

(3) Availability of Human Resources in Sagar Division

The table below shows the staffing status of the governmental and community-based health workers. The number of medical specialists posted is extremely low compared with general medical officers. The proportion of paramedical positions filled is 100% or more except nursing staff. Note that HA (Female)/LHV positions are overfilled (200.8%), which it may imply that they are required to play a complementary role to nursing staff. More than 90% of the total number of required posts is satisfactorily filled in three districts, Tikamgarh, Damoh, and Chhatarpur.

It should be noted again that the numbers of staff are not the same in every document that was provided to us, and information regarding private facilities and practitioners is poor.

Table 4-24 Staffing Status of Governmental and Community-based Health Professionals

Professional category	Tikamgarh		Damoh		Sagar		Chhatarpur		Panna		Total		
	Required	Filled (%)	Required	Filled (%)	Required	Filled (%)	Required	Filled (%)	Required	Filled (%)	Required	Filled (%)	
Medical staff Specialist *	Surgeon	12	1 8.3%	4	1 25.0%	21	1 4.8%	10	2 20.0%	10	1 10.0%	57	6 10.5%
	Ob / Gyn	8	1 2.5%	4	3 75.0%	13	2 15.4%	7	2 28.6%	7	1 14.3%	39	9 23.1%
	Paediatricians	8	1 12.5%	4	3 75.0%	1	1 7.7%	7	1 14.3%	7	0 0%	39	6 15.4%
	Anaesthetist	1	0 0%	1	1 100%	1	1 100%	1	1 100%	1	1 100%	5	4 80.0%
	Other specialist	13	N/A	9	N/A	17	N/A	12	N/A	12	N/A	63	N/A
General MO / Physician / Dentists	48	39 81.3%	33	36 109.1%	75	52 69.3%	68	56 82.4%	42	20 47.6%	266	203 76.3%	
Paramedical staff	Head nurse	4	0 0%	4	0 0%	4	0 0%	4	1 25.0%	4	0 0%	20	1 5.0%
	Staff nurse	44	28 63.6%	28	28 100%	60	42 70.0%	40	19 47.5%	40	4 10.0%	212	121 57.1%
	HA(Female) / LHV	18	63 350%	15	28 186.7%	29	75 258.6%	41	50 122.0%	15	21 140.0%	118	237 200.8%
	HA (Male)	19	28 147.4%	16	24 150.0%	30	44 146.7%	42	1 2.4%	16	24 150.0%	123	121 98.4%
	MPW(Female) / ANM	177	160 90.4%	180	162 90.0%	277	243 87.7%	233	261 112.0%	158	139 88.0%	1,025	965 94.1%
	MPW (Male)	156	160 102.6%	162	141 87.0%	245	204 83.3%	189	198 104.8%	140	136 97.1%	892	839 94.1%
	Other paramedics	102	N/A	60	N/A	160	N/A	139	N/A	87	N/A	548	N/A
Administrative staff	126	N/A	84	N/A	184	N/A	163	N/A	111	N/A	668	N/A	
Community-based health professionals	Trained Dai	N/A	1,200	N/A	802	N/A	1,591	N/A	639	N/A	681	N/A	1,591
	JSR	N/A	819	N/A	283	N/A	419	N/A	320	N/A	181	N/A	2,022
	AWW	N/A	819	N/A	756	N/A	N/A	N/A	880	N/A	569	N/A	N/A

Note: *1) Physician specialists are grouped into general medical officers in this table.
*2) The numbers of required posts are computed using the staffing norms of Table 4-8. Both Block-level PHCs and Sector-level PHCs are grouped simply into PHCs
N/A: Data not available

Source: Study on Health Facilities and Human Resources, JICA Development Study on Reproductive Health in MP, conducted by ORG-MARG, 2001

In the following table, the distribution of clinical resources in hospitals and other district health facilities in each district is shown.

Table 4-25 Distribution of Doctors and Nurses in Hospital and Other Rural Health Facilities in Each District in Sagar Division

District Prof. Categ.	Tikamgarh		Damoh		Chhatarpur		Panna		Sagar	
	Hosp.* ¹	Dist.* ²	Hosp.	Dist.	Hosp.	Dist.	Hosp.	Dist.	Hosp.	Dist.
GP / Internal	11	28	14	22	22	34	6	14	1	47
Ob/Gyn.	1	0	3	0	1	1	1	0	3* ³	1
Paediatrician	1	0	3	0	1	0	0	0	0	0
Surgeon	1	0	1	0	1	1	1	0	0* ⁴	0
Anaesthetist	0	0	1	0	1	0	1	0	1	0
Nurse tutor	0	0	0	0	1	0	0	0	N/A	0
Nurse (Degree)	0	0	0	0	1	0	0	0	N/A	0
Staff nurse.	10	18	23	5	3	16	0	4	N/A	25

Note: *1) District Hospital

*2) All health facilities except the district hospital under DPHFW in the district

*3) 1 specialist and 2 residents or GP

*4) OB/Gyns conduct surgery

GP: General practitioner, N/A: Data not available

Of not is the limited number of lady doctors. Since women in Sagar Division do not like to visit male doctors, this becomes an important quality of care issue and strong barrier to the utilisation of services.

Table 4-26 Number of Lady Doctors in Sagar Division

District	Hospital		Other Health Facilities	
	GP*	Ob/Gyn	GP	Ob/Gyn
Chhatarpur	2	1	-	1
Panna	-	1	-	-
Tikamgarh	-	1	1	-
Damoh	2	1	1	-
Sagar	-	3**	2	-
Total	4	7	4	1

Note: * GP: General practitioner, ** in maternal hospital

The total numbers of doctors in the district would allow for all the facilities (except SCs) in three districts to have at least one doctor if they were distributed uniformly. Many doctors posted in S-PHCs do not stay in the village and come from the town everyday, or they do not work at S-PHCs.

In the case of Chhatarpur and Panna 20% of the health facilities would still not have one doctor even if uniformly distributed. However, in the case of Panna this will change shortly since 15 doctors were already hired.

Even in cases like Tikamgarh, Damoh and Sagar districts, where many health facilities have more than one doctor (1.3 ~1.5 doctors/health facility on average), there are no Ob/Gyns and/or surgeons outside the hospital. In fact, only Chhatarpur has one Surgeon and one Ob/Gyn in the periphery.

For some districts it was possible to obtain from the health authorities the distribution of staff per Block. These data are displayed in the next tables.

In Damoh, not only are specialists absent, but also the number of GP doctors per block is not enough to fill the PHCs posts. RH services in the district are mainly under the responsibility of MPW/ANMs.

In Sagar, there are no Ob-Gyns, Paediatricians, or Surgeons working outside the Hospitals. GPs and Internal Medicine doctors are not prepared to provide reproductive health services routinely or in emergency situations. Therefore, in the case of Sagar District there is no adequate coverage of women and children. Multipurpose Workers and Supervisors provide basic services, but they have no technical support or medical supervision. There are no nearby services for referral.

On the other hand, there are 48 doctors, mainly GPs who provide services at the block level. Since this figure means that there are 1.3 doctors/HF, all the Blocks could provide reproductive health services and emergency obstetrics if the doctors were adequately trained to respond to such. There are five times more TBAs (Dais) than field nursing staff. One should ask if these figures are cost-effective in a situation where there is no possibility of adequate supervision.

In Panna, there are also only GPs and internal medical doctors at the district level. In other words, there is medical staff providing maternal and child health care services. In Pawai Block there is no provision of services. As in other districts, the number of Dais is 4-5 times the number of ANMs.

4.4 HEALTH PROVIDERS' COMPETENCY AND AVAILABLE SERVICES

4.4.1 Health Providers at Community Level

(1) ANM (MPW/F) and LHV's

1) Training

The ANM Training Centres are a 100% centrally funded scheme under the family welfare programme. The duration of training is 18 months, including field training in midwifery at a CHC for six months. The eligibility criteria for admission are ten years of basic education and a pass grade in the secondary school examination (ten pass).

Although LHV's are the supervisors of the ANM's, their pre-service training is the same as the in-service short courses that they undertake. To become a supervisor an ANM after 5 years of work undergoes a 6-month refresher course with management skills training at the nursing school, which is not adequate for a supervisor.

There are 32 ANM Training Centres in MP. Each has an annual admission target of either 40 or 60 students, with a total capacity of 1,740 annual admissions for trainees.

The syllabus for ANM training was designed by the Indian Nursing Council in 1977 and updated in 1986 but not since. Training consists of courses in sciences and health. The texts and manuals used are similarly outdated and lacking in important information about recent developments. The trainers receive little material or training to advance their knowledge about changes in the national health programme or health care. Nine of the 32 ANM Training Centres

In MP are without a Principal, and many tutor positions are vacant and remain so for long periods of time. There are no provisions for post-training follow-up.¹

ANMs receive 18-months of formal training in Nursing and Midwifery. The curriculum includes the topics seen in the next table. Some 33% also received additional short-courses in MCH/IUD insertion under the umbrella of the RHC Programme or UNFPA sponsorship in the last 5 years.

Table 4-27 Training Received by ANMs/LHVs in Sagar Division

Type of Training	% Received	Type of Training	% Received
Screening Clients For Spacing Methods	100.0	Child Survival & Safe	65.5
Prenatal Care	100.0	Motherhood (CSSM)	65.5
Neonatal Care	100.0	Safe Abortion	51.7
Immunization Programme	100.0	Acute Respiratory Infection	44.8
Control of Diarrhoeal Diseases /ORT	100.0	RTI/STD	37.9
Nutrition	100.0	Community Needs Assessment	37.9
Reproductive & Child Health (RCH)	100.0	MTP	17.2
Safe Delivery	96.6	PAP Smear Examination/Tests	6.9
Counselling Techniques	96.6	Family Planning	6.9
IUD Insertion	89.7	Minor Illness/Surgery	6.9
Checking Blood pressure	89.7		

Source: Study on Health Facility and Human Resource conducted by ORG-MARG, under the JICA Development Study on Reproductive Health in MP, 2001

ANM Training Centre (ANMTC)

Tikamgarh has an ANM Training Centre (ANMTC) while Damoh does not and has to rely on getting trainees from the Sagar district ANMTC. Nevertheless, it is not recommendable to increase the number of ANMTCs until the state manages to make the existing ones effective.

The Tikamgarh ANMTC has filled only three of seven staff positions. The post of principal was filled for about a year and a half when the school was first founded in the early 1980's. Since then it has remained vacant, and a tutor is assigned as acting to handle administrative responsibilities as well as training. The school also has one housekeeper, a clerk, a helper, two cooks, a sweeper, and a chowkidar (night watchman). The school is using the 1977 syllabus. While the building could benefit from being painted, it is generally adequate. However, the materials and teaching aids are old and in disrepair and often inappropriate, and the tutors, who were not selected for their training skills and received no TOT to develop them, do not receive regular in-service training (their last in-service was in 1997 or 1998).

Selection of ANM trainees

There is a fundamental flaw in the approach to selection of ANM trainees. The selection is treated as a strategy for decreasing unemployment, rather than a part of the process of assuring qualified health care providers. Candidates must be registered at the unemployment office of the

¹ Dept. of Public Health and Family Welfare, the government of MP. Training Needs Assessment, Draft Report. 2000.

