CHAPTER II

REVIEW OF LITERATURE
The review of the relevant studies have been made in this Chapter under two broad headings: studies on factors affecting MCH and FP practices and studies on the utilization aspects of the health services. Each of these studies have been reviewed considering the objective, study design, main findings and conclusions. The reasons for carrying out the present study and main conclusions are given in the end of the Chapter.
2.1 Studies on Factors Affecting FP and MCH Practices

Nair P.S. (1982) used the Census Data to study the role of socio-economic factors in contraception. The Census data from 15 States was analysed, considering the independent variables like urbanisation, female literacy, per capita income, family size, population, population density. These variables were related to rate of contraception by calculating zero-order correlation coefficients, multiple regression analysis and partial correlation coefficients using the SPSS computer package. Urbanisation, female literacy, per capita income and family size were found to explain a substantial part of inter-state variance in contraceptive acceptance in the country.

Mouli A.S.C. and Mouli S. (1981) compared the socio-demographic characteristics of adopters and non-adopters of IUDs and sterilisation in rural areas of Bangalore district. The economic status differed only marginally; caste and education were observed to be related to acceptance of FP. The exposure to mass media was having a favourable impact on FP acceptance. Nearly 42.3 percent of the adopters were motivated by ANMs; 7.6 percent by Medical Officers; 15.3 percent by friends, and rest were self-motivated. The


decision to undergo sterilisation was taken by both the husband and wife in 57.6 percent of the cases. The reasons for non-adoption of any family planning method was disinterest (35.3 percent), non-availability of male children (17.7 percent) recent marriage (17.7 percent), and other reasons were lack of knowledge about FP methods; and belief that methods being determinental to health.

Mehta B.C. (1975) analysed various correlates of fertility regulation, using the Census Data for various States. IUD and sterilisations acceptors were taken as adopters of family planning. The correlation coefficients and multiple regression analysis techniques were used. Literacy level explained 46 percent and income level 38 percent of the variance and together these variables explained 56 percent of the variance in performance of family planning in different States. The low social status of women was observed to be reflected in the dominancy of female sterilisation.

Krishna Kumari, K. (1990) related the breastfeeding with conception interval. 415 women in one of the wards in Trivandrum city, who had not practiced contraception


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between their first and second conceptions and who had their last child 5 years of age were included in the study. These women were asked about their lactational history including onset, duration, return of menstruation, and month of conception. The relationship between the independent variables like breastfeeding, post-partum amenorrhoea and age; and between the dependent variable (conception interval) and independent variables was determined using zero-order correlation and partial correlation analyses. The extent to which the conception interval can be prolonged as a result of lactation, post-partum amenorrhoea and age was also studied by linear regression method. Multiple regression analysis was carried out to find the effect of the factors on conception. The lift-table techniques were used to find out the average waiting time for next conception. The zero order correlation and partial correlation analysis showed a positive relationship between breastfeeding and conception interval. The study revealed the paramount effect of breastfeeding in prolonging the conception interval especially when women are younger and not using any contraceptive.

Rajaretnam T. (1990) by developing the life cycle charts demonstrated that the population control is influenced much more by the timings of the births and not merely by 'family size'. Irrespective to the number of

children produced, the timing of birth was observed to have an independent impact on population control. Delaying marriage or and spacing births, would produce a considerable impact on population growth; because late born children are late to grow, late to marry and late to reproduce and this "late" process would continue generation after generation.

Ali, M.R. (1981) related the decisions to adopt family planning with personal values such as theoretical, economic, aesthetic, social, political and religious, which are acquired during socialisation. The study was carried out by administrating the Allport - Vernon - Lindzey scale of values to 50 individuals. The socio-economic and demographic variables like education, occupation, religion and location of residence were held constant. The dependent variables considered were early, late and non-adoption of family planning. The early adopter was one who adopted family planning measures at least within 6 years of marriage (provided he did so before the birth of a fourth child); and late adopter was defined as one who had adopted family planning measures after 6 years. The theoretical and aesthetic values were observed to be positively related and religious values to be negatively related to family planning. High social and economic values were observed to induce desires for a large number of children. Almost all

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the values were related to the socio-demographic variables like age, sex, profession, education, income and date of marriage. Theoretical values increased with age and the aesthetic values were found to be high between 25 and 35 years of age. The theoretical values were higher in males and aesthetic values were higher in females. Both these values increased with education and income. These were higher in urban persons.

Gandotra M.M. & Pandey, D. (1982) observed that there was a significant relationship between family structure, and husband-wife communication and family planning. The study was carried on the data of 600 rural households and 1224 urban households in Baroda district; to know the fertility differences by type of family and to study the influence of family structure on the attitudes of the members towards family planning. The extent of use of family planning methods was found to be higher among couples in nuclear families irrespective to the place of residence. The husband-wife communication on family planning was found to be significantly higher in urban nuclear families as compared to urban joint families, but there was no significant difference in family planning communication between husband and wife in rural families.

Bhatia J. C. & Neumann A.K. (1980) studied the role of inter-spousal communication on the practice of contraception. It was observed that out of those couples which had discussed family size with their spouses, 47.2 percent used family planning methods. In contrast, of those who never discussed the desired number of children with their spouses only 12.8 percent had practiced family planning. The net effect of inter-spousal communication on the practice of family planning was observed to exceed that of other socio-economic variables used in the analysis.

