Summer Training at
National Rural Health Mission (NRHM)
Government of Haryana
(April 9, 2012 - June 1, 2012)

Social Marketing of Oral Contraceptive Pills and Condoms by ASHA workers in Mewat District of Haryana

By
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Under the guidance of
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Post Graduate Diploma in Hospital and Health Management
2011-2013

Institute of Health Management Research,
Jaipur
2012

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CERTIFICATE

This is to certify that **Dr. Sonali Bhardwaj (P.T.), student of PGDHM 2011-2013,** has undergone Summer Training in **National Rural Health Mission, Haryana** from April 9 to June 1, 2012. The title of the summer internship project was "***Social Marketing of Oral Contraceptive Pills and Condoms by ASHA workers in Mewat district of Haryana- Issues and Challenges.***"

The candidate carried out all the studies related to the summer training. Her approach to the studies has been sincere, scientific and analytical.

This summer training as partial fulfilment of the course requirement is recommended for the award of Post Graduate Diploma in Health and Hospital Management (PGDHM).

We wish her success in all future endeavours.

Dr. P. R. Sodani
Dean (Academic and Students Affairs)
IIHMR, Jaipur

Susmit Jain 24/8/12

Dr. Susmit Jain
Assistant Professor
IIHMR, Jaipur

TO WHOM IT MAY CONCERN

This is to certify that Ms. Sonali Bhardwaj did her summer training under State Institute of Health & Family Welfare, Haryana on the topic **"Social Marketing of Oral Contraceptive Pills and Condoms by ASHA workers in Mewat District of Haryana – issues and challenges"** from 9th April, 2012 to 31st May, 2012 under the guidance of Dr. Sapra, DD (Family Welfare) O/o DGHS Haryana.

Her approach has been sincere, scientific and analytical towards the study. I wish her good luck in all future endeavours.

3.07

Dated: 22nd June 2012

Principal SIHFW
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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Sonali Bhardwaj,** student of Institute of Health Management and Research, Jaipur has successfully completed her Summer Internship w.e.f. 9th April 2012 to 1st June 2012 from **'State Institute of Health Family Welfare, Panchkula (Haryana)'.**

She undertook the research project titled, **"Social Marketing of Oral Contraceptive Pills and Condoms by ASHA workers in Mewat District of Haryana"** under my guidance. The project was assigned to her by Finance Commissioner, Government of Haryana.

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

Dr. Pankaj Vats

Director Health Services (Family Welfare)

National Rural Health Mission

Panchkula (Haryana)

Dated: May 30, 2012

Director Health Service (F.W.
Haryana, Panchkula

ACKNOWLEDGEMENT

I started off my training with a vision in my mind so as to be able to learn about the practical aspects of healthcare delivery system in a more detailed manner. Hereby, I take this opportunity to express my deep sense of gratitude to all those who have been instrumental in successful completion of my summer training.

I take immense pleasure to thank **Dr. S. D. Gupta** (*Director- Institute of Health Management Research*) and **Dr. P.R. Sodani** (*Dean, Institute of Health Management Research, Jaipur*) for placing me in such an esteemed organization (NRHM) to undertake my summer training. I would thank **National Rural Health Mission (NRHM), Haryana** to provide me with an opportunity to work with **State Institute of Health and Family Welfare (SIHFW), Haryana** where I gained basic knowledge about working of health functionaries.

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Sonali Bhardwaj

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LIST OF ABBREVIATIONS/ACRONYMS

NRHM....National Rural Health Mission
ASHA....Accredited Social Health Activist
VHSC.....Village Health and Sanitation Committee
IPHS.....Indian Public Health Standards
AYUSH.....Ayurveda, Yoga and Naturopathy, Unani, Sidha, Homeopathy
SKS.....Swasthya Kalyan Samiti
ANM..... Auxiliary Nurse Midwife
GNM.....General Nurse Midwife
SN.....Staff Nurse
SHM.....State health Mission
DHS.....District Health Society
FRU.....First Referral Unit
WCD.....Women and Child Development
HMIS.....Health Management Information System
SC.....Sub Centre
PHC.....Primary Health Centre
CHC.....Community Health Centre
GH.....General Hospital
DPM.....District Programme Manager
SPMU.....State Programme Management Unit
EDL.....Essential Drug List
BCC....Behaviour Change Communication
IEC.....Information, Education and Communication
DD.....Deputy Director
DHS.....Director Health Services
APD.....Assistant Project Director
SDC.....State Drug Controller
ADO.....Additional Deputy Officer
Trg.....Training
Mal.....Malaria
Plg.....Planning
M&E.....Monitoring and Evaluation
Lab.....Laboratory
FW.....Family Welfare
AIDS.....Acquired Immuno Deficiency Syndrome
RCH.....Reproductive and Child Health
HE.....Health Education
SIHFW.....State Institute of Health and Family Welfare
NIHFW.....National Institute of Health and Family Welfare
NUT.....Nutrition
NUR.....Nursing
TO.....Training Officer
JD.....Joint Director
AD.....Additional Director
ASDC.....Additional State Drug Controller
Opth.....Ophthalmology
Jt.....Joint
TB.....Tuberculosis
MO.....Medical Officer
I/C.....In-charge
LHV.....Lady Health Visitor
SBA.....Skilled Birth Attendant
PPIUCD.....Postpartum Intra-Uterine Contraceptive Device
PNC.....Post Natal Care
DTO.....District Training Officer
OCP.....Oral Contraceptive Pill
MCTS.....Mother and Child Tracking System
CC.....Conventional Contraceptives
EC.....Eligible Couples
FP.....Family Planning
ECP.....Emergency Contraceptive Pill
IFA.....Iron and Folic Acid
AWW.....Anganwadi Worker
STD.....Sexually Transmitted Disease
HIV.....Human Immunodeficiency Virus
MCH.....Maternal and Child Health

1.1 NATIONAL RURAL HEALTH MISSION (NRHM), HARYANA

Organization Profile:

National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country.

- ✓ It aims to undertake architectural correction of the health system to enable to effectively handle increased allocations as promised under the National Common Minimum programme and promote policies that strengthen public health management and service delivery in the country.
- ✓ It has as its key components provision of a female health activist (ASHA) in each village; a village health plan prepared through a local team headed by Village Health & Sanitation Committee (VHSC) of the Panchayat; strengthening of public hospitals for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.
- ✓ It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.
- ✓ It aims at effective integration of health concern with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.

Situational Analysis:

Aim of Mission Flexible pool is to support the health care delivery system by improving infrastructure, providing critical manpower, communalizing the health care delivery system, risk pooling for poor and improvement in quality of health care. Thus all the activities under Component – B are to support the remaining components of the NRHM.

It is most important to first establish community based institutions and provide essential manpower to health institutions to achieve the goal of NRHM. Considering this, main thrust given during 2008-09 was on establishment of various community based committees and to appoint critical staff to institutions. Accordingly, special drives were undertaken to establish or re-activate Village Health & Sanitation Committees, to form and register the Swasthya Kalyan Samitis (SKS) and to make the planning and monitoring committees functional. This has lead to formation of VHSCs in 92% villages and registration of SKS in over 97% health institutions. Guidelines were also issued to the committees and institutions about sources of funds and utilization of funds received by them. In addition, adequate powers were delegated to District Societies and SKS so that the districts can plan and implement activities as per their need. These important activities have resulted into almost three time utilisation of

NRHM funds as compared to last year for making the health institutions functional and community friendly.

To meet the shortage of doctors a special recruitment drive was made during the year 2008-09. Appointments of doctors were taken out of the preview of staff selection commission and the appointment was done by departmental committee. 825 doctors including 525 specialists were recruited. State Govt has also revised its placement policy. Appointments of contractual staff including staff Nurses/ANMs etc. are done by the SKS and are area specifics.

Haryana could not do much progress in the field of Monitoring, trainings and demand generation measures. Although regular meetings of State Health Mission (SHM) and DHS and quarterly meetings of Chairman of DHM has resulted into making NRHM important and leading activity in District. Training was another area which was streamlined during this year. Considering the importance of training and strengthening of training infrastructure, lot of planning was carried out in last 2 quarters.

Accomplishments and Shortcomings:

1) *Improving availability of critical manpower*
   It is important to provide ASHA, additional ANM at SCs, 3 staff nurses at 160 24x7 PHCs and 4 additional staff nurses at 40 FRU for round the clock services and close supervision. In addition to this, staff nurses and specialists are also required in Rural and District Hospitals to provide services as per IPHS. Almost 14000 ASHAs were appointed in the current financial year and their trainings were done. Time taken for translation of modules and printing has slowed the process of training. It was also revealed that it is difficult to find ASHAs in Mewat and because of high illiteracy rate in this backward district.
2) *Institutionalising the community involvement in health care delivery*
   VHSCs, SKS and Planning & Monitoring Committees have been formed in most of the areas along with convergence of VHSCs with WCDs. However, there are some health institutions without SKS which are mainly newly established PHCs. Haryana government has been instrumental in transferring of user fees in SKS accounts of hospitals that has resulted into constant flow of resources to SKS and thus, giving them more independence for activities.
3) *Strengthening of physical infrastructure and facilities*
   Good physical infrastructure which includes cleanliness, availability of water and drainage system and other basic facilities is important for admitting patients and providing basic obstetric services. Considering this, emphasis was given to functionalize the health institutions by utilising SKS funds and major part of budget received under Mission Flexi-pool for repairs. Efforts have been started to improve HMIS facilities so as

to reduce the burden on health staff and also improve the quality of reporting at various health facilities.

4) *Upgrading health institutions for quality services*

It is important to make the health institutes capable for providing obstetric and paediatric services to achieve the NRHM goals. Government of India has developed Indian Public Health Standards for SCs, PHCs and Hospitals. During last year, 4 hospitals were identified for up gradation but no hospital except for GH Panchkula could be improved. Main constrains in this regard were availability of trained specialists and provision of blood storage units. Various measures including improved service conditions and hiring of private specialists and incentive to government specialists and requirement for blood storage units are being taken up on priority with hospitals as well as provision of uninterrupted supply of essential drugs.

5) *Services to vulnerable population and un-served areas*

Various schemes have been started for them including Anaemia Control Program, Mass De-worming, health check-ups for school children and Mobile Medical Units for un-served areas. They also provide with higher incentives to medical/Para Medical staff in Mewat district of Haryana.

6) *Improving quality of service delivery*

Quality assurance project is being implemented in 6 districts of the state. Monitoring and Evaluation is another weak area of NRHM in Haryana. Though Haryana has excellent web-based functioning MIS, the NRHM indicators could not be incorporated in it resulting in very poor flow of essential information, wasting a lot of time of DPM, SPMU in collecting same information again and again. This was more evident during the review meetings taken by SHM and FCHM. On this background, it is proposed to completely overhaul the MIS from village to state level and develop efficient feedback system.

7) *Procurement plan of the state*

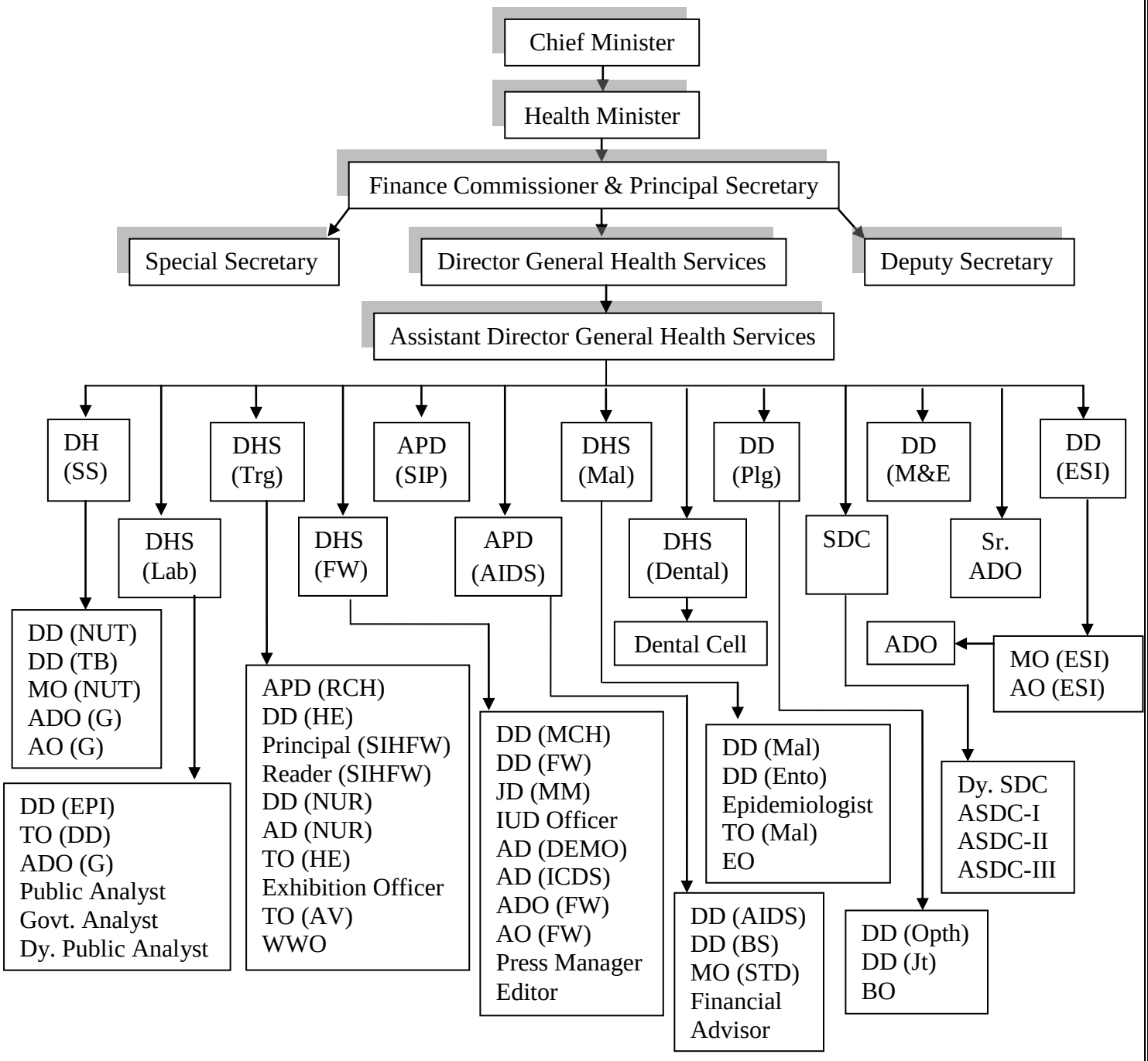
Important components that need to be catered to include- Development of procurement policy, devising procurement mechanism and its implementation and providing efficient distribution and demand generation system to get proper feedback to procurement system. To ensure quality and timely availability of drugs, dynamic Essential Drug List (EDL) has been prepared but, lot of issues were seen regarding rational use of drugs and warehouses with inadequate capacity in districts. The store record system is poor and demand generation is based more on assumption than actual demand at ground level. It is proposed to provide web-based medicine distribution system in the state along with the strengthening of warehouses.

