The Gender and Reproductive Health Research Initiative
Mapping a Decade of Reproductive Health Research in India

Reproductive Health Services in India

An Annotated Bibliography of Selected Studies (1990-2000)

Sunita Bandewar
Shelley Saha

Centre for Enquiry into Health and Allied Themes (CEHAT)

A CREA Publication

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The Gender and Reproductive Health Research Initiative has been supported by The Ford Foundation. Support for printing, publishing and dissemination has been provided by The Rockefeller Foundation.

Suggested Citation:
Bandewar, Dr. S., S. Saha, Reproductive Health Services in India: An Annotated Bibliography of Selected Studies (1990-2000). The Gender and Reproductive Health Research Initiative. CEHAT and CREA. New Delhi. 2002.

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Published and disseminated by:
Creating Resources for Empowerment in Action (CREA)
2/14, Shantiniketan, Second Floor, New Delhi 110021
Phone: 91-11-4107983, 91-11-6874733 Telefax: 91-11-6883209,Phone:
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CONTENTS

ASPECTS OF WOMEN'S REPRODUCTIVE HEALTH IN INDIA: AN ANNOTATED BIBLIOGRAPHY OF SELECTED STUDIES (1990-2000)

Background

This annotated bibliography lists studies carried out during 1990-2000 on selected aspects of women's reproductive health in India as part of a series of annotated bibliographies on gender and women's reproductive health. These bibliographies are part of the *Gender and Reproductive Health Research Initiative* sponsored by the Ford Foundation.

In September 1998, the Ford Foundation in New Delhi hosted interested individuals involved in women's health issues as activists or researchers to discuss their concerns about the future of reproductive health research in India. The participants spent a day sharing their experiences and briefly reviewing the content, nature and geographical distribution of studies in reproductive health in India that Ford Foundation had funded over the past few years. After discussion, the participants decided on a process for identifying gaps in research on reproductive health and for promoting future research that would address issues that had not been addressed or adequately explored.

The agreed upon process was to have the following stages:

- Prepare annotated bibliographies of social science research or clinical studies referring to social dimensions on seven major areas of reproductive health, drawing mainly on published research over the period 1990-2000.
- Based on the annotated bibliographies, prepare critical reviews of literature on each of the six areas of reproductive health. This review would examine, from a gender perspective, the entire body of research covered by the annotated bibliographies and identify the content gaps, methodological issues and ethical concerns.
- Disseminate the critical reviews as widely as possible to women's groups and NGOs, to those involved in women's studies, and to university departments dealing with health/population issues and reproductive health, in order to encourage the participation of a wide cross-section of actors in future research in the area.
- Invite brief research proposals to carry out studies that will address the research gaps identified by the reviews. Proposals will be short-listed by a team of experienced activists and researchers. The next step may consist of a workshop to help develop these proposals into fully fledged research plans.

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

The following subject areas were chosen for the annotated bibliography series:

1. Selected aspects of reproductive health: maternal health, reproductive tract infections and contraceptive morbidity
2. Selected aspects of general morbidity in women, especially the interface between communicable and non-communicable diseases and reproductive morbidity
3. Sexuality and sexual health
4. Abortion
5. HIV/AIDS
6. Reproductive health services

Scope and Format

This particular volume contains selected annotations of studies on 'Reproductive Health Services' in India during the 1990s. No such category of 'Reproductive Health Services' actually exists, especially in the public health services. Apart from maternity services and family planning services, the services for reproductive health must be accessed as part of the general health care services. Thus, a review of reproductive health services must also include a review of literature on general health care services.

This volume presents 132 annotations that have been structured around five sub-themes:
1. Health care service providers (22)
2. Quality of health care services (23)
3. Women's health care needs (18)
4. Health care: access, utilisation and expenditure (33)
5. Policy: analysis, critique and alternative perspectives (36)

These sub-themes evolved during the literature search and annotation. Often, a particular piece of research work dealt with more than one sub-theme, which made it difficult to categorise. For example, health care service providers constitute an essential part of health care service delivery system and yet they are presented separately because there was substantial research material on them, though mostly the grassroots level health workers. Ordering material around these sub-themes enabled us to recognise the research issues involved and identify the research gaps in a more focused manner.

The research classified under the sub-themes "health care service providers" and "quality of health care services" covers the issues regarding health care services from the delivery point of view. The research under the sub-themes "women's health care needs" and "health care: access, utilisation and expenditure" primarily looks at health care services from the users perspective, which in addition to others also may have used a socio-economic lens while examining people's access to and utilisation of health care services. The last sub-theme, "policy: analysis, critique and alternative perspectives" addresses aspects of both providers and users.

LITERATURE SEARCH

The guiding framework

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

For the former, we relied upon the definition of what constitutes reproductive health. Reproductive health is defined as "a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relations free from fear of pregnancy and contracting disease."[1]

The various elements or the key reproductive health issues are:
- RTIs/STDs/HIV
- Adolescent health
- Maternal health
- Mental health
- Gynaecological health
- Older women's health
- Alternative health care
- Anaemia/nutrition
- Sexuality; sex education; sexual health; violence; sexual abuse
- Male involvement, responsibility, needs
- Infertility/Sterility
- Abortion, contraception
- Access to socio-economic rights
- Occupational health[1]

The key tenets underlying the above issues are:
- Empowerment
- Right to information
- Women's political participation

1 Mohmood Fathalla (1988), World Health Organisation.

- Accountability
- Access to primary health centres[2]

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

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

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

In addition, subject matters such as access to and utilisation of health care services and health expenditure are additional important aspects of health care services. These aspects interface between users' socio-cultural and economic characteristics and the socio-cultural context of an illness or a particular health care need. How much clients use health care services reflects how appropriately the services take into account users' perspectives, needs and constraints.

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

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

Health care provision alternatives should be examined, especially ones that meet women's health care needs. They often are inspired with the idea of improving access to quality health care services. Our intention to include these in the guiding framework was to understand their strengths in terms of their peculiarities. These peculiarities may have helped to bring about changes in the prevalent power relationship - be it between men and women or service providers and policy makers as part of the establishment and the people as users of health services. These in turn may have helped to sustain these community-based structures to deliver health care services.

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

We also searched for documentation on advocacy efforts to improve the reproductive health care services and enhance women's access to such improved reproductive health care services.
However, we could not find much information either on alternative experiments in health care service provision or advocacy efforts for improving access to health care services, which highlights the fact that such experiments and alternatives need to be documented and advocated.

2 A Ford Foundation Report (1997). Advocacy for reproductive health and women's empowerment in India.

Sources of Research Literature and the Problems Encountered

List of Journals Scanned

1. Asia-Pacific Population Journal
2. AIDS Supplementary
3. Demography India
4. Economic and Political Weekly
5. Health for the Millions
6. Health and Population: Perspective and Issues
7. Health Transition Review
8. ICMR Bulletin
9. Indian Journal of Community Health
10. Indian Journal of Community Medicine
11. Indian Journal of Gender Studies
12. Indian Journal of Maternal and Child Health
13. Indian Journal of Medical Research
14. Indian Journal of Paediatrics
15. Indian Journal of Preventive and Social Medicine
16. Indian Journal of Public Health
17. Indian Journal of Social Work
18. Indian Journal of Social Science
19. Indian Paediatrics
20. International Family Planning Perspectives
21. International Journal of Gynaecology and Obstetrics
22. Issues in Medical Ethics
23. Journal of Indian Medical Association
24. Journal of Postgraduate Medicine
25. Journal of Obstetrics and Gynaecology
26. Journal of Social Science and Medicine
27. Lancet
28. National Medical Journal of India
29. Reproductive Health Matters
30. Radical Journal of Health
31. Social Action
32. Studies in Family Planning
33. The Indian Journal of Nursing and Midwifery
34. The Journal of Family Welfare
35. World Health Forum

Note: The above journals were scanned, but relevant material for this volume was gathered from the 22 journals in bold type.

The following types of literature were reviewed to make the search as exhaustive and up-to-date as possible:
1. Research papers published in journals
2. Unpublished research papers presented in various seminars, conferences and workshops
3. Reports of research studies published by institutions, mostly in-house

Journals: We prepared an exhaustive list of journals and later narrowed the list down depending upon the journal's coverage of the issues of concern. We selected journals that dealt with the following subjects:

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

The articles/papers selected for this annotated bibliography volume are picked from 35 journals. However, the relevant material included in this volume comes from only 22 of those journals.

Libraries and institutions: We mostly relied on the libraries of various educational institutions and other NGOs in Pune and Mumbai. We also wrote to NGOs requesting their research reports. However, the experience was not very encouraging. Various types of difficulties were encountered at several levels. For instance, research reports are often confined within the concerned NGO and/or funding agency and access was difficult. Many research efforts and findings remain undocumented, and many areas of known research remain invisible to literature search and critical review. The problems encountered are not unusual, but they clearly point to the need to create mechanisms to document and disseminate research methodologies and findings of studies intended to serve social causes and benefit people at large.

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

Formation of an Electronic Database

Researchers assisting in collecting the research material from various libraries and other sources found the guiding framework useful while screening the journals and other materials. The relevant articles were photocopied to be physically and electronically organised to form the database. The electronic database is the modified version of the bibliographies. Advantages included easy access to a list of research material that we had gathered. 'Sort' and 'find' facilities allowed us to assess and retrieve the material that we collected.

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

Acknowledgements

We wish to express our deep gratitude to the following persons for their invaluable contribution during various phases of the project.

- Dr. Bela Ganatra and Dr. Siddhi Hirve for their contribution during the literature search, preparing the electronic database, for providing us access to their library and the database, and during the first phase of preparing the draft annotated bibliography volume.
- Dr. Amar Jesani for his invaluable advice and guidance to us during the initial phase of conceptualising and in setting the ball rolling.
- Ms. Madhuri Sumant, Ms. Anjali Ganpule and Ms. Rohini Lele for their tireless efforts in creating and maintaining the electronic database.
- Mr. Kiran Mandekar and Mr. Dattatraya Taras for their help and cooperation in innumerable ways in addition to word processing and DTP work.
- Dr. Anant Phadke for support during critical moments and above all for emotional backing and allowing us to fall back on him when required.
- Dr. T. K. Sundari Ravindran for keeping up the spirit of the entire group through warm communications and for coordinating this national initiative.
- Ms. Hutokshi Doctor and Ms. Ishita Deven for editorial help.
- The Ford Foundation for financial support.

We must add that although we greatly benefited from the advice and help received from all of those mentioned above, the errors and omissions in this volume are our own.

SUMMARY AND OBSERVATIONS

Health Care Service Providers

Health care providers are one of the important elements of the health care delivery system. They play an important role in determining the 'character' of the health care delivery system -- whether clients get gender sensitive treatment and whether clients receive quality care depend upon the health care service providers. A number of factors contribute to and shape their health care delivery. Factors that influence the quality of health care delivery by providers include: the kind of training (such as skills, both clinical and communication, and orientation) they undergo; the opportunities that they have in the extremely competitive medical care market; the infrastructural facilities for their services; and their place in the hierarchy of the health care delivery system, especially in the case of public health care delivery system. Other systemic factors that influence the quality of care include: the distribution of health care providers; regulatory mechanisms that are in place (or absent); the working conditions; and the gender aspects that are taken into account. Also, providers' perceptions of and attitudes towards women's illnesses and their circumstances play a significant role in shaping the health care delivery and quality of care offered to women. Providers' understanding of women's changing health care needs and changing socio-political contexts also impacts health care delivery.

From the health care service provider literature, we considered the three aspects:

1. Type of sector in which they are working (public/private/voluntary)
2. System of medicines to which they belong
3. Their position in the hierarchical health care service delivery system in India

These could also form the analytical categories. In addition, we also critically examined the conceptual frameworks used and analytical categories -- gender, socio-economic and cultural characteristics of the service providers and users -- considered by researchers.

The following list is a summary of the observations made in the research literature on health care service providers:

- Paramedics (nurses, ANMs, community health workers, trained and untrained TBAs) are the most researched health care providers by social and health science researchers, medical professionals and state administrators/authorities.
- Some studies assessed their prescribed roles as MCH service providers (16, 17, 18, 19); some explored their roles beyond this narrow scope of service provision but still within the gamut of MCH care (20, 8); some explored their prospective role as service providers of the set of services outside the MCH care (8, 21). Most studies were concerned with advocating or promoting services, either MCH or non-MCH, by TBAs that they are accessible, approachable and affordable. TBAs' services are considered indispensable (18).
- One of the studies explored the feasibility of utilising services of *dais* for purposes other than childbirth-related services (8).
- Several studies assessed the TBA's professional competence and quality of care in delivering MCH services (2, 18, 19). The studies found that TBAs are poorly equipped to deliver quality care, even intra-natal care (17, 18, 19).
- In a rare instance, a study examined the profiles of rural private practitioners (15). Most of them practice modern medicine regardless of whether they were formally qualified.
- Another study assessed how effectively traditional medical practitioners could function as community health educators, especially for contraception (20).
- Two studies emphasised the contribution of trained TBAs in reducing maternal and perinatal mortality when they are adequately and appropriately trained (5, 16).
- Many studies recommended that TBAs need to be supported by training and continuing education to ensure quality of care (2, 3, 16, 17, 18, 19). Some recommended rewards, incentives and strengthening the economic structure of *dais* (3,17, 21).

- Two studies dealt with factors affecting utilisation of services and choice of providers (3, 10). When choosing indigenous health care service providers, clients consider: proximity of the service providers; health care cost; the cultural beliefs and practices shared by the providers (10). In another study, poor utilisation of services by women was attributed to their unawareness (3). The study recommends educating people to about these services.
- Two important studies dealt with the working conditions of women health care service providers (6, 9). One of the studies examined women health workers, the ANMs and their problems created by the bureaucratic pressures and ill-functioning systems (6). The study looked at the problems they face because of their secondary status in the society and in their own families. The analysis is more from a human rights perspective. The other study examined the linkages between the working conditions of women health workers and the quality of family planning health care services provided by them (9).
- One study demonstrated the usefulness of some techniques and exercises to improve pulmonary function of nursing students (13). This study differs from others for the primacy it gives to the personal health concerns of health care service providers.
- Another study records the positive attitude of the staff nurses towards the in-service training programme (14). Most of the nurses were motivated to acquire more knowledge and skills and to work for professional development.
- Most of the research on health care service providers is in the public health care service sector, with a concentration on primary and grassroots level health care services. There was little research on secondary and tertiary level health care service providers.
- Other than paramedics, no other service providers have been studied in a noticeable manner.
- Most of the research on health care providers from the public sector is in relation to delivery of family planning services and other government programmes, such as MCH. Treatment services for other reproductive health care needs have not received any attention.
- Research on extension workers has concentrated on their role in promoting family planing services, while there is little recognition of the fact that they are basically community health workers with a much larger role to play.
- Various aspects of health care service providers from the private sector are less researched. Because of the private health care sector's large contribution in reproductive health services, this absence of research is a colossal gap in the existing research.
- There are no macro level studies that could provide an authentic profile of health care providers from various systems of medicines regarding their socio-economic characteristics, educational qualifications and other specialisation.
- In addition to the professionally equipped health care providers with formal qualifications, a large number of 'quacks' and traditional health care providers provide health care services. However, little systematic information is available about them.
- Most of the research on health care service providers is conducted from the perspective of quality of health care services they deliver. Thus, the thrust has been to evaluate quality of their training/inputs; and knowledge, attitude and practice etc. However, rarely one comes across studies on the aspects such as work environment, work load; working hours; level of stress; health status; means to update medical knowledge coinciding to shifts in the government policies; membership to and participation in local or national level associations of health care providers regardless of their hierarchy in the medical health care system or their systems of medicines or the sector (private or public) they belong to.
- No literature available on providers' perceptions about the prevailing health care system, perceptions about their roles and responsibilities, concepts of social accountability and ethics in medical practice. Some of these concepts also need to be operationalised to begin with before any empirical research is conceived. This also has significance in the light of 'hi-tech' reproductive technology that is being used.
- There is certain amount of documentation of prevalence and typology of violence. However, health care providers' role in meeting the health care needs of survivors of violence is totally untouched area. There are some initiatives taken in the last two to three years at various fronts. These experiences need to be documented and disseminated. Some focused work on this theme is essential for laying down the strategies to structure the health care services to meet these needs. The present initiatives can lay the foundation for research, action, intervention and advocacy work in this area.

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

Quality of health care services

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

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

- Most of the studies adopted uncritically the well-known model of quality of care proposed by the Population Council.
- Most of the research on quality of care is concentrates on the family planning programme and its various components. As a consequence, they restrict themselves to public sector.
- Most of the quality of care studies are basically the evaluation studies conducted as regards various government programs, such as, family planning, MCH, ICDS. Barring some exception like that one conducted by ICMR task force (10), there are no national level studies one comes across. Most of these studies are shaped by perspective of programmers or providers. In that, the programme contents seem to have been accepted without any critique.
- In addition to studies on quality of family planning services, substantial efforts have gone into the study of quality of abortion care (9, 13).
- A good beginning has been made with regards to study of quality of care in the private sector. Studies on physical standards in private sector, exploratory studies on developing accreditation system for private sector, are important contributions (17).
- Most of the studies limited their scope to studying aspects related to access to health care facilities, infrastructure and availability of qualified human power. Except a few, the other aspects of structure like planning, management and supervision, record keeping systems did not draw much attention of the researchers (10, 14).
- Spatial distribution when examined, was mostly of public health care facilities and not of the private health care facilities (10, 18). One study on private health care sector indicates that most of the health

care facilities are situated in urban areas (17).

- Studies reviewed show that health care facilities generally have inadequate infrastructural facilities coupled with unhygienic environment (3, 7, 11, 20). Lack of facilities, such as, clean sanitary block with adequate water supply, have much more grave implications for women users of services.
- Not many studies looked into availability of drugs at health care facilities. Some did so while studying infrastructure (7, 10, 18).
- Some studies looked into human power related issues (4, 7, 10, 17, 18). Adequacy of personnel, availability of appropriately qualified providers, the minimum facilities that they have to facilitate their service provision.
- Non-medical indicators of quality of care, which are difficult to operationalise and measure have been less dealt with.
- Some studies looked into provider-client interaction, the personal dimension of services (6, 7, 11, 13, 21). While assessing quality of family planning services, in terms of provider-client interaction or their competence, it is mostly confined to the lower cadre of health workers (6, 7, 21).
- While users' satisfaction and perception find place in the literature (11, 12, 16), there are no studies on outcome of service provision in terms of bio-medical indicators. The hospital-based study to assess patients' satisfaction found that patients were more than satisfied with the various aspects of care - physical infrastructure, client-provider relationship, provider competence, and medical facilities. Researchers interpreted that it was due to very low socio-economic status and low expectations of patients' from the health system. Also the fact they were interviewed in the hospital, according to researchers, may have positively affected the responses of users (11). The other study noted that the patients' never complained about inadequate quality of care at the PHC, for the fear of penalty (16).
- One study on women's perceptions about and expectations of quality of care is an important contributions (9). It shows as to how women apply different criteria of quality of care to different health care need situations. Cost of care, severity of illness, chronic nature of illness, illness requiring stay/admission at health care facility, illness requiring immediate medical attention were some of the factors those determined situation specific criteria for quality of care.
- Another study demonstrated as to how the pressure of meeting targets affects the quality of family planning services making the sterilisation camps a frightful event for women (20).
- None of the studies touched upon workload of providers, which may have implications for quality of care that they offer.
- Perspectives of the top managers concerning health care services they offer are likely to influence the quality of services delivered by them. However, there were hardly any such studies.
- Nursing care is an important aspect of quality of care. However, not much attention is paid to this in the research on quality of care.
- Not many studies simultaneously looked into all the three dimension of quality of care. This, therefore, looses on the opportunities to analyse the nature of their inter-relationship.
- Not much efforts have gone into studying quality of reproductive health care services. Such studies could be taken up drawing from the earlier research efforts and experiences.
- Research efforts are required to develop minimum standards for reproductive health care services. Some research efforts have gone into it. However, such material could not be accessed.
- Not many have shared the methodologies sufficiently enough with readers in their communications. Thus not providing much scope for reviewers to opine on it.
- Methodological problems continue to plague these studies, especially those taken up by the hospital staff or the NGOs who have been involved in health intervention through the implementation of the government health schemes.
- In contrast, the non-mainstream researchers and community based NGOs have been experimenting with feminist methodologies. There is need to draw on experiences of these groups.
- There is need to critique various methodologies used in studies and to address the common issues, and to replicate some of the studies after such a review.
- Also, having grasped the fact that generally the 'soft' facets of quality of care are weaker, concrete advocacy strategies to strengthen them need to be planned.
- Most of the evaluation studies on the family planning programme remain on paper. The process of translating research findings into programme inputs does not take place.
- There is considerable amount of research available on quality of care. However, gender perspective needs to be strengthened.

Women's health care needs

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

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

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

- Prevalence/incidence of illnesses, and their contribution to women's morbidity and mortality are the thrust areas of these research studies.
- Both, hospital and community-based studies were found to understand women's health care needs. Most of the community-based studies were primarily to study the perceived morbidity. (1, 4, 8, 9, 10, 13, 16). In certain instances, recording of perceived morbidity was complemented by clinical examination. (11, 14).
- The hospital-based studies primarily involved understanding morbidity and mortality burden by making assessments of type and nature of morbidity by conducting clinical examinations.
- Both, hospital- and community-based studies applied case-control/quasi-experimental methodological approaches. (9, 10). These generally helped understand the determinants or correlates of morbidity pattern.
- The studies included here cover both general and women specific illnesses. A range of gynaecological and obstetric illnesses has been studied. Prevalence of RTIs/STDs, perinatal outcomes of teenage mothers, post-abortion complications; complications arising out of or from caesarean sections were the illnessess studied either for their share in women's mortality or morbidity.
- In one study, the issue of child sexual abuse was studied. It also studied the impact of incest on a woman's adult life. (8). It was primarily to establish that this is also a middle and upper middle class Indian phenomenon. Despite some of its methodological constraints, the study has initiated the process of recognising it as one of the major areas of concern and needs attention both at research and advocacy level. It is an important contribution for it has cracked the prevailing myth that sexual abuse and incest are the characteristics of the lower class.
- Some studies focused on correlates or determinants of morbidity/mortality. In that, demographic and socio-economic characteristics of people, cognitive and behavioural factors such as personal hygiene, household environment and sanitation, and exposure to health education were the factors used in the analysis.
- In two of the studies, characteristics of health care facilities/providers determining the quality of care have also been included in correlates analysis (4, 9).
- The thrust of the abortion research has been on studying socio-economic characteristics of abortion seeking women, factors leading to unwanted pregnancy, their choice of abortion service provider, post-abortion complications, women's expectations of abortion services (2, 10, 12, 13, 15).

