"Factors Affecting Acceptance of Non Scalpel Vasectomy among Males: A Case of Uttar Pradesh"

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

By

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By

Dr. **Rajeev Bhatia**

Under the guidance of

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Certificate of Internship Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Dr .Rajeev Bhatia has successfully completed his internship in our organization from February, 2011 to April, 2011. During this intern he has worked on Factors Affecting Acceptance of Non Scalpel Vasectomy Among Males: A Case of Uttar Pradesh under the guidance of me and my team at Engender Health India.

(Signature)

_____ (Name)

_____ (Designation)

Certificate of Approval

The following dissertation titled **"**Factors Affecting Acceptance of Non Scalpel Vasectomy Among Males: A Case of Uttar Pradesh**"** is hereby approved as certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the under signed do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name Signature

_____ _____

_____ _____

_____ _____

Certificate from Dissertation Advisory Committee

This is to certify that Dr Rajeev Bhatia **,** a participant of **Post Graduate Diploma in Health and Hospital Management,** worked under our guidance and supervision. He is submitting this dissertation titled **"**Factors Affecting Acceptance of Non Scalpel Vasectomy Among Males: A Case of Uttar Pradesh**"** in partial fulfillment of the requirements for the award of the **Post Graduate Diploma in Health and Hospital Management.**

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

Dr. SK Patel,
Assistant Professor,
IIHMR, New Delhi,

Dr. Hari Singh ,
Project Director- Respond Project,
Engenderhealth International,

ACKNOWLEDGEMENT

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

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

I am also thankful to Dr Sangram K Patel for his guidance and support during entire tenure.

I am also thankful to Dr Anupama for her guidence and support during entire tenure.

ABSTRACT

INTRODUCTION

The Program of Action adopted by consensus at the 1994 International Conference On Population and Development (ICPD) stresses the importance of reproductive rights and reproductive health for both men and women.Emphasizing the need for equity in gender relations and responsible sexual behavior, the Program of Action notes that males as well as females must have access to appropriate information and services to achieve good sexual health and exercise their reproductive rights and responsibilities.

No scalpel vasectomy (NSV) was developed in China in 1974 and introduced to United States by Dr. Marc Goldstein from Cornell Medical Center, New York, in 1985. The procedure performed under local anesthesia using two specialized instruments designed in China: an extracutaneous vas deferens fixation clamp and dissecting clamp. The primary difference between NSV and conventional incisional technique lies in the delivery of the vas deferens. In a traditional vasectomy, the surgeon makes one or two incisions to gain access to the vas deferens; in the no-scalpel method, a small puncture in size is all that required. The puncture hole is gently stretched to pull the vas deferens. Then the vas deferens is cut and both ends are cauterized and closed with titanium clips or tied. This method results in fewer complications and rarely requires sutures to close the surgical site. Recovery time is usually faster and less painful because the procedure itself is less traumatic. Vasectomy played a dominant role in India's national family planning program, from the program's inception in the 1950s through the mid-1970s. Male sterilization accounted for 65% of the 32.7 million sterilizations performed between 1956 and 1980.

By the late 1970s, however, vasectomy acceptance had begun to decline drastically. This decline has been attributed to laparoscopic female sterilization becoming more widely available and popular, as well as a public backlash against the national program's high-

pressured approach to vasectomy (large camps, cash incentives and reportedly coercive practices).

In much of the developing world individuals and couples do not have access to the full range of contraceptive options that they should have, and long-acting and permanent methods of contraception in particular remain highly underutilized.Long-acting and permanent methods such as intrauterine devices (IUDs), implants, female sterilization (such as tubal ligation), and male sterilization, or vasectomy are by far the most effective (99% or greater) type of modern contraception and are very safe, convenient, and cost-effective in the long-run. They are all clinical methods and must be provided in health facilities by trained doctors, nurses, and/or midwives.

No-Scalpel Vasectomy is one of the most effective contraceptive methods available for males. It is more effective than the oral pill or the injectable contraceptive. It is an improvement on the conventional vasectomy with practically no side effects or complications.

OBJECTIVE

To Study the Factors which are affecting to acceptance of Non Scalpel Vasectomy (NSV) among Males in community of Uttar Pradesh

METHODOLOGY

- Study population was client who have adopted NSV as their first choice of family planning in last five years

- The Total Sample size is 70

- Simple Random Sampling method was adopted for selection of client

Data Collection

Data collection was done through structured questionnaire distributed to clients.
In depth interview of clients.

RESULTS

The study interviewed 70 NSV clients 92% were residing in rural area and eight percent client were residing in urban area. Average age of NSV client was around 34.8 years.

Type of occupation in which the respondents were mainly involved included Agricultural labourer Thirty One percent, Unskilled worker twenty six Percent, Skilled worker Ten percent while Four percent were self employed. By exploring in to motivational factors we can see that sixty percent client were motivated by either ANM, ASHA, LHV while forty five percent client were motivated by AWW and other public sector worker. eighty eight percent client were either satisfied or very satisfied after adopting procedure, five percent client were not satisfied after adopting NSV while five percent client give moderate response

CONCLUSION RECOMMENDATION

- Male participation in FP services and adoption of NSV in specific is to be increased through BCC, availability of services for male while realizing the role of men in decision making in a patriarchal society and addressing to the prevalent myths with male sterilization.
- There should be more involvement of middle socio-economic and higher socio-economic group by mass media campaign To involve upper middle class group efforts should be made more effectively on public plate form i.e. Lok Mahotsav,

fair in city during such occasion counter related to NSV should be made so that community can get proper advice and get some attention regarding NSV.

- Private practitioners should be involve in prompting the programme to involve urban population and people from higher educational background and middle class people as they prefer to visit private practitioner even for minor ailments.
- Registered Medical Practitioners (RMPs) should be involve to rural population and breakdown myths and misconception regarding NSV.

