Dissertation Title

Perception of ASHA s regarding factors affecting the acceptance of 'No scalpel Vasectomy' among males in Jharkhand

A dissertation report for

Post graduate diploma in health & hospital management

By
Dr.Navin Khede

International Institute of Health Management Research

New Delhi

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Roll No. PG/09/024

Under the guidance of

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Designation: Country Director
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Certificate of Internship Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Dr.Navin Khede has successfully completed his internship in our organization from February, 2011 to April, 2011. During this intern he has worked on "Perception of ASHAs regarding factors affecting the acceptance of ' No Scalpel Vasectomy' among males in Jharkhand"
The study of West singhbhum District of Jharkhand under the guidance of me and my team at Engender Health India.

(Signature)

_____ (Name)

_____ (Designation)

Certificate of Approval

The following dissertation titled "Perception of ASHAs regarding factors affecting the acceptance of ' No Scalpel Vasectomy' among males in Jharkhand". The Study of Jharkhand**"** is hereby approved as 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 under signed 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
_____	_____
_____	_____
_____	_____

Certificate from Dissertation Advisory Committee

This is to certify that Dr Navin Khede **,** a participant of **Post Graduate Diploma in Health and Hospital Management,** worked under our guidance and supervision. He is submitting this dissertation titled "Perception of ASHAs regarding factors affecting the acceptance of ' No Scalpel Vasectomy' among males in Jharkhand". The study of Jharkhan 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 best of our knowledge and no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr Hari Singh
Designation: Country Director
Engender Health International

Dr Preetha GS
Designation: Assistant Professor
IIHMR, New Delhi

ACKNOWLEDGEMENT

Public Health is a diverse & growing field of study in India. An important challenge today is to link institutional service delivery with National public health program & community oriented services. There needs to be equal emphasis on public health practice with a clear vision of reaching the unreached.

With these thought in mind I joined Engender Health India. I am graciously thankful to Dr Hari Singh for his guidance. I am also thankful to Mr Dawood Alam, Mr.Vivekanand Pandey for their support during the entire tenure.

My special thank to Dr Preetha GS for taking the pain of describing in detail every minor doubt .

I would like to express my thanks to my colleagues in the Organization, who helped me to mould with the organization's culture in a very short period

ABSTRACT

INTRODUCTION

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

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.

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 West Singhbhum district of Jharkhand

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

Sampling- The Total Sample size is 60

Selection of blocks-

There are 15 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 this 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 reffered.Study of previous record of ASHAs helped in this process.

Data Collection –

Qualitative questionnaire was developed for the study groups

Analysis was done with percentage

RESULT

- There is a less acceptance of NSV among males because They think once NSV done than 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
- 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.

- 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 agreed on this point. 16 were disagreed where 8 were strongly disagreed
- 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.

CONCLUSION

- 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
- 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

RECOMMENDATION

- 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.

Table of Contents

ABBREVIATIONS

ANM	Auxiliary-nurse-Midwife
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Worker
CHC	Community Health Centre
CMO	Chief Medical Officer
LHV	Lady Health Visitors
NSV	Non Scalpel Vasectomy
MO	Medical Officer
MOI/C	Medical Officer In charge
MP	Madhya Pradesh
MPW	Multi Purpose Workers
PHC	Primary Health Centre
PRI	
RMP	Registered Medical Practitioners
UP	Uttar Pradesh

PART-I

INTERNSHIP REPORT

Organization Profile

EngenderHealth

EngenderHealth is a leading international reproductive health organization working to improve the quality of health care in the world's poorest communities. EngenderHealth empowers people to make informed choices about contraception, trains health providers to make motherhood safer, promotes gender equity, enhances the quality of HIV and AIDS services, and advocates for positive policy change. The non-profit organization works in partnership with governments, institutions, communities, and health care professionals in more than 25 countries around the world. Since 1943, EngenderHealth has reached more than 100 million people to help them realize a better life.

Mission

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

EngenderHealth se dedica a mejorar la salud y el bienestar de la población de las comunidades más pobres del mundo, compartiendo su experiencia en salud sexual y reproductiva y promoviendo una mejor calidad de la atención a la salud. Asimismo, EngenderHealth promueve la equidad de género, aboga por prácticas y políticas sólidas, e incentiva a la población a ejercer sus derechos a una vida mejor y más saludable. EngenderHealth trabaja en colaboración con organizaciones locales y se adapta a las características y necesidades de cada contexto.

EngenderHealth œuvre à améliorer la santé et le bien-être au sein des communautés les plus pauvres dans le monde. Pour ce faire, nous diffusons notre expertise en santé sexuelle et reproductive, et améliorons la qualité des soins de santé. Nous encourageons l'égalité entre les sexes, plaidons pour des pratiques et politiques viables, et encourageons à la revendication du droit à une vie meilleure et plus saine. Nous travaillons en partenariat avec des organisations locales, et nous adaptons nos activités aux besoins locaux.

The RESPOND Project Support to Expanding awareness, acceptance and access to No-scalpel Vasectomy in Uttar Pradesh,Jharkhand India ,October 2009 — September 2012

Background

The RESPOND Project, a five-year cooperative agreement funded by the U.S. Agency for International Development (USAID), will operate through September 2013. RESPOND works to increase the use of high-quality family planning (FP) services. It addresses the unmet need for healthy timing, spacing, and limiting of childbearing by improving access to long-acting and permanent methods (LA/PMs) of contraception.

RESPOND promotes renewed and sustained focus on four essential programmatic principles:

- Employing evidence-based holistic planning that brings together supply, demand, and advocacy
- Ensuring the fundamentals of care—informed and voluntary decision making, medical safety, and ongoing quality improvement
- Addressing gender equity in decision making, services, and programs
- Ushering programs from pilot to scale and from advocacy to action

Vision

Throughout their reproductive lives, women's and men's childbearing intentions evolve. It is therefore important to ensure that they have access to a range of effective contraceptives.

Long-acting contraception (intrauterine devices and hormonal implants) and permanent methods (female and male sterilization):

- Are highly safe and provide continuous protection
- Are the most effective methods of FP available
- Can meet a range of clients' reproductive intentions (i.e., can help them delay, space, or limit births)

- Promote greater continuation of FP

Yet, LAPMs are the least available and least used methods in the majority of developing countries.

FP programs can best meet their citizens' individual reproductive health needs as well as national development goals by responding to existing unmet need, and unmet need for LA/PMs remains particularly high. To do so, however, requires an investment in make available a balanced contraceptive mix that includes LA/PMs among the choices and options. Only then will a program optimize its reach and effectiveness.

India

RESPOND will provide technical assistance and and advice to the Government of Uttar Pradesh (GoUP) and other local partners efforts to expand the awareness of, acceptance and access to No-Scalpel Vasectomy (NSV). Specifically, RESPOND will support that state's goal to increase vasectomy prevalence from 2% (2008-09) to 3% in 1009/10, 5 % in 2010/2011 and 7.5 % in 2011/12 of total sterilization procedures conducted.