- One of the studies on induced abortions in rural society indicates that all the abortions performed by quacks and paramedics lead to post-abortion complications. The reasons mentioned for approaching these providers were secrecy, availability, affordability and accessibility of the abortion services, which reflect upon the need to improve upon the MTP services (12).
- A health care centre-based study on abortion patterns among adolescents showed that almost about half of the abortion seekers were unmarried (16). It also showed that larger number of younger girls reach second trimester by the time they approached health care facilities for an abortion. The reasons were girls' failure to realise that they were pregnant, concealment of pregnancy and conflict with parents.
- However, not all studies had adequate information on whether these unwanted pregnancies were results of coercion or otherwise. Understanding of these factors would facilitate the strategy designing to prevent adolescent pregnancies. For instance it would be educating them about safe sex in case of non-coercive conceptions as demonstrated in one of the studies (2). Preventing coercive adolescent conceptions would require addressing the larger gamut of social issues.
- Abortions among unmarried adolescents need to be studied with broader conceptual framework that would throw light on circumstances and situations of teenagers, which push them to have unwanted conceptions. These could be done in a hospital-based set up as community-based studies on such subjects are difficult to conduct. It also involves a range of ethical issues to be resolved before taking up such a study.
- Studies on teenage pregnancies highlight the negative implications of teenage pregnancies. (2, 3, 6). These studies demonstrate that the teenage mothers are at greater risk. Antenatal complications (anaemia, pre-eclampsia, eclampsia, antepartum haemorrahage, intrauterine foetal death), prematurity, low birth weight babies, breech presentations, need for ceaserean sections, longer labour hours, and much greater risk of maternal mortality are some of the areas of concern as demonstrated by these studies. These studies recommend additional efforts and resources to serve and protect their health.
- An assessment of general and gynaecological health status of adolescents indicate that young girls suffer from the adverse health consequences of low economic status, unhygienic practices, and poor nutrition. They need to be provided with appropriate health care facilities and health education (12). This was a small-scale study. Firstly, there is need for a larger survey to understand the scenario for a larger area/society. Secondly, a longitudinal study would be insightful to understand the nature and type of illness that women suffer over the time as a result of poor health status in their young age.
- One single tertiary hospital-based study on incidence of deliveries by caesarean section (CS) indicates that there is a progressive increase in it (5). The indications for CS have widened over time. The substantial increase in caesarean sections for the reasons of high-risk pregnancies were attributed to early diagnosis of obstetric complications and medical disorders associated with pregnancy.
- In one of the large sample sized community based studies, women's health status as regards maternal events was studied to explore whether improved health care delivery system would contribute to a great extent in reducing the maternal mortality (9). The study highlights the inclusion of prompt and accessible medical management as an essential component, redesigning the referral system to include bypassing inappropriate referrals. This study, however, did not explore the probable correlates of maternal mortality such as socio-economic and demographic parameters.
- In another gynaecological morbidity study conducted in a slum in Bombay, it was found that socio-economic indicators dropped out as significant predictors, and age and parity became important correlates of clinically diagnosed morbidity unlike the perceived morbidity (14). This primarily points at the need to have more of such studies. Women's perceived morbidity perhaps needs to be located outside the medical paradigm of health and needs further exploration to be able to provide them such support and care.
- In another large sample sized study, quality of obstetric care received has shown strong and pervasive influence on reported gynaecological morbidity (4).
- Application of sound methodologies marks some of the large community-based studies (4, 9, 10, 16). However, not much reference is made in these research- based communications to various possible ethical issues involved while conducting the research.

- However, some of the studies were also small scale (small sample size, smaller geographical area) ones. Given the diverse characteristics of the nation, such small scale, local studies have both advantages and disadvantages. The advantage is that they would allow the local level planning vis-a-vis health care services. The disadvantage is that they can't be generalised, regardless of the use of reasonably sound methodologies for obvious reasons.
- Emphasis on morbidity along with mortality reflects on the fact that 'health achievement' is being conceptualised and understood in a more nuanced and holistic manner than before. This shift in understanding people's health, if pursued, operationalised and translated into policy planning and designing would have far reaching implications for well-being of people in general and women in particular.

Health care: Access, utilisation and expenditure

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

In that various facets/aspects of health care services on the one hand and people's perceptions, attitudes, socio-economic and cultural backgrounds on the other hand gradually were conceptualised as the factors influencing utilisation of health care services. These research trends emerged in the mid 80s and now are visible because of their considerable proportion in the health research. This was an important shift in the health research as it went beyond the conventional framework to understand linkages between health care service system and the socio-economic and cultural factors vis-à-vis access and utilisation and in turn health status of people. This was an important paradigm shift from understanding people's health status in terms of medical determinants alone to understanding it in terms of socio-cultural determinants.
As stated earlier, we included the studies, which looked into access, utilisation, and expenditure patterns in relation to people's general health care needs as there are not many studies available on these aspects as regards people's reproductive health care needs. This, we thought, would give us a glimpse of the situation vis-à-vis reproductive health care needs of people and the extent to which the present health care delivery system is meeting these needs.

- Except a few which were health care facility based studies (13, 14, 17, 20), the rest were community based ones. Some had both the components. (24).
- Access, utilisation and expenditure patterns have been studied along with prevalence of morbidity through community based studies. All the studies examined the issues involved from the users' perspective.
- In general, age, literacy/educational achievement of the family, urban/rural location, economic class (landholdings, per capita consumption at family level), caste and religion were some of the variables included in the studies to assess the differentials in utilisation and health expenditure. At times, education of women and their husbands were specifically looked into as regards their impact on health care utilisation and expenditure patterns (16).
- Tapping differentials in utilisation of private and public health care facilities has been one of the thrust areas in most of the studies (4, 7, 9, 18, 21, 22, 23, 25, 27, 32).
- In rare instances, type of illness was considered as an independent variable to explain type of health care sought.
- Women's status - as dependent or otherwise - was also considered as an explanatory variable (18, 20). These studies found that dependent women, such as, girls and aged women, used more health care per episode compared to those women who were either heads of households or wives of heads of households.
- There were studies, which looked into gender differentials as regards prevalence of illnesses, health care sought and money expended on treatment (7, 9, 18, 21, 22, 23, 25, 27).
- In a rare instance, aggregate level development related variables at the village level were operationalised and treated as explanatory variables to explore their association with utilisation of health care services.
- A number of studies limited themselves to look into users' perceptions of reasons for not using particular health care services (3, 4, 10). In these studies, people often came up with the characteristics of health care facilities and health care service providers that obstructed them from

utilising these services, especially the public health care facilities. This was referred to as 'perceived quality of care' and included factors, such as, inadequate facilities (8), longer waiting period, arrogant attitude and behaviour of all the staff, non-availability of medicines (4). Providers, such as, trained birth attendants were preferred given the fact they share the same socio-cultural environment as that of users. Perceived efficacy of treatment was found to be an important factor in determining use of health care services (18).

- Knowledge and views about, and attitude towards the health care programmes/ providers/ facilities were included in the set of explanatory variables in some studies (16, 17).
- Some other studies revealed the potential causal relationship between people's socio-economic background and their utilisation of health care services (3, 4, 7, 9). However, not many communications mentioned about the operational definition of socio-economic status of users.
- Some studies, especially those with the thrust on women specific health care needs, considered type of work that women were engaged in, and parity as explanatory variables in addition to those mentioned above (14, 15).
- Exploration of the patterns of association between 'physical availability of health care facilities' and their utilisation was achieved by designing the appropriate methodologies (25).
- ANC, contraceptives, services related to MCH are the most studied aspects as regards utilisation of health care services. Some specifically studied abortion care needs. But some focussed on a vast canvas of general health care needs during the specific recall period (7, 9, 18, 21, 22, 23, 25, 27).
- The abortion related research indicates that the concern about the issue of abortion is more because of its contribution to nation's population reduction rather than its adverse consequences for women's health on account of unsafe abortion care services that women may have to approach for.
- Not many studies articulated the need for national level policies for regulating and monitoring the private sector as one of the measures to improve people's access to safe, rational and affordable treatments/health care.
- Utilisation and expenditure studies have very clearly brought out the impact of socio-economic variables, and gender on utilisation and expenditure patterns. Gender is the factor that affects all arenas of woman's life. Thus, there is need to see linkages between reproductive health and other aspects, such as, work, environment. Policies and programmes (even outside the purview of health care policies and even outside the national policies) need to be analysed in an integrated and comprehensive manner.
- Some of the studies were inadequately conceptualised and were quite less rigourous methodologically, a major constraint in itself.

Policies: Analysis, Critique and Alternative Perspectives

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

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

- The research has adequately demonstrated that the existing health care delivery system though not so inadequate, does not meet people's health care needs for it is unevenly distributed over rural and urban areas across classes and across gender (13, 24).

- The research brings out the issues regarding inaccessibility emerging out of overwhelmingly large proportion of private health care services in the total health care service sector, which could be accessed only by those who can purchase these services (5, 7, 13).
- The situation regarding access, in a broader sense, worsens in absence of any regulatory mechanism in place, which would ensure affordable, safe, rational health care service delivered humanely to its users (13).
- The research which have critiqued increasing privatisation of health care sector expresses the concern that increase in and expansion of these services would not meet people's need.
- The studies which have looked into the problems of health care service delivery system, especially arising of large and wide spread private health care sector, counter argue the argument in favour of privatisation of health care based on the issues mentioned above (13).
- It is encouraging to note that alternatives for improving the existing system also have been suggested either based on experiences of other nations or drawing paralles from our own nation in some other areas (3, 13). For instance, it is suggested, based on experiences of developed countries, that Planned National Health Services could achieve universal provision of health care services (13).
- The community-based experiments to enhance women's access to safe, affordable and humane health care services were mostly the alternatives to the existing health care service delivery system. They were not without problems and perhaps would remain small-scale efforts, at the most could be replicable in similar situations (14, 15, 29). Interestingly, all of these have been primarily to meet women specific health care needs. The process rather than outcome has been considered important in developing and establishing these alternatives. Such alternatives, many of which remain undocumented, have been primarily based on the bottom-up approach and emerged as a result of paradigm shift from top-bottom to participatory development one. Not often could such initiatives offer an articulation of the issues regarding self-sustainability, replicability and mainstreaming.
- As anticipated, there were communications based on critical perspectives on RCH approach to women's health and assessment of RCH programme after its implementation as well (9, 10, 20, 22, 23). This critical perspective highlighted the failure of the reproductive health concept to articulate its links with general health and socio-economic conditions. It is argued that the reproductive health strategy was accepted in international initiatives, such as, ICPD, Cairo without any discussion on development strategies or SAP. The basis of the shift was political convenience rather than epidemiological needs (22).
- The other two communications provide a critique of RCH at its implementation level assuming perhaps that there was little that could be done to stop the encroachment of the strategy. Another communication deals exclusively with nurses as critical service providers in the changing paradigm of women's health (20).
- There has generally been a dearth of literature on the health of tribals. Health of tribal women seems to be an area out of sight with almost no research available. Health status of tribals and their access to the health care system would provide some evidence on tribal women vis-à-vis these matters. In one of the rare communications, some of the issues related to health status of tribals and public policy for health care were articulated (24).
- It points at the need to have a development paradigm with health as a central focus. The agenda should consist of provision of basic education, basic health care and capacity-building within the framework of a stable and sustainable land use policy. The structural interconnectivity between income, food, security, female literacy and good health needs to be taken note of.
- Not much effort has gone into making an assessment of the existing medical education system in the light of people's changing health care needs and overall change in socio-political context. Whatever little efforts that have gone in are primarily on education and training of nurses and other paramedics such as midwives (4, 8).
- As regards private health sector, some efforts are also made to understand the investments in medical care equipment, expressing the need to look into issues related to resource allocation and management and optimisation of resources (31). However, these are only small scale studies. Macro level, empirical studies as well as analysis of secondary data (viz. from Central Information Bureau of Health) giving nationwide understanding of the situation are required. As part of this research agenda, analysis of equipment specifically required for reproductive health care needs can be taken up.

- A couple of studies looked into financial aspects of health care (6, 21). The micro-level analysis of finances allocated for post-partum centres (PPC) raises doubts about the possibility of a post-partum programme with a separate financial identity co-existing with the present FW/MCH services in the country (21). The macro-analysis of public health expenditure shows that investment by the public sector for health care has been inadequate for the people's needs (6). The data on various dimensions of health expenditure shows that allocative efficiency is a major area of concern.
- One of the studies traces the social and political origins of the development of the health sector of Maharashtra and compares it with that of Punjab and Kerala (7). It states that though Maharashtra has attained good health indicators, there is still a wide urban-rural as well as regional disparity. The private sector has seen unregulated and unaccounted growth. This communication highlights the need to combat the negative effects of the rapid and unregulated growth of the private health sector in Maharashtra.
- One of the communications was to address the issue of quality assurance in nursing (30). The author lists a range of obstacles in raising the standard of nursing in India. The communications indicate that a range of issues need further exploration to translate the concern about quality assurance in nursing into reality.
- In general, it appears that policy research in certain areas has offered alternatives for improving the existing health care services. However, it seems that empirical research needs to be adequately informed by these alternative perspectives. Revamping policies though would require concerted efforts, the immediate need is certainly to advocate, in a broader sense, for these alternatives.

It is hoped that this annotated bibliography would facilitate the planning of research on reproductive health services in the coming decade any such research effort constitutes a public domain, we make an appeal to researchers, others concerned and interested to make use of this work, which either directly or indirectly would contribute to an understanding of issues involved in the health care delivery system, to improving health care services to be equitable and gender-sensitive and to improving women's access to health care services. We would appreciate a communication from you about the way this annotated bibliography has been made use of at your end.[2]

2 For your convenience, we have enclosed a 'feedback sheet' at the end of this volume for such communication. Please do make use of this.

RESPONSE SHEET

1. Name:

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The tables in the following pages provide a summary overview of the
- nature of the study
- geographic region covered
- objectives and methodology
- salient results

The annotated bibliographies follow these summary tables. These are organised into the following fields:

Abstract number:
Author(s):
Title:
Source:
Place of study:
Period of study:
Aims and objectives:
Study conducted by:
Nature of study:
Methodology:
Findings:
Reviewer's notes (optional):

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AWW	Angan Wadi Worker
CBR	Crude Birth Rate
CFWP	Comprehensive Family Welfare Project
CHV	Community Health Volunteer
CNA	Community Needs Assessment
CPA	Consumer Protection Act
CPR	Couple Protection Rate
CMIE	Centre for Monitoring Indian Economy
CS	Caesarean Section
CSSM	Child Survival and Safe Motherhood
CSW	Commercial Sex Worker
DDA	Delhi Development Authority
EBA	Economically Backward Areas
EDA	Economically Developed Areas
FGD	Focus Group Discussion
FICCI	Federation of Indian Chambers of Commerce and Industry
FHW	Female Health Worker
FMPW	Female Multipurpose Workers
FPP	Family Planning Programme
GDP	Gross Domestic Product
GNM	General Nursing and Midwifery
GO	Government Organisation
HFA	Health For All
HIV	Human Immuno-deficiency Syndrome
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
IFPS	Innovations in Family Planning Services
IEC	Information, Education and Communication
IUCD	Intra Uterine Contraceptive Device
LBW	Low Birth Weight
LHV	Lady Health Volunteer
LTMGH	Lokmanya Tilak Memorial General Hospital
MCH	Maternal and Child Health
MCR	Maternal Care Receptivity
MHW	Male Health Worker
MOHFW	Ministry of Health and Family Welfare
MPCE	Monthly Per Capita Consumption Expenditure
MPW	Multi-Purpose Health Worker
MPR	Morbidity Prevalence Rate
MSS	Mahila Swasthya Sangh
MTP	Medical Termination of Pregnancy
NACO	National AIDS Control Organisation
NGO	Non Government Organisation
NFHS	National Family Health Survey
NIHFW	National Institute of Health and Family Welfare
NSS	National Sample Survey
ORS	Oral Rehydration Salt
OT	Operation Theatre
PAP	Proportion of Ailing Persons
PBD	Performance-Based Disbursement

PERFORM	Project Evaluation and Review for Organisational Resource Management
PFI	Population Foundation of India
PHC	Primary Health Centre
PHCF	Public Heath Care Facility
PID	Pelvic Inflammatory Disease
PPC	Proportion of Persons Reporting Commencement
PPS	Probability Proportional to Size
PRC	Population Research Centre
PTP	Planned Teaching Programme
PVOH	Private Voluntary Organisation in Health
QA	Quality Assurance
QHC	Quality of Health Care
RCH	Reproductive and Child Health
ROME	Reoriented Medical Education Scheme
RTI	Reproductive Tract Infection
SAP	Structural Adjustment Programme
SD	Standard Deviation
SDP	Service Delivery Point
STD/STI	Sexually Transmitted Disease/Infection
TBA	Traditional Birth Attendant
TFA	Target Free Approach
TFR	Total Fertility Rate
THP	Tribal Health Project
UNICEF	United Nations International Children's Education Fund
UTI	Urinary Tract Infection
VLI	Village Level Index
WB	World Bank

OVERVIEW OF ANNOTATIONS					
ANNO NO.	**OBJECTIVE**	**STUDY PERIOD**	**STUDY AREA**	**TYPE OF STUDY**	**METHODS OF DATA COLLECTION**
1	To study perceptions, opinions and level of job satisfaction among the health and family welfare personnel.	Not specified	**Kerala** Rural	Empirical, analytical, health centre-based	In-depth interviews and observations
2	To evaluate the impact of TBA training programme on their performance.	1984-85	**Rajasthan** Rural	Empirical, evaluatory, health centre-based	Survey method
3	To assess the utilisation of the services of TBAs.	Not specified	**Aligarh, Uttar Pradesh** Rural	Empirical, analytical, community-based	Survey method
4	To understand the livelihood of TBAs.	1994	**Bihar** Rural	Empirical, descriptive, community-based	Interviews
5	To show that involving paramedics in rural obstetric care reduces perinatal mortality.	Not specified	**Sevagram, Maharashtra** Rural	Empirical, analytical, community-based	Survey method
6	To study perceptions of ANMs as regards to their status, role and problems.	1990-92	**Pune, Wardha, Beed, Ratnagiri, Maharashtra** Rural	Empirical, descriptive,health centre-based	Survey method
7	To ascertain the state of preparedness of MSS groups and also their linkage with the health delivery system and their activities.	Not specified	**Haryana** Rural	Empirical, descriptive, community-based	Survey method
8	To assess the learning needs of TBAs regarding AIDS.	Not specified	**Coimbatore, Tamil Nadu** Rural	Empirical, evaluative, health centre-based	Survey method
9	To understand problems of female health workers and the implications.	Not specified	Not stated	Empirical, descriptive, health centre-based	Not stated
10	To understand people's choice for traditional medicines.	1995	**Bangalore, Karnataka** Rural	Empirical, descriptive, community-based	Survey method
11	To identify information needs of primigravid women and to provide it accordingly.	Not specified	**Karnataka** Urban	Empirical, descriptive, health centre-based	Survey method

12	To develop and evaluate an alternative teaching curriculum model for undergraduate medical students.	1986-87	**Pondicherry** Urban	Empirical, evaluative,health centre-based	Intervention study, survey method
13	To explore two methods for improving pulmonary functioning of nursing students.	Not specified	**Manipal, Karnataka** Urban	Empirical, analytical, health centre-based	Survey method andpulmonary function measurement
14	To evaluate an in-service training programme for staff nurses.	1998	**Andhra Pradesh** Urban	Empirical, evaluative, training centre-based	Intervention study,survey method
15	To study the profile of rural private practitioners.	1986-90	**Uttar Pradesh** Rural	Empirical, descriptive, community-based	Survey method and review of secondary sources
16	To evaluate training workshop for TBAs.	1990	**West Bengal** Rural	Empirical, evaluative, training centre-based	Evaluation of training workshop
17	To assess the cost and quality of intra-natal care provided by trained traditional birth attendants in the homes.	1993	**Vellore, Tamil Nadu** Rural	Empirical, analytical, prospective and retrospective community-based	Survey method and observation
18	To study in-depth the role of TBAs in providing intra-natal care.	1984-85	**New Delhi** Rural and urban	Empirical, descriptive, community-based	Survey method and observation
19	To evaluate dai training programme and their role in rendering MCH services to the rural population.	1988-89	**Kolhapur, Maharashtra** Rural	Empirical, descriptive, community-based	Survey method and review of previous records
20	To assess the knowledge and attitudes of TBAs with regard to family planning.	1989-91	**Ambala, Haryana** Rural	Empirical, descriptive, community-based	Survey method
21	To assess the feasibility of utilising the services of dais in case finding for tuberculosis patients.	Not specified	**Sriperumbudur Tamil Nadu** Rural	Empirical, descriptive, community based	Survey method
22	To evaluate the impact of primary health care projects initiated under private voluntary organisations in health.	1981-87	**13 states of India** Rural	Empirical, analysis of secondary data	Not applicable

OVERVIEW OF ANNOTATIONS					
ANNO NO.	**OBJECTIVE**	**STUDY PERIOD**	**STUDY AREA**	**TYPE OF STUDY**	**METHODS OF DATA COLLECTION**
1	To assess the delivery pattern of MCH services.	Not stated	**Varanasi, Uttar Pradesh** Urban	Empirical, Evaluative, Community-based	Survey method and analysis of records
2	To develop a simplified MCH scoring system for the community-based assessment of babies.	1987-92	**New Delhi** Urban	Empirical, Descriptive, Community-based	Community assessment through scoring system
3	To assess the IEC aids and materials supplied to a PHC and their utilisation.	Not stated	**Haryana** Rural and Semi-urban	Empirical, Evaluatory, Health Centre-based	Survey method
4	To study inter-regional differences in allopathic health services provided by different health sectors.	1961-86	**Andhra Pradesh** Rural	Empirical, Analysis of secondary data	Not applicable
5	To find out causes for not using antenatal services.	1987-88	**Uttar Pradesh** Rural	Empirical, Analytical, Community-based	Survey method
6	To assess the type and quality of information provided to normal parturient mothers by labour room personnel.	Not stated	**Vellore, Tamil Nadu**	Empirical, Descriptive, Health Centre-based	Survey method
7	To synthesise available evidence on the standards of care provided by the Indian programme and the relationship between quality of care and effective family planning use.	Not applicable	**Maharashtra, Karnataka, T. Nadu, Bihar, W. Bengal, M.P, Kerala, Gujarat, Orissa, U.P.**	Empirical, Meta-analysis of research studies	Not applicable
8	To find out the causes of the failure of the National Family Welfare Programme.	1993	**Delhi** Urban	Empirical, Evaluatory, Health Centre-based	Survey method
9	To understand women's needs in which they seek health services.	1994-96	**Pune, Maharashtra** Rural	Empirical, Analytical, Community-based	Survey method
10	To evaluate primary health care facilities.	1987-89	**Nationwide** Rural	Empirical, Evaluatory, Health Centre-based	Survey method
11	To assess quality of services provided by a government hospital through patients' perspectives.	1996	**Mumbai, Maharashtra**	Empirical, Descriptive, Health Centre-based	Survey method

12	To study the pattern of ANC, morbidity and pregnancy outcome and to identify MCH problems.	1989	**Ahmedabad, Gujarat**	Empirical, Descriptive, Prospective, Community-based	Survey method
13	To develop a database on availability of abortion facilities and to identify the reasons for under-utilisation of MTP services.	1992-97	**Tamil Nadu, Maharashtra, U.P, Gujarat**	Empirical, Descriptive, Health Centre-based	Survey method
14	To evaluate a simplified home-based MCH recording and reporting system.	Not stated	**Ambala, Haryana** Rural	Empirical, Evaluatory, Health Centre-based	Survey method
15	To assess the community attitudes regarding PHC services and their level of satisfaction with and expectations from PHCs.	Not stated	**Varanasi, Uttar Pradesh** Rural	Empirical, Descriptive, Community-based	Interview of users of PHC
16	To gain in-depth understanding of how villagers view both government and private health services, and how they think about the available family planning services.	1992	**Uttar Pradesh** Rural	Empirical, Descriptive, Community-based	Group discussions with a structured discussion guide
17	To document and review various guidelines available in the government, NGO and private sectors for the minimum physical standards necessary for provision of health care of various kinds.	1994-95	**Maharashtra** Rural and Urban	Empirical, Descriptive, Health Centre-based	Survey method
18	To examine the role of programme inputs in explaining the relative family welfare programme performances of the PHCs.	1990-92	**Karnataka** Rural	Empirical, Descriptive, Health Centre-based	Survey method
19	To document the processes in developing a socio-culturally sensitive, specific health education program and to assess the impact of this programme on levels of IUD continuation.	1987-95	**Gujarat** Rural	Empirical, Descriptive, Community-based	Survey method
20	To evaluate the quality of care provided at a sterilisation camp under the FPP.	1994	**Kerala** Rural	Empirical, Descriptive, Health Centre-based	Observations
21	To examine how welfare programme personnel interact with clients. To understand providers' view regarding family welfare services. To gather clients' views regarding family welfare services.	1994	**Kerala** Rural	Empirical, Descriptive, Community and Health Centre-based	Multiple qualitative research methods
22	To study acceptability and complications of IUD, causes of removal, acceptance, attitude of women towards IUD and spacing, availability of para-medical person for motivation and attitude of health visitors.	1977-87	Not stated	Empirical, Descriptive, Retrospective,Health Centre-based	Survey method
23	To find out the effects of medical negligence.	Not stated	**Nellore, Andhra Pradesh** Rural	Empirical, Descriptive, Health Centre-based	Case studies

