Chapter IV
MATERNAL AND CHILD HEALTH SERVICES IN RURAL AREAS

4.1 RURAL PRIMARY HEALTH CARE INFRASTRUCTURE

The programme of establishing primary health centres in each Community Development Block having a population of 60,000 to 80,000 was launched as an integral part of the Community Development Programme in 1952. Each Primary Health Centre Complex consisted of the main centre with 6 beds located at the Block Head Quarters, and 4 Sub Centres. The staff consisted of 1 Medical Officer, 1 Sanitary Inspector, 4 Midwives (ANMs) and 2 Ancillary personnel. The centre was to be supported by district organization for referral consultation, laboratory, medical, surgical, nursing and administrative services.

Subsequently, over the past forty years the health services organization and infrastructure have undergone extensive changes and extension following review by a number of Expert Committees, namely, the Mudaliar Committee (1962), Chaddha Committee (1963), Mukherjee Committee (1966), Jungalwala Committee (1967), Kartar Singh Committee (1973) and Srivastava Committee (1975). Progressive changes have been introduced into the programme over the sixth and seventh Five Year Plan Period when the national norms for population coverage were adopted. During the Eighth Five Year Plan, the emphasis was mainly on consolidation of the existing health infrastructure rather than expansion. The thrust has been of qualitative improvement in the health services through strengthening of physical facilities like provision of essential equipments, supply of essential drugs and consumable, construction of building and staff quarters, filling up of vacant posts of medical and paramedical staff and in-service training of staff.

India was a signatory to the Alma Ata Declaration of 1978 and committed for attaining the goal of "Health For All by 2000 AD" through the Primary Health Care approach. Consequently while formulation of the Sixth Five Year Plan (1980-85), a
critical review was made of the approaches adopted during the previous Five Year Plans. Based upon this, a long term perspective plan was outlined by the Government for achieving the Health For All goals. The National Health Policy was officially adopted by the Parliament in 1983. "Health For All" principles and strategies were also incorporated in the Sixth (1980-85) and Seventh (1985-90) Five Year Plans.

The Government has started concentrating on the development of rural health infrastructure so as to provide primary health services to about 75 percent of rural population, which had by and large remained neglected. The stress in the National Health Policy is on the provision of preventive, promotive and rehabilitative health services to the people, thus representing a shift from medical care to health care and from urban to rural population. The main objective is to place the health of the people in the hands of the people through the primary health care approach.

The delivery of Primary Health Care is the foundation of rural health care system and forms an integral part of the national health care system. For developing vast human resources of the country, accelerating the socio-economic development and attaining improved quality of life, Primary Health Care is accepted as one of the main instruments of action. Primary Health Care is essential health care made universally accessible to individuals and acceptable to them through their full participation and at a cost the community can afford.

In the rural area, services are provided through a network of integrated health and family welfare delivery system. Health care programmes had been restructured and reoriented from time to time for attaining the objectives of "Health for All" by 2000 AD as envisaged in National Health Policy. Priority was accorded to extension, expansion and consolidation of the rural health infrastructure viz. sub centres, primary health centres and community health centres. Primary health centre pays particular attention to the point of initial contact between the members of the community and the health services. Sophisticated and specialized needs are referred to secondary and tertiary levels.
The Primary Health Care infrastructure has been developed as a three-tier system and is based on the following population norms.

Table 4.1.1: Population Norms

<table>
<thead>
<tr>
<th>Centre</th>
<th>Plain Area</th>
<th>Hilly/Tribal Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub Centre</td>
<td>5000</td>
<td>3000</td>
</tr>
<tr>
<td>PHC</td>
<td>30000</td>
<td>20000</td>
</tr>
<tr>
<td>CHC</td>
<td>120000</td>
<td>80000</td>
</tr>
</tbody>
</table>

Source: Bulletin on Rural Health Statistics in India, December, 1999, Rural Health Division, DGHS & Department of Family Welfare, MOHFW, GOI, New Delhi.

Sub-Centres

It is most peripheral contact point between the Primary Health Care System and the community. It is manned by one Multi Purpose Worker (Male) and one Multi-Purpose Worker (Female)/ANM. Only 97,757 Sub Centres established after 01.04.1981 are funded by Ministry of Health and Family Welfare, out of a total number of 137006 Sub Centres functioning in the country as on 31.12.1998. The rest are being funded under the State Minimum Needs Programme/Basic Minimum Services Programme. The pattern of assistance is as under:
Table 4.1.2 : Sub-Centre Budget

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Recurring</td>
<td></td>
</tr>
<tr>
<td>Equipment, furniture etc.</td>
<td>3,200/-</td>
</tr>
<tr>
<td>Recurring</td>
<td></td>
</tr>
<tr>
<td>Salary of MPW(F)/ANM - 1</td>
<td>As per State Government Pay Scales</td>
</tr>
<tr>
<td>Salary of HA(F)/LHV (one LHV for ever 6 Sub Centres)</td>
<td>and allowances.</td>
</tr>
<tr>
<td>Honorarium to Voluntary Worker @ Rs. 50/-</td>
<td>600/- per annum</td>
</tr>
<tr>
<td>p.m.</td>
<td></td>
</tr>
<tr>
<td>Rent for the building</td>
<td>1,000 - per annum</td>
</tr>
<tr>
<td>Medicines</td>
<td>2,000/- per annum</td>
</tr>
<tr>
<td>Contingencies</td>
<td>600/- per annum</td>
</tr>
</tbody>
</table>

Source: Bulletin on Rural Health Statistics in India, December, 1999, Rural Health Division, DGHS & Department of Family Welfare, MOHFW, GOI, New Delhi.

