Studies in Reproductive Health Services in India (1990-1991) : Selected Annoted Bibliography

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INTRODUCTION

BACKGROUND

This annotated bibliography is a compilation of studies carried out during 1990-1999 on reproductive health services in India. It is one of a series of annotated bibliographies that is being brought out as part of the Gender and Reproductive Health Research Initiative.

In September 1998, activists and researchers involved in women's health issues came together to share about their concerns regarding the future of reproductive health research in India. The meeting was hosted at New Delhi by the Ford Foundation, which over the past few years, has funded several studies on Reproductive Health Practices in India. After a day's sharing of experiences and briefly reviewing the content, nature and geographical distribution of such studies, the meeting decided on a process for (a) identifying gaps in research on Reproductive health and (b) promoting future research on hitherto unaddressed issues.

This process was to have the following stages:

1. Preparing annotated bibliographies of social science research or clinical studies referring to social dimensions on seven major areas of reproductive health, drawing mainly on published research over the period 1990-99.

2. Based on the annotated bibliographies, preparing critical reviews of literature on each of the seven areas of reproductive health. The purpose of this review would be to examine, from a gender-sensitive perspective, the entire body of research covered by the annotated bibliographies, to identify the content gaps, methodological issues and ethical concerns.

3. Disseminating the critical reviews as widely as possible to encourage the participation of a broad cross-section of individuals in future research in the area. Dissemination to be aimed at women's groups, NGOs, those involved in women's studies and university departments dealing with health/population issues and reproductive health.

4. Inviting research proposals (brief) for carrying out studies that will address the gaps in research identified by the reviews. Proposals will be short-listed by a team of experienced activists and researchers. The next step may consist of a workshop to help develop these proposals into full-fledged research plans.

5. The importance of involving a wide cross-section of people working for women's health and women's reproductive health from a gender perspective would govern the short-listing of proposals. Every effort would be made to encourage first-time researchers and activists to participate in the process, and to counter the notion that research is a 'specialist' concern and activity.

The subject areas chosen for the annotated bibliography are as follows:

1. Selected aspects of reproductive health: maternal health, reproductive tract infections and contraceptive morbidity.

2. Selected aspects of general morbidity in women, including the interface between communicable and non-communicable diseases and reproductive morbidity
3. Sexuality and sexual health
4. HIV/AIDS
5. Reproductive health services

In addition, researches in infant-feeding and breast-feeding practices in India are also annotated.

Critical review papers on each of the themes mentioned above are being prepared and would be published separately. These papers would contain

- Summary findings
- Critical analysis of methodologies used
- Content analysis of the literature reviewed and
- Research gaps in the existing research.

We hope this would facilitate the process of developing the short and long term research agenda and advocacy priorities as regards health care services and women's health.

SCOPE & STRUCTURE OF THE VOLUME

As stated earlier, of the set of six selected annotated bibliography volumes on aforesaid aspects of reproductive health, this particular volume contains selected annotations of studies **in India during 1990s, on Reproductive Health Services**.

At the outset we must clarify that no such category of 'Reproductive Health Services' exists, especially in the public health services. Apart from maternity services and family planning services, the services for reproductive health must be accessed as part of the general health care services. Thus a review of reproductive health services must also include review of literature on general health care services.

The volume presents 132 annotations. We structured this volume around five sub-themes:

1. Health care service providers (22),
2. Quality of health care services (23),
3. Women's health care needs (18),
4. Health care: access, utilisation and expenditure (33),
5. Policy: Analysis, critique and alternative perspectives (36).

These sub-themes evolved while doing the literature search and annotating them. This primarily was based on the quantum of the accessed research material with focus and thrust on a particular aspect of health care services. Often, a particular piece of research work dealt with more than one sub-theme, which made it difficult to categorise. For example, health care service providers constitute an essential part of health care service delivery system and yet they are presented separately for there was substantial research material on them, though mostly the grassroots level health workers. The exercise of ordering material around these sub-themes enabled us to recognise the research issues involved therein and identify the research gaps in a more focused manner.

The research classified under sub-themes '1' and '2' cover the issues regarding health care services from the delivery point of view while those under sub-theme '3' and '4' have primarily looked at health care services from users' perspective, which in addition to others also may have used socio-economic lense while examining people's access to and utilisation of health care services. The sub-theme '5' being policy analysis and critique have addressed both these aspects.

Under each of these sub-themes, the volume carries an overview of the annotations, actual annotation and references. The annotations under each sub-theme are arranged in an alphabetical order of name of the first author. The serial numbers in the theme-wise overview tables coincide with that of annotations as well as references under each theme. **This forms the key for readers to locate a particular piece of work in the overview table, in the set of annotations and in the reference list under each theme.**

LITERATURE - SEARCH

The Guiding Framework

It was essential to draw up the conceptual framework, which would facilitate the literature search and selection of the material. The **various components of the reproductive health** on the one hand and **different aspects of health services** on the other hand helped us to lay down such a **guiding framework**.

For the former, we relied upon the definition of what constitutes reproductive health. Reproductive health is defined as "a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth 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 from fear of pregnancy and contracting disease."[1]

The various elements or the key reproductive health issues are:

- RTIs/STDs/HIV;
- Adolescent health
- Maternal health
- Mental health;
- Gynaecological health;
- Older women's health;
- Alternative health care;
- Anaemia/nutrition;
- Sexuality; sex education; sexual health; violence; sexual abuse;
- Male involvement, responsibility, needs;
- Infertility/Sterility;
- Abortion, contraception;
- Access to socio-economic rights;
- Occupational health.[1]

The key tenets underlying above issues are:

- Empowerment,
- Right to information,
- Women's political participation,
- Accountability,
- Access to Primary Health Centres.[2]

While the definition of reproductive health limits itself to needs related specifically to reproductive health of women and couples, the issues that underlie should be wide ranging to cover the complexities stated above. At operational level, we primarily relied on the above definition of reproductive health while selecting the material. However, we searched for material which designed the research to look beyond the clinical aspects of women's reproductive health and carried the analysis to understand the above mentioned tenets those underlie women's reproductive health. Such an understanding ultimately would enable to design, plan and operationalise woman-centred and gender sensitive health care services.

The **various important dimensions of health care services** could be comprehensively summarised in terms of:

Structure: Physical access (availability, approachability and adequacy); physical standards (instruments, equipment, drugs etc.); and human power (various service providers).
Process: Provider-client interactions, providers' competence, provider-client relationship and continuity. And lastly,
Outcome: Bio-medical and socio-behavioural consequences of health care service provision.

In addition, subject matters such as **access to and utilisation of health care services and health expenditure** are some of the other important aspects while studying health care services. These aspects interface between users' socio-cultural and economic characteristics and the socio-cultural context of an illness or a particular health care need; and features and nature of health care services. The extent of utilisation of health care services reflects upon the extent to which they are appropriately designed taking into account users' perspectives, needs and constraints.

Medical and nursing education, training of the other paramedical and grass roots health workers contribute to the quality of health care provided. This depends upon the quality – in a comprehensive manner - of such education and training. This constitutes an important aspect of health care services.

Economics, costing and financing of health care services also significantly affect the quality of health care services. Such studies would tell us about the relationship and analysis of the resource constraints and quality of health care services being offered.

Alternatives tried in provision of health care services, especially the ones to meet women's health care needs required to be looked at. They often are inspired with the idea of improving access to quality health care services. Our intention to include these in the guiding framework was to understand their strengths in terms of their peculiarities. These peculiarities may have helped to bring about changes in the prevalent power

relationship – be it between men and women or service providers and policy makers as part of the establishment and the people as users of health services. These in turn may have helped to sustain these community-based structures to deliver health care services.

Various forms and approaches have been tried out. Seeking people's participation has been the common thrust of the efforts made by NGOs. In general, NGOs are known for their innovative alternatives. One comes across such alternatives in health care and reproductive health care service provision too, which have left impressions for two reasons. One, they are sustainable, which makes them stand out. Two, the government has been adopting some of these successful alternatives to be implemented through national health care service delivery system.

We thought that a critical review of these efforts would provide space to explore the possibilities of mainstreaming such experiments.

We also searched for **documentation of advocacy efforts to bring about improvement in the reproductive health care services and enhancing women's access** to such improved reproductive health care services as it would help get insights into such efforts.

However, we could not get much information either on alternative experiments in health care service provision or advocacy efforts for improving access to health care services, which highlights the fact that such experiments and alternatives need to be documented and advocated.

Sources of Research Literature and the Problems Encountered

The journals, which carry research material offering social analysis and insights into the various aspects of reproductive health and health care services, were concentrated upon for selecting the material. It was rather difficult to have access to material that we felt may be of relevance to such a critical review of research. **We looked for the following while doing literature search** so as to be exhaustive and up to date to the extent possible:

1. Research papers published in journals
2. Unpublished research papers presented in various seminars, conferences and workshops
3. Reports of research studies published by institutions, mostly in-house.

Journals: We prepared an exhaustive list of journals and later narrowed it down depending upon their coverage of the issues of our concern. We selected those journals, which dealt with the following subject/s:

1. Obstetrics and gynaecology
2. Preventive & social medicine / public health / community medicine
3. Health / reproductive health / family welfare / family planning
4. Pediatrics / child health
5. Social-cultural and economic aspects of women's health

The articles/papers selected for this annotated bibliography volume are picked **from 35 journals.** However, the material that has been included in this volume depending upon their relevance to the theme comes from 22 journals from among these.

Libraries and institutions: We mostly relied on the libraries of various educational institutions and other NGOs in Pune and Mumbai. We also wrote to NGOs requesting them to send us their research reports. However, the experience was not very encouraging. The difficulties were at various levels and of various types. They were not different from what one generally experiences. For instance, often there is a tendency to confine the research reports within the concerned NGO and/or funding agency. This reduced our access to research to a great extent. It was also not rare to find that such research efforts and findings remained undocumented. As a result, a particular research area known to be explored substantially remained out of the purview of this literature search and its critical review. The problems that we encountered are not unusual but clearly points to the need to set up some mechanisms to document and disseminate research methodologies and findings of studies intended to serve social cause and benefit people at large.

Web-sites: We also tried to access material by exploring some relevant web sites, although not very rigorously. However, not much was available on these web sites. Thus, developing a comprehensive web site for health research itself could be one of the means of better dissemination of research in India.

Formation of an Electronic Database

Researchers assisting in collecting the research material from various libraries and other sources found the guiding framework useful while screening the journals and other forms of the material. The relevant articles were photocopied to be physically and electronically organised to form the database. The electronic database is the modified version of bibliographies. The advantage was in terms of easy access to list of research material that we had. The facilities such as 'sort' and 'find' allowed us to assess and retrieve the material that we collected over the time. In general, this facilitated screening of the material to be considered for annotation. The articles/material were organised physically according to alphabetical order on authors' name, coinciding the order in the electronic database.

Incidentally, these databases have been found useful by other researchers also who are working on related subjects.

PRESENTATION OF ANNOTATIONS

The various heads used to present each of the annotations are as follows:

Author/s: The first three authors are specified.
Source: The source and year of publication. The latter could be either the publishing journal or the institution (and often the same as the one, which conducted study).
Place of study: Study area - the district and the state.
Location: Whether the study was conducted in rural and/or urban area.
Period of study: Period during which study has been conducted. This is important to be noted as the results and findings of the study need to be read in that light.

Type of research: Type of methodology or a mix of methodologies used to conduct the study. We classified the studies based on the type of methodologies employed. The classification is presented below under the subhead 'classification of studies'.
Aims and objectives: As stated by the author/s.
Methodology: A brief description of the methodological approach, sampling frame, tools of data collection and methods of data analysis. The studies based on secondary data would not carry this sub-head.
Background and perspective: Provides a brief description about author's perspective about the issue at hand. This is used only for annotations included in the section titled 'Policies: Analysis, Critique and Alternative Perspectives'.
Findings: In addition to findings, it also presents recommendations made, if any.
Recommendations: Unlike other four sections**,** this separate head has been used for the annotations included in the section titled 'Policies: Analysis, Critique and Alternative Perspectives'. This is because one of the prime concerns of these communications were to provide recommendations.
Reviewer's note: Within the scope of the stated aims and objectives of a particular research, it either contains critique and/or highlights the contribution it has made to the subject matter because of its peculiarities.
Key words: When not stated by the authors, we coined them. Key words coined by reviewers are presented in italics.

While annotating the research communications, we maintained the language, vocabulary, and line of arguments as was used in the original research papers. This was primarily to reach to readers of this annotated bibliography the original flavours of research writings without contaminating them with reviewers' biases or judgement. The separate head titled 'reviewer's note' in the present volume has been used to have such a space for reviewer's comments.

Classification of Studies

Based on the type of methodologies used, the studies reviewed are classified in the following categories and sub-categories as below.

1. Theoretical: The conceptual studies are placed under this category.

2. Empirical Research: Studies based on observation and experience than on theory and abstraction. They use either primary or secondary data. The empirical studies are classified below:

2.1 Studies based on where they are situated are classified as:

2.1.1 Community based
2.1.2 Health Care facility based

2.2 Studies based on the design used are classified as:

2.2.1 Descriptive study: Studies whose prime concerns are with description rather than with the testing of hypothesis or proving causality. These include:

- Situational Analysis studies

- Epidemiological studies
- Exploratory studies and
- Cross-sectional or community surveys
- Documentation of alternative experiments in Health Service Provision, especially Women's Health Care Services.

2.2.2 Analytical Study: Studies, which have tried to establish a cause for certain occurrence.

2.2.3 Evaluative Study: Studies, which have evaluated certain programme or policy.

Following are the highlights of the review of literature.

SUMMARY AND OBSERVATIONS

Health Care Service Providers

Health care providers constitute one of the important elements of the health care delivery system. *They play an important role in determining the 'character' of the health care delivery system.* In that, whether clients get gender sensitive treatment, whether clients receive quality care depend upon the health care service providers. *There are number of factors which contribute to and are responsible for shaping their health care delivery.* The kind of training (such as, skills, both clinical and communication, orientation) that they undergo; the opportunities that they have in the extremely competitive medical care market; the infrastructural facilities that their services are supported with; their place in the hierarchy of the health care delivery system, especially in case of public health care delivery system are some of the factors which have impact on quality of health care delivery by them. The other systemic factors that influence the quality of care are the distribution of health care providers that exists, regulatory mechanism that are in place (or absent), the working conditions that are provided to them, and the gender aspects that are taken into account. Also, providers' perceptions of and attitudes towards women's illnesses, their circumstances would play a significant role in shaping the health care delivery and quality of care offered to women. *Providers' understanding of women's changing health care needs and changing socio-political context would also impact health care delivery.*

We examined the body of research literature on health care service providers to understand the thrust areas of the research. In that, we considered the three aspects of the health care services/ providers. First, the type of sector in which they are working, that is public/ private/ voluntary. Second, system of medicines to which they belong to. Third, their position in the hierarchial health care service delivery system in Ifdia. These could also form the analytical categories. In addition, we also critically looked at conceptual frameworks used and analytical categories - gender, socio-economic and cultural characteristics of the service providers and users - considered by researchers for understanding the issues involved.
Following is the summary and observations made of the research literature on health care service providers.

- Paramedics (nurses, ANMs, community health workers, trained and untrained TBAs etc.) are the most researched health care providers by social and health science researchers, medical professionals and state administrators/authorities.
- Some made an assessment of their prescribed role as MCH service providers (16, 17, 18, 19); some explored their role beyond this narrow scope of service provision but still within the gamut of MCH care (20, 8); some xplored their prospective role as service providers of the set of services outside the MCH care. (8, 21). In most of these studies, a common concern in advocating or promoting services, either MCH or non-MCH, by TBAs has been that they are accessible and approachable and even affordable. TBAs' services are considered indispensable. (18).
- One of the studies was to explore feasibility of utilising services of dais for purposes other than child birth related services. (8).
- Efforts were made to assess their professional competence in delivering MCH services. In that, the current status of quality of care being delivered by TBAs; impact of training were assessed (2, 18, 19). It is found that TBAs are poorly equipped to deliver quality care, even the intra-natal care. (17, 18, 19).
- In a rare instance, profile of rural private practitioners was studied. (15). It highligths that most of them practice modern medicine regardless of whether they were formally qualified to do or not.
- In yet another study, it was assessed as to how effectively the traditional mdical practitioners would play the role of community health educators, especially as regards contraception. (20).
- A couple of studies emphasised the contribution of trained TBAs in reducing maternal and perinatal mortality provided they are adequately and appropriately trained. (5, 16).
- Many studies recommended that TBAs need to be supported by training and continuing education so as to ensure quality of care delivered by them. (2, 3, 16, 17, 18, 19). Some recommended rewards, incentives and strenghtening of economic structure of dais (3,17, 21).
- A couple of studies dealt with factors affecting utilisation of services and choice of providers. (3, 10). Proximity of the service providers enhancing accessibility and approachability which saves on travelling long distance; less expensive health care; same cultural beliefs and practices shared by the users and providers etc. are some such considerations on part of the users while choosing indigenous health care service providers. (10). In another study, poor utilisation of services by women was attributed to their unwareness. (3). The study recommends to educating people to utilise these services.
- The two important contributions are the ones, which dealt with the working conditions of women health care service providers. (6,9). One of the studies looks at women health workers, the ANMs, and their problems arising out of the bureaucratic pressures and ill-functioning. (6). It looks at problems they face because of their secondary status in the society and in their own families. The analysis is more from the human rights perspective. The thrust of the other study was on examining the linkages between the working conditions of women health workers and quality of family planning health care services provided by them. (9).

- One of the studies demonstrated usefulness of some techniques and exercises to improve pulmonary function of nursing students. (13). It is different from others for the primacy it gives to health concerns of these health care service providers.
- Another study records positive attitude of the staff nurses towards the in-service training programme. (14). It was found that most of them were motivated to acquire more knowledge and skills and to work for professional development.
- Most of the research on health care service providers is in public health care service sector. In that, it concentrated on primary health care and grassroots level health care services. There was not much research on service providers at the secondary and tertiary level health care services.
- Other than paramedics, no other service providers have been studied in a noticeable manner.
- Most of the research on health care providers from the public sector is in relation to delivery of family planning services and other government programmes, such as MCH. Services required for treatment of other reproductive health care needs have not received any attention.
- Research on extension workers has concentrated on their role in promoting family planing services while there is little recognition of the fact that they are basically community health workers having a much larger role to play.
- Various aspects of health care service providers from the private sector are less researched area. The contribution of the private health care sector in reproductive health services should be large as it is true in case of general and specialised health care. Against this backdrop, absence of any systematic study on share of private health care sector in reproductive health care services is a colossal gap in the existing research.
- There are no macro level studies, which could give us an authentic profile of health care providers from various systems of medicines as regards their socio-economic characteristics, educational qualification and other specialisation.
- Besides these professionally equipped health care providers with formal qualifications, a large number of 'quacks' and traditional health care providers engage themselves in health care service provision. However, not much systematic information is available about them.
- Most of the research on health care service providers is conducted from the perspective of quality of health care services they deliver. Thus, the thrust has been to evaluate quality of their training/inputs; and knowledge, attitude and practice etc. However, rarely one comes across studies on the aspects such as work environment, work load; working hours; level of stress; health status; means to update medical knowledge coinciding to shifts in the government policies; membership to and participation in local or national level associations of health care providers regardless of their hierarchy in the medical health care system or their systems of medicines or the sector (private or public) they belong to.
- No literature available on providers' perceptions about the prevailing health care system, perceptions about their roles and responsibilities, concepts of social accountability and ethics in medical practice. Some of these concepts also need to be operationalised to begin with before any empirical research is conceived. This

also has significance in the light of 'hi-tech' reproductive technology that is being used.

- There is certain amount of documentation of prevalence and typology of violence. However, health care providers' role in meeting the health care needs of survivors of violence is totally untouched area. There are some initiatives taken in the last two to three years at various fronts. These experiences need to be documented and disseminated. Some focused work on this theme is essential for laying down the strategies to structure the health care services to meet these needs. The present initiatives can lay the foundation for research, action, intervention and advocacy work in this area.
- Emergence of corporate medical care facilities does not seem yet to be the concern or priority for researchers.
- The research is required to develop training inputs for the health care providers to enable them to meet the physical and mental health care needs of survivors of violence.
- One does not come across any research during the current decade or in the past on any of the aspects of medical education. While the health policies have changed at least superficially in response to the change in health scenario and health care needs of our people, no efforts were ever made to look into the kind of training received by medical doctors. The paradigm shifts from 'family planning/family welfare/population control' to 'reproductive and child health' is not reflected in the syllabi. There certainly is a need to restructure medical education to better equip the fresh graduates to face the challenges arising from these shifts. In addition to this, it is also essential that mechanisms to ensure upgrading and updating of skills and knowledge are in place.
- Profile of health education institutions and quality of education being provided at these institutions - faculty profile, numerical strength of the faculty and its sufficiency, lab facilities, sufficiency as regards hands-on practice, content of the courses - medical and social aspects, ethics, pattern of examination, continuing education need to be subjected to the scrutiny.
- Presently, counselling has little importance in the medical care system in India. Health care providers need to be studied to develop this area.
- Needless to mention that Indian Medical Association (IMA) and its regional and local chapters should be playing an important role in these changing scenario. However, no voices of the IMA are heard. Studying IMA could form one of the research areas.

Quality of health care services

In recent years, there has been a growing recognition among policy makers and researchers that the quality of care provided by the health care system is an important determinant of utilisation of health services. Expansion of health care services did not show an expected improved health status of people. This was primarily because quantitative expansion of services did not mean quality services obstructing their utilisation. Reproductive health care services need not be an exception to this analysis and trends. Internationally, assessment of quality of care in its initial phases emerged as an area of concern vis-à-vis family welfare programmes, which is true in the Indian situation as well. Eventually, the concept of 'quality care' was applied to other health care services, too.

We reviewed the studies along the three major components of health care delivery system, namely, 'structure', 'process' and 'outcome' referred to earlier in the paper. Following is the summary and observations made of the research literature on quality of health care services:

- Most of the studies adopted uncritically the well-known model of quality of care proposed by the Population Council.
- Most of the research on quality of care is concentrated upon family planning programme and its various components. As a consequence, they restrict themselves to public sector.
- Most of the quality of care studies are basically the evaluation studies conducted as regards various government programs, such as, family planning, MCH, ICDS. Barring some exception like that one conducted by ICMR task force (10), there are no national level studies one comes across. Most of these studies are shaped by perspective of programmers or providers. In that, the programme contents seem to have been accepted without any critique.
- In addition to studies on quality of family planning services, substantial efforts have gone into the study of quality of abortion care. (9, 13).
- Some good beginning has been made with regards to study of quality of care in the private sector. Studies on physical standards in private sector, exploratory studies on developing accreditation system for private sector, are important contributions. (17).
- Most of the studies limited their scope to studying aspects related to access to health care facilities, infrastructure and availability of qualified human power. Except a few, the other aspects of structure like planning, management and supervision, record keeping systems did not draw much attention of the researchers. (10, 14).
- Spatial distribution when examined, it was mostly of public health care facilities and not of the private health care facilities. (10, 18). One study on private health care sector indicates that most of the health care facilities are situated in urban areas. (17).
- Studies reviewed show that health care facilities generally have inadequate infrastructural facilities coupled with unhygienic environment. (3, 7, 11, 20). Lack of facilities, such as, clean sanitary block with adequate water supply, have much more grave implications for women users of services.
- Not many studies looked into availability of drugs at health care facilities. Some did so while studying infrastructure. (7, 10, 18).
- Some studied looked into human power related issues. (4, 7, 10, 17, 18). Adequacy of the personnel, availability of appropriately qualified providers, the minimum facilities that they have to facilitate their service provision.
- Non-medical indicators of quality of care, which are difficult to operationalise and measure have been less dealt with.
- Some studies looked into provider-client interaction, the personal dimension of services. (6, 7, 11, 13, 21). While assessing quality of family planning services, in terms of provider-client interaction or their competence, it is mostly confined to the lower cadre of health workers. (6, 7, 21).
- While users' satisfaction and perception find place in the literature (11, 12, 16), there are no studies on outcome of service provision in terms of bio-medical indicators. The hospital-based study to assess patients' satisfaction found that patients were more than satisfied with the various aspects of care - physical infrastructure, client-provider relationship, provider competence, and medical facilities. Researchers

interpreted that it was due to very low socio-economic status and low expectations of patients' from the health system. Also the fact they were interviewed in the hospital, according to researchers, may have positively affected the responses of users. (11). The other study noted that the patients' never complained about inadequate quality of care at the PHC, for the fear of penalty. (16).

- One study on women's perceptions about and expectations of quality of care is an important contributions. (9). It shows as to how women apply different criteria of quality of care to different health care need situations. Cost of care, severity of illness, chronic nature of illness, illness requiring stay/in-admission at health care facility, illness requiring immediate medical attention were some of the factors those determined situation specific criteria for quality of care.
- Another study demonstrated as to how the pressure of meeting targets affects the quality of family planning services making the sterilisation camps a frightful event for women. (20).
- None of the studies touched upon workload of providers, which may have implications for quality of care that they offer.
- Perspectives of the top managers concerning health care services they offer are likely to influence the quality of services delivered by them. However, there were hardly any such studies.
- Nursing care is an important aspect of quality of care. However, not much attention is paid to this in the research on quality of care.
- Not many studies simultaneously looked into all the three dimension of quality of care. This, therefore, looses on the opportunities to analyse the nature of their inter-relationship.
- Not much efforts have gone into studying quality of reproductive health care services. Such studies could be taken up drawing from the earlier research efforts and experiences.
- Research efforts are required to develop minimum standards for reproductive health care services. Some research efforts have gone into it. However, such material could not be accessed.
- Not many have shared the methodologies sufficiently enough with readers in their communications. Thus not providing much scope for reviewers to opine on it.
- Methodological problems continue to plague these studies, especially those taken up by the hospital staff or the NGOs who have been involved in the health intervention through the implementation of the government health schemes.
- In contrast, the non-mainstream researchers and community based NGOs have been experimenting with feminist methodologies. There is need to draw on experiences of these groups.
- There is need to critique various methodologies used in studies and to address the common issues, and to replicate some of the studies after such a review.
- Also, having grasped the fact that generally the 'soft' facets of quality of care are weaker, concrete advocacy strategies to strengthen them need to be planned.
- Most of the evaluation studies on family planning programme remain on paper. The process of translating research findings into programme inputs does not take place.
- There is considerable amount of research available on quality of care. However, gender perspective needs to be strengthened.

Women's health care needs

In India, it was in mid 80s that the women's silence about their own illnesses, specially gynaecological morbidity came into light through the pioneering empirical research in Gadchiroli, Maharashtra. This research threw open a range of issues vis-à-vis women's health and also facilitated further research on the subject matter. Also, health researchers, health activists and groups working at grassroots level based on their experiences over the time could develop gender sensitive conceptualisation of women's health and their silence about their sufferings. Analysis of available data, with all their constraints, from this perspective gender differentials vis-a-vis health care and related matters unfavourable to women were revealed.

Against this backdrop, it is essential to understand various correlates and determinants of women's illnesses. This would help better planning and delivery of health care services. One way to understand women's health care needs is by understanding the extent and type of illnesses they suffer from. This must include both, the perceived and clinical morbidity/health care needs. This would help understand the type of health care services that need to be made available to them at various levels. On the other hand, adverse health consequences that women and for that matter people may suffer from could also be result of exposure to poor quality health care services. Women's health care needs studied from this perspective will have contribution to make for arriving at recommendations for improving health care services and making them women sensitive.

The literature search on this sub-theme has not been as exhaustive as it was for the other sub-themes. This was primarily because it constituted the full-fledged theme for preparing annotated bibliography and critical review paper, being done by two other sub-groups participating in this initiative. We concentrated more on those studies, which dealt with the service component and other socio-economic and cultural characteristics of the users/community along with prevalence and incidence of various illnesses.

- Prevalence/incidence of illnesses, and their contribution to women's morbidity and mortality are the thrust areas of these research studies.
- Both, hospital-and community-based studies were found to understand women's health care needs. Most of the community-based studies were primarily to study the perceived morbidity. (1, 4, 8, 9, 10, 13, 16). In certain instances, recording of perceived morbidity was complemented by clinical examination. (11, 14).
- The hospital-based studies primarily involved understanding morbidity and mortality burden by making assessments of type and nature of morbidity by conducting clinical examinations.
- Both, hospital- and community-based studies applied case-control/quasi-experimental methodological approaches. (9, 10). These generally helped understand the determinants or correlates of morbidity pattern.
- The studies included here cover both general and women specific illnesses. A range of gynaecological and obstetric illnesses has been studied. Prevalence of RTIs/STDs, perinatal outcomes of teenage mothers, post-abortion complications; complications arising of caesarean sections were the illnessess studied either for their share in women's mortality or morbidity.
- In one study, the issue of child sexual abuse was studied. It also studied the impact of incest on woman's adult life. (8). It was primarily to establish that this is also a middle and upper middle class Indian phenomenon. Despite some of its methodological constraints, the study has initiated the process of recognising it as one of the major areas of concern and needs attention both at research and

advocacy level. It is an important contribution for it has cracked the prevailing myth that sexual abuse and incest are the characteristics of the lower class.

- Some studies focussed on correlates or determinants of morbidity/mortality. In that, demographic and socio-economic characteristics of people, cognitive and behavioural factors such as personal hygiene, household environment and sanitation, and exposure to health education were the factors used in the analysis.
- In two of the studies, characteristics of health care facilities/providers determining the quality of care have also been included in correlates analysis. (4, 9).
- The thrust of the abortion research has been on studying socio-economic characteristics of abortion seeking women, factors leading to unwanted pregnancy, their choice of abortion service provider, post-abortion complicatiofs, women's expectations of abortion services. (2, 10, 12, 13, 15).
- One of the studies on induced abortions in rural society indicates that all the abortions performed by quacks and paramedical lead to post-abortion complications. The reasons mentioned for approaching these providers were secrecy, availability, affordability and accessibility of the abortion services, which reflect upon the need to improve upon the MTP services. (12).
- A health care centre-based study on abortion patterns among adolescents showed that almost about half of the abortion seekers were unmarried. (16). It also showed that larger number of younger girls reach to second trimester by the time they approached health care facilities for an abortion. The reasons, such as, girls' failure to realise that they were pregnant, concealment of pregnancy and conflicts with parents.
- However, not all studies had adequate information on whether these unwanted pregnancies were results of coercion or otherwise. Understanding of these factors would facilitate the strategy designing to prevent adolescent pregnancies. For instance it would be educating them about safe sex in case of non-coercive conceptions as demonstrated in one of the studies. (2). Preventing coercive adolescent conceptions would require to address to the larger gamut of social issues.
- Abortions among unmarried adolescents need to be studied with broader conceptual framework, which would throw light on circumstances and situations of teenagers, which push them to have unwanted conceptions. These could be done in hospital-based set up as community-based studies on such subjects are difficult to conduct. It also involves a range of ethical issues to be resolved before taking up such a study.
- Studies on teenage pregnancies highlight the negative implications of teenage pregnancies. (2, 3, 6). These studies demonstrate that the teenage mothers are at greater risk. Antenatal complications (anaemia, pre-eclampsia, eclampsia, antepartum haemorrahage, intrauterine foetal death), prematurity, low birth weight babies, breech presentations, need for ceaserean sections, longer labour hours, and much greater risk of maternal mortality are some of the areas of concern as demonstrated by these studies. These studies recommend additional efforts and resources to serve and protect their health.
- An assessment of general and gynaecological health status of adolescents indicate that young girls suffer from the adverse health consequences of low economic status, unhygienic practices, and poor nutrition. They need to be provided with appropriate health care facilities and health education. (12). This was a small-scale study. Firstly, there is need for a larger survey to understand the scenario for a larger area/society. Secondly, a longitudinal study would be insightful to understand the nature and type of illness that women suffer over the time as a result of poor health status in their young age.

- One single tertiary hospital-based study on incidence of deliveries by caesarean section (CS) indicate that there is a progressive increase in it. (5). The indications for CS have widened over the time. The substantial increase in caesarean sections for the reasons of high-risk pregnancies were attributed to early diagnosis of obstetric complications and medical disorders associated with pregnancy.
- In one of the large sample sized community based study, women's health status as regards maternal events was studied to explore whether improved health care delivery system would contribute to a great extent in reducing the maternal mortality. (9). The study highlights the inclusion of prompt and accessible medical management as an essential component, redesigning the referral system to include bypassing inappropriate referrals. This study, however, did not explore the probable correlates of maternal mortality such as socio-economic and demographic parameters.
- In another gynaecological morbidity study conducted in a slum in Bombay, it was found that socio-economic indicators dropped out as significant predictors, and age and parity became important correlates of clinically diagnosed morbidity unlike the perceived morbidity. (14). This primarily points at the need to have more of such studies. Women's perceived morbidity perhaps needs to be located outside the medical paradigm of health and needs further exploration to be able to provide them such a support and care.
- In another large sample sized study, quality of obstetric care received has shown strong and pervasive influence on reported gynaecological morbidity. (4).
- Application of sound methodologies marks some of the large community-based studies. (4, 9, 10, 16). However, not much reference is made in these research-based communications to various possible ethical issues involved while conducting the research.
- However, some of the studies were also small scale (small sample size, smaller geographical area) ones. Given the diverse characteristics of the nation, such small scale, local studies have both advantages and disadvantages. The advantage is that they would allow the local level planning vis-a-vis health care services. The disadvantage is that they can't be generalised, regardless of the use of reasonably sound methodologies for obvious reasons.
- Emphasis on morbidity along with mortality reflects on the fact that 'health achievement' is being conceptualised and understood in a more nuanced and holistic manner than before. This shift in understanding people's health, if pursued, operationalised and translated into policy planning and designing would have far reaching implications for well-being of people in general and women in particular.

Health care: Access, utilisation and expenditure

After Independence, there has been substantial growth in the number of doctors. However, access to health care to majority of the population has been limited. This made policy makers and researchers to look for the factors which may have obstructed people's access to these health care services.

In that various facets/aspects of health care services on the one hand and people's perceptions, attitudes, socio-economic and cultural backgrounds on the other hand gradually were conceptualised as the factors influencing utilisation of health care services. These research trends emerged since mid 80s and now are visible because of their considerable proportion in the health research. This was an important shift in the

health research as it went beyond the conventional framework to understand linkages between health care service system and the socioeconomic and cultural factors vis-à-vis access and utilisation and in turn health status of people. This was an important paradigm shift from understanding people's health status in terms of medical determinants alone to understanding it in terms of socio-cultural determinants.

As stated earlier, we included the studies, which looked into access, utilisation, and expenditure patterns in relation to people's general health care needs as there are not many studies available on these aspects as regards people's reproductive health care needs. This, we thought, would give us a glimpse of the situation vis-à-vis reproductive health care needs of people and the extent to which the present health care delivery system is meeting these needs.

- Except a few which were health care facility based studies (13, 14, 17, 20), the rest were community based ones. Some had both the components. (24).
- Access, utilisation and expenditure patterns have been studied along with prevalence of morbidity through community based studies. All the studies examined the issues involved from the users' perspective.
- In general, age, literacy/educational achievement of the family, urban/rural location, economic class (landholdings, per capita consumption at family level), caste and religion were some of the variables included in the studies to assess the differentials in utilisation and health expenditure. At times, education of women and their husbands were specifically looked into as regards their impact on health care utilisation and expenditure patterns. (16).
- Tapping differentials in utilisation of private and public health care facilities has been one of the thrust areas in most of the studies. (4, 7, 9, 18, 21, 22, 23, 25, 27, 32).
- In rare instances, type of illness was considered as an independent variable to explain type of health care sought.
- Women's status – as dependent or otherwise – was also considered as an explanatory variable. (18, 20). These studies found that dependent women, such as, girls and aged women, used more health care per episode compared to those women who were either heads of households or wives of heads of households.
- There were studies, which looked into gender differentials as regards prevalence of illnesses, health care sought and money expended on treatment. (7, 9, 18, 21, 22, 23, 25, 27).
- In a rare instance, aggregate level development related variables at the village level were operationalised and treated as explanatory variables to explore their association with utilisation of health care services.
- A number of studies limited themselves to look into users' perceptions of reasons for not using particular health care services. (3, 4, 10). In these studies, people often came up with the characteristics of health care facilities and health care service providers which obstructed them from utilising these services, especially the public health care facilities. This was referred to as 'perceived quality of care' and included factors, such as, inadequate facilities (8), longer waiting period, arrogant attitude and behaviour of all the staff, non-availability of medicines (4). Providers, such as, trained birth attendants were preferred given the fact they share the same socio-cultural environment as that of users. Perceived efficacy of treatment was found to be an important factor in determining use of health care services. (18).
- Knowledge & views about, and attitude towards the health care programmes/ providers/ facilities were included in the set of explanatory variables in some studies. (16, 17).

- Some other studies revealed the potential causal relationship between people's socio-economic background and their utilisation of health care services. (3, 4, 7, 9). However, not many communications mentioned about the operational definition of socio-economic status of users.
- Some studies, especially those with the thrust on women specific health care needs, considered type of work that women were engaged in, and parity as explanatory variables in addition to those mentioned above. (14, 15).
- Exploration of the patterns of association between 'physical availability of health care facilities' and their utilisation was achieved by designing the appropriate methodologies. (25).
- ANC, contraceptives, services related to MCH are the most studied aspects as regards utilisation of health care services. Some specifically studied abortion care needs. But some focussed on a vast canvas of general health care needs during the specific recall period. (7, 9, 18, 21, 22, 23, 25, 27).
- The abortion related research indicates that the concern about the issue of abortion is more because of its contribution to nation's population reduction rather than its adverse consequences for women's health on account of unsafe abortion care services that women may have to approach for.
- Not many studies articulated the need for national level policies for regulating and monitoring the private sector as one of the measures to improve people's access to safe, rational and affordable treatments/health care.
- Utilisation and expenditure studies have very clearly brought out the impact of socio-economic variables, and gender on utilisation and expenditure patterns. Gender is the factor that affects all arenas of woman's life. Thus, there is need to see linkages between reproductive health and other aspects, such as, work, environment. Policies and programmes (even outside the purview of health care policies and even outside the national policies) need to be analysed in an integrated and comprehensive manner.
- Some of the studies were inadequately conceptualised and were quite less rigourous methodologically, a major constraint in itself.

Policies: Analysis, Critique and Alternative Perspectives

The studies which attempted to analyse the health care service system from a broader perspective enabling to articulate the issues and concerns at policy level have been included under this sub-theme. They may have used either empirical research or secondary data or even a synthesis of empirical research that exited. Some communications are primarily documentation of experiments suggesting the possible alternative strategies for improving people's and women's access to health care services; providing space for their participation at all levels, such as, designing policies, its implementation, regulation and monitoring. By and large the areas that are covered are health care service delivery system; health care service providers; health budget; medical education; especially nursing; health care management; implementation; monitoring and regulation of health care service delivery system. It also includes assessments/evaluations of some of the national programmes, such as, family welfare programmes and National AIDS Control progamme. Obviously, one comes across alternative strategies and perspectives emerging out of these syntheses and evaluations.

Since women's health care needs are situated in the context of the general health care service facilities, it is essential to understand the policy issues involved in case of the latter. Over and above this, one then needs to look into issues that would be specific to women's need for health care services. This also explains inclusion of health policy research in this annotated volume, which is more generic than specific.

- The research has adequately demonstrated that the existing health care delivery system though not so inadequate, does not meet people's health care needs for it is unevenly distributed over rural and urban areas across classes and across gender. (13, 24).
- The research brings out the issues regarding inaccessibility emerging out of overwhelmingly large proportion of private health care services in the total health care service sector, which could be accessed only by those who can purchase these services. (5, 7, 13).
- The situation regarding access, in a broader sense, worsens in absence of any regulatory mechanism in place, which would ensure affordable, safe, rational health care service delivered humanely to its users. (13).
- The research which have critiqued increasing privatisation of health care sector expresses the concern that increase in and expansion of these services would not meet people's need.
- The studies which have looked into the problems of health care service delivery system, especially arising of large and wide spread private health care sector, counter argue the argument in favour of privatisation of health care based on the issues mentioned above. (13).
- It is encouraging to note that alternatives for improving the existing system also have been suggested either based on experiences of other nations or drawing paralles from our own nation in some other areas. (3, 13). For instance, it is suggested, based on experiences of developed countries, that Planned National Health Services could achieve universal provision of health care services. (13).
- The community-based experiments to enhance women's access to safe, affordable and humane health care services were mostly the alternatives to the existing health care service delivery system. They were not without problems and perhaps would remain small-scale efforts, at the most could be replicable in similar situations. (14, 15, 29). Interestingly, all of these have been primarily to meet women specific health care needs. The process than outcome has been considered important in developing and establishing these alternatives. Such alternatives, many of which remain undocumented, have been primarily based on bottom-up approach and emerged as a result of paradigm shift from top-bottom to participatory development one. Not often such initiatives could offer an articulation of the issues regarding self-sustainability, replicability and mainstreaming.
- As anticipated, there were communications based on critical perspectives on RCH approach to women's health and assessment of RCH programme after its implementation as well. (9, 10, 20, 22, 23). This critical perspective highlighted the failure of the reproductive health concept to articulate its links with general health and socio-economic conditions. It is argued that the reproductive health strategy was accepted in international initiatives, such as, ICPD, Cairo without any discussion on development strategies or SAP. The basis of the shift was political convenience rather than epidemiological needs. (22).
- The other two communications provide critique of RCH at its implementation level assuming perhaps that there was little that could be done to stop the encroachment

of the strategy. Another communication deals exclusively with nurses as critical service providers in the changing paradigm of women's health. (20).

- There generally has been dearth of literature on health of tribals. Health of tribal women seems to be an area out of site with almost no research available. Health status of tribals and their access to health care system would provide some evidence on tribal women vis-à-vis these matters. In one of the rare communications, some of the issues related to health status of tribals and public policy for health care were articulated. (24).
- It points at the need to have a development paradigm with health as a central focus. The agenda should consist of provision of basic education, basic health care and capacity-building within the framework of a stable and sustainable land use policy. The structural interconnectivity between income, food, security, female literacy and good health needs to be taken note of.
- Not much effort has gone into making an assessment of the existing medical education system in the light of people's changing health care needs and overall change in socio-political context. Whatever little efforts that have gone into are primarily on education and training of nurses and other paramedics such as midwives. (4, 8).
- As regards private health sector, some efforts are also made to understand the investments in medical care equipment, expressing the need to look into issues related to resource allocation & management and optimisation of resources. (31). However, these are only small scale studies. Macro level, empirical studies as well as analysis of secondary data (viz. from Central Information Bureau of Health) giving nationwide understanding of the situation are required. As part of this research agenda, analysis of equipment specifically required for reproductive health care needs can be taken up.
- A couple of studies looked into financial aspects of health care. (6, 21). The micro-level analysis of finances allocated for post-partum centres (PPC) raises doubts about the possibility of a post-partum programme with a separate financial identity co-existing with the present FW/MCH services in the country. (21). The macro-analysis of public health expenditure shows that investment by the public sector for health care has been inadequate for the people's needs. (6). The data on various dimensions of health expenditure shows that allocative efficiency is a major area of concern.
- One of the studies traces the social and political origins of the development of the health sector of Maharashtra and compares it with that of Punjab and Kerala. (7). It states that though Maharashtra has attained good health indicators, there is still a wide urban-rural as well as regional disparity. The private sector has seen unregulated and unaccounted growth. This communication highlights the need to combat the negative effects of the rapid and unregulated growth of the private health sector in Maharashtra.
- One of the communications was to address the issue of quality assurance in nursing. (30). The author lists a range of obstacles in raising the standard of nursing in India. The communications indicates that a range of issues needs further exploration to translate the concern about quality assurance in nursing in reality.
- In general, it appears that policy research in certain areas has offered alternatives for improving the existing health care services. However, it seems that empirical research needs to be adequately informed by these alternative perspectives. Revamping policies though would require concerted efforts, the immediate need is certainly to advocate, in a broader sense, for these alternatives.

It is hoped that this annotated bibliography would facilitate the planning of research on reproductive health services in the coming decade. Any such research effort since constitutes a public domain, we make an appeal to researchers, others concerned and interested to make use of this work, which either directly or indirectly would contribute to an understanding of issues involve in health care delivery system, to improving health care services to be equitable and gender-sensitive and to improving women's access to health care services. We would appreciate a communication from you about the way this annotated bibliography has been made use of at your end.[3]

HEALTH CARE SERVICE PROVIDERS

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE C
1.	To study perceptions, opinions and level of job satisfaction among the health and family welfare personnel.	Not stated	**Kerala** Rural	Empirical Health C
2.	To evaluate the impact of TBA training programme on their performance.	1984-85	**Rajasthan** Rural	Empirical Evaluato Health C
3.	To assess the utilisation of the services of TBAs.	Not stated	Aligarh **Uttar Pradesh** Rural	Empirical Commun
4.	To understand the livelihood of TBAs.	1994	**Bihar** Rural	Empirical Descripti Commun
5.	To show that involving paramedics in rural obstetric care reduces peri-natal mortality.	Not stated	Sevagram **Maharashtra** Rural	Empirical Commun
6.	To study perceptions of ANM as regards to their status, role and problems.	1990-92	Pune, Wardha, Beed, Ratnagiri **Maharashtra** Rural	Empirical Descripti Health C
7.	To ascertain the state of preparedness of MSS groups as also their linkage with the health delivery system and their activities.	Not stated	**Haryana** Rural	Empirical Descripti Commun
8.	To assess the learning needs of TBAs regarding AIDS.	Not stated	Coimbatore **Tamil Nadu** Rural	Empirical Evaluativ Health C

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE C
9.	To understand problems of female health workers and its implications.	Not stated	Not stated	Empirical Descripti Health C
10.	To understand people's choice for traditional medicines.	1995	Bangalore **Karnataka** Rural	Empirical Descripti Commun
11.	To identify information needs of primigravid women and to provide it accordingly.	Not stated	***Karnataka U r b a n***	Empirical Descripti Health C
12.	To develop and evaluate an alternative teaching curriculum model for undergraduate medical students.	1986-87	**Pondicherry** Urban	Empirical Evaluativ Health C
13.	To explore two methods for better improvement of pulmonary functioning of nursing students.	Not stated	Manipal **Karnataka** Urban	Empirical Health C
14.	To evaluate in-service training programme for staff nurses.	1998	**Andhra Pradesh** Urban	Empirical Evaluativ Training based
15.	To study the profile of rural private practitioner.	1986-90	**Uttar Pradesh** Rural	Empirical Descripti Commun
16.	To evaluate training workshop for TBAs.	1990	***West Bengal*** Rural	Empirical Evaluativ Training based

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE C
17.	To assessment of cost and quality of intra-natal care provided by trained traditional birth attendants in the homes.	1993	Vellore **Tamil Nadu** Rural	Empirical Prospect Retrospe Commun
18.	To study in-depth the role of TBAs in providing intra-natal care.	1984-85	***New Delhi*** Rural and Urban	Empirical Descripti Commun
19.	To evaluate dai training programme and their role in rendering MCH services to the rural population.	1988-89	Kolhapur **Maharashtra** Rural	Empirical Descripti Commun
20.	To assess the knowledge and attitudes of TBAs with	1989-91	Ambala	Empirical

	regard to family planning.		**Haryana** Rural	Descripti Commun
21.	To assess feasibility of utilising the services of dais in case finding for tuberculosis patients.	Not stated	***S r i p e r u m b u d u r Tamil Nadu*** Rural	Empirical Descripti Commun
22.	To evaluate the impact of primary health care projects initiated under private voluntary organisation in health.	1981-87	**13 states** of India Rural	Empirical Analysis secondar

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HEALTH CARE SERVICE PROVIDERS

SELECTED ANNOTATIONS

1. Job satisfaction among health and family welfare personnel: A case study of two primary health centres in Kerala

Authors **:** Baburajan P.K. and Verma R.K.
Source **:** The Journal of Family Welfare, 1991
Place of study **:** Kerala
Location **:** Rural
Period of study **:** Not Stated
Type of research **:** Empirical, Analytical, Health Centre-based

Aim: To analyse the perceptions and opinions of the health and family welfare personnel of two primary health centres (PHCs) which differed in terms of family welfare performance and various job-related issues; to study the level of job-satisfaction among them and the factors which affect job-satisfaction.