8) *BCC/IEC activities in the state*

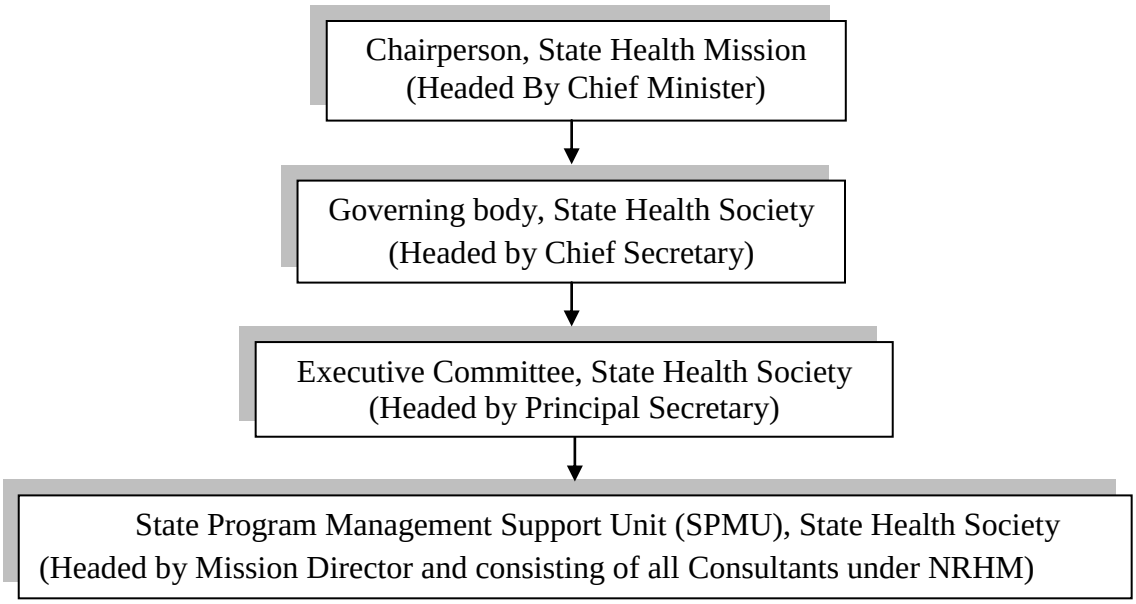
It has been decided to improve community participation through Sakshar Mahila Samooh (SMS) which is a self help group of educated women group of the village and are registered NGOs. These women take the health education to each and every household using specially designed IEC material in local language.

The State Govt. has re-constituted the State Health Society, Haryana (SHSH) District Health & Family Welfare Societies (DHFWs) and Swasthya Kalyan Samitis (SKS) on recommendation from National Programme Coordination Committee, NRHM (NPCC). These consists of officials from Government sector and members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives who are responsible for proper functioning and management of the hospital / PHC.

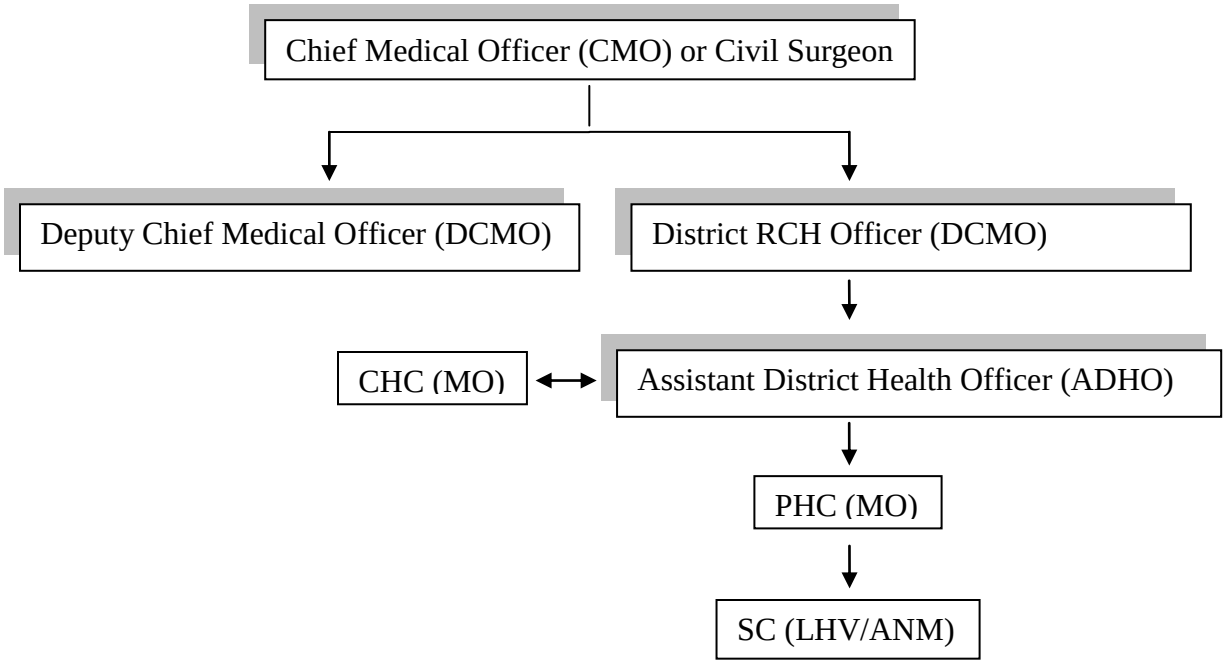
Organization Structure of Health Department of Haryana



Organogram of NRHM at State Level: State Health Mission



Organogram of NRHM at District Level: District Health Mission



1.2 STATE INSTITUTE OF HEALTH AND FAMIY WELFARE, HARYANA

Organization Profile:

State Institute of Health and Family Welfare **(SIHFW)**, Panchkula, Haryana was established in December, 1991 under IPP VII and has been envisaged as the state level institution for improving the total effectiveness of health care delivery system by imparting knowledge and technical skills at different levels. NIHFW is the Nodal Agency for coordinating training under NRHM for the whole country, with which SIHFW Haryana liaises since 21.12.2000 for coordinating the work of States- Haryana and Jammu & Kashmir and UT- Chandigarh.

Roles and Accomplishments:

- ✓ Specifically, it is responsible for imparting training of trainers of identified selected institutions in accordance with the approved training plans. Also, identify training institutions for skill-based training, assist the state authorities and nodal agencies in selection of appropriate training institutions for implementing skill-based training, provide guidance to the districts in preparation of district training plans and procuring training materials from nodal agencies and translate, adapt and print copies as per requirements of the state government.

- ✓ It has master trainers in NRHM (8), SBA (4), IMNCI (unreported), SPMU (7), ASHA (unreported), Contraceptive Updates (5) and IUD 380-A (5).

- ✓ It has been helping in adaptation, translations, printing and distribution of the training modules for in-service training courses of health functionaries in Hindi language.

- ✓ It is adept in making Comprehensive Training Plan (CTP) that incorporates trainings under RCH from phase 1 and Programme Implementation Plan (PIP) for various health programmes. Also, involved in preparation of District Action Plans (DAP) and Village Action Plans (VAP) for all districts of Haryana.

- ✓ Quarterly and monthly progress reports along with the training calendar CTP are submitted to NIHFW on regular basis. Good rapport has been established between both.

- ✓ It is well-equipped with 2 conference halls, 1 library, hostel with mess facility, internet availability, 1 IT department, RO drinking water supply and 2 transportation vehicles along with hygienically well-maintained reception and rooms.

Key Observations and Learnings:

- ✓ Good amount of trainings of trainers are taking place in the institute. During our training tenure of two months, trainings on PPIUCDS, PNC, DTO meetings etc. were conducted.

- ✓ A white board on the entrance is constantly being maintained by the Librarian regarding Thoughts and Messages by great authors, which is a good initiative to motivate the employees for work-life balance and positive approach towards work.

- ✓ There is an inadequate communication and liaison between the states of Haryana and Jammu & Kashmir and UT of Chandigarh at SIHFW Panchkula.

- ✓ Some posts of Consultants like Consultant (Management) and Consultant (Finance) are missing that need to be filled up for accelerated functioning and monitoring in all the districts as monitoring visits are not conducted on a regular basis by SIHFW.

- ✓ Monitoring visits by the staff to all the districts were conducted on appointment of new Director, NRHM (Dr. Gupta).

- ✓ Visits of IHMR trainees were conducted to PHC- Old Panchkula, PHC- Kot, AWC- village Mankain (Kot), SC- Ramgarh and SC- Nada Sahib.

2 PROJECT REPORT

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

2.1 INTRODUCTION

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

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

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

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

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

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

welfare, she also has a major role in counseling women of the community in adopting Family Planning (FP) measures.

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

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

2.2 RATIONALE

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

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

2.3 OBJECTIVES

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

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

2.4 METHODOLOGY

- **Study Area:** Mewat District Of Haryana State, India
- **Study design:** Cross-Sectional Exploratory Study
- **Sampling:** Cluster Sampling (22 villages chosen in total under 3 CHCs: Nuh, Ferozpur Jhirka, Punhana.
- **Study Sample:** 35 ASHA workers and 175 community females (5 females per ASHA)
- **Tool and Technique:** Interview Schedule (Pre-Structured and Structured Questionnaire)

About Study area: Mewat

Mewat district is one of the 21 districts of Haryana state in northern India. The district was carved as the 20th district of Haryana from erstwhile Gurgaon and Hathin Block of Faridabad districts on 4 April 2005, though Hathin sub-division was shifted to new district Palwal in 2008. It is bounded by Gurgaon district on the north, Rewari district on the west and Faridabad and Palwal districts on the east. Nuh town is the headquarters of this district.

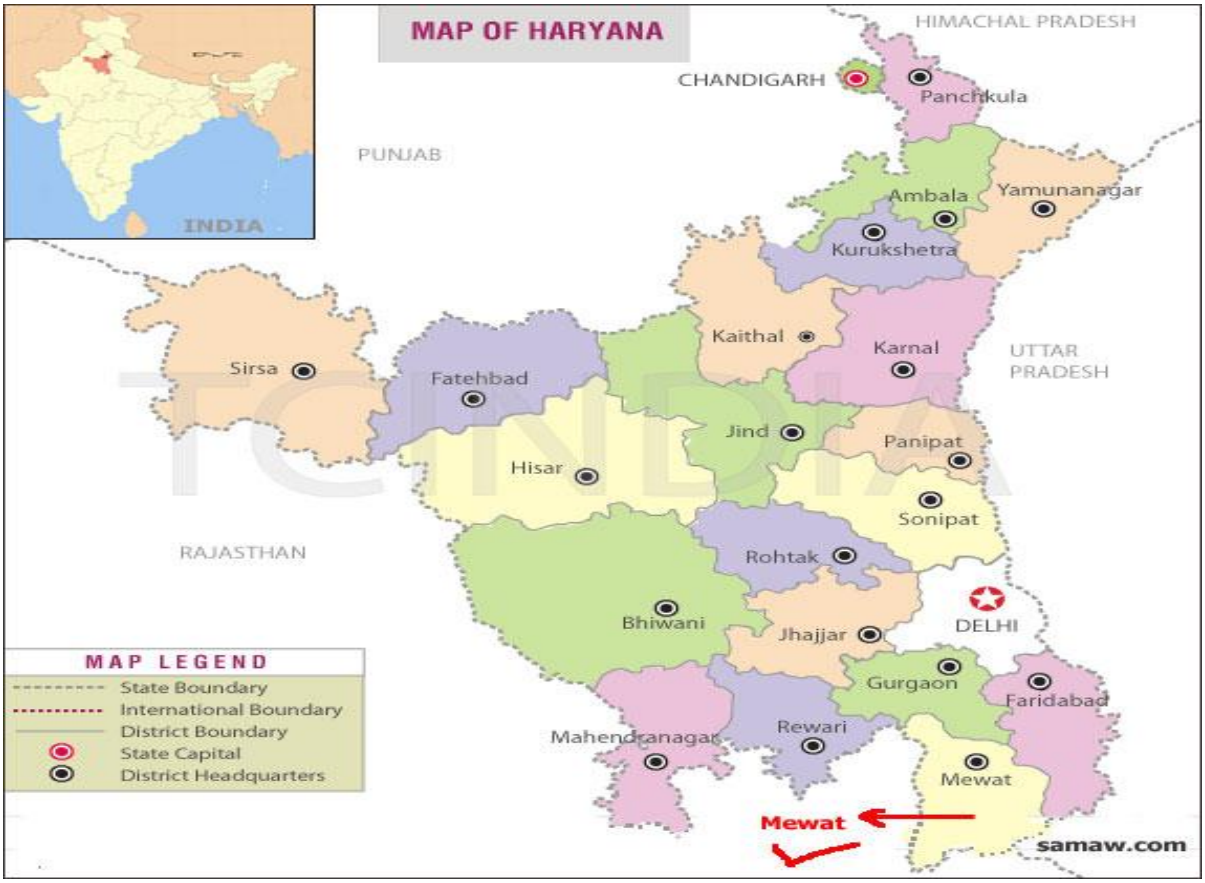
The area is a distinct ethnic and socio-cultural tract. The Meos, who trace their roots to the early Aryan immigration into northern India, call themselves Kshatriyas and have preserved their social and cultural traits to a surprisingly large extent, unlike the other tribes of nearby areas. During the regime of the Tughlak dynasty in the 14th century, these people embraced Islam but till today, they have maintained their age-old distinctive ethno-cultural identity. Historically, the region has been extremely turbulent and has been subject to repeated invasions and resultant plundering throughout the post-Vedic period, largely due to the situational peculiarity of the area and the non-sub-jugative attitude of the people. The

destruction and devastation over the centuries resulted in backwardness and gross underdevelopment of both the area and its proud people.

According to the 2011 census, Mewat District has a population of 1,089,406 and population density of 729 inhabitants per square kilometre (1,890 /sq m). Its population growth rate over the decade 2001-2011 was 37.94 percent. Mewat has a sex ratio of 906 females for every 1000 males and a literacy rate of 56.1 percent.