Ministry of Labour, and that office advertises the training, receives applications, and participates in the selection (along with the CMHO, District Collector, and a couple of others). ANM training is just as crucial as the training of nurses and doctors and should be accorded equal importance. **This requires a rethinking and redesign of the recruitment and selection process. Recruitment needs to be more rationalized also.** It also needs to be more aggressive since ANMTCs in general do not fill all their trainee positions. In Tikamgarh, for example, there are 35 students filling 60 positions. The situation is similar in the Sagar district ANMTC.

The 1998 Manual on Community Needs Assessment Approach states the following:

“To be a good ANM, it is necessary that:

- i) she should be a qualified person recruited for the training. She should regularly participate in in-service training for upgrading of her knowledge and skills;
- ii) she should be a good motivator and counsellor;
- iii) she should motivate and counsel adolescents in the area about reproductive health so that they are not misinformed: they have to be treated as youth on the threshold of adulthood;
- iv) she should motivate the community for the delayed marriage explaining that before a particular age the human body is not ready for the stress of child bearing;
- v) she should motivate recently married couples to use temporary methods of contraception;
- vi) she should motivate women with two or more children to use terminal methods of contraception;
- vii) she should motivate the women of the community to avail of the facilities for antenatal care during pregnancy;
- viii) she must educate them that 15 out of every 100 pregnant women are likely to have problems during pregnancy. Therefore, it is important for all women to have preventive antenatal care which helps in the detection of possible complications;
- ix) she must learn how to use the haemoglobimeter to facilitate detection and treatment of anaemic mothers;
- x) she must counsel all pregnant women to have two doses of Tetanus Toxoid, prophylactic dose of IFA tablets; balanced diet and adequate rest;
- xi) she should encourage women to have domiciliary deliveries by trained personnel or institutional deliveries;
- xii) she must educate women about the danger signs during pregnancy and delivery;
- xiii) she must motivate women to come for post-natal check ups;
- xiv) she must motivate women to bring their children for immunisation;
- xv) she must motivate women to bring their children for administration of Vitamin A solution every six months starting from nine months of age till the age of three years;
- xvi) she must counsel women to bring children with breathing difficulties for examination and treatment to the sub-centre;
- xvii) she must educate women about the process and role of oral rehydration therapy with ORS or home available fluids and urge them to bring the children for examination and treatment to the Sub-centre.

Of the 17 crucial tasks of the ANM described above, 15 are related to IEC. However, **the ANM is taught nothing about Communication during her training.**

There are ten MPW (male) Training Centres in MP, each of which has an annual admission capacity of 60 trainees. The eligibility criteria are the same as those for ANMs, ten pass. **Their**

training also follows an outdated syllabus developed by the Indian Nursing Council, the materials and trainers are similarly out of date, the facilities for the men are generally in poor condition, and all resources are inadequate.

The Manual for CNAA states that the M-MPW's chief responsibility is participation in the malaria, tuberculosis, and leprosy programmes, and when he is in the SC, he should assist the ANM in immunisations, distribution of ORS, detection and treatment of ARI, motivation of male sterilisation acceptors, and condom distribution.

The role of the M-MPW is described in one page, in comparison with the four pages that describe the role of the ANM.

a) Practice

According to our survey of health providers (sample survey), over 60% have an average age of 39 years and belong to an OBC or general caste. Over 80% have between 9 and 14 years of education, and over 95% have been in the service for over 10 years. The number of clients seen per week averages 184 - or 13 per day. Half of the clients are women followed by children (about 40%). Men constitute 12% of their clientele.

Antenatal care is the most frequent service provided, followed by postnatal care and family planning. Deliveries account for 11% of their workload. ANMs and LHVs do not attend to cases of abortion, STD, chronic illnesses, or malnutrition. Only 7% of their cases are emergencies. Regarding child diseases, diarrhoea and fever account for most of their clients. Half of ANMs do not ask the new mother to go to the health centre or tell them only if they have a problem. ANMs conduct relatively few deliveries, although this is supposed to be one of the crucial tasks of the ANM. This calls for a review of the role of ANMs. The number of ANM Training Centres (TCs) in the state is adequate to produce a much larger number of ANMs annually, although they are lacking an effective strategy for recruiting good candidates.

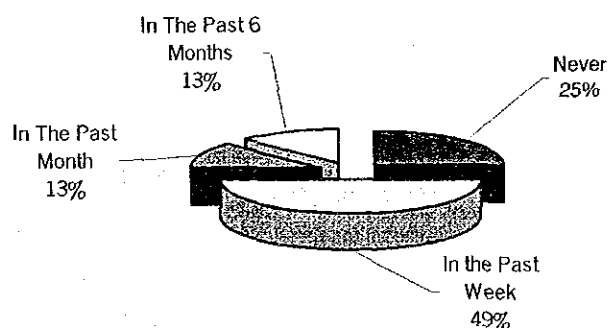


Figure 4-5 When ANMs Last Attended a Delivery in Sagar Division

Source: Community Survey conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

The problems or medical conditions that the ANMs/LHVs have encountered give an idea of their experience with a specific situation. In this case, the types of frequent situations/medical conditions that ANMs have never encountered lead us to believe that chances are good that they were not able to recognise them.

Table 4-28 Condition Never Encountered by ANM/LHVs

Condition Never Encountered	(%)
Sepsis Puerperal	83
Obstructed Labour	67
Eclampsia	67
Complication of abortion	67
Postpartum Haemorrhage	50

Source: Study on Health Facility and Human Resource conducted by ORG-MARG, under the JICA Development Study on Reproductive Health in MP, 2001

It is important that clinical staff know when to refer patients to a higher health facility, particularly in the case of Sagar Division where transportation is not easily available.

Table 4-29 Proportion of ANMs who Recognise Warning Signs That are Reasons to Refer Women to the Health Facility in Pregnancy or Labour

Warning signs for referring	(%)
Anaemia/Pallor/Fatigue/Restlessness	83.3
Hyper Tension/Headache/Swelling/Fits	66.7
Abnormal Lie/Position Of Foetus	50.0
Haemorrhage/Heavy Bleeding	50.0
Prev. Bad Obstetric History/Abdominal Scars/Prev. Still Birth	33.3
Cessation Of Foetal Movement/ Baby Does Not Move	16.7
Obstructed/Prolonged Labour	16.7
Diabetic/Heart Disorder	16.7

Source: Study on Health Facility and Human Resource conducted by ORG-MARG, under the JICA Development Study on Reproductive Health in MP, 2001

In the table above one can observe the absence of recognition of the need for referral to the health facility in many life-threatening cases. These are situations that require immediate intervention since they put at risk the lives of many women and their babies.

Ten percent of ANMs/LHVs reported they do not face any problems in the provision of RH services. Almost all ANMs reported that health facilities have overall adequate and appropriate conditions for RCH care, and 80% say the facilities are either clean or very clean. 70% say that the equipment available is not enough, and drugs are not sufficient for 80% of the ANMs. A need for further training was mentioned by 67% of them, yet almost none was able to specify in what subjects this training was necessary.

Among her many tasks, the ANM is expected to assure full immunisation in her catchment area. In practice, the ANM in each SC is supposed to provide vaccinations every Tuesday. One obstacle to her providing care during home visits is that she is not given a carrier for medicines, contraceptives, or other supplies except for the carrier to maintain the cold chain when transporting vaccines to the villages.

Evaluations have uncovered important constraints in the system, among them:

- Inadequate mobility of health workers
- Remote areas that make it difficult for the health workers to conduct outreach sessions and transport vaccines, drugs, and equipment
- The problem of delivery of vaccines and drugs to outreach session sites. Presently in most states the health workers have to collect the vaccine from block PHCs and then take them to the session sites, giving them very little time and motivation for conducting sessions.
- Supervision:
 - An experienced ANM can receive training and be promoted to be a Lady Health Visitor (LHV). The LHV is generally posted to a PHC where she should deliver health services and supervise ANMs in the SCs associated with her PHC. However, the training an LHV receives for this promotion is little more than an abbreviated repetition of the original ANM training. This represents a lost opportunity to develop new skills that are needed for the new responsibilities that the LHV will assume, the most obvious being supervision and micro-level planning for development of a needs based work plan to be taught to ANMs, adult education for expanding the technical skills of ANMs, and communication techniques for giving group educational sessions during community visits. Supervision currently amounts to little more than collection of reports.
 - PHCs are supposed to be responsible for supervision of SCs; however, there too many SCs under them and no structured supervision mechanism.
 - Notably absent from the syllabus of the ANMTCs is any course on communication, although one of the major responsibilities of the ANM is health education in home visits and while providing primary health care. The effort to revise the syllabus should include communication course(s) to train the future ANM how to communicate health messages so as to promote behaviour modification, and how to design and use simple materials available in the community.

(See also Supporting Report, Chapter 2, 2.1)

(2) The Dai

Another important health provider/worker in Madhya Pradesh is the Dai.

Dais play an important role in many rural societies across the developing world. In Madhya Pradesh it has been also the case but with a particularity: over 93 % of Dais belong to the Basore caste, a scheduled caste with high untouchability by the other castes. This means that they are often called not to conduct the delivery of the newborn, but rather to deliver the membranes only after the baby's delivery had been conducted by a relative.

Government has put a lot of emphasis in training Dais with the target of one trained Dai per 1000 inhabitants. Dais are also supposed to collaborate with the Government in the implementation of vertical women's health programmes and directly with the ANM/MPW in the provision of pre- and post-natal care, as well as care of the newborn. International agencies and NGOs have also placed a lot of emphasis on training Dais as the main health provider at the village level.

Dais are often among the elderly in the village, and the majority are over 35 years of age. The average age of Dais ranges from 38 years in Panna to 48 in Tikamgarh. Over 90 % have less than 1.5 years of schooling.

Dai usually start their activities in their early 20s, and over 76 % of them have been working for more than 10 years. They work in their village and neighbouring villages every day of the week and are "on call" 24 hours a day. The number of clients ranges from of 3 to 10 clients per week on average. The large majority of these clients (over 80 %) are women, while the rest of their clients are children. Only very rarely do Dais see a male patient.

Training of Dais is mainly conducted at the PHC and focuses on normal delivery. Although the presence of intense bleeding in the postpartum period is a frequent cause of maternal mortality, the percentage of Dai who received training in postnatal care is very low.

There is no training of Dais in the treatment of malnutrition, emergency obstetrical care, or treatment of the complications of abortion, despite the fact that these are important causes of maternal deaths. Moreover, training in counselling on RTI/HIV/AIDS is basically non-existent, although frequently women have complaints related to RTIs.

Table 4-30 Curriculum for the Training of Dai

(Unit: %)

Subject	District				
	Tikamgarh	Damoh	Sagar	Chhatarpur	Panna
Delivery	98	94	92	100	96
Antenatal	78	3	8	37	41
Post-natal	75	3	0	30	25
Child Fever	24	0	0	0	0
Child ARI	2	0	0	0	0
Education on nutrition	19	6	0	27	30
Treatment of malnutrition	0	0	0	0	0
Child Diarrhoea	37	0	0	0	0
Emergency obstetrical care	0	0	0	0	0
Nutrition	0	0	0	0	0
Family Planning	39	3	4	0	4
Counselling (FP/STI/HIV/AIDS)	2	3	0	3	0
Treatment of complicated abortion	0	0	0	0	0

Source: Community Survey conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

Training has a strong focus on safe delivery, and knowledge of prenatal care is abysmal. Less than 15% of Dais recognised at least 2 danger signs of pregnancy. For example, an abnormal position of the foetus that often leads to complicated labour was only indicated by 28% of the Dais interviewed as a danger sign in pregnancy.