Methodology: Two PHCs were selected on the basis of sterilisation and IUD performance from one of the top-performing districts in the state. The performance of PHC I was better than the average performance for the district as a whole while the performance of PHC II was below average. Selection of the PHCs from the same district ensured homogeneity of socio-economic conditions and topographical features. An-depth interviews using the job satisfaction scale developed by Paliwal and Sawhney and observations were used for data collection. At the two PHCs, 88 out of 104 health personnel including doctors were interviewed.

The relationship between the background characteristics of the respondents and job-satisfaction was analysed using the correlation technique. Step-wise regression was employed to ascertain the important determinants of job-satisfaction.

Findings: PHC I had catered to a larger population than the low-performing PHC II. It had a proportionately larger number of sub-centres to reach its population. The PHCs were similar as regards their period of establishment, distance from the nearest town, infrastructure, adequacy of health staff - except in the case of Medical Officers - vis-à-vis population to be covered. All the paramedical staff possessed the essential qualifications for their respective posts.

PHC I was better placed with regard to maintenance of records, display of charts ('spot map', 'who is who', and 'control chart') and the number of group meetings held. PHC I was engaged in various activities other than the scheduled ones, unlike PHC II. The better-performing PHC was using innovative methods to monitor activities. Doctors of PHC I were found to be more task- and programme-oriented than doctors of PHC II. The officials at PHC I were more democratic in their outlook (wanting to delegate powers) and had more frequent interactions with their staff. Doctors of PHC I consistently perceived problems related to their programme and looked for solutions, that is, programme administration, whereas doctors of PHC II saw problems as something different from priorities. Paramedical staff from both PHCs perceived programme-related problems in a more or less similar manner.

It was found that the average job-satisfaction score did not differ significantly between the personnel of the two PHCs. About 40.9 per cent of them were moderately satisfied and about 25 per cent were least satisfied. Age, residential status and experience were negatively related with job-satisfaction. The important determinants of job-satisfaction were confidence in getting a promotion and availability of infrastructure. The popular notion that salary affects job-satisfaction stood disproved in this study.

The authors conclude that the above factors, along with organisational factors, are a necessary precondition for performance, motivation, leadership and management qualities of the medical officers, and are therefore important for programme productivity.

Reviewer's note: The job-satisfaction scale was tested for its validity and reliability, and can therefore be used further for similar purposes. The paper assumes significance in lieu of the TFA (renamed CNA) approach, which depends a lot on grassroots level workers for its better implementation.

Key words: *Paramedics, Job-satisfaction.*

2. Impact of training on the performance of traditional birth attendants

Authors	**:** Benara S.K. and Chaturvedi S.K.
Source	**:** The Journal of Family Welfare, 1990
Place of study	**:** Rajasthan
Location	**:** Rural
Period of study	**:** 1984-85
Type of research	**:** Empirical, Evaluatory, Health Centre-based

Aim: To evaluate the impact of the TBA training programme on their performance as well as their proper utilisation.

Methodology: The study was conducted in three PHCs included under the Reorientation of Medical Education (ROME) Scheme of SMS Medical College, Jaipur. A cross-sectional study design was adopted for the survey and the data were collected from 364 TBAs in the three PHCs using the structured interview technique. Of them, 182 were trained and 182 were untrained dais.

Findings: There was a significant improvement in the performance of trained dais as compared to untrained dais. About 64 per cent of the mothers delivered by the trained dais had registered at the sub-centre during pregnancy as compared to about 25 per cent of those delivered by untrained dais. A significant difference revealed between the trained and untrained dais was in terms of contact with pregnant mothers, and advice given regarding immunisation, anaemia prophylaxis, family planning and personal hygiene (all at $p<0.001$). Almost half (45.6%) of the trained dais preferred to use a blade for cutting the umbilical cord compared to 15.4 per cent of the untrained dais. Almost all (95.6%) the trained dais contacted the health worker for various purposes, as compared to only 49.4 per cent of untrained dais, largely for antenatal and postnatal care, including pregnancy complications, registration of births and deaths, and family planning motivation.

The conclusion is that training can be helpful in forging a functional relationship between the organised health service system and the community at large.

3. Role of traditional birth attendants in maternal care services: A rural study

Authors : Bhardwaj N., Yunus M., Hasan S.B., et al.
Source : Indian Journal of Maternal and Child Health, 1990
Place of study : Aligarh, Uttar Pradesh
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Analytical, Community-based

Aim: To assess utilisation of the services of TBAs.

Methodology: The study was conducted in four randomly selected villages that were covered by the ICDS. All the 212 registered women were asked about the nature of assistance received at delivery.

Findings: Dominant characteristics of the sample: Hindus (96.7%), illiterate (93.0%) and poor (68.5 %) constituted the sample; about 33.5 per cent were high-caste, 30.2 per cent belonged to backward castes and 30.2 per cent were from the scheduled castes. About 96.6 per cent (205/212) of deliveries were conducted at home and were similar to those reported by the NIHFW. Of these, 89.6 per cent were assisted by untrained dais (TBAs), 11 by ANMs, nine by doctors, two by relatives and none by trained dais.

The poor utilisation of existing intra-natal services was because the women were illiterate and poor. Caste did not seem to play any significant role. It is recommended that there is a need to educate people to utilise the services of trained personnel already available, to strengthen domiciliary services and to train TBAs intensively. The study

also recommends a reward or incentive for TBAs and adequate support to TBAs through supervision and continuing education.

Reviewer's note: The article does not mention whether the villages had any trained dais whose services could be sought by women. The utilisation of any health care services is influenced by multiple factors. In the absence of any analysis of these factors, the study becomes less insightful.

Key words: Traditional Birth Attendants, Trained Dai, Home Deliveries, Service Utilisation.

4. Endangered professionals: Traditional birth attendants of South Bihar

Author : Chattopadhyay M.
Source : Economic and Political Weekly, 1996
Place of study : South Bihar
Location : Rural
Period of study : 1994
Type of research : Empirical, Descriptive, Community-based

Aim: To understand how the livelihood of TBAs in South Bihar villages is being threatened, partly by the entry of modern medicine and partly by state decree.

Methodology: Interviews.

Findings: The study details how alternative medicine works in villages and describes the stable patron-client relationship between villagers and locally-based TBAs in remote areas. TBAs belong to the scheduled caste called Turi. This caste group's right to serve village women during deliveries is recognised by the people and village panchayats. No formal training is available to them, but they offer years of experience. They lack even elementary gynaecological and obstetric knowledge. Their knowledge about reproductive organs and other related matters has little scientific basis and content. Consequently, they often cause, quite unknowingly, damage to the new-born and at times even death. During enumeration of the population it was found that the infant mortality rate was quite high. Misconceptions about breast-feeding new-borns prevailed. Remuneration of TBAs varied according to the caste hierarchy afd sex of the new-born.

The patron-client relationship is shaken by modern medical practices. The literate population, the Bhumihars (general caste) go to the hospitals for their health care needs. The people's acceptance of modern medicine is seen by the TBAs as a threat to the future of their profession.

In 1973, UNICEF trained 241 TBAs for 15 days in the maternity ward of a health centre or district rural hospital. There has been a dramatic improvement in the condition of hygiene during deliveries. TBAs can serve as a first contact system. They can become important allies in organizing efforts to improve the health of the community and fill the void in some pockets where facilities for modern treatment are either still totally absent or not immediately and easily available. The author also suggests that if the practice of these TBAs is banned by legislation, alternative livelihood must be provided to them.

Key words: *Patron-client Relationship, Remuneration, Traditional Birth Attendants.*

5. Paramedics in rural obstetric care

Authors	**:** Chhabra S., Aher K. and Jajoo U.N.
Source	**:** Journal of Obstetrics and Gynaecology, 1990
Place of study	**:** Sevagram, Maharashtra
Location	**:** Rural
Period of study	**:** Not Stated
Type of research	**:** Empirical, Analytical, Community-based

Aim: To show that involving paramedics in rural obstetric care reduces perinatal mortality.

Methodology: In 19 villages around the Sevagram Medical College at Wardha, Maharashtra, women who were likely to have pregnancies were selected for the study. A total of 1,334 pregnancies (of 723 women) could be included in the study. Information on the obstetric history of women was collected.

Findings: The provision of obstetric care by paramedics reduced the perinatal mortality rate from 45.55 per 1,000 births during 1985-86 to 24.84 per 1,000 births at the end of 1990. The pregnancy wastage was reduced from 13.86 per cent to 5.82 per cent through ANMs visits.

Reviewer's note: The authors have done a non-probability sampling of eligible women and estimated pregnancy wastage in their whole reproductive life so far. The methodology used to estimate ever pregnancy wastage is unlikely to yield reliable estimates. Data to support the inference about paramedics reducing perinatal mortality was not presented in this particular paper.

Key words: *Paramedics, Obstetric Care.*

6. Women in health care: Auxiliary nurse midwives

Author	**:** Iyer A., Jesani A., Fernandes A., et al.
Source	**:** Women in Health Care: Auxiliary Nurse Midwives, FRCH, 1995
Place of study	**:** Pune, Wardha, Beed and Ratnagiri, Maharashtra
Location	**:** Rural
Period of Study	**:** 1990-92
Type of research	**:** Empirical, Descriptive, Health Centre-based

Aim: To study the status of ANMs in the health services, in the community and in their homes through an understanding of their social role and day-to-day problems as perceived and experienced by them.

Methodology: The sample consisted of 183 ANMs from two PHCs in each of three talukas from each of four districts representative of differing levels of socio-economic

development as measured by the CMIE index of development. In addition, two talukas from the tribal belt of Pune district were included to have a total of 27 PHCs in the study. In addition one ANM from each of the selected PHCs was singled out for in-depth interaction over a maximum period of three days.

Tools of data collection included interview schedules. Urban-based women constituted the team. Researchers insisted upon ANMs being alone while being interviewed so that they could talk freely, without fear of repercussions. Privacy was respected and coercion was avoided while eliciting information from them.

Findings: It analyses the socio-economic background of the recruits in terms of their community, educational qualifications, occupational profile, agricultural land holding and income distribution. It reviews trends in the professional preparation of ANMs through training and retraining programmes as well as on-going supervision and guidance on the job. It recreates the life and experience of village-level health work. It highlights aspects of work which are problematic at a cultural level; informs about the forces that guide women into a profession dominated by women and one discredited and even stigmatised. It contemplates the complex relationship between the role of ANMs as wage labourers in the health services and the social ramifications of this role at the household level and in the marriage market.

It is concluded that the economic role of ANMs is not translated into social status nor does it lead to empowerment to the fullest extent possible. Their professional and administrative subordination (to doctors and nurses) is compounded by their gender, youth, negative social image, disadvantaged socio-economic backgrounds and their status as outsiders in the community. Located in a non-institutional setting and while trying to achieve a delicate balance between their role as family planning motivators (as defined by the state) and as health care workers (as demanded by the people), they encounter many unpleasant experiences.

Deficient and inappropriate training, notional professional supervision, and grossly inadequate facilities, equipment and infrastructure limit the scope and efficiency of their work, affecting their relationship with both the district health bureaucracy and the community. Dogged by work-related problems, they have few sure-fire channels of redress and virtually no support system. Not many admit dissatisfaction with the job. Their challenge centres around fighting and overcoming the daily battle of survival. ANMs survive by achieving practical, down-to-earth solutions.

Reviewer's note: The study gains its credibility from its approach to the situation of ANM's and from the broad sweep of its objectives. The study makes a significant contribution to research on ANMs. In addition, the scientific statewide spread of the study and a sound methodology facilitate generalisation of the findings.

Key words: *Auxiliary Nurse Midwife, Problems, Implications.*

7. Situational analysis of preparedness of the Mahila Swasthya Sangh (MSS) for health and family welfare activities

Author	**:** Lal S., Khanna P., Singh Vashisht B.M., et al.
Source`	**:** Indian Journal of Preventive and Social Medicine, 1994
Place of study	**:** Haryana
Location	**:** Rural
Period of study	**:** Not Stated
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To ascertain the state of preparedness of MSS groups, their linkage with the health delivery system and also to collect information on the activities initiated by these women's groups.

Methodology: Nine MSS groups were covered from nine randomly selected villages belonging to one rural block. The sample consisted of 82 non-official members of the MSS and 200 non-members from nine villages. Non-official members were interviewed to collect information on various aspects like their initial training/orientation, meetings held and subjects discussed, responsibilities taken and help rendered to village functionaries. Non-members were interviewed to find out the reach and effect of MSS activities amongst other women. Records of the past one year kept with MPWs were analysed to ascertain the activities conducted, meetings held and number of women who participated.

Findings: The study finds that these MSS groups were inadequately trained and seldom took the initiative in organizing and conducting meetings on their own. Village respondents never mentioned these groups as health education sources. The most often-covered subjects in the meeting comprised immunization (93 %), ORS and diarrhoea (80.5%), contraception (59.7%), sanitation (29.3%), antenatal check-up (24.4%), diet during pregnancy (19.5%) and initiation of early breast-feeding (11.0%). The MSS officials could hardly contact 15 per cent of the women in their homes while AWWs contacted 53.5 per cent of women through home visits.

The authors state that young women are most busy in work outside and within the home and hardly find time for MSS activities. The authors therefore recommend the equal involvement of men's groups. They express the need to train health workers in communication skills and to support women for self-help and self-reliance in many of the essential health tasks.

Key words: Mahila Swasthya Sangh, Interpersonal Communication, Women Development, Women Organisation.

8. The effectiveness of a Planned Teaching Programme (PTP) based on the learning needs of traditional birth attendants regarding prevention and control of AIDS

Author	**:** Meerah R.
Source	**:** Indian Journal of Nursing & Midwifery, 1998
Place of study	**:** Coimbatore, Tamil Nadu
Location	**:** Rural
Period of study	**:** Not Stated
Type of research	**:** Empirical, Evaluative, Health Centre-based

Aim: To assess the learning needs of TBAs regarding AIDS, to develop and test a planned teaching programme.

Methodology: The study was conducted in two phases in three randomly selected community health centres of a conveniently selected district of Tamil Nadu. In phase I, learning needs were assessed and analysed. In phase II, the PTP was developed, administered and evaluated for its effectiveness.

In both the phases, a structured interview schedule was used for data collection. A descriptive survey design was used in Phase I to collect data, identify learning needs, review existing literature and validate the criteria checklist. The reliability of the tool was established by the test-retest method using rank order correlation. The reliability of the tool was found to be high (r=0.95). The PTP included a flip chart (20 cards), and a role play. The flip chart was pre-tested and found to be relevant and adequate. The script of the role play was validated by nine experts based on an evaluative criteria checklist. The PTP was tested for its effectiveness by the pre-test/post-test control group design.

Thirty TBAs in the experimental group and 30 in the control group were selected randomly from two community health centres. Descriptive and inferential statistics were used while analysing the data.

Findings: The study revealed that TBAs have inadequate knowledge of every aspect of AIDS. The maximum deficit was found in the area of 'meaning and causes of AIDS'. The minimum deficit was in the area of prevention and control measures to be taken by TBAs. The PTP was found to be effective in increasing the cognitive behaviour of TBAs and found to be an effective tool for providing information regarding prevention and control of AIDS through statistical tests.

The author recommends that public health nurses should establish and maintain links with TBAs by means of a two-way referral system of clients between health personnel and TBAs. A positive and supportive working relationship between TBAs and ANMs should be promoted. It was expressed that grassroots health care personnel need to have in-service education on AIDS and that AIDS content should be integrated in the curriculum of the undergraduate and graduate nursing programme.

Reviewer's note: The elaborate methodology enhances the scientific approach of the study along with its replicability in similar experiments.

Key words: Dais (TBAs), AIDS, Knowledge, Training Programme, Childbirth.

9. Female health workers: Problems and implications

Author : Mishra R.
Source : Economic and Political Weekly, 1997
Place of study : Not Stated
Location : Not Stated
Period of study : Not Stated
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To study the problems that female health workers are facing, their implications for the quality of health care services they are providing, and to suggest some immediate measures to improve their working conditions.

Methodology: The sample consisted of 264 FHWs, including LHVs and ANMs. Profile data on age, education, residence, type of family, marital status and husband's employment.
Findings: FHWs are the most vital link in the entire chain of the health care delivery system in rural areas. They work with people confronted with illiteracy, poverty, unemployment, deep-rooted social customs and tabogs. They have to provide services in places where there is a lack of health culture among the people. Thus, it is difficult and challenging to motivate the rural masses to use the health and family welfare services available at PHCs and sub-centres. FHWs face problems which are transfer-related, health-related, official, social, etc. The implications of these problems do not remain restricted to individual FHWs but ultimately affect the quality of health care services that they are providing. The author strongly feels that unless these problems faced by the FHWs are addressed on a priority basis, the health and family welfare services will continue to be poor.

The author also suggests that the problems of FHWs be solved without further delay. These include issues regarding transfer, children's education, security, filling up the backlog of vacant posts, supply shortage and transport facilities.

Reviewer's note: The study is significant because one rarely comes across research that attempts to look into the problems of women health workers. However, no reference to the methodology makes it a fragile communication.

Key words: *Female Health Workers, Problems, Implications.*

10. Indigenous health care system in Karnataka: An exploratory study

Author : Muthurayappa R.
Source : Radical Journal of Health, 1998
Place of study : Bangalore, Karnataka
Location : Rural
Period of study : 1995
Type of research : Empirical, Descriptive, Community-based

Aim: To understand the people's decision to utilise traditional medicines, the type of disease/ ailments for which such medicines are sought, and to study the characteristics of practitioners and their clients.

Methodology: The Veeregowdanadoddi primary health centre of Magadi taluka constituted the study area since the traditional system of medicine is still predominant here. From the 67 villages, 26 indigenous medical practitioners were identified with the help of PHC health workers. Of these, 16 who were practicing full-time were included in the study. A separate interview schedule was used to collect information from the health care providers and their clients. Ten clients of each of the practitioners were interviewed, mainly to cross-check whether indigenous medicines are really effective in treating diseases and the reasons for the preference for indigenous medicine over modern medicine. Provider-client interactions were also observed. The data gathered from the practitioners include: type of training, method of disease diagnosis, knowledge of medicines and method of treatment, type of disease they treat and their perception of indigenous and modern medicines. A good rapport was established with the indigenous health practitioners before the interview.

Findings: The traditional practitioners have never had formal training. Traditional healers pass on their powers informally by word of mouth. Diagnosis of the disease is based on physical examination and the symptoms of the disease. Practitioners treat more than one disease and prescribe only indigenous medicines. The users of indigenous medicines are mostly from the weaker sections. The traditional therapy is always family-based food habits, home remedies, rituals etc. When both traditional and modern systems of medicine are available in villages, villagers accept traditional medicine. The reason behind this is the dependence on and confidence in traditional medicine men. Also, to avail of modern health facilities villagers have to travel long distances. The traditional approach establishes faith and assurance in patients, which modern medicine lacks. The traditional practitioners share the cultural beliefs and practices of the patients, which leads patients to have faith in them.

Reviewer's note: This study throws light on the people's choice of traditional systems of medicine. There is not much documentation available on these aspects of health care.

Key words: *Indigenous Medicines, General Health Care, Traditional Healers.*

11. Teaching primigravid women about warning signs in pregnancy using specaally designed information booklet

Author	**:** Noronha J.
Source	**:** Indian Journal of Nursing & Midwifery, 1998
Place of study	**:** Karnataka
Location	**:** Urban
Period of study	**:** Not Stated
Type of research	**:** Empirical, Descriptive, Health Centre-based

Aim: To identify the information needs of pregnant women and teach them with the help of a specific module. To find out the relationship between the level of pre-test knowledge and age, education, economic status and type of family. To determine the effectiveness of an information booklet on 'warning signs in pregnancy' as evident from the gain in knowledge scores and post-test acceptability scores.

Methodology: The sample for phase I for assessment of learning needs consisted of 30 Primigravid women with gestational age of less than 36 weeks who had visited the hospital at the time of data collection. For phase II, 40 subjects were selected to overcome sampling mortality. This was a purposive sampling. One group pre-test/post-test design was used to test the effectiveness of the information booklet.

Since the study aimed at developing and evaluating an information booklet, it used the 'System's Model' for the development of learning material/modules. (WHO SEARO, 1985).

Findings: There is no association between knowledge regarding warning signs of pregnancy and the demographic variables, i.e. age, education, socio-economic status, type of family. The mean post-test score of 88.8 was significantly higher than the mean pre-test knowledge score of 25.5. The author therefore feels that the booklet is a practical strategy to reduce complications during pregnancy and thus reduce maternal morbidity and mortality. Patient education is a process of assisting people to learn and incorporate health-related behaviour into everyday life. The educational role of the nurse also needs to be emphasised. At the end, the author emphasised the role of nurses in imparting health information and assisting the community in developing its self-care potential; the need to encourage the dissemination of health information and introduce information about educational technology methods in the nursing curriculum; the need to train personnel to prepare appropriate teaching material for teaching self-care abilities based on these needs; and the need to set up multimedia centres for teaching and client education.

Reviewer's note: Sound methodology and the application of valid statistical tests make the study significant and noteworthy. However, it does not deal with the cultural differences in women's backgrounds that may impact on their knowledge requirement and knowledge receptivity.

Key words: Warning Signs, Pregnancy, Information Booklet, Teaching.

12. Competency-based curriculum in the primary prevention of obstructed labour

Author : Oumachigui A., Bhupathy A., Rajaram P., et al.
Source : Journal of Obstetrics and Gyneacology, 1990
Place of study : Pondicherry
Location : Urban
Period of study : 1986-87
Type of research : Empirical, Evaluative, Health Centre-based

Aim: To develop and test an alternative teaching curriculum model for undergraduate medical students in management of labour.

Methodology: Ninety-five medical undergraduate students included in the study were posted in the labour room for a month. Objectives in terms of what students should be able to do were defined. A structured questionnaire was administered to the students at the end of the one-month period.

Findings: During evaluation, 98 per cent of the students felt confident of managing normal labour and in the use of partograms for early detection of obstructed labour. About 90 per cent of students have achieved proficiency in obstetrical examination and management of the normal course. They seemed to have acquired adequate skills and knowledge to refer a patient to a specialist utilising objective criteria. They developed favourable attitudes towards pain relief and fluid and electrolyte imbalances that could occur in obstructed labour.

The authors advocate a revision in the existing 'subject-ceftred' curricular models to more 'competency-based' learning. It requires a clear definition of tasks, statement of objectives, thorough assessment of the students' achievement, flexible time schedules, and commitment on the part of the teachers and a change in the pattern of examination.

Reviewer's note: The study brings to light the limitations of subject-centred curricular models that reiterate the need to review the present system of medical education.

Key words: *Obstructed Labour, Competency Based Curriculum, Medical Education.*

13. The effectiveness of incentive spriometry and deep breathing exercises in improving pulmonary function

Author	**:** Pavithran S.
Source	**:** Indian Journal of Nursing & Midwifery, 1998
Place of study	**:** Manipal
Location	**:** Urban
Period of study	**:** Not Stated
Type of research	**:** Empirical, Analytical, Health Centre-based

Aim: To explore which of the two methods better improves the pulmonary function of nursing students.

Methodology: The sample consisted of 57 subjects, 19 in each group, i.e. two experimental and one control group. A comparative-evaluative approach pre-test/post-test control design with two experimental groups was used. The subjects were the pre-service nursing students of the selected nursing college. The tool consisted of measurement records for pulmonary function indices and a questionnaire for assessing environmental factors. Reliability of the tools was ensured by inter-rater reliability.

Findings: The findings reflect that the majority of normal young individuals who are undergoing health professional courses do not demonstrate normal pulmonary function, but they have the potential to improve it by simple, cost-effective exercises through modification of their health behaviour. This indicated that both incentive spirometry and

deep-breathing exercises had a significant impact on pulmonary function. It is suggested that including exercises in educational institutions should be a mandatory co-curricular function of the teachers.

Nursing education involves intensive hours of clinical and classroom studies. Nursing students do not often take up regular physical exercise because of the burden of rigorous studies, clinical work and other academic duties. Exposure to diseases in clinical areas on top of low nutritional levels makes them vulnerable to infection. Added to this, most of the students suffer from varying degrees of anaemia. Regular exercise is essential to help them feel fit and confident.

Reviewer's note: The study deals with the workload and nature of work and its implications for the health of nursing students. The same logic can be extended to those who are in the nursing profession. Workload, leisure time, work environment and hoards of other issues are important as they would have implications for the quality of care that they deliver.

Key words: Spirometry, Nursing Students, Pulmonary Function, Anaemia, Breathing Exercises.

14. Report of an assessment on 'How staff nurses evaluated the clinical nursing inservice training imparted to them at four training centres in the state of Andhra Pradesh under World Bank Project'

Author : Razia R.
Source : Indian Journal of Nursing & Midwifery, 1998
Place of study : Andhra Pradesh
Location : Urban
Period of study : 1998
Type of research : Empirical, Evaluatory, Training Centre-based

Aim: To evaluate the in-service training programme designed for the staff nurses, to assess the outcome in terms of the nurses' perception of the training programme and their opinion about the training imparted to them.

Methodology: The sample consisted of 110 trainees from six batches of all four training centres. A questionnaire was developed using the 'semantic differential' format with a seven-point scale to assess opinions and attitudes. Opinions on the 'need for in-service training', 'objectives of the programme' and 'specific components covered' were gathered, along with identificatory data and comments for improvement.

Findings: The Andhra Pradesh Vaidya Vidhana Parishad (APVVP), which provides primarq and secondary health services to people in Andhra Pradesh, sought assistance from the World Bank to develop and implement activities for improving health care delivery in all its hospitals. The training covered essential skills in key clinical areas. It consisted of 72 hours of theory and 180 hours of clinical practice in the areas of basic nursing concepts and techniques, casualty nursing, acute medical care, post-operative care, OT techniques, nurse's role in CSSD, burns nursing, ophthalmic nursing, labour room nursing and paediatric care. The results indicated a positive attitude of the staff nurses towards the in-service training programme; they felt all seven objectives were achieved and were satisfied with all the specific components of the training programme.

It was observed that by the end of the training programme most of them were motivated to acquire more knowledge and skills and to work for professional development. It was the first such programme on a large scale for the development of nursing staff in the country.

Reviewer's note: As a follow-up to the evaluation of the training progamme, it would be beneficial to examine how and to what extent this training has impacted the quality of care received by the users of the services. Also, clinical training in isolation, without incorporating 'training in communication and/or counselling skills' and 'understanding of gender issues' seems to be only a partial achievement.

Key words: *Clinical Training, Evaluation, Staff Nurse, Quality of Nursing.*

15. The rural private practitioner[1]

Authors	**:** Rohde J. and Viswanathan H.
Source	**:** Health for the Millions, 1994
Place of study	**:** Uttar Pradesh
Location	**:** Rural
Period of study	**:** 1986-90
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To study the profile of the rural private practitioner.

Methodology: Using the random sampling method, 488 private practitioners from 330 villages in Uttar Pradesh were included in the study. The 'rural mother' was asked to name the 'doctor'. Traditional midwives and practitioners of methods other than medicine (witch doctors, faith healers) were separated. Qualification or licensing or training was a criterion not used to define the rural private practitioner as in some other studies.

Findings: The authors describe the profile of the rural private practitioner. The dominant medical system practised by most of these practitioners was allopathy, regardless of their training, which was more so for untrained practitioners. The authors find that the chemist was the only drug supply and information source for the doctor, who usually operates alone. Almost all 'doctors' expressed great interest in becoming members of associations, which may provide them the opportunity to interact with other practitioners and to learn. The study estimates the average cost of health care at Rs 45 per case of diarrhoea and assumes that this cost would apply to all routine illnesses.

The authors recommend the acceptance and acknowledgement of the existence of the rural private practitioner and suggest ways to bring them into the mainstream through support and training rather than control, so that they are better equipped to provide health care. The authors conclude by recommending the need to establish links between the government health services and rural private practitioners.

Key words: *Rural Private Practitioners, Government Health Care Services.*

16. Mobilising Traditional Birth Attendants for safe motherhood

Author : Roy Chowdhury N.N.
Source : Journal of the Indian Medical Association, 1990
Place of study : West Bengal
Location : Rural
Period of study : 1990
Type of research : Empirical, Evaluatory, Training Centre-based

Aim: To evaluate a training workshop for TBAs.

Methodology: The data were gathered from the grassroot level workers, namely TBAs, ANMs or female MPWs and medical officers of the PHCs in three districts of West Bengal in a model workshop on the evaluation of their services.
Findings: The model workshop was organised by t`e Ministry of Health and Family Welfare, Government of India, and the National Academy of Medical Sciences, West Bengal Chapter, for the evaluation of training and services rendered by the grassroots level workers - namely TBAs, ANMs, MPWs and medical officers of PHCs in three different districts of West Bengal. The Sixth Plan in our country aimed at training one million TBAs in each Plan year, so that by 1982-83 each village would have at least one trained TBA. It is claimed that there are about 30,000 trained TBAs in West Bengal's rural areas but the exact number of trained TBAs in India is still not known. It is also not known how many untrained TBAs are still providing maternity service in the rural areas, causing large numbers of avoidable mortality and morbidity among pregnant women and neonates. Taking into account the types of TBAs found in rural areas, their misconceptions, misinformation and superstitions about pregnancy and childbirth, the current training programme for TBAs was designed for 30 days, to be imparted by medical officers and nursing personnel in PHCs . The curriculum consisted of a theoretical background on aseptic safe delivery, anatomy and physiology of reproductive organs, pre-intra-postnatal care, infant care, family welfare and immunisation of pregnant women and children under one year.

The author suggests that the emphasis should further be on helping them identify the high-risk groups of pregnant women (the risk approach of MCH care) and refer them in proper time to PHCs. TBAs should be taught about the warning signals for referral during pregnancy and labour (all sorts of complicated situations taken into account). After the training, the TBAs should be given a delivery kit for safe delivery and newborn care (checklist given). TBAs should be followed-up after the training to ascertain their ability to identify high-risk cases and refer them to PHCs, reduction in maternal and perinatal deaths, increase in the frequency of antenatal and postnatal visits, family welfare activities and immunisation services. By giving proper training to TBAs, maternal and perinatal mortality can be lowered to a considerable extent.

Key words: *Traditional Birth Attendant, Training Programme, Maternal Mortality.*

17. Assessment of cost and quality of intranatal care provided by trained Traditional Birth Attendants in the home

Author : Sahachowdhury S.
Source : Indian Journal of Nursing & Midwifery, 1998

Place of study : Vellore, Tamil Nadu
Location : Rural
Period of study : 1993
Type of research : Empirical, Analytical, Prospective and Retrospective, Community-based

Aim: To find out the cost of home-care, to describe the pattern of intra-natal care provided by trained dais and to find out if there exists any association between cost incurred and age, education, occupation, religion, family income and parity of mothers and experience of dais.

Methodology: A total of 90 deliveries assisted by 42 dais were observed. An interview guide for mothers to get data on demographic variables and a proforma to assess the expenditure involved in delivery in terms of personnel, money and material. An observation checklist was used to assess the intra-natal care provided by TBAs.

Findings: Most of the families (92.2 %) spent upto Rs 25 for the mother and baby. About half spent more than Rs 25 and the remaining spent upto Rs 25. The mean cost of the home deliveries in three areas showed no significant difference when applied ANOVA. About 62.2 per cent of families did not give any reward to the dai and 12.2 per cent of families did not pay any fee to the dai. Neither the dai nor the family members gave any importance to the amount to be paid to the dai for delivery. Job-satisfaction was an important reason. Chi-square showed that there was an association between cost of delivery and the occupation of the wife and parity of the mother. Housewives paid more than the employed (unskilled labourers) and primipara women paid more than multipara women for delivery. The senior and more experienced dais tefded to be more expensive. The quality of care observed was found poor, unsafe and unhygienic.

The study recommends that a system of witnessing, reporting and recording data with regard to home deliveries conducted by dais should be undertaken. This is to evaluate both the quality and cost aspects of services, considering the heavy investment in this training and the large number of deliveries attended by them in rural areas. The government should take the initiative in strengthening the economic structure of dais. Concentrating on their training would improve health care in rural India at a lower cost than present.

Key words: Cost of Delivery, Intranatal Care, Quality, Traditional Birth Attendants, Dais, Home Delivery.

18. An indepth study of the role of Traditional Birth Attendants in providing intranatal care in an urban slum and villages of Delhi

Author : Sharma N., Bali P., Bhargava V.L., et al.
Source : Journal of Obstetrics and Gyneacology, 1990
Place of study : New Delhi
Location : Rural and Urban
Period of study : 1984-85
Type of research : Empirical, Descriptive, Community-based

Aim: To study in-depth the role of TBAs in providing intranatal care.

Methodology: In an urban slum and four villages of Delhi, 25 functioning TBAs were interviewed, 35 deliveries conducted by them were observed and in 81 deliveries which could not be observed, a reliable attendant was interviewed. A DDA dispensary and a mobile van of AIIMS served the slum. An MCH centre served four villages with ANM. The results in the two areas did not show much difference. No statistical methods were used as this was a descriptive study.

Findings: It was found that the majority of women preferred home delivery by TBAs, particularly in the slum, since they were economical, accessible and helped with household chores. Even in areas where MCH services were available, only 52 per cent preferred ANMs. Except one, none had a delivery kit. All except one did pervaginum examination with bare, unwashed hands, though their findings were generally accurate. The majority conducted deliveries also without washing their hands. The most common position for conducting deliveries was lying down, since it was the practice in hospitals. The cord was cut with a new razor blade and left without any dressing. Recognition and management of danger signals was unsatisfactory. Self-management of complications by TBAs consisted of abdominal manipulations to correct presentation, hasten delivery and manual removal of retained placenta.
The study recommends some elementary training of TBAs serving urban slums, given the indispensable nature of their service. An active collaboration of these with the existing health services is suggested to help strengthen the MCH services.

Reviewer's note: Though the research clearly brings out the poor quality of intranatal care offered by TBAs, it does not delve into the probable systemic problems which may have caused TBAs to have no delivery kits. Neither does it delve into the reasons why women do not want to have deliveries conducted by ANMs in the MCH catchment area. These issues need to be addressed to, as upgrading their skills alone will not solve the problem. Besides, if women prefer TBAs because they help them in their household chores, MCH areas equipped with ANM services may need to adopt a different strategy. Users of these services need to be informed about risks involved in seeking intranatal services by TBAs when the latter are not adequately trained. It also points at issues such as a woman's need to have someone attending the home during their maternal care period, which lie outside the health care system.

Key words: *Traditional Birth Attendant, Intranatal Care.*

19. Current status of trained dais

Author **:** Shrotri A. and Bhatlavande P.V.
Source **:** Journal of Obstetrics and Gyneacology of India, 1994

Place of study : Kolhapur, Maharashtra
Location : Rural
Period of study : 1988-89
Type of research : Empirical, Descriptive, Community-based

Aim: To evaluate dai training programmes and to determine the role played by them in rendering MCH services to the rural population.

Methodology: Records of dai training programmes conducted since 1976 at 65 PHCs in Kolhapur district were scrutinised and 1,420 dais were identified. A fresh survey was conducted during 1988-89 in the district to register the dais. All dais were interviewed by nurse midwives through interview schedule.

Findings: The overall proportion of functioning dais was only 61.83 per cent. The proportion of non-functioning dais was 15.5 per cent (for reasons like death, migration, appointments as peon/CHG, old age). Motivational factors for taking up the profession were analysed. Perceptions of dais on antenatal services, advice regarding contraception and baby care and immunisation were explored. The concept of risk screening and advising hospital delivery for selected cases did not seem to exist, probably because the dai's first contact with the pregnant mother generally occurs when she is called for some difficulty during labour.

The study provides recommendations for improving the functional capacity of dais. 1) A 62 per cent functioning of dais indicates a need to conduct similar surveys in all districts to organise training programmes. The process of identifying untrained birth attendants should be an ongoing one and training programmes should be organised for the newly identified women. 2) The training curriculum needs to be revised and its scope widened to cover MCH care in its broader perspective to include antenatal and postnatal care to the mother and care of neonates. 3) Opinion leaders in the rural community should be encouraged to find a venue for MCH activities. 4) A link should be established between the dai, VHG and other health workers. A meeting of all health workers should be held periodically or quarterly to review the situation.

Reviewer's note: The study highlights the need to support this existing system of obstetric care in rural areas.

Key words: *Traditional Birth Attendant, Training, Role, Maternal and Child Health Services.*

20. Perceptions of Traditional Birth Attendants regarding contraceptive methods

Author : Singh A. and Kaur A.

Source : The Journal of Family Welfare, 1993
Place of study : Ambala District, Haryana
Location : Rural
Period of study : 1989-91
Type of research : Empirical, Descriptive, Community-based

Aim: To assess the knowledge and attitude of TBAs with regard to family planning.

Methodology: The perceptions of the advantages and disadvantages of family planning and various contraceptive methods of 200 trained TBAs were gathered by recruiting a female social worker who was trained in interview techniques. Most of the interviews were conducted at the site of the training sessions. A list of 13 responses on family planning was prepared, which was read out to them and the responses were collected on a three-point scale.

Findings: About 2/5th had accepted the terminal method of family planning (tubectomy - 21%, vasectomy 12.5%) and a small percentage used the spacing method (Nirodh - 5%). The remaining 61.5 per cent had not used any method of contraception. The advantages of contraception as identified by 81.5 per cent of the TBAs were the possibility of better education, better health and better food care for the children. Various side effects of using family planning methods were cited by the TBAs.

Reviewer's note: An area-specific study of this kind can help to pinpoint educational strategies for them so that TBAs can be involved in contraceptive awareness-building programmes. To understand changes in perceptions and attitudes as a consequence of training, a mixed sample of trained and untrained TBAs would have been more logical. The rating of statements relating to perceptions loses on nuanced responses of TBAs.

Key words: *Traditional Birth Attendants, Perceptions, Contraception.*

21. Role and acceptability of Traditional Birth Attendants (dais) in a rural community in South India

Authors : Subramanian T., Charles N., Balasubramanian R., et al.
Source : Indian Journal of Preventive and Social Medicine, 1996
Place of study : Sriperumbudur, Tamil Nadu
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community-based

Aim: To find out the feasibility of utilising the services of dais in identifying cases of tuberculosis and delivering drugs to diagnosed patients and to those suffering from other minor ailments.

Methodology: Of the 48 villages served by PREPARE in the taluka, 24 villages were selected by simple random sampling. Systematic random sampling was used to select houses. A total of 466 individuals, either the head of the household or any other responsible person available, were interviewed. The interview schedule was used for data collection.

Findings: The majority of villagers found services by dais useful and available at all times as they reside in the village itself. Both male and female respondents were aware of the services of the dais in the villages. Dais were also able to supply drugs for minor ailments, after proper training. Both men and women sought their help for the treatment of minor ailments. About 31 per cent of the respondents did not mention the availability of the government health facilities in their villages.

Given the fact that in rural areas health care facilities are inadequate and there is a shortage of medical and auxiliary staff and limited financial resources, the author recommends that a new system of health care delivery in rural areas be devised. The author suggests by referring to other research studies that dais can be considered grassroots level health workers in rural areas and can be effectively involved in any health programmes. Some sort of financial support to dais from the government is also recommended.

Reviewer's note: The research question as to whether dais can be used for diagnosis of TB remains unanswered. Systemic issues are not taken into account.

Key words: Traditional Birth Attendants, Rural Dais, Community Acceptability of Rural Dais.

22. Private voluntary organizations in health II: An overview

Authors : Ved R.
Source : Indian Journal of Community Health, 1997
Place of study : 13 states of India
Location : Rural
Period of study : 1981-87
Type of research : Empirical, Analysis of Secondary Data

Aim: To evaluate the impact of primary health care projects initiated under PVOH-II.
Methodology: Sample size: Primary health care projects initiated by 131 NGOs.

Findings: PVOH-II supported 131 small and large NGOs in 13 states for periods ranging from three to five years for projects on primary health care with a focus on MCH.

A Technical Assistance Unit was also formed late in the initiative to render need-based technical support to NGOs. PVOH-II NGOs typically covered populations ranging from 45,000 to 100,000. All NGOs used the three-tier service delivery strategy with emphasis on providing services at the community level through community health workers with varying degrees of success. Providing curative care was the strategy used by most NGOs to gain access to the community. The majority of projects trained TBAs. The emphasis was on safe delivery. Little attention was paid to neonatal care, though one project successfully trained TBAs in neonatal resuscitation. Most projects facilitated government services, though some provided the services directly. Two major thrusts of PVOH-II were ensuring community participation and sustainability. Though several NGOs articulated community participation in their proposals, few attempted to introduce elements of community participation in their activities and even fewer were able to transfer the responsibility of health into the community's hands. Community participation strategies were limited to strengthening or forming village women's groups, and training village health workers. The inability to evoke community participation in these projects could be due to a lack of understanding of people's real capability in contributing to the programme. NGO personnel need skills to facilitate and maintain constructive dialogues with the community on their health related needs and priorities. Most NGOs saw community participation as an instrument to provide services rather than as a mechanism to empower communities to take charge of their own health. Thus NGOs became 'givers' of health to passive community recipients. Sustainability was originally taken to mean organization sustainability, i.e. the ability of the organization to continue its activities in the absence of grants. NGOs started levying fees for service. The focus on preventive and promotive health services was diluted. Collaboration and establishment of linkages with the government and other providers was de-emphasized. Many NGOs experimented with income-generation activities for women, which failed for various reasons. Sustainability was re-defined to mean sustaining the health impact of mothers and children achieved during the life of the PVOH-II project. This facilitated some of the NGOs to emphasize preventive and promotive aspects of health. PVOH-II demonstrated the capability and commitment of the voluntary sector in providing preventive and promotive services.

Reviewer's note: The author has provided a critique based on the participatory evaluation findings of some of the primary health care projects initiated under PVOH-II. Concepts like community participation and sustainability are seen to be more often 'programme-driven' than 'user-driven'.

Key words: *Non Governmental Organisation, Community Participation, Health Services*

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QUALITY OF HEALTH CARE SERVICES

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVES	STUDY PERIOD	STUDY AREA	TYPE
1.	To assess the delivery pattern of MCH services.	Not stated	**Varanasi Uttar Pradesh** Urban	Empiric Evaluat Commu
2.	To develop a simplified MCH scoring system for the community-based assessment of babies.	1987-92	**New Delhi** Urban	Empiric Descrip Commu
3.	To assess the IEC aids and materials supplied to a PHC and their utilisation.	Not stated	**Haryana** Rural and	Empiric Evaluat

			Semi-urban	Health
4.	To study inter-regional differences in allopathic health services provided by different health sectors.	1961-86	**Andhra Pradesh** Rural	Empiric Analysi second
5.	To find out causes for not availing of antenatal services.	1987-88	**Uttar Pradesh** Rural	Empiric Commu
6.	To assess the type and quality of information provided to normal parturient mothers by labour room personnel.	Not stated	Vellore **Tamil Nadu**	Empiric Descrip Health
7.	To synthesize available evidence on the standards of care provided by the Indian programme and the relationship between quality of care and effective family planning use.	Not applicable	**Maharashtra, Karnataka, T.Nadu, Bihar, W.Bengal, M.P, Kerala, Gujarat, Orissa, U.P.**	Empiric Meta a research

QUALITY OF HEALTH CARE SERVICES

SELECTED ANNOTATIONS

1. An assessment of delivery pattern of MCH services in urban Varanasi

Author : Agrawal K., Tandan J., Srivastava P., et al.
Source : Indian Journal of Preventive and Social Medicine, 1994
Place of study : Varanasi, Uttar Pradesh
Location : Urban
Period of study : Not Stated
Type of Research : Empirical, Evaluative, Community-based

Aim: To assess the delivery pattern of MCH services.

Methodology: The delivery pattern of MCH services were assessed by taking into account both the providers view point as well as that of beneficiaries. Five hundred beneficiaries were selected through systemic random sampling technique from the Family Register of FHWs of a randomly selected ward Bhelupura of Varanasi Corporation. Data were collected from these beneficiaries by administering a pretested and fully structured questionnaire at their residences for the type and extent of domicilary services provided by LHV/ANM. Health care personnel were assessed through record analysis of the center for two consecutive years.

Findings: Only 26.2 per cent of the beneficiaries had knowledge of MCH centres. Around 25 per cent of the beneficiaries had utilised them.

The ratios of various health care providers, such as, medical officers, public health nurses, health visitors, ANMs and trained dais to population were not fulfilling the government recommended ratios. It is concluded that the health care providers therefore were unable to cater optimum services to the beneficiaries.

Reviewer's note: The universe has introduced a bias in the sample and is evident from demographic profile of the sample. Moreover, the socio-economic and demographic data are not at all used in the analysis to throw light on linkages, if any exist. Indicators used for assessment are grossly inadequate.

Key words: Health Care provider, Delivery Pattern, Beneficiary, Quality of Services.

2. An innovative simplified MCH score for assessing ideal babies in the Well Baby Shows of Postpartum Outreach Programme

Author : Anandalakshmy P.N. and Mittal S.
Source : Indian Journal of Maternal and Child Health, 1995
Place of study : New Delhi
Location : Urban
Period of study : 1987-1992
Type of research : Empirical, Descriptive, Community-based

Aim: To develop a simplified MCH scoring system for the community-based assessment of babies.

Methodology: The study population consisted of the 83,000 people catered to by the AIIMS's Postpartum Programme. Welfare services to improve maternal and child health status included periodic baby shows, immunisation camps, ideal family shows and family welfare camps.

The parameters included for the MCH scoring systems were age at marriage and educational status of the eligible couple, wife's age at first childbirth, number of living children in relation to duration of marriage, immunisation status of living children, and inter-birth interval and contraceptives used for limiting/spacing. Also included were the usual criteria of general health and hygiene of children enrolled for the community-based assessment of babies in these family welfare and immunisation camps-cum-well baby shows. The score was also used to gauge the coverage of the services rendered in the area. It details the scoring system for the various parameters.

Findings: The data from the five clusters were presented separately for five, three or two years, depending upon the period of service provision in the respective areas. The other variable that impacted the scores was the 'mode of service provision', that is weekly clinics or periodic health services or services provided by the weekly mobile health van. The areas with weekly clinics showed better scores. However, the other services also had a positive impact.

It helped to strengthen promotional and educational activities in areas where poor scores were observed. The scoring system is viewed as a rapid assessment tool, which can be used by field workers and nursing students without any formal training in statistics or research methodology.

Reviewer's note: The top-down approach dominates the methodology. It is driven by programmatic goals. The criteria included are beyond the control of the couple. The study does not talk about participation rates in such a show vis-à-vis the proportion of

total eligible couples/children. Nowhere do the parameters or the scoring system seem to assume the importance of 'processes' that constitute the programme.

Key words: Methodology of Scoring, Well Baby Show, Postpartum Programme, MCH & Family Welfare, Immunisation Coverage, Target Group.