According to the Census of India 2001, the total population of Mewat was 9, 93,617 (including Hathin Block of district Palwal) of which 46,122 (4.64 percent) lived in urban areas and the major chunk 9, 47,495 (95.36 percent) of the population lived in rural areas. Out of the total population of 9, 93,617 people, there are 5, 24,872 males and 4, 68,745 females. The SC population is around 78,802. The total numbers of households are 1, 42,822 out of which 1, 35,253 (95 percent) are in rural areas and remaining 7569 (5 percent) are in urban areas. The total number of BPL households are 53125 including Hathin Block. BPL category makes 38.5 percent (39667) of the population. The population of Mewat is 80 percent Meos (Muslims) and rests are manly Hindus.

Map 1: Map of Haryana showing the study area i.e. Mewat



Map 2: Map of district Mewat of Haryana

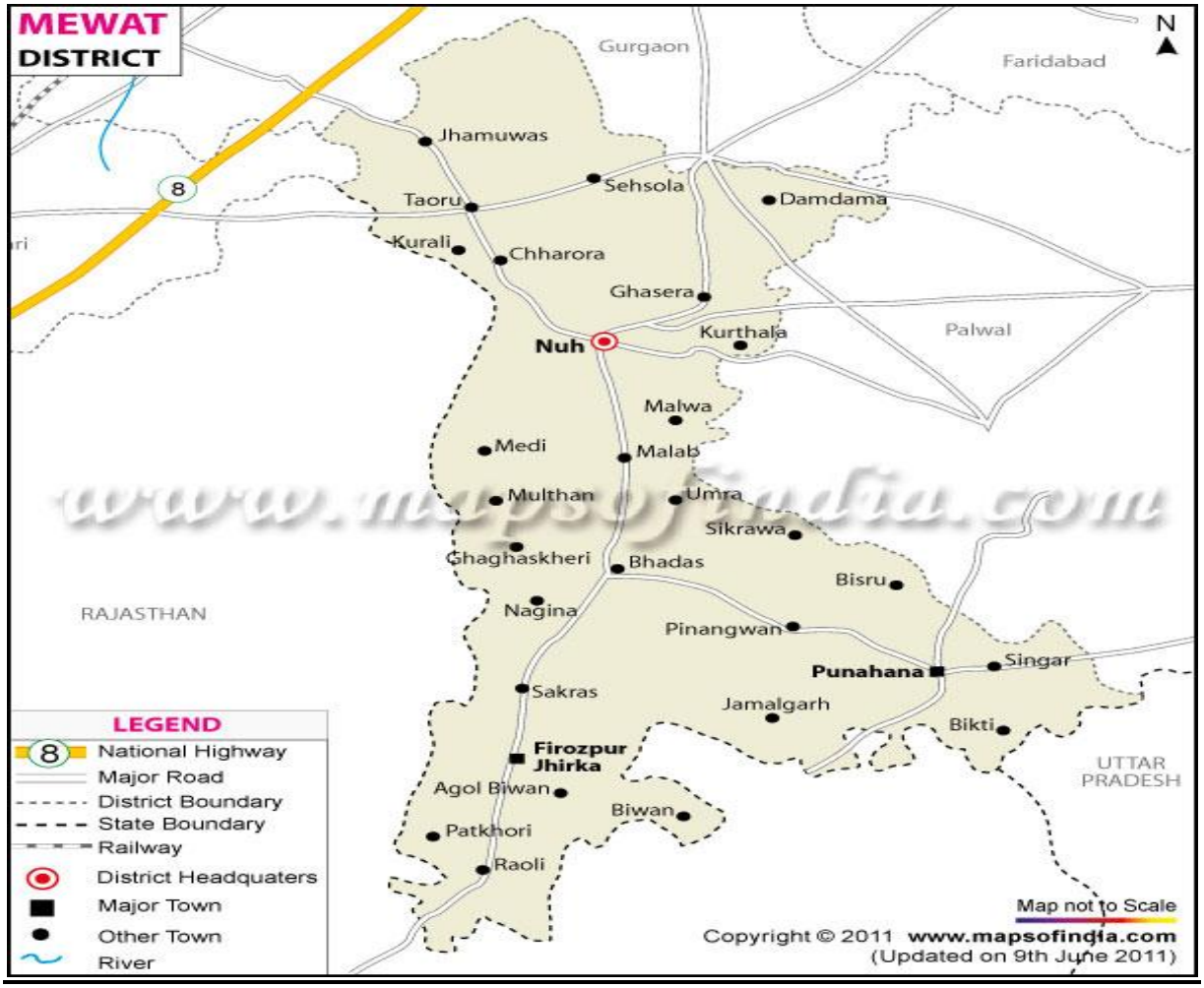


Table 1: Administration set-up of Mewat district of Haryana

Division	***Number***	***Name***
Sub Divisions	3	Nuh, Ferozpur Jhirka, Hathin
Tehsils	5	Taoru, Nuh, Hathin, Ferozpur Jhirka, Punhana
Sub Tehsils	1	Nuh
Blocks	6	Taoru, Nagina, Ferozpur Jhirka, Punhana, Hathin, Nuh
Municipal Committees	3	Taoru, Nuh, Firozpur Jhirka
CHCs	4	Nuh, Ferozpur Jhirka, Punhana, Hathin
PHCs	17 including 4 Block PHCs	
SCs	110	
PRIs	3 tier set-up	
Villages	564	

Table 2: Gram Panchayats of Mewat district of Haryana according to blocks

Block	*Gram Panchayat*
Taoru	48
Nuh	82
Ferozpur Jhirka	85
Nagina	50
Punhana	79
Hathin	78

(Source: District Action Plan, 2006)

Table 3: Couple Protection Rate of Mewat district of Haryana

CPR per 1000 Eligible Couples of Mewat is 26 percent i.e. 47186 out of 185495 Eligible Couples. CPR per 1000 EC block-wise is given below:

Block	*Rate*
Punhana	24.24
Ferozpur Jhirka	21.8
Nuh	26.3
Hathin	45.0
Total	30.8

(Source: Civil Surgeon's Office)

Table 4: Status of National Family Welfare Programme in Mewat district of Haryana

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

(Source: Civil Surgeon's Office)

Table 5: Age-wise breakup of Contraception Usage in Mewat district of Haryana:

Rural (age-group in years)	*No. of EC*	*CC users*	*OCP users*	*% using any method*
15-19	26284	1032	240	6.45
20-24	31118	1916	1344	19.84
25-29	30963	5147	2309	34.98
30-34	31749	2260	2242	33.43
35-39	28958	2525	917	30.52
40-44	27357	1204	341	20.84
Total	176429	14084	7393	24.86

Urban (age-group in years)	*No. of EC*	*CC users*	*OCP users*	*% using any method*
15-19	1422	50	0	3.5
20-24	1694	151	92	25.74
25-29	1689	181	91	41.39
30-34	1525	187	69	54.3
35-39	1367	200	47	56.69
40-44	1371	254	35	39.75
Total	*9068*	*1023*	*334*	*36.76*

(Source: Civil Surgeon's Office)

Table 6: Contraception usage by number of living children in Mewat district of Haryana:

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

(Source: Civil Surgeon's Office)

About National Family Welfare Programme (NFWP)

As 100 percent centrally sponsored programme, the approach under the programme during the First and Second Five Year Plans was mainly 'Clinical' under which facilities for provision of services were created. It was replaced by 'Extension and Education Approach' which envisaged expansion of services facilities along with spread of message of small family norm. In the IV Plan (1969-74), it was proposed to reduce birth rate from 35 per thousand to 32 per thousand by the end of plan. The objective of the V plan (1974-79) was to bring down the birth rate to 30 per thousand by the end of 1978-79 by increasing integration of family planning services with those of Health, Maternal and Child Health (MCH) and Nutrition, so that the programme became more readily acceptable.

The years 1975-76 and 1976-77 recorded a phenomenal increase in performance of sterilization. However, in view of rigidity in enforcement of targets by field functionaries and an element of coercion in the implementation of the programme in 1976-77 in some areas, the programme received a set-back during 1977-78. As a result, the Government made it clear that there was no place for force or coercion or compulsion or for pressure of any sort under the programme and it had to be implemented as an integral part of "Family Welfare" relying solely on mass education and motivation.

2.5 DATA ANALYSIS AND RESULTS

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

A. ANALYSIS OF ASHA WORKERS:

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

Demographics:

Figure 1:

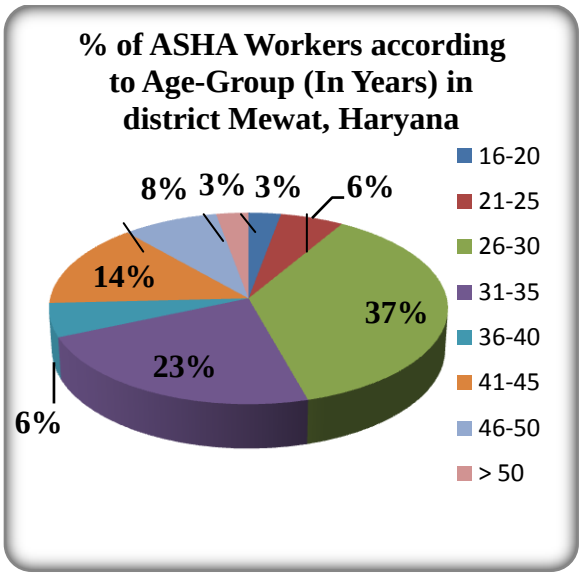


Figure 2:

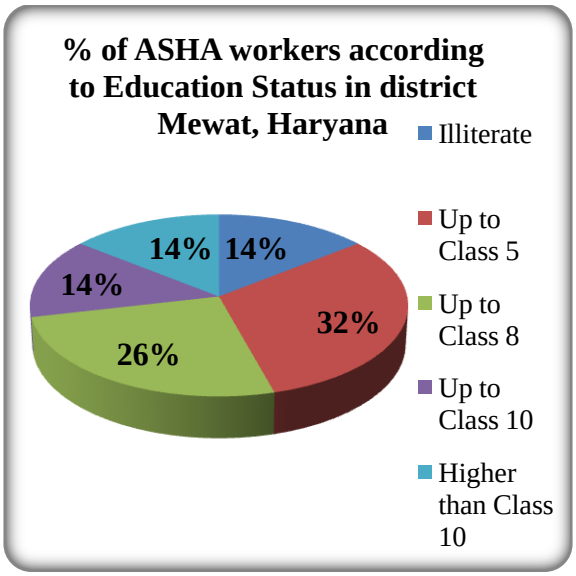


Figure 3:

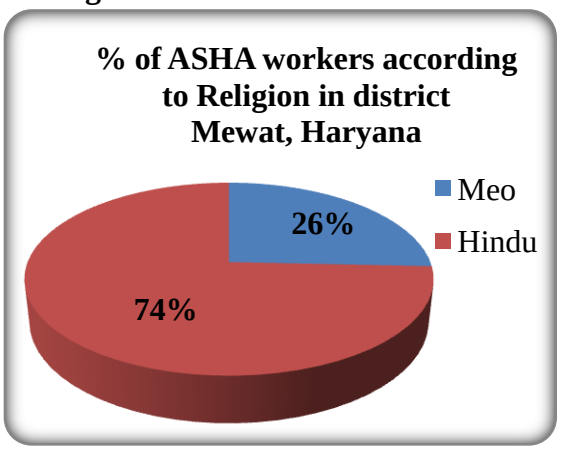
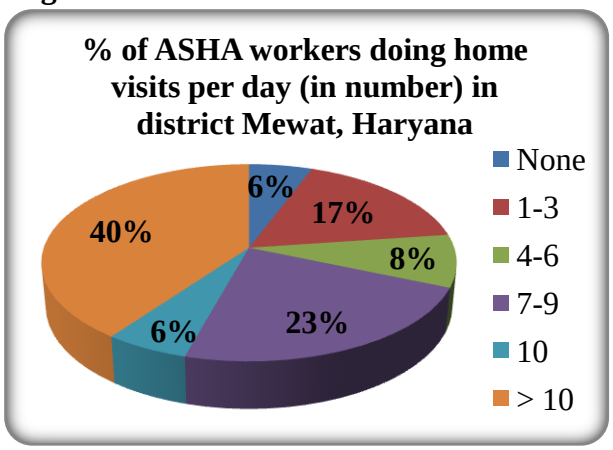


Figure 4:



Services provided by ASHA workers:

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

Awareness about Family Planning Methods:

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

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

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

Table 7 shows that there was a little awareness about natural methods and maximum about barrier methods (male condoms), IUCDs and OCPs. However, there was no awareness

regarding other barrier methods like cervical cap and female condoms, spermicidal methods and other hormonal methods like Trans-dermal patches.

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

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

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

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

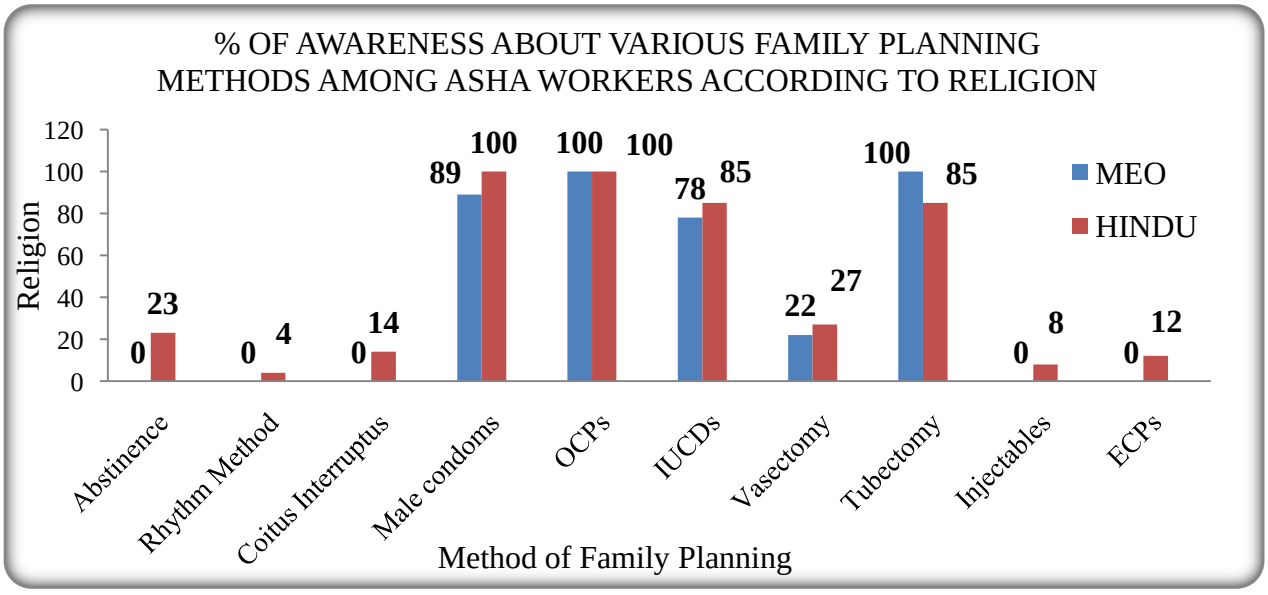


Figure 5 shows that Hindu ASHAs were more aware of FP methods, except OCPs where the percentage was equal among both Hindu and Meo ASHAs.

