

**Assessment of Coverage, Quality and Client Satisfaction with the
Family Welfare and Maternal and Child Health Services in
Jalna District, Maharashtra**

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List of Abbreviations

ANC	: Antenatal care
ANM	: Auxiliary Nurse Midwife
ARI	: Acute Respiratory Infection
AWW	: Anganwadi Worker
CHC	: Community Health Centre
CSSM	: Child Survival and Safe Motherhood
FRU	: First Referral Unit
GIPE	: Gokhale Institute of Politics and Economics
ICDS	: Integrated Child Development Scheme
IEC	: Information, Education and Communication
IIPS	: International Institute for Population Sciences
IUD	: Intra Uterine Device
LHV	: Lady Health Volunteer
MCH	: Maternal and Child Health
MOHFW	: Ministry of Health and Family Welfare
MPW	: Multi Purpose Worker
MTP	: Medical Termination of Pregnancy
NFHS	: National Family Health Survey
ORS	: Oral Rehydration Salt
ORT	: Oral Rehydration Therapy
PHC	: Primary Health Centre
RCH	: Reproductive and Child Health
RTI	: Reproductive Tract Infection
STD	: Sexually Transmitted Diseases
TBA	: Traditional Birth Attendant
TFA	: Target Free Approach

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Chapter 1

Introduction and Methodology

The 1994 Cairo International Conference on Population and Development formalised a growing international consensus that improving reproductive health, including family planning, is essential to human welfare and development. Specifically, Cairo conference called for broader, more holistic approaches to population that link demographic concerns, including fertility reduction, with a range of objectives for social development and poverty reduction, particularly those that improve the health and socio-economic status of women and increase the involvement of men in, and their responsibility for, sexual and reproductive behaviour (United Nations, 1995). At the programme level, the conference called for high-quality, client-centred approaches that address a range of reproductive health needs, including safe motherhood and family planning, as well as other problems such as reproductive tract and sexually transmitted infections. The conference recommendations offer a more effective way to achieve the objectives of population policy, poverty reduction, and improvement in human welfare than the previous approach and are also more acceptable on humanitarian grounds.

Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmities in all matters relating to the reproductive system and to its functions and processes (WHO). Reproductive health can be further defined as a state in which “people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and child birth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relations free of the fear of pregnancy and of contracting disease” (Fathalla, 1998). According to the above definitions, reproductive health implies that people have the capability to reproduce and the freedom to decide if, when and how often to do. Hence, the principal goal of a reproductive health programme is to reduce unwanted fertility safely and to provide high-quality health services, thereby satisfying the needs of individuals, as well as stabilizing the population. A growing body of evidence and the consensus achieved in Cairo suggested that India’s old system (pre 1996) of numerical, method-specific targets and

monetary incentives for providers would not help in achieving desired population goals. The evidences also suggested that setting a broad range of reproductive health goals reduces fertility and enhances client satisfaction and health. Hence, the government of India strongly supported the Cairo programme of action in general, and the reproductive health approach in particular. Towards this government of India has taken several policy initiatives in recent years to enhance the access and quality of family planning and reproductive health services.

India's population policy has a long history. India launched its national Family Planning (later Family Welfare) programme in 1951 with a primary objective of reducing its population growth rate. India's population policy and programme have evolved over the past five decades. It started with clinical approach in the beginning and during the 1960s, massive efforts were made to recruit acceptors of Intra Uterine Devices (IUDs) and to promote the use of condoms. During the 1970s serious efforts were made to promote male and female sterilization through mass campaigns. The excesses of these mass campaigns generated a set back to the programme. But in the 1980s, India renewed its commitment to voluntary family planning. As a result, public support to the programme started increasing gradually. However, in the process of implementing the programme, a strategy based on rewards, cash incentives to acceptors and providers and targets for the workers were introduced to expedite the progress. Unfortunately setting of targets led to an adverse consequence of inflating the performance statistics. Also emphasis on numerical targets was a major reason for the lack of attention paid to the needs of individual clients and quality of services provided. As a result targets were completely withdrawn from 1st April 1996 throughout the country. Now Family Welfare Programme is being implemented on the basis of Target Free Approach (TFA). Besides, the focus of the national Family Welfare Programme has undergone a change from a segregated approach under Family Planning and Maternal and Child Health Services to that of integrated approach under Reproductive and Child Health (RCH) Services. This means that RCH is equivalent to Family Planning + CSSM (Child Survival and Safe Motherhood) + prevention of RTI (Reproductive Tract Infection) and AIDS + a client approach to provide family welfare and health care services.

Clearly, the new RCH approach is in line with the Cairo conference recommendations. The concept of a reproductive health approach is therefore central to this new vision of family welfare/population policy.

As the national Family Welfare Programme moved from target based activity to client centred demand driven quality services programme, naturally there is a change in various aspects of its operations including increased level of male participation. Implicit in the above change is the access to appropriate health care services that will enable women to go through pregnancy and childbirth safely and provide the couple with the best chance of having a healthy infant. The following are the illustrative list of services being provided to general public from Sub-Centres and Primary Health Centre (PHC) and in some cases, with tie-up of referral, from nearest Community Health Centres (CHCs) and district hospitals, under the new family welfare programme from the 1st April 1996.

I. Mother Care Services

(A) Ante Natal Care (ANC):

- (i) Registration of ANC cases preferably before 16th week of pregnancy**
- (ii) Provision of ante natal care to pregnant mothers by at least three visits**
- (iii) Detection and treatment of anaemic pregnant mothers**
- (iv) Timely detection and referral of high risk pregnant mothers**

(B) Natal Care:

- (i) Maximum efforts to promote institutional deliveries**
- (ii) Assistance by LHV, ANM or trained birth attendants for home deliveries**
- (iii) Detection and referral of high risk labour cases**
- (iv) Identification of existing Dais and organising dai training**
- (v) Provision of Dai Kits**

(C) Post Natal Care:

- (i) Growth Monitoring of new born**
- (ii) Detection and referral of high risk new born babies**
- (iii) Neo-Natal resuscitation wherever facilities are available and by education of dais and community in other areas**

II. Immunization

Immunization services against following **communicable diseases** to children:

- Tuberculosis, Polio, Diphtheria, Whooping Cough, Tetanus, and Measles

III. Prophylactic Services

Prophylactic services against **anaemia and Vitamin A deficiency** to

- (i) Pregnant Mothers
- (ii) Nursing Mothers and IUD Acceptors
- (iii) Children below 5 years of age

IV. Curative Services for

- (i) Diarrhoea cases with ORS
- (ii) Respiratory infection cases with cotrimoxazole

V. Contraceptive Services

- (i) Male Sterilisation Operation
- (ii) Female Sterilisation Operation
- (iii) Copper T. insertions
- (iv) Oral Pill – distribution
- (v) Nirodh distribution
- (vi) Indigenous/traditional methods
- (vii) Natural methods

VI. MTP

- (i) Assessing abortion needs and providing the same by early detection
- (ii) Assessing need for expanding services by increasing trained staff and registered centres

VII. Emergency Obstetric Care

- (i) Assessing expected high risk cases
- (ii) Provide for referral in existing Post Partum Centres
- (iii) Provide for referral at identified First Referral Units

VIII. Nutrition Counselling and Supplementary Nutrition

- (i) Linkages with ICDS and Anganwadi for provision of supplementary nutrition for pregnant/lactating mothers and for infants
- (ii) Nutrition Counselling through linkages with ICDS/AWW/ANM for anaemic children, adolescents and mothers

Activities at Sub-centre and PHC

Activities being carried out at Subcentre and PHC level for provisions of quality of care to general public:

At sub-centre level

Immunization, MCH Information Education and Communication Services are to be provided by Sub-centre

- Activities carried out during an **immunization/MCH session** are:

For children

- Immunization of children
- Administration of Vitamin-A concentrated solution for prophylaxis and therapy
- Diagnosis of anaemia in children and distribution of IFA (small) tablets

For Pregnant Women

- Ante-natal check up of pregnant women
- TT immunization
- Administration of IFA for prophylaxis and therapy
- Deworming of pregnant women who show clinical signs of anaemia (in 2nd/3rd trimester) in areas with high prevalence of Hook Worm infestation

Communication and counselling

- On infant feeding (exclusive breast-feeding and weaning)
- On home management of diarrhoea and ARI
- On birth spacing as a health promotion measure
- Recognition of danger signs for seeking immediate medical help

Provide

- Prepared ORS solution to child with diarrhoea and give ORS packets for use at home
- Tablets Cotrimoxazole to child with Pneumonia
- Oral Pills and Condoms

Gather Information by talking to mothers

- On new births or pregnancies in the village
- Cases of measles, diarrhoea and Pneumonia
- Counselling on polio and neonatal death
- Counselling for reproductive health

It is also expected that the health workers should contact local influential persons like Anganwadi workers, TBA, Village Pradhan, Panchayat members, other sector workers etc. and obtain their help for mobilising the beneficiaries. Special efforts should be made with their help to identify and motivate drop-outs and those who do not avail services from out reach areas. The opportunity should be utilized by sub-centre team to inform the mothers and organised groups about the different services and to encourage them to avail these. The above list of services provided under the new policy is a reproductive and child health approach that clearly meets the health needs of individual clients and provides a high-quality service.

Expected Outcome of Target Free Family Welfare Programme :-

- Universal ANC registration and at least 3 ante natal check-ups of all pregnant women
- Universal T.T. vaccination of pregnant women
- Increase in the proportion of institutional deliveries as compared to the existing level
- Increase in the proportion of deliveries by trained persons
- Provision of quality obstetric care for complications of pregnancy, abortions and complications of deliveries at CHC level or FRU level
- Universal registration of births and neonatal deaths in the area
- Appropriate measures for underweight babies

- Promotion of breast-feeding
- Universal immunization of infants
- Universal availability of ORS in all villages at all time
- Provision of facility of treatment of ARIs including pneumonia at all sub-centres
- Improvement in acceptance of contraceptives by couples with wife <30 years of age
- Improvement in acceptance of contraceptives by couples having 2 or less children with larger spacing between children
- Improvement in the proportion of spacing methods in the contraceptive method mix
- Availability of oral pills and condoms in all villages at all times
- Counselling for RTI and STD at sub-centre level
- Referral of suspected cases of RTI/STD from sub-centre and diagnosis and treatment facilities for RTI and STD at CHC and district level
- To ensure adequate postnatal care and FP counselling; all mothers should be visited after 15 days of delivery or EDD

Monitoring and Evaluation

Since ANM, the Male Health Worker and Medical Officer at the PHC level are the main functionaries in the programme, monitoring and evaluation of their work would provide the information about the functioning of the programme under the new approach. This evaluation could be done in two ways. One way is to examine their performance on the basis of the prescribed norms and the other way is to seek the client's views regarding the provision of services. The second method is essential in order to assess the ANM's/MPW's performance regarding the IEC component because the performance in this respect is not quantifiable.

Present Project

As intended under the new approach, for assessing the coverage, quality and client satisfaction with family welfare services, client surveys are to be conducted in one district per quarter by the Population Research Centres in the concerned states. These surveys are designed in such a way that they are economical and rapid so that the results will be

available within a short period of starting the surveys. The survey instruments are kept short and simple, keeping the requirements in mind. It was suggested by the ministry to select 1000 eligible couples from the concerned district. The suggested sampling method for the survey is to:

- select 25 PHCs randomly per district
- select 2 ANMs randomly per PHC
- select one village from the ANM's area
- select 20 eligible couples in each village

An interview schedule supplied by the MOHFW was used to collect the information from the clients (MOHFW, 1996). A copy of the same is given in Appendix I. As could be seen from the structure of the interview schedule, the intention mainly is to know about the client's family planning performance, the information about the recent delivery, information about breast-feeding and nutritional practices, the information about the ANM's visit and her counselling and lastly their opinion about the government health services. As mentioned earlier, this survey also intends to examine the ANM's role as far as IEC services are concerned and the clients' view about the services available at the health centres.

While describing the sampling design, it was mentioned that for each selected household, information included in the client-based family welfare record would be obtained by first extracting that information from the workers' register and then confirming it with the clients. In case the family is not recorded with worker, the information will be collected only from the mother. This process of extracting information from workers' registers is meant for improving the quality of their recorded data over time. The above mentioned procedure implies that the households have to be selected without the help of the eligible couple register and the information is to be checked with the one contained in the register. As described above the survey is to be conducted for all eligible couples, i.e., currently married couples with wife having age between 15-44 years. However, a close

examination of the questionnaire would reveal that it is meant mainly for younger women, who have recently given birth to a child. Hence as far as the questions on delivery, breast-feeding, nutrition and child diseases are concerned, we restricted them to women who had given birth to a child during the last five years or were currently pregnant.

Using a systematic sampling procedure, 25 PHCs were selected from all PHCs in Jalna district. It should be noted that the selection of the district was done after consulting the state authorities. Selection of two ANMs from each PHC meant selection of two sub-centres from each PHC. The selection of sub-centres was done in the office with the help of the list of PHCs and their sub-centres provided by the District Health Officer, Jalna. The selection of villages under the selected sub-centres and the selection of households in the selected village were done by the investigators using random sampling procedure. Appendix-II gives the list of villages. The data for study were collected during February-March 1998.

Chapter Scheme

The present report is divided into seven chapters. The current chapter discusses the background for the rapid survey and methodology. Chapter two contains a demographic and socioeconomic profile of the Jalna district and the survey respondents. Chapter three discusses the issues related to maternal health (trouble during pregnancy, place of delivery, assistance during delivery and problems after delivery). Chapter four presents the eligible women's awareness and practice regarding nutrition and health of children, particularly breast-feeding practices and childhood illness such as ARI and diarrhoea. Chapter five analyses the family planning acceptance levels and differentials and fertility preferences. Chapter six presents the eligible women's opinion about the government health centres. Summary of findings and conclusion of the present study are presented in Chapter seven.

Chapter 2

Socio-economic and Demographic Profile of Jalna District and Characteristics of Eligible Women

Jalna district is located in the Marathwada region of Maharashtra, which is considered to be backward in many respects, and is bordered by Buldhana district in the north, Bid district in the south, Parbhani in the east and Aurangabad in the west. Jalna district is coming under the Aurangabad division for the administrative purposes.

Jalna district has an area of 7718 sq. kms. constituting 2.5 percent of the total area of the state and has a population of 1,362,546 persons (1.73 percent of the state) including 695,740 males and 666,806 females according to the 1991 census. Among the 30 districts of the state it ranks 23rd in area and 26th in population. Hence Jalna is one of the smaller districts in the state in terms of area and population.

Table 2.1 compares the various social and economic indicators of Jalna district with that of Maharashtra state as a whole. The comparison with the state should be made cautiously, since the indicators for state are affected by the development of Greater Bombay. Jalna district registered a population growth rate of 32 percent during the decade 1981-91, which is much higher than the growth rate of the state (26 percent). Among the 30 districts of the state, Jalna district ranks 5th in average growth rate during 1981-91. The higher population growth rate of the district can be observed in its higher crude birth rate and total fertility rate than the state. During the period 1981-91 birth rate in the district had increased from 31.05 to 32.64 and consequently total fertility had increased from 4.30 to 4.47. But Maharashtra as a whole both CBR and TFR have registered a decline during the period 1981-91.

Level of urbanization and population density are low in Jalna as compared to the state level. Jalna district is predominantly rural: eighty-three percent of the population is living in rural areas and only the rest of 17 percent is living in urban areas. Jalna district ranks 23rd in the proportion of urban population to total population in the state.

Corresponding proportion for the state is 38.69 percent. In Jalna district there were 958 females per 1000 males in 1991. The sex ratio of the district (958) is higher than the state average of 934. The proportion of SC and ST population in the district is lower than the state average.

According to the 1991 census estimates both infant mortality rate and under-five mortality rate in the district (76 and 94 respectively) are more or less similar to the state average (71 and 91 respectively). But between 1981-91 the decline in IMR and under-five mortality is much higher in the district than in the state. The decline in IMR between 1981-91 is 45 percent in Jalna and 38 percent in the state. Likewise the decline in under-five mortality between 1981-91 is 53 percent in the district and 37 percent in the state.

As far as total literacy level is concerned, Jalna considerably lags behind the state. As per 1991 census, only 46 percent of its population aged 7 and above are literate as compared to the 65 percent in the state as a whole. In female literacy level, the district (27 percent) further lags behind the state (52 percent). Proportion of main workers in the population is slightly higher in Jalna (44 percent) than in the state as a whole (39 percent). Likewise the work participation rate for females is also higher in the district (43 percent) than in the state (33 percent). But when we look at the percentage of workers engaged in non-agricultural work it is evident that the higher work participation in the district is due to agriculture; i.e., among the workers proportion engaged in non-agricultural work is much lower in the district (17.6 percent) than in the state (40 percent). Hence it is clear that the industrial activity in the district is considerably lower than the state level. State government has declared Jalna as an industrially backward district. Godavari river is the main source of irrigation in the district. Cotton, sugarcane, jowar, bajra, and oil seeds are major crops cultivated in the district. Percentage of net area irrigated to net area sown in the district is considerably lower than the state average.

The information related to basic infrastructural facilities show that though the 100 percent of villages and towns are electrified in the state, per capita domestic

consumption of electricity (which could be considered as a proxy for standard of living) is very low in Jalna (17 kwh) as compared to the state (75.1 kwh). Motor vehicles per lakh of population is also much lower in Jalna as compared to the state. Better road and transport facilities increases the rural-urban connectivity, influence peoples' attitude towards lifestyle and access to various facilities (including health and family planning). It can be seen from the table that the road length per 100 sq. kms. is much lower in the Jalna district than the state as a whole. It means that access to various facilities including health care is on an average lower in the district than in the state. In terms of railway route length also the district lags behind the state level. Number of telephones and commercial banks per lakh of population (which are closely related with the industrial activities) are lower in the district as compared to the state.

Information regarding housing and amenities from 1991 census shows that the district scores less than the state in proportion of households living in pucca houses. Clearly the housing condition in the district is not up to the level of the state. Amenities in the house show that the proportion of households having electricity is much lower in the district as compared to the state level. But the proportion of households with safe drinking water is slightly higher in the district than in the state. Only 11 percent of the households in the district are having toilet facility as against 30 percent in the state as a whole. The proportion of the households having all the three facilities in the district (7 percent) is much lower than the state level (28 percent).

