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- Schemenner, R.W., Huber, J.C. and Cook, R.L. (1987), "Geographic Differences and the Location of New Manufacturing Facilities," Journal of Urban Economics, Vol. 21, No. 1, pp. 83-104.

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ORIENTATIONS: A CAPACITY BUILDING TOOL FOR IMPROVING KNOWLEDGE AND PERCEPTION OF HEALTH WORKERS REGARDING NON SCALPEL VASECTOMY

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ABSTRACT

India was the first country in the world that started family planning program after recognizing the seriousness and ill effects of population growth. Despite of this India failed to control the population explosion. Community health workers are the backbone of any program and solely responsible for programs success and failure. If they have proper knowledge and clarity of concepts they can easily mobilize the community. So the aim of the study is to assess the current knowledge of community health workers regarding non scalpel vasectomy and effect of orientation in improving their knowledge. The study was conducted in tribal district of Jharkhand, India. And pre and posttest non experimental study design was used to assess the knowledge and improvement in knowledge of community health worker. Purposive sampling technique was used for the selection of participants. Before the orientation majority of the health worker have misconception about the ejaculation, losing strength etc. which significantly improved (p – 0.05) after the orientation. So it was suggested that for success of any public health program there community level health worker should have complete and proper knowledge and their capacity can be built by giving them such small on site trainings.

KEYWORDS
capacity building, family planning, health worker, NSV, orientation.

INTRODUCTION

Family planning enables couples and individuals to plan desired number of children and the timing and spacing of their births. It can be achieved through use of family planning methods [1]. The vision of WHO/RHR is the attainment of the highest possible level of sexual and reproductive health by all people. It strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved or marginalized, have access to sexual and reproductive health information and services [2].

India was the first country in the world that recognized the need of population stabilization for development and sustainability for a good quality of life in 1951 and launched National Family Planning Programme in 1952. In third five year plan, the approach changed from clinic to extension education approach and later on it became an integral part of Maternal and Child Health activities but it failed to make much impact. Program suffered a setback in 1976 due to element of coercion introduced in the program and its political fallout; the political support was lost [3].

The Population Policy 1977 clearly underscored that "compulsion in the area of family welfare must be ruled out for all times to come," and emphasized the need for an educational and motivational approach to make it a completely voluntary acceptance of family planning. As a result of that in 1996, the Government of India initiated the target-free Community Needs Assessment Approach, which involved formulating plans in consultation with communities [4].

In 2000, the National Population Policy was reformulated to achieve long-term population stabilization by 2045 and replacement level of fertility by 2010. The policy ingeminates the commitment to voluntary, informed choice and to citizens' consent while accessing reproductive health care, including contraception. The immediate objective was to address the unmet need for contraception [5].

Despite of these efforts from the government, acceptance of family planning methods is very low. According to Population Stabilization Fund report only 54 per cent are using any of the family planning methods out of which male participation is only 7 per cent (male sterilization - 1 percent and condom use - 6 percent). Rest of the methods are female oriented i.e. 34 per cent female sterilization, 4 per cent oral contraceptive pills and 2 per cent IUD. Remaining 7 per cent uses any traditional method of contraception for limiting their family size [6]. According to DLHS – III, female sterilization is one of the most accepted contraceptive methods with 74 per cent among currently married women whereas male participation is only 2 percent [7]

According to the latest National Family Health Survey (NFHS-3), two out of three (66 percent) married Indian women aged 15–49 years who practice family planning method still use female sterilization. In rural areas, this proportion is even higher, with 70 per cent of contraceptive users relying on female sterilization. Overall, 37 per cent of all married Indian women of reproductive age are sterilized [8].

RATIONALE

In India, gender inequalities favor men and reproductive - sexual health decisions are usually made by them as a result of which male participation in family planning is very poor. According to Ringhieum et al and Raju S et al stated in their studies that Indian men have a mentality that family planning is the responsibility of females of the family. Some of the main reasons for this disproportion between male and female participation in family planning are gender sensitive strategies and, to a larger extent, family planning programs are female oriented [9,10], men feel that the sterilization operation is easier to perform on women than on men [11].

The main reasons cited by men who said their wives would adopt female sterilization were that "only women undergo sterilization and not men" "Male sterilization is very unpopular". Due to inadequate information, people talk of various side effects of the method like "Men become weak, men cannot do any heavy work, limbs become weak and painful, and men get cold and fever" [11,12].

