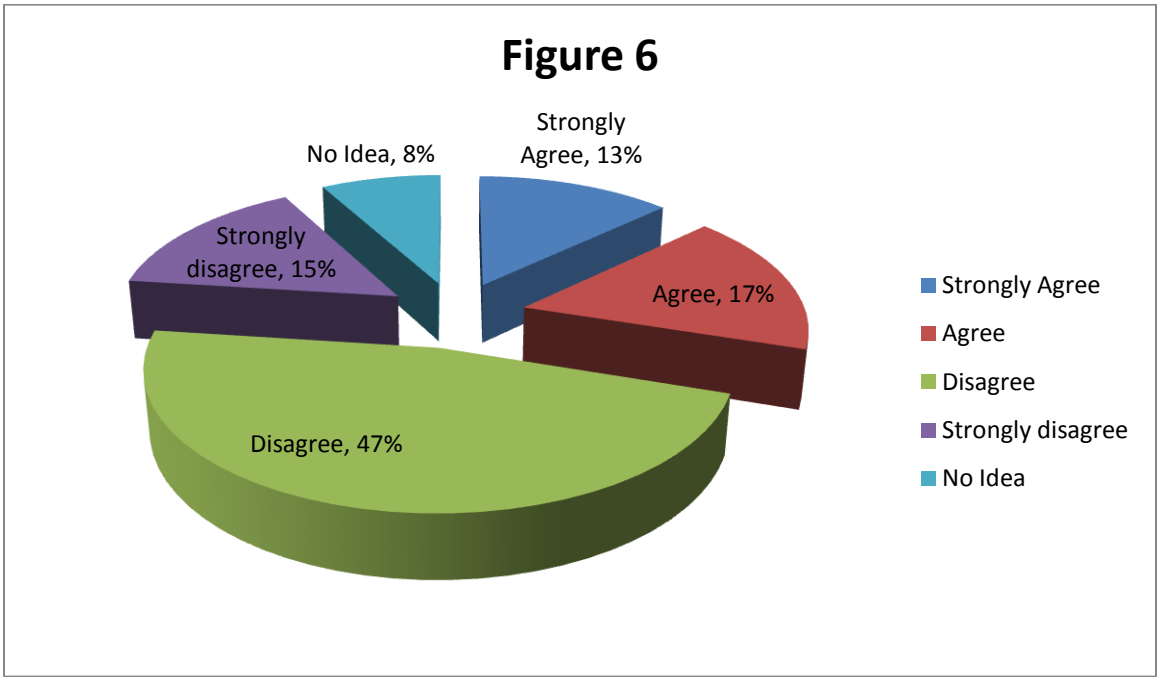
✓ People preferred female sterilization rather than NSV.



68% strongly agreed and 27% agreed on this point. Only 5% disagreed which shows males are less willing to go for NSV and preferred to go for female sterilization for their wife.

They think tubectomy is less complicated and safe method than NSV.

✓ Wife not allowed their husbands for the NSV.