3. An assessment of family welfare communication activities at the primary health centre level

Author : Bahl S.K. and Trakroo P.L.
Source : The Journal of Family Welfare, 1996
Place of study : Haryana
Location : Rural and Semi-urban area
Period of study : Not Stated
Type of research : Empirical, Evaluative, Health Centre-based

Aim: To assess the IEC aids and materials supplied to a PHC and their utilisation under the family planning and MCH programmes. To assess the communication abilities of the health personnel at different levels of primary health care. To assess the reach of communication persons and their activities in the community.

Methodology: The primary health centre under study covered over 148,000 people, scattered across 123 villages and semi-urban areas. The villages were selected with regard to their access to health care facilities, i.e., one village where the PHC was located, one village where the sub-centre was located and two villages that did not have any health centre. The reach of communication activities was assessed from about 250 villagers residing in four villages of the PHC block. The data were collected through observation, interview schedules and available records.

Findings: There was a variation in the use of IEC material across the staff categories. All the health workers and field supervisors reported that they used posters quite regularly during their fieldwork while the medical officers did not. Only 15 of the workers reported using pamphlets/leaflets during the last one year. The models had been used only by 5 per cent of the workers. Flip charts, slides, flash cards and graphs had not been used because they were not available. On the communication skills indicator, none of the health workers scored high; most (84%) had low communication skills. An assessment of the knowledge, attitudes and practices of the health personnel with regard to various dimensions of MCH and family planning indicated that health workers, supervisors and medical officers were at different levels. An assessment of the reach of health personnel indicated that the reach and effectiveness of the communication activities leaves much to be desired.

There is a need to keep proper records of IEC material in order to reduce its misuse, and to develop a community-based feedback system to evaluate the total IEC efforts for enhancing accountability. Health personnel also need to be trained for effective interpersonal communication. The potential of folk media needs to be exploited in villages. The preparation of IEC material must be decentralised to meet local needs, cut expenditure and to provide opportunities for local talent.

Reviewer's note: The study does not highlight the reasons why health workers do not use IEC aids and materials. Knowing the reasons would have helped overcome the constraints and strengthen the IEC component in Family Welfare and MCH programmes.

Key words: *IEC activities, Communication, Skills, Health Personnel*.

4. Inter-regional variations in health services in Andhra Pradesh

Authors : Baru R.V.
Source : Economic and Political Weekly, 1993
Place of study : Krishna, Guntur, Mahbubnagar and Medak, Andhra Pradesh
Location : Rural and Urban
Period of study : 1961-86
Type of research : Empirical, Analysis of Secondary Data

Aim: To study inter-regional differences in allopathic health services provided by the government, private and voluntary sector in Andhra Pradesh.

Methodology: The study reviewed policy and contrasted health infrastructure and manpower in two economically advanced and two backward districts of Andhra Pradesh.

Findings: The author compared the health infrastructure (using various indicators like doctor or hospital bed/population ratios) available in these districts. The public sector bed/population ratio for advanced districts was more favourable than for backward ones but from 1961 onwards the gap has narrowed down. PHC/population ratios presented little variation across the two sets of districts. The sub-centre/population: ratio was poorer in backward districts. The review of various categories of personnel in the public sector shows that there was no significant difference between two sets of distracts as far as doctors were concerned. There was a difference in the personnel/population ratios across selected districts for nurses and paramedical staff. This paucity of paramedical staff in backward districts affected the functioning of PHCs and SCs in these areas.

The public health care amenities were concentrated in villages with a population of 5,000 or more in all four districts, reducing accessibility of services in backward districts where villages were comparatively smaller, more dispersed and unlikely to be connected by pucca roads.

Information on the private sector was limited. The author observes that the voluntary sector, mainly comprising missionaries, was also skewed towards advanced talukas in advanced districts. Pucca roads, communication and electricity seemed to influence the presence of these agencies. A number of voluntary agencies seemed to have stationed themselves in and around Hyderabad so that the staff could live within the city.

The overall trend was for health services in all three sectors to be concentrated in the more advanced districts (with the least variation seen for public health services). The author concludes that political factors, and the general level of economic and infrastructural development influences the spread of health services in all the three sectors.

Key words: *Health Services, Public, Private, Voluntary.*

5. Maternal care receptivity and its relation to perinatal and neonatal mortality

Author : Bhardwaj N., Hasan S.B. and Zaheer M.
Source : Indian Paediatrics, 1995
Place of study : Uttar Pradesh
Location : Rural
Period of study : 1987-88
Type of research : Empirical, Analytical, Community-based

Aim: To assess maternal care services provided to pregnant mothers at their doorsteps and to find out why women are not availing of antenatal services.

Methodology: Two hundred and twelve pregnant women in different trimesters were identified from the study area and were registered and followed up every month till delivery and the neonatal period. Antenatal services were provided to these mothers at their doorsteps through home visits to overcome different reasons for non-utilisation such as physical inaccessibility, long waiting hours and socio-economic factors. A scoring system was adopted to assess the maternal care services provided to the sample population. The scoring system took into account the following factors: (i) time of commencement of antenatal care; (ii) frequency of antenatal home visits; (iii) number of doses of tetanus toxide immunisation accepted; and (iv) place and person attending the delivery. During follow-up, scores were assigned to each of these factors. The scores were added to give the 'Maternal Care Receptivity'(MCR). Depending on the score, MCR was ranked as high (11 to 8), moderate (7 to 4) or poor (3 to 0). Routine antenatal check-ups were also carried out.

Findings: The study showed that of 212 women, the majority (75.9%) were moderate in their receptivity of maternal care services. About 17 per cent of the women were poor in their reception and only 7 per cent of the women were highly receptive of the maternal care services even when they were provided at their doorsteps.

The study found that the major cause of under-utilisation of services was the illiteracy of the women, ignorance of the necessity of antenatal services and a deep-rooted faith in the TBAs. Statistical analysis showed that mothers who were poor or moderate in their reception of maternal care services have higher rates of perinatal and neonatal mortality whereas mothers with high MCR did not have any perinatal and neonatal mortality. The study showed the need to generate awareness among mothers through health education for better reception of maternal health services.

Reviewer's note: The study does not give the socio-demographic characteristics of the respondents, which are important variables affecting receptivity to services.

Key words: Maternal Care Receptivity, Perinatal Mortality, Neonatal Mortality.

6. The extent of information provided by health personnel to parturient mothers during their stay in the labour room

Author : Celcy M.
Source : Indian Journal of Nursing & Midwifery, 1998
Place of study : Vellore, Tamil Nadu
Location : Not Applicable
Period of study : Not Stated
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To assess the type and quality of information provided to normal parturient mothers by labour room personnel (nurses, doctors, ANMs and students).

Methodology: A sample of 60 mothers was drawn using the simple random sampling method. Data were collected from the time of admission until two hours after delivery. The various areas of care covered were admission, rest and sleep, fluid therapy, breathing exercises, elimination, pelvic examination, catheterisation, instrumentation, second stage/ third stage of labour, immediate postnatal care and breast-feeding. Information provided with rationale was considered complete and given a score of 2. Information without rationale was given a score of 1. Percentages, mean, SD, 't' test and 'F' test were the statistics used.

Findings: Only 38.4 per cent of the required information was provided during the stated period, which is highly inadequate. The most information was provided in the areas of rest and sleep and second stage labour (>60%). The focus on second stage labour was presumably to safeguard the health of the baby and to complete the second stage labour as quickly as possible. It was also influenced by the midwife or obstetrician's distress and excessive anxiety about the outcome of labour. The least amount of information (<10%) was given during per vagina examination, catheterisation and instrumentation. Demographic variables were not significantly associated with the amount of information given.

Giving adequate information in this situation positively influences the mother's psychological needs and smoothens the process of childbirth. It is her right to get a clear explanation of the proposed treatment she will undergo in a hospital. Specific information and assurance areas are listed. It is suggested that structured informational guides be given to all antenatal mothers during their last visit to antenatal clinics. Nurses need to recognise this need, which also helps to project a positive image of nursing and midwifery in India.
Reviewer's note: Recognition of women's right to information during maternal care is a good beginning.

Key words: Information, Parturient Mothers, Communication, Childbirth, Labour.

7. A synthesis of research findings on quality of services in the Indian Family Welfare Programme

Authors : Foo G.H.C.
Source : Proceedings from the National Workshop, 1996
Place of study : 10 States of India
Location : Rural
Period of study : Not Stated

Type of research **:** Empirical, Meta-analysis of Research Studies

Aim: To synthesise available evidence on the standards of care provided by the Indian programme and the relationship between quality of care and effective family planning use.

Methodology: A review of available evidence from qualitative and survey research on the quality of care provided by the family welfare program. This is a synthesis of 28 research papers presented at the workshop.

Findings: The findings from various qualitative and survey research projects have been collated and analysed under three aspects: user's perception of quality of care; provider's perception of quality of services and the problems faced; and linkages between quality of care and contraceptive use.

The synthesis of findings on the users' perspective revealed that clients perceive the private sector as offering health and family planning services that are superior in quality to those offered by the government. In addition, clients' assessments of the individual dimensions, which compositely define quality of care, displayed considerable interstate variation, paralleling the standards of service extent in the states. All these studies found that clients were generally not offered a method choice, and that the information they were given by providers on individual contraceptive methods was extremely limited, with the issues of contraindications and side-effects seldom raised. In spite of such marked deficiencies in the quality of care, clients' expectations were so low that the majority expressed satisfaction with the services they receive.

The synthesis of findings on the providers' perspective revealed the negative effect of method specific family planning targets on the quality of services offered by family planning providers as well as the need to arrive at commonly agreed upon standards of care, which guide providers' performance. Medical officers felt that the inadequacy of infrastructural facilities and logistical supplies together with the late payment of salary and the lack of travel allowances mitigate against the provision of quality services. ANMs were unable to define quality, to identify gaps in their services, or to propose improvements. They were generally satisfied with their work.

The synthesis of findings from various studies can attribute the poor quality of care in sterilisation camps to the intersection of a number of factors. These include inadequate physical infrastructure and logistical support, absence of clear guidelines and protocols setting standards to be met in services and procedures; an absence of understanding what constitutes quality services; and indifference among many providers to adhering to standards of performance and to the human dimension entailed in providing health services; and finally, the provision of services largely within the context of meeting targets and thereby achieving volume rather than quality.

The report concludes with some findings of the effects of quality of care indicators like frequency of visits by health workers, client-provider interaction time, women's perception of health services on contraceptive use and continued use.

Key words: *Quality of Care, Family Welfare Programme, Users' Perspective, Providers' Perspective.*

8. Quality of family planning services in India: The user's perspective

Author : Gangopadhay B. and Das D.N.
Source : The Journal of Family Welfare, 1997
Place of study : Delhi
Location : Urban
Period of study : 1993
Type of research : Empirical, Evaluative, Health Centre-based

Aim: To find out the causes of the failure of the National Family Welfare Programme.

Methodology: A questionnaire was administered to 125 females in the age group of 15-45 who had ever used contraception. It contained questions regarding socio-economic and household information and had open-ended questions to elicit their perception on family planning methods, source of information, and selection of family planning methods. The information received was checked with records maintained at family planning centres and from the AWW.

Findings: The respondents were mainly from the low-income, underprivileged group. About 85 per cent of the respondents were receiving services from the family planning centre of nearby hospitals, 10 per cent from private doctors and the rest (5%) from other government hospitals and dispensaries in the city. The respondents mostly belonged to the lower socio-economic group. The respondents had an average of at least two living children irrespective of the method used. The main sources of FP information were neighbours and relatives (87%), doctors (81%) and the electronic media (70%). The cafetaria approach was not practised in government facilities. A third of the respondents reported that they received poor quality of counselling and their fears and doubts were not addressed. Private practitioners were preferred because they offer better information and counselling, save time with smaller queues and convenient timings, and also because the contraceptives are of better quality. Many recorded cases of contraceptive failure may reduce the faith of couples on the family planning programme.

The findings depict the need to develop an IEC programme to increase the awareness of the benefits of child spacing. They also reveal that the service providers should be sensitive to the clients' needs and help them make an informed choice. The political and religious leaders should actively participate in the population programme.

Reviewer's note: The methodology adopted for the study was not adequately articulated. The method of sample selection is not given. Only females were interviewed.

Key words: *Users' Perspective, Evaluation, Family Planning Programme, Informed Choice.*

9. Women's perspectives on the quality of general and reproductive health care: Evidence from rural Maharashtra

Author : Gupte M., Bandewar S. and Pisal H.
Source : Improving Quality of Care in India's Family Welfare Programme - The Challenge Ahead, 1999

Place of study : Pune, Maharashtra
Location : Rural
Period of study : 1994-96
Type of research : Empirical, Analytical, Community-based

Aim: To understand women's needs in a variety of situations, in which they seek health services, including abortion services.

Methodology: Six villages were selected on the basis of their access to health services, their size (ranging from 1,500 to 3,500 inhabitants), and accessibility by transport to nearby towns. In monthly focus group discussions that took place over eight months, data were gathered on women's needs for health care delivery. On the basis of the discussions, a list of 21QHC indicators was drawn up.

To understand women's needs related to abortion in real-life situations, they were asked not only about abortion services but also about general health care and obstetrical care needs. Of a total of 67 women, 61 ever-married women who had regularly been part of the focus-group meeting were interviewed about QHC, 49 were interviewed about their choice of providers, and 67 were interviewed about their preference for public or private abortion services. The first two involved rank–ordering exercises. Women were required to be literate for this. As the three interviews were lengthy, it proved impossible to interview all 67 women for all three sets of data.

Findings: The study documents women's choice of providers, their feelings about both public and private health services, and their perceptions of QHC. The concept of QHC, according to them, was not a fixed entity, but instead depended on their social circumstances and specific health needs. The contrast between some of the QHC indicators for abortion and non-abortion services helps one to understand the complex social milieu in which women's decision-making (or lack of it) about abortion in particular and sexuality in general takes place.

The findings indicate that women's major concerns about the quality of general health care services reflect the needs of any rural population. The services must be nearby and easily accessible, and a doctor should be available for handling emergencies at any time. Women expect a doctor to pay attention when he examines and treats them. Most women consider empathy, concern and counselling from the doctor very important, especially in abortion care. Cleanliness is an important criterion for general health care and deliveries. In the case of abortion care, among married women, the doctors' insistence on the husband's signature was a major obstacle. In case of abortion outside marriage, secrecy was given precedence over all other considerations. Confidentiality on the part of the doctor received the highest cumulative score and was the first ranked score among the indicators of quality.

In various health care-seeking situations - ranging from minor illnesses to chronic illnesses, emergency, ANC/PNC, delivery gynaecological illnesses, sex determination, abortion within and outside marriage - women choose providers pragmatically. The first choice of married women seeking abortions is the private sector, as the government programme asks for the husband's signature and pressurises them about contraception. Women resent having to pay for health services in the private sector because a PHC staff is insensitive towards women or its facilities are inadequate.

Key words: *Quality of Health Care, Womef's Perspectives, Providers*.

10. Evaluation of quality of family welfare services at the primary health centre level

Author : Task Force, ICMR
Source : Indian Council of Medical Research, 1991
Place of study : Nationwide
Location : Rural
Period of study : 1987-89
Type of research : Empirical, Evaluative, Health Centre-based

Aim: To carry out an independent evaluation of family welfare services being offered at the level of Primary Health Care centres.

Methodology: ICMR in collaboration with the state health directorates carried out a study through its network of 35 Human Reproduction Research Centres located in medical colleges in different parts of the country. A total of 398 PHCs from 199 districts, located in 18 states and a Union Territory (Pondicherry) were evaluated. A major component of the assessment of quality involved observation of the ANMs in the field and while they were providing services. This was complemented by an examination of the records and reports maintained at the PHCs and sub-centres for their completeness and accuracy. Further, the records of a sub-sample of beneficiaries were examined to find out the details of care provided. These were matched with the responses of the beneficiaries. The limitations of the methodology are mentioned.

Findings: According to the new pattern recommended, there should be one PHC for 30,000 population. The data from this study indicates that the recommended pattern was achieved in only 12 per cent of PHCs. It was observed that resources in terms of physical facilities were comparatively satisfactory at PHCs, but greatly deficient at the level of sub-centres which are really the first contact point for the community. This was especially so with respect to routine antenatal care. With regard to manpower, there was a substantial shortage of ANMs. In fact, the sanctioned pattern of ANMs indicated a need for increasing the number of posts for this category of health functionary. Nearly half of the sub-centre's facilities for normal delivery were absent. The majority of the PHCs were lacking in functional equipment and/or trained manpower to carry out pregnancy termination even after two decades of the MTP Act.

Antenatal, intra-natal, neonatal and child care services were included for the evaluation of MCH care provided at PHCs. The study underlined the urgent need to equip ANMs with better skills and facilities so as to improve their performance in various aspects of MCH care. Records were found to be deficient in details of care provided. Facilities were virtually non-existent at sub-centres, which are the very first level of contact for the community. In the case of postnatal care, surprisingly, advice on family planning was the only component addressed "properly" during the postnatal period, confirming the programme's emphasis on family planning. The situation with regard to support facilities like water supply, toilet facilities and availability of transport was generally satisfactory.
Reviewer's note: This study does not reveal the impact of multiple factors on the performance of ANMs in MCH care delivery.

Key words: *Primary Health Centre, Sub-centre, Quality of Care.*

11. Patient satisfaction in the context of socio-economic background and basic hospital facilities: A pilot study of indoor patients of LTMG Hospital, Mumbai

Authors	**:** Iyer A., Jesani A. and Karmarkar S.
Source	**:** CEHAT
Place of study	**:** Mumbai
Location	**:** Urban
Period of study	**:** 1996
Type of research	**:** Empirical, Descriptive, Health Centre-based

Aim: To assess the quality of services provided by the Lokmanya Tilak Municipal General (LTMG) Hospital through the patients' perspective.

Methodology: The authors interviewed 123 indoor patients - that is about 10 per cent of the bed strength - during their stay in hospital to assess their satisfaction with hospital services. Patients were selected by the simple random method A close-ended interview schedule was used for data collection. Information was collected on the reasons for seeking care at LTMG Hospital, their experience of indoor care, quality and adequacy of physical and medical facilities, interpersonal provider-patient relationships, expenditure incurred and the patient's satisfaction with hospital care.

Findings: The study found gender bias in the allocation of beds per ward (33% for females compared to 46 % for males). This bias is further marked (20% for females compared to 55% for males) when the all-female beds in obstetrics are excluded. About 6.9 per cent of all female patients belonged to the 18-45 age group. Four-fifths of these women were admitted for gynaecological and obstetric care. About 54 per cent were non-earners. A high proportion of females among non-earners, their low representation in the service sector and much lower average income levels, indicated gender-specific economic activities. The majority of patients were literate. However, the percentage of post-matriculate education was low (10.5%) and lower still among female patients. A majority of the patients were Hindus, and most of them belonged to the upper castes. The proportion of scheduled castes in the sample was exactly twice the 1991 census figures for Greater Bombay. The data about living conditions, when seen in the light of other socio-economic data, showed that patients seeking indoor care at LTMG hospital were in many ways disenfranchised members of society. The largest number of patients were those who lived most of the year in Mumbai, indicating that the hospital has largely remained a metropolitan institution. Its role as a regional centre is indicated, but not to any significant degree. The study found that though the hospital is a tertiary-level care provider, about a third of the patients did not seek medical treatment from any other provider before coming to the hospital. About a third of patients were referred.

The study found that dissatisfaction with private providers creeps in earlier than it does in the case of public providers. The majority of the patients came to the hospital because they perceived it to be good, with adequate support facilities. The study reported on the quality of care provided by the hospital in terms of the quality and adequacy of physical facilities, inter-personal relationships, adequacy of medical facilities, and the patient's satisfaction with these.

Based on their findings, the authors recommend steps to improve and strengthen peripheral public health care as well as hospital management.

Reviewer's note: The limitations of the methodology were explicitly articulated. The authors note that the responses of the patients may have been influenced by the hospital environment since the interviews were conducted while the patients were still admitted. The study findings could have been strengthened by complementing patient interviews with provider interviews.

Key words: *Quality of Care, Patients' Satisfaction, Public Health Care Facility.*

12. A longitudinal study on some aspects of maternal and child health in an urban community of Ahmedabad

Authors : Kartha G.P., Kumar P. and Purohit C.K.
Source : Indian Journal of Preventive and Social Medicine, 1993
Place of study : Ahmedabad City, Gujarat
Location : Urban
Period of study : 1989
Type of research : Empirical, Descriptive, Prospective, Community-based

Aim: To study the pattern of ANC, and the morbidity and pregnancy outcome; and to identify MCH problems in the locality.

Methodology: A baseline house-to-house survey enumerated all couples in a geographically-defined urban area. All new pregnancies that occurred in that area were registered and followed-up for antenatal care and delivery. The study population consisted of 500 families with a total population of 2,564. In all, 36 pregnant women were followed till term.

Findings: The socio-demographic features of the studied families showed that the majority of families were nuclear, small-sized, and belonging to the middle- to lower-middle class. The sex ratio was 815. The literacy rate was 74.1 per cent. The overall quality of antenatal care was good. The majority of the pregnant woeen had regular antenatal check-ups with an average of 3.7 visits. Twenty-six of the 36 pregnant women were fully vaccinated against tetanus. Three-fourths of the mothers said they had regularly taken iron and folic acid supplements. Most were home deliveries, though trained birth attendants or health personnel supervised the majority of deliveries. The total pregnancy wastage was 4. Low birth weight (according to the Indian criteria, ie < 2,000 gm) stood at 10.3 per cent.

The study areas showed a positive health profile – low birth rate (13.2), low infant mortality (27), high contraceptive prevalence rate (72.0 %), and a low incidence of LBW. The study area is served by government., non-government and private health agencies. The effect of positive health cannot, therefore, be attributed solely to this urban health centre. However, the joint effect of these services presents a positive picture of maternal and child health.

It is concluded that the available health services have helped combat morbidity and mortality. Apart from these health interventions, however, the high literacy rate, especially of females, and the predominantly middle class social milieu in the studied area could also have contributed to better maternal and child health levels. The study also emphasised the need for a similar study with a large sample and control population.
Reviewer's note: Despite the longitudinal design of the study, the findings are purely descriptive in nature. Consequently, the impact of socio-demographic variables is not assessed.

Key words: Maternal and Child Health Care, Urban slums, Urban Health Centre.

13. Situation analysis of Medical Termination of Pregnancy (MTP) services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh

Author : Khan M.E., Rajagopal S., Barge S., et al.
Source : Working Paper, CORT, Baroda, 1998
Place of study : Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh
Location : Rural
Period of study : 1992-97
Type of research : Empirical, Descriptive, Health Centre-based

Aim: This is part of a larger study conducted by this organisation to develop a database on the availability of abortion facilities and to identify the reasons for the under-utilisation of MTP services.

The extent of MTP facilities in rural and semi-urban areas was central to this study, which also attempted to pinpoint how many of the MTP facilities were approved, and what the quality of the MTP services was as regards trained personnel and required infrastructure.

Methodology: In this multicentric study, the method of situational analysis of MTP services was used. It was conducted in two phases. Gujarat and Maharashtra were covered in the first phase and Tamil Nadu and UP in the second phase. The methodology in the second phase was revised, based on the experiences of the first phase. Clients' perceptions on the quality of MTP services were also studied. It is a large study in terms of coverage. It covered 61 districts from four states. In Gujarat and Maharshtra it covered about 58 per cent of the total number of districts, while in UP and Tamil Nadu it covered between 38-40 per cent. The sample size was 510 health care units (public sector: 380, private sector: 130). It also included about 241 private abortion providers who were trained in Indian systems of medicine or homoeopathy.

Findings: That MTP services are differentially distributed over the states has been shown using the secondary data. The survey data indicates that not all the public sector units which have been allowed to provide MTP services are functional. This was due to various reasons: lack of trained doctors, lack of equipment, lack of both trained doctor and equipment, non-functional equipment, no anaesthetist, etc. At the public health care units, the MTP providers were not always trained.

Post-abortion contraception was insisted upon, though it is not a pre-condition for obtaining MTP care, except in UP. As regards this, Maharashtra and UP showed declining trends.

It was observed that the quality of training was not up to the mark. Anadequate training was attributed to a low case- load of MTP in the designated training institutions and low priority given to the MTP trainees over the resident doctors/MD students. Also mentioned were the other administrative and financial hurdles which serve as demotivating factors for trainees, and also dissuade their superiors from sending them for MTP training.

As regards essential equipment, Gujarat and Maharashtra were relatively better off, while UP was the poorest. Essential drugs were generally available in all states except Gujarat, where availability was comparatively on the lower side.

Clients' perception of the quality of MTP services were sought on 'information exchange' and the waiting period, efforts made to protect modesty and make the client comfortable, and costs incurred for the procedure. In general the study indicates that MTP services have not been given the attention they deserve.

Reviewer's note: The study covers only the registered MTP service centres. A large number of non-registered institutions provide abortion care.

Key words: *MTP Services, Quality of MTP Services, Clients' Perception on Quality of MTP Services Received.*

14. Streamlined records benefit maternal and child health care

Authors : Kumar R.
Source : World Health Forum, 1993
Place of study : Ambala, Haryana
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Evaluative, Health Centre-based

Aim: To evaluate a simplified home-based MCH recording and reporting system.

Methodology: The study reviews the existing MCH recording and reporting system and then evaluates the implementation of a simplified, home-based recording system. A review of the recording and reporting system was conducted at 10 sub-centres under five PHCs. The registers maintained by health workers, as well as those of their supervisors and medical officers, were studied to ascertain the information system, the difficulties of recording and reporting, and ways of improving the system. Six months after the introduction of the new systems, 14 health workers were interviewed to gauge the usefulness of the new system.

Findings: A review of the existing system showed that records were incomplete. The procedures of record-maintenance were perceived to be cumbersome and time consuming. There were several other problems: there were no printed forms available; shortage of stationery led to registers being maintained on loose sheets; supervisors

experienced difficulty in acquiring information from the health workers; and duplication of work dominated the information management system.

The study finds that though the new system was simpler to use and information retrieval and reporting was easier than before, only about 50 per cent of the records were updated. Though the records were properly completed, under-reporting of vital events continued.

The bottom-up approach made it possible to develop a community-based information system. Family cards were helpful in coordinating the efforts of various agencies providing maternal and child health services and avoiding duplication. The community can use this for evaluating services.

The major drawback was that senior administrators paid little attention to data on vital events. The author recommends commitment at the highest level and improved supervision in order to strengthen the information system.

Reviewer's note: Though the authors say that the main advantage of the simplified system is transmission of information to the community, it would be interesting to see whether the evidence suggests that this actually occurs and whether the community actually puts the information to use.

Key words: *MCH, Management Information System.*

15. Assessment of community attitude regarding the services of PHC: A medical geographic study

Authors : Kumar V.K. and Singh J.
Source : Indian Journal of Preventive and Social Medicine, 1994
Place of study : Varanasi, Uttar Pradesh
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community-based

Aim: To assess community attitudes regarding PHC services and their level of satisfaction with and expectations from PHCs.

Methodology: The cross-sectional survey was conducted on 195 respondents (one adult member from each of the family who has utilized facilities from PHC at one time or the other).

Findings: The authors found communication between health staff and the community to be most problematic. They opine that monitoring of home visits by health staff and re-training to be imperative. They conclude that more than half the respondents were dissatisfied with the PHC services but would not complain for fear of penalization. The authors then list some of the common expectations of the community viz. free and better medicines, proper treatment, attention from PHC staff and an ambulance service for an emergency.

Reviewer's note: Only those respondents whose family had utilized the PHC services were included. The respondents may not be representative and it would have been also insightful to study the attitudes and expectations of those people who did not use PHC services.

Key words: *Provider-client Communication, Community's Expectations, Health Services.*

16. Quality of health and family planning services in rural Uttar Pradesh: The client's view

Author : Levine R.E., Cross H.E., Chabbra S., et al.
Source : Demography India, 1992
Place of study : Uttar Pradesh
Location : Rural
Period of study : 1992
Type of research : Empirical, Descriptive, Community-based

Aim: To gain in-depth understanding of how villagers in Uttar Pradesh view both government and private health services, and how they think about the available family planning services.
Methodology: A special unit of the Indian Market Bureau carried out a set of 20 small, in-depth, focus group interviews with married, 15-34 year old males and females. The selection was made at the level of districts and villages. Districts were selected from each of the five socio-cultural regions. Villages with access to government health care services were selected. In each of the socio-cultural regions, four group discussions were held – three with women and one with men. Each FGD lasted for about hour and a half and was moderated by a trained group leader who followed a structured discussion guide. Discussions were tape-recorded, then translated into English. The transcripts were content-analysed.

Discussions on general health issues helped in establishing a rapport with the people before proceeding to the sensitive topic of contraceptive use.

The reports states the advantages and disadvantages of FGD and its implications for generalisation of the findings.

Findings: Important determinants of treatment-seeking behaviour fall into the categories of physical or financial access. In the Indian context, indicators of quality of care include experiences with effectiveness of treatment, thoroughness of examination, care by a doctor (as opposed to paramedical personnel), waiting time, timings of the facilities, provision of medication, provider-patient communication, and doctors' qualifications. The respondents evaluated the private sector positively on almost all the indicators except one, that is, qualification of the providers. The public sector was evaluated negatively on all the indicators, except two – treatment experience and qualification of providers.

There was a fairly high level of awareness of family planning methods among both men and women. Respondents reported that government health personnel do not involve them in the choice of a particular contraceptive method. Some also doubted the

reliability or efficacy of the method. Respondents elaborated on the kind of family planning services they wanted.

The author provides a list of recommendations based on this data to overcome the existing constraints and shortcomings of the programme.

Key words: *Quality of Health care, Family Planning Services, Focus Groups.*

17. Physical standards in the private health sector

Author : Nandraj S. and Duggal R.
Source : Radical Journal of Health, 1996
Place of study : Satara, Maharashtra
Location : Rural and Urban
Period of study : 1994-95
Type of Research : Empirical, Descriptive, Health Centre-based

Aim: To document and review various guidelines available in the government, NGO and private sectors for the minimum physical standards necessary for provision of health care of various kinds.

The framework of minimum standards for quality care was evolved on the basis of existing information discussed as per the findings and its critique at a workshop.
Methodology: A sample of 53 practitioners from different systems of medicine and specialities and 49 hospitals was covered from two talukas of Satara district in Maharashtra. Both economically backward (EBA) and developed areas (EDA) were chosen to get a comparative and a representative picture of the state.

A combination of methodologies was used as this was an exploratory study. A range of secondary data sources was used to acquire information on private health facilities. The names of persons practicing without any qualifications were collected through informal discussions with key informants in the villages.

Findings: Some of the problems faced were: inadequacy of data on the size, functioning and nature of the private health sector; difficulties in categorising different aspects of physical standards as the size of health facilities ranged from three-bed to 500-bed hospitals; difficulties in defining the various units under study and their various functions; difficulties in defining qualitative terms for the observation schedule to minimise the subjectivity in observational data.

The majority (59%) of the health practitioners was concentrated in the urban areas. The gender and age distribution show a very high male concentration in both economically developed areas (EDA) and economically backward areas. The mean age of the EDA practitioner is higher and this is perhaps indicative of the push factor in EDAs as a

consequence of over concentration which is forcing new practitioners to move gradually into EBAs. This is a welcome trend which needs to be encouraged. The local government can play an important role in discouraging new entrants in over-served areas. Only 9 per cent of the allopaths were found practicing in EBAs. An overwhelming majority were practising allopathy without having the necessary degree. Record maintenance was found very poor, with no proper format.

Three-fourths of the hospitals were situated in urban areas. In the last two decades the private sector has grown phenomenally. The doctor was the administrator of the institution for all the hospitals in the sample. The data revealed that in 85.7 per cent of the hospitals, patient were admitted only by the doctor-owner and only in 14.3 per cent of the hospitals could other doctors admit their patients. This practice was more prevalent in the EDA. None of the hospitals were registered by any authority. The average beds per hospital was 11, which raises the issue of efficiency and efficacy in running smaller hospitals.

Reviewer's note: This study contains an elaborate review of literature on the private health care sector. Limitations of the study and the problems faced during research are articulated. This would help direct research in this area in the future.

Key words: *Physical Standards, Quality, Health Care.*

18. Programme inputs and performance of the family planning programme: Evidence from a comparative study of PHCs

Authors : Narayana M.R.
Source : The Journal of Family Welfare, 1995
Place of study : Chitradurga, Karnataka
Location : Rural
Period of study : 1990-91 to 1992-93
Type of Research : Empirical, Descriptive, Health Centre-based

Aim: The paper examines the role of programme inputs in explaining the relative family welfare programme performances of PHCs.

Methodology: Six PHCs, two each from 'good', 'average' and 'poor performance' categories were selected, based on their 1990-91 performance (numerical achievement as a percentage of the target). One each from these three performance categories was with equal initial conditions and one each with unequal conditions. It covered five of nine talukas in the district. A structured questionnaire was administered in 1993.

Findings: The initial condition of the PHC as also the population it covers does not determine its relative performance. The availability and utilization of vehicles did improve programme coverage and performance though this was not always true. For sporadic sterilization camps, availability of good public/ private transport and a high level of awareness of the venue and timings of the camp were critical to the success of the camp. It was also seen that vacant posts of health staff make a strong difference between good and average performance rather than between good and poor

performance. Strong dissatisfaction was evident in relation to the inadequacy of financial incentives to the various categories of health staff. It was also seen that the erratic supply of medicines and medical items had no relation to the PHC's performance.

A surprising finding was that the performance of PHCs was inversely related to the programme inputs, thus suggesting that performance was determined by factors beyond the recordable programme inputs, such as popularity, dynamism, commitment and motivation of the health staff. Secondly, the responsiveness, attitude and behaviour of the people towards family planning may also affect it. The authors conclude that there is no strict correspondence between programme inputs and performance. This implies that a practical solution for better and more balanced family welfare performance should aim at simultaneously (or discriminately) providing all (or selected) complementary (or substitutable) programme inputs in time, in adequate quantity and in adequate quality.

The author feels that an assessment of the role and problems of the programme inputs considered in this paper will help in rethinking targets for the PHCs.

Key words: *Family Welfare Programme, Performance, Programme Inputs,Comparative Study.*

19. The effects of quality of services upon IUD continuation among women in rural Gujarat

Author **:** Patel D., Patel A. and Mehta A.
Source **:** Working paper, Action Research in Community Health (ARCH),
Mangrol, Gujarat.
Place of study **:** Rajpipla, Gujarat
Location **:** Rural
Period of study **:** 1987-95
Type of Research **:** Empirical, Descriptive, Community-based

Aim: To document the processes in developing a socio-culturally sensitive and specific health education programme and to assess the impact of this programme on levels of IUD continuation.

Methodology: Women with IUD insertion were prospectively followed-up for a period of two years to study continuation of IUD use. The study was conducted pre- and post-intervention. A health education programme was an intervention. There were 56 women in the pre-intervention and 80 in the post-intervention phase.

Findings: The authors initially undertook to understand women's fears of IUD and reasons for non-acceptance and discontinuation. A culturally-sensitive health education programme was then developed, mainly through free and informal communication (talks, slides, posters, pictures etc) at the clinic or community meetings. Women's anatomy was explained and the process of IUD insertion was demonstrated on a thermocol model.

With health education, overall IUD acceptance increased. This increase was more amongst tribal as compared to upper caste women. Discontinuation of IUD was significantly lower amongst women with post-IUD complaints in the intervention (i.e. during the health education programme) phase as compared to the earlier (non-

intervention) phase. Though the proportion of women with post-IUD complaints was similar in both phases, retention of IUD was higher in the intervention phase. Continuation rates were significantly higher in the intervention phase especially when removal of IUD due to problems only was considered.

The authors conclude that specific and sensitive health education programmes (counselling) which address women's perceptions and apprehensions of IUD can improve continuation rates. The authors infer that intimate and prolonged interaction with women, or an exceptionally high order of dedication by the health worker (counsellor) is not mandatory for implementing such a health education programme. Visual materials and an explanation of the female anatomy are essential.

The study does not argue that the IUD is either the best spacing method available for rural women or the most preferred method. It demonstrates that given the voluntary choice of methods made by women, IUD's continuation rates can be improved markedly by providing specific health education which effectively addresses women's perceived fears and apprehensions.

Key word: *IUD Acceptance, Health Education.*

20. Quality of care in laparoscopic sterilisation camps: Observations from Kerala, India

Authors : Ramanathan M., Dilip T.R. and Padmadas S.S.
Source : Reproductive Health Matters, 1995
Place of study : Palakkad, Kerala
Location : Rural
Period of study : 1994
Type of Research : Empirical, Descriptive, Health Centre-based

Aim: To evaluate the quality of care provided at a sterilization camp under the FPP.

Methodology: The study observed the events in a single sterilization camp and also interviewed 19 women clients prior to their participation in the camp. Cross-sections of husband were also interviewed before the women had operations. A few women were interviewed post-operatively. Some of the organisers of the camp were interviewed to identify the problems they faced in running the camps.

Findings: Most of the women were in their 20s; on average they had two children. Their husbands were day labourers, semi-skilled and skilled workers among them. All the women were accompanied either by their husbands or women relatives. Junior public health nurses responsible for motivating these clients to accept sterilisation accompanied some.

The paper reports on the observation findings of a sterilization camp. One surgical team did 48 laparoscopic sterilizations in just over two hours (averaging 2 minutes and 40 seconds per sterilization) in clear violation of the norms laid down by the programme.

Counselling of women before surgery was inadequate. The surgeon never changed his gloves, the linen on the operating tables was never changed. Though the building had facilities like access to running water, electricity with a standby generator in case of power failure, and attached toilet, these were inadequate. The women had to wait for a long time after completing registration formalities for the surgical team to arrive. Pelvic examinations were not done prior to sterilization for all women. Post-operative care was lacking. For nursing staff of the taluka hospital deputed for this, it meant extra work. The surgeon who officiated at this camp belonged to another taluka who had to finish his scheduled surgery at his own place and thus delayed the camp. According to the supervising doctor, the need to fulfil the targets frequently resulted in wrangling between health workers.

The authors conclude that though the situation at the sterilization camp was much better than other states, with efforts made to disinfect the place and sterilize the instruments, with better planning and management, available resources could be put to more effective use in organizing such camps more frequently. The lack of quality of care in service provision has far-reaching implications both for women's health and health policy.

Key words: *Sterilisation Camp, Quality of Care.*

21. Quality of client-provider interaction and family welfare services (MCH and FP programmes) in rural Karnataka

Author : Reddy P.H.
Source : Working paper, Centre for Technology Development, Bangalore
Place of study : Kolar, Kerala
Location : Rural.
Period of Study : 1994
Type of research : Empirical, Descriptive, Community and Health Centre-based

Aim: To examine how welfare programme personnel interact with clients in a given setting, and the quality and frequency of such interaction. To understand the providers' view of, and satisfaction with, the information and quality of family welfare services provided. To gather the clients' view of, and satisfaction with, the information and quality of family welfare services received.

Methodology: The contexts included were antenatal clinics, immunisation clinics, deliveries, postnatal services and family planning camps. Multiple qualitative research methods - observation, informal interviews and discussions, semi-structured interviews, and group discussions - were employed in the collection of data. Two PHCs and three sub-centres under each of the two PHCs were selected.

Findings: It was found that interaction between clients and ANMs was quite frequent, unlike that between clients and MHWs. The quality of interaction differed at the level of SCs and at higher levels. Better interaction at the sub-centre level was attributed to the necessity on the part of ANMs to be on good terms with clients to meet targets. The

quality of interaction between clients and MHWs was poor. In general the quality of family planning services was found to be poor.

It is suggested that there is a need to allocate more funds to fill vacant posts, buy and supply adequate pre- and post-operative drugs etc. Periodic re-service training programmes need to be organised for medical, paramedical and non-medical personnel. The gaps in knowledge, skills and practices identified should be recognised while designing the curricula of these re-service training sessions. Top management should be committed to the concept of quality. Regular monitoring and supervision mechanism is required. It said that the present supervisory styles are autocratic and fault-finding. They should be changed to democratic and supportive supervisory styles. The author also suggests rewards for those maintaining quality and a demotion for the others.

Key words: Client-provider Interaction, Quality, Family Welfare Services.

22. Intra-Uterine Device as a means of contraception in our population

Author : Sarbajna S.
Source : Journal of Obstetrics and Gynaecology of India
Place of study : Indian Iron and Steel Company Hospital
Location : Not Stated
Period of Study : 1977-87
Type of research : Empirical, Descriptive, Retrospective, Health Centre-based

Aim: To study the acceptability and complications of IUCD, causes of removal of IUCD, acceptance in different socio-economic groups, the attitude of women from different socio-economic groups towards IUCD and spacing, availability of paramedical personnel for motivation, attitude of health visitors.

Methodology: The hospital records of 460 women who had an IUCD inserted were reviewed over a period of 11 years. In addition, women were interviewed regarding their attitude towards IUCD.

Findings: During the study period of 11 years, 460 women used the IUCD, of which 169 (36.7%) had complaints, with 38 (8.4%) women removing the IUCD. Menstrual irregularity was found in the form of menorrahagia, dysmenorrhoea and spotting. This was more commonly encountered in the cases of post-MTP insertion. The most important cause of removal was menstrual irregularity. The others constituted failure of IUCD, severe vaginitis, opting for another method, and desire for pregnancy.

The majority of IUCDs were inserted for women from the middle socio-economic group. Women in the low socio-economic group were ignorant and indifferent about IUCD. Women from high and middle socio-economic groups showed a definite negative attitude towards IUCD, mainly due to the false belief that it caused cancer and menstrual irregularity.

The hospital had fewer health visitors than required. Health visitors were found to be indifferent towards the IUCD. It was revealed that they had an interest in tubectomy and

vasectomy due to incentives involved in those. It is concluded that an adequate number of health visitors must be available for motivation.

Reviewer's note: Methods and subjects have been inadequately described in the study.

Key words: *IUCD, Acceptability, Complications.*

23. Quality of care at community hospital

Author : Subrahmanyam V.
Source : Economic and Political Weekly, 1997
Place of study : Nellore, Andhra Pradesh
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To find out the effects of medical negligence.

Methodology: Case studies were undertaken to explore the situation.
Findings: This study was undertaken in a Government Community Hospital in Kavali town of Nellore district to find out the factors that affect the right to health of common people. The study found that besides the negligence of health personnel, other factors are also responsible for the gross violation of the people's right to health. These include: politicisation of the institution, rampant corruption, profit motive of doctors, inadequate infrastructural facilities, unhygienic environment and the subservience of authorities to the ruling political bosses.

Key words: *Right to Health, Negligence.*

QUALITY OF HEALTH CARE SERVICES

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WOMEN'S HEALTH CARE NEEDS

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
1.	To share the experiences of the researchers who conducted a community-based study on gynaecological morbidity.	1986	Gadchiroli **Maharashtra** Rural	**Empiri Explor Comm**
2.	To determine the factors leading to unwanted pregnancy and highlighting possible preventive measures.	1982-84 and 1985-88	Pune, **Maharashtra** & Panji, **Goa**	Empiric Descrip Health
3.	To compare the incidences of various complications and outcomes of teenage pregnancy with the overall incidence in the hospital and with those of teenage pregnancies reported in the literature.	1988	Mumbai **Maharashtra**	**Empiri Descri Retros Health based**
4.	To conduct a community-based study on reproductive morbidity and its determinants. The study was part of the major research effort to investigate the pathways through which a mother's education influences her child survival.	1993	**Karnataka** Rural	Empiric Descrip Commu
5.	To project the mortality due to caesarean sections in one of Bombay's leading teaching institutions and compare with the data available from the literature.	1981-90	Mumbai **Maharashtra**	Empiric Descrip Retrosp Health-
6.	To study perinatal outcome in teenage mothers.	Not stated	Wardha	Empiric

			Maharashtra	Descrip Prospe Health

WOMEN'S HEALTH CARE NEEDS

SELECTED ANNOTATIONS

1. A community study of gynaecological disease in Indian villages

Author : Bang R. and Bang A.
Source : Learning about Sexuality – A Practical Beginning, The Population Council
Place of study : Gadchiroli, Maharashtra
Location : Rural
Period of study : 1986
Type of Research : Empirical, Exploratory, Community-based

Aim: To share the experiences of the researchers who conducted a community-based study on gynaecological morbidity. The study was sought to determine 1) the prevalence, types and distribution of gynaecological diseases in rural woman, 2) the awareness and perception of the women about their gynaecological and sexual disorders and 3) the proportion of women who have access to gynecological care.

Methodology: Two representative villages, from the work area of SEARCH, were selected. All women, regardless of whether they had symptoms or not were examined in order to estimate true prevalence of gynaecological morbidity. Medical examinations were done in the respective villages in the hospital setting. Each woman was to visit five units, registration, interview by a female social worker, history and examination by a female and gynaecologist, pathology laboratory, and dispensary. Privacy was ensured during interview and examination.

Findings: In this paper, researchers have documented their personal experiences while conducting this study with the hope that it may be useful to evolve more relevant methodology for further research in this field. The article reveals how interactions with the study community should be made for their better cooperation.

It was found that 92 per cent of the women had gynaecological disorders. Each woman had an average of 3.6 diseases, but only 7 per cent of the women had ever sought medical care. This study generated interest among public health personnel in various parts of the world as it projected women's gynecological diseases as an important public health problem.

The study also invites our attention to the fact that the existing taboo and inhibitions regarding sexual health prevent women from securing an easy access to medical care. Also, women found overemphasis on Family Planning in our health care services as a hindrance in utilisation of health services. Therefore, though 92 per cent of the women were found suffering from gynaecological problems, only 7 per cent of the women had ever sought medical care.

Reviewer's note: This article also details as to how to approach a new community for studying sensitive topics.

Key words*: Sexuality, Gynaecological Morbidity*.

2. Unwanted adolescent pregnancy: Its present status

Author	**:** Behera R.C. and Padte K.
Source	**:** Journal of Obstetrics and Gynaecology of India, 1991
Place of study	**:** Pune, Maharashtra; Panji, Goa
Location	**:** Not Applicable
Period of study	**:** 1982-84 and 1985-88
Type of research	**:** Empirical, Descriptive, Health Centre-based

Aim: To determine the factors leading to unwanted pregnancy and highlighting possible preventive measures.

Methodology: Two hundred women seeking abortion care were interviewed at the two hospitals over 3 years each in sequence. Data collection was done using a specially designed proforma.

Findings: Demonstrated higher percentage of unwanted adolescent pregnancies among middle and late adolescents, with 45 and 54 per cent respectively. A high incidence of unwanted pregnancy was found among rural population (68%), housewife (69%), under matriculate (53%), and lower economic group (67%). Causes included out-of-wedlock (15%), quick succession or pregnancies (34%), small family norm (15%), failure of contraception (5%), recent marriage (6%), education and career consciousness (6%), medical grounds (7%), marital mal-adjustment (2%) and drugs taken (10%). Ninety two per cent of the cases had inadequate sex education, and 84 per cent did not use contraception.

The women seeking abortion were counselled for not going ahead with induced abortion, but it was highly unsuccessful (90%), whereas post-abortive contraceptive counselling was quite successful (78%).

It concludes that unwanted adolescent pregnancy has taken a new dimension due to rapid changes in socio-economic environment and changes in the philosophy of life. The author states that legalisation or liberalisation is not the solution for unwanted adolescent pregnancies but prevention of pregnancies through extensive sex education and effective contraception is required.

Reviewer's note: Conclusions derived reflect constraints of hospital-based studies. In absence of any statistics on adolescent pregnancies in the past, attributing it to changing

socio-economic environment and to the change in life philosophy is a little far fetched. The unwanted adolescent pregnancies perhaps are more visible than before for more women are seeking abortion care from the hospitals than before and a good indication.