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.[1] From the national family planning program inception in the 1950s through the mid-1970s, vasectomy played a dominant role. Out of 32.7 million sterilizations registered by the Indian government's family planning program between 1956 and 1980, 65% were vasectomies. [2] By the late 1970s, however, vasectomy use had begun to decline drastically, due to laparoscopic female sterilization becoming more widely available and popular and a public backlash to the national program's high pressured approach to vasectomy (large camps, cash incentives and reportedly coercive practices).[3], [4]

In Uttar Pradesh (UP) vasectomy prevalence is 0.2%, one fourth the national rate of 0.8%. Female sterilization in UP exceeds vasectomy by a factor of 90 to 1. Twelve percent of married women of reproductive age, i.e. 4.1 million couples, have unmet need to limit. NSV providers are in short supply with a single NSV training center at the Department of Urology, King George Medical University, Lucknow, serving the entire state of UP. Private sector provision of vasectomy services is limited.

Since 2009, RESPOND partners EngenderHealth and JHUCCP have provided technical assistance to the Government of Uttar Pradesh (GoUP) to expand awareness, acceptance and access to NSV. RESPOND's technical assistance is closely aligned with the State's National Rural Health Mission (NRHM) Action Plan and is supportive and synergistic of the State's planned interventions and activities and sets the stage for expansion and scale up of NSV interventions.

RESPOND's technical assistance follows a holistic Supply-Demand-Advocacy (S-D-A) model that complements the GoUP's strategic approach. On the supply side, RESPOND supports efforts to strengthen service delivery components such NSV provider training and service site readiness that will result in the increased availability of NSV service sites with skilled, motivated, well-supported NSV service providers. On the demand side, engaging communities and providing correct information about NSV increases knowledge, improves the image of NSV services, and motivates couples to consider NSV. Advocacy is targeted at an improved policy and creating supportive environment for NSV services with policies based on evidence and maximizing resources to meet the needs of generating

demand while ensuring quality NSV services. Together, these components lead to a better-resourced, more productive, supported, and sustainable program and improved health of Uttar Pradesh population. RESPOND/India works in three divisions of Uttar Pradesh (Meerut, Kanpur and Allahabad), and will also implement a core-funded initiative to promote all long-acting and permanent methods through the private sector in Kanpur.

RESPOND's Strategic Approach

The USAID Mission in Delhi has awarded the RESPOND Project/ NY[1] a grant to support UP's efforts to expand awareness and acceptance of vasectomy and access to No-Scalpel Vasectomy (NSV) services. RESPOND's role is to provide technical assistance, support and advice to the GoUP and other local partners in implementation of activities under the NRHM and other strategies. Funding for implementation rests primarily with the GoUP and GOI.

The holistic Supply-Demand-Advocacy (S-D-A) model [Figure 3] developed by EngenderHealth under the ACQUIRE Project complements the GoUP's strategic approach. On the **supply side**, strengthened service delivery components—planning, training, supervision, and logistics—ensure service site readiness and will result in the increased availability of male-friendly service sites with skilled, motivated, well-supported NSV service providers. On the **demand side,** engaging communities and providing up-to-date, accurate information about NSV not only increases knowledge, but improves the image of NSV services. Finally, the S-D-A model incorporates **advocacy** for an improved policy and program environment for FP with policies based on the best available evidence and maximizing resources to meet needs for NSV services. Together, these components lead to a better-resourced, more productive, supported, and sustainable program.

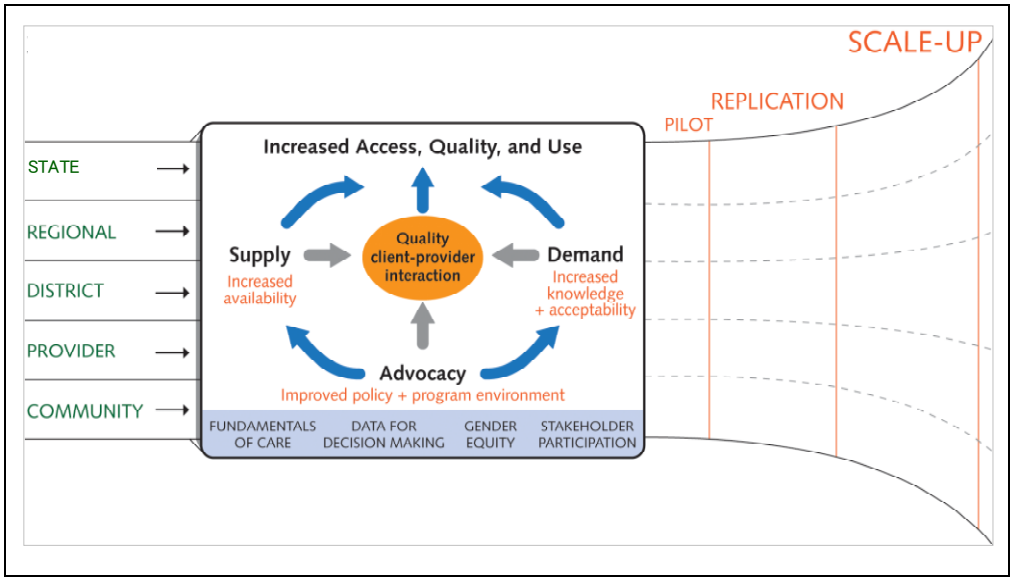
Reflection from the Internship

RESPOND Project activities will address one or more of three intermediate results

I.R.1 Strengthened effective delivery and increased/sustained performance of No-Scalpel Vasectomy (NSV) **[Increase supply of quality NSV]**
I.R.2 Increased public demand for NSV through dispelled myths and misconceptions **[Increase demand for NSV]**
I.R.3 Strengthened commitment, policy support and enabling environment for NSV **[Improve advocacy and policy in support of NSV]**

RESPOND Expanded Supply-Demand-Advocacy Framework

Figure-1



I.R.1 Strengthened effective delivery and increased/sustained performance [Increase supply of quality NSV]

A 2006 assessment in five states that had successfully implemented policies to increase use of NSV (Andhra Pradesh, Jharkhand, Madhya Pradesh, Punjab and Sikkim) noted three key supply side characteristics of successful state vasectomy revitalization efforts 1) state capacity to scale-up NSV training, 2) year-round service provision—a combination of static sites and scheduled camps, and 3) stimulated private sector involvement and public-private collaboration.[2]

I.R.1.1 Increased public sector capacity to provide quality NSV services through strengthening health systems involved in service provision.

RESPOND recognizes that provider ***competence*** is only one of the "**Cs**" necessary to ensure the availability of safe, quality NSV services. In addition providers must be ***comfortable*** providing NSV service. This is achieved by ensuring the *readiness* of their home facilities to provide services—essential equipment and supplies are stocked, infection prevention protocols practiced, facility staff are oriented to NSV and *male-friendly* services, and NSV providers

receive supportive supervision and on-site coaching. Through continued practice of one's skills competence is maintained. And it is through continued performance/practice that one develops ***confidence.*** In order for providers to perform NSV procedures, there must be ***clients,*** which one achieves by engaging communities and
and providing up-to-date, accurate information about NSV. When these "**C**" are in place, the result is ***committed*** providers working in better-resourced, more productive, supported, and sustainable programs.