On the whole, the Jalna district lags behind the state in almost all the aspects like literacy, urbanization, work force in the modern sectors, per capita domestic consumption of electricity, road and transport facilities, housing and amenities and in commercial activities. The Centre for Monitoring Indian Economy (CMIE) has constructed a development index for all the states and districts of India by considering the various above mentioned socio-economic and development indicators. The CMIE index of development for Jalna district (65) is much lower than the average development index for the Maharashtra (164) state (CMIE, 1993).

Characteristics of eligible woman

This section provides a short descriptive summary of some socio-economic and demographic characteristics of the eligible women of the current survey such as religion, caste, occupation, education, age, number of living children, number of living sons and age of youngest child. This information on the characteristics of the eligible women is essential for the interpretation of survey findings and can provide an approximate indication of the representativeness of the survey.

Table 2.1 presents the percent distribution of eligible women (age 15-44) by selected background characteristics. The distribution of women by religion shows that almost eight out of ten women are Hindu (79 percent), eight percent are Muslim, ten percent are Bouddha and two percent are Christian and Jains. The caste composition of the women indicates that, Marathas, the numerically dominant caste of Maharashtra, accounted for 47 percent of the eligible women. Eighteen percent of the women belong to scheduled caste and scheduled tribe (SC and ST) and fifteen percent belong to other Hindu communities. Non-Hindus accounted for 20 percent.

Table 2.1 also shows the distribution of women by their occupational status. About four out of ten women (38 percent) reported that they are housewives, and are not working. The remaining sixty percent are working in various activities. Among the women working, most of them are engaged in agriculture either as cultivators or as agricultural labourers. One-fifth of the women is engaged in non-agricultural labour activities. A very small proportion (3 percent) of them are engaged in services and business

Literacy and educational attainment of women show that about 65 percent of the eligible women have never attended schools (illiterates). Thirteen percent of the women have primary education (1-4 years), another 13 percent have middle school education (5-7 years) and the remaining seven percent have high-school education (8-10 years). Only few (2.1 percent) have gone beyond high school level education.

The age distribution of the eligible women shows that the present sample is consisted of fairly young women as 77 percent of them are below 30 years of age. Only the remaining 23 percent of them are coming under the age group 30-44 years.

The distribution of eligible women by number of living children shows that 2 percent of the eligible women do not have any living children at the time of survey. Nineteen percent have one child, 25 percent have two children and 30 percent have three children. The remaining 24 percent have four or more children. The average number of living children for women age 15-44 in rural Jalna at the time of survey is found to be 2.7. The distribution of women by number of living sons reveals that 15 percent of them does not have any sons. Proportion of respondents with one living son is 36 percent and another 36 percent have two living sons. The proportion having 3 or more living sons is 9 percent. The average number of living sons per women at the time of survey is observed to be 1.4.

Distribution of women by age of youngest child shows that 29 percent of them have infants below age 1, and same percent are of women have their youngest child in the age group 1-2 years. For the 30 percent of women, age of the youngest child is more than 3 years.

The socio-economic and demographic profile of Jalna district as compared to the Maharashtra state reveals that relatively the district lags behind the state in many aspects of development. It means that the households in the district are on an average not better off than the state as a whole. This underdevelopment will certainly have its implications in the health and welfare of women and children in the district.

Table 2.1. Comparative demographic and socio-economic indicators for Maharashtra State and Jalna District.

Indicators	Maharashtra	Jalna
<u>Population@</u>		
Growth rate of population during 1981-91 (percentage)	25.73	32.26
Annual exponential growth rate, 1981-91	2.29	2.81
Density of population per sq. km. 1991	257	177
Sex ratio (number of females per 1000 males), 1991	934	958
Percentage of urban population, 1991	38.69	16.93
Percentage of scheduled castes population, 1991	11.09	12.93
Percentage of scheduled tribe population, 1991	9.27	2.07
Work participation rate, 1991, male	52.2	52.3
Work participation rate, 1991, female	33.1	42.8
Percentage of main workers to total population, 1991	39.28	43.96
Percentage of other than agril. workers to total worker, 91	40.38	17.60
Percent of cultivations among main workers, 1991	32.8	46.8
Percent of agricultural labourers among main workers, 1991	26.8	35.6
Percent literates (Total), 1991	64.87	46.25
Percent literates (Males), 1991	75.56	64.43
Percent literates (Females), 1991	52.32	27.30
Percent literates (Rural), 1991	55.52	42.00
Percent literates (Urban), 1991	79.20	66.77
Crude birth rate, 1981 [#]	31.75	31.05
Crude birth rate, 1991 [#]	29.75	32.64
Total fertility rate, 1981 [#]	4.30	4.30
Total fertility rate, 1991 [#]	3.72	4.47
Infant mortality rate, 1981 [#]	119	137
Infant mortality rate, 1981 [#]	74	76
Underfive mortality rate, 1981 [#]	145	198
Underfive mortality rate, 1991 [#]	91	94
Average household size, 1991	5.1	5.3
<u>Agriculture@, 1990-91</u>		
Percentage of net area sown to geographical area, 1990-91	58.7	79.2
Average size of operational holdings, 1990-91 (in hect.)	2.2	2.3
Percentage of net area irrigated to net area sown, 1990-91	13.9	8.1
Percentage of gross irrigated area to gross cropped area, 90-91	15.4	15.8
Foodgrains production per capita (in kg.)	173	330

table contd...

Table 2.1. Comparative demographic and socio-economic indicators for Maharashtra State and Jalna District.

Indicators	Maharashtra	Jalna
<u>Infrastructure[@], 1990-93</u>		
Percentage of villages and towns electrified	100	100
Per capita domestic consumption of electricity (kwh)	75.1	17.3
Motor vehicles per lakh of population	3652	1310
Road length per 100 sq. km. (kms.)	58	37
Railway route length per 100 sq. km. (kms.)	1.8	1.1
Number of post and telegraph offices per lakh of population	17	14
Number of telephones per lakh of population, 1990-91	1,328	204
Number of commercial banks per lakh of population, 1993	7.0	5.0
<u>Housing and Amenities, 1991[†]</u>		
Percentage of households living in pucca houses	52.2	34.06
Percentage of households living in semi-pucca houses	36.14	51.43
Percentage of households living in kutcha houses	11.67	14.50
Percentage of households having electricity	69.40	42.04
Percentage of households having safe drinking water	68.49	71.07
Percentage of households having toilet facility	29.56	10.74
Percentage of households having all three facilities	25.82	8.67
Percentage of households having none of the 3 facilities	13.42	19.97
Percentage of households using cowdung cake for cooking	9.59	13.09
Percentage of households using LPG for cooking	16.40	3.15
Percentage of households using wood for cooking	49.28	71.67
Percentage of households using kerosene for cooking	20.28	8.29
CMIE Index of development [*]	164	65

Sources:

* : CMIE, 1993

@ : Government of Maharashtra, 1995

† : Office of the Registrar General and Census Commissioner, 1994

: Registrar General, 1997

Table 2.2. Percent distribution of eligible women by selected socio-economic and demographic characteristics, Jalna, 1998

Characteristics	Number	Percent
Religion		
Hindu	793	79.3
Muslim	84	8.4
Bouddha	101	10.1
Christian	16	1.6
Jain	4	0.4
Not given	2	0.2
Caste		
Brahmin	18	1.8
Maratha	470	47.0
Scheduled Caste	56	5.6
Scheduled Tribe	120	12.0
Others	128	12.8
Non-Hindus	203	20.3
Not given	5	0.5
Occupation		
Housewives	377	37.7
Cultivation & agril. labourer	395	39.5
Non-agril. labourer	194	19.4
Others*	34	3.4
Years of schooling		
Illiterate	644	64.4
1-4 years	133	13.3
5-7 years	129	12.9
8-10 years	73	7.3
11+ years	21	2.1
Total	1000	100.0

Note: * includes anganwadi workers, ANMs, teachers, govt. service, business women and social workers.

table contd...

Table 2.2. Percent distribution of eligible women by selected socio-economic and demographic characteristics, Jalna, 1998

Characteristics	Number	Percent
Age of women		
15-19	133	13.3
20-24	322	32.2
25-29	318	31.8
30-34	167	16.7
35-39	55	5.5
40-44	5	0.5
No. of living children		
0	23	2.3
1	190	19.0
2	245	24.5
3	304	30.4
4	152	15.2
5	62	6.2
6+	24	2.4
<i>Mean number of living children</i>	-	2.7
No. of living sons		
0	145	14.5
1	406	40.6
2	355	35.5
3	72	7.2
4+	22	2.2
<i>Mean number of living sons</i>	-	1.4
Age of the youngest child		
No living child	23	2.3
0-5 months	121	12.1
6-11 months	166	16.6
12-17 months	92	9.2
18-24 months	194	19.4
25-36 months	107	10.7
37+ months	297	29.7
Total	1000	100.0

Chapter 3

Maternal Health

It has been recognised in India, since the first five-year plan, that maternal and child health (MCH) services need to be provided by the government as a major component of efforts to increase the infant and child survival. Substantial improvement in child survival prospects is almost a precondition for acceptance of contraception by a large number of couples. The Ministry of Health, Government of India, took steps to strengthen maternal and child health services in the successive five-year plan periods. In Maharashtra, as in other states of India, MCH services are available at the health centres and hospitals run by the government or they can be obtained in nursing homes and hospitals, which are run either by private doctors or by NGOs. Since the majority of the doctors and hospitals are concentrated in urban areas, government health centres and government programmes play a vital role in the provision of MCH services in rural areas. The Auxiliary Nurse Midwife (ANM), not only assists the Medical Officer and the female Health Assistant in providing these services but she is supposed to visit the households to register pregnant women and give them antenatal care throughout the pregnancy, natal care at the time of delivery and also postnatal care for the mother and the child. She is supposed to refer cases with any complication, which are beyond her capacity to treat, to the PHC. Since most of the deliveries in rural India are still conducted at home, *dais* (traditional birth attendants) are important and recognising their role, the government conducts training programmes to conduct safe delivery for them.

An important objective of this survey is to provide information on maternal and child health care practices. The relevant information was collected from the mothers who have given a live birth during last five years preceding the survey. If women had more than one live birth during the five years preceding the survey, the information was collected for the more recent delivery. Hence, this chapter presents the details about the latest deliveries of the sample women. The factors on which the data have been collected are household visitation by ANM, trouble during pregnancy, place of delivery,

attendance at delivery, use of safe delivery kit, problems immediately after delivery and place of treatment. These information can be used to identify groups of women whose babies are “at risk” because of non-use of maternal health services. The information will also assist policy makers in planning the appropriate strategies to improve maternal and child-care. These factors are either indicators of reproductive health or reproductive health care. But if we analyse this information along with the data on background characteristics of women, we would further be able to assess the differentials and trends in it.

Household Visitation by ANM

ANMs are a key component in the family planning programme’s service delivery system. Their direct contact with clients through household visitation remains a key strategy in the programme’s educational and motivational efforts. ANMs visit eligible women in their homes to provide MCH and family planning information and supplies. This approach was necessiated by the fact that many women are restricted by work, by custom or by distance to the health facility. In order to assess the extent of coverage of ANM, the present survey included a question about ANM’s visit. Table 3.1 shows the proportion of eligible women who said that they had been visited by the ANM in the three months prior to the survey. The data show that the household visitation by ANM is quite high: three-fourth of the women said that in the previous three months ANM had visited them in their house. All the women who said that the ANM had visited them during the last three months prior to the survey (764) were further asked whether they were satisfied with the amount of time ANM had spent with them. Almost all of them (98 percent) said that they were satisfied with the time the ANM had spent with them.

Table 3.2 shows the proportion of women who said that they had been visited by the ANM three months prior to the survey according to their background characteristics. Some women are more likely than others to have been visited by ANM. Older women are less likely to have been visited by ANM because they are more likely to be infecund or sterilized hence no need for MCH services. More educated women are more likely than the less educated women to be visited by the ANM. As for

differences by occupation, housewives, those engaged in agriculture and 'others' are more likely, and non-agricultural labourers are less likely to have been visited by ANM. Women with two living children and those with a child below two years of age are more likely to have been visited by ANM than women with three or more living children and women with children more than three years old. ANM's visit is not associated with either women's contraceptive use status or their current pregnancy status. Women residing in sub-centre village are more likely to have been visited by ANM than the women residing in PHC village and village without any health facility. Differentials in ANM's visit by religion and caste are not much pronounced. Women who want more children are more likely to have been visited by ANM than the women who desire no more children.

The patterns of visits according to the characteristics of the women are as expected. Younger women, women with less children, women with child below two years of age and women desire additional child are more likely to be visited. Despite the higher proportion of eligible women visited, still ANM has to increase her coverage to more illiterate women and women engaged in non-agricultural labour activities.

Trouble During Pregnancy

Before analysing the data it may be mentioned that, to minimise the recall lapse error, question regarding trouble during pregnancy is asked to women only those who have given birth during the last five years preceding the survey. Of the total 1000 women covered, 763 women were given birth in the five years preceding the survey. The rest of 237 women did not have any birth during the reference period. The percent distribution of women who have given birth by trouble during pregnancy is presented in Table 3.3. It may be observed from the table that, in case of 82 percent of women aged 15-44, there were no trouble during their most recent pregnancy. Nevertheless, about 9 percent of these women have suffered from vomiting/nausea during their pregnancy. A small proportion of women have suffered from swelling of feet (4 percent), bleeding (1 percent), tiredness (2.4 percent), faint (1.4 percent), pain in waist and back (1 percent) and abdominal pain (1 percent). Thus, it is clear that the prevalence of trouble during

pregnancy is not very high and the kind of trouble that they have faced does not appear to be serious in nature as shown in Table 3.3. The ante-natal care in Maharashtra is generally perceived to be adequate. For instance, according to the NHFS, Maharashtra, in 1992-93, even in rural areas, 78 percent of women had availed of the ante-natal care services (GIPE and IIPS, 1994). Further improvement in this level would, in future, reduce the pregnancy-related problems mentioned above.

Percent distribution of women who had trouble during pregnancy by age is given in Table 3.4. It is observed that there is a clear U shaped relationship between age and trouble during pregnancy. Proportion of women who had trouble is lower in the age group 20-29 (17 percent) as compared to women in the age group 15-19 (21 percent) and 30-44 years (20 percent). Trouble during pregnancy is lowest among women aged 25-29 years (14.5 percent).

Place of Delivery and Assistance During Delivery

An important element in reducing health risk for mothers and children is to increase the proportion of babies that are delivered in health facilities. Proper medical attention and hygienic condition during delivery can reduce the risk of infections and facilitate management of complications that cause serious illness for either mother or new born. In order to ascertain the situation in rural Jalna, respondents who have given birth during the five years preceding the survey were asked, where they gave birth and who assisted at the delivery. Hence this section discusses place of delivery and assistance during delivery. Of the total 1000 women, 763 have given birth during the five years preceding the survey. Out of these 763 women 69 women were pregnant again at the time of survey. For these 69 women place of delivery and type of assistance during delivery questions were not administered. Hence this section analyses the information collected from 694 women.

Table 3.5 presents the distribution of women who have given birth during the five years prior to the survey (roughly 1993-1998) by place of delivery. It shows that one-fourth of the deliveries have occurred in health facilities: 10 percent in public health

institutions (government hospital and PHC) and 15 percent in private medical institutions. Hence, the utilization of private health facilities is slightly higher than the utilization of public health facilities. The data indicate that a large majority of the women (75 percent) in rural areas of Jalna district have delivered their babies at their own home or at mother's home.

According to NFHS the proportion of deliveries occurred in health facilities in rural Maharashtra was 25 percent for the years 1989-92 (GIPE and IIPS, 1994). When we compare the NFHS data with the present survey we could observe that during the last six years there is no increase in the proportion of deliveries occurring in health facilities in rural areas of Jalna district. Also 25 percent of institutional deliveries in rural Jalna is much lower than the goal to be achieved (33 percent) under the TFA of Government of India (MOHFW, 1996). All the 519 women who have delivered their babies at their or their mother's home were further asked about the information on type of assistance received during delivery. If more than one person is found to have assisted during the home delivery, only the most qualified attendant is considered for the purpose of analysis. It is observed from Table 3.6 that the majority of the deliveries (55 percent) at home were attended by untrained personnel (relatives and untrained *dais*). Only the remaining 45 percent of them were assisted by trained personnel (doctors, nurses, and trained *dais*).

The information provided in Tables 3.5 and 3.6 can be combined to get the proportion of women assisted by the trained and untrained personnel during their delivery. Out of the total 694 women, 175 delivered in health facility. Among the remaining 519 women who delivered at home, 233 received the assistance of trained personnel. Women delivered in medical institutions and women assisted by trained personnel for home delivery together works out to 408 (175+233). Hence the proportion of deliveries assisted by the trained personnel in rural areas of Jalna is 59 percent (Table 3.7). Proportion of deliveries assisted by trained personnel in rural Maharashtra according to NFHS was 37.6 percent during 1989-92 (GIPE and IIPS, 1994). The comparison of NFHS and the result of the present survey indicates that in

the recent years mothers seeking medical supervision for deliveries have considerably increased: i.e., 38 percent in rural Maharashtra during 1989-92 and 59 percent in rural Jalna during 1993-98. But this is clearly much lower than the desired goal of Government of India (95 percent trained assistance for deliveries) under the TFA (MOHFW, 1996). A survey conducted by Salunke *et al* (1997) in all the districts of Maharashtra, for the Directorate of Health services, found that, in Jalna 56 percent (rural and urban together) of the deliveries were assisted by trained personnel during 1997.

Table 3.8 presents the percent distribution of women by trouble during pregnancy and place of delivery. It reveals that among those who had trouble during pregnancy a relatively higher proportion (36 percent) delivered their child in a health facility than those who did not face any trouble (23 percent).

Differentials in Place of Delivery and Type of Assistance

Table 3.9 presents the distribution of women who have given birth during five years period preceding the survey by place of delivery according to selected background characteristics. It shows that the proportion of women delivered in health facilities is higher for younger women than for older women. For example, 35 percent of the women aged 15-19 have delivered their babies in health facilities as compared to only 27 percent of women aged 30 and above. Education of women has a clear positive association with proportion delivered in health facility. Only one-fifth of the illiterate women delivered in health facility whereas about 54 percent of the women with 8 and more years of education delivered at health facility. Even the effect of primary education on delivery at health facility is considerable. Proportion of SC and ST women delivered their child in health facilities is considerably lower than the women from other caste groups. Slightly higher proportion of Hindus have delivered at health facility than non-Hindus. The percentage of institutional deliveries is higher among housewives than either those engaged in agricultural or non-agricultural activities. The reason perhaps the housewives may be from the better-off section of the rural community. With increasing number of living children and increasing age of youngest child the proportion of

institutional deliveries are consistently decreasing. Still a very large proportion (about 75 percent) of women aged 20 years and above and women with three or more living children have delivered their child at home. This implies that relatively larger proportions of high-risk births are delivered at home. Women living in PHC village are more likely to deliver in health facility than the women living in either the sub-centre village or village without any government health facility.