Key words: *Unwanted Adolescent Pregnancy, Indications for Abortion, Preventive Measure.*

3. Outcome of teenage pregnancy

Author : Bhalerao A.R., Desai S.V., Dastur N.A., et al.
Source : Journal of Postgraduate Medicine, 1990
Place of study : Mumbai, Maharashtra
Location : Not Applicable
Period of study :1988
Type of research : Empirical, Descriptive, Retrospective, Health Centre-based

Aim: To collect data about the pregnant teenagers and to compare the incidences of various complications and outcomes of teenage pregnancy with those of teenage pregnancies reported in the literature.

Methodology: Two hundred consecutive cases upto age of 19 years of the total 3,150 confinements during the period under review - July 1988 to October 1988 - constituted the sample. Medical, obstetric and socio-economic aspects of the pregnant girls were studied.

Findings: The incidence of teenage pregnancy was 6.3 per cent. Most belonged to poor or lower middle class families and were housewives. Six (3%) were unmarried, 173 (86.5%) were nullipara. Antenatal complications occurred were anaemia (25.5%), pre-eclampsia (8.5%), eclampsia (1.5%), premature opening of os (3.0%), VDRL positive (1.5%), intrauterine foetal death (2.0%), antepartum haemorrhage (1.0%). There were 8 per cent spontaneous abortions, 16 per cent premature vaginal deliveries as against overall incidence of 10 per cent in the hospital, 58.5 per cent full term normal deliveries.

The disaggregated data for the age group of 15-17 years indicated that outcome of pregnancy becomes worst in this age group compared to the age group 17-19 years. Low birth weight (LBW) incidence was 46.2 per cent for the teenage as compared to 30 per cent for the overall incidence in the hospital. LBW incidence for the age group of 15-17 years was 71.5 per cent and for age group of 17-19 years it was 44.1 per cent. Perinatal mortality was 65.2 per 1,000 total births compared to 45 per 1,000 total births in the hospital.

It concludes that teenagers are definitely at greater risk, requiring additional efforts and resources to serve and protect their health. More attention needs to be paid for prevention and treatment of antenatal complications, prematurity and LBW.

Reviewer's note: Study of socio-economic aspects as correlates of incidence of teenage pregnancies and other related aspects would have been insightful.

Key words: *Teenage Pregnancy, Outcome*.

4. Self-reported symptoms of gynaecological morbidity and their treatment in South India

Author : Bhatia J.C. and Cleland J.
Source : Studies in Family Planning, 1995
Place of study : Karnataka
Location : Rural
Period of study : 1993
Type of research : Empirical, Descriptive, Community-based

Aim: To conduct a community-based study on reproductive morbidity and its determinants. The study was part of the major research effort to investigate the pathways through which a mother's education influences her child survival.

Methodology: The main study had several components - anthropological studies; investigation of primary schools in three states of India; a cross-sectional survey; and a prospective study. The conduct of the study was designed in such way that inputs of the in-depth qualitative studies could be fed into the subsequent quantitative studies. The intricate inter-linkages between child's survival and that of mother's health were noticed. Therefore, detailed information was collected in the cross-sectional and prospective study on different aspects of mothers' health.

This study was conducted in a sub-district with 293 villages and a small town, because it was typical of rural Karnataka and within reasonable distance of the capital city. The study population comprised of women who were less than 35 year old and had at least one child under five year of age. The achieved sample size was 3,600 (2,400 in rural and 1,200 from the town). No representative sample was pursued for the survey was exploratory. All eligible women in the town and 48 villages having a population of at least 500 persons were included in the sample. Female interviewers conducted the interviews. Extensive training, enough time for rapport establishment before starting the work, support of the experienced survey specialists in the field, daily interactions of the work characterized the study.

The questions on reproductive morbidity were framed based on the comprehensive list of reproductive morbidities along with details of symptoms and everyday terminology prepared by an experienced female obstetrician/ gynaecologist. Four groups of independent variables conceived were socio-economic, demographic, factors related to last live-birth and cognitive and behavioral factors.

Findings: Approximately one-third of the women included in this study reported current symptoms of at least one reason for reproductive morbidity. Ninety per cent of abortions were reported to be spontaneous. The causes of which may be outcome of prior infection or a cause of subsequent infection. Among others, menstrual problems (7.3%), symptoms of lower reproductive tract infections (16.9%), anaemia (23.4%), and symptoms of acute PID (5.2%) were reported. Prolapse, urinary tract infections, infertility (secondary), haemorrhoids were less frequently reported.

Analysis of the determinants was limited to menstrual problems, lower reproductive tract infection, acute PID and anaemia. Bivariate analysis revealed socio-economic differentials. Among demographic indicators, age at first pregnancy and total number of pregnancies were consistently related to all four morbid conditions. About 41 per cent

reported disorders or problems were associated with their last live-births. With regard to cognitive and behavioural factor, personal hygiene, household environment and sanitation, and exposure to health education were related to reported morbidity. Analysis also demonstrated relationship with socio-economic variables, health education and autonomy in addition to duration of problem and age of the respondent. Experience of obstetric problems and complications associated with the last live-birth, place of last delivery were found to have strong and pervasive influence on reported gynaecological morbidity. Most importantly, reporting of the symptoms indicative of lower reproductive tract infections, acute PID and anaemia were significantly higher among tubectomised women than among those who were not using any method of contraception or were using a reversible method.

The most common source of treatment was private medical practitioner. Women rarely used PHCs and sub-centres. Better-educated women from more affluent households sought more treatment for symptoms of gynaecological problems than their less privileged counterparts, although the difference between the two was not statistically significant. Exposure to health education emerged as a major predictor of therapy-seeking behaviour.

The results strongly suggest that the quality of care and, in particular, hygienic conditions, may be poorer in government hospitals than in private hospitals and clinics. The data show that delivery in a government hospital may offer little advantage over home delivery in terms of protection against infection.

According to the authors, the results of the study, if substantiated by clinical examinations, will have far-reaching implications for India's family planning programme. It is stated that obstetric problems can act as a warning sign of more persistent problems of reproductive illhealth. Therefore, health services targeting follow-up diagnosis and treatment for these women should be made feasible. The authors were of the view that a radical review of facilities available under the primary health care system is required along with a more systematic evaluation of the private medical sector.

Key words: *Reproductive Health, Morbidity, Utilisation, Prevalence*.

5. Caesarean section: How safe is it?

Author : Bhide A.G.
Source : Journal of Obstetrics and Gynaecology of India, 1991
Place of study : Mumbai, Maharashtra
Location : Not applicable
Period of study : 1981-90
Type of research : Empirical, Descriptive, Retrospective, Health Centre-based

Aim: To project the mortality due to caesarean sections in one of the Bombay's leading teaching institutions and compare it with the data available from the literature.

Methodology: All cases delivered at Nowrosjee Wadia Maternity Hospital during the reference period of 1981-90 were studied. The mortality occurring in the cases of caesarian section (CS) was reviewed.

Findings: The data show that there was a progressive increase in incidence of CS in recent years from 6.5 per cent in 1981-82 to 9.0 per cent in 1989-90. Mortality from CS has declined from 321.5/100,000 in 1981-82 to 190.8/100,000 in 1989-90. It was attributed to advances in medical technology, which have made it easier to take a decision in favour of CS. Though on decline, mortality and morbidity associated with CSs is nowhere comparable to that following a vaginal delivery.

The indications for CS have also widened. They include repeat CS, foetal distress (both remained about the same over the decade), breech presentation (increased by about 6%), antepartum haemorrhage (decreased by about 2%), cephalo-pelvic disproportion (decreased by about 8%), high risk pregnancies (increased by about 11%). The main causes of post caesarean deaths were haemorrhage (9 in 10 yrs), sepsis (4), embolism (2), medical disorder (2), anaesthesia (1). Increase of 11 per cent in CSs for an indication of high risk pregnancy is attributed to early diagnosis of obstetric complications and medical disorders associated with pregnancy. Higher maternal mortality in case of CSs compared to vaginal delivery is attributed partly to the complications that lead to CSs and partly to the risks inherent in the abdominal route of delivery.

It is suggested that each case must be reviewed before resorting to CS. There is a need for good prenatal care, better knowledge of medical disorders and well supervised intranatal care with the help of good anaesthesiologist, so as to minimise maternal mortality due to CS.

Reviewer's note: It has not studied the socio-economic profile of women undergoing CSs, which may have been insightful. Gives a clear comparative statistics on CS and vaginal deliveries and the respective mortality rate. Despite a large sample size, being a tertiary-level hospital based study it has its own constraints. It indicates the need for community-based incidence study to provide better insights into women's health status and the incidence of CSs.

Key words: *Caesarean Section, Mortality.*

6. Perinatal outcome in teenage mothers

Author	**:** Chhabra S.
Source	**:** Journal of Obstetrics and Gynaecology of India, 1991
Place of study	**:** Wardha, Maharashtra
Location	**:** Not Applicable
Period of study	**:** Not Stated
Type of research	**:** Empirical, Descriptive, Prospective, Health Centre-based

Aim: To study perinatal outcome in teenage mothers.

Methodology: The study was conducted in one of the rural medical centres, which drains most of the abnormal cases from nearby villages and townships. Teenage mothers constituted around 11 per cent of all deliveries, around 75 per cent of them were primigravidae. Four hundred cases were analysed in each of the two groups of teenage mothers and controls in age group 20-29 years.

Findings: Total of 400 teenage pregnancies were studied. Of these mothers, 5 per cent were below the age of 15 years and 87 per cent were between the age 18 to 19 years. Anaemia was prevalent in 70 per cent and toxaemia of pregnancy occurred in 14 per cent. In the study group 70 per cent had normal delivery, 73.7 per cent cases with breech presentation required CSs. In the control group, 38.8 per cent of the breech presentations required caesarean sections. In the study group and the control group, CS rate were 21.5 per cent and 19.5 per cent, mothers with low birth weight were 11 per cent and 7 per cent; perinatal loss was 77.5 per 1000 births and 57.5 per 1, 000 births; maternal mortality was 520.8 and 257.1 per 100,000 live-births. In 43 per cent women from the study group and in 29 per cent from the control group, labour lasted for more than 12 hours.

It concludes that young mothers are at higher risk of some pregnancy problems and adverse perinatal outcome. The author cites an example of another study, which found that poor care than age is important factor in primigravidae. Teenage and subsequent pregnancies should be discouraged to reduce perinatal and maternal risks. This group requires high priority services.

Key words*: Teenage Mothers, Perinatal Outcome*.

7. Morbidity in Tamil Nadu: Levels, differentials and determinants

Author **:** Duraisamy P.
Source **:** This paper is based on the project, "Morbidity, Utilisation of and Expenditure on Medical Services in Tamil Nadu", 1997
Place of study **:** Tamil Nadu
Location **:** Not Applicable
Period of study **:** 1973-74 to 1986-87
Type of research **:** Empirical, Analysis of Data from NSS 42nd Round

Aim: To study the levels, trends, differentials and determinants of morbidity in Tamil Nadu.

Findings: Author details and discusses the concept and issues involved in defining and measuring prevalence and incidence of morbidity. Further, he explains the nature of data on morbidity in different rounds of NSS and the problems and issues as regards comparability of the data for analytical purpose. Using individual data, the difference in the morbidity pattern across socio-economic and economic characteristic of the population was studied. Age-sex specific distributions of type of illness were examined. The determinants of morbidity were estimated using regression techniques. Reasons for not seeking treatment were also analysed.

The morbidity prevalence rates for the years 1980-81 and 1986-87 were comparable and estimates indicated that the overall morbidity prevalence rate has increased during the period. The overall morbidity prevalence rate was 28 and 32 per 1,000 in rural and

urban areas of Tamil Nadu. Overall, the morbidity prevalence rate was higher among males (29 per 1,000) compared to females (27 per 1,000). The untreated illnesses were found to be higher in females than in males. Distribution of type of illness among age-sex groups suggested that the communicable diseases were concentrated in the younger age while the aged people suffer more from non-communicable ailments. The female headed households experienced a higher morbidity compared to male headed households. The data on morbidity prevalence showed that males had a higher risk of being sick compared to females. Increase in age increased the risk of being sick. As the level of education increased, the morbidity risk reduced. The effect of per capita consumption expenditure was positive and consistently significant in all the morbidity functions. More than 50 per cent of the untreated cases report that the ailment was not serious enough to seek medical treatment. About 20 per cent of the cases did not seek treatment due to financial constraints.

The analysis points to the need for targeted health interventions to reduce the morbidity among children and elderly persons. In general, improvement in education would reduce the extent of sickness among people. The high prevalence rate of cardiovascular diseases needs attention and measures to reduce the burden of treatment of the poor and needy are necessary.

Key words: *Morbidity, Gender Specificity*.

8. Voices from the silent zone

Author	**:** Dubey V., Prakash S. and Gupta A.
Source	**:** The RAHI Findings, 1998
Place of study	**:** Delhi, Bombay, Madras, Calcutta and Goa
Location	**:** Urban
Period of study	**:** 1997
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To document child sexual abuse and to look into the impact of incest on woman's adult life; to establish incest and child sexual abuse also as a middle and upper middle class Indian phenomenon.

Methodology: The study was carried out amongst English speaking middle and upper class women currently living in Delhi, Bombay, Madras, Calcutta and Goa. The majority of them were graduate and undergraduate students. Respondents also included housewives and employed women. Questionnaires were used for data collection. The majority of the questionnaires were administered to women after making them aware of the purpose of the survey. Others were distributed at random with the help of the network of resource people. The study was based on 600 questionnaires out of 1,000.

Findings: About 76 per cent of the respondents had experienced sexual abuse in childhood or adolescence. In case of 71 per cent of the respondents, abusers were either relatives or others they knew.

For many respondents, filling up the questionnaire has been of therapeutic value as it was a non-threatening way to collect information on such a sensitive issue. This study

also gives valuable information about family system and people's peception of the issue in general and the kind of action required for effective prevention of sexual violence. The study brings into light a range of misconceptions in the area of sexual abuse and perceptions regarding its effect on women's life.

Difficulties in expressing the complexities of experiences in English language, difficulties in accuracy of interpretation of the responses to such a sensitive subject, time constraint for rapport establishing with the women were some of the limitations of the study as articulated by authors. It recommends areas of research on the subject of incest and child sexual abuse.

Reviewer's note: The high prevalence of sexual abuse revealed through this study needs to be seen in the light of the fact that it was a self selected sample from among the upper class. As high as 40 per cent non-response needs to be taken into account while interpreting the data. There is no clear mention of the way the universe was defined. Though generalisation cannot be drawn, the study certainly brings to light the possible magnitude of sexual abuse and incest.

Key words: *Child Sexual Abuse*.

9. Too far, too little, too late: A community-based case-control study of maternal mortality in rural west Maharshtra, India

Author	**:** Ganatra B.R., Coyaji K.J. and Rao V.N.
Source	**:** Bulletin of the WHO, 1998
Place of study	**:** Pune, Aurangabad and Ahmednagar, Maharashtra
Location	**:** Rural
Period of study	**:** 1993-95
Type of research	**:** Empirical, Descriptive, Prospective, Community-based

Aim: To study the events from the onset of a complication to death/recovery and to delineate the factors that determine survival in women who develop a complication.

Methodology: This was a population-based, matched case-control study. It covered 400 villages, with a total population of 686,000 spread over well-delineated but noncontiguous rural areas in Pune, Aurangabad and Ahmednagar districts of Maharashtra. The public health infrastructure in the study area was similar to that of the rest of the state. Cases were enrolled prospectively over the period 15 January 1993 to 15 December 1995. All deaths were screened to determine whether they were maternal. All identified maternal deaths were enrolled in the study without exception. The ICD-10 definition of maternal death was used as the case definition. The control and cases were drawn from the same population base. Information was obtained from several sources such as vital registration records, primary health centre registers, public and private medical facilities serving the study area. These potential controls were divided into two groups - women with normal pregnancies and women with serious pregnancy related complication.

Each maternal death was matched to two or more women with the same bio-medical complications (complication-matched control) and to one normal pregnancy from the

same village (geographical control). All controls were randomly selected from the control pool.

Data collection included a structured interview as well as histories taken from the husband's family and the woman's own family, interviews with health care providers and a review of available medical records. Families were followed up one year later to ascertain the fate of the live born children of the maternal deaths.

Findings: Of the 570 deaths identified, 121 (21.2%) deaths fitted the definition of maternal death. Direct obstetric causes accounted for 71.9 per cent of the maternal deaths. It was found that logistic difficulties in obtaining transport or money played a role in 45 per cent of the deaths, inadequate medical management at hospital level in 25 per cent of the cases and shortages of blood and other essential drugs in 28 per cent of the deaths. Domestic violence was the second-largest cause of pregnancy related mortality, exceeded only by post-partum haemorrhage.

The medical causes of maternal mortality in this study were similar to the picture seen worldwide, but the proportion of post-abortion deaths was surprisingly lower than has been reported elsewhere. This coupled with the fact that not a single death was due to septic abortion suggests that in the study area, abortions (whether legal or illegal) were being performed in relatively 'safe' circumstances. The study has demonstrated that existing services were often too remote or have too little to offer and that patients, logistics and health service factors combine to result in a medical intervention for a maternal illness being instituted far too late to be effective. Delays in seeking treatment were obscured by critical health service delays that operate after a woman had made her first health contact. The inability of most health facilities (both private and government) to deal with obstetric complications and unwillingness to accept potentially serious cases leads to patients being shunted from one facility to another. The stepwise hierarchical referral system further increases misreferrals.

The findings that have been quantified for the first time highlight the need for inclusion of prompt and accessible medical management as an essential component of maternal mortality prevention programmes. Redesigning the referral system to include bypassing inappropriate referrals, and identifying and strengthening area-specific institutions (government and non-government) which are potentially capable of providing obstetric care, would be an effective way of reducing the time spent in reaching appropriate health care facility. In addition to it, ways to increase the time between onset of a complication and possible death also need to be explored.

Reviewer's note: A large sample community-based study conducted using a sound methodology makes this reasearch significant.

Key words: *Prevalence, Complication, Maternal Mortality, Health Care Interventions*.

10. Induced abortions in a rural community in Western Maharashtra: Prevalence and patterns

Author **:** Ganatra B.R., Hirve S.S., Walawalkar S., et. al.
Source **:** Working Paper of Ford Foundation, 1998

Place of study : Pune, Ahmadnagar, Auragabad, Maharashtra
Location : Rural
Period of study : 1994-96
Type of research : Empirical, Descriptive, Prospective, Community-based

Aim: To study mortality rate of post-abortion complications. To study women's considerations while choosing an abortion service provider. To understand women's expectations about and experience of abortion services.

Methodology: The study area covered 139 villages with a total population of 324,431. Most of the study area was situated within a distance of 20-80 km of a large town or a city. All the district hospitals, a few PHCs and some rural hospitals including small private hospitals provided MTP services in the study area.

Multiple sources and informants were used for case-finding. Information was collated from self-reporting, snow-ball sampling, community women's groups, school teachers and health functionaries within the community to identify women who had undergone induced abortion during the study period of 18 months. Potential ethical problems in the use of such information were overcome by adopting a study design that enrolled cases prospectively over the study period.

A total of 1,950 induced abortion occurred in 1,853 women who were identified from the study population. The identified women were categorised as currently married or currently not married. A structured interview schedule with open- and close-ended probes was used for the married group and an in-depth unstructured interview schedule was used for the 'out-of-wedlock' women. Dummy interviews using the same tools were simultaneously administered to other women so that the respondents were not singled out.

Findings: Calculated through indirect ways, the induced abortion rate in the study population in the period of 12 months was 19.1 per 1,000 women in the age group of 15-45 years. About 74.1 per cent of the pregnancies were terminated as they were unwanted. It indicates the vast unmet need for contraceptive services. It was found that about one in every six pregnancy terminations among married women were sex-selective; about two-thirds of the women complained of a problem that was severe enough to disrupt their routine work. Post-abortion care was found lacking. The median gestation at which pregnancies were terminated was 10.9 weeks, with 70.9 per cent first trimester abortions. About 3.4 per cent pregnancies were terminated after 20 weeks, that is the legally permissible limit for termination. Knowledge of legality was low even among abortion seekers. Women not currently married constitute a special group of abortion seekers who had different needs and who behaved differently from married women.

About 81 per cent of the pregnancies were terminated in the private sector. About 45.9 per cent of all abortions were terminated illegally. Traditional practitioners were used by only 2 per cent of the married women, whereas the use was significantly higher by the women who were not currently married. This suggests that the group is socially marginalised and is exposed to exploitation and insensitivity of service providers. The most common reasons mentioned by married women for choosing a provider were that the provider was experienced in conducting abortions, was patient and good-natured, explained the procedure and answered their queries, and performed the abortion in a place where facilities like blood and oxygen were available. Nearly one-third of the

respondents said that cost considerations played a role in their choice. About a third stated that it was important for them that the provider was female, and the same number said that they chose a particular provider because repeated visits and an overnight stay at the hospital were not required. Around 12 per cent stated that they chose a particular provider, as they did not insist on contraceptive use.

Reviewer's note: The large sample size marks the study. A large number of dummy interviews has been conducted. This communication does not make any reference to whether these data have been used for furthuring knowledge. In absence of any reference made it raises ethical issues vis-à-vis the time taken of the dummy respondents and the public funds expended for the same. The method of 'case-finding' for studying induced abortion incidence is also not ethically sound.

Key words: *Induced Abortions, Morbidity, Contraceptives*.

11. General and reproductive health of adolescent girls in rural South India

Author : Joseph G.A., Bhattacharji S., Joseph A., et. al.
Source : Indian Pediatrics, 1997
Place of study : Arcot, Tamil Nadu
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community-based

Aim: To assess the general and reproductive health of female adolescents.

Methodology: Both quantitative and qualitative methods were used to assess the general and reproductive health of female adolescents in Arcot district of Tamil Nadu. The qualitative method of data collection included focus group discussions and key informant interviews. The quantitative survey was conducted by administering questionnaires. Objective checklist was used to determine knowledge. For the quantitative survey, 4 villages were randomly chosen based on presence or absence of high school and by population greater or less than 1,000. From the selected villages 50 adolescent girls were chosen randomly to be included in the sample. Anthropometry, blood pressures and other clinical examinations were also conducted for these girls to assess their health status.

Findings: In the focus group discussions, adolescents spoke of having headaches, body pains, and fatigue. There was reluctance to discuss sexual health problems, but many reported concerns about menstrual irregularities. Most girls stated that they would feel more comfortable attending a separate adolescent clinic run by female physicians. In interviews with 190 girls, the most frequently cited health complaints were fatigue, palpitations, frequent headaches, backache and abdominal pain. Over 20 per cent suffered from joint pains, weight loss, poor appetite and recurrent respiratory problems. Those with higher educational status had fewer health complaints. About 30 per cent were anaemic and their heights, weights and body mass indexes were typical of those found in chronically undernourished populations. Levels of knowledge about topics, such as, menstruation, contraception, nutrition, and AIDS were extremely low.

Female doctors were preferred for gynaecological check-ups. An overwhelming majority declared that specific health care facilities for adolescents were lacking. Overall, these findings indicate a need for both health education and special treatment services for girls who have suffered the health consequences of low economic status, unhygienic practices, and poor nutrition.

Key words: *Adolescent Girls, Health Status, Health Care Services.*

12. Induced abortions in rural society and need for peoples' awareness

Authors	**:** Mondal A.M.D.
Source	**:** Journal of Obstetrics and Gynaecology, 1991
Place of study	**:** 24 Parganas, West Bengal
Location	**:** Rural
Period of study	**:** 1989-90
Type of research	**:** Empirical, Descriptive, Prospective, Health Centre-based

Aim: To find out reasons for acceptance of induced abortions in rural areas, the reasons for approach to illegal abortionists, the magnitude and nature of complications thereof.

Methodology: The study was carried out in Baduria PHC of 24 Parganas in West Bengal. From two adjoining villages 300 females with one or more abortions were identified within the stipulated study period. Histories of induced abortions along with socio-cultural and obstetric histories were taken.

Findings: All the abortions performed by quacks and paramedicals had led to post-abortion complications. Out of the total cases aborted by MBBS private practitioners 45.8 per cent had led to complications. Reasons for these were improper aseptic techniques, lack of training, overconfidence and popularity in the area ignoring quality of care. Reasons for approaching quacks were secrecy, availability, affordability and accessibility of the abortion services. Lady doctors were preferred while choosing abortion service provider.

Contraceptive acceptance was far from the requirement. The authors expressed the need for more MTP facilities. Simultaneously, people also should be made aware of the available MTP services.

Key words: *Induced Abortion, Complications of Induced Abortion.*

13. MTP programme in Uttar Pradesh

Authors : Mukharji R.
Source : The Directorate of Family Welfare, Uttar Pradesh
Place of study : Uttar Pradesh
Location : Not Applicable
Period of study : 1987-88 to 1991-92
Type of research : Empirical, Analysis of Secondary Data

Aim: To analyse socio-economic scenario of MTP acceptors.

Findings: Five hundred and fifty four institutions and 1,208 doctors have been approved in Uttar Pradesh (UP) after 1976 to conduct MTPs. In UP, there was 1 MTP centre per 3 lakh population in 1987-88 and 1 MTP centre per 2.40 lakh population in the year 1991-1992. In the year 1991-92, there was 20 per cent increase in MTP cases. Women in the age group 25-29 years terminated the largest number of pregnancies. There were 6.9 per cent second trimester abortions. As regards post-MTP coverage, 13-22 per cent cases opted for sterilization and 7-19 per cent got IUD inserted.

Difficulties in the programme were found in terms of provision of funds for instruments; maintenance & repair of the apparatus; cultural inhibitions that women have; and under-reporting of private doctors.

It is suggested that IEC activities are undertaken in an area-specific approach manner for specific population groups like Muslim population. There is a need to use film/folk media/electronic media to expand the programme. Spacing methods should be encouraged through our health programmes to reduce morbidity and unplanned pregnancy. It is suggested that approval of doctors and institutions should be decentralised by the Director General of Health Services.

Reviewer's note: The objective stated does not seem to be pursued in the presentation. It is hard to find connection between the objective and body of the paper. It also does not adequately clarify as to why IEC should focus on Muslim population.

Key words: *MTP Programme, MTP Services, MTP Incidence.*

14. Gynaecological morbidity among women in a Bombay slum

Author : Parikh I., Taskar V., Dharap N., et al.
Source : Streehitkarini
Place of study : Mumbai
Location : Urban
Period of study : 1989
Type of research : Empirical, Descriptive, Community-based

Aim: To determine the levels, patterns and correlates of gynaecological morbidity in an urban slum, focusing on women's perceptions and assessment of their gynaecological health as well as the conclusions of medical assessments of laboratory tests.

Methodology: The study was undertaken in a slum area of Mumbai served by Streehitkarini, a health-based voluntary organsiation in Bombay. The survey comprised of socio-demographic survey of respondents including their reported symptoms and morbidity and reproductive histories; and clinical examination and laboratory tests.

A random sample of ten per cent (sample size = 1,500) of ever married women residing in slum was drawn. No replacement was attempted resulting into sample loss of 446 respondents. Of the remaining 1,054, 298 refused a gynaecological examination. Effective sample thus comprised of 756 women, representing an overall sample loss of 50 per cent and a refusal rate of 28 per cent.

Interviews were conducted by two trained extension workers at respondents' homes. They were requested to attend the Streehitakarini clinic for subsequent medical examination. Other qualitative data were also obtained through group discussions with health workers, informal interviews with health practitioners and 100 community women on their perceptions of disease patterns.

Findings: Over 70 per cent of all respondents reported gynaecological complaints; more than 70 per cent had clinical evidence of either vaginitis, cervicitis, prolapse or PID; and about 49 per cent had STD or an endogenous infection as assessed by laboratory test. Evidence of STD infections such as chlamydia and trichomoniasis was found in 15 per cent and 10 per cent of all cases. As many as 39 per cent and 21 per cent of all respondents reported low backache and lower abdominal pain respectively. Also, from among the 15 leading conditions listed duriing the 'free listing' exercise, eight reflect gynaecological conditions.

Associations between socio-economic indicators and morbidity were weak. It may be because the respondents with income level above the poverty line are more likely to report any gynaecological condition, and more likely to have a laboratory diagnosed STDs. Older and higher parity women are more likely to report low back or lower abdominal pain and menstrual problems. In contrast, the correlates of laboratory-detected morbidity suggest that older women are somewhat less likely than younger women to experience either STDs or any endogenous infections. Also evident was a consistent inverse relationship between infection and parity. Women currently using contraception reported higher morbidity. This indicates that socio-economic determinants drop out as significant predictors, and age and parity become more important correlates of clinically diagnosed morbidity.

Health workers reported that few women would resort to clinics or doctors for gynaecological problems. Gynaecological conditions were rarely taken seriously untill they became grave. Cost of treatment and male physician were said to act as further deterrents. Discussions with women revealed that health seeking for gynaecological complaints was minimal and though they were aware of home remedies they were rarely used.

The findings show high prevalence of gynaecological morbidity thus proving it a major public health problem. Gynaecological morbidity in the current health programmes have remained largely unaddressed. The report presents a forceful plea for greater attention to, and investment in reproductive health care needs of poor Indian women.

Reviewer's note: Profile of the non-respondents would have been useful given the 50 per cent 'no-response' rate.

Keywords: *Correlates of Gynaecological Morbidity, STD, RTI, Treatment Seeking Behaviour*.

15. MTPs in Indian adolescents

Author : Salvi V., Damania K.R., Daftary S.N., et al.
Source : Journal of Obstetric and Gynaecology, 1991
Place of study : Mumbai, Maharashtra
Location : Not Applicable
Period of study : 1982-86
Type of research : Empirical, Descriptive, Retrospective, Health Centre-based

Aim: To analyse MTPs in Indian adolescents.

Methodology: The study analysed 932 MTPs sought by adolescents (15-20 years) at the Nowrosjee Wadia Maternity Hospital, between the reference period of January 1, 1982 to December 31, 1986. Data on age, marital status, gestational age, the method of termination and the contraception accepted were analysed for adolescents and non-adolescents.

Findings: Of 932, 154 (16.6%) were below the age group of 18 years, 532 (57.1%) were primigravidae. The majority (78.8%) of those below 18 years were unmarried. Of all the adolescent MTP seekers about 48.8 per cent were unmarried. Younger the patient, later she presented to the clinic. Of the total patients attending the clinic only 21.2 per cent presented in the second trimester as compared to 34.9 per cent in the adolescent age group. The situation was worst in the youngest patients as 75 per cent of the 15 year old girls presented only in the second trimester. This was attributed to failure on part of the girls to realise that they were pregnant, concealment of pregnancy and conflicts with parents.

The younger patients had a higher incidence of the potentially more complicated procedures of second trimester method of termination (only 44.4% suction evacuations) as compared to the older girls (85.5% suction evacuation in the girls aged 20 years). About 38.9 per cent of the adolescents accepted IUCD as compared to 48.4 per cent of the total clinic population. Around 2.5 per cent of the adolescent patients even completed their child bearing and accepted sterilisation.

Reviewer's note: Disaggregated data on marital status and acceptance of contraception would have been insightful. It also points at the need to study the situations which lead adolescents to terminate pregnancies.

Key words: *MTP, Adolescents*.

16. Health transition in India
Part I - Differentials and determinants of morbidity in India : Disaggregated analysis
Part II - Health scenario and public policy in India

Author : Shariff A.
Source : Working Paper, National Council of Applied Economic Research, 1995
Place of study : Nationwide

Location : Rural and Urban
Period of study : 1993
Type of research : Empirical, Descriptive, Community-based

Aim: ***Part I***: To study morbidity pattern and its determinants across the Indian states.
Part II: To critique the public health policy in India.

Methodology:
Part I: A three-stage stratified sample design with varying probabilities in the first stage was adopted. District/towns, villages/urban blocks and the households were the sampling units in subsequent stages. For rural sample, 718 villages from 410 districts in the country were selected. Households listed in the villages were stratified into five income groups. Households from each strata were selected with equal probability using random number tables. For urban sample, the cities/towns with population exceeding five lakh were included in the sample. The remaining cities were grouped into six strata based on their population size and from each stratum a sample of towns was selected independently. The samples of blocks selected vary between 2 and 30, depending upon the size of the town. All households in the selected blocks were listed, stratified by income categories and then selected. A total of 6,354 rural and 12,339 urban households were covered.

The sample was representative of the respective rural and urban population but not adequate for disaggregate analysis at the state level. The methodology was detailed covering various aspects, such as, definition, reference period, date of survey; types and nature of illness categorisation; factors influencing the reporting of morbidity; measurement of income.

Part II: Not applicable

Findings: ***Part I*** **-** Sex and age of individuals showed important associations with morbidity. The results highlight extremely high levels of morbidity prevalence among the very young (0-4 year) and the very old. A further disaggregation suggested that most of the male advantage in morbidity come from the age categories 15-34 years and 35-59 years thus pointing to a very high reproductive morbidity among the Indian women. Regional level disaggregation points to a substantial and significant female disadvantage in the three lower-central states namely Rajasthan, Madhya Pradesh and Orissa. Further, contrary to the expectation, the female disadvantage was high and significant in the urban areas.

Disaggregated analysis showed that the education of the household heads had large, positive and highly significant association with morbidity of children less than age of 5 years. Fairly negative and significant effects of household income on morbidity were seen. The magnitude of this association was larger and much stronger among the younger population. This highlights age and gender discrimination with regard to utilisation of hospitalisation services in rural and urban areas.

Public hospitals were preferred for hospitalisation. The rate of hospitalisation was significantly low in central and eastern parts and significantly high in western parts when compared with south India. In urban areas, the relative dependence on public markets was low and less variable than in rural areas. About 32 per cent and of those who

reported sick had used public facilities for treatment. Women in productive ages had a tendency to resort to private health care in all parts of India. The public health care utilization was relatively high in case of Hindus, those living in eastern parts of India and those suffering from infectious sickness in rural and those from non-infectious in urban areas. As distance to the service centre increased, resort to public facilities declined compared to private services.

The survey has estimated a reported morbity prevalence rate of 104 for the rural and 101 per 1,000 for the urban areas for all India during the reference period of 30 days. The actual morbidity may be high. Author expressed the need to standardise the concepts, definitions and reference periods so as to estimate more accurate morbidity rates.

Part II - According to the author role of prevention in maintaining health was probably the most misunderstood aspect of health care schemes in the country both, at individual and policy level. At the policy level the emphasis has always been on curative medicine. Expanding the medical supply approach to include establishing and maintaining the health producing (disease inhibiting) infrastructure and services is essential.

The author expressed that in spite of concerted efforts the health infrastructure and supplies are inadequate and inaccessible to people. Besides, there exists a misplaced emphasis as far as the current policy is concerned which focuses on creating physical infrastructure and upgrading institutions through cosmetic changes. It is necessary to adopt epidemiological and target approach for reducing the deaths that have endemic and epidemic characteristics. The health services should be placed as close to the people as possible to ensure maximum benefit to the communities to be served. Making people depend less on the modern medicine and reorienting them in the attributes of traditional medicine and self-medication would increase the accessibility to health care. For example, as delivery mostly takes place at home, training birth attendants and providing them simple and inexpensive aseptic delivery kits on a mass scale could ensure safe delivery.

The national health programme should integrate and amalgamate the new health concepts largely originating from the allopathic system of medicine with the local concepts and practices. Indian health care programme should build a multi-type health care system. it is suggested that in order to improve access to reproductive health care services female medical practitioners are inducted at the services centres on the one hand and female health guides at the village level on the other.

The author states that the public policy in India is conceived and implemented as a partial approach. An integrated, holistic and people centered approach is missing in both conceptualization and propagation of policy. The approach is bureaucratic and there is a water tight compartment approach to policy. Public policy also appears to have a fire fighting approach, thus making its presence felt only in case of crisis which otherwise remains silent. The public policy also addresses only the short term, politically rewarding and often superfluous programmes. The current emphasis on involving the NGOs in health and welfare sectors does not necessarily amounts to the people's participation. There is a need to integrate local bodies like 'panchayats' in health care provision.

Keyword: *Determinants, Health Care Utilisation, Health Care Expenditure, Morbidity, Prevalence.*

17. Backpain, the feminine affliction

Author	**:** Shatrugna V., Soundarajan N., Sunadaraiah P., et al.
Source	**:** Economic and Political Weekly, 1990
Place of study	**:** Hyderabad, Andhra Pradesh
Location	**:** Not Applicable
Period of study	**:** 1987
Type of research	**:** Empirical, Descriptive, Retrospective, Health Centre-based

Aim: To study incidence of various kinds of osteoporotic fractures in women.

Methodology: The study was carried out in two parts: a) retrospective and b) study of currently admitted women in the orthopaedic ward of the Osmania General Hospital. A total of 289 case sheets from 297 women of 18 years and above admitted in the hospital during the reference period of January and October 1987 were analysed. Also a 10 per cent (107) systematic sample of all men admitted during the same reference period was used to study the incidence of these fractures in the men's ward to get a comparative view. For the qualitative study 37 adult women admitted in the orthopaedic ward during the period of the study (Sept-Oct 1987) were interviewed. The reason for selection of women with osteoporosis fracture is very well justified by stating the limitation of identifying the calcium level, which was one of the important factors responsible for thinning of bone.

Findings: The authors highlight the importance of recognising backpain as an important health complaint in women's life. This complaint which otherwise remains delegitimised for doctors inflicts on women's bodies in a variety of ways throughout their lives. The causes of backpain and its correlation with working pattern and calcium deficiency have been explained.

The analysis showed differences in the pattern of utilisation of services and treatment seeking behavior among the women and the men for this specific illness. For various reasons women had to leave the hospitals before the completion of the course unlike men. The quality of services offered by hospital in terms of personnel, record keeping, interpersonal relationship were found less than satisfactory. The need for woman sensitive hospital set-up with increased sympathetic humanpower was brought out.

Recently medical scientists are engaged in finding quick solutions which have opened new areas of research. For example, there is need for further research in 'chronic calcium deficiency' and its role in osteoporosis or the need to study the role of bonesetters or doctors who did not insist on hospitalisation. To acknowledge and understand the services offered by these practitioners is important and significant for the speedy recovery of fractures in women in the context of utilisation of larger health care system. But these medical solutions deflect the question of osteoporosis into areas that do not have much relationship to women's day to day lives.

Incomplete record keeping on various important factors such as occupation, income, fertility history, periods of breast feeding, age of menopause, previous drugs used, dietary history in the case sheets limited the scope of study in terms of cross comparison

and examining correlation of these various factors with osteoporotic fractures. Difficulties were also faced due to various reasons in retrieving the information on the various above mentioned factors in the cases from qualitative study. Also the number of women interviewed was very small for quantitative analysis.

Reviewer's note: The paper highlights the problem and difficulties faced while conducting this study. This would help researchers interested in taking up similar research in the future to pre-empt some of the problems.

Key words: *Backpain, Calcium Deficiency, Osteoporosis Fracture, Women, Diet, Incidence, Service Utilisation*.

18. Research summary of STD prevalence study in Tamil Nadu

Author : Voluntary Health Services (VHS)
Source : Report of AIDS Prevention and Control Project
Place of study : Tanjore, Ramanathapuram and Dindigul, Tamil Nadu
Location : Rural and Urban
Period of study : 1995
Type of research : Empirical, Descriptive, Community-based

Aim: To study the community prevalence of STD.

Methodology: The entire state constituted the universe. A multi-stage sampling design was adopted. In the first stage, three districts were randomly selected. In the second stage, a population proportionate sampling of urban/rural clusters was used to select 30 clusters from each of the selected districts. A cluster was defined as a panchayat village or an urban ward as enumerated in the census. In the third stage, fifteen households were randomly selected from each of the clusters to form the unit of the study. All adults, including men and women in the age group of 15-45 years residing in these households formed the study subjects. A total of 20,975 people were examined in the medical camp.

A combination of survey and medical/clinical camp was used for data collection. Careful sampling, necessary pilot-testing and standardisation of medical camps, ethical clearance from the ethics committee mark the study. The HIV results were kept confidential and available only to the database manager.

Findings: The AIDS Prevention And Control Project (APAC) was focused at reducing the sexual mode of transmission of HIV/AIDS, as it is the major mode of transmission in the country accounting for 80 per cent of the HIV infections. The data revealed that most of the people with STDs go to private clinics and only 25 per cent go to PHC facilities. A very few (2% each) get attention at the secondary and tertiary level hospitals in the state. Only 52 per cent of people with STDs go to allopathic practitioners and the rest to who practice alternative system of medicines.

RTIs were very common in the community. Around 32 per cent (men and women included) complained of genital discharge. Vaginal discharge was observed in 42 per cent of women. The overall prevalence of STDs was 15.8 per cent in the community.

These data, according to the author, are very important for developing and implementing programmematic solutions to prevent STDs and HIV transmission an India. Estimates

based on findings of this study show that for a population of 25 million about 2,425,000 people have any one of the six STDs measured in the study; about 1,325,000 people were infected with Hepatitis-B virus and carry the surface antigen; about 450,000 people were infected by HIV.

The programmatic solutions recommended to reduce STDs and HIV in the community include introduction of syndromatic management of STDs at PHC level through integration of RTI/STI; popularising syndromic treatment of STDs among private practitioners, strengthening government STD clinics and STD services; expansion of STD operational research; expansion of HIV diagnosis, support and care services in the rural area; and initiating ELISA (Hbs Ag) screening for high risk.

Key words: *STD Prevalence, Health Care Services*, *HIV/AIDS.*

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HEALTH CARE: ACCESS, UTILISATION AND EXPENDITURE

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
1.	To assess the utilization of antenatal care services in peri-urban area of east Delhi.	1991	**Delhi** Peri-urban	**Empiric Descrip Commu**
2.	To identify the managerial gaps and demographic and cultural factors that affect utilisation of ANC services.	1988	Varanasi **Uttar Pradesh** Rural	Empirica Commu
3.	To study as to why women go in for tertiary level health care facility to meet health care needs.	Not stated	Sevagram, **Maharashtra** Rural	**Empiric Descrip Health based**
4.	To study preferences of the people regarding health care providers in relation to their socio-economic backgrounds. To identify necessary interventions for increasing services to the poorer people.	Not stated	**Gujarat, Maharashtra, Karnataka, Uttar Pradesh & Rajasthan** Rural	Empirica Descript Commu
5.	To conduct a survey of married men with reference to sexual and reproductive health knowledge and behaviour in relation to their own needs and those of their wives.	1995 - 96	**Uttar Pradesh** Rural and Urban	Empirica Descript Commu
6.	To provide state level estimates of family planning practices and to identify these groups in the need of family planning services.	1992-93	***Uttar Pradesh*** Rural and Urban	Empirica Analysis seconda
7.	To investigate and critically analyse health expenditure patterns in India at both the micro and macro levels. Also to evolve a methodology for the study of health expenditure.	1987	Jalgaon **Maharashtra** Rural and Urban	Empirica Descript Commu

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
8.	To determine the health requirements, the unmet need, the level of satisfaction, the problems with the existing health system and ways for its improvement, the paying capacity of the community for such an improvement.	Not stated	Sidhpur **Gujarat** Rural	Empirica Descript Commu
9.	To collect information on the components of household expenditure; and to analyse the relationships between household health expenditure and socio-economic variables.	1991	Sagar & Morena **Madhya Pradesh** Rural and Urban	**Empiric Descrip Commu**
10.	To understand the constraints of pregnancy related referrals.	1993	Dausa **Rajasthan** Rural	Empirica Descript Commu
11.	To collect state level data on practices and services related to mother and child health and family planning.	1992-93	**Nationwide** Rural and Urban	**Empiric Descrip Commu**
12.	To pilot test potential of traditional practitioners to motivate and recruit family planning acceptors in order to increase contraceptive knowledge and use in rural communities; to study the acceptability of traditional practitioners as providers of family planning services.	1984-87	Muzaffarnagar **Uttar Pradesh** Rural	Empirica Descript Commu
13.	To gain an insight into the health status of the people of rural Kerala; to study the associations between health status and socio-economic characteristics of the people, and the utilisation of health care.	1987	***K e r a l a*** Rural	Empirica Descript Commu Health C
14.	To study attitudes of housewives from low economic group towards abortion as a family planning method.	Not stated	Pune **Maharashtra** Urban	Empirica Descript Health C

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
15.	To explore some of the determinants of utilization of selected MCH care services.	1995	Coimbatore ***Tamil Nadu*** Rural	Empirica Descript Commur
16.	To examine the factors associated with utilization of reproductive health services and to understand the factors that differentiate users from non-users of reproductive health services.	1991	Chandrapur **Maharashtra** Rural	**Empiric Descrip Commu**
17.	To examine the pattern and role of practices related to childbirth in some urban ICDS areas.	1989 - 91	Allahabad **Uttar Pradesh** Urban	Empirica Descript Health C
18.	To assess patterns in morbidity reported with and without probing, utilisation of health facilities and expenditure on health care among women in rural and urban Nasik district.	1996	Nasik **Maharashtra** Rural and Urban	**Empiric Descrip Commu**
19.	To evaluate the magnitude and reasons of non-use and unsatisfactory use of contraceptives in the existing rural socio-cultural and obstetric background to enable effective means to tackle the problem of population growth.	1989-90	**West Bengal** Rural	Empirica Descript Commur
20.	To examine characteristics of and services offered by private nursing homes and hospitals in Delhi. To analyse the resort patterns of people from different socio-economic groups and discern the factors that influenced the choice of health care for specific groups of people.	Not stated	**Delhi** Urban	Empirica Descript Health C
21.	To document and analyse perceived morbidity patterns, constraints of women in accessing health care facilities and their utilisation and patterns in expenditure on women's health.	1994	Mumbai **Maharashtra** Urban	Empirica Descript Commur

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
22.	To study nature and type of illnesses suffered by the family members, the system of medicine used and their perceptions about its effectiveness.	1990	*Nationwide* Rural and Urban	Empirica Descript Commu
23.	42nd Round: To assess utilisation of medical services. 52nd round: To study the curative aspects of the general health care system in the country and also the mother and child health care programmes and also the morbidity profile of the population.	1986-87; 1995-96	*Nationwide* Rural and Urban	**Empiric Descrip Commu**
24.	To assess the perceptions and experiences of programme personnel from the district level to the grass-roots level about popularizing reversible methods of family planning in rural areas; to understand the extent of community leaders' knowledge about reversible methods and their perceptions regarding couples accepting them; and to study the knowledge and attitudes of couples toward reversible methods.	1990	Belgaum & Gulbarga **Karnataka** Rural	Empirica Descript Health C Commu
25.	To examine the spatial variations in the gender bias in use of public health care facilities and in relation to the economic development of an areas.	1991	Bhiwani & Kurukshetra ***Haryana*** Rural	**Empiric Analytic Commu**
26.	To present the experience of maternity among lower caste Mukkuwar women and their responses to modern medical management of pregnancy and birth.	Not stated	Kanyakumari **Tamil Nadu** Rural	Empirica Descript Commu
27.	To study morbidity, health care utilisation and health expenditure in details. It covers both treated and untreated illness episodes.	1993	*Nationwide* Rural and Urban	Empirica Descript Commu

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
28.	To study inter-village variations in the practice of family planning by different methods in Orissa; and to study the factors associated with the differential practice of family planning methods.	1982	Cuttack, Ganjam, Kalahandi, Puri & Phulbani **Orissa** Rural	**Empiric Descrip Commu**
29.	To study the utilization pattern of sources of the various treatment by rural women for common maternal and child health problems.	Not stated	Rohtak **Haryana** Rural	Empirica Descript Commu
30.	To bring about an increase in awareness in the use of modern contraception; to reduce the infant and under five mortality rate to below the country's rural average; and to raise the status of women.	1992-95	Kheda ***Gujarat*** Rural	**Empiric Descrip Commu**
31.	To evaluate cost-effectiveness of monthly introductory small cash incentives as a strategy to increase the use of modern temporary methods of contraception among rural Indian women.	1985-91	Thanjavur **Tamil Nadu** Rural	Empirica Descript Commu
32.	To situate reproductive health care in the context of women's perceptions and experiences of illness in general as well as in terms of the material, ideological and political dynamics of household, kin and gender relations.	Not stated	Jaipur ***Rajasthan*** Rural	Empirica Descript Commu
33.	To understand the reasons for the unmet need for family planning; to explore the reasons underlying the gap between intentions to limit fertility and action; and to understand when and how the intentions to limit family size are translated into reality.	1989 and 1995	Bharuch & Panchmahal **Gujarat** Rural	Empirica Descript Commu

HEALTH CARE: ACCESS, UTILISATION AND EXPENDITURE

SELECTED ANNOTATIONS

1. Utilisation of antenatal care services in peri-urban areas of east Delhi

Authors : Aggarwal O.P., Kumar R., Gupta A., et al.
Source : Indian Journal of Community Medicine, 1997
Place of study : Delhi
Location : Peri-urban
Period of study : 1991
Type of research : Empirical, Descriptive, Community-based

Aims: To assess the utilisation of antenatal services in peri-urban areas of east Delhi.