Under IFPS-1 and IFPS-2 over 200 doctors were trained in NSV (November 1995-March 2009). Though 77% of the providers trained in NSV under IFPS-I were assessed as performing to standard during a follow-up visit, the current status of many of these providers as well as thought trained under IFPS-2 is unknown. RESPOND will work with the Directorate of Family Welfare and district CMOs to determine how many of these providers are still in public service, available to provide NSV services and the needs for coaching and updates.

Activities

- Conduct follow-up (phone/mail) previously trained NSV providers to determine who is providing NSV and where (potential pool of NSV surgeons for the State's vasectomy revitalization efforts).
- In consultation with DoFW and SIFPSA develop a plan/time table for updating skills of previously trained NSV providers who are motivated/positioned to support the State's vasectomy revitalization efforts.
- Analyze and summarize collected & synthesized Best Practices Initiatives for mobile camps and static "special day" services
- Organize/conduct skills update/refresher training workshops (2) for up to 10 NSV providers trained under IFPS-I and IFPS-II projects.
- Conduct NSV trainee follow-up and coaching at the work site for up to 20 providers [Priority will be given to supporting providers in Allahabad, Kanpur and Meerut Divisions trained by the newly established NSV Centres of Excellence at Allahabad, Kanpur and Meerut Medical Colleges].
- Conduct site-level orientations to *male-friendly services* at up to 30 facilities [Priority to be given to District Hospital and Community Health Center levels in Allahabad, Kanpur and Meerut Divisions]
- Strengthen mobile camps and "special day" services linked to community awareness in 10 districts [Priority to be given to districts in Allahabad, Kanpur and Meerut Divisions]

I.R.1.2 Greater participation of the private sector (Commercial and NGO) in NSV service provision

The GoUP has noted the need to stimulate private sector involvement. RESPOND will explore opportunities to enhance Public-Private Partnerships in collaboration with national professional organizations such as the Indian Medical Association (IMA), the Federation of Obstetrics and Gynecology Societies of India (FOGSI), the National Association for Voluntary Sterilization of India (NAVSI), and the NSV Surgeons India (NSV SI). We will investigate opportunities to partner with existing projects/initiatives such as the FHI's *Urban Reproductive Health Project* (Allahabad) and PSI's *Pahel* (Kanpur), social franchising

networks such as the *Merry Gold Network* (Allahabad and Kanpur) and the *Saathiya Youth Friendly Network* (Allahabad), NGO service networks such Parivar Sewa Sansthan (PSS) (Kanpur) and the Family Planning Association of India (FPAI) (Kanpur), and private hospitals and nursing homes (Meerut)

Activities

- Conduct assessment of opportunities to engage private sector in NSV services/promotion and explore opportunities to enhance Public-Private Partnerships. A report identifying ways through which private sector providers could become more active advocates of NSV and identify opportunities, obstacles and action steps to increase private provider services for NSV will be submitted to the DoFW, SIFPSA and USAID.
- Identify key private sector facilities/organizations to positioned to participate in the State's vasectomy revitalization efforts
- Conduct site-level orientations to *male-friendly services* at Merry Gold Hospitals and Merry Silver clinics staffed to provide NSV Services.
- Identify opportunities for implementing the Jansankhya Sthirata Kosh's (JSK) *Santushti* strategy.[3]

I.R.2 Increased public demand for NSV through dispelled myths and misconceptions **[Increase demand for NSV]**

The States BCC Strategy calls for a multimedia approach to include 1) interpersonal communication, 2) community engagement, and 3) mass media. The strategy focuses on community based approaches while using mass media to create an enabling environment. Community based approaches to BCC include home visits, group meetings and working with existing local structures and community groups.

RESPOND partner JHU/CCP will focus on two key areas during the project's start up phase—1) conduct formative research as a foundation to future development by DoFW, SIFPSA and other partners of NSV demand generation interventions and targeted behavior change communication with appropriate messages, and 2) strengthen counseling modules for use in training of frontline workers (MOs, Staff Nurses, ANMs, etc.) to include clear messages about NSV that counter myths and misconceptions

Activities

Cross-cutting

- Conduct formative research critical to demand creation program design
- Review existing (and past) BCC materials on NSV used in UP as well as other States; identify the need for BCC materials; develop a plan to design and produce BCC materials

Interpersonal Communication

- Analyze existing curricula and other training materials on NSV and FP Counseling to identify the needs for updates or adaptation
- Strengthen counseling modules for use in provider training for MOs, Staff Nurses, ANMs, LHVs and other frontline workers to include clear messages about NSV that counter myths and misconceptions

- Pilot test NSV counseling modules in up to 10 districts [Linked to *male-friendly* orientations under IR1.1
- Explore tapping into existing hot-lines, e.g. Jansankhya Sthirata Kosh's Call Centre on Reproductive Health, Family Planning and Child Health and the Saathiya Youth Friendly Network

Community Engagement

- Develop job aids and design NSV modules for training of community outreach workers and other agents with trusted access and influence at the community level to ensure they are knowledgeable about NSV.
- Pilot test job aides and modules in 1-2 districts.

Mass Media

- Conduct a rapid assessment of previous Mass Media materials and messages focused on vasectomy in UP
- Explore tapping into existing call-in programs either on radio or television to disseminate information

I.R.3 Strengthened commitment, policy support and enabling environment for NSV **[Improve advocacy and policy in support of NSV]**

RESPOND will work with the DFW, SIFPSA and other key partners to identify champions/potential champions at all system levels and from the community - as well as public, private, and NGO sectors. Participatory involvement will help to develop capacity and sustainability, build commitment, and ensure interventions are appropriate.

Activities

- Increase advocacy on NSV by sensitizing policy makers in the Central and State Government including principal secretary, DG (FW), Directors, CMOs, SIFPSA representatives and District CMOs
- Provide TA to districts for local planning for NSV. Foster data-based analysis of results to guide implementation plan adjustment as needed. Work through strategic partnerships with policymakers and managers at the central and district levels to focus on evidence-based advocacy, forecasting and planning using Reality √.

Work Plan: April 2010—September 2012 (Implementation Phase)

RESPOND's role is to provide technical assistance, support and advice to the GoUP and other local partners in implementation of activities under the NRHM and other strategies to expand awareness and acceptance of vasectomy and access to No-Scalpel Vasectomy (NSV) services. Assistance will be designed to be supportive and synergistic of the State's planned interventions and activities. The scope and details of this assistance will be developed in close consultation with the DoFW, SIFPSA and other key stakeholders within the framework of the project's 3 intermediate results—increased supply of quality NSV, increase demand for NSV, and improved advocacy and policy in support of NSV.

