

Evaluation of Sterilisation Bed Reservation Scheme in Maharashtra

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Section-I

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Introduction

As per the information provided by the government authorities, 'A scheme for reservation of sterilisation beds in hospitals run by Government, Local bodies and Voluntary Organisations was introduced as early as in the year 1964 in order to provide immediate facilities for tubectomy operations in hospitals where such cases could not be admitted due to lack of availability of beds. The scheme envisages greater involvement of local bodies and NGO'.

'At present (31.4.2000) the Government of India is supporting 3217 sterilisation beds throughout the country. Table 1.1 gives the list for all states. As per the list, 84% of these beds are with the NGO's, 14% with local bodies and 2% only with the state governments. It is observed that Maharashtra has maximum i.e. 799 beds reserved. Out of these, no beds are sanctioned for the government hospitals and there is equal distribution between the local bodies and the voluntary organisations'. 'In order to expand the tubectomy facilities and involvement of NGOs, the Government of India has made a provision of sanctioning 200 such beds each year during the ninth plan period'.

The Sterilisation bed scheme

'Under this scheme, the Government of India gives a performance based maintenance grant for sterilization beds to various organisations and local bodies. The details are as under:-

'The maintenance grant under 'Sterilisation Bed Scheme' would be admissible at the rate of Rs. 4500 per bed per annum subject to the minimum achievement of 60 tubectomies per bed per annum by local bodies/voluntary organisations'.

'If the local bodies/voluntary organisations fail to achieve the target of 60 tubectomies per bed per annum, as stated above, but the performance level is 45 tubectomies per bed per annum, the maintenance charges at the rate of Rs. 3000 would be admissible. If the performance level of the Institutions of voluntary organisation/Local Bodies is below the target level of 45 tubectomies per bed per annum, proportionate grant at the

norm of 45 tubectomies per bed per anum and at the rate Rs. 3000 per anum would be admissible. These norms have been effective from 1.4.95.

Eligibility for Sanction

A voluntary organisation registered under the society act, 1960 and having a fully equipped operation theatre, medical and paramedical staff and well qualified medical officers with post graduate qualification is eligible for reservation for sterilisation beds. The eligibility for reservation of beds is decided on the basis of the performance of tubectomy operations done during last two years in a routine course. The Institution willing to implement the scheme is required to submit the application on the prescribed format to the state government concerned. The concerned state government will process the proposal and forward the same to the Ministry of Health & Family Welfare, Government of India for according administrative approval.

Objectives

The objectives of the present study are:

1. To know whether the number of sterilisation beds sanctioned to the organisation under sterilisation bed scheme are physically present.
2. To know the present status of availability of medical personnel, equipments and facilities with the institution required for doing sterilisations.
3. To know the quarterly distribution of sterilisation performed by the institution during the years, 1999-2000 and 2000-2001.
4. To know the demographic characteristics of the acceptors and their eligibility status.
5. To verify the authenticity of the sterilisations performed.
6. To know the bottlenecks of the scheme, suggestions for its greater acceptance and improvement of the functioning of the scheme.
7. To know the ratio of beds reserved under the scheme to total beds available.

As per the suggestions given by the MOHFW, the methodology was as follows,

'Every effort should be made to cover all the institutions. However, if the no. of institutions in a big state are more than 20, the smaller institutions having 5 or less beds may be left out'.

Since evaluation has to be done for 2 years, authenticity of the sterilisations(tubectomy) performed by the institutions may be tested for ten percent of the total acceptors of 1999-2000 and 2000-2001. However, for the institutions having larger number of beds, the total number of acceptors to be covered may be decided by the surveying agency itself in such a manner that the sample so decided is sufficient to achieve the desired objectives'.

Methodology adopted in the Present study

The data for Maharashtra reveal that there are 80 hospitals of NGOs and 69 hospitals local bodies, which are implementing this scheme. Further the total acceptors for 2000-2001 are near about 53000. Thus, it is obvious that it is not possible to cover all the institutions and it is also not possible to cover 10 percent of the acceptors, which would then turn out to be 4500. Hence, it was not possible to follow the methodology suggested by the Government authorities.

We decided to cover two per cent of the acceptors(i.e. about 900 acceptors, considering institutions having more than 5 beds reserved). As suggested in the guidelines, the institution with less than 5 acceptors were excluded. This resulted into 48 hospitals of the NGOs and 48 hospitals of local bodies with about 18000 and 27000 acceptors. It was decided that 20 hospitals of NGOs and 14 hospitals of local bodies would be selected and from each of them 18 and 38 acceptors would be selected. For selecting the hospitals of NGOs and hospitals of local bodies, a pps method of sampling was used. Table 1.2 and Table 1.3 give the entire list of institutions and the list of selected institutions respectively.

The list of the 80 NGOs and 69 corporation hospitals, where this scheme is under implementation is clearly indicative of the regional imbalances. Only 19 hospitals of NGOs and 5 corporation hospitals come from the regions of Vidarbha and Marathwada. The urban population of these two regions taken together forms 26.4 percent of the total urban population of Maharashtra as per the 2001 census. For 26.4 percent of population only 23.75 percent of the NGOs and 7.24 percent of the local bodies are given the benefit of this scheme. Regional imbalances in development can arise out of a number of factors, some of which cannot be tackled by the government and hence no solutions. However, when a scheme launched by the government is being implemented, how come, these two areas remain deprived of it? One could

understand the situation as far as the NGOs are concerned. If these areas do not have adequate number of NGOs, it might be difficult to have the scheme implemented in these areas through the NGOs. But what about the local bodies/corporations? They are there in every small town/city. How is it that the authorities in-charge of this scheme did notice this during last 38 years? As per the guidelines, the Local bodies/NGOs have to apply for getting this scheme. The authorities may make this as an excuse. But the crux of the matter lies in the fact that this scheme has not been supervised properly. The authorities say that the concerned participants do not show any initiative; they do not attend the annual meetings etc; while our investigational team found that many people working in the field of health did not know about the scheme. Lack of proper dissemination, inadequate initiative and no interest on the part of the authorities have led to this regional imbalance. It has been well documented that Marathwada and some of the districts in Vidarbha are lagging behind in achieving fertility decline. Thus, these are the areas needing strengthening of the programme. But as far as this scheme is concerned, there seems to be total negligence on the part of the government in terms of achieving a balance in the distribution of the facilities. We do not mean to say that only the supply variables are important in determining the fertility decline; but it also should be borne in mind that every small effort should be made to strengthen the programme, wherever necessary. Districts from Western Maharashtra, most of which are developed both socially and economically and hence the atmosphere is conducive for generating adequate demand for family planning services. Therefore, the normal infrastructure for providing family planning services could be enough to fulfil the demand. But we find, to the contrary at the region has many other Non-governmental institutions, which also participate in the programme. In such circumstances, whenever any scheme on the part of the government, is being launched, it has to be seen that all regions are equally benefited. To sum up, we would like to recommend that even now the NGOs and local bodies in Marathwada and Vidarbha could be urged to apply and get the benefit of the scheme.

Section II

Information about the Institutions included in the sample

As mentioned in the 'Introduction', 20 NGOs and 13 local bodies were selected. However 2 NGOs were found to be closed. Thus the sample reduced to hospitals under 18 NGOs and 13 local bodies. This points to the lack of supervision of the state authorities. We had selected the sample on the basis of the list given by the state office. Thus, there was no mention of closure of these institutions. A questionnaire was addressed to 31 institutions which had implemented the bed-reservation scheme. The questionnaire contains questions, mainly on the following topics.

- i. the schemes (along with BRS) being implemented by the organisations.
- ii. the population coverage
- iii. the performance
- iv. physical facilities
- v. facilities regarding staff and equipments
- vi. efforts of motivation and follow up
- vii. availability of the operation facilities
- viii. average waiting time for sterilisation
- ix. average distance needed to be traveled by the acceptor
- x. screening procedure
- xi. record-keeping and checking
- xii. maintenance grant and associated details
- xiii. opinion about the schemes beneficiary nature and
- xiv. suggestions for improvement

This information could be grouped into (i) Facilities, (ii) Coverage, (iii) Quality of care, (iv) Performance, (v) Problems in implementing the scheme and (vi) Opinion about the scheme and suggestions for improvement. In the forthcoming paragraphs, we analyze the data with respect to the topics mentioned above. Table 2 A,B & C give the information.

Facilities

This would cover schemes implemented by the organisation, physical facilities (water, electricity, operation theater, etc.), beds available, staff and equipment, frequency of availability of services. Table 2.A gives the relevant data

Schemes

The hospitals could have 4 schemes such as the Post-partum centre, Urban Family Welfare Clinic, Health Posts, and the Bed reservation scheme for the implementation of the family planning programme. Naturally, if there are more schemes the funding is more, beds and other facilities are more and hence the performance could be more. It is noticed that out of the 18 NGOs, 5 NGOs have only the Bed Reservation Scheme (BRS) while there are 6 NGOs with more than or equal to 3 facilities. Among the local bodies, there is none with only BRS, while there are 8 local bodies with more than or equal to 3 facilities. In short, the local bodies have an added advantage of having more schemes.

Physical Facilities

As far as physical facilities are concerned, all NGOs and local bodies have no problem regarding operation theatre, water and electricity. There are difficulties in terms of the availability of vehicles. Ten NGOs do not have a vehicle, while only 4 local bodies don't have it.

Bed- Strength

Availability of beds, under the scheme, and in the entire of hospitals is an important factor linked with the performance. From Table 2.A it can be seen that the total bed-strength of the NGOs is either very small (i.e. < 20) or more than 100. On the other hand, the bed-strength of the local body hospitals is evenly spread. The average bed-strength of NGOs is 140, while it is only 94 for the local body hospitals. Of course, if we exclude one NGO hospital with 700 beds, being an abnormal observation, the average comes down to 100.