Methodology: The study population consisted of mothers of 276 live born children. The data were collected through a semi-structured, open-ended questionnaire. The survey instruments were pre-tested.

Findings: The findings revealed that 74.3 per cent of mothers had been registered at one of the medical care centres. Of them, 10.8 per cent did not receive tetanus toxoid vaccines, 26.4 per cent did not pay even a single visit during the antenatal period, whereas 23.2 per cent paid five or more visits. Seventy per cent of the deliveries took place at home, of which 81.9 per cent were conducted by untrained village dais. Of all mothers, 27.2 per cent did not receive any iron/folic acid tablets. Mothers who did not registered themselves were mostly illiterate, belonged to the poorer strata, were generally below 25 years of age and had three or more children. Amongst the unregistered mothers, 95.8 per cent delivered at home and had not received iron tablets or TT immunisation.

The study recommends that an attempt be made to register all the antenatal mothers so that they come under the umbrella of the MCH care package for ensuring safe motherhood and better survival of their children.

Key Words: *Antenatal Care, Registration of Antenatal Mothers, Village Untrained Dais.*

2. Managerial gaps in the delivery of ANC services in a rural area of Varanasi

Author : Bhattacharya R. and Tandan J.
Source : Indian Journal of Public Health, 1991
Place of study : Varanasi, Uttar Pradesh
Location : Rural
Period of study : 1988
Type of research : Empirical, Evaluative, Community-based

Aim: To identify the managerial gaps and demographic and cultural factors that affect utilisation of ANC services.

Methodology: This was a case study of Tikri village in Uttar Pradesh with a population of 3,500, distributed in 12 caste-based hamlets. Fifty-two women in the age-group of 15-39 years from 22 households (chosen by stratified random sampling methods) were interviewed. A pre-tested questionnaire was used to record information about various socio-demographic aspects and cultural practices related to pregnancy and childbirth.

Findings: Literacy of the women and their husbands was found statistically significant as were various socio-economic factors affecting the pattern of utilisation. Unlike many other studies, it was found that women living near a health centre do not necessarily utilise ANC services more than those residing far away. This indicated that there are other factors, which influence the utilisation of health services.

The study also showed that 92 per cent of the primigravidae and all the multigravidae did not use the services at all. In the case of the primigravidae, cultural beliefs were very strong and the mother-in-law featured strongly as a general health care provider. Strong beliefs in natural childbirth, coupled with a fear and dislike of hospitals, explained why most of the high-caste families opted for deliveries at home.

Reviewer's note: Though the study was conducted to elicit information on cultural factors affecting utilisation, the report scarcely deals with any cultural beliefs or attitudes of respondents. The term 'case study' has been loosely used. The concept of managerial gap was neither elaborated nor there are any data to refer it.

Key words: *Health Care Provider, Delivery Pattern, Utilisation of ANC Services.*

3. Reasons why reproductive health care seekers sought admission to tertiary level health care facilities in rural central India

Authors : Chabbra S. and Saraf S.
Source : Health and Population – Perspectives and Issues, 1997
Place of study : Sevagram, Maharashtra
Location : Rural
Period of study : Not stated
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To study the perceived reasons for reproductive health care seekers (women) going in for tertiary-level-health care facilities. And thus plan and provide appropriate health care at the centre and appropriate training to nursing students, medical undergraduates and postgraduates.

Methodology: The study was conducted at the Department of Gynaecology and Obstetrics at the Mahatma Gandhi Institute of Medical Sciences, Sevagram. The sample consisted of women, excluding very sick ones, who were hospitalised for reproductive health disorders over a period of six months. The total sample consisted of 1,120 women. Women came from distances ranging from 3-500 kms.

Findings: The most obvious reasons for seeking treatment at the tertiary level - irrespective of the nature of the case, locality, age etc.- were economic, referrals, and the fame of the health facility and expert doctors. The other common reasons were availability of expertise, insurance benefits and appropriate health care. Poor people and illiterates preferred to go to tertiary health care institutions because of economic reasons while the better-off women went because they were referred. This shows that patients come here not by choice but for reasons beyond their direct control.
Reviewer's note: There was no attempt to analyse the findings in the tables presented. The closing discussion bears no relation to the data presented. In the absence of any data on the satisfaction rating of respondents on the kind of treatment received and their perceptions of reasons for seeking treatment from tertiary health care facilities, the study did not meet its stated aims and objectives.

Key words: *Tertiary Level Health Care Facility, Reproductive Health Care, Women.*

4. Factors affecting health seeking and utilisation of curative health care

Author : Chirmulay D.

Source : BAIF Development and Research Foundation, 1997
Place of study : Gujarat, Maharashtra, Karnataka, Uttar Pradesh and Rajasthan
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community-based

Aim: To study the preferences of people regarding health care providers in relation to their socio-economic backgrounds. To identify necessary interventions for increasing services to poorer people.

Methodology: This was a cross-sectional study conducted in five states in selected rural areas. Information was gathered from 3,000 households in each of the study areas. About 90 per cent of all households could be covered. The interview schedule contained questions related to demographic information, the socio-economic status of the household, morbidity in the previous week, morbidity for specific ailments, and type of treatment sought. Qualitative data were collected by anthropologists using interview guides and focus-group sessions on health culture of the area and health-seeking behaviour.

Univariate, bivariate and multivariate analysis were used to understand the utilisation pattern across different socio-economic groups.

Findings: Inability to move and work and loss of appetite or interest in the surroundings were considered indicators of sickness. This perception of 'health' influenced the people's choice of provider and their treatment-seeking behaviour. The perceived quality of services was an important determinant of the pattern of utilisation. Private practitioners were perceived to be providing better services because they included injections as part of every treatment and were willing to make home visits which were convenient, especially where transportation was inadequate. The government heath services were not popular because of the longer waiting period involved, the arrogant attitude and behaviour of all the staff, and non-availability of medicines.

No gender-related differences were noted in the morbidity prevalence and pattern of treatment-seeking. Levels of education in the family, caste, affordability (asset-holding) and culture were the factors which determined the utilisation pattern. In general, those with better levels of education, those belonging to dominant and higher castes, and those with more assets preferred private practitioners. However, in traditional and cultural strongholds, relatively uniform behaviour was observed across caste and economic groups.

Recommendations included improvement of infrastructural facilities at the PHCs, continuing medical education for PHC doctors and ANMs, improving stocks of medicines at PHCs, and a re-evaluation of the links between emoluments and quality of care delivered by medical and para-medical staff.
It is suggested that the image of PHC services in the minds of the community be improved. Programmes to improve the economic condition of poor rural households should go hand-in-hand with the development of health infrastructure. This study (and

there are many others) indicates that we are far short of meeting reproductive health care needs in every sense.

Reviewer's note: This study does not tell us much about the formation of focus groups and their profile/composition. It does not pin-point the respondents from each household, and whether the reported morbidity was proxy. Recording the gender of the respondent is very important if it is proxy data. The absence of gender differentials as regards reported morbidity and treatment-seeking needs to be seen in this light. Concepts such as culture - which has been treated as an independent variable - is not explained.

The suggestion for programmatic inputs to uplift the economic status of poor households is far too broad and general, without any concrete suggestions. Recommendations on improving PHC services are not based on data, as there is no data on these aspects presented anywhere in the paper. Also, there is no analysis on the links between utilisation and these factors. The recommendations seem more general than drawn from empirical data.

Key words: *Utilisation of Health Care Services, Traditional Healers, PHC, Private Practitioners, Socio-economic Status, Tradition, Culture, Gender.*

5. Uttar Pradesh male reproductive health survey 1995 - 1996

Author (contributors) **:** deGraft-Johnson J., Tsui A.O., Buckner B., et al.
Source **:** The EVALUATION Project, Carolina Population Centre, 1997
Place of study **:** Nainital, Aligarh, Kanpur Nagar, Banda and Gonda, Uttar Pradesh
Location **:** Rural and Urban
Period of Study **:** 1995-96
Type of research **:** Empirical, Descriptive, Community-based

Aim: To conduct a probability sample survey of married men between the ages of 15 and 59 with reference to sexual and reproductive health knowledge and behaviour in relation to their own needs and those of their wives.

Methodology: A household survey of 6,727 husbands was conducted. This constituted the second stage of a larger 1995 statewide survey of health and family planning facilities and households, called PERFORM (Programme Evaluation Review for Organisational Resource Management). The PERFORM Survey, a stratified, multi-stage cluster sample survey, interviewed nearly 45,000 married women of childbearing age in 40,000 households; 2,500 fixed-site service delivery points; 6,350 staffers and 22,000 individual health agents in 28 UP districts. The sample of husbands was selected from men meeting the eligibility criteria of being married, living with the wife and falling between the ages of 15 and 59 in all households selected for the PERFORM survey in these five districts.

The various aspects covered in the study were knowledge of and attitudes toward female reproductive issues; knowledge and use of family planning methods; physical accessibility and quality of family planning services; domestic violence; medical and

health expenditure; premarital and extramarital sexual experiences; symptoms of sexual morbidity; gender differences in fertility intention and contraceptive behaviour. The basic analytical categories used were residence (rural/urban), literacy, husband's education, number of children, age of husband, household assets and occupation. As regards reproductive health services the only aspect covered is family planning services. In that it had talked of men's cognitive access and physical access to these services.

Findings: It was found that men's knowledge of FP sources is very high: 98 per cent for any method, 97 per cent for sterilisation, 84 per cent for the pill, 59 per cent for IUD, 91 per cent for condom and 79 per cent for MTP. Distance from FP services and time taken to reach these services were the aspects covered as regards physical access to FP services. The percentage of husbands reporting travel distances above 10 kms are 29 per cent for sterilisation, 27 per cent for MTP, 19 per cent for IUD, 6 per cent for the pill and 4 per cent for condoms. Travel times of 30 minutes or more were reported by 48 per cent of husbands for IUD, 62 per cent for sterilisation, 58 per cent for MTP, 32 per cent for the pill and 25 per cent for condom. As regards follow-up visits, only 39 per cent reported a post-sterilisation visit to the facility and 24 per cent a home visit from a health worker, either for their wives or themselves. Only 12 per cent received a home visit following acceptance of a temporary FP method.

The study also marginally covered the issue of domestic violence: it looked into the type of violence, the period when it started, its frequency, woman's status vis-à-vis pregnancy and un-consensual sex. The survey shows that although some husbands were physically abusive of wives, most were willing to spend on the health care of their wives, children and parents, often to a greater extent than on themselves. Most annual medical/health expenditures were for doctors' fees and medicines/drugs, again with wives and children being the primary beneficiaries.

Men were poorly informed about the female reproductive cycle and signs of pregnancy complications. Infertility problems were largely attributed to the wife. Relatively little spousal communication occurs on unwanted pregnancy. As regards sexual morbidity, 9 per cent report having symptoms currently. The prevalence of STDs (syphilis, gonorrhea, chlamydia or HIV/AIDS) is probably higher than indicated by reported symptoms. These findings suggest that there is a need to improve the existing health care packages/services as regards content (clinical and non-clinical) and outreach/structure.

Reviewer's note: The communication adequately presents the sampling method. Similarly, sharing of the difficulties and ethical dilemmas that may have been faced by field investigators during the conduct of the survey would have been useful for future research given the complexities of the subject at hand.

Key words: *Reproductive Health, Knowledge, Attitude, Practice, Prevalence, Utilisation.*

6. Eight million women have unmet family planning needs in Uttar Pradesh

Authors : Devi D.R., Rastogi S.R. and Rutherford R.D.
Source : Unknown
Place of study : Uttar Pradesh

Location : Rural and Urban
Period of study : 1992-93
Type of research : Empirical, Analysis of NFHS Data

Aim: To provide state-level estimates of family planning practices and to identify those groups especially in need of family planning services.

Findings: For the 1992-93 National Family Health Survey, data were collected by interviewing a representative sample of 11,014 currently married women of reproductive age in Uttar Pradesh. Results showed that nearly half of currently married women in UP had a need for family planning, either met or unmet, for Family Planning. The proportion of unmet needs was highest amongst those who live in rural areas, amongst the illiterate, amongst Muslims, amongst scheduled tribes and amongst those who had either a small or large number of children.

Family planning needs were subdivided into 'need for limiting' and 'need for spacing'. Fifty-five per cent of women in UP with unmet family planning needs had an unmet need for limiting while 89 per cent had unmet needs for spacing. The proportion of need for spacing that was unmet was especially high among women living in rural areas with less education, whether they were Hindus, Muslims or scheduled tribes. The proportion of needs for limiting varied sharply by economic status: it was high among women who lived in rural areas, were illiterate, were Muslims or have at least five living children.

The study points out that the Family Welfare Programme has ample scope for reducing the proportion of unmet needs. It also recommends greater emphasis on spacing methods such as pills and condoms, which would be helpful in improving maternal and child health. As some women prefer to use spacing methods rather than sterilisation to limit their family size, intensified promotion of spacing methods may have the added benefit of reducing the unmet need for limiting.

Key words: *Women, Unmet Need, Family Planning.*

7. Cost of health care: A household survey in an Indian district

Author : Duggal R. and Sucheta A.
Source : Foundation for Research in Community Health, 1989
Place of study : Jalgaon, Maharashtra
Location : Rural and Urban
Period of study : 1987
Type of research : Empirical, Descriptive, Community-based

Aim: This is part of a larger study to investigate and critically analyse health expenditure patterns in India at both the micro and macro levels. It also aimed at evolving a methodology for the study of health expenditure. This report confines itself to a discussion of the findings of a household survey to examine disaggregated health expenditure in terms of various categories of health expenditure and socio-economic differentials.

Methodology: The household survey was a pilot study conducted in one taluka of Jalgaon district. It was a longitudinal study conducted in three rounds during January to June 1987. Each round covered a recall period of one month in each of the three seasons: winter, summer and monsoon.

For the urban sample, six wards were randomly selected from Jalgaon city. For the rural sample, six villages were randomly selected from Jalgaon taluka. Approximately 590 households were canvassed. In the first round, 582 households responded. This number dropped to 525 in the second round, and 522 in the third round. The investigators tried to ensure that in each round they interviewed the same respondents. The data from the three rounds was pooled for analysis.
For the purposes of analysis, a household-level variable called 'class' was created. The class of a household was determined on the basis of the landholding of the main earner, the per capita consumption, and the educational level of its members. Both prevalence and incidence of illnesses had been estimated. Incidence refers only to episodes of illness that started in the reference period, whereas prevalence refers to all episodes that existed during the reference period, irrespective of when they began.

Findings: The morbidity prevalence rate for males was 145 per 1,000 and for females 153 per 1,000 males and females, respectively. Morbidity was highest among the youngest and oldest age groups. It was higher in rural areas than in urban areas. Within urban areas, the slum population had a higher morbidity. Within rural areas, those in remote villages had the highest morbidity. The poorest class reported the lowest morbidity prevalence rate, and the richest class reported the highest. Rich classes reported a greater proportion of acute, minor illnesses.

Health care utilisation: For more than three-fourths of the episodes, private health care facilities were used. Non-utilisation was higher in rural areas. At the same time, utilisation of private care was higher in rural areas. Within urban areas, public facility utilisation was higher among the slum population. Within rural areas public facility utilisation was higher in developed areas. The lowest socio-economic class had the highest non-utilisation rate and the highest public sector utilisation rate.

Health care and expenditure: Fees and medicines together accounted for the major portion of private health expenditure. The cost per illness episode was directly proportional to the level of income and consumption expenditure. The report also looks at indirect costs due to morbidity, in terms of restricted activity and subsequent loss of income.

Also discussed are methodological issues relating to household surveys on morbidity and health care.

Key words: *Household Health Expenditure, Health Care Utilisation, Illness, Prevalence, Incidence*

8. Unmet health needs and paying capacity of the community in Sidhpur area: A focus group-based case study

Authors **:** Gupta R.B., Pulikkal A. and Kurup S.

Source : The Journal of Family Welfare, 1995
Place of study : Sidhpur area, Gujarat
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community-based

Aim: To determine the health requirements of the community, the level of satisfaction with the existing system, the problems with the existing health system and ways to improve it and people's capacity to contribute towards the improvement of health services. To build a database on other related issues in order to develop a self-sustaining health system.

Methodology: The study was conducted by a health intervention agency called Aga Khan Health Services (AKHS). It conducted a benchmark survey and also focus group discussions. This particular communication discussed the results drawn from the qualitative data collected through seven focus groups. The participants were from six different villages from among the 23 villages that constituted the work area. A team consisting of a moderator, documentor and interpreter conducted focus group discussions in order to include the opinions of all the sections of the community. To avoid domination, participants of a particular group were selected in such a way that their background characteristics were similar. Both males and females constituted the focus groups. A tape-recorder was used to record the proceedings.

Findings: Ismailis, the dominant community in the area, constituted about 60 per cent of the sample. They were economically better off than their Hindu counterparts. More than two-thirds of the sample were literate. The average family size was around three children. The majority were agricultural labourers.

Health services in the area were inadequate and of poor quality. The AKHS services, though satisfactory, were inadequate. A full-fledged hospital with diagnostic, curative and maternal care facilities in Sidhpur town, and primary health care facilities at the village level, were the immediate needs of the people. People incurred high health expenditure ranging from Rs 50-2,000 per illness episode, and Rs 600-1,500 for a delivery. Most of this money was spent on transport and doctors' fees. The community, especially the Ismailis, was willing to contribute amounts ranging from Rs 500-10,000 per household, for building and maintaining a diagnostic and curative centre.

The two communities, Hindu and Ismaili, differed in their awareness of health care and the pattern of utilisation. The latter were better informed about preventive health, hygiene and immunisation. This was because of the higher level of literacy and income. The majority of Ismailis sought health care from private doctors as they could afford to pay their fees, unlike the majority of Hindus, who were poor.

Reviewer's note: This approach to effecting improvements in the health care system is built around the premise that the people themselves should take the initiative and contribute to building a sustainable health care system if the public health care delivery system fails. Nowhere is the failure of the public health care system questioned; nowhere is a mechanism to demand accountability articulated. Such experiments are limited in scope. They would not be the solution to the problem.

Key words: *Health Care System, Utilisation, Awareness, Sustainable Health Care System,Paying Capacity, Focus Group.*

9. A study of household health expenditure in Madhya Pradesh

Author : George A., Shah I. and Nandraj S.
Source : Foundation for Research in Community Health, 1994
Place of study : Sagar and Morena, Madhya Pradesh
Location : Rural and Urban
Period of study : 1991
Type of research : Empirical, Descriptive, Community-based

Aim: The study aimed to collect information on the components of household expenditure, and to analyse the relationship between household health expenditure and socio-economic variables. In the process, data on the incidence and prevalence of morbidity and utilisation of health care were also collected.

Methodology: The study was conducted in 770 households in two districts. The households were selected on the basis of the Centre for Monitoring the Indian Economy (CMIE) district-level indicators of economic development. Sagar is one of the better-developed districts of Madhya Pradesh, while Morena is under-developed.

For the urban sample, in the first stage of sampling, the district headquarters and one more town were selected in each district. From each town, two wards were randomly selected. The village where the PHC was located, the village where the sub-centre was located, and the remote village (remote in terms of distance from the PHC) all selected randomly, together made up the rural sample for that district. In the second stage of sampling, households were randomly selected from the wards and villages. In all, 770 households were interviewed.

The survey was conducted in two rounds. The monsoon round was conducted in September 1990, while the winter round was conducted in February 1991. The recall period was one month. Data from both rounds were pooled for analysis. For the purpose of analysis, a variable called 'class' was created. The class of a household was determined on the basis of the landholding of the main earner, the level of per capita consumption, and the educational level of its members. Data on prevalence of morbidity and incidence of morbidity were analysed separately. Prevalence was defined to include all episodes of illness that prevailed during the month of reference, even if the episode began prior to the month of reference. Incidence, on the other hand, only included episodes that began in the month of reference.

Findings: The prevalence rate of morbidity during the monsoon was 365 and 256 during winter. The incidence rate was 195 in the monsoon and 108 in winter. Urban areas registered a marginally higher prevalence rate than rural areas, especially for acute diseases. In rural areas, prevalence was lowest in places that were further away from health facilities. Prevalence was lowest in the two lower classes, and highest in the two upper classes. Higher

classes reported greater prevalence of ailments of the nervous and cardiovascular system. Except for the age group 25-44, in all other age groups, male morbidity was higher than female.

The utilisation of the private sector for health care was 69.5 per cent. Only in 15.7 per cent of the episodes did public health care was sought. Injections were rampantly given.

Nearly three-fourths of the expenditure per episode was on doctor's fees and medicines. The cost per episode was slightly higher in rural areas than in urban areas. Among infants, the expenditure per episode was higher for females than males. Once again, in the age group 25-44, the expenditure per episode was higher for females than for males. In all other age groups, it was higher for males.

Key words: *Household, Utilisation, Expenditure, Health Care, Prevalence.*

10. Perceptions and constraints of pregnancy related referrals in rural Rajasthan

Authors	**:** Hitesh J.
Source	**:** The Journal of Family Welfare, 1996
Place of study	**:** Dausa, Rajasthan
Location	**:** Rural
Period of study	**:** 1993
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To understand the constraints of pregnancy-related referrals.
Methodology: This was part of an action research project. A total of 206 women from 12 sub-centres who were referred for high-level care were picked up from the registers. They were traced back to record their experiences regarding referral services. These women were interviewed in-depth to determine their perceptions regarding the signs of a high-risk pregnancy, and their subsequent referrals. They were also asked whether they availed of referral services or not and reasons for doing so.

Findings: Of the 206 women who were referred for various pregnancy-related high-risk factors, 185 did not avail of the referral. The common reasons cited were unavailability of transport, unsympathetic attitudes of health staff, non-availability of doctors especially female doctors at the referral centres, earlier negative experiences, and expense. The faith of mothers-in-law in traditional healers and inability to understand the need for such care also prevent women from availing of referral services. Interestingly, more than 90 per cent of women who did not avail of referrals stated that the TBA had advised against it. An absence of follow-up was also mentioned as a reason for not availing of referrals. The factors that motivated family members to take the woman to the next level of referral were sound economic status and possession of private transport. Some women also reported that referrals were possible because their relatives offered to take care of their homes and children.

A well-designed IEC programme for family members of pregnant women is recommended. The health system needs to support TBAs. The referral centre must develop a follow-up and feedback mechanism.

Key words: *Utilisation, Referral Services, Determinants.*

11. National Family Health Survey (MCH and Family Planning), 1992-93: India

Author	**:** International Institute of Population Sciences (IIPS)
Source	**:** Summary Report, India, NFHS**,** IIPS, 1995
Place of study	**:** Nationwide
Location	**:** Rural and Urban
Period of study	**:** 1992-93
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To collect data at the state level on a wide range of areas, such as issues related to marriage, contraception, child bearing and child rearing; to estimate the various indicators of health status such as infant mortality rate and maternal mortality; to examine the pattern of health care delivery and utilisation; and to study socio-economic differentials.

Methodology: The National Family Health Survey was a household survey conducted in 24 states and Delhi. Interviews were conducted with a nationally representative sample of 89,777 ever married women in the age group of 13-49. The methodology and questionnaires used were uniform across the country. The sample design adopted in each state was a systematic, stratified sample of households, with two stages in rural areas and three stages in urban areas. The target sample size was set considering the size of the state, the time and resources available for the survey and the need for separate estimates for urban and rural areas. The urban and rural samples were drawn separately and sample allocation was proportional to the size of the urban-rural population. Three questionnaires were used to collect the data - household questionnaire, woman's questionnaire and village questionnaire.

Findings: Fertility continues to decline. The estimated CBR was 28.7 per 1,000 population for the period 1990-92. The TFR was 3.4 children per woman. Child-bearing in India was found concentrated in the age group 15-29. Women on an average marry at around 17 years of age. Overall 29 per cent of women in India have unmet family planning needs. However, 58 per cent of women did not intend to use contraception at any time in the future, indicating the need to have a strong IEC component to motivate couples to use contraception. Utilisation of both antenatal care and delivery services was poor. During the four years preceding the survey, mothers received ANC care for only 62 per cent of births, with substantial urban-rural difference. At the national level only 34 per cent of deliveries were assisted by trained personnel, with wide interstate variations.

The infant mortality rate was 52 per cent higher in rural areas than in urban areas. The infant mortality rate declined sharply with increasing education, ranging from a high rate of 101/1,000 live births for illiterate women to a low of 37/1,000 live births for women with at least a high school education. The maternal mortality rate was estimated to be 437 maternal deaths per 1,00,000 live births. Only 35 per cent of children aged 12-13 months were fully vaccinated, indicating the need for substantial improvement in the vaccination coverage. Ten per cent of children under age four were ill with diarrhoea. Most mothers were not aware of ORS, indicating the need to pay attention to the prevention and treatment of diarrhoea. Inadequate nutrition continues to pose a serious problem. Data show that there is a need to expand nutritional programmes to cover infants and very

young children. Educational attainment showed a strong association with every important variable considered in the NFHS. Data show a sex ratio unfavourable to females, lower female literacy, lower school attendance rate for girls aged 6-14, low level of female employment, relatively low female age at marriage, higher female post-neonatal and child mortality rates, lower immunisation coverage for females, less medical care for female children and preference for sons. All these offer evidence of discrimination against females. These are therefore the areas that need to be addressed in all social development programmes.

Questions regarding knowledge of AIDS, asked in 13 of the 25 NFHS states, indicate that in most states a large majority of ever-married women had never heard of the disease. The findings thus provide a clear indication of the challenges ahead for organisations working in the area of AIDS in providing even the most basic information about AIDS and ways to prevent the spread of the disease.

The data reveal that there were considerable variations across states and communities in all the socio-economic, demographic and health parameters. The data on various indicators show that India had experienced a considerable reduction in crude birth and crude death rates. However, substantial efforts are required to reduce infant and child mortality. India is doing poorly in the provision and utilisation of health care services, including antenatal and intranatal care and immunisation services.

Key words: *Prevalence, Illness, Treatment, Gender, Women, Infant Mortality, Maternal Mortality, Status of Outreach Health Services*.

12. Use of traditional medical practitioners to deliver family planning services in Uttar Pradesh

Authors	**:** Kambo I.P., Gupta R.N., Kundu A.S., et al.
Source	**:** Studies in Family Planning, 1994
Place of study	**:** Muzaffarnagar, Uttar Pradesh
Location	**:** Rural
Period of study	**:** 1984-87
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To test the potential of traditional practitioners in motivating and recruiting family planning acceptors in order to increase contraceptive knowledge and use in rural communities; to study the acceptability of traditional practitioners as providers of family planning services.

Methodology: One PHC block in each intervention and non-intervention area was selected. The two blocks selected were matched with respect to a few key variables, such as number of villages, population size, number of households, eligible couples, traditional medical practitioners, family planning performance of primary health centres and proximity to district headquarters. The sample size consisted of 37 villages and 22 traditional practitioners. The baseline and follow-up (cross-sectional) survey enrolled about 1,850 women in both areas.

The intervention consisted of training 22 practitioners for 11 days. The training emphasised motivational and counselling skills and the use of the cafeteria approach. A

comparison of the pre- and post-training questionnaires revealed a substantial improvement in the knowledge of the trainees. Practitioners received a monthly honorarium of Rs 50. There was no formal mechanism for supervising the intervention. However, the informal monthly meetings between the concerned PHC and district health officials, the practitioners and the project investigators, provided a forum for interaction and discussion, replenishing of stocks and monitoring of records. The meetings also provided opportunities for continuous education.

Findings: The pre-intervention baseline survey revealed the extent of education and counselling required to overcome the inertia, passivity and misinformation prevalent in relation to family planning in these villages. The involvement of traditional practitioners significantly improved knowledge of both permanent and reversible methods. The use rate for both permanent and reversible contraceptive methods increased dramatically. For reversible methods, it was twice as high as for permanent methods. The increased use of contraceptives occurred largely among young couples, particularly among those below 25 years. There was a distinct shift from permanent to reversible methods. Availability of enhanced follow-up services was an invisible advantage. A higher use rate was observed among groups that are traditionally difficult to reach, suggesting that accessibility increases acceptability and indicating that traditional practitioners have the power to influence such groups. Male acceptance of contraception remained untouched. This suggested the need for greater efforts to promote male methods. The majority of women obtained contraceptives from the traditional practitioners.

The author pinpoints some programme areas where positive change is necessary for large-scale
interventions: for instance, a well-organised referral system, a good supervisory system to monitor the work of these practitioners and a mechanism to ensure that the relationship between traditional practitioners and the organised health and family planning infrastructure remains effective.

Key words: *Traditional Practitioner, Spacing Method, Family Planning Services, Male Involvement.*

13. Health and development in rural Kerala

Author	**:** Kannan K.P., Thankappan K.R., Kutty V.R. et al.
Source	**:** Kerala Sastra Sahitya Parishad (KSSP), 1991
Place of study	**:** Kerala
Location	**:** Rural
Period of study	**:** 1987
Type of research	**:** Empirical, Descriptive, Community and Health Centre-based

Aim: Kerala is unique in that it has attained a demographic transition to low death rates and low birth rates, even in absence of widespread economic development. However, it has been postulated that the decrease in mortality has not been accompanied by a similar decrease in morbidity. KSSP conducted this study to gain an insight into the health status of the people of rural Kerala, the associations between health status and socio-economic characteristics of the people, and the utilisation of health care.

Methodology: The health survey was conducted in two parts. One was a household survey conducted in all the villages of the state in July 1987. A random sample was drawn from the villages under each panchayat. The recall period used was two weeks. The second part of the survey involved a census of health care institutions in all the panchayats and municipal areas of Kerala during the latter half of July 1987. Only 68 per cent of the total area could be covered in this census.

For the purposes of analysis, all households were categorised according to their socio-economic status (SES) and their environmental status (ENS). The SES was calculated on the basis of per capita income, household land ownership, household educational status and housing condition. The environmental status was determined on the basis of source of drinking water, sanitation facility, cooking device, waste water disposal, solid waste disposal, and cleanliness in the immediate surroundings of the house.

Findings: Morbidity prevalence rate for acute illnesses was 206.3 and for chronic illnesses 138.1. The study showed that the morbidity rate in Kerala (as measured by the KSSP study) was higher than the all-India average (as seen in the NSS surveys). The authors suggest that the remarkable decrease in Kerala's mortality statistics has been a result of medical interventions preventing death, rather than effective prevention of disease. Poverty had not decreased, nor had sanitation or drinking water facilities improved. Thus, communicable diseases continue to prevail. On the other hand, there had been a shift in Kerala's demographic structure, with a higher proportion of adults and aged than the all-India average. These groups are more susceptible to chronic degenerative diseases, and thus Kerala's morbidity statistics were high on this count as well. Thus, Kerala had a high prevalence of communicable diseases such as fever and diarrhoea, as well as chronic diseases such as bone and joint ailments, hypertension.

Class: Both acute and chronic illness prevalence rates decrease with an improvement in socio-economic status (SES). The decrease in chronic illness prevalence rates was not as marked as for acute illnesses. Presumably this was because the lower classes suffer chronic illnesses related to poverty - such as tuberculosis - whereas the higher classes suffer chronic illnesses related to affluence, such as hypertension and diabetes. As expected, with an improvement in environmental status (ENS) also, there was a decrease in the morbidity prevalence rate.

Gender: The prevalence of chronic illnesses was higher among females than among males. Compared to men, women were less likely to suffer from tuberculosis, heart disease, peptic ulcers, and diabetes. However, they showed a higher tendency to suffer from hypertension, and bone and joint ailments.

Cost of treatment: There was a positive relation between the cost of treatment and the socio-economic status of the patient. For those in the lower SES, the share of transportation in the cost of treatment was much higher than for the higher SES.

The authors also suggest that the fact that each household was interviewed by an investigation team of three members including one female investigator, and the fact that the survey was conducted in the monsoon, when communicable diseases are most prevalent, may have caused an upward bias in the reporting of morbidity.

Key words: *Prevalence, Morbidity, Cost, Treatment, Gender.*

14. Abortion for family planning: Attitude of housewives of low income group towards abortion for family planning

Author : Kanitkar S.
Source : Unpublished
Place of study : Pune, Maharashtra
Location : Urban
Period of study : Not Stated
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To study attitudes of housewives from low economic groups towards abortion as a family planning method.

Methodology: A questionnaire was administered to 150 women who underwent MTP at the out-patient's department, at the Family Planning Association of India (FPAI) hospital, Pune. Information was gathered on age, income, occupation, education of husband and wife, number of living children and their sex, use of contraception, if any, attitudes about MTP as a family planning method, reasons for MTP, decision-making and psychological post-abortion consequences.

Findings: Of the 150 interviewees, 133 considered MTP a family planning method. Sixty-five (64 tubectomies, 1 vasectomy) underwent sterilisation. The rest (85) opted for CuT. The majority of them (65 of the 80) said that they wouldn't like to go for MTP again. Of those sterilised, most (53) already had a family with the desired number of members and the rest (12) said they were not able to afford more children. Thirty-seven of the 85 seem to have opted for MTP as a spacing method while another 27 were waiting for living children to grow up before they went in for sterilisation. Ten gave economic reasons and only nine underwent MTP on account of failure of contraceptive used. In 115 cases partners had jointly decided on MTP and in 20 cases, it was the woman who decided on her own. Mental relief after MTP was expressed by all. Of the total, 119 couples had used some contraceptives in the past. Discontinuation on account of dissatisfaction with them resulted in these pregnancies. The author highlights the social sanction and family approval for MTP while discussing the results. The author advocates the provision of safe abortion services in remote areas of India to help check population growth and meet the needs of maternal child welfare.

Key words: *MTP, Family Planning.*

15. Utilisation and determinants of selected MCH care services in rural areas of Tamil Nadu

Authors : Kavitha N. and Audinarayana N.
Source : Health and Population – Perspectives and Issues, 1997
Place of study : Coimbatore, Tamil Nadu
Location : Rural

Period of study : 1995
Type of research : Empirical, Descriptive, Community-based

Aim: To explore some of the determinants of utilisation of selected MCH care services, such as antenatal (antenatal check-up and iron and folic acid tablets), natal (place of delivery) and postnatal (check-up) health care services in rural areas of Tamil Nadu.

Methodology: The sample consisted of 134 currently married women with at least one living child less than four years of age from two villages/district. Information was gathered on 172 live-born and currently living children. Data on still births and children who died before the date of the survey were not collected, so that women did not get emotional and affect the quality of the response and also the overall response rate.

Caste, respondent's education, spouse's education, respondent's work status, monthly family income, exposure to mass media and number of living children were treated as explanatory variables. Logic regression coefficients were estimated with 't' values. Also, probabilities were estimated for each of the dependent variables.

Findings: Woman's educational level had a positive influence on the utilisation of antenatal and natal services. Women from higher castes were also more likely to avail of antenatal and postnatal care. Women belonging to non-SC communities and of lower parity utilised the postnatal check-up services more than women of scheduled castes and higher parity. Monthly family income had a positive influence on postnatal care. Use of antenatal services had a positive effect on the place of delivery. Interestingly, working women (mostly engaged in agriculture and weaving) were less likely to utilise antenatal services than non-working women.

In conclusion it was suggested that education in general and female education in particular must be encouraged in rural areas. Adult education and social education could be used as vehicles for this purpose. Village-level meetings to interact with women, educate them and clarify issues related to MCH care were recommended.

Reviewer's note: It would have been interesting to know the nature of women's work which prevented them from seeking antenatal care as compared to non-working women. The characteristics of the health care system would constitute another set of explanatory variables, which were not taken into consideration in this analytical framework.

Key words: *MCH, Utilisation, Socio-economic Determinants, Exposure to Mass Media.*

16. Utilisation of reproductive health services in rural Maharashtra

Authors : Khan A.G., Roy N. and Surender S.
Source : The Journal of Family Welfare, 1997
Place of study : Chandrapur, Maharashtra
Location : Rural
Period of study : 1991

Type of research **:** Empirical, Descriptive, Community-based

Aims: To examine the factors associated with utilisation of reproductive health services in rural Maharashtra and to understand the factors that differentiate users of reproductive health services from non-users.

Methodology: A two-stage stratified random sampling of villages with and without health facility was done. Two hundred and thirty-five women with at least one child between one to two years of age were interviewed.

Findings: Only 13 per cent of illiterate women had utilised the overall reproductive health services. This increased with the educational status of women. The husband's educational status was more likely to influence the woman's utilisation of reproductive health services. Variables like the economic status of the family, type of family and caste did not influence utilisation patterns. Neither age nor loss of child influenced utilisation patterns that, however, were associated with increasing parity.

The study finds that utilisation of services was not influenced by village development factors like population size, proximity to a town, literacy levels etc. Programme-related factors like the health worker's visits to the village also did not influence utilisation of services. However, the family's views on the programme did favourably influence utilisation of services.

The study concludes that knowledge of health services does not by itself increase its utilisation. The authors recommend the need to involve husbands in reproductive health care as well as to extend the services especially to primiparous women.

Reviewer's note: Nowhere in the communication 'reproductive health' is defined.

Key words: *Reproductive Healtb Services, Utilisation, Users, Non-users, Associated Factors.*

17. Childbirth practices among women in slum areas

Author **:** Khandekar J., Dwivedi S., Bhattacharya M., et al.
Source **:** The Journal of Family Welfare, 1993
Place of study **:** Allahabad, Uttar Pradesh
Location **:** Urban
Period of study **:** 1989-91
Type of research **:** Empirical, Descriptive, Health Centre-based

Aim: To examine the pattern and role of practices related to childbirth in some urban Integrated Child Development Scheme (ICDS) areas of Allahabad.

Methodology: Thirty-five centres were chosen randomly out of a total of 100 centres. Each centre caters to an approximate population of 1,000. All the pregnant women registered at the selected Anganwadi centres during the course of one year formed the study population. In all, there were 661 women. Each Anganwadi centre was visited on a

fixed date every month to interview mothers who registered at the centre during each month.

A pre-tested schedule was administered. A detailed history of past illnesses including obstetric problems, family history of diseases, information about tetanus toxide immunisation during the antenatal period, and childbirth practices including the type of instruments used at the time of delivery were obtained.

Findings: All the women were permanent residents of the area and were mostly from the lower socio-economic group. Women undergoing their second or third delivery utilised these services the least. More primiparas as compared to others had been immunised. Almost two-fifths of the women had delivered at home while the rest utilised public or private hospitals. Untrained personnel, irrespective of parity, conducted the majority of the births. Those who utilised trained persons for delivery were by and large primiparas. Awareness of the pregnant woman and the need for trained birth assistance were greater among women with educated husbands. Among the deliveries assisted by trained personnel, the perinatal mortality rate was 67.4 per 1,000 live births. It was 154.8 per 1,000 live births in the case of untrained assistance.

The majority of the slum-dwellers surveyed had no faith in hospitals. They preferred to trust the untrained dai who belonged to the same socio-cultural milieu. The unhygienic practices of untrained persons were attributed to ignorance, illiteracy and lack of education of the dais and family members. The complications occurring during delivery clearly show the inability of untrained persons to identify 'high-risk mothers'.

In conclusion it is stated that untrained dais play an important role in the provision of natal care in urban slums. It is essential to train them to make these services acceptable and safe.

Key words: *Natal Care, Untrained Dais, Training, Urban Slums.*

18. Health, households and women's lives: A study of illness and childbearing among women in Nasik district, Maharashtra

Author : Madhiwalla N., Nandraj S. and Sinha R.
Source : Centre for Enquiry into Health and Allied Themes, 2000
Place of study : Nasik, Maharashtra
Location : Rural and Urban
Period of study : 1996
Type of Research : Empirical, Descriptive, Community-based

Aim: To assess patterns in morbidity as reported with and without probing, utilisation of health facilities and expenditure on health care among women in rural and urban Nasik district.

Methodology: Nasik district was selected for the study because it is an averagely developed district as far as the socio-economic and demographic profile of the rest of the state is concerned. Within the selected district, Igatpuri taluka was selected for its sizeable tribal and non-tribal population. The rural sample consisted of 903 households from Igatpuri taluka, while the urban sample consisted of

382 households from Nasik town. In all, data were collected for 3,581 women and 3,631 men.
Only women investigators were used, and only women respondents were interviewed. A list of 14 questions probing specific symptoms was administered to collect information on indications of illness among the women that might not otherwise be reported. Since multiple symptoms could be indicative of the same illness episode, the researchers devised a method of constructing episodes on the basis of up to three symptoms, as well as the duration and perceived causes of the symptoms, and the link of a symptom to a life event. The reference period for questions on morbidity was one month prior to the interview.

Findings: The morbidity among women was higher than that reported in earlier household surveys. The morbidity rate for females was found to be 812 per 1,000 and for males it was 307 per 1,000. The morbidity rate for females was so high, mainly because of the probing. The important categories of illness for women were fevers and respiratory illnesses, followed by reproductive illnesses and aches and pains. General aches, pains and weakness were also a significant category. The pattern of morbidity among women showed links to their living environment (air, water, food), work, childbearing and contraception.

Socio-economic status: Morbidity was highest among those who were the sole women in their household. It was relatively high among scheduled caste women, and unskilled non-working women.

The relationship between access to health care and reported morbidity: Women who had easier access to health care facilities (in terms of distance to the facility) reported higher morbidity.

Health care utilisation: Utilisation of health care by women was low. Forty-five per cent of the episodes were not treated. Many women resorted to informal care. Home remedies constituted 15 per cent of the services whereas self-medication constituted 11 per cent. Use of informal care was higher among urban than rural women. In urban areas women sought treatment for 49 per cent of the episodes reported by them and used 21 informal facilities for every 100 episodes. In contrast, rural women sought treatment for 57 per cent of the episodes and used 15 informal facilities for every 100 episodes. 'Dependent' women – unmarried girls and aged women – used more health care per episode than women who were heads of the household or wives of male heads. In general, women from deprived groups – women from remote villages, scheduled castes and urban minority communities – did not receive health care for a large proportion of their illnesses.

Type of health care facility used: In rural areas, 24.2 per cent of all facilities used and 30.3 per cent of the formal facilities used by rural women were government facilities or home-based care provided by government paramedics. In urban areas, 10 per cent of the total facilities and 17.3 per cent of formal facilities used were public sector services. Certain types of illnesses, such as aches/pains, injuries, weakness and problems of the sensory organs were mostly treated in the informal sector. Whereas other illnesses such as fevers and gastrointestinal infections were treated mostly in the formal sector. Health care utilisation was related to the nature of illness. Long-term illnesses were not treated as frequently as short-term infectious illnesses.

The perceived efficacy of treatment was an important factor in determining the use of health care. For long-term illnesses women adhered to a mode of treatment which gave them partial relief if not complete cure. For 12.4 per cent of the episodes treatment was not sought because health facilities were either not accessible or inadequate.

The expenditure on health care showed trends corresponding to the utilisation of health care. Expenditure per episode, per capita and per facility in the rural areas was higher than urban areas. Among the components of expenditure, doctor's fees, the cost of medicines and injections comprised the major part of out-patient expenditure. There was a considerable difference in the expenditure incurred on men and women in each facility.
The findings on maternity events and contraception revealed the low access to health care for rural women. Untrained personnel conducted around 70 per cent of the deliveries in rural areas and 33 per cent in urban areas. Only 38 per cent of the deliveries were followed by postnatal care; the percentage was higher in urban areas as compared to rural areas. Public centres were primarily used for postnatal care due to immunisation facilities. Contraceptive services were overwhelmingly accessed from the public sector, except for medical shops where oral contraceptive pills were bought.

At the end, the study raises various key issues on ways to improve women's health. The study also highlights various problems in the provision of public health services: the hierarchical structure of the services and the high dependence of directives from above which allows village-level workers no autonomy to decide the priorities and programmes for the village. Health workers complained of a paucity of equipment, drugs, and most importantly, lack of referral back-up. The health workers were of the view that all these factors lead to people losing faith in the public health system. The near-total dependence on private services clearly had a negative impact on poor women who were driven out by their inability to purchase services. It was evident that the withdrawal (or absence) of the public sector was resulting in greater neglect of poor women's health needs.

Reviewer's note: It needs to be noted that the data were both self reported and proxy. However, the analysis remained aggregated. Disaggregated data would have given a better picture.

Key words: *Prevalence, Illness, Cost, Treatment, Gender, Women, Utilisation, Expenditure.*

19. Non-use, unsatisfactory use and satisfactory use of contraceptives

Authors : Mondal A.
Source : Journal of Obstetrics and Gynaecology, 1992
Place of study : West Bengal
Location : Rural
Period of study : 1989-90
Type of research : Empirical, Descriptive, Community-based

Aim: To evaluate the magnitude and reasons of non-use and unsatisfactory use of contraceptives in the existing rural socio-cultural and obstetric background, to enable effective steps to tackle the problem of population growth.

Methodology: It was a random survey of 340 women, which included users, non-users and unsatisfactory users of contraceptives at a PHC (Baduria) and two adjoining villages. Socio-cultural and obstetric histories were taken. Information on the use of contraceptives was sought.

Findings: Out of 340 females, 164 did not use contraceptives and 54 were unsatisfactory users (irregular/<6 months). Early marriage, high parity, frequent childbirths and lower acceptance of MTPs were the factors leading to non-use of contraceptives. These women were mostly illiterate, or had minimal education and belonged to the lower socio-economic classes. Of them, 42.7 per cent were ignorant about contraception and 39 per cent were non-serious. A consistent proportion ($1/5^{th}$ to $1/6^{th}$) were unsatisfactory users irrespective of age, religion, distance, occupation, education and socio-economic status. The findings suggested that one-time motivation of non-users (61%) and unsatisfactory users (81%) increased acceptance of contraceptives and sterilisation. The study recommended long-term measures directed towards socio-economic uplift and short-term measures directed towards identification and health education of non-users and unsatisfactory users keeping in mind the underlying causes for increased contraceptives, MTPs and sterilisation.

Reviewer's note: The authors categorise women with contraceptive use of less than six months as 'unsatisfied users' but have not specified the cause of discontinuation of contraceptive use. The concepts such as socio-cultural and socio-economic are not defined. Besides, analysis does not deal with 'socio-cultural' aspects as stated in the objectives.

Key words: *Contraceptives, Users, Non-users, Socio-cultural Context.*

20. Private nursing homes and their utilisation: A case study of Delhi

Authors : Nanda P. and Baru R.
Source : Health for the Millions, 1994
Place of study : Delhi
Location : Urban
Period of study : Not Stated
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To examine the characteristics and services of private nursing homes and hospitals in Delhi. To analyse the resort patterns of people from different socio-economic groups and to discern the factors that influenced the choice of health care for specific groups of people.