RESPOND will provide TA so that local organizations take control and perform effectively. Principles of **organizational change**, **cultural change**, and **organizational learning** will underpin this approach, ultimately creating an environment for sustainability in public and private sectors. RESPOND will use a participatory process to create local ownership of project results, creating support for the S-D-A model and developing a cadre of individuals who can help non-target districts to improve and sustain NSV services as the program scales up beyond the project target areas and brings about change at the state and district policy levels.

During the project's start-up phase (Oct '09-Mar'10) RESPOND in coordination with the D-FW will convene 1.5-day workshop with stakeholders to develop a 2-year work plan (FY2010/11 to FY2011/12) for revitalizing NSV in U.P. The 2-year work plan will identify strategic and geographic priorities for the RESPOND Project's technical assistance. The activities included in **Table 1** are illustrative of the type of technical assistance REPOND can provide.

Table 1: Illustrative Activities for RESPOND technical assistance March 2010—September 2012

IR1 Increased supply of quality NSV	IR2 Increase demand for NSV	IR3 Improved advocacy and policy in support of NSV
Develop on-going mechanism for conducting NSV trainee follow-up and coaching at the work site by DoFW	Work closely with SIFPSA and the Government of UP to develop relationships to work in tandem on BCC interventions in the 2010 Implementation Plan and provide input into the plan for the following year	Work through strategic partnerships with policymakers and managers at the central and district levels to focus on evidence -based advocacy, forecasting and planning using Reality √.
Build capacity for local trainers to assist clinical and non-clinical personnel to shift vasectomy biases as well as assisting providers in interpersonal communication (e.g., *how* to communicate, not just *what* to say)	Work in close partnership with Panchayats through their Health and Welfare Committees to incorporate NSV information into their outreach and community mobilization activities.	Increase advocacy on NSV by sensitizing health professionals from the public and private sector, using forums like Federation of Obstetric and Gynecology Societies of India (FOGSI) and Indian Medical Association (IMA)
Develop capacity of additional medical colleges to conduct NSV training and serve as Centres of Excellence	Develop locally appropriate language spots for airing on state wide media as well as local level community radio with emphasis on locations where NSV readily available. Develop accompanying television spots	Identify champions or potential champions all system levels and from the community well as public, private, and NGO sectors.
Identify, test, implement, evaluate and scale up select holistic, evidence-based approaches/ models for expanding access to NSV services the private sector	Develop NSV posters for clinic use and client materials for use by providers when counseling clients on NSV as a method choice	
Explore opportunities for strengthening NSV component of antenatal/delivery/postpartum care programs with the obejctive to test, evaluate and scale up best practices	Use folk media, puppet theater, and/or community drama to encourage dialogue about NSV as a safe method	
	Explore profiling NSV champions through testimonials for those that have undergone NSV or have supporte their partners, clients, etc. to create normative changes around acceptance of NSV as a method used by others like them	

PART-II

PROJECT REPORT

Introduction

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 the Family Welfare programme.

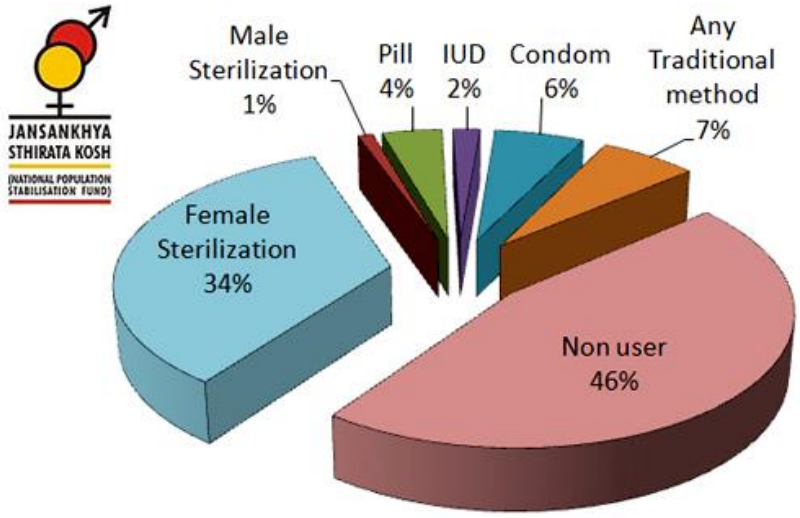
principal reason for the low (or declining) use of vasectomy is the failure of health professionals to make information and services available and accessible to men. This failure has often been a result of health professionals' lack of knowledge, misinformation, personal dislike of vasectomy, or untested presumptions about what men thought and wanted [5] 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 indicate they may be willing to take.

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.

Figure-2

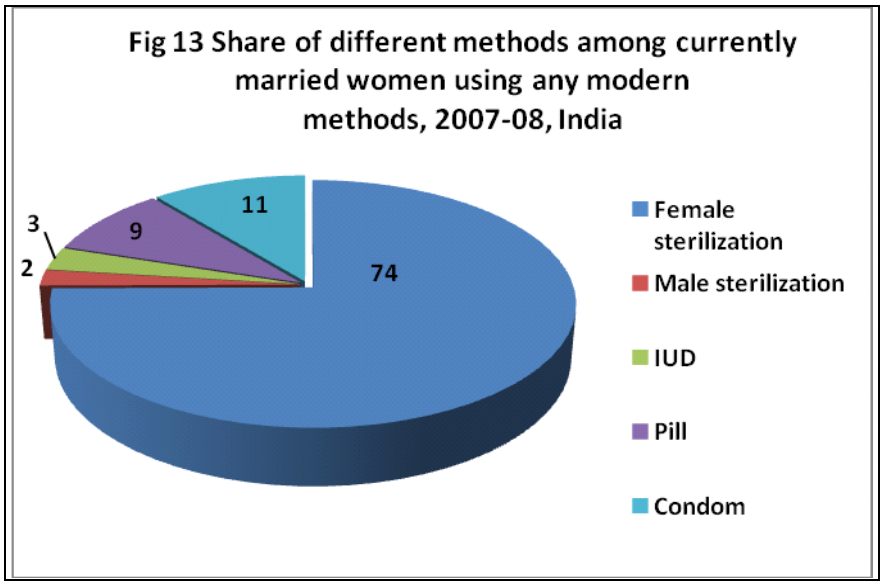


Current use of Family Planning Methods

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 12 Getting 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 field workers were in attendance. These regular monthly meetings with all of the thanalevel 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 toward 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 malefriendly 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 (Green et 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 behaviour 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 this factors so the related solutions can introduce

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 West Singhbhum district of Jharkhand.