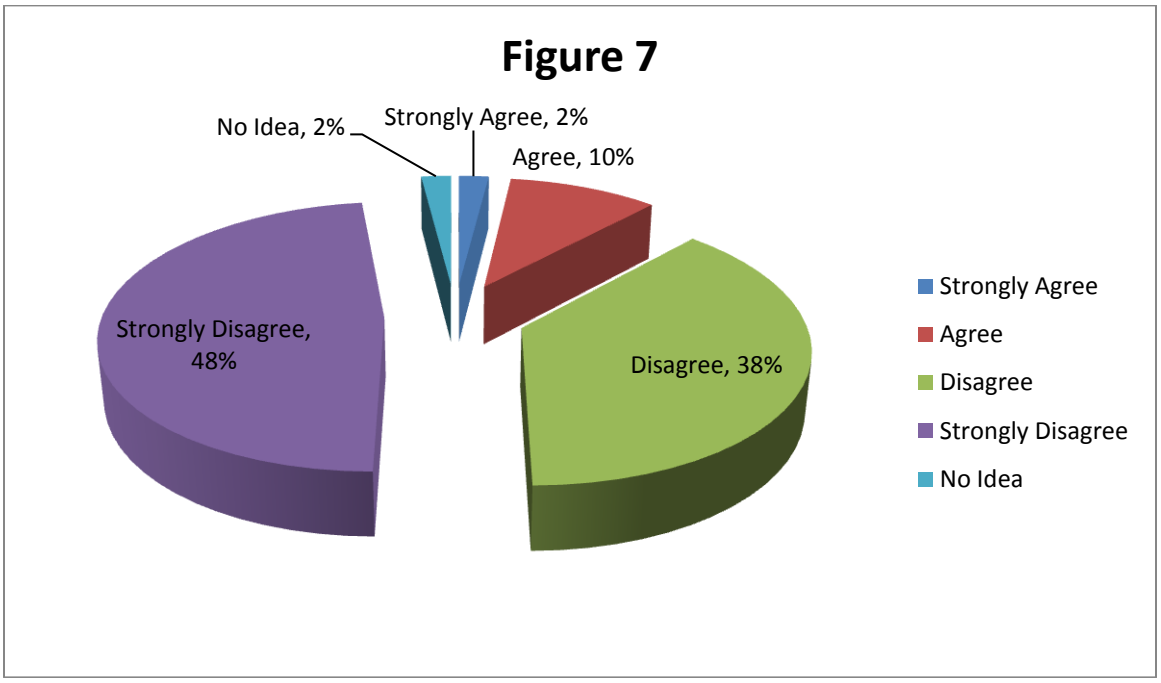


Maximum percentage of ASHAs are not agreed for this but though 13%strongly agreed and 17 agreed for this .This shows a little fear of the wife about NSV.

This also indicates the failure rate of NSV after failure of NSV if wife get pregnant than question arise for her character.

The failure cases are not because of wrong NSV procedure but because of the post operative precautions which are necessary in NSV like need to use any temporary family planning method for at least 3 months after NSV.

✓ After NSV Beneficiary and Motivators are not getting the 1100 Rs and 200 Rs respectively, provided by Gov.Facility.

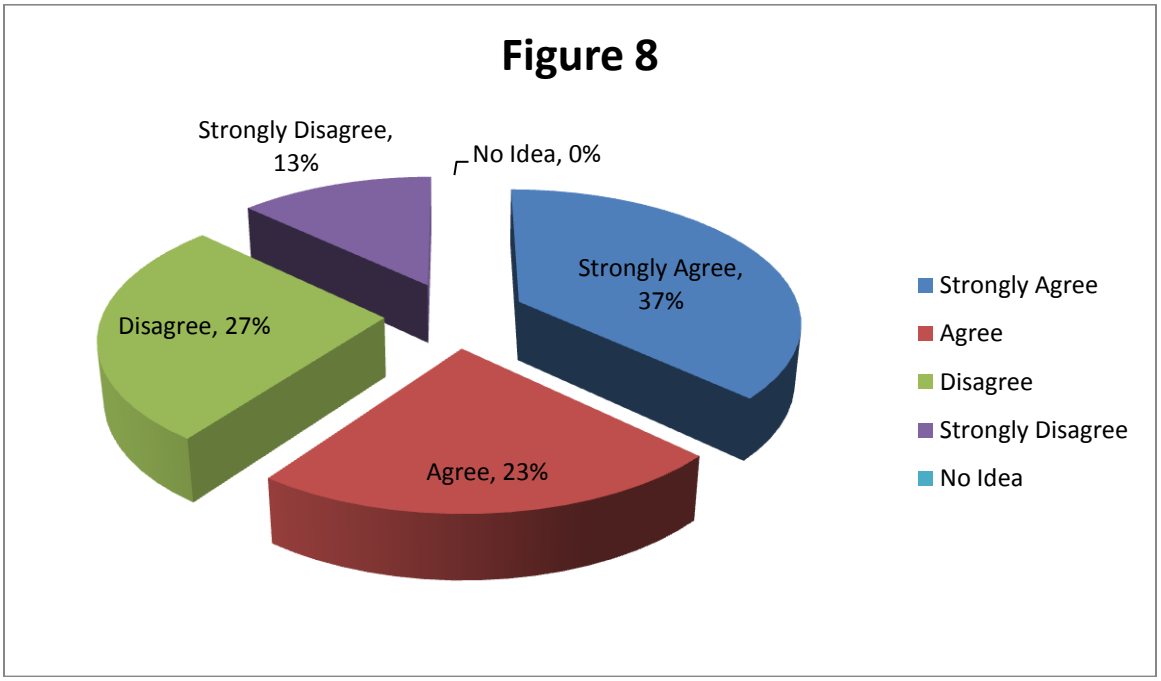


Only 2% strongly agreed and 25agreed on this opinion.