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

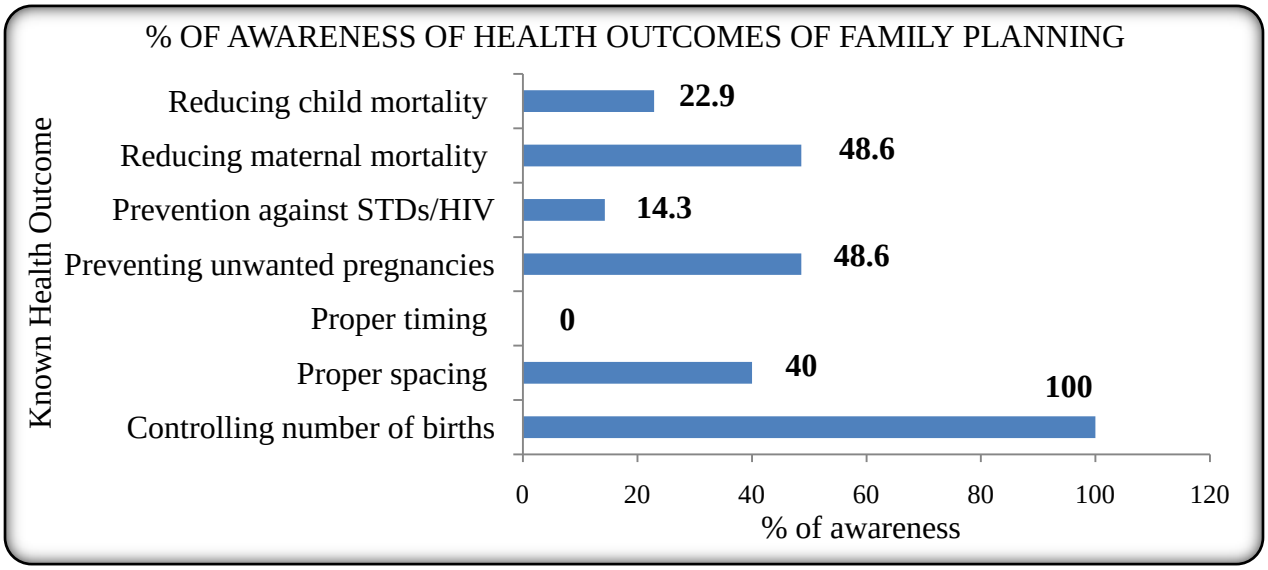


Figure 6 shows that ASHAs were less aware of health outcomes of FP, except that it controls number of births. Few knew about other outcomes, while none knew that FP is helpful in establishing proper timing of births.

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

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

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

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

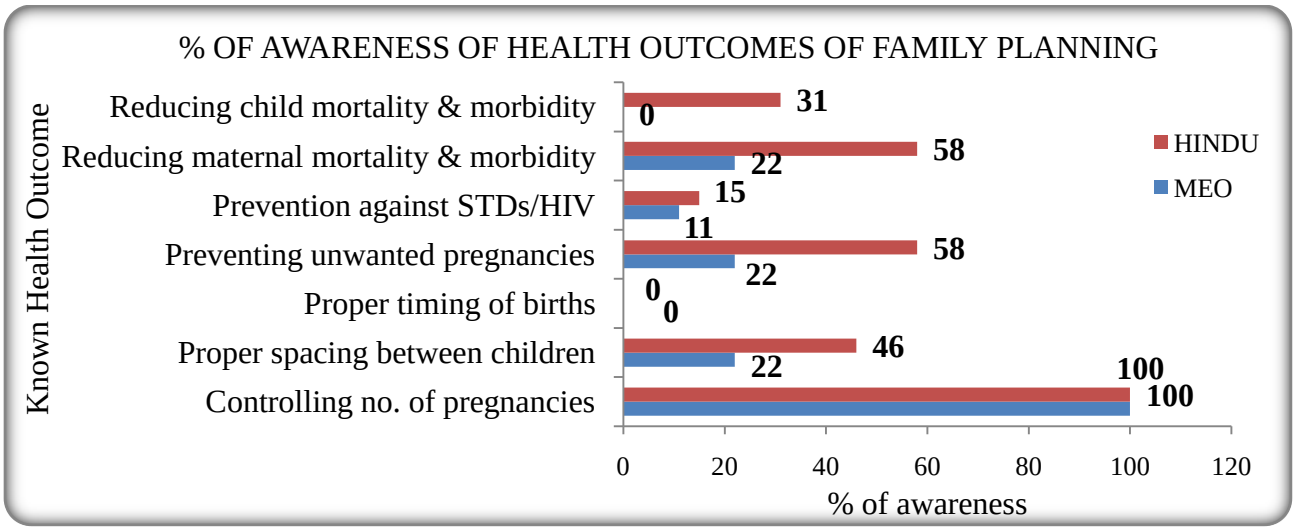


Figure 7 depicts that Hindu ASHAs were more aware of health outcomes of FP, except controlling number of births. However, none knew about proper timing of births and Meo ASHAs were not aware of reduction in child morbidity and mortality as a health outcome of Family Planning.

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

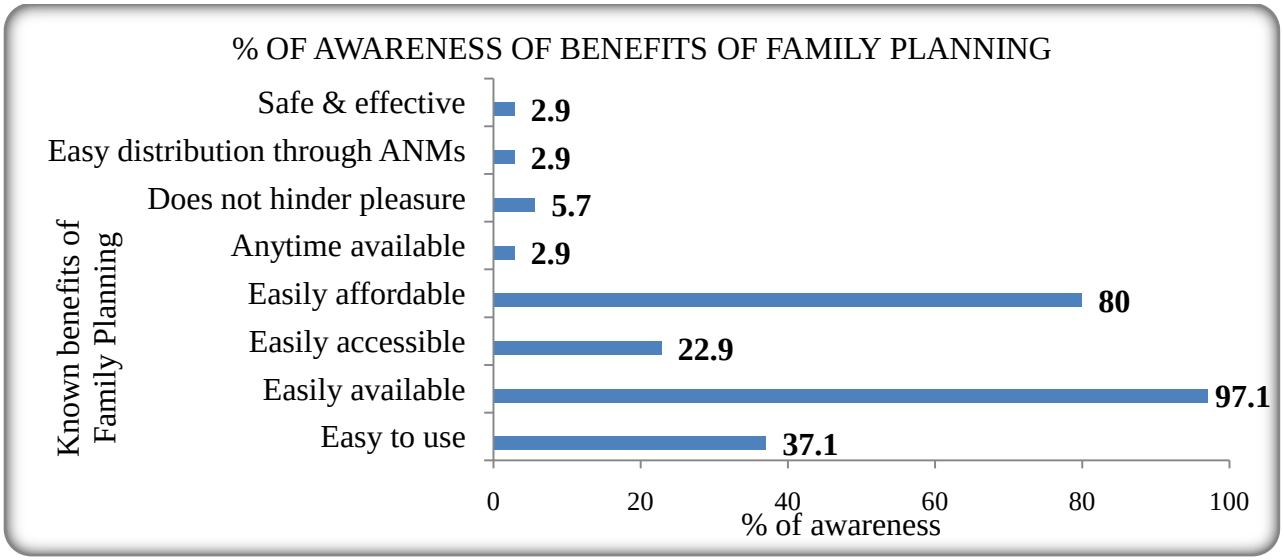


Figure 8 depicts that majority knew that being easily available and affordable are one of the best benefits of using FP methods, especially OCPs and Condoms. A *striking feature* to note was that an ASHA worker of a village reported that she was distributing the OCPs and Condoms to ANMs of her village and that, she was herself not involved in any of the social marketing campaigns.

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 9:

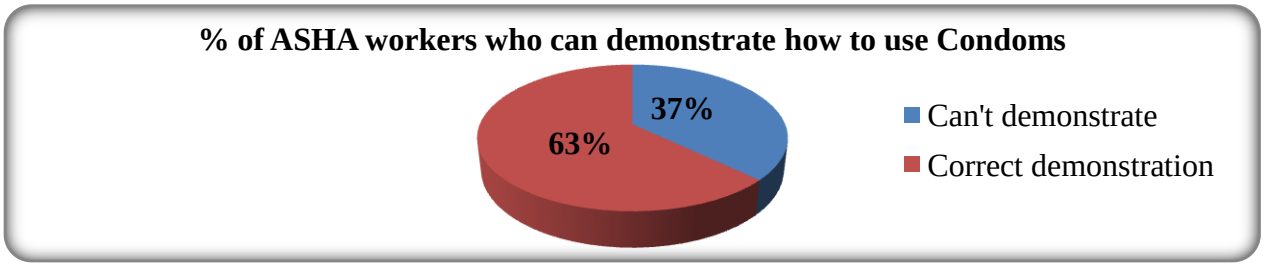


Figure 9 shows that around 1/3rd of ASHAs were able to correctly demonstrate the use of condoms to the community females.

Figure 10:

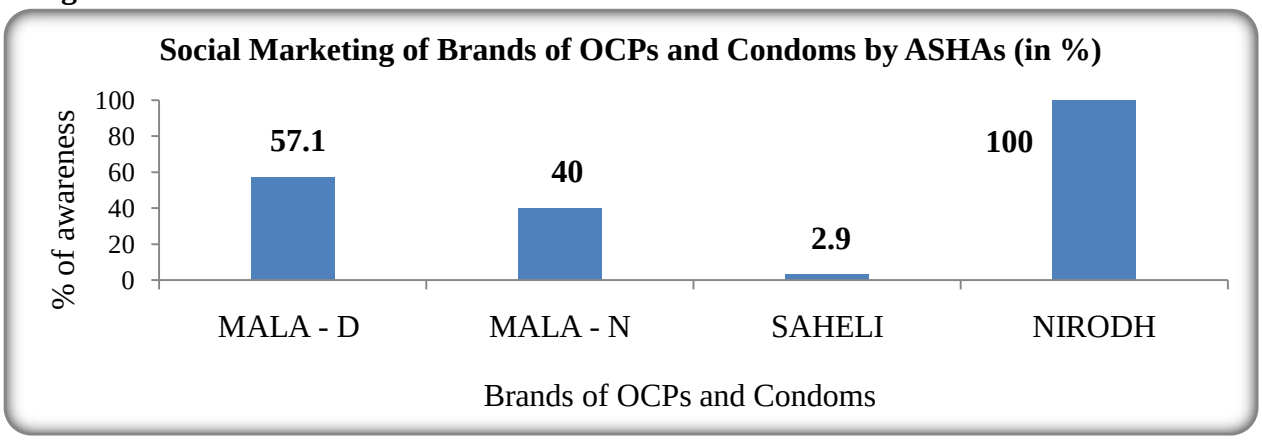


Figure 10 shows that ASHAs were able to do 100 percent social marketing of condoms w.r.t. their brand names, however, only half of them did the branding of OCPs. Majority were involved in social marketing of Mala-D than Mala-N and Saheli as per their brand names.

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

AGE-GROUP	FAMILY PLANNING METHOD TO BE USED			
	OCP	Condoms	IUCD	Sterilization
18-25 years	✓ 1			
18-30 years	✓ 8	✓ 8	✓ 3	
18-35 years	✓ 2	✓ 2	✓ 3	
18-45 years	✓ 1	✓ 1	✓ 1	✓ 1
More than 25 years				✓ 1
More than 30 years			✓ 2	✓ 3
More than 35 years			✓ 2	✓ 3
More than 40 years				✓ 2
Don't know	✓ 20	✓ 20	✓ 20	✓ 20
Any method at any age	✓ 1	✓ 1	✓ 1	✓ 1

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

Figure 11:

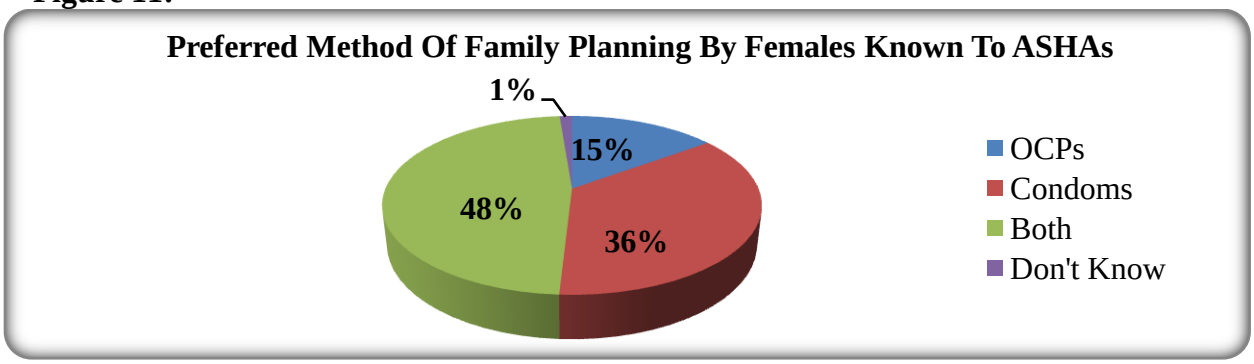


Figure 11 depicts that majority of ASHAs reported that both OCPs and Condoms were the preferred methods of FP by the females of their villages as known to them, and still Condoms were the next preferred measure than OCPs.

Knowledge of ASHA workers about Use of OCPs in district Mewat, Haryana:

- Regarding *options* available, 51 percent ASHAs were aware of 28 pills pack and nine percent knew about 21 pills pack, while 26 percent reported that there are 30 pills in a pack and 14 percent had no knowledge at all.
- 3 out of 35 ASHAs did not know the *criteria* of taking OCPs i.e. the daily uptake of a pill.
- 94 percent ASHAs knew about the correct *timing* of taking OCPs i.e. at night after meals and that, every pill has to be taken at the same time of the day.
- Only about 69 percent ASHAs were able to communicate correctly as what to do if a female *forgets to take a pill* on a particular day, while 14 percent gave incorrect knowledge and 17 percent were unaware regarding the same.
- Six percent ASHAs reported that OCPs can be taken during *breastfeeding*; however none knew which type of OCPs (combination pills) can be taken. Among the rest, 83 percent denied their use while breastfeeding and 11 percent had no knowledge regarding the same.
- Regarding awareness about *side-effects* of using OCPs. Only 37 percent knew about bleeding disturbances that can occur as a result of OCP use or their wrong use, while few know about other side-effects like nausea (23 percent); headache and migraine (14 percent); weight gain and white discharge from vagina (11 percent); cardiovascular effects like DVT and general malaise (6 percent); breast tenderness, fullness and discomfort, anaemia because of excessive bleeding, allergy on body and blisters in mouth and stomach (3 percent). However, none knew about mood changes and cancers (cervical/breast) as one of the major side-effects.
- *Contraindications* of OCP use known to ASHAs were mainly lactating mothers for first 6 months (46 percent); undiagnosed abnormal bleeding, age more than 40 years

(17 percent); cardiac abnormalities (14 percent); pregnancy, smoking, diabetes mellitus (6 percent); cancers (cervical/breast), hyperthyroidism, tuberculosis and epilepsy (3 percent). None knew about contraindications like gall bladder and renal diseases, Thromboembolism, etc.