Table 3.10 provides information on assistance during home delivery by selected background characteristics. Deliveries to mothers age below 25 (47 percent) are more likely than those to mothers age above 25 (42 percent), to be assisted by a trained birth attendant. Use of trained birth attendant is higher among literate mothers than illiterate mothers. Proportion of deliveries attended by trained personnel is higher for Muslims than for Hindus. The percentage of deliveries attended by the trained personnel is lower among SC and ST than among other caste groups. Housewives and 'others' are more likely than the other working women to receive the assistance of trained personnel. Women with one living child are slightly more likely to be assisted by the trained birth attendants than the women with more than one living child. Women with youngest child age below 3 years are more likely to be assisted by the trained personnel than the women with the child above 3 years of age. Presence of health facility in village has considerably increased the assistance of trained personnel for home delivery. Women living in PHC and sub-centre villages are more likely to take the assistance of trained personnel than the women living in villages without any public health facility. The information provided in Table 3.10 indicates that still more than half of home deliveries are attended by untrained persons and the proportion is very high for illiterate women, SC and ST women and women residing in villages without any health facility. Hence efforts should be taken to ensure the highly trained delivery assistance to all rural women.

Table 3.11 provides the type of personnel attended the delivery (inclusive of deliveries both at health facility and at home). It shows that 28 percent of women have delivered under the supervision of a doctor and 31 percent delivered under the assistance of nurse or trained *dai*. Relatives and others provided assistance in 41

percent of deliveries. Older women and women who have already had many births are much more likely to have received no trained assistance at delivery, whereas births to younger women, women with one living child, and women with youngest child below 3 years of age tend to receive more assistance of trained persons. With increasing level of education women are much more likely to have the assistance of trained persons, including more frequent supervision by a doctor. Presence of public health facility in village made more women to seek trained assistance at delivery: 68 percent of women residing in villages with health facility sought trained supervision at delivery whereas only 54 percent of women residing in villages without any health facility sought medical supervision at delivery.

All the women who have delivered at home were further asked about whether the birth attendants have used the disposable delivery kit or not. About half of the women (47 percent) said that the safe delivery kit was used at the time of delivery (Table 3.12). The low usage of these specific clean delivery kits may be due to the shortage of supply or that the message of using safe equipment in home deliveries has not reached the bulk of the rural women in the Jalna district.

Weighing of Baby

Nine out of ten babies born in hospital are weighed at birth because a facility for weighing is available in the hospital. Exclusively for this reason babies born at home are almost never weighed at birth (Table 3.13). On the whole, a majority of the babies (72 percent) were not weighed whereas only 8 percent of the babies born at home were weighed. Though a considerable proportion of home deliveries was conducted by trained personnel, the practice of weighing baby was not followed by them. Under the TFA, the government of India's desired goal is to achieve 95 percent recording of the birth weight of new born babies (MOHFW, 1996).

Problems Immediately after Delivery

The percent distribution of women who have given birth during the five years period prior to the survey according to the problems immediately after delivery is

presented in Table 3.14. As reported by mothers, about 94 percent of them had no problems immediately after delivery. Among the women who had trouble (6 percent) fever, bleeding, caesarean delivery related problems are the common complications reported. The mothers who had trouble immediately after delivery were further asked about the place of treatment (Table 3.15). Majority of the mothers (64 percent) sought treatment in private hospitals for the problems they had. The proportion sought treatment in public health facilities is 28 percent. Eight percent of the women never took any treatment for the problems they had after delivery. A higher proportion of deliveries at private hospitals and higher proportion of treatment sought at private hospitals for the problems they had faced after delivery together suggests the mothers' inclination towards the private health care facilities. But this trend cannot be attributed to the people's desire towards private health care. It may be due to the easy accessibility of the private health establishments.

Advise for Hospital Delivery

One of the functions of the ANM is to encourage the expectant mothers to go for institutional delivery. It is found that among the women who have given birth during the last five years 45 percent of them were advised to go for hospital delivery by ANM in rural areas of Jalna (Table 3.16). It should be mentioned here that, under the TFA, 33 percent of the expected deliveries should take place in institutions. Hence ANM's motivation to higher proportion of pregnant women would result in higher proportion of institutional deliveries. In the current survey only 25 percent of the women have found to deliver in institutions.

Conclusions

Prior to the implementation of TFA there were activities relating to antenatal and natal care. However, under the new programme of TFA there is a more emphasis on them. There are some goals to be achieved regarding registration of deliveries, birth weight of the baby, immunization of mothers and children, institutional deliveries, deliveries by trained person etc. For instance, according to the policy adopted by the Government of India, the goals are 60 percent registration for pregnancy (registration

before 16 weeks), 100 percent immunization for mothers and children, 33 percent for institutional deliveries, 95 percent deliveries by trained persons, 95 percent for recording of the birth weight etc. This information would help us to analyse the results of the present survey.

One of the major objectives of this study is to provide the information on maternal and child health care practices in the selected district. The information were collected from the mothers who have given birth during the last five years preceding the survey. The information elicited from the eligible women are household visitation by ANM, trouble during pregnancy, place of delivery, attendance at delivery, use of safe delivery kit, problems immediately after delivery and place of treatment.

The results show that not only the household visitation by the ANM during the last three months prior to the survey is quite high but also all the eligible women (98 percent) were satisfied with the amount of time the ANM had spent with them. Differentials in household visitation by the ANM according to the background characteristics of eligible women revealed that, as expected, younger women, women with two children, women with youngest child below 2 years of age and women residing in sub-centre villages are more likely to be visited.

The survey indicates that the prevalence of trouble during pregnancy in the study area is not very high and also the kind of trouble that they had faced does not appear to be serious. But trouble during pregnancy is found to have a U shaped relationship with age as expected.

The data show that only 25 percent of the women have given birth in health facilities, which is lower than the norm set (33 percent) by the government under the RCH approach. Further, the utilization of private health facilities is slightly higher than the public health facilities for deliveries. The comparison of NFHS results with the present survey indicates that there is no increase in the proportion of institutional deliveries in recent years. But 45 percent of the home deliveries were attended by the

trained personnel, which is much lower than the goal to be achieved under the RCH approach (95 percent). Proportion of institutional delivery and assistance by trained personnel for the home delivery together works out to 59 percent in Jalna. The comparison of NFHS and the result of the present survey indicate that in rural areas mothers seeking medical supervision for deliveries have considerably increased in recent years in rural Maharashtra. But the 59 percent trained assistance for deliveries are well below the norm of 95 percent trained assistance under the TFA. Differentials in place of delivery show that younger and educated women and women with less number of children delivered more in health facility than the older, illiterate and women with more children. The proportion of mothers who received no trained assistance for home delivery is high among mothers aged 20 and above, mothers who have no education, SC and ST mothers women engaged in agricultural labour activities and mothers with higher order births. Presence of Public Health Centre in the village made more women to seek trained assistance for delivery than at home.

Ninety percent babies born in health facility were weighed whereas only 8 percent of babies born in home were weighed on the whole only 29 percent of the babies were weighed. This is well below the government's norm of 95 percent recording of birth weight of new born babies under the RCH approach.

Table 3.1. ANM's visit and satisfaction of the eligible women

ANM's visit	Number	Percent
Has the ANM visited you during the last three months?		
Yes, visited	764	76.4
No, not visited	234	23.4
Not given	2	0.2
Total	1000	100
If yes, were you satisfied with the amount of time? (n=764)		
Yes, satisfied	748	97.9
No, not satisfied	16	2.1
Total	764	100

Table 3.2. Percentage of eligible women who reported having been visited by ANM in the three months prior to the survey by selected background characteristics.

Background Characteristic	Number of women visited by ANM	Percent of women visited by ANM	Total number of women
Age			
15-19	107	80.5	133
20-24	264	82.0	322
25-29	245	77.0	318
30-34	109	65.3	167
35-44	39	65.0	60
Education			
Illiterate	473	73.4	644
1-4 years	106	79.7	133
5-7 years	106	82.2	129
8+ years	79	84.0	94
Religion			
Hindu	609	76.8	793
Muslim	61	72.6	84
Bouddha	78	77.2	101
Others	16	72.7	22
Caste			
Maratha	355	75.5	470
SC & ST	139	75.5	184
Others	118	82.5	143
Non-Hindus	152	74.9	203
Occupation			
Housewife	295	78.2	377
Cultivn. & agril. labour	310	78.5	395
Non-agril. labour	130	67.0	194
Others	29	85.3	34
Total	764	76.4	1000

table contd...

Table 3.2. Percentage of eligible women who reported having been visited by ANM in the three months prior to the survey by selected background characteristics.

Background Characteristic	Number of women visited by ANM	Percent of women visited by ANM	Total number of women
Number of living children			
0	14	60.9	23
1	150	78.9	190
2	206	84.1	245
3	230	75.7	304
4+	164	68.9	238
Age of the youngest child			
No living child	14	60.9	23
0-11 months	249	86.8	287
12-24 months	239	83.6	286
25-36 months	80	74.8	107
37+ months	182	61.3	297
Contraceptive use			
User	350	77.8	450
Non-user	414	75.3	550
Currently pregnant			
Yes	70	77.8	90
No	694	76.3	910
Want no more children			
No	447	73.5	608
Yes	317	83.9	378
Type of village			
PHC village	58	72.5	80
Sub-centre village	236	84.3	280
Other village	470	73.4	640
Total	764	76.4	1000

Table 3.3. Percent distribution of women who have given birth during the five years preceding the survey by trouble during pregnancy (n=763).

Type of trouble	Number	Percent
No trouble	627	82.2
Swelling of feet	33	4.3
Bleeding	7	0.9
Excessive tiredness	18	2.4
Faint	11	1.4
Pain in waist & back	7	0.9
Blood pressure	4	0.5
Abdominal pain	7	0.9
Vomiting/nausea	66	8.7
Numness	1	0.1
Total number of women with problems	135	17.7
<i>Not reported</i>	<i>1</i>	<i>0.1</i>
Total*	763	100

* total will exceed 100 percent because of the multiple problems mentioned by the women

Table 3.4. Percent distribution of women who had trouble during pregnancy by age (n=762).

Age of women	Women who did not have trouble		women who had trouble		Total	
	No.	%	No.	%	No.	%
15-19	91	78.4	24	20.7	116	100
20-24	255	81.5	58	18.5	313	100
25-29	212	85.5	36	14.5	248	100
30-44	69	80.2	17	19.8	86	100
Total	627	82.3	135	17.7	762	100

Table 3.5. Percent distribution of women who have given birth during the last five years by place of delivery (n=694).

Place of delivery	Number	Percent
Health facility		
Government hospital/PHC	70	10.1
Private hospital	105	15.1
Home		
At respondent's home/parents' home	519	74.8
Total	694	100.0

Table 3.6. Percent distribution of women who have given birth during the last five years by type of personnel attended the home delivery (n=519).

Person attended the home delivery	Number	Percent
Trained personnel		
Nurse	30	5.8
Trained <i>dai</i>	187	36.0
Private doctors	16	3.1
Untrained personnel		
Untrained <i>dai</i> /Relatives	286	55.1
Total	519	100

Table 3.7. Percent distribution of women who have given birth during the last five years by type of personnel attended the delivery (n=694).

Person attended the delivery	Number	Percent
Trained personal	408	58.8
Untrained personnel	286	41.2
Total	694	41.2

Table 3.8. Trouble during pregnancy and place of delivery

Place of delivery	women who did not have trouble		women who had trouble		Total
	No.	%	No.	%	
Institution	133	23.1	42	36.2	175
Home	444	76.9	74	63.8	518
Total	577	100.0	116	100.0	693

Table 3.9. Percent distribution of women who have given birth during 5 years preceding the survey by place of delivery according to selected background characteristics (n=694).

Background characteristic	Place of delivery				Total	
	Health facility		Home		No.	%
	No.	%	No.	%		
Age						
15-19	36	35.0	67	65.0	103	100
20-24	63	22.9	212	77.1	275	100
25-29	53	22.8	179	77.2	232	100
30-44	23	27.4	61	72.6	84	100
Education						
Illiterate	82	18.5	362	81.5	444	100
1-4 years	30	33.3	60	66.7	90	100
5-7 years	26	28.6	65	71.4	91	100
8+ years	37	53.6	32	46.4	69	100
Religion						
Hindu	145	26.6	401	73.4	546	100
Muslim	12	17.4	57	82.6	69	100
Bouddha	10	15.2	56	84.8	66	100
Others	8	61.5	5	38.5	13	100
Caste						
Maratha	91	28.3	230	71.7	321	100
SC & ST	18	14.5	106	85.5	124	100
Others	37	35.6	67	64.4	104	100
Non-Hindus	29	20.0	116	80.0	145	100
Occupation						
Housewife	94	34.1	182	65.9	276	100
Cultivn & agril. Labour	51	18.5	224	81.5	275	100
Non-agril. labour	24	19.7	98	80.3	122	100
Others	6	28.6	15	71.4	21	100
Total	175	25.2	519	74.8	694	100

table contd...

Table 3.9. Percent distribution of women who have given birth during 5 years preceding the survey by place of delivery according to selected background characteristics (n=694).

Background characteristic	Place of delivery				Total	
	Health facility		Home		No.	%
	No.	%	No.	%		
No. of living children						
1	58	39.2	90	60.8	148	100
2	54	30.0	126	70.0	180	100
3	34	17.5	160	82.5	194	100
4+	28	16.6	141	83.4	169	100
Age of youngest child						
0-11 months	82	28.7	204	71.3	286	100
12-24 months	64	25.9	183	74.1	247	100
25 + months	28	17.7	130	82.3	158	100
Type of village						
PHC village	18	34.0	35	66.0	53	100
Sub-centre village	47	25.3	139	74.7	186	100
Other village	110	24.2	345	75.8	455	100
Total	175	25.2	519	74.8	694	100

Table 3.10. Percent distribution of women who have given birth during 5 years preceding the survey by the type of assistance received during home delivery, according to selected background characteristics (n=519).

Background Characteristic	Attendant assisting during delivery at home					
	Trained personnel		Untrained personnel		Total	
	No.	%	No.	%	No.	%
Age						
15-19	31	46.3	36	53.7	67	100
20-24	101	47.6	111	52.4	212	100
25-29	75	41.9	104	58.1	179	100
30-44	26	42.6	35	57.4	61	100
Education						
Illiterate	154	42.5	208	57.5	362	100
1-4 years	31	51.7	29	48.3	60	100
5-7 years	33	50.8	32	49.2	65	100
8+ years	15	46.9	17	53.1	32	100
Religion						
Hindu	168	41.9	233	58.1	401	100
Muslim	41	71.9	16	28.1	57	100
Bouddha	19	33.9	37	66.1	56	100
Others	5	100.0			5	100
Caste						
Maratha	95	41.3	135	58.7	230	100
SC & ST	40	37.7	66	62.3	106	100
Others	33	49.3	34	50.7	67	100
Non-Hindus	65	56.0	51	44.0	116	100
Occupation						
Housewife	93	51.1	89	48.9	182	100
Cultivn & agril.labour	92	41.1	132	58.9	224	100
Non-agril. labour	37	37.8	61	62.2	98	100
Others	12	80.0	3	20.0	15	100
No. of children						
1	45	50.0	45	50.0	90	100
2	55	43.7	71	56.3	126	100
3	77	48.1	83	51.9	160	100
4	31	35.8	56	64.4	87	100
5+	24	44.4	30	55.6	54	100
Age of youngest child						
0-5 months	42	45.2	51	54.8	93	100
6-11 months	48	43.2	63	56.8	111	100
12-24 months	85	46.4	98	53.6	183	100
25-36 months	33	50.8	32	49.2	65	100
37 + months	24	36.9	41	63.1	65	100
Type of village						
PHC village	18	51.4	17	48.6	35	100
Sub-centre village	81	58.3	58	41.7	139	100
Other village	134	38.8	211	61.2	345	100
Total	233	44.9	286	55.1	519	100

Table 3.11. Percent distribution of women who have given birth during 5 years preceding the survey by the type of assistance received during delivery, according to the background characteristics (n=694).

Background characteristic	Type of assistance during delivery							Total
	Doctor		Nurse/trained dai		Trained Personnel (i+ii)	Relatives/others		
	No.	% (i)	No.	% (ii)		No.	% (iii)	
Age								
15-19	39	37.9	28	27.2	65.1	36	35.0	103
20-24	67	24.4	97	35.3	59.7	111	40.3	275
25-29	60	25.9	68	29.3	55.2	104	44.8	232
30-34	25	29.8	24	28.6	58.4	35	41.6	84
Education								
Illiterate	93	20.9	143	32.2	53.1	208	46.9	444
1-4 years	32	35.6	29	32.2	67.8	29	32.2	90
5-7 years	29	31.9	30	33.0	64.9	32	35.1	91
8+ years	37	53.6	15	21.7	75.3	17	24.7	69
Religion								
Hindu	160	29.3	153	28.0	57.3	233	42.7	546
Muslim	13	18.8	40	58.0	76.8	16	23.2	69
Bouddha	10	15.2	19	28.8	44.0	37	56.0	66
Others	8	61.5	5	38.5	100.0	-	-	13
Caste								
Maratha	103	32.1	83	25.9	58.0	135	42.0	321
SC/ST	20	16.1	38	30.6	46.7	66	53.3	124
Other caste	38	36.5	32	30.8	67.3	34	32.7	104
Non-Hindu	30	20.7	64	44.1	64.8	51	35.2	145
Occupation								
Housewives	104	37.7	83	30.1	67.8	89	32.2	276
Cultivn & agril. labour	56	20.4	86	31.3	51.6	133	48.4	275
Non-agril. labour	25	20.5	36	29.5	50.0	61	50.0	122
Others	6	28.6	12	57.1	85.7	3	14.3	21
No. of living children								
1	63	42.6	40	27.0	69.6	45	30.4	148
2	56	31.1	53	29.4	60.6	71	39.4	180
3	39	20.1	72	37.1	57.2	83	42.8	194
4	19	18.6	27	26.5	45.1	56	54.9	102
5+	13	19.4	24	35.8	55.2	30	44.8	67
Age of youngest child								
0-5 months	34	28.1	36	29.8	57.9	51	42.1	121
6-11 months	55	33.3	47	28.5	61.8	63	38.2	165
12-17 months	69	27.9	80	32.4	60.3	98	39.7	247
25-29 months	17	20.7	33	40.2	61.0	32	39.0	82
37+ months	15	19.7	20	26.3	46.1	41	53.9	76
Type of village								
PHC village	19	35.8	17	32.1	67.9	17	32.1	53
Sub-centre village	56	30.1	72	38.7	68.8	58	31.2	186
Other village	116	25.5	128	28.1	53.6	211	46.4	455
Total	191	27.5	217	31.3	58.8	286	41.2	694

Table 3.12. Distribution of home delivery by use of disposable delivery kit

Use of disposable delivery kit	Number	Percent
Yes, used	242	46.6
No, not used	277	53.4
Total	519	100.0

Table 3.13. Per cent distribution of women according to whether the baby was weighed after birth or not.