Maximum percents didn't agreed which shows beneficiaries and motivators immediately gets their money after NSV done.

It also indicates the transparency of the system for the NSV.

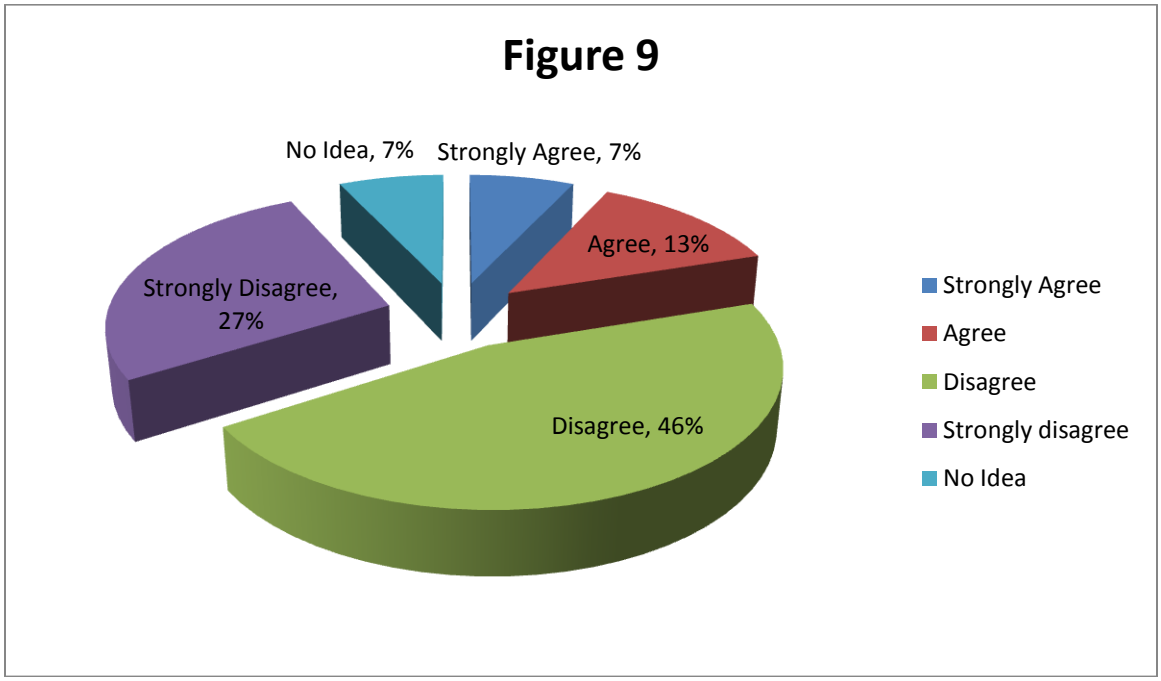
✓ There is no facility for NSV at nearby Hospital from the community.



37%ASHAs strongly agreed and 23% agreed for this point because in some blocks there is no NSV provider so they have to go whether at the district Hospital or at the PHC where NSV provider is present.

