CHAPTER IV

MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PERCEPTIONS, PRACTICES AND UTILISATION OF SERVICES
Profile of Respondents

Family
Joint 60.8
Nuclear 39.2

Head of Family
Husband 36.1
Mother-in-Law 17.9
Father-in-Law 46

Decision Maker for H&FW
Husband 55
Self 5.4
Father-in-Law 15.5
Mother-in-Law 24.1
The chapter describes the socio-cultural practices and concepts related to mother and child health, nutrition, causative factors for common childhood diseases, indigenous practices in common ailments and perceptions of women about the MCH & FP interventions.

The knowledge of rural mothers (having children less than 6 years of age) in context of the simple maternal and child health interventions has been described and the knowledge score of the women has been related with the variables like education, socio-economic status, head of family, and exposure to mass media by calculating Karl Pearson's correlation coefficient and by comparing the characteristics of low scoring women (score less than first quartile value) with high scoring women (score more than third quartile value).

The maternal and child health practices of the rural women have been listed and the adoption index for the MCH & FP interventions has been related to distance from health institution, education, exposure to mass media and MCH & FP interventions knowledge score of women by calculating correlation coefficients. The predictive equations for estimation of adoption index have also been developed using the multiple regression analysis using the SSP-PC Computer package.
Profile of Respondents

Caste

- B.C./S.C.: 24.1
- Others: 75.9

Socio-Economic Status

- III: 37.5
- IV: 49.5
- II: 6.5
- V: 6.5
The last portion of the Chapter has description on Governmental health services infrastructure and functioning in the rural areas. The Institutions like Primary Health Centre, Rural Hospital and Sub-centres have been discussed in terms of their functioning. The extent of utilisation of MCH & FP services has also been discussed in terms of coverage of potential beneficiaries for maternal and child care, and source of treatment sought by the women.
2.1 Discrimination of Male and Female Children

The sex discrimination was apparent right from the child birth. The social ceremonies were being usually held with the birth of a male child, where as in the female child birth these were being usually avoided. Miller, B.D. (1980) has related the female neglect with the dowry and cost of marriage in rural northern Indian. He postulates that marriage costs for one's children have a strong affect on rural Indians' attitudes towards the sex of their children which can and does result in differential treatment of sons and daughters. Thus where daughters must be married and a high cost to their parents, then sons will be greatly preferred over daughters, and the daughters would be subjected to parental neglect.

2.2 MCH Related Social Ceremonies

The social ceremonies like "Doodhi Dhona", 'Chati', 'Dasutan', 'Piliya' and 'Kuan Pujan', related to child birth usually provided the opportunities for strengthening the social relationships and meeting the social obligations. Some of the ceremonies like 'Doodhi Dhona' could be a reason for delaying the breastfeeding of newborn child in the rural areas.

Miller, B.D. Female Neglect and Cost of Marriage in Rural India, Contribution to Indian Sociology, 14(1), 1980, 95-129.
2.3 Concept of 'Hot' 'Cold' Food Items

Almost all the food items were classified in terms of their nature and effect on the body. Foods like pulses, undiluted milk, egg, jaggary, meat, tea, mango, apple halwa etc. were considered 'Hot', whereas rice, diluted milk, curd, buttermilk, oranges, banana, green leafy vegetables, khichri, kheer etc. were considered 'Cold'. Ghee, fried foods, meat, egg, undiluted milk were considered as 'heavy' foods and potato, tomato, guava, pulses etc. were considered as 'wind' producing foods. Mathew C.E.M. (1978) studied cultural beliefs and practices related to health in villages of Tamil Nadu. He also observed a similar classification of foods, into 'Hot', 'Cold', 'Wind' producing foods according to their effect in the body. The most observed prohibition was of 'cold' foods after child-birth. 'Hot' foods were avoided for infants. There were dietary restrictions of lactating mothers for fear of ailment in the breast-fed infant.

2.4 Causative Factors for Common Childhood Diseases

Tuberculosis was considered to be due to weakness and untreated cough or fever. Exposure to 'Cold' in fever, defect in blood or evil eye were causative factors for poliomyelities in the opinion of local masses. Measles was

considered to be due to untreated fever, 'Heat' in body and
due to Goddess. The Diarrhoea in children was considered to
be due to teeth eruption, intake of spicy foods by
lactating mother, and displacement of intestine ('Dharan').
Worm infestation in children was associated with eating
sweet foods (Gur) and soil eating behaviour. Mathews C.E.M.
(1978) observed that many of the beliefs about health and
disease were based on concept of 'Tridosa' Diarrhoea, Cough,
Scabies, Jaundice, Anaemia and Kwashiorkor were believed to
be due to 'Heat'. Fever, asthma 'fits' were considered to
be due to 'Cold. Diseases like diarrhoea, cyanosis in
newborn and respiratory infections were considered to be
transmitted to infant from mother's milk. Some type of
diarrhoeas were considered to be due to displacement or
twisting of intestine. Chickenpox, measles, mumps and
small-pox were attributed to Goddess 'Mariamma'. Mooley et
al (1986) studied the rural community in Vidharva
(Maharashtra). They observed that diseases were mainly
related to change in climate or habits. Chickenpox and
measles were mentioned to be due to 'Heat' in the body. For
dog bite and snake bite folk healers were usually consulted.

2.5 Indigenous Practices in Common Ailments

The decoction prepared from leaves of Tulsi, Ginger, Dry date fruits, Black-peper and Water was considered very effective in fever. For dry cough Ginger juice in honey, or dry date fruit boiled in milk and decoction of Tulsi, Ginger, Black-peper were considered to be useful. The paste of Neem leaves in Jaggary was the indigenous practice for round work infestation. For thread worm infestation cotton swab dipped in mother's milk was placed on the anal region of child and was considered to be curative. The paste of Neem bark in oil or 'Multani' in water were considered to cure skin infections. For discharging red eyes, kajal, honey and paste of garlic (boiled in milk) were the suggested indigenous practices. The intake of salt and 'Herd' in warm water or massage of hand and abdomen were considered to be effective indigenous remedies for pain abdomen. The use of Turmeric powder and Ghee at local site was considered to facilitate healing of wounds. Intake of Isabogol husk in curd, mint leaves boiled in water, ghee added to tea, onion juice, paste of mango seed, opium etc. was considered to cure diarrhoea. For Pneumonia, massage of chest wall with hot oil and placing cotton around the chest was the usual indigenous practice. Old jaggary, Kala jira, Ajwain were considered useful in infertile women. For menstrual irregularities intake of ghee (prepared from Cow's milk) on empty stomach and carrot seeds boiled in milk were suggested.
Rizvi (1986) studied the socio-cultural practices related to health among Jaunsar tribal community of UP. It was observed that climate, geography beliefs and economic status of the tribals influenced their attitudes towards health and disease. For most of the diseases indigenous medicines were being used and the tribals had an extensive knowledge of herbs. Bose S. (1980) studied the health situation in rural areas of Nadia district of West Bengal. He found that nearly 59 percent of the households had gone to folk healers from time to time mainly for diseases like mumps, measles, chickenpox, jaundice, asthama, skin diseases, dog and snake bites, gastro intestinal and gynaecological diseases. In rural areas of Tamil Nadu, Mathews (1978) observed that diseases like diarrhoea, Kwashiorkor severe anaemia, measles, whooping cough, and respiratory complaints were being mainly treated by traditional methods. Thus the indigenous practices in the rural communities play an important role in health and disease. Some of these may appear vague to the practitioners of modern system of medicine, but the fact is that these are being practiced by a significant segment of rural population. A scientific study may be required to evaluate their effectiveness.