It has been decided during 1997 that the states will have the choice of opening new sub-centres out of the funds provided to them under the BMS Programme.

**Primary Health Centres (PHCs)**

PHC is the first contact point between village community and the Medical Officer. These are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme. A PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4-6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services. As on 31.12.98, 23179 PHCs are functioning in the country.
Community Health Centres (CHCs)

CHCs are being established and maintained by the State Government under MNP/BMS. It is manned by medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labor Room and Laboratory facilities. It serves as a referral centre for 4 PHCs. As on 31.12.98, 2913 CHCs are functioning in the country.

4.2 MATERNAL AND CHILD HEALTH COMPONENT

It is being increasingly realized that unless there is a significant improvement in the quality of maternal and child health (MCH) services, besides the widespread propagation of family planning methods, it is unlikely that there will be a decline in fertility concomitant with improved health of the woman as well as her child. In recognition of this, the family welfare programme seeks to promote MCH as its primary object in its quest to achieve national demographic goals.

Good health of children inculcates a sense of security in the parents that their offspring will survive and live a healthy life, which in turn contributes to the acceptance of small family norm. Hence under basic maternal and child health care services, the mothers should be provided with ante-natal, natal and post natal care, and infants and pre-school children should be monitored for their growth and development, adequate protection with immunization, and early detection and treatment of diarrhoea and other childhood diseases.

The importance of maternal and child health development and the crucial role in improving the quality of our human resources has been repeatedly stressed, and the major thrust of all welfare programmes has been directed towards the health of mothers and children, emphasizing preventive, promotive and educational aspects of MCH services.
MCH continued to be a priority area in the post-independence health policies. The Bhore Committee viewed these services not only as a measure for reducing maternal mortality but as a necessity in order that women could adequately perform the function of motherhood. Facilities for the protection of women’s health in the productive sphere were mainly meant to ensure her reproductive adequacy. The poor health conditions of women and children could be improved only through eliminating deep-rooted social evils and by developing health concienceness among people.

The protection of the health of the expectant mother and her child became of paramount importance and the mother was recognized to be the channel for educating the entire family. Increasingly, however, investments in the reproductive health of the woman became far more important than her health related only to child birth. Though MCH continued to have importance in government priorities, its focus became narrower and its implementation poor. The MCH programmes did not recognize the real causes of maternal mortality and their impact on the section of the population which accounted for a large proportion of maternal deaths.

There has been a revival of interest in MCH in recent years which has to be seen in the context of other development such as the status of women and the current priorities of the state. There is growing concern for women’s reproductive health and rights at national and international forums. The changing health status, health care structure and the priorities of health have sharpened the class and sex differential more than ever before.

Family planning programme has witnessed large variations in implementation as also similar variations have been witnessed in the implementation of Child Survival and Safe Motherhood interventions. National Family Health Survey, 1998-99 data also shows a high unmet need and wide variations in the percentage of cover in ante-natal care, female literacy, and immunisation status of children. While the availability of better health services and improved nutritional standards have helped to bring down the death rate considerably, the birth rate continues to be
high. The need for a determined effort to bring down the rate of growth of population can not, therefore, be over emphasized.

Recognizing the close relationship between high birth rates and high infant mortality, the Family Welfare Programme has gradually shifted its focus away from family planning to a general effort to improve maternal and child health since 1985. The Universal Immunisation Programme exemplifies this gradual, change with increased efforts in the rural areas and urban slums, to provide maternal health services and care to children under five. The impact of the Immunisation Programme is reflected in a significant drop in the infant mortality rate, from 95 in 1987 to 71 per thousand live births in 1999.

The Family Welfare Programme is still perceived as a Government Programme. This perception has to change. As family planning is an intensely personal and private matter, the Government agencies can at best contribute to raising awareness and making available services and supplies but the success of the programme depends upon the personal and private decisions of individuals, couples and families. What is needed is congruence and convergence between the national objective of population stabilisation and each couple’s perception specially the women’s perception, of the desired family size. As these perceptions are largely influenced by values and ethos of the local community or neighbourhood, it is imperative for the programme to effectively respond to these issues. Active support and participation of all opinion leaders, non-government and voluntary agencies, youth, women and social organisations and the Panchayati Raj Institutions are also needed to transform the programme into people’s movement.
4.3 MCH TO RCH APPROACH

Over the years of implementation of Family Welfare Programme, it has been felt that people have not responded to the services provided enthusiastically due to many reasons; eg. the programme does not address completely the needs of women and children, the programme is not in tune with the implementation needs of the health workers, workload of the programme has not been set with consideration to the local demographic and health needs of the population etc. In response to these needs the government has now reoriented the family welfare programme to provide an integrated package of services. The new programme is RCH programme, the objective of which is to improve the quality, coverage, effectiveness and access of services.

A paradigm shift has been visualized for operationalising reproductive health programmes. The focus has been changed from population control approach of reducing numbers to a client based approach of addressing the reproductive health needs of clients. This agenda recognizes the need to change the programme's current thrust on achieving demographic objectives of societal fertility reduction to an explicit concern for assisting clients to meet their personal reproductive goals. Reproductive and Child Health Programme focuses on reducing the burden of unplanned and unwanted child bearing and related morbidity and mortality (Jain and Bruce, 1994).