Table of Contents

ABBREVIATIONS

ANM	Auxiliary-nurse-Midwife
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Worker
BDO	Block Development Officer
CHC	Community Health Centre
CMO	Chief Medical Officer
CMOFW	Chief Medical Officer Family Welfare
DM	District Magistrate
LHV	Lady Health Visitors
NSV	Non Scalpel Vasectomy
MO	Medical Officer
MOI/C	Medical Officer In charge
MP	Madhya Pradesh
MPW	Multi Purpose Workers
PHC	Primary Health Centre
PRI	Panchayati Raj Institution
RMP	Registered Medical Practitioners
SN	Staff Nurse
UP	Uttar Pradesh

PART-I

INTENSHIP REPORT

Organization profile:-

EngenderHealth

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

Mission

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

The RESPOND Project Support to

Expanding awareness, acceptance and access to

No-scalpel Vasectomy in Uttar Pradesh,Jharkhand India ,October 2009 — September 2012

Background

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

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

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

Vision

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

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

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

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

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

India

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

Vasectomy is safer, simpler, less expensive and equally as effective as female

sterilization. Yet, in India female sterilization prevalence exceeds vasectomy prevalence by a factor of 37 to 1.[1] From the national family planning program inception in the 1950s through the mid-1970s, vasectomy played a dominant role. Out of 32.7 million sterilizations registered by the Indian government's family planning program between 1956 and 1980, 65% were vasectomies. By the late 1970s, however, vasectomy use had begun to decline drastically, due to laparoscopic female sterilization becoming more widely available and popular and a public backlash to the national program's high pressured approach to vasectomy (large camps, cash incentives and reportedly coercive practices).

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

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

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

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

RESPOND's Strategic Approach

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

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

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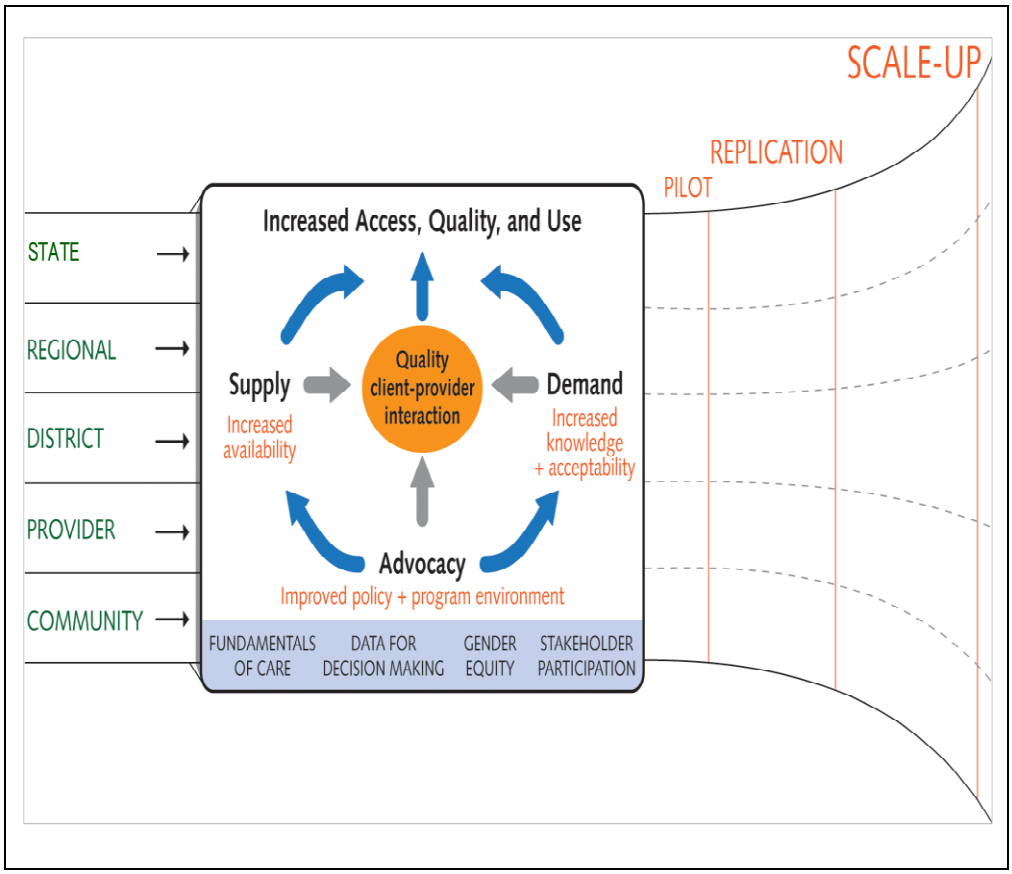
RESPOND Project activities will address one or more of three intermediate results

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

policies based on the best available evidence and maximizing resources to meet needs for NSV services. Together, these components lead to a better-resourced, more productive, supported, and sustainable program.

RESPOND Expanded Supply-Demand-Advocacy Framework



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

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

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

RESPOND recognizes that provider **competence** is only one of the "**Cs**" necessary to ensure the availability of safe, quality NSV services. In addition providers must be **comfortable** providing NSV service. This is achieved by ensuring the readiness of their home facilities to provide services—essential equipment and supplies are stocked, infection prevention protocols practiced, facility staff are oriented to NSV and male-friendly services, and NSV providers receive supportive supervision and on-site coaching. Through continued practice of one's skills competence is maintained. And it is through continued performance/practice that one develops **confidence.** In order for providers to perform NSV procedures, there must be **clients,** which one achieves by engaging communities and
and providing up-to-date, accurate information about NSV. When these "**C**" are in place, the result is **committed** providers working in better-resourced, more productive, supported, and sustainable programs.

Under IFPS-1 and IFPS-2 over 200 doctors were trained in NSV (November 1995-March 2009). Though 77% of the providers trained in NSV under IFPS-I were assessed as performing to standard during a follow-up visit, the current status of many of these providers as well as thought trained under IFPS-2 is unknown. RESPOND will work with the Directorate of

Family Welfare and district CMOs to determine how many of these providers are still in public service, available to provide NSV services and the needs for coaching and updates.