Desh Pande S. & Bharani B. (1980) observed in their study in district Indore in Madhya Pradesh that although people were aware of FP methods, yet they did not practice them, in the absence of proper guidance regarding the availability, use and side effects. The survey was carried out in Indore city and nine surrounding villages. One thousand target couples were interviewed on knowledge various contraceptives, source of knowledge and reasons for acceptance or non-acceptance of contraceptive methods. The vasectomy and tubectomy were the best known contraceptive methods; nearly 93.9 percent of the respondents knew these


methods. The knowledge of behavioural methods (coitus interruptus and rhythm methods) was almost negligible. Oral pills were known to 50 percent of the urban and 21 percent of rural couples. Condom was also almost universally known. The rural couples had adopted permanent methods more than the spacing methods were more acceptable. The rural and urban differences in contraceptive practice in the study was found to be statistically significant.

Audinarayana, N. (1988) in his study in rural areas of Chittoor District of Andhra Pradesh observed that the respondents had a poor knowledge of the legislation on the age of marriage; especially among the Scheduled Castes. The study analysed the knowledge and attitude of 360 rural respondents towards the legislation on raising the age at marriage. The result revealed that although the knowledge of the legislation was poor, yet when informed, most of them were in favour of the minimum age prescribed in the legislation. Those who already had the knowledge of the act, had a favourable attitude towards it, and preferred a higher age at marriage for boys and girls. It was observed that the Caste Hindus were more knowledgeable and favourably inclined towards the legal ages than the Harijans, who were still in favour of early age at marriage, especially of girls.

Ramachandran, L. (1989) observed that ante-natal and natal care had a relation to perinatal and neonatal morbidity and mortality. A careful watch on signs and symptoms of high risk pregnancy conditions and their management wherever necessary could result in decreased morbidity and mortality, among newborns. Education of women was observed to influence the pregnancy outcome. The effective MCH care was observed to result in better acceptance of family planning. The current health care delivery system was observed to be lacking in extent of coverage and availability of care.

Sharma S. et al (1985) studied the factors affecting the child development knowledge of rural and urban expectant mothers. The expectant women visiting four Primary Health Centres and two urban hospitals in district, Ludhiana, Punjab, were administered a tool containing 82 statements on child development and infant care. The mean scores of urban expectant mothers were higher than the rural expectant mothers. The knowledge score of employed women (both in urban and rural areas) were higher than their unemployed counterparts. The income level was also positively associated with the knowledge score of women both in urban and rural areas. A positive correlation between knowledge

score and education level was also observed in urban expectant women. They concluded that there was significant difference between rural and urban expectant mothers in their knowledge of child development. It was also found that the various sources of information for expectant mothers were mainly books, magazines, radio, TV and peer group.

Srivastava, J.N. & Saxena D.N. (1988) studied the correlates of immunisation in rural Uttar Pradesh. 1256 rural mothers who had an infant or delivered a child in last one year were interviewed. The immunisation coverage of the children for DPT, OPV and BCG Vaccines was studied against the factors like distance from PHC and socio-economic status, religion, caste, education of father and mother, occupation of father, and housing. The study revealed a low coverage of children for immunisation. The analysis brought out that ante-natal consultation had a strong and positive influence on immunisation coverage of children, the distance from PHC played a marginal negative role. Hindus had higher coverage as compared to Muslims. Education of both husband and the wife was found to exercise a promoting influence on immunisation coverage. The education of mother had a more pronounced effect. The children of manual labourers and people living in Kacha houses and from low socio-economic status had poor coverage.

Jasudason & Shirur (1980), studied the socio-cultural aspects of food during pregnancy in the Telengana region of Andhra Pradesh. They observed that the nutritional needs of pregnant and lactating women in terms of availability and quality of food, was much neglected. As regards food taboos, a large number of foods like Pulses, Legumes, Leafy Vegetables and Fleshy foods were mentioned, and were avoided during pregnancy. The breastfeeding practices, beliefs and taboos in Karnataka were studied by.

2.2 Studies on Factors Affecting Utilisation of Health Services

Chutani, C.S. et al (1976) carried out a study in four community development blocks of Haryana, Rajasthan and Madhya Pradesh. The sample comprised of 4 PHCs villages, 1/3rd of the sub-centre villages and stratified 10 percent sample of peripheral villages i.e. within 5 kms. from PHC and those more than 5 kms. from PHC. The community survey was carried out in 10 percent of the households or any other responsible person was interviewed regarding their knowledge and awareness of PHC and sub-centre, and frequency of use of the services, the level of satisfaction was estimated, and those dis-satisfied were asked about the reasons. A total of 876 households in the sampled villages were surveyed. Nearly 84.8 percent of the respondents were aware of the existence of PHC. The awareness ranged from 100 percent in PHC villages to 64.4 percent in villages beyond 5 Kms. from PHC. About 91.4 percent of those living in sub-centre villages were aware of the existence, while only 60 percent living in peripheral villages knew of sub-centre.

48.3 percent of the respondents reported to have utilised the services of PHC at one time or other. A further break up revealed that 79.5 percent of the respondents and or their families from the PHC villages had

utilised the services. The percentage was 50.3 for those residing beyond 5 Kms. from PHC. The utilisation of services of sub-centre was limited to the sub-centre villages. About 57.4 percent of the respondents in these villages were reported to have utilised the services. The respondents who had never used PHC services were asked to state reasons. 57.5 percent mentioned "more faith in private practitioners" 28.84 percent were prejudiced against PHC, 15.3 percent felt no need to visit PHC, 9.6 percent felt that facilities available were inadequate, and 2 percent mentioned distance factor.