The lack of knowledge about postnatal care is even more marked. Only 15% of Dais mentioned any signal of puerperal sepsis as a reason for referring women to a health facility.

In 95% or more of the cases, training was provided less than 5 years ago with the exception of family planning. Sixty percent of the trained Dais received training in family planning between 5 and 10 years ago.

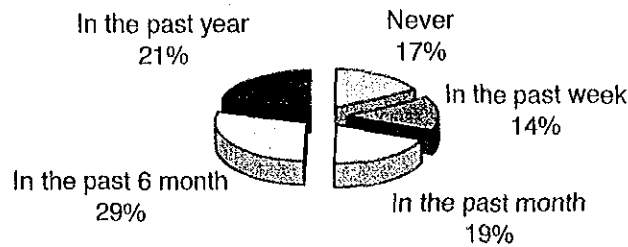


Figure 4-6 Last Time the Dai Assisted a Delivery

Source: Community Survey conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

Despite all the efforts placed on training Dais in safe delivery procedures, 17% percent of them have never performed a delivery, about half perform 2 or fewer deliveries a year, and only about 1/3 conducts 1-4 deliveries /month.

The number of deliveries performed per year does not ensure enough practice to conduct safe deliveries. Moreover, in a large number of cases the Dai is called only after the baby is born and just to deliver the placenta. In fact, over 20% of all Dai in Sagar Division have faced these cases.

It would be interesting to explore the ethnic and social reasons for the highly significant differences between the districts regarding this issue.

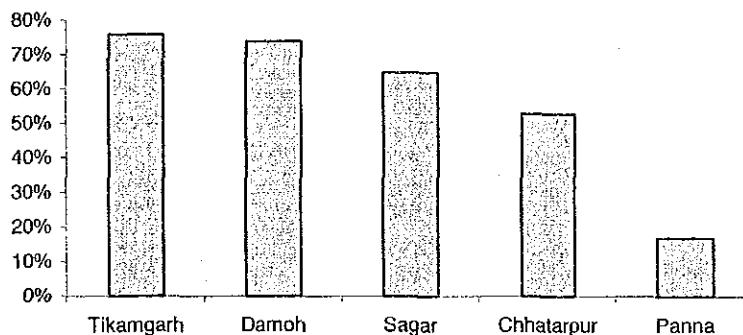


Figure 4-7 Differences between the District regarding the Calling of Dai only for Deliver the Membranes

Source: Community Survey conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

While in Panna only 17% of Dais have ever experienced this situation, the percentage in Chhatarpur rises to 53%, and in Damoh and Tikamgarh to 74% or more.

The most common recommendations that the Dai gives to the mother after birth can be seen in the following graph.

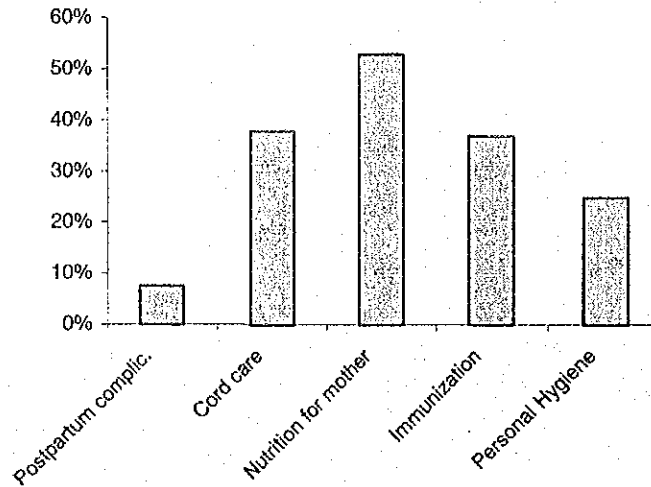


Figure 4-8 The Most Common Advice Given by Dai to the Mother after Birth

Source: Community Survey conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

In 57% of deliveries, new mothers are not told to go to the health facility for postpartum follow-up, or are told to go only in the case of some problem. Note that postpartum complications, such as bleeding or vaginal discharge, are only mentioned by 7% of Dais.

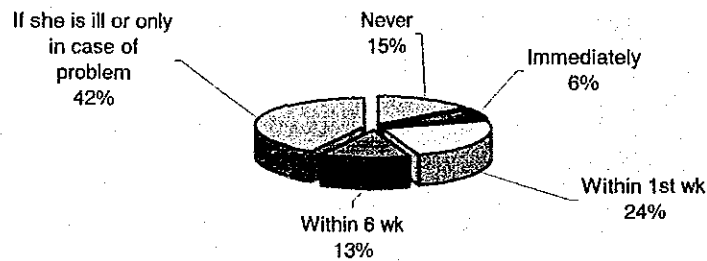


Figure 4-9 Time of Referring Women of the Health Facilities after a Normal Birth

Source: Community Survey conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

The proportion of life-threatening situations in which Dais refer pregnant and delivering women to the health facility can be seen in the following table:

Table 4-31 Warning Signs for Referring Pregnant and Delivering Clients to the Health Facility

Warning signs for referring	(%)
Hyper Tension/Headache/Swelling/Fits	50
Anaemia/Pallor/Fatigue/Restlessness	46
Obstructed/Prolonged Labour	45
Haemorrhage/Heavy Bleeding	35
Abnormal Lie/Position Of Foetus	28
Cessation of Foetal Movement/ Baby Does Not Move	24
Prev. Bad Obstetric History/Abdominal Scars/Prev. Still Birth	23

As in the case of the ANM/LHV, this is a situation that requires immediate attention.

After cutting the umbilical cord with a sterile instrument, over 90% of Dai don't treat it at all, which is the proper care.

Treatment of ARI and diarrhoea is not an area where Dais feel knowledgeable, nor are they trained in these subjects.

One of the main difficulties with the training of Dai is how to select a woman to become a trained Dai. In the majority of cases, the choice has been to select someone from the Basore caste. Apparently, there is a strong pressure from the population to follow tradition and caste "rules". On the other hand, a large number of people do not respect the Basore Dais or call them to conduct deliveries due to their "untouchability." Experiences in training members of other castes have not been very successful.

Dais are to be supervised by the ANM/MPW and LHV, although this interaction seldom occurs. Dais receive their kits from the Government health centres as they deliver their performance reports, which happens between the same day they perform a delivery and one month later.

(See also "Case Study Report" in Supporting report, Chapter 2, 2.1)

(3) The JSR

The main function of JSRs is to collaborate with the health centre to organise camps and distribute medicines. JSR have not been trained in maternal and child health care activities. They are considered private providers and almost none receive any monetary compensation from the government. As private providers their work is limited to minor curative procedures. Nevertheless, the Government strongly relies on them for the implementation of National Programmes in the villages.

To find out what JSRs are doing with their training, we conducted a small follow-up study among all the JSRs in one Block in Sagar Division. A total of 26 had been trained since 1996. Of these, 24 were contacted. Of the 24 for whom we obtained information, 18 were personally interviewed, and information was gathered from parents, wife, or a neighbour in six cases. A total of 16 were working in private practice, generally part-time, and participating in government camps and health fairs; two were working full-time in health but not in government activities; five worked only when requested in government camps but not in any private practice; and one was not working at all in health. Those who work part-time as JSRs worked in agriculture as their main source of

income. Their medical practice earns them between Rs 1,000 and Rs 2,000 monthly from which they must buy their medications.

All the practicing JSRs reported treating only common ailments: malaria, cold, fever, vomiting, and diarrhea. None provides family planning, antenatal, natal or postpartum care. The only RCH work they do is treatment of ARI and diarrhea with ORS. They refer serious cases to the PHC. Their principal modes of treatment are medicines, drips, and injections. They also do some public health work by putting bleaching powder provided by the government in the wells for purification and distributing chlorine tablets.

Among those who practice, several expressed interest in receiving continuing education to keep up on new developments. They reported receiving no supervision or training since the initial training, no kits, loans, or medications from the government.

Several of the JSRs reported that their practice is limited because there are already other providers in the village, among them Anganwadi workers, ANMs, LHVs, and unqualified doctors. Some reported difficulties with practicing at all because villagers are too poor to pay for services or they pay with in-kind, leaving the JSR unable to buy medicines. Others reported that it is preferable to work in neighbouring villages, rather than their own, since people who are not their neighbours are more likely to pay and they can demand payment of clients who are not their neighbours.

Many of the JSRs reported they had heard about the training from the radio. This might be a good strategy for other training programmes, such as for ANMs, that suffer from lack of recruits.

(4) The AWW

Although the ICDS Programme and its Anganwadi workers (AWW) and centres (AWC) do not belong to the Ministry of Health and the RCH Programme, they are key figures in the health of women and children.

Responsibilities: The AWW is responsible for monitoring the growth of children to seven years of age, providing supplementary nutrition for pregnant and lactating women and children (160 grams of daliya to women, 80 to children, and 160 to malnourished children), educate pregnant and lactating women about proper nutrition, and provide them iron and folic acid tablets (IFA) to combat anaemia. Additionally, the AWW generally serves as a depot holder in her village for condoms, pills, ORS, IFA tablets, bleaching powder which she puts in the wells to purify the water, and chlorine tablets for families who get their water from other sources; occasionally the AWW serves as a depot holder for Vitamin A, paracetamol, chloroquine, or other drugs or medical supplies. ICDS programme provides AWW with medicine kit.

Quality of works and training: The quality of the work of the ICDS is highly variable from one centre to another, but it is very dependent on the amount of training the AWW has received. An AWW receives 15 days of initial training, which enables her to distribute daliya (the supplement), inform women that they should eat the foods depicted in a poster when they are pregnant and lactating, and conduct some simple, supposedly educational, activities with children 3-6, such as teaching them songs and poems. Later there is a 56-day training, as well as additional 15-day training courses to expand the AWW's skills. However, there is no consistency in the amount of training an AWW receives.

In Tikamgarh district, for example, we found two AWWs who had begun work in 1996; one had received 86 days of training, while the other had received only the initial 15-day training. The level of activity in the centres varies directly with the amount of training the AWWs had received. The AWW with more training conducted regular activities with the children, made home visits to all the households in her village, weighed the children fairly often (about six times in a year, according to a quick review of her record book), distributes contraceptives and medications, makes referrals to the SC or district hospital, puts bleaching powder in the wells and provides chlorine tablets, cooks daliya for the children, and distributes the raw daliya to women. She knew exactly how many children in the village were grade III or IV malnourished, and could tell us that the number had been reduced to three from five. The AWW who has received only the initial 15-day training since 1996 occasionally conducts activities for the children, prepares daliya for them and distributes it to women, serves as a depot holder, weighs children more or less regularly, and conducts a few home visits to pregnant women to provide traditional advice on nutrition (advises them to eat foods that are cool).