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE OF STUDY	METHODS OF DATA COLLECTION
1	To share the experiences of the researchers who conducted a community-based study on gynaecological morbidity.	1986	**Gadchiroli Maharashtra** Rural	Empirical, exploratory, community-based	Interviews and clinical examination
2	To determine the factors leading to unwanted pregnancy and highlighting possible preventive measures.	1982-84 and 1985-88	**Pune, Maharashtra and Panji, Goa**	Empirical, descriptive, health centre-based	Interview using a specially designed proforma.
3	To compare the incidences of various complications and outcomes of teenage pregnancy with the overall incidence in the hospital and with those of teenage pregnancies reported in the literature.	1988	**Mumbai Maharashtra**	Empirical, descriptive, retrospective, health centre-based	Interviews
4	To conduct a community-based study on reproductive morbidity and its determinants. The study was part of the major research effort to investigate the pathways through which a mother's education influences her child's survival.	1993	**Karnataka** Rural	Empirical, descriptive, community-based	Survey method
5	To project the mortality due to caesarean sections in one of Bombay's leading teaching institutions and compare with the data available from the literature.	1981-90	**Mumbai Maharashtra**	Empirical, descriptive, retrospective, health-centre based	Analysis of case records
6	To study perinatal outcome in teenage mothers.	Not stated	**Wardha Maharashtra**	Empirical, descriptive, prospective, health centre-based	Follow-up of patients coming to the hospital
7	To study the levels, trends, differentials and determinants of morbidity in Tamil Nadu.	1973-74 to 1986-87	**Tamil Nadu**	Empirical, Analysis of secondary data	Not applicable
8	To document child sexual abuse and to look into the impact of incest on woman's adult life; to establish incest and child sexual abuse also as a middle and upper middle class Indian phenomenon.	1997	**Delhi, Bombay, Madras, Calcutta and Goa** Urban	Empirical, descriptive, community-based	Survey method
9	To study the events from the onset of a complication to death/recovery and to delineate the factors that determine survival in women who develop a complication.	1993-95	**Pune, Aurangabad and Ahmednagar Maharashtra** Rural	Empirical, descriptive, prospective, community-based	Survey method

10	To study mortality rate of postabortion complications, and to examine provider choice and the expectations and experience of abortion services from women's perspective.	1994-96	**Pune, Aurangabad and Ahmednagar Maharashtra** Rural	Empirical, descriptive, prospective, community-based	Survey method
11	To assess general and reproductive health of female adolescents.	Not stated	**Arcot Tamil Nadu** Rural	Empirical, descriptive, community-based	Survey questionnaires,focus group discussions and key informant interviews
12	To find reasons for acceptance of induced abortions in the rural areas, the reasons for approach to illegal abortionists, the magnitude and nature of complications, and to find out the necessity of people's awareness.	1989-90	**24 Parganas West Bengal** Rural	Empirical, descriptive, prospective, health centre-based	Case histories of clients visiting the PHC
13	To analyse the socio-economic scenarios of MTP acceptors.	1987-88 to 1991-92	**Uttar Pradesh**	Empirical, analysis of secondary data	Not applicable
14	To determine the levels, patterns and correlates of gynaecological morbidity in an urban slum, focusing on both women's perceptions and assessment of their gynaecological health as well as the conclusions of medical assessments and laboratory tests.	1989	**Mumbai Maharashtra** Urban	Empirical, descriptive, community-based	Survey method, clinical examination and laboratory tests,group discussions and informal interviews
15	To analyse MTPs in Indian adolescents.	1982-1986	**Mumbai Maharashtra**	Empirical, descriptive, retrospective, health centre-based	Analysis of case records
16	***Part I***: To study morbidity pattern and its determinants across the Indian states. ***Part II***: To critique the public health policy in India.	1993	**India** Urban and rural	Empirical, descriptive, community-based, Theoretical	Survey method and analysis of literature
17	To study incidence of various kinds of osteoporotic fractures in women.	1987	**Hyderabad Andhra Pradesh**	Empirical, descriptive, retrospective, health centre-based	Analysis of case histories of inpatients and interviews of current patients
18	To study the community prevalence of STD.	1995	**Tanjore, Ramanathapuram, Dindigul Tamil Nadu** Rural and urban	Empirical, descriptive, community-based	Survey method

OVERVIEW OF ANNOTATIONS

ANNO NO.	OBJECTIVE	STUDY PERIOD	STUDY AREA	TYPE OF STUDY	METHODS OF DATA COLLECTION
1	To assess the utilisation of antenatal care services in a peri-urban area of east Delhi.	1991	**Delhi** Peri-urban	Empirical, descriptive, community-based	Survey method
2	To identify the managerial gaps and demographic and cultural factors that affect utilisation of ANC services.	1988	Varanasi **Uttar Pradesh** Rural	Empirical, evaluative, community-based	Case study
3	To study the perceived reasons why reproductive health care seekers (women) use tertiary level health care facilities.	Not stated	Sevagram, **Maharashtra** Rural	Empirical, descriptive, health centre-based	Interview of female inpatients
4	To study preferences of the people regarding health care providers in relation to their socio-economic backgrounds. To identify necessary interventions for increasing services to the poorer people.	Not stated	**Gujarat, Maharashtra, Karnataka, Uttar Pradesh and Rajasthan** Rural	Empirical, descriptive, community-based	Survey method, in-depth interview and focus group discussions.
5	To conduct a survey of married men with reference to sexual and reproductive health knowledge and behaviour in relation to their own needs and those of their wives.	1995 - 96	**Uttar Pradesh** Rural and urban	Empirical, descriptive, community-based	Survey method
6	To provide state level estimates of family planning practices and to identify groups in the need of family planning services.	1992-93	**Uttar Pradesh** Rural and urban	Empirical,Analysis of secondary data	Not applicable
7	To investigate and critically analyse health expenditure patterns in India at both the micro and macro levels. Also to evolve a methodology for the study of health expenditure.	1987	Jalgaon **Maharashtra** Rural and urban	Empirical, descriptive, community-based	Survey method
8	To determine the health requirements, the unmet need, the level of satisfaction, the problems with the existing health system and ways for its improvement, and the paying capacity of the community for such an improvement.	Not stated	Sidhpur **Gujarat** Rural	Empirical, descriptive, community-based	Focus group discussions

9	To collect information on the components of household expenditure; and to analyse the relationships between household health expenditure and socio-economic variables.	1991	Sagar and Morena **Madhya Pradesh** Rural and urban	Empirical, descriptive, community-based	Survey method
10	To understand the constraints of pregnancy-related referrals.	1993	Dausa **Rajasthan** Rural	Empirical, descriptive, community-based	In-depth interviews
11	To collect state level data on practices and services related to mother and child health and family planning.	1992-93	**Nation-wide** Rural and urban	Empirical, descriptive, community-based	Survey method
12	To pilot-test the potential of traditional practitioners to motivate and recruit family planning acceptors in order to increase contraceptive knowledge and use in rural communities; to study the acceptability of traditional practitioners as providers of family planning services.	1984-87	Muzaffarnagar **Uttar Pradesh** Rural	Empirical, descriptive, community-based	Survey (pre and post)
13	To gain an insight into the health status of the people of rural Kerala; to study the associations between health status and socio-economic characteristics of the people, and the utilisation of health care.	1987	**Kerala** Rural	Empirical, descriptive, Community and health centre-based	Survey method
14	To study attitudes of housewives from a low economic group towards abortion as a family planning method.	Not stated	Pune **Maharashtra** Urban	Empirical, descriptive, health centre-based	Survey method
15	To explore some of the determinants of utilisation of selected MCH care services.	1995	Coimbatore **Tamil Nadu** Rural	Empirical, descriptive, community-based	Survey method
16	To examine the factors associated with utilisation of reproductive health services and to understand the factors that differentiate users from non-users of reproductive health services.	1991	Chandrapur **Maharashtra** Rural	Empirical, descriptive, community-based	Survey method
17	To examine the pattern and role of practices related to childbirth in some urban ICDS areas.	1989 - 91	Allahabad **Uttar Pradesh** Urban	Empirical, descriptive, health centre-based	Interviews of pregnant women coming to Anganwadi centres
18	To assess patterns in morbidity reported with and without probing, utilisation of health facilities and expenditure on health care among women in rural and urban Nasik district.	1996	Nasik **Maharashtra** Rural and urban	Empirical, descriptive, community-based	Survey method

19	To evaluate the magnitude and reasons of non-use and unsatisfactory use of contraceptives in the existing rural socio-cultural and obstetric background to enable effective means to tackle the problem of population growth.	1989-90	**West Bengal** Rural	Empirical, descriptive, community-based	Survey method
20	To examine characteristics of and services offered by private nursing homes and hospitals in Delhi. To analyse the resort patterns of people from different socio-economic groups and discern the factors that influence the choice of health care for specific groups of people.	Not stated	**Delhi** Urban	Empirical, descriptive, health centre-based	Interviews of clients of the selected health facilities
21	To document and analyse perceived morbidity patterns, constraints of women in accessing health care facilities and their utilisation and patterns in expenditure on women's health.	1994	Mumbai **Maharashtra** Urban	Empirical, descriptive, community-based	Survey method
22	To study the nature and type of illnesses suffered by the family members, the system of medicine used and their perceptions about its effectiveness.	1990	**Nation-wide** Rural and urban	Empirical, descriptive, community-based	Survey method
23	42nd Round: To assess utilisation of medical services. 52nd round: To study the curative aspects of the general health care system in the country and also the mother and child health care programmes and also the morbidity profile of the population.	1986-87; 1995-96	**Nation-wide** Rural and urban	Empirical, descriptive, community-based	Survey method
24	To assess the perceptions and experiences of programme personnel from the district level to the grass-roots level about popularizing reversible methods of family planning in rural areas; to understand the extent of community leaders' knowledge about reversible methods and their perceptions regarding couples accepting them; and to study the knowledge and attitudes of couples toward reversible methods.	1990	Belgaum and Gulbarga **Karnataka** Rural	Empirical, descriptive, Health Centre and community-based	Survey method and key in-depth interviews
25	To examine the spatial variations in the gender bias in use of public health care facilities and in relation to the economic development of an area.	1991	Bhiwani and Kurukshetra **Haryana** Rural	Empirical, Analytical, community-based	Survey method
26	To present the experience of maternity among lower caste Mukkuwar women and their responses to modern medical management of pregnancy and birth.	Not stated	Kanyakumari **Tamil Nadu** Rural	Empirical, descriptive, community-based	Case studies

27	To study morbidity, health care utilisation and health expenditure in details. It covers both treated and untreated illness episodes.	1993	**Nation-wide** Rural and urban	Empirical, descriptive, community-based	Survey method
28	To study inter-village variations in the practice of family planning by different methods in Orissa; and to study the factors associated with the differential practice of family planning methods.	1982	Cuttack, Ganjam, Kalahandi, Puri and Phulbani **Orissa** Rural	Empirical, descriptive, community-based	Survey method
29	To study the utilisation pattern and sources of the various treatments sought by rural women for common maternal and child health problems.	Not stated	Rohtak **Haryana** Rural	Empirical, descriptive, community-based	Survey method
30	To bring about an increase in awareness in the use of modern contraception; to reduce the infant and under five mortality rate to below the country's rural average; and to raise the status of women.	1992-95	Kheda **Gujarat** Rural	Empirical, descriptive, community-based	Intervention study
31	To evaluate cost-effectiveness of monthly introductory small cash incentives as a strategy to increase the use of modern temporary methods of contraception among rural Indian women.	1985-91	Thanjavur **Tamil Nadu** Rural	Empirical,descriptive, community-based	Intervention study
32	To situate reproductive health care in the context of women's perceptions and experiences of illness in general as well as in terms of the material, ideological and political dynamics of household, kin and gender relations.	Not stated	Jaipur **Rajasthan** Rural	Empirical, descriptive, community-based	Not stated
33	To understand the reasons for the unmet need for family planning; to explore the reasons underlying the gap between intentions to limit fertility and action; and to understand when and how the intentions to limit family size are translated into reality.	1989 and 1995	Bharuch and Panchmahal **Gujarat** Rural	Empirical, descriptive, community-based	Focus group discussions and in-depth interviews

ABSTRACT NO. 1

Author(s) : Baburajan, P. K., and R. K. Verma

Title : Job Satisfaction among Health and Family Welfare Personnel: A Case Study of Two Primary Health Centres in Kerala

Source : The Journal of Family Welfare, 1991

Place of study : Kerala

Location : Rural

Period of study : Not specified

Type of research : Empirical, analytical, health centre-based

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

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

Findings:

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

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

The average job satisfaction score did not differ significantly between the personnel of the two PHCs. About 40.9 percent of them were moderately satisfied and about 25 percent were least satisfied. Age, residential status and experience were negatively related with job satisfaction. The important determinants of job satisfaction were confidence in getting a promotion and availability of infrastructure. The popular notion that salary affects job satisfaction was disproved in this study.
The authors conclude that the above factors, along with organisational factors, are a necessary precondition for performance, motivation, leadership and management qualities of the medical officers, and are therefore important for programme productivity.

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

Key words: *Paramedics, job satisfaction*

ABSTRACT NO. 2

Author(s) : Benara, S. K., and S. K. Chaturvedi

Title : Impact of Training on the Performance of Traditional Birth Attendants

Source : The Journal of Family Welfare, 1990

Place of study : Rajasthan

Location : Rural

Period of study : 1984-85

Type of research : Empirical, evaluatory, health centre-based

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

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

Findings:
There was a significant improvement in the performance of trained dais as compared to untrained dais. About 64 percent of the mothers delivered by the trained dais had registered at the sub-centre during pregnancy as compared to about 25 percent of those delivered by untrained dais. A significant difference revealed between the trained and untrained dais was in terms of contact with pregnant mothers, and advice given regarding immunisation, anaemia prophylaxis, family planning and personal hygiene (all at $p<0.001$). Almost half (45.6 percent) of the trained dais preferred to use a blade for cutting the umbilical cord compared to 15.4 percent of the untrained dais. Almost all (95.6 percent) the

trained dais contacted the health worker for various purposes, as compared to only 49.4 percent of untrained dais, largely for antenatal and postnatal care, including pregnancy complications, registration of births and deaths and family planning motivation.
The conclusion is that training can be helpful in forging a functional relationship between the organised health service system and the community at large.

Key words: *Traditional birth attendants, training, performance, utilisation*

ABSTRACT NO. 3

Author(s)	:	Bhardwaj, N., M. Yunus, S. B. Hasan, et al.
Title	:	Role of Traditional Birth Attendants in Maternal Care Services: A Rural Study
Source	:	Indian Journal of Maternal and Child Health, 1990
Place of study	:	Aligarh, Uttar Pradesh
Location	:	Rural
Period of study	:	Not specified
Type of research	:	Empirical, analytical, community-based
Aim	:	To assess utilisation of the services of TBAs.
Methodology	:	The study was conducted in four randomly selected villages that were covered by the ICDS. All of the 212 registered women were asked about the nature of assistance received at delivery.

Findings:
Dominant characteristics of the sample: Hindus (96.7 percent), illiterate (93.0 percent) and poor (68.5 percent) constituted the sample; about 33.5 percent were high-caste, 30.2 percent belonged to backward castes and 30.2 percent were from the scheduled castes. About 96.6 percent (205/212) of deliveries were conducted at home and were similar to those reported by the NIHFW. Of these, 89.6 percent were assisted by untrained dais (TBAs), 11 by ANMs, nine by doctors, two by relatives and none by trained dais.
The poor utilisation of existing intra-natal services was because the women were illiterate and poor. Caste did not seem to play any significant role. It is recommended that there is a need to educate people to utilise the services of trained personnel already available, to strengthen domiciliary services and to train TBAs intensively. The study also recommends a reward or incentive for TBAs and adequate support to TBAs through supervision and continuing education.

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

Key words: *Traditional birth attendants, trained dai, home deliveries, service utilisation*

ABSTRACT NO. 4

Author(s) : Chattopadhyay, M.

Title : Endangered Professionals: Traditional Birth Attendants of South Bihar

Source : Economic and Political Weekly, 1996

Place of study : South Bihar

Location : Rural

Period of study : 1994

Type of research : Empirical, descriptive, community-based

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

Methodology : Interviews

Findings:

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

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

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

Key words: *Patron-client relationship, remuneration, traditional birth attendants*

ABSTRACT NO. 5

Author(s) : Chhabra, S., K. Aher, and U. N. Jajoo

Title : Paramedics in Rural Obstetric Care

Source : Journal of Obstetrics and Gynaecology, 1990

Place of study : Sevagram, Maharashtra

Location : Rural

Period of study : Not specified

Type of research : Empirical, analytical, community-based

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

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

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

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

Key words: *Paramedics, obstetric care*

ABSTRACT NO. 6

Author(s) : Iyer, A., A. Jesani, A. Fernandes, et al.

Title : Women in Health Care: Auxiliary Nurse Midwives

Source : Women in Health Care: Auxiliary Nurse Midwives, FRCH, 1995

Place of study : Pune, Wardha, Beed and Ratnagiri, Maharashtra

Location : Rural

Period of study : 1990-92

Type of research : Empirical, descriptive, health centre-based

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

Methodology : The sample consisted of 183 ANMs from two PHCs in each of three talukas from each of four districts representative of differing levels of socio-economic development as measured by the CMIE index of development. In addition, two talukas from the tribal belt of Pune district were included to have a total of 27 PHCs in the study. In addition one ANM from each of the selected PHCs was singled out for in-depth interaction over a maximum period of three days.

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

Findings:

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

The authors conclude that the economic role of ANMs is neither translated into social status nor does it lead to empowerment to the fullest extent possible. Their professional and administrative subordination (to doctors and nurses) is compounded by their gender, youth, negative social image, disadvantaged socio-economic backgrounds and their status as outsiders in the community. Located in a non-institutional setting and trying to achieve a delicate balance between their role as family planning motivators (as defined by the state) and as health care workers (as demanded by the people), they encounter many unpleasant experiences.

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

Reviewer's note:

The study gains its credibility from its approach to the situation of ANMs and from the broad sweep of its objectives. The study makes a significant contribution to research on ANMs. In addition, the scientific state-wide spread of the study and a sound methodology facilitate generalisation of the findings.

Key words: *Auxiliary nurse midwife, problems, implications*

ABSTRACT NO. 7

Author(s) : Lal, S., P. Khanna, B. Vashisht, M. Singh., et al.

Title : Situational Analysis of Preparedness of the Mahila Swasthya Sangh (MSS) for Health and Family Welfare Activities

Source : Indian Journal of Preventive and Social Medicine, 1994

Place of study : Haryana

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

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

Key words: *Mahila Swasthya Sangh, interpersonal communication, women development, women organisation*

ABSTRACT NO. 8

Author(s) : Meerah, R.

Title : The Effectiveness of a Planned Teaching Programme (PTP) Based on the Learning Needs of Traditional Birth Attendants Regarding Prevention and Control of AIDS

Source : Indian Journal of Nursing and Midwifery, 1998

Place of study : Coimbatore, Tamil Nadu

Location : Rural

Period of study : Not specified

Type of research : Empirical, evaluative, health centre-based

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

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

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

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

Findings:

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

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

Reviewer's note:

The elaborate methodology enhances the scientific approach of the study along with its replicability in similar experiments.

Key words: *Dais (TBAs), AIDS, knowledge, training programme, childbirth*

ABSTRACT NO. 9

Author(s) : Mishra, R.

Title : Female Health Workers: Problems and Implications

Source : Economic and Political Weekly, 1997

Place of study : Not specified

Location : Not specified

Period of study : Not specified

Type of research : Empirical, descriptive, health centre-based

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

Methodology : The sample consisted of 264 FHWs, including LHVs and ANMs. Profile data included age, education, residence, type of family, marital status and husband's employment.

Findings:

FHWs are the most vital link in the entire chain of the health care delivery system in rural areas. They work with people confronted with illiteracy, poverty, unemployment, deep-rooted social customs and taboos. They have to provide services in places where there is a lack of health culture among the people. Thus, it is difficult and challenging to motivate the rural masses to use the health and family welfare services available at PHCs and sub-centres. FHWs face problems that are transfer-related, health-related, official, social, etc. The implications of these problems do not remain restricted to individual FHWs but ultimately affect the quality of health care services that they are providing. The author strongly feels that unless these problems faced by the FHWs are addressed on a priority basis, the health and family welfare services will continue to be poor.

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

Reviewer's note:

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

Key words: *Female health workers, problems, implications*

ABSTRACT NO. 10

Author(s) : Muthurayappa, R.

Title : Indigenous Health Care System in Karnataka: An Exploratory Study

Source : Radical Journal of Health, 1998

Place of study : Bangalore, Karnataka

Location : Rural

Period of study : 1995

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

Reviewer's note:

This study examines the people's choice of traditional systems of medicine. There is not much documentation available on these aspects of health care.

Key words: *Indigenous medicines, general health care, traditional healers*

ABSTRACT NO. 11

Author(s) : Noronha, J.

Title : Teaching Primigravid Women about Warning Signs in Pregnancy Using Specially Designed Information Booklet

Source : Indian Journal of Nursing and Midwifery, 1998

Place of study : Karnataka

Location : Urban

Period of study : Not specified

Type of research : Empirical, descriptive, health centre-based

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

Methodology : The sample for phase I for assessment of learning needs consisted of 30 Primigravid women with gestational age of less than 36 weeks who had visited the hospital at the time of data collection. For phase II, 40 subjects were selected to overcome sampling mortality. This was a purposive sampling. One group pre-test/post-test design was used to test the effectiveness of the information booklet.
Since the study aimed to develop and evaluate an information booklet, it used the 'System's Model' for the development of learning material/modules (WHO SEARO, 1985).

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

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

Key words: *Warning signs, pregnancy, information booklet, teaching*

ABSTRACT NO. 12

Author(s) : Oumachigui, A., A. Bhupathy, P. Rajaram, et al.

Title : Competency-based Curriculum in the Primary Prevention of Obstructed Labour

Source : Journal of Obstetrics and Gynaecology, 1990

Place of study : Pondicherry

Location : Urban

Period of study : 1986-87

Type of research : Empirical, evaluative, health centre-based

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

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

Findings:

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

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

Reviewer's note:

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

Key words: *Obstructed labour, competency-based curriculum, medical education*

ABSTRACT NO. 13

Author(s) : Pavithran, S.

Title : The Effectiveness of Incentive Spirometry and Deep Breathing Exercises in Improving Pulmonary Function

Source : Indian Journal of Nursing and Midwifery, 1998

Place of study : Manipal

Location : Urban

Period of study : Not specified

Type of research : Empirical, analytical, health centre-based

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

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

Findings:

The findings reflect that the majority of normal young individuals who are undergoing health professional courses do not demonstrate normal pulmonary function, but they have the potential to improve it by simple, cost-effective exercises through modification of their health behaviour. This indicated that both incentive spirometry and deep-breathing exercises had a significant impact on pulmonary function. It is suggested that including exercises in educational institutions should be a mandatory co-curricular function of the teachers.

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

Reviewer's note:

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

Key words: *Spirometry, nursing students, pulmonary function, anaemia, breathing exercises*

ABSTRACT NO. 14

Author(s) : Razia, R.

Title : Report of an Assessment on 'How Staff Nurses Evaluated the Clinical Nursing In-Service Training Imparted to Them at Four Training Centres in the State of Andhra Pradesh Under World Bank Project'

Source : Indian Journal of Nursing and Midwifery, 1998

Place of study : Andhra Pradesh

Location : Urban

Period of study : 1998

Type of research : Empirical, evaluatory, training centre-based

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

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

Findings:

The Andhra Pradesh Vaidya Vidhana Parishad (APVVP), which provides primary and secondary health services to people in Andhra Pradesh, sought assistance from the World Bank to develop and implement activities for improving health care delivery in all its hospitals. The training covered essential skills in key clinical areas. It consisted of 72 hours of theory and 180 hours of clinical practice in the areas of basic nursing concepts and techniques, casualty nursing, acute medical care, post-operative care, OT techniques, nurse's role in CSSD, burns nursing, ophthalmic nursing, labour room nursing and paediatric care. The results indicated a positive attitude of the staff nurses towards the in-service training programme; they felt all seven objectives were achieved and were satisfied with all the specific components of the training programme. It was observed that by the end of the training programme most of them were motivated to acquire more knowledge and skills and to work for professional development. It was the first such programme on a large scale for the development of nursing staff in the country.