Yesudian, CAK (1981) Studied the Differential Utilisation of Health Services in a Metropolitan City. Out of 120 National Sample Survey investigation units in the city, one unit was selected for the study. The selected area had Government General Hospital and a private hospital run by Christian Mission. Almost all the social classes were represented in the area. 100 households each from high, middle, low and very low class were selected (after collecting information on education, occupation, income of the head of households). A structured interview schedule was used to collect the information from 400 households. The respondents were asked to identify the communicable and chronic diseases from a list of 11 diseases. Those who

correctly identified 9-11 were graded to have good knowledge; 5-8 as average; 0-4 as poor knowledge of diseases. Good knowledge of diseases was present in 90 percent of households of high class, 78 percent of Middle class, 30 percent of low and 24 percent of very low class. Education was considered to be the main variable influencing the knowledge of illnesses. The perception of the subjects regarding certain signs and symptoms such as - headache, body ache, chest pain, stomach ache, diarrhoea, cough, cold and tooth ache, was investigated. None of the social classes had perceived all the nine symptoms and diseases important to seek medical treatment. A majority of respondents from high class had perceived 4 or more symptoms to seek medical care; while among the majority in low class, 1-2 symptoms were perceived as serious enough to seek treatment; the very low class respondents did not perceive any of the symptoms serious enough to seek treatment. Most of (75 percent) of the high class households mentioned to seek medical treatment immediately for all symptoms and diseases perceived important for medical treatment. In middle class 58 percent preferred to wait and see the severity of symptoms and diseases before seeking treatment. Forty-five percent of low and 45 percent of very low class respondents mentioned to seek treatment when the illness affected the day-to-day work and illness incapacitated them. Of the 465 patients only 382 had sought some type of health services. The number of patients who had not gone for
medical care increased with the fall in social class. Among the 382 who sought medical care, social class position played a role in selection of health services. 96.7 percent of patients from high, 72.7 percent from middle and 6.5 percent from low and 4.5 percent from very low class sought private health services. 93.5 percent of low and 95.5 percent of very low patients who sought treatment consulted public health services.

Srinivasan, S. (1984), used anthropological field methods such as observation and interview techniques to collect data from five primary health centres in Kanchipuram and Alangayam blocks. A quota sampling of 25 respondents from each of the five sample villages in the selected PHC were drawn at random. 125 respondents were interviewed in the sample villages. Data was also collected by interviewing medical officer incharge of PHCs. 65.6 percent of the respondents had utilised medical care services rendred by PHC. 64.8 percent utilised services of RMPs also. All the respondents preferred the injection form of treatment for diseases since it brought about quicker relief. The supply of medicines at PHCs was inadequate considering the heavy attendance in OPDs. Besides the supply of medicines was irregular. The frequency of visits by the PHC staff to their respective field areas were very


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The medical officers expressed their inability to supervise the field work of the field staff. The health centres were not centrally located in the blocks. The people living close to the PHC utilised the services to the maximum extent as compared to people living far away from it.

Rao, P.H. (1985) Carried out a Case Study of Utilisation of PHC in Bihar. He observed that the PHC sub-system worked independent of the other Government health facilities (Ayurvedic dispensaries etc.) operating in the area. The PHC was open on 6 days a week that too in forenoons. So people had to depend on private practitioners during remaining time. Only one M.O. was available at PHC at a time. The M.O. incharge had to seek the permission of district officers even for small purchases which required lot of time. Inordinate delays in the approval and sanction of T.A. bills were hindering the effective supervision at various levels. It was evident from interviews with M.O. and para-medical staff, that there was no conscious planning for various activities by either the medical or para-medical staff. There were no regular visits from the district officers for guidance to M.O. and for providing specialists care to patients. Most of the time they came to convey messages regarding new targets and Family Planning camps.

M.Os visits to sub-centres were limited due to lack of transport facilities. The PHC vehicle was not in working condition for past 5 years. M.O. Incharge expressed inability to take disciplinary action against the non-performing staff because of anticipated unpleasant repercussions. The meetings were mainly for collecting the information from field-staff regarding different activities, no constructive exchanges between M.O., Supervisors and Field staff took place during the meetings (like planning of future activities or solving problems of staff). Although female M.O. was available but MTPs were not being carried out despite facilities (these were performed at MOs private clinic). Maintenance of vehicles, refrigerators, and other equipment was very poor. Narration of symptoms by patients was the main basis for diagnosis. Occasionally feeling of pulse, patting of stomach were adopted. Instruments like stethoscope, blood pressure instrument, thermometer etc. were seldom used. Due to availability of a narrow range of drugs at PHC, MOs prescribed the drugs to be purchased from Chemists.
Richard, J. (1986), studied various social economic and demographic factors affecting medical care utilisation. The social, economic and demographic variables studies were sex and age of head of the household; religion, education of head and of the highly educated person in the family, annual income, household size, place of residence in village, social participation, electricity, distance from town, total debt of the household, total wealth of household, members of the family, condition of the house, cleanliness of the house, existence of a separate kitchen, provision of separate bathroom, degree of water supply. Some of these factors directly affect an aspect of medical care utilisation and some of these are indirect indicators of a factor that affects medical and health care utilisation. Nearly 81.5 percent of the respondents were doing home treatment for common ailments in initial stages. This aspect was explained by factors like average annual income (b=0.157), distance from town (b=0.141), existence of separate bathroom in house (b=0.112), extent of social participation (b=0.071). All these explained 12 percent of the variations in behaviour. Preference for home treatment in initial stages was shown by persons who had lower annual income, being far away from towns, living in houses with no bathrooms, and poor housing. The behaviour was explained by