AWW's knowledge on nutrition: Although the AWW is the principal person responsible for improving the nutrition of women and children, in fact, the training she receives does not enable her to provide adequate education. None of the AWWs interviewed knew what foods contained iron, which foods helped absorption of iron, or which hindered absorption. In fact, a review of the syllabus for induction training reveals that the AWWs are not taught about anaemia in women and the role of nutrition. At all levels of training, they are simply able to use a poster to tell women to eat the foods depicted there during pregnancy and lactation. None of the AWWs interviewed had been taught to measure the height of children to identify stunted (height for age) or wasted (weight for height) children. The accuracy of the weights obtained for infants is suspect since the AWWs are not given a proper baby-weighing scale; they use an adult scale adding a metal tray for infants. Some AWWs are given growth charts indicating adequate and inadequate levels of weight for age, but others just note the weight in a notebook and have no objective criteria for determining if the child is underweight (weight for age).

Some AWWs have faulty information that has not been corrected during years of regular supervision. For example, one AWW reported that she was informed during initial training she should register and provide daliya to a maximum of eight pregnant women, eight lactating women, 34 children 0-2, and 34 children 3-6. Even if there are more people who fall in a category in her village, she believes she can only accommodate the target number. This AWW has been operating for two years in this way, and she has received only the original 15-day training. She is unusual in not being a depot holder for medications; there is an ANM in her village, and she refers to the SC.

The poor quality of the training, particularly on health and nutrition, has been confirmed several times in recent years by evaluations conducted by CARE and a recent evaluation/social assessment. The latter found little understanding of nutrition in 22 of 40 villages studied that have an AWC. "Health and nutrition education is considered as important and easy by a very small number of AWWs." It states further, "the education and training to the AWWs has not helped them in imparting non-formal nutrition and health education." In fact, the person in charge of training at the state level reports that the state has decreased the amount of training an AWW receives in recent years. Earlier the AWWs used to receive an induction training of three months (72 working days), which has been reduced to 15 days currently. She further reports that it is the responsibility of the CDPO or the district officer to nominate AWWs for further training, but they do not keep proper records. The state manner of allocating funds also limits training: the fiscal year begins April first, but the first funds for the year are not received until July. Also the state

does not release the second tranche of funds in a year to any AWC Training Centre until all 16 AWCTCs in the state have submitted their reports on expenditures. And these funds are gradually decreasing to the detriment of the quality of the training. For example, an integral part of training is a kit with which the AWWs learn how to develop their own IEC materials, but last year funds were not received to purchase kits.

Casteism and AWW's works: The effectiveness of the ICDS Programme is hampered by casteism. If an AWW is from a higher caste, the SC can not enter the centre or eat the prepared supplement with other women. If the AWW is from the scheduled caste, women from a higher caste may not enter the centre although they may be equally poor and malnourished. Also, a higher caste AWW will not make home visits to women of a lower caste.

On the other hand, there were favourable reports on the pre-school activities. Parents feel confident of good and personalized care of their children by the AWW, who generally has good rapport with the children.

In another village, there is a centre with an empty building, but no AWW, only a non-literate helper. Filling the post has become a political issue that has yet to be resolved. The politically powerful want their daughter or daughter-in-law to be named to the post, but none of these women meet the educational criteria, while other women in the village do. Interestingly, this non-literate helper was provided with a store of medications in March 2000 including sulphacetamide eye drops, paracetamol, mercurochrome, benzyl benzoate for scabies, tincture of iodine, cotton rolls and bandages, mebendazole, trimethoprim and sulphamethoxazole tablets, but no contraceptives. She also received 40 Dai kits since she is supposed to accompany the Dai during deliveries. The ICDS Programme did not train her how to use these medications, so she consulted the ANM.

Management of the Programme: Management of the programme is not rationalized. The operations are separate from the training centre, each reporting directly to Bhopal. In fact, when we requested a copy of the training curriculum from the District Programme Officer, he could not supply it since it rested only in the training centre. He answered evasively when we asked if he had ever seen the curriculum. The District Programme Officer reports that training is cyclic: when a supervisor sees that a worker has not been trained in some time, he is supposed to submit the AWW's name for training. This has not resulted in a standardized training schedule.

The District Programme Officer supervises Child Development Project Officers (CDPOs), who in turn directly supervise some AWWs and 6-7 supervisors each. The CDPOs are males with a B.S. but no previous training in nutrition. They receive a two-month foundation course. In fact, there appears to be not a single nutritionist in the state structure.

Last year an evaluation of the ICDS Programme in Madhya Pradesh was conducted in five districts, including Chhatarpur. Below are the principal strengths and weaknesses of the programme cited in the draft report:

Strengths:

- The AWW reaches even remote villages
- The AWW facilitates other development department functionaries
- The programme helps create awareness
- A mechanism is in place to provide services to women and children
- The AWW facilitates women in improving their economic condition
- She mobilises the community and its resources
- She prepares children for formal education
- She provides local blends to the services.

Weaknesses:

- Lack of proper selection and training of AWWs
- Lack of infrastructure in many AWCs
- Politicisation of AWW selection at the local level
- Often poor quality of the supplemental nutrition
- Lack of variety in the supplement
- No toilet
- Inadequate space in the AWCs
- Conventional methods used for non-formal education
- Maintaining records consumes much of the AWW's time
- Lack of a monthly calendar except for immunisations
- Low levels of morale and pay
- Lack of incentives for AWWs and helpers
- Lack of adequate support from supervisors and project
- Lack of problem solving mechanism
- Limited impact on social evils
- One-way communication (top-to-bottom)
- Poor hygienic conditions.

(5) Non-allopathic Medicine Providers

Non-allopathic medicine practices are also present at the community level. Some, like the Ayurvedic, Unani and Homeopathic are recognised and legalised by the Government. According to the quantitative and qualitative research conducted, at the community level their importance is minimal.

It is worth emphasising here that all these health providers, including Dais, have very limited experience, knowledge and skills to identify life-threatening situations during pregnancy and delivery.

(6) Private Doctors and Clinics

Private doctors, clinics and nursing homes offer services that those that can afford prefer over the government services, particularly if they consider the situation a "serious" one, like a child's illness.

4.4.2 Health Providers at Health Facilities

(1) Nurses

Nurses are posted at larger health facilities, such as B-PHCS, CHCs, and hospitals. Their duties are mainly in the inpatient wards or surgery rooms. Only seldom do they provide outpatient RCH services. However, 63% of them conduct deliveries. About half of them supervise LHV's work, but they do not go to the field. Almost all enjoy working at their present post and feel that facilities need to have better infrastructure, the presence of a lady doctor, and more medicines.

(2) Doctors

Doctors are present in theory in all facilities above SC. However, many PHCs do not have a doctor among their staff. Even in the case when there is a doctor, he or she is usually a GP not providing RCH services.

At B/PHC and CHC levels the presence of one or more doctors is the rule. However, in none of these facilities from the 5 districts is the doctor an Ob-Gyn. The same is true for Anaesthesiologists. There is 1 surgeon in Chhatarpur. None of these doctors provides reproductive health services including emergency obstetrics, which are only available in the hospitals in the district capital.

None of the GPs had received any training in reproductive health nor are they interested in such training.

4.4.3 Health Worker's Competency – Beneficiary Survey Results

Our beneficiary study looked at health providers' skill using a methodology that compared what the provider did during a consult with what should have been done, commonly called the "gold standard." In this case the client's recollection of what the provider did or said was used. While the methodology is generally regarded less accurate than professional observation of the consult, nevertheless it has the benefit of allowing the opportunity to gather the opinions of the clients about the services received. This study looked at three types of RCH services: family planning, antenatal care, and paediatric visits.

(1) Family Planning

Among family planning clients interviewed, 43% were new acceptors and 57% were follow-up clients, coming for a routine revisit, resupply, or resolution of a problem. Because this study was conducted in SCs, PHCs, and CHCs, and there are few users of any method other than sterilisation, which is usually obtained in a camp or hospital, the cases in the study are too few to be highly reliable, but they are worth studying for the general trend.

The following should occur during the visit of a new family planning acceptor:

- The provider should describe all methods available to the client (informed choice)
- The client should receive the method of her own choice (voluntary choice)
- The method should be available at the service site
- The provider should tell the client when to return for a follow-up visit.

Nearly all clients reported that providers described other methods. More than 90% of clients received a method during the visit. Four-fifths of them received the method of their choice. A fifth reported that there was a method other than the one they received that they would have

preferred to use, including users who would have preferred sterilization, a method that is not offered at this level of the health system. There was only one case where a user did not receive the method of choice because of a stock-out. The weakest point in the protocol was telling clients when to return for a follow-up visit: a third failed to do so, at least according to the recall of the patient, which is a reasonable criterion for this step in the service.

A slightly larger number of clients were making a follow-up visit or were coming for resupply. These were in the main (85%) users of orals or condoms. In a follow-up the basic protocol calls for the provider to ask if the client is having any problem with the method, resolve it to the client's satisfaction if so, and resupply the method if the client wishes it. Just under half reported that the provider asked if they were having any problem with the method. Fortunately, 94% reported they were not, so there were too few cases to learn anything about the provider's ability to resolve problems in this study. Almost two-thirds of clients had planned to get a resupply of the method, and all of these plus a few who had not planned to do so received a resupply. Overall the performance was reasonably strong, but we were unable to make any assessment of the provider's ability to resolve problems. Also, a serious problem in the system is the over-reliance on female sterilization, which has been addressed elsewhere. Because this study was not conducted in hospitals or camps, we were unable to determine the extent of informed and voluntary choice of sterilization acceptors, but this issue is addressed elsewhere in this report in a discussion of satisfaction with the decision.

In focus groups, many people reported contraceptive failures for themselves or others in their communities, generally for pills or tubectomy. While a pill failure may reflect poor patient compliance or poor instructions in use of the method, a tubectomy failure can be explained only by poor provider skills. A sterilization failure should be a rare occurrence, and training should be improved.

(2) Paediatric Care

More of the visits under study were paediatric care of a child under three than for family planning. Children in their first year of life accounted for 70% of all under-threes, and they were seen in the lower levels of the health system. In a well child visit, the gold standard calls for the provider to:

- Determine how old the child is
- Weigh the child
- Measure her/his height
- Discuss with the mother how the child is growing
- Discuss the child's nutrition and what to do when the child has diarrhoea or a respiratory problem (*major killers of children in this region*)
- Provide any immunisations needed
- Set up a return visit
- Discuss the importance of delaying the next pregnancy.

Less than a third of children were weighed during the visit, and even fewer (22%) had their height measured. However, 65% of mothers said the provider talked with them about how the child was growing, and even more (71%) discussed what foods the child should eat. Just over half received an immunisation, while three-quarters were told when to return for other immunisations. Providers were much more conscientious about discussing what to do about diarrhoea than respiratory problems: 80% discussed diarrhoea while only 33% discussed respiratory problems. Nearly two-thirds reported the provider discussed the importance of child spacing. Other than immunisations and education about diarrhoea and family planning, the provider performance

was weak in child health visits. There is a clear need to make improvements after determining what is most needed: equipment such as baby scales, training and supervision, or protocols, or other interventions.