Qualitative questionnaire was developed for the study groups

Analysis was done with percentage

Population

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

Sampling- The Total Sample size is 60

Selection of blocks-
There are 15 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 this 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 reffered.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

Total 15 Blocks	Selected 6 Blocks
	High Performing Blocks
1. Sadar	1.Manoharpur
2. Tantnagar	2.Jhinkpani
3. Khuntpani	3.Chakradharpur
4. Goilkera	
5. Chakradharpur	Poor Performing Blocks
6. Manjhari	4 Sadar
7. Jagannathpur	5.Tantnagar
8. Kumardungi	6.Tonto
9. Jhinkpani	

10. Sonua
11. Manoharpur
12. Manjgaon
13. Bandgaon
14. Tonto
15. Bada Jamda

Selection of 10 ASHAs from each selected Block

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 than 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 agreed on this point. 16 were disagreed where 8 were strongly disagreed

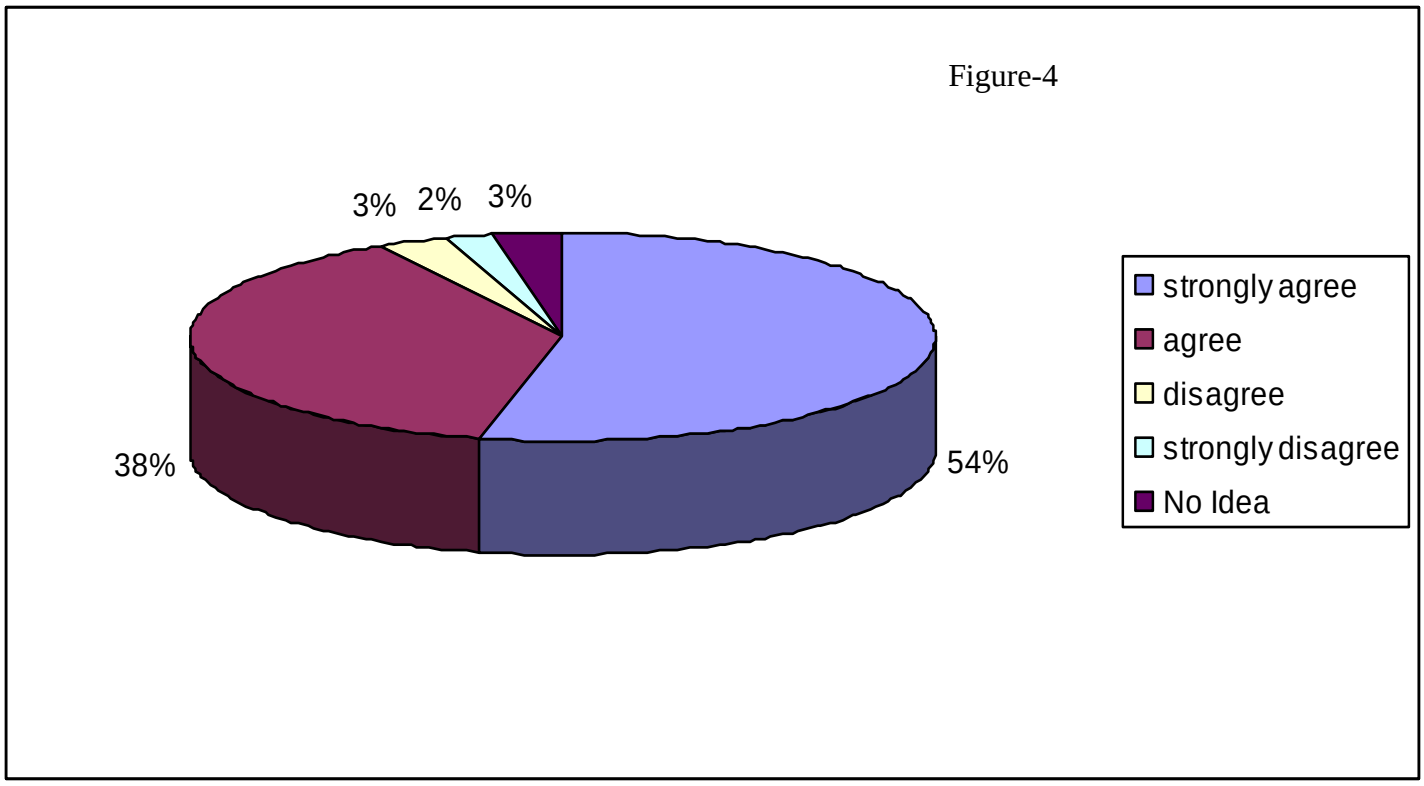
- The attitude of doctor and other staff towards client is not well so males didn't go for NSV in the hospital. Only 4 of the 60 strongly agreed where 8 agreed.28 didn't agreed ,16 strongly not agreed .4 of them didn't have any idea.

- 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.

Analysis and interpretation

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

Figure-4

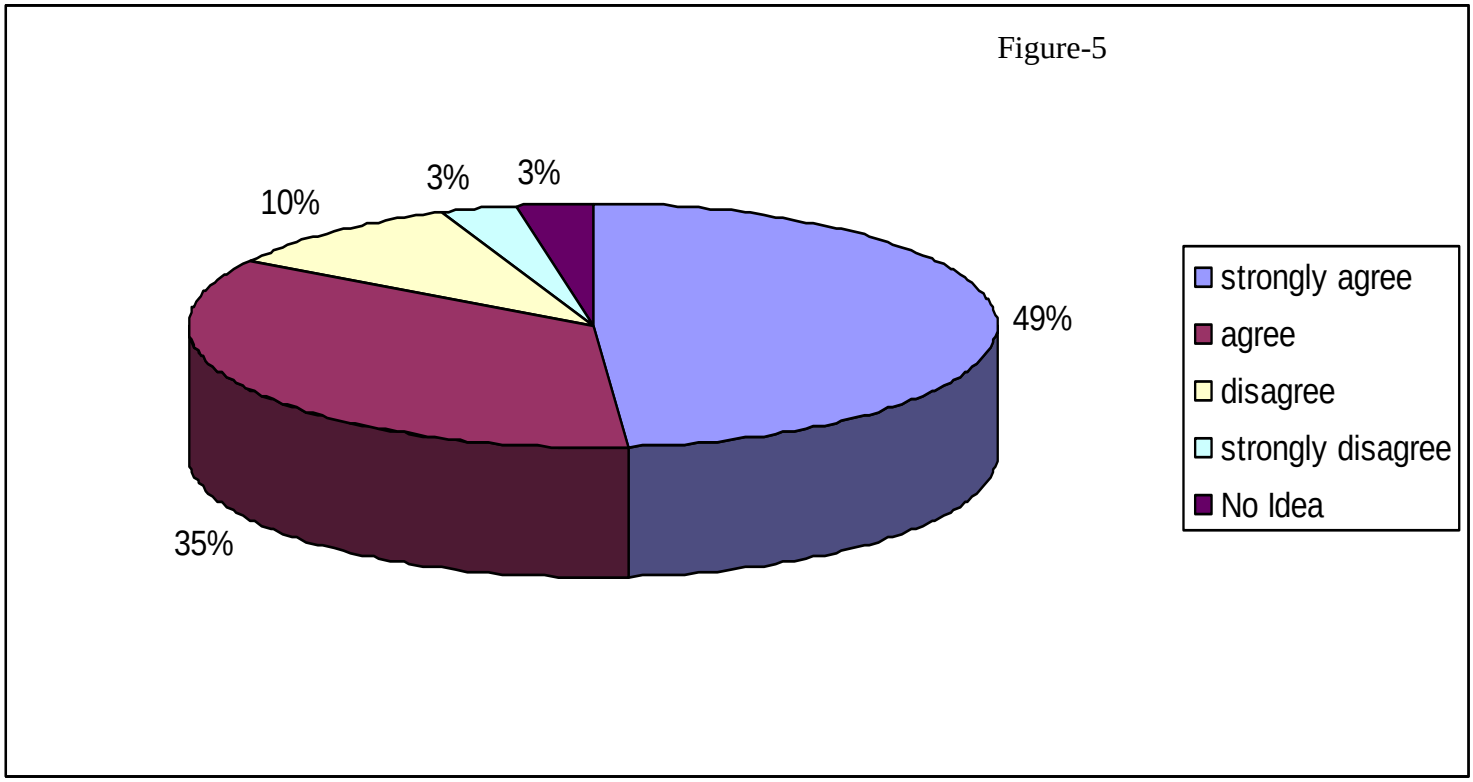


54% ASHAs strongly agreed and 38% agreed on this matter which shows the strongest myth about NSV in community

