

Table 4-43 Induced Abortion, Decision Maker for Induced Abortion and Place of Performing the Abortion

(Unit: %)

Details	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Whether had induced abortion at the time of unwanted pregnancy (Base: Those ever-married women aged 15-49 years having unwanted pregnancy)									
Yes	71.4	50.0	56.0	50.0	50.0	50.0	66.7	50.0	53.8
(N)	5	9	14	1	6	7	6	15	21
Decision maker for the abortion (Base: Those ever-married women aged 15-49 years having unwanted pregnancy and induced abortion)									
Herself	60.0	11.1	28.6		16.7	14.3	50.0	13.3	23.8
Husband	20.0	66.7	50.0				16.7	40.0	33.3
Both	20.0	11.1	14.3		83.3	71.4	16.7	40.0	33.3
Other person in household				100.0		14.3	16.7		4.8
Jointly with others in the household		11.1	7.1					6.7	4.8
Total N	5	9	14	1	6	7	6	15	21
Place where abortion was performed (Base: Those ever-married women aged 15-49 years having unwanted pregnancy and induced abortion)									
At home		11.1	7.1		16.7	14.3		13.3	9.5
At Dai's home		22.2	14.3		16.7	14.3		20.0	14.3
In CHC/Hospital	20.0	33.3	28.6		33.3	28.6	16.7	33.3	28.6
In PHC	20.0	11.1	14.3		16.7	14.3	16.7	13.3	14.3
Private clinic	60.0	22.2	35.7	100.0	16.7	28.6	66.7	20.0	33.3
N	5	9	14	1	6	7	6	15	21

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

4.6.4 Institutional Deliveries

Because Dai training has little impact on maternal mortality, new strategies need to be developed to increase the proportion of births attended in medical facilities, which would decrease maternal mortality ratio (MMR).

There is some evidence from our study that there is potential for more institution-based deliveries.

Two-thirds of rural women and almost two-fifths of urban women reported that home is the best and safest place to deliver a baby. While the home is the place most rural women reported as best for deliveries, the proportion of rural women who mention an institution, usually public, as best (27.8%) is higher than the proportion whose last delivery occurred there. Fully 61.5% of urban women mentioned an institution, again a much higher proportion that actually deliver there. Also, the doctor was mentioned by 38% of women as the best person to help during delivery, compared to 26.7% each for the Dai and relatives. (See Table 4-44.)

Table 4-44 Opinion about the Best Place and Person for Delivery

(Unit: %)

Detail	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Best place for conducting deliveries (Base: All ever-married women aged 15-49 yrs)									
Home	30.0	56.5	52.1	47.7	80.2	75.1	38.6	68.6	63.7
Govt. Hospital	53.3	23.0	28.1	37.2	11.5	15.6	45.5	17.1	21.8
PHC	11.1	14.0	13.5	1.2	4.6	4.0	6.3	9.2	8.7
Private clinic/Hospital	4.4	1.6	2.1	7.0	1.1	2.0	5.7	1.3	2.0
Maternity Home	1.1	0.2	0.4	7.0	0.2	1.3	4.0	0.2	0.8
SC		0.2	0.2		1.1	0.9		0.7	0.6
Her parents' home		0.7	0.6					0.3	0.3
Others		0.5	0.4		0.2	0.2		0.3	0.3
Don't know		3.4	2.8		1.1	0.9		2.2	1.9
N	90	444	534	86	460	546	176	904	1080
Best person for conducting deliveries (Base: All ever-married women aged 15-49 yrs)									
Doctor	74.4	37.8	44.0	47.7	29.1	32.1	61.4	33.4	38.0
Her relatives	22.2	30.9	29.4	26.7	28.3	28.0	24.4	29.5	28.7
Dai		24.8	20.6	12.8	36.3	32.6	6.3	30.6	26.7
ANM or LHV	3.3	4.7	4.5	7.0	3.3	3.8	5.1	4.0	4.2
No one		0.5	0.4	3.5	1.1	1.5	1.7	0.8	0.9
Her friends		0.5	0.4	1.2	0.2	0.4	0.6	0.3	0.4
Others					0.2	0.2		0.1	0.1
Don't know		0.9	0.7	1.2	1.5	1.5	0.6	1.2	1.1
N	90	444	534	86	460	546	176	904	1080

Note: * Percentages are not added to 100, as it was a multiple response question

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

When the home is the preferred place, it is generally because it is customary to deliver at home (46.8%), the woman receives more personal attention (46.1%), the cost is low (11.5%), or cleanliness is better (7.8%).