Regarding the beds available for sterilisation it is observed that the NGO hospitals on an average have 9 beds available, while the Municipal (local body) hospitals have it at 10, indicating no difference. As far as beds under the BRS are concerned, they are on an average 9 for both the institutions. Thus, one could say that on paper, at least, the beds available for sterilisation does not differ between the

institutions. However, there could be benefits of an overall large bed-strength. There was difference in the figures for beds reserved as per the records and actual survey. The number of beds actually reserved is less than that sanctioned under the scheme.

Staff

Although in absence of the norm regarding staff, one may not be in a position to talk exactly about the adequacy of the staff, some general comments could be made. Table does not give the figures. It is observed that many of the NGOs and local bodies have to run the programme with one/ two doctors, 2-4 nurses, 1 O. T. attendant, one laboratory technician and anaesthetist (many a times shared). Once again, we would like to mention that if the parent institution had adequate facilities, the staff problems may not arise. Here, it would be better if we could examine the staff availability against the work-load. If we assume 50,000 as the population covered, it includes 8500 eligible couples. If we assume unmet need of 10%, 850 couples need to be protected. Assuming 6 days of hospitalisation, 8 beds and 365 work-days, 486 couples can be provided the services. Although the capacity does not cover the entire catchment area, one could say that it is within the capacity of one doctor with the necessary paramedical staff. However, if the bed-strength is more, more medical and paramedical staff are necessary.

Equipments

Regarding the availability of Laproscope, Tubal rings, sterilisation equipments and emergency drugs, the institutions are well-equipped. Only 6 institutions did not have the tubal rings.

Frequency of availability of the services

Among the 18 NGO-hospitals, 12 are giving the services daily, while among 13 local body-hospitals 10 are giving the services daily.

Thus, as far as the facilities are concerned, the NGO hospitals could occasionally suffer due to absence of other schemes for support and shortage of beds in some cases.

Coverage

Under this broad item, the population coverage, the no. of couples opting for sterilisation and spacing methods, and average distance needed to be travelled by the

acceptor would be included. Unfortunately, authorities of a numbers of institutions could not give information on some of these parameters. Whatever information is available, it leads us to conclude that the NGOs cover a population of about 40-50, thousand, while the local bodies cover somewhat more, i.e. about 60,000. Since a very few institutions could give the data about the eligible couples in the catchment area, it is better not to talk about such coverage and its differentials. The average distance required to be travelled by an acceptor also gives the idea of geographical coverage. It was observed that the NGO- hospitals catered to an area within a distance of 11 km from the hospitals, while this distance for the corporation hospitals was 15 kms. The average for the corporation hospitals turns out to be higher mainly on account of the hospitals in Mumbai, which have wider coverage. Under the 'quality of care' factors such as motivation and follow up, average waiting time for getting sterilised, screening procedure, consent-taking, aseptic precaution, sterilisation certificate and record keeping and checking would be included.

Follow up and Motivation

As far as the follow up and motivation is considered, it is generally observed that the staff of the hospital do not pay follow up visits, the patients are asked to visit the hospital after fixed intervals of time after the operation. In most of the cases are self-motivated; at some places we find a mention of motivation by the hospital staff. Wherever PPCs are there, the staff could motivate the couples/women at the time of ANC/delivery. Alternatively, wherever health-posts are existing, the ANMS in charge of the health-posts could motivate the couples. Since the information was not given in exact terms in many cases, data are not given in the table. But one could definitely say that majority of the cases are self-motivated, indicating that it is mainly a demand-driven programme.

Time-gap for actual sterilisation

The time- lag between acceptance and actual sterilisation is one more important indicator of not only the quality of care but also closely related to the principle of reservation of the beds for sterilisation. Wherever this basic requirement is observed, strictly the time lag should be minimum. Alternatively, wherever the parent institution has ample bed facilities, there is higher possibility of reserving the beds and hence the time lag is minimum. If there is no problem regarding the

availability of beds, time lag could at the most be one day. But the information about the same reveals that there seven institutions which have reported 2-4 days as the time lag. This time period is not that big to worry about. However, one would like to know more about the probable reasons for such a lag. If we identify the institutions, which have reported such a lag, we may get to know about the reasons. Interestingly, they are mainly (except one) the corporation hospitals and half of them are from Mumbai. As far as the availability of beds concerned, two of the Mumbai-based hospitals have a big bed-strength but still they report a lag of 2-3 days. Further, their bed- occupancy rate also is much less than 100, indicating enough space. On the other hand, there are two other hospitals (Jalna Mission hospital and Matru Seva Sangh, Nagpur) which also report a lag of 2-3 days but then it could be explained on the ground of their high bed occupancy rate. Does this mean that the corporation hospitals, in general, are not bothered about the consequences of a time-lag? Or are their clients fixed to such an extent that the time-lag will not affect the performance? Another explanation could be in terms of huge demands for beds for purposes other than sterilisation/family planning. If such demands are really huge, the beds reserved for sterilisation also might not be getting reserved in real sense of term. This could be true to a certain extent for the Mumbai-based Municipal hospitals, as the network of Municipal hospitals is widespread in Mumbai in comparison with the other government hospitals. Further, there is a huge populace in Mumbai, which can not afford hospitalisation charges of the private hospitals. Whatever, the reasons, the fact remains that there is some time lag between acceptance of and actual sterilisation.

Screening procedures etc.

Screening procedures, requirement of consent forms, aseptic precaution, proper information prior to operation.....are all qualitative aspects of the implementation of the scheme. It appears from the information given by the persons in-charge that they are following proper procedures. However, in case of issuing the certificates, not all the Institutions are issuing the certificate on their own. Sixteen institutions are giving them only on demand and only seven institutions are giving on the day of discharge. In short, it means that the acceptor is not keen of having the certificate and the institutions are responding accordingly. Fortunately, at the moment, one may not come across a situation where he/she will have to produce an evidence

regarding sterilisation but if in future 'having got sterilised' is linked with matter such as contesting for elections, getting a promotion..... etc. not having a certificate may create a problem. It is better that all the Institutions issue certificate, whether the couples demand it or not.

Records are maintained by all the Institutions. But here, we would like to recommend that they should have a uniform pattern for the registers. Registers of some Institutions did not have information on method of sterilisation, age and sex of youngest child... etc. because of this, comparison of the characteristics of acceptors can not be done fully. As far as checking of the registers is concerned, only in two cases it is reported that it is not checked and in 3-4 cases it is checked by the DHO. Further, some of the institutions have reported that it was checked two years ago. One report says that it was checked after ten years and so on. In short, there appear lapses in checking the registers. It is not only revealed by the responding Institutions, but the fact that two Institutions out of 34 selected Institutions had been closed down and the state office at Pune did not know about it makes it clear that they have not checked the registers in recent years. An improvement is definitely needed in this matter. A regular interaction of the authorities with the institutions will definitely help the Institute improve its performance.

Section III gives the detailed analysis of performance of the Institutions and hence no comments are made here.

Problems in implementing the scheme

The availability of the grant in time is an important factor behind proper implementation of the scheme. Fourteen out of 31 institutions have reported that the maintenance grant does not get released in time. Out of these, 7 are from local bodies and 7 from NGOs. It means that the local bodies are having more problem in relative terms. The period elapsed between the sanction and the release of the grant ranges from 6 months to 4-5 years. This is a serious matter. If the institutions do not get the grants in time, they will find it difficult to maintain the performance. Bu surprisingly the authorities at the central office were complaining that the institutions are not very keen to collect their grants. If you believe in what the authorities and the Institutions say, the only conclusion we can draw is that neither of them is keenly interested in this scheme particularly.

Adequacy of funds

Another important concern is regarding adequacy of funds under the scheme. As per the scheme, the government pays rupees 4500 per bed if the criteria of 60 tubectomies per bed are performed. Thus it is Rs. 75 per case that the hospital gets. If the hospital has another sources of funding, this amount would be an additional source of funding, but if the hospitals does not have other source, this amount is definitely inadequate. As the table shows as many as fifteen NGO hospitals have reported that the funds are inadequate while only 6 corporation hospitals have reported that the funds are inadequate. The difference between these two kinds of organisations is due to the differences in their funding structure. Leaving apart the difference, even at overall level, the funding is reported to be inadequate by two-third of institutions. The amounts are definitely inadequate, if assessed in isolation. But if the parent institution has other good resources at hand, the reservation schemes gets implemented in a better way. In this case, one has to make a distinction between the NGOs and local bodies/corporations. The local bodies have to provide services at highly subsidised rate and for providing the services they get grants from the government. On the other hand NGOs have to create funds on their own. They provide services and earn from them. This scheme is one, from which they can not get any earning but they have to spend on it. In this connection it is worth noting that many of them complain that if they used these beds for other purposes, they would earn much more and hence they find these funds inadequate. The genuine reason for inadequacy of funds reported by the corporation or NGOs also could be in terms of real inadequacy in terms of the expense to be incurred. Under the compensation under the family planning programme, it is understood, the government gives Rs. 185 per acceptor, out of which generally Rs. 85 go to acceptor, doctor and nurse and Rs. 100 go to the institution for the medicines/ other purpose, including the room space. Under the bed reservation scheme, the hospital gets Rs. 75 per acceptor thus resulting into 260 per acceptor, out of which Rs. 175 go to the institution. This amount may be inadequate for the NGOs if compared with the revenue that could be generated if the beds are used for other purposes, but as far as the corporation hospitals are concerned, it is not a very small amount, because even by the revised government rates the hospital gets Rs. 160 for an operation or Rs. 260 for third or later delivery. In short, the NGOs' complaint is in right place and if the amounts are not raised, they may find it difficult to implement

the scheme. However, it should be noted here that some NGOs charge (heavily) the patient for sterilisation

About the beneficiary nature of the scheme and intention to continue the scheme

As the table indicates, 24 institutions have stated that the scheme is beneficial and 23 institutions have stated that they intend to continue with it. Only 2/3 institutions do not appear to be happy with it. The main reason for positive response is reported as 'To support the national family planning programme'. It is surprising to have a positive response in the intentions and a serious complaint regarding the inadequacy of funds. One institution does not seem to be in favour of continuing the scheme. It is the corporation hospital Borivali. In their opinion, the funds are inadequate, there is a staff shortage and also have difficulties of transport. In fact the inadequacy of funds has been reported by many institutions but in spite of it they intend to continue with the scheme. Thus we could conclude that all the institutions under study intend to continue with the scheme but at the same time complain about the shortage of funds.

