

NSV Evaluation Report

For

RCH/ NRHM, Rajasthan

By



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(An ISO 9001: 2008 Certified Institution)



Executive Summary

Under RCH Program, Government of India has stressed upon programs to promote male involvement in different activities of RCH including male sterilization technique of Non Scalpel Vasectomy (NSV).

NSV has been a neglected method of permanent contraception since long. In the year 2000, NSV was started in Rajasthan, but for 2-3 years very few couples adopted NSV as a method of choice. After 2003, with extensive media publicity couples have started adopting NSV as a method of contraception.

A concurrent evaluation of NSV program was carried out by SIHFW in the second quarter of 2008 to assess the strengths and weaknesses of the program. The scope of the study covered:

1. Assessment of impact of promotional services for NSV;
2. Exploring the reasons for non participation of male in sterilization;
3. Getting feel of the perception of personnel associated with NSV;
4. Assessment of the knowledge, attitude and practice prevailing in the community for NSV.

The study was carried out in 14 districts of Rajasthan (two districts per zone). The selection of districts was done on the basis of state average regarding NSV and accordingly districts were categorized as high performance and low performance districts. The district which had more than state average (3%) during the year 2007 - 2008 was selected as high coverage district whereas district less than state average was selected as low coverage districts.

High Coverage Districts: Bhiwara, Alwar, Churu, Jodhpur, Kota and Rajsamand.

Low Coverage Districts: Nagaur, Dausa, Ganganagar, Jalore, Jhalawar, Dungarpur and Karauli

From each district, two blocks were selected. Next two PHCs were selected from each block on basis of distance (one nearest and one farthest). Keeping the same criterion, two SCs from each PHC were selected for the study. All the villages in these SCs were covered.

To assess the impact from high coverage district, 10 beneficiaries (who had undergone NSV) and 5 non-beneficiaries from each SC were interviewed. Similarly, from low coverage district 5



beneficiaries and 5 non beneficiaries each SC was contacted. Total 818 beneficiaries and 549 non beneficiaries were interrogated through structured questionnaire.

Observations:

A Medical Officers stays at PHC for around three years. Out of total 54 MO interviewed only 13 % Medical Officers had undergone training regarding NSV. It is worthwhile to mention here that the person who was the in-charge of the activity was not trained regarding NSV. In majority of cases, alternate arrangements like posting of trained workers from other PHC were made.

In 73.5 % cases amount given to the beneficiaries was Rs 1100. However in 12.3% the prescribed norms were defied.

There was an increase in NSV adoption as compared to previous years. It was observed in 70.4% cases, where Medical Officers reported that there was an increase in NSV adoption as compared to previous years. The factor behind increase in NSV adoption was reported to be availability of good surgeon and wide publicity of the program.

The myth related to impotence was reported mainly from Dausa, Alwar and Dholpur districts. 39.7 % of the motivator accepted that there was a problem in motivation due to myths. They further added that due to myths, extra efforts were made to motivate a person for NSV adoption.

In 69.4% cases respondents were told to go for semen test after three months of NSV and till then condom was advised. Semen test was done in 73.4% respondents.

54.8% of them were ready to adopt within a year followed by within two years. It indicates that around 78.5 % of the respondents were ready to adopt with in 2 years.

Out of total 73 motivators, majority of them were educated till the primary level. Undergraduate motivators performed well as compare to motivators educated above this level. It shows that personal interest, dedication and involvement in any program has created more difference result rather than education qualification. Personal relationship, trust and commitment for follow up are the key issues for motivating the person.



Motivators were mainly insisted by doctors for the motivation. Self motivation contributed 35.6% only. LHV and other health staff contributed 12.3 % only and that reflects on the concern of staff for NSV. No private doctor has contributed in motivation of people to work for promotion of NSV.

In 19.2 % motivators who motivated for adoption of NSV had undergone NSV themselves. In all cases the place of motivation was government centre irrespective of the districts surveyed. Role of private sector in this field is negligible.

There was a provision for financial incentive for motivation to the extent of Rs. 200 peoples for NSV adoption. 84.9 % of motivators had received motivation incentive for their work.

It appears that the economic status of family plays an important role in the acceptance of a terminal method. Families of poor income group are more reluctant to accept the family planning method specially the NSV rather than higher income group families. Highest numbers of acceptors are from middle income group.

96.5% of the beneficiaries who visited nearby sub centre were advised about the family planning methods. In majority of cases, NSV adoption was advised to the beneficiary respondents followed by Nirodh during their visit to centre.

Majority of the NSVs were done at the CHC level, 21% in camps while PHC contributed 19.3% only.

In 44.5% cases, NSV was conducted by the team of doctors from district hospital. Medical Officer of CHC conducted 32.3 % NSV followed by the team of doctors from CHC.

About 50% respondents received information regarding NSV from health staff posted at health centres. Anganwadi workers were also played an important role in motivating respondents for NSV. Friend and relatives also contributed.



In 70.3% cases, respondents were told about the positive and negative aspects of the NSV. The positive aspects told to respondents includes, a person can work after NSV, no cut on body and no side effects on body.

It was reported by the respondents that in 66.6% cases, follow up was done after NSV. Follow up were not done in majority of cases in Alwar district. Follow up cards were prepared of 63.6% respondents.

12.8 % of the total respondents experienced problem after NSV operation and of these a large number did not receive any services for the problem. Only 36.2 % respondents reported that they have received services immediately. 2.4 % of the respondents reported that they had to pay for services rendered to them after NSV. They were mainly from Kota, Alwar and Rajsamand districts.

In 69.4 % cases respondents were advised to go for semen test after three months of NSV and use the condoms till then. In Majority of cases of Ganganagar, Kota, Dungarpur, Jhalawar and Rajsamand respondents were not told to go for semen test.

Out of total 568 respondent contacted those who had not adopted NSV stated that they need more children in 38.6 % cases followed by fear and health problem. Religious taboos dictated 13.3 % of the total respondents.

Condom (70.7%) was the main choice of the respondents who did not adopt NSV in all the districts surveyed. The main source of information was the ANM followed by LHV and Medical Officers.

The respondents were enquired about whether they were ready to adopt NSV in future. About 32.2 % of the respondents told that they were ready to adopt NSV in future. Majority (78.5%) of them were ready to adopt within 2 years.



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Assessment of NSV: 2008

Based on the findings recommendations were made which included- rigorous BCC, availability of services through functional centres in each CHC, PROVIDER bias towards males needs to be addressed, training to each MO posted at PHC, NSV acceptors can be used as counselors for the purpose, follow-up services after operation, increasing motivation money and like.