(3) Ante- and Postnatal Care

Antenatal care is important to the successful outcome of a pregnancy and an opportunity to provide education about problems that may require immediate care and other issues in pregnancy and delivery. Enough antenatal care cases were identified to enable us to make reliable observations about their quality (192). Just over half of these were first time ANC visits for this pregnancy. The gold standard calls for the provider to:

- Check blood pressure
- Do an abdominal exam
- Listen to the baby's heartbeat
- Give tetanus toxoid and IFA
- Take a history of previous pregnancies
- Answer any questions the woman may have
- Schedule a return visit
- Discuss the progress of the pregnancy with the woman
- Educate the pregnant woman about proper nutrition in pregnancy, breastfeeding, the benefits of delivering in a medical institution, problems that occur during pregnancy, labour, delivery, and the postnatal period that need immediate attention.

The procedures that providers performed conscientiously (in at least three-quarters of cases) were abdominal examination (76%), provision of tetanus toxoid (79%) and IFA tablets (87%), educating the woman about foods to eat during pregnancy (77%), answering the woman's questions (92%), setting a time for a return visit (89%), and discussing the progress of the pregnancy with the woman (91%).

There is room for improvement in discussing the benefits of delivering in a medical institution (63%), listening to the baby's heartbeat (46%), checking blood pressure (52%), taking a history of previous births (52%), discussing family planning after the birth (60%), and educating about breastfeeding (63%). Women were asked what danger signs they know during pregnancy, labour and delivery, and in the postpartum period to determine the level of effective education by the provider or others. Their responses were recorded for the most common problems that require immediate attention.

For danger signs during pregnancy, women mentioned:

- swelling of the hands or face or hypertension (61%)
- fever (57%)
- anaemia or fatigue (47%)
- vaginal bleeding or spotting (27%)
- malposition of the foetus (19%).

For danger signs during labour and delivery, women mentioned:

- swelling of the hands or face (78%)
- prolonged labour (64%)
- tears or vaginal lacerations (15%)
- cord wrapped around the baby's neck (12%).

For danger signs following delivery, women mentioned:

- heavy vaginal bleeding (57%)
- a listless baby (53%)
- late delivery of the placenta (42%)
- fever or sustained vaginal discharge (32%)
- convulsions (12%).

These findings suggest which aspects of education of the pregnant woman need the most strengthening. Results may also indicate a need to provide missing equipment: absence of a sphygmomanometer, for example, could be the reason for the poor performance in taking blood pressure.

In rural areas the ANM is supposed to provide prenatal care to all pregnant women and visit every newly delivered mother during the first week following the birth of a child. Only one quarter of respondents in the household survey who recalled the prenatal care they received in their last pregnancy reported that the ANM had performed an abdominal exam. Only 3-4% of respondents reported receiving a visit from the ANM in the first week postpartum, and an additional 13% reported the ANM visited within the first two months. Nearly half of all women respondents reported that the ANM did not visit at all, while 10% could not remember. Both qualitative and quantitative improvements are needed in pre- and postnatal care.

(4) Health Education

Health education is an important part of any RCH visit, especially among a population that has low levels of literacy and education, and thus few alternatives for learner healthier practices. In general inadequate levels of health education are provided during health care visits. Providers are reasonably conscientious about providing education on child immunizations (64%), and nutrition (60%), but no other subject is discussed in even half of the visits studied in this beneficiary survey. The most frequently neglected topics are sexually transmitted infections, mentioned by only 2% of respondents, and HIV/AIDS, mentioned by only 7%. Other subjects that could improve are education about family planning, child growth and monitoring, and oral rehydration, provided to 37% of non-contraceptors, and 48% and 28% respectively of all visits. Although providers are conscientious about nutrition education, its content and quality should be further studied given the very poor nutritional status of women and children in this region.

Educational materials are important tools for health care providers. Our study explored with recent users of services whether they had received any educational material during the visit. Only 22% responded positively, while 76% had not received any. There were no differences by type of facility: the lack of materials is equally prevalent at all levels. When a beneficiary reported having received material, it was most likely to be on antenatal or postnatal care (44%), immunisations (28%), family planning or child health (13% each). Almost no one had received any material on RTIs, HIV/AIDS, or delivery services. There is a need to increase the availability and distribution of client materials on all RCH topics and throughout the system, which would also entail training staff in their use.

4.4.4 Quality & Appropriateness of Training in RCH Programmes

Several international agencies such as UNFPA, DANIDA, Family Planning Association of India (FPAI) etc., as well as the government (RCH Project, for example) have had training programmes in Sagar Division. The training activities have been targeting all levels of clinical personnel and community health workers.

Nevertheless, training activities do not follow an assessment of needs, priorities and criteria for inclusion of staff in the training or even to design curricula that correspond to the found priorities. Furthermore, since the training does not follow any strategy or tactic to fill the gaps in population coverage, the services provided are still not responding to the needs.

It may also happen that while the curricula address training needs (both UNFPA and DANIDA have conducted training needs assessment), the course itself is not conducive to sound learning and skill development.

Regarding areas such as interventions in emergency obstetrics, there have been no training activities either for nursing staff or for doctors.

Regarding the knowledge and skills of Dai and ANM/LHV, their lack of preparedness puts at risk the life of the women.

There are no scheduled training activities for emergency obstetrical care and diagnosis and treatment of RTIs for physicians and nurses or for the development of management skills. Most officials with management responsibilities do not have any formal or informal training in this area.

Despite the efforts and the human and financial resources used in RCH training in the last 10 years, the outcome has not responded to the needs. Its quality and appropriateness need to be reviewed.

State Training policy (in-service training)

Last January, DANIDA sponsored a workshop with other agencies and government officials and the directorate from the Health Management Institute to discuss and approve policies for in service and pre-service training. The assembly concluded that it was necessary to have only one organ in charge of all the training in Madhya Pradesh, both in-service and pre-service. By having these decisions and accreditation centralised in one body it would be easier to orchestrate training in a synergistic and cost effective manner. Decisions about the composition of this body and its minutes and action plan were to be decided shortly.

4.4.5 Care at the Health Facility Level

The health services offered at the different level health facilities in Sagar Division can be seen in the Table 4-32.

As a result of constraints: 1) the lack of adequate facilities, equipment and supplies, 2) the total absence of Ob-Gyns in the periphery and the lack of skills and knowledge from the GPs available, and 3) the limited skills of LHV and ANM/MPW, the delivery of reproductive health care services is very limited in number and quality in the health facilities of Sagar Division.

Despite the "official norms", almost all peripheral health units limit themselves to the provision of routine family planning, antenatal care, and normal delivery as well as child care of common/endemic diseases such as acute respiratory infections and diarrhoea. Nevertheless, the utilization of services is very low. An exception might be immunization where the provision of services at the SC is high. Antenatal care and normal delivery are mainly provided at home through the visits of the ANM/MHW, and so is family planning if the chosen method allows for it.

Emergency situations and surgical interventions are referred to the hospital, since there is not one peripheral health facility that contains a functioning operating room and an Ob/Gyn, surgeon, and anaesthetist. Emergency obstetrics is offered only at the district hospitals. At every level of health unit, any deliver that is not evolving normally or that needs medical intervention, is referred to the hospital.

Besides the constraints stated above, it was repeatedly mentioned that in a small village if something "goes wrong" during deliver and the mother dies, the populace becomes very angry and may harm the medical attendant, even if it is a doctor. So health professionals, both doctors and nursing staff, prefer to refer the patient rather than intervene more aggressively.

RTIs/STDs are treated at all levels although most of the nursing staff are not well prepared, and there are no Medical Officers trained in this area.

Almost no one provides medical termination of pregnancy (MTP).

Antenatal care is offered in all the facilities, but urine and blood tests are only performed in a few sites. *Regarding family planning, all the facilities offer counselling, pills, IUD and condoms. Male sterilisation is very rare and female sterilisation is usually performed in "camps". Potential clients are identified during the needs assessment that occurs in February. The results are used to plan the "camps" and number of cases of sterilisation. A surgeon is nominated to attend to the "camp", and surgery goes on until the targets for that area are met. These camps might be held in different health units in the district with the technical support of the Hospital. Sterilisation may also happen in the Hospital or CHC/B-PHC.*

Table 4-32 Services Offered at the Health Facility and at Community/Home in Sagar Division.

H. Facility	Hospital	CHC	B-PHC	PHC	SHC
Service					
Antenatal care	1	1	1	1	1
Normal delivery	1	1	1	1	1
Postnatal care	1	1	1	1	1
Blood test anaemia	1	X	X	X	0
Blood test malaria	1	X	X	X	0
Urine test	1	X	X	X	0
M.T.P.	1	X	X	0	0
Complicated abortion	1	X	X	0	0
Caesarean /EmOC	1	0	0	0	0
Blood transfusion	0	0	0	0	0
Syndr. diagnosis RTI	1	X	X	X	0
Lab. Diagnosis RTI	1	X	X	0	0
Treatment for RTI	1	X	X	X	0
FP counselling	1	1	1	1	1
Pill	1	1	1	1	1
IUD	1	1	1	1	1
Surgical female sterilisation	1	X	X	0	0
Surgical male sterilisation	1	X	X	0	0
Complication of FP	1	X	X	0	0
Normal new-born care	1	1	1	1	1
High risk new-born care	0	0	0	0	0
Diarrhoea	1	1	1	1	1
Fever	1	1	1	1	1
Ac. Respiratory Infections	1	1	1	1	1
Immunisation M & C.	1	1	1	1	1
IEC activities	0	0	0	0	0

Note: 1 - Available in most facilities of the mentioned type,
X - Available in some facilities of the mentioned type,
0 - Not available in the mentioned type of facility

Table 4-33 Type of Laboratory Services Actually Provided at the Health Facility during Last Week

Laboratory Services	(Unit: %)				
	Dist. Hosp.	CHC	B-PHC	S-PHC	SC
Malaria testing	100	100	100	100	72*
Syphilis testing	80	17	0	0	0
Haemoglobin Measurement	100	83	28	22	21
Urine testing for Protein Measurement	80	100	43	33	23
Total N	5	6	7	18	39

Note: *Only slide testing

Source: Study on Health Facility and Human Resources under JICA Development Study on Reproductive Health, conducted by ORG-MARG, 2001

4.5 REFERRAL SYSTEM AND EOC

4.5.1 Referral System

Figure 4-9 shows the referral system for rural areas in Madhya Pradesh. The former system for rural areas, which allowed two vertical routes, was officially abolished in 1998. Having in theory upgraded all the block-level PHCs to CHCs, the present system was then introduced. Under the present system, the cases that can not be managed at a SC or a PHC are referred to the CHC that is directly covering those health facilities. Similarly, the cases that can not be managed at a CHC are referred to the District Hospital. However, daily supervision and reporting are executed in the sequence of SHC, PHC, CHC and the Chief Medical & Health Officer (CMHO) who heads the District DHFW. Separately, supervision and reporting between the District Hospital and District DHFW are executed directly between Civil Surgeon and CMHO.

Both Damoh and Tikamgarh districts presently are transitioning to the new system because upgrading of the block-level PHCs to CHCs has been delayed. In order for a Block-level PHC to be upgraded, certain conditions for facilities, staffing, functions, and number of beds must be satisfied. The table on the next page shows the responsibilities of each party in the process of an obstetric emergency as the referral is defined in the norms.