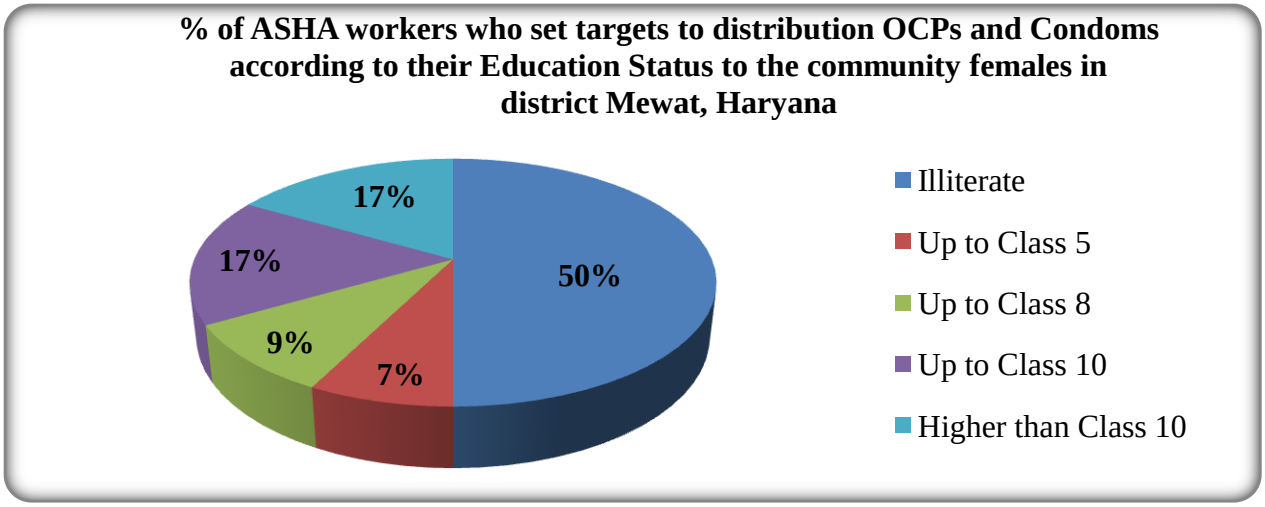
It was seen that knowledge of using OCPs and their side-effects and contraindications was higher among ASHAs who were better educated and amongst Hindu ASHAs than Meo ASHAs.

Training Needs Assessment of ASHA Workers

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

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

Figure 12:



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

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

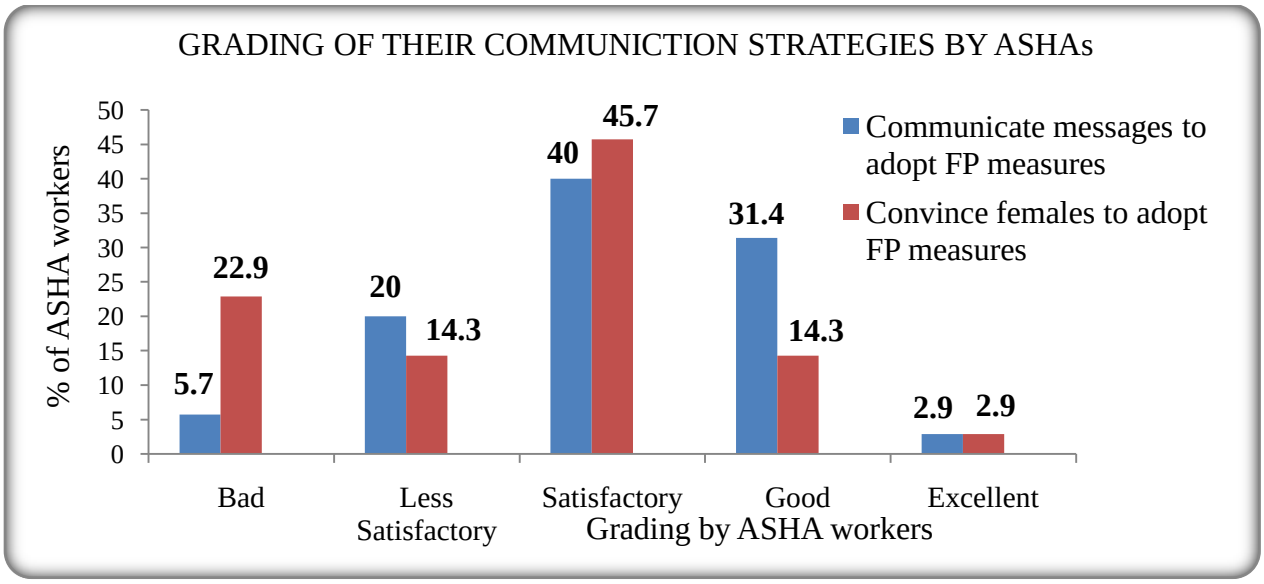


Figure 13 shows that majority of ASHAs graded their communication strategies as satisfactory.

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

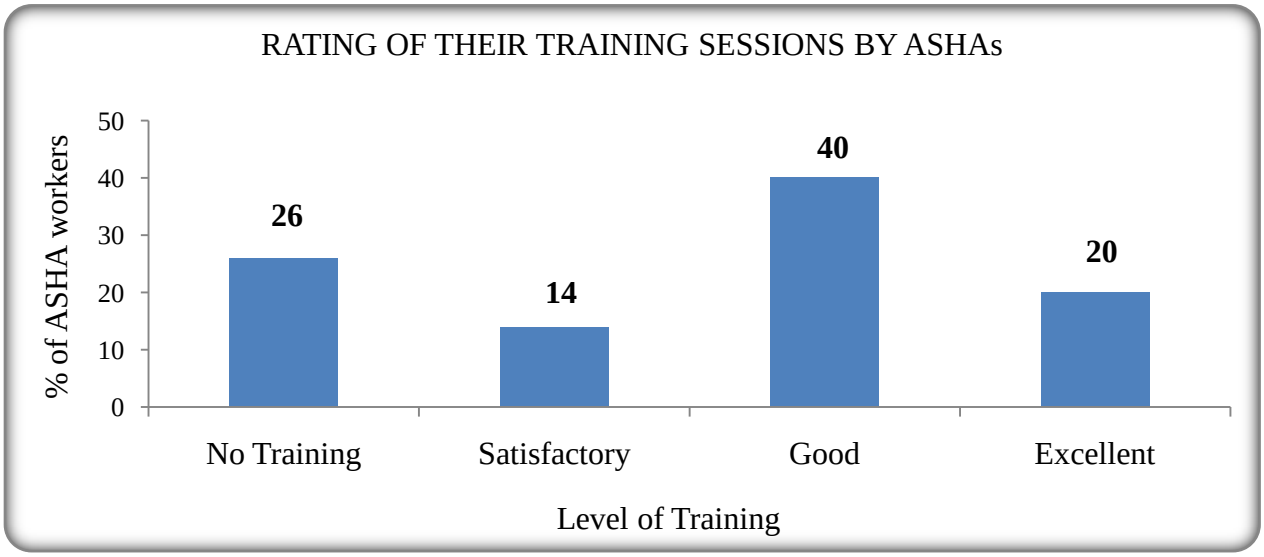


Figure 14 shows that majority of ASHAs rated their trainings as good; however those who received trainings on family planning and its measures were such 74 percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Feedback on trainings received by ASHA workers:

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

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

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

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

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

Other key findings regarding trainings of ASHAs workers:

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

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

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

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

B. ANALYSIS OF BENEFICIARIES: The study sample of 175 females showed following results in the district of Mewat, Haryana.

Demographics

Figure 15:

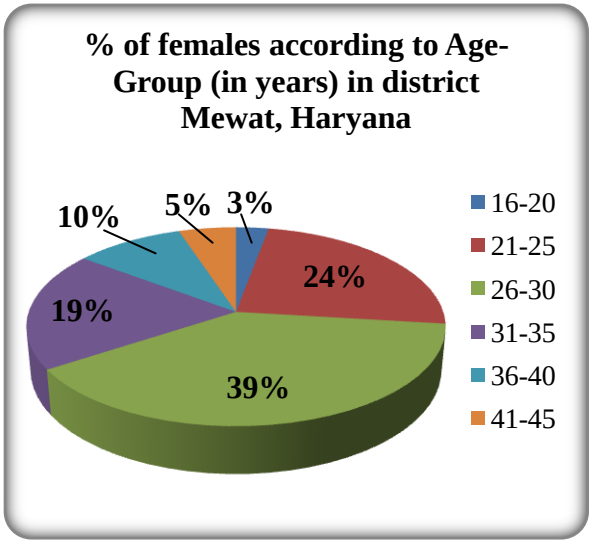


Figure 16:

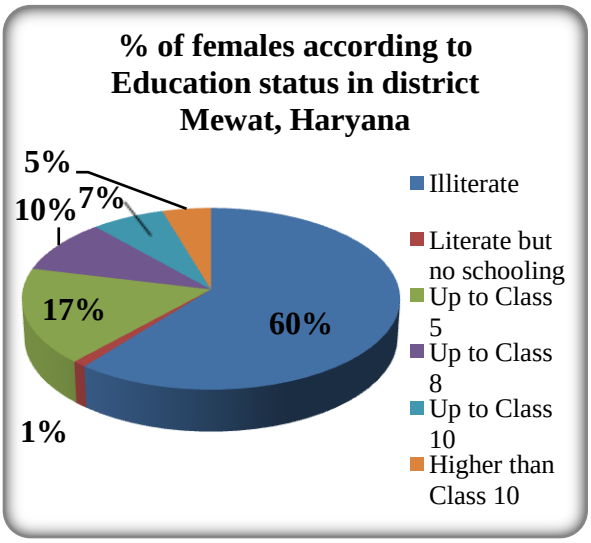


Figure 17:

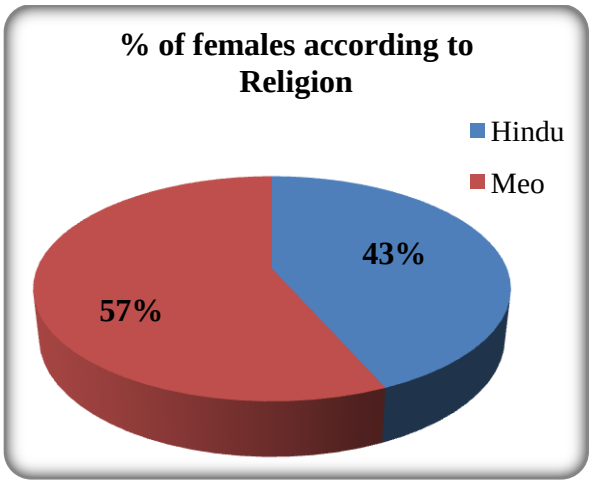


Figure 18:

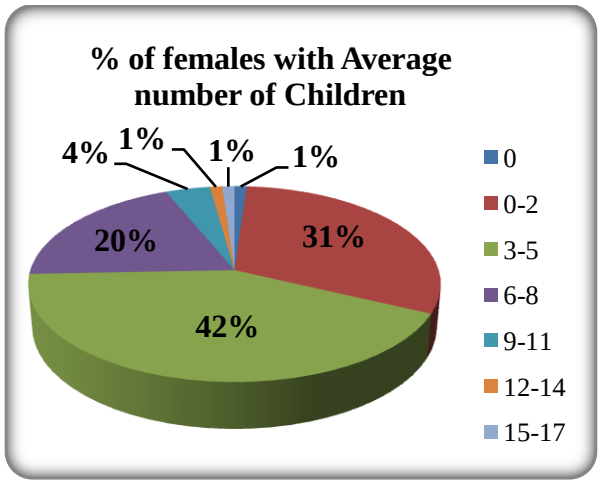


Table 19: Education status of sample community females according to their religion in district Mewat, Haryana (in %).

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

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

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

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

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

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

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

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

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

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

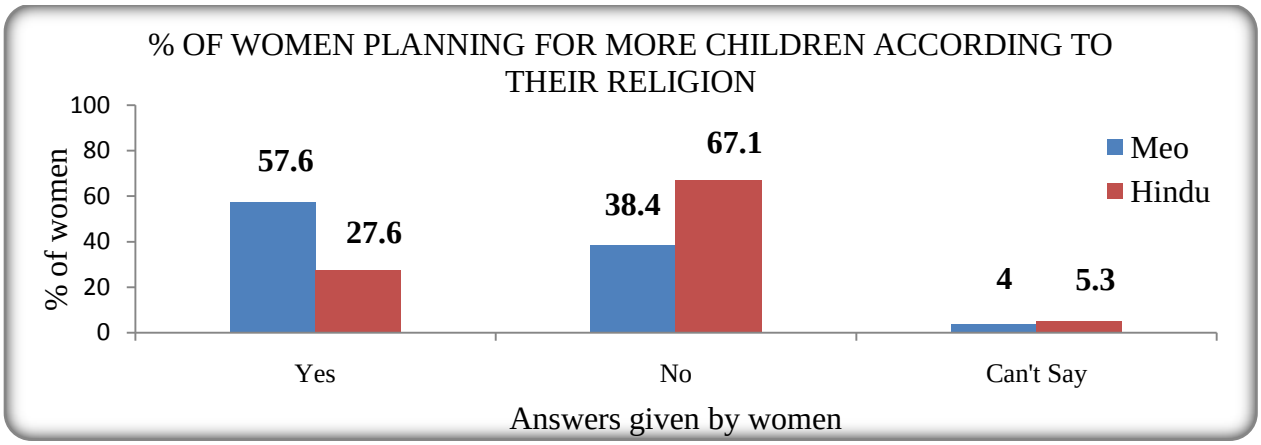


Figure 19 clearly shows that Meo women were planning for more children with their existing status than Hindu women.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 20:

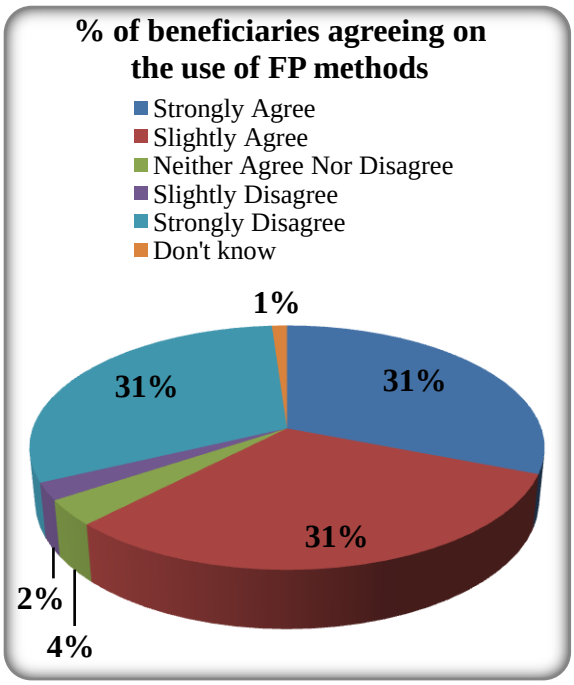


Figure 21:

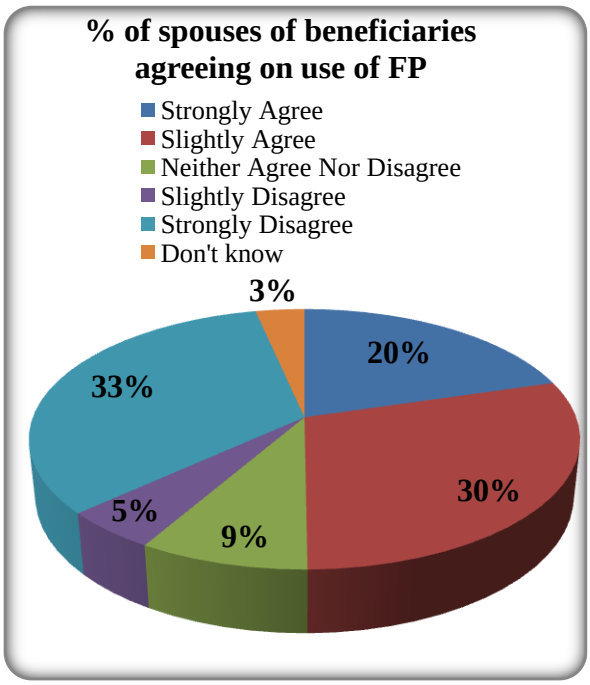


Figure 20 shows that an equal percentage of females strongly and slightly agreed on the use of FP methods, however the percentage was quite less (only 31 percent). Surprisingly, another 31 percent females strongly disagreed on the use of FP methods.

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

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

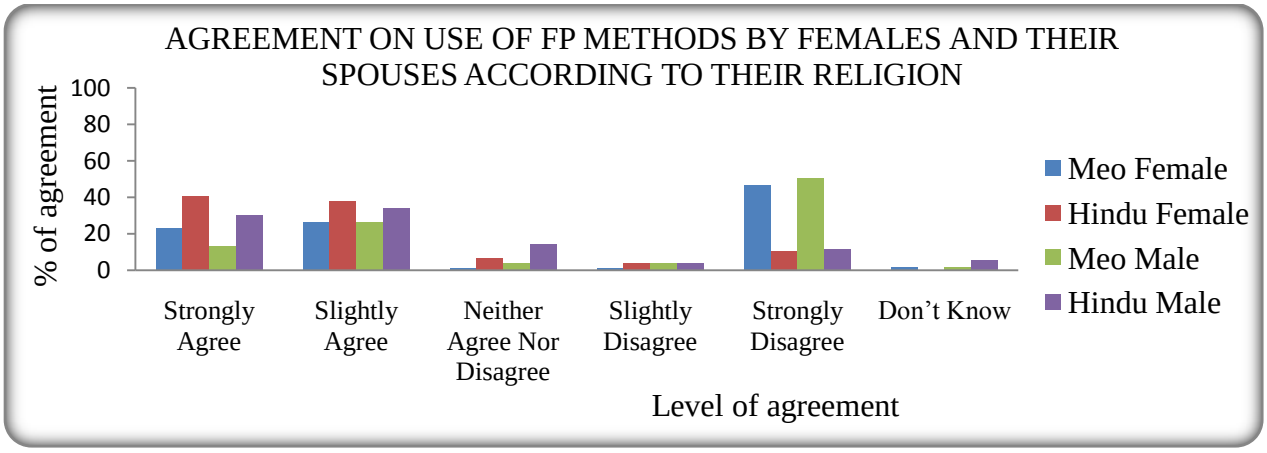


Figure 22 depicts that Hindu women were more willing to adopt family planning methods than Meos and, spouses of women were more unlikely to agree for adoption of any FP method as compared to their counter-parts, which was more among Meos than Hindus.

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

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

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

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

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

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

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

BENEFITS	OCPs		CONDOMS	
	NUMBER	PERCENT	NUMBER	PERCENT
Easy to use	35	20.0	21	12.0
Easily available	64	36.6	66	37.7
Easily accessible	15	8.6	17	9.7
Easily affordable	27	15.4	41	23.4
Anytime available	2	1.1	11	6.3

Does not hinder pleasure	12	6.9	8	4.6
Safe	22	12.6	25	14.3
Effective	3	1.7	12	6.9
Good compliance	2	1.1	1	0.6

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

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

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

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

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

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

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

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

EDUCATION STATUS	USERS OF FP METHODS					
	EVER USERS			CURRENT USERS		
	Yes	No	Total	Yes	No	Total
Illiterate	49	57	102	46	60	102

Literate but no schooling	1	1	2	0	2	2
Up to class 5	26	4	30	23	7	30
Up to class 8	17	0	17	17	0	17
Up to class 10	11	1	12	10	2	12
Higher than class 10	7	1	8	6	2	8
Total	111	64	175	102	73	175
Degrees of freedom	5			5		
Chi-Square Value(calculated)	36.59			32.81		
Chi-Square Value(table)	20.515			20.515		

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

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

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

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

Table 34: Cross-tabulation between education status and current use of OCPs and Condoms by the beneficiaries in district Mewat, Haryana (in number).

EDUCATION STATUS	CONDOMS CURRENT USERS			OCPS CURRENT USERS		
	Yes	No	Total	Yes	No	Total

Illiterate	17	89	102	14	92	102
Literate but no schooling	0	2	2	0	2	2
Up to class 5	12	18	30	6	24	30
Up to class 8	7	10	17	4	13	17
Up to class 10	5	7	12	2	10	12
Higher than class 10	2	6	8	4	4	8
Total	43	132	175	30	145	175
Degrees of freedom	5			5		
Chi-Square Value(calculated)	13.092			8.312		
Chi-Square Value(table)	11.07			11.07		

Table 34 depicts that the current users of OCPs and Condoms were more among higher educated females. As calculated value was more than table value for Condoms, statistical significance was proved at $p<0.05$ showing an association between education status of females and use of condoms by them. However, for OCPs, calculated value was less than the table value, so statistical significance could not be proved at $p<0.05$ showing no association between education status of females and use of OCPs by them.

Table 35: Cross-tabulation between education status and consistent use of OCPs and Condoms in district Mewat, Haryana (in number).

EDUCATION STATUS	CONSISTENCY OF USE								
	OCPs				CONDOMS				
	Consistent use		Intention to use consistently		Consistent use		Intention to use consistently		
	Yes	No	Yes	No	Yes	No	Yes	No	Total
Illiterate	12	94	10	93	11	95	6	90	102
Literate but no schooling	0	2	0	2	0	2	0	2	2
Up to class 5	5	25	5	24	4	26	6	19	30
Up to class 8	5	12	4	13	5	12	4	12	17
Up to class 10	1	11	0	10	3	9	4	6	12
Higher than class 10	4	4	2	6	2	6	3	5	8
Total	27	148	21	148	25	150	23	134	175
Degrees of freedom	5		5		5		5		
Chi-Square Value (calculated)	12.109		13.463		6.729		20.851		
Chi-Square Value (table)	11.07		11.07		11.07		11.07		

Table 35 shows that consistent use of OCPs was more among educated females, but intention to use OCPs consistently dropped among all. Similarly, consistent use of Condoms was more among educated females, but intention to continue with use of Condoms dropped among illiterates and those educated up to class 8, however, it increased among those educated up to class 5, class 10 and higher than class 10.

Statistical significance was however, proved only among consistent users of OCPs and those who intended to continue with use of OCPs at $p<0.05$ showing their association with the two. However, there was no statistical significance among consistent users of condoms at $p<0.05$. But, statistical significance was proved among those females who had an intention to continue with use of condoms at $p<0.05$ showing their association with education.

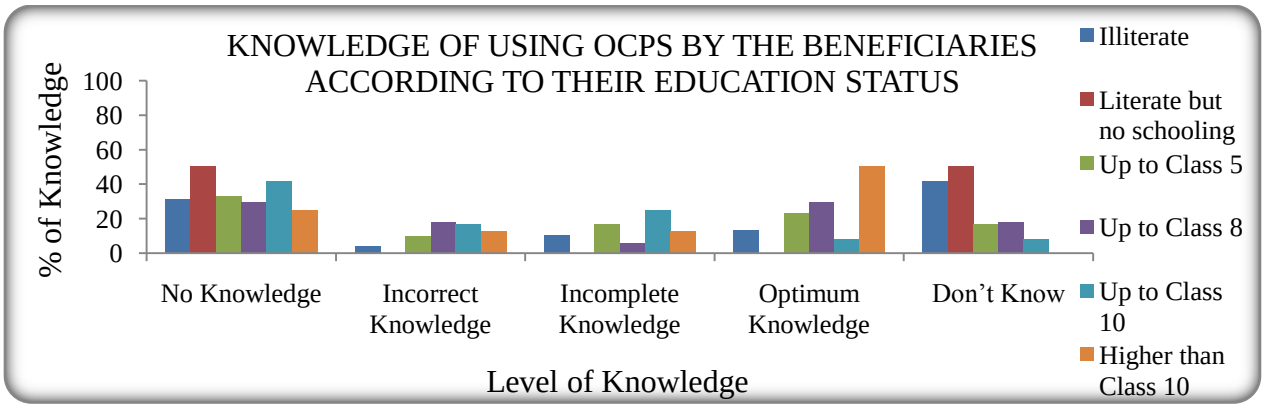
Table 36: Reasons for inconsistent use of OCPs and Condoms by the ever or current users in district Mewat, Haryana (in % out of total females).

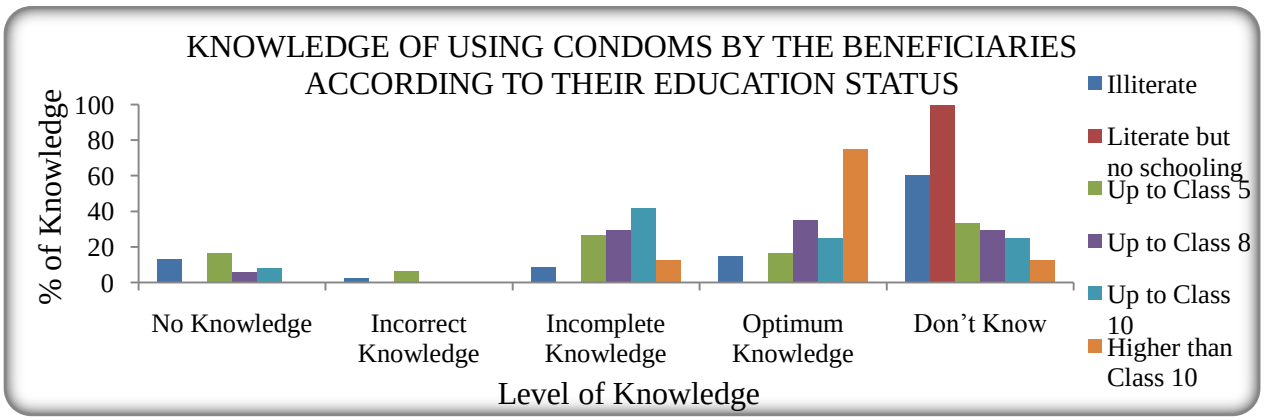
REASONS FOR INCONSISTENT USE OF OCPs AND CONDOMS BY EVER OR CURRENT USERS		
	OCPs	CONDOMS
Religious restrictions	34.3	34.9
Unavailable	0.0	3.4
Unaffordable	0.6	0.6
Inaccessible	0.6	2.9
Lack of knowledge	29.7	50.9
Low quality	1.1	8.0
Family pressure	12.6	10.9
Husband doesn't approve	8.6	32.6
Developed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

Willing for pregnancy	1.1	1.1
Unwilling to use any external means	3.5	3.5
Feel shy to ask repeatedly from ASHA/ANM	0.0	1.7
Has to be taken in secrecy	0.0	0.6

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

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





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

major proportion had an incomplete knowledge of using condoms. Around 75 percent of study sample beneficiaries had optimum knowledge of using condoms.

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

Tables 37, 38: Cross-tabulation between religion and knowledge of using OCPs and Condoms by the beneficiaries in district Mewat, Haryana (in number).

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

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

Table 38 shows similar results. Majority of Meos and Hindus had not even heard how to use Condoms; however, the percentage was almost double in Meos than the latter. Only 18 percent of Meos and 24 percent of Hindus had optimum knowledge of using condoms. A high percentage of Hindu females reported of having an incomplete knowledge how to use them (26 percent). Statistical significance was proved showing association between Religion and those having knowledge how to use Condoms at $p<0.001$.

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

Table 39: Side effects of OCPs known to beneficiaries in district Mewat, Haryana.

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

Table 39 shows the knowledge of beneficiaries about possible side-effects of using OCPs. Around 26 percent knew that OCPs can cause bleeding disturbances. Low percentage of them knew about other side-effects. A striking feature to note was around 3 percent of them believed that using OCPs is life-threatening and after using them, the user goes to hell.

Table 40: Cross-tabulation between education status and side effects of OCPs known to the beneficiaries in district Mewat, Haryana (in %).

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

Table 40 shows that majority of females did not about any side-effects of using OCPs (55 percent). Those educated up to class 8 had best knowledge than the rest of the lot.