4.3.1 Paradigm Shift

Target Free Programme from April, 1996

In April, 1996, GOI took a landmark decision to withdraw the system of estimating workload as well as monitoring the programme based on centrally determined method - specific contraceptive target system. Instead it adopted a Community Need Assessment (CNA) based on bottom-up approach where self estimated goals/workload are to be used by the health workers.
Decentralized Participatory Planning

Planning actually begins at the grassroots level/village level with members of panchayat and mahila swasthya sangh and other villagers closely interacting with the ANM and male health worker for deciding about the actual requirement of various family welfare services. This improves the sustainability of the programme by having sense of involvement and community owning the programme thereby increasing utilisation of services as well as by ensuring sense of responsibility and accountability among the health workers. The plans are prepared for sub centres which are aggregated to make the PHC plan which in turn gets aggregated to form the district plan.

Integrated RCH Package

Integrated RCH package includes, essential RCH package which gives basic, minimum, model framework of RCH services at different levels in the district viz. Community, sub centre, PHC, FRU and district hospital. The essential components are,

- Prevention and management of unwanted pregnancy,
- Services to promote safe motherhood,
- Services to promote child survival,
- Nutritional services to vulnerable groups,
- Prevention and treatment of RTIs and STIs,
- Reproductive health services for adolescents,
- Health Sexuality and gender related counseling, and
- Establishment of an effective referral system.
State/District Specific RCH Strategy

Considering the variations with regard to various parameters/indicators of RCH among states and districts, area specific approach has been worked out separately for different groups of states and districts. States and districts classified based on parameters like CBR, TFR, female literacy level, percentage women registered for ANC, percentage of hospital delivery, percentage delivered by untrained birth attendant etc. Additional inputs are provided to poor performing states and districts.

Greater Emphasis on Quality

Provision of good quality care is the crux of the RCH programme. Good quality care ensures client satisfaction which is one of the major goals of the programme. This in turn would increase the service utilisation. Therefore provision of good quality care by health personnel would determine the success of the programme.

In-service training of health personnel with due focus on practical skills is a major input for improving quality of care. Need has also been felt for shift from vertical training structure with training in different components of care at different locations and different times to a comprehensive RCH training package which would include clinical components as well as managerial and communication components.

Comprehensive Integrated Training with District as the Coordinator

An important feature of the training in future will be the involvement of the field functionaries and the anganwadi workers as well as functionaries from other developmental sectors. Planning and management of training programme would be the responsibility of the district. Central and state govs. will support the district in training of trainers and production of training materials.
Increased Involvement of NGO and Private Sector

Service providers from NGO and private sector are involved in the delivery of services as well as in providing training and for IEC. Social marketing of contraceptives and RCH products is another area of involvement. Mother NGOs have been selected across States to implement RCH Programme through FNGOs.

Area Specific IEC Campaigns

While there is attempt to evolve national IEC strategy for RCH, emphasis is placed on development of local area specific communication strategies to create more demand for RCH services and to promote informed decision making for use of services. Thus health personnel and trained in IEC skills to motivate people for used right kind of services for meeting their needs. Special emphasis is also placed on IPC and use of local traditional media for increasing acceptance and impact.

Change in Financing Mechanism

Direct financing of states through State Committee on Voluntary Action (SCOVA) with the object of avoiding delays in implementation due to budgetary constraints have been started.

Management Information System

The CNA approach is based on participatory planning and monitoring with involvement of stake holders (women and men). The reporting system including items reported have undergone change and the indicators developed from the reports are also changed.
Introduction of Quality and Impact Indicators

Alternative quality and impact indicators are replacing the method specific contraceptive and other quantitative targets for monitoring programme. Good quality care assessed through process indicators, prompt service, increasing accessibility etc. are being used.

Independent/Rapid Evaluation

The system of monitoring and evaluation has undergone changes. It is participatory involving different stake holders and focus is on quality. Evaluation by PRCs and other independent team has been introduced through household and health facility surveys which provide data regularly for enabling corrective actions as and when needed. Quality of services based on clients health seeking behavior will also be monitored/evaluated.

Gender Concerns

All efforts have been made to make the programme as gender-sensitive as possible. Women's groups are involved in planning and monitoring.

Increased Male Participation in the Programme

Need for increased male participation in the RCH programme has been given considerable importance. More responsibility in child rearing by males, increased acceptance of male contraception, informed decision making for service use jointly by males and females, male participation in RCH service provision etc. are important.
Multisectoral Participation in Health and Nutrition Services

Convergence with other sectors for success of the programme particularly for nutrition has been given due consideration. Awareness generation training programmes are planned for functionaries from all developmental sectors.

Involvement of Panchayati Raj System

Panchayati Raj system is expected to lay a significant role in planning for RCH services particularly for identification of the needs of local population for RCH services. The system is also to play a role in the implementation, particularly financial support and transport support for referral of women to hospitals for deliveries. For evaluation of the programme the panchayat system extends support in assessing the client satisfaction. Therefore special efforts to provide RCH awareness training to panchayat members is envisaged.

RCH Services for Special Population Groups

Certain vulnerable segments of population like tribal population, urban slum dwellers, adolescents who have prominent specific service needs for RCH need to be addressed through specially designed additional programmes/projects.