poor socio-economic status (SES). 18.4 percent who went to physicians or hospital in initial stages of diseases had higher SES. When illness was prolonged for more than 1 week, 43.3 percent preferred consulting physician and 53.1 percent mentioned that they would visit hospital. Those who preferred going to physician were more wealthy and had better type of water supply in house. Those who preferred hospital especially government hospital had higher age of head of household, lower level of education and higher preference for government hospital. When asked about choice of physicians, 44.8 percent preferred Private Medical Practitioner, 42.9 percent government doctor. Those who preferred a place which gave "Quick Relief" were characterised by higher income, better condition of the house, higher education of head of family, staying in main village, higher social participation, having separate bathroom in house and having electricity. Those who mentioned preference for place of treatment due to "free services", had poor living conditions, lower income and lower level of cleanliness in house. Nearly 65.9 percent of respondents preferred hospital as place for delivery. The higher educational level, income and lower family size, the higher was the preference for hospital as place for delivery. The preference for local Dai was determined by religion and social participation. Hindus with lower social participation preferred local Dai for delivery. 5 percent of the respondents mentioned to have used family planning methods. The use was found to be determined by religion,
household size and social participation. The larger the household size, and higher the social participation and the higher was acceptance for family planning methods. For infants 27.5 percent preferred mostly native practices; 4.6 percent preferred mostly modern and 67.7 percent both. Those who expressed preference for native practices had lower level of education, lower level of cleanliness, living away from town, higher family size and lower social participation.

Singh R. Kumar, N. (1988) made Qualitative Assessment of the Functioning of a PHC in a Tribal Setting. The study was carried out in PHC located on Jabalpur - Mandla Road, 40 Kms. from district headquarters. The PHC covered 131 villages with total population of 50,604. 70 percent of the population was tribal population (Gonds). The PHC had one Medical Officer incharge and three male medical officers. The services were extended to the villages through 10 male and 16 female MPW, 85 Dais and 57 Health Guides. OPD hours at PHC were 8-12 PM and 5-6 PM. During the 7 days observation period it was noted that Doctor was available at 8.50 AM at the earliest and 9.15 AM at the latest. On an average, in morning shift, Doctor spent 1.46 hours at OPD (against stipulated 4 hours); while in evening, 0.26 hours (against the specified 1 hour). The total average daily

availability of Doctor was 2 hours. Usually one Doctor was present the others being on leave or absent from their duties. An average of 85 patients (60 new and 25 old) visited OPD per day. The analysis of OPD record showed attendance of patients per day as 57 during June-August, 53 in September to November, 49 during December to February and during March to May. 33.2 percent of the patients were 0-4 years of age, about 11.5 percent of OPD patients were infants and 38.7 percent were in age group 25-44 years. There was no sex differential observed for the age group 25-44 years. Majority of the patients (53.0 percent) were from the PHC village itself, and almost all were from surrounding 37 villages (out of 131 covered by PHC). 93.0 percent patients came within a distance of 6 Kms. from PHC. 69 percent had to travel less than 15 minutes to reach PHC. 92 percent of patients came on foot. The Jeep allotted to PHC, had not been in working order for the past one year and was waiting condemnation by the office of CMO. The CMO had provided a Jeep for family planning work. it was exclusively being used by the Medical Officer incharge to make field visits for instructing field staff to motivate family planning cases to family planning camps. The vehicle was rarely used for other health activities. The PHC had 6 beds, the beds were in good condition (mattress, bedsheets, blankets, pillows etc.). During the previous year 16.7 percent of the 180 bed days per month were utilised. A
further analysis showed that beds were mainly being utilised for eye camps and family planning camps. It was found that only MO Incharge was regularly attending PHC while the other MOs belonged to neighbouring districts and were going to home districts and were doing private practice in those areas. The MO Incharge did not seem to mind their absence because he then remained the sole practitioner in his area. He was earning approximately Rs.2500/- to Rs.3000/- per month from private practice. The Compounder too was found to charge Rs.2-3 from patients for giving them "better" medicines. In the three tier system of PHC, sectors and sections, the sector supervisors did not seem to have any important supervisory role. All the MPW working under them received targets for different health programmes individually from the MO Incharge. There was lack of coordination and team spirit. Another discouraging factor was that field staff was not getting their TA/DA in time. Most of the time the emphasis was on family planning sterilisation. In the monthly meeting which lasted for about 2 hours, the MO incharge and Block Extension Officer spent most of time instructing the workers to bring sterilisation cases and that in case of non-achievement of F.P. targets their salary would be withheld. The MO Incharge mentioned that the performance of MPW was being solely judged by his/her family planning achievement.
Khan, ME; Anker, R. and Dastidar, SKG (1989) made micro-level evaluation of the access to health and Family Planning services in rural Uttar Pradesh. The Primary Health Centre was housed in a rented building consisting of 3 rooms, a veranda and open courtyard. The courtyard had a cattle shed in one corner where the landlord kept his animals. One room was used by two male Doctors who shared a table and sat opposite each other while examining patients. The second room was utilised by Pharmacist to dispense medicines and the third room was used as store-cum-office. The PHC was in its present site for 15 years. No water was available at PHC & PHC rendered OPD services only. The working hours were from 8 to 11 AM and 3 to 5 PM. Each patient was charged 50 NP as registration fee. The Civil Dispensary had three rooms. One room was used as clinic, other for storage and third as operation theatre. Its timings were from 8 AM to 1 PM and 3 to 5 PM. The staff consisted of one male Doctor, a Compounder and a Waterman. The clinic was mainly used for consultation as it had very few medicines. The sub-centre in village Kishanpur had an ANM and a trained Dai. The centre was opened about 6 months before the initiation of the study. The residents mentioned that the sub-centre was of little use. During the 20-day observation period, it opened for 7 days. The ANM was