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

Figure-5

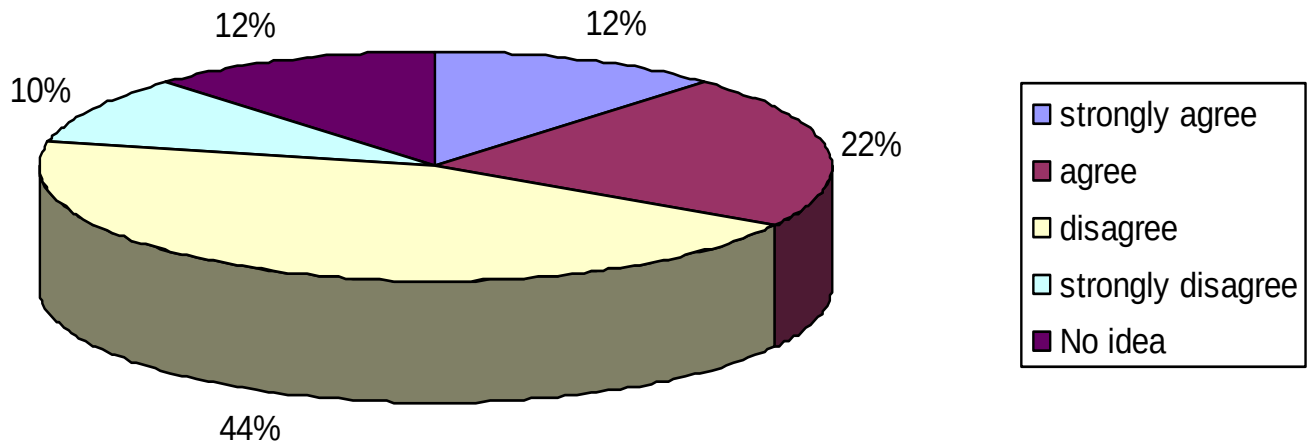


49% ASHAs strongly agreed and 35% agreed on this myth of community and give opinion that this is another strong reason why people are less willing to accept NSV

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

- ✓ People can not accept NSV because they are suffering from some disease like Hydroce, Hernia etc.

Figure-6



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

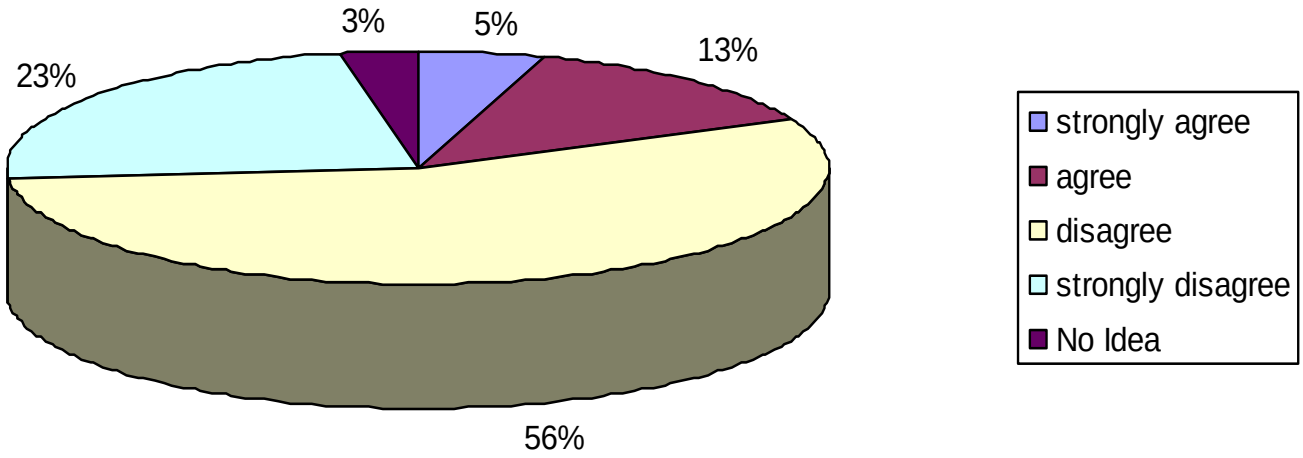
Though 22% agreed and 12% strongly agreed on this point.

West Singhbhum 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

Figure-7



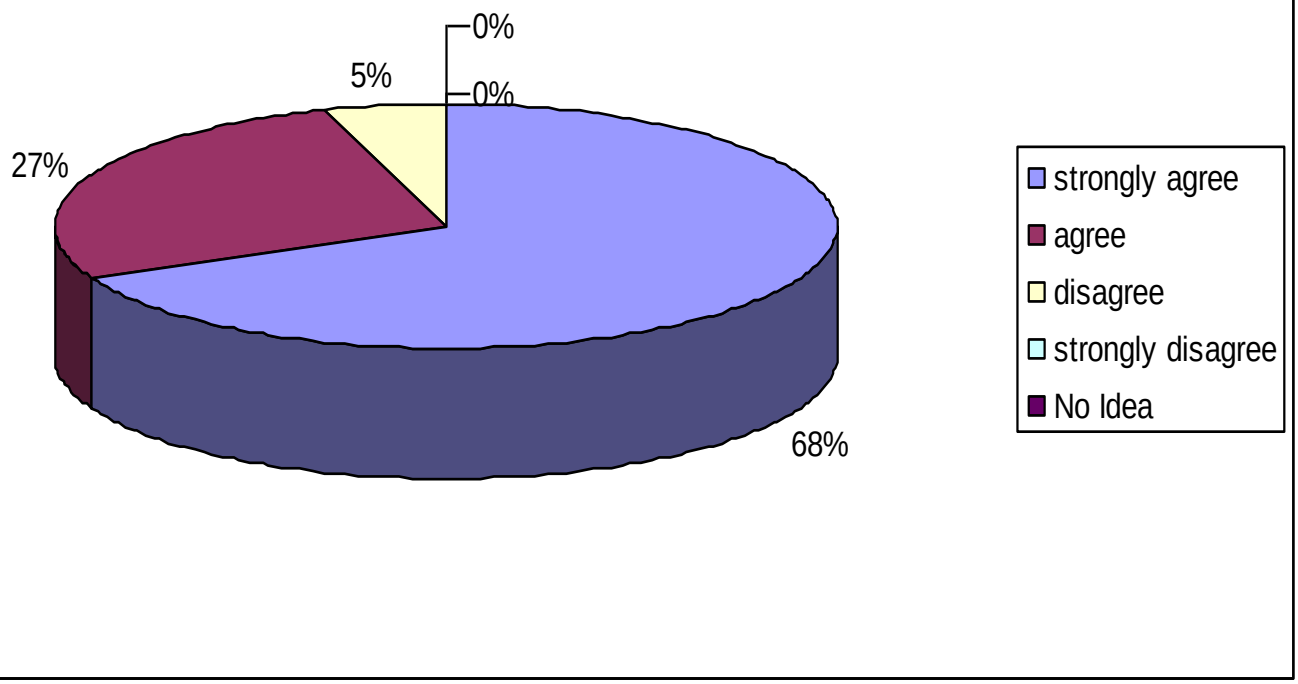
Only 13% ASHAs agreed and 5% strongly agreed for this perception of community