Figure 4-10 shows the referral system in urban areas. The referral system in urban areas used to have a structure similar to that of rural areas. However, there is only one Civil Hospital (in Sagar) in five districts of Sagar division. Many Urban Family Welfare Centres (UFWCs) have been integrated into the District Hospitals as one of their departments. In Damoh district, the District Hospital with an UFWC is the only DHFW health facility, and governmental referral systems in urban areas do not exist. In Tikamgarh district there are three governmental health facilities in the urban area: one District Hospital with an UFWC, one Civil Dispensary, and one MCH Centre, which is comparable to the former UFWC. The present referral systems at the District Hospitals of Damoh and Tikamgarh are as follows:

Table 4-34 Referral Norms for an Obstetric Emergency

Phase	Type of parties involved in the process of an obstetric emergency referral				
	(a) Lower HF from which a case is transferred	(b) Higher HF to which a case is transferred	(c) Pregnant woman's family	(d) Pregnant woman's GP	
(1) Routine prior to an obstetric emergency	a11 Be aware of the nearest First Referral Unit (FRU) in the area	(none)	cd11 Make an advanced transport arrangement in case of an obstetric emergency		
When an obstetric emergency occurs	(2) Prior to transport	a21 Provide necessary medication (lactate/saline/glucose, antibiotic, etc.) a22 Sedate the patient a23 Give a referral slip/note on her medical findings and medication given a24 Contact the higher HF in advance by telephone, if it is available there	b21/31 Do necessary preparation (labour room, operation theatre, equipment, etc.)	cd21 Arrange the quickest mode of transport c22 Find family members, relatives, or friends who can donate blood and accompany the patient	(none)
	(3) During transport	a31 Assign a health worker to care the patient and to provide health technical support to the accompanying patient's family, if possible.		c31 Keep the patient in the left lateral position to prevent pressure to aorta/vena-cava, asphyxia, and inhalation of vomitus c32 Put a soft mouth gag between her teeth in case of imminent eclampsia c33 Give the patient frequent sips of water to prevent dehydration	(none)
	(4) After transport	(none)	b41 Start immediately treatment for the patient	(none)	(none)
	(5) After delivery	a51 Review and record the feedback from HF to which a case is transferred	b51 Provide feedback to the lower HF which a case is transferred	c51 If GP subsidy scheme is applicable, claim the transport cost to GP.	d51 If the transport cost is claimed, pay to the patient or her family.

Source: 1) Directorate of Public Health & Family Welfare, Government of Madhya Pradesh (2001)
2) Ministry of Health & Family Welfare (1994) National Child Survival and Safe Motherhood Programme, New Delhi, pp.42-43

Figure 4-10 Referral system and supervision/reporting system in rural areas of Madhya Pradesh

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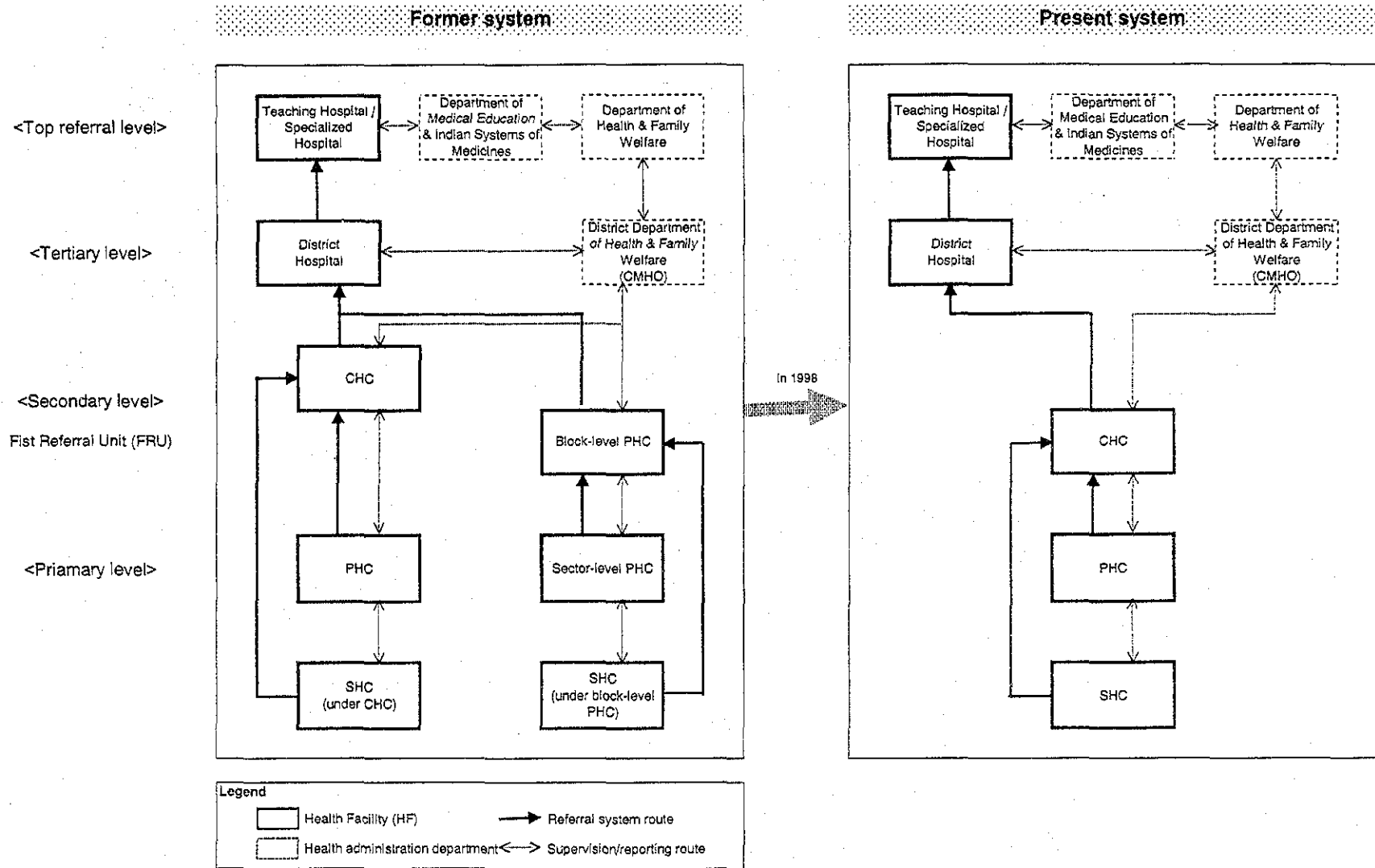
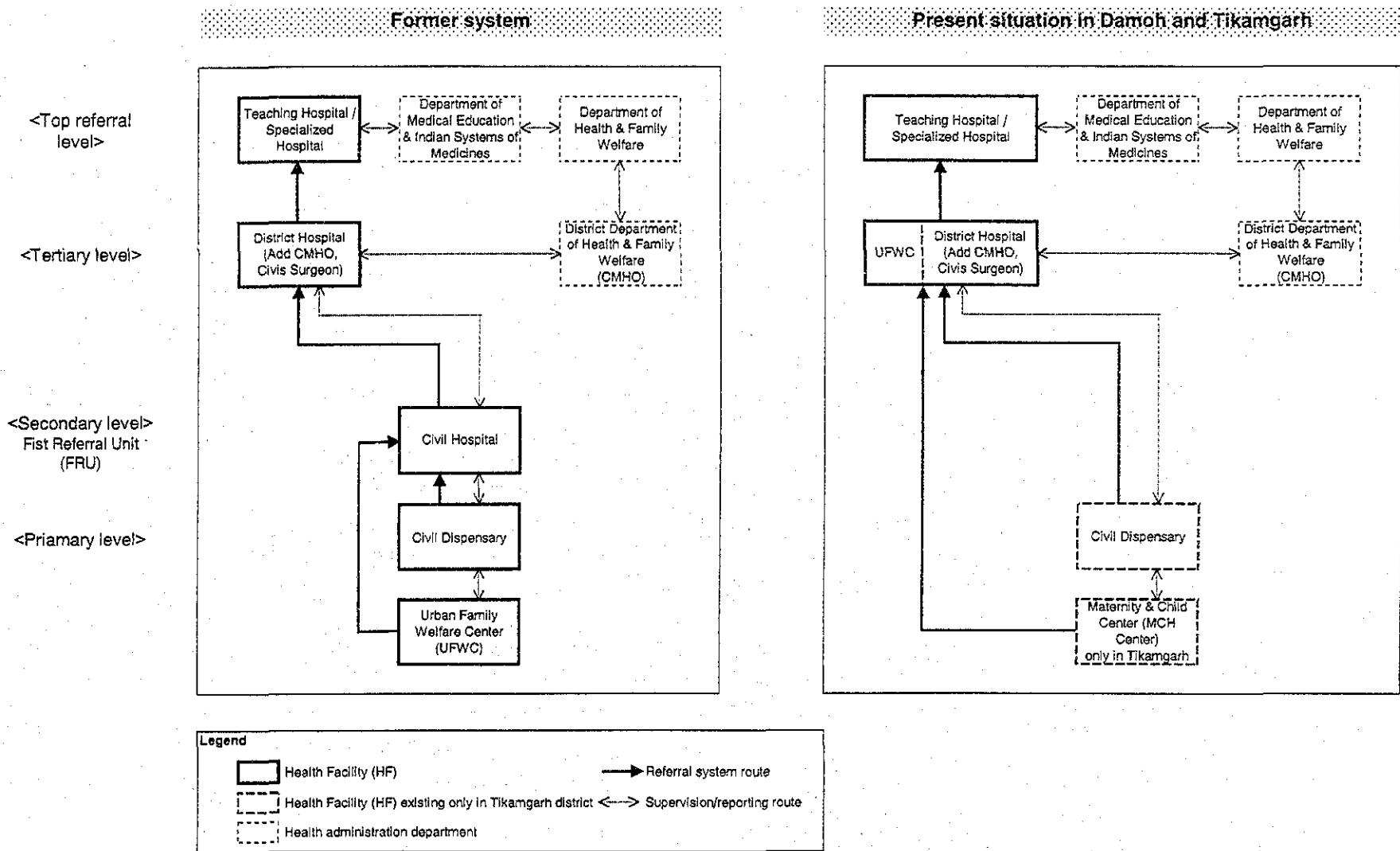


Figure 4-11 Referral system and supervision/reporting system in urban areas of Madhya Pradesh

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4.5.2 Actual Situation of Referral System

(1) Results of the Facility Survey

The results of the health facility survey showed that only 51 of 75 health facilities (68.0%) gave first aid treatment prior to referring the cases to higher level facility (-ies). Though 55 (73.3%) health facilities provided referral information in written form to higher levels, only 11 (14.3%) health facilities received that information from lower referral ones. This gap might indicate that patients and their accompanists tend to misplace referral slips and communication means such as the postal system are not strong enough. Similarly, another gap was detected between transferring lower and receiving higher health facilities: whether they know the health facilities that are above or under them. While 37.3% of lower ones know higher ones, only 8.6% of higher ones know lower ones.