Some reproductive health practitioners have recognized that the failure to target men has weakened the impact of family planning programs, because men can easily 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 [13]. Therefore, there is a growing realization that unless men are reached, the Reproductive and Child Health Program, including family welfare efforts, will have limited impact [14].

Despite the introduction of "no-scalpel" vasectomy and campaigns to promote male involvement in family planning and reproductive health, the acceptance of vasectomy remained negligible- 2 per cent of currently married couples nationally [6]. A major effort has been made to train trainers for this procedure in the medical colleges at the district level.

Although "No-Scalpel" vasectomy is in fact a safer and less invasive procedure than tubal sterilization, NSV is poorly accepted due to fear of loss of libido, strength, failure of the method and an attitude that makes birth control as a responsibility of the woman at large because of the limited knowledge and awareness about the simplicity and safety of the procedure.

Knowledge of contraception, as usually measured in national surveys, is unlikely to reflect a familiarity with and understanding of contraceptives adequate to lead to use. Of equal importance as awareness of contraceptive methods is knowledge of where these methods can be obtained, what are the main side effects are and how to use the selected method correctly [15].

Evidence from a number of small-scale studies in various parts of the country indicates that inadequate knowledge of contraceptive methods is a reason for not accepting family planning [16]. Incomplete or erroneous information on where to obtain methods and how to use them is strongly associated with unmet need [17]. Findings from the 2005–2006 National Family Health Survey show that mass media were men's primary source of family planning information. Television and radio may be major sources of information, as they are very popular among the rural population; however, mass media messages tend to be rather generic, and viewers are unable to ask questions and have their doubts clarified. Even though few men receive information from health workers [18] one to one communication is effective only when the community health workers have complete and right knowledge about the NSV. Community based small scale orientation and trainings of health workers will be useful in enhancing their knowledge about non scalpel vasectomy and indeed male participation in family planning. So this study aimed to assess the knowledge and perception of community health workers regarding non-scalpel vasectomy and to assess the effect of orientation on their knowledge and perception. So that in long run, it will increase the male participation in family planning.

RESEARCH METHODOLOGY

Study Design: Pre-test-Post-test non experimental study design

Study area: This study was conducted in Simdega district of Jharkhand, India

Population: Community based workers i.e. SAHIYA who were the substitutes of accredited social health activists (ASHA) in Jharkhand. So the target population for the study was the community based health workers of Simdega district.

Sampling Technique and Sample Size: Purposive sampling technique was used to select the two best performing and two least performing blocks out of total seven blocks in the district on the basis of previous performance in non-scalpel vasectomy.

After selection of blocks, simple random sampling technique was used to choose two groups of 25 community based health workers from each block i.e. 50 from each block. In total 200 participants were chosen from selected four blocks

Orientation: Four sessions were held in the primary health centers where NSV orientation was given to the participants by the medical officer of the facility and basic points like eligibility criteria, procedure, precaution, myths and perceptions related to NSV were discussed. Role play was the part of orientation in which one health worker played role of community health worker and five other played role of head of the family and family member. After the role play points of misconceptions where the health workers faced problem in explaining the facts about NSV and male participation were discussed.

Data Collection Technique: As the study was based on Pre & Post-test non experimental study design, data was collected before and after the orientation on NSV, with the help of self-administered questionnaire.

Data Analysis: Data analysis was done with the help of SPSS - 16.

RESULTS

A total of 200 community health workers in 8 groups from four blocks of Simdega district of Jharkhand were recruited in the study. Average age of the study group was 29.53 years. Qualification of the study group was divided into five group i.e. primary, middle, secondary, higher secondary and graduate and distribution of health workers according to their educational qualification was shown in table – 1

TABLE – 1: QUALIFICATION OF PARTICIPANTS

Qualification	Frequency
Up to Primary	4 (2%)
Primary to Middle	34 (17%)
Middle to Secondary	117 (58.5%)
Secondary to Higher secondary	38 (19%)
Higher secondary to graduate	7 (3.5%)
Total	200

Average score obtained by the community health workers before the orientation was 6.23 out of 10 and the same score improved to 8.90 after receiving an orientation on non-scalpel vasectomy. There was statistically significant improvement in the knowledge of community health worker from high performing blocks (P value – 0.007) as well as least performing blocks (P value – 0.002) after receiving orientation. But before and after the orientation there was no significant difference in the knowledge of health workers in best and least performing blocks (table – 2). Question wise performance of the community health workers from both groups in pre & post orientation test is given in table 3. Initially 61.5% of health workers had misconceptions that after NSV one will face problem of ejaculation, 70.5% were unaware of the fact that minimum time period of contraception use is three months after NSV procedure is done, also 77%

had misconception that one has to rest for long after non scalpel vasectomy and 45.5% thought that this is not a stitch free technique for sterilization and after orientation these figures reduced to 31.5%, 16.5%, 21.5% and 4.5% respectively. Overall performance of the health workers improved in comparison to previous score.