2.6 Perceptions of Mothers of MCH & FP Interventions (Services).

I. During Antenatal Period

i) Not taking bed-rest for at least 2 hours per day in last trimester of pregnancy - The perception was that the newborn child would be active and the woman would not have any difficulty during labour. There had been a feeling among women that continuing doing work would keep their digestive system in order. The beliefs were fed to women from their mothers, mother-in-laws, Dais or other elderly women. Since the rural women had to work at home as well as in the fields, their non-availability or less availability for work due to pregnancy state is likely to disturb the normal routine and functioning of the household, to avoid this, the beliefs seem to be propagated by elderly women.

ii) Not increasing dietary intake by at least one extra diet during last three months of pregnancy - The belief was that the smaller baby would be easy to deliver. The reason for this practice may be because of the consumption pattern of foods in the household in the rural area. Mostly women eat after feeding the men and children and other elderly members in the family, with the result less food is left for them in the end.
iii) Non-Consumption of at least 100 Tablets of Iron and Folic Acid during Pregnancy - The women had a feeling that these tablets were "Hot" and could cause damage to the baby. And since majority of rural women did not have access to sufficient quantity of milk, these tablets could not be digested by them. The Iron Folic Acid tablets are known to cause loose motions and darkening of the colour of urine. In the rural setting the darkening of urine colour is related to excessive "Heat" or "Garmī" in the body.

iv) Not taking Injection of Tetanus Toxoid during Pregnancy - Intake of injection during pregnancy without any other apparent illness may cause damage to the foetus. The fear of injection or of complications like abscess formation and ignorance of the benefit of Tetanus Toxoid intake could be the possible explanations.

v. Not coming for regular ante-natal checkups during pregnancy - The belief was that health worker or Doctor during pregnancy should be consulted if there was some serious ailment or complication, otherwise in normal pregnancy there was no need for any check-up. The working time of sub-centres and Primary Health Centres usually clashes with the working time of rural women (at home or in the
fields). The services of Sub-centre and Health Centre may not be actually accessible and available to the women.

II. During Intra-natal Period

i) Not getting the delivery done in well lighted and ventilated room - The exposure to 'Cold' during labour would result in baby aches later on. This was the belief for getting the delivery in inner room of the house.

ii) Delivery of Child in Rural Area - The delivery is usually carried out on cot (easy to clean), and Dais use old clothes for cleaning. The umbilical cord of the baby is cut after expulsion of placenta using new blade. The mouth of the newborn child is cleaned with hand ("Kagh Udhana"). The newborn is given bath same day after rubbing its body with paste (prepared by mixing Ghee with wheat flour), this is supposed to make the skin of the baby clean and free from hairs. Usually Turmeric powder mixed in Ghee is applied on the umbilical stump, especially if there is pus discharge. The newborn child is usually given no new clothing, but the clothing prepared from old clothes. For first 3 days the baby is fed "Ghuti" prepared by mixing water, milk and Gur or Honey by using a cotton swab. The Ghuti is believed to clean the stomach of child.
III. During Post-natal Period

i) Not encouraging early ambulation of mother after delivery - The maternal body is "raw", or "Kanchi" after delivery and thus complete rest was required. Early ambulation would result in body aches and weakness later on. And if mother get exposed to "Cold" the newborn child would get ailments too.

ii) Not feeding the breast milk to newborn after 2-3 hours of birth - The belief was that the initial breast milk (Colostrum) contains dirty secretions which had accumulated during the pregnancy and should therefore be discarded. The social custom of ceremonially washing the breasts of mother on 3rd day after delivery ("Doodhi Dhona Ceremony") could also be responsible for the practice.

IV. Child Care

i) Not introducing top feeds for infant at 5-6 months of age - There was a belief that mother's milk was sufficient for child upto atleast 1 year. The other belief had been that an infant of 5-6 months of age could not digest foods (cereals).

ii) Diarrhoea - The occurrence of diarrhoeal episode among young children was usually not considered to be a serious problem by the mothers in the area.
Climatic conditions like extreme of hot or cold weather were considered to cause diarrhoea. Mothers associated 'Teething' of young children with loose motions, believing that the two conditions go together and diarrhoea would stay till teething was complete. The displacement of "Dharan" (intestine) from its normal position was also considered to cause diarrhoea. Intake of Spicy, Heavy, and 'Hot' foods by mothers was believed to cause diarrhoea in breastfed children. If a lactating woman breastfed her child immediately after doing work in field or at home, the child could have diarrhoea. Diarrhoea was widely seen to be an indication of the break down of the digestive system of the child, which therefore needed rest in diarrhoeal episode. The feeding during diarrhoea was influenced by this belief. Heavy foods (undiluted milk, gur, ghee, cereals etc.), 'hot' foods, 'sour foods', spicies were restricted. Instead "light" foods like Rice, Khichri, Curd etc. were given but the amount given was much less to meet the diamonds of the child. The indigenous remedies for diarrhoea were Isabogol husk in Curd, Mint Leaves boiled in water, Ghee added to tea, Onion juice, Paste of Mango seeds, Brandy in tea and Opium.
iii) **Pneumonia** - The pneumonia in children was usually related to exposure of child to cold, climatic change, intake of "Cold" foods (Buttermilk, Curd, Banana, Guava etc.) especially after some exertion, intake of "Sour" foods, intake of water after consuming "Ghee" or Fried foods. It was usually recognised by mothers from the rapid movements of the chest wall. The mothers usually covered the child extensively and put cotton around the chest of the child to keep it warm. The home remedies tried, consisted of the herbal tea decoction, Ginger juice in honey, Garlic boiled in milk. The intake of 'Sour' foods, 'Fried' foods, 'Cold' foods and Ghee was usually avoided. The fluids were also restricted.

V. **Early child bearing after marriage and need for male children** - The married girls were encouraged to have early pregnancies after marriage. The need to have male children in the family was felt, in order to have security in old age and to have a heir to their property. The women who did not have children or had only female children were sometimes avoided during social interactions and social gatherings. They were being considered somewhat inferior or unfortunate.
VI. Family Planning methods - The terminal method of family planning (tubectomy) was preferred over other spacing methods because of the latter were non-accessible and available and their were difficulties in their use and disposal. The female sterilisation was preferred over male sterilisation because of the belief that males had to do "hard" work and after operation it may not be possible to do that.

VII. Not encouraging higher education for girls - The belief was that the parents of highly educated girl would find it extremely difficult to have a suitable educated match. And higher the education and qualifications of the boy the higher would be the dowry. The educational qualification for girls was usually limited upto middle or high and thereafter efforts were made to marry them off. Moreover, the higher education institutions were usually near the towns and the parents felt that was difficult for girls to go out of village for higher education.
EDUCATION PROFILE

WOMEN
- HIGH SCORER
- LOW SCORER

HUSBANDS

HEAD

A = NIL
B = PRIMARY
C = MIDDLE
D = HIGH
E = HIGH+
3.1 Knowledge Score for MCH & FP Interventions of Women

The mean knowledge score for maternal care, child care and FP was 18.46, 73.98 and 32.24 respectively. The average total score was 125.58 and it ranged from 69-161. The modal value was 121 and median was 127. The Karl Pearson's Correlation Coefficient was calculated between knowledge score and other variables like education, SES, head of family and exposure to mass media. The child care score was positively and significantly correlated with education of women, education of husbands and with exposure of women to mass media. There was a significant positive correlation between maternal care score and exposure to mass media. The FP score was also significantly correlated to exposure of women to mass media.