Activities

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

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

The GoUP has noted the need to stimulate private sector involvement. RESPOND will explore opportunities to enhance Public-Private Partnerships in collaboration with national professional organizations such as the Indian Medical Association (IMA), the Federation of Obstetrics and Gynecology Societies of India (FOGSI), the National Association for

Voluntary Sterilization of India (NAVSI), and the NSV Surgeons India (NSV SI). We will investigate opportunities to partner with existing projects/initiatives such as the FHI's Urban Reproductive Health Project (Allahabad) and PSI's Pahel (Kanpur), social franchising networks such as the Merry Gold Network (Allahabad and Kanpur) and the Saathiya Youth Friendly Network (Allahabad), NGO service networks such Parivar Sewa Sansthan (PSS) (Kanpur) and the Family Planning Association of India (FPAI) (Kanpur), and private hospitals and nursing homes (Meerut)

Activities

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

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

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

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

Activities

Cross-cutting

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

Interpersonal Communication

- Analyze existing curricula and other training materials on NSV and FP Counseling to identify the needs for updates or adaptation
- Strengthen counseling modules for use in provider training for MOs, Staff Nurses, ANMs, LHVs and other frontline workers to include clear messages about NSV that counter myths and misconceptions
- Pilot test NSV counseling modules in up to 10 districts [Linked to male-friendly orientations under IR1.1
- Explore tapping into existing hot-lines, e.g. Jansankhya Sthirata Kosh's Call Centre on Reproductive Health, Family Planning and Child Health and the Saathiya Youth Friendly Network

Community Engagement

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

Mass Media

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

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

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

Activities

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

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

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

of the project's 3 intermediate results—increased supply of quality NSV, increase demand for NSV, and improved advocacy and policy in support of NSV.

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

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

Table 1: Illustrative Activities for RESPOND technical assistance **March 2010—September 2012**		
IR1 Increased supply quality NSV	**IR2 Increase demand f NSV**	**IR3 Improved advocacy a policy in support of NSV**
Develop on-going mechani for conducting NSV train follow-up and coaching at t work site by DoFW	Work closely with SIFPSA a the Government of UP develop relationships to work tandem on BCC interventions in the 20 Implementation Plan a provide input into the plan the following year	Work through strate partnerships with policymak and managers at the central and district levels to focus evidence -based advocacy, forecasting a planning using Reality √.
Build capacity for local train	Work in close partnership wit	Increase advocacy on NSV

to assist clinical and non-clinica personnel to shift vasector biases as well as assisti providers in interpersonal communicati (e.g., how to communicate, not j what to say)	Panchayats through their Hea and Welfare Committees incorporate NSV information into th outreach and community mobilizati activities.	sensitizing health profession from the public and private sect using forums like Federation of Obstetric a Gynecology Societies of In (FOGSI) and Indian Medi Association (IMA)
Develop capacity of additio medical colleges to condu NSV training and serve as Centres of Excellenc	Develop locally appropri language spots for airing state wide media as well local level community radio with emphasis on locatic where NSV is readily availab Develop accompanying television spo	Identify champions or potent champions at all system levels a from the community - as well public, private, and NGO sector
Identify, test, impleme evaluate and scale up select holist evidence-based approach models for expanding access to NSV services t private sector	Develop NSV posters for cli use and client materials for u by providers when counseling clients NSV as a method choice	
Explore opportunities strengthening NSV compon of antenatal/delivery/postpartum care programs with t	Use folk media, puppet theat and/or community drama encourage Dialogue about NSV as a s method	

obejctive to test, evaluate a scale up best practices		
	Explore profiling NS champions through testimonials for tho that have undergone NSV or ha supported their partners, clients, etc. create normative chang around acceptance of NSV as a method used others like them	

Monitoring and Evaluation [Results framework with illustrative indicators]

A **strong evaluation component** will document the steps and process for scale-up and institutionalization within the targeted districts. A performance management plan (PMP) will be submitted to the Mission within the first 3 months of the Project. Project reporting will include routine progress reports.

A core component of this proposal is to monitor compliance with USAID policies and regulations. The project will pay a special attention to monitoring implementation of the current State's compensation plan for vasectomy acceptors as well as for providers to ensure compliance with the Tiahrt Amendment. RESPOND will integrate compliance monitoring into the PMP and donor reports. The PMP will include a compliance protocol including a process for staff to conduct routine monitoring visits as an integral part of their field work and job aides to assist them to collect data and address vulnerabilities that they identify.

The focus of the monitoring will not be to simply gather information on implementation and process, but to also provide "behavioral" data. An illustrative example of how monitoring activities may be conceptualized includes the use of call in programs to gage audience knowledge, interest, attitudes, and issues that the target audience is grappling with regarding NSV. Questions may also be incorporated in ongoing omnibus surveys to examine issues of reach and impact. Rapid audience assessments will similarly provide data on immediate impact of the media programs.

RESPOND will work with local supervisors within districts to collect, analyze, and use the data, thus generating local ownership. RESPOND/BGD will continue to refine clinical checklists and to use them to continuously monitor and report on provider performance in project districts.

Implementation and Mobilization Plan

With a Project start date of October 1, 2009, the first quarter of the RESPOND Project will correspond to the first quarter of USAID/Delhi Fiscal Year (FY) cycle. Figure 4 presents key pre-Project and Q1 and Q2 of Project Year (PY) 1 activities to enable the rapid start-up. Interventions/activities in Project Years 2 and 3will be designed in close consultation with USAID and GoUP and will be closely linked to NRHM Action plan and other planning/funding mechanisms**.**

REFLECTIVE LEARNING

A lot of activities were carried out at district which can be broadly classified under three categories.

ADVOCACY

Advocacy was done with district official District magistrate (DM), Chief Medical Officer (CMO), Chief medical Officer Family Welfare (CMOFW), Block Development Officer(BDO) for promotion of No Scalpel Vasectomy (NSV) in district.

Advocacy was done for arrangement of Six Camp for NSV in district which were not started till January 2011 although these are supposed start from September 2010 for the year 2010-11.

Advocacy was done for availability of IEC material at district and camp were arranged.

DEMAND

Demand generation activities through client mobilization. Training of peripheral staff i.e. Accredited Social Health Activists (ASHA), Auxiliary-nurse-Midwife(ANM) at Primary Health Centre(PHC), Community Health centre(CHC) and through ASHA Coaching and community mobilization.