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

Figure-8

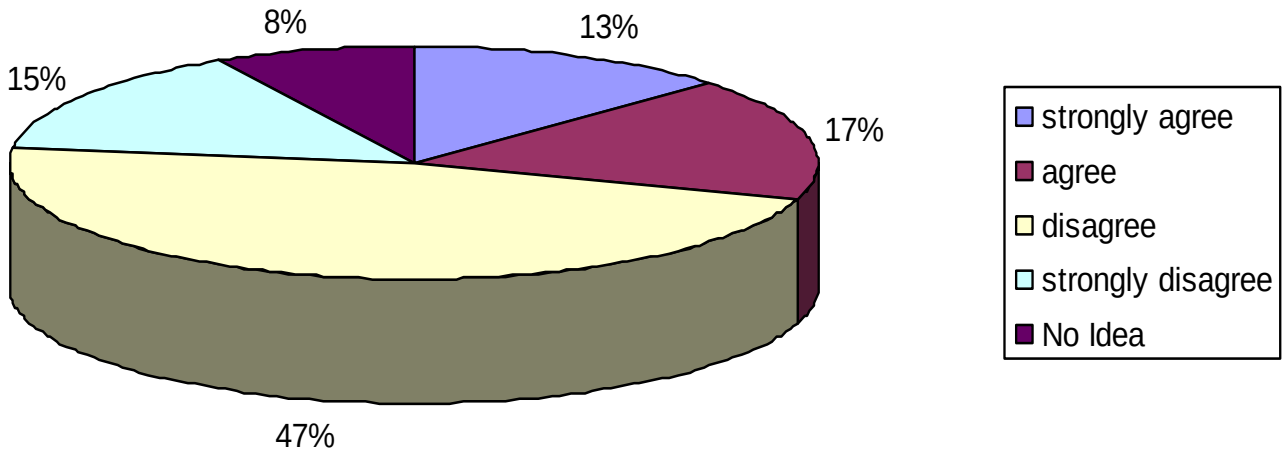


68% strongly agreed and 27% agreed on this point. Only 5%disagreed which shows males are less willing to go for NSV and preferred to go for female sterilization for their wife

They think tubectomy is less complicated and safe method than NSV

✓ Wife not allowed their husbands for the NSV

Figure-9



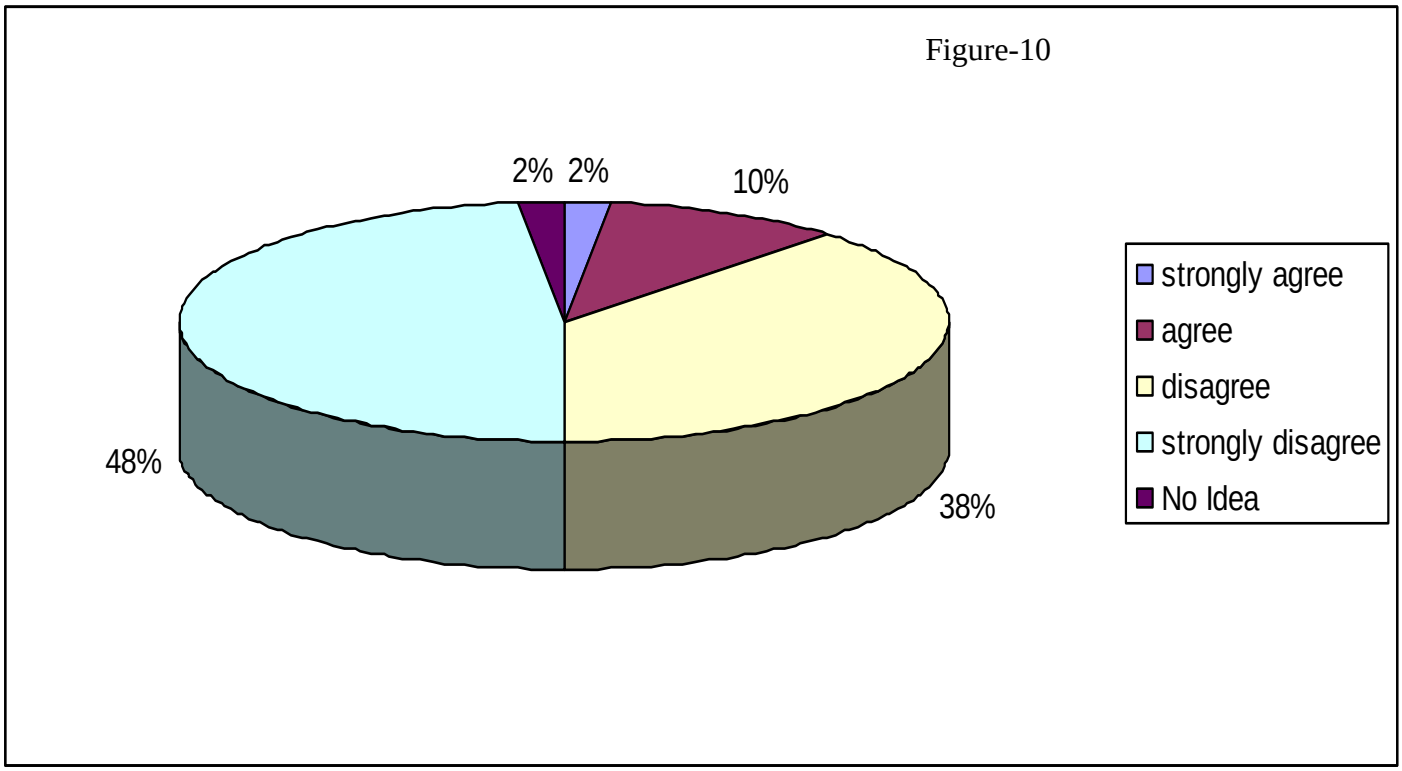
Maximum percentage of ASHAs are not agreed for this but though 13%strongly agreed and 17 agreed for this .This shows a little fear of the wife about NSV