Reviewer's note:

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

Key words: *Clinical training, evaluation, staff nurse, quality of nursing*

ABSTRACT NO. 15

Author(s) : Rohde, J., and H. Viswanathan

Title : The Rural Private Practitioner

Source : Health for the Millions, 1994

Place of study : Uttar Pradesh

Location : Rural

Period of study : 1986-90

Type of research : Empirical, descriptive, community-based

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

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

Findings:
The authors describe the profile of the rural private practitioner. The dominant medical system practised by most of these practitioners was allopathy, regardless of their training, which was more so for untrained practitioners. The authors find that the chemist was the only drug supply and information source for the doctor, who usually operates alone. Almost all 'doctors' expressed great interest in becoming members of associations, which may provide them the opportunity to interact with other practitioners and to learn. The study estimates the average cost of health care at Rs 45 per case of diarrhoea and assumes that this cost would apply to all routine illnesses.
The authors recommend the acceptance and acknowledgement of the existence of the rural private practitioner and suggest ways to bring them into the mainstream through support and training rather than control, so that they are better equipped to provide health care. The authors conclude by recommending the need to establish links between the government health services and rural private practitioners.

Key words: *Rural private practitioners, government health care services*

ABSTRACT NO. 16

Author(s) : Roy, Chowdhury N. N.

Title : Mobilising Traditional Birth Attendants for Safe Motherhood

Source : Journal of the Indian Medical Association, 1990

Place of study : West Bengal

Location : Rural

Period of study : 1990

Type of research : Empirical, evaluatory, training centre-based

Aim : To evaluate a training workshop for TBAs.

Methodology : The data were gathered from the grassroot level workers, namely TBAs, ANMs or female MPWs and medical officers of the PHCs in three districts of West Bengal in a model workshop on the evaluation of their services.

Findings:

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

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

Key words: *Traditional birth attendant, training programme, maternal mortality*

ABSTRACT NO. 17

Author : Sahachowdhury, S.

Title : Assessment of Cost and Quality of Intranatal Care Provided by Trained Traditional Birth Attendants in the Home

Source : Indian Journal of Nursing and Midwifery, 1998

Place of study : Vellore, Tamil Nadu

Location : Rural

Period of study : 1993

Type of research : Empirical, analytical, prospective and retrospective, community-based

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

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

Findings:

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

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

Key words: *Cost of delivery, intranatal care, quality, traditional birth attendants, dais, home delivery*

ABSTRACT NO. 18

Author(s) : Sharma, N., P. Bali, V. L. Bhargava, et al.

Title : An In-Depth Study of the Role of Traditional Birth Attendants in Providing Intranatal Care in an Urban Slum and Villages of Delhi

Source : Journal of Obstetrics and Gynaecology, 1990

Place of study : New Delhi

Location : Rural and urban

Period of study : 1984-85

Type of research : Empirical, descriptive, community-based

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

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

Findings:

The study found that the majority of women preferred home delivery by TBAs, particularly in the slum, since they were economical, accessible and helped with household chores. Even in areas where MCH services were available, only 52 percent preferred ANMs. Except for one TBA, none had a delivery kit. All except one did pervaginum examination with bare, unwashed hands, though their findings were generally accurate. The majority conducted deliveries also without washing their hands. The most common position for conducting deliveries was lying down, since it was the practice in hospitals. The cord was cut with a new razor blade and left without any dressing. Recognition and management of danger signals was unsatisfactory. Self-management of complications by TBAs consisted of abdominal manipulations to correct presentation, hasten delivery and manual removal of retained placenta.

The study recommends some elementary training of TBAs serving urban slums, given the indispensable nature of their service. An active collaboration of these with the existing health services is suggested to help strengthen the MCH services.

Reviewer's note:

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

Key words: *Traditional birth attendant, intranatal care*

ABSTRACT NO. 19

Author(s) : Shrotri, A., and P. V. Bhatlavande

Title : Current Status of Trained Dais

Source : Journal of Obstetrics and Gynaecology of India, 1994

Place of study : Kolhapur, Maharashtra

Location : Rural

Period of study : 1988-1989

Type of research : Empirical, descriptive, community-based

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

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

Findings:
The overall proportion of functioning dais was only 61.83 percent. The proportion of non-functioning dais was 15.5 percent (for reasons like death, migration, appointments as peon/CHG, old age). Motivational factors for taking up the profession were analysed. Perceptions of dais on antenatal services, advice regarding contraception and baby care and immunisation were explored. The concept of risk screening and advising hospital delivery for selected cases did not seem to exist, probably because the dai's first contact with the pregnant mother generally occurs when she is called for some difficulty during labour. The study provides recommendations for improving the functional capacity of dais: 1) A 62 percent functioning of dais indicates a need to conduct similar surveys in all districts to organise training programmes. The process of identifying untrained birth attendants should be an on-going one and training programmes should be organised for the newly identified women; 2) The training curriculum needs to be revised and its scope widened to cover MCH care in its broader perspective to include antenatal and postnatal care to the mother and care of neonates; 3) Opinion leaders in the rural community should be encouraged to find avenues for MCH activities; and 4) A link should be established between the dai, VHG and other health workers. A meeting of all health workers should be held periodically or quarterly to review the situation.

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

Key words: *Traditional birth attendant, training, role, maternal and child health services*

ABSTRACT NO. 20

Author(s) : Singh, A., and A. Kaur

Title : Perceptions of Traditional Birth Attendants Regarding Contraceptive Methods

Source : The Journal of Family Welfare, 1993

Place of study : Ambala District, Haryana

Location : Rural

Period of study : 1989-91

Type of research : Empirical, descriptive, community-based

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

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

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

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

Key words: *Traditional birth attendants, perceptions, contraception*

ABSTRACT NO. 21

Author(s) : Subramanian, T., N. Charles, R. Balasubramanian, et al.

Title : Role and Acceptability of Traditional Birth Attendants (Dais) in a Rural Community in South India

Source : Indian Journal of Preventive and Social Medicine, 1996

Place of study : Sriperumbudur, Tamil Nadu

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, community-based

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

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

Findings:
The majority of villagers found services by dais useful and available at all times because they reside in the village itself. Both male and female respondents were aware of the services of the dais in the villages. Dais were also able to supply drugs for minor ailments, after proper training. Both men and women sought their help for the treatment of minor ailments. About 31 percent of the respondents did not mention the availability of the government health facilities in their villages.
Given the fact that in rural areas health care facilities are inadequate and there is a shortage of medical and auxiliary staff and limited financial resources, the author recommends that a new system of health care delivery in rural areas be devised. The author suggests by referring to other research studies that dais can be considered grassroots level health workers in rural areas and can be effectively involved in any health programmes. Some sort of financial support to dais from the government is also recommended.

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

Key words: *Traditional birth attendants, rural dais, community acceptability of rural dais*

ABSTRACT NO. 22

Author(s)	:	Ved, R.
Title	:	Private Voluntary Organizations in Health II: An Overview
Source	:	Indian Journal of Community Health, 1997
Place of study	:	13 states of India
Location	:	Rural
Period of study	:	1981-87
Type of research	:	Empirical, analysis of secondary data
Aim	:	To evaluate the impact of primary health care projects initiated under PVOH-II.
Methodology	:	Sample size: primary health care projects initiated by 131 NGOs

Findings:
PVOH-II supported 131 small and large NGOs in 13 states for periods ranging from three to five years for projects on primary health care with a focus on MCH. A Technical Assistance Unit was also formed late in the initiative to render need-based technical support to NGOs. PVOH-II NGOs typically covered populations ranging from 45,000 to 100,000. All NGOs used the three-tier service delivery strategy with emphasis on providing services at the community level through community health workers with varying degrees of success. Providing curative care was the strategy used by most NGOs to gain access to the community. The majority of projects trained TBAs. The emphasis was on safe delivery. Little attention was paid to neonatal care, though one project successfully trained TBAs in neonatal resuscitation. Most projects facilitated government services, though some provided the services directly. Two major thrusts

of PVOH-II were ensuring community participation and sustainability. Though several NGOs articulated community participation in their proposals, few attempted to introduce elements of community participation in their activities and even fewer were able to transfer the responsibility of health into the community's hands. Community participation strategies were limited to strengthening or forming village women's groups, and training village health workers. The inability to evoke community participation in these projects could be due to a lack of understanding of people's real capability in contributing to the programme. NGO personnel need skills to facilitate and maintain constructive dialogues with the community on their health-related needs and priorities. Most NGOs saw community participation as an instrument to provide services rather than as a mechanism to empower communities to take charge of their own health. Thus NGOs became 'givers' of health to passive community recipients. Sustainability was originally taken to mean organisation sustainability (i.e., the ability of the organisation to continue its activities in the absence of grants). NGOs started levying fees for service. The focus on preventive and promotive health services was diluted. Collaboration and establishment of linkages with the government and other providers was de-emphasised. Many NGOs experimented with income-generation activities for women, which failed for various reasons. Sustainability was re-defined to mean sustaining the health impact of mothers and children achieved during the life of the PVOH-II project. This facilitated some of the NGOs to emphasize preventive and promotive aspects of health. PVOH-II demonstrated the capability and commitment of the voluntary sector in providing preventive and promotive services.

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

Key words: *Non-governmental organisation, community participation, health services*

ABSTRACT NO. 1

Author : Agrawal, K., J. Tandan, P. Srivastava, et al.

Title : An Assessment of Delivery Pattern of MCH Services in Urban Varanasi

Source : Indian Journal of Preventive and Social Medicine, 1994

Place of study : Varanasi, Uttar Pradesh

Location : Urban

Period of study : Not stated

Type of Research : Empirical, evaluative, community-based

Aims and objectives : To assess the delivery pattern of MCH services.

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

Findings:

Only 26.2 percent of the beneficiaries had knowledge of MCH centres. Around 25 percent of the beneficiaries had utilised them.

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

Reviewer's note:

The universe has introduced a bias in the sample as is evident from demographic profile of the sample. Moreover, the socio-economic and demographic data are not at all used in the analysis to examine linkages, if any exist. Indicators used for assessment are grossly inadequate.

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

ABSTRACT NO. 2

Author(s) : Anandalakshmy, P. N., and S. Mittal

Title : An Innovative Simplified MCH Score for Assessing Ideal Babies in the Well-Baby Shows of Postpartum Outreach Programme

Source : Indian Journal of Maternal and Child Health, 1995

Place of study : New Delhi

Location : Urban

Period of study : 1987-1992

Type of research : Empirical, descriptive, community-based

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

Methodology : The study population consisted of the 83,000 people catered to by the AIIMS's Postpartum Programme. Welfare services to improve maternal and child health status included periodic baby shows, immunisation camps, ideal family shows and family welfare camps.
The parameters included for the MCH scoring systems were age at marriage, educational status of the eligible couple, wife's age at first childbirth, number of living children in relation to duration of marriage, immunisation status of living children, and inter-birth interval and contraceptives used for limiting/spacing. Also included were the usual criteria of general health and hygiene of children enrolled for the community-based assessment of babies in these family welfare and immunisation camps-cum-well-baby shows. The score was also used to gauge the coverage of the services rendered in the area. It details the scoring system for the various parameters.

Findings:
The data from the five clusters were presented separately for five, three or two years, depending upon the period of service provision in the respective areas. The other variable that impacted the scores was the 'mode of service provision,' -- weekly clinics or periodic health services or services provided by the weekly mobile health van. The areas with weekly clinics showed better scores. However, the other services also had a positive impact and helped to strengthen promotional and educational activities in areas where poor scores were observed. The scoring system is viewed as a rapid assessment tool that can be used by field workers and nursing students without any formal training in statistics or research methodology.

Reviewer's note:
The top-down approach dominates the methodology. It is driven by programmatic goals. The criteria included are beyond the control of the couple. The study does not talk about participation rates in such a show vis-à-vis the proportion of total eligible couples/children. Nowhere do the parameters or the scoring system seem to assume the importance of 'processes' that constitute the programme.

Key words: *methodology of scoring, well baby show, postpartum programme, MCH and family welfare, immunisation coverage, target group*

ABSTRACT NO. 3

Author(s) : Bahl, S.K., and P. L. Trakroo

Title : An Assessment of Family Welfare Communication Activities at the Primary Health Centre Level

Source : The Journal of Family Welfare, 1996

Place of study : Haryana

Location : Rural and semi-urban area

Period of study : Not stated

Type of research : Empirical, evaluative, health centre-based

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

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

Findings:

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

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

Reviewer's note:

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

Key words: *IEC activities, communication skills, health personnel*

ABSTRACT NO. 4

Author(s) : Baru, R. V.

Title : Inter-Regional Variations in Health Services in Andhra Pradesh

Source : Economic and Political Weekly, 1993

Place of study : Krishna, Guntur, Mahbubnagar and Medak, Andhra Pradesh

Location : Rural and urban

Period of study : 1961-1986

Type of research : Empirical, analysis of secondary data

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

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

Findings:

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

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

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

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

Key words: *Health services, public, private, voluntary*

ABSTRACT NO. 5

Author(s) : Bhardwaj, N., S. B. Hasan, and M. Zaheer

Title : Maternal Care Receptivity and Its Relation to Perinatal and Neonatal Mortality

Source : Indian Paediatrics, 1995

Place of study : Uttar Pradesh

Location : Rural

Period of study : 1987 - 1988

Type of research : Empirical, analytical, community-based

Aims and objectives : To assess maternal care services provided to pregnant mothers at their doorsteps and to find out why women are not using antenatal services.

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

Findings:

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

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

Reviewer's note:

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

Key words: *Maternal care receptivity, perinatal mortality, neonatal mortality*

ABSTRACT NO. 6

Author(s) : Celcy, M.

Title : The Extent of Information Provided by Health Personnel to Parturient Mothers during Their Stay in the Labour Room

Source : Indian Journal of Nursing and Midwifery, 1998

Place of study : Vellore, Tamil Nadu

Location : Not applicable

Period of study : Not stated

Type of research : Empirical, descriptive, health centre-based

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

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

Findings:

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

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

Reviewer's note:

Recognition of women's right to information during maternal care is a good beginning.

Key words: *Information, parturient mothers, communication, childbirth, labour*

ABSTRACT NO. 7

Author(s) : Foo, G. H. C.

Title : A Synthesis of Research Findings on Quality of Services in the Indian Family Welfare Programme

Source : Proceedings from the National Workshop, 1996

Place of study : Ten States of India

Location : Rural

Period of study : Not stated

Type of research : Empirical, meta-analysis of research studies

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

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

Findings:

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

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

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

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

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

Key words: *Quality of care, family welfare programme, users' perspective, providers' perspective*

ABSTRACT NO. 8

Author(s) : Gangopadhay, B., and D. N. Das

Title : Quality of Family Planning Services in India: The User's Perspective

Source : The Journal of Family Welfare, 1997

Place of study : Delhi

Location : Urban

Period of study : 1993

Type of research : Empirical, evaluative, health centre-based

Aims and objectives : To find out the causes of the failure of the National Family Welfare Programme.

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

Findings:

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

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

Reviewer's note:

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

Key words: *Users' perspective, evaluation, family planning programme, informed choice*

ABSTRACT NO. 9

Author(s) : Gupte, M., S. Bandewar, and H. Pisal

Title : Women's Perspectives on the Quality of General and Reproductive Health Care: Evidence from Rural Maharashtra

Source : Improving Quality of Care in India's Family Welfare Programme: The Challenge Ahead, 1999

Place of study : Pune, Maharashtra

Location : Rural

Period of study : 1994 - 1996

Type of research : Empirical, analytical, community-based

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

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

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

Findings:

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

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

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

Key words: *Quality of health care, women's perspectives, providers*

ABSTRACT NO. 10

Author(s) : Task Force, ICMR

Title : Evaluation of Quality of Family Welfare Services at the Primary Health Centre Level

Source : Indian Council of Medical Research, 1991

Place of study : Nationwide

Location : Rural

Period of study : 1987 - 1989

Type of research : Empirical, evaluative, health centre-based

Aims and objectives : To carry out an independent evaluation of family welfare services being offered at Primary Health Care centres.

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

Findings:

According to the new pattern recommended, there should be one PHC for 30,000 population. The data from this study indicate that the recommended pattern was achieved in only 12 percent of PHCs. It was observed that resources in terms of physical facilities were comparatively satisfactory at PHCs, but greatly deficient at the level of sub-centres that are really the first contact point for the community. This was especially true for routine antenatal care. With regard to manpower, there was a substantial shortage of ANMs. In fact, the sanctioned pattern of ANMs indicated a need for increasing the number

of posts for this category of health functionary. Nearly half of the sub-centre's facilities for normal delivery were absent. The majority of the PHCs lacked functional equipment and/or trained manpower to carry out pregnancy termination even after two decades of the MTP Act.

Antenatal, intra-natal, neonatal and childcare services were included for the evaluation of MCH care provided at PHCs. The study underlined the urgent need to equip ANMs with better skills and facilities to improve their performance in various aspects of MCH care. Records were found deficient in details of care provided. Facilities were virtually non-existent at sub-centres. In the case of postnatal care, surprisingly, advice on family planning was the only component addressed "properly" during the postnatal period, confirming the programme's emphasis on family planning. The situation with regard to support facilities like water supply, toilet facilities and availability of transport was generally satisfactory.

Reviewer's note:
This study does not reveal the impact of multiple factors on the performance of ANMs in MCH care delivery.

Key words: *Primary health centre, sub-centre, quality of care*

ABSTRACT NO. 11

Author(s) : Iyer, A., A. Jesani, and S. Karmarkar

Title : Patient Satisfaction in the Context of Socio-Economic Background and Basic Hospital Facilities: A Pilot Study of Indoor Patients of LTMG Hospital, Mumbai

Source : CEHAT

Place of study : Mumbai

Location : Urban

Period of study : 1996

Type of research : Empirical, descriptive, health centre-based

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

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

Findings:
The study found gender bias in the allocation of beds per ward (33 percent for females compared to 46 percent for males). This bias is further marked (20 percent for females compared to 55 percent for males) when the all-female beds in obstetrics are excluded. About 6.9 percent of all female patients

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

The study found that dissatisfaction with private providers creeps in earlier than it does in the case of public providers. The majority of the patients came to the hospital because they perceived it to be good, with adequate support facilities. The study reported on the quality of care provided by the hospital in terms of the quality and adequacy of physical facilities, interpersonal relationships, adequacy of medical facilities, and the patient's satisfaction with these. Based on their findings, the authors recommend steps to improve and strengthen peripheral public health care as well as hospital management.

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

Key words: *Quality of care, patients' satisfaction, public health care facility*

ABSTRACT NO. 12

Author(s)	:	Kartha, G.P., P. Kumar, and C. K. Purohit
Title	:	A Longitudinal Study on Some Aspects of Maternal and Child Health in an Urban Community of Ahmedabad
Source	:	Indian Journal of Preventive and Social Medicine, 1993
Place of study	:	Ahmedabad City, Gujarat
Location	:	Urban
Period of study	:	1989
Type of research	:	Empirical, descriptive, prospective, community-based
Aims and objectives	:	To study the pattern of antenatal care, and the morbidity and pregnancy outcome; and to identify MCH problems in the locality.

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

Findings:

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

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

The study concluded that the available health services have helped combat morbidity and mortality. Apart from these health interventions, however, the high literacy rate, especially of females, and the predominantly middle class social milieu in the studied area could also have contributed to better maternal and child health levels. The study also emphasised the need for a similar study with a large sample and a control population.

Reviewer's note:

Despite the longitudinal design of the study, the findings are purely descriptive in nature. Consequently, the impact of socio-demographic variables is not assessed.

Key words: *Maternal and child health care, urban slums, urban health centre*

ABSTRACT NO. 13

Author(s) : Khan, M.E., S. Rajagopal, S. Barge, et al.

Title : Situation Analysis of Medical Termination of Pregnancy (MTP) Services in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh

Source : Working Paper, CORT, Baroda, 1998

Place of study : Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh

Location : Rural

Period of study : 1992 - 1997

Type of research : Empirical, descriptive, health centre-based

Aims and objectives : This study is part of a larger study conducted by the organisation to develop a database on the availability of abortion facilities and to identify the reasons for the under-utilisation of MTP services.
The extent of MTP facilities in rural and semi-urban areas was central to this study, which also attempted to pinpoint how many of the MTP facilities were approved, and what the quality of the MTP services was regarding trained personnel and required infrastructure.

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

Findings:

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

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

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

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

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

Reviewer's note:

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

Key words: *MTP services, quality of MTP services, clients' perception on quality of MTP services received*

ABSTRACT NO. 14

Author(s) : Kumar, R.

Title : Streamlined Records Benefit Maternal and Child Health Care

Source : World Health Forum, 1993

Place of study : Ambala, Haryana

Location : Rural

Period of study : Not stated

Type of research : Empirical, evaluative, health centre-based

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

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

Findings:

A review of the existing system showed that records were incomplete. Health workers perceived the procedures of record maintenance to be cumbersome and time consuming. There were several other problems: no printed forms were available; shortage of stationery led to registers being maintained on loose sheets; supervisors experienced difficulty in acquiring information from the health workers; and duplication of work dominated the information management system.

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

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

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

Reviewer's note:

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

Key words: *MCH, management information system*

ABSTRACT NO. 15

Author(s) : Kumar V.K., and J. Singh

Title : Assessment of Community Attitude Regarding the Services of PHC: A Medical Geographic Study

Source : Indian Journal of Preventive and Social Medicine, 1994

Place of study : Varanasi, Uttar Pradesh

Location : Rural

Period of study : Not stated

Type of research : Empirical, descriptive, community-based

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

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

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

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

Key words: *Provider-client communication, community's expectations, health services*

ABSTRACT NO. 16

Author(s) : Levine R.E., H. E. Cross, S. Chabbra, et al.

Title : Quality of Health and Family Planning Services in Rural Uttar Pradesh: The Client's View

Source : Demography India, 1992

Place of study : Uttar Pradesh

Location : Rural

Period of study : 1992

Type of research : Empirical, descriptive, community-based

Aims and objectives : To gain in-depth understanding of how villagers in Uttar Pradesh view both government and private health services, and what they think about the available family planning services.

Methodology : A special unit of the Indian Market Bureau carried out a set of 20 small, in-depth focus group interviews with married, 15-34 year old males and females. The selection was made at the level of districts and villages. Districts were selected from each of the five socio-cultural regions. Villages with access to government health care services were selected. In each of the socio-cultural regions, four group discussions were held - three with women and one with men. Each FGD lasted for about an hour and a half and was moderated by a trained group leader who followed a structured discussion guide. Discussions were tape-recorded, then translated into English. The transcripts were content analysed.
Discussions on general health issues helped in establishing a rapport with the people before proceeding to the sensitive topic of contraceptive use.
The reports states the advantages and disadvantages of FGDs and their implications for generalisation of the findings.

Findings:
Important determinants of treatment-seeking behaviour fall into the categories of physical or financial access. In the Indian context, indicators of quality of care include experiences with effectiveness of treatment, thoroughness of examination, care by a doctor (as opposed to paramedical personnel), waiting time, timings of the facilities, provision of medication, provider-patient communication and doctors' qualifications. The respondents evaluated the private sector positively on almost all the indicators except one - qualification of the providers. The public sector was evaluated negatively on all the indicators, except two - treatment experience and qualification of providers.
There was a fairly high level of awareness of family planning methods among both men and women. Respondents reported that government health personnel do not involve them in the choice of a particular contraceptive method. Some also doubted the reliability or efficacy of the method. Respondents elaborated the kind of family planning services they wanted.
The author provides a list of recommendations based on this data to overcome the existing constraints and shortcomings of the programme.