TABLE – 2: PRE AND POST TEST SCORE OF THE BEST AND LEAST PERFORMING BLOCKS

Questions on Knowledge and Perception	Pre - Test Responses			Post - Test Responses		
	Best Performing	Least Performing	Total	Best Performing	Least Performing	Total
Eligibility criterion	74	82	156	96	91	187
No. of stitches	56	53	109	96	95	191
Duration of operation	84	78	162	97	95	192
Reasons for painless procedure	88	83	171	92	91	183
Use of other contraception	32	27	59	81	86	167
One can return to home	86	62	148	97	98	195
Change in strength	86	78	164	97	96	193
Effect on ejaculation	38	39	77	72	65	137
Effect on sexual performance	78	76	154	90	88	178
Resume to normal work	23	23	46	80	77	157
Total score	**645**	**601**	**1246**	**898**	**882**	**1780**
Percentage	**6.45**	**6.01**	**6.23**	**8.98**	**8.82**	**8.9**

DISCUSSION AND RECOMMENDATION

It is clear from the study that after the orientation there was an improvement in the knowledge and clarity of perception about NSV in the community based health worker. There is 43 per cent increase in the knowledge regarding NSV after orientation. And the community based health workers were more or less aware of the NSV procedure i.e. who is eligible for the NSV, what is the procedure, how many stitches are applied in the operation, why it is painless etc. The main issues which came into picture are post-operative care and misconception about ejaculation, erection, weakness, sexual performance and the minimum days of rest after NSV. From the earlier studies it was found, men feel that sterilization operation is easier to perform on women than on men [9] in current study also health workers believed that NSV need stitches and require longer duration to resume to normal work.

Another factor according to men is that NSV affect the labor intense work [11] while from the study it was found that 97 per cent community based workers agree on the point that physical strength doesn't change after the operation as well as one can resume to normal work only after two days of NSV by 23 per cent SAHIYAs before the orientation and by 79 per cent SAHIYAs after the orientation. Evidence from a number of small-scale studies in various parts of the country indicates that inadequate knowledge of contraceptive methods is a reason for not accepting family planning [16] and from the current study it was found that community based health workers did not have the correct and full knowledge about the NSV procedure that is the reason why males are not accepting NSV because their myths and misconceptions are not addressed by the community based health workers.

Mass media messages tend to be rather generic, and viewers are unable to ask questions and have their doubts clarified [18, 19], community based health workers are the only source of information for the tribal population living in the tribal areas of Simdega where mass media is not accessible. So it becomes necessary that SAHIYA have complete and right knowledge of the procedure/services.

It is clear from the analysis that most them were lacking in the knowledge about ejaculation after non scalpel vasectomy, duration of post-operative contraception use, use of stitches and the time required to resume to normal work. And these are the basic issues which create hindrance in motivating the client for the NSV because one will not agree for the NSV if he has doubt about the ejaculation, application of stitches and time required to resume to normal work. Apart from these, duration of post-operative contraception use also plays an important role in NSV acceptance in community. If client did not know that it is necessary for him to use other contraceptive methods for three months to avoid unwanted pregnancy, in that case his wife conceives then there is a bad impression about the technique and the acceptance for the NSV decreases drastically.

After the orientation it was noticed that knowledge of community based health workers has improved which enables them to communicate the right information and remove the wrong perception from the community regarding NSV.

So it is very important that community based health workers who have direct contact with the community should have right and complete knowledge about NSV. So that, they are able to resolve the myths and misconceptions of community regarding NSV and can increase in the acceptance for NSV and male involvement in family planning which is the prime need of the time.

LIMITATIONS

Study was carried out with a small group of health workers in only one district so we cannot generalize the status of the knowledge and their perception to the whole population. Secondly, due to time constraint improvement in the knowledge was assessed only on the bases of pre and post-test score, impact of the orientation was not assessed by increased male participation in family planning programs after the intervention.

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