Special Focus on Certain Service Components

Two service components have been added to essential RCH package viz. prevention and management of RTI and STDs. Under comprehensive RCH programme, care for gynecological morbidity as well as infertility management, screening and management of cancers are also added. Special focus is also on provision of safe abortion services.
4.3.2 Reproductive and Child Health Programme in Rajasthan

The Reproductive and Child Health Programme is directed towards wider coverage and improving quality of Family Welfare Services in the State. The RCH Programme covering all earlier components of Child Survival and Safe Motherhood Programme, also covers the areas like RTI/STI and adolescent health issues. The main objective of the programme is to reduce infant and child mortality and to realize population stabilisation in the State. The programme is being implemented at national level with the support of World Bank. This programme is being implemented in all 32 districts in three phases. The programme is being implemented for 5 years starting from 1997-98. The major components being implemented in the State are as follows:

i. **Minor Civil Works** for repair works at PHC/SC as well as arrangements of water and electricity.

ii. **Major Civil Works** at each CHC and the district hospital for construction and upgradation of OT and Labour Room along with arrangement of water and electricity.

iii. **24 Hours Delivery Services** is directed towards improving the availability of delivery services to increase institutional deliveries in the State. The CHCs and PHCs with essential delivery services, where routine night delivery is very low, are covered under the scheme.

iv. **Referral Transport Services** for providing referral transport to pregnant women of poor families for emergency obstetric care. The activity is being implemented through Village Panchayats in 18 districts of Rajasthan.

v. **IEC Activities through ZSS** for awareness generation on RCH issues. The activity is being implemented through Zila Saksharata Samitis.
vi. **Outreach Services** is directed towards awareness generation and improvement in quality of care and strengthening immunisation. The activity is being initiated in 5 districts of Rajasthan.

vii. **RCH Camps** to provide different reproductive health services at 10 selected backward PHCs in 11 districts of Rajasthan.

viii. **Dai Training** is directed towards improving delivery services in rural areas. Six districts of Rajasthan are covered under the scheme.

ix. **RCH Sub Project** is being implemented in 2 districts viz, Jaipur (slum) and Tonk. Under RCH Sub Project, different activities like Civil Works, IEC, Innovative Activities, Procurement, Baseline Survey, Hiring of Staff etc are being implemented.
4.4 VOLUNTARY SECTOR IN HEALTH CARE

Health care in India has a long tradition of voluntarism. For centuries, traditional healers have taken care of the health needs of their own community as a part of their social responsibility by using the knowledge passed on to succeeding generations regarding the medicinal value of herbs and plants locally available. This tradition still continues, particularly in the tribal pockets of the country.

Unfortunately, the institutionalized voluntarism that evolved during the colonial era was completely dominated by the thinking of the colonizers who completely ignored the rich traditional systems of health care in India. This was partly due to the fact that much of this effort grew out of the activities of Christian missionaries. The Indian elite who had been partially involved in the voluntary effort during that phase, also firmly believed in the supremacy of Western approach. Consequently, there was little possibility of evolving a health system which assimilated the best of both approaches.

After Independence, till the mid 1960s, voluntary effort in health care was again limited to hospital based health care by rich family charities or religious institutions. In the mid 1960s the effectiveness of the Western curative model of health care in the less developed countries came under serious attack by development planners. Various models of community health programmes were evolved by voluntary agencies which emphasized decentralized curative services where trained village level workers play a key role. Much more importance was given to preventive aspects where the community plays a more effective part in their own health care. Unfortunately, this refreshing trend too ignored the important role of traditional healers and dais in health care, and very little attention was paid to the Indian systems of medicine.

In India, though the voluntary sector which traditionally includes private-philanthropic-not-for-profit organizations, is rather small and is concentrated in a few states, it has become an important segment of the health care scene. While
some NGOs develop their own approaches to providing health care, others implement the government programme, more effectively. NGOs like the Lions and Rotary clubs play supportive roles like providing additional resources or filling important resource gaps.

NGOs have also contributed to developing new models of service delivery which are more effective and cost efficient. The concept of community health worker, for example, was first tried in the NGO sector which was later adopted in the government, in the form of a Community Health Guide scheme (Antia and Bhatia, 1993). NGOs main attraction is some of their skills and qualities like community mobilization and involvement, use of local resources, developing micro plans, accountability and flexibility etc which distinguishes them from the government, and which are needed to implement the new population and RH programme.

Government programmes, because of their sizes and administrative structures, cannot be very flexible. NGOs on the other hand, have the advantages of size and structure and therefore can be flexible and innovative in their functioning.

Most state governments find NGO innovations difficult to adopt because the administrative environment of the government is different from that of the NGOs. NGOs have more control over their workers; they can reward or punish their workers as necessary. Also, NGOs recruit only a few workers compared to the government. Therefore, they can select them carefully and train them more frequently. NGOs are also known to have committed and motivated leadership. As a result of these differences, many ideas which works in the NGO programmes, are not expected to work in the government set-up.

Since government programmes are designed centrally and have little scope for local adaptations, they find community involvement rather difficult to practice. On the other had, NGO programmes are flexible; can respond to the local needs and therefore can have better rapport with the communities. There are many
examples of communities, under the leadership of NGOs taking such measures as running non-formal schools, contributing grain and vegetables for village nutrition programme, agriculture development activities etc. Under the Panchayati Raj System, the scope for involving community is substantial. Government of Rajasthan has already initiated Referral Transport Scheme for emergency obstetric care under RCH Programme. The scheme is being implemented in 18 districts through village Panchayats. Though, slowly but gradually the scheme is gaining momentum in providing referral transport to poor pregnant women in the State.

Accountability to client is a cornerstone for improving the service quality. NGOs, because of their funding pattern, feel accountable to the clients or to the funding agency. The government staff, for the same reason, do not feel accountable to the clients. The staff gets paid even if it does not provide services, and is not rewarded if it provides better services. Therefore, the government staff has no incentives to provide better quality service. Some of them even feel that since clients get free services or get cash incentives for services, they have no right to demand good quality services (Ramasundaram, 1995).

The mechanism of developing quality standards needs far more attention in India than it has received so far. In several developed countries, service quality norms have been legislated. In India, only the investment levels have been legislated, not the quality norms. NGOs can help in bringing about this change. Now, under RCH approach greater emphasis is being given to quality of care in Rajasthan as well as at national level and other states.