3.2 Comparison of Low and High Scoring Women

The various socio-economic and demographic variables among the high scoring (total score more than Q3, 138) and low scoring (total score less than Q1, 113) were compared. Of the High Scoring women, 59.5 percent had received formal schooling as compared to the value of 41.1 percent observed in the low scorers. This difference was statistically significant. The educational level of the husbands was higher in High Scoring women as compared to that of low scoring women. However, there was no significance difference in the education levels of head of the family in the two groups.
HEAD OF THE FAMILY

HIGH SCORER

FATHER-IN-LAW (46.2%) — HUSBAND (48.7%)
MOTHER-IN-LAW (5.1%)

LOW SCORER

FATHER-IN-LAW (67.6%) — MOTHER-IN-LAW (2.7%)
HUSBAND (29.7%)
In 48.7 percent of the high scoring women, the family was headed by their husbands as compared to the figure of 29.7 percent among the low scoring group. There was no statistically significant difference in the distribution of the type of family among low and high scoring women. It was observed that 78.4 percent of women in high scoring group and 35.9 percent of women in low scoring group had frequent exposure to mass media. This difference was statistically significant. The mean total adoption index for MCH & FP interventions was 43.2 in low scoring group which was significantly lower than the mean value of 60.2 observed among the high scoring women.

Although there is plenty of literature on utilisation of health services, yet one is unable to make definitive statements about why some use health services and others do not. Mc Kinlay (1972) six sets of factors that may be important to understand differences in utilisation. These are economic causes, socio-demographic variables, geographic location of health services, organisational behaviour, socio-psychological variables and socio-cultural factors. Singh A.K. (1984) defines modernity as an aggregate of certain personality-cum-attitudinal traits which facilitate individual growth and development with social responsibility and make the individual an effective agent of socio-economic

TYPE OF FAMILY

HIGH SCORER

Joint (70.3%)  Nuclear (29.7%)

LOW SCORER

Joint (53.9%)  Nuclear (46.1%)
and political development. It is now being increasingly recognised that concern for economic and political development is because of the concern for man and the well being of man is the main pursuit of modernity. A person, with health modernity has scientific and rational attitudes to health and disease, which are also reflected in his behaviour. Sahay M. & Singh A.K. (1989) have related health modernity with socio-economic status and educational level. Singh, K.P. (1982) also observed that modernity makes a person more progressive and open minded and thus enables him to take more rational view of things and also brings about changes in the value system.

Audinarayana et al (1989) concluded that individual modernity is negatively related with the fertility behaviour of women and suggested that there was an urgent need to cultivate modern values among women through adult education programmes, and exposure to mass media. Several authors (Inkeles et al 1974) have related modernity to level of education, exposure to mass media urban residence, type of occupation, openness to change, orientation towards time and readiness for new experience.

SOCIO ECONOMICS STATUS

HIGH SCORER

IV (54.5%) - III (32.2%)

LOW SCORER

IV (46.3%) - III (43.6%)
Studies (Reddy N. 1989) on awareness of various developmental programmes revealed that poor had limited knowledge of developmental and welfare programmes. The awareness of and contacts with officials of these programmes are also less among the disadvantaged. Moreover, their exposure to mass media is also less. The attitudes towards and perceptions of the programmes play an important role in acceptance and adoption of change. The way people interpret the programmes and their predisposition towards these programmes are regarded as important determinants. People usually perceive the changes in villages in terms of the facilities which meet their felt needs and those that were desired by them. The disadvantaged segment of the rural population was observed to perceive lesser accessibility to facilities and also the lesser level of satisfaction from those to which they had access.

ADOPTION INDEX AMONG 
LOW & HIGH SCORING WOMEN

A = CHILD CARE, B = MATERNAL CARE
C = F.P.
4.1 Adoption Index for MCH & FP Intervention

The mean total adoption index for the MCH & FP interventions was 51.47 among the women. The value of adoption index for FP was lowest (39.01) and for child care interventions it was the highest (60.44). The average adoption index for maternal interventions was 46.85. Nearly 45.3 percent of women had total adoption index value exceeding the mean. The mean value of the total adoption index was 52.5 for women residing in villages located near health institutions as compared to index value of 48.2 for women residing in village (Achej) located away from health institutions. The percentage of women having their total adoption score value exceeding the mean was 51.6 percent and 26.6 percent (respectively) for these two categories of women. Geographical location of the health service has been an important factor affecting its utilisation. It has been observed that the closer the proximity of services, the higher the usage will be.

The education of respondent was observed to be positively and significantly correlated with the maternal, child care, family planning and total adoption index. The education of husband was observed to be significantly and positively correlated with FP adoption index. However, the positive correlations observed between education level of husbands and adoption index for maternal care and child care interventions were not significant. There was no significant correlation between education of head and the
adoption index. The education as an important socio-demographic variable has been related to utilisation of health services. Education by creating social change coupled with subsequent changes, it changes decision making, produces new values and ideas. This change re-orient the family members discover desirable goals. Education also increases the caring power of mothers. The child care, family planning and total adoption indices were positively correlated with exposure of the respondent to mass media.

The knowledge scores for maternal care, child care, family planning were observed to be significantly and positively correlated with maternal, child and total adoption indexes. However, there was no significant correlation between knowledge score for FP and adoption index for family planning. The stepwise multiple -regression analysis was used with the help of computer package. The adjusted value of $R^2$ ($R^2$) was highest for the multiple regression equation between the independent variables total MCH & FP score of women and education of women, thereby making this equation to be the best suited for prediction of adoption index (MCH & FP). Everett Rogers (1962) has analysed several studies on adoption of innovation and defined a model. He has considered the antecedent variables as those aspects of the individual and the individuals' situation that may influence the extent to

which adoption will occur. For instance, an individual who is more 'cosmopolitan' i.e. more oriented to persons and places outside the local community is more likely to change his beliefs. Further, a situation in which the community's norms stress change and innovativeness will be a situation in which individuals are more likely to change their beliefs.

The source of information available is to the individual is one of the critical factors. Thus mass media efforts may create an awareness of alternatives available to the individual. At the later stages of adoption the 'local' and 'personal' sources of information become critical for convincing the person and without them the change may not be complete. Another factor in the adoption process is the way one perceives characteristics of the innovation. If the persons can see no relative advantage they may not adopt the innovation. The greater incompatibility of the change with the existing beliefs, the less is the likelihood of the adoption of the innovation. It should be noted that adoption is a process occurring over time. The individual becomes aware of alternatives, develops an interest in the alternatives and eventually after evaluation and trials adopts it. Thus a change in beliefs requires motivational, educational and reward systems to keep the individual progressing through the change process.
5.1 Services Rendered at PHC Dighal and RH Beri

The average number of OPD cases, indoor admissions, emergency cases, X-rays and lab investigations done at Rural Hospital were higher than those at PHC Dighal during the period between January to December 1990, despite more Medical Officers being posted at PHC Dighal. The possible reasons could be due to difference in popularity of Doctors, and in the operationalisation of services at the two centres. It was observed that the indoor bed occupancy rate was 16.9 percent for PHC Dighal and 76.0 percent for Rural Hospital Beri. The difference could be attributed to relatively better functioning of indoor services at RH Beri. At PHC Dighal staff nurses were not available. Moreover, in the absence of Lady Medical Officers delivery and MTP cases were being referred.