Key words: *Quality of health care, family planning services, focus groups*

ABSTRACT NO. 17

Author(s) : Nandraj S., and R. Duggal

Title : Physical Standards in the Private Health Sector

Source : Radical Journal of Health, 1996

Place of study : Satara, Maharashtra

Location : Rural and urban

Period of study : 1994 - 1995

Type of research : Empirical, descriptive, health centre-based

Aims and objectives : To document and review various guidelines available in the government, NGO and private sectors for the minimum physical standards necessary for provision of health care of various kinds.
The framework of minimum standards for quality care was evolved on the basis of existing information discussed as per the findings and its critique at a workshop.

Methodology : A sample of 53 practitioners from different systems of medicine and specialities and 49 hospitals was covered from two talukas of Satara district in Maharashtra. Both economically backward (EBA) and economically developed areas (EDA) were chosen to get a comparative and a representative picture of the state.
A combination of methodologies was used for this exploratory study. A range of secondary data sources was used to acquire information on private health facilities. The names of persons practising without any qualifications were collected through informal discussions with key informants in the villages.

Findings:
Some of the problems faced were: inadequacy of data on the size, functioning and nature of the private health sector; difficulties in categorising different aspects of physical standards because the size of health facilities ranged from three-bed to 500-bed hospitals; difficulties in defining the various units under study and their various functions; and difficulties in defining qualitative terms for the observation schedule to minimise the subjectivity in observational data.
The majority (59%) of the health practitioners were concentrated in the urban areas. The gender and age distributions show a very high male concentration in both economically developed areas and economically backward areas. The mean age of the EDA practitioner is higher and this is perhaps indicative of the push factor in EDAs due to an over-concentration that is forcing new practitioners to move gradually into EBAs. This is a welcome trend that needs to be encouraged. The local government can play an important role in discouraging new entrants in over-served areas. Only nine percent of the allopaths were found practicing in EBAs. An overwhelming majority were practising allopathy without having the necessary degree. Record maintenance was found very poor, with no proper format.
Three-fourths of the hospitals were situated in urban areas. In the last two decades the private sector has grown phenomenally. The doctor was the administrator of the institution for all the hospitals in the sample. The data revealed that in 85.7 percent of the hospitals, patient were admitted only by the doctor-owner, and only in 14.3 percent of the hospitals could other doctors admit their patients. This practice was more prevalent in the EDA. None of the hospitals were registered by any authority. The average beds per hospital were 11, which raises the issue of efficiency and efficacy in running smaller hospitals.

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

Key words: *Physical standards, quality, health care*

ABSTRACT NO. 18

Author(s) : Narayana, M. R.

Title : Programme Inputs and Performance of the Family Planning Programme: Evidence from a Comparative Study of PHCs

Source : The Journal of Family Welfare, 1995

Place of study : Chitradurga, Karnataka

Location : Rural

Period of study : 1990-91 -- 1992-93

Type of research : Empirical, descriptive, health centre-based

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

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

Findings:

The initial condition of the PHC and the population it covers do not determine its relative performance. The availability and utilisation of vehicles did improve programme coverage and performance though this was not always true. For sporadic sterilisation camps, availability of good public/private transport and a high level of awareness of the venue and timings of the camp were critical to the success of the camp. It was also seen that vacant posts of health staff make a strong difference between good and average performance rather than between good and poor performance. Strong dissatisfaction was evident in relation to the inadequacy of financial incentives to the various categories of health staff. It was also seen that the erratic supply of medicines and medical items had no relation to the PHC's performance.

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

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

Key words: *Family welfare programme, performance, programme inputs, comparative study*

ABSTRACT NO. 19

Author(s) : Patel D., A. Patel, and A. Mehta

Title : The Effects of Quality of Services upon IUD Continuation among Women in Rural Gujarat

Source : Working paper, Action Research in Community Health (ARCH), Mangrol, Gujarat

Place of study : Rajpipla, Gujarat

Location : Rural

Period of study : 1987 - 1995

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

With health education, overall IUD acceptance increased. This increase was more among tribal as compared to upper caste women. Discontinuation of IUD was significantly lower among women with post-IUD complaints in the intervention (i.e., during the health education programme) phase as compared to the earlier (non-intervention) phase. Though the proportion of women with post-IUD complaints was similar in both phases, retention of IUD was higher in the intervention phase. Continuation rates were significantly higher in the intervention phase especially when removal of IUD due to problems only was considered.

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

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

Key word: *IUD acceptance, health education*

ABSTRACT NO. 20

Author(s) : Ramanathan, M., T. R. Dilip, and S. S. Padmadas

Title : Quality of Care in Laparoscopic Sterilisation Camps: Observations from Kerala, India

Source : Reproductive Health Matters, 1995

Place of study : Palakkad, Kerala

Location : Rural

Period of study : 1994

Type of research : Empirical, descriptive, health centre-based

Aims and objectives : To evaluate the quality of care provided at a sterilisation camp under the FPP.

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

Findings:

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

The paper reports on the observation findings of a sterilisation camp. One surgical team did 48 laparoscopic sterilisations in just over two hours (averaging 2 minutes and 40 seconds per sterilisation), in clear violation of the norms laid down by the programme. Counselling of women before surgery was inadequate. The surgeon never changed his gloves, the linen on the operating tables was never changed. Though the building had facilities like access to running water, electricity with a standby generator in case of power failure, and attached toilet, these were inadequate. The women had to wait for a long time after completing registration formalities for the surgical team to arrive. Pelvic examinations were not done prior to sterilisation for all women. Post-operative care was lacking. For nursing staff of the taluka hospital doing this, it meant extra work. The surgeon who officiated at this camp belonged to another taluka who had to finish his scheduled surgery at his own place and thus delayed the camp. According to the supervising doctor, the need to fulfil the targets frequently resulted in wrangling between health workers.

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

Key words: *Sterilisation camp, quality of care*

ABSTRACT NO. 21

Author(s) : Reddy, P.H.

Title : Quality of Client-Provider Interaction and Family Welfare Services (MCH and FP Programmes) in Rural Karnataka

Source : Working paper, Centre for Technology Development, Bangalore

Place of study : Kolar, Kerala

Location : Rural

Period of study : 1994

Type of research : Empirical, descriptive, community and health centre-based

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

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

Findings:

It was found that interaction between clients and ANMs was quite frequent, unlike that between clients and MHWs. The quality of interaction differed at the level of sub-centres and at higher levels. Better interaction at the sub-centre level was attributed to the necessity on the part of ANMs to be on good terms with clients to meet targets. The quality of interaction between clients and MHWs was poor. In general the quality of family planning services was found to be poor.

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

Key words: *Client-provider interaction, quality, family welfare services*

ABSTRACT NO. 22

Author(s) : Sarbajna, S.

Title : Intra-Uterine Device as a Means of Contraception in Our Population

Source : Journal of Obstetrics and Gynaecology of India

Place of study : Indian Iron and Steel Company Hospital

Location : Not stated

Period of study : 1977 - 1987

Type of research : Empirical, descriptive, retrospective, health centre-based

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

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

Findings:
During the study period of 11 years, 460 women used the IUCD, of which 169 (36.7 percent) had complaints, with 38 (8.4 percent) women removing the IUCD. Menstrual irregularity was found in the form of menorrahagia, dysmenorrhoea and spotting. This was more commonly encountered in the cases of post-MTP insertion. The most important cause of removal was menstrual irregularity. Other causes included failure of IUCD, severe vaginitis, opting for another method and desire for pregnancy.
The majority of IUCDs were inserted for women from the middle socio-economic group. Women in the low socio-economic group were ignorant and indifferent about IUCD. Women from high and middle socio-economic groups showed a definite negative attitude towards IUCD, mainly due to the false belief that it caused cancer and menstrual irregularity.
The hospital had fewer health visitors than required. Health visitors were found to be indifferent towards the IUCD. It was revealed that they had an interest in tubectomy and vasectomy due to incentives involved in those. It is concluded that an adequate number of health visitors must be available for motivation.

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

Key words: *IUCD, acceptability, complications*

ABSTRACT NO. 23

Author(s) : Subrahmanyam, V.

Title : Quality of Care at Community Hospital

Source : Economic and Political Weekly, 1997

Place of study : Nellore, Andhra Pradesh

Location : Rural

Period of study : Not stated

Type of research : Empirical, descriptive, health centre-based

Aims and objectives : To find out the effects of medical negligence.

Methodology : Case studies were undertaken to explore the situation.

Findings:

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

Key words: *Right to health, negligence*

ABSTRACT NO. 1

Author(s) : Bang. R., and A. Bang

Title : A Community Study of Gynaecological Disease in Indian Villages

Source : Learning about Sexuality: A Practical Beginning, The Population Council

Place of study : Gadchiroli, Maharashtra

Location : Rural

Period of study : 1986

Type of Research : Empirical, exploratory, community-based

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

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

Findings:

In this paper, researchers documented their personal experiences while conducting this study with the hope that it may be useful to evolve more relevant methodology for further research in this field. The article reveals the importance of interactions with the study community to gain their cooperation.

Ninety-two percent of the women had gynaecological disorders. Each woman had an average of 3.6 diseases, but only 7 percent of the women had ever sought medical care. This study generated interest among public health personnel in various parts of the world because it projected women's gynaecological diseases as an important public health problem.

The study also highlights the fact that the existing taboos and inhibitions regarding sexual health prevent women from securing easy access to medical care. Also, women found that family planning emphasis in health care services was a hindrance in utilisation of health services. Therefore, though 92 percent of the women were found to suffer from gynaecological problems, only 7 percent of the women had ever sought medical care.

Reviewer's note:

This article also details as to how to approach a new community for studying sensitive topics.

Key words: *Sexuality, gynaecological morbidity*

ABSTRACT NO. 2

Author(s) : Behera, R. C., and K. Padte

Title : Unwanted Adolescent Pregnancy: Its Present Status

Source : Journal of Obstetrics and Gynaecology of India, 1991

Place of study : Pune, Maharashtra; Panji, Goa

Location : Not applicable

Period of study : 1982-84 and 1985-88

Type of research : Empirical, descriptive, health centre-based

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

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

Findings:

The study demonstrated a high percentage of unwanted adolescent pregnancies among middle (45 percent) and late adolescents (54 percent). A high incidence of unwanted pregnancy was found among rural population (68 percent), housewives (69 percent), under matriculate (53 percent), and lower economic group (67 percent). Causes included out-of-wedlock (15 percent), quick succession of pregnancies (34 percent), small family norm (15 percent), failure of contraception (5 percent), recent marriage (6 percent), education and career consciousness (6 percent), medical grounds (7 percent), marital maladjustment (2 percent) and drugs taken (10 percent). Ninety-two percent of the cases had inadequate sex education, and 84 percent did not use contraception.

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

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

Reviewer's note:

Conclusions derived reflect constraints of hospital-based studies. In the absence of any statistics on adolescent pregnancies in the past, attributing unwanted adolescent pregnancy to changing socio-economic environment and to the change in life philosophy is a little far-fetched. The unwanted adolescent pregnancies perhaps are more visible than before for more women seeking abortion care from the hospitals.

Key words: *Unwanted adolescent pregnancy, indications for abortion, preventive measure*

ABSTRACT NO. 3

Author(s) : Bhalerao, A. R., S. V. Desai, N. A. Dastur, et al.

Title : Outcome of Teenage Pregnancy

Source : Journal of Postgraduate Medicine, 1990

Place of study : Mumbai, Maharashtra

Location : Not applicable

Period of study : 1988

Type of research : Empirical, descriptive, retrospective, health centre-based

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

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

Findings:

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

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

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

Reviewer's note:

Study of socio-economic aspects as correlates of incidence of teenage pregnancies and other related aspects would have been insightful.

Key words: *Teenage pregnancy, outcome*

ABSTRACT NO. 4

Author(s) : Bhatia, J. C., and J. Cleland

Title : Self-Reported Symptoms of Gynaecological Morbidity and Their Treatment in South India

Source : Studies in Family Planning, 1995

Place of study : Karnataka

Location : Rural

Period of study : 1993

Type of research : Empirical, descriptive, community-based

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

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

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

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

Findings:

Approximately one-third of the women included in this study reported current symptoms of at least one reason for reproductive morbidity. Ninety percent of abortions were reported to be spontaneous. The causes of which may be outcome of prior infection or a cause of subsequent infection. Among others, menstrual problems (7.3 percent), symptoms of lower reproductive tract

infections (16.9 percent), anaemia (23.4 percent), and symptoms of acute PID (5.2 percent) were reported. Prolapse, urinary tract infections, infertility (secondary) and haemorrhoids were less frequently reported.

Analysis of the determinants was limited to menstrual problems, lower reproductive tract infection, acute PID and anaemia. Bivariate analysis revealed socio-economic differentials. Among demographic indicators, age at first pregnancy and total number of pregnancies were consistently related to all four morbid conditions. About 41 percent reported disorders or problems that were associated with their last live-births. With regard to cognitive and behavioural factor, personal hygiene, household environment and sanitation, and exposure to health education were related to reported morbidity. Analysis also demonstrated a relationship with socio-economic variables, health education and autonomy in addition to duration of problem and age of the respondent. Experience of obstetric problems and complications associated with the last live-birth, and place of last delivery were found to have strong and pervasive influence on reported gynaecological morbidity. Most importantly, reporting of the symptoms indicative of lower reproductive tract infections, acute PID and anaemia were significantly higher among tubectomised women than among those who were not using any method of contraception or were using a reversible method.

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

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

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

Key words: *Reproductive health, morbidity, utilisation, prevalence*

ABSTRACT NO. 5

Author(s)	:	Bhide, A. G.
Title	:	Caesarean Section: How Safe Is It?
Source	:	Journal of Obstetrics and Gynaecology of India, 1991
Place of study	:	Mumbai, Maharashtra
Location	:	Not applicable
Period of study	:	1981-90
Type of research	:	Empirical, descriptive, retrospective, health centre-based

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

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

Findings:

The data show that there was a progressive increase in the incidence of CS in recent years from 6.5 percent in 1981-82 to 9.0 percent in 1989-90. Mortality from CS has declined from 321.5/100,000 in 1981-82 to 190.8/100,000 in 1989-90. This improvement was attributed to advances in medical technology that have made it easier to take a decision in favour of CS. Though on decline, mortality and morbidity associated with CSs is not comparable to that following a vaginal delivery.

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

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

Reviewer's note:

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

Key words: *Caesarean section, mortality*

ABSTRACT NO. 6

Author(s) : Chhabra, S.

Title : Perinatal Outcome in Teenage Mothers

Source : Journal of Obstetrics and Gynaecology of India, 1991

Place of study : Wardha, Maharashtra

Location : Not applicable

Period of study : Not specified

Type of research : Empirical, descriptive, prospective, health centre-based

Aims and objectives : To study perinatal outcome in teenage mothers.

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

Findings:

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

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

Key words: *Teenage mothers, perinatal outcome*

ABSTRACT NO. 7

Author(s) : Duraisamy, P.

Title : Morbidity in Tamil Nadu: Levels, Differentials and Determinants

Source : This paper is based on the project, "Morbidity, Utilisation of and Expenditure on Medical Services in Tamil Nadu," 1997

Place of study : Tamil Nadu

Location : Not applicable

Period of study : 1973-74 to 1986-87

Type of research : Empirical, analysis of data from NSS 42nd round

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

Methodology : Not stated

Findings:

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

The morbidity prevalence rates for the years 1980-81 and 1986-87 were comparable and estimates indicated that the overall morbidity prevalence rate has increased during the period. The overall morbidity prevalence rate was 28 and 32 per 1,000 in rural and urban areas of Tamil Nadu. Overall, the morbidity prevalence rate was higher among males (29 per 1,000) compared to females (27 per 1,000). The untreated illnesses were found to be higher in females than in males. Distribution of type of illness among age-sex groups suggested that the communicable diseases were concentrated in the younger age while the aged people suffer more from non-communicable ailments. The female headed households experienced a higher morbidity compared to male headed households. The data on morbidity prevalence showed that males had a higher risk of being sick compared to females. Increase in age increased the risk of being sick. As the level of education increased, the morbidity risk reduced. The effect of per capita consumption expenditure was positive and consistently significant in all the morbidity functions. More than 50 percent of the untreated cases report that the ailment was not serious enough to seek medical treatment. About 20 percent of the cases did not seek treatment due to financial constraints.

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

Key words: *Morbidity, gender specificity*

ABSTRACT NO. 8

Author(s)	:	Dubey, V., S. Prakash, and A. Gupta
Title	:	Voices from the Silent Zone
Source	:	The RAHI Findings, 1998
Place of study	:	Delhi, Bombay, Madras, Calcutta and Goa
Location	:	Urban
Period of study	:	1997
Type of research	:	Empirical, descriptive, community-based
Aims and objectives	:	To document child sexual abuse and to look into the impact of incest on woman's adult life; to establish incest and child sexual abuse also as a middle and upper middle class Indian phenomenon.

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

Findings:

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

For many respondents, answering the questionnaire has been of therapeutic value because it was a non-threatening way to collect information on such a sensitive issue. This study also provides valuable information about family systems and people's peceptions of the issue in general and the kind of action required for effective prevention of sexual violence. The study brings into light a range of misconceptions in the area of sexual abuse and perceptions regarding its effect on women's lives.

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

Reviewer's note:

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

Key words: *Child sexual abuse*

ABSTRACT NO. 9

Author(s) : Ganatra, B. R., K. J. Coyaji, and V. N. Rao

Title : Too Far, Too Little, Too Late: A Community-Based Case-Control Study of Maternal Mortality in Rural West Maharashtra, India

Source : Bulletin of the WHO, 1998

Place of study : Pune, Aurangabad and Ahmednagar, Maharashtra

Location : Rural

Period of study : 1993-95

Type of research : Empirical, descriptive, prospective, community-based

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

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

Each maternal death was matched to two or more women with the same bio-medical complications (complication-matched control) and to one normal pregnancy from the same village (geographical control). All controls were randomly selected from the control pool.

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

Findings:

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

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

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

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

Key words: *Prevalence, complication, maternal mortality, health care interventions*

ABSTRACT NO. 10

Author(s) : Ganatra, B. R., S. S. Hirve, S. Walawalkar, et. al.

Title : Induced Abortions in a Rural Community in Western Maharashtra: Prevalence and Patterns

Source : Working Paper of Ford Foundation, 1998

Place of study : Pune, Ahmadnagar, Auragabad, Maharashtra

Location : Rural

Period of study : 1994-96

Type of research : Empirical, descriptive, prospective, community-based

Aims and objectives : To study the mortality rate of postabortion complications. To study women's considerations while choosing an abortion service provider. To understand women's expectations about and experience of abortion services.

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

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

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

Findings:

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

About 81 percent of the pregnancies were terminated in the private sector. About 45.9 percent of all abortions were terminated illegally. Traditional practitioners were used by only 2 percent of the married women, whereas the use was significantly higher by the women who were not currently married. This suggests that the group is socially marginalised and is exposed to exploitation and insensitivity of service providers. The most common reasons mentioned by married women for choosing a provider were that the provider was experienced in conducting abortions, was patient and good-natured, explained the procedure and answered their queries, and performed the abortion in a place where facilities like blood and oxygen were available. Nearly one-third of the respondents said that cost considerations played a role in their choice. About a third stated that it was important for them that the provider was female, and the same number said that they chose a particular provider because repeated visits and an overnight stay at the hospital were not required. Around 12 percent stated that they chose a particular provider because they did not insist on contraceptive use.

Reviewer's note:

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

Key words: *Induced abortions, morbidity, contraceptives*

ABSTRACT NO. 11

Author(s)	:	Joseph, G.A., S. Bhattacharji, A. Joseph, et. al.
Title	:	General and Reproductive Health of Adolescent Girls in Rural South India
Source	:	Indian Pediatrics, 1997
Place of study	:	Arcot, Tamil Nadu
Location	:	Rural
Period of study	:	Not specified
Type of research	:	Empirical, descriptive, community-based

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

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

Findings:

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

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

Key words: *Adolescent girls, health status, health care services*

ABSTRACT NO. 12

Author(s) : Mondal, A. M. D.

Title : Induced Abortions in Rural Society and Need for Peoples' Awareness

Source : Journal of Obstetrics and Gynaecology, 1991

Place of study : 24 Parganas in West Bengal

Location : Rural

Period of study : 1989-90

Type of research : Empirical, descriptive, prospective, health centre-based

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

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

Findings:
Most abortions performed by quacks and paramedicals had led to postabortion complications. Out of the total cases aborted by MBBS private practitioners, 45.8 percent had led to complications. Reasons for these were improper aseptic techniques, lack of training, overconfidence and popularity in the area, and ignoring quality of care. Reasons for approaching quacks were secrecy, availability, affordability and accessibility of the abortion services. Lady doctors were preferred when choosing an abortion service provider.
Contraceptive acceptance was far from the requirement. The authors expressed the need for more MTP facilities. Simultaneously, people also should be made aware of the available MTP services.

Key words: *Induced abortion, complications of induced abortion*

ABSTRACT NO. 13

Author(s) : Mukharji, R.

Title : MTP programme in Uttar Pradesh

Source : The Directorate of Family Welfare, Uttar Pradesh

Place of study : Uttar Pradesh

Location : Not applicable

Period of study : 1987-88 to 1991-92

Type of research : Empirical, analysis of secondary data

Aims and objectives : To analyse the socio-economic scenarios of MTP acceptors.

Findings:
Five hundred and fifty-four institutions and 1,208 doctors have been approved in Uttar Pradesh (UP) after 1976 to conduct MTPs. In UP, there was 1 MTP centre per 300,000 population in 1987-88 and 1 MTP centre per 240,000 population in the year 1991-1992. In the year 1991-92, there was a 20 percent increase in MTP cases. Women in the age group 25-29 years terminated the largest number of pregnancies. There were 6.9 percent second trimester abortions. For post-MTP coverage, 13-22 percent of cases opted for sterilization and 7-19 percent had an IUD inserted.
Difficulties identified in the programme included provision of funds for instruments; maintenance and repair of the apparatus; women's cultural inhibitions; and under-reporting of private doctors.
It is suggested that IEC activities be undertaken in an area-specific approach manner for specific population groups like the Muslim population. There is a need to use film/folk media/electronic media to expand the programme. Spacing methods should be encouraged through our health programmes to reduce morbidity and unplanned pregnancy. It is suggested that approval of doctors and institutions should be decentralised by the Director General of Health Services.

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

Key words: *MTP programme, MTP services, MTP incidence*

ABSTRACT NO. 14

Author(s) : Parikh, I., V. Taskar, N. Dharap, et al.

Title : Gynaecological Morbidity among Women in a Bombay Slum

Source : Streehitkarini

Place of study : Mumbai

Location : Urban

Period of study : 1989

Type of research : Empirical, descriptive, community-based

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

Methodology : The study was undertaken in a slum area of Mumbai served by Streehitkarini, a health-based voluntary organisation in Bombay. The survey consisted of a socio-demographic survey of respondents including their reported symptoms and morbidity and reproductive histories, clinical examination and laboratory tests.
A random sample of ten percent (sample size = 1,500) of ever married women residing in slum was drawn. No replacement was attempted resulting into sample loss of 446 respondents. Of the remaining 1,054, 298 refused a gynaecological examination. Thus, the effective sample was 756 women, representing an overall sample loss of 50 percent and a refusal rate of 28 percent.
Interviews were conducted by two trained extension workers at respondents' homes. They were requested to attend the Streehitakarini clinic for subsequent medical examination. Other qualitative data were also obtained through group discussions with health workers, informal interviews with health practitioners and 100 community women's perceptions of disease patterns.

Findings:
Over 70 percent of all respondents reported gynaecological complaints. More than 70 percent had

clinical evidence of either vaginitis, cervicitis, prolapse or PID. About 49 percent had an STD or an endogenous infection as assessed by laboratory test. Evidence of STD infections such as chlamydia and trichomoniasis was found in 15 percent and 10 percent of all cases, respectively. As many as 39 percent and 21 percent of all respondents reported low backache and lower abdominal pain, respectively. Also, from among the 15 leading conditions listed during the 'free listing' exercise, 8 reflect gynaecological conditions.