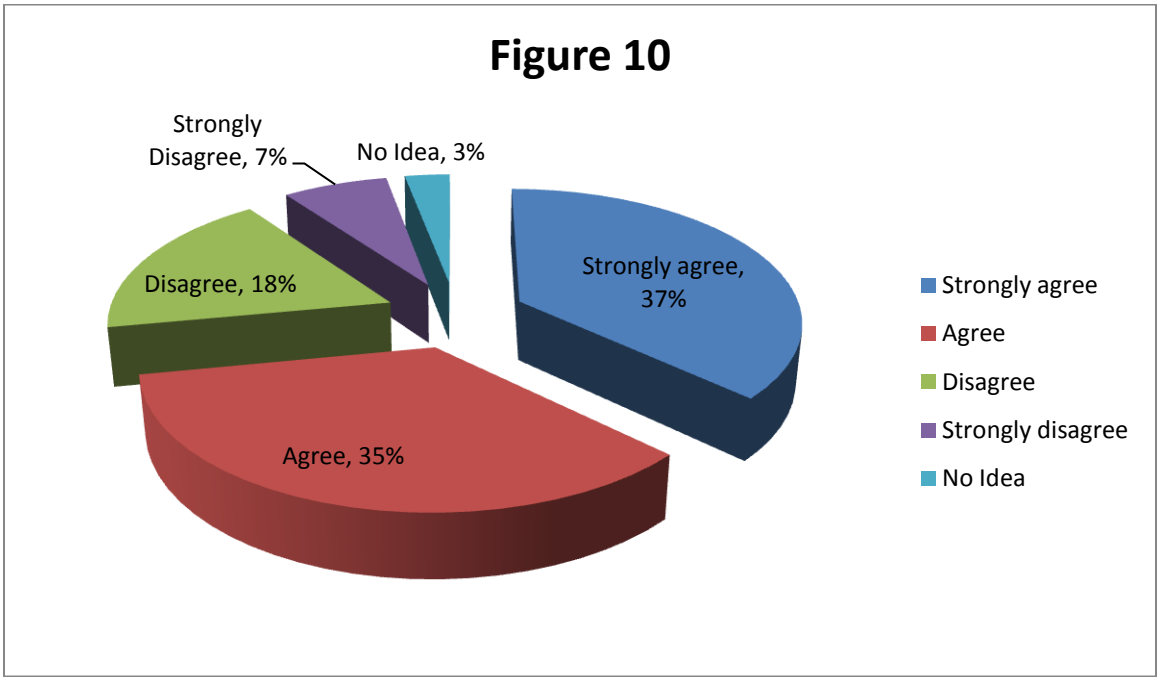
13% strongly disagreed and 27% disagreed on this point. This is because they might be from the block where there is NSV provider is present.

✓ The attitude of doctor and other staff towards NSV client is not well.



Maximum percentage is disagreed for this point which shows there is no issue related to the attitude of the health staff towards NSV clients.

✓ People don't have the transport facility to come in hospital for NSV.



37% strongly agreed and 35% agreed on this issue which shows the weak transport facility in the district.

Sometimes might be client is ready to go for NSV but due to his residence is very interior so unable to reach at the facility on the day of NSV Camp.

18% disagreed on this point might be because they belong from the District Town where regular NSV is available.

CONCLUSION & DISCUSSION

- ✓ The results clearly showing the perception of ASHAs regarding myths and misconceptions among community for NSV. It also showing the some other challenges related with the NSV.

- ✓ Common myths are their worry about their sexual life after NSV and they think they will be weak after NSV.

- ✓ ASHAs also agreed on some other challenges like there is no facility for NSV at nearby Hospital in some blocks. Due to this reason they have to travel a long for NSV.

- ✓ There are no NSV trained doctors in some blocks and its very difficult to trained also because for that it need the client load in the camp than only doctors can trained. After training also doctors avoid to operate.

- ✓ Transport facility is also weak ,maximum clients comes with their bicycles in the facility for NSV and riding bicycle within 7 days after NSV is prohibited. This is very common cause of client rejection.

- ✓ According to the ASHAs perception, females also sometimes not allowing their husbands for NSV. This percentage is not very high but though there are some reasons behind this. Common cause is fear of failure of NSV. There are some failure cases in the community, in this situation female comes in critical situations and question comes on their character. These failure cases are commonly occurs because clients do not take post operative care. After NSV there is need to use any temporary family planning method for at least 3 months or for at least 20 ejaculations which people generally avoids.

- ✓ Males still believes that family planning is the responsibility of their female partner and that's why they preferred their wife should go for tubectomy.

- ✓ Attitude of the health staff for the NSV clients is good and clients can come without any fear regarding staff attitude.

- ✓ According to ASHAs view, there is no financial problem for giving money to the motivators and beneficiaries .These shows the transparency of the health system in family planning.

- ✓ There is another problem of hydrocele patients. Munger is highly affected with the hydrocele and patients are rejected because of hydrocele.

- ✓ According to ASHAs , most of the couples want small family ,Very few couples want more than 2 or 3 children

RECOMMENDATIONS

- ✓ Proper information about NSV is very important factor to resolve the problems related to myths about NSV.

- ✓ There is a need to orient the ASHAs, ANMs and other health staff about NSV its benefits and about post operative precautions.

- ✓ After NSV it must to distribute the condom packets to the client for at least three months.

- ✓ For NSV camp there is need to give the transport facility for the clients.

- ✓ Need to train doctors at least one doctor in each facility and regular follow up of that doctor is equally important.

- ✓ Organize separate Hydrocele camps.

- ✓ Need to do the post operative counseling.