SUPPLY

- Arrange Camp in district.
- Supply through quality of care services to client for NSV through Training of staff who is either directly or indirectly involved in NSV.
- Arrangement of medicine required for NSV and instruments required for NSV at facility.
- Arrangement of provider for camp at the facility.
- Ensure quality of care to the client for NSV at facility through regular advocacy at district level and regular training of staff involved in NSV at facility.

PART-II

DISSERTATION REPORT

1. INTRODUCTION

The Program of Action adopted by consensus at the 1994 International Conference On Population and Development (ICPD) stresses the importance of reproductive rights and reproductive health for both men and women.

Emphasizing the need for equity in gender relations and responsible sexual behavior, the Program of Action notes that males as well as females must have access to appropriate information and services to achieve good sexual health and exercise their reproductive rights and responsibilities. 1

No scalpel vasectomy (NSV) was developed in China in 1974 and introduced to United States by Dr. Marc Goldstein from Cornell Medical Center, New York, in 1985. The procedure performed under local anesthesia using two specialized instruments designed in China: an extracutaneous vas deferens fixation clamp and dissecting clamp. The primary difference between NSV and conventional incisional technique lies in the delivery of the vas deferens. In a traditional vasectomy, the surgeon makes one or two incisions to gain access to the vas deferens; in the no-scalpel method, a small puncture in size is all that required. The puncture hole is gently stretched to pull the vas deferens. Then the vas deferens is cut and both ends are cauterized and closed with titanium clips or tied. This method results in fewer complications and rarely requires sutures to close the surgical site. Recovery time is usually faster and less painful because the procedure itself is less traumatic. 2 .

Vasectomy played a dominant role in India's national family planning program, from the program's inception in the 1950s through the mid-1970s. Male sterilization accounted for 65% of the 32.7 million sterilizations performed between 1956 and 1980. 3

By the late 1970s, however, vasectomy acceptance had begun to decline drastically. This decline has been attributed to laparoscopic female sterilization becoming more widely available and popular, as well as a public backlash against the national program's high-pressured approach to vasectomy (large camps, cash incentives and reportedly coercive practices).

In much of the developing world individuals and couples do not have access to the full range of contraceptive options that they should have, and long-acting and permanent methods of contraception in particular remain highly underutilized.

Long-acting and permanent methods such as intrauterine devices (IUDs), implants, female sterilization (such as tubal ligation), and male sterilization, or vasectomy are by far the most effective (99% or greater) type of modern contraception and are very

safe, convenient, and cost-effective in the long-run. They are all clinical methods and must be provided in health facilities by trained doctors, nurses, and/or midwives.

No-Scalpel Vasectomy is one of the most effective contraceptive methods available for males. It is more effective than the oral pill or the injectable contraceptive. It is an improvement on the conventional vasectomy with practically no side effects or complications.

Sterilization accounts for 79 percent of modern method of contraceptive users. Male sterilization, however, constitutes only two percent of the total method used. The most common reason for the non-involvement of men is misconception about vasectomy. Research shows that there is a wide

spread belief among men and women that vasectomy makes men physically weak, impotent and unable to enjoy sex. 4

Non-scalpel vasectomy (NSV) has been well recognized world wide as an

alternative technique of performing male sterilization. The reasons for its popularity include low complication rate, require minor surgical procedure and quick recovery rather than the conventional vasectomy procedure (Kumar, V., R.M. Kaza et.al.). The failure rates of NSV have been observed to be between 0.2 to 0.4 percent. Studies show a lower complication rate for NSV as compared to conventional vasectomy. The primary benefits of NSV versus conventional (incision or scalpel) vasectomy are less discomfort, ten times fewer complications, no sutures and faster recovery. Depending on the doctor, NSV can usually be done in about 7 to 15 minutes.

Addressing the need for enhancing male participation in the family welfareprogramme, government is committed to improve the facility for the same. Attempts are being made

to increase access to quality family planning services by revamping the availability and provision of NSV services

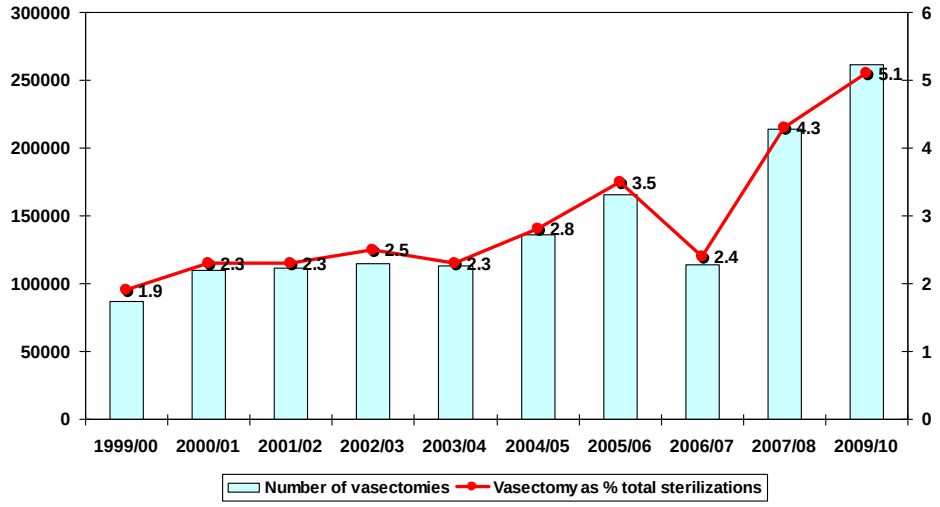
Studies indicated that NSV has a lower incidence of infection and hematoma due to small puncture wound, no suture closure, minimal dissection and tissue trauma. A prospective, randomized study in Thailand comparing the side effects of 2 vasectomy techniques showed that of 523 men, 1.34% became infected and 1.72% developed hematoma or bleeding after traditional incisional procedure. Of 680 men who underwent NSV, 0.15% became infected and 0.3% developed hematoma or bleeding. Overall percentage of complications after NSV 0.4% versus 3.1% for conventional vasectomy. 5

India was the first country in the world that recognized the need for population stabilization in 1951 as an essential prerequisite for sustaining a good quality of life and a National Family Planning Program was launched in 1952. The approach changed from clinic to extension education approach in third fifth year plan and later on it was an integral part of MCH activities but it could not make much impact. Program suffered a setback in 1976 due to element of coercion introduced in the program and its political fallout; the political support was lost

The Population Policy 1977 clearly underscored that “compulsion in the area of family welfare must be ruled out for all times to come,” and emphasized the need for an educational and motivational approach to make acceptance of family planning completely voluntary.