	Number	Percent
Hospital delivery (n = 173)		
Weighed	157	90.8
Not weighed	16	9.2
Total	173	100.0
Home delivery (n = 519)		
Weighed	40	7.7
Not weighed	479	92.3
Total	519	100.0
Total (n = 692)		
Weighed	197	28.5
Not weighed	495	71.5
Total	692	100.0

Table 3.14. Per cent distribution of women who have given the birth during the five years preceding the survey by problems immediately after delivery.

Type of problem	Number	Percent
No problem	654	94.4
Problems:		
1. Fever	4	0.6
2. Bleeding	9	1.3
3. Caesarean delivery	7	1.0
4. Caesarean delivery + others	19	2.7
Total	693	100.0

Table 3.15. Per cent distribution of women who had problems immediately after delivery by place of treatment (n = 39)

Place of treatment	Number	Percent
ANM	2	5.1
Primary Health Center	4	10.3
Government Hospital	5	12.8
Private Hospital	25	64.1
No treatment	3	7.7
Total	39	100.0

Table 3.16. Per cent distribution of women who have given birth during the five years preceding the survey by ANM's advise for hospital delivery

ANM's advise	Number	Percent
Yes, advised for hospital delivery	311	45.0
No, not advised for hospital delivery	380	55.0
Total	691	100.0

Chapter 4

Awareness and Practise regarding Nutrition and Health of Children

The Family Welfare Programme under the new Target Free Approach has changed from a segregated approach to that of an integrated approach with the emphasis on RCH services. RCH approach includes CSSM programme. Under the CSSM programme it was decided that the ANM should hold mother's meetings periodically and give them information about proper practice of breast-feeding, initiation of supplementary food etc. At the same time she was also expected to give them information about the symptoms of ARI (Acute Respiratory Infection) and diarrhoea. The Maharashtra government had also organised intensive training programme for the ANMs to educate them with the above mentioned services. In the present survey an attempt is made to see whether the ANMs have succeeded in carrying the information to the rural women. The questions in our questionnaire pertain to the ANM's advise about breast-feeding, initiation of supplementary food, knowledge about ARI and diarrhoea and home management of diarrhoea.

Advise and Practise about Breast-feeding

Infant feeding has an impact on both the child and the mother. Feeding practices are important determinants of children's nutritional status and many studies have shown the beneficial effects of breast-feeding on nutritional status, morbidity and mortality of young infants. Breast-feeding also has an indirect effect on the post-partum fertility of mothers. In particular, more frequent breast-feeding is associated with longer periods of post-partum amenorrhea, which in turn are related to longer birth intervals, and thus lower fertility levels.

Table 4.1 presents the proportion of women advised by ANM about proper breast-feeding. Among the women who have given birth during the five years preceding the survey 42 percent of them were advised by ANM and the rest of them (58 percent) were not advised for proper breast-feeding practices. More than half of the women not advised by the ANM clearly indicate that still she has to improve her services. Among

the women those who have received the advise were further asked about the type of advise received from ANM. Table 4.2 shows that two types of advise were prominently given to women by ANMs: one is to initiate of breast-feeding immediately after the delivery (84 percent) and another is not to squeeze out the first milk (colostrum) from the breast (53 percent). Exclusive breast-feeding for four months was advised to 12 percent of women. Proportion of women advised to give liquid supplements with breast-milk after four months was 4 percent. The type of advise given by the ANM to the women seems to be proper.

Background characteristics of women according to the advise by ANM for proper breast-feeding is given in Table 4.3. It shows that advise by ANM varies much according to the characteristics of women. Percentage of mothers advised for breast-feeding increases as mothers' level of education increases: only 37 percent of women who had no education were advised, compared with 61 percent of women with 8 and more years of schooling. Maratha and SC and ST women were the ones least advised by the ANM than the women from other communities. Non-agricultural labourers were least advised by ANM than the women in the other occupational categories. Women with three or less children and women with a child age below three years were slightly more likely to be advised by the ANM than the others. Women residing in sub-centre villages are more likely to be advised by the ANM than the women residing in PHC villages and villages without any health facility. The introduction of the advise about proper breast-feeding is a recently introduced component in the programme. The observations indicate that the ANM still has to extend her services to the illiterates, non-agricultural labourers and SC and ST women.

The early initiation of breast-feeding is important since it benefits both mother and the infant. It is generally recommended that the first breast-milk should not be squeezed from the breast, but should be given to the child, because it contains colostrum, which provides natural immunity to the child. Colostrum and breast-milk are sufficient for new-born infants; it is not necessary to feed them anything else. In fact,

when the neonate is given anything other than the breast-milk, contaminants may cause infection, leading to diarrhoea.

Table 4.4 shows how soon after birth breast-feeding was initiated. This information was collected for all the women who had a birth during five years before the survey. Although all women breast-feed their child, the early initiation of breast-feeding is not common. Only 17 percent of women began breast-feeding within one hour of birth and only 34 percent began breast-feeding during the first 24 hours of birth. This suggests that the knowledge of the benefits associated with the early initiation of breast-feeding has not reached most women in rural Maharashtra, indicating a need for the enhanced efforts of the ANM and launching of an information campaign on the subject. But it seems in recent years the proportion of women initiating breast-feeding early is gradually increasing. For instance, for rural Maharashtra during 1989-93, NFHS found that only 15 percent of the women breast-fed their child within a day of birth (GIPE and IIPS, 1994). In the present survey, for rural Jalna, for the period 1994-98, the proportion started within a day is 34 percent. A substantial increase over a period of six years. Proportion started within an hour has also witnessed a substantial increase: 6 percent during 1989-93 in rural Maharashtra and 17 percent during 1994-98 in rural Jalna.

Differentials in the timing of initiation of breast-feeding according to the background characteristics of women are presented in Table 4.5. It shows that there are substantial differences by background characteristics. Age of the women is negatively associated with the early initiation of breast-feeding. For instance, those who initiated breast-feeding within an hour of birth is 22 percent among women aged 15-19 years whereas it is only 12 percent among women aged 30-44 years. Very clear positive association emerges between education of women and early initiation of breast-feeding. Women who had at least high school education are more than twice as likely to initiate breast-feeding within an hour and within a day of birth as compared to illiterate women. Bouddhas are less likely to initiate early than the women from other religions. SC and ST women are less likely to initiate feeding within a day than the women from other

castes. Likewise, women engaged in agricultural and non-agricultural activities were initiated feeding later than the housewives and 'others'. With the increase in the number of living children proportion initiating early breast-feeding is consistently decreasing. Similarly higher proportion of women with youngest child age two and below initiated feeding earlier than the women with youngest child age above two years.

It is interesting to note that the proportion of first hour and first-day breast-feeding is highest among the women who were advised by the ANM than the women who were not advised. It signifies the role of ANM in enhancing the maternal and child health. Women who delivered at a health facility and women who were assisted by a health professional at delivery are much more likely to initiate early breast-feeding than the women delivered at home and without trained assistance. Women residing in sub-centre villages are more likely to initiate breast-feeding earlier than the women residing in other villages. Although there are differences in the initiation of breast-feeding by background characteristics, the postponement of breast-feeding in all groups shows that feeding practices for new-born infants are not beneficial. Overall, two-third of infants did not start breast-feeding in the first day of life. Though in recent years there is an improvement in the early initiation of breast-feeding, the role of ANM should be further improved to guide the expectant mothers for the proper feeding practices. The observation that early initiation of breast-feeding by the women who received advise from ANM than the women who were not received the advise could be taken as an indication of advise being more effective than the women's own awareness. This finding is encouraging for the health department personnel in the sense that, advice, if properly given, could change the breast-feeding practices and ultimately result in increased health and survival of children.

The faulty breast-feeding practices by women in rural Jalna can be further seen in Table 4.6. Only 30 percent women have given colostrum to the new born babies and the remaining 70 percent of women have removed colostrum before initiating the feeding. The unhealthy feeding practices by women needs utmost attention in the IEC component of the RCH approach.

Childhood Illness and Treatment

This section considers the knowledge and treatment of the common childhood diseases. Acute respiratory tract infection (ARI), primarily pneumonia, and diarrhoea are the common cause of morbidity and death among children under five years of age. Early diagnosis and treatment with antibiotics can prevent a large proportion of deaths caused by ARI.

As per the guidelines of the new RCH approach under the target free situation, ANMs are expected to hold mothers' meetings and tell them about the symptoms and prevention of the major ailments of infancy and childhood. Hence, women who have given birth during the last five years preceding the survey were asked questions about knowledge of ARI and ANM's advise about the home management of diarrhoea. This section also includes 69 currently pregnant women and 20 first time pregnant women. It can be observed from Table 4.8 that only 31 percent of women (244 out of 783) are aware about ARI. For those who had knowledge about ARI, ANMs are the major source of information for half percent of the women. It is clear that, though ANMs are visiting a large number of eligible women, they are not really carrying the important messages to them. According to NFHS prevalence of ARI among children under four years of age in rural Maharashtra during 1992-93 was 7.5 percent. Also prevalence of ARI was felt to be higher among the children living in rural areas and children of illiterate mothers. The treatment pattern of ARI also showed that education of the mother helps in giving better treatment (GIPE and IIPS, 1994). Since mothers' characteristics are related to the ARI an attempt is made here to analyse the knowledge of ARI with the background characteristics of women. It shows that knowledge about ARI is higher among women age 20 years and above than the women in the age below 20 years. Knowledge about ARI is lower among illiterate women as compared to the literate women as expected. Knowledge is lower among SC and ST women and the women engaged in non-agricultural labour. Knowledge about ARI is lower among women with one living child than the women with two or more living children. Knowledge is lower among women desiring another child than the women not desiring another child.

Since ANMs have been trained to inform the mothers about ARI, it is essential to examine the association between ANMs visit and knowledge about ARI. The data clearly indicate that knowledge about ARI is related to ANM's visit: 34 percent of women visited by ANM have knowledge about ARI compared to only 18 percent among those who have not visited by ANM. Women's level of knowledge about ARI is lowest in villages without any public health facility: half of the women residing in sub-centre villages are aware about ARI compared to only one-fourth of women in villages without any public health facility. Hence, nearness to the public health facility considerably increases the women's knowledge and awareness about childhood diseases. Overall, the table shows that knowledge is lower among the women in general and further lower among younger, illiterate, SC and ST women and women with infants. Though large proportion of women (61 percent; Table 3.1) were visited by the ANM during the last three months prior to the survey the knowledge level for ARI is not very high. Thus, it can be said that all the ANMs are not carrying the information to the mothers. This finding suggests some modifications/improvement in the ANMs training so that they will be able to make the mothers more aware about ARI.

Knowledge of Diarrhoea

Deaths due to diarrhoea are a significant proportion of deaths, especially children under five years of age in India. Deaths from acute diarrhoea are most often due to the dehydration that results from the loss of water and electrolytes. For this reason, nearly all diarrhoea deaths can be prevented by prompt administration of rehydration solutions. The government of India has launched the Oral Rehydration Therapy (ORT) programme as one of its priority activities for child survival. A major purpose of this programme is to increase the awareness among women and in the community about Oral Rehydration Salt (ORS) packets, which are made widely available. The programme also promotes use of home management of diarrhoea through home made solution of sugar, salt and water. Now, under the RCH approach this instruction is provided to the community through ANMs. In order to gauge the extent of work done by ANM, women who have given birth during the five years preceding the survey and the currently pregnant women were asked whether the ANM advised about the home management of diarrhoea. Table

4.9 shows that 60 percent of the women have received the advise from ANM for the home management of diarrhoea. According to NFHS, ORS was known to 46 percent of rural women in Maharashtra in 1992-93. The comparison of NFHS figure with the present survey shows the substantial increase in the knowledge of women during the last six years. Further, this increase is mainly due to the efforts of the ANMs. The type of advise received by women shows that the dissemination of home management of diarrhoea by the ANMs are proper. Women were advised by ANMs to administer home made solution (sugar, salt and water solution), or more liquid or combination of these in case of diarrhoeal episode for infants and children (Table 4.10).

The differentials in the ANM's advise about home management of diarrhoea by selected background characteristics of mothers are given in Table 4.11. It shows that, proportion of women advised for diarrhoea is higher among women aged above 20 years than among women aged below 20 years. Likewise proportion of women advised is higher among literate than among illiterates. Higher proportion of Muslim women was advised by the ANM than the women from other religions. SC and ST women were the ones least advised by the ANMs compared to women from other caste groups. Proportion of women received advise is lowest among women engaged in non-agricultural labour activities than the women from other occupational categories. Number of living children and age of youngest child is not showing any association with ANMs advise except for the women with no child. Proportion of women received advise is lower among women with no child than among women with child.

The preceding section clearly shows that knowledge about danger signs of ARI is very low compared to the knowledge about home management of diarrhoea among the women in rural Jalna. Dissemination of information about ARI is relatively new assignment to the ANMs. Further training in this aspect to ANM may increase their understanding about ARI and ultimately result in effective dissemination to the mothers and increase in the health and survival of children. Early initiation of breast-feeding is not common among women in Jalna. Only 17 percent of women breast-fed their child within an hour of birth and only 34 percent breast-feed within 24 hours of birth. A

comparison of this result with NFHS shows a substantial increase in the early initiation of feeding in recent years. Though there is an increase in the early initiation of feeding, still a large majority of women squeeze out the first milk from their breast before feeding the children and thus deprive the new borns from getting colostrum which provides them natural immunity and nutrition.

Table 4.1. Percent distribution of women by ANM's advise about proper breast-feeding.

Did ANM advise you about breast-feeding ?	Number	Percent
Yes, advised	290	41.8
No, not advised	404	58.2
Total	694	100.0

Table 4.2. Percent distribution of women who have received advise from ANM by type of advise received (n=290).

Type of advise	Number	Percent [@]
1. Breast-feed immediately after delivery	243	83.8
2. Don't squeeze first milk (colostrum) from breast	155	53.4
3. Breast-feed exclusively for four months	35	12.1
4. Give liquid supplements with breast milk after four months	11	3.4
5. Introduce supplementary food after six months	10	1.4
Total number of women received advise	290 [@]	-

[@]: total will not add to 100 percent because of the multiple advise received by women from ANM

Table 4.3. Percent distribution of women who have given birth during the 5 years preceding the survey by advice given by ANM for breast-feeding, according to selected background characteristics.

Background characteristic	Advice by ANM for breast-feeding		Total no. of women
	No. of women advised	Percent of women advised	
Age			
15-19	44	42.7	103
20-24	120	43.6	275
25-29	87	37.5	232
30-44	39	46.4	84
Education			
Illiterate	164	36.9	444
1-4 years	41	45.6	90
5-7 years	43	47.3	91
8+ years	42	60.9	69
Caste			
Maratha	125	38.9	321
Other caste	54	51.9	104
SC & ST	47	37.9	124
Non-hindus	64	44.1	145
Occupation			
Housewife	129	46.7	276
Cultivn & agril. labour	114	41.5	275
Non-agril. labour	31	25.4	122
Others	16	76.2	21
No. of living children			
1 child	65	43.9	148
2 children	79	43.9	180
3 children	83	42.8	194
4 + children	63	37.3	169
Age of youngest child			
0-11 months	184	41.6	442
12-24 months	43	47.3	91
25-36 months	37	45.1	82
37 +months	26	34.2	76
Desire for next child			
Yes	132	40.4	327
No	158	43.1	367
Type of vilage			
PHC vilage	19	35.8	53
Sub-centre vilage	86	46.2	186
Other vilage	185	40.7	454
Total	290	41.8	694

Table 4.4. Percent distribution of women who have given birth during the last five years by timing of initiation of breast-feeding.

Timing of initiation of breast feeding	Number	Percent
Within one hour of birth	115	16.6
After one hour but within a day of birth	117	16.9
Second day	54	7.8
Third and fourth day	371	53.5
Fifth day or later	25	3.6
Not given / Not available	12	1.7
Total	694	100.0

Table 4.5. Per cent distribution of women who have given birth during the 5 years preceding the survey by timing of initiation of breast-feeding according to selected background characteristics (n=682).

Background Characteristic	Initiation of breast-feeding						Total No. of women
	Within 1 hour of birth		Within 1 day of birth ¹		Second day and after		
	No.	%	No.	%	No.	%	
Age							
15-19	22	22.2	40	40.4	59	59.6	99
20-24	48	17.6	99	36.4	173	63.6	272
25-29	35	15.4	69	30.3	159	69.7	228
30-44	10	12.0	24	28.9	59	71.1	83
Education							
Illiterate	60	13.8	123	28.2	313	71.8	436
1-4 years	14	15.9	33	37.5	55	62.5	88
5-7 years	20	22.2	34	37.8	56	62.2	90
8+ years	21	30.9	42	61.8	26	38.2	68
Religion							
Hindu	89	16.7	180	33.7	354	66.3	534
Muslim	14	20.3	23	33.3	46	66.7	69
Bouddha	10	15.2	19	28.8	47	71.2	66
Others	2	15.4	10	76.9	3	23.1	13
Caste							
Maratha	59	18.8	108	34.4	206	65.6	314
SC & ST	20	16.4	36	29.5	86	70.5	122
Others	10	9.9	37	36.6	64	63.4	101
Non Hindus	26	17.9	51	31.2	94	64.8	145
Occupation							
Housewife	60	22.1	122	41.2	150	55.1	272
Cultvn & agril. labour	32	11.9	76	28.1	194	71.9	270
Non-agril. Labour	20	16.8	26	21.8	93	78.2	119
Others	3	14.3	8	38.1	13	61.9	21
Total	115	16.9	232	34.0	450	66.0	682

table contd...