Micro-planning is an essential skill for implementing any new programme. NGOs have developed these skills since they work closer to the field and frequently deal with new programmes. The need for District officers to practice the micro-planning skills have been long since recognized. Several training programmes have been organized for them but those have had little effect on the micro-planning capacity in the government programme. In the government set-up, say
the government officers, planning is difficult because government programmes operate under uncertain environment. They face sudden changes in policies and programmes; they experience shortages in supplies; they have to deal with unexpected emergencies like floods and outbreaks, all of which throw micro-plans out of gear.

Integrating reproductive health with the FW programme is the most feasible mode of achieving universal access to reproductive health services, in India. Since the GOI has already taken the critical step of removing contraceptive targets, this programme can now focus on service quality and access to services. However, this would require a change in the manner in which the service package is devised, delivered and monitored.

Rajasthan has experienced a strong NGO movement and has a vast network of NGOs across the State. Many NGOs are working in close coordination with government and implementing government supported health programmes in remote and inaccessible areas like NGO Mobile Health Camp in 25 districts under IPP-IX. Many NGOs are running different health programmes supported by external donors. NGOs are also being involved in organizing RCH Camps in 11 districts. The major contribution of NGOs are being received in special rounds of Pulse Polio Immunisation in the State. The leading NGOs of Rajasthan working in the health sector are IIHMR-Jaipur, RVHA-Jaipur, Sewa Mandir-Udaipur, Urmul Trust-Bikaner, SURE-Barmer, GVVS-Jodhpur, ECAT-Nagaur etc.
4.5 REVIEW OF LITERATURE

The fact that birth, death, infant and maternal mortality rates are still unacceptably high and that the proportion of couples, with wives in the child bearing age, practicing family planning is low indicates the need for more health and family welfare facilities. But the available facilities are not being fully utilised. Before proceeding to the cure of the problem, it may be mentioned that some believe that it is not the lack of resources or infra-structural facilities, but rather that of proper policies and priorities that acts as an impediment to the improvement of health status of people.¹

The expansion of the infrastructure facilities implies that there is unmet demand for health and family welfare services. But it is observed that there are situations where excellent primary care facilities are available and are grossly underutilised at all. It would be helpful if some light is thrown on the areas in which under-utilisation is more. It is highly significant that the services supplied and not utilised are mainly in preventive field.² Another area in which facilities are available but are underutilised is that of family planning.³

There is need to identify the people who do not utilise the health and family welfare services. It may be noted that there are people both in rural and urban areas who do not utilise or utilised only rarely the health and family welfare services. In a rural area of Maharashtra, about one fourth of the 3606 households visited PHCs and/or Sub-Centre during 12 months preceding the survey.⁴

² Mackay, D. M. (1982), "Primary Health Care may be needed but is it wanted" World Health Forum, 3 : 88-89.
It is important to identify the reasons for under-utilisation and non-utilisation on health and family welfare services available in government institutions. First and most important factor is the way in which the concept of sickness and its cure are interpreted. People tend to believe that sickness and its cure are not in their hands or that sickness can be cured by mantravadis or local healers. People of this type are less likely to utilise modern health and family welfare services. People who interpret sickness and its cure in secular or modern term are more likely to utilise government health and family welfare services. "The nature of Indian and Hindu Society, with a greater degree of pluralism and probably any other society, has been a factor that has permitted much of the change. Yet fundamentally what is happening is a transition from one type of society to another, essentially to Western type of society. Those who accept modern health services most readily are persons who believe that they have, to a considerable extent, joined this new and a different society".5

A study of 1331 currently married women in the reproductive age-group of 15-49 years and 1299 husbands of currently married women in the reproductive age group of 15-49 in the rural areas of Karnataka revealed that about 69 percent of the former and 70 percent of the latter utilised health and family welfare services available in the government institutions during 12 months preceding the survey. The study also revealed that utilisation of services in government institutions varied according to religion, literacy level, age, number of living children, type of family of the respondents, per capita income of the households.6 A study conducted in sample villages and taluk headquarter towns in another district of Karnataka revealed that utilisation of health and family welfare services available at

government institutions varied according to the literacy level, occupation and income of the heads of households.\textsuperscript{7}

The situation is no different in urban areas. A case study conducted in a metropolitan city in India revealed that households belonging to low and very low classes utilised health and family welfare services available in government institutions much less often than their counterparts belonging to high and middle classes did.\textsuperscript{8}

Distance between people and service delivery units is identified as a factor in the utilisation of health and family welfare services. That is when the distance between people and service delivery units is short, utilisation of services is better.\textsuperscript{9}

Social class, which includes such factors as education, occupation and income, is another factor which makes for differences in the utilisation of health and family welfare services. Upper and middle classes utilise these services more often than the lower class does. "The lower classes often try to live with their illness as far as possible. They do not perceive the need to seek the medical care unless and until the disease starts affecting their day to day work or incapacitating them. They consider their illness as one of the main crises they face in their day to day life".\textsuperscript{10} A number of other factors such as awareness of different services available in government institutions, quality of services, waiting time, availability of medicines, payment of money for the services, etc. are identified as the factors affecting the utilisation of health and family welfare services.