Through the 1980s and 90s vasectomy continued to decline. To reverse this decline, the central government renewed its attention to vasectomy in hopes of revitalizing the method. Over the past decade, the number of procedures performed in the public sector doubled and vasectomy’s contribution to the sterilization mix rose from 1.9 % to 5.1%. [**Figure 1**] In eight states— Delhi, Haryana, Himachal Pradesh, Manipur, Punjab, Sikkim, Tripura, and West Bengal—vasectomy’s contribution to the sterilization mix is greater than 10 percent. In Uttar Pradesh, vasectomy accounts for 2.3% of the sterilization mix.

Figure 1
Vasectomy Trend in India, 1999–2009



In 1996, the government initiated the target-free Community Needs Assessment Approach, which involved formulating plans in consultation with communities

In 2000, the National Population Policy was reformulated to achieve long-term population stabilization by 2045 and replacement level of fertility by 2010. The policy reiterates the commitment to voluntary and informed choice, and to citizens' consent while accessing reproductive health care, including family planning. The immediate objective is to address the unmet need for contraception

A major factor contributing to vasectomy's resurgence has been the program's focus on Non Scalpel Vasectomy (NSV). Commonly known as the 'no suture, no cut' (Bina Tanka-Bina Chira,) operation, NSV is characterized by less pain, fewer complications and quicker return to sexual activity than conventional vasectomy. The increased uptake of vasectomy has also coincided with a revised compensation plan for vasectomy acceptors, as well as providers—80% of the procedures were performed after September 2007 when the new scheme was put in place. 6

Now this is clear that male participation in family planning is very poor. They thought that family planning is the whole sole responsibility of female. Some of the main reasons for this disproportion between male and female participation in family planning are gender sensitive strategies have been neglected and, to a large extent, family planning programs have remained female oriented (7) some reproductive health practitioners have recognized that the failure to target men has weakened the impact of family planning programs, because men can significantly influence their partners' reproductive health decisions and use of health services especially in societies where women do not possess the same decision-making powers as men and Men feel that the sterilization operation is easier to perform on women than on men 8,9.

Vasectomy in Uttar Pradesh

In Uttar Pradesh (UP) 12% of married women of reproductive age—4.1 million couples—have an unmet need for limiting.[4] Vasectomy prevalence is 0.2%, one fourth the national rate of 0.8%. In 8 of UP's 18 divisions, vasectomy accounted for less than 1% of the sterilizations performed in 2008/09

While awareness of vasectomy is high, misinformation about vasectomy is pervasive. In one study in rural U.P., while nine out of 10 men and women reported being aware of vasectomy, less than half of the men and only one-fourth of the women had correct information on the procedure/method.[5] Misconceptions about vasectomy causing weakness, both physically and sexually, and requiring long periods of rest following the procedure are common.

2. REVIEW OF LITERATURE

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

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

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

To popularize the acceptance of NSV among men and to involve them to actively participate in family planning, there is a need for rigorous mass media campaign to highlight the advantages of NSV and the places of its availability. The mass media campaigns should highlight the advantages of NSV viz. (i) how it is a painless operation and (ii) benefits of the post-NSV sexual life of the acceptor 12

Getting men involved in FP, the study recommended the importance, not only of motivation, but that efforts should be made to create a male-friendly service delivery system at the existing service delivery centers (H & FWCs). A series of orientation meetings were held at the various phases of the project, at which all officers and field workers were in attendance. These regular monthly meetings with all of the thanalevel FP workers were an excellent opportunity for in-depth discussions. 13.

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

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

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

3. RATIONALE

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

Though equally easy, non-scalpel vasectomy is not being preferred due to various myths and misconceptions. Fear of loss of libido and strength, method failure, and an attitude that makes birth control as the responsibility of the woman explain in large part the poor acceptance of the method Of the couples opting for a permanent method of contraception, as many as 67.3% chose vasectomy in 1963. This increased to 75% during 1976-1977 but dropped steeply to 21.4% in 1980-81, 6.2% in 1990-91 and 2.3% in 2000-2001.

District Pratapgarh is located in Allahabad division of Eastern Uttar Pradesh and situated on the bank of river Sai and popularly known as Belha-Pratapgarh. Main Occupation of population is agriculture and Pratapgarh is world famous for production of Anwla fruit.

There is declining trend of all family planning methods in Pratapgarh particularly NSV in last five years and Pratapgarh is main focusing district of government for last two years.

Total unmet need of family planning was 37.6 according to DLHS II which increases by 1% and become 38.6% according to DLHS III. Unmet need for limiting the family was 24.6 in DLHS III while in DLHS II it was 19.5.

Percentage of NSV among all method was 0.2% in DLHS III which also declined to 0.1% in DLHS III.

Education level and socio economic status of client play a major role in accepting NSV as a family planning methods .

Client satisfaction after adopting NSV also play an important role because it is found that a satisfy client can motivate to another person for adopting NSV more successfully

than any one and people have believe on that client because that client who have undergone NSV is one among that community itself.

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

4. OBJECTIVE

To Study the Factors which are affecting to acceptance of Non Scalpel Vasectomy (NSV) among Males in community of Uttar Pradesh.:

Specific Objectives

1. To study the background characteristics of NSV acceptors in Pratapgarh district of Uttar Pradesh.
2. To identify barriers for adopting NSV by community.
3. To study the factors related with client satisfaction for NSV services in Pratapgarh district of Uttar Pradesh.
4. To make recommendations for improved acceptance of NSV.

5. METHODOLOGY

The study conducted in district Pratapgarh of Uttarpradesh as in year 2009-10 and 2010-11 pratapgarh was one among high focused district of state government due to declining the trend of NSV.