5.2 Utilisation of Services at PHC Dighal and Rural Hospital Beri

Nearly 56 percent of OPD cases at Rural Hospital Beri and 63.4 percent of OPD cases at PHC Dighal were males. For indoor treatment also, the proportion of males was higher at both the institutions. Some studies have observed that for every three men who avail of health services only one woman does so, although the percentage of sick women appears to be higher than that of sick men at any given time. Because of social barriers, women usually do not go to male Doctors in the rural areas. Moreover, the normal working hours of the Clinics are often not convenient for women to attend.
Generally a woman is not inclined to seek treatment unless she is severely ill. Gove (1973) has attributed the social norms prevalent in the society as one of the important determinant of difference in behaviour pattern of men and women in ailment.

5.3 Utilisation of Services and Place of Residence

It was observed that 45 percent of indoor cases at Rural Hospital Beri and 68.7 percent of indoor cases at PHC Dighal were from local villages. For out door treatment the proportion of cases from local villages was 43.8 percent (for Rural Hospital, Beri) and 71.1 percent (for PHC, Dighal). Nearly 60 percent of indoor cases at RH Beri, and 68.7 percent of indoor cases at PHC Dighal were from villages situated within 3 miles distance. For utilisation of OPD services also, 56.2 percent of patients at RH Beri and 94.1 of patients at PHC Dighal belonged to villages located within 3 miles distance. Chutain C.S. et al (1976), observed in their study in the States of Rajasthan, Madhya Pradesh and Haryana, that the utilisation of PHC services, was 79.5 percent among the respondents from PHC villages and it decreased to 50.3 percent for those residing beyond 5 Km.


distance from PHC. Srinivasan, S. (1984) also observed that people living close to PHC utilised the services to the maximum extent as compared to those living far away from it. The study carried out by Rao, P.H. (1985) in Bihar revealed that nearly 43.2 percent of people who visited PHC were within 3 miles distance. Datta, B.K. et al (1976) observed the treatment seeking behaviour of rural masses in Maharashtra. They found that 32.2 percent of the households got medical help within a Km. of their house, 22.6 percent within 1-5 kms, 17.5 percent within 5-9 kms and 27.7 percent travelled a distance of 9 or more Kms. to get medical help. Thus distance of the health facility from place of residence has been observed to have an inverse relationship with the utilisation.

5.4 Type of Cases Seeking Treatment at RH Beri and PHC Dighal

At RH Beri, the common ailments for which patients were admitted were fevers (20.3 percent), Pneumonias (18.0 percent), Diarrhoeas (13.5 percent), Surgical Problems (9.0 percent), Injuries (6.7 percent), and Delivery cases (16.9 percent). Whereas at PHC Dighal, the main conditions for admission of patients were Diarrhoeas (26.4 percent).


Surgical problems (25.5 percent), Fevers (11.8 percent), Injuries (10.0 percent), Pneumonias (8.1 percent) and 1.8 percent were delivery cases. The multiple boils, fevers, diarrhoeas and scabies were the main diseases among cases seeking treatment at the OPD at RH Beri and PHC Dighal. This pattern of ailments does not require high level of technical skills. Most of these could be managed by appropriately trained paramedical manpower, located at sub-centres. The PHC & RH are expected to have difficult cases referred from the village level functionaries. This may also be indicative of the ineffective functioning of the institutions below the level of PHC.
Residence of Patients Visiting RH Beri and PHC Dighal

<table>
<thead>
<tr>
<th>Residence</th>
<th>Indoor</th>
<th>OPD</th>
<th>Indoor</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 3 Miles</td>
<td>40.0</td>
<td>43.8</td>
<td>31.3</td>
<td>23.0</td>
</tr>
<tr>
<td>&lt; 3 Miles</td>
<td>15.0</td>
<td>12.4</td>
<td>16.5</td>
<td>71.1</td>
</tr>
<tr>
<td>Same Village</td>
<td>45.0</td>
<td>45.8</td>
<td>52.2</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Legend:
- □ > 3 Miles
- / < 3 Miles
- \ Same Village
TIME SPENT PER VISIT TO PHC-DIGHAL

CONSULTATION (3.0%) —
WAIT TIME (22.6%) —
TRAVEL TIME (27.6%) —
OTHER ACTIVITIES (46.8%) —
LESS THAN 3 MILES

WAIT TIME (19.5%) —
TRAVEL TIME (30.5%) —
CONSULTATION (1.2%) —
OTHER ACTIVITIES (48.8%) —
MORE THAN 3 MILES
5.5 Patient Time Consumed during Visit to PHC Dighal and RH Beri

The average time spent on visit to RH Beri was 115.0 minutes (for patients coming from within 3 miles) and 163.1 minutes (for patients coming from villages located at more than 3 miles). Out of this time the patients spent only 3-4 minutes with the Doctor. Similarly at PHC Dighal, the total time spent for visit was 87.0 minutes (for patients coming from villages located within 3 miles distance) and 150.0 minutes (for patients coming from villages situated at more than 3 miles distance), and time spent with Doctor was on an average 2.6 minutes and 1.85 minutes respectively for these two categories. Thus the time spent in consultation with Doctor in these Governmental Health Institutions was nearly 1-2 percent of the total time consumed during the visit to these institutions. When patients sought treatment at PHC/RH they had to spend nearly 20-40 minutes waiting for their turn to get examined by the Doctor. Then they had to be in line to collect their medicines from Pharmacy or to get some X-rays or other investigations done at these institutions. Besides they have to make preparations for visits and have to make arrangements for the work at their homes.

TIME SPENT PER VISIT TO RH-BERI

MORE THAN 3 MILES

OTHER ACTIVITIES (73.8%) -
CONSULTATION (2.8%)
TRAVEL TIME (10.5%)
WAIT TIME (12.2%)

LESS THAN 3 MILES

CONSULTATION (2.8%) -
TRAVEL TIME (10.5%)
WAIT TIME (31.7%)
OTHER ACTIVITIES (55.0%)
Rao P.H. (1985) observed that the respondents in his study preferred treatment from private practitioners because they spent enough time with their patients and provided personalised attention to their clients. Khan M.E. et al (1989) in their micro level study in rural Uttar Pradesh also found that the respondents spent 2-3 hours for their visit to PHC and if the child was sick mother had to accompany it to PHC and thus the whole family's schedule got disturbed which might result in loss of wages and disruption of other important work. So the visit to PHC were considered bothersome and expensive and majority preferred local practitioners. Bose S. (1980) studied 406 households in Nadia district of West Bengal and observed that most of respondents who had utilised the PHC services were unsatisfied with the services, due to long wait, unconcerned behaviour of staff and cost of transport and lack of medicines.


Doctor Patient Interaction at RH Beri and PHC Dighal

RH Beri

Talked Only 71%

Talked & Examined 22%

None 7%

PHC Dighal

Talked only 81%

Talked & Examined 10%

None 9%
5.6 Doctor-Patient Interactions at PHC Dighal and RH Beri

70.9 percent of patients coming to RH Beri and 81.8 percent at PHC Dighal mentioned that Doctor had only talked to them during the consultation. Nearly 21.9 percent of patients attending OPD at RH Beri and 10.2 percent at PHC Dighal mentioned that the attending Doctor had examined them. When asked to express about their satisfaction of the services utilised during the visit, 13.6 percent of patients at PHC Dighal and 29.0 percent of patients at RH Beri replied positively. The main reasons for non-utilisation of PHC services in the study by Chutani et al (1976), were more faith of respondents in private practitioners (57.5 percent), prejudice against PHC Doctors and staff (28.8 percent). Singh et al (1988) made qualitative assessment of the functioning of PHC in a tribal setting and observed that although the PHC had 4 Medical Officers, yet the total average daily availability of Doctor was 2 hours. On an average, in the morning shift, the Doctor spent 1.46 hours at OPD (against the stipulated 4 hours), while in the evening, 0.26 hours (against the specified 1 hour). It was observed that during the 7 days observation period usually one Doctor was present and others being on leave or absent from their duties.