\textsuperscript{7} Devi, Manjula (1986), "Awareness and utilisation of government health service in Gulbarga district", International Institute for Population Sciences (Mimeo), Mumbai.
A comparative study of functioning of health and family welfare programme shows that health consciousness among the people of Kerala is much more than Bihar and was clearly reflected in cares received by pregnant mothers during pregnancy period and at the time of delivery.\textsuperscript{11}

Utilisation of government health services including MCH and immunization facilities was low and most families preferred private doctors to state services mainly because of distance of PHC/Government hospitals restraining people to utilise the government services, the PHC functionaries were charging for providing the services and functionaries were not fully trained to perform their duties and also were not working properly.\textsuperscript{12}

The family welfare programme remains mainly a government programme, it has not taken shape of the community programme. Ideally it should be community programme with support from government, but it is still a government programme with a little support from community.\textsuperscript{13}

Health workers are not making systematic regular home visits and as a result both MCH and Family Planning Programme suffer. Regular home visits by health workers in their area pay good dividend in providing MCH and Family Planning services, thereby convincing couples to accept family planning methods.\textsuperscript{14}


Simmon (1981) attempted to pinpoint the determinants of family planning performance at the PHC level. They observed that factors, directly affecting the performance of the PHC, were the number of visits of the 'change agent' and attitudes of the villagers towards family planning.\(^{15}\)

Bose (1981) examined the logistic support and facilities for primary health care with special attention on human settlement pattern, physical accessibility and delivery of services at local level. The study covered U.P., Kerala, Bihar, M.P. and Rajasthan. The state of Kerala enjoyed the maximum accessibility to health and education facilities.\(^{16}\)

Elder (1972) studied the organization and management of PHC in the state of Uttar Pradesh from a holistic perspective.\(^{17}\) The main factors affecting the performance of the PHC are the number of visits by functionaries, their personal characteristics and attitude of the people towards family welfare planning.

A time series analysis of the MCH/FW programme was made by Sinha and Sadashivaiha (1978). The lack of follow-up, inadequate evaluation, training, lack of job satisfaction and several problems faced by programme personnel were the main causes of failure of MCH and FW programmes. This study revealed that the performance of UP reached a peak in 1971, Karnataka, Punjab and Delhi in 1972, Assam, Bihar and Haryana in 1973, Jammu and Kashmir, Kerala, Orissa, Madhya Pradesh and Tamil Nadu in 1974. Fluctuations were observed in Andhra Pradesh, Gujarat, Maharashtra, and Rajasthan.\(^{18}\)

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17 Elder, R. E. (1972), "Development Administration in a North India State", Chapel Hill, University of North Carolina.
A study on the under-utilization of PHCs was undertaken by the operations Research Group (ORG), Baroda. The study covered, Bihar, Gujarat and Kerala (Khan and Prasad, 1975. The study showed that the amount of training received by the workers, closer linkage with local leaders in their extension efforts, their own perception about ideal family size and contraceptives, etc. had a positive influence on the success of family welfare programme. In contrast, educational level of the functionaries higher than required by the job and their urban background had a negative influence on their job performance. The study also revealed that many workers in Bihar and Uttar Pradesh were themselves not practicing family planning. For them, the concept of spacing did not exist.\(^{19}\)

An evaluation conducted by Indian Council of Medical Research (ICMR, 1989) showed that more than 80 % pregnant women were not registered and in about half it was less than 40 % and 10 % PHCs did not have any record of pregnant women. The situation regarding tetanus toxoid (TT) and Iron Folic Acid tablets was also unsatisfactory. Only about 15 % of PHCs had achieved satisfactory outreach to the community.\(^{20}\)

The more recent data from National Family Health Survey 1992-93, (NFHS, 1994) is however more optimistic. At national level about 40 % of rural women and 70 % of urban women had received antenatal service and the coverage with tetanus toxoid was higher – 55 % for rural and 80 % for urban women.\(^{21}\)

The latest data made available by NFHS 2, 1998-99 provides valuable insights for status of women and child health in Rajasthan. Proportion of pregnant women, with any ANC check up, 2 or more doses of TT and given any IFA are 47.5

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percent, 52.1 percent and 39.3 percent respectively which shows substantial improvement in maternal health services in Rajasthan. The institutional delivery has been very poor in Rajasthan and as per this survey the ratio is still very low at the level of 21.5 percent. The proportion of fully immunised children at the level of 17.3 percent, which has come down from a level of 21.1 percent in 1992-93 (NFHS 1), has caused a great concern for deteriorating immunisation services in the state. The increase in contraceptive prevalence rate has been very slow which could reach to level of 40.3 percent only as per NFHS 2, 1998-99.\textsuperscript{22}

The scope of reproductive health should be expanded to include all aspects of women’s health. Reproductive tract infections are an important reason for the poor acceptance and low continuation rates of contraceptive methods such as IUD. There has been found a higher incidence of gynecological symptoms among women who had undergone tubectomy, and yet there is no provision for their management in the family planning programme.\textsuperscript{23}

There are wide social and cultural gaps that exists between the providers and users of services. In order to bridge this gap, more attention should be focussed on the users’ perspective within the overall framework of the service delivery system. There is a need to specially focus on women since they constitute the major client group or users of these programmes and also have the greatest problem of access, both physical and social, to health services.\textsuperscript{24}

There is fundamental link between family planning and abortion. Effective contraception is an important means of preventing unwanted pregnancies and avoiding the need for abortion. Despite the fact that abortion is legal, poor women in India, particularly in rural areas, do not have access to safe abortion services. The Medical Termination of Pregnancy (MTP) Act enacted in 1971 could not fulfil the desired needs of rural women. Today there are more illegal abortions in India than there were prior to the MTP Act with about 15,000-20,000 abortion related deaths occurring annually among women.25