1: includes children who started breast-feeding within one hour of birth.

Table 4.5. Per cent distribution of women who given birth during the 5 years preceding the survey by timing of initiation of breast-feeding according to selected background characteristics (n=682)

Background Characteristic	Initiation of breast-feeding						Total No. of women
	Within 1 hour of birth		within 1 day of birth ¹		Second day and after		
	No.	%	No.	%	No.	%	
No. of living children							
1	40	27.6	63	43.4	82	56.6	145
2	30	16.9	64	36.2	113	63.8	177
3	31	16.1	65	33.7	128	66.3	193
4+	14	8.4	40	24.0	127	76.0	167
Age of youngest child							
0-11 months	55	19.4	103	36.3	181	63.7	284
12-24 months	43	17.6	89	36.5	155	63.5	244
25 + months	17	11.0	40	26.0	114	74.0	154
Advice for BF by ANM							
Advice given	98	34.1	200	69.7	87	30.3	287
Advice not given	17	4.3	32	8.1	363	91.9	395
							100
Place of delivery							
Health facility	55	32.0	110	64.0	62	36.0	172
Home	60	11.8	112	22.0	388	76.1	510
Assistance for delivery							
Trained personnel	101	25.3	101	25.3	198	49.5	400
Untrained personnel	14	5	16	5.7	252	89.4	282
Type of village							
PHC village	6	11.3	17	32.1	36	67.9	53
Sub-centre village	49	26.6	72	39.1	112	60.9	184
Other village	60	13.5	143	32.1	302	67.9	445
Total	115	16.9	232	34.0	450	66.0	682

1: includes children who started breast-feeding within one hour of birth

Table 4.6. Percent distribution of women who have squeezed out colostrum before initiating feeding.

Did you remove colostrum before initiating feeding?	Number	Percent
Yes, removed colostrum	474	69.5
No, not removed colostrum	208	30.5
Total	682	100

Table 4.7. Percent distribution of women by initiation of supplementary food

Initiation of supplementary food	Number	Percent
Within five months	90	13.0
6-11 months	344	49.6
12 months and after	77	11.1
No supplementary food,	57	8.2
Child between 5-11 months		
child below five months	121	17.4
Not reported	5	0.7
Total	694	100.0

Table 4.8. Percent distribution of women according to their knowledge about danger signs of ARI

Knowledge about danger signs of ARI	Number	Percent
Knows (Information from ANM)	115	14.7
Knows (Information not from ANM)	129	16.5
Do not know	539	68.8
Total	783	100

Table 4.9. Percent distribution of women who have given birth during the 5 years preceding the survey by their knowledge about ARI, according to selected background characteristics (n=783).

Background characteristic	Knowledge of ARI		Total
	Yes		
	No.	%	
Age			
15-19	34	25.8	132
20-24	97	30.7	316
25-29	87	35.1	248
30-44	26	29.9	87
Education			
Illiterate	121	24.3	498
1-4 years	38	37.3	102
5-7 years	39	37.5	104
8+ years	46	58.2	79
Religion			
Hindu	200	32.4	618
Muslim	19	26.0	73
Bouddha	22	28.6	77
Other	3	20.0	15
Caste			
Maratha	126	34.7	363
Other caste	38	33.0	115
SC& ST	37	25.7	144
Non-Hindus	43	26.7	161
Occupation			
Housewife	108	34.7	311
Cultivn & agril. labour	89	29.7	300
Non-agril. labour	36	24.5	147
Others	11	44.0	25
Total	244	31.2	783

table contd...

Table 4.9. Percent distribution of women who have given birth during the 5 years preceding the survey by their knowledge about ARI, according to selected background characteristics (n=783).

Background characteristic	Knowledge of ARI		Total
	No.	%	
No. of children living			
0	2	8.7	23
1	48	26.7	180
2	70	34.1	205
3	70	34.8	201
4	32	30.5	105
5+	22	31.9	69
Age of youngest child			
No living child	2	8.7	23
0-5 months	27	22.3	121
6-11 months	56	33.9	165
12-24 months	102	35.8	285
25-36 months	37	34.6	107
37+months	20	24.4	82
ANM's visit			
Yes	219	34.1	642
No	25	17.9	140
Desire for another child			
Yes	100	26.0	385
No	144	36.2	398
Type of Village			
PHC village	20	37.0	54
Sub-centre village	104	49.8	209
Other village	120	23.1	520
Total	244	31.2	783

Table 4.10. Percent distribution of women according to the ANM's advise about home management of diarrhoea

ANM's advise about home management of diarrhoea	Number	Percent
No advise	310	39.6
Yes give more liquid	78	10.0
Yes home made solution	271	34.6
Yes ORS	9	1.1
Combination of the above	115	14.7
Total	783	100.0

Table 4.11. Percent distribution of women who have given birth during the 5 years preceding the survey by, advise by ANM, for diarrhoea, according to selected background characteristic (n=783)

Background characteristic	No. of women advised	Percent of women advised	Total no. of women
Age			
15-19	66	49.6	133
20-24	201	63.8	315
25-29	148	59.7	248
30-44	58	66.7	87
Education			
Illiterate	276	55.5	497
1-4 years	69	67.0	103
5-7 years	65	62.5	104
8+ years	63	79.7	79
Religion			
Hindu	367	59.5	617
Muslim	53	71.6	74
Bouddha	43	55.8	77
Others	10	66.7	15
Caste			
Maratha	216	59.7	362
Other caste	74	64.3	115
SC & ST	79	54.9	144
Non-Hindus	104	64.2	162
Occupation			
Housewife	215	68.9	312
Cultivn & agril. labour	181	60.5	299
Non-agril. labour	56	38.1	147
Others	21	84.0	25
Total	473	60.4	783

table contd...

Table 4.11. Percent distribution of women who have given birth during the 5 years preceding the survey by, advise by ANM, for diarrhoea, according to selected background characteristic (n=783)

Background characteristic	No. of women advised	Percent of women advised	Total no. of women
No. of living children			
No living child	7	30.4	23
1	102	56.7	180
2	131	63.9	205
3	124	61.7	201
4+	109	62.6	174
Age of youngest child			
No living child	7	30.4	23
0-11 months	166	58.0	286
12-24 months	181	63.3	285
25 + months	119	63.0	189
Type of village			
PHC village	38	70.4	54
Sub-centre village	126	60.3	209
Other village	309	59.4	520
Total	473	60.4	783

Chapter 5

Fertility Preferences and Family Planning

This chapter presents a description of levels and differentials in fertility, fertility preferences and current use of contraception. It also discusses the role of ANM in promoting the use of spacing methods, trouble due to use of family planning methods and general health problems of eligible women.

Number of Living Children

It may be seen from Table 5.1 that eligible women in rural Jalna on an average have 2.7 living children at the time of survey. The table also shows the differentials in the mean number of living children according to selected background characteristics. The average number of living children increases steadily with age from 1.0 child for women aged 15-19 years to 3.7 children to women age 40-44 years. As expected, with increasing level of education of women number of living children is consistently decreasing. Illiterate women on an average have 2.9 children whereas the average number of living children for women with 8 and above years of schooling is only 2 children. Mean number of living children is highest for Muslims (3.3) and lowest for Hindus (2.6). Bouddhas and 'others' fall in between (3.0). Among the different Hindu communities mean living children is not varying much. Number of living children is higher for Non-Hindus than for Hindus. Mean number of living children is slightly lower for housewives than for working women. It seems that the average family size norm among the women in rural areas of Jalna district is to have 3 children: the mean number of living children for women using contraceptives is 3.0 and for non-users it is 2.3 children.

Desire for More Children

In the present survey women were asked questions about their desire for additional children. The questions dealt with (1) whether the women wanted another child and (2) if so, how soon she would like to have her next child. Responses to these questions are analysed in the succeeding section. The results obtained from these

questions on fertility preferences can be useful as an indicator of general attitudes and possible future course of fertility.

In the survey, eligible women were asked, "Do you want any more children?" Women who want to have another child were then asked, "When do you want to have the child?" Table 5.4 presents the distribution of eligible women by desire for more children. Almost 61 percent of the eligible women age 15-44 in rural Jalna say they want no more children (20 percent say no more children and another 41 percent either have been sterilized or say that they cannot have any more children (20+41=61). Only 38 percent of eligible women want to have a child some time in the future. However, among the women who want to have a child in future the vast majority of these women (25 percent of all eligible women) say they would like to wait two or more years before having their next child. Only three percent of women say they want to have a child after one year and about one percent is undecided about when to have another. But about nine percent of these women say they want to have another child any time in the future. Thus, the vast majority of women want either to space their next birth or to limit childbearing altogether. These women can be considered to be potentially in need of family planning services.

After assessing the extent of desire for more children, it is worthwhile to examine the characteristics of women who do not want any more children. Table 5.5 shows the percentage of eligible women who want no more children by number of living children and background characteristics. As mentioned earlier, women who are sterilized (or whose husbands are sterilized) are included among those who want no more children. Figures in the bottom row show that the desire to stop childbearing increases significantly among women with two or more children. Fifty-three percent of women who have two children want no more children, and about eighty-five percent of women who have three or more children want to stop childbearing. But still a 15-20 percent of the women with three or more children desiring another child is a cause of concern. However it can be said that a majority of the couples in rural Jalna want to limit childbearing with two to three children.

The percent distribution of currently married women by desire for no more children according to age indicates the expected pattern, i.e., younger women (15-24) with one or two children are more likely to want to have another child, whereas older women (25 years and above) tend to want to stop childbearing. For example, only four percent of women age 15-19 want to stop childbearing, while among women 30 and above almost everyone want to stop childbearing. Overall, there is a negative relationship between proportion of women who want no more children and level of their education. This negative relationship is at least partially a result of the concentration of more educated women at younger ages, thus, lower parities, where women are more likely to express a desire for more children. There is an interesting pattern in the data on proportion wanting no more children by education. At parity one, women with no education are slightly more likely to want no more children than women with 5 and above years of education. At parities two and higher the proportion who want no more children is higher among women with education than the illiterate women. Proportion of women want no more children is lower among Muslims, higher among 'others' and Hindus fall in between. There is not much variation in proportion want no more children by women's caste and occupation. Desire to stop childbearing increases with the number of living sons. Almost all the women want to stop childbearing if they have two sons. The excessive sex preference for sons can also be seen in the table. Within each parity, desire to stop childbearing is stronger in families with more boys. For example, at parity two, only 53 percent want to stop childbearing, but if both of them are boys 87 percent want to stop childbearing.

Advise for Spacing Methods by ANM

We have seen in the foregoing section that 61 percent of the women in rural Jalna do not want to have any more children, and another 25 percent want to space the birth for another two years. Hence the demand for family planning services also must be higher in the community. This section deals with the current use of contraception, trouble due to the use of contraception and discontinuation of method.

Before analysing the contraceptive prevalence an attempt is made here to analyse the ANM's role in promoting the use of spacing method. Under the new target free approach of the family planning programme, it is expected that ANMs should emphasize on spacing methods. Table 5.6 gives the percent distribution of eligible women by ANM's advise about spacing methods. It is observed that out of 1000 women 27 percent of the women were given advise about spacing methods by the ANMs. In order to assess whether the advise for spacing methods was given at a proper stage, differentials in advise according to background characteristics of women were prepared (Table 5.7). It is observed that the proportion of women received advise for spacing methods by ANM is higher for women age below 30 and lower for women age above 30. For example, 36 percent of the women in the age group 20-24 were advised as against only 11 percent in the age group 30-44. Most of the women age 30 and above must have completed their family building process and they need the terminal methods thus advise is lower for them. There is a positive association between education of women and ANM's advise for spacing method. Only 24 percent of the illiterate women received the advise as against 46 percent of the women with 8 or more years of schooling. One of the reasons for the less advise for illiterate women may be due to the fact that these women are older than the literate or higher educated women. Differentials in advise by religion and caste of the women are not much pronounced. Differentials in occupation of women show that those who engaged in agricultural and non-agricultural labour were less advised by the ANM than others.

Differentials in advise by number of living children show that, motivation for spacing methods is decreasing with the increase in the number of children: motivation is highest for women with two children (41 percent) and lowest for women with three or more children (22 percent). Proportion of women with age of youngest child below three years received advise higher than the women with youngest child age above three years. Women residing in sub-centre villages were more likely to be advised for spacing methods than the women from other villages. In general, younger women, women with lower parity and women with younger child below 3 years of age were advised for spacing method more by the ANM than the older women, women with higher parity and

women with younger child above three years. The quality of the advise in terms of selection of women for advise is revealed by the above observations. Involving more and more young and low parity couples in the spacing programme is an indicator of good quality of service.

Current Use Contraception

Information on the current level of contraceptive use, i.e., contraceptive prevalence, is important for measuring the success of the family planning programme. Contraceptive prevalence is defined as the proportion of eligible women age 15-44 who were using some method of family planning at the time of survey. The present survey has collected information on current use of family planning methods. The tables 5.8 and 5.9 present the level and differentials in current use of contraception. Fifty-five percent of the eligible women are using contraception in rural Jalna: 41 percent permanent methods and 14 percent temporary methods. Permanent methods, particularly tubectomy, are the most prevalent methods. Of the 14 percent of temporary method users six percent are IUD users, five percent are pill users and another three percent are condom users. The data show that the method mix of the contraceptive acceptance is slightly improving. Since the involvement of males in family planning is less, appropriate motivational strategies need to be developed to involve men in taking an active part in the adoption of family planning methods.

The current use of contraception as observed in NFHS for rural Maharashtra during 1992-93 was 54 percent. The same level of acceptance in rural Jalna during 1998 indicates that the district is slightly lagging behind the state. But the method mix of the acceptance has definitely increased in the district. The current use of temporary methods as observed in NFHS for rural Maharashtra in 1992-93 (GIPE and IIPS, 1994) is only 3 percent, where it is 15 percent for rural Jalna in 1998.

Differentials in current use of family planning show that current use vary with the age of women. Current use is lowest among the youngest women (22 percent). The level of current use rises to a higher level of 78 percent for the women age 30-44 years.

However, the fact that 22 percent of women age 15-19 are current users indicates that women in rural areas are now willing to accept contraception early in their reproductive lives. NFHS found that only 8 percent of the rural women in Maharashtra in the age group 15-19 were using modern methods during 1992-93. Twenty-two percent current use among the same age group of women in rural Jalna in 1998 clearly indicates the rising trend in the acceptance of contraception by the younger couples in rural areas. Hence it can be said that the programme is improving qualitatively in the recent years. Even the current use among the women age 20-24 is also showing a steady increase: 31 percent in 1992-93 to 42 percent in 1998.

The relationship between education and current use is not consistent. But the acceptance in women with eight and above years of schooling is higher than (60 percent) the illiterate women (55 percent). Current use is slightly lower among SC and ST women than the women from other communities. As expected, acceptance of contraception is lowest among Muslims compared to the women from other religions however, 46 percent of acceptance among Muslims is an appreciable development. Current use among different occupational categories shows that acceptance is slightly high among housewives than the working women.

Number of living children is an indicator of actual reproductive behaviour. The relationship between number of children and contraceptive use provides an indication of the effect of actual reproductive behaviour on use and/or the opposite - the effect of contraceptive use on the number of children. Current use demonstrates a clear positive relationship with the number of living children up to three children. The proportion using any contraceptive method rises from a low of 29 percent of eligible women with one child to 72 percent of women with three children and 63 percent for women with four or more children. Seven in ten women with three living children using contraception clearly indicates the majority of the couples' desire to stop childbearing with three children in rural areas. Current use among 50 percent of the couples with two children also indicates half of the couples' desire to stop childbearing only with two children. A very strong positive association exists between the number of living sons a

couple has and current use of contraception. The comparison of data on current use by number of living children and number of living sons show that there is a clear sex preference among couples before accepting contraception. For example, only 52 percent of couples accepted contraception with two living children but couples accepted contraception with two sons are about 80 percent. The relationship between current use and age of youngest child is also consistently positive. Eighty-five percent women are current users if their last child's age is above three years. Acceptance of contraception in sub-centre villages is considerably higher than in the other villages.

On the whole it can be said that the family planning programme in rural Jalna is improving qualitatively. The method-mix of the acceptance is increasing steadily in recent years. The higher acceptance of contraception by the younger couples with lower parities will certainly accelerate the fertility transition in rural areas in the coming years.

Problems with Current Method

An understanding of the problems that current users experience is important in efforts to improve family planning service delivery. All current users in the survey were asked whether they had experienced problems with the method they were using. Table 5.10 presents the information. It shows that, six percent of the contraceptive acceptors had a problem due to the acceptance of the method. The women who had trouble due to the use of method were further asked about the place of treatment for the trouble. All the women who had trouble had sought treatment. Majority of these women (59 percent) took treatment in private health facility and the rest of these women took it from public health facilities.

General Health Problems of the Women

All the women in the survey were asked about the general health problems that they are facing and the treatment seeking behaviour for the health problem. The information is presented in Table 5.11. It shows that about 20 percent of the women are suffering from some or the other health problems. The remaining 80 percent reported that they do not have any problems. Back-ache (10 percent), abdominal pain (4 percent)

and white discharge (1 percent) are the common health problems that they are facing. The treatment seeking behaviour of the women for their health problems shows that one-fourth of them have not taken any treatment. Among those who took treatment two-third of them had gone to the private doctors and the remaining one-third only had taken the treatment from public health facilities. Hence, for the curative care most of the women are approaching private health facilities. This may be due to either the better quality of services or the easy accessibility of the private health care.

Unmet need for family planning

Currently married women who reported that they either do not want any more children or that they want to wait two or more years before having another child, but are not using any contraceptive method, are defined as having unmet need for family planning. Current users of family planning are said to have a met need for family planning. The total demand for family planning is the sum of the met need and the unmet need for family planning. Table 5.12 shows the percent of currently married women with unmet need, met need and total demand for family planning services, according to whether there is a need for spacing or limiting births. The foot-note of the table gives detailed definitions of these concepts.