Suggestions for improvement

The person-in-charge of the programme have given number of suggestions of the improvement. Appendix 2 gives them. One common suggestion, naturally is regarding increasing the maintenance grant. Another suggestion is regarding the timeliness of the release of grants. Some of them complaint of the rigidity of targets, while some of them advocate for linking the targets with the facilities. Some have suggested periodical training of the medical offices/nursing staff, while others complain that because of the necessity of the HIV tests the funds fall short. One suggestion is in the form of increase in the facilities, taking into account the increase in the demand in future. There is also one suggestion about publicity about the scheme.

Section III

Sterilisation Performance

The performance of the institutions under the Bed Reservation Scheme can be checked in a number of ways. First could be the quantitative assessment through the bed occupancy rate and secondly through the qualitative aspects of the performance, namely the age of the acceptor and the number of living children at sterilisation. Table 3 provides the information on these three. The Bed occupancy Rate (BOR) is calculated as the percentage ratio of number of patient days divided by the product of the available bed-strength and 365. Symbolically,

$$\text{BOR} = \frac{\text{No. of patient - days}}{\text{Bed - strength} * 365} \times 100$$

For instance the Tarachand Hospital's performance is 287 and it has 5 beds reserved for sterilisation. Therefore, the BOR for Tarachand hospital is $\frac{287 \times 6}{5 \times 365} = 94.4\%$

(The performance is multiplied by 6 to convert the number of patients into patient-days)

An adjustment is needed in calculating the BOR in case the sterilisations are laproscopic sterilisations and not tubectomies. In this case the performance need not be multiplied by 6, since the laproscopic sterilisation needs at the most, one day of hospitalisation. Sometimes the tubectomy cases also are kept in the hospital only for 3 days. In fact, rather than the adjustment in the calculations, the fact that the hospitals are performing laproscopies and claiming the compensation as tubectomies is worth noting.

Along with this adjustment, there is one problem of interpretation. It was observed that the sterilisation performance of the entire hospital is shown under the bed reservation scheme and hence the BOR does not necessarily reflect the performance under the bed reservation scheme. Thus, one does not know whether it would be appropriate to calculate the BOR on the basis of the beds under reservation scheme. At the most, it could be taken as a partial indicator of availability of beds for sterilisation. Bearing this limitation in mind, let us examine the BORs for the selected institutions with the bed reservation scheme. It seems to be varying very widely. For instance, the BOR for Wai hospital is just 8 percent while that for the Jawahar

medical association 156.3 percent. Leaving the abnormal cases at both the ends, the range reduces to 30% - 156%. If we calculate sterilisations per bed, it is higher for the corporation hospital (53%) against (40%) for NGOs. The reasons may lie in the fact that the corporation hospitals have their regular funding for the sterilisation programme (PPC, Health post, UFWC, ...etc.) and the bed reservation scheme is one of them while for at least some of the NGOs, funding could be a problem. Total availability of beds could be another factor. Further the demand from the concerned areas also could affect the performance. In this context, if one examine the BORs of institutions with respect to their location and availability of beds, one may get explanations for the differentials. Among the corporation hospitals, those from Mumbai have a large share in the performance (about 48%), while that among the NGOs is 35 percent. The share of beds reserved for the NGO hospitals and corporation hospitals in Mumbai are 37 and 40 percent respectively. It means that the corporation hospitals in Mumbai are doing better than those of the NGOs. On the other hand the NGOs in town/cities other than Mumbai are doing better. Could it be due to multiplicity of facilities in Mumbai as against lack of them in other clinics/towns? The better performance of the corporation hospitals might be due to their better accessibility leading to generation of the demand.

As far as the total number of beds available is concerned, it is found that the average bed-strength for NGOs is 158, while that for corporation hospitals is 78 only. Interestingly, among the NGOs, non-Mumbai NGOs have higher bed strength, while Mumbai based NGOs (except Wadia hospital at Parel with 305 beds) have the total beds available ranging from 8-20. On the other hand the corporation hospitals in Mumbai have larger bed-strength (ranging from 30 to 350). The non-Mumbai NGOs have an average bed-strength of 220, while that for the corporations is 40 only.

The differentials in the bed-strength are wider than those in performance, meaning thereby that the total bed-strength may not be very closely related to the performance. An attempt was made to examine this relationship graphically. Graph 1 shows the relationship between the total bed-strength and the absolute performance (number of sterilisation). The '●' sign represents the NGOs, while the '▲' sign represents the corporation hospitals. Jawahar Medical Association has 700 beds, which is an abnormally big size and hence we have treated it as an outlier and have

not considered it for the graph. There are two observations, which can be made immediately. One is that the scatter for NGOs is the wide-spread scatter in comparison with that for corporation hospitals and another is that the graph seems to be clearly divided into two parts. One for the hospital with less than 100 beds and another for hospitals with more than 100 beds. The fact that there is a wide variation in the bed-strength for NGO hospitals partly explains the wide-spread scatters of performance values. Further most of the corporation hospitals (except two in Mumbai) having bed-strength less than 80, alongwith some NGOs with similar bed strength form a compact scatter, while those NGOs/corporation hospitals having bed-strength more than 100 form another scatter. Both the scatters, interestingly, depict an upward moving linear shape, indicating that as the bed-strength of the hospital increases the performance increases.

A general explanation for the rising trends could be given thus; as the total bed-strength increases, more facilities including more beds are available for the programme and hence the performance increases. However, this simple explanation may not get justified for hospitals having a small bed-strength but having a higher performance or conversely for hospitals showing lower performance inspite of higher bed-strength. Here there are examples such as Kutumb Niyojan Kendra at Thane, Matru Seva Sangha at Nagpur and Young Muslim Association at Amarawati, which are performing well inspite of the smaller bed-strength. On the other hand there are hospitals such as Mission hospital at Wai or N. M. Wadia at Pune. It could be noticed that the first group of hospitals (with higher performances)are institutions working in a single field of family planning and are established organisations and hence are performing well. On the other hand there are reasons for failure inspite of adequate bed-strength. In case of Wai hospital, there were some internal problems and in case of Wadia hospital, it was reported that the areas allotted to them were far off areas and hence the hospital could not attract the patients. On the whole, it appears that the NGOs look at the scheme just as one source of funding and hence the performance would result as an impact of funds from other sources. For the corporation hospitals, the question of the funding sources does not arise and hence their performance will be mainly determined by the by the demand and the quality of services.

Some broad criteria could be framed for allotting the scheme to hospitals. If it

is a corporation or local body hospital, the decision should depend upon the existing demand because the performance is demand-driven. Among the NGOs, if it is an NGO totally devoted to family planning, it will perform better even with a small bed-strength. Otherwise, the linear trend suggests that an all-purpose NGO hospital with a larger bed-strength will perform in a better way. In the forthcoming paragraphs we propose to assess the qualitative aspect of the performance. As stated earlier, the age of woman and the parity at sterilisation could be used as the indicators of the quality of performance. Percentage of woman getting sterilised before age 25 and percentage of woman getting sterilised at 1 or 2 issues are the indicators used.

The percentage of women getting sterilised before age 25 ranges from 3% in Borivali hospital to 43% in Baramati hospital. Among the NGOs the range is 5 to 43%, while the same for the corporation hospitals it is 3 to 36 %. The variation in the percentage of women getting sterilised with one or two children is not that wide. It varies among the NGOs from 23 (excluding the case of young muslim association at Amarawati) in Solapur to 69 in a hospital at Parel, Mumbai. The range for the corporation hospitals is 27 in Solapur to 66 in Kolhapur. The differences in variation in these indicators can be reasonably explained. The age at sterilisation varies on account of factors such as age at marriage and pace of family building, while the while the parity at sterilisation indicates only the desired family size, which is what we expect as a qualitative aspect of the performance. Hence this indicator is treated as the one to assess the quality of the performance. The proportion is 54% for the NGOs and 46% for the corporation hospitals. In view of the goal of having this at 60%, the performance is not bad. As per NFHS-II, this proportion for urban Maharashtra is 50%. It is clearly observed that on the whole, the NGOs are doing a better job in terms of having a higher percentage of women getting sterilised at one or two children. Again among them, particularly among corporation hospitals, the corporation hospitals in Mumbai are better than the other corporation hospitals, while this difference among the NGOs is less significant. This phenomenon also is an effect of the demand forces. Generally, the clientele of the corporation hospitals will be from the lower socio-economic stratas and hence their norms regarding family size will be higher. However, the better performance of the Mumbai corporation hospitals can be explained by the better awareness among even the lower strata in Mumbai. (According to NFHS-II, the TFR for the slum-dwellers in Mumbai was 2.69 as

against 2.74 for the rural Maharashtra). The NGO hospitals' clientele may not necessarily come from the lower strata and hence not much difference between the qualitative dimension of the performance of the Mumbai based NGOs and the other NGOs . one could go further and examine how size-norm varies between women of different ages coming from different areas. It is observed that wherever, this proportion is low, indicating that the two-child norm is not accepted to all women.