Table 4-35 Level of Function of Referral System in Sagar Division

		Tikamgarh	Damoh	Sagar	Chhatarpur	Panna	Total
Practice necessary first aid treatment prior to referring cases	Always / Frequently	16 (76.1%)	14 (58.3%)	8 (80.0%)	7 (63.6%)	6 (66.7%)	51 (68.0%)
	Sometimes	4 (19.1%)	9 (37.5%)	2 (20.0%)	4 (36.4%)	3 (33.3%)	22 (29.3%)
	Never	1 (4.8%)	1 (4.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (2.7%)
	Total	21 (100.0%)	24 (100.0%)	10 (100.0%)	11 (100.0%)	9 (100.0%)	75 (100.0%)
Know the official direct higher referral facility	Yes	20 (95.2%)	14 (58.3%)	7 (70.0%)	8 (72.7%)	6 (66.7%)	55 (73.3%)
	No	1 (4.8%)	10 (41.7%)	3 (30.0%)	3 (27.3%)	3 (33.3%)	20 (26.7%)
	Total	21 (100.0%)	24 (100.0%)	10 (100.0%)	11 (100.0%)	9 (100.0%)	75 (100.0%)
Inform higher referral facility in written form in advance	Always / Frequently	6 (28.6%)	12 (50.0%)	4 (40.0%)	1 (9.1%)	5 (55.6%)	28 (37.3%)
	Sometimes	7 (33.3%)	8 (33.3%)	3 (30.0%)	4 (36.4%)	3 (33.3%)	25 (33.3%)
	Never	8 (38.1%)	4 (16.7%)	3 (30.0%)	6 (54.5%)	1 (11.1%)	22 (29.3%)
	Total	21 (100.0%)	24 (100.0%)	10 (100.0%)	11 (100.0%)	9 (100.0%)	75 (100.0%)
Know the official direct lower referral facilities	Yes	0 (0.0%)	3 (25.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (8.6%)
	No	9 (100.0%)	9 (75.0%)	5 (100.0%)	5 (100.0%)	4 (100.0%)	32 (91.4%)
	Total	9 (100.0%)	12 (100.0%)	5 (100.0%)	5 (100.0%)	4 (100.0%)	35 (100.0%)
Receive referral information from lower referral facility in advance	Always / Frequently	2 (22.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (25.0%)	5 (14.3%)
	Only emergency case	0 (0.0%)	4 (33.3%)	1 (20.0%)	1 (20.0%)	0 (0.0%)	6 (17.1%)
	Never	7 (77.8%)	8 (66.7%)	4 (80.0%)	4 (80.0%)	1 (75.0%)	24 (68.6%)
	Total	9 (100.0%)	12 (100.0%)	5 (100.0%)	5 (100.0%)	4 (100.0%)	35 (100.0%)
Record on referral cases	Yes (in referral record form)	2 (22.2%)	1 (8.3%)	1 (20.0%)	0 (0.0%)	3 (75.0%)	7 (20.0%)
	Yes (in treatment record)	0 (0.0%)	1 (8.3%)	1 (20.0%)	3 (60.0%)	0 (0.0%)	5 (14.3%)
	Yes (others)	0 (0.0%)	1 (8.3%)	0 (0%)	0 (0.0%)	0 (0.0%)	1 (2.9%)
	No	6 (66.7%)	7 (58.3%)	3 (60.0%)	1 (20.0%)	0 (0.0%)	17 (48.6%)
	Don' know	1 (11.1%)	2 (16.7%)	0 (0.0%)	1 (20.0%)	1 (25.0%)	5 (14.3%)
	Total	9 (100.0%)	12 (100.0%)	5 (100.0%)	5 (100.0%)	4 (100.0%)	35 (100.0%)

Note: *1) Forty Sub-Health Centres (SHCs) are not included because they are primary health facilities that are the lowest in referral system.

Source: Health Facility Survey in this study

(2) Qualitative Study in Damoh and Tikamgarh

1) Damoh District Hospital (Prem Shanker Dhagat Memorial Hospital)

The majority of inpatients in the maternity ward (20 beds) and the paediatric ward (20 beds) have not been referred from lower health facilities but have directly sought admission: only two of 90 inpatients were referral cases in the maternity ward during a 1.5 month-period from 01st November to 14th December 2000. Though a referral slip from the lower facility is attached to the treatment record, there is no system by which referral cases from lower facilities are recorded in separate forms or files. When further referring to the teaching hospital in Jabalpur, a referral slip is issued. However, no record of the referral is prepared. An emergency obstetric case of convulsion referred from the lower facility to the District Hospital provides some lessons on transport in the referral system (See Supporting report, B, Part II).

2) Tikamgarh District Hospital (Rajendra Hospital)

The total number of referral cases from the lower facilities in the maternity ward (30 beds) was difficult to specify because the majority of them were transferred to the District Hospital without referral slips/notes but only based on the verbal advice from the health professionals of the lower facilities, and the District Hospital does not have a system to record referral cases from the lower facilities except that referral slips/notes are attached to the treatment records when they are issued.

A gynaecologist and her four support staff (one head nurse, one staff nurse, and one MPW(Female)/ANM) know which patients amongst the currently admitted are the referral cases. However, once they are discharged, the maternity ward staff soon forget which cases are referrals because there is no recording system. According to one spot observation made on 19 December 2000, 29 of 30 beds were occupied and four of 29 were the referral cases from the lower facilities. This may indicate that there may be more referral cases from the lower facilities in Tikamgarh than in Damoh.

Referring a case to the teaching hospital in Gwalior, which is an official top referral facility for the district and is a four-hour drive away from Tikamgarh, the District Hospital issues a referral slip/note. However, the District Hospital cannot issue a referral slip to the patients when referring to the teaching hospital in Jansi, which is not an official top referral facility¹ for the district but is located only a two-hour drive away from Tikamgarh. To which of these two teaching hospitals a case will be referred depends fully on the preference of a patient and her family. The number of cases referred to Jansi accounts for approximately 75% of the total of referral cases from the District Hospital to the teaching hospitals. This is probably due to better access to the teaching hospital in Jansi though it is not an official top referral facility. Amongst 376 inpatients in the maternity wards from 01st November to 20th December 2000 (50 days), 65 (17.3%) were referred to teaching hospitals. One case study of continuous amnionitis accompanying unconsciousness² indicates again poor transport from a PHC to the District Hospital (See Supporting Report, B, Part II).

Referrals are few and in a much lower proportion of cases than what would be expected knowing the usual percentage of complicated pregnancies and delivers.

¹ The teaching hospital in Jansi is located not in Madhya Pradesh but in Uttar Pradesh. Therefore, it is not an official top refer facility for Tikamgarh district.

² Amnionitis accompanying unconsciousness is one of the most common obstetric problems in Tikamgarh district.

Despite the referral system that has a complex pyramid for health facilities' scopes of work and more recently the inclusion of the First Referral Unit, almost all cases are referred to the main hospital. As has been mentioned, most peripheral units do not have adequate physical and human resources to solve emergencies or difficult medical situations.

Very little information is available about the referred cases. There are no files or records that report adequately the reason, hour and condition of the patient when she was referred. Most often the mean of transportation and the time elapsed are also not known. Therefore, it is impossible to assess correctly the outcome of the referrals.

4.5.3 Communication and Transportation System

There is no communication and transportation system for emergency care.

Transportation to transfer the patient from the health unit is almost non-existent. Even when there is a vehicle available, it is not used to transfer patients from one unit to another. Therefore, clients have to arrange their own transportation and pay for it. It may be a carriage, a motorbike, or less often a car. Transport is not easy to obtain since there are not many vehicle available in the villages. Afterwards a new adventure begins – the travel to the Hospital in the capital of the district. Roads are very bad and bumpy and more suitable for carriages than for motor vehicles. With the latter, and with luck, one may slightly pass the speed of 10Kms per hour on most of the roads. In a few long hours and if the patient doesn't collapse meantime, she arrives at the hospital.

The same way that the patient was sent to the hospital without any note from the doctor or nursing staff, the doctors from the hospital also do not provide feedback to the sender.

Telecommunication is available only at hospitals and a few CHCs. PHCs and SCs have no means to communicate with upper level health facilities in case of emergency.

4.6 HEALTH SERVICE UTILIZATION AND RCH CARE SEEKING BEHAVIOUR

4.6.1 Reproductive Intentions

(1) Desire for Additional Children

The average number of living children among women of reproductive age is 2.6 with slightly more boys than girls. Two-thirds of currently married urban women of reproductive age want no more children, while slightly fewer rural women want no more. A desire to end childbearing predominates after the second child at which point 69.3% and 60.2% of women in Tikamgarh and Damoh report wanting no more, and it increases with higher parity. Even more rural husbands report they want to end childbearing. Interestingly less than 2% of women and men interviewed reported that the decision was up to God or they were undecided. Men who want another child most often reported their reason as a desire to have a son (37.1%).

Table 4-36 Desire for More Children

(Unit: %)

Details	Tikamgarh			Damoh			Total		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
By women (All currently married women those are not currently pregnant or don't know whether pregnant)									
Want more	28.4	30.7	30.3	23.3	28.5	27.6	26.0	29.6	29.0
Want no more	67.9	59.1	60.6	61.6	57.2	57.9	64.9	58.1	59.3
Can not get pregnant	2.5	8.2	7.2	15.1	12.0	12.5	8.4	10.1	9.8
Up to God		0.5	0.4		1.0	0.9		0.8	0.6
Undecided	1.2	1.5	1.5	0.0	1.3	1.1	0.6	1.4	1.3
N	81	391	472	73	383	456	154	774	928
By men (All interviewed husbands)									
Want more	32.1	32.9	32.8	30.1	38	36.8	31.2	35.5	34.8
Want no more	66.7	65.3	65.6	65.8	59.4	60.3	66.2	62.3	62.9
Wife can not get pregnant	1.2	0.7	0.8	4.1	2.1	2.4	2.6	1.5	1.6
God's will		0.7	0.6		0.5	0.4		0.6	0.5
Don't know		0.2	0.2					0.1	0.1
N	81	401	482	73	421	494	154	822	976

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

(2) Decision-maker of Number of Children

Nearly two-thirds of women and men reported that the husband and wife should make the decision together about the number of children in the family. However, among those who felt that one or the other should make the decision, women reported the husband seven times more often than the wife. More rural women reported the husband should make this decision than urban women. Husbands almost never stated the wife should make the decision.

Table 4-37 Decision-Maker of Number of Children in Family

(Unit: %)

Details	Tikamgarh			Damoh			Total		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
All currently married women									
Husband	21.0	33.8	31.6	15.1	26.4	24.6	18.2	30.1	28.1
Herself	3.7	4.9	4.7	1.4	3.1	2.9	2.6	4.0	3.8
Husband & wife together	72.8	55.5	58.5	82.2	65.5	68.2	77.3	60.5	63.3
God		0.8	0.6		0.8	0.7		0.8	0.6
Parent in-law		4.6	3.8		3.1	2.6		3.9	3.2
Other		0.3	0.2		0.3	0.2		0.3	0.2
Don't know	2.5	0.3	0.6	1.4	0.8	0.9	1.9	0.5	0.8
N	81	391	472	73	383	456	154	774	928
All interviewed men									
Husband	25.9	48.4	44.6	37.0	25.4	27.1	31.2	36.6	35.8
Wife	1.2	1.5	1.5	1.4	1.2	1.2	1.3	1.3	1.3
Husband & wife together	72.8	47.1	51.5	60.3	72.2	70.4	66.9	60.0	61.1
God		1.0	0.8		0.5	0.4		0.7	0.6
Parent in-law		0.5	0.4	1.4	0.2	0.4	0.6	0.4	0.4
Other		0.2	0.2		0.2	0.2		0.2	0.2
Don't know		1.2	1.0		0.2	0.2		0.7	0.6
N	81	401	482	73	421	494	154	822	976

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

4.6.2 Reproductive Knowledge

(1) Knowledge of the Need to Space Pregnancies

Knowledge of the need to space pregnancies is nearly universal: nine out of ten women and men report that there should be at least two years between pregnancies, and adults and adolescents of both sexes report in focus groups that intervals of two to five years is important. Among the reasons for the need to space pregnancies, the health of mother and child and economic well-being predominate.