Seventeen percent of currently married women in rural areas of Jalna have an unmet need for family planning services - 8.6 percent for spacing purposes and 8.7 percent for limiting births. Together with the 55 percent who are currently using a contraceptive method, the total demand for family planning among currently married women is 72 percent. Therefore, if all women who say they want to space or limit their children were to use methods, the contraceptive prevalence rate would increase from 55 percent to 72 percent of married women. The table also indicates that only 76 percent of the family planning need in rural Jalna is currently being met by current programme. However only 55 percent of the demand for spacing compared to 84 percent of demand for limiting is satisfied through the current programme in the district. Thus, it is clear that there is an urgent need for expanding the availability of spacing as well as terminal methods in family planning programme.

Differentials in unmet need for family planning

As expected, unmet need for spacing purposes is higher among younger women, while unmet need for limiting childbearing is higher among older women (Table 5.13). The total unmet need for family planning decreases consistently with age suggesting considerable unmet demand for family planning, particularly for spacing, among younger women in rural Jalna. This clearly indicates that at younger ages currently married women in the district want to space the next birth and most of their needs are not satisfied. Unmet need is lower among women with at least 8 years of education than among less educated women. Surprisingly unmet need for family planning is lower among SC/STs and Muslims. Twenty-six percent of women with one child are in need of family planning services, compared with 17 percent of women with two children. As expected, unmet need for spacing is higher among lower parity women, while unmet need for limiting childbearing is higher among higher parity women. Unmet need for family planning is lower among women residing in villages with health facilities than among women residing in villages without any public health facility. Hence provisions/availability of family planning services nearer to the couples reduces the unmet demand.

Table 5.1. Mean number of living children by background characteristics

Characteristic	Mean number of living children	Number of women
Age		
15-19	1.0	133
20-24	2.1	322
25-29	3.2	318
30-44	3.7	227
Education		
Illiterate	2.9	644
1-4 years	2.7	133
5-7 years	2.2	129
8+ years	2.0	94
Religion		
Hindu	2.6	793
Muslim	3.3	84
Bouddha	3.0	101
Others	3.0	22
Caste		
Maratha	2.5	470
SC& ST	2.7	176
Other caste	2.6	151
Non-Hindus	3.1	203
Occupation		
Housewives	2.5	377
Cultivn & agril. labour	2.8	395
Non-agril. labour	2.8	194
Others	2.8	34
Contraceptive use		
User	3.0	550
Nonuser	2.3	450
Total	2.7	1000

Table 5.2. Percent distribution of eligible women by desire for more children

Desire for more child	Number	Percent
Yes	378	37.8
No	196	19.6
Sterilized	412	41.2
Undecided	13	1.3
Not given	1	0.1
Total	1000	100

Table 5.3. Percent distribution of women who want more children by time period for next child (n=378)

Time period	Number	Percent
Any time	86	22.8
After 1 year	30	7.9
After 2 years	152	40.2
After 3 years	51	13.5
After 4 years	10	2.6
After 5 years	40	10.6
Undecided	9	2.4
Total	378	100.0

Table 5.4. Percent distribution of eligible women by desire for children

Desire for children	Number	Percent
Have another anytime	86	8.6
Have another after one year	30	3.0
Have another after two years	253	25.3
Have another, undecided when	9	0.9
Undecided	13	1.3
Want no more	196	19.6
Sterilized	412	41.2
Not given	1	0.1
Total	1000	100

Table 5.5. Percentage of women who want no more children by number of living children and selected background characteristics (n=608).

Background characteristics	Number of living children ¹				Total
	1	2	3	4+	
Age					
15-19	0.0	14.3	50.0	NC	3.8
20-24	4.8	47.0	61.9	87.7	46.0
25-29	33.3	67.7	84.9	75.9	76.4
30-44	100.0	83.9	96.4	93.8	97.4
Education					
Illiterate	6.8	44.5	77.5	83.4	62.0
1-4 years	6.3	58.5	86.7	90.0	68.4
5-7 years	2.3	57.1	87.2	100.0	53.5
8+ years	0.0	76.3	81.3	70.0	52.1
Religion					
Hindu	5.4	53.0	80.9	85.5	59.9
Muslim	0.0	53.8	52.6	72.2	51.2
Bouddha	0.0	44.4	86.5	94.1	71.3
Others	0.0	71.4	100.0	90.0	81.8
Caste					
Maratha	5.4	52.6	79.5	82.8	57.7
Other caste	6.5	56.4	85.7	93.5	62.9
SC& ST	4.2	50.0	79.7	85.4	63.1
Non-Hindus	0.0	54.1	77.6	83.5	64.5
Occupation					
Housewife	5.8	57.5	82.1	81.0	57.6
Cultivatn & agril. labour	0.0	52.0	76.6	88.8	62.3
Non-agril. labour	10.3	39.5	85.1	82.8	63.4
Others	0.0	63.5	75.0	90.0	64.7
No. of living sons					
0	2.6	8.6	10.5	9.1	5.5
1	6.0	43.7	63.0	76.1	44.8
2+	NC	86.7	95.1	93.4	93.1
Total	4.5	53.0	80.1	84.9	60.8

Note: 1: includes current pregnancy.

Women who have been sterilized, or whose husbands have been sterilized, are considered to want no more children.

NC: Not computed because there are no cases on which to base a percentage.

Table 5.6. Percent distribution of eligible women by ANM's advise about spacing methods

Method advised	Number	Percent
1. IUD	32	3.2
2. Oral Pill	33	3.3
3. Condom	17	1.7
4. IUD & Oral Pill, IUD & Condom	42	4.2
5. Cu-T, Oral pill, Condom	147	14.7
6. No child	20	2.0
7. Not given	4	0.4
8. No advise	705	70.5
Total	784	100.0

Table 5.7. Percent distribution of women advised by the ANM for spacing methods, according to background characteristics.

Background characteristics	Number of women advised	Percent of women advised	Total number of women
Age			
15-19	33	24.8	133
20-24	115	35.7	322
25-29	99	31.1	318
30-44	24	10.6	227
Education			
Illiterate	152	23.6	644
1-4 years	43	32.3	133
5-7 years	33	25.6	129
8 + years	43	45.7	94
Religion			
Hindu	218	27.5	793
Muslim	18	21.4	84
Bouddha	25	24.8	101
Others	10	45.5	22
Caste			
Maratha	143	30.4	470
Other caste	35	23.2	151
SC& ST	42	23.9	176
Non-Hindus	51	25.1	203
Occupation			
Housewife	136	36.1	377
Cultivatn & agril. labour	87	22.0	395
Non-agril. labour	37	19.1	194
Others	11	32.4	34
Total	271	27.1	1000

table contd...

Table 5.7. Percent distribution of women advised by the ANM for spacing methods, according to background characteristics (n=271)

Background characteristics	Number of women advised	Percent of women advised	Total number of women
No. of living children			
0	-	-	23
1	54	28.4	190
2	100	40.8	245
3	66	21.7	304
4+	51	21.4	238
No. of living sons			
No living son	39	26.9	145
1 son	118	29.1	406
2 sons	93	26.2	355
3+ sons	21	22.3	94
Age of youngest child			
No child	-	-	23
0-11 months	105	36.6	287
12-24 months	100	35.0	286
25-36 months	36	33.6	107
37+ months	30	10.1	297
Want more children			
Yes	111	28.3	392
No	160	26.3	608
Type of Village			
PHC village	9	11.3	80
Sub-centre village	96	34.3	280
Other village	166	25.9	640
Total	271	27.1	1000

Table 5.8. Percent distribution of eligible women by current use of family planning

Method currently using	Number	Percent
Using any method	550	55.0
<i>Permanent method</i>		
Tubectomy	409	40.9
Vasectomy	3	0.3
<i>Temporary method</i>		
IUD	62	6.2
Oral Pill	45	4.5
Condom	31	3.1
Not using any method	450	45.0
Total	1000	100.0

Table 5.9. Percent distribution of women using contraceptives, according to selected background characteristics (n=1000).

Background characteristic	Percent distribution using contraceptives					
	Non-user		User		Total	
	No.	%	No.	%	No.	%
Age						
15-19	104	78.2	29	21.8	133	100
20-24	187	58.1	135	41.9	322	100
25-29	109	34.3	209	65.7	318	100
30-44	50	22.0	177	78.0	227	100
Education						
Illiterate	292	45.3	352	54.7	644	100
1-4 years	58	43.6	75	56.4	133	100
5-7 years	62	48.1	67	51.9	129	100
8+ years	38	40.4	56	59.6	94	100
Religion						
Hindu	354	44.6	439	55.4	793	100
Muslim	45	53.6	39	46.4	84	100
Bouddha	44	43.6	57	56.4	101	100
Others	7	31.8	15	68.2	22	100
Caste						
Maratha	209	44.5	261	55.5	470	100
SC & ST	85	48.3	91	51.7	176	100
Others	62	41.1	89	58.9	151	100
Non-Hindus	94	46.3	109	53.7	203	100
Occupation						
Housewife	159	42.2	218	57.8	377	100
Cultivn & agril. labour	184	46.6	211	53.4	395	100
Non-agril. labour	92	47.4	102	52.6	194	100
Others	15	44.1	19	55.9	34	100
No. of living children						
0	23	100.0	-	-	23	100
1	135	71.1	55	28.9	190	100
2	117	47.8	128	52.2	245	100
3	86	28.3	218	71.7	304	100
4+	89	37.4	149	62.6	238	100
Total	450	45.0	550	55.0	1000	100

table contd...

Table 5.9. Percent distribution of women using contraceptives, according to selected background characteristics (n=1000).

Background characteristic	Percent distribution using contraceptives					
	Non-user		User		Total	
	No.	%	No.	%	No.	%
No. of living sons						
0	113	77.9	32	22.1	145	100
1	244	60.1	162	39.9	406	100
2	70	19.7	285	80.3	355	100
3	16	22.2	56	77.8	72	100
4+	7	31.8	15	68.2	22	100
Age of youngest child						
No living child	23	100.0	-	-	23	100
0-11 months	184	64.1	103	35.9	287	100
12-24 months	149	52.1	137	47.9	286	100
25-36 months	48	44.9	59	55.1	107	100
37+months	46	15.5	251	84.5	297	100
Type of village						
PHC village	37	46.3	43	53.8	80	100
Sub-centre village	109	38.9	171	61.1	280	100
Other village	304	47.5	336	52.5	640	100
Total	450	45.0	550	55.0	1000	100

Table 5.10. Percent distribution of current users of family planning by trouble due to use of methods and place of treatment for the trouble.

	Number	Percent
Trouble (n=550)		
Yes	34	6.2
No	516	93.8
Total	550	100.0
Place of treatment for trouble (n=34)		
PHC	8	23.5
Private Doctor	20	58.8
Govt. Dispensary	5	14.7
Ayurvedic Doctor	1	2.9
Total	34	100.0

Table 5.11. Percent distribution of women by their general health problems

Health problem	Number	Percent
Problems		
1. White discharge	12	1.2
2. Backache, pain in waist	101	10.1
3. Abdominal pain	37	3.7
4. 1+2,1+3,2+3	6	0.6
5. 1/2/3 & other	8	0.8
6. Other trouble	39	3.9
7. No problem	797	79.7
Total	1000	100.0
Treatment for health problems (n=203)		
No treatment	53	26.1
Treatment from:		
ANM / MPW	19	9.4
Priamary Health Centre	14	6.9
Government Hospital	16	7.9
Private hospital	100	49.3
Vaidya	1	0.5
Total	203	100.0

Table 5.12. Percent of currently married women with unmet need, met need and total demand for family planning services.

Demand for family planning	Number	Percent
<u>Unmet need for family planning</u> ¹		
(a) unmet need to space	86	8.6
(b) unmet need to limit	87	8.7
Total unmet need	173	17.3
<u>Met need (currently using)</u> ²		
(a) met need to space	105	10.5
(b) met need to limit	445	44.5
Total met need	550	55.0
<u>Total demand for family planning</u>		
(a) total demand to space	191	19.1
(b) total demand to limit	532	53.2
Total demand	723	72.3
<u>Percent of need satisfied</u> ³		
(a) percent of need satisfied to space		55.0
(b) percent of need satisfied to limit		83.6
Total percent of need satisfied	-	76.1
Total number of women		1000

Note:

1. Unmet need for spacing includes women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and who say they want to wait 2 or more years for their next birth. Also included women who are unsure whether they want another child or want another child but unsure when to have the birth.

Unmet need for limiting includes women who are neither pregnant nor amenorrhoeic and who are not using any method of family planning and who want no more children

2. Met need for space refers to women who are using spacing methods of family planning and say they want to have another child or undecided whether to have another. Met need to limit refers to women who are using any method of family planning and who want no more children.

3. Met need divided by total demand for family planning.

Table 5.13. Percent of currently married women with unmet need for family planning services by background characteristics.

Background Characteristic	Unmet need for family planning						Number
	To space		To limit		Total		
	No.	%	No.	%	No.	% of women	
Age							
15-19	35	26.3	2	1.5	37	27.8	133
20-24	35	10.9	23	7.1	58	18.0	322
25-29	13	4.1	32	10.1	45	14.2	318
30-44	3	1.3	30	13.2	33	14.5	227
Education							
Illiterate	52	8.1	53	8.2	105	16.3	644
1-4 years	11	8.3	14	10.5	25	18.8	133
5-7 years	17	13.1	14	10.9	31	24.0	129
8+ years	6	6.4	6	6.4	12	12.8	94
Religion							
Hindu	71	9.0	67	8.4	138	17.4	793
Muslim	7	8.3	4	4.8	11	13.1	84
Others	8	6.5	16	13.0	24	19.5	123
Caste							
Maratha	51	10.9	41	8.7	92	19.6	470
SC& ST	11	6.3	9	5.1	20	11.4	176
Other caste	10	6.6	17	11.3	27	17.9	151
Non-Hindus	14	6.9	20	9.9	34	16.7	203
Occupation							
Housewife	30	8.0	31	8.2	61	16.2	377
Cultivn & agril. labour	38	9.6	41	10.4	79	20.0	395
Non-agril. labour	15	7.7	11	5.7	26	13.4	194
Others	3	8.8	4	11.8	7	20.6	34
No. of children							
No children	-	-	-	-	-	-	3
1	47	24.7	2	1.1	49	25.8	190
2	18	7.3	23	9.4	41	16.7	245
3	16	5.3	24	7.9	40	13.2	340
4	2	1.3	24	15.8	26	17.1	152
5+	3	3.5	14	16.3	17	19.8	86
Type of village							
PHC village	5	6.3	6	7.3	11	13.8	80
Sub-centre village	16	5.7	21	7.5	37	13.2	280
Other village	65	10.2	60	9.4	125	19.6	640
Total	86	8.6	87	8.7	173	17.3	1000

Chapter 6

Visit to Government Health Centres

In order to ascertain the health seeking behaviour of the eligible women all of them were asked whether they have ever visited government health centres. It would also be useful to know about the characteristics of the women who have ever visited/not visited government health centre anytime. The relevant data are presented in Table 6.1. It is observed that out of the total 1000 women only 34 percent of them have ever visited the government health centres and the remaining 66 percent did not visit the government health centres. Ever visit to government health centres is varying according to the background characteristics of women. It may be observed from the table that women from below age 30, non-Hindus, non-Maratha community, those engaged in non-agricultural activities and women with child below 3 years of age are more likely to visit government health centres than the other women. Half of the women residing in PHC villages have ever visited government health centres compared to 30 percent of women residing in sub-centre and other villages. Hence proximity to the PHC increases the visit of the women to the health centers.

Reasons for Not Visiting Government Health Centres

All the women who have not visited the government health centres were further asked to give main reason for it. It is found that the poor quality of services (no proper examination and non-effectiveness/non-availability of treatment/medicines) preference for private health facility (28 percent) and long distance of the government health facility from the place of residence (24 percent) were the major reasons cited for the non-utilization of government health facilities (Table 6.2). Non-availability of doctors/health workers, and charge for the treatment are given by one percent of women for their non-visit. The analysis of the reasons for the non-visit to the government health centres clearly tells us that the preference to private facilities, long distance and poor quality/service related problems are major reasons for disliking public health facility. Providing health facility either within a village or close to a village and reducing isolation

of villages by providing transport facilities will enhance the utilization of government health facilities by the people.

Opinion of the Respondents about the Government Health Centres

Acceptance of family planning and utilization of health care facilities often depends as much on the supply of such services and facilities as on the demand. Opinion of the community towards the public health facilities can also be expected to have an effect on family planning and health service utilization. The availability of health care facilities close to a community is also critical to the health and well being of mothers and children. In the present survey opinion of the respondents (who have ever visited the public health centres) regarding facilities and functioning of the government health centres were ascertained. Their opinion was sought on the centre's facility, timing, availability of doctor, waiting time, privacy in examination, quality of examination, friendliness of staff, availability of medicine, effectiveness of treatment and corruption. These items adequately include the aspects, which are indications of quality of the provision of services. The relevant information is presented in Table 6.3. As far as the responses of those who have visited the government health health centres (34 percent), the table gives interesting information. Since these are the women utilizing the health services, it is expected that they should not have negative attitudes about them. However, in case of some of the items, the opinion of the users is mixed. For example, only 86 percent of the users opined that the health centre is well equipped and the remaining 14 percent said that the centre is somewhat well equipped. Almost all the respondents who have visited the health centre said that the centre's timing is convenient to them. Non availability of the doctors in the health centres is one of the major complaints against the public health facilities. The opinion of our respondents reveals the mixed experience. Eighty-one percent of the respondents reported that the doctor was available whenever they had visited the centre . For 15 percent of the respondents the doctor was available only sometimes. and about three respondents reported that the doctor was never available at their visits. Long waiting time for getting the service will make the clients unhappy and will affect the performance of the centre. One in ten women reported that waiting time was too long always and 61 percent reported that

waiting time was never too long. The remaining 28 percent of the respondents opined that sometimes waiting time was too long. As far as privacy in the examination is concerned 84 percent of the respondents were satisfied with the amount of privacy at the health centres. Most of the respondents (90 percent) are also happy with quality of the examination. Friendliness of the staff is appreciated by 88 percent of the respondents. With respect to the availability of the medicines, 73 percent of the respondents said that medicines were always available to them. One-fourth of them was opined that sometimes medicines were not available. Almost nine out of ten respondents agreed that doctors always explained to them about how to take medicines. As far as effectiveness of the treatment is concerned two-third of the respondents agreed that the treatment given to them was always effective. Only one percent of the women reported that the doctors in health centres always asks for money and 98 percent reported that they had never taken money.