To sum up, there is large amount of variation in the performance of the Institutions. An NGO hospital with larger bed-strength and a corporation hospital with adequate demand perform better. The NGO hospitals are better in qualitative aspect of the performance.

The quarter-wise distribution of performance does not show any specific pattern, which could be linked with the fulfillment of target.

Section IV

Findings of Acceptor Survey

As mentioned in the introductory pages, it was decided to select 18 acceptors per NGO hospital and 38 acceptors per corporation hospital for the survey. (The objectives behind this survey were to know the authentically eligibility status and demographic characteristics of the acceptors). With the above-given norms the expected sample size would be 892 acceptors. However, out of the 33 (34 units) selected institutions, 2 Institutions (NGOs) were found closed at the time of the survey. Thus, the actual sample size became 18 NGOs and 13 (14 units) corporation hospitals leading to 856 acceptors. However, the acceptor survey done in the institutions outside Mumbai led us to take a decision that there was no point in doing survey in Mumbai. The main reason, naturally was the difficulty in tracing the households.

The problem obviously is more serious in clinics. The addresses are incomplete to such an extent that sometimes the field workers had to spend full day in contacting only 2-3 women. Sometimes a number as large as of 72 acceptors had to be contacted for getting 18 acceptors. Appendix-I gives the relevant data. This also would have been done in Mumbai, if the information which is available from the survey is that important. But as seen from the acceptor's questionnaire, it is mainly the characteristics of the acceptors that are revealed by the survey. The survey from non-Mumbai area showed that the performance is authentic. The information of acceptors characteristics is useful for judging the type of people, who are the beneficiaries of the concerned hospitals. This information, to an extent, could be availed from the R3 registers maintained by the hospitals. Thus, looking at the difficulties of tracing the households (given the incomplete addresses) in Mumbai and the relative importance of that information, we decided to exclude Mumbai from the acceptor survey. Therefore, we now have 13 NGO hospitals and 8 (9 units) corporation hospitals from Non-Mumbai regions, thus with 234 and 342 acceptors for the survey. Because of difficulties in contacting, the number of acceptors from NGOs falls short by 5, leading to 229 acceptors. For Mumbai, the information, whatever was available from the R3 registers is analysed. Two panels of Table 4 give the same. Let us first examine the characteristics of the women from Non-Mumbai areas.

Age at sterilisation

Age at sterilisation is a good indicator of the qualitative aspect of the sterilisation programme. The younger the age, better is the quality of the performance. It is observed that around 40-50 per cent of the women are getting sterilised before the age of 25 years. The NFHS-II findings for the entire state tally well with those of the urban acceptor survey (the present survey). It means that either there is not much difference between the age-pattern of the acceptors of rural and urban areas or the urban hospitals under the study might be catering to a population which has characteristics similar to the characteristics acceptors of the entire state. We could broadly say that the hospitals under study are catering mainly to socio-economically lower stratum of the society.

Number of children at sterilisation

Number of children is a more important and clearer indicator of the stage of family building at which the sterilisation is done. It also demonstrates the family size norm. Here, the rural-urban difference is clearly demonstrated. The NFHS-II data show that in Maharashtra, only 26 per cent of the women are getting sterilised at less than or equal to two children, while the data from our urban survey show that about 40 per cent get sterilised at less than or equal to two children. This is indicative of the fact that the quality of the performance of the concerned hospitals is definitely good.

Education of the acceptor

Education of the acceptor is an indicator of the social status of the clientele of the hospitals under study. It is observed that about 25-30 per cent of the acceptors are illiterate, while the NFHS figures for the entire state is higher. However the urban literacy for women is of the same order and hence one could definitely say that the clientele of the hospitals is not very selective, educationally.

Occupation of the acceptor and the acceptor's husband

As the work participation rate of women in urban Maharashtra is within the range of 10-15 percent, it is not unexpected that the percentage of housewives among the acceptors is as high as 88-90 percent. In such circumstances, occupation of the husband can be used to assess the economic status of the clientele. For NGO hospitals, 30 percent of acceptors have their husbands engaged in manual labour, while this percentage for corporation hospitals is much higher, i. e. 45 percent. This again is not

unexpected. Generally, the acceptors going to the corporation hospitals are expected to be coming from lower strata, in comparison to those going to NGO hospitals.

Age and sex of the youngest child

These two variables indicate the timing of sterilisation and the presence of preference of a particular sex. The average age of youngest child was observed to be 19 and 16 months respectively for the NGO and corporation hospitals. About 40 percent of the acceptors seem to have got sterilised immediately after delivery. It is interesting to find that in nearly about 60 percent of the cases, in both types of hospitals, the youngest child is a boy. If desired family size was the only criterion for getting sterilised, this percentage should have been equal to or close to 50 percent. But the present finding clearly indicates that the couples had waited for a son before they got sterilised. Interestingly, this phenomenon is not different for the two kinds of hospitals, clearly indicating the universality of 'son preference'.

Characteristics of acceptors from Mumbai

The second panel gives the data on characteristics of acceptors from the hospitals selected from Mumbai. As stated previously, these indicators are based on the R3 registers maintained by the hospitals and not on the basis of the survey. Some of the registers are not complete. Hence the indicators are based on whatever information is available. They are Age, Number of living children, Number of male children and Number of female children, Age & sex of the youngest child and education of the acceptor and her husband. It is observed that 55-60 percent of the sterilised are with less than or equal to two children. One of the requirements of the current family planning programme is that 60 percent of the sterilisations should be of the couples with less than or equal to two children. It appears that the acceptors from the selected Mumbai-based hospitals are observing this norm. The difference between the two groups of hospitals is not significant. Even that little gap vanishes when we compare the percentage of women getting sterilised with two sons/two daughters. The son-preference is clearly getting reflected. The same also is reflected in the figure on sex of the youngest child. Interestingly, the proportion of women getting sterilised with the last child being a boy for Mumbai-based NGOs is higher than that for NGOs from other areas. The figures for the levels of illiteracy of acceptors from the two types of hospitals clearly indicate the difference in the type of

demand for the two kind of hospitals. The clientele of the corporation hospital come from a lower stratum of the society. The third panel gives some information about the quality of the services for non-Mumbai hospitals. It is expected that whenever sterilisation programme is carried out properly, there should be a proper follow-up, complications should be nil, in case there is a complication, compensation should be paid, medicines should be given free of charge, the payments should be as per the norm, the acceptors should stay in the hospital for 6-7 days and the sterilisation certificate should be immediately given. It is sad to note that in case of only 17 and 23 percent of the cases, follow-up services were given, there were a small number (4-5 %) of cases with complication, but almost none were given a compensation. Medicines were given free to only 21 percent of the cases in case of NGO hospitals and to 43 percent of the cases in case of corporation hospitals. This finding is very surprising as the compensation amount of Rs. 185 includes some amount for medicines also. Both NGOs and corporation must be receiving them, then how is it that, particularly, the clients of the NGOs (majority of them) are not getting medicines free of charge? The corporation hospitals have a better performance in this case. Is the difference due to the accepted norm that in the government-run hospitals or hospitals of local bodies, almost everything is done free of charge, while if the NGOs charge, the acceptors may not object and hence they can charge? Whatever the reasons, it is not fair on the part of mainly the NGOs/corporation to charge for medicines.

It is a pleasure to note that the compensation amounts are paid as per norms. As far as the duration of stay is concerned, about 12% of the cases under NGOs have stayed for less than 6 days, while this percentage is only 6 for the corporation hospitals. It is difficult to understand, why only 39 percent of the clients of the corporation hospitals and 55 percent of those under the NGO hospitals have got the sterilisation certificate. The authorities of some NGOs/corporation have reported that they give the certificate only on demand. Those who got the certificate, majority of them got it in one/two days.

As mentioned in the beginning remarks of this section, there were two purposes behind conducting the acceptor survey. One was to know about the characteristics of the acceptors and another was to know the authenticity and eligibility

status. One more purpose could be added; namely, to check the information recorded in the R3 registers. Our acceptor survey indicated that there were no ineligible cases and all cases were authentic. We also checked the information recorded in the R3 registers with the information collected in the survey. This exercise was done only for 5 NGOs and 5 corporation hospitals. It was observed that the difference between the information in register and the information from survey arises mainly in case of age and to a small extent in case of number of living children. Table 5 gives the same. It could be observed from the table that error in age reporting is of 2-4 years. It is further observed that error is more in case of corporation hospitals. As far as the quantitative aspect of the performance is concerned, this error is not important but if we look at the age to assess the qualitative aspect, this error may mislead the reader. Hence it is essential that the age is properly recorded.

To sum up, the data on characteristics of the acceptor suggest that generally, the clientele of the corporation hospitals come from a lower socio-economic stratum, the quality of performance as judged through number of children at sterilisation is of a higher level, as expected it is better for the acceptors in Mumbai and the condition regarding follow-up and medicines are not desirable.

Section V

Conclusions and Recommendations

Whenever any scheme is to be evaluated, it needs to be assessed, whether it is relevant today, whether it was planned properly, whether it is functioning properly, and lastly whether it is beneficial. We hereby intend to present our findings in view of the above mentioned criteria.

Whether Relevant Today

As stated in the introductory write-up, the scheme was initiated in 1964 with an objective that the family planning performance could be raised if the institutions are offered an incentive amount against reservation of beds for sterilisation. The Institutions which adopt this scheme are expected to motivate the eligible couples in their area, thus leading to fulfil the goal of 60 acceptors per bed to get an amount of Rs. 4500. In 1964, when the idea of birth-control had not been accepted by large populace, such a scheme had relevance. But after nearly 40 years, with significant changes in the levels of awareness and huge inputs from the programme authorities, at least in most of the big towns/cities in Maharashtra, there is very little need to motivate people to use family planning methods. The concerned authorities at the Institutions, many of them, do not seem to be making any efforts to motivate. In such circumstances, the grants under the scheme are just looked at as another source of funding for the hospital and no special efforts are made to raise the performance. In this sense, the scheme may not be called as relevant from the point of view of raising performance through motivation by providing incentives.