When an institution was mentioned - the PHC, government hospital, or a private clinic or maternity - the most important reasons were the presence of a doctor, medicines, or cleanliness. The government could promote these advantages more widely and increase the level of personal attention on the maternity wards as a strategy for increasing institutional births and decreasing maternal mortality.

State government officials often express the concern that there is inadequate capacity in the public health system to attend all deliveries in an institution. While this is true, there is a great deal of unused capacity, and this study demonstrates that there is unsatisfied demand for institutional deliveries at a level the government probably does have the capacity to satisfy.

Table 4-45 Reasons for Preferring Places for Delivery

(Unit: %)

Reasons	Best Place for Deliveries								Total
	Home	Govt. Hospital	PHC	SC	Her Parents Home	Private Clinic	Maternity Home	Other	
Tikamgarh									
More personal attention	41.4	18.0	5.6		66.7	18.2		50.0	29.1
Doctor is there	1.4	76.0	91.7	100.0	33.3	72.7	100.0	50.0	38.0
Customary	47.5	2.7	5.6			9.1			27.2
Has medicines	6.1	24.7	23.6		33.3	36.4	100.0	50.0	15.2
Low cost/less expensive	15.8	20.0	19.4						17.0
Hygienic	7.6	4.0	8.3						6.4
Cleanliness	13.3	28.0	23.6			45.5	100.0		19.8
Other	4.3	11.3	2.8			9.1			6.2
Don't know	1.8	2.7							1.7
N	278	150	72	1	3	11	2	2	519
Damoh									
More personal attention	46.1	8.2	9.1			18.2	42.9		37.5
Doctor is there	1.0	85.9	81.8	80.0		100.0	57.1	100.0	21.3
Customary	46.8	2.4							35.9
Has medicines	2.4	34.1	40.9	80.0		54.5	57.1	100.0	11.6
Low cost/less expensive	11.5	11.8	36.4	40.0		9.1			12.6
Hygienic	8.3	8.2	9.1			9.1			8.1
Cleanliness	7.8	24.7	27.3	20.0		36.4			11.8
Other	5.6	2.4							4.6
Don't know	0.5								0.4
N	410	85	22	5		11	7	1	541

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

4.6.5 Knowledge about RCH Services

Perhaps the most basic determinant of health service utilisation is knowledge of the location of the nearest facility. Knowledge about RCH services was explored in the household survey with both men and women.

(1) Awareness of the Nearest Health Facility

In Tikamgarh 11.8% of women, 4.8% of women in Damoh, and 6% of men reported they did not know the location of the nearest government health facility. Fully 46% of the women in Tikamgarh and 37% in Damoh reported they did not know where the district hospital is. In Damoh the urban population was more likely to know the location of the district hospital than the rural population, but in Tikamgarh there was no difference.

Antenatal Care (ANC): Our study found in Tikamgarh and Damoh that 95% of women knew at least one site where ANC was provided. Respondents generally mentioned a government health facility - the sub-centre, PHC, or hospital - as the source of antenatal care. Less than one fifth of women respondents mentioned a private source.

Immunisation: For sources of immunisation government facilities again were mentioned by nearly four-fifths of women, and 4% did not know any source.

Table 4-46 Awareness of Nearest Government Health Facilities

(Unit: %)

	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Whether aware of nearest government health facility (Base: All ever-married women aged 15-49yrs)									
Yes	100.0	85.8	88.2	94.2	95.4	95.2	97.2	90.7	91.8
No	0.0	14.2	11.8	5.8	4.6	4.8	2.8	9.3	8.2
N	90	444	534	86	460	546	176	904	1,080
Whether aware of nearest government health facility (Base: All interviewed husbands)									
Yes	100.0	92.3	93.6	95.9	94.1	94.3	98.1	93.2	94.0
No		7.7	6.4	4.1	5.9	5.7	1.9	6.8	6.0
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) Knowledge of Available Services

Women of reproductive age often do not know that all government health facilities provide ANC services and immunisation for children, as shown in the table below.

Antenatal Care (ANC): Only about one-third of women in rural area of Tikamgarh and half of women in rural area of Damoh reported the SC and ANM/LHV is the place or person to go for ANC. The situation was almost the same for the PHC: only one-third of women in rural areas in both districts know that the PHC provides ANC services.

In urban areas, the District Hospital is recognised as a place for getting ANC by a little over half women. Private clinics/hospitals and practitioners are in second place following the District Hospital.

Immunisation for Children: Although the SC and ANM/LHV are more popular for immunisation than ANC, only half of women in rural area know these are the place and person to visit for immunisation.

Table 4-47 Awareness of Place/Person for Antenatal Care and Immunisation for Children

(Unit: %)

Detail	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Aware of place/person for antenatal care*(Base: All ever-married women aged 15-49 yrs)									
PHC		32.9	29.2		32.6	28.2		32.7	28.7
SC/ANM/LHV		28.4	25.2		46.3	40.1		37.5	32.9
Govt. Hospital/Dispensary	64.3	27.5	31.6	45.1	14.8	18.8	53.5	21.0	25.0
Private/NGO clinic or hospital	30.4	10.6	12.8	29.6	5.4	8.7	29.9	8.0	10.7
Private practitioner, allopathic	8.9	5.0	5.4	16.9	8.0	9.2	13.4	6.5	7.4
CHC	8.9	2.7	3.4	15.5	3.0	4.7	12.6	2.9	4.1
Dai		1.6	1.4		1.3	1.1		1.4	1.3
UFWC/PPC		0.2	0.2	1.4	0.2	0.4	0.8	0.2	0.3
Private practitioner, Ayurvedic		0.2	0.2		0.4	0.4		0.3	0.3
Others		1.8	1.6		1.5	1.3		1.7	1.5
Don't know	1.8	8.6	7.8	4.2	3.0	3.2	3.1	5.8	5.4
Aware of place/person for immunisation for children* (Base: All ever-married women aged 15-49 yrs)									
SC/ANM/LHV		40.5	36.0	8.5	51.5	45.8	4.7	46.1	41.0
PHC	10.7	27.0	25.2	1.4	29.3	25.6	5.5	28.2	25.4
Govt. Hospital/Dispensary	64.3	17.8	23.0	43.7	6.1	11.1	52.8	11.8	16.9
Private/NGO clinic or hospital	19.6	3.6	5.4	7.0	1.3	2.1	12.6	2.4	3.7
Private practitioner, allopathic	5.4	1.8	2.2	12.7	2.0	3.4	9.4	1.9	2.8
CHC	8.9	0.9	1.8	12.7	1.1	2.6	11.0	1.0	2.2
UFWC/PPC		0.5	0.4	1.4	0.2	0.4	0.8	0.3	0.4
Dai		0.2	0.2					0.1	0.1
Others	1.8	16.2	14.6	15.5	15.9	15.8	9.4	16.0	15.2
Don't know	1.8	5.9	5.4	4.2	2.8	3.0	3.1	4.3	4.2
N	56	444	500	71	460	531	127	904	1031

Note: * Percentages are not added to 100, as it was a multiple response question

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 the beneficiary survey clients who had recently received services were asked to name all the services they knew were available at the service delivery point. Even though women already have access to and use the services at health facilities, their knowledge of available services is limited, and there is a big difference between Tikamgarh and Damoh.

The type of service women mentioned most frequently was immunisations, spontaneously mentioned by 87% of service users, followed by family planning, antenatal care (71% of all beneficiaries but significantly less likely to be mentioned by users of the CHC), and postnatal care (56%). However, the proportions dropped for care of sick children (36%), although it was significantly more likely to be mentioned by clients of the PHC than the CHC or SC; child growth and monitoring, mentioned by 32%; maternity care (32%, but significantly more likely to be mentioned by users of block level PHCs); curative care for adults (9%); and gynaecology (8%).

These data provide some guidance for designing informational programmes about services available in public health care institutions. Health care managers and providers should not take

for granted that the population is aware of the services their institutions offer because in many cases, but not all, knowledge levels are low.

Table 4-48 Client Knowledge of Availability of RCH Services at Health Facilities

RCH services	(Unit: %)					
	Tikamgarh	Damoh	Sagar	Chhatarpur	Panna	Total
Immunisation	97.0	79.7	67.5	95.0	95.3	86.5
Family planning	88.6	67.6	45.8	76.3	89.1	73.9
Antenatal care	97.6	51.2	31.3	88.8	96.9	71.2
Postnatal care	76.6	45.9	19.3	61.3	75.0	55.9
Care of the sick child	28.1	49.3	34.9	25.0	28.1	35.9
Well child care, growth and monitoring	52.7	24.6	9.6	30.0	35.9	32.3
Delivery/maternity care	48.5	17.9	8.4	38.8	53.1	31.6
Gynaecology	16.8	1.9		7.5	10.9	7.5
Other	0.6	0.5	1.2			0.5
N	167	207	83	80	64	601

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

A total of 48.8% of clients in Damoh do not know about the availability of ANC service, 11.4% and 32.4% of clients in Tikamgarh and Damoh do not know about the availability of Family Planning services, 47.3% and 75.4% of clients in Tikamgarh and Damoh do not know about the availability of Well Child Care, Growth and Monitoring, and 51.5% and 82.1% of clients in Tikamgarh and Damoh do not know about the availability of Delivery and Maternity Care.

(3) Men's Knowledge of Women's and Children's Health and Practice

1) Emergency Obstetric Care (EmOC)

Government facilities, especially the district hospital, are mentioned by over three-quarters of women as the place they go for emergency obstetrical care (EmOC), but 30% of urban and 13% of rural men but would not take their wife to the hospital if she had a difficult delivery, again because they believe it not to be necessary (94%). This intransigence on the part of men may be a reason behind the failure of women to obtain timely emergency obstetrical care and demonstrates a need to educate the husbands of pregnant women about danger signs in pregnancy and the need for professional care.

Another possible explanation of the men's reluctance to obtain hospital care for their wife in a difficult delivery is their perception of the cost: 84% of rural men and 69% of urban men stated that they believed the amount they would have to pay for their wife to deliver a baby in the hospital to be excessive. Over a third stated they thought a reasonable amount that they could pay would be Rs.200 (about US \$4) or less. Another 44% were willing to pay Rs.300 - 500.

Table 4-49 Opinion of Husbands about Taking Their Wife to Hospital during Complicated Delivery

(Unit: %)

Detail	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Opinion about taking their wife to hospital during complicated delivery (Base: All husbands)									
Yes	82.7	81.3	81.5	46.6	84.1	78.5	65.6	82.7	80.0
No	17.3	17.7	17.6	41.1	9.7	14.4	28.6	13.6	16.0
Don't know		1.0	0.8	12.3	6.2	7.1	5.8	3.6	4.0
N	81	401	482	73	421	494	154	822	976
Reason for not taking their wife to health facility during such delivery									
<i>(Base: Those husbands who did not take their husband to health facility)</i>									
Not necessary	92.9	90.1	90.6	100.0	95.1	97.2	97.7	92.0	93.6
Poor quality of care		4.2	3.5		2.4	1.4		3.6	2.6
Costly		2.8	2.4		2.4	1.4		2.7	1.9
Others	7.1		1.2				2.3		0.6
Don't know		2.8	2.4					1.8	1.3
N	14	71	85	30	41	71	44	112	156

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

2) Source of Information on Woman's and Child Health for Husbands

Over half of rural men and a third of urban men reported they had never heard or read anything on the topic. Those who had some exposure mentioned the television, friends, relatives and neighbours, a doctor, the MPW, and