Table 4-38 Ideal Time Between Two Pregnancies

(Unit: %)

Details	Tikamgarh			Damoh			Total		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
All ever-married women 15-49 yrs									
<1 Year	1.1	0.7	0.7	1.2	3.5	3.1	1.1	2.1	1.9
1 Year	3.3	12.2	10.7	4.7	7.4	7.0	4.0	9.7	8.8
2 Years	48.9	48.0	48.1	40.7	51.3	49.6	44.9	49.7	48.9
3 Years or more	43.3	23.2	26.6	45.3	25.2	28.4	44.3	24.2	27.5
DK	3.3	16.0	13.9	8.1	12.6	11.9	5.7	14.3	12.9
N	90	444	534	86	460	546	176	904	1,080
All interviewed husbands									
<1 Year		1.2	1.0	1.4	1.9	1.8	0.6	1.6	1.4
1 Year	3.7	5.0	4.8	2.7	2.9	2.8	3.2	3.9	3.8
2 Years	28.4	33.2	32.4	24.7	44.4	41.5	26.6	38.9	37.0
3 Years or more	40.7	41.6	41.5	52.1	38.7	40.7	46.1	40.1	41.1
More than 3 yrs	24.7	10.5	12.9	15.1	7.8	8.9	20.1	9.1	10.9
Don't know	2.5	8.5	7.5	4.1	4.3	4.3	3.2	6.3	5.8
N	81	401	482	73	421	494	154	822	976

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

The most important sources of information about spacing for both men and women were reported to be television and friends, relatives or neighbours, the latter group being the traditional source of information about family life and sexual relations.

(2) Gap between Knowledge and What Social Pressure Allows

In focus groups carried out with adolescent and adult men and women, participants reported that the benefits of spacing at least two or three years allow for improvement of the couple's economic situation and the woman's health. However, while the groups stated that newly married couples should wait at least two year for the first baby in order to enjoy marital life together, they recognised the social difficulties involved since the communities tend to make fun of couples who do not produce a pregnancy soon after marriage. In all, there is a gap between knowledge of beneficial practices and what social pressure and traditional practices allow them to do.

(3) Knowledge of Family Planning Method

Knowledge of some methods of family planning is at less than optimal levels even among women who receive services from the government health sector. In our beneficiary survey women were asked to name all the ways they know to prevent a pregnancy. Not surprisingly, the most frequently mentioned was female sterilisation (85%), closely followed by the pill (84%). Two-thirds mentioned the IUD, and a little over half, the condom. Only a quarter of women spontaneously mentioned vasectomy, and fewer than 2% mentioned any traditional method or injectables, a method available from some private sector sources but not in the public sector. While knowledge of the existence of a method is not sufficient to increase its use - witness the high levels of knowledge but low levels of use of the pill - it is a first step.

A total of 51.5% and 81.6% of women in Tikamgarh and Damoh do not know male sterilisation, 20.8% of women in Damoh do not know the pill, 10.8% and 55.1% of women in Tikamgarh and Damoh do not know the IUD, 23.4% and 65.2% of women in Tikamgarh and Damoh do not know the condom.

Table 4-39 Client Awareness of Family Planning Methods

(Unit: %)						
Details	Tikamgarh	Damoh	Sagar	Chhatarpur	Panna	Total
Modern method						
Female sterilisation	96.4	82.1	57.8	88.8	95.3	85.0
Male sterilisation	48.5	18.4	4.8	23.8	28.1	26.6
Pill	95.8	79.2	55.4	91.3	96.9	84.0
IUD, loop	89.2	44.9	30.1	88.8	98.4	66.7
Condom, Nirodh	76.6	34.8	18.1	66.3	81.3	53.2
Injectables, depo provera	0.6	1.0			1.6	0.7
Traditional method						
Rhythm, timing	3.0	0.5	1.2	2.5		1.5
Withdrawal	1.2		1.2			0.5
N	167	207	83	80	64	601

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

In focus groups adults and adolescents of both sexes said that they generally learn about sex and family life from their married brother-in-law, sister-in-law, their married friends, or a married sister. They generally learn about childcare from their parents and other elders.

4.6.3 Current Contraceptive Use

(1) Current contraceptive use

In Tikamgarh 61% of urban women and 49% of rural women were using some method of contraception. In Damoh 67% of urban women and 56% of rural women were contracepting. Nearly all who contraceptive use female sterilisation (87%). The second most popular method was the condom, used by less than 3% of currently married women of reproductive age.

Table 4-40 Current Use of Contraception

(Unit: %)

Details	Tikamgarh			Damoh			Total		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Currently married and non-pregnant women 15-49 years									
Using any method	60.5	48.6	50.6	67.1	56.4	58.1	63.6	52.5	54.3
Any modern method									
Female Sterilisation	42.0	42.7	42.6	60.3	50.1	51.8	50.6	46.4	47.1
Male Sterilisation	1.2	0.8	0.8		0.8	0.7	0.6	0.8	0.8
Condom/Nirodh	12.3	3.1	4.7	2.7	0.8	1.1	7.8	1.9	2.9
IUD/Loop				1.4	0.5	0.7	0.6	0.3	0.3
Pill	3.7	0.5	1.1	1.4	1.3	1.3	2.6	0.9	1.2
Any traditional method									
Rhythm/Safe Period		1.3	1.1	1.4	2.9	2.6	0.6	2.1	1.8
Withdrawal/Other natural	1.2		0.2				0.6		0.1
Other		0.3	0.2					0.1	0.1
N	81	391	472	73	383	456	154	774	928
All men interviewed									
Using any method	59.3	48.6	50.4	69.9	48.5	51.6	64.3	48.5	51.0
Any modern method									
Female Sterilisation	37.0	41.6	40.9	60.3	43.2	45.7	48.1	42.5	43.3
Male Sterilisation		0.5	0.4	1.4	0.7	0.8	0.6	0.6	0.6
Condom/Nirodh	17.3	5.2	7.3	2.7	1.4	1.6	10.4	3.3	4.4
IUD/Loop	1.2	0.2	0.4	2.7		0.4	1.9	0.1	0.4
Pill	2.5	0.5	0.8	1.4	1.0	1.0	1.9	0.7	0.9
Any traditional method									
Rhythm/safe period		0.5	0.4	1.4	1.4	1.4	0.6	1.0	0.9
Withdrawal/ Other natural					0.5	0.4		0.2	0.2
Other	1.2		0.2		0.2	0.2	0.6	0.1	0.2
N	81	401	482	73	421	494	154	822	976

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

(2) Source of information

The most important source of information for women about the method they use was the **husband** in both districts, followed by health personnel (doctor, nurse, ANM, LHV), and friends, neighbours, or relatives other than the mother-in-law. Men reported they generally learned about family planning from **friends, relatives or neighbours (52%)**, while 13% reported television, the MPW, the government doctor, or other as a source of information.

(3) Source of family planning method

The principal source for sterilisation is the government camp. Other sources where sterilisation was obtained were the PHC and District Hospital. Those respondents who reported that their husband were using sterilisation reported he obtained it at either the district hospital as in Tikamgarh or a government camp in Damoh. The principal source of spacing methods was the PHC, followed by the district hospital and CHC. Data of male sterilisation and any spacing method must be interpreted carefully as the base is very small.

Table 4-41 Source of Currently Used Family Planning Method

(Unit: %)

Details	Tikamgarh					Damoh				
	Fs	MS	Con	Pill	Other	FS	MS	Con	IUD	Pill
<i>(Base: All non pregnant currently married women aged 15-49 yrs using any FP method)</i>										
District Hospital	23.4	100.0	9.1	20.0		24.2			33.3	
CHC	3.5		4.5			3.4				
PHC	31.3		13.6	20.0		14.4		20.0		33.3
SC/ANM/MPW	1.0		4.5	20.0		3.0			33.3	16.7
Anganwadi centre or Worker			4.5					20.0		16.7
Private practitioner	0.5		9.1			0.8		20.0	33.3	
Government Camp	38.8					53.0	100.0			
Other	1.5		54.5	40.0	100.0	1.3		40.0		33.3
N	201	4	22	5	1	236	3	5	3	6

Details	Combined						
	FS	MS	Con	IUD	Pill	Other	
District Hospital	23.8	57.1	7.4	33.3	9.1		
CHC	3.4		3.7				
PHC	22.2		14.8		27.3		
SC/ANM/MPW	2.1		3.7	33.3	18.2		
Anganwadi centre or Worker			7.4		9.1		
Private practitioner	0.7		11.1	33.3			
Government Camp	46.5	42.9					
Other	1.4		51.9		36.4	100.0	
N	437	7	27	3	11	1	

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001

(4) Regret of Permanent Contraception

Women were asked if they were satisfied with their decision to be operated. While not terribly large, the proportion of sterilised women who were not satisfied (14%) is higher than that found in studies conducted in other countries, and it indicates a need to increase education about alternative methods. (A study of regret conducted in the mid-1990s in Sao Paulo, Brazil, for example, found that 6% of women who had undergone sterilisation immediately following a Caesarean section were somewhat or very ambivalent and another 2% were dissatisfied.)

(5) Reasons for Not Using Contraception

Want more children: When the couple was not using a method, the reason was a desire for more children among nearly two-thirds of the men, while the health of the woman or fear of side effects accounted for a fifth of non-use, fairly low by international standards.

Fear and belief of side effects of contraception: Nevertheless, in focus groups among both males and females, adults and adolescents mentioned beliefs that pills cause numerous side effects, such as heating of body, pain in waist or wrist, and others. They also mentioned that vasectomy causes weakness in men, which appears to be a very widespread belief and a

serious barrier in a population that earns a living through manual labour. Some women mentioned specific incidents of women who experienced problems following tubectomy. Although fear of side effects may not be a large barrier to using some family planning method, numerous myths exist in this population, and they serve to prevent use of certain methods, notably vasectomy.

(6) Unwanted Pregnancy and Abortion

Women were asked if they had ever experienced a pregnancy at a time that was not convenient, and 3.6% (25 out of 534 women in Tikamgarh and 14 out of 546 women in Damoh) reported they had. Just over half of these had an induced abortion at the time, with the decision being made about equally by the husband, the wife, and the two together. Other household members rarely entered into the decision-making. A third of abortions were performed in a private clinic, 29% in the CHC or hospital, 14% each in the PHC or Dai's home, and 10% in the woman's home.

Knowledge of where to obtain an abortion appears to be universal, judging from focus groups discussions with both youth and adults. They expressed an acceptance of the practice, more for unmarried than married women.

Table 4-42 Unwanted Pregnancy

Details	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
<i>Whether ever had unwanted pregnancy (Base: all ever-married women aged 15-49 yrs)</i>									
Yes (%)	7.8	4.1	4.7	2.3	2.6	2.6	5.1	3.3	3.6
(N)	7	18	25	2	12	14	9	30	39

Source: KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG, under JICA Development Study on Reproductive Health in MP, 2001