Satisfaction Level of Patients

RH Beri

Yes: 52%
No: 24%
No Response: 24%

PHC Dighal

Yes: 22%
No: 14%
No response: 64%
Khan et al (1989) also observed that villagers did not utilise Governmental services because of good treatment available through private practitioners at reasonable cost in the village itself. Moreover, the 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. Mathew C.E.M. (1978) studied the health and village culture in Tamil Nadu. He observed that PHC treatment was being sought for a few diseases. But even those who went for PHC services, did not utilise these to the best of their advantage. There was very little communication between the patients and the Doctor. When respondents were asked to mention the contents of the 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 who went to private practitioners learnt more details about cause and treatment of diseases.


The sociological research (Enlow & Swisher 1979) has shown that there is a "Competence gap" between Doctors (Allopathic) and patients. The Doctors' authority in the consultation depends to a considerable extent on his monopoly of knowledge. It would be expected, at least initially, the Doctors would not be inclined to transform this prestige by sharing technical knowledge with patient. On the other hand empirical evidence is there to suggest that sharing of information brings about reassurance and understanding that is an important part of the actual process of therapy. Sharing of information is also important as the basis of achieving patients cooperation with the therapeutic process. Infact, research suggests that nearly 50 percent of the patients will not follow the Doctor's advice and do not comply with medical regimen. One estimate suggests that wasted drugs, as a result of non-compliance may well cost in excess of $300 millions per year (Walton et al 1980).

Tuckett et al (1985) has shown that medical consultations were successful in situations where they simply confirmed the patients' existing view of the character of their illness. However, where there were

differences between Doctors' and patients' views of the illnesses or where the patients' knowledge was inappropriate, then the consultations with Doctors tended to be unsuccessful in the sense that the information was not successfully communicated, not remembered or not acted upon. A practical proposal for resolving the "Competence-Gap" has been to encourage Doctors to treat seriously the 'Lay-Knowledge' of their patients and to listen more carefully to what is said and expressed by lay persons during the consultation. The solution to the Doctor-Patient relationship would require macro-sociological change in the relation between professions and lay-groups in order to bring about a more effective system of communication in the consultation.

5.7 Specialists Services at PHC Dighal and RH Beri

The average number of cases seen per visit by the Specialist from Medical College, under the ROME Scheme, varied from 6.51 (Dental) to 22.13 (Pediatrics). The further analysis by categories of Specialists visiting the block Beri during the year 1990, revealed that most of the time Post-graduate students or House Surgeons working in different Specialities at the Medical College visited PHC Dighal and RH Beri representing the respective specialities. It was observed that Senior Specialists from the Medical College were not visiting the Centres, as a result the corresponding infrastructure and resources were not
mobilised from the Medical College. Moreover, the services of specialists were available on adhoc basis. These could be the probable factors for poor utilisation of Specialists service.

One of the objectives of the ROME scheme, which was introduced in 1977 in Medical Colleges, was to upgrade the quality of health services in rural areas by providing expertise in specialists services from the Medical Colleges. For this each Medical College in the country was allocated three Community Development Blocks in the first phase. In the later phase, it was expected that the Medical College would take responsibility for preventive, promotive and curative health services in the district. The Centre provided one time grant to the State Governments at the rate of Rs.4.79 lakhs per Medical College, which was later increased to Rs.16.04 lakhs per Medical College. The amount was meant to strengthen the infrastructure in PHCs selected for rural training. The State Governments were expected to take the subsequent responsibility of running the Scheme. The Government of India set up an evaluation team (1985), which collected information from 82 Medical Colleges all over the country. It was observed that 78.8 percent of the Medical Colleges had involvement of Preventive and Social Medicine Department, 43.6 percent of Medicine Department, 45.1 percent of OBG, 37.0 percent of Surgery, 33 percent of

PRESCRIBING BEHAVIOUR OF DOCTORS IN PHC DIGITAL

CONTENT ANALYSIS OF PRESCRIPTIONS

A - DIAGNOSIS WRITTEN
B - CORRECT DOSE FOR ALL DRUGS
C - INSTRUCTIONS FOR PATIENTS
D - DURATION OF TREATMENT
E - CLINICAL FEATURES MENTIONED
ENT and Psychiatry Departments of Medical Colleges. 32 percent of PHCs taken over the Medical Colleges had strengthening of physical infrastructure under the Scheme.

5.8 Prescribing Pattern of Doctors in RH Beri & PHC Dighal

The review of 350 prescriptions of Generalists (MBBS) and 110 prescriptions of Specialists (Post-graduate Diploma or Degree) revealed that none of the generalists' prescriptions and 9.5 percent of the specialists' prescriptions had brief clinical features written on them. Correct dosage schedule was observed for all drugs in 45.6 percent of the prescriptions of generalists and 73.0 percent of the prescriptions of specialists. The duration of treatment and instructions for patients were not written in majority of the prescriptions. 84.5 percent of the prescriptions given by generalists and 83.1 percent by Specialists had more than 2 drugs.

Rao P.H. (1985) also study the treatment patterns of PHC in Bihar. It was observed that due to availability of narrow range of drugs at the PHC, the Medical Officers prescribed the drugs to be purchased from outside. The research (Walton et al 1980), suggest that nearly half of the patients do not comply with medical regimen and it is


Budget Expenditure on Drugs

A 56%

A - ANTIBIOTICS
B - SULFA DRUGS
C - ANTIPYRETICS
D - ANTI SPASMODICS
E - DRUGS FOR SKIN INFECTIONS
F - VITAMINS
G - DRUGS FOR EYE INFECTIONS
H - OTHERS
estimated that the wasted drugs as a result of non-compliance may well exceed $300 millions per year. A successful communication with patient is an important part of therapeutic process. And a prescription is an important document available with patient. If the drug dosage duration of treatment, precautions to be taken during therapy, along with salient findings and diagnosis are mentioned by the prescribing Doctor on the prescription, as has been envisaged under the general principles of prescription writing, the prescription is likely to be more effective. Moreover, it would also help in the better follow up of the patient in subsequent visits. In the absence of a good prescription the patient may continue to take inadequate amount of drugs for inadequate duration or may experience side effects if he fails to take precautions during intake of certain type of drugs. Ensuring proper prescribing behaviour of Doctors may result in increased efficacy of their prescriptions and may result in saving the scarce drug resource in the Government Health Institutions.

5.9 Pattern of Drug Consumption at PHC Dighal

The cost of drugs indented in one year for PHC Dighal and for ROME Scheme during 1988-89 was Rs. 1.5 lakh. 56.3 percent of the amount was towards purchase of antibiotics, 12.6 percent for Sulfa drugs, 8.3 percent for antiphysretic-analgesics, 7.9 percent for antispasmodic drugs, 5.1 percent for vitamins, 2.3 percent for drugs for eye infections, 5.6
ACTIVITIES OF HEALTH PERSONS
DURING FIELD VISIT
percent for drugs used for skin infections and 1.7 percent for mixtures, ointments, linctus etc. It was further observed that more money was being spent for purchase of costlier drug preparations and a meager proportion for cheaper but equally effective drug formulations. This type of pattern of drug consumption can be related to the prescribing behaviour of the Doctors, which in turn is influenced by the Drug Representatives of various drug companies. In the Medical College settings the freshly graduated Doctors mainly learn about the market preparations of drugs through literature distributed by the drug representatives or through direct interactions with them. The Medical College faculty hardly spends time in the form of formal session on this important aspect. As a result the cost of prescriptions containing the costly market preparations, goes up tremendously. The needs therefore is to guide the Doctors through various continuing education programme and inculcate in them a rationale prescribing behaviour in which simple, cheap and equally effective drug preparations should be included.