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

Figure-10



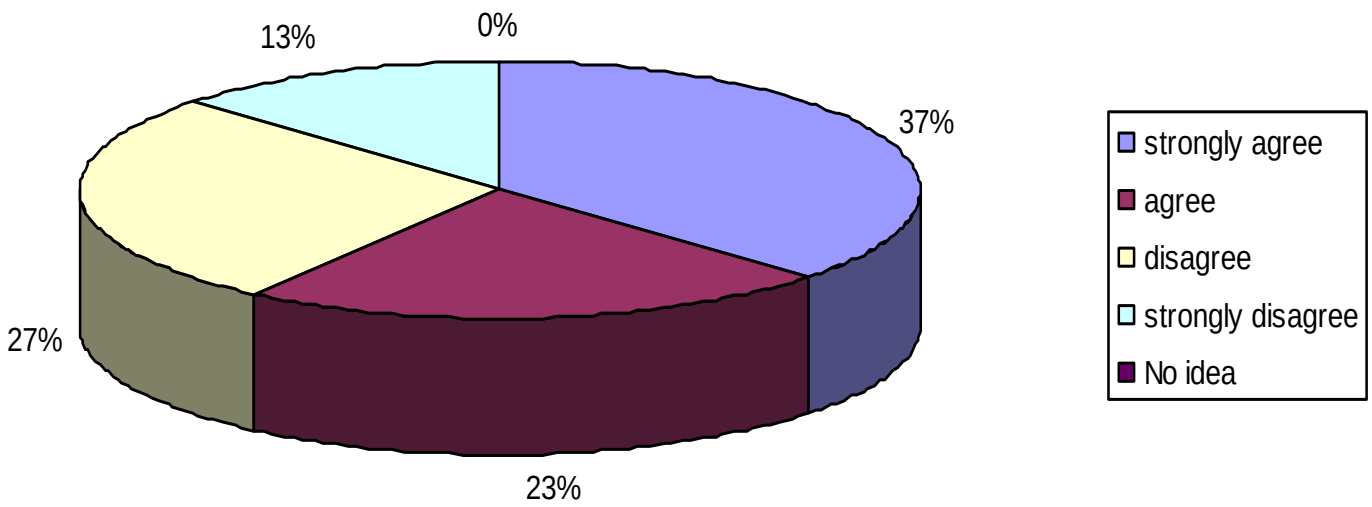
Only 2% strongly agreed and 25agreed on this opinion

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

Figure-11

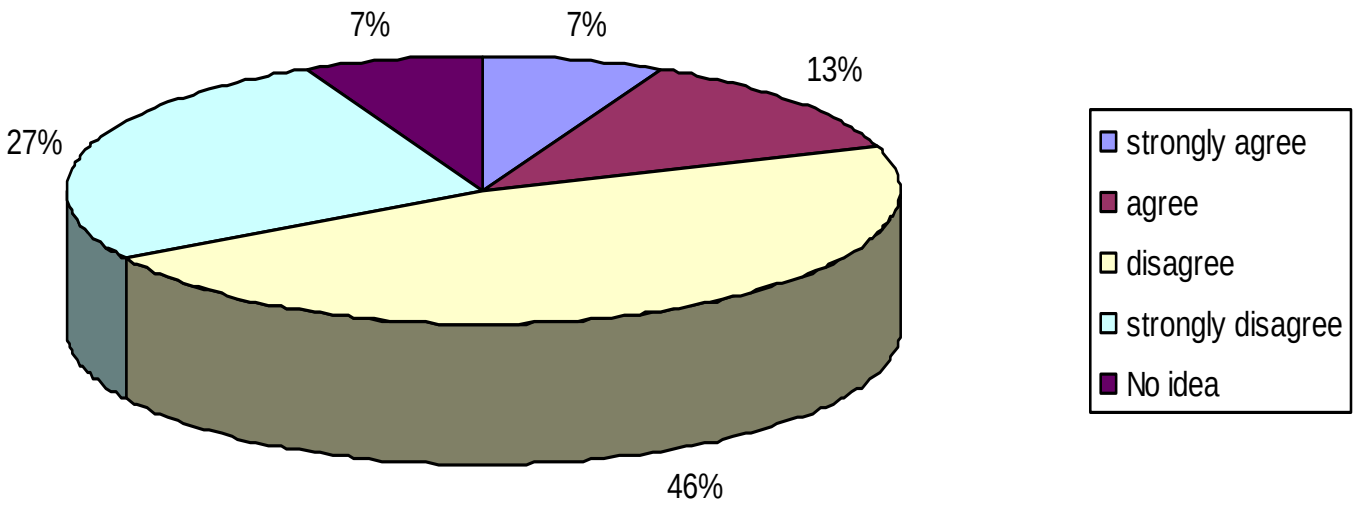


37%ASHAs strongly agreed and 23% agreed for this point because in some blocks there is no NSV provider so they have to go whether at the district Hospital or at the PHC where NSV provider is present

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

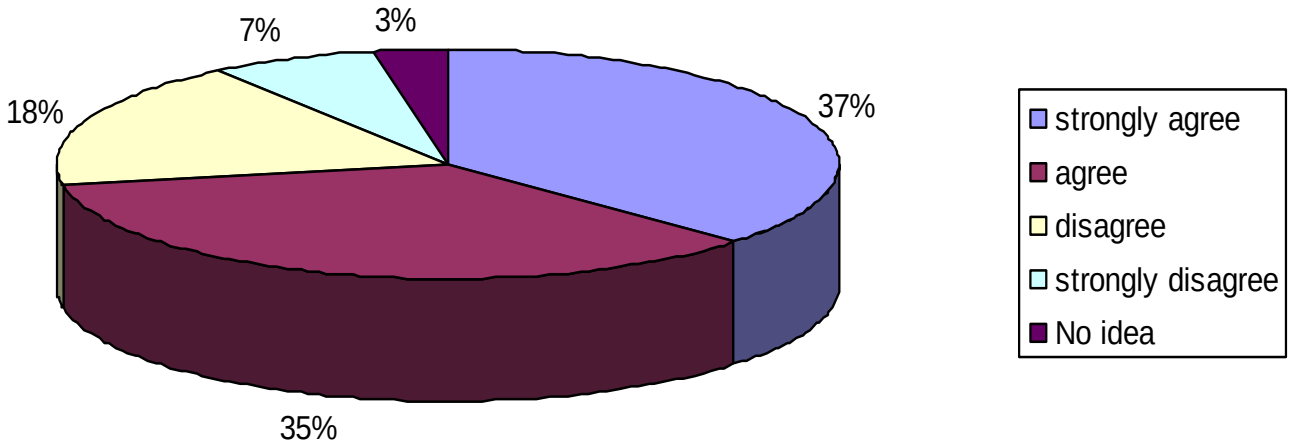
Figure-12



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

Figure-13



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 and 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. West singhbhum 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 Jharkhand 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

Reference:

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