Overall, the opinion of the women towards government health centres appears to be encouraging. But it does not mean that they were happy about almost all the aspects of the centre. Still a considerable proportion of women is apprehensive about infrastructure, waiting time, availability of doctors and medicines, effectiveness of treatment and privacy during examination. These shortcomings of government health centres should be improved in order to increase the coverage under the public health system. Otherwise even small proportion of dissatisfied clients can cause a damage to the public health programme which aims the welfare of the people.

The Relationship between Opinion about Government Health Centre and Acceptance of Contraception.

To know whether eligible women's opinion about the government health centre really matters in the utilization of services we have cross-classified the women's opinion with the acceptance of family planning. However, this linkage need not necessarily mean that negative opinion mean a lower acceptance of family planning. It may be that the perception about health centre is an outcome of the family planning services received rather than it influencing the decision to use family planning. This is particularly true in

a program, which emphasises sterilization. Only seven items, which have adequate numbers in each cell (more than 30), were given consideration. Table 6.4 relates the opinion about government health centre and current use of contraception. It shows that, barring some exceptions, level of current use increases along with the positive opinion about the government health centre. In other words, in general it appears that, women with positive attitude about the government health centres accepted contraception more than the women with negative attitudes. For example, the women who said that the centre is well equipped are more likely (66 percent) than the women with the opinion of somewhat equipped (54 percent) to accept contraception. Likewise, women who find the availability of doctors always are more likely (69 percent) to accept contraception than the women who said that the doctor was available only sometimes (39 percent). This pattern is true for opinion regarding waiting time, friendliness of staff, availability of medicines, and effectiveness of treatment. Out of eight items considered only in one item (privacy for examination) positive opinion shows the lower acceptance of contraception. The above analysis clearly indicates that the supply of good infrastructure and provision of good quality services will certainly enhance the peoples' demand for health care services from public health facilities.

Table 6.1. Percent distribution of eligible women ever visited government health centres according to background characteristics (n=342).

Background characteristics	Women ever visited govt. health centres		
	Number of Women visited	Percent of women visited	Total number of women
Age			
15-19	42	31.6	133
20-24	124	38.5	322
25-29	114	35.8	318
30-44	62	27.3	227
Education			
Illiterate	218	33.9	644
1-4 years	43	32.3	133
5-7 years	50	38.8	129
8+ years	31	33.0	94
Religion			
Hindu	257	32.4	793
Muslim	36	42.9	84
Bouddha	38	37.6	101
Others	11	50.0	22
Caste			
Maratha	128	27.2	470
SC& ST	67	38.1	176
Other caste	64	42.4	151
Non-Hindus	83	40.9	203
Occupation			
Housewife	147	39.0	377
Cultivatn & agril.Labour	108	27.3	395
Non-agril. Labour	73	37.6	194
Other	14	41.2	34
No. of children living			
No living child	4	17.4	23
1	65	34.2	190
2	87	35.5	245
3	104	34.2	304
4+	82	34.5	238
Age of youngest child			
No living child	4	17.4	23
0-11 months	109	38.0	287
12-24 months	115	40.2	286
25-36 months	44	41.1	107
37+ months	70	23.6	297
No. of sons living			
No living son	41	28.3	145
1	144	35.5	406
2	126	35.5	355
3+	31	33.0	94
Type of village			
PHC village	39	48.8	80
Sub-centre village	81	28.9	280
Other Village	222	34.7	640
Total	342	34.2	1000

Table 6.2. Main Reason for not visiting government health centre.

Reasons	Number	Percent
1. Government health centre too far	160	24.3
2. Poor quality of service	13	2.0
3. Non-availability of doctors/health workers	5	0.8
4. Doctors/health workers do not examine properly	68	10.3
5. Medicines are not/rarely given	37	5.6
6. Medicines are of bad quality	76	11.6
7. Services are charged	2	0.3
8. Getting treatment from ANM/MPW/Anganwadi worker	7	1.1
9. Relatives are doctors	5	0.8
10. Do not get time to go	11	1.7
11. No need	70	10.6
12. Prefer private services	183	27.8
13. Others	14	2.1
14. Not given	7	1.1
Total	658	100.0

Table 6.3. Womens' opinion about government health centre (n=342)

Opinion	Number	Percent
Do you find centre well equipped ?		
Very well	295	86.3
Somewhat	46	13.5
Not reported	1	0.3
Are the centre's timing convenient?		
Yes	331	96.8
No	9	2.6
Not reported	2	0.6
Is doctors available when you visit ?		
Always	278	81.3
Sometimes	52	15.2
Never	9	2.6
Not reported	3	0.9
Do you have to wait long for service ?		
Always	35	10.2
Sometimes	95	27.8
Never	210	61.4
Not reported	2	0.6
Is there privacy where you are examined ?		
Very much	286	83.6
Somewhat	35	10.2
Not much	19	5.6
Not reported	2	0.6
Are you examined properly ?		
Very well	306	89.5
Somewhat	23	6.7
Not much	8	2.3
Not reported	5	1.5
Is the staff friendly ?		
Very much	300	87.7
Somewhat	36	10.5
Not much	5	1.5
Not reported	1	0.3
Total	342	100.0

table contd...

Table 6.3. Womens' opinion about government health centre (n=342)

Opinion	Number	Percent
Are medicines available at the centre ?		
Always	250	73.1
Sometimes	87	25.4
Never	4	1.2
Not reported	1	0.3
Do they explain how to take medicine ?		
Always	301	88.0
Sometimes	35	10.2
Never	3	0.9
Not reported	3	0.9
Is the treatment effective ?		
Always	222	64.9
Sometimes	114	33.3
Never	4	1.2
Not reported	2	0.6
Is doctor asks for money ?		
Always	3	0.9
Sometimes	2	0.6
Never	336	98.2
Not reported	1	0.3
Total	342	100.0

Table 6.4. Women's opinion about government health centre and acceptance of contraception

Opinion	Number of women	Number of users	Percent of users
Do you find centre well equipped ?			
Very well	295	194	65.8
Somewhat	46	25	54.3
Is doctors available when you visit ?			
Always	278	192	69.1
Sometimes	52	20	38.5
Do you have to wait long for service ?			
Always	35	17	48.6
Sometimes	95	59	62.1
Never	210	142	67.6
Is there privacy where you are examined ?			
Very much	286	184	64.3
Somewhat	35	24	68.6
Is the staff friendly ?			
Very much	300	196	65.3
Somewhat	36	22	61.1
Are medicines available at the centre ?			
Always	250	167	66.8
Sometimes	87	50	57.5
Do they explain how to take medicine ?			
Always	301	198	65.8
Sometimes	35	19	54.3
Is the treatment effective ?			
Always	222	149	67.1
Sometimes	114	68	59.6

Chapter 7

Summary and Conclusions

The present study is an attempt to assess the coverage, quality and client satisfaction with the family welfare and maternal and child health services. The study forms one of the series of rapid surveys undertaken by the Population Research Centre of the Ghokhale Institute of Politics and Economics at the request of the Ministry of Health and Family Welfare. The study was conducted in rural areas of Jalna district in Maharashtra. Currently married women in the reproductive age group of 15-44 years form the unit of analysis for the study. To select the eligible women, in the first stage 25 PHCs were selected randomly from the district. In the second stage two ANMs per PHC were selected and in the third stage one village from each of the ANMs area was selected. Finally 20 eligible women from each selected villages were randomly selected for the interview. Thus interview was conducted among 1000 eligible women in rural parts of Jalna. An interview schedule specifically developed for the rapid survey to meet the data requirements of the study was administered to the selected respondents. Information from 1000 eligible women was obtained from personal interviews by the specially trained investigators. Though 1000 eligible women were interviewed, information related to delivery, breast-feeding and child health was restricted only to women who have given a live birth during the five years prior to the survey. Data for the study were collected during the months of February-March 1998.

The socio-economic and demographic profile of the Jalna district reveals that on an average the district lags behind the Maharashtra state in many aspects like literacy, urbanization, decline in population growth and fertility, work force in modern sectors, standard of living, housing and household amenities. In fact, the district is located in the Marathwada region of the state which is considered as backward in development.

Characteristics of the eligible women reveal that 8 out of 10 of them are Hindus. Among the Hindus, Maratha is the major community followed by SC/STs and other Hindu communities. Sixty-two percent of the eligible women are working in various activities, mostly in agriculture, and rest of them are housewives. Two-third of the women are illiterates. The age distribution of the eligible women shows that they are

fairly young as 77 percent of them are below 30 years of age. The average number of living children and living sons of the eligible women are 2.7 and 1.4 respectively. Twenty nine percent of women are with infants below age one and another 20 percent have their youngest child in the age group 1-2 years. Three-fourth of the women have given birth to a child during the five years (1993-98) preceding the survey.

Maternal Health

One of the major objectives of this rapid survey is to provide the information on maternal and child health care practices in the selected districts. The relevant information was collected from the mothers who have given birth during the last five years preceding the survey. Household visitation by ANM, trouble during pregnancy, place of delivery, assistance during delivery, use of safe delivery kit, problems immediately after delivery and place of treatment were the information elicited from the respondents.

ANM's direct contact with clients through household visitation is a key strategy in the family welfare programme's educational and motivational efforts. It is found that in Jalna not only the household visitation by the ANM during the last three months prior to the survey was quite high (76 percent) but also almost all the eligible women were satisfied with the amount of time the ANM had spent with them. Differentials in household visitation by the ANM according to the background characteristics of eligible women revealed that, the pattern of visits are as expected. Younger women, women with two living children, women with a child below 2 years of age and women desire additional child are more likely to be visited than the older women, women with three or more children and women with children more than three years old. But relatively ANM had visited less proportion of illiterate women and women engaged in non-agricultural activities. Women residing in sub-centre village are more likely to be visited by the ANM than the women residing in other villages.

The information on trouble during pregnancy indicated that the trouble women had faced during pregnancy was not very high and also the kind of trouble the pregnant women had faced does not appear to be serious in nature in the study area. But the trouble during pregnancy was found to have a U shaped relationship with age, as expected.

The care that women receive during pregnancy and child birth reduces the health risk for both mother and children. The expected outcome of TFA is the increase in the proportion of institutional deliveries and deliveries assisted by the trained personnel. The study shows that 25 percent of the women have given birth in health facilities (10 percent in public institution and 15 percent in private medical institutions) and the remaining 75 percent delivered at home. Proportion of institutional deliveries in the rural areas of Jalna is clearly lower than the norm (33 percent) set by the government of India under the RCH approach. According to NFHS, 25 percent of deliveries have occurred in health facilities during 1989-92 in rural areas of Maharashtra. Twenty five percent of institutional deliveries in rural Jalna during 1993-98 suggest that the situation should be improved. Among the women who have delivered at home during the last five years prior to the survey only 45 percent of them have received the assistance of trained persons and the remaining 55 percent were assisted by the relatives and untrained *dais*.

Proportion of institutional delivery and assistance by the trained personnel for home delivery together works out to 59 percent trained assistance for the delivery in the study area. The comparison of NFHS results and the results of the present survey indicates that in rural areas mothers seeking medical supervision for deliveries have considerably increased in recent years in Maharashtra: 38 percent in rural Maharashtra during 1989-92 and 59 percent in rural Jalna during 1993-98. However, this improvement is much lower than the desired goal of government of India for trained assistance for deliveries (95 percent) under the RCH approach.

Differentials in place of delivery according to the characteristics of eligible women reveal that younger and educated women and women with less number of children are more likely to deliver in health facility than the older, illiterate and women with more children. Women residing in PHC villages are slightly more likely to deliver in a health facility than the women residing in other villages. The proportion of mothers who received no trained assistance for home delivery was high among mothers aged 20 and above, mothers who have no education, SC and ST mothers and mothers with higher order births. Differentials in trained assistance for home delivery also show

the same pattern as that of differentials in place of delivery. Again presence of public health facility in village has considerably increased the assistance of trained personnel for home delivery. Women residing in PHC/SC villages are more likely (57 percent) to take the assistance of trained personnel than the women residing in villages without any health facility (39 percent).

Type of assistance during delivery (inclusive of both institutional and home deliveries) revealed that 28 percent of women have delivered under the supervision of a doctor and 31 percent under the assistance of nurse/trained *dai*. Older women, women who have already had many births are much more likely to have received no assistance at delivery, whereas, younger, educated and lower parity women and women residing in villages with public health facilities are much more likely to have the assistance of trained persons, including more frequent supervision by a doctor. SC and ST women, women engaged in agricultural and non-agricultural labour activities and women from Bouddha religion were the ones received very lower level of trained assistance for the delivery.

Nearly half of the women who have delivered at home said that their birth attendants have used the disposable delivery kit supplied by the ANM. Nine out of ten babies born in health facility were weighed whereas only 8 percent of babies born in home were weighed. On the whole, only 28 percent of the babies were weighed and the remaining 72 percent of the babies were not weighed. This is well below the government's norm of 95 percent recording of birth weight of new born babies under the RCH approach. Regarding the problems after delivery 94 percent of the women said that they did not have any problem immediately after delivery. Among the 6 percent of the women who had trouble after delivery most of them sought treatment in private hospitals. Among the women who have given birth during the last five years preceding the survey, 45 percent of them were advised to go for hospital for delivery by the ANMs.

Awareness and Practice regarding Nutrition and Health of Children

Under the CSSM programme ANM should hold mother's meetings periodically and give them information about proper practice of breast-feeding, initiation of

supplementary food and symptoms and treatment of ARI and diarrhoea. In rural Jalna it is found that 42 percent of the women were advised by ANM about proper breast-feeding. Among those who have received advise by ANM for proper breast-feeding majority of them were advised to start breast-feeding immediately after the delivery (84 percent) and to feed colostrum to the new born (53 percent). More than half of the women not advised by ANM indicate that still she has to improve her IEC services. ANM's advise for proper breast-feeding according to the background characteristics of women showed that women with higher level of schooling, non SC and ST women and women with child below three years of age were more likely to be advised by the ANM. But illiterate women, women belong to SC and ST communities and women engaged in non-agricultural labour activities were least likely to be advised for proper breast-feeding. Advise by ANM to higher proportion of lower parity women and women with child below 3 years of age clearly indicates that the new RCH programme is improving qualitatively in recent years in rural areas. However the observation also indicates that, for the further qualitative improvement of the programme, ANM's IEC services should percolate to illiterate and SC and ST women.

Although there is a universal breast-feeding practise, the early initiation of breast-feeding is not common in the study area. Only 17 percent of women started breast-feeding within one hour of birth and only 34 percent started breast-feeding within one day of birth. It means that two out of three infants did not start breast-feeding in the first day of life. The faulty breast-feeding practise is further witnessed in the removal of colostrum before initiating the feeding: 70 percent women have removed colostrum and only the remaining 30 percent of women fed the colostrum to the new born. These suggest that the knowledge of benefits associated with the early initiation of breast-feeding and the value of colostrum has not reached many women in rural Jalna, indicating a need for the enhanced IEC efforts of the ANM. The early initiation of breast-feeding appears to be gradually increasing in recent years in rural Maharashtra. During 1989-93, NFHS found that only 15 percent of the rural women breast-fed their child within a day of birth. In the current survey the proportion started within a day is 34 percent. A substantial increase over the six years period.

Differentials in timing of initiation of breast-feeding according to the background characteristics show that early initiation of breast-feeding is negatively associated with age and number of living children and positively associated with education. Scheduled caste women are less likely to initiate early feeding. Early initiation is higher among women with youngest child age below two years. Women who were advised by the ANM for breast-feeding, women who were delivered at health facility and women who were assisted by trained personnel at delivery were much more likely to initiate early breast-feeding than the women who were not advised by ANM and women who were delivered at home and without trained assistance. Although there were differentials in the initiation of breast-feeding the postponement of breast-feeding in all groups showed that the feeding practices for new-born infants are not beneficial. However, the observation clearly indicates that ANM's advise plays a major role in enhancing the early initiation of breast-feeding. This finding is encouraging for the health department in the sense that, advise, if properly given, could change the breast-feeding practices and ultimately result in increased health and survival of children. The fact that seven out of 10 women removing colostrum before initiating the feeding in rural Jalna further indicates the faulty feeding practices and the need for effective IEC strategy.

ANMs are also expected to inform mothers about the symptoms and prevention of the major ailments of infancy and childhood. Hence, women were asked questions about knowledge of ARI and ANM's advise about home management of diarrhoea. It is observed that only 31 percent of the women had knowledge about ARI. Knowledge is further lower among women of younger, illiterate, SC and ST, non-Hindu and labourer categories. For those who had knowledge about ARI, for half of them ANMs are the source of information. It is clear that though ANMs were visiting large number of eligible women, they are not really carrying the important messages to the rural women. However, ANM's home visit is found to significantly increase the women's knowledge about ARI. The findings suggest that ANM's training has to be improved so that they will be able make the mothers more aware about ARI. Further, presence of public health facility in the village is found to have increased the knowledge about ARI considerably among rural women.

The study found that 60 percent of women have received the advise from ANM for home management of diarrhoea. According to NFHS the ORS was known to 46 percent of rural women in Maharashtra in 1992-93. The data of the present survey not only show the substantial increase in the knowledge of home management of diarrhoea during the last five years but also indicates the ANM's efforts in increasing the knowledge of ORS.

The above information clearly shows that knowledge about danger signs of ARI is very low as compared to the knowledge about home management of diarrhoea among the rural women. Dissemination of information about ARI is a relatively newly added assignment to the ANMs. Further training in this aspect to ANM may increase their understanding about ARI and ultimately result in effective dissemination to mothers and increase in health of children.

Fertility Preferences and Family Planning

Eligible women on an average had 2.7 living children at the time of survey. As expected, education is found to have inversely related with number of living children. Mean number of living children is highest for Muslims (3.3) and lowest for Hindus (2.6). Sixty-one percent of the eligible women said that they want no more children (20 percent said no more children and another 41 percent have been sterilized or they can not have any more children). Thirty-eight percent of eligible women wanted to have a child some time in the future. Among the women who want to have a child in the future a majority of them said that they would like to wait two or more years before having their next child. Thus, a vast majority of women want either to space their next birth or to limit childbearing altogether. Hence the potential demand for family planning is very high in the study area. It is found that desire to stop childbearing increases among women with two or more children. Fifty-three percent of women who have two living children want no more children and 85 percent of women with three or more living children want to stop childbearing. Hence, it seems, majority of the couples in the study area wants to limit childbearing with two to three children.