5.10 Activities Carried During Field Visits by Health Personnel of PHC Dighal

The analysis of available records for one year (1989-90) revealed that the Medical Officer Incharge had made on an average 7.5 field visits per month. The purpose of the field visit was mentioned to be family planning work (4.5),
meetings (1.8), pay collection (1.4), immunisation (0.3) and other activities (0.5).

The average number of field visits made per month were 17.7 for Health Assistant, 15.2 for Multipurpose Health Worker Female, and 14.7 for Multipurpose Health Worker Male. Nearly 60 percent of the field visits by these health personnel were made for family planning work. Even the PHC vehicle moved on an average 9.6 times per month for family planning work. Thus it is observed that at PHC level, the Family Planning work overshadows almost all other health activities. Most of the efforts and resources are directed towards the family planning work. Undoubtedly, the population control is the need of the hour, but it must also be realised that population control has complex socio-economic and cultural dimensions. Several social scientists have related population growth with the economic structure and level of economic development of the society. The viable family size has been related to the probability of survival and mortality prevalent in the communities. The status of women and their educational achievements have also been related to the birth rate. Therefore at the PHC level in addition to making/available good quality family planning services, concentrated efforts should be made to ensure better survival and health for children and mothers. The details of the activities during field visit by multipurpose health workers during last 1 week revealed that on an average 9.2 minutes were being spent in the household. The
distribution of Nirodh, providing information on immunisation and carrying out chlorination of wells were mentioned to be their main activities. When asked to mention the difficulties faced during field visits, their main difficulties were non-availability of rural women (because of work in fields) inadequate material for health education and lack of interest of rural masses in health related programmes. The multipurpose health workers deliver the health services to the community, as envisaged under various health programmes. Almost all health programmes have health education as an important component. But these workers are not adequately equipped to carry out various health education activities. Moreover, the rural women, the target groups at which these activities should be directed are not usually available when the health workers visit their homes, since during the working time of health workers women too are busy in work at fields or at home. As a result the potential beneficiaries remain illinformed about health activities and this may be a reason for non-utilisation of the Government health facilities.
Job Dissatisfaction Among Health Staff at Block Beri

B.C. Muthaya's Scale
5.11 Job Dis-satisfaction Score for Functionaries at PHC Dighal

The mean score was highest for Medical Officers. Nearly half of the Multipurpose Workers, 60 percent of Health Assistants, 66 percent of Anganwadi Workers, and 20.0 percent of ICDS Supervisors had a job dissatisfaction score exceeding the mean values for the respective categories. Job satisfaction is the amount of congruence between one's expectations of the job and the rewards that the job provides. Job satisfaction results when there is a fit between the job characteristics and the wants of the employee. Wanous (1974) found correlation between job satisfaction and performance. Edward and Porter (1973) have developed a model that suggests that performance leads to rewards and if these are perceived to be equitable, the employee's satisfaction is the result. The system concept assumes that satisfaction and productivity are in a circular relationship, in which each affects the other. This model assumes that performance leads to rewards and satisfaction, which then leads to more efforts because of high perceived expectancy. The high effort leads to effective performance, which again leads to satisfaction in a circular relationship.


5.12 Performance of MCH Services Delivered Through Sub-centres

The details services rendered by Sub-centres located at Dhandhalan (0.6 Kms. from PHC Dighal), Wazirpur (7.5 Kms. from PHC Dighal), Jahajgarh (12.5 Kms. from PHC) and Achej (19.6 Kms. from PHC) were also studied. The average number of vaccines given per month were highest for Sub-centre located at Dandhalan. The performance of the Sub-centre in terms of OPD cases attended, and average number of Antenatal cases seen per month was highest for Dandhalan Sub-centre. The percentage of eligible couples protected by family planning methods was 76.1 percent for Dandhalan, which was also the highest of the four Sub-centres. The performance of the Sub-centre Achej was least in almost all the performance indicators. The average consumption of drugs per month was also highest at Sub-centre Dandhalan as compared to other Sub-centres. Thus it was observed that the performance of Sub-centre was related to the distance from health Institution and maintenance of headquarter by health centre.

5.13 Drug Availability at Sub-centres Under PHC Dighal

The records of drugs issued to Sub-centres under PHC Dighal in the year (1988-89) were examined against the drug norm for Sub-centres issued by Government of India. It was observed that the average amount of drugs issued to a Sub-centre during the year was nearly 24.7 percent of the norm (This excluded cost of family planning methods and Iron Folic Acid Tablets, these were usually available in plenty).
5.14 MCH Services Rendered by Trained Dais in Block Beri

81.3 percent of the trained Dais interviewed, belonged to Scheduled Caste and Backward Class. All were rendering intra-natal care. 86.6 percent mentioned to be providing ante-natal care to mothers. It was observed that 26.6 percent of the Dais were also engaged in the practice of carrying out abortions by use of various aborticents. More than half of them were making vaginal examination for recognition of pregnancy and for ascertaining the onset of labour. The other undesirable practice was cleaning secretions from mouth of newborn with finger and advice of 'Ghuti' feeding to the newborn child.

5.15 Extent and Pattern of Utilisation of Maternal Care Services

Of the 942 households (surveyed during ICDS Annual Survey 1991) 56.7 percent were eligible for MCH services under ICDS and nearly 66.9 percent of the eligible households were utilising the ICDS services. About 44.3 percent of women had contacted MPW (F), 11.3 percent Doctors, 11.3 percent Untrained Dais, 6.8 percent Trained Dais and 18.0 percent other persons during their last pregnancy. Nearly 71.4 percent of mothers had their first contact with health personnel, or Dais or Anganwadi worker in or after 4th month of pregnancy. 41.4 percent of the women had received upto 3 contacts during the last pregnancy. About 45.5 percent of women had not received
supplementary nutrition, 49.9 percent did not receive Iron Folic Acid Tablets for 100 days. 80.6 percent of the women had their last delivery conducted at home by Trained Dais (47.1 percent), Untrained Dais (23.8 percent), others (13.9 percent). Only 7.9 percent mentioned that Health Worker (Female) had conducted their last delivery. Nearly 86.9 percent of the women had received Tetanus Toxoid injection.

5.16 Extent and Pattern of Child Care Services

95 percent of the children (12-24 months, n=201), had received BCG, 93 percent three doses of DPT, OPV and 85 percent had received measles vaccines. But 74 percent had not received Iron Folic Acid Tablets. It was observed that 36.2 percent had not received Vitamin-A, and 37.1 percent had not received the supplementary nutrition.