Whether planned properly

As mentioned earlier, the list of institutions with the scheme shows that more than 90 per cent of the institutions are in the Western Maharashtra. In fact many of the towns in Vidarbha and Marathwada do not have adequate private/ government health facilities and hence if such schemes, which add to the resources, are given to the local bodies, the performance may significantly increase. The lack of proper planning is clearly reflected in the allotment of funds. We recommend that at least the hospitals run by Municipal councils corporation hospitals in Marathwada and Vidarbha have to be informed about the scheme and it needs to be seen that they get

the benefit of such a scheme. The relevance of the scheme will be felt more there. In fact a close check and supervision should lead the authorities to identify the non-performing NGOs / small NGOs which have not been able to perform, the scheme should be withdrawn from there and should be launched wherever the need is more. There should have been a provision for a periodical revision of the incentive amount. The current rates have been prevailing since 1990. Almost all the Institutions have complained about the inadequacy of funds.

The scheme should have been planned with more initiative from the government. According to the current provision under the scheme, an application has to be sent by the Institution. We would suggest that the state government should take initiative in calling the applications from the needy areas.

It was found that during the field-work, particularly in Mumbai, that some of the NGOs charge the patients for sterilisation, whereas, the corporation hospitals, by rule, cannot charge. In such circumstances, the planners of the scheme should have been more strict about the allotment of the scheme.

Further, there should have been a provision of sending the grants to various corporation hospitals in a city individually. Sometimes there are delays in getting the grants from the central office.

Whether Functioning Properly

This assessment can be done in different ways. First is through the performance and second through the quality of care maintained. As far as the performance figures are concerned, they are for the total performance of the hospital, which could have facilities for family planning services, other than the bed reservation scheme. Thus, the performance will only indirectly indicate the contribution of the scheme. One way of assessment would be to assess the contribution of all Institutions (taken together) having this scheme towards the total sterilisation performance of the state. It is observed that in Maharashtra, the number of sterilisations annually performed during the recent period was 5.7 lakhs, out of which 1.8 lakh sterilisation have been in urban areas. Estimated number of sterilisations for 2001 would be approximately 2 lakhs. 45000 sterilisations (i.e. about 23 percent) have been carried out by the Institutions with the scheme (with more than 5 beds). Thus, one may say that if there are improvements in the scheme, it

might help significantly in increasing the hospital performance and thereby the state performance.

There are wide variations in the performance. Wai hospital has the bed occupancy rate of 8 percent, while Jawahar Medical Association at Dhule has it at 156 percent. These variations point towards the probable variation in the demand and the efficiency of the hospital, particularly that of the family planning services including the bed reservation scheme. The efficiency of provision of services would depend upon both, the physical infrastructure and staff availability and the financial conditions. Total beds representing the size of the hospital generally should broadly represent the availability of facilities. It is observed that hospitals such as Wadia hospital, Pune and Wai Mission hospital, inspite of their big size, are having a very low performance, showing the functional inefficiency.

As far as the availability of funds is concerned, the institutions have complained about both the routine maintenance grant and that under the bed reservation scheme. Rather than the adequacy of funds, it is the lack of timeliness in the release of the grants, that is more troublesome. The reservation of a bed for sterilisation is the main issue underlying the scheme. Whether the beds are reserved really, can only be assessed by examining the time lag between acceptance and actual sterilisation. The data indicate that the time-lag is actually of 1-2 days only. However, principally, even this lag also should be avoided in order to follow the spirit behind the scheme.

Another important thing that has been noticed is that the performance is mainly demand driven. Generally, it is found that a corporation hospital with adequate demand and an NGO hospital with ample bed-strength are good performers. Rarely special efforts are taken for motivation and hence on account of functional lapses demand is not generated, which leads to limitations in increasing the performance.

Lack of efforts also is reflected in the quality of care. Follow up services are provided to very few acceptors. Similar is the case with provision of medicines free of charge. Improvement in these matters is necessary if the scheme is to be successful.

Total neglect in supervision has led to number of problems. Records have not

been checked since last two years. This situation is being exploited by some hospitals in Mumbai. Many of them are carrying out laproscopies and probably claiming for tubectomies. For instance, if 360 laproscopies are carried out, it needs only 360 patient days, while 360 tubectomies need 360×6 , i.e. 2160 patient days. The former institution needs only one bed for 360 sterilisations, while the latter needs 6 beds. In such circumstances, both the institutions will get the same incentive amount i.e. 4500×6 , while the inputs incurred by the latter institutions are six fold.

A close supervision could have avoided such lapses. Incidentally, we would like to recommend in this case, that if laproscopy is popularised and trained doctors are made available, resources could be better utilised by propogating laproscopies.

Whether it is beneficial

Going by the opinions of the authorities at the selected institution, many of them find it beneficial and intend to continue with it, inspite of the persistent complaints about the lack of timeliness in getting the grants and the adequacy of the grants. Since the scheme is not the only source of funding for the family planning services and since it does not set any target in absolute terms, the institutions are willing to continue with it.

After meeting the authorities of the Institutions, and after analysing the data, we think that the scheme could be more beneficial if

- (i) Allotment of the scheme is done judiciously.
- (ii) The Corporation Municipal hospitals in small towns and remote areas are given priority.
- (iii) A close supervision and checking of records is done periodically.
- (iv) Motivational activities in the backward areas are rigorously followed.
- (v) The incentive amounts are raised periodically.
- (vi) Release of grants is timely
- (vii) More publicity about the scheme is done
- (viii) Follow-up services are provided, and lastly
- (ix) There are incentives for good performance and penalty for the low performance; just cutting the grants for low performance may not be enough.

Appendix I

Information about the Acceptor Survey

| | Hospital Name | Cases to be contacted | Sample selected | No. of cases traced |
|----|--|-----------------------|-----------------|---------------------|
| 1 | N. M. Wadia Hospital Pune | 18 | 40 | 40 |
| 2 | Sane Guruji Hospital, Maharashtra, Arogya Mandal, Hadapsar | 18 | 36 | 36 |
| 3 | Seth Tarachand Hospital, Pune | 18 | 35 | 35 |
| 4 | Karanjepool M. A. M. | 18 | 27 | 27 |
| 5 | Barshi Mat. Home | 18 | 41 | 40 |
| 6 | Jalna Mission Hosp. | 18 | 72 | 72 |
| 7 | Dhanraj Girjee Hosp., Solapur | 18 | 36 | 30 |
| 8 | Rajarshi Shahu Hosp., Solapur | 18 | 36 | 30 |
| 9 | Jawahar Med. Foundation, Dhule | 18 | 36 | 25 |
| 10 | Young Muslim Trust Hosp. Amarawati | 17 | 37 | 37 |
| 11 | Matru Seva Sangha, Nagpur | 18 | 36 | 36 |
| 12 | Mission Hosp., Wai | 15 | 20 | 20 |
| 13 | M. M. Agashe Hosp., Satara | 18 | 36 | 36 |
| 14 | Sanjay Gandhi Hosp., Bopodi | 38 | 83 | 83 |
| 15 | Cottage Hosp., Sangamner | 38 | 76 | 76 |
| 16 | Jijamata Hosp., Nasik | 38 | 76 | 72 |
| 17 | Leady Duffrin Hosp., Solapur | 38 | 100 | 100 |
| 18 | Maternity Home, Ramtek | 38 | 72 | 72 |
| 19 | Savatribai Phule Hosp., Kolhapur | 38 | 72 | 72 |
| 20 | Maternity Home, Dhule | 76 | 102 | 102 |
| 21 | Municipal Hosp., Pandharpur | 38 | 110 | 106 |

Appendix II

| Sr.No. | Hospital Name | Suggestions |
|------------------------------|--|---|
| NGO'S | | |
| 1 | N. M. Wadia Hospital Pune | i) Programme should not be target oriented. |
| 2 | Sane Guruji Hospital, Maharashtra, Arogya Mandal, Hadapsar | No suggestions |
| 3 | Seth Tarachand Hospital, Pune | No suggestions |
| 4 | Karanjepool M. A. M. | No suggestions |
| 5 | Barshi Mat. Home | i) Pay regularly, FP incentive should be raised, vehicle should be provided for follow-up |
| 6 | Jalna Mission Hosp. | i) Pay regularly, FP incentive should be raised, vehicle should be provided |
| 7 | Dhanraj Girjee Hosp., Solapur | i) Grant should be increased |
| 8 | Rajarshi Shahu Hosp., Solapur | i) Grant should be increased |
| 9 | Jawahar Med. Foundation, Dhule | i) Maintainance Grant should be increased and released in time, terget should be realistic |
| 10 | Young Muslim Trust Hosp. Amarawati | i) Grant should be obtained in time |
| 11 | Matru Seva Sangha, Nagpur | i) Grant should be increased & obtained in time |
| 12 | Mission Hosp., Wai | No suggestions |
| 13 | M. M. Agashe Hosp., Satara | No suggestions |
| Corporation Hospitals | | |
| 14 | Sanjay Gandhi Hosp., Bopodi | No suggestions |
| 15 | Cottage Hosp., Sangamner | i) Posts of field worker, health worker should be field ii) Full grant should be released |

Continued....