Methodology: Sixty-five private nursing homes of varying sizes (in terms of number of beds) were selected through stratified random sampling for an in-depth study. To get an insight into utilisation patterns, 171 users from different socio-economic groups were interviewed at two government hospitals, private nursing homes and a resettlement colony.

Findings: The study reveals that there were about 1,300 nursing homes and 7,000 qualified private doctors in Delhi. Of the 65 nursing homes studied, only 22 (34 %) were registered. The low level of registration of nursing homes implies that difficulties in implementing regulatory systems and prescribing minimum standards. Nearly 65 per cent of the owners had been in government service, which according to other studies was a means to build professional and social contacts to help themselves establish their private practice. The percentage of promoters from business background increased in proportion to the size of the establishment. The authors note with concern the increasing 'corporatisation' of medical care services in Delhi.

On an average consultant doctors were paid a salary between Rs 3,000-5,000; nurses were paid between Rs 1,000-1,700; technical staff Rs 900-1,200 and ayahs Rs 500-800. All employed at least one consultant doctor. In most husband-wife teams, the women doctors were found to be gynaecologists. According to the doctors, there was a high turnover of nurses because they are often lured away by better salaries. The 'A' grade nurses prefer the public sector because of job security and other benefits.

The majority of the owners ranked 'outpatient services' as the area of highest return, the second being 'maternity services' and the third general surgery and investigative facilities. The areas of return varied according to the size of nursing homes. Nearly 98 per cent of the nursing homes offered outpatient services, maternity and general surgery. Seventy-five per cent had ultrasound facilities and 63 per cent had X-ray, ECG, EEG facilities. Close to 50 per cent of the large nursing homes had scans. The larger the size of the nursing home, the greater the chances of an attached pharmacy.

A fairly large percentage resorted to allopathy, but other systems were also used in combination with allopathy. The income level and type of ailment influenced the choice of provider. Utilisation patterns showed that the private sector was preferred for minor ailments while the government sector was preferred for hospitalisation for maternal services and surgery, especially for the lower-income groups. The attitude of nurses, time spent with the doctor and quality of services influenced the satisfaction levels of users. It is, therefore, crucial that funds for government hospitals are not cut indiscriminately.

The study also revealed the haphazard growth of medical services in Delhi – both public and private services were concentrated in certain pockets, while large parts of Delhi remained poorly serviced.

One of the major points for policy consideration is that the Delhi Nursing Home Act of 1953 with amendments in 1992 needs to be revised to improve effective monitoring of the growth and quality of services. National-level policies are also required for regulating and monitoring the private sector.

Key words: *Private Health Care Facilities, Human Power, Choice of Provider, Determinants, Utilisation, Quality of Care..*

21. Women and health care in Mumbai: A study of morbidity, utilisation and expenditure on health care in the households of the metropolis

Author	**:** Nandraj S., Madhiwalla N., Sinha R., et al.
Source	**:** Centre for Enquiry into Health and Allied Themes, 1998
Place of study	**:** Mumbai, Maharashtra
Location	**:** Urban
Period of study	**:** 1994
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To document and analyse perceived morbidity patterns; constraints of women in accessing health care facilities and their utilisation; and patterns in expenditure on women's health.

Methodology: The study was conducted in the L ward of Greater Mumbai city, a congested pocket with residential units as well as small-scale factories and commercial establishments, poor sanitation, insufficient water supply, acute noise and air pollution. The majority of the population consisted of migrant labourers and entrepreneurs. The survey was conducted in five clusters - two slums, two chawls and one apartment block. The selection of the clusters was on the basis of their 'class character'. The predetermined sample size was 425. House listings were done in the identified clusters. Households were identified for survey through systematic sampling. In all, 430 households were covered in the study.

The data were collected through interview schedules. Since women were the focus of the study, female investigators conducted the interviews, and the respondents were all women. A 'probe list' - a list of 14 symptoms - was used to probe the existence of specific symptoms among women which might otherwise go unreported. Each symptom reported after probing was recorded as an independent episode. During the survey a conducive environment was created which would encourage women to feel unhindered to speak about their health problems.

Findings: The monthly prevalence rate for males was 169 per 1,000 as compared to 571 per 1,000 for females after probing. Reproductive illness accounted for 28.2 per cent of all episodes among females, the majority of them being related to menstruation and child-bearing. The findings point to a strong relationship between women's work lives and their health. After probing, women had a higher morbidity rate than men across all age-groups. Slum-dwellers suffered higher morbidity than non-slum-dwellers in each age-group, gender group and occupation group.

Of the total illness episodes, 32.5 per cent were not treated. For 85 per cent of the illness episodes, private facilities were used. With regard to deliveries the public sector accounted for only 30 per cent, as compared to the private sector which accounted for 31.7 per cent. All the three abortions reported utilised private facilities. Only 38 per cent of the total contraception users utilised public facilities. There was a wide disparity in the utilisation of public health facilities at different levels. In that, tertiary hospitals were

overloaded, the first referral systems like health posts were underutilised. Utilisation of the formal health sector was lower among women than men.

Access to health care facilities in terms of distance and who provided health care were major factors which influenced utilisation. In case of nearly two-thirds of the illness episodes, health facilities with less than 10 minutes distance from home were approached.

Among women, fevers, respiratory and gastrointestinal illnesses were treated more than reproductive
illnesses. Unwell men received equal treatment irrespective of age, whereas among women, those in the age-group of 0-11 years have a higher number of treated illnesses. The study doesn't show any direct impact of education on health-seeking behaviour.

The most common reason given for non-treatment of an illness was that the illness was not serious enough to be attended to. Financial constraints were also an important reason for non-treatment, more so for women than for men.

Expenditure on women's health care was lower than on males. For those illnesses that were reported only after probing, expenditure was generally lower than for the other illnesses.

The findings of the study raise the issue of non-utilisation of health services, especially by women, both for deliveries and other illnesses, even in a metropolitan city like Mumbai which has better public health facilities as compared to other parts of the country.

Key words: *Prevalence, Morbidity, Utilisation, Expenditure, Women, Gender Differentials.*

22. Household survey of medical care

Author	**:** National Council for Applied Economic Research (NCAER)
Source	**:** NCAER, New Delhi, 1992
Place of study	**:** Nationwide (Major States & Union Territories)
Location	**:** Rural and Urban
Period of study	**:** 1990
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To study the nature and type of illnesses suffered by family members, the system of medicine used and their perceptions of the efficacy of the systems used.

Methodology: The study was based on an all-India survey which covered both rural and urban areas in all States and Union Territories except Manipur, Nagaland, Sikkim, Tripura, Arunachal Pradesh, Andaman and Nicobar islands, Dadra Nagar Haveli, Lakshadeep and Mizoram. In all, 371 districts were covered. The sample was a multi-stage stratified sample. For the rural sample, two-five villages per district were selected, with a probability of selection equal to the proportion of the population of that village in the district
population. In all, 1,061 villages were selected. All the households in the village were

listed, and then classified according to level of income. Households were then randomly selected from each income slab.

For the urban sample, all 41 cities of the country with a population of above 5 lakhs were included. The remaining cities/towns were classified into five strata on the basis of population size, and a random sample was taken from each stratum. The 632 cities and towns selected covered 61 per cent of the total urban population. A sample of blocks was selected from each sample town depending on the size of the town. A total of 1,873 blocks were selected. The blocks were selected independently for each town with equal probability. All households in the selected block were listed, and households were randomly selected from each income slab.

Findings: *Morbidity pattern:* The prevalence rate of treated illnesses for the country as a whole was found to be 67.70 episodes in urban areas and 79.06 illness episodes in rural areas per 1,000 population. Some of the states which reported a higher rate of illness than the all-India average were Assam, Jammu and Kashmir, Kerala, Meghalaya and Pondicherry. In almost all the states the reported prevalence rate of illness for which treatment was sought worked out lower for the females than males for both adults and children up to the age of 14 years. This sex differential in morbidity probably showed the extent of under-reporting of illness by females and lack of medical attention during illness.

In almost all the states the prevalence rate declined from the low- to the high-income category, thus suggesting that people belonging to the lower-income group were more susceptible to various illnesses, perhaps due to poor living conditions and lower nutritional status.

Type of morbidity: Fever was the most common ailment treated, followed by illness due to respiratory and gastrointestinal infections. There was not much difference in the pattern of illness by place of residence (rural and urban).

System of medical treatment received: Eighty per cent of the illness episodes in the urban areas and 75 per cent of the cases in rural areas were treated under the allopathic system of medicine. The percentage of cases for which allopathic treatment was sought was slightly higher in high-income households, especially in rural areas.
Compared to other systems of medical care, people perceive the allopathic system to be more effective. Nearly 60 per cent of the cases treated by the allopathic system of the households felt that the treatment was fully effective. A surprising finding was that a large number of cases (75% in urban and 65% in rural) where the households resorted to only self-medication they expressed a feeling that the treatment was fully effective. The possible explanation of this finding could be that self-medication was resorted to only for minor treatments. In small proportion of cases, the household's felt that 'rituals' were fully effective.

Type of health care facility: In 55 per cent of illness episodes treatment was sought from private facilities, whereas for 33 to 39 per cent of cases treatment was sought from government facilities. There were wide variations across states regarding the type of health care facility utilised. With the increase in the income level of households the dependence on state health care decreased in both rural as well as urban areas. The study shows the preference for private doctors in case of minor ailments. The primary health centres and sub-centres catered to 8.2 per cent of the cases in rural areas.

As regards physical accessibility to health care facilities, it was found that people residing in rural areas had to travel longer distances as compared to their urban counterparts. This increased the average cost of treatment of illnesses. For 54.6 per cent of cases in Meghalaya and 33.5 per cent of cases in Orissa, people had to travel more than 10 kms to seek treatment.

Household expenditure on health care: In urban areas the average cost of treating each illness episode was Rs 142.60 as compared to Rs 151.81 for rural areas. The study reveales that there exists a gender preference in favour of males in the treatment of illness episodes. This gender discrimination was more prominent in the urban areas of Haryana, Karnataka, Meghalaya, Orissa, Punjab and Tamil Nadu and in rural areas of Punjab and Rajasthan. The average expenditure of treatment was high under the allopathic system followed by the homoeopathic system of medicine. The study also provides average expenditure by types of diseases. The data showed that urban households spend a lot in treating accident cases, whereas in rural areas the average expenditure on treatment of degenerative diseases was as high as Rs 776.23. The average expenditure on treating respiratory illnesses was quite low in both rural and urban areas.

Key words: *Prevalence, Morbidity, Health Care, Utilisation, Out-of-pocket Expenditure.*

23. NSS 42nd Round (1986-87); NSS 52nd Round (1995-96)

Author	**:** National Sample Survey Organisation (NSSO)
Source	**:** Department of Statistics, Government of India, 1992 &1998
Place of study	**:** Nationwide (Major States & Union Territories)
Location	**:** Rural and Urban
Period of study	**:** 1986-87; 1995-96
Type of research	**:** Empirical, Descriptive, Community-based

Aim: *42nd Round:* To make an assessment of utilisation of medical services.

52nd round: To study the curative aspects of the general health care system in the country; and mother and child health care programmes. To study the morbidity profile of the population.

Methodology: The NSS surveys are carried out in successive 'rounds'. Each round is of approximately one-year duration. Questions on morbidity were first asked in the seventh round of the NSS, in 1953-54. Subsequently three other surveys included morbidity as a topic. Thereafter, surveys on social consumption and morbidity were conducted in the 42nd round (1986-87), and in the 52nd round (1995-96).

Much of the data had been collected from proxy respondents which might understate the actual level of morbidity. The tools for data collection were modified in the 52nd round to collect variations in responses and avoid misreporting.

The NSS 42nd round: The survey covered the whole of India except for a few areas of Jammu and Kashmir and Nagaland. A two-stage stratified sampling design was adopted. In the first stage villages and blocks were selected in rural and urban areas respectively, and in the second stage households were selected. The sample villages were selected with probability proportional to population with replacement in the form of two independent inter-penetrating sub-samples (IIPNS). The sample blocks were selected by simple random sampling without replacement in the form of IIPNS. The survey was conducted in a sample of 8,346 villages and 4,568 urban blocks. Two households from each village/block were selected through stratified random sampling.

The NSS 52nd round: The survey covered the whole of India except for a few interior areas of Jammu and Kashmir, Nagaland and the Andaman and Nicobar Islands. A two-stage stratified sampling design was adopted. The census villages and urban blocks were selected for rural and urban areas respectively as the first stage and in the second stage the households were selected. The survey was conducted in a sample of 7,663 villages and 4,991 urban blocks. Ten households from each village/block were selected through stratified random sampling. In the 52nd round, an equal probability sampling scheme for villages was used, instead of the usual NSS practice of selecting villages with a probability proportional to their population.

The data was collected through household interviews. As far as possible, all adult male members of the household were interviewed. Probes were used to gather information about the illnesses that might have occurred in the household. The recall period used was 15 days.

Findings:

The NSS 42nd round: The prevalence rate of hospitalisation was 28 per 1,000 persons in rural areas and 17 per 1,000 persons in urban areas. The male-female ratio among hospitalised persons was about 56:44, both in the rural and urban sectors. The preference for treatment as an in-patient in a public hospital over other types of hospitals was observed in most of the states except Andhra Pradesh, rural Kerala, Maharashtra and rural Punjab, where private hospitals were given preference. The data reveal that the allopathic system of medicine was used in more than 98 per cent of hospitalised cases in both rural and urban areas. At the national level, the percentages of hospitalised cases under the 'no payment' and 'employers' medical welfare scheme' categories were observed to be 23 and 6 respectively in the rural sector as against 20 and 13 in the urban sector. The average payment made to government hospitals was Rs 320 per case as against Rs 733 for private hospitals in the rural sector. The corresponding figures for the urban sector were Rs 385 and Rs 1,206 respectively.

It was observed that the number of days spent in government hospitals was more than in private hospitals for both the rural and urban sectors of India. The average number of days spent in hospital per hospitalised person was about 16 and 15 days respectively in rural and urban areas. The average total expenditure was Rs 853 in rural areas as against Rs 1,183 in urban areas. The average payment to hospital or total expenditure per hospitalised case varied considerably over the type of hospital, type of ward and also over the rural and urban sectors of states.

The proportion of ailing persons in the rural sector was higher than in the urban sector of the country. The proportion of persons with ailments treated was found higher among males than females in the bottom expenditure groups, while a reverse pattern was observed in the higher expenditure groups.

In rural India, about 53 per cent of treatment was availed of from private doctors while public hospitals and private hospitals accounted for 18 per cent and 15 per cent respectively. The corresponding percentages for urban India were 52, 23 and 16 respectively. The allopathic system of medicine was used to treat 96 per cent of cases in both urban and rural areas. At the national level the average duration of sickness treated was nearly the same irrespective of the type of institution or the place of residence.

In rural areas the major causes for not seeking treatment were - the ailments were not considered serious (75%), financial difficulties (15%) and no medical facility (3%). In urban areas the major causes for not seeking treatment were - the ailments were not considered serious (81%), financial difficulties (10%) and no medical facility (less than 1%).

The NSS 52nd round: The data show that the gender-specific estimated proportion of ailing person (PAP) for acute ailments was about three times as high as that for chronic ailments. For both rural and urban areas, age-specific PAPs for acute ailments showed a distinct U-pattern and positively sloped pattern for chronic ailments. The data show that people aged 60 years and above were more prone to ailments.

There was no significant difference between rural and urban areas as far as ailing persons reporting commencement (PPC) was concerned. This may be due to a higher level of health consciousness in urban areas as compared to rural households with the same level of morbidity leading to higher illness reporting. The data show large interstate and intrastate variations in PAP and PPC.

An analysis of data from Kerala shows that, contrary to popular perception, the level of morbidity is relatively high. One of the reasons for this may be that with better health care facilities in the state, there is a large proportion of the population aged 60 years or more (9.4%) and this segment is more prone to illness.

In order to establish a relationship between level of health consciousness and reporting of morbidity, IMR had been taken as a broad indicator of health consciousness. The data show a very interesting phenomenon: IMRs and PAPs for rural areas of Kerala, Punjab and Madhya Pradesh show a negative relationship between IMR and morbidity-reporting, contrary to data on rural areas of Bihar, Assam, Rajasthan, Orissa and Uttar Pradesh.

A positive association between monthly per capita consumption expenditure (MPCE) and PAP, in both rural and urban areas was observed. The range of variations in PAP was larger in rural areas as compared to urban areas. The level of morbidity increased with a rise in the standard of living. This may be due to the fact that the reporting of morbidity improves with improvement in the conditions of living.

The urban morbidity rates were higher than the comparable estimates of the 28th and 42nd rounds. The observed differences may be due to different methodologies used to collect the data over this period.

The data on disease-specific morbidity were collected on the basis of self-perceived morbidity, though this method of collecting information is highly questionable. The data showed a rise in accident-related morbidity, especially in urban areas. A declining trend for chronic diseases were observed.

The survey shows that the percentage of ailing persons treated was higher in urban areas as compared to rural areas. The percentage of untreated ailing persons varied from 26 per cent in the lowest income group to 10 per cent in the highest expenditure group in rural areas. In urban areas it was 9 per cent and 19 per cent respectively. The survey also examined reasons for not seeking treatment: the most prominent cause was not perceiving the illness as severe, followed by financial constraints. It was found that the private sector was utilised more in cases of non-hospitalised treatment. The comparison between the 42nd and 52nd round shows that there was a significant increase in utilisation of the private sector in between the two rounds. There existed a wide inter-state variation in percentage of treated ailments as well as use of government sources for treating ailments. Utilisation of public health care facilities for treatment was found to be among the lowest in Punjab, Haryana and rural Uttar Pradesh; it was reported to be highest in rural Orissa and Rajasthan.

During the period 1995-96, about 2 per cent of the urban population and 1.3 per cent of the rural population was hospitalised at any time during the reference period. The data did not show any significant gender-differential in either area.

The estimates showed a strong positive association between average MPCE and the rate of hospitalisation in both rural and urban areas. There were wide interstate variations in the rate of hospitalisation. The survey shows that charitable institutions also played an important role in providing hospitalised treatment. But still, PHCs and CHCs accounted for a higher proportion of hospitalised treatment than charitable institutions in rural areas. There was also a great interstate variation regarding reliance on the public sector for hospitalised treatment. The proportion (per 1,000) of hospitalised treatment received from public sector hospitals varied from 225 in rural Andhra Pradesh to 906 in rural Orissa.

Cost of treatment: The data show that in rural areas Rs 151 was spent on an average on every episode of non-hospitalised treatment per ailment by a male, as compared to Rs 137 in case of females. The figures for urban areas were Rs 187 and Rs 164 respectively. For hospitalised ailments, Rs 3,778 was spent on an average on every episode by a male in rural areas as compared to Rs 2,510 in case of females. The figures for urban areas were Rs 4,185 and Rs 3,625 respectively. This shows the presence of gender discrimination as regards expenses incurred per ailment though estimates on the proportion of ailing persons treated did not reflect any perceptible difference between male and female populations of either rural or urban areas.

Key words: *Prevalence, Morbidity, Health Care, Utilisation, Out-of-pocket Expenditure.*

24. Factors inhibiting the use of reversible contraceptive methods in rural South India

Authors : Rajaretnam T. and Deshpande R.V.
Source : Studies in Family Planning, 1994
Place of study : Belgaum and Gulbarga, Karnataka
Location : Rural
Period of study : 1990
Type of research : Empirical, Descriptive, Health Centre and Community-based

Aim: To assess the perceptions and experiences of programme personnel, from the district level to the grassroots level, on popularising reversible methods of family planning in rural areas; to understand the extent of community leaders' knowledge of reversible methods and their perceptions regarding the couples accepting them; and to study the knowledge and attitudes of couples towards reversible methods.
Methodology: The study was undertaken in two districts. Each district had two sub-divisions with 10-15 PHCs under each sub-division. From each sub-division one PHC was selected at random. From each of the selected PHCs, a further three sub-centres were selected in such a way that one was the PHC headquarter and the other two fell under different primary health units of the same PHC. All villages covered by these sub-centres were selected as the study area. In all, 43 villages were covered in the survey. It was proposed to select 1,000 households proportionately from the selected villages by a systematic cluster sampling technique. Altogether, 998 households were covered, from which 995 currently married women (15-44 years) were listed. From these, 815 (82%) women and 136 husbands (from the targeted number of 200) could be interviewed.

Of programme personnel, all the available divisional joint directors and district health officers of both the districts were interviewed. At the PHC level, all the available medical officers and the male and female senior health assistants of the six selected PHCs were interviewed. Similarly, at the sub-centre, all the available junior health assistants were interviewed. In all, one divisional joint director and three district health officers, six medical officers, five senior health assistants and 20 junior health assistants were interviewed. For the coverage of community leaders, a maximum of three of the most influential leaders were identified from each village by interviewing a sample of currently married women, their husbands, shopkeepers, etc..

Findings: *Family planning practice:* The data show that the practice of family planning was limited to sterilisation methods, that women accept early sterilisation, but usually after having three living children. CPR due to both reversible and permanent methods was 40.6 per cent for women interviewed in the study area, whereas the CPR based on the husbands' interview was 41.2 per cent. Contraceptive users had an average of 3.9 living children, while non-users had 1.9 living children. About 38 per cent of the women had given birth to their first child within two years of consummation of marriage. The majority of the non-users had short open birth intervals (less than two years).

Perception of programme personnel: The officers interviewed indicated that they had not made attempts to ensure better performance for reversible methods in their areas, nor did they suggest strategies to popularise the methods. The study indicates the need to motivate middle-level managers to make efforts to popularise reversible methods. Health workers and supervisors were not interested in motivating the use of reversible methods. This has led to ignorance and thus non-use at the couple level. The study findings suggest the need for commitment of programme managers at all levels, training of supervisors and health workers to motivate couples and provision of adequate services at clinics.

Perception of community leaders: Virtually all of them knew about terminal methods whereas only 73-90 per cent knew about reversible methods after probing. About one-fourth of the leaders did not know of service sources for reversible methods, and the majority did not know that field workers were distributing contraceptives. Government health facilities were cited as the major source of contraceptive methods. The leaders felt that reversible methods were unpopular because they were not well-known, because people thought they had undesirable side-effects or high failure rates, and because people thought they were inconvenient to use. When asked how to improve the FPP, the suggestions made were providing incentives, regular visits by health workers and easy access to service outlets.

Perception of the community: The majority of the respondents were aware of the benefits of a longer interval but few were able to achieve it. Knowledge about service outlets for permanent methods was almost universal. Private institutions were mentioned more often as service outlets for reversible methods. The main reason for not using contraceptives was the desire for more children. And 18 per cent specifically stated that they wanted male children. The major reasons for the unpopularity of reversible methods were their side-effects and failure rates.

At the end, three suggestions were made to popularise reversible methods in rural areas: 1) A strong commitment from programme managers at all levels. 2) Proper direction and training of field workers, enable them to educate and motivate couples to use reversible methods. 3) Provision of adequate services at clinics and in villages.

Key words: *Reversible Contraceptives, Perceptions, Knowledge, Programme Personnel, Contraceptive Methods, Community Leaders, Community.*

25. Gender bias in utilisation of health care facilities in rural Haryana

Author : Rajeshwari
Source : Economic and Political Weekly, 1996
Place of study : Bhiwani and Kurukshetra, Haryana
Location : Rural
Period of study : 1991
Type of research : Empirical, Analytical, Community-based

Aim: To examine the spatial variations in gender bias in the use of public health care facilities (PHCFs) and in relation to the economic development of an area.

Methodology: Two districts from the state were selected and from each district two tehsils were selected based on the provision of public health care infrastucture. In each of these tehsils, two villages were selected: one with a public health care facility and the other 5-10 kms away from such a facility. Thus there were four villages with PHCs and the other four with no PHCs. In all, 389 households spread over eight villages were studied.

Utilisation was considered with reference to preventive (infant's immunisation, antenatal care, care during childbirth) and curative care (level of medical intervention in case of ailment). Availability of public health care facilities, occupational category as proxy of economic status of the household and educational status of the head of the household were examined as determinants of health care utilisation.

Findings: The study show that the availability of public health care facilities at the place of residence had a positive impact on women's health status when the comparison was made between the PHC and non-PHC villages. The data reveal that infant and child mortality was highest where there was no medical facility and trained birth attendance. It concludes that the level of female health care is positively affected by economic development and the gender disparity is reduced with the overall economic development of an area.

The economic status of the household showed an association with women's health care where public health care facilities were not located nearby. The educational status of the head of the household emerged as an important factor which had a positive effect on women's health care (both preventive and curative) in PHC and non-PHC villages.

It is suggested that the provision of public health care facilities at the place of habitation coupled with increased educational status or awareness of various health care programmes would reduce the selective bias against women.

Reviewer's note: A sharing of details of the tools of data collection and the basic profile of the respondents would have been useful. Also it is not clear whether the data were proxy.

Key words*: Utilisation, Public Health Care Facilities (PHCF), Gender, Economic Status.*

26. Medical management and giving birth: Responses of coastal women in Tamil Nadu

Authors : Ram K.
Source : Reproductive Health Matters, 1994
Place of study : Kanyakumari, Tamil Nadu
Location : Rural
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community-based

Aims: To present the experience of maternity among lower-caste Mukkuwar women and their responses to modern medical management of pregnancy and birth.

Methodology: An ethnographic approach was used to study maternity practices amongst lower-caste Mukkuvar women.

Findings: The study argues that a woman's decision on whether or not to seek medical care during pregnancy and where to give birth, was influenced by class and caste. The article highlightes various causes for the non-utilisation of modern medicine during delivery: prolonged stay during delivery disrupting their daily activities, caste distance between the provider and the user creates a power hierarchy, treatment by the hospital staff during delivery is harsh, and there are unnecessary medical interventions.

From their perspective as fisher-women, the older forms of hierarchy were simply mapped onto newer versions, with high-caste intolerance of impurity, pollution and lack of learning transposed into the idiom of hygiene, rationality and medical science. Despite prolonged exposure to reforms and interventions, women still derive their fundamental ideas of femininity and maternity from more archaic religious and regional cultural currents.

Key Words: *Perception, Coastal Women, Medical Management, Maternity.*

27. Household survey of health care utilisation and expenditure

Author : Ramamani S.
Source : National Council for Applied Economic Research (NCAER), New Delhi, 1995
Place of study : Nationwide (Major States & Union Territories)
Location : Rural and Urban
Period of study : 1993
Type of research : Empirical, Descriptive, Community-based

Aim: To collect detailed data on morbidity, health care utilisation and health expenditure. The study covers both treated and untreated illness episodes.

Methodology: All the states and Union Territories of the country except Manipur, Nagaland, Sikkim, Tripura, Andaman and Nicobar Islands, Arunachal Pradesh, Dadra and Nagar Haveli, Lakshadweep, Mizoram and Jammu and Kashmir were included. The sample was selected through multi-stage stratified sampling. All the districts within the selected states and union territories were covered. From each district, 2 villages were selected with probability proportional to the population of the village. In all, 718 villages were selected. For the urban sample, all 53 cities that had a population greater than 5 lakhs were included in the sample. The other cities and towns were stratified into five groups on the basis of population size, and a sample of towns was randomly selected from each group, with an increasing sample fraction as the size class increased. Blocks between 2 and 30 were randomly selected from each city/town, depending on the population size of the town. Thus, 1,509 blocks were selected.

For the household selection, households in selected blocks/villages were listed - with up to 150 households per block/village. The households were classified into five income categories, and then sample households were selected randomly from each stratum. The sample consisted of 18,693 households, with 12,339 urban and 6,354 rural households.

The survey instrument was a detailed household questionnaire, which was administered to the head of the household. For all questions relating to illness and health care utilisation and expenditure, the recall period was one month prior to the interview. The survey was based on lay reporting of illness and not on clinical examination. The interviewers were asked to note the symptoms in detail, as described by the households. Afterwards the symptoms were classified/grouped under different illness names using the World Health Organisation's Manual on Lay Reporting of Health Information.

Both the prevalence and incidence of illness were estimated; incidence relates to all episodes that started in the reference period of one month prior to the interview, while prevalence relates to all episodes that existed during the reference period, irrespective of when they started.

Findings: *Morbidity profile:* The reported prevalence rate of illness for the reference period was 106.7 and 103.0 per 1,000 population for the rural and urban areas respectively. The prevalence rate of treated illness was 94 per 1,000 population. The survey results did not indicate any significant sex differentials in the overall prevalence of illnesses at the all-India level, although some states did exhibit such differentials. The prevalence rates of illness by different age-groups reveals a very high morbidity rate for the 60+ age-group, for both rural and urban areas. There were wide variations in the reported prevalence rates of illness across different states, with Kerala having the highest reported morbidity.
Nature of illness: Fever seemed to be the most common illness among both adults and children, accounting for 30 per cent and 25 per cent of reported illnesses in rural and urban areas respectively. The next highest reported morbidity was respiratory infections, which were higher among children than adults. In the rural areas, the prevalence rate of cardiovascular diseases (per 1,000 population) was 4.5 and 3.1 respectively for adult males and females. The corresponding figures for urban areas were 9.0 for adult males and 7.7 for adult females.

The disease pattern was dominated by acute illnesses. Acute illness comprised 73 per cent of the reported illnesses in the rural areas and 68.5 per cent of the reported illnesses in urban areas. Serious communicable diseases accounted for 14.5 per cent and 13.3 per cent of all reported illnesses respectively in rural and urban areas. With the increase in the income status of households, the prevalence rate of serious communicable diseases and acute illnesses decreased, and the prevalence of chronic illnesses increased.

Hospitalisation: The reported number of hospitalisation cases (per 1,000 population) was 7.1 and 9.7 for rural and urban areas respectively. In most of the states, the number of hospitalisation cases (per 1,000 population) was lower for females than males.

Untreated illnesses: Approximately 12 and 8 per cent of the illness episodes were not treated in rural and urban areas respectively. The major cause cited for non-treatment was 'not considering the illness serious enough'.

Utilisation of outpatient health care services: The percentage of illness episodes for which treatment had been sought from the private health sector was 52 and 59 per cent for rural and urban areas respectively. In both rural and urban areas the utilisation of private health facilities was highest for acute illnesses.

Self-medication was also found high in treating acute illnesses. In rural areas, the utilisation of public health facilities for accidents and injuries was 60 per cent and 70 per cent respectively for the male and female population. In both rural and urban areas, with an improvement in income and education of the household, the utilisation of public facilities decreased and utilisation of private facilities increased. On the whole, for all occupational categories, the utilisation of private facilities was found higher. For 90 per cent of illnesses, the allopathic system of medicine was sought.

Utilisation of hospitalisation facilities: For 62 per cent of the hospitalised illness episodes in rural areas and 60 per cent of the cases in urban areas, treatment had been sought from public health facilities. The data reveal that people's dependence on public health facilities was higher for natal, intra-natal and preventive health care. Home deliveries accounted for 23.4 and 11.2 per cent of the deliveries in rural and urban areas respectively.

The most important reason for using public health facilities in both rural and urban areas was that they are free/inexpensive. Close proximity was also cited as a reason for using public health services, whereas 'good reputation' was cited as an important reason for seeking treatment from private health facilities. On an average people had travelled longer distances for seeking treatment in the rural areas as compared to urban areas.

Household expenditure on health care: Expenditure on health care includes the doctor's fees, cost of medicine, cost of diagnostic tests, transportation costs, expenses incurred for special diet for the patient, and other incidental expenses. Poor households had spent more than 7 per cent of their income on treatment as compared to 2.7 per cent by rich households. Urban households had spent more in treating illness than their rural counterparts. The average expenditure per illness episode was lower for children. In both rural and urban areas the average household expenditure per illness episode was lower for female adults and female children as compared to males. For treatment as inpatients people seemed to prefer public health facilities, the most important reason being that they are less expensive than private health facilities. Poor states like Uttar Pradesh, Rajasthan and Madhya Pradesh had spent comparatively smaller amounts per illness episode. In states where the dependence on private health providers was higher, the amount spent per illness episode was also found to be fairly high.

Key words: *Prevalence, Morbidity, Health Care, Utilisation, Out-of-pocket Expenditure, Treated and Untreated Illness.*

28. Acceptance of family planning and linkages with development variables: Evidence from an 80-village study in Orissa

Author : Sinha R.K. and Kanitkar T.
Source : The Journal of Family Welfare, 1994
Place of study : Cuttack, Ganjam, Kalahandi, Phulbani and Puri, Orissa
Location : Rural
Period of study : 1982
Type of research : Empirical, Descriptive, Community-based

Aim: To study intervillage variations in the practice of family planning by different methods in Orissa; and to study the factors associated with the differential practice of family planning methods.

Methodology: Data collected in a large sample survey were used. A total of 80 villages, 16 from each district having health facilities and not having health facilities, were selected from five districts, through a two stage sampling design. A random sample of 50 households was selected from each of the villages by probability proportion to size (PPS). Individual-level data on knowledge and practice were collected from newly-married women in the household. Village-level data on infrastructural facilities, educational facilities, health facilities, mass media and other aspects were obtained. Using the available information a composite village level index (VLI) was constructed, indicative of the overall developmental status of the village. The information was divided into eight major categories. The VLI ranged from 0-80 and graded into four groups. The score was observed to range between 7 and 59.

Findings: The average VLI score was 26.8 with a standard deviation of 10.7 and coefficient of variation of 40 per cent, indicating the heterogeneous development levels of the villages. Literacy levels in the village and the village level index did not show any association with acceptance of sterilisation but it was significantly related to acceptance of spacing methods. Perhaps this was because sterilisation is a one-time method, requires only one-time motivation and is aggressively promoted by programme managers. It was also independent of the acceptor's literacy or educational attainment. On the contrary, the acceptance of spacing methods takes into account the motivational aspect and hence was not independent of literacy or educational attainment of the individual. The existence of PHC/sub-centre facilities in the village did not have any impact on the acceptance of spacing methods. The findings of this study clearly bring out the importance of aggregate level development related variables and education for the promotion of spacing methods.

Key words: *Family Planning, Spacing Methods, Development Index.*

29. The extent and pattern of utilisation of health services by rural women: A study in District Rohtak, Haryana

Authors	**:** Sood A.K. and Nagla B.K.
Source	**:** Indian Journal of Preventive Social Medicine, 1994
Place of study	**:** Rohtak, Haryana
Location	**:** Rural
Period of study	**:** Not Stated
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To study the pattern of utilisation of various treatment sources by rural women for common maternal and child health problems.

Methodology: The study was carried out in block Beri of Rohtak district in Haryana. Four sub-centre villages were selected by stratified random sampling considering their distances from the PHC. The sampling unit was women with children less than six years of age. A list was prepared in each village of households having women with children less than six years of age.

Systematic random sampling was used to select women for the survey. In all, 162 women were interviewed through a semi-structured schedule.

Findings: It was observed that nearly 61.8 per cent of the women had contacted private practitioners, 50.0 per cent had contacted anganwadi centres, 21.0 per cent faith-healers, 18.4 per cent sub-centres, 19.7 per cent PHCs and 6.5 per cent government hospitals in the last six months. During the analysis of the data the socio-demographic characteristics of the respondents were taken into account. Some of these factors directly affected and some indirectly affected medical and health care utilisation. The data reveal that respondents who had a lower annual income, lived far from towns, and in inadequate houses with no bathrooms showed a preference for home treatment in the initial stages. Respondents who preferred hospitals, especially government hospitals, had higher age of head of household, lower levels of education and high preference for government hospitals. PHCs and hospitals were mostly preferred for prolonged ailments or severe ailments not cured by other sources. Those who preferred a place which gives "quick relief" were characterised by higher income, better condition of the house, higher education of head of family, residence in main village, higher social participation, separate bathrooms in the house and electricity. On the other hand, those who mentioned a preference for place of treatment due to 'free services' had poor living conditions, lower incomes and lower levels of cleanliness in the home.

The data showed that the higher the educational level, income and lower family size, the higher the preference for a hospital as the place for delivery. Religion and social participation determined the preference for the local dai. Hindus with lower social participation preferred a local dai for delivery. Religion, household size and social participation determined the use of family planning methods. The larger the household size and higher the social participation, the higher the acceptance of family planning methods. For treatment of infants, 27.5 per cent preferred mostly traditional practices, 4.6 per cent preferred modern practices and 67.7 per cent preferred both. Those preferring native practices had lower levels of education, lower levels of cleanliness, higher family size and lower social participation. They lived away from town.

The article also highlighted the findings of three other studies on health care utilisation undertaken in various parts of the country.

Reviewer's note: The recall period is six months. A separate presentation of maternal health and child health problems would have been insightful. The article does not clearly define the concept of 'social participation'.

Key words: *Maternal Health Problems, Child Health Problems, Treatment Sources.*

30. Please use the health services: More and more

Authors : Srivastava R.K. and Bansal R.K.
Source : World Health Forum, 1996
Place of study : Kheda, Gujarat
Location : Rural
Period of study : 1992-1995
Type of research : Empirical, Descriptive, Community-based

Aim: The long-term objective was that family size should be reduced and the people's quality of life be raised. The immediate objectives of the project were to bring about an increase in awareness of modern contraception from 48 per cent to 73 per cent, to reduce the infant and under-five mortality rate to below the country's rural average; and to raise the status of women.

Methodology: The project was initiated in 30 villages where there was already a well-established network of primary care centres. It was an intervention project, therefore, no strict methodology was followed.

Findings: The paper details the various activities undertaken in the project. The interventions were essentially IEC activities carried out by village family welfare workers with the involvement of the milk cooperatives and supported by a central team from a medical college. The unique feature of the project was that village health workers were available throughout the day, and basic drugs were made available at all times. Also, the project provided an opportunity to medical students to relate theory to practice. The article also describes the constraints that affected the project. The authors claim that substantial progress can be made through this kind of initiative, although it would take much longer to see its direct benefits.

Reviewer's note: The sharing could be used to draw lessons from to improve government health services for better utilisation.

Key words: *Modern Contraception, Status of Women, Village Health Workers.*

31. Introductory small cash incentives to promote child spacing in India

Authors : Stevens J.R. and Stevens C.M.
Source : Studies in Family Planning, 1992
Place of study : Thanjavur, Tamil Nadu
Location : Rural
Period of study : 1985-91
Type of research : Empirical, Descriptive, Community-based

Aim: To evaluate the cost-effectiveness of monthly introductory small cash incentives as a strategy to increase the use of modern temporary methods of contraception among rural Indian women.

Methodology: A four-phase intervention study was designed to evaluate such a strategy. In phase 1, small incentives as an intervention to promote acceptance and continuation of spacing methods were pilot-tested. In phase 2, a controlled study, the

impact of interventions in terms of cash incentives and five visits with contact persons was compared with the control area. Phase 3 was designed to study the impact of (a) smaller cash incentives with only one visit and (b) of only contact persons. The results of these two strategies were compared. Phase 4 was to introduce this intervention strategy through the government health services in three places - in the slums of Madras city (incentive); in two PHCs in rural areas (intervention area – incentive + contact person, control area - only contact person).

The sample size varied in these phases. In Phase 1, a total of 398 women were acceptors of spacing methods. In Phase 2, 500 women in each intervention and control area were enrolled in the study. An evaluation survey of Phase 2 included random samples of 150 women each from the intervention and control area. In Phase 3,250 women were enrolled in each of the two intervention areas. The evaluation survey of Phase 3 included a random sample of 100 women from both intervention programmes. In Phase 4, 2,821 women were acceptors in the slums of Madras; 475 and 3,068 women enrolled in the two PHC areas.

Findings: The programme demonstrates the power of small cash incentives to rapidly attract potential women acceptors to the clinic. It is evident that this method overcame disinterest, inertia, and passivity of poor and illiterate women towards available contraceptive methods.

Phase 1 showed that small cash incentives were very effective in promoting participation in the project. During this phase the programme achieved very high acceptor rates for temporary methods. Critics suggested that this phenomenon might well be owing less to the incentives and more to the fact that women preferred to come to a high quality private clinic where they were treated with concern and respect, rather than to insensitive government facilities.

Phase 2 showed that though initial acceptance was higher with introductory incentives, subsequent delivery of condoms and pills by the village contact person was similar in both incentive and non-incentive villages. Follow-up population-based surveys indicate that the quality of knowledge was better and the number of users was greater in the incentive villages.

Phase 3 demonstrated that a single introductory incentive or appointment of contact person only recruited more women acceptors, but knowledge and evidence of actual use of spacing methods was less.

Phase 4 attempted to introduce the introductory incentive programme in urban and rural government clinics yielded mixed results. In urban slums, government health services were rapidly able to upscale the programme. In the rural PHCs, the staff were unable to upscale the programme on their own.

The authors conclud that introductory incentive programmes served to increase awareness and acceptance of spacing methods though the continuation rate was only about 50 per cent. Many women distrust government services because of the rude behaviour of the health personnel, but the

authors argue that incentives were less coercive than the conditions under which poor women live because it served to diminish the timidity of women.

Key words: *Cash Incentives, Use of Contraception.*

32. Households, kinship and access to reproductive health care among rural Muslims in Jaipur

Authors	**:** Unnithan-Kumar, M.
Source	**:** Economic and Political Weekly, 1999
Place of study	**:** Jaipur, Rajasthan
Location	**:** Rural
Period of study	**:** Not Stated
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To situate reproductive health care in the context of women's perceptions and experiences of illness in general as well as in terms of the material, ideological and political dynamics of household, kin and gender relations.

Methodology: The paper does not detail the methodology used to conduct this research. The study was conducted in the rural Nagori Sunni community in Jaipur district.

Findings: It was found that most of the reproductive problems of women were related to menstruation and white discharge. There was a high incidence of maternal morbidity and anaemia along with child mortality. Women articulated their health problems in very general terms. Women perceived their illness as related to causes lying outside the purely physiological domain. References to the influence of the soul and spirit upon a person's health indicated that the health of the individual and the social body was connected in public perception.

Women tended to use the services of private medical practitioners and traditional healers much more than government institutions. Of the health services available within a radius of 1-6 kms, none of the private doctors frequented by the Nagori Muslims offered reproductive health examinations or antenatal check-ups for women. In seeking medical attention with regard to reproductive health related problems, women had to traverse greater distances. For reproductive health services women went equally to private and government doctors but preferred to see government doctors in private where they were promised greater attention.

It was found that the sexual division of household labour and the division of labour among women of the household had implications for women's health. It imposed the physical burden of hard and continuous labour with little respite during weakness or illness. It also made it difficult for women to take time out to consult health specialists. The toll on women's health varied with the development cycle of the household. The division of household tasks worked in favour of the age of women only if they had younger women to shoulder the heavier tasks. The average monthly income of families was Rs 1,500-2,000, besides three quintals of wheat from a single agricultural season. Most of the women were found engaged in agricultural activity, which is seasonally determined. One of the common work-related physical ailments which Nagori women suffer was prolapse of uterus. It was found that gender ideologies played an important

role in the inequitable distribution of resources in the household and had its implications for women and children's health.

In the majority of cases a woman's marital home was within a radius of 1-4 kms from their natal home. The social and physical proximity of natal kinspersons had important implications for Nagori women's access to health care services in many ways. These mainly included additional human power, emotional support and financial support. The average health expenditure for women alone over 10 months was Rs 1,000-10,000. This high expenditure on health was a result of treatment delayed till the acute stage.

The author in the end draws conclusions for policy. These include the need to address the question of access to existing services, provision of facilities which take into account the context-specific, gender and age health needs of the local populations; the need for a health programme to be broad-based so as to tackle wider sources in the environment from which diseases stem. It was recommended that women's access to health care services could be improved by encouraging all sorts of health delivery activity - private, govern
ment and NGO - in a manner that recognises their specific strengths and weaknesses. In order to establish an effective referral network, it is suggested that resource persons within each village be located who are not only informed about matters of hygiene and basic medication but also about health services, health rights and statistics and the politics of health matters in general.

Reviewer's note: In the absence of any reference made to the methodology, the potential of such studies and methodologies used (the ethnographic approach seems to have been used) remains obscure. It makes a significant contribution for there are not many studies dealing with Muslim women and their health concerns.

Key words: *Muslim Women, Reproductive Problems, Reproducive Health Problems, Support, Health
Expenditure.*

33. Unmet need for family planning in Gujarat: A qualitative exploration

Authors	**:** Visaria L.
Source	**:** Economic and Political Weekly, 1997
Place of study	**:** Bharuch and Panchmahal, Gujarat
Location	**:** Rural
Period of study	**:** 1989 and 1995
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To understand the reasons for the unmet need for family planning from the women's perspective. To
explore the reasons underlying the gap between intentions to limit fertility and action; and to understand when and how the intentions to limit family size are translated into reality.

Methodology: A quasi-longitudinal study design was adopted in two districts of Gujarat, covering the same population at two points of time - 1989 and 1995. The data were

collected through 11 focus groups and in-depth interviews. The participants for focus groups were carefully selected. About 18 to 20 women were invited for each discussion. Efforts were made to make each group as homogeneous as possible in terms of caste, level of literacy and acceptance of sterilisation.

Findings: The issues discussed broadly were women's desired fertility and their reasons for wanting a specific number of children, sex preference of wanted children, apprehension about use of contraceptive methods for limiting and spacing children and inter-spouse communication on issues related to sexuality, desired fertility and contraceptive use. The author had frequently referred to NFHS data for giving a macro-perspective.

The women reported that if their husbands wanted more children, they had no choice but to comply. Most women desired two to three children provided there was at least one son, preferably two. But on their own,
women didn't mind not having sons.The reason for the desired fertility was mainly economic. When asked whether not having children would eventually not bring more income in the house, they appeared much more concerned about the present outflow of income as opposed to an unknown future inflow.
Son-preference was universal and strong, the ideal family notion comprising 50 per cent or more sons.
Contraceptive use primarily depended on socio-cultural factors like familial and societal pressure to prove fertility immediately after marriage, a near lack of communication between husband and wife on issues related to sexuality, pregnancy and contraception, and pressure to have at least one son. Lack of autonomy, inability to negotiate fertility, sexuality and contraception, and the fear of being discarded by the husband forced women to rationalise their fertility behaviour soon after marriage.

The author examined the logic behind women's preference for sterilisation over spacing: women preferred to complete their desired family and then go in for sterilisation that involved fewer hassles. The fear of side-effects and the apprehension of inability to conceive after use of spacing methods also made women prefer limiting methods to spacing methods. The women voiced their complaints against the health workers, indicating that they were provided with little information or supplies. They said that the nurse (health worker) worked efficiently only when she was concerned about 'targets'.

Finally, the author suggests some programmatic implications - viz. counselling of couples together on contraception, broadening the scope of the family planning programme to include all those with potential need, i.e. men and women, married and unmarried, with the emphasis on sex education. The author suggested undertaking similar studies in order to get a ground level perspective on the situation.