frequently absent from duty. The study village had a Health Guide, who had 5 years of formal education and belonged to Backward Class. He had a medicine kit for common ailments. Since he had six acre of land and was the only male member of his family, he was usually busy with his farm work and hardly had time to discharge his responsibility. The study village had 12 private practitioners. None of them was qualified. However, they were the main source of medical assistance for local inhabitants. 88 percent of those who reported to have fallen sick and taken treatment were treated by the private practitioners. All private practitioners used allopathic medicines. Two of them were Ayurvedic Graduates, one was Pharmacist and the rest had worked as Assistant to Doctors within or outside village. Ten of the practitioners were local resident. They charged Rs.3-5 per visit. One conducted illegal abortions and charged Rs.50-200 for the services. All practitioners belonged to higher castes. Informal discussions with villagers and main informants revealed that villagers did not utilise governmental services because of good treatment available through private practitioners at reasonable cost in the village itself. Moreover, village practitioners did not keep fixed clinic hours and their services were available even at night. In case of serious ailments, the private practitioners with their own contacts, helped patients to get necessary facilities and services. In turn, he was paid for his assistance. The villagers were quite satisfied with this arrangement. The Government sub-centre
in village was of little use, since ANM rarely visited it. Visits to PHC or civil dispensary were expensive and bothersome due to distant location, single trip requiring 2-3 hours, loss of wages and disruption of other important work. If the child was sick, mother had to accompany it to PHC, and the whole family's schedule got disturbed. After bearing all the costs, the necessary drugs were usually not available and the Doctor might not be there. The PHC provided only inexpensive drugs and asked patients to buy costly medicines from the market. If the disease continued, it required more visits and more loss of time and expenses on the family. So, majority preferred local practitioners. Most of the informants were not aware of the Government programme to provide iron and folic acid tablets to pregnant women. Only 4 out of 20 knew of sub-centre but were not sure of the services provided by it. The main reasons were that sub-centre was newly opened and ANM was rarely visiting it. Although, female informants were aware that nutritious foods should be eaten during pregnancy (main emphasis was on Ghee in later stage of pregnancy and thereafter) but for most women poverty did not permit such care. The villagers lacked information about cheap food items which were locally available and known to be particularly good for the pregnant women. Arhar dal was considered gas producing and avoided during pregnancy. Pregnancy was taken as a natural phenomenon which did not require any special attention unless there were
complications. Majority of informants were not aware of medical check up, TT immunisation, iron and folic acid tablets. Most women did strenuous work throughout pregnancy and sometimes they worked for 13-14 hours a day. Almost all births took place at home and were assisted by Dais. The ANM rarely conducted deliveries and charged Rs. 30-60 per case. The normal money given to Dai was Rs. 5-10 plus some grains.

Ram, E.R. and Datta, B.K. (1976) Studied Medical Care for Rural Masses and its Relationship with Income and Education Levels, in Miraj Taluka of Sanghi District of Maharashtra. In major illnesses 80.3 percent consulted Doctors, among those who contacted Doctors, 67.2 percent consulted allopathic, 24.9 percent RMPs and 7.8 percent consulted Ayurvedic Doctors. 32.2 percent of the households got medical help within a Km. of their house, 22.6 percent within 1-5 Kms. and 17.5 percent, 5-9 Kms., and 27.7 percent travelled a distance of 9 or more Kms. to get medical help. For minor illness, 72.5 percent of the households who sought medical help, 30.9 percent consulted allopathic, 29.3 percent Ayurvedic and 39.6 percent RMPs. 61.0 percent got their medical help within 1 Km. distance, 30.3 percent between 1-5 Kms, 8.3 percent between 5-9 Km., 10.4 percent

in 9 Kms. or more distance. Of the households who responded to this question, 12.9 percent did not spend any money, 42.6 percent spent Rs.50/- or less, 19.6 percent Rs.51-100, 12.5 percent Rs.101-200 and 12.2 percent spent Rs.200/- per year. The proportion of households which spent more money on medical care increased with higher educational level of the family members. 22.9 percent of households which had at least one matriculate and above, spent Rs.200+/ above in comparison to 1.4 percent and 12.4 percent of households which had all "illiterate" and at least one literate but non-matric member respectively. Of the 1393 households in the lowest income group (Annual income less than Rs.1200/-) 16.1 percent did not spend any money on medical care, whereas among households in the higher income group (Rs.3601 and above), 8.1 percent did not spend money, while among the households in the medium income groups (Rs.1201-2400 and Rs.2401 to 3600) 11-12 percent did not spend any money. The average annual income of household was Rs.2472/- and the average annual expenditure on medical care was found to be Rs.72/- per household (average household size being 5.9).
Probability of Change in Attitude

\[ P = ip (i-e) \]

\( P \) = probability of taking a certain action.
\( p \) = perceived probability that the action will lead to a certain goal.
\( e \) = perceived effort required to take the action (time, money or other resources).
\( i \) = \( i_C + i_I + i_V \) = perceived importance of that goal.
\( i_C \) = importance of compliance factors or direct rewards.
\( i_I \) = importance of identification factors or reward due to identification.
\( i_V \) = importance of internalisation factors or reward due to integration with values.