| Sr.No. | Hospital Name | Suggestions |
|--------|----------------------------------|--|
| 16 | Jijamata Hosp., Nasik | i) Funds should be released in time |
| 17 | Leady Duffrin Hosp., Solapur | No suggestions |
| 18 | Maternity Home, Ramtek | No suggestions |
| 19 | Savatribai Phule Hosp., Kolhapur | i) Funds should be released in time ii) Maintainance Grant should be increased |
| 20 | Maternity Home, Dhule | No suggestions |
| 21 | Municipal Hosp., Pandharpur | No suggestions |
| 22 | Chembur Maternity Home, Mumbai | i) Incentive should be withdrawn |
| 23 | N. M. Wadia, Parel, Mumbai | i) NGOs with long tract record should be provied with the necessary support to serve better |
| 24 | Pophale Hosp., Mumbai | i) Funds should be released in time |
| 25 | M. N. Agashe Hosp., Satara | i) Maintainance Grant should be increased |
| 26 | Someshwar Hosp., Baramati | i) Target per bed should be reduced |
| 27 | Municipal Hosp. , Dhule | i) No incentives should be given to clients |
| 28 | PPC, Mumbai | i)Time to time training of M. O. & staff ii) Postal correspondence with Programme Director should be improved |
| 29 | Borivali Mat. Hosp., Borivali | i)Funds should directly to the Hosp. ii) Additional nursing staff should be given |
| 30 | Kutumb Niyojan Kendra, Thane | i) Grant should be increased |
| 31 | Choksi Hosp., Maslad, Mumbai | i) Incentive should be increased |

Table 1.1 : Sterilisation Bed Scheme (Position of Beds as on 31.4.2000)

| Sr. No. | States/UTs | Govt. | Local Bodies | Vol. Orgn. | Total |
|----------------|-------------------|--------------|---------------------|-------------------|--------------|
| 1 | Andhra Pradesh | 40 | 0 | 290 | 330 |
| 2 | Assam | 0 | 0 | 11 | 11 |
| 3 | Bihar | 0 | 0 | 90 | 90 |
| 4 | Gujrat | 0 | 60 | 323 | 383 |
| 5 | Harayana | 0 | 0 | 76 | 76 |
| 6 | Jammu & Kashmir | 0 | 0 | 14 | 14 |
| 7 | Karnataka | 0 | 0 | 247 | 247 |
| 8 | Kerala | 0 | 0 | 128 | 128 |
| 9 | Madhya Pradesh | 10 | 0 | 45 | 55 |
| 10 | Maharashtra | 0 | 400 | 399 | 799 |
| 11 | Meghalaya | 0 | 0 | 4 | 4 |
| 12 | Mizoram | 0 | 0 | 7 | 7 |
| 13 | Punjab | 5 | 0 | 5 | 10 |
| 14 | Rajasthan | 0 | 0 | 30 | 30 |
| 15 | Tamil Nadu | 0 | 0 | 585 | 585 |
| 16 | Uttar Pradesh | 0 | 0 | 97 | 97 |
| 17 | West Bengal | 5 | 5 | 253 | 263 |
| 18 | Delhi | 0 | 2 | 86 | 88 |
| | Total | 60 | 467 | 2690 | 3217 |

Table 1.2 : List of Organisations Under the Sterilisation Bed Reservation Scheme, NGOs

| Sr.No | Name of Voluntary Orationisation |
|--------------|---|
| 1 | Bombay Mother and Children Society Mumbai |
| 2 | Planned Parenthood Center, Mumbai |
| 3 | Kutumb Sudhar Kendra run by F.P.A.I. Mumbai |
| 4 | Dr. Bababahi Nanavati Hosp. Mumbai |
| 5 | Family Planning Association & Medical Aid Trust, Mumbai |
| 6 | Mahila Utkarsh Mandal, Kalyan |
| 7 | Kutumb Niyojan Adarsh Kendra, Thane (run by F.P.A.I.) |
| 8 | Panvel Maternity and Infant Welfare League, Dist. Raigad |
| 9 | Paranjape Medical Foundation, Khopoli, Dist. Raigad |
| 10 | Matru Mandir, Deorukh, Ratnagiri |
| 11 | Rani Jankibai Maternity Home, Savantwadi, Dist. Sindhudurg |
| 12 | St Lukes Hosp., Vengurla |
| 13 | Bai Budhibai Shantidas Mulchand Shaha Memorial trust. Dhule |
| 14 | Mohammadiya Tibbya Collage and Hosp., Malegaon |
| 15 | M. D. R. P. Samaj's Medical Collage and Research Center, Gangapur road Nashik |
| 16 | Abhay Yuva Kalyan Kendra. Dhule |
| 17 | National Integrated Medical Association, Malegaon |
| 18 | Fair Baank James Friendship Memorial Hosp. |
| 19 | Comprehensive Rural Health Project, Jamkhed |
| 20 | Salvation Army Booth Hosp., Ahmednagar |
| 21 | Dhanraj Girji Hosp., Solapur |
| 22 | Barshi Maternity General Co-operative Hosp., Barshi, Dist. Solapur |
| 23 | Family Planning Association of India |
| 24 | Welfare Center, Barshi |
| 25 | St. Luks's Health and Welfare Center Nanaj, Tal. North Solapur |
| 26 | City F.F. Bureau Solapur |
| 27 | Rajarshi Shahu Medical Foundation, Solapur |

Table 1.2 continued...

| Sr.No | Name of Voluntary Oraganisation |
|--------------|--|
| 28 | Jagdale Mama Hosp. Barshi, Dist. Solapur |
| 29 | Sou Shantibai Shantilal Phade, Charitable Turst Akluj, Dist. Solapur |
| 30 | Seth Govindji Ravaji Ayurvedie Mahavidyalay, Solapur |
| 31 | Sutika Seva Mandir, Pune |
| 32 | Maharashtra Arogya Mandal Hadapsar, Pune |
| 33 | Karanjepool Center run by Mah. Arogya Manda, Pune |
| 34 | A. P. Nanal Rugnalay, Pune |
| 35 | Seth Ambalal Bapubhai Charitable Dispensary, Manchar |
| 36 | Lokmanya Medical Foundation, Chinchwad, Pune |
| 37 | F.P.A. I., Pune |
| 38 | Dwarika Sangamnerkar Hospital, Pune |
| 39 | M.T.E. Society, (Sanjeevan Hospital, Pune) |
| 40 | Dr. Babasaheb Ambedkar Medical Trust, Pune |
| 41 | Ashwood Memorial Hosp., Daund, Pune |
| 42 | Bombay Mothers and Children Society, Rajgurunagar unit (Khed) |
| 43 | Polie Welfare Dispensary, Pune |
| 44 | Poona Medical Foundation, (Ruby Hall Clinic, Pune) |
| 45 | Walchandnagar Industries Hosp., Pune |
| 46 | Seth Tarachand Ramnath Ayurvedic Hosp., Pune |
| 47 | Sevadham Trust, Sadashiv Peth, Pune |
| 48 | Willes F. Pierce Memorial Hosp., Wai, Dist. Satara |
| 49 | Krushna Hosp & Medical Research Centre, Karad, Dist. Satara |
| 50 | Dr. M.N. Agashe, Dharmarth Rugnalay, Satara |
| 51 | Wanless Hosp., Miraj Dist. Sangli |
| 52 | Aruna Nursing Home, (Sanjay Bane Memorial Trust Wategon,) Dist. Sangli |
| 53 | Mary Wanless Hosp. Kolhapur |
| 54 | Akola Nursing Home, run by Jankalyan Sanstha, Akola. |

Table 1.2 continued ...

| Sr.No | Name of Voluntary Organisation |
|---------------|--|
| 55 | Rwnalad Memorial Hospital, Washim, Akola |
| 56 | Vaneeta Samaj, Amravati |
| 57 | Jog Charitable Medical Relief Fund, Amravati |
| 58 | Young Muslim Social Association, Amravati |
| 59 | Matru Seva Sangh Mahal Maternity Home, Nagpur |
| 60 | Mure Memorial Hosp., Nagpur |
| 61 | Nagarik Sahkari Rugnalay, Nagpur |
| 62 | Nimunabai Titpurde Hosp., Nagpur |
| 63 | Janta Maternity Home and Hosp., Nagpur |
| 64 | Matru Seva Sangh Mat. Home, Wardha |
| 65 | Matru Seva Sangh, Highnghat, Wardha |
| 66 | Navajeevan Rugnalay Pachod, Tal. Paithan. Dist. Aurangabad |
| 67 | Jalna Mission Hosp., Jalna Hospital |
| 68 | Priyadarshani Mahila Mandal, Nanded |
| 69 | Nanded Medical Foundation |
| P.P.C. | |
| 70 | Naurooji Wadia Maternity Home, Parel |
| 71 | N.M. Wadia Solapur |
| 72 | N.M. Wadia Pune |
| 73 | K.E.M. Pune |
| 74 | Talegaon General Hosp., Pune |
| 75 | Matru Seva Sangha, Sitabardi, Nagpur |
| 76 | Mahatma Gandhi Institute Sevagram, Wardha |
| 77 | Anand Medical Foundation Kothrud, Pune |
| 78 | Pravara Medical Trust, Loni Dist. Ahmednagar |
| 79 | Dalvi Memorial Hosp., Nagpur |
| 80 | M. N. Agashe Dharmartha Rugnalaya, Satara |