Study population was client who have adopted NSV as their first choice of family planning in last five years.

Exclusion Criteria

Client who have adopted NSV with in Three months from starting of study are not included under study population.

Sampling- The Total Sample size is 70

Selection of study Population.

Total 280 person adopted NSV in last five years and 3 months prior to starting of study. Out of them 70 persons were chosen by simple Random selection technique. 70 client out of 280 client were chosen on the basis that one fourth of acceptors should be included under study.

Even district is a big district with 16 Blocks in district it was seen that NSV was done only in seven blocks of district.

Fifteen client were selected from each of good performing blocks of district i.e. Sukhpal Nagar and Lalganj.

Eight client were selected from remaining five block each i.e. Amargarh, Patti, Mandhata, Babganj, Kauhandaur.

15 client* 2 Block = 30 client
8 client* 5 Block = 40 client
Total = 70 client

Simple Random Sampling method was adopted for selection of client.

Data Collection

Data collection was done through structured questionnaire distributed to clients.
In depth interview of clients.

6. RESULTS

Table 1: Background characteristics of the NSV Client Pratapgarh District	
Particulars	No. of client
Age (in years)	
25-29	10
30-34	20
35-39	24
40-44	12
45+	4
Mean age in years	36.8 years
Age of wife (in years)	
<=19	3
20-24	12
25-29	20
30-34	22
35-39	7
40-44	4
45+	2
Mean age in years	30.2
Education level	
Illiterate	15
Upto primary	20
Upto higher secondary	25
Upto graduation	8
Above graduation	2
Occupation	
Agricultural labourer	22
Unskilled worker	18
Cultivator	10
Skilled worker	7

Petty trade/shop owner	5
Self employed	3
Others	5

The study interviewed 70 NSV clients 92% were residing in rural area and eight percent client were residing in urban area. Average age of NSV client was around 36.8 years. 32 % client were in 35-39 age group while Five percent client were among 45+ age group. It is good indicator that middle aged client have more percentage who are adopting NSV and 78% of client adopted NSV before completing forty year of age.

Married respondents'wife were approximately five years younger to them, with an average age of around 30 years. 83 % of women were aged below 30 years when their husband chose NSV as family planning method.

With respect to NSV client education level Twenty one percent client were uneducated, thirty six percent of client upto higher secondary education level, Eleven percent client were educated up to graduation and Three percent client were postgraduate. This table indicate that NSV acceptance is more accepted by people who are uneducated or educated up to higher secondary level, and people who are educated up to higher level are less accepting NSV.

Type of occupation in which the respondents were mainly involved included Agricultural labourer Thirty One percent, Unskilled worker twenty six Percent, Skilled worker Ten percent while Four percent were self employed. Majority of acceptor are either agricultural labour or unskilled worker, only Ten Percent acceptor were skilled persons.

These results are quite similar with the study conducted by UNFPA in Madhya Pradesh where average age of client was thirty four year of age and thirty one percent of client were illiterate and Thirty three percent client were from agricultural labourer background and twenty two percent client were unskilled. While findings are contradictory with study conducted by UNFPA in Andhra Pradesh where median age of client was Thirty years of age and Forty Seven percent client were self employed.

HOUSEHOLD CHARACTERSTICS

Table 2 : Household Characterstics of NSV client district Pratapgarh	
Particulars	No. of client
Type of house	
Kachcha	40
Semi-pucca	25
Pucca	5

Exploring into household characteristics of respondent data table indicates that more than half acceptor of NSV of district reside in kachcha house and more than one third client reside in semipucca house only seven percent client reside in pucca house. This table indicate that people from low and low middle socio-economic background are in more proportion who are accepting NSV.

These findings are similar to study conducted by UNFPA in Madhya Pradesh where Sixty five percent client were residing in kachcha house and Twenty seven percent of client were residing in semi-pucca house.

While study conducted in Andhra Pradesh indicate that only 11 % client reside in kachcha house and 65 % in semi-pucca house and 25 % in Pucca house.

FAMILY SIZE OF NSV ACCEPTORS

Table 3 Family Size of NSV Acceptors in district Pratapgarh	
Particulars	No. of client
No. of living children	
1	2
2	17
3	21
4 or more	30
Mean no. of living children	3.7

Exploring into family size of NSV acceptors we can state that average no. of children were 3.7 among NSV acceptor clients. Near about three fourth of acceptor have either three or more than three no. of children in family. As by table 1 we have seen that 78% client have accepted NSV before forty years of age but by that age majority of client having either three or more children early age of marriage which is still in practice in districts of Eastern UP could be one reason behind this.

These findings are similar to study conducted by UNFPA in Madhya Pradesh where Seventy percent of client have either three or more then three children while contradictory with findings of study conducted by UNFPA in Andhra Pradesh where 75% client have Two children.

SORCE OF MOTIVATION FOR ACCEPTING NSV

Table 4 Source of Motivation for accepting NSV in district Pratapgarh

Particular	Percentage
Health workers (Nurse, ANM, LHV, Male nurse supervisor, ASHA)	60
Other public sector worker, AWW	45
Relatives, parents, friends	31.4
Media (Radio, newspaper)	28.5
Other NSV user	21.4
Government doctor	20
Private doctors	4.2
Compounder	2.8
Others	17

By exploring in to motivational factors we can see that sixty percent client were motivated by either ANM, ASHA, LHV while fourty five percent client were motivated by AWW and other public sector worker, twenty eight percent client were motivated by media and twenty percent by Govt. Doctors, private doctors could motivate only four percent of client for adopting NSV. Most of client were motivated by public health professionals, involvement of private sector professionals to be increased.

These findings are quite similar with study conducted by UNFPA in Madhya Pradesh and Andhra Pradesh where main source of motivation was also from public Health Professionals(ANM, LHV, AWW, ASHA).