Source - Mathews, C.M.E. (1978)
Mathew, C.M.E. (1978) Studied the Health and Village Culture in Tamil Nadu. Villagers classified foods as 'Hot', 'Cold', 'Wind' producing according to their 'effect in the body'. The most carefully observed prohibition was against 'Cold' foods on certain occasions, such as after child birth. Groundnuts and Jaggery was considered cough producing. 'Hot' foods were avoided for infants. There were dietary restriction of lactating mother for fear of ailment in breast fed child. Although poor family consumed leafy vegetables yet the quantity consumed was much less to meet Vitamin 'A' deficiency. "Hot foods" were Beans, Gram, Groundnuts, "Cold foods" were mainly Tomato, Pumpkin, Gourds, Radish, Buttermilk, Ladies-finger and Ragi. "Airy" foods comprised of root vegetables Potatoes, Sweet Potato, Drumstick, Yams. Many of the beliefs about health and disease were based on Tridosa concept of Ayurveda, Diarrhoeas, Cough, Scabies, Jaundice, Anaemia and Kwashiorker were believed to be due to 'heat', Fever, Asthma, Fits due to 'Cold'. Diseases from mothers milk included Diarrhoeas, Cyanosis in newborn and respiratory infections. Abdominal pain was attributed to bad food. Disease attributed to sexual intercourse included V.D. and Lepromatous leprosy. Some types of diarrhoeas were attributed to displacement or twisting of intestine. Chickenpox, Measles, Mumps and Smallpox were attributed to

Goddess "Mariamma". For diseases arising through supernatural powers, spiritual treatment in the form of chanting of 'Mantras', or tying of charms or carrying out of rituals was preferred. For children's diseases due to mothers milk, traditional treatment was preferred. Of the 'Tridosa' diseases, the one due to 'Air' were mainly being treated by Traditional practitioners but for those due to 'Heat' or 'Cold' other Doctors were consulted. The diseases treated mainly by traditional or spiritual methods included most of those which lead to high infant and preschool child mortality like Diarrhoea, Kwashiorkor, Severe Anaemia, Cyanosis in newborn, measles, whooping cough and some respiratory complaints. The allopathic treatment was being sought for a few diseases. But even those who went for allopathic services, did not utilise these to the best advantage. Most had no ideas of what disease they had or what was prognosis or for how long they would need to take treatment. There seemed to be very little communication between patient and doctor. When respondents were asked to mention the contents of communication, 60-70 percent said that they had asked when to come again or how and when to take the medicines, 20-26 percent did not ask any question, only 2-9 percent asked about disease its cause and prevention. In contrast those who went to traditional practitioners, learnt about cause and treatment of diseases. In both the phases, the respondents had very little knowledge of how to prevent diseases. Many did not believe that prevention was possible. There was little
knowledge about immunisation, which was mainly confined to Smallpox. Very few felt any need for antenatal care. Only 13 to 21 percent saw doctor or dai when pregnant. Pregnancy was treated very lightly and no special care was considered to be necessary. Only 10 to 20 percent of deliveries took place in health centre or hospital. About Family Planning knowledge, in terms of real understanding of the method was very low and there were many wrong ideas. Tubectomy was thought of as turning the Uterus upside down and vasectomy as cutting the "Nerve". There was even less knowledge of temporary methods. Poverty was found to be a very important factor in ill health.

Bose, S. (1980) Studied Health Situation in a Village in West Bengal. The data was collected from all the 406 households of village Belgraria in Nadia district of West Bengal, by interviewing head of the households. In addition, information was collected from local allopathic, homoeopathic doctors and folk healers. In the village, 43.0 percent of the households took homoeopathic treatment, 26.0 percent Allopathic, 12 percent preferred folk medicine and 7 percent home remedies. When some one in family fell ill, in one third of the households indigenous medicines were preferred. When these were ineffective, they consulted physicians or folk healers. The poor people were observed