Key words: *Unmet Need, Family Planning, Targets, Efficiency, Sex Preference, Desired Family Size, Women's Autonomy.*

HEALTH CARE: ACCESS, UTILISATION AND EXPENDITURE

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POLICIES: ANALYSIS, CRITIQUE AND ALTERNATIVE PERSPECTIVES

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
1.	To study the feasibility of using interns as health educators to meet the need of having doctors who can act as social workers, educators, friends, guides and philosophers.	Not stated	*K a r n a t a k a* Rural	**Empirica Descript Health based**
2.	To analyse the entry of corporate houses in the field of medical care.	Not applicable	Not applicable	**Theoreti**
3.	To explore the development of new public management (NPM) techniques in the health sector.	1997	**Tamil Nadu**	Empirical Descripti Health C
4.	To offer an historical account of midwifery in India and to understand its implications for the future.	Not applicable	Not applicable	**Theoreti**
5.	Perspective note on the health care utilization patterns and preferences in the public and the private sector in the context of universalization of health care.	Not applicable	Not applicable	**Empirica Analysis seconda**
6.	To compile and analyse data on public expenditure on health care and selected programmes/ activities	1950-51 to 1994-95	Not applicable	**Empirica** Analysis

	across states.			secondar Policy an
7.	To trace the social and political origins of the development of the health sector of Maharashtra and compare it with that of Punjab and Kerala.	1980 onwards	*Maharashtra*	**Empirica** Analysis secondar Policy an
8.	To compare the traditional nursing model with the community nursing model and to discuss various issues and problems related to integration.	Not applicable	Not applicable	Theoretic (program designing

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE
9.	To assess the actual impact on the lives of women of the paradigm shift in FWP, with the adoption of the TFA approach and the government's new RCH initiative.	1998	**Andhra Pradesh, Gujarat, Haryana, Karnataka, MP, Rajasthan, Tamil Nadu, UP & WB** Rural	Empirical Commun
10.	To conduct a social assessment for IEC/RCH planning.	1996-97	Aurangabad **Maharashtra** Rural	**Empirica** **Descript** **Commun**
11.	To identify the gaps in the FWP and to suggest strategies for making the programme more woman-centred and holistic.	Not applicable	Not applicable	**Empirica** **Analysis** **seconda** Policy an
12.	To compile existing research on sexual and reproductive behaviour of adolescents; and to make programme and research recommendations related to adolescent reproductive health.	1965-96	*Nationwide*	**Empirica** **Analysis** **seconda** Policy an
13.	To review the health achievements of the decade and to provide a holistic analytical framework for the understanding of the health care sector. To address the issue of whether or not privatisation would solve our health care problems.	Not applicable	Not applicable	Theoretic
14.	To develop alternative approaches to providing quality health care services, with the thrust on maternal and child health care.	1978-89	Aurangabad **Maharashtra** Rural	Empirical Descripti Commun

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE O
15.	To question the research process adopted for carrying out community-based clinical research in women's reproductive health.	1987-1995 (reference period)	Gujarat Rural	Theoretica
16.	To remind ourselves of the autonomy that midwives used to enjoy and to introduce some new concepts in midwifery.	Not applicable	Not applicable	Theoretica
17.	To assess training needs with the focus on RCH; and to assess the status of the MCH programme in Maharashtra.	1992 -93	***M a h a r a s h t r a*** Rural	Empirical, Descriptiv Health Ce
18.	To suggest alternatives to Family Planning Programme.	Not applicable	Not applicable	Theoretica
19.	To examine the potential links between FP and MCH programmes and the emerging needs of the global AIDS epidemic; to assess the feasibility of organising comprehensive reproductive health programmes in developing countries.	Not applicable	Not applicable	Theoretica
20.	To highlight the need to equip nurses to meet the demands of RCH and implementation of RCH programmes.	Not applicable	Not applicable	Theoretica
21.	To review certain financial issues related to the Post-partum Programme in India.	Not applicable	Ajmer, Jodhpur & Udaipur *R a j a s t h a n* Urban	**Empirical Analysis secondar** Programm
22.	To examine the concept of reproductive health as it emerged in the 1980s, its consequences for health research and FPP in India, its advocacy for the third world agenda, and the reasons behind it.	Not applicable	Not applicable	**Empirical Analysis secondar** Policy ana
ANNO NO.	**OBJECTIVE**	**STUDY PERIOD**	**STUDY AREA**	**TYPE O**
23.	To study ground-level implications of the TFA and the RCH programme from the women's perspective; to	1996-97	Not applicable	Empirical, Policy ana

	examine and evaluate the new performance indicators developed by the Government of India (GOI) in the TFA manual; to examine NGO experiences in women's health to draw relevant lessons for delivery of government health services.			
24.	To highlight the need to formulate a health policy for tribals which would (a) relate to epidemiology and levels of social development; (b) have the central focus on the well-being and survival of the tribals; (c) be based on considerations of cost-effectiveness and sustainability.	Not applicable	Not applicable	**Empirical Analysis secondar** Policy ana
25.	To review the evidence (secondary sources) on family size, child survival and fertility by socio-economic categories followed by the findings from an empirical study.	1985-87	Mandya **Karnataka** Rural	Empirical, Communit
26.	To evaluate the National AIDS Control Programme.	1992-97	*N a t i o n w i d e* Rural and Urban	Empirical, Evaluative Health Ce Communit
27.	To review some of the health programmes launched since 1947 for the improvement of women's health.	Not applicable	Not applicable	**Empirical Analysis secondar**
28.	To highlight the NGO perspective on women's health and population issues in preparation for ICPD.	Not applicable	Not applicable	Theoretica
29.	To document the alternative approach adopted to attend to women's reproductive health care needs by a women-centred and community-based organization.	Not applicable	Not applicable	Empirical, Communit

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE C
30.	To highlight the significance of QA in nursing, status of QA programmes, the need for preparing local and national standards and inculcating the concept and culture of quality among nursing professionals.	Not applicable	Not applicable	Theoretica
31.	To analyse the pattern of investment in medical equipment in private hospitals in a metropolitan city in India.	1992-93	Madras *T a m i l N a d u*	Empirical, Health Ce

			Urban	
32.	To examine the causal relationship between women's work and reproductive health.	Not applicable	*T a m i l N a d u* Rural and Urban	**Empirical** Analysis c data
33.	To describe the UP state project for which Project Evaluation & Review for Organisational Resource Management (PERFORM) was designed; the performance-driven benchmark that defines PERFORM indicators; and to present the results from a district pilot test of PERFORM.	Not stated	Jhansi *U t t a r P r a d e s h* Rural and Urban	Empirical, Communit Health Ce
34.	To explore the rationale of target-setting and its consequences in the context of the FP programme; to suggest alternatives to target-setting and to identify areas for further policy and operational research.	Not applicable	Not applicable	Theoretica
35.	To review the policy, programme and strategic changes in the FPP.	Not applicable	Not applicable	Empirical, Analysis c data, Policy ana
36.	To compare and contrast the status of health services in the rural and urban sector and in the public, private and voluntary sectors.	Not applicable	Not applicable	**Empirical** Analysis c data

POLICIES: ANALYSIS, CRITIQUE AND ALTERNATIVE PERSPECTIVES

SELECTED ANNOTATIONS

1. Interns as health educators

Authors : Bansal R.
Source : World Health Forum, 1995
Place of study : Karnataka
Location : Rural

Period of study : Not Stated
Type of Research : Empirical, Descriptive, Health Centre-based

Aim: To study the feasibility of using interns as health educators to meet the need of having doctors who can act as social workers, educators, friends, guides and philosophers.

Methodology: Interns in their rural posting at a Primary Health Center in Karnataka were involved as health educators in two innovative health programs – one for mothers and the other for school children. The interns administered a questionnaire to assess the knowledge of mothers on health issues and then offered health education based on the needs. In case of school health education, based on the child-to-child approach, school children were trained to be as school health guides.

Findings: The study found that interns derived immense satisfaction from the experience of being trainers. Also based on the feedback of 25 mothers, the study infered that the program had made some impact on the knowledge and attitudes amongst mothers who had consequently initiated actions.

Reviewer's note: The author anticipates methodological improvements to occur as the experiments proceed.
It would have been interesting to see evaluation data of success of experiment. The methodology is inadequately presented. In absence of in-built follow-up strategies such initiatives may find difficult to sustain on their own.

Key words: *Interns, Health Educators, School Health Guides, Health Education.*

2. The rise of business in medical care

Authors : Baru R.
Source : Health for the Millions, 1994
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To analyse the entry of corporate houses in the field of medical care.

Findings: This paper describes the entry of industrial houses into the health care sector. Hospitals owned by corporates have essentially been a South India-phenomenon, with Hyderabad having the maximum number of these ventures. These multi-speciality hospitals, based on the American experience, offer more traditional services like cardiology, paediatrics etc., even though in the US, health care corporations have been shifting towards more profitable areas like psychiatry. These hospitals cater to the middle and upper classes, though the lower and working classes also use their services if they are able to borrow money and sell off personal assets. The promoters of these hospitals had used their political and social links to pressurise the Indian government into offering them a variety of concessions like land subsidies and exemption of import duty on equipment. But the government, in turn, has not been able to impose any

conditions on them, and the policy had been one of accommodating the interests of business in the provision of medical care.

Key words: *Medical Care, Corporate Sector.*

3. 'New public management' and health care in the Third World

Authors	**:** Bennett S. and Muraleedharan V.R.
Source	**:** Economic and Political Weekly, 2000
Place of study	**:** Tamil Nadu
Location	**:** Not Applicable
Period of study	**:** Jan to Aug 1997
Type of research	**:** Empirical, Descriptive, Health Centre-based

Aim: To explore the development of new public management (NPM) techniques in the health sector in Tamil Nadu. To describe the extent to which new organisational arrangements for the provision of health services have been adopted; to assess the performance of these new service arrangements; and to identify factors affecting the capacity of governments to take on new roles.

Methodology: Case studies of health care institutions.

Findings: The paper clarifies concepts associated with NPM such as the definition of capacity. The study focussed on Tamil Nadu, although some comparisons with other states were also drawn. The case studies assessed how the government performed in new roles in three specific areas - contracting, regulation and autonomous organisations.

The first case study cites examples of services in health care institutions being contracted out in order to improve efficiency. The case study also talks about the profits and losses involved in contracting out services and the constraints involved. For example, if the organisational and administrative structure is highly centralised, even getting an approval can become a time-consuming task. Personnel policies can also form a major obstacle to greater contracting.

The second case study discusses regulations governing private health care. In Tamil Nadu, the private health care sector is governed by the Tamil Nadu Private Clinical Establishment Act. Laws related to private health care were further strengthened by the extension of the Consumer Protection Act to medical services. This strengthening was evident from the increase in the number of medical malpractice cases being heard in consumer courts. The regulatory role of state-level medical councils was found virtually non-existent. Inertia, lack of motivation, lack of funding, and self-interest were the major problems associated with the non-functioning of state medical councils. The implementation of the Nursing Home and Hospital Act had also been problematic.

One of the frequently-cited problems in consumer courts was the difficulty in getting doctors to testify in medical negligence cases against other doctors. The paper also highlights the hindrances being encountered by the government in implementing the Private Clinical Establishments Act in Tamil Nadu. Due to strong pressure exerted by medical professionals (from both within and outside government service), very little progress had been made in setting standards. Policy-makers were of the view that, in

order to gain the confidence of the private sector, they must simultaneously address problems in public hospitals.

The last case study talks about the autonomy of health care centres. It discusses the establishment of a 'board' to create stronger mechanisms for downward accountability by including community members on the board, and for strengthening management by incorporating skills from the private sector. In the Indian health sector there is no strong central policy on the devolution of government responsibilities to autonomous organisations. There has likewise been little interest in the notion of autonomous hospitals. The study talks about the functioning of three organisations – the Tamil Nadu Medical Supply Corporation (TNMSC), the State Aids Control Society (TNSACS) and the Tamil Nadu Blindness Control Society (TNBCS) - which are to some extent autonomous. The chief features of these organisations were: they took on functions which were previously the sole responsibility of the Department of Health; they continued to have a public welfare orientation in all their activities; they continued to receive virtually all their finances from government or international donors; and they continued to be controlled ultimately by the Department of Health.

A variety of motivations for establishing these autonomous bodies were given: for example, financial flexibility, which allowed for faster implementation of key policies and their ability to draw upon local private sector expertise in management. While assessing the performance of these organisations it was found that the financial and administrative flexibility did appear to have helped these organisations emerge as more capable than government. This was reflected in the superior record of autonomous organisations in timely payments to suppliers and contractors, and the significant quality improvements witnessed under the TNMSC regime. At the same time informants in Tamil Nadu repeatedly emphasised the importance of good leadership and lack of political interference.

The last section of the paper considers the factors affecting government capacity to take on the roles implied by NPM. The high degree of centralisation and the strong control structures simultaneously create strong incentives to pursue aspects of NPM and barriers to effective implementation. Virtually all the NPM modalities entail a shift in power structures, and hence their implementation may be politically difficult. The effective direct delivery of health care services requires a host of support systems such as planning and budgeting systems, financial systems and procurement systems. Some of these systems become even more important with the introduction of NPM modalities. Also, the paper emphasises the need for strong, incorruptible leadership. The government had a major role to play in the area of co-ordination and the creation of consensus amongst the entire range of actors concerned with the regulatory environment.

One of the core tenets of NPM was that strong incentives for performance should be created both for individuals and organisations. For example, some of the NPM mechanisms introduced greater flexibility in the way staff was hired and remunerated. In the last section, the paper discusses the external factors which hinder or help government performance. For instance, strong public sector unions hinder the capacity of the government, whereas NGOs can assist the government in performing its roles. For example, NGOs can help the government monitor health care services in remote areas.

One of the major limitations of the study was that most of the interviewees were relatively senior officials within the Department of Health: the views of more junior staff and those working in remote areas had not been recorded.

Key words: *Regulation, Health Care Management, Private Health Care Sector.*

4. Midwifery in India: Past, present and future

Authors : Bose R. and Prakasamma M.
Source : Indian Journal of Nursing & Midwifery, 1998
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To offer an historical account of midwifery in India and to understand its implications for the future.

Background and perspective: The study gives a brief historical account of midwifery in India, both before and after Independence. It highlights the role of ANMs as midwives in reducing maternal mortality and improving women's health status. However, over time, ANMs have lost their midwifery skills to target-oriented family planning programmes, as they were entrusted with a range of responsibilities in addition to their primary responsibility of providing midwifery assistance to the rural population. PHCs have not been able to provide the required supervisory support to the sub-centres and villages due to a lack of qualified obstetricians or lady doctors who could handle obstetric emergencies. The provision of skilled professional midwives with training in life-saving procedures, and facilities to implement these, would be more practical in the long run, since an obstetrician for every PHC seems an unlikely possibility in the present situation.

Midwifery training, practices and regulation are all changing - for the better - in several neighbouring South-east Asian countries, with help from the WHO. These countries are seeing marked improvements in the relationship between MMR and trained assistance, and in standard-setting and module development activities for improved midwifery services. These standards are also field-tested in Indonesia, Bangladesh, Bhutan and Thailand.

A proposed action plan highlights the need for (1) an assessment of the requirement for rural midwifery services in terms of type and number of personnel, (2) an assessment of the available midwifery humanpower in the country, (3) a decision on the level of skills required and the category of personnel, (4) a reassessment of the role of traditional birth attendants and strategies to make maximum use of available resources and (5) designing a training strategy, identifying training locations and trainers and implementing training programmes.

Reviewer's note: The action plan offers a framework for working towards the goal. However, it requires a cost and feasibility analysis for such an action plan to get translated into reality. It is also important to know the views of those constituting these structures before any planned measures are actually executed.

Keywords: Midwife, Midwifery, ANM, Multipurpose Health Worker.

5. Health care utilisation in India

Authors : Duggal R.
Source : Health for the Millions
Place of study : Not Applicable
Location : Not Applicable

Period of study : Not Applicable
Type of Research : Empirical, Analysis of Secondary Data

Aim: This is a perspective note on the health care utilization patterns and preferences in the public and the private sector in the context of universalization of health care.

Findings: India's health system is characterized by mixed ownership as well as by plurality of systems. Curative care in Public Health in rural areas is inadequate. Utilization of PHCs is very poor. PHCs take care of only about 8 per cent of the morbidity. The medical care budget for PHCs is very low and the emphasis is on family planning and immunization. Poor access, long waiting period and inadequate supplies are the main reasons for poor utilization of public services. Overcrowding of prime public health facilities like city hospitals and inadequacy of ordinary public health services have resulted in the private 'for-profit' health sector to flourish irrespective of its quality and efficacy.

This increasing support to a 'for-profit' private health sector can only lead to a process of further human degradation. Such a private health care sector exploits the vulnerability of the majority and profits from their misery. Universalization of health care services, that is ensuring that those who are not able to pay are not excluded from having access to quality health care services, can assure a fair equity in health care access and availability.

Key words: *Health Care, Utilisation, Private Health Sector, Paying Capacity.*

6. Health expenditure across states (Part I & Part II)

Author : Duggal R., Nandraj S. and Vadair A.
Source : Economic and Political Weekly, 1995
Place of study : Not Applicable
Location : Not Applicable
Period of study : 1950-51 to 1994-95
Type of research : Empirical, Analysis of Secondary Data, Policy Analysis

Aim: To compile and analyse data on public expenditure on health care and selected programmes/ activities across states.

Background and perspective: The structure and pattern of health care continued to be unequal after independence. Several factors contributed to the inequality - production of doctors for the private sector, disproportionate concentration of medical services in urban areas, financial subsidies by the state for setting up private practices and private hospitals, allowing a large number of doctors and nurses trained at the cost of the public exchequer to migrate abroad. The public-private dichotomy restricts access of the poor to health care services. The inequality in rural-urban distribution of health care services is severe. The state's efforts to improve health access of the rural population by setting up PHCs and massive expansion failed, with the quality of the services offered being poor and consequently remaining underutilised. As a result, the rural population crowds the taluka or district hospitals, approaches private practitioners in cities or local private practitioners who are often qualified in non-allopathic systems, or persons running a practice without any qualifications at all.

The huge private sector (80%) in our country naturally accounts for a large part of health care expenditure. This has reduced the role of the public sector in health in spite of its wide array of services. The rural-urban disparity as regards availability of health services is more than evident. Even the government's initiative to improve the access of the rural poor to health services through PHCs has not been able to achieve its expected impact in most states. However, some states which have had a consistently high investment in the health sector, especially in rural areas, have been able to reduce this gap. For instance, where bed:population ratios are concerned, the least urban-rural gap is in Kerala (twice) and Punjab (thrice). The largest gap is in Bihar (76 times). Usually the better-developed states like Goa, Haryana, Karnataka, Maharashtra, Gujarat and Punjab have a higher per capita expenditure as compared to less socially developed states like Bihar, Orissa, Rajasthan and Madhya Pradesh.

Findings: The present study refers to health expenditure as mainly the expenditure incurred by the ministries of health and family welfare. The data show that investment by the public sector for health care has been inadequate for the peoples' needs. Since 1970 there has been a declining trend in the allocation of resources by the state which became more prominent during the '90s, especially with regard to expenditure for hospitals and dispensaries. Expenditure on hospitals and dispensaries was mainly for curative care. This is the main reason for the non-functioning of the public hospitals and the consequent growth of private hospitals.

The expenditure on disease programmes and medical education is justified to a greater extent. Family planning expenditure had grown rapidly upto 1991-92 before showing a downward trend. Like family planning, the MCH programme reached a peak during 1991-94, and since then has slowed down. It was found that while calculating the per capita growth rates of health expenditure, except for the few initial years, the total government expenditure has been significantly more than on health as such, especially so in the '90s. The share of public health expenditure in national income peaked in the mid-'80s to 1.3 per cent of per capita GNP and since then has declined to 0.95 per cent. Structural adjustment has led to a decrease in grants from the centre. States' share in health spending has increased from 71.6 per cent in 1974-82 to 85.7 per cent in 1992-93 whereas grants from the centre declined drastically from 19.9 per cent in 1974-82 to 3.3 per cent in 1992-93. The share of central grants for public health declined from 27.92 per cent in 1984-85 to 17.17 per cent in 1992-93 and for disease programmes from 41.47 per cent in 1984-85 to 18.50 per cent in 1992-93 in spite of an increase in morbidity and mortality due to malaria, tuberculosis, blindness, diarrhoea and other communicable and non-communicable diseases. Though most of the states show a declining trend in the expenditure on disease programmes as a percentage of health expenditures, it is considerable in the states of Assam, Karnataka, Punjab, Rajasthan, Madhya Pradesh and Tamil Nadu.

On an average, health administration constitutes around 9 per cent of the total health expenditure. The other major expenditure is on the production of doctors and nurses, with doctors getting more emphasis. States that have more hospitals, such as Tamil Nadu, West Bengal, Karnataka, Kerala, Maharashtra and Uttar Pradesh, along with the central government, spend a substantial amount on the production of doctors.

The data on various dimensions of health expenditure shows that allocative efficiency is a major area of concern.

Key words: *Health Expenditure, Regional Disparity, Rural-urban Disparity.*

7. State of health care in Maharashtra – A comparative analysis

Authors : George A. and Nandraj S.
Source : Economic and Political Weekly, 1993
Area covered : Maharashtra
Period of data : 1980 onwards
Type of research : Empirical, Analysis of Secondary Data, Policy Analysis

Aim: To trace the social and political origins of the development of the health sector of Maharashtra and compare it with that of Punjab and Kerala.

Methodology: The study uses data from different secondary sources, such as: Centre for Monitoring Index and Ecomomy (CMIE) basic statistics; Sarvekshana; Sample Registration System, National Institute of Health and Family Welfare; Rural Health Bulletin, Ministry of Health and Family Welfare (MOHFW), GOI; Central Bureau of Health Information (CBHI), Director General of Health Services, GOI; Health Information of India, GOI; Indian systems of Medicine and Homeopathy in India, Planning and Evaluation Cell, MOHFW, GOI; Foundation for Research in Community Health (FRCH), Comptroller and Auditor General of India, GOI; Civil Budget estimates, Department of Finance, Government of Maharashtra.

The various indicators covered were socio-economic (per capita income, share of various sectors in the state Domestic Product, the extent of connectedness by roads, electrification, urbanisation, SC/ST population, size of land holding, sex ratio, female literacy etc.); health indicators (mortality, life expectancy and morbidity, infant mortality, death rate, birth rate); health infrastructure, both in the public and private health care sector (dispensaries and hospitals both, availability of hospital beds, distance to be travelled to access health care facilities etc.); health personnel (availability and distribution of doctors from various systems of medicines); health expenditure (public, private and household). Interstate and intra-state comparative analysis offers variations across states and within the state.

Background and perspective: Various health indicators show that Maharashtra has attained a relatively high growth against a background of industrialisation and impressive economic development, while Kerala shows substantial development in the health sector despite low economic development and low levels of industrialisation. The first pattern could be attributed to the trickle-down effect of capitalist modernisation, while the Kerala pattern is rooted in socio-political, geographic and demographic characteristics.

Findings and conclusion: Though Maharashtra has attained good health indicators, there is still a wide urban-rural as well as regional disparity. Public spending on health has decreased drastically since the First Five-year Plan, though the outlay for FP programmes has increased. The major part of the expenditure on health goes towards salaries and for the urban areas. Irrigation and power became top priority at the expense of health, probably because of the emergence of the powerful sugar lobby.

The private sector has seen unregulated and unaccounted growth, which has in turn led to poor distribution, irrational and unethical practices and declining standards of care. A

recent phenomenon has been the entry of business into the provision of medical care as well as medical education.

NGOs have played an important role in health care in Maharashtra. They have experimented with innovative systems of health delivery, though only on a small scale, without any attempt at national or state-level impact. Though NGOs have better reach, they have been able to institute little change in people's participation in health. They have advocated user fees and have often weaned patients away from the government sector rather than from the private sector.

Maharashtra's moderate achievement in the field of health care needs to be juxtaposed against the severe rural-urban and intra-regional disparities if we are to arrive at a more realistic understanding of the situation. Reducing these disparities will demand conscious political action. The inheritors of the radical traditions of the non-brahmin and dalit movements and the radical section of the industrial labour movement can be expected to take up this corrective role some time in the future. Meanwhile, NGOs can play a role in creating awareness of these health issues.

It is necessary to combat the negative effects of the rapid and unregulated growth of the private health sector in Maharashtra. The broadest possible platform should be created to regulate the chaotic growth of the public sector. NGOs with experience in the health sector must take the lead in building public opinion on this matter.

Key words: *Health care, Health Indicators, Disparity, Economic Indicators, Socio-political Particularities.*

8. Integration of primary health care concepts in GNM curriculum

Author : Gulani K.K.
Source : Indian Journal of Nursing & Midwifery, 1998
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical (Programme designing)

Aim: To compare the traditional nursing model with the community nursing model and to discuss various issues and problems related to integration.

Background and perspective: The GNM Programme is the basic nursing education course in India. The focus of the course is more on patient care at the secondary and tertiary levels within the hospital setting than on primary prevention and health promotion at the community level. The declaration of Health for All through the primary health care approach ushered in a community-oriented nursing education model.

The article explains at length the concept of community-oriented nursing, which would help nurses acquire knowledge and skill most relevant to the health care needs of the community. It emphasises the health care needs of under-served, underprivileged and high-risk groups, which could be met if the learning experiences of the students are based in community settings, with the focus on preventive and promotive aspects. The author stressed that it is the right attitude of the student that will bring about a change in

public attitudes and in practice. Therefore it is essential to analyse today's nursing syllabus and revise it to make it more relevant.

Community-oriented nursing care implies that a nurse should be prepared to fulfil the following functions: to identify health problems and plan need-based comprehensive health care; to mobilise community participation and work in partnership with the community; to function in a team and collaborate with those responsible for socio-economic development programmes; to promote self-reliance among families and communities; to provide guidance and support to ANMs and village health workers; to train and collaborate with indigenous practitioners and community health workers. A process and strategy for such integration were also suggested.

Reviewer's note: The paper is significant in that it deals with medical education, a rare concern among researchers.

Key words: Nursing Education, Community Health, Curriculum, Integration, Primary Health Care.

9. Community needs-based reproductive and child health in India: Progress and constraints

Authors	**:** Health Watch Trust
Source	**:** Health Watch Trust, 1999
Place of study	**:** Andhra Pradesh (AP), Gujarat, Haryana, Karnataka, Madhya Pradesh (MP), Rajasthan, Tamil Nadu (TN), Uttar Pradesh (UP), West Bengal (WB)
Location	**:** Rural
Period of study	**:** 1998
Type of research	**:** Empirical, Evaluative and Community-based

Aim: To assess the actual impact on the lives of women of the paradigm shift in FWP, with the adoption of the TFA approach and the government's new RCH initiative.

Methodology: The case studies were conducted in nine states and a common methodology was followed in order to do a comparative analysis of the states. Data from the beneficiaries and health care providers (HCP) were collected using focus group discussions (FGDs) and in-depth interviews. Two districts – better-developed and relatively backward – were selected from each state. In most of the states, two PHCs were selected from each district – better and poor-performing PHCs – to hold discussions with the HCPs. From each PHC, two sub-centre villages were selected for FGDs with women or other clients.

Background and perspective: The Government of India launched the TFA in 1996. This meant that the centrally-determined targets ceased to exist and instead the community demand for quality services would be the driving force behind the FWP. The new approach envisaged decentralised planning at the level of PHCs, where grassroots workers would set targets for themselves after an assessment of the needs of the clients. This shift in approach also included more comprehensive reproductive health services, which were formally launched in 1997. This implied a major organisational change, the implementation of which in a vast bureaucratic system would be a daunting

task. Participating NGOs felt the need to document government processes involved in moving towards these two important goals.

Findings: The study reveals that most of the field workers like the ANMs were aware of the TFA. The strategies adopted in some states were seen to have tremendous potential for replication. For instance, an effective system for streamlining the supply of drugs to PHCs; linking admission to post-graduate medical education and rural services by giving priority in admissions to those who have worked in rural areas; mobilising the private sector for the infrastructural development of PHCs and sub-centres. The integrated RCH approach had led to improvement in the rapport between ANMs and women: this was quite perceptible in Karnataka, Andhra Pradesh and Tamil Nadu.

Attitudes and mindsets: Ordinary people in many states like Andhra Pradesh and Haryana had not heard about the new RCH programme, though there was a lot of inter-district variation. There is tremendous variation in the level of understanding across states and also across different levels in the administration. It was found that the political leadership continues to believe in the old approach of sterilisation, targets and incentives. Much of the lack of progress in the RCH programme can be attributed to the inability of the programme to bring about a shift in the attitudes of officials, service providers and communities. The training, along with the entire health system hierarchy, places no emphasis on anything other than quantitative achievements.

Targets and incentives: The study reveals a mixed picture. In some states targets are fixed at the district level, in some targets are predetermined on the basis of a computer database, while in others targets are decided on the basis of ANM reports and with the assistance of Lady Health Visitors (LHVs). People appeared motivated and came forward on their own to seek advice - health workers did not need to chase targets (e.g. TN, Haryana, Karnataka, Gujarat and AP). On the other hand, health administrators and district functionaries were found preoccupied with sterilisation targets and their ability/inability to meet them (e.g. Rajasthan, UP and MP). In some states (e.g. Karnataka) increments of ANMs were not linked to target achievements. There is an emphasis on the identification of high-risk pregnancies, which had reduced the IMR in recent years. In WB, targets are determined on the basis of actual information, instead of uniform targets for each worker. The most important method of client segmentation was the number of living children and not clients' preferences. In some states (e.g. MP) incentives to clients have been withdrawn. But this has not affected the performance of PHCs, and clients had no complaints about the withdrawal. Workers felt that they were now given realistic targets.

Monitoring health workers: Interstate variations were found. In TN, health workers meet the Medical Officer at least six times a month, whereas in the case of Rajasthan they met only once a month. There were other variations too: in some places (e.g. TN) the MO reviews all the issues related to mother and child services while in others (e.g. Rajasthan) the MO was only empowered to report on issues related to FP. Some ANMs (e.g. in Karnataka) felt that while they were strictly supervised, their male counterparts were not. In certain states, ANMs reported that they were yet to comprehend how to assess community needs and wanted more training in this direction. Micro-planning in the new approach was yet to gain momentum and so was the involvement of panchayats.

Quality of care and client-centred approach: Health workers observed a marked change in the attitude of clients (e.g. Gujarat, TN and AP) and greater awareness among the women on health and other related issues. With the exception of TN, no significant change was observed in the service environment in most states. No marked improvement in service providers' attitudes towards clients was recorded. Sterilisation continues to be the most popular method of contraception. There was no appreciable improvement in quality of care even in static centre-based sterilisation camps.

The range of services provided at PHCs/sub-centres: In certain states (e.g. TN) there was a wider range of reproductive health services available to women. In some others (e.g. AP, WB) TT injections and iron-folic acid tablets are all that are offered by way of antenatal care, with 75 per cent of deliveries being conducted by dais. There was hardly any individual counselling or input in terms of diet, rest and workload during pregnancy. Postnatal care exists only on paper. There were no facilities available to meet the high demand for abortion. And no facilities for the treatment of RTI/STD in the RCH camps (e.g. UP). Tubal ligation was the most common activity at the camps. Supplies and services were better than in earlier sterilisation camps.

Improvements (if any) in women's access to reproductive health: There has not been much improvement in women's access to basic health care though there were some encouraging signs. Women were still viewed as reproductive mechanisms and fertility control was still the central objective of the new approach. Client segmentation and target-setting was still of primary importance to the government.

Reviewer's Note: The issues highlighted in the report need to be addressed if the government is really serious about significantly improving health care for women.

Key words: RCH, TFA, Quality of Care, Targets and Incentives, Attitudes and Mindsets, ANM, Health Workers.

10. Social assessment of RCH

Author : Institute of Health Management, Pachod
Source : District IEC Planning for RCH, Report 1, 1998
Place of study : Aurangabad, Maharashtra
Location : Rural
Period of study : 1996-97
Type of Research : Empirical, Descriptive, Community-based

Aim: To conduct a social assessment for IEC/RCH planning.

Methodology: Eight villages from Paithan block of Aurangabad district were selected from one PHC area based on population size, literacy, high scheduled caste population, location and proportion of children in the 0-6 years age group. Data from 870 households were collected to assess levels of health service utilisation and estimate prevalence of key RCH behaviours. It utilised rapid appraisal techniques having both qualitative and quantitative research methods. The qualitative methods used were focus group discussions, case studies, participatory problem identification method (PPIM), modified social mapping, body mapping and the Pachod-*anna* scale.

Background and perspective: IEC programmes had been based on the belief that awareness creation leads to a change in health status indictors such as mortality, morbidity and fertility. This unidimensional focus on awareness creation leads programmes and policies with excessive emphasis on 'information transmission'. The knowledge-behaviour gap had shown that higher awareness does not always result in behavioural change. Operationalistion of programmatic goals and services to be demand based, careful IEC planning is essential.

Findings: It was seen that behaviours occur in clusters and was not randomly distributed. There was a need for conducting behaviour analysis to understand the currently practiced and new behaviours. There was also a need to consider the access to media and comprehensibility levels while designing IEC inputs. Experience had shown that rural audience was most comfortable with visuals, which were close to their reality and they can identify themselves with it. Women stated a preference for interactive channels such as group meetings and home visits.

It was recommended amongst others that social assessments are conducted state-wise, the state considers the establishment of a separate IEC research cell within the IEC Bureau. The information from the social assessment was presented in the context of management frameworks for planning purpose, workshops were organised for staff at the public health care facilities and for percolation of the findings of the social assessment, and a few pilot projects were undertaken to develop and test the 'social influence' approach.

Reviewer's note: The methodology used is well documented. The concept of 'social assessment' is not clearly defined. The Pachod anna scale used for rating attitudes has its own limitations. There is a general tendency to give an average rating. Many a times this does not bring the actual attitude of the respondent. The action plan is quite impressive. However, cost involved in this exercise would be a limiting factor. With decreasing budget allocation in health it needs to be seen how feasible it is to undertake these types of studies.

Key words: *Redefinition of IEC, Knowledge-behaviour Gap, Audience, IEC Strategy.*

11. Addressing women's reproductive health needs: Priorities for the Family Welfare Programme

Authors : Jejeebhoy S.J.
Source : Economic and Political Weekly, 1997
Place of study : Not Applicable
Period of data : Not Applicable
Type of research : Empirical, Analysis of Secondary Data, Policy Analysis

Aim: The paper identifies the gaps in the FWP and suggests strategies for making the programme more woman-centred and holistic. The author used data from other research – primary and secondary – to provide perspective and determine the priorities for India's FWP.

Background and perspective: The thrust of India's FPP has been disproportionately focused on achieving demographic targets by increasing contraceptive prevalence,

notably female sterilisation. The neglect of women's needs has led to their poor reproductive health. Gender inequalities, both within the household and outside, severely constrain the ability of women and adolescent girls to acquire good health and avail of woman-centred health services. The FPP has been critiqued for its over-emphasis on population control, sterilisation, financial incentives and target approach. It was severely condemned for its coercive nature during the Emergency in the mid-'70s, and for being insensitive to the situations of women and their problems in seeking these services.

The author takes stock of the prevalence of maternal mortality and its causes. The extent of reproductive morbidity is noted. It is difficult to assess the magnitude of, and the factors underlying, women's reproductive morbidity. There are a few community-based studies, which have tried to fill the gap in our knowledge about RTIs and other aspects of reproductive health. Unsafe motherhood is still a reality in much of India and particularly in rural areas. Maternal health activities are unbalanced, focusing on immunisation and the provision of iron and folic acid, rather than on sustained care of women or on the detection and referral of high-risk cases.

There is a need to improve access to safe abortion and to pay attention to the context in which abortion occurs. Little evidence is available on the levels and patterns, determinants or consequences, of infertility in India. Health services are rarely comprehensive enough to meet the health care needs of the population. The same is true of sexually-transmitted diseases. There has been a tendency for both research and services to focus on high-risk groups, neglecting the potentially high-risk groups. A primary health care system that caters to the growing problem of STDs, is urgently needed.

Further, the author identifies and discusses the risk elements affecting reproductive health. These include malnutrition attributable to gender disparities; vulnerability and neglect of adolescent girls; contraceptive patterns and overemphasis on terminal methods and female methods; poor quality of health care services; poorly-addressed health information needs and sex education needs, specially of women and adolescents. An analysis of socio-cultural and economic factors is offered, along with remedial measures to make it possible to offer a comprehensive reproductive health care package to women. The author points out that there is no solid empirical evidence in support of successful NGO projects. There is a need for more action research. A growing recognition that population dynamics, quality of life and women's status are closely inter-related points to the need for a fresh look at India's population programme.

Key words: *Family Welfare Programme, Reproductive Health, Reproductive Health Services, Access, Quality of Care.*

12. Adolescent sexual and reproductive behaviour

Authors : Jejeebhoy S.J.
Source : ICRW Working Paper No. 3, 1996
Area covered : Nationwide
Period of data : 1965-1996
Type of research : Empirical, Analysis of Secondary Data, Policy Analysis

Aim: To compile the existing research on sexual and reproductive behaviour; and to make programme and research recommendations related to adolescent reproductive health in India.

Background and perspective: The author highlights the fact that little information is available on this significant section of the population. Adolescents are rarely considered a distinct group with special needs apart from those of children and adults. Much of the available information is recent and exploratory and there is a lack of data on almost every aspect of adolescent reproductive health, including sexuality, reproductive morbidity, abortion-seeking, and reproductive choice. Also, methodologies currently employed in research on adolescent reproductive health in India tend to be limited. The literature review is organised around the profile of adolescents in India; adolescent reproductive health behaviour; knowledge of sexual, contraceptive and reproductive health; their attitudes to marriage and sex; sexual and reproductive decision-making by adolescents; and their use of reproductive and family planning services.

Findings: There are an estimated 190 million 10-19-year-old adolescents in India, over one-fifth of the population. Adolescent marriage and adolescent fertility are disturbingly high. Unlike other countries, adolescent fertility in India occurs mainly within the context of marriage. Half of all women aged 15-19 have experienced a pregnancy or a birth. Apart from early marriage and fertility, there is little information on other aspects of adolescent reproductive health problems. Adolescent sexual behaviour, sexual awareness and attitudes remain poorly-explored topics, and available findings are not entirely representative. Both unmarried and married women are vulnerable to being unprotected from pregnancy and sexually transmitted infection. They are also unlikely to have any decision-making powers in their sexual relationships. Most family planning and reproductive health services in India, as elsewhere, target adult women. The author, based on the literature review, puts forward a list of recommendations for programme planners and researchers.

Recommendations: These include the need to intensify efforts to postpone early marriage among adolescent girls; address negative health implications of the lack of autonomy of married adolescent girls; address the nutritional needs of adolescent girls; provide more education to adolescents on anatomy and physiology; respond more sensitively to the special needs of unmarried adolescent girls and boys. Research recommendations include the necessity of investigating reproductive health needs and decision-making authority among married adolescent girls; investigating pre-marital sexual behaviour, awareness and attitudes among more representative samples of adolescent girls and boys; describing the levels, patterns and context of abortion behaviour among both unmarried and married adolescent girls, and awareness of its legal status; conducting community-based studies on obstetric and gynaecological morbidity among adolescent girls, and sexually transmitted infections among boys and girls; investigating adolescents' access to health care, and the constraints they face in acquiring good health; and using rigorous, in-depth, sensitive and culturally-appropriate research designs to elicit data about adolescents.

Key words: *Adolescent, Sexual Behaviour, Reproductive Health Behaviour.*

13. Private sector and privatisation in health care services

Authors : Jesani A. and Anantharam S.
Source : The Foundation for Research in Community Health, 1993
Place of study : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical, Review of Secondary Sources

Aim: To review the health achievements of the decade and to provide a holistic analytical framework for the understanding of the health care sector. To address the issue of whether or not privatisation would solve our health care problems.

Background and perspective: It tries to capture the problem of health care development. It presents data on various facets of the health care system.

It traces the history of state involvement in health care in India vis-à-vis developed countries. It also documents how Indian systems of medicine gradually lost their importance to western systems of medicine.

The study cites the problem of access to health data. The quality of available data is also questionable. There is not much data available on the private health sector, health finance, expenditure and investment. The analysis of health care provisions incorporates (1) health human power and their sectoral distribution; (2) hospitals and dispensaries; and (3) corporatisation of health care. The data show that there was a polarisation of human power against rural services. A significant proportion (63.7% in 1981) of homoeopathic doctors were residing in rural areas. As far as paramedics were concerned, nurses show the least inclination to settle in rural areas. The data on training of human power and facilities were found unreliable. An analysis of the class and caste background of doctors shows that our country has failed to give the depressed strata of people the opportunity to become doctors. More and more medical colleges are being set up in violation of all policy statements made since the Fifth Five-Year Plan. The paper also presents data on the training infrastructure for non-allopathic systems of medicine, sectoral distribution of health care facilities, production of medical technologies and expenditure on various aspects of health.

The study concludes that our health care system is weighted towards curative medicine. Though rural health facilities were oriented towards comprehensive care, the gap between planning and implementation is wide. The paper also talks about irrational medical practices prevalent among doctors, for example, the indiscriminate use of injections. The private sector occupies 80 per cent of the total health sector, enjoying the privilege of setting the norms and value systems of medical practice.

The study provides an overview of the experiences of developed countries regarding health services. It shows that countries with better Planned National Health Services have actually achieved universal provision of health care services.

It discusses the emerging issues in health care. Public financing of health expenditure in India constitutes a very small component, thus making user-charges the predominant method of financing. Thus, the market in health care is given unrestrained scope to operate. The effects of the market on the health care sector are quite evident. But so far no initiative to regulate this sector has come from the government. The reimbursement of providers is predominantly through fee-for-service methods.

Towards the end of the report, the arguments in favour of privatisation are countered. The conclusion is that it is very doubtful whether continued expansion of the health care market will do the people's health status any good. The issue of involving the private sector in health care under the state's control remains unexplored. This scepticism is expressed because such an involvement itself implies that the private sector has a non-market orientation.

Key words: *Private Health Care Services, Regulation, Universal Access.*

14. Alternative approaches to MCH services

Author : Khale M. and Dayalchand A.
Source : Indian Paediatrics, 1991
Place of study : Aurangabad, Maharashtra
Location : Rural
Period of study : 1978-89
Type of Research : Empirical, Descriptive, Community-based

Aim: To develop alternative approaches to providing quality health care services, with the thrust on maternal and child health care.

Methodology: This is an analytical description of the alternative approach that the Institute of Health Management (IHMP) has adopted since 1978 to implement a health programme in 52 villages of Paithan taluka, covering a population of 60,000.

Background and perspective: The Government of India has accepted a strategy of primary health care. The National Health Policy has identified MCH services as priority areas. However, the available national statistics indicate that the targets have not been reached. Evaluatory research indicated that the quality of MCH services is poor. But some efforts by NGOs have shown positive results.

After a detailed baseline survey in 1978, the IHMP started providing MCH services in its project villages through TBAs and FMPWs. IHMP developed alternative approaches to provide a comprehensive package of services: they decided to provide MCH services using health posts which are fixed facilities provided by the community. FMPW were employed by the NGO: they made fortnightly visits to the villages. At the health posts these FMPWs examined and treated pregnant women, and also made home visits along with TBAs and CHVs to register antenatals, postnatals, high-risk cases and severely malnourished children. One FMPW covered six villages in a week and two FMPWs were required to cover all the villages in the PHC area (a PHC generally caters to 24 to 25 villages) on a fortnightly basis. These visits ensure effective coverage of antenatals and provide supportive supervision of grassroots-level workers. This decentralised approach required reallocation of resources - from salaries and expenditure on maintenance of sub-centres to effective transportation and incentives for TBAs.

Another new approach adopted was giving incentives to the TBAs on the basis of outcome rather than activities. The TBAs were given Rs 20 as an incentive for every neonatal survival through early pregnancy detection. The proportion of women receiving

minimum antenatal care has increased from 57 per cent in 1978 to 74 per cent in 1988. Ninety per cent of the children were immunised.

The other alternative strategy attempted was to decentralise micro-planning and monitoring. The FMPWs were made to prepare a planner, which provided them with an estimation of their workload, and helped in time efficiency and self-evaluation. During the monthly group meetings with the community, each worker was made to present the actual work done as against the estimated workload, which was cross-verified by the male MPW during his home visit. The dynamics resulting at the group meetings gave rise to the standard of productivity, which every member of the team tried to achieve.

In another attempt to evolve alternative approaches, IEC strategy was used for demand generation. The IHMP used women and children as agents of change to disseminate information in its programme area. In these awareness camps they were given the opportunity for self-expression. Each camp ended with a decision and it was the responsibility of these women to implement the decision taken and to inform the community about it. This process helped generate demand and consequently created new norms in society. The health post also acted as a venue for group interaction and dissemination of information.

The above approaches constituted the comprehensive package provided by the NGO to its project areas. And the package showed remarkable results. The neonatal mortality rate came down from 94.8 in 1978 to 39.1 per 1000 live births in 1988. Maternal mortality has also shown a consistent downward trend.

It is concluded that alternative approaches when introduced as a comprehensive package have proved successful in providing effective MCH services.

Reviewer's note: Touching upon the issues of socio-cultural and family dynamics, which to a great extent influence women's access to health care services would have been insightful. Such alternative approaches need to deal with the issues, such as, its sustainability and the probable scope of its mainstreaming.

Key words: *Decentralised Health Delivery System, MCH Services, Comprehensive Health Care Service Package.*

15. Dilemmas and conflicts in clinical research on women's reproductive health

Author : Khanna R.
Source : Reproductive Health Matters, 1997
Place of study : Gujarat
Location : Rural
Period of study : 1987-1995 (reference period)
Type of research : Theoretical

Aim: To question the research process adopted for carrying out community-based clinical research in women's reproductive health.

Background and perspective: Social Action for Rural and Tribal Inhabitants of India (SARTHI), an Indian NGO, responded to the needs of local women, articulated through

participatory action research, by instituting a modest women's health programme in 1987. By 1992, this programme had evolved and expanded to eight villages, with trained women providing maternal and child health services and treatment for common gynaecological symptoms with validated herbal medicines.

As SARTHI was about to begin work on STDs, a donor agency proposed that the NGO engage in qualitative and clinical research on STDs in women and men. Because of the availability of a clinical research team, the project began with the clinical research component, which involved screening and treatment camps in two villages in April and August 1994. The first camp failed because 80 per cent of the people who had consented to participate did not attend, including women who had reported symptoms during house visits. The second camp was designed with a high level of community participation from the outset. In this case, the self-selected sample who sought treatment overwhelmed the logistics of the camp. Then, after 94 of the 868 patients were recruited for the STD study, the laboratory had an internal crisis and failed to deliver results for four months (14 women and three men were positive). The people's health needs proved to be so great that research was curtailed in favour of initiating service delivery mechanisms.

Conclusions: The lessons learned include the value of bottom-up research, the importance of attention to process instead of outcome alone, and the importance of interventions to increase women's autonomy in seeking health care. It was concluded that as an alternative research paradigm, the research activities of activist and community-based organisations must be integrated and community-controlled. Such a paradigm should be useful for study participants as well as researchers. It should enable the people to prioritise their needs, ask the right questions about problems they identify, and participate in the data collection and analysis process. Researchers need to find the appropriate language and suitable methods for communicating significant research findings to members of the community.

Key words: *Participatory Action Research, Alternative Research Paradigm, Reproductive Health.*

16. Truth, virtue and beauty of Midwifery

Author : Korah L.
Source: : Indian Journal of Nursing & Midwifery, 1998
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To remind ourselves of the autonomy that midwives used to enjoy and to introduce some new concepts in midwifery.

Background and perspective: This concept paper illustrates how midwifery, the domain of women, was captured by male medical professionals, and how midwives came to be sidelined and dismissed as uneducated, irrational and traditional. Traditional midwifery was taken over by male doctors who treated childbirth as a scientific and medical event requiring clinical management. But once midwifery schools were set up in

the West, midwifery grew into a science and an art. And childbirth became a regulated medical event even in the hands of midwives.

The author also introduces the new methods and techniques of birthing, such as, team midwifery and water birth that are being adopted in contemporary times by midwives in the western world. These new techniques, which are rational but women-friendly, question the traditional hospital model of birthing. The empowerment of women by providing them information, education, choice and continuity, is central to the concept of 'birthing centres'.