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

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

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

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

Keywords: *Correlates of gynaecological morbidity, STD, RTI, treatment seeking behaviour*

ABSTRACT NO. 15

Author(s) : Salvi, V., K. R. Damania, S. N. Daftary, et al.

Title : MTPs in Indian Adolescents

Source : Journal of Obstetrics and Gynaecology, 1991

Place of study : Mumbai, Maharashtra

Location : Not applicable

Period of study : 1982-86

Type of research : Empirical, descriptive, retrospective, health centre-based

Aims and objectives : To analyse MTPs in Indian adolescents.

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

Findings:

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

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

Reviewer's note:

Disaggregated data on marital status and acceptance of contraception would have been insightful. It also points to the need to study the situations that lead adolescents to terminate pregnancies.

Key words: *MTP, adolescents*

ABSTRACT NO. 16

Author(s) : Shariff, A.

Title : Health Transition in India
Part I: Differentials and determinants of morbidity in India, disaggregated analysis
Part II: Health scenario and public policy in India

Source : Working Paper, National Council of Applied Economic Research, 1995

Place of study : Nation-wide

Location : Rural and urban

Period of study : 1993

Type of research : Empirical, descriptive, community-based

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

Methodology : *Part I*: A three-stage stratified sample design with varying probabilities in the first stage was adopted. District/towns, villages/urban blocks and the households were the sampling units in subsequent stages. For the rural sample, 718 villages from 410 districts in the country were selected. Households listed in the villages were stratified into five income groups. Households from each strata were selected with equal probability using random number tables. For the urban sample, the cities/towns with population exceeding 500,000 were included in the sample. The remaining cities were grouped into six strata based on their population size and from each stratum a sample of towns was selected independently. The samples of blocks selected vary between 2 and 30, depending upon the size of the town. All households in the selected blocks were listed, stratified by income categories and then selected. A total of 6,354 rural and 12,339 urban households were covered.

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

Part II: Not applicable

Findings:

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

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

Public hospitals were preferred for hospitalisation. The rate of hospitalisation was significantly low in central and eastern parts and significantly high in western parts when compared with south India. In urban areas, the relative dependence on public markets was low and less variable than in rural areas. About 32 percent of those who reported sick had used public facilities for treatment. Women in reproductive ages had a tendency to resort to private health care in all parts of India. The public health care utilisation was relatively high in case of Hindus, those living in eastern parts of India and those suffering from infectious sickness in rural and those from non-infectious in urban areas. As distance to the service centre increased, resort to public facilities declined compared to private services.

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

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

The author expressed that in spite of concerted efforts the health infrastructure and supplies are inadequate and inaccessible to people. Besides, there exists a misplaced emphasis, as far as the

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

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

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

Keyword: *Determinants, health care utilisation, health care expenditure, morbidity, prevalence*

ABSTRACT NO. 17

Author(s) : Shatrugna, V., N. Soundarajan, P. Sunadaraiah, et al.

Title : Backpain, the Feminine Affliction

Source : Economic and Political Weekly, 1990

Place of study : Hyderabad, Andhra Pradesh

Location : Not applicable

Period of study : 1987

Type of research : Empirical, descriptive, retrospective, health centre-based

Aims and objectives : To study incidence of various kinds of osteoporotic fractures in women.

Methodology : The study was carried out in two parts: 1) retrospective and 2) study of currently admitted women in the orthopaedic ward of the Osmania General Hospital. A total of 289 case sheets from 297 women of 18 years and above admitted in the hospital during the reference period of January and October 1987 were analysed. Also a 10 percent (107) systematic sample of all men admitted during the same reference period was used to study the incidence of these fractures in the men's ward to get a

comparative view. For the qualitative study, 37 adult women admitted in the orthopaedic ward during the period of the study (September to October 1987) were interviewed. The reason for selecting women with osteoporosis fracture is very well justified by stating the limitation of identifying the calcium level, which was one of the important factors responsible for thinning of bone.

Findings:

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

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

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

Incomplete recordkeeping on various important factors such as occupation, income, fertility history, periods of breastfeeding, age of menopause, previous drugs used, and dietary history in the case sheets limited the scope of study in terms of cross-comparison and examining the correlation of these various factors with osteoporotic fractures. The above mentioned factors created difficulties in retrieving the information for the qualitative study. Also the number of women interviewed was very small for quantitative analysis.

Reviewer's note:

The paper highlights the problem and difficulties faced while conducting this study. This would help researchers interested in pursuing similar research in the future to pre-empt some of the problems.

Key words: *Backpain, calcium deficiency, osteoporosis fracture, women, diet, incidence, service utilisation*

ABSTRACT NO. 18

Author(s)	:	Voluntary Health Services (VHS)
Title	:	Research Summary of STD Prevalence Study in Tamil Nadu
Source	:	Report of AIDS Prevention and Control Project
Place of study	:	Tanjore, Ramanathapuram and Dindigul, Tamil Nadu
Location	:	Rural and urban

Period of study : 1995

Type of research : Empirical, descriptive, community-based

Aims and objectives : To study the community prevalence of STD.

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

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

Findings:

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

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

These data, according to the author, are very important for developing and implementing programmatic solutions to prevent STDs and HIV transmission in India. Estimates based on findings of this study show that for a population of 25 million, about 2,425,000 people have any one of the six STDs measured in the study; about 1,325,000 people were infected with Hepatitis-B virus and carry the surface antigen. About 450,000 people were infected by HIV.

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

Key words: *STD prevalence, health care services, HIV/AIDs*

ABSTRACT NO. 1

Author(s) : Aggarwal, O. P., R. Kumar, A. Gupta, et al.

Title : Utilisation of Antenatal Care Services in Peri-Urban Areas of East Delhi

Source : Indian Journal of Community Medicine, 1997

Place of study : Delhi

Location : Peri-urban

Period of study : 1991

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

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

Key Words: *Antenatal care, registration of antenatal mothers, village untrained dais*

ABSTRACT NO. 2

Author(s) : Bhattacharya, R., and J. Tandan

Title : Managerial Gaps in the Delivery of ANC Services in a Rural Area of Varanasi

Source : Indian Journal of Public Health, 1991

Place of study : Varanasi, Uttar Pradesh

Location : Rural

Period of study : 1988

Type of research : Empirical, evaluative, community-based

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

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

Findings:

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

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

Reviewer's note:

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

Key words: *Health care provider, delivery pattern, utilisation of ANC services*

ABSTRACT NO. 3

Author(s) : Chabbra, S. and S. Saraf

Title : Reasons Why Reproductive Health Care Seekers Sought Admission to Tertiary Level Health Care Facilities in Rural Central India

Source : Health and Population - Perspectives and Issues, 1997

Place of study : Sevagram, Maharashtra

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, health centre-based

Aims and objectives : To study the perceived reasons why reproductive health care seekers (women) use tertiary level health care facilities. To plan and provide appropriate health care at the centre and appropriate training to nursing students, medical undergraduates and postgraduates.

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

Findings:

The most obvious reasons for seeking treatment at the tertiary level, without respect to the nature of the case, locality, age and so forth, were economic, referrals, and the fame of the health facility and expert doctors. The other common reasons were availability of expertise, insurance benefits and appropriate health care. Poor people and illiterates preferred to go to tertiary health care institutions because of economic reasons while the wealthier women went because they were referred. This shows that patients come here not by choice but for reasons beyond their direct control.

Reviewer's note:

There was no attempt to analyse the findings in the tables presented. The closing discussion bears no relation to the data presented. In the absence of any data on the satisfaction rating of respondents on the kind of treatment received and their perceptions of reasons for seeking treatment from tertiary health care facilities, the study did not meet its stated aims and objectives.

Key words: *Tertiary level health care facility, reproductive health care, women*

ABSTRACT NO. 4

Author(s) : Chirmulay, D.

Title : Factors Affecting Health Seeking and Utilisation of Curative Health Care

Source : BAIF Development and Research Foundation, 1997

Place of study : Gujarat, Maharashtra, Karnataka, Uttar Pradesh and Rajasthan

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, community-based

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

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

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

Findings:

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

No gender-related differences were noted in the morbidity prevalence and pattern of treatment-seeking. Levels of education in the family, caste, affordability (asset holding) and culture were the factors that determined the utilisation pattern. In general, those with better levels of education, those belonging to dominant and higher castes, and those with more assets preferred private practitioners. However, in traditional and cultural strongholds, relatively uniform behaviour was observed across caste and economic groups. Recommendations included improvement of infrastructural facilities at the PHCs, continuing medical education for PHC doctors and ANMs, improving stocks of medicines at PHCs, and a re-evaluation of the links between emoluments and quality of care delivered by medical and para-medical staff. It is suggested that the image of PHC services in the minds of the community be improved. Programmes to improve the economic condition of poor rural households should go hand-in-hand with the development of health infrastructure. This study (and there are many others) indicates that health programmes are far short of meeting reproductive health care needs in every sense.

Reviewer's note:

This study does not tell us much about the formation of focus groups and their profile/composition. It does not pin-point the respondents from each household, and whether the reported morbidity was proxy. Recording the gender of the respondent is very important if it is proxy data. The absence of gender differentials as regards reported morbidity and treatment seeking needs to be seen in this light. Concepts such as culture, which has been treated as an independent variable, is not explained. The suggestion for programmatic inputs to uplift the economic status of poor households is far too broad and general without any concrete suggestions. Recommendations on improving PHC services are not based on data, and there are no data on these aspects presented anywhere in the paper. Also, there is no analysis on the links between utilisation and these factors. The recommendations seem more general than drawn from empirical data.

Key words: *Utilisation of health care services, traditional healers, PHC, private practitioners, socio-economic status, tradition, culture, gender*

ABSTRACT NO. 5

Author(s) : deGraft-Johnson J., A. O. Tsui, B. Buckner, et al.

Title : Uttar Pradesh Male Reproductive Health Survey 1995 - 1996

Source : The EVALUATION Project, Carolina Population Centre, 1997

Place of study : Nainital, Aligarh, Kanpur Nagar, Banda and Gonda, Uttar Pradesh

Location : Rural and urban

Period of study : 1995-96

Type of research : Empirical, descriptive, community-based

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

Methodology : A household survey of 6,727 husbands was conducted. This constituted the second stage of a larger 1995 state-wide survey of health and family planning facilities and households, called PERFORM (Programme Evaluation Review for Organisational Resource Management). The PERFORM Survey, a stratified, multi-stage cluster sample survey, interviewed nearly 45,000 married women of childbearing age in 40,000 households; 2,500 fixed-site service delivery points; 6,350 staffers and 22,000 individual health agents in 28 UP districts. The sample of husbands was selected from men meeting the eligibility criteria of being married, living with the wife and falling between the ages of 15 and 59 in all households selected for the PERFORM survey in these five districts.
The various aspects covered in the study were knowledge of and attitudes toward female reproductive issues; knowledge and use of family planning methods; physical accessibility and quality of family planning services; domestic violence; medical and health expenditure; premarital and extramarital sexual experiences; symptoms of sexual morbidity; gender differences in fertility intention and contraceptive behaviour. The basic analytical categories used were residence (rural/urban), literacy, husband's education, number of children, age of husband, household assets and occupation. For reproductive health services the only aspect covered is family planning services. The survey queried men's cognitive access and physical access to these services.

Findings:

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

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

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

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

Key words: *Reproductive health, knowledge, attitude, practice, prevalence, utilisation*

ABSTRACT NO. 6

Author(s) : Devi, D. R., S. R. Rastogi, and R. D. Rutherford

Title : Eight Million Women Have Unmet Family Planning Needs in Uttar Pradesh

Source : Unknown

Place of study : Uttar Pradesh

Location : Rural and urban

Period of study : 1992-93

Type of research : Empirical, analysis of NFHS data

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

Methodology : Not stated

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

Family planning needs were subdivided into 'need for limiting' and 'need for spacing.' Fifty-five percent of women in UP with unmet family planning needs had an unmet need for limiting while 89 percent had

unmet needs for spacing. The proportion of need for spacing that was unmet was especially high among women living in rural areas with less education, whether they were Hindus, Muslims or scheduled tribes. The proportion of needs for limiting varied sharply by economic status: it was high among women who lived in rural areas, were illiterate, were Muslims or have at least five living children.
The study points out that the Family Welfare Programme has ample scope for reducing the proportion of unmet needs. It also recommends greater emphasis on spacing methods such as pills and condoms, which would be helpful in improving maternal and child health. Because some women prefer to use spacing methods rather than sterilisation to limit their family size, intensified promotion of spacing methods may have the added benefit of reducing the unmet need for limiting.

Key words: *Women, unmet need, family planning*

ABSTRACT NO. 7

Author(s) : Duggal, R., and A. Sucheta

Title : Cost of Health Care: A Household Survey in an Indian District

Source : Foundation for Research in Community Health, 1989

Place of study : Jalgaon, Maharashtra

Location : Rural and urban

Period of study : 1987

Type of research : Empirical, descriptive, community-based

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

Methodology : The household survey was a pilot study conducted in one taluka of Jalgaon district. It was a longitudinal study conducted in three rounds during January to June 1987. Each round covered a recall period of one month in each of the three seasons: winter, summer and monsoon.
For the urban sample, six wards were randomly selected from Jalgaon city. For the rural sample, six villages were randomly selected from Jalgaon taluka. Approximately 590 households were canvassed. In the first round, 582 households responded. This number dropped to 525 in the second round, and 522 in the third round. The investigators tried to ensure that in each round they interviewed the same respondents. The data from the three rounds were pooled for analysis.
For the purposes of analysis, a household-level variable called 'class' was created. The class of a household was determined on the basis of the landholding of the main earner, the per capita consumption, and the

educational level of its members. Both prevalence and incidence of illnesses had been estimated. Incidence refers only to episodes of illness that started in the reference period, whereas prevalence refers to all episodes that existed during the reference period, without regard to when they began.

Findings:

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

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

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

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

Key words: *Household health expenditure, health care utilisation, illness, prevalence, incidence*

ABSTRACT NO. 8

Author(s) : Gupta, R. B., A. Pulikkal, and S. Kurup

Title : Unmet Health Needs and Paying Capacity of the Community in Sidhpur Area: A Focus Group-Based Case Study

Source : The Journal of Family Welfare, 1995

Place of study : Sidhpur area, Gujarat

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

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

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

Reviewer's note:

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

Key words: *Health care system, utilisation, awareness, sustainable health care system, paying capacity, focus group*

ABSTRACT NO. 9

Author(s) : George, A., I. Shah, and S. Nandraj

Title : A Study of Household Health Expenditure in Madhya Pradesh

Source : Foundation for Research in Community Health, 1994

Place of study : Sagar and Morena, Madhya Pradesh

Location : Rural and urban

Period of study : 1991

Type of research : Empirical, descriptive, community-based

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

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

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

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

Findings:

The prevalence rate of morbidity during the monsoon was 365 and 256 during winter. The incidence rate was 195 in the monsoon and 108 in winter. Urban areas registered an originally higher prevalence rate than rural areas, especially for acute diseases. In rural areas, prevalence was lowest in places that were further away from health facilities. Prevalence was lowest in the two lower classes, and highest in the two upper classes. Higher classes reported greater prevalence of ailments of the nervous and cardiovascular system. Except for the age group 25-44, in all other age groups, male morbidity was higher than female.

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

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

Key words: *Household, utilisation, expenditure, health care, prevalence*

ABSTRACT NO. 10

Author(s) : Hitesh, J.

Title : Perceptions and constraints of pregnancy related referrals in rural Rajasthan

Source : The Journal of Family Welfare, 1996

Place of study : Dausa, Rajasthan

Location : Rural

Period of study : 1993

Type of research : Empirical, descriptive, community-based

Aims and objectives : To understand the constraints of pregnancy-related referrals.

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

Findings:

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

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

Key words: *Utilisation, referral services, determinants*

ABSTRACT NO. 11

Author(s) : International Institute of Population Sciences (IIPS)

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

Source : Summary Report, India, NFHS, IIPS, 1995

Place of study : Nation-wide

Location : Rural and urban

Period of study : 1992-93

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

The infant mortality rate was 52 percent higher in rural areas than in urban areas. The infant mortality rate declined sharply with increasing education, ranging from a high rate of 101/1,000 live births for illiterate women to a low of 37/1,000 live births for women with at least a high school education. The maternal mortality rate was estimated to be 437 maternal deaths per 100,000 live births. Only 35 percent of children aged 12-13 months were fully vaccinated, indicating the need for substantial improvement in the vaccination coverage. Ten percent of children under age four were ill with diarrhoea. Most mothers were not aware of ORS, indicating the need to pay attention to the prevention and treatment of diarrhoea. Inadequate nutrition continues to pose a serious problem. Data show that there is a need to expand nutritional programmes to cover infants and very young children. Educational attainment showed a strong association with every important variable considered in the NFHS. Data show a sex ratio unfavourable to females, lower female literacy, lower school attendance rate for girls aged 6-14, low level of female employment, relatively low female age at marriage, higher female post-neonatal and child mortality rates, lower immunisation coverage for females, less medical care for female children and preference for sons. All these offer evidence of discrimination against females. These are therefore the areas that need to be addressed in all social development programmes.

Questions regarding knowledge of AIDS, asked in 13 of the 25 NFHS states, indicate that in most states

a large majority of ever-married women had never heard of the disease. The findings thus provide a clear indication of the challenges ahead for organisations working in the area of AIDS in providing even the most basic information about AIDS and ways to prevent the spread of the disease.
The data reveal that there were considerable variations across states and communities in all the socio-economic, demographic and health parameters. The data on various indicators show that India had experienced a considerable reduction in crude birth and crude death rates. However, substantial efforts are required to reduce infant and child mortality. India is doing poorly in the provision and utilisation of health care services, including antenatal and intranatal care and immunisation services.

Key words: *Prevalence, illness, treatment, gender, women, infant mortality, maternal mortality, status of outreach health services*

ABSTRACT NO. 12

Author(s) : Kambo, I. P., R. N. Gupta, A. S. Kundu, et al.

Title : Use of Traditional Medical Practitioners to Deliver Family Planning Services in Uttar Pradesh

Source : Studies in Family Planning, 1994

Place of study : Muzaffarnagar, Uttar Pradesh

Location : Rural

Period of study : 1984-87

Type of research : Empirical, descriptive, community-based

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

Methodology : One PHC block in each intervention and non-intervention area was selected. The two blocks selected were matched with respect to a few key variables, such as number of villages, population size, number of households, eligible couples, traditional medical practitioners, family planning performance of primary health centres and proximity to district headquarters. The sample size consisted of 37 villages and 22 traditional practitioners. The baseline and follow-up (cross-sectional) survey enrolled about 1,850 women in both areas.
The intervention consisted of training 22 practitioners for 11 days. The training emphasised motivational and counselling skills and the use of the cafeteria approach. A comparison of the pre- and post-training questionnaires revealed a substantial improvement in the knowledge of the trainees. Practitioners received a monthly honorarium of Rs. 50. There was no formal mechanism for supervising the intervention. However, the informal monthly meetings between the concerned PHC and

district health officials, the practitioners and the project investigators, provided a forum for interaction and discussion, replenishing of stocks and monitoring of records. The meetings also provided opportunities for continuous education.

Findings:

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

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

Key words: *Traditional practitioner, spacing method, family planning services, male involvement*

ABSTRACT NO. 13

Author(s) : Kannan, K. P., K. R. Thankappan, V. R. Kutty, et al.

Title : Health and Development in Rural Kerala

Source : Kerala Sastra Sahitya Parishad (KSSP), 1991

Place of study : Kerala

Location : Rural

Period of study : 1987

Type of research : Empirical, descriptive, community and health centre-based

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

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

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

Findings:

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

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

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

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

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

Key words: *Prevalence, morbidity, cost, treatment, gender*

ABSTRACT NO. 14

Author(s) : Kanitkar, S.

Title : Abortion for Family Planning: Attitude of Housewives of Low Income Group Towards Abortion for Family Planning

Source : Unpublished

Place of study : Pune, Maharashtra

Location : Urban

Period of study : Not specified

Type of research : Empirical, descriptive, health centre-based

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

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

Findings:

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

Key words: *MTP, family planning*

ABSTRACT NO. 15

Author(s) : Kavitha, N., and N. Audinarayana

Title : Utilisation and Determinants of Selected MCH Care Services in Rural Areas of Tamil Nadu

Source : Health and Population - Perspectives and Issues, 1997

Place of study : Coimbatore, Tamil Nadu

Location : Rural

Period of study : 1995

Type of research : Empirical, descriptive, community-based

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

Methodology : The sample consisted of 134 currently married women with at least one living child less than four years of age from two villages/districts. Information was gathered on 172 live-born and currently living children. Data on still births and children who died before the date of the survey were not collected, so that women did not get emotional and affect the quality of the response and also the overall response rate.
Caste, respondent's education, spouse's education, respondent's work status, monthly family income, exposure to mass media and number of living children were treated as explanatory variables. Logic regression coefficients were estimated with 't' values. Also, probabilities were estimated for each of the dependent variables.

Findings:

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

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

Reviewer's note:

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

Key words: *MCH, utilisation, socio-economic determinants, exposure to mass media*

ABSTRACT NO. 16

Author(s) : Khan, A. G., N. Roy, and S. Surender

Title : Utilisation of Reproductive Health Services in Rural Maharashtra

Source : The Journal of Family Welfare, 1997

Place of study : Chandrapur, Maharashtra

Location : Rural

Period of study : 1991

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

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

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

Reviewer's note:

'Reproductive health' is not defined anywhere in the study.

Key words: *Reproductive health services, utilisation, users, non-users, associated factors*

ABSTRACT NO. 17

Author(s) : Khandekar, J., S. Dwivedi, M. Bhattacharya, et al.

Title : Childbirth Practices among Women in Slum Areas

Source : The Journal of Family Welfare, 1993

Place of study : Allahabad, Uttar Pradesh

Location : Urban

Period of study : 1989-91

Type of research : Empirical, descriptive, health centre-based

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

Methodology : Thirty-five centres were chosen randomly out of a total of 100 centres. Each centre caters to an approximate population of 1,000. All of the pregnant women registered at the selected Anganwadi centres during the course of one year formed the study population. In all, there were 661 women. Each Anganwadi centre was visited on a fixed date every month to interview mothers who registered at the centre during each month.
A pre-tested schedule was administered. A detailed history of past illnesses including obstetric problems, family history of diseases, information about tetanus toxoid immunisation during the antenatal period, and childbirth practices including the type of instruments used at the time of delivery were obtained.

Findings:
All of the women were permanent residents of the area and were mostly from the lower socio-economic group. Women undergoing their second or third delivery utilised these services the least. More primiparas as compared to others had been immunised. Almost two-fifths of the women had delivered at home while the rest utilised public or private hospitals. Untrained personnel, irrespective of parity, conducted the majority of the births. Those who used trained persons for delivery were by and large primiparas. Awareness of the pregnant woman and the need for trained birth assistance were greater among women with educated husbands. Among the deliveries assisted by trained personnel, the perinatal mortality rate was 67.4 per 1,000 live births. It was 154.8 per 1,000 live births in the case of untrained assistance.
The majority of the slum-dwellers surveyed had no faith in hospitals. They preferred to trust the untrained dai who belonged to the same socio-cultural milieu. The unhygienic practices of untrained persons were attributed to ignorance, illiteracy and lack of education of the dais and family members. The complications occurring during delivery clearly show the inability of untrained persons to identify 'high-risk' mothers.
In conclusion the authors stated that untrained dais play an important role in the provision of natal care in urban slums. It is essential to train them to make these services acceptable and safe.