to rely more or home remedies or consult folk healers than the richer persons. Among poor, homoeopathy was more popular, mainly because of lower costs. The PHC was located at 6 Kms. and the nearest Government hospital was at a distance of 11 Kms. from the village. The health workers and PHC staff hardly carried out activities for improvement of sanitation. Health workers visited the village mainly for family planning work and immunization. The coverage of children with DPT, OPV had been very poor. Only 17.0 percent of the households had visited Government hospital, mainly during accidents, for X-rays, and Tuberculosis. Most of them who utilised the services were unsatisfied with the services, due to long wait, unconcerned behaviour of the staff, cost of transport and lack of medicines. There were 7 allopathic practitioners practicing in or near the village. None of them was graduate in Medicine. One was RMP, and the rest were Compounders or Vaccinators. They were practicing for 10-30 years and charged Rs.1-2 as consultation fee and Re.1/- for injection. They invariably gave injections. Although these Doctors were not able to interpret the results of X-rays and other investigations, yet they were making their patients undergo these tests. Doctors were offering 40-50 percent of treatment on credit. Sometimes the amount was being paid back in kind (Vegetable, grain or labour). There were three homoeopathic practitioners in the area. The villagers preferred this form of treatment mainly it being cheaper and without side
effects. There were four folk healers, all above 60 years of age. They usually did not take money but patients paid something in kind. 59 percent of the households had gone to these healers for treatment from time to time, mainly for diseases like Mumps, Measles, Chickenpox, Jaundice, Asthama, Skin Disease, Dog and Snake bites, Gastrointestinal and Gynaecological diseases. The poor people usually performed medico-religious practices. "Goddess Mansa" was worshiped as a mean of protection against Snake bites, "Shitla" for protection against Smallpox. The offering varied from hair of the person to money, sweets, flowers etc. In serious ailments, sacrifice of goat was offered. The supernatural causes of diseases as perceived by villagers were breech of taboos (Leprosy, VD), wrath of Goddess (Smallpox), Spirit of intrusion (Tetanus, Psychosomatic ailments).

Mooley, P.G. (1986) Carried out Sociological Study of Health and Illness in a Village Community in Vidarbha (Maharashtra) Most of the respondents felt illness to have occurred when it made the individual bedridden and he is unable to work. Minor ailments were not cared for. Most of the respondents consulted local practitioner during major illness. Diseases were mainly related to change in climate or habits. Chickenpox and measles were mentioned to be due to "Heat" in body. Tetanus was associated with injury with

iron objects (especially rusted iron). For Dog bite and Snake bite folk healer was usually consulted. Knowledge about immunization was inadequate. Diet was not being increased during pregnancy. Certain foods were being avoided for lactating women. Colostrum was being considered bad and discarded. Breastfeeding was being started on 3rd day after delivery. Semisolids or top foods were introduced when child was able to eat with its own hands.

Rizvi, S.N.M. (1986) Studied the Socio-Cultural Factors Influencing the Health in a Tribal Community. 300 respondent households from 33 villages situated in the Jaunsar Bawari area of U.P., were selected by purposive sampling. Interview technique was used for data collection. Quasi-participant observation technique was also used to supplement the data. Health was taken as absence of all disease from a person's body. It was observed that climate, geography, beliefs, isolation and poverty of the tribals influenced the attitudes towards health and state of illness. For most of the diseases indigenous medicines were commonly used. Jaunsaris had an extensive knowledge of drugs and herbs. Among the tribals most of the customs and practices with regard to health and disease had no modern scientific basis. Child mortality was very high. Social factors had a profound influence on the tolerance/acceptance of many disorders.

1. Rizvi, S.N.M. Factors Influencing Health in a Tribal Community - a Socio-cultural Analysis, Ind. Diss. Abs. 15(1), 1986, 4-5.
Banerji, D. (1981) carried out a study in 19 villages from 9 States in the country to study the behaviour of the rural population in context of various health institutions available and accessible to them and their cultural perceptions and cultural meaning of various health problems. There was wide differences in the environmental conditions and in access to health Institutions between the small privileged class and the vast majority of the rural population. The bulk of the health problems among the poor were generated by the extremely poor environmental conditions in which they lived and those problems could be dealt only by improving the living conditions. Since this is essentially related to the economic, social and political conditions, improvement of health status of population is also essentially an economic, political and social issue.

Djurfeldt, G. and Lindberg, S. (1973) in their case study of the introduction of Western medicine in a Tamil village, analysed the health situation in the village and its relationship with prevailing economic and political order. The study was carried out in Thaipyur village situated 20 miles south of Madras (Tamil Nadu). The data was collected by survey on demographic and economic aspects; interview and observation methods were used to collect ethnographic data; and case study technique was utilised to collect information on social aspects. The authors observed that health of the Thaipyur inhabitants was a social and historical product. Their bad health was attributed to impoverishment and exploitation which started long ago. The health of the people could be improved only by raising their economic level; and the allopathic system of medicine alone could not solve the health problems. They concluded that only a profound transformation of the economic and political structure could give the people of Thaipyur the means to improve their own health.

Kumar, A. (1973) carried out case studies on the working of Auxiliary Nurse Midwives (ANMs). He studied ANMs with poor performance in terms of the family planning activities carried out by them, in six districts of Rajasthan in order to bring out the salient individual characteristics of these workers. He observed that there was lack of self initiative for work and lack of coordination between health personnel. The concept of 'health team' was also not practiced. The concerned Medical Officers and Lady Health Visitors were either unaware of the performance of these ANMs or had not given serious attention to them. The training of the ANMs in the area of family planning was also observed to be inadequate. They also lacked the proper knowledge of their job responsibilities. The methods of motivation taught during the course of their basic training did not seem to work in the field situations. There were difficulties regarding the provision of basic equipment for the ANMs, like delivery kits and other equipments required for the insertion of IUDs.

Bhattacharya, K (1986) studied the relationship between motivation and productivity. The study was carried out in the Tablet Department of the Sarabhai Basic Drug Plant, which had the individual incentive scheme

operational. The Supervisors and Chemists were administered a questionnaire containing items on three components of valance - instrumentality - expectancy to measure the motivational force of the employees. The average incentive earned by the employees over a 2 months period was taken as an index of performance. Two-way analysis of variance was carried out. The data supported the hypothesis that a positive relationship exists between the employees' motivation and their performance.