5.17 Source of Treatment

It was observed that 61.8 percent of the women (with children less than 6 years of age, n=163), had contacted private Doctors, 50.0 percent Anganwadi Workers, 21.0 percent Faith Healers, 18.4 percent Sub-centre Health Workers, 19.7 percent PHC and 6.5 percent Government hospital in last 6 months for treatment. Several studies (Rao, P.H. 1985; Khan, M.E. et al, 1989; Bose, S. 1980) have observed the preference of medical services from Private Practitioners, because of factors like more personal attention paid by the Private Practitioners, and their easy availability and accessibility to the masses.
HEALTH WORKER (FEMALE) EXAMINING PATIENT AT SUBCENTRE DANDHLAN

HEALTH WORKER (FEMALE) DOING IMMUNISATION AT SUBCENTRE WAZIRPUR
6.1 Case Study on Functioning of Sub-Centres

Sub-Centre Dhandhalan - The Health Worker (Female) at village Dhandhalan maintained her headquarter and stayed in a room adjacent to the sub-centre. She had been in the sub-centre since 1974 and never transferred to any other sub-centre. She was on the pay roll from Medical College, Rohtak. Moreover, she belonged to other district and was available on weekends and other holidays. The sub-centre building was donated by local villagers and maintenance work was also carried by them periodically. The sub-centre had one room with Varandah and one room set for Health Worker (Female). There was 1 Begha of land in the sub-centre area and a boundary wall all around. The electricity was available and water top connection was also provided. The health worker (female) had been making regular visits in the village and even conducted home deliveries. She was well accepted by the local community. The sub-centre had adequate equipment and supplies. The health worker often accompanied cases to the PHC, which was located at 0.62 Km. from the sub-centre. The performance of the sub-centre in terms of OPD cases seen per month, antenatal mothers registered, immunisations given and family planning work done was much better than the other three sub-centres included in the study.
HEALTH WORKER (FEMALE) DOING IMMUNISATION AT SUBCENTRE JAHAJGARH

PHARMACIST AND STAFF NURSE EXAMINING PATIENT AT PHC NEW PATTERN JAHAJGARH
**Sub-centre Wazirpur**

Mrs. Shakuntala was the MPW (F) at sub-centre located in village Wazirpur. She belonged to village Beri, located 1.2 Km. from Wazirpur. Her father-in-law had been a member of local Municipal Committee. She was not maintaining her headquarter at village Wazirpur and the villagers told that she used to come to village once or twice in a week. She was in the sub-centre since 1989-90. Her behaviour with the Supervisors was also not very cooperative. She was known to given threats to Supervisors/MOs who marked her absent or complained against her, due to her political connections. The sub-centre building had two small rooms, without electricity or water, and was donated by local villagers. The building was also used for holding local meetings by village Panchayat. The maintenance of the sub-centre was poor. The worker too was callous in maintaining her records and reports. The performance of the sub-centre in terms of OPD cases, Immunisations, and Family Planning work, number of deliveries conducted by MPW (F) was not satisfactory.

**Sub-centre Jahajgarh**

The sub-centre at Jahajgarh, had Health Worker (Female) Bharpai Devi. She was earlier staying in the sub-centre as her husband was also posted in nearby village. But for the last 2 years, since the transfer
of her husband, she too started commuting daily from nearby town. The sub-centre building, which had electricity and hand-pump, was no longer in use. The worker was told to be coming only on 2-3 days in a week. Her attendance records was maintained at Dispensary, but since the Medical Officer posted at the dispensary was also visiting infrequently, there was no effective control. The dispensary was exclusively looked after by the Pharmacist who also was commuting from Rohtak. The performance of the sub-centre which was at one time one of the best (when MPW (F) maintained headquarters) was declining as per the available records and reports.

Sub-Centre Achej

The sub-centre located at village Achej was 19.6 Km. from PHC headquarters at Dighal and was away from the main road. The communication and transport was also poor. There were 1-2 buses in morning and evening passing through the village. The sub-centre was considered to be a punishment posting by Block and District Health Authorities. The workers posted in the sub-centre rarely visited the village, and there had been almost yearly transfers of workers to and from the sub-centre. The sub-centre had no building, but some drugs and equipment were kept in an Almirah, which was placed in a Anganwadi Centre. Many of the local villagers were not even aware of workers posted in the
sub centre, since the sub-centre remained more or less closed except for 1-2 days in a month when immunisations were carried out that too in Anganwadi Centres. The Supervisory visits of Medical Officers to the centre were also very rare. The performance of sub-centre was poor and there were hardly any records available at the sub-centre.

6.2 Rural Hospital Beri

RH Beri, was located at the Block Headquarters and was in the centre of the block. The communication and transport facilities were very good and there were direct buses even to Delhi, Rohtak and Chandigarh from the town. The town had Municipal Committee and one Voluntary Organisation and one citizen forum. The RH had One post of Medical Officer and One post of Lady Medical Officer, alongwith other supporting staff. Invariably the hospital had Doctor couples posted, so the indoor and other facilities for delivery etc. had been fairly well-developed. Moreover, the local citizen forum also had been very active and vigilant about the services rendered at the hospital. The forum had written about facilities and services available at hospital directly to the Director, Medical College, Chief Medical Officer and even to Health Minister. So the availability of services and facilities was ensured by the concerned officers. The hospital complex had fairly good residential accommodation available for staff and Doctors, Nurses and other Staff was
maintaining headquarters. The performance of RH Beri was better as compared to that of PHC Dighal.

6.3 Primary Health Centre, Dighal

PHC Dighal was located at Rohtak Jajjhar Road, 17.6 Kms. from Rohtak. The PHC had one Block Medical Officer and 4 Medical Officers. Since it was adopted for rural training by Medical College, Rohtak, interns were also posted there for 3 months. The centre had residential facilities for MOs, interns and other staff. Since the centre was near Rohtak, had good transport facilities and other infrastructure, it was a preferred posting place, especially for those Medical Officers who had their spouses in Government service at Rohtak. The Block Medical Officer posted at the centre since 1990 was commuting daily from Rohtak, and so was the case with other Medical Officers except 1 who was maintaining headquarters. The indoor with 10 beds was not regularly maintained since the staff Nurse was not staying at Dighal. The patients were usually kept for observation and referred to Rohtak. The delivery facilities were available but in the absence of lady Medical Officer, and Health Assistant (Female) not maintaining headquarters, these cases were invariably referred to Rohtak.

Since transport services were good, many a times villagers preferred to go to Rohtak. Although interns were available, yet most of the cases after OPD hours were being
managed by Pharmacist, who had been in the centre since 1979, and had earned a reputation in the area. He was also staying in the Campus and had well developed contacts with local villagers. Although the population covered by PHC was divided into five sectors, with each of the 5 Medical Officers being incharge of one sector for supervision and support, yet it was mainly the BMO who made field visits. The other MOs were moving only for 1-2 days in a month during immunisation days, or family planning camp days. The sector meetings, were usually not attended by Medical Officers and the concerned Health Assistants use to collect reports from the workers. The monthly meetings held at PHC Dighal, were attended by all health workers and BMO/or in his absence one Medical Officer used to conduct the meeting. Sometimes Officers from the District or Medical College also attended these monthly meetings. The main agenda item in the monthly meetings was the reviewing of family planning achievement of workers, issuing verbal or written warnings to workers with poor performance in family planning and invariably the workers argued about inadequate vehicle, and other support from the centre which had resulted in their poor performance. The workers were communicated about next month's FP camps and the FP work expected from them. Quite frequently the meetings were not started on the fixed time because of non-arrival of BMO. The emphasis on other health programmes, problem solving and continuing education of staff was inadequate in most of monthly meetings. The
workers also collected their monthly supplies on the meeting day. The office of the CDPO was situated in the campus of health centre. The CDPO had been allocated one quarter also, but she was not staying there and was commuting from Rohtak. The joint field visits by BMO and CDPO were not a routine. The communication to CDPO office was limited to monthly report and information about immunisation camp dates (for which ICDS vehicle was also utilised). Most of the time the MO's were critical of the ICDS Scheme and functionaries.
The main conclusions which emerge from the discussion in the Chapter are the followings:

1. The social ceremonies and customs in the area were related to the maternal and child health. The sex discrimination was also apparent. For the female child birth, the ceremonies like "Chati", "Dasutan", "Piliya", and "Kuan Pujan" were being usually avoided. The ceremonial washing of mothers' breasts by Sister-in-Law on 3rd day of child birth ("Doodhi Dhona") could be related to delaying of initial breast feeds (Colostrum) to the newborn child. The special food items like "Gola", "Gond", "Ajwain" etc. were being given to women after delivery and were considered to help the women in recovering from the stress of child birth. Almost all the food items were classified in terms of their effect on body into "hot", or "cold", "heavy" or "light", and was observed to be one of the important determinent of feeding children during ailments.