- ✓ Involve private Hospitals for the family planning

All above activities can further describe through supply-demand-advocacy model.

Increased supply of quality NSV services

- ✓ Increased public sector capacity to provide quality NSV services.
    - Training and follow up of NSV providers.
    - Facilitating readiness of NSV sites
    - Strengthening state capacity to scale up NSV trainings.
- ✓ Greater participation of private sector in NSV services.

Increased demand for NSV

- ✓ Formative research and BCC strategy development for NSV promotion
- ✓ Demand generation:
    - Orientation of ASHAs on NSV and strengthen their Interpersonal Communication Skills.
    - Health Talks in private factories
- ✓ Support to National Rural Health Mission (NRHM), Government of Bihar in improving community and mass media messaging

Improved advocacy and policy in support of NSV

- ✓ Stakeholder sensitization.
- ✓ Coordination with concerned authorities to resolve barriers.
- ✓ Facilitate experience sharing among stakeholders.

REFERANCE

1. WHO definition of family planning from PARK PSM

2. WHO about us, sexual and reproductive health, The department of reproductive health and research (http://www.who.int/reproductivehealth/about_us/en/index.html, accessed on 12 march 2011)

3. Saini NK, Singh M, Gaur DR, Kumar R, Awareness and practices regarding spacing methods in urban slum of Rohtak. Indian journal of community medicine, April-june 2006, vol.31, No.2

4. Ministry of Health & Family Welfare of India**,** Community Needs Assessment Approach in Family Welfare Programme, <http://mohfw. nic.in/cnaa.htm>, accessed Aug. 21, 2008.

5. Fact sheet: Population and development. Report of UNFPA, India. United Nation Population (http://india.unfpa.org/drive/PopulationandDevelopment.pdf accessed on 28 Feb. 2011

6. IIPS, Key findings from National Family Health Survey-3, 2005–2006, (http://www.nfhsindia. org/factsheet.html), accessed Dec. 4, 2006

7. Ringheim K, When the client is male: client-provider interaction from a gender perspective, *International Family Planning Perspectives,* 2002, 28(3):170–175

8. Raju S and Leonard A, eds.,*Men as Supportive Partners in Reproductive Health:Moving fromRhetoric to Reality*,NewDelhi: Population Council, 2000

9. Mbizvo MT and Basset MT, Reproductive health and AIDS prevention in Sub-Saharan Africa: the case for increased male participation, *Health Policy and Planning,* 1996, 11(1):84–92.

10 Murthy Ram s et al Analysis of factors influencing the acceptability of vasectomy in ANDHRA PRADESH Health and Population -*Perspecth/es and Issues* 26 (4): 162-182, 2003

11 A. BALAKRISHN A(1966): Sutureless Vasectomy- An Innovative Approach; Journal of Family Welfare, Vol. 42 NO. 3, P. 8-12.

12 S.K NIGAM, S.K. MALIK & H.C. DAS (1994): A profile of Acceptors of NonScalpel Vasectomy; Journal of Family Welfare, Vol 40, No. 1, P. 19-21.

13 NIPORT, Mitra and Associates, and Macro Internationals Inc. 1996-97. Bangladesh Demographic and Health Survey, Dhaka.

14 Alexis, E. 1996. Ensuring male responsibility in reproductive health. Unpublished

15 Green et al. 1996. Involving men in reproductive health: policy implications for developing countries [Unpublished].

16 Barge S et al Non- Scalpel Vasectomy and client satisfaction in Madhya Pradesh 2007

Annexure **Questionnaire for ASHA**

Name :

Profession:

Village :

Block :

Age :

Sex :

Education Qualification:

There is a less acceptance of NSV among males because

1. They think once NSV done than they will be physically weak

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

2 They think after NSV they will be unable to make sexual relations with their wife

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

3 They are suffering from some other disease like Hydrocele,Hernia

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

4 They think large family is better than small family

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

5 They preferred Female sterilization

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

6 Their wife not allowed them

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

7 Beneficiary and Motivators not getting the 1100 Rs and 200 Rs respectively, provided by Gov.Facility

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

8 There is no facility for NSV at nearby Hospital

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

9 The attitude of doctor and other staff towards NSV client is not well

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea

10 They don't have the transport facility to come in hospital for NSV

A Strongly agreed **B** Agreed **C** Not Agreed **D** Strongly not agreed **E** No Idea