Key words: *Natal care, untrained dais, training, urban slums*

ABSTRACT NO. 18

Author(s) : Madhiwalla, N., S. Nandraj, and R. Sinha

Title : Health, Households and Women's Lives: A Study of Illness and Childbearing among Women in Nasik District, Maharashtra

Source	:	Centre for Enquiry into Health and Allied Themes, 2000
Place of study	:	Nasik, Maharashtra
Location	:	Rural and urban
Period of study	:	1996
Type of research	:	Empirical, descriptive, community-based
Aims and objectives	:	To assess patterns in morbidity as reported with and without probing, utilisation of health facilities and expenditure on health care among women in rural and urban Nasik district.
Methodology	:	Nasik district was selected for the study because it is an typically developed district as far as the socio-economic and demographic profile of the rest of the state is concerned. Within the selected district, Igatpuri taluka was selected for its sizeable tribal and non-tribal population. The rural sample consisted of 903 households from Igatpuri taluka, while the urban sample consisted of 382 households from Nasik town. In all, data were collected for 3,581 women and 3,631 men. Only women investigators were used, and only women respondents were interviewed. A list of 14 questions probing specific symptoms was administered to collect information on indications of illness among the women that might not otherwise be reported. Since multiple symptoms could be indicative of the same illness episode, the researchers devised a method of constructing episodes on the basis of up to three symptoms, as well as the duration and perceived causes of the symptoms, and the link of a symptom to a life event. The reference period for questions on morbidity was one month prior to the interview.

Findings:

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

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

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

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

Type of health care facility used: In rural areas, 24.2 percent of all facilities used and 30.3 percent of the formal facilities used by rural women were government facilities or home-based care provided by

government paramedics. In urban areas, 10 percent of the total facilities and 17.3 percent of formal facilities used were public sector services. Certain types of illnesses, such as aches/pains, injuries, weakness and problems of the sensory organs were mostly treated in the informal sector. Other illnesses such as fevers and gastrointestinal infections were treated mostly in the formal sector. Health care utilisation was related to the nature of the illness. Long-term illnesses were not treated as frequently as short-term infectious illnesses.

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

The expenditure on health care showed trends corresponding to the utilisation of health care. Expenditure per episode, per capita and per facility in the rural areas was higher than urban areas. Among the components of expenditure, doctor's fees, the cost of medicines and injections comprised the major part of outpatient expenditure. There was a considerable difference in the expenditure incurred on men and women in each facility.

The findings on maternity events and contraception revealed the low access to health care for rural women. Untrained personnel conducted around 70 percent of the deliveries in rural areas and 33 percent in urban areas. Only 38 percent of the deliveries were followed by postnatal care; the percentage was higher in urban areas as compared to rural areas. Public centres were primarily used for postnatal care due to immunisation facilities. Contraceptive services were overwhelmingly accessed from the public sector, except for medical shops where oral contraceptive pills were bought.

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

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

Key words: *Prevalence, illness, cost, treatment, gender, women, utilisation, expenditure*

ABSTRACT NO. 19

Author(s) : Mondal, A.

Title : Non-use, Unsatisfactory Use and Satisfactory Use of Contraceptives

Source : Journal of Obstetrics and Gynaecology, 1992

Place of study : West Bengal

Location : Rural

Period of study : 1989-90

Type of research : Empirical, descriptive, community-based

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

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

Findings:

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

Reviewer's note:

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

Key words: *Contraceptives, users, non-users, socio-cultural context*

ABSTRACT NO. 20

Author(s) : Nanda P., and R. Baru

Title : Private Nursing Homes and Their Utilisation: A Case Study of Delhi

Source : Health for the Millions, 1994

Place of study : Delhi

Location : Urban

Period of study : Not specified

Type of research : Empirical, descriptive, health centre-based

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

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

Findings:

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

On average, consultant doctors were paid a salary between Rs. 3,000-5,000; nurses were paid between Rs. 1,000-1,700; technical staff Rs. 900-1,200 and ayahs Rs. 500-800. All employed at least one consultant doctor. In most husband-wife teams, the women doctors were found to be gynaecologists. According to the doctors, there was a high turnover of nurses because they are often lured away by better salaries. The 'A' grade nurses prefer the public sector because of job security and other benefits. The majority of the owners ranked 'outpatient services' as the area of highest return, the second being 'maternity services' and the third general surgery and investigative facilities. The areas of return varied according to the size of nursing homes.Nearly 98 percent of the nursing homes offered outpatient services, maternity and general surgery. Seventy-five percent had ultrasound facilities and 63 percent had X-ray, ECG, EEG facilities. Close to 50 percent of the large nursing homes had scans. The larger the size of the nursing home, the greater the chances of an attached pharmacy.

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

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

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

Key words: *Private health care facilities, human power, choice of provider, determinants, utilisation, quality of care*

ABSTRACT NO. 21

Author(s) : Nandraj, S., N. Madhiwalla, R. Sinha, et al.

Title : Women and Health Care in Mumbai: A Study of Morbidity, Utilisation and Expenditure on Health Care in the Households of the Metropolis

Source : Centre for Enquiry into Health and Allied Themes, 1998

Place of study : Mumbai, Maharashtra

Location : Urban

Period of study : 1994

Type of research : Empirical, descriptive, community-based

Aims and objectives : To document and analyse perceived morbidity patterns, constraints of women in accessing health care facilities and their utilisation, and patterns of expenditure on women's health.

Methodology : The study was conducted in the L ward of Greater Mumbai city, a congested pocket with residential units as well as small-scale factories and commercial establishments, poor sanitation, insufficient water supply, acute noise and air pollution. The majority of the population consisted of migrant labourers and entrepreneurs. The survey was conducted in five clusters: two slums, two chawls and one apartment block. The selection of the clusters was on the basis of their 'class character.' The predetermined sample size was 425. House listings were done in the identified clusters. Households were identified for survey through systematic sampling. In all, 430 households were covered in the study.

The data were collected through interview schedules. Since women were the focus of the study, female investigators conducted the interviews, and the respondents were all women. A 'probe list' (a list of 14 symptoms) was used to probe the existence of specific symptoms among women that might otherwise go unreported. Each symptom reported after probing was recorded as an independent episode. During the survey a conducive environment was created that would encourage women to feel unhindered to speak about their health problems.

Findings:

The monthly prevalence rate for males was 169 per 1,000 as compared to 571 per 1,000 for females after probing. Reproductive illness accounted for 28.2 percent of all episodes among females, the majority of them being related to menstruation and childbearing. The findings point to a strong relationship between women's work lives and their health. After probing, women had a higher morbidity rate than men across all age groups. Slum-dwellers suffered higher morbidity than non-slum-dwellers in each age group, gender group and occupation group.

Of the total illness episodes, 32.5 percent were not treated. For 85 percent of the illness episodes, private facilities were used. For deliveries, the public sector accounted for only 30 percent, as compared to the private sector that accounted for 31.7 percent. All of the three abortions reported utilised private facilities. Only 38 percent of the total contraception users used public facilities. There was a wide disparity in the utilisation of public health facilities at different levels. Tertiary hospitals were overloaded, and the first referral systems, such as health posts, were under-utilised. Utilisation of the formal health sector was lower among women than men.

Access to health care facilities in terms of distance and who provided health care were major factors that influenced utilisation. In the case of nearly two-thirds of the illness episodes, health facilities less than 10 minutes distance from home were approached.
Among women, fevers, respiratory and gastrointestinal illnesses were treated more than reproductive illnesses. Unwell men received equal treatment irrespective of age; whereas, among women, those in the age-group of 0-11 years have a higher number of treated illnesses. The study doesn't show any direct impact of education on health-seeking behaviour.
The most common reason given for non-treatment of an illness was that the illness was not serious enough to be treated. Financial constraints were also an important reason for non-treatment, more so for women than for men.
Expenditure on women's health care was lower than on males. For those illnesses that were reported only after probing, expenditure was generally lower than for the other illnesses.
The findings of the study raise the issue of non-utilisation of health services, especially by women, both for deliveries and other illnesses, even in a metropolitan city like Mumbai, which has better public health facilities as compared to other parts of the country.

Key words: *Prevalence, morbidity, utilisation, expenditure, women, gender differentials*

ABSTRACT NO. 22

Author(s)	:	National Council for Applied Economic Research (NCAER)
Title	:	Household Survey of Medical Care
Source	:	NCAER, New Delhi, 1992
Place of study	:	Nation-wide (Major States and Union Territories)
Location	:	Rural and urban
Period of study	:	1990
Type of research	:	Empirical, descriptive, community-based
Aims and objectives	:	To study the nature and type of illnesses suffered by family members, the system of medicine used and their perceptions of the efficacy of the systems used.
Methodology	:	The study was based on an All-India survey that covered both rural and urban areas in all States and Union Territories except Manipur, Nagaland, Sikkim, Tripura, Arunachal Pradesh, Andaman and Nicobar islands, Dadra Nagar Haveli, Lakshadeep and Mizoram. In all, 371 districts were covered. The sample was a multi-stage stratified sample. For the rural sample, two to five villages per district were selected, with a probability of selection equal to the proportion of the population of that village in the district population. In all, 1,061 villages were selected. All of the households in the village were listed and then classified according to level of income. Households were then randomly selected from each income slab. For the urban sample, all 41 cities of the country with a population of

above 500,000 were included. The remaining cities/towns were classified into five strata on the basis of population size, and a random sample was taken from each stratum. The 632 cities and towns selected covered 61 percent of the total urban population. A sample of blocks was selected from each sample town depending on the size of the town. A total of 1,873 blocks were selected. The blocks were selected independently for each town with equal probability. All households in the selected block were listed, and households were randomly selected from each income slab.

Findings:

Morbidity pattern: The prevalence rate of treated illnesses for the country as a whole was found to be 67.70 episodes in urban areas and 79.06 illness episodes in rural areas per 1,000 population. Some of the states that reported a higher rate of illness than the all-India average were Assam, Jammu and Kashmir, Kerala, Meghalaya and Pondicherry. In almost all of the states the reported prevalence rate of illness for which treatment was sought worked out lower for the females than males for both adults and children up to the age of 14 years. This sex differential in morbidity probably showed the extent of under-reporting of illness by females and lack of medical attention during illness.

In almost all the states the prevalence rate declined from the low- to the high-income category, thus suggesting that people belonging to the lower-income group were more susceptible to various illnesses, perhaps due to poor living conditions and lower nutritional status.

Type of morbidity: Fever was the most common ailment treated, followed by illness due to respiratory and gastrointestinal infections. There was not much difference in the pattern of illness by place of residence (rural and urban).

System of medical treatment received: Eighty percent of the illness episodes in the urban areas and 75 percent of the cases in rural areas were treated under the allopathic system of medicine. The percentage of cases for which allopathic treatment was sought was slightly higher in high-income households, especially in rural areas. Compared to other systems of medical care, people perceive the allopathic system to be more effective. Nearly 60 percent of the cases treated by the allopathic system of the households felt that the treatment was fully effective. A surprising finding was that in a large number of cases (75 percent in urban and 65 percent in rural) where the households resorted to only self-medication they expressed a feeling that the treatment was fully effective. The possible explanation of this finding could be that self-medication was resorted to only for minor treatments. In a small proportion of cases, the households felt that 'rituals' were fully effective.

Type of health care facility: In 55 percent of illness episodes treatment was sought from private facilities. For 33 to 39 percent of cases treatment was sought from government facilities. There were wide variations across states regarding the type of health care facility utilised. With the increase in the income level of households the dependence on state health care decreased in both rural as well as urban areas. The study shows the preference for private doctors in case of minor ailments. The primary health centres and sub-centres catered to 8.2 percent of the cases in rural areas.

Regarding physical accessibility to health care facilities, the study found that people residing in rural areas had to travel longer distances as compared to their urban counterparts. This increased the average cost of treatment of illnesses. For 54.6 percent of cases in Meghalaya and 33.5 percent of cases in Orissa, people had to travel more than 10 kilometers to seek treatment.

Household expenditure on health care: In urban areas the average cost of treating each illness episode was Rs. 142.60 as compared to Rs. 151.81 for rural areas. The study revealed a gender preference in favour of males in the treatment of illness episodes. This gender discrimination was more prominent in the urban areas of Haryana, Karnataka, Meghalaya, Orissa, Punjab and Tamil Nadu and in rural areas of Punjab and Rajasthan. The average expenditure of treatment was high under the allopathic system followed by the homeopathic system of medicine. The study also provides average expenditure by types of diseases. The data showed that urban households spend a lot in treating accident cases, whereas in rural areas the average expenditure on treatment of degenerative diseases was as high as Rs. 776.23. The average expenditure on treating respiratory illnesses was quite low in both rural and urban areas.

Key words: *Prevalence, morbidity, health care, utilisation, out-of-pocket expenditure*

ABSTRACT NO. 23

Author(s) : National Sample Survey Organisation (NSSO)

Title : NSS 42nd Round (1986-87); NSS 52nd Round (1995-96)

Source : Department of Statistics, Government of India, 1992 and 1998

Place of study : Nation-wide (Major States and Union Territories)

Location : Rural and urban

Period of study : 1986-87; 1995-96

Type of research : Empirical, descriptive, community-based

Aims and objectives : *42nd Round*: To make an assessment of utilisation of medical services.
52nd Round: To study the curative aspects of the general health care system in the country and mother and child health care programmes. To study the morbidity profile of the population.

Methodology : The NSS surveys are carried out in successive 'rounds.' Each round is of approximately one-year duration. Questions on morbidity were first asked in the seventh round of the NSS in 1953-54. Subsequently three other surveys included morbidity as a topic. Thereafter, surveys on social consumption and morbidity were conducted in the 42nd round (1986-87), and in the 52nd round (1995-96).
Much of the data had been collected from proxy respondents, which might understate the actual level of morbidity. The tools for data collection were modified in the 52nd round to collect variations in responses and avoid mis-reporting.
The NSS 42nd round: The survey covered the whole of India except for a few areas of Jammu and Kashmir and Nagaland. A two-stage stratified sampling design was adopted. In the first stage villages and blocks were selected in rural and urban areas respectively, and in the second stage households were selected. The sample villages were selected with probability proportional to population with replacement in the form of two independent inter-penetrating sub-samples (IIPNS). The sample blocks were selected by simple random sampling without replacement in the form of IIPNS. The survey was conducted in a sample of 8,346 villages and 4,568 urban blocks. Two households from each village/block were selected through stratified random sampling.
The NSS 52nd round: The survey covered the whole of India except for a few interior areas of Jammu and Kashmir, Nagaland and the Andaman and Nicobar Islands. A two-stage stratified sampling design was adopted. The census villages and urban blocks were selected for rural and urban areas respectively as the first stage and in the second stage the households were selected. The survey was conducted in a sample of 7,663 villages and 4,991 urban blocks. Ten households from each village/block were selected through stratified random sampling. In the 52nd round, an equal probability sampling scheme for villages was used, instead of the usual NSS practice of selecting villages with a probability proportional to their population.
The data were collected through household interviews. As far as possible,

all adult male members of the household were interviewed. Probes were used to gather information about the illnesses that might have occurred in the household. The recall period used was 15 days.

Findings:

The NSS 42nd round: The prevalence rate of hospitalisation was 28 per 1,000 persons in rural areas and 17 per 1,000 persons in urban areas. The male-female ratio among hospitalised persons was about 56:44, both in the rural and urban sectors. The preference for treatment as an inpatient in a public hospital over other types of hospitals was observed in most of the states except Andhra Pradesh, rural Kerala, Maharashtra and rural Punjab, where private hospitals were given preference. The data reveal that the allopathic system of medicine was used in more than 98 percent of hospitalised cases in both rural and urban areas. At the national level, the percentages of hospitalised cases under the 'no payment' and 'employers' medical welfare scheme' categories were observed to be 23 and 6 respectively in the rural sector as opposed to 20 and 13 in the urban sector. The average payment made to government hospitals was Rs. 320 per case compared to Rs. 733 for private hospitals in the rural sector. The corresponding figures for the urban sector were Rs. 385 and Rs. 1,206 respectively.

The study observed that the number of days spent in government hospitals was more than in private hospitals for both the rural and urban sectors of India. The average number of days spent in hospital per hospitalised person was about 16 and 15 days, respectively, in rural and urban areas. The average total expenditure was Rs. 853 in rural areas compared to Rs. 1,183 in urban areas. The average payment to hospital or total expenditure per hospitalised case varied considerably over the type of hospital, type of ward and also over the rural and urban sectors of states.

The proportion of ailing persons in the rural sector was higher than in the urban sector of the country. The proportion of persons with ailments treated was found higher among males than females in the bottom expenditure groups, while a reverse pattern was observed in the higher expenditure groups.

In rural India, about 53 percent of treatment was from private doctors while public hospitals and private hospitals accounted for 18 percent and 15 percent, respectively. The corresponding percentages for urban India were 52, 23 and 16, respectively. The allopathic system of medicine was used to treat 96 percent of cases in both urban and rural areas. At the national level the average duration of sickness treated was nearly the same irrespective of the type of institution or the place of residence.

In rural areas the major causes for not seeking treatment were: the ailments were not considered serious (75 percent), financial difficulties (15 percent) and no medical facility (3 percent). In urban areas the major causes for not seeking treatment were: the ailments were not considered serious (81 percent), financial difficulties (10 percent) and no medical facility (less than 1 percent).

The NSS 52nd round: The data show that the gender-specific estimated proportion of ailing person (PAP) for acute ailments was about three times as high as that for chronic ailments. For both rural and urban areas, age-specific PAPs for acute ailments showed a distinct U-pattern and positively sloped pattern for chronic ailments. The data show that people aged 60 years and above were more prone to ailments.

There was no significant difference between rural and urban areas as far as ailing persons reporting commencement (PPC) was concerned. This may be due to a higher level of health consciousness in urban areas as compared to rural households with the same level of morbidity leading to higher illness reporting. The data show large interstate and intrastate variations in PAP and PPC.

An analysis of data from Kerala shows that, contrary to popular perception, the level of morbidity is relatively high. One of the reasons for this may be that with better health care facilities in the state, there is a large proportion of the population aged 60 years or more (9.4 percent) and this segment is more prone to illness.

In order to establish a relationship between the level of health consciousness and reporting of morbidity, IMR had been taken as a broad indicator of health consciousness. The data show a very interesting phenomenon: IMRs and PAPs for rural areas of Kerala, Punjab and Madhya Pradesh show a negative relationship between IMR and morbidity-reporting, contrary to data on rural areas of Bihar, Assam, Rajasthan, Orissa and Uttar Pradesh.

A positive association between monthly per capita consumption expenditure (MPCE) and PAP, in both rural and urban areas was observed. The range of variations in PAP was larger in rural areas as compared to urban areas. The level of morbidity increased with a rise in the standard of living. This may

be due to the fact that the reporting of morbidity improves with improvement in the conditions of living. The urban morbidity rates were higher than the comparable estimates of the 28th and 42nd rounds. The observed differences may be due to different methodologies used to collect the data over this period. The data on disease-specific morbidity were collected on the basis of self-perceived morbidity, though this method of collecting information is highly questionable. The data showed a rise in accident-related morbidity, especially in urban areas. A declining trend for chronic diseases was observed.

The survey shows that the percentage of ailing persons treated was higher in urban areas as compared to rural areas. The percentage of untreated ailing persons varied from 26 percent in the lowest income group to 10 percent in the highest expenditure group in rural areas. In urban areas it was 9 percent and 19 percent, respectively. The survey also examined reasons for not seeking treatment. The most prominent cause was not perceiving the illness as severe, followed by financial constraints. The survey found that the private sector was used more in cases of non-hospitalised treatment. The comparison between the 42nd and 52nd round shows that there was a significant increase in utilisation of the private sector in between the two rounds. There existed a wide interstate variation in percentage of treated ailments as well as use of government sources for treating ailments. Utilisation of public health care facilities for treatment was found to be among the lowest in Punjab, Haryana and rural Uttar Pradesh. It was reported to be highest in rural Orissa and Rajasthan.

During the period 1995-96, about 2 percent of the urban population and 1.3 percent of the rural population was hospitalised at any time during the reference period. The data did not show any significant gender differential in either area.

The estimates showed a strong positive association between average MPCE and the rate of hospitalisation in both rural and urban areas. There were wide interstate variations in the rate of hospitalisation. The survey shows that charitable institutions also played an important role in providing hospitalised treatment. But still, PHCs and CHCs accounted for a higher proportion of hospitalised treatment than charitable institutions in rural areas. There was also a great interstate variation regarding reliance on the public sector for hospitalised treatment. The proportion (per 1,000) of hospitalised treatment received from public sector hospitals varied from 225 in rural Andhra Pradesh to 906 in rural Orissa.

Cost of treatment: The data show that in rural areas Rs. 151 was spent on an average on every episode of non-hospitalised treatment per ailment by a male, as compared to Rs. 137 in case of females. The figures for urban areas were Rs. 187 and Rs. 164, respectively. For hospitalised ailments, Rs. 3,778 was spent on an average on every episode by a male in rural areas as compared to Rs. 2,510 in case of females. The figures for urban areas were Rs. 4,185 and Rs. 3,625, respectively. This shows the presence of gender discrimination as regards expenses incurred per ailment though estimates on the proportion of ailing persons treated did not reflect any perceptible difference between male and female populations of either rural or urban areas.

Key words: *Prevalence, morbidity, health care, utilisation, out-of-pocket expenditure*

ABSTRACT NO. 24

Author(s) : Rajaretnam, T., and R. V. Deshpande

Title : Factors Inhibiting the Use of Reversible Contraceptive Methods in Rural South India

Source : Studies in Family Planning, 1994

Place of study : Belgaum and Gulbarga, Karnataka

Location : Rural

Period of study : 1990

Type of research : Empirical, descriptive, health centre and community-based

Aims and objectives : To assess the perceptions and experiences of programme personnel, from the district level to the grassroots level, on popularising reversible methods of family planning in rural areas; to understand the extent of community leaders' knowledge of reversible methods and their perceptions regarding the couples accepting them; and to study the knowledge and attitudes of couples towards reversible methods.

Methodology : The study was undertaken in two districts. Each district had two sub-divisions with 10-15 PHCs under each sub-division. From each sub-division one PHC was selected at random. From each of the selected PHCs, a further three sub-centres were selected in such a way that one was the PHC headquarter and the other two fell under different primary health units of the same PHC. All villages covered by these sub-centres were selected as the study area. In all, 43 villages were covered in the survey. The study proposed to select 1,000 households proportionately from the selected villages by a systematic cluster sampling technique. Altogether, 998 households were covered, from which 995 currently married women (15-44 years) were listed. From these, 815 (82 percent) women and 136 husbands (from the targeted number of 200) could be interviewed.

Of programme personnel, all of the available divisional joint directors and district health officers of both the districts were interviewed. At the PHC level, all of the available medical officers and the male and female senior health assistants of the six selected PHCs were interviewed. Similarly, at the sub-centre, all of the available junior health assistants were interviewed. In all, one divisional joint director and three district health officers, six medical officers, five senior health assistants and 20 junior health assistants were interviewed. For the coverage of community leaders, a maximum of three of the most influential leaders were identified from each village by interviewing a sample of currently married women, their husbands, shopkeepers and so forth.

Findings:

Family planning practice: The data show that the practice of family planning was limited to sterilisation methods and that women accept early sterilisation, but usually after having three living children. CPR due to both reversible and permanent methods was 40.6 percent for women interviewed in the study area; whereas, the CPR based on the husbands' interview was 41.2 percent. Contraceptive users had an average of 3.9 living children, while non-users had 1.9 living children. About 38 percent of the women had given birth to their first child within two years of consummation of marriage. The majority of the non-users had short open birth intervals (less than two years).

Perception of programme personnel: The officers interviewed indicated that they had not made attempts to ensure better performance for reversible methods in their areas, nor did they suggest strategies to popularise the methods. The study indicates the need to motivate middle-level managers to make efforts to popularise reversible methods. Health workers and supervisors were not interested in motivating the use of reversible methods. This has led to ignorance and thus non-use at the couple level. The study findings suggest the need for commitment of programme managers at all levels, training of supervisors and health workers to motivate couples and provision of adequate services at clinics.

Perception of community leaders: Virtually all of the community leaders knew about terminal methods,

but only 73-90 percent knew about reversible methods after probing. About one-fourth of the leaders did not know of service sources for reversible methods, and the majority did not know that field workers were distributing contraceptives. Government health facilities were cited as the major source of contraceptive methods. The leaders felt that reversible methods were unpopular because they were not well-known, because people thought they had undesirable side-effects or high failure rates, and because people thought they were inconvenient to use. When asked how to improve the FPP, the suggestions made were providing incentives, regular visits by health workers and easy access to service outlets.