AVAILABILITY OF SERVICES

Table 5 Place and Type of operative services availed	
Particular	No. of Client
Facility from where NSV operation availed	
Camp	34
PHC/CHC	26
District Hospital	10
Distance of facility from residence	
5-10 min walk from house	3
Within the same village/town	16
Adjoining village/town	38
District head quarter town	10
Others	3

By exploring into availability of services we can see that near about half of client accepted NSV in a camp which was in adjoining village or town. Only fourteen percent client adopted technique in district head quarter. Table explores that Camp is successful

way to conduct NSV probably our health professionals get more focused during camp, while on fixed day basis they are not so much concerned as in camp. Provider are available in camp while on fixed day basis they work on their respective facility and no. of provider are very less in districts so availability of provider could be one determining factor for low acceptance of NSV.

These findings are quite similar with study conducted by UNFPA in Madhya Pradesh and Andhra Pradesh where 45% and 42% client respectively adopted NSV in camp and 18% and 22% client respectively adopted NSV at district head quarter.

PREOPERATIVE SERVICES AVAILED

Table 6 Preoperative services availed NSV Client	
Particular	No. of Client
Underwent following laboratory exam.	
Haemoglobin test (Hb Estimation)	48
Urine analysis for sugar (Urine Alb Examination)	58
Physical examinations conducted by doctor	
Blood pressure	34
Temperature measurement	26
General condition	45
Nutritional status	23
Examination of external genitalia	44

By analyzing table we can see that among NSV acceptors near about seventy percent client have undergone Haemoglobin estimation and eighty three percent have undergone urine sugar examination.

Among all clients sixty three percent client told that doctor examined their penis, testicles and scrotum, and blood pressure was measured in forty nine percent client.

Table indicate that Preoperative services are available for client and these are providing to client at regular basis which is good indicator.

These findings are similar with study conducted by UNFPA in Andhra Pradesh where 86% client have undergone Hb estimation and 76% have undergone Urine Examination.

POSTOPEATIVE CARE

Table 7 Postoperative services availed NSV client	
Particular	No. of Client
Provided some medicines before leaving for home after operation	64
Instructed to wear tight underwear or a loin-cloth to keep scrotum from moving and subsequent possibility of bleeding and haematoma formation	58
Receive the discharge card with particulars of date of surgery and name of the institution	33
Receive written post-operative instructions from the place of operation	8
Receive date and place of follow-up	63
Provided atleast 30 condoms with proper advice	

By analyzing table we can see that more than ninghty percent client got medicine and at least 30 condoms for post operative care while fourty seven percent client got discharged card with them.

Table indicate that postoperative services are also available for clients. Discharge card was provided to 47% client, may be some client forget about card and did not know it's important and some of them forget to collect it from health professionals as in district

Pratapgarh it is in practice that ANM and ASHA keep card with them and give it to client afterwards.

SATISFACTION WITH NSV

Table 8 Satisfaction after adopting NSV	
Particular	Percentage
Degree of satisfaction	
Very satisfied	57.1
Satisfied	31.4
Somewhat satisfied	4.2
Not much satisfied	4.2
Not satisfied	2.8
Reason for satisfaction*	
Successful method	61.4
No side effects	45.7
Family members are happy	14.2
Painless operation	32.8
Takes less time	21.4
Got money	17.1
Did not have to pay extra money	4.2
Others	7.1
Person with whom NSV experience was shared	
Friends	68.5
Relatives	32.8
Spouse	47.1
Neighbour	28.5
Colleagues	4.2

By analyzing table we can state that eighty eight percent client were either satisfied or very satisfied after adopting procedure, five percent client were not satisfied after adopting NSV while five percent client give moderate response.

Sixty one percent client stated they were satisfied after adopting NSV because it is an successful procedure while fourty five percent client said there is no side effect of procedure. Fifteen percent client stated that they were satisfied as their family members are happy with their decision, thirty three percent client agreed that NSV is painless procedure, twenty one percent client were satisfied as NSV take less time while seventeen percent client were satisfied that they got some monetary benefit in return of adopting the procedure.

These findings are similar with findings of study conducted by UNFPA in Madhya Pradesh where 88% client were satisfied while in Andhra Pradesh 98.5% client were satisfied.

Table also indicate that sixty nine percent clients share experiences with their friends, thirty three percent client shared experiences with their relatives, forty seven percent client shared their experiences with their spouse, twenty eight percent client shared experiences with their neighbour while only four percent client shared experiences with their colleagues.

These findings are similar with findings of study conducted by UNFPA in Madhya Pradesh and Andhra Pradesh where client shared their experiences with their friends or relatives and only 2 % and 1% client respectively shared their experiences with colleagues.

7. CONCLUSION

The Indian family welfare program has been over shadowed by sterilization methods, which incidentally also happens to be the most popular contraceptive method used by couples in India. However, contribution of the male sterilization has been negligible. Non acceptability of male sterilization has been due to various myths and misconceptions that continue to prevail in the community. Non scalpel vasectomy (NSV) a male family planning method has been recognized as an alternative to the conventional vasectomy.

Acceptors of NSV are largely from the low socio-economic group. Majority of client were in 35-39 years age group and their wives in 30-34 years age group which is a good indicator that majority of acceptors from median age group and accepting NSV before completing forty year of age. Majority of NSV acceptors are educated up-to higher secondary level and from agricultural or laborer background so there is minimal involvement of people from higher educational qualification and a regular source of household income.

Majority of laborer are residing in kachcha house or semi pucca house which clear indicate that people from low socio-economic background are accepting NSV.

Majority of client were having four or more children with an average 3.7 children per client, but age of client were less then forty years this is probably due to early age of marriahe of client which is still in practice in rural areas of Eastern UP.

Main source of motivation of client were peripheral health workers i.e. ASHA, ANM, AWW. Very few client were motivated by private doctor and compounder, more involvement of private health professionals should be there.

Majority of client accepted NSV in camp mode in peripheral facility very few accepted in district hospital.

While considering Preoperative services almost all the client undergone essential laboratory examination i.e. urine albumine for sugar and haemoglobin estimation while external genitalia examination was done for almost all the clients.

While considering post operative care almost all client got essential medicine and at least 30 condom for use and got well counsel by Doctor or other staff.

More than 90% client were satisfied after adopting NSV while seven percent client were dissatisfied with procedure. Main reason for satisfaction was that it is a successful method and there is no side effect after adopting NSV.