Indian Council of Medical Research (ICMR) (1991) 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. The main focus of the evaluation was to look into the quality of family welfare services provided to the target population residing in the rural areas. Different methodologies such as observation of the ANM in the field, scrutiny of records and their verification, and examination of the facilities available at the PHCs and sub-centres were utilized for assessment. A total of 398 PHCs from 199 districts were evaluated during 1987-89. These districts were located in 18 States and a Union

 Territory (Pondicherry). It is realised that the findings of the study cannot be generalized either with regard to a particular State or to the country as a whole, since the selection of the States and the districts was not based on the random procedure of sample selection from statistical viewpoint. However, since, nearly 50 per cent of the districts in the country were evaluated, this evaluation does provide a fairly good insight into the quality of services provided by the primary health centres in the country. As per the new pattern recommended, there should be one PHC for 30,000 population. The data from this study indicate that the recommended pattern was achieved in only 12 percent PHCs; only the State of Maharashtra was found to be largely implementing this new pattern of population coverage. The evaluation revealed many strengths and weaknesses of the health care system. It was observed that while the resources in terms of physical facilities were comparatively satisfactory at PHCs, these were greatly deficient at the level of sub-centres which is the first contact point for the community; this was specially so with respect to the routine antenatal care. With regard to manpower position, there was substantial shortage of ANMs; infant the sanctioned pattern of ANMs indicated the need to increase the number of posts for this category of health functionary. The labour room and operation theater which are essential infrastructures required for the delivery of good quality of FW services, were generally observed to be poorly equipped and maintained at PHC level. In nearly half
of the sub-centres facilities for normal delivery were absent. Furthermore, the fact that majority of the PHCs were lacking in functional equipment and/or trained manpower to carry out pregnancy termination even after 2 decades of the MTP act was a serious concern. The status regarding supportive facilities like maintenance of cold chain, availability of transport and water was satisfactory. Adequate and ready supply of drugs, vaccines and contraceptives are essential to build up credibility of the programme. While total absence of medicines and emergency drugs like cortico steroids and I.V. fluids was not a problem in most PHCs, however inadequate supply of one or more drugs was common occurrence specially in the sub-centres. It was noted that approx. 40 percent PHCs did not have any stock of oxygen readily available. The contraceptives, vaccines and nutritional supplements were in adequate supply both at PHCs and sub-centres. The records keeping related to different components of the FW programme revealed that though many registers were expected to be maintained, however the updating of these registers for ready reference was not in practice. This was specially true with respect to immunization and antenatal/pregnancy registers. It was not possible to ascertain the doses/type of immunization and other care provided to an individual at a glance. The eligible couple register though maintained comparatively better in most PHCs, was also not kept updated with appropriate information. The quality of care
administered by the ANM in the field indicated that coverage of antenatal care was inadequate and where the services were provided these were limited to administration of Tetanus Toxoid and distribution of Iron/Folic Acid tablets. Recording of births and deaths essential for monitoring and delivery of care was not being carried out. This was reflected by total absence of records in one-third of the PHCs and grossly deficient in the remaining. The quality of services related to family planning was better than the MCH component in terms of coverage and follow up care. However the outreach of FP services both for spacing and terminal methods required substantial improvement. Then mean age and parity of sterilization acceptors was observed to be 28.6 years and 3.5 respectively, compared to 25.8 years and 2.3 for the IUD acceptors. These findings reiterate that the programme emphasis should focus on younger women for delaying the age at birth of the first child and adequate spacing between births for subsequent children, through intensive campaign for promotion of spacing methods. The results of the evaluation clearly indicate that the quality and coverage of FW services as currently being offered in the National Programme is poor and that the MCH component is substantially weak in most instances. Thus, while a great deal of effort and resources are required for improving the manpower and other infrastructural facilities, steps to enhance the managerial, supervisory and technical skills of health functionaries (medical and paramedical staff) for improving both the quality and coverage of services are
necessary. Furthermore, continuous monitoring and evaluation - the two important management tools for improving the programme performance need to be strengthened at all levels.
Most of the earlier studies have investigated some aspects of utilisation of MCH & FP services, and have highlighted the inadequacy of Governmental health care delivery system. The present study differs from those studies in the sense that it has been planned in an area, which has well developed health infrastructure as compared to any other block in the district and it attempts to specifically study the simple MCH & FP interventions most of which have been available through the Governmental health infrastructure. These interventions are likely to affect the MCH status in the country to a great extent and UNICEF has impressed upon the developing nations of the world to emphasise on the implementations of these interventions through their health systems in the next few decades. The present study attempts to know the perception of women about MCH & FP interventions, their socio-cultural practices related to MCH and analyse the Government health infrastructure and functioning.
The main conclusions which can be drawn from the Chapter are as follows:

1. The fertility behaviour and adoption of birth limiting practices and methods have been related to various socio-demographic factors, economic factors, exposure to mass media, status of women and husband-wife communication.

2. Some studies have related poor performance under the FP programme to the poor level of knowledge of the potential beneficiaries of the programmes.

3. The knowledge of women about child health and development has been observed to be related to education, income and exposure to mass media.

4. The utilisation of health facilities in the rural areas have been related to distance, quality of services, sources available, motivation and job-satisfaction level of the functionaries.