Perception of the community: The majority of the respondents were aware of the benefits of a longer interval but few were able to achieve it. Knowledge about service outlets for permanent methods was almost universal. Private institutions were mentioned more often as service outlets for reversible methods. The main reason for not using contraceptives was the desire for more children. And 18 percent specifically stated that they wanted male children. The major reasons for the unpopularity of reversible methods were their side-effects and failure rates.

At the end, three suggestions were made to popularise reversible methods in rural areas: 1) a strong commitment from programme managers at all levels; 2) proper direction and training of field workers to enable them to educate and motivate couples to use reversible methods; and 3) provision of adequate services at clinics and in villages.

Key words: *Reversible contraceptives, perceptions, knowledge, programme personnel, contraceptive methods, community leaders, community*

ABSTRACT NO. 25

Author(s) : Rajeshwari

Title : Gender Bias in Utilisation of Health Care Facilities in Rural Haryana

Source : Economic and Political Weekly, 1996

Place of study : Bhiwani and Kurukshetra, Haryana

Location : Rural

Period of study : 1991

Type of research : Empirical, analytical, community-based

Aims and objectives : To examine the spatial variations in gender bias in the use of public health care facilities (PHCFs) and in relation to the economic development of an area.

Methodology : Two districts from the state were selected and from each district two tehsils were selected based on the provision of public health care infrastucture. In each of these tehsils, two villages were selected: one with a public health care facility and the other 5-10 kilometres away from such a facility. Thus there were four villages with PHCs and the other four with no PHCs. In all, 389 households spread over eight villages were studied. Utilisation was considered with reference to preventive (infant's

immunisation, antenatal care, care during childbirth) and curative care (level of medical intervention in case of ailment). Availability of public health care facilities, occupational category as proxy of economic status of the household and educational status of the head of the household were examined as determinants of health care utilisation.

Findings:

The study shows that the availability of public health care facilities at the place of residence had a positive impact on women's health status when the comparison was made between the PHC and non-PHC villages. The data reveal that infant and child mortality was highest where there was no medical facility and trained birth attendance. The study concludes that the level of female health care is positively affected by economic development and the gender disparity is reduced with the overall economic development of an area.

The economic status of the household showed an association with women's health care where public health care facilities were not located nearby. The educational status of the head of the household emerged as an important factor that had a positive effect on women's health care (both preventive and curative) in PHC and non-PHC villages.

The author suggested that the provision of public health care facilities at the place of habitation coupled with increased educational status or awareness of various health care programmes would reduce the selective bias against women.

Reviewer's note:

More details on the tools of data collection and the basic profile of the respondents would have been useful. Also, it is not clear whether the data were proxy.

Key words: *Utilisation, public health care facilities (PHCF), gender, economic status*

ABSTRACT NO. 26

Author(s)	:	Ram, K.
Title	:	Medical Management and Giving Birth: Responses of Coastal Women in Tamil Nadu
Source	:	Reproductive Health Matters, 1994
Place of study	:	Kanyakumari, Tamil Nadu
Location	:	Rural
Period of study	:	Not specified
Type of research	:	Empirical, descriptive, community-based
Aims and objectives	:	To present the experience of maternity among lower-caste Mukkuwar women and their responses to modern medical management of pregnancy and birth
Methodology	:	An ethnographic approach was used to study maternity practices among lower-caste Mukkuwar women.

Findings:
The study argues that a woman's decision on whether or not to seek medical care during pregnancy and where to give birth, is influenced by class and caste. The article highlights various causes for the non-utilisation of modern medicine during delivery: prolonged stay during delivery disrupting their daily activities, caste distance between the provider and the user creates a power hierarchy, treatment by the hospital staff during delivery is harsh, and unnecessary medical interventions.
From their perspective as fisher-women, the older forms of hierarchy were simply mapped onto newer versions, with high-caste intolerance of impurity, pollution and lack of learning transposed into the idiom of hygiene, rationality and medical science. Despite prolonged exposure to reforms and interventions, women still derive their fundamental ideas of femininity and maternity from more archaic religious and regional cultural currents.

Key Words: *Perception, coastal women, medical management, maternity*

ABSTRACT NO. 27

Author(s) : Ramamani, S.

Title : Household Survey of Health Care Utilisation and Expenditure

Source : National Council for Applied Economic Research (NCAER), New Delhi, 1995

Place of study : Nation-wide (Major States and Union Territories)

Location : Rural and urban

Period of study : 1993

Type of research : Empirical, descriptive, community-based

Aims and objectives : To collect detailed data on morbidity, health care utilisation and health expenditure. The study covers both treated and untreated illness episodes.

Methodology : All the states and union territories of the country except Manipur, Nagaland, Sikkim, Tripura, Andaman and Nicobar Islands, Arunachal Pradesh, Dadra and Nagar Haveli, Lakshadweep, Mizoram and Jammu and Kashmir were included. The sample was selected through multi-stage stratified sampling. All of the districts within the selected states and union territories were covered. From each district, two villages were selected with probability proportional to the population of the village. In all, 718 villages were selected. For the urban sample, all 53 cities that had a population greater than 500,000 were included in the sample. The other cities and towns were stratified into five groups on the basis of population size, and a sample of towns was randomly selected from each group, with an increasing sample fraction as the size class increased. Blocks between 2 and 30 were randomly selected from each city/town, depending on the population size of the town. Thus, 1,509 blocks were selected.
For the household selection, households in selected blocks/villages were listed, with up to 150 households per block/village. The households were

classified into five income categories, and then sample households were selected randomly from each stratum. The sample consisted of 18,693 households, with 12,339 urban and 6,354 rural households.

The survey instrument was a detailed household questionnaire that was administered to the head of the household. For all questions relating to illness and health care utilisation and expenditure, the recall period was one month prior to the interview. The survey was based on lay reporting of illness and not on clinical examination. The interviewers were asked to note the symptoms in detail, as described by the households. Afterwards the symptoms were classified/grouped under different illness names using the World Health Organisation's Manual on Lay Reporting of Health Information.

Both the prevalence and incidence of illness were estimated; incidence relates to all episodes that started in the reference period of one month prior to the interview, while prevalence relates to all episodes that existed during the reference period, irrespective of when they started.

Findings:

Morbidity profile: The reported prevalence rate of illness for the reference period was 106.7 and 103.0 per 1,000 population for the rural and urban areas, respectively. The prevalence rate of treated illness was 94 per 1,000 population. The survey results did not indicate any significant sex differentials in the overall prevalence of illnesses at the all-India level, although some states did exhibit such differentials. The prevalence rates of illness by different age groups reveals a very high morbidity rate for the 60+ age group, for both rural and urban areas. There were wide variations in the reported prevalence rates of illness across different states, with Kerala having the highest reported morbidity.

Nature of illness: Fever seemed to be the most common illness among both adults and children, accounting for 30 percent and 25 percent of reported illnesses in rural and urban areas, respectively. The next highest reported morbidity was respiratory infections, which were higher among children than adults. In the rural areas, the prevalence rate of cardiovascular diseases (per 1,000 population) was 4.5 and 3.1, respectively for adult males and females. The corresponding figures for urban areas were 9.0 for adult males and 7.7 for adult females.

The disease pattern was dominated by acute illnesses. Acute illness comprised 73 percent of the reported illnesses in the rural areas and 68.5 percent of the reported illnesses in urban areas. Serious communicable diseases accounted for 14.5 percent and 13.3 percent of all reported illnesses, respectively, in rural and urban areas. With the increase in the income status of households, the prevalence rate of serious communicable diseases and acute illnesses decreased, and the prevalence of chronic illnesses increased.

Hospitalisation: The reported number of hospitalisation cases (per 1,000 population) was 7.1 and 9.7 for rural and urban areas, respectively. In most of the states, the number of hospitalisation cases (per 1,000 population) was lower for females than males.

Untreated illnesses: Approximately 12 and 8 percent of the illness episodes were not treated in rural and urban areas, respectively. The major cause cited for non-treatment was 'not considering the illness serious enough.'

Utilisation of outpatient health care services: The percentage of illness episodes for which treatment had been sought from the private health sector was 52 and 59 percent for rural and urban areas, respectively. In both rural and urban areas the utilisation of private health facilities was highest for acute illnesses. Self-medication was also found high in treating acute illnesses. In rural areas, the utilisation of public health facilities for accidents and injuries was 60 percent and 70 percent, respectively, for the male and female population. In both rural and urban areas, with an improvement in income and education of the household, the utilisation of public facilities decreased and utilisation of private facilities increased. On the whole, for all occupational categories, the utilisation of private facilities was found higher. For 90 percent of illnesses, the allopathic system of medicine was sought.

Utilisation of hospitalisation facilities: For 62 percent of the hospitalised illness episodes in rural areas and 60 percent of the cases in urban areas, treatment had been sought from public health facilities.

The data reveal that people's dependence on public health facilities was higher for natal, intra-natal and preventive health care. Home deliveries accounted for 23.4 and 11.2 percent of the deliveries in rural and urban areas, respectively.

The most important reason for using public health facilities in both rural and urban areas was that they are free or inexpensive. Close proximity was also cited as a reason for using public health services, whereas 'good reputation' was cited as an important reason for seeking treatment from private health facilities. On an average, people had travelled longer distances for seeking treatment in the rural areas as compared to urban areas.

Household expenditure on health care: Expenditure on health care includes the doctor's fees, cost of medicine, cost of diagnostic tests, transportation costs, expenses incurred for special diet for the patient, and other incidental expenses. Poor households had spent more than 7 percent of their income on treatment as compared to 2.7 percent by rich households. Urban households had spent more in treating illness than their rural counterparts. The average expenditure per illness episode was lower for children. In both rural and urban areas the average household expenditure per illness episode was lower for female adults and female children as compared to males. For treatment as inpatients people seemed to prefer public health facilities. The most important reason was that they are less expensive than private health facilities. Poor states like Uttar Pradesh, Rajasthan and Madhya Pradesh had spent comparatively smaller amounts per illness episode. In states where the dependence on private health providers was higher, the amount spent per illness episode was also found to be fairly high.

Key words: *Prevalence, morbidity, health care, utilisation, out-of-pocket expenditure, treated and untreated illness*

ABSTRACT NO. 28

Author(s)	:	Sinha, R. K., and T. Kanitkar
Title	:	Acceptance of Family Planning and Linkages with Development Variables: Evidence from an 80-Village Study in Orissa
Source	:	The Journal of Family Welfare, 1994
Place of study	:	Cuttack, Ganjam, Kalahandi, Phulbani and Puri, Orissa
Location	:	Rural
Period of study	:	1982
Type of research	:	Empirical, descriptive, community-based
Aims and objectives	:	To study inter-village variations in the practice of family planning by different methods in Orissa; and to study the factors associated with the differential practice of family planning methods.
Methodology	:	Data collected in a large sample survey were used. A total of 80 villages, 16 from each district having health facilities and not having health facilities, were selected from five districts, through a two-stage sampling design. A random sample of 50 households was selected from each of the

villages by probability proportion to size (PPS). Individual-level data on knowledge and practice were collected from newly married women in the household. Village-level data on infrastructural facilities, educational facilities, health facilities, mass media and other aspects were obtained. Using the available information a composite village level index (VLI) was constructed, indicative of the overall developmental status of the village. The information was divided into eight major categories. The VLI ranged from 0-80 and graded into four groups. The score was observed to range between 7 and 59.

Findings:
The average VLI score was 26.8 with a standard deviation of 10.7 and coefficient of variation of 40 percent, indicating the heterogeneous development levels of the villages. Literacy levels in the village and the village level index did not show any association with acceptance of sterilisation but it was significantly related to acceptance of spacing methods. Perhaps this was because sterilisation is a one-time method, requires only one-time motivation and is aggressively promoted by programme managers. It was also independent of the acceptor's literacy or educational attainment. On the contrary, the acceptance of spacing methods takes into account the motivational aspect and hence was not independent of literacy or educational attainment of the individual. The existence of PHC/sub-centre facilities in the village did not have any impact on the acceptance of spacing methods. The findings of this study clearly bring out the importance of aggregate level development related variables and education for the promotion of spacing methods.

Key words: *Family planning, spacing methods, development index*

ABSTRACT NO. 29

Author(s) : Sood, A. K., and B. K. Nagla

Title : The Extent and Pattern of Utilisation of Health Services by Rural Women: A Study in District Rohtak, Haryana

Source : Indian Journal of Preventive Social Medicine, 1994

Place of study : Rohtak, Haryana

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, community-based

Aims and objectives : To study the pattern of utilisation of various treatment sources by rural women for common maternal and child health problems.

Methodology : The study was carried out in block Beri of Rohtak district in Haryana. Four sub-centre villages were selected by stratified random sampling considering their distances from the PHC. The sampling unit was women

with children less than six years of age. A list was prepared in each village of households having women with children less than six years of age. Systematic random sampling was used to select women for the survey. In all, 162 women were interviewed through a semi-structured schedule.

Findings:

The study found that nearly 61.8 percent of the women had contacted private practitioners, 50.0 percent had contacted anganwadi centres, 21.0 percent faith-healers, 18.4 percent sub-centres, 19.7 percent PHCs and 6.5 percent government hospitals in the last six months. During the analysis of the data the socio-demographic characteristics of the respondents were taken into account. Some of these factors directly affected and some indirectly affected medical and health care utilisation. The data reveal that respondents who had a lower annual income, lived far from towns, and in inadequate houses with no bathrooms showed a preference for home treatment in the initial stages. Respondents who preferred hospitals, especially government hospitals, had higher age of head of household, lower levels of education and high preference for government hospitals. PHCs and hospitals were mostly preferred for prolonged ailments or severe ailments not cured by other sources. Those who preferred a place that gives "quick relief" were characterised by higher income, better condition of the house, higher education of head of family, residence in main village, higher social participation, separate bathrooms in the house and electricity. On the other hand, those who mentioned a preference for place of treatment due to 'free services' had poor living conditions, lower incomes and lower levels of cleanliness in the home.

The data showed that the higher the educational level, income and lower family size, the higher the preference for a hospital as the place for delivery. Religion and social participation determined the preference for the local dai. Hindus with lower social participation preferred a local dai for delivery. Religion, household size and social participation determined the use of family planning methods. The larger the household size and higher the social participation, the higher the acceptance of family planning methods. For treatment of infants, 27.5 percent preferred mostly traditional practices, 4.6 percent preferred modern practices and 67.7 percent preferred both. Those preferring native practices had lower levels of education, lower levels of cleanliness, higher family size and lower social participation. They lived away from town.

The article also highlighted the findings of three other studies on health care utilisation undertaken in various parts of the country.

Reviewer's note:

The recall period is six months. A separate presentation of maternal health and child health problems would have been insightful. The article does not clearly define the concept of 'social participation.'

Key words: *Maternal health problems, child health problems, treatment sources*

ABSTRACT NO. 30

Author(s)	:	Srivastava, R. K., and R. K. Bansal
Title	:	Please Use the Health Services: More and More
Source	:	World Health Forum, 1996
Place of study	:	Kheda, Gujarat

Location : Rural

Period of study : 1992-95

Type of research : Empirical, descriptive, community-based

Aims and objectives : The long-term objective was to reduce family size and raise people's quality of life. The immediate objectives of the project were to bring about an increase in awareness of modern contraception from 48 percent to 73 percent; to reduce the infant and under-five mortality rate to below the country's rural average; and to raise the status of women.

Methodology : The project was initiated in 30 villages where there was already a well-established network of primary care centres. It was an intervention project, therefore, no strict methodology was followed.

Findings:
The paper details the various activities undertaken in the project. The interventions were essentially IEC activities carried out by village family welfare workers with the involvement of the milk cooperatives and supported by a central team from a medical college. The unique feature of the project was that village health workers were available throughout the day, and basic drugs were made available at all times. Also, the project provided an opportunity for medical students to relate theory to practice. The article also describes the constraints that affected the project. The authors claim that substantial progress can be made through this kind of initiative, although it would take much longer to see its direct benefits.

Reviewer's note:
The sharing could be used to draw lessons to improve government health services for better utilisation.

Key words: *Modern contraception, status of women, village health workers*

ABSTRACT NO. 31

Author(s) : Stevens, J. R., and C. M. Stevens

Title : Introductory Small Cash Incentives to Promote Child Spacing in India

Source : Studies in Family Planning, 1992

Place of study : Thanjavur, Tamil Nadu

Location : Rural

Period of study : 1985-91

Type of research : Empirical, descriptive, community-based

Aims and objectives : To evaluate the cost-effectiveness of monthly introductory small cash incentives as a strategy to increase the use of modern temporary methods of contraception among rural Indian women.

Methodology : A four-phase intervention study was designed to evaluate such a strategy. In phase 1, small incentives as an intervention to promote acceptance and continuation of spacing methods were pilot-tested. In phase 2, a controlled study, the impact of interventions in terms of cash incentives and five visits with contact persons was compared with the control area. Phase 3 was designed to study the impact of (a) smaller cash incentives with only one visit and (b) of only contact persons. The results of these two strategies were compared. Phase 4 was to introduce this intervention strategy through the government health services in three places: in the slums of Madras city (incentive); in two PHCs in rural areas (intervention area: incentive + contact person, control area: only contact person).

The sample size varied in these phases. In Phase 1, a total of 398 women were acceptors of spacing methods. In Phase 2, 500 women in each intervention and control area were enrolled in the study. An evaluation survey of Phase 2 included random samples of 150 women each from the intervention and control area. In Phase 3,250 women were enrolled in each of the two intervention areas. The evaluation survey of Phase 3 included a random sample of 100 women from both intervention programmes. In Phase 4, 2,821 women were acceptors in the slums of Madras; 475 and 3,068 women enrolled in the two PHC areas.

Findings:

The programme demonstrates the power of small cash incentives to rapidly attract potential women acceptors to the clinic. It is evident that this method overcame disinterest, inertia, and passivity of poor and illiterate women towards available contraceptive methods.

Phase 1 showed that small cash incentives were very effective in promoting participation in the project. During this phase the programme achieved very high acceptor rates for temporary methods. Critics suggested that this phenomenon may be due less to the incentives and more to the fact that women preferred to come to a high quality private clinic where they were treated with concern and respect, rather than to insensitive government facilities.

Phase 2 showed that though initial acceptance was higher with introductory incentives, subsequent delivery of condoms and pills by the village contact person was similar in both incentive and non-incentive villages. Follow-up population-based surveys indicate that the quality of knowledge was better and the number of users was greater in the incentive villages.

Phase 3 demonstrated that a single introductory incentive or appointment of contact person only recruited more women acceptors, but knowledge and evidence of actual use of spacing methods was less.

Phase 4 attempted to introduce the introductory incentive programme in urban and rural government clinics and yielded mixed results. In urban slums, government health services were rapidly able to upscale the programme. In the rural PHCs, the staff was unable to upscale the programme on their own.

The authors conclude that introductory incentive programmes served to increase awareness and acceptance of spacing methods though the continuation rate was only about 50 percent. Many women distrust government services because of the rude behaviour of the health personnel, but the authors argue that incentives were less coercive than the conditions under which poor women live because it served to diminish the timidity of women.

Key words: *Cash incentives, use of contraception*

ABSTRACT NO. 32

Author(s) : Unnithan-Kumar, M.

Title : Households, Kinship and Access to Reproductive Health Care among Rural Muslims in Jaipur

Source : Economic and Political Weekly, 1999

Place of study : Jaipur, Rajasthan

Location : Rural

Period of study : Not specified

Type of research : Empirical, descriptive, community-based

Aims and objectives : To situate reproductive health care in the context of women's perceptions and experiences of illness in general as well as in terms of the material, ideological and political dynamics of household, kin and gender relations.

Methodology : The paper does not detail the methodology used to conduct this research. The study was conducted in the rural Nagori Sunni community in Jaipur district.

Findings:

The study found that most of the reproductive problems of women were related to menstruation and white discharge. There was a high incidence of maternal morbidity and anaemia along with child mortality. Women articulated their health problems in very general terms. Women perceived their illness as related to causes lying outside the purely physiological domain. References to the influence of the soul and spirit upon a person's health indicated that the health of the individual and the social body was connected in public perception.

Women tended to use the services of private medical practitioners and traditional healers much more than government institutions. Of the health services available within a radius of 1-6 kilometres, none of the private doctors frequented by the Nagori Muslims offered reproductive health examinations or antenatal check-ups for women. In seeking medical attention with regard to reproductive health-related problems, women had to travel greater distances. For reproductive health services women went equally to private and government doctors but preferred to see government doctors in private where they were promised greater attention.

The study found that the sexual division of household labour and the division of labour among women of the household had implications for women's health. It imposed the physical burden of hard and continuous labour with little respite during weakness or illness. It also made it difficult for women to take time out to consult health specialists. The toll on women's health varied with the development cycle of the household.The division of household tasks worked in favour of the age of women only if they had younger women to shoulder the heavier tasks. The average monthly income of families was Rs. 1,500-2,000, besides three quintals of wheat from a single agricultural season. Most of the women were engaged in agricultural activity, which is seasonally determined. One of the common work-related physical ailments which Nagori women suffer was prolapse of uterus. Gender ideologies played an important role in the inequitable distribution of resources in the household and had implications for women and children's health.

In the majority of cases a woman's marital home was within a radius of 1-4 kilometres from her natal home. The social and physical proximity of natal kinspersons had important implications for Nagori women's access to health care services in many ways. These mainly included additional human power, emotional support and financial support. The average health expenditure for women alone over 10 months was Rs. 1,000-10,000. This high expenditure on health was a result of treatment delayed until the acute stage.

The author in the end draws conclusions for policy. These conclusions include the need to address the question of access to existing services; provision of facilities that take into account the context-specific, gender and age health needs of the local populations; the need for a health programme to be broad-based so as to tackle wider sources in the environment from which diseases stem. The author recommended that women's access to health care services could be improved by encouraging all sorts of health delivery activity (private, government and NGO) in a manner that recognises their specific strengths and weaknesses. In order to establish an effective referral network, the author suggested that resource persons within each village be located who are not only informed about matters of hygiene and basic medication but also about health services, health rights and statistics and the politics of health matters in general.

Reviewer's note:
In the absence of any reference made to the methodology, the potential of such studies and methodologies used (the ethnographic approach seems to have been used) remains obscure. The study is significant because there are not many studies dealing with Muslim women and their health concerns.

Key words: *Muslim women, reproductive problems, reproductive health problems, support, health expenditure*

ABSTRACT NO. 33

Author(s) : Visaria, L.

Title : Unmet Need for Family Planning in Gujarat: A Qualitative Exploration

Source : Economic and Political Weekly, 1997

Place of study : Bharuch and Panchmahal, Gujarat

Location : Rural

Period of study : 1989 and 1995

Type of research : Empirical, descriptive, community-based

Aims and objectives : To understand the reasons for the unmet need for family planning from the women's perspective; to explore the reasons underlying the gap between intentions to limit fertility and action; and to understand when and how the intentions to limit family size are translated into reality.

Methodology : A quasi-longitudinal study design was adopted in two districts of Gujarat, covering the same population at two points of time, 1989 and 1995. The data were collected through 11 focus groups and in-depth interviews. The participants for focus groups were carefully selected. About 18 to 20 women were invited for each discussion. Efforts were made to make each group as homogeneous as possible in terms of caste, level of literacy and acceptance of sterilisation.

Findings:

The issues discussed broadly were women's desired fertility and their reasons for wanting a specific number of children, sex preference of wanted children, apprehension about use of contraceptive methods for limiting and spacing children and inter-spouse communication on issues related to sexuality, desired fertility and contraceptive use. The author had frequently referred to NFHS data for a macro-perspective.

The women reported that if their husbands wanted more children, they had no choice but to comply. Most women desired two to three children provided there was at least one son, preferably two. But on their own, women didn't mind not having sons. The reason for the desired fertility was mainly economic.

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Annotated Bibliographies (1990-2000):

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