Under the new approach of the family welfare programme ANM is expected to promote the use of spacing methods. Our analysis of ANM's advise about spacing

methods showed that 27 percent of the eligible women were given advise about spacing methods by the ANM. We have also assessed whether the ANM advised the women for spacing methods at proper stage. It showed that younger women, women with lower parity, and women with youngest child below 3 years of age were advised for spacing methods more by the ANM than the older women, women with higher parity, and women with youngest child above three years of age. The quality of the advise in terms of selection of women for advise is clearly revealed by these observations. Involving more and more young and low parity couples in spacing programme is an indicator of good quality services by the ANM.

Current use of contraception among the eligible couples is found to be 55 percent in the study region: 41 percent are permanent method users, particularly tubectomy, and the remaining 14 percent are temporary method users. According to NFHS, during 1992-93, contraceptive prevalence was 54 percent in rural Maharashtra. Fifty-five percent current use in rural Jalna in 1998 indicates that contraceptive prevalence has not increased in recent years. But the method mix of the acceptance has changed considerably during these years. During 1992-93, only 3 percent of couples were found to use temporary methods in rural Maharashtra according to NFHS. Acceptance of temporary methods by 14 percent of couples in rural Jalna in 1998 clearly shows the improvement in the method mix of the acceptance. However, the involvement of males in family planning is less, appropriate motivational strategies need to be developed to involve men in taking an active part in the adoption of family planning methods.

Contraceptive prevalence level is 22 percent among women aged 15-19 and 42 percent among women aged 20-24 in rural Jalna. The corresponding prevalence levels in rural Maharashtra in 1992-93 according to NFHS were 8 percent and 31 percent respectively. This observation clearly indicates the rising trend in contraceptive acceptance among the younger women in rural areas. Hence it can be said that the programme is improving qualitatively in recent years as more women in rural areas are now willing to accept contraception early in their reproductive lives. The proportion using any contraceptive method is 72 percent among women with three living children. Seven in ten women with three living children using contraception indicates the couples

desire to stop childbearing with three children. Also the mean number of living children for the current users and non-users is found to be 3 and 2.3 respectively. Current use among eligible couples also shows the clear sex preference before accepting contraception. For instance, only 52 percent of the couples accepted contraception with two living children but couples accepted contraception with two living sons are 80 percent. Levels and differentials in contraceptive prevalence in rural Jalna show that though the contraceptive prevalence level is moderate, the recent years have witnessed a steady increase in the acceptance of contraception by the younger couples. Further, the method mix of the acceptance has also improved considerably. The increasing acceptance of contraception by the younger couples with lower parities is a sign of qualitative improvement of the programme and certainly this will help to accelerate the fertility transition in rural areas in the coming years.

Unmet need for family planning is 17 percent among currently married women in rural Jalna, i.e., they have no desire for additional children or they want to wait for at least two years before having another birth, but they are not using family planning. Seventy-two percent of the demand for family planning is met by current programmes. However, only 55 percent of the demand for spacing, in contrast to 84 percent of the demand for limiting, is satisfied through current family planning programmes. The findings clearly bring out the need for expanding the availability of spacing methods in family planning programmes in the district.

An understanding of the problems that current users experience is important in efforts to improve family planning service delivery. In Jalna, except very few (6 percent), most contraceptive users did not have any problems due to the acceptance of the method. About one-fifth of the women were found to suffer from general health problems. Back ache, abdominal pain and white discharge were common health problems that these women are facing. The treatment seeking behaviour of the women for their health problems showed that 26 percent of them have not taken any treatment and among those who sought treatment most of them had gone for private health facilities.

Visit to Government Health Centres

Out of the total eligible women only 34 percent of them have ever visited the government health centres any time and the remaining 66 percent have never visited the government health centres. The reasons for the non-visit to government health centres tell us that preference to private health facility, long distance to the government health facility and poor quality/service related problems are major reasons for disliking the public health facility. Providing health facility either within the village or close to a village and reducing isolation of villages by providing transport facilities will enhance the utilization of health facilities by the people. In the present survey opinion of the respondents (who have ever visited the public health centres) regarding facilities and functioning of the government health centres were ascertained. Eighty-six percent of the women opined that the health centre is well equipped and the remaining 14 percent said that the centre is only somewhat well equipped. Almost for all the women centre's timing was convenient. Eighty-one percent of the women reported that the doctor was available whenever they had visited the centre. Only for sixty-one percent of women the waiting time was not too long and for the remaining women waiting time was sometimes or always too long. Ninety percent women were happy with the quality of examination. Friendliness of the staff was appreciated by 88 percent of the women. Seventy-three percent of women opined that the medicines were always available to them. Nine in ten women agreed that the doctors have always explained to them about how to take medicines. Three fourth of the women agreed that the treatment given to them at the centre was always effective. Overall, the opinion of the women towards government health centres appears to be encouraging. But all the women are not universally happy about all the aspects of the health centre. Still a considerable proportion of them is apprehensive about infrastructure, waiting time, availability of doctors and medicines, and effectiveness of treatment. These shortcomings of the public health facilities should be improved in order to increase the coverage as well as to increase the utilization of facilities under the public health system. Otherwise, even a small proportion of dissatisfied clients can cause a damage to the public health programmes.

To know whether women's opinion about government health centre really matters in the utilization of services we have cross-classified their opinion with the

acceptance of family planning. Level of current use of contraception is found to increase with positive opinion about the health centre. In other words, in general it appears that, women with positive attitude about government health centres accepted contraception more than the women with negative attitudes. From the analysis of opinion of women and acceptance of contraception it can be concluded that supply of good infrastructure and provision of good quality services will certainly increase the people's confidence and demand for health care services from public health facilities.

References

- Bhat, P.N.M. 1996. Contours of fertility decline in India: a district level study based on the 1991 census. In: K. Srinivasan (Ed.), *Population Policy and Reproductive Health*. New Delhi: Hindustan Publishing Corporation.
- Centre for Monitoring Indian Economy, 1993. *District Profiles*. Mumbai: Centre for Monitoring Indian Economy.
- CMIE. 1993. Profiles of districts. Economic Intelligence Services, Centre for Monitoring Indian Economy Pvt. Ltd., Mumbai.
- Fathalla, M. 1998. Research needs in human reproduction. In: E. Diczfalusy, P.D. Griffin and J. Kharlna (eds.), *Research in Human Reproduction. Biennial Report (1986-87)*. Geneva : World Health Organization.
- Gokhale Institute of Politics and Economics (GIPE) and International Institute for Population Sciences (IIPS), 1994. *National Family Health Survey 1992-93, Maharashtra*. Pune: GIPE and Mumbai: IIPS.
- Government of Maharashtra, 1995. *Selected Indicators for Districts in Maharashtra and States in India 1992-93*. Mumbai : Directorate of Economics and Statistics, Government of Maharashtra.
- Ministry of Health and Family Welfare (MOHFW), 1996. *Manual on Target Free Approach in Family Welfare Programme*. New Dehli : Ministry of Health and Family Welfare.
- Office of the Registrar General and Census Commissioner, 1994. *Census of India, 1991. Housing and Amenities: A Data Base on Housing and Amenities for Districts, Cities, and Towns*. New Delhi: Office of the Registrar General, India.
- Registrar General, 1997. *District level estimates of fertility and child mortality for 1991 and their relations with other variables*. Occasional Paper No.1. of 1997. New Delhi: Office of the Registrar General, India.
- Salunke, S.R., S.S. Narvekar, V.T. Godbole, and M.A. Talwalkar. 1997. Programme for children in Maharashtra: an assessment. Maharashtra: Directorate of Health Services.
- United Nations, 1995. *Population and Development: Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. Volume 1*. New York: United Nations, Department for Economic and Social Information and Policy Analysis. ST/ESA/SER.A/149.

APPENDIX-I

**Population Research Centre
Gokhale Institute of Politics and Economics, Pune
(Deemed to be a University)**

**Survey of Coverage, Quality and Client Satisfaction with respect to Family
Welfare and Maternal and Child Health Services**

Background Characteristics of the Eligible Women

Name of the District:

Name of the Tehsil:

Name of the Primary Health Centre:

Name of the Subcentre:

Name of the Village:

Name of the ANM:

Serial No. of the Family:

Name of the respondent:

Serial No. of the Eligible Couple in ECR:

Address:

Religion:

Hindu	1
Muslim	2
Buddha	3
Christian	4
Others	5
No response	9

Caste:

Brahmin	1
Saraswat/CKP	2
Maratha	3
Other caste	4
S.C.	5
S.T.	6
Not Applicable	7
No response	9

Age(in completed yrs.):

Education:

Occupation:

No. of living children:

No. of living sons:

No of living daughters:

Age of the youngest child (in months):

Opinion of the Eligible Women Regarding the Availability of the Family Welfare Services

1. Were you visited by the ANM in past 3 months?

Yes - 1 No - 2 No response - 9

2. If visited, are you satisfied with the amount of time spent by her?

Yes - 1 No - 2 No response - 9

3. Did you give birth to a child in the past 5 years? Are you currently pregnant?

Yes - 1 No - 2 No response - 9

Question No. 4 through 17 should be asked to only those women who have replied 'YES' to Question No. 3.

Skip to Question 18 if the woman neither had a birth in the past 5 years prior to the survey date nor is she currently pregnant.

4. Did you have any of the following problems while you were pregnant with your last child or if you are currently pregnant?

Swelling of feet	1	Vomiting, Nausea,	
Bleeding	2	don't feel hungry	6
Excessive tiredness	3	No problem	7
Faint	4	Not Applicable	8
Night blindness	5	No response	9

5. Were you advised to go to hospital for delivery?

Yes -1 No-2 N.A.-8 No response-9

6. Where did you deliver your child?

Government hospital	1	To be delivered-Govt.	5
Private hospital	2	To be delivered-Private	6
PHC	3	To be delivered- home	7
At home	4	N.A.	8
		No response	9

7. If delivered at home, who conducted the delivery?

Nurse/Private doctor	1	Yet to be delivered	5
Trained Dai	2	Delivered in hospital	6
Relatives	3	N.A.	8
Private doctor	4	No response	9

8. If delivered at home, was the disposable delivery kit used?

Yes, Nurse did	1	N.A.	8
Yes, Relatives did	2	No response	9
No	3		

9(A). Did the ANM advise you on breast-feeding?

Yes -1 No - 2 N.A.- 8 No response - 9

9(B). If 'YES' in 9(A), what advice?(Multiple answers)

Breast feeding immediately after delivery	1	Advice about liquid feeding	
Give cholstrum to the child	2	after completion of 4 months	4
Breast feeding for 4 months fully	3	Advice about supplementary food	
		after completion of 6 months	5

10(A). When did you start breast-feeding the child? (How many days after delivery)

Within 1 hour after delivery	1	After 6-7 days	6
Same day but after 1 hour	2	Yet to be delivered	7
After 24 hours	3	N.A.	8
After 2-3 days	4	No response	9
After 4-5 days	5		

10(B). Whether the colostrum was removed before breast feeding?

Yes -1	No-2	N.A.-8	No response-9
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11. When did you start giving supplementary food to the child?(In months)

Months _____	N.A. 88	No response 99
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12. Are you aware of the danger signs of ARI? Did the ANM advise you on this?

Yes -1	No-2	N.A.-8	No response-9
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13. Did the ANM tell you about the treatment to be taken in case child has diarrhoea?

Yes, continue breast feeding, as usual	1
Yes, give food & fluid items as usual	2
Yes, give only fluid items to the child	3
Yes, give home made remedy	4
Yes, asked to use ORS	5
Nurse did not tell anything	6
N.A.	8
No response	9

14. Was your baby weighed immediately after birth?

Yes -1	No-2	N.A.-8	No response-9
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15. Did you have any trouble immediately after delivery?

Fever	1	Other (clarify)	4	N.A.	8
Bleeding	2	No trouble	5	No response	9
White discharge	3				

16. If had any trouble, did you take any treatment for it?

Yes, from ANM	1	No treatment	5
Yes, from PHC	2	No trouble	6
Yes, Govt. dispensary	3	N.A.	8
Yes, Private dispensary	4	No response	9

17. Did the ANM advise you about any Family Planning method for delaying the pregnancy?

Yes, Cu-T	1	Yes, Cu-T, OP, and Condom	5
Yes, Oral pill	2	Has children, no advice	6
Yes, Condom	3	No advice	7
Yes, any 2 from Cu-T, OP & Condom	4	No children, No advice	8
		No response	9

18. Do you want any more child(ren)? (If pregnant then other than this one.)
Yes -1 No - 2 Sterilised - 3 Using FP method - 4 No response - 9

19. If yes, when do you want your next child?
After years (1 - 7) Already sterilised - 8 No response - 9

20. If 'No' in 18 then why you didn't use any Family Planning method?

21. Are you currently using any method of Family Planning?
No 1 Yes, Condom 5
Yes, sterilisation/tubectomy 2 Yes, Others 6
Yes, Cu-T 3 No Response 9
Yes, Oral Pills 4

22. Do you have any problems due to the use of this method?
Yes - 1 No - 2 Non-user - 3 No response - 9

23. Did you take any treatment in case of problems? If Yes, then from Where?
Yes, from PHC 1
Yes, from Private doctor 2
Yes, from government dispensary 3
Yes, from Vaid 4
Yes, home remedies 5
No treatment taken 6
No treatment. no trouble 7
Non user 8
No response 9

24. Have you used and discontinued any method in the past?
Yes, Cu-T 1
Yes, Oral Pill 2
Yes, Condom 3
Yes, Others 4
No, using only one method 5
No, never used any method 6
N.A. 8
No response 9

25. Do you have any of the following health problems?
White discharge 1 Other problem(specify) 4
Back Ache 2 No response 9
Abdominal Pain 3

26. If yes, did you go for any treatment?
Trouble but no treatment 1 Yes, from private 5
Yes, from ANM 2 No trouble 8
Yes, from PHC 3 No response 9
Yes, from Govt. dispensary 4

27. Do you ever go to the Govt. dispensary?

Yes-1 No-5 No response-9

If yes, which PHC or a nearby government dispensary?

PHC-1 Other PHC - 2 Rural Hospital -3 Urban Hospital - 4

If the answer is 'No' then go to Question No. 39

If 'YES' in Q.27 then,

Please give your opinion on the following aspects of the Government Health Facilities

28. Do you find the centre well equipped?

Very well - 1 Somewhat - 2 Not well equipped - 3

29. Are the centre timings convenient?

Yes - 1 No - 2 Not recorded - 3

30. Is the doctor available when you visit?

Always -1 Sometimes - 2 Never - 3

31. Do you have to wait long for service?

Always - 1 Sometimes - 2 Never - 3

32. Is there privacy where you are examined?

Very much - 1 Somewhat - 2 Not much - 3

33. Are you examined properly?

Very well- 1 Somewhat - 2 Not much - 3

34. Is the staff friendly?

Very much - 1 Somewhat - 2 Not much - 3

35. Are medicines available at the centre?

Always -1 Sometimes - 2 Never - 3

36. Do they explain how to take medicine?

Always - 1 Sometimes - 2 Never - 3

37. Is the treatment effective?

Always - 1 Sometimes - 2 Never - 3

38. Does the doctor ask for money?

Always - 1 Sometimes - 2 Never - 3

39. Give reasons for not going to the government dispensary?

Appendix – II

List of the PHCs and Villages covered for the present Survey

Tehsil	PHC	Sub-centre	Village
1. Mantha	1. Patoda	1. Helas 2. Vanjola	1. Helaswadi 2. Kedarwakadi
	2. Dahiphal Khandare	1. Sarate Ojhar 2. Belora	1. Sarate 2. Pokhari
	3. Mantha	1. Dhoksal 2. Naygaon	1. Pimparkheda 2. Pihali Wadgaon
2. Partur	1. Satona	1. Mapegaon 2. Usmanpur	1. Revalgaon 2. Saona (Bu.)
	2. Ashti	1. Loni 2. Ashti No. 2	1. Loni 2. Paratwadi
	3. Shreshti	1. Shreshti 2. Amba	1. Shreshti 2. Amba
3. Jalna	1. Pirpimpalgaon	1. Gondegaon 2. Kadwanchi	1. Vanjar Ubraj 2. Kharpudi
	2. Manegaon	1. Savargaon 2. Uchwad	1. Savalegaonghare 2. Maujpuri
4. Ambad	1. Dudhnakalegaon	1. Golapangari 2. Revgaon	1. Samangaon 2. Revgaon
	2. Shahagad	1. Shahagad 2. Charmapur	1. Walkeshwar 2. Charmapur
	3. Jamkhed	1. Parner 2. Chinchkheda	1. Shirner 2. Pimparkhed
5. Badnapur	1. Dabhadi	1. Waghrol 2. Chikhali	1. Dongargaon 2. Chanegaon
	2. Badnapur	1. Akola 2. Dhopateshwar	1. Nikalak 2. Padali

Contd...

List of the PHCs and Villages covered in the present Survey

Tehsil	PHC	Subcentre	Village
5. Badanapur	3. Wakulani	1. Roshangaon 2. Bajarvahegaon	1. Nanegaon 2. Bajarvahegaon
6. Ghansavangi	1. Ranjani	1. Masegaon 2. Kandari	1. Giradgaon 2. Kandari
	2. Kumbhar Pimpalgaon	1. Raja Takali 2. Ku. Pimpalgaon	1. Raja Takali 2. Ku. Pimpalgaon
	3. Ghansavangi	1. Dhakephal 2. Bodakha	1. Pirgayabwadi 2. Devhirava
	4. Rani Ucheqaon	1. Talegaon 2. Gurupimpri	1. Antarwala 2. Shindewadgaon
7. Bhokardhan	1. Hasanabad	1. Talegaon 2. Hasanabad	1. Talegaon 2. Hasanabad
	2. Re. Pimpalgaon	1. Re. Pimpalgaon 2. Danapur	1. Re. Pimpalgaon 2. Bhayadi
	3. Rajur	1. Kedarkheda 2. Chandaithombari	1. Pesora 2. Wadgaon
	4. Walsavangi	1. Walsavangi 2. Jalichadev	1. Walsavangi 2. Jalichadev
8. Jafrabadi	1. Tembhumni	1. Kumbharjhari 2. Akola	1. Kumbharjhari 2. Akola
	2. Mahora	1. Jafrabad 2. Janefal	1. Pimpalkhuta 2. Janefal
	3. Varud (Bu.)	1. Bharaj (bu.) 2. Khasgaon	1. Bharaj (bu.) 2. Kumbari