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

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

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

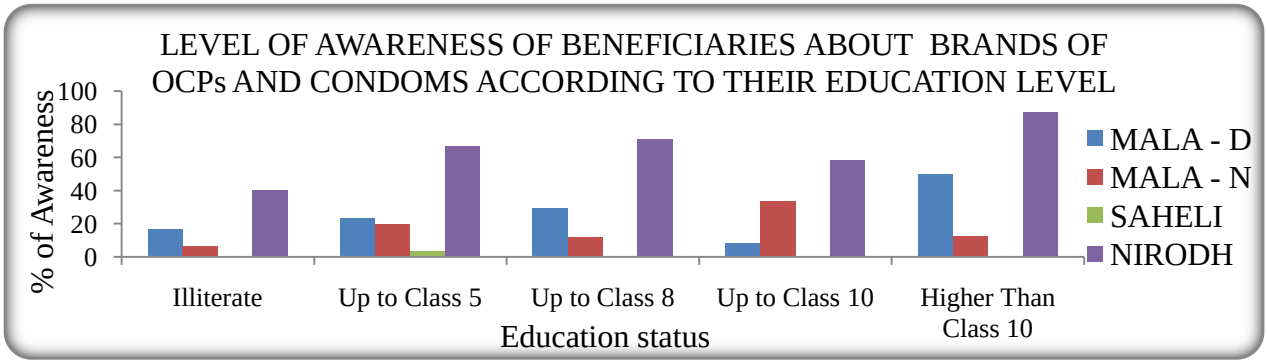


Figure 25 depicts that knowledge of brands of OCPs and Condoms as marketed by various sources was better among better educated females. Condom was known by its brand name (Nirodh) by majority of them among all groups, and the awareness was known to increase as the education status improved. Mala-D showed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

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

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

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

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

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

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

Table 41: Rating by the beneficiaries on the ability of ASHA workers to guide and inform them regarding various health services and social marketing of OCPs and condoms (in %).

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

Table 41 reports the rating of ASHAs by beneficiaries on their ability to counsel them about health services and social marketing of OCPs and Condoms. Majority of them reported the counselling to be satisfactory (33 percent). But, around 26 percent even reported the counselling ability to be bad, amongst which were those who did not want to take any

services from ASHAs. Despite all this, majority reported that SM ability of ASHAs was bad (37 percent), while others believed it to be satisfactory (23 percent) or good (19 percent).

Other key findings:

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

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

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

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

2.6 CONCLUSION

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

2.7 SUGGESTIONS

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

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

2.8 LIMITATIONS OF THE STUDY

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

2.9 BIBLIOGRAPHY

- S.K.Singh, H.Lhungdim, S.Niranjan. Evaluation of Social Marketing of Contraceptives undertaken by HLFPPT in some selected districts of Bihar, Jharkhand and Orissa. *International Institute of Population Sciences*. February, 2005.
- Barbara Janowitz, Margarita Suazo, Daniel B. Fried, John H. Bratt, Patricia E.Bailey. Impact of Social Marketing on Contraceptive Prevalence and Cost in Honduras. *Studies in Family Planning*, published by *Population Council*. Mar-Apr, 1992; 23 (2): 110-117.
- Condom Social Marketing: Rigorous Evidence - Usable Results. *UNAIDS*. June, 2011.
- Neil Price. Monitoring Reproductive and Sexual Health Programmes. John Snow International (UK), *Resource Centre for Sexual and Reproductive Health*.
- Contraceptive Social Marketing, India. Project by NGO *Parivar Seva Sanstha*. 2004
- Joy Riggs-Perla, Anuradha Bhattacharjee, Paula Quigley, and Venkat Raman through the *Global Health Technical Assistance Project*, and by Sarah Harbison and Mihira Karra of *United States Agency for International Development*. September, 2007.
- D C Walsh, R E Rudd, B A Moeykens and T W Moloney. Social Marketing for public health. *Health Affairs*. 1993; 12, (2): 104-119.
- Philip D. Harvey. The Impact of Condom Prices on Sales in Social Marketing Programs. *Studies in Family Planning*, January/February, 1994; 25 (1).
- Making condoms work for HIV prevention: Cutting-edge perspectives. *UNAIDS*. June 2004.
- Condom Social Marketing: Selected Case Studies. *UNAIDS*. November 2000.
- Neil Price. Contraceptive Safety and Effectiveness: Re-Evaluating Women's Needs and Professional Criteria. *Reproductive Health Matters*. May, 1994; 2 (3): 51-54.
- Binh Dinh, Hai Phong, Quang Ninh, Can Tho,Tay Ninh and Quang Tri Provinces. Condom Social Marketing Using Non-Traditional Outlets. *Family Health International Viet Nam HIV/AIDS Intervention*. 1999-2002.
- A Baseline Survey of Minority Concentration Districts of India. *Institute for Human Development*. 2008.
- J. Davies, Consultant, Honolulu, and S.N. Mitra, Mitra and Associates, Dhaka. *Bangladesh Family Planning Social Marketing Project and Population Services International*. December, 1984.
- Mahbubur Rahman, Toslim Uddin Khan. Social Marketing: A Success Story in Bangladesh. 2007.
- Saroj Pachauri. Expanding Contraceptive Choice in India- Issues and Evidnece. *Journal of Family Welfare*. 2004; 50.
- V. S. Chandrashekar, Madhwaraj Ballal, Barbara Janowitz and Gita Pillai. Expanding Contraceptive Use in Urban Uttar Pradesh: Social Marketing. *Urban Health Initiative*. March, 2010.
- Update on the ASHA Programme. *National Rural Health Mission*, MoHFW. January 2012.

3 SPECIAL STUDY ON WORKING OF SWASTHYA KALYAN SAMITI AT PHC- OLD PANCHKULA, HARYANA

Introduction:

One of the core strategies of the National Rural Health Mission (NRHM) is to empower local Governments to manage, control and make them accountable for public health services at various levels. Keeping in view the Panchayati Raj Institution (PRI) concept, it was decided to constitute the "**Swasthya Kalyan Samitis"** at the level of PHCs, CHCs, Sub-District Hospitals and District Hospitals so as to provide an oversight of all NRHM activities at the village and block levels; to monitor, evaluate, co-ordinate the work at various levels; and to serve as link to the District Health Society.

Frequency of meetings:

Swasthya Kalyan Samitis (SKS) are required to meet once in a month on a pre-determined day in order to review the work and progress done by them at different levels. The term of its members is usually one year on rotation basis.

Constitution and Members:

- **Swasthya Kalyan Samitis at PHC Level:**
    - MO I/C of PHC – Chairman & Convener
    - All MOs including AYUSH – Members
    - Sarpanch of village where PHC is located – Member
    - 1 Sarpanch by rotation from other villages (Tenure 1 year) – Member
    - 1 SMS head of the PHC village – Member
    - 1 SMS head of the PHC village by rotation (Tenure 1 year) – Member
    - Head of the Village level Committee (VLC) cum VHSC of PHC Village – Member
    - 1 member of VLC cum-VHSC by rotation (Tenure 1 year)- Member
    - ANM of the PHC village – Member
    - ASHA & AWW of PHC Village– Member
    - 1 ANM, ASHA, AWW by rotation from other villages (Tenure 1 year) – Members
    - Supervisor, ICDS of PHC Village – Member
    - Head Master of the PHC village – Member
    - Dental Surgeon – Member Secretary
    - The above committee may co-opt any non official member/ social activist from the village.

- **Swasthya Kalyan Samitis at CHC Level:**

    - SMO I/C of CHC – Chairman & Convener
    - All PHC I/Cs & AYUSH at CHC– Members
    - Sarpanch of CHC Village – Member
    - Head Master of the CHC village – Member
    - 2 Sarpanchs by rotation (Tenure 1 year) – Members
    - SMS head of the CHC village – Member
    - 2 SMS head of the PHC village by rotation (Tenure 1 year) – Members
    - Head of the CHC Village level committee-cum-VHSC – Member
    - 2 head of the village level committee-cum-VHSC by rotation (Tenure 1 year) – Members
    - CDPO, WCD – Member
    - Representative of the Deptt. of Water Supply & Sanitation – Member
    - Secretary, Municipal Committee (wherever applicable)- Member
    - BDPO of the area
    - Dental Surgeon – Member Secretary

- **Swasthya Kalyan Samiti at Sub District Hospital Level:**

    - Medical Superintendent of Sub District Hospital – Chairman
    - Deputy Civil Surgeon of area- Co-Chairman
    - All SMOs including Dental Surgeon– Members
    - Senior Most Doctors from each specialty in the hospital & AYUSH Doctor – Members
    - Matron/ Nursing Sister Incharge of Hospital – Member
    - District Ayurveda Officer – Member
    - Drug Inspector of Area- Member
    - Area Representative of District Red Cross Society – Member
    - SDO/ JE, PWD (B&R) – Member
    - CDPO (ICDS) – Member
    - Secretary, Municipal Committee (wherever applicable) – Member
    - Up to 3 eminent citizens nominated by Deputy Commissioner – Members
    - Mother/Field NGO representative (two) to be nominated by District Health and Family Welfare Society – Member
    - Store In-charge (Pharmacist) – Member
    - Representative of IMA- Member
    - Representative of Deputy Commissioner - Member
    - Resident Medical Officer (RMO) or one of the SMO appointed with the approval of District Health and Family Welfare Society - Member Secretary

- **Swasthya Kalyan Samitis at Disrtict Hospital Level:**

    - Civil Surgeon – Chairman
    - PMO/ Medical Superintendent of District Hospital- Co-Chairman
    - All SMOs including Dental Surgeon– Members
    - Senior Most Doctor from each specialty in the hospital & AYUSH Doctor- Members
    - Matron/ Nursing Sister Incharge of Hospital – Member
    - District Ayurveda Officer – Member
    - District Drug Controller – Member
    - Secretary, District Red Cross Society – Member
    - Executive Engineer/SDO PWD (B&R) – Member
    - Programme Officer/CDPO (ICDS) – Member
    - Secretary, Municipal Committee (wherever applicable) – Member
    - Up to 3 eminent citizens nominated by Deputy Commissioner –Members
    - Mother/Field NGO representative (two) to be nominated by District Health and Family Welfare Society – Member
    - Chief Pharmacist of Central Store – Member
    - President of District IMA – Member
    - Representative of Deputy Commissioner (not below the rank of a HCS officer) – Member
    - Resident Medical Officer (RMO) or one of the SMOs appointed with the approval of District Health and Family Welfare Society - Member Secretary

Allocation of funds:

According to District Action Plan, there is flexibility in utilizing funds for accessible and affordable health services through Panchayati Raj Institutions & community organizations.

- *Sakshar Mahilla Samooh*- Rs. 5,000/- for 6 months is given to 6167 SMS to create health awareness in the rural population
- *VLC-cum-VHSC*- Rs. 10,000/- is allotted to 6200 VLC-cum-VHSCs
- *Sub Centre*- Rs. 10,000/- each per year as untied funds & Rs. 10,000/- per year to every sub-centre for maintenance of building.
- *SKS (PHC)* - Untied grant of Rs. 25,000/- for health actions, Rs. 50,000/- for maintenance of PHCs & Rs. 1, 00,000/- for health care of the community.
- *SKS (CHC)* - Untied grant of Rs. 50,000/- for health actions, Rs. 1, 00,000/- for maintenance of CHCs & Rs. 1, 00,000/- for health care of the community.
- *District Hospital (DH)* - Rs. 5, 00,000/- is allotted to District SKS.

Assessing the functioning of SKS at various levels:

Table 42: Check-List designed to assess the *level of functioning* of SKS at various levels.

S. No.	***Particular***	***Yes***	***No***	***Could not be ascertained***
1.	Whether there is compliance to minimal standards for healthcare facility and hospital care and protocols of treatment as issued by State Health Society based on IPHS norms?			
2.	Whether there is availability of clear guidelines about utilization of funds?			
3.	Whether there is transparency with regard to management of funds?			
4.	Whether there is proper availability of funds at PHC/CHC/DH levels?			
5.	Whether funds or resources are generated locally through donations and other norms?			
6.	Whether there is any upgradation or modernization of health services provided by PHC/CHC/DH?			
7.	Whether any outreach services or health camps are organized at these facilities?			
8.	Whether Citizen's Charter in health facility is displayed or not?			
9.	Whether there is any operationalization of a Grievance Redressal Mechanism to ensure full compliance of citizen charter?			
10.	Whether community participation is ensured in the functioning of healthcare service delivery at all levels?			
11.	Whether scientific disposal of hospital waste is fully ensured?			
12.	Whether proper trainings for doctors and staff are ensured?			
13.	Whether subsidized food, safe drinking water, hygiene and sanitation are ensured to all patients?			
14.	Whether proper procurement of drugs and medicines is ensured?			
15.	Whether there is proper use, timely maintenance and repair of hospital building, equipments and machinery?			
16.	Whether there is appropriate monitoring and supervision of healthcare service delivery targets?			

Table 43: To compute the *Availability and Utilization of funds* done at each level of healthcare delivery system - PHC/CHC/DH under SKS.

Area	*Previous Financial Year*			*Current Financial Year*		
	Sanction	Release	Expenditure	Sanction	Release	Expenditure
Healthcare						
Annual Maintenance Grants						
Untied Funds						

During the field visit, the availability and utilization of funds by Primary Health Centre, old Panchkula for the financial year 2011-2012 granted by its SKS were discussed with Mr. Krishna Kumar (MPHWM). Sanction, Release and Expenditure of funds were looked into. AMG of Rs. 20,000 and Untied funds of Rs. 1.25 lacs were sanctioned to the facility.

Table 44: Utilization of funds as per SKS records as on March 31, 2012 for PHC, Old Panchkula in Haryana.