India is still far away from the National Health Policy goals of Crude Birth Rate of 21 and Couple Protection Rate of 60. In spite of increasing resources diverted to Family Welfare Programme, which is a name given to MCH and FP Programmes in India, now about Rs 50 per eligible couple per year, the results do not seem to be commensurate. This indicates that weakness in the management of the programme could be the main reason.26

The current accounting system does not calculate the cost per client served and other similar cost measures. Given the gross under-utilisation of capacity of family welfare system it would be very important to measure such costs. For example, a PHC clinic having one full time doctor and 3-4 supporting staff on an average examines about 24 cases in a day as per a study in selected PHCs in Gujarat.27 Hardly any patients are admitted to the PHC which is supposed to have indoor facility. A recent study done in 2 PHCs of Karnataka on time use in PHCs has shown that on average 30% of time of professional manpower is wasted in

unproductive activities. Cost of this wasted time in a PHC is estimated at about Rs 2,40,000 to 4,40,000 per year.\textsuperscript{28} / 

A recent study conducted in Ahmednagar district in Maharashtra shows very interesting results about the factors affecting the use of MCH and Family Planning services. ANC registration in PHC/SC villages was much higher than that in other villages. ANC registration and immunisation rates were sensitive to the education of mothers. But these did not vary much by social and economic background. Family planning use however, was higher in other villages and among illiterate women. In these groups, sterilisation was much higher than the use of spacing methods which was very low.\textsuperscript{29} 

While India's FW Programme has many strengths such as its size and number of services provided, its main weakness has been the poor quality of services. This weakness has been attributed mainly to the fact that for many years the programme pursued the strategy of achieving contraceptive targets. Therefore, following the Cairo Conference recommendations, the Government of India decided to change this strategy of FW Programme and to focus instead on improving health status of women. At the programme level, this change implied providing high quality services, meeting client's reproductive health needs and ensuring client satisfaction.\textsuperscript{30} / 

Health functionaries have the opinion that there are many problems faced by them which is responsible for poor quality of services. Therefore in any assessment of the factors contributing to differentials in a challenging programme of social engineering such as the family welfare, it is essential to ascertain the views of

health functionaries. A case study conducted in Gujarat shows that Medical Officers working at PHCs at large feel that female health workers must stay in the allotted official quarters or the sub-centres. To facilitate this, the sub-centres should be built (or some accommodation should be acquired) in the centre of the village rather than at some distance from the village. The area of jurisdiction of the health workers should be reduced because without access to vehicle, it is not easy for a female health worker to make her regular rounds.\(^{31}\)

Early and universal female marriage is very much favoured in Rajasthan and this has naturally contributed to a great extent in retaining high fertility levels in the State. Also low socio-economic status of the masses, low female literacy levels, very low female work participation rate, prevalence of substantial child labour, and preference for male children have been the likely barriers to adoption of small family norms by masses at a large scale. There is gross under utilisation of MCH Services in Rajasthan even in those villages where PHC and sub-centre are located. A very small proportion of pregnant women are provided domiciliary services by the health staff. A huge majority of deliveries are conducted by untrained professionals. The status of child immunisation has also found to be very poor in Rajasthan.\(^{32}\)

A study conducted on knowledge and utilisation of MCH services in Delhi slums indicate low utilisation of the maternal and child health services provided by the public health care system. The important reason for the non-utilisation of these services may be lack of knowledge about these services provided by the Government which may in turn be attributed to the high level of illiteracy and lower accessibility of these institutions providing the services. It was found that a very


large number of deliveries were being conducted at home and continued to be attended by traditional dais under the most unhygienic conditions. Analysis of data on immunisation shows that the vaccination rate in these slums fell short of the achievement of the goal of universal immunisation against the major vaccine preventable diseases. There is need to increase service utilisation by generating awareness among the women of these slums regarding the free MCH services provided by the Government.\textsuperscript{33}

It is encouraging that even in the so called BIMARU sates, a few region show some dynamism. They are north-western arid plain and Aravalli hill range in Rajasthan, Malwa and Narmada valley range in Madhya Pradesh, southern plateau of Bihar and Kumaon region of Uttar Pradesh. The most backward regions of India are north Bihar plain, Bundelkhand, Bhojpur and south-western plains of Uttar Pradesh, and the extremely arid region of Rajasthan. Reducing fertility in these regions, and more generally in north India, is a formidable task as they are backward in many respect. They have the highest levels of illiteracy, poverty, malnutrition, child mortality, son preference and joint family living. These problems are compounded by low exposure to mass media and limited extension work carried out by the health staff. In such regions fertility decline is largely guided by a slow process of diffusion, wherein new information and practices get transmitted only through personal contact.\textsuperscript{34}

In order to promote the use of family planning, there is need to address the issue of strong son preference with its roots in social mores and which contributes to raising wanted fertility and leads to some unwanted fertility. Measures to weaken the preference for sons include improving the status of women through education and employment. There are very few direct policy interventions to enhance women's autonomy, and improve their bargaining or negotiating capacity within the


household, except education which is sensitive to women’s needs. Equally important is lowering of infant and child mortality. Strong policy intervention on this front would not only enhance the credibility of the health personnel and the government among the people, but would also raise the acceptance of the family planning programme among those who are hesitant to do so.\(^{35}\)

The lower level of home visits by health workers is an important factor adversely affecting the utilisation of MCH and Family Planning services. In a four state study conducted by Roy and Verma (1999), it was found that outreach visits are significantly higher in southern states than in northern states of India. Around 89 percent and 93 percent of women surveyed in Tamil Nadu and Karnataka respectively were visited by a female health worker within last three months in comparison to 53 percent and 61 percent of women from Bihar and West Bengal respectively.\(^{36}\) Similarly, a study conducted in Uttar Pradesh found that less than 10 percent of surveyed women reported to have been visited by a female health worker during the preceding three months.\(^{37}\)

Now, under the target free approach of family welfare programme in India, the policy is to provide greater choice of contraceptives to clients from all available methods of contraceptives. But evidences show that clients generally receive limited information for contraceptive choices from providers. In Maharashtra, more than 60 percent of respondents under a study reported that they were not told

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about spacing methods during the visit of health worker. Generally the major thrust is given to female sterilisation and, to a lesser extent to IUD. The male sterilisation is rarely offered as an option of family planning.