Most of clients shared their experiences with their friends and spouse while very small no. of client share it with their colleague.

Sixty percent of client while probed into in depth interview answered that even they were satisfied with NSV but they were not satisfied with behaviour of staff at health care facility particularly in district head quarter.

Thirty Percent client told that they would not motivate other clients even they are satisfied due to feeling of mockery among relatives and colleagues and some social norm they could not motivate others.

Delay in procedure was also a major contributor of client dissatisfaction in availing services.

Availability of provider also seemed a major cause of low acceptance of NSV.

8. RECOMMENDATION

In view of the above findings, it is imperative that certain corrective measures need to be taken. . These would be essential not only to further strengthen the program within the district but also enhancing it in other districts of the state.

Short Term

- Male participation in FP services and adoption of NSV in specific is to be increased through BCC, availability of services for male while realizing the role of men in decision making in a patriarchal society and addressing to the prevalent myths with male sterilization.
- There should be more involvement of middle socio-economic and higher socio-economic group by mass media campaign To involve upper middle class group efforts should be made more effectively on public plate form i.e. Lok Mahotsav, fair in city during such occasion counter related to NSV should be made so that community can get proper advice and get some attention regarding NSV.
- Private practitioners should be involve in prompting the programme to involve urban population and people from higher educational background and middle class people as they prefer to visit private practitioner even for minor ailments.
- Registered Medical Practitioners (RMPs) should be involve to rural population and breakdown myths and misconception regarding NSV.
- Regular reorientation of the health workers who are directly involved in the provision of services, will be beneficial for the program. Complete and correct knowledge about the service being provided would help them to motivate clients for the use of NSV as well as ensure appropriate follow up service to the acceptors. This would also lead to more satisfaction among the users.
- More number of trained doctors should be available to provide the service Combination of strategies should be used to promote NSV in the community Use of mass media to disseminate information regarding NSV, health worker

consciously talk more about the method in the community as well as involve NSV users to motivate others in the community

- NSV acceptors should be honored at public platforms and designated as NSV champions so that they can get confidence and motivate to other community members also as in study we have seen that NSV client are good motivator source for other community members.

- PRIs should make more responsible in promoting NSV in rural community by promoting activities i.e. Nukkad Natak, helding community meetings. As rural population have believe among PRIs and they could be good mediator for interaction with community.

- As indicated in study that community accept NSV in camp and distance of facility from residence is also a concern of community to overcome this problem we can arrange camp more frequently and in different area so that community can get services more frequently and near by to their residence and community from each block should get equal opportunity to use facility of NSV camp.
- As indicated in study NSV acceptor shared their experiences with friends and relatives but not with their colleagues, while explored in depth interview they shared that discrimination at working place and mockery are reason for that. Health professional can counsel the client that they are superior from other male persons of community because they concern about health of their wife and children so they take a step ahead of their colleague, by proper counseling client get confidence and sense of self respect so that they can share their experiences with their neighbor and colleagues as client motivation is best motivation factor for promoting NSV in community.

Long term

- Ensure availability of the NSV services beyond mega camps through existing facilities. This would necessitate decentralization of services to more health facilities (CHC and PHC) to enhance accessibility of the service. Accordingly health infrastructure needs to be strengthened. Fixed day services in more of district so that client should get services when he require.

- Practical strategies to involve and increase the number of NSV trained doctors in the state has to be addressed. System has to ensure that the available trained doctors are positioned adequately to provide the requisite services.
- Need for advocacy among the private providers. Partnering with them will provide an opportunity to reach out to large section of the community. As in study it is clearly indicated that facility was quite far from residence of client and only in camp mode. Fixed day approach at major facilities could be a good alternative with a adequate numbers of providers.
- Ensure that quality of service is retained in promotion of NSV method as an alternate family planning method. But perceiving that mere introduction of this scheme would have an impact on level of fertility and stabilization of population will be a fallacy, unless the type of NSV acceptors currently being enrolled are critically looked into and streamlined.
- The study demonstrates that while there is a need and scope to capitalize on the new family planning technology, it is equally imperative to strengthen the system This should go hand in hand with creating an enabling environment within the community.

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10. ANNEXURE :

QUESTINNAIRE

This is ensured that this questionnaire for research purpose and information collected will be used for research purpose only. All the data is confidential and will not be shard with any one else who is not involved in study.

Name	
Age at the time of accepting NSV	
Age of wife at the time of accepting NSV	
Education level	Illiterate Upto primary Upto higher secondary Upto graduation Above graduation
Occupation of head of family	Agricultural labourer Unskilled worker Cultivator Skilled worker Petty trade/shop owner Self employed Others
Type of House	Kachcha Semi pucca Pucca
No. of children	1 2 3 4 or more

Source of motivation for accepting NSV	Health workers (Nurse, ANM, LHV, Male nurse supervisor, ASHA) Other public sector worker, AWW Relatives, parents, friends Media (Radio, newspaper) Other NSV user Government doctor Private doctors Compounder Others	
Facility from where NSV accepted	Camp PHC/CHC District Hospital	
Distance of facility from residence	5-10 min walk from house Within the same village/town Adjoining village/town District head quarter town Others	
Pre operative examination which was performed in facility	Laboratory Examination	Hb estimation
		Urine analysis
	Physycal examination	Blood Pressure
		Temperature
		General condition
		Nutrition status
		External genitalia
Post operative care taken in facility	Provided some medicines before leaving for home after operation Instructed to wear tight underwear or a loin-cloth to keep scrotum from	

	moving and subsequent possibility of bleeding and haematoma formation Receive the discharge card with particulars of date of surgery and name of the institution Receive written post-operative instructions from the place of operation Receive date and place of follow-up Provided atleast 30 condoms with proper advice	
Are you satisfied after adopting NSV	No	Not at all
		Not very much
	YES	Very satisfied
		Satisfied
		Some what satisfied
Reason for satisfaction	Successful method No side effects Family members are happy Painless operation	

	Takes less time Got money Did not have to pay extra money Others
Persons with whom you shared your experiences of NSV	Friends Relatives Spouse Neighbour Colleagues