Table 1.3 : List of Organisations Under the Sterilisation Bed Reservation Scheme, Local Bodies

| | Name of Institutions (Local Bodies) |
|----|---|
| 1 | Lady Dufferin Hosp., run by Solapur Mun. Corporation Hospital |
| 2 | M. C. Pundharpur, Dist. Solapur |
| 3 | M. C. Barshi, Dist. Solapur |
| 4 | Municipal Council, Sangli |
| 5 | Municipal Council, Dhule |
| 6 | Municipal Council, Mumbai |
| 7 | Municipal Council, Ichalkarnagi (K.E.M. Hosp.) Dist. Kolhapur |
| 8 | Pujya Kasturba Hosp., Satara |
| 9 | N. M. Wadia Dispensary, Malegaon |
| 10 | Municipal Hosp. Yevla Dist Nashik |
| 11 | Municipal Corporation, Nashik |
| 12 | Jijamata Maternity Home, Nasik |
| 13 | Bytco Hosp., Nashik Road |
| 14 | M.I.D.C., Satpur |
| 15 | Indira Gandhi Maternity Home, Nasik |
| 16 | Upanagar, Nasik |
| 17 | Dasak, Nasik |
| 18 | Norwadi, Nasik |
| 19 | Municipal Council, Yerandol, Dist Jalgon |
| 20 | Municipal Council, Pachora |
| 21 | Municipal Council, Bhivandi. Dist. Thane |
| 22 | Municipal Council, Shrirampur, Dist. Ahmadnagar |
| 23 | Municipal Council, Achalpur, Dist. Amarawati |
| 24 | Municipal Council, Nagpur |

Table 1.3 continued ...

| | Name of Institutions (Local Bodies) |
|----------------|--|
| 25 | Municipal Council, Pune |
| 26 | Dalvi Maternity Home, Wakadewadi, Pune |
| 27 | Kamala Neharu Hospital, Pune |
| 28 | Bopodi Maternity Home (Sanjay Gandhi Maternity Home) |
| 29 | Yearwada Hospital |
| 30 | Haelth Camp |
| 31 | Municipal corporation, Pimpri-Chinchwad |
| 32 | Jijamata Hospital |
| 33 | Akurdi Hospital |
| 34 | Talera Hospital |
| 35 | Municipal Council, Nanded, |
| P. P. C | |
| 36 | Dr. R. N. Kupar Hospital, Juhu, Mumbai |
| 37 | K. E. M. Mumbai |
| 38 | L. T. M. G. Hosp. Sion, Mumbai |
| 39 | B. T. L. Nair Hosp., Mumbai |
| 40 | Sonavane Hospital, Pune |
| 41 | Boyes Maternity Home, Solapur |
| 42 | Savatribai Phule Hospital, Kolhapur |
| 43 | Phaltan Dispensary, Satara |
| 44 | Municipal Council, Sangamner |
| 45 | Municipal Council, Warora |
| 46 | Municipal Council, Latur |
| 47 | Municipal Council, Ramtek |

Table 2A : Physical Infrastructure, Staff and Equipment

| Sr. No | Item | | Voluntary Organisation | Local Body | Total |
|-------------------------------------|-------------------------------------|---|------------------------|------------|-------|
| 1 | Registration | Yes | 17 | 12 | 29 |
| | | No | 1 | 1 | 2 |
| 2 | Scheme Participation | Post Partum Centre | - | 1 | 1 |
| | | UFWC | - | - | - |
| | | Health Post | - | - | - |
| | | Sterilisation Bed Scheme | 5 | - | 5 |
| | | PPC+Ster. Beds Scheme | 4 | 1 | 5 |
| | | PPC+UFWC+Ster. Beds Scheme | - | 3 | 3 |
| | | PPC+UFWC+Health Post+ Ster. Beds Scheme | 3 | 2 | 5 |
| | | Health Post +Ster. Beds Scheme | 2 | - | 2 |
| | | Health Post +Ster. Beds Scheme | 1 | 1 | 2 |
| | | PPC+Health Post+ Ster. Beds Scheme | - | 3 | 3 |
| UFWC+Health Post+ Ster. Beds Scheme | 3 | 2 | 5 | | |
| 3 | Population Covered | Less than 30,000 | 3 | 2 | 5 |
| | | 30,000 to 50,000 | 4 | - | 4 |
| | | 50,000 to 70,000 | 4 | 5 | 9 |
| | | 70,000 + | 1 | 1 | 2 |
| | | Not Given | 6 | 5 | 11 |
| 4 | Sterilisation Performance 1999-2000 | Less than 200 | 5 | 1 | 6 |
| | | 200 to 400 | 4 | 2 | 6 |
| | | 400 to 600 | 3 | 6 | 9 |
| | | 600 to 800 | 1 | 2 | 3 |
| | | 800 to 1000 | 1 | 1 | 2 |
| | | 1000 to 2000 | 3 | 1 | 4 |
| | | 2000 + | 1 | - | 1 |
| 5 | Sterilisation Performance 2000-2001 | Less than 200 | 5 | 1 | 6 |
| | | 200 to 400 | 5 | 2 | 7 |
| | | 400 to 600 | 1 | 6 | 7 |
| | | 600 to 800 | 2 | 3 | 5 |
| | | 800 to 1000 | - | - | - |
| | | 1000 to 2000 | 5 | 1 | 5 |
| | | 2000 + | - | - | - |

Table 2A continued....

| Sr. No. | Item | | Voluntary Organisation | Local Body | Total |
|---------|-----------------------------------|-------------------|------------------------|------------|-------|
| 6 | Beds available in the Hospital | Less than 20 | 7 | 1 | 8 |
| | | 20 to 50 | - | 7 | 7 |
| | | 50 to 100 | 1 | 2 | 3 |
| | | 100 to 200 | 8 | 1 | 9 |
| | | 200 to 500 | 1 | 2 | 3 |
| | | 500 + | 1 | - | 1 |
| 7 | Beds available for sterilisation | 3 | 1 | - | 1 |
| | | 5 | 3 | 1 | 4 |
| | | 6 | 3 | 3 | 6 |
| | | 7 | 3 | 1 | 4 |
| | | 8 | 2 | - | 2 |
| | | 10 | 2 | 4 | 6 |
| | | 12 | - | 1 | 1 |
| | | 14 | 1 | - | 1 |
| | | 15 | - | 1 | 1 |
| | | 18 | 1 | - | 1 |
| | | 20 | 1 | 1 | 2 |
| | | 21 | - | 1 | 1 |
| 25 | 1 | - | 1 | | |
| 8 | Beds sanctioned under the Scheme | 3 | 1 | - | 1 |
| | | 4 | 1 | - | 1 |
| | | 5 | 3 | 2 | 5 |
| | | 6 | 3 | 4 | 7 |
| | | 7 | 3 | 1 | 4 |
| | | 8 | 2 | - | 6 |
| | | 10 | 2 | 4 | 2 |
| | | 15 | - | 1 | 1 |
| | | 18 | 1 | - | 1 |
| | | 20 | 1 | 1 | 2 |
| 25 | 1 | - | 1 | | |
| 9 | Availability of Operation Theatre | Yes | 18 | 13 | 31 |
| | | No | - | - | - |
| 10 | Availability of Water Supply | Yes | 18 | 13 | 31 |
| | | No | - | - | - |
| 11 | Availability of Electricity | Yes | 18 | 13 | 31 |
| | | No | - | - | - |
| 12 | Availability of Transportation | Yes | 8 | 8 | 16 |
| | | No | 10 | 4 | 14 |
| | | Municipal Vehicle | - | 1 | 1 |

Table 2B : Quality of Care

| Sr. No | Item | | Voluntary Organisation | Local Body | Total |
|--------|---------------------------|--|---|---------------------------------|----------------------------------|
| 1 | Follow-up visits | Yes No | No follow-up visits | | |
| 2 | Motivation | Yes No | No motivation activities (except one or two Institutions) | | |
| 3 | Facilities available | Daily basis Fixed day(s) Weekly Camp(s) Daily+Camp(s) | 12 4 1 - 1 | 10 3 - - - | 22 7 1 - 1 |
| 4 | Average Distance | Less than 5 kms. 5 to 10 kms. More than 10 kms. | 2 6 10 | 1 3 9 | 3 9 19 |
| 5 | Screening | Yes No | 17 1 | 13 - | 30 1 |
| 6 | Consent Forms | Yes No | 18 - | 13 - | 31 - |
| 7 | Aseptic precautions | Yes No | 18 - | 13 - | 31 - |
| 8 | Information to Patient | Yes No | 18 - | 13 - | 31 - |
| 9 | Sterilisation Certificate | 1 day 3 days 5 days 6 days 7 days On discharge On demand | 2 - 1 1 2 4 8 | - 1 - 1 - 3 8 | 2 1 1 2 2 7 16 |
| 10 | Maintained Register | Yes No | 17 - | 14 - | 31 - |
| 11 | Register Checked | Yes No | 16 2 | 12 1 | 28 3 |

Table 2C : Performance, Funding and Suggestions

| Sr. No | Item | | Voluntary Organisation | Local Body | Total |
|--------|-------------------------------------|----------------------------------|------------------------|------------|-------|
| 1 | Maintainance Grant released in time | Yes | 10 | 3 | 13 |
| | | No | 7 | 7 | 14 |
| | | Funds go directly to Head Office | 1 | 3 | 4 |
| 2 | Scheme beneficial for Hospital | Yes | 15 | 9 | 24 |
| | | No | 2 | 1 | 3 |
| | | Not given | 1 | 2 | 3 |
| | | Not applicable | - | 1 | 1 |
| 3 | Problems in getting funds | Yes | 10 | 4 | 14 |
| | | No | 6 | 4 | 10 |
| | | Funds go directly to Head Office | 2 | 5 | 7 |
| 4 | Funds adequate | Yes | 1 | 3 | 4 |
| | | No | 15 | 6 | 21 |
| | | Funds go directly to Head Office | 2 | 4 | 6 |
| 5 | In favour of continuing the scheme | Yes | 15 | 8 | 23 |
| | | No | 1 | 1 | 2 |
| | | Not given | 2 | 4 | 6 |