Reviewer's note: These are important breakthroughs. A few women's groups and innovative individuals in India too have been experimenting with the gentle art of midwifery. The question is how to bring these experiments into the mainstream.

Key words: Midwifery, Childbirth, Birthing Centre, Team Midwifery.

17. Status of maternal and child health in Maharashtra

Author : Kulkarni S. and Parasuraman S.
Source : Paper presented in Workshop on Child Health and Family Planning Policy Issues in Maharashtra, 1997
Place of study : Maharashtra
Location : Rural
Period of study : 1992 -93
Type of research : Empirical, Descriptive, Health Centre-based

Aim: To assess training needs with the focus on RCH, based on the evaluation of CSSM training for health functionaries in Maharashtra. This assessment was done in the context of the shift in emphasis from MCH to CSSM and finally RCH. To assess the status of the MCH programme in Maharashtra.

Methodology: Part of the analysis is based on data from the National Family Health Survey for Maharashtra, during which information was gathered from a representative sample of 4,106 ever-married women aged 13-49 from 4,063 households. The training needs were assessed through focus group discussions, in-depth interviews, responses to open-ended questions in the survey of 670 functionaries including medical officers and paramedicals, and in-depth interviews of trainers. Training programmes were evaluated by using the methods of content analysis of training material and observation of training programmes. Training programmes were assessed for their relevance to actual field conditions and the feasibility of the trainees actually utilising the knowledge gained and skills acquired during the training. This, according to the researchers, would indicate how far we are equipped to shift to the comprehensive strategy implied in the RCH approach.

Findings: In rural areas, government health centres and government programmes play a key role in the provision of pre-natal, intra-natal and post-natal services, including family planning services, immunization and treatment of common childhood diseases. The implementation of the programme depends to a large extent on the performance of auxiliary nurse midwives, village health guides and traditional birth attendants. These grassroots-level functionaries are the backbone of the MCH programme. This paper

discusses the in emphasis implied in the changing approach - from MCH to CSSM and finally to RCH. It presents the current status of the MCH programme in Maharashtra in terms of reach and utilization of services. Socio-economic differentials in use are discussed with the help of secondary data from the NFHS survey. The paper also discusses the hurdles in improved utilisation of these services. It examines the clients' reasons for not using ANC care: not feeling any need for ANC and not having the custom of seeking any ANC were reasons cited in both underdeveloped and developed states. Thus, persuading poor, illiterate, and older women seems to be a big challenge for field workers. The author recognises the limitations of ANMs in terms of time and energy. And highlights the fact that the physical outreach of grassroots health workers is severely limited for lack of transport facilities. IEC activities are advocated to convince these women of the need for ANC.
In the second part, after having taken the stock of the status of MCH/CSSM, the strengths and weaknesses of the training programme are presented. Policy changes and paradigm shifts are translated in terms of grassroots-level workers and their training. CSSM training programmes were conducted in all the districts of Maharashtra during 1992-97 in five phases. During 1992-96, 3,746 medical officers and 14,454 paramedical staff were already trained and 1,282 medical officers and 15,585 paramedics were yet to be trained. The strengths of the programme have been identified as: well-designed, comprehensive modules which help standardise the content of training and sensitise the grassroots functionaries on the main philosophy of the CSSM approach; taking vital message to the functionaries; diagnosis of ARI; impressing on health workers the importance of minute details regarding precautions to be taken for maintenance of cold chain. Besides, they were also trained to assess symptoms, complications, severity, need of referral etc. This is likely to help initiate a process of systematic decision-making at the grassroots, thereby initiating the process of developing the trainees as grassroots-level managers of the health system.

The trainees were found lacking in precision and clarity on various aspects of illness and health situations that they were expected to encounter in the field. The other weaknesses were: wastage of resources because of a lack of co-ordination between the multiple, overlapping training programmes that an individual health worker undergoes; lack of continuing use of knowledge; lack of an effective monitoring system and interdisciplinary approach; and involvement of non-medicos in training.

Some logistical problems are also highlighted, such as the lack of regular and adequate supply of medicines and instruments, poor distribution of electricity, and unavailability of ANMs in the village.

Reviewer's note: This study is a significant contribution because it focuses on paramedics, who are important health care providers. They are the bridge between people/women and the health care system. From this perspective, their empowerment is necessary if RCH is to be meaningful in reality.

Key words: *Maternal and Child Health, Child Survival and Safe Motherhood, Reproductive and Child Health Programmes.*

18. Family welfare programmes in India with special reference to NGO collaboration

Authors : Mukherjee S.
Source : Health and Population–Perspectives and Issues, 1991
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To suggest alternatives for the FPP.

Findings: The author recommends the formation of an apex body called VAFAD (Voluntary Action for Family Welfare and Health), with regional branches throughout the country. This body will deal with the voluntary sector for training, funding, monitoring, IEC activity and co-ordination etc. This will help government organisations and NGOs to complement and supplement each other's efforts to stabilise population and improve maternal and child health.

Key words: *Voluntary Sector, Family Welfare, MCH.*

19. Relationship between AIDS and family planning programmes: A rationale for developing integrated reproductive health services

Authors : Pachauri S.
Source : Health Transition Review, 1994
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To examine the potential links between family planning and maternal and child health programmes and the emerging needs of the global AIDS epidemic; to assess the feasibility of organising comprehensive reproductive health programmes in developing countries to include the prevention and control of RTIs including STIs and HIV/AIDS.

The author builds an argument in favour of developing a comprehensive programme, using relevant and specific references and views.

Background and perspective: Although reproductive health is one of the primary concerns of family planning programmes, problems related to sexuality and the sexual health needs of clients have not been explicitly addressed. RTIs have tended to remain invisible because of the 'culture of silence' that envelops them. The emergence of AIDS has brought about a renewed interest in STIs which have been neglected in both developed and developing countries. Scientists have begun to identify several links between HIV and sexually transmitted infections. The proponents of a broad, integrated approach to reproductive health believe that reproductive health is inextricably linked to reproductive rights and freedom.

In India and elsewhere, changing priorities, particularly pressures to reduce rapid population growth rates, have led nations to move towards more focused family planning programmes. In many cases programme targets are achieved at the cost of other reproductive health needs. Following a growing recognition of the important links between socio-economic development - particularly of women - and fertility reduction,

researchers have begun to question the rationale of population control policies. The argument now is that limited approaches are counterproductive even in attaining the objective of reduced birth rates, and that a broader reproductive health approach may be more effective in reducing fertility and meeting people's needs.

Women's health advocates argue for comprehensive reproductive health services and contend that the present services must be redesigned as they do little to address the health needs of adolescents, the unmarried, the infertile, those with RTI and those with unintended pregnancies. The inclusion of facilities for the diagnosis and treatment of RTIs is of central concern to the providers of family planning services as they affect the safety and quality of these services and the demand for fertility regulation.

In addition to laying down several good reasons for the development of an integrated approach, the author also explores the need to examine the programme and cost implications of organising such services, particularly in poor countries where scarce resources must be re-allocated for such purposes.

The arguments against integrating AIDS and STI control services within family planning and MCH programmes are: (a) the diagnosis and treatment of these infections is too expensive, complicated, and technically sophisticated for developing countries; (b) these infections are related to sexual behaviour which is difficult to change; (c) their inclusion may stigmatise the programmes.

The epidemiological and programmatic reasons for such integration are: (a) these services require access to the same population segment - sexually active persons; (b) providers of these services require similar skills to address the needs of their clients; (c) both aim at modifying sexual behaviour; (d) condoms, other barrier methods and spermicides are common technologies at present available for the prevention of AIDS, STIs and unwanted pregnancies; (e) since AIDS and STIs can seriously affect the health of the mother and the newborn child, their diagnosis and management during pregnancy is particularly important.

The author offers a cost-benefit analysis for the implementation of such an integrated programme and discusses the lessons learnt from the family planning programme which may be relevant to the development of integrated approaches. He stresses the significance of health education, counselling, training and supervision in the design and implementation of integrated reproductive health programmes.

The need for effective protection methods against both pregnancy and STIs has been intensified by the AIDS pandemic. And these protection methods/technologies must be assessed for their acceptability, safety and effectiveness in preventing fertility as well as infection. Currently available protection methods such as condoms, spermicides, barrier methods, oral contraceptives, intrauterine devices, sterilisation and abortion, are analysed in terms of safety, effectiveness and acceptability, particularly with respect to the prevention of infection.

Conclusion: In the conclusion, the compelling reasons for developing integrated programmes are reiterated. But the author cautions that integration must not compromise the efficacy of existing services. The lessons learnt from the FPP and HIV prevention programmes could reinforce each other and be mutually supportive.

The author articulates the need for research on developing methods - preferably those that are within the control of women - for the prevention of HIV/STIs as well as contraceptive methods that can protect against both infection and unplanned pregnancy. He also recommends research to develop microbicides; and operations research to assess the feasibility and effectiveness of integrating services, particularly in resource-poor settings.

Key words: *FPP, MCH, Comprehensive Reproductive Health Services.*

20. Implementing the RCH programme: Challenges before nurses

Author	**:** Prakasamma M.
Source	**:** Indian Journal of Nursing & Midwifery, 1998
Place of study	**:** Not Applicable
Location	**:** Not Applicable
Period of study	**:** Not Applicable
Type of research	**:** Theoretical

Aim: To highlight the need to equip nurses to meet the demands of RCH and implementation of RCH programmes.

Background and perspective: The study highlights the significance of nursing services and the need to make nursing education socially relevant and appropriate to the needs of the community. Nursing education has been keeping up with changing trends in health policies and developments. The author gives a brief account of changes in nursing education congruent with the national Family Planning Programme and primary health care programme and policy. The education and training of ANMs underwent hasty changes in order to meet the changing needs of these programmes. ANMs were thus stripped of their midwifery competence over the course of time, although midwifery was the very reason for their emergence.

The implementation of RCH policies now demands that these critical health care providers revert to their originally-designed set of skills and knowledge, and most important, change their mindsets which have been geared towards 'target-oriented' family planning services for the last four decades. Their services are now expected to be more technically efficient, more concerned with quality, and gender-sensitive.

The author proposes an action plan to prepare the cadre of midwifes/ANMs in response to the needs of RCH at four levels - the peripheral, PHC, supervisory and teaching levels - taking into account the current status and future requirements. The author also recommends: (a) in-service training of ANMs and staff nurses to meet the needs of the RCH programme; (b) revision of the basic ANM and GNM syllabi; (c) estimates of budgetary requirements for implementation of such a revision.

Reviewer's note: In addition to recommendations made, it is time to understand how nurses themselves perceive their proposed role vis-à-vis the changing priorities of the RCH programme. Their workload, their rights and responsibilities on the one hand and the returns and incentives that they are compensated with on the other, need hard and critical examination in order to determine whether the latter are commensurate with the former.

Key words: Reproductive and Child Health, Midwifery, Nursing, ANM, Education.

21. Post-partum programme in India: Some financial issues in Rajasthan (sub-district level)

Authors : Purohit B.C. and Siddiqui T.A.
Source : The Journal of Family Welfare, 1993
Place of study : Ajmer, Jodhpur and Udaipur, Rajasthan
Location : Urban
Period of study : Not Applicable
Type of research : Empirical, Analysis of Secondary Data, Programme Analysis
Aim: To review certain financial issues related to the Post-partum Programme in India.

Background and perspective: The Post-partum Programme in India began in 1966 with two hospitals, but by 1981 the second phase of the programme had covered all the hospitals at the sub-district level. Though initially the focus was on providing family planning counselling and services during the post-partum period, the focus later shifted to the provision of MCH services right from conception to well after birth. From inception to 1995, the programme was funded centrally but implemented by the state health authorities. The central funds are mainly for providing services or construction of facilities. Though the central government does not sanction incentives to family planning acceptors under this programme, in practice, state and local governments have been spending on this account.

Till 1988-89 expenditure on the post-partum programme at the sub-district level usually fell short of the allocations, but from 1989-90 there was a substantially higher expenditure in relation to the allocations. In Rajasthan there has been an increase of Rs 13.060 million in fund allocation for the state. Also there has been no gap between the number of sub-divisional post-partum centres as approved by the central government and those sanctioned by the state government. As per the existing system the funds received from the central government go to the state government, then to the Chief Medical Officer and Health Officer, next to the Principal Medical and Health Officer and finally to the post-partum centres. This method of channeling funds means that the post-partum centres have no financial identity distinct from the existing MCH services. There is no provision for separate supportive staff including accounting personnel. This supports the notion that the post-partum centres is an additional input to the main FW/MCH centre. Post-partum centre officials lack awareness of various financial aspects of their post-partum centres.

Findings: The study elicited information from three districts of Rajasthan about the factors influencing the present system. It was found that trends at state-level aggregates as well as district-level disaggregates depict almost the same picture. Though the gap between actual and allocated funds is not substantial, the reasons for this discrepancy lie in inaccuracies in the demands for funds placed by the post-partum centres to their respective Principal Medical Officers or Chief Medical Officers and Health Officers. This inaccuracy becomes evident when an item-wise break-up of the total budgetary expenditure shows that salaries and TA/DA occupy a major share of the expenditure of the post-partum centres and in some years exceeds the allocated budget. The trends of

these two items thus indicate the likelihood of a discrepancy in the deployment of staff in different categories in relation to requirements. The study found that in some places, in order to fill the vacancy caused by non-availability of a particular specialist or created by a staff member leaving the post-partum centres, an adjustment was generally made by utilising the services of a specialist working in the base hospital. In the process, sometimes personnel who lacked the requisite specialisation background were deployed. This sort of adjustment was made by adjusting the salaries of the deputed staff against the post-partum centre account, which was reflected in a diversion in the actual estimates of the salary component from the allocated or demanded budget.

The article cites various examples like incentives given to acceptors of sterilisation where the finances of two programmes were mixed up. This raises doubts about the possibility of a Post-Partum Programme with a separate financial identity co-existing with the present FW/MCH services in the country.

Key words: *Post-partum Programme, Allocation of Finances.*

22. Reproductive health: A public health perspective

Authors	**:** Qadeer I.
Source	**:** Economic and Political Weekly, 1998
Place of study	**:** Not Applicable
Period of study	**:** Not Applicable
Type of research	**:** Empirical, Analysis of Secondary Data, Policy Analysis

Aim: To examine the concept of reproductive health as it emerged in the 1980s, its consequences for health research and FPP in India, its advocacy for the third world agenda, and the reasons behind it.

Background and perspective: The concept of reproductive health failed to articulate its links with general health and socio-economic conditions. The emphasis on the human development approach - which incorporates health, empowerment and rights as central objectives - is not without its problems. Though the human development lobby insists on the relevance of basic needs, population control strategies still remain their key to achieving sustainable development. The population policy therefore gets linked to sustaining existing patterns of development and to adjusting population numbers.
The replacement of the concept of 'women's health' by 'reproductive health' by advocates of human development did not examine either the epidemiological basis of reproductive health or the reasons behind women's silence vis-à-vis reproductive health problems which would have revealed the immensity of the women's health problems and the social constraints on women's lives. Overlooking the causes of reproductive ill health which lie outside conventional medical boundaries may lead to a superficial and medicalised
intervention strategy and may thus fail to cure reproductive ill health.

The life cycle approach, by identifying reproduction as the criterion for defining stages of life, actually medicalises it and undermines the social processes at work. The compartmentalised perception of family and reproduction breaks the unity of production and reproduction in human societies. This then leads to isolated activism, which misses out on issues of socio-economic influence and the links between general health and

reproductive health. It ignores the need to create simultaneous cushions in the social sphere while intervening at the family level.

As a consequence, it leaves a limited and narrow scope at the level of operationalisation. It transforms reproductive health into technologically-determined services. Deprived of its social content, medicalised reproductive health can be as coercive as the earlier FPP services.

Research geared to improving the reproductive health of women lacks contextualisation. The studies did not focus on issues besides reproduction - like their livelihood. Mostly prescribed by the funders with some exceptions, reproductive health research does not arise either out of the perceived needs in women's lives or epidemiological priorities.

Supported by international funding agencies at the ICPD in Cairo, the reproductive health strategy was accepted in principle without any discussion on development strategies or SAP. The basis of the shift was political rather than epidemiological.

Deeply rooted in the social matrix of each society, the actual expression of reproductive health needs depends upon the status and social position of the women in it. Therefore, women may not be in a position to articulate their needs. There is a need to identify the possible levels of intervention as well as evolving strategies for intervention. At the family and community level, therefore, the only way to tackle reproductive health issues is to locate them within the broader spectrum of women's needs. At the policy level, the debate on health can be meaningful only if it addresses fully the socio-economic political context of health.

Further, with the help of mortality data from the Model Registration Scheme, the author critiqued the reproductive health approach. This analysis, according to her, emphasises the following: (1) The importance of dealing with the health problems of girls under 15 years of age who bear the highest load of mortality and enter the reproductive age with a disadvantage. (2) The importance of communicable diseases which not only kill the young but remain the major killers of women in the 15-45 years age group. (3) The inappropriateness of identifying reproductive age groups for intervention when communicable diseases, anaemia and malnutrition are their major killers. They are common to all age groups. (4) The need to retain the focus on maternal mortality, and not opt for broadening the base of MCH services, thereby diluting the available efforts as well as resources of the public sector. (5) The need to recognise the impact of general illness on maternal health. The complications caused add to maternal mortality. This data gives a clear basis for policy-level interventions in the area of public health.

Based on analysis of expenditure on family welfare and health, it is strongly recommended that within reproductive health, priorities should be clearly articulated and reflected in the budgetary allocations. Also, MCH, nutrition, contraceptive services and communicable disease control must be integrated. This alone can give optimal results, not just for reproductive health but for women's health as a whole.

Key words: *RCH, Public Health.*

23. Emerging issues in reproductive health

Authors : Ramachandran V. and Visaria L.
Source : Economic and Political Weekly, 1997
Place of study : Not Applicable
Location : Not Applicable
Period of study : 1996-97
Type of research : Empirical, Policy Analysis

Aim: To study ground-level implications of the TFA and the RCH programme from the women's perspective; to examine and evaluate the new performance indicators developed by the Government of India (GOI) in the TFA manual; and to examine NGO experiences in women's health to draw relevant lessons for delivery of government health services.

Methodology: Eight regional consultative meetings comprising NGOs, researchers, social activists, government officials, training institutions, medical professionals and representatives of ANM unions were organised between June 1996 and January 1997 to respond to TFA introduced by the government in family planning. This study draws upon the reports of these consultations.

Findings: The TFA manual was found to be self-contradictory and inconsistent in many places. It was difficult to comprehend, with the paradigm shift not very clear. The recommendations were for widespread dissemination through district/block level workshops to create awareness amongst service providers, spell out specific implementation strategies for community participation and monitoring and evaluation systems to assess the impact on the quality of services and the attitudes of providers.

Recommendations: Specific recommendations were made for strengthening the RCH programme. These included: catering to wide-ranging health care needs of women, including mental health and occupational health care; improving health care delivery at PHCs (such as regular services of gynaecologists); improving infrastructural facilities; providing effective communication systems and transportation for critical cases at all PHCs; and communicating to people the links between sexual health, sexual practices, sexually transmitted diseases, RTIs etc.

A range of recommendations was made specifically on ANMs, given the fact that they are the fulcrum around which all change revolves. If the ANM is to be the first and most accessible link between the people and the health system, she must be given the necessary tools, both medical and human, to sustain that position effectively. Capacity-building of male health workers is also recommended.

The meetings also recommended involvement of women's groups in planning, implementing and monitoring the RCH programme. The authors conclude with the recommendation that relations between NGOs and GOs must be strengthened, especially in planning, implementing and monitoring RCH programmes. They lament the lack of information-sharing during the planning phases.

Key words: *Reproductive and Child Health, ANM, NGO, TFA..*

24. Health care services in tribal areas of Andhra Pradesh: A public policy perspective

Authors : Rao K.S.

Source : Economic and Political Weekly, 1998
Place of study : Not Applicable
Period of study : Not Applicable
Type of research : Empirical, Analysis of Secondary Data, Policy Analysis

Aim: To highlight the need to formulate a health policy for tribals which would (a) relate to epidemiology and levels of social development; (b) have the central focus on the well-being and survival of the tribals; (c) be based on considerations of cost-effectiveness and sustainability.

Background and perspective: The paper is divided into three parts. The first part gives a brief overview of the health status of the tribals living in the scheduled areas of Andhra Pradesh. The second part provides a critique of the recent initiatives of the state government for providing better health care. The third part briefly outlines the thrust areas of the new paradigm.

Health status of the tribals: The health of tribals is characterised by very high incidence of nutritional deficiency, maternal and under-5 mortality. There is a high prevalence of malaria and TB. These factors have serious consequences for the tribal population. The sex ratio is declining at a faster rate and there is 75 per cent stunting/wastage among tribal children.

Health care services in tribal areas are far from satisfactory. There is a need for a 'differential' approach restricted to the setting of differential norms for establishing facilities but not in content or approach. The physical access of health care facilities is one of the major barriers for health-service utilisation. The lack of accommodation, poor infrastructure, large-scale absenteeism and vacancies, poorly-trained and unmotivated personnel and lack of maintenance are the main reasons for the near absence of health care facilities. This pushes the tribals to private facilities where they incur high expenditure. With increasing landlessness among tribal populations compared to 1981, for the majority of tribals illness has serious economic consequences on their fragile incomes.

Public policy for health care of tribals: Centralised top-down planning and the inability of the tribals to articulate their need for health care services, are the two main reasons for an ambivalent public policy. Though the objectives of the Tribal Health Project (THP) launched in four districts of AP provide for a package of services, the outcomes are confined to reducing morbidity among mothers and children alone. The positive aspect of the THP is that, for the first time, an attempt has been made to build on the concept of people's participation. The strategy seeks to anchor itself in the positive aspects of tribal life such as community homogeneity. This was to be achieved by providing for a CHW, and constitution of village health committees.

A serious shortcoming of the health policy for tribals is the reiteration of the routine compartmentalised approach. In view of the strong association of TB, malaria, AIDS and STDs with reproductive health, the policy framework falls short of assessing the operational inadequacies for improving the implementation of these public health programmes.

Need for a new paradigm: There is a need to develop a more people-oriented strategy for tribal

development. The development paradigm will need to make health the central focus of the overall development strategy. The agenda should consist of provision of basic education, basic health care and capacity-building within the framework of a stable and sustainable land use policy. The structural interconnectivity between income, food secuirty, female literacy and good health needs to be taken note of.

Key words: *Tribal Health, Public Policy Perspective.*

25. Myths of reproductive profligacy of poor: Evidence from Mandya district

Author : Rao M.
Source : Economic and Political Weekly, 1997
Place of study : Mandya, Karnataka
Location : Rural
Period of study : 1985-87
Type of research : Empirical, Descriptive, Community-based

Aim: To review the empirical evidence (secondary sources) on family size, child survival and fertility by socio-economic categories followed by the findings from an empirical study (primary sources).

Methodology: The primary data were collected from three villages. They were selected on the basis of being primarily agrarian in an area of advanced agricultural techniques, with an average-performance primary health centre with easy access. It also details the Labour Exploitation Index that had been used for the purpose of stratification. A detailed household schedule was utilised to obtain data on both demographic and socio-economic features of households in addition to data on health and family planning variables. Qualitative data was obtained through unstructured, in-depth interviews. The study population comprised 670 such families (a co-resident domestic group comprising the reproductive unit of husband and wife and their offspring, natural or adopted, who shared the same kitchen).

Background and perspective: The author builds his argument by critiquing assertions about the profligacy of the poor in India and the popular understanding that this causes the poverty of the poor and of the country. In that he makes references to literature dating back to the 19th century and studies and reports of national-level committees such as the Bhore Committee, which adopted this position. However, there is a dearth of data on family size and its determinants, fertility and mortality, by socio-economic categories.

Findings: The data reveales that the poor in India have the smallest family size. This is governed by a higher load of infant and child mortality and thus lower child survival. It is also governed by a lower level of fertility as measured by the index of children ever-born ratio. This calls for further large-scale studies. The findings presented here have profound policy implications.

Key words: *Child Survival, Family Size.*

26. HIV/AIDs in India: A country responds to a challenge

Author : Salunke S.R., Shaukat M., Hira S.K., et al.
Source : AIDS Supplementary, 1998
Place of study : Nationwide
Location : Rural and Urban
Period of study : 1992-97
Type of research : Empirical, Evaluative, Health Centre and Community-based

Aim: To evaluate the National AIDS Control Programme.

Methodology: Sentinel Surveillance was initiated to monitor trends in HIV epidemic at 56 sites in the country from 1992. Three rounds of sentinel surveillance of population groups considered to be at higher risk (STD clinic attendees and intravenous drug users) and lower risk (antenatal clinic attendees) had been completed.

A survey based on prevention indicators was also used to assess the impact of the National AIDS Control Programme at the end of its first 3 years. The survey was conducted at two sites (rural and urban) in five states - Maharashtra, Tamil Nadu, West Bengal, Delhi and Haryana. A set of nine prevention indicators was used to assess the impact of the national programme. External teams at the population level and at the STD facilities carried out the evaluations. In each component, 1,800 multistage, stratified, randomly selected respondents were taken.

The four groups studied were commercial sex workers in Mumbai and Calcutta; STD attendees in Mumbai, Madurai; Bangalore and Surat; intravenous drug users in Manipur and pregnant women in Mumbai, Pondicherry and Imphal.
Backgroud and perspective: Along with a brief introduction to progress of HIV pandemic in India from 1986, it reviews the prevalence of HIV in various vulnerable groups at the outset. Paper describes major components of the NACO. They were programme management; STD control; condom distribution; information, education and counselling (IEC) and social mobilisation (NGO); blood safety and reduction of the impact of HIV/AIDS through community and palliative care.

Authors also refer to the different approaches to estimate the impact of the HIV epidemic on mortality. One approach involved comparing observed death rates with the numbers expected under certain assumptions about the population size and previously recorded death rates. Another approach has been based on seroprevalence estimates obtained from serological surveys, which have been used to project AIDS cases and deaths. Both of these methods indicate that a substantial number of under-reported AIDS cases and deaths have occurred in Mumbai over the past decade. This has created an understanding among policy makers and large industries that illness and death among the productive workforce will have an economic impact.

Findings: The indicators selected highest and lowest percentages in urban and rural areas were arrived at. Of these there was no information on the last two indicators for rural areas. The respondents selected by survey had knowledge of at least two HIV/AIDS prevention methods in 54.4 -77.9 per cent of cases in targeted metro areas and in 13.4-63.8 per cent of cases in rural areas. The findings suggest that the present level of condom availability was adequate because condom access was assured in almost 100 per cent of urban and rural areas through various sources. A small per cent

reported at least one non-regular sexual partner that translates into a large number of individuals at risk because of the large population of India. Condom promotional activity in association with STD case management in some areas appeared limited but it was reported that overall diagnosis and management of STD appears satisfactory.

The article states the future course of action to be adopted by the government and NACO to prevent and control HIV. It delineates the prospective strategies of the government. In that, emphasis is on the area of surveillance, focus on women and children's issues, a shift from raising awareness towards focused intervention among commercial sex workers (CSW), migrant populations and other behaviour-based groups at high-risk of HIV, strengthening care and counselling programme to lend credibility to prevention programmes, addressing ethical issues concerning people with HIV infection, encouraging industry to treat HIV as a developmental issue, and investing resources in areas of priority research. There is a consensus among the policy makers to improve health services for women. It is also proposed that reproductive tract infection intervention would be integrated into STD services at the primary health care level.

Key words: *Prevalence, Surveillance, Mortality, AIDS Prevention and Control.*

27. Women and health

Authors : Shatrugna V.
Source : The Indian Journal of Social Science, 1994
Place of study : Not Applicable
Period of study : Not Applicable
Type of research : Empirical, Analysis of Secondary Data

Aim: To review some of the health programmes launched by India since 1947 for the improvement of women's health.

Background and perspective: The dominant assumptions and world-view of the health programme launched after 1947 caused their failures. The author states that these programmes were based on modern medicine's view of human beings as dissected and fragmented entities, totally unconnected to the social realities around them. This flawed world-view locates disease and illness in organs and functions, and proceeds to treat these organs and their malfunctions, regardless of the environmental, social and cultural factors at play here. The fact that the system's advantages could be exploited only when all the other links could be taken care of - such as the nutritional status, the immune status, regularity of visits, follow-up, medication and rest was ignored. An examination of the assumptions about women's health and disease and the constraints that operate in their lives revealed that a mere increase in the number of health personnel, beds or hospitals may not ensure health care for women and their children. It is therefore necessary to recognise the limitations that exist before making the system responsive to the needs of women.

The various limitations of the programmes were illustrated by analysing the constraints of a number of nutrition programmes launched by the government for women and children, to bridge the calorie, protein and nutrient gaps. Even when food supplies reached the woman under various nutrition supplementation programmes, the woman had to share it with other household members and very often the food became a

substitute rather than a supplement. The National Anaemia Prophylaxis Programme ignores the host of problems that have their roots in anaemia, offering at best a temporary solution.

It also critiques the MCH and Family Planning Programme for their misplaced priorities, and the poor quality of care, which impacts women and their well-being. The health care system is still insensitive and indifferent to women's needs. It has emerged as a powerful, urban-based, capital-intensive, curative and individually-controlled system. The emphasis has been on doctors, specialists, and hospitalised individual care to women's aging bodies and minds. The author concludes that the health care system will also have to reach out and get involved in understanding the social ramifications of disease.

Key words: *Women's Health, Government Programmes, Nutrition Status, MCH, FPP.*

28. Women, health and population in India – An NGO perspective

Authors : Singh P.
Source : Unpublished draft paper
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To highlight the NGO perspective on women's health and population issues in preparation for the ICPD.

Methodology: Synthesis of 18 regional meetings of NGOs, held in the context of preparation for the ICPD, 1994.

Background and perspective: The basis for action is the failure of family planning programmes in spite of a massive deployment of human resources, funds, technology and political will. Given that work and employment are the foremost priorities for India's masses, all health and family welfare policies and programmes must take this reality as the basis for initiating action to promote the health and well-being of people. Poverty and illhealth is also related to the unsustainable use of natural resources. Women's health, in particular, suffers from the lack of basic sanitation facilities and clean drinking water. The inter-relationship between reproductive health and reproductive rights needs to be recognized. The issues highlighted by NGOs were the need to have an integrated approach, to recognize the links between poverty, population, women's status, literacy and development, and to integrate health policies with socio-economic and development policies. Decentralization and accountability were emphasised for the family welfare programmes, as was the need for gender equality, women's autonomy and the role of men in the programme.

Recommendations: It was recommended that in addition to restructuring and upgrading the existing status of health care systems, complete and detailed information on all aspects of a woman's body and her reproductive rights must be made available to her. It was emphasised that a sound family planning policy and its implementation must support the principle of voluntary freedom of choice in matters of procreation. Indicators for the assessment of family planning were suggested. The indicators included:

improvement in infant and child survival, decrease in maternal mortality, decrease in maternal morbidity, improvement in the rate of safe abortions, decrease in proportion of women in reproductive age groups suffering from anaemia and sexually transmitted diseases, provision of balanced and complete information on contraceptives, and availability to women of a method of their choice. There is a need to revive numerous time-tested traditional health and family planning practices. Relevant IEC packages should be made available for women to become aware of and learn to take care of their own bodies and health so as to be in a position to make informed choices in the matter of their reproductive health and family planning. The role of the media is underscored in changing social attitudes and vocalising various issues. Research is recommended to establish the links between women's health, poverty, and demographic processes. NGOs can take the lead in influencing population policy through international and national forums.

It is concluded that there is a need for a change in perspective where it is clearly understood that population policies must be seen as comprehensively encompassing socio-economic and human resource development strategies.

Key words: *NGO, Women's Health, Population.*

29. Rural women take reproductive health matters into their own hands: Rural Women's Social Education Centre (RUWSEC)

Author	**:** Sokhi S.S.
Source	**:** Series on Upscaling Innovations in Reproductive Health in Asia, 1998
Place of study	**:** Not Applicable
Location	**:** Not Applicable
Period of study	**:** Not Applicable
Type of research	**:** Empirical, Descriptive, Community-based

Aim: To document the alternative approach adopted to attend to women's reproductive health care needs by a women-centred and community-based organisation.

Background and perspective: This is a case study of Rural Women's Social Education Centre (RUWSEC), highlighting its women-centred reproductive health approach. RUWSEC has been both women-centred and community-based in its values, objectives and strategies. It has proved its major organisational strengths through its appropriate and successful programme implementation, the formation of women's associations, employment of programme managers, administrators and health workers from the community itself, and action research to determine current health needs. RUWSEC was founded by a group of women from the same community.

In terms of objectives, the reproductive health service programme aims to be affordable, accessible, comprehensive and sensitive to gender issues. According to the community's feedback, it seems to be achieving its objectives in practice. The programme includes single women, older women, youth and men along with married women of child bearing age in an attempt to meet the reproductive health needs of the whole community.

The reproductive health intervention programmes are planned based on a sound assessment of women's health status, service provision and women's position in the

home. The programme has laid down evaluation processes, development indicators, as well as the personnel management processes. In-depth needs assessment and action research have been critical in reviewing the programme and constantly checking whether the programme is still meeting community needs.

Key words: *Reproductive Health, Health Care.*

30. Quality assurance in nursing

Author : Sridhar S.S.
Source : Indian Journal of Nursing & Midwifery, 1998
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To highlight the significance of QA in nursing; to review the status of QA programmes at international and national levels; the need for preparing local and national standards which are feasible and implementable in various aspects; and inculcating the concept and culture of quality among nursing professionals.
Background and perspective: The author gives an account of the development of the 'quality of care' concept and its importance at a time when consumers are increasingly aware of the need for quality health care, and in the light of standardised nursing education, advanced medical technology and various social, political and economic factors pressurising the profession. Efforts all over the world towards quality assurance in the nursing profession are worth taking note of. The author states that quality assurance programmes in India are still at a rudimentary stage. Baseline studies are needed to know the status of nursing and its involvement in quality assurance.

Various committees to date have looked into different aspects of the health care delivery system. But none of them have listed the importance of improving the standards of nursing care. The licensing bodies, the Indian Nursing Council and the State Registration Councils, which are responsible for laying down minimum standards, have limited their role to registration of educational institutions and practitioners and to some extent the standardisation of nursing education, examinations and qualifications.

All senior professionals in India opine that nursing standards are poor. Most private nursing homes are staffed by unqualified persons. Non-availability of qualified nurses and financial constraints in private hospitals are responsible for the recruitment of unqualified and underqualified staff. The author lists a range of obstacles to raising the standard of nursing in India. This includes various categories of nurses, ambiguity about their job descriptions, lack of adequate nurse administrators, inter-professionality problems, the absence of a regulatory body to assess the standards of nursing services and the absence of Indian publications on nursing.

The author states that the nursing profession is badly in need of standards. The CPA and other consumer organisations are demanding quality service. They need to be informed about what to expect from a qualified nurse and who is a qualified nurse.

Reviewer's note: The paper opens up a range of areas for research as well as advocacy.

Key words: *Quality, Standards, Nursing Practice, Profession.*

31. Investment in medical equipment: Study of private hospitals in Madras city

Author	**:** Sukanya S.
Source	**:** Radical Journal of Health, 1996
Place of study	**:** Madras, Tamil Nadu
Location	**:** Urban
Period of study	**:** 1992-93
Type of research	**:** Empirical, Descriptive, Health Centre-based

Aim: To analyse the pattern of investment in medical equipment in private hospitals in a metropolitan city in India.

Methodology: The sample consisted of 50 private hospitals in Madras city. The survey population for this study constituted all the 'for-profit' private hospitals in Madras offering general and multi-speciality services in allopathic medicine. Thus it excluded voluntary hospitals, government hospitals institutions offering services to in-patients or out-patients alone and nursing homes specialising in a single service alone. As the information on private hospitals were not available, thus a two-phase sampling technique was adopted. In the first phase of data collection, a list of 130 hospitals was prepared and questionnaires were mailed to them seeking information about the nature, size (departments, total manpower and bed capacity), and form of the hospital (sole proprietary, partnership, corporate, trust). The sampling framework for the second phase of data collection was based on this information. The response rate for the first phase of data collection was only 10 per cent and hence the method of sampling was changed from two-phase sampling to purposive sampling. A questionnaire was designed to collect data on the investment decisions of private hospitals. The market value of medical equipment for the year 1992 was taken for analysis.

Perspective and findings: Increasing privatisation and corporatisation has had a significant impact on the pattern of investment in medical equipment that this study analyses. This study has categorised medical equipment into four distinct classes. Big corporate hospitals may invest in costly medical equipment that is not related to the health care needs of the people. Introduction of compulsory medical audit/technology assessments may require information on the commitment of resources to capital equipment. For example, the study observed that the investment in imaging equipment was the highest among the different categories of medical equipment, indicating the need to closely monitor investment in imaging equipment.

The author suggests that the sample should cover more geographical regions - rural and urban - for a better understanding of the health care industry in India. The study highlights the impact of corporatisation on the investment pattern of hospitals. On an average, a corporate hospital invests almost 20 times more than a sole proprietary hospital. As huge resources are sunk into medical equipment, studies on resource management assume relevance. Further studies on the comparison of private and public sector hospitals regarding investment pattern, rate of utilisation of medical

equipment and the price charged by them, can be undertaken. The author believes such an understanding will help policy-makers in (i) efficiently allocating scarce resources to various health services, (ii) regulating the investment pattern of private hospitals for providing health care suited to the needs of the people.

Key words: *Private Hospital, Insurance, Investment in Medical Equipment, Resource Management, Utilisation.*

32. Work and reproductive health: A Hobson's choice for Indian women?

Author	**:** Swaminathan P.
Source	**:** Economic and Political Weekly, 1997
Place of study	**:** Tamil Nadu
Location	**:** Rural and Urban
Period of study	**:** Not Applicable
Type of research	**:** Empirical, Analysis of Secondary Data

Aim: To examine the causal relationship between women's work and reproductive health.

Methodology: 1981 and 1991 census data and NFHS are the main sources of data used.

Background and perspective: The observed statistical correlation between an increase in outside employment of women and a decrease in birth rates has focused attention on the demand for increasing women's wage employment as a primary goal, not necessarily on its own merits, but as part of the demographic drive to reduce fertility. At what cost to women's welfare do such demographic outcomes occur? The existing structural nature of women's work (domestic as well as non-domestic) has severe in-built hazards for women and health (reproductive and otherwise) which no amount of first-rate quality of care and/or access to health services alone can deal with. Focusing on Tamil Nadu (India), the author argues in addition that a demographic model state need not necessarily be a reproductively safe place.

Findings: The study focuses on employment and on the structure of women's work outside the home. These data are seen in the light of child mortality, a proxy indicator for reproductive health. The data shows that about 80 per cent of female workers are still confined to the primary sector of the economy. The distribution of workers by industrial categories reveals that, proportionately, the percentage of female workers in the age-group 0-14 years outnumbers males in the same age-group in each of the industrial categories. In most districts, more than 70 per cent of women and girl children work either as agricultural labourers and/or cultivators. This phenomenon has a lot to do with the cropping pattern in Tamil Nadu. Women outnumber men in the casual labour category in weeding and harvesting. Infant mortality indicators were high in the rural areas, among agricultural labourers and among manual labourers. In the absence of epidemiological studies, it is difficult to establish causality between the nature of women's employment and resultant impact on reproduction. However, some community-based research has indicated the links between the inflexibility of mortality indicators beyond a point, and the nature of women's tasks, especially in the rural areas of Tamil Nadu.

Further, it analyses the domestic nature of work in general and documents the adverse health consequences of inadequate and/or almost negligible investment in basic infrastructure (like fuel, drinking water), particularly in the rural areas. The argument is supported by analysing the domestic chore of fuel collection as an illustration of (a) the physical energy that needs to be continuously expended in such tasks in addition to wage-earning employment, for sheer survival; (b) the technological exclusion and/or inappropriateness that is the hallmark of the planning process in this sector, and the consequences for health because of the criminal negligence of this sector. Lastly, it carries a discussion on emerging trends in employment as evidenced by recent NSS data, and the discouraging scenario as far as alleviation of domestic drudgery is concerned. Based on the data trends, the author draws attention to the fact that low investment in rural infrastructure has a direct bearing on the health (reproductive and otherwise) of rural women because of the enormous strain they have to undergo for the most basic tasks. In such a context it becomes increasingly difficult to support policies aimed solely at improving women's participation in market activities.

Key words: *Reproductive Health, Work, Morbidity, Mortality.*

33. Monitoring the quality of family planning care through the PERFORM system of indicators

Author : Talwar P.P., Tsui A.O. and Narayana G.
Source : Paper presented for the Quality of Care Workshop, Bangalore, 1995
Place of study : Jhansi, Uttar Pradesh
Location : Rural and Urban
Period of study : Not Stated
Type of research : Empirical, Descriptive, Community and Health Centre-based

Aim: To describe the UP state project for which Project Evaluation & Review for Organisational Resource Management (PERFORM) was designed; the performance-driven benchmark that defines PERFORM indicators; and the results from a district pilot test of PERFORM.

Background and perspective: At the outset the author discusses the concept of quality of services and quality of care in the context of the Family Planning Programme in India. The USAID-funded, ten-year, Innovations in Family Planning Services (IFPS) Project is designed to serve as a catalyst for the Government of India to reorient and revitalise the country's family planning services. Performance-Based Disbursement (PBD) mechanism is a unique feature of the project. It also collects information on a wider range of input, output and outcome indicators in order to monitor the IFPS Project's progress towards its reproductive goals. IFPS activities are to be implemented in three phases. The first five-year phase involves starting, testing and evaluating service delivery innovations in 15 of UP's 66 districts. The second phase will involve replication in other districts of successful activities accompanied by demonstrable outputs in terms of expanded numbers of service points, increased numbers of clients, or heightened awareness of new family planning services. The third two-year phase focuses on the achievement of project objectives and their impact on contraceptive use. PERFORM collects information at institutional and individual levels using the probability sample approach. It

is designed in such a way that it would assess the environment of access to and quality and promotion of family planning services for both the public and private sectors. Seven survey schedules have been developed to provide a systematic assessment.

A pilot test of the PERFORM system was carried out with a sample of 288 SDPs and 524 eligible women. The author claims that the values obtained for the quality of services and quality of care indicators provide empirical confirmation of PERFORM's measurement capabilities for indicators. In addition to other indicators of quality, interviewers were also asked to rate their impressions of how staff interacted with clients and a comparison was made between facility and staff-based indicators with clients' perception.

The outcome of the PERFORM pilot test (1) highlights the way operationalising the quality concept in service and care helps derive performance indicators, at the programme, client levels, that are useful to programme managers for monitoring and evaluating the achievement of their service objectives and (2) illustrates how quality of care measurements can be integrated into ongoing data collection systems for research or evaluation of projects or programmes.

The author emphasises that the PBD system helps reinforce programmatic commitment to the quality care of its clients. The role of the PERFORM indicator system is to provide a logical and operational structure to the concept within an ongoing monitoring effort, thereby maintaining, if not strengthening, programmatic commitment to this project.

Key words: *Quality of Care, Measurements.*

34. Target-setting in Family Planning Programmes: Problems and potential alternatives

Authors : Townsend J.W. and Khan M.E.
Source : Demography India, 1993
Place of study : Not Applicable
Location : Not Applicable
Period of study : Not Applicable
Type of research : Theoretical

Aim: To explore the rationale of target-setting and its consequences in the context of the FP programme in India; to suggest alternatives to target-setting and to identify areas for further policy and operational research.

Findings: Target-setting resulted in inevitable consequences like a skewed emphasis on specific methods, neglect of the quality of services as well as the needs of women, false reporting and an achievement of short-term targets but with no decline in the ultimate goal, viz. decline in fertility.

The author cites the experiences of Mexico, Indonesia and Bangladesh in employing the concept of targets in different ways. The alternatives to target-setting suggested are: to change the strategy and rationale of service delivery by improving and strengthening MCH care, responding to the unmet need for contraception, and improving the quality of Family Planning services.

Key words: *Target-setting, Family Welfare Programme, Quality, MCH.*

35. Family welfare programmes and population stabilisation strategies in India

Authors	**:** Zodgekar A.V.
Source	**:** Asia - Pacific Population Journal, 1996
Place of study	**:** Not Applicable
Period of study	**:** Not Applicable
Type of research	**:** Empirical, Analysis of Secondary Data, Policy Analysis

Aim: To review the policy, programme and strategic changes in the FPP.

Background and perspective: The author reviews the philosophy of the FPP at its inception in the First Five-Year Plan and follows the changes in structure, administration and implementation in order to influence the reproductive behaviour of the population and increase the number of acceptors of various family planning methods. The author discusses the achievements and limitations of India's FWP. Increase in health care facilities and services, contribution to large-scale awareness about family planning, contraceptives and more available facilities are some of the achievements. With the help of data on the current fertility rate and couple protection rate, mean age of acceptors and average living children, the author demonstrates that the state's family planning programme still has not been able to limit population growth. The pace of the fertility decline is slowing; it almost came to a halt in the 1980s. The FPP has not been able to recruit younger couples with lower parity. It has not been able to popularise the use of reversible methods.

While examining the reasons for its failure, the author looks into its philosophy and implementation strategy, and also looks at the recent proposed changes to India's population policy. The target approach is looked at critically. Given the diverse and pluralistic nature of Indian society, it is articulated that there is a need to decentralise the planning and decision-making processes of the FPP. Under 'quality of information and services' it is argued that public services in India lack sufficient out-reach, are of poor quality, and have inadequately-trained staff. The programme also suffered bad publicity and rumours on account of lack of after-service and concern, apathy and coercion. The role of information, education and communication is highlighted for the creation of greater demand for family planning and health services.

Recommendations: The importance of improving women's status, lowering infant and overall mortality, micro- and macro-level socio-economic development, literacy, and poverty alleviation is emphasised in influencing a society's population growth rate. The author concludes by recommending improvement in the quality of information and services through better IEC and recognition of the need to change the image of the family welfare programme from that of birth control to improving people's quality of life. It is suggested that without some improvement in socio-economic conditions, family planning alone cannot provide solutions. The programme needs to be focused on the achievement of various welfare-oriented targets rather than increasing the number of contraceptive acceptors.

Key words: *Family Planning Programme, Quality of Life, Socio-economic Development.*

36. Health services in rural and urban areas

Authors : Voluntary Health Association of India (VHAI)
Source : Health for the Millions, 1997
Place of study : Not Applicable
Period of study : Not Applicable
Type of research : Empirical, Analysis of Secondary Data

Aim: To compare and contrast the status of health services in the rural and urban sector and in the public, private and voluntary sectors.

Findings: The paper highlights the development of the health services infrastructure in India. Though rural health services are being developed on a relatively normative pattern, no serious effort is being made to systematically develop an urban health services network, which has grown on a rather ad hoc basis and in a haphazard manner. Rural health services are grossly inadequate, forcing the rural population to seek care from private practitioners (qualified and unqualified) of various systems of medicine.
The urban health system too has no outreach programmes and mainly provides institution-based curative services. The Urban Revamping Scheme initiated in 1984 envisaged the creation of urban health posts to cover areas based on their populations. However the scheme continues to face problems due to non-availability of drugs and equipment, the lack of proper outreach services and lack of focus on detection, treatment and referral of cases. The paper concludes by recommending the establishment of referral systems, links between primary, secondary and tertiary levels of care and intersectoral coordination.

Key words: *Health Care Services, Urban, Rural, Private, Public.*

POLICIES: ANALYSIS, CRITIQUE AND ALTERNATIVE PERSPECTIVES

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