Area of Utilization	**Received**	**Expenditure**	**Balance**
Janani Suraksha Yojana (Centre)	90,000	23500	
ASHA Honorarium	620000	511100	
Mobilization	22000	86400	
Training	27400	28800	
Vaccination	27400	28800	
Untied funds	125000	24661	103027
Annual Maintenance Grants	20000	35000	
Indira Bal Swasthya Yojana	14100	14100	
Routine Immunization	3000	3000	
Janani Suraksha Yojana (State)	291500	272000	
Outreach	4000	4000	
IMNCI	9000		
Jachcha Bachcha Scheme	10000	75200	
Cold Chain Unit	1000	1000	
Breastfeeding Trainings	500	500	
Peer Educator	18300	15400	
JSY Delivery ASHA Incentives	25000		25000
IUCD Incentives	12000	12000	25000
IPPI	105650	105650	
Measles Control	60000	60000	
JSK Maternal Audit	22000	60000	
Infant Death Audit	10000	9900	
Maternal Death Audit	5000		5000

4 LEARNINGS FROM SUMMER TRAINING

- ✓ The most important learning was to analyze the way how a **health facility** functions and how people at various levels are involved to work towards attainment of a common goal in the betterment of the community as a whole.
- ✓ Work of SIHFW as a **Training Institution** was analyzed and was found to be good as per availability of trainers, training materials, arrangements of space, food, etc.
- ✓ During training at SIHFW, functioning of **public health facilities** like GH- Panchkula, PHC-Old Panchkula, PHC- Kot, AWC- village Mankain (Kot), SC- Ramgarh and SC-Nada Sahib and implementation of various health programmes at those health facilities was analyzed through monitoring visits with NRHM Consultants. Some beneficiaries of slums around Nada Sahib SC were also interviewed to get in-depth details of their health status and particularly PNC of recently delivered mothers and immunization status of their children.
- ✓ During project work, visits to GH, PHC, AWC and SC in the villages of district **Mewat** of Haryana, which is regarded as one of the most backward places of India in terms of its health and demographic indicators, were done and the working of key functionaries was analyzed.
- ✓ Work of **Swasthya Kalyan Samiti (SKS)** was analyzed in detail at PHC, Old Panchkula and how utilization of funds was done in the previous financial year, including AMGs, etc.
- ✓ Key **loop-holes were found in the functioning of health facilities** of Panchkula were analyzed that have been discussed in detail earlier.
- ✓ Working of **Sakshar Mahila Samooh** (SMS) was discussed in detail at AWC of Barota village of district Mewat in Haryana.
- ✓ Key **problems associated with the project** assigned have been discussed before. Lack of education and religious myths prevent the female population of Mewat to adopt family planning measures and social marketing of contraceptives by ASHAs, especially OCPs and Condoms can be an effective step towards promoting their use in the area.
- ✓ National family Welfare Programme of India was studied in detail.
- ✓ Ongoing Social marketing Campaigns in other states of India and other countries of the world were studied and their impact on fertility and population growth was analyzed.
- ✓ Findings of **projects assigned to other trainees** were equally knowledgeable. They were mainly on the following topics and covered different districts of Haryana:
    - Rational use of drugs at health facilities
    - Effectiveness of ASHA workers in full immunization coverage of children
    - Data validity and reporting in HMIS and MCTS
    - Antenatal Anaemia and its effect on the infant
    - Prevalence of Non-Scalpel Vasectomy and people's perception towards them
    - Immunization status of children in urban slums

- ✓ **Interacting with the key persons** in the health institutions was a great experience; it taught me the overall way of interaction; taking responsibility of works assigned; how to tackle problems at work place and during field visits; maintain reliability, validity, authenticity, rhythm and esteem of the assigned projects at different places.
- ✓ Getting **acquainted with a range of responses** from the community and knowing about their knowledge, attitudes and practices and other grass-root level problems that exist related to adoption of healthier behavior and their satisfaction level (health as well as non-health needs) while visiting and getting treated at a health facility.
- ✓ Use of **SPSS and MS-Excel** was a major addition toward development of my statistical skills as well as computer proficiency.

5 ANNEXURE

5.1 LIST OF PERSONS INTERACTED WITH DURING SUMMER TRAINING

NAME	AFFILIATION
Dr. Pankaj Vats	Director Health Services (Family Welfare), NRHM, Panchkula, Haryana
Dr. Usha Gupta	Principal, SIFFW, Panchkula, Haryana
Dr. Jatinder Kumar Sapra	Deputy Director (Family Welfare), NRHM, Panchkula, Haryana
Dr. Puneet Gupta	Consultant (Training), NRHM, Panchkula, Haryana
Dr. Kashmir Singh	Consultant, SIHFW, Panchkula, Haryana
Dr. Arpita	Faculty, SIHFW, Haryana
Dr. A.K. Rao	Chief Medical Officer/Civil Surgeon (CMO), General Hospital, District Mewat, Haryana
Dr. Maheshwari	District Training Officer (DTO), General Hospital, District Mewat, Haryana
Ms. Sonia	District Programme Manager (DPM), General Hospital, District Mewat, Haryana
	ASHAs, ANMs, AWWs of many villages in Haryana
	Other trainees in SIHFW, Haryana

5.2 DEVELOPED QUESTIONNAIRE FOR PROJECT

Confidential, For research purpose only

INFORMED CONSENT FORM FOR ASHA WORKERS

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

Introduction:

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

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

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

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

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

ASHA's Name:
ASHA's Signature:

INTERVIEW SCHEDULE FOR ASHA WORKERS

SECTION: A

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

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

SECTION: B

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

15.	What are the benefits of using family planning measures, particularly OCPs and Condoms?	1. Easy to use 2. Easily available 3. Easily accessible 4. Affordable 5. Anytime available 6. Does not hinder pleasure 7. Others (Specify) _____	
16.	Are you able to make the females of this village aware of family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
17.	Are you able to make the females understand about the benefits of using family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
18.	Are you able to convince females regarding the use of OCPs and condoms as family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	
19.	Can you tell the names of brands of OCPs and Condoms that you might/might not have in stock?	OCPs / Condoms	
20.	Which method do you suggest the females to use according to different age groups?	Age-Group (years) / Method	
21.	Do you know which method is preferred by the females of this village amongst OCPs and Condoms?	1. OCPs 2. Condom 3. Both 4. None	
22.	Are you aware of the intention to continue with the use of OCPs and condoms in future by the couples who are already using them?	1. Yes 2. No 98. Can't say 99. Don't know	
23.	Can you demonstrate how to use the condoms?	1. Can't demonstrate 2. Incorrect demonstration 3. Correct demonstration	

24.	What are the options available in prescribing or using OCPs?	1. 21 pills pack 2. 28 pills pack 3. Every alternate day 4. Others (Specify) _____ 99. Don't know	
25.	What is the criterion of using OCPs?	1. Day-wise pill 2. Any pill any day 3. Others (Specify) _____ 99. Don't know	
26.	Is there any difference if OCPs are taken at any time of the day during the entire day?	1. Yes 2. No 98. Can't say 99. Don't know	
27.	What do you suggest if a woman forgets to take a pill on a particular day?	1. Take the pill as soon as u remember and next pill at the same time of day 2. Take two pills the next day at any time of day 3. It doesn't matter, take the next pill at the same time of day 99. Don't know	
28.	Can OCPs be taken during breastfeeding?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 30**
29.	If yes, which OCPs can be taken during breastfeeding?	1. Mini pills 2. Combination pills 3. Any pill 98. Can't say 99. Don't know	
30.	What are the side effects of using OCPs?	1. Nausea 2. Headache and Migraine 3. Breast tenderness, fullness and/or discomfort 4. Mood changes 5. Bleeding Disturbances 6. Weight gain 7. Hypertension 8. Cardiovascular effects like DVT, MI, Stoke, PE, etc 9. Cancers (Cervical/Breast) 10. Others (Specify)	

		_____ 99. Don't know	
31.	In what medical or biological or social conditions, you should not take OCPs?	1. Cancers (Breast/ Genitals) 2. History of Thromboembolism 3. Cardiac abnormalities 4. Undiagnosed abnormal bleeding 5. Congenital hyperlipidaemia 6. Smoking 7. Age over 40 years 8. Lactating mothers in first 6 months 9. Diabetes Mellitus 10. Gall bladder disease 11. Chronic Renal disease 12. Epilepsy 13. Migraine 14. Amenorrhoea 15. Others (Specify) _____ 99. Don't know	

SECTION: C

Questions pertaining to Training Needs Assessment of ASHA workers			
S. No.	**Question**	**Response**	**Skip to**
32.	Do you have any set targets to increase the usage of OCPs and condoms in your community?	1. Yes 2. No	
33.	How do you grade your ability to communicate the messages regarding use and benefits of OCPs and condoms to the females of your village?	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
34.	How do you grade your ability to convince the females regarding use of OCPs and condoms on a consistent basis?	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
35.	Are you able to listen attentively, without interruption to somebody with whom you disagree?	1. Yes 2. No	
36.	When in a conflict situation, are you able to handle the situation without offending the other person?	1. Yes 2. No	
37.	Have you ever had any training related to communication and adoption of family planning measures to the community?	1. Yes 2. No 98. Can't say	

		99. Don't know	} **Q. 46**
38.	If yes, what information did it convey to you?	_____ _____ _____	
39.	Rate your training session on a scale of 5.	1. Bad 2. Less satisfactory 3. Satisfactory 4. Good 5. Excellent	
40.	Give a feedback on your training session regarding promoting the use of OCPs and condoms?	1. Overcrowded sessions 2. Trainers didn't explain the material clearly 3. Trainers weren't able to clarify the doubts 4. Trainers weren't competent enough to solve problems 5. Unsatisfactory provision for food & accommodation 6. No compensation received 7. Others (Specify) _____	
41.	What were the positive aspects of your training session?	_____ _____ _____	
42.	What were the negative aspects of your training session?	_____ _____ _____	
43.	In your opinion, how was the quality of theoretical training being provided to you?	1. Incomplete 2. Optimum 3. Too much 4. Need to repeat	
44.	In your opinion, how was the quality of practical training being provided to you?	1. Incomplete 2. Optimum 3. Too much 4. Need to repeat	
45.	Do you think sessions should be incorporated in your training modules to teach about adoption of family planning measures?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 49**
46.	If yes, can you suggest some methods w.r.t.	_____	

	education level of the females in your village?	_____ _____	
47.	Do you think you will be able to perform better if additional trainings about family planning are provided to you?	1. Yes 2. No 98. Can't say 99. Don't know	
48.	In your opinion, what should be the duration of these training sessions per day?	_____ Hours	
49.	Would you face any problems if such trainings are provided to you?	1. Place of training too far 2. Family doesn't approve 3. Insufficient time 4. Lack of motivation 5. Others (Specify) _____	
50.	In your opinion, what are the motivating factors that encourage you to involve yourself in such training programs?	1. Financial Incentives 2. To get more exposure in village 3. To improve conditions in your village 4. Social prestige 5. Peer pressure 6. Others (Specify) _____	

Thanks, End of Survey!

Confidential, For research purpose only

INFORMED CONSENT FORM FOR COMMUNITY FEMALES

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

Introduction:

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

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

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

May I begin the interview now?

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

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

Respondent's Name:
Respondent's Signature:

INTERVIEW SCHEDULE FOR COMMUNITY FEMALES

SECTION: A

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

9.	If yes, why?	1. Support to the family 2. More working hands 3. More income 4. Family tradition 5. Others (Specify) _____	

SECTION: B

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

14.	How do you perceive your spouse's attitude towards use of family planning measures?	1. Strongly favourable 2. Quite favourable 3. Neither favourable nor unfavourable 4. Quite unfavourable 5. Strongly unfavourable 99. Don't know	
15.	What are the health outcomes of family planning?	1. Controlling number of pregnancies 2. Proper spacing between children 3. Proper timing of births 4. Prevent unwanted pregnancies 5. Prevention against STDs/HIV 6. Reducing maternal mortality & morbidity 7. Reducing child mortality & morbidity 8. Others (Specify) _____ 99. Don't know	
16.	What are the benefits of using OCPs?	1. Easy to use 2. Easily available 3. Easily accessible 4. Affordable 5. Anytime available 6. Does not hinder pleasure 7. Others (Specify) _____	
17.	What are the benefits of using Condoms?	1. Easy to use 2. Easily available 3. Easily accessible 4. Affordable 5. Anytime available 6. Does not hinder pleasure 7. Others (Specify) _____	
18.	Have you ever used any family planning method?	1. Yes 2. No	**} Q. 28**
19.	If yes, which family planning method have you ever used?	1. Abstinence 2. Rhythm Method 3. Coitus Interruptus 4. Male Condoms 5. Female Condoms	

		6. Cervical Cap 7. Oral Contraceptive Pills 8. Spermicidal Methods 9. IUCDs 10. Male Sterilization (Vasectomy) 11. Female Sterilization (Tubectomy) 12. Injectables 13. Transdermal Patches 14. Others (Specify) _____	
20.	Are you a current user of any family planning method?	1. Yes 2. No	**} Q. 28**
21.	Which family planning method are you using now?	1. Abstinence 2. Rhythm Method 3. Coitus Interruptus 4. Male Condoms 5. Female Condoms 6. Cervical Cap 7. Oral Contraceptive Pills 8. Spermicidal Methods 9. IUCDs 10. Male Sterilization (Vasectomy) 11. Female Sterilization (Tubectomy) 12. Injectables 13. Transdermal Patches 14. Others (Specify) _____	
22.	Do you use OCPs on a consistent basis?	1. Yes 2. No	**} Q. 23**
23.	If no, what is the reason?	1. Unavailable 2. Unaffordable 3. Inaccessible 4. Lack of knowledge 5. Low quality 6. Family pressure 7. Husband doesn't approve 8. Fear of side effects 9. Doubt on effectiveness 10. Topic of mockery and laughter among society 11. Problems with storage in house, away from children 12. Others (Specify)	

		_____	
24.	Do you intend to continue with the use of OCPs on a consistent basis in future?	1. Yes 2. No 98. Can't say	
25.	Do you use condoms on a consistent basis?	1. Yes 2. No	} **Q. 27**
26.	If no, what is the reason?	1. Unavailable 2. Unaffordable 3. Inaccessible 4. Lack of knowledge 5. Problems with disposal 6. Low Quality 7. Family pressure 8. Husband doesn't approve 9. Hinders pleasure 10. Fear of side effects 11. Doubt on effectiveness 12. Topic of mockery and laughter among society 13. Problems with storage in house, away from children 14. Others (Specify) _____	
27.	Do you intend to continue with the use of condoms on a consistent basis in future?	1. Yes 2. No 98. Can't say	
28.	Do you know how and when to use OCPs?	1. No knowledge 2. Incorrect knowledge 3. Incomplete knowledge 4. Optimum knowledge 99. Don't know	
29.	Do you know how and when to use Condoms?	1. No knowledge 2. Incorrect knowledge 3. Incomplete knowledge 4. Optimum knowledge 99. Don't know	
30.	Are there any side effects of using OCPs?	1. Yes 2. No 98. Can't say 99. Don't know	} **Q. 32**

31.	What are the side effects of using OCPs?	1. Nausea 2. Headache and Migraine 3. Breast tenderness, fullness and/or discomfort 4. Mood changes 5. Bleeding Disturbances 6. Weight gain 7. Hypertension 8. Cardiovascular effects like DVT, MI, Stoke, PE, etc 9. Cancers (Cervical/Breast) 10. Others (Specify) _____ 99. Don't know	
32.	In what medical or environmental conditions, should you not take OCPs?	1. Cancers (Breast/ Genitals) 2. History of Thromboembolism 3. Cardiac abnormalities 4. Undiagnosed abnormal bleeding 5. Congenital hyperlipidaemia 6. Smoking 7. Age over 40 years 8. Lactating mothers in first 6 months 9. Diabetes Mellitus 10. Gall bladder disease 11. Chronic Renal disease 12. Epilepsy 13. Migraine 14. Amenorrhoea 15. Others (Specify) _____ 99. Don't know	
33.	Name some brands of OCPs that you are aware of?	_____ _____ _____	
34.	Name some brands of Condoms that you are aware of?	_____ _____	
35.	Is there any method of family planning that is preferred by you? Any specific reason for the same?	_____ _____ _____	

36.	Is there any method of family planning that is preferred by your spouse? Any specific reason for the same?	_____ _____ _____	

SECTION: C

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

Thanks, End of Survey!