Table 3 : Quantative and Qualitative Aspects of performance of the selected Institutions

| | Name of the Institution | NGO/ Corporation | Total beds | Beds under scheme | Performan ce (Absolute) | BOR (%) | Percentage of acceptors with | |
|----|-------------------------------------|---------------------|---------------|----------------------|-------------------------------|------------|------------------------------|------------------------|
| | | | | | | | Age<=25 yrs. children | <= 2 livng children |
| 1 | N. M. Wadia Hospital, Pune | NGO | 200 | 10 | 125 | 20.5 | 24.0 | 59.2 |
| 2 | Seth Tarachand Hospital, Pune | NGO | 200 | 5 | 287 | 94.4 | 26.5 | 59.9 |
| 3 | Maharashtra Arogya Mandal, Pune | NGO | 200 | 25 | 1501 | 98.8 | 30.8 | 54.8 |
| 4 | Jawahar Medical Association, Dhule | NGO | 700 | 7 | 666 | 156.3 | 15.3 | 48.8 |
| 5 | Barshi Maternity Home, Barshi | NGO | 125 | 6 | 206 | 56.4 | 13.6 | 31.6 |
| 6 | Karanjepool Centre, Baramati | NGO | 12 | 8 | 99 | 20.4 | 43.4 | 54.5 |
| 7 | Dhanraj Girji Hospital, Solapur | NGO | 152 | 5 | 220 | 60.3 | 30.5 | 42.3 |
| 8 | Rajarshi Shahu Hospital, Solapur | NGO | 15 | 5 | 136 | 44.7 | 22.8 | 22.8 |
| 9 | Matru Seva Sangha, Mahal, Nagpur | NGO | 80 | 7 | 543 | 127.5 | 11.0 | 65.6 |
| 10 | Jalna Mossion Hospital, Jalna | NGO | 200 | 5 | 373 | 122.7 | 15.3 | 30.3 |
| 11 | Young Muslim Association, Amarawati | NGO | 14 | 7 | 621 | 145.8 | 8.1 | 14.4 |
| 12 | Mission Hospital, Wai | NGO | 150 | 4 | 20 | 8.2 | 40.0 | 45.0 |
| 13 | Agashe Rugnalaya, Satara | NGO | 128 | 8 | 228 * | 46.8 | 27.8 | 63.3 |
| 14 | Kutumb Sudhar Kendra, Mumbai | NGO | 9 | 7 | 224 * | 52.8 | 13.4 | 58.2 |
| 15 | Planned Parenthooh Centre, Mumbai | NGO | 12 | 10 | 167 * | 27.8 | 13.8 | 60.1 |
| 16 | FPAI & Medical Aid Trust, Mumbai | NGO | 8 | 3 | 86 | 47.1 | 4.7 | 62.8 |
| 17 | N. M. Wadia Hospital, Parel, Mumbai | NGO | 305 | 20 | 705 * | 57.9 | 10.3 | 68.7 |
| 18 | Kutamb Niyojan Kendra, Thane | NGO | 20 | 20 | 375 * | 30.9 | 14.5 | 55.9 |

Table 3 continued....

| | Name of the Institution | NGO/ Corporation | Total beds | Beds under scheme | Performance (Absolute) | BOR (%) | Percentage of acceptors with | |
|----|---|---------------------|---------------|-------------------------|---------------------------|------------|------------------------------|------------------------|
| | | | | | | | Age<=25 yrs. children | <= 2 livng children |
| 19 | Sanjay Gandhi Memorial Hospital, Bopodi, Pune | Muni.Corp. | N. G. | 7 | 166 | 39.0 | 30.1 | 38.6 |
| 20 | Jijamata Maternity Home, Nasik | Muni.Corp. | 21 | 5 | 272 # | 89.3 | 22.7 | 31.2 |
| 21 | Municipal Hospital, Dhule | Muni.Corp. | 50 | 10 | 199 (3 months) | 131.6 | 8.0 | 30.7 |
| 22 | Cottage Hospital, Sangamner | Muni.Corp. | 56 | 6 | 343 # | 94.0 | 29.9 | 35.4 |
| 23 | Municipal Hospital, Pandharpur | Muni.Corp. | 50 | 10 | 547 | 90.0 | 17.0 | 30.5 |
| 24 | Leady Duffrin Hospital, Solapur | Muni.Corp. | 60 | 20 | 674 | 65.4 | 22.8 | 26.7 |
| 25 | Municipal Hospital, Ramtek | Muni.Corp. | 16 | 6 | 203 * | 55.6 | 27.1 | 49.5 |
| 26 | Municipal Hospital, Kolhapur | Muni.Corp. | 30 | 10 | 425 * | 69.8 | 21.9 | 66.3 |
| 27 | Santacruz Hospital, Mumbai | Muni.Corp. | 271 | 10 | 433 | 71.2 | 16.9 | 52.8 |
| 28 | Rajawadi Hospital, Mumbai | Muni.Corp. | 350 | 15 | 461 *# | 56.7 | 22.6 | 55.8 |
| 29 | Boriwali Hospital, Mumbai | Muni.Corp. | 40 | 6 | 398 *# | 109.2 | 3.3 | 61.0 |
| 30 | Malad Hospital, Mumbai | Muni.Corp. | 40 | 6 | 330 # | 91.1 | 17.0 | 44.3 |
| 31 | Chembur Hospital, Mumbai | Muni.Corp. | 30 | 5 | 396 # | 65.1 | 16.9 | 52.8 |

Notes * : These figures are for the adjusted tubectomy performance. For its adjustment, 6 laproscopies are equated to one tubectomy.

#: In this case, while calculating the BOR, the number of days of hospitalisation is taken 3 instead of 6.

For Boriwali Hospital in absence of data on method of sterilisation, half of the sterilisations are taken as Tubectomies, while the other half is taken as Laproscopies

Table 4 : Characteristics of Acceptors and their Experience about Quality of Care

| I. | Characteristics of Acceptors (Areas excluding Mumbai) | NGO | Corporation | NFHS-II |
|------------|--|------------|--------------------|----------------|
| 1 | Percentage of illiterate acceptors | 25.3 | 31.6 | 51.3 |
| 2 | Percentage of literates among acceptors' husbands | 15.7 | 17.4 | |
| 3 | Percentage of housewives among acceptors | 90.8 | 87.7 | |
| 4 | Percentage of husbands engaged in labour/casual labour | 29.7 | 44.8 | |
| 5 | Madian age at marriage(yrs) of acceptors | 18.0 | 18.0 | |
| 6 | Madian age at marriage (yrs) of husbands | 23.0 | 22.0 | |
| 7 | Percentage of acceptors with age <= 25 yrs | 43.7 | 53.3 | 49.6 |
| 8 | Percentage of acceptors with <= 2 living children | 41.0 | 35.8 | 26.1 |
| 9 | Average age of the youngest child (months) | 19.0 | 16.0 | |
| 10 | Percentage of acceptors with last child being a boy | 60.7 | 59.1 | |
| II. | Characteristics of Acceptors (Mumbai) | NGO | Corporation | |
| 1 | Percentage of illiterate acceptors | 22.9 | 40.7 | |
| 2 | Percentage of illiterates among acceptors' husbands | 9.3 | 22.8 | |
| 3 | Percentage of acceptors with age <= 25 yrs | 13.0 | 8.4 | |
| 4 | Percentage of acceptors with <= 2 living children | 60.1 | 54.6 | |
| 5 | Percentage of acceptors with 2 sons | 35.7 | 36.8 | |
| 6 | Percentage of acceptors with 2 daughters | 20.5 | 20.0 | |
| 7 | Age of the youngest child (months) | 23.0 | 17.0 | |
| 8 | Percentage of acceptors with the last child being a boy | 64.2 | 59.3 | |

Table 4 continued

| III. | Quality of Care (Areas other than Mumbai) | NGO | Corporation | |
|-------------|---|------------|--------------------|--|
| 1 | Percentage of acceptors with follow-up services availed | 17.0 | 22.8 | |
| 2 | Percentage of acceptors with complication after sterilisation | 4.8 | 4.4 | |
| 3 | Percentage of acceptors having got compensation for complication | 0.0 | 1.2 | |
| 4 | Percentage of acceptors receiving medicines free of cost | 21.4 | 43.3 | |
| 5 | Percentage of acceptors receiving the compensation amount as per the norm | 97.8 | 98.2 | |
| 6 | Percentage of acceptors having stayed in the hospital for <6 days | 11.0 | 5.6 | |
| 7 | Percentage of acceptors having received the sterilisation certificate | 55.0 | 39.0 | |
| 8 | Average time gap between discharge and getting the certificate | 2.2 | 1.3 | |

Table 5 : Average difference (for age of women and no. of children) between those recorded in the R-3 register and as per survey

| Sr. No. | NGO Hospital | Average Difference in Women's Age | Average Difference in No. of Children |
|---------|--|-----------------------------------|---------------------------------------|
| 1 | Rajarshi Shahu Medical Foundation, Solapur | 3.12 | Nil |
| 2 | Matru Seva Sangha Sutika Griha, Nagpur | 1.4 | 1.0 |
| 3 | Mission Hospital, Wai | 3.3 | 2.0 |
| 4 | Dhanraj Girjee Hospital, Solapur | 2.3 | 2.6. |
| 5 | Someshwar Hospital, Karanjepool | 2.15 | 2.0 |
| | Corporation Hospital | | |
| 1 | Nagarpalika Hospital, Dhule | 3.28 | 1.5 |
| 2 | Municipal Hospital, Pandharpur | 3.20 | 1.4 |
| 3 | Jijamata Hospital, Nasik | 2.11 | 1.4 |
| 4 | Savitribai Phule Hospital, Kolhapur | 3.17 | 1.5 |
| 5 | Municipal Corporation Hospital, Ramtek | 2.96 | 1.3 |

Graph 1 : Performance against Total Bed Strength