The follow up services to the users of family planning is an important quality indicator and matters in confidence building and popularity of the programme which are necessary for higher acceptance of family planning methods. A study conducted in Gujarat clearly shows the dissatisfaction among family planning acceptors for poor follow up and postoperative care. There were general complaint expressed by clients about the charges for such services which are provided free of charge at all government health institutions.

Considerable international attention has focussed upon recent efforts by the Government of India to improve the quality and range of services provided through the Family Welfare Programme. The policy shift towards more client-centered services represents, nevertheless, a significant and positive step, and, if accomplished, is likely to yield substantial dividends-not only in terms of meeting client's reproductive needs but also in terms of India's broader demographic goals. By themselves, these policy changes fail to redress systematic and complex problems of implementation that plague much of the Indian Programmes, problem that often defy simple or ready intervention.

Family planning programmes traditionally have focussed on women as the primary beneficiaries of service provision. Men have been considered only as silent

partners. Moreover, a recent review of studies of couple's behaviour indicates that reproductive health interventions targeted at couples demonstrate greater impact than those aimed at a single sex.  

A case study on male involvement in family planning in a south Indian family spanning five generations indicate that among the members of the high caste Brahmin family interviewed, men maintained significant involvement in family planning over several generations, although their involvement took several forms as the variety of contraceptive methods increased. Fertility levels dropped during periods of greatest male involvement and virtually no female involvement in reproductive decision making. Male as well as female motivation for smaller families has been rooted in economic considerations that are part of broader social and cultural context. A critical component is the perpetuation of key cultural values about role of the extended family and about spousal roles and responsibilities.  

The need for reaching men with reproductive health programmes was affirmed at both the ICPD and the Fourth World Conference on Women held in Beijing in 1995. Reproductive health programmes are likely to be more effective for women when men are involved in some way. In India, where women's autonomy is particularly low, educating and involving men in reproductive health matters may be the only effective means of influencing change in the poor health outcomes of women and girls. Practices that contribute to poor female health status such as the preferential allocation of food and health resources to boys, are deeply rooted in cultural norms and persist despite changes in other factors known to contribute to women's status.  

India consists of areas and states that differ greatly from each other historically, culturally, geographically, and economically. Therefore, that fertility practices of the various regions differ widely as well is not surprising. The recent fertility decline in India has been much more pronounced in the south of the country than in the northern 'Hindi Belt'. South India-the states of Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu-is an area characterized by related Dravidian languages, the historical connections, and a common way of organizing kinship. Female sterilisation is the most commonly used means of contraception in India. In South India, the popularity of female sterilisation compared with other contraceptive methods is greater than it is in India as a whole. The widespread use of the procedure is the single most important proximate determinants behind reduced fertility of women in South India.44

Interest in creating family planning programmes arose in many countries only after declines in mortality and other aspects of development led to decreases in fertility preferences and created a potential demand for contraceptives in the population and a concern about fertility among government leaders. Therefore, at their beginning, the immediate task for programmes was not to decrease fertility preferences, but rather to legitimate contraception and make it available as the solution to pre-existing problems of unmet need. Several kinds of evidences have demonstrated that family planning programmes sometimes do not affect preferences but do help to crystallise latent demand created not by the programme but by other development processes.45

A study by Bongaarts and Bruce (1995) found that the causes of unmet need went far beyond the simple issue of access to contraceptive services and often involved

the cultural barriers to method use for women who said they wanted no more children.  

On the matter of knowledge, there are many potential informational barriers to contraceptive use. Women must be aware of contraceptives methods, they must know where supplies of these methods can be obtained and they must know how to properly use the method they select. There are few settings in which most women possess all the necessary information. Elsewhere, many are aware of only one or two rather than the full range of available methods. Incomplete or erroneous information about where to obtain methods and how to use them may be even more prevalent.  

One of the central questions in population policy has been the extent of unintended fertility and, correspondingly, the amount of unsatisfied demand for fertility regulation. The extent for demand for fertility regulation is crucial to determining strategies to reduce high fertility. In more practical terms, unmet need results in unwanted pregnancies, which in turn more often than not lead to unwanted births, because in most societies a large proportion of unwanted pregnancies are carried to term. Unwanted fertility remains a more substantial problem than is acknowledged by political leaders in many developing countries and by donor agencies around the world. Roughly one-fifth to one-quarter of births in the developing world are unwanted, with the number of pregnancies that are unwanted even higher.  

The strong effects of female literacy, child mortality, and son preference on fertility levels contrast with tenuous correlation between the latter and various indicators of overall development and modernization such as male literacy, urbanization, and even poverty. Fertility decline is not just the byproduct of economic growth, it depends on improvements in the specific conditions that are conducive to changed fertility goals and that help parents to realize these goals. ⁴⁹

Access to public health services may also play a role in reducing fertility, independently of education and income. Aside from direct effects through improved access to contraception, public health services may reduce fertility by enhancing child survival. These effects may be small where services are of poor quality, as is true in much of north India. The access to public health services reduces mortality but has significant effect on fertility. ⁵⁰

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