2. It was observed that common childhood diseases were also related with some factor or the other. Tuberculosis was considered to be due to "weakness" and untreated "cough" or fever, Poliomyelitis was related to exposure to "cold" in fever or "defect" in blood, or evil eye; measles were considered to be due to untreated fever, "Heat" in body and some attributed it to Goddess. The diarrhoea was related to teeth
eruption, intake of Spicy foods by lactating mother and displacement of intestine ("Dharan"). The worm infestation in children was associated with eating Jaggary or Soil. The indigenous practices mentioned for common diseases, need to be critically assessed, and if found effective could provide an alternative and cheaper form of therapy.

3. The rural mothers had rational explanations for their MCH practices. The rest during pregnancy was avoided and the reasons were that work would keep the digestive system in order and the mother would not have difficulty at time of labour. The diet was also not increased during pregnancy because it was felt by them that smaller babies would be easier to deliver.

The Iron Folic Acid Tablets too were considered "Hot" and could harm the baby in womb and were thus being discarded. The deliveries were being avoided in well ventilated and lighted rooms, since exposure of women to "Cold" during labour could result in body aches later on. The early movements of mothers after delivery were also not encouraged as maternal body was considered to be "Kachi" after child birth.

The starting of top feeds especially cereals at the age of 5-6 months was considered to harm the "Liver" of the child. The feeds were being restricted
during diarrhoeal episode in children, since in their opinion rest to intestine was required.

The married girls too were encouraged to have early child bearing and those women who did not have children or had only female children were being avoided during social interactions.

The majority of the beliefs and perceptions of the women about MCH & FP interventions were fed to them from their Mothers, Mother-in-Laws, Dais, Elderly women, Peer groups. These could be considered in the health education campaigns since these are one of the important factor affecting utilisation of the services.

4. The Knowledge Score of Women for the MCH & FP interventions was observed to be related to education of women, education of husband, and exposure to mass media, positive and significant correlations were observed with these variables.

The education is an important variable that affects the decision making, produces new values and ideas, and increase the caring power of mothers. The recent advancement in mass media especially satellite television could be effectively used in enhancing the knowledge the rural masses in health and related areas.
5. The adoption index for child care interventions was highest (mean value being 60.44) and it was lowest for family planning interventions (mean value = 30.01). Nearly 45.3 percent of the women had total adoption index value exceeding the mean value of 46.85. The mean value of total adoption index was higher than the mean value for women residing in the far off village (Achej). The adoption index was observed to be related to education of respondents, and exposure to mass media.

The prediction equations for Adoption index from independent variables like education, exposure to mass media and MCH & FP knowledge score of women were calculated using multiple regression analysis. These equations may be tested in the rural settings and may be used by the Health Planners, Managers, and Researchers.

6. The Primary Health Centre at Dighal, Rural Hospital at Beri, and Four Sub-centres (Dandhalan, Wazirpur, Jahajgarh and Achej) were the Institutions included in the study. The bed occupancy at PHC Dighal was 16.9 percent and it was 76.0 percent at the Rural Hospital Beri. The services rendered in terms outdoor and indoor cases attended, X-rays done and other investigations carried out were on an average higher for the Rural Hospital. This was observed to be due to the availability of Medical Officer, Lady Medical
Officer and other supporting staff at RH Beri, (who were maintaining the headquarters). It was also seen that the performance of the sub-centre Dandhalan, were the Health Worker (Female) was maintaining the headquarter, was much more than that of other three sub-centres (where the health workers were not residing). The infrastructure and facility availability was also better at Dandhalan sub-centre.

Thus the mobilisation of resources occur if the health functionaries are motivated and stay in the local health Institutions.

7. The utilisation of PHC & RH services was observed to be related to the place of residence. 60.0 percent of indoor cases at RH Beri and 68.7 percent of indoor cases at PHC Dighal were from village situated within 3 miles of distance. For utilisation of OPD services also 94.1 percent of patients at PHC Dighal and 56.2 percent of patients at RH Beri of the Institution. The patient time consumed per visit to PHC & RH ranged from 87.0 minutes to 163.1 minutes, out of which 1.85-2.6 minutes were spent with the Doctor in consultation.

8. The Doctor-Patient interaction, in 70.9 to 81.8 percent of the patients, was limited to verbal talking - mainly be the Doctor. When asked to express their satisfaction of the services utilised during the visit 13.6 percent of patients at PHC Dighal and 29.0 percent
of patients at RH Beri replied positively. Thus there is need to ensure more productive communication during consultations. The sharing of information about disease and related aspects is important for achieving patients cooperation with the therapeutic process. The Doctors too should treat seriously the "Lay Knowledge" of their patients and listen more carefully to what is expressed by the patients during the consultation.

9. The analysis of the prescriptions of the Doctors in these health Institutions revealed that duration of treatment, instructions to the patients were not written in majority of them. The correct dosage schedule for all drugs was observed in 45.6 percent of the prescriptions written by generalists and 73.0 percent of the prescriptions written by specialists. The correct prescription writing as per the general guideline of prescription writing is mostly not done by majority of the Doctors on the plea that they have to examine a large number of patients in the Governmental Institutions. But it should be realised that a good complete prescription is likely to be more effective and it would also help in the better follow up of the patient in subsequent visits. Thus ensuring proper prescribing behaviour of Doctors may result in increased efficacy of their prescriptions and may
result in the saving of scarce drug resources in the Government Health Institutions.

10. The analysis of available records (1989-90) related to the field visits by Health personnel of PHC Dighal and movement of PHC vehicle revealed that nearly 60-70 percent of the total field visits were made by Health Workers, Health Assistants and Medical Officer Incharge of the PHC for family planning work, whereas the rest of visits were for attending meetings, collecting salary and for other health activities. Undoubtedly, the population control is the need of the hour, but it must also be realised that it has complex socio-economic and cultural dimensions. Population growth has been related to viable family size (mortality prevalent in the community and probability of survival), and other socio-economic developmental aspects. So other health activities envisaged for the Primary Health Centres, which ensure better survival and health for children and mothers, must be given the due importance. The family planning work should not overshadow these health activities, in terms of resources and efforts rearrived.

11. The job dissatisfaction score (using B.C. Muthaya's Scale) was highest for Medical Officer (29.4) followed by Health Workers (22.8) and Anganwadi Workers (27.3). The Health Assistants had a mean score value of 22.0 and ICDS Supervisors had mean score of 19.2. 66.0
percent of Anganwadi Worker, 60 percent of Health Assistants and Medical Officers, and half of the Health Workers had a job dissatisfaction score exceeding the mean value for the respective categories. Job satisfaction has been correlated with assumes that satisfaction and productivity are in a circular relationship, in which each affects the other. If the performance leads to rewards and satisfaction, it would lead to more efforts. Thus in the governmental health organisations, a suitable mechanism for performance based incentives is required so that the personnel working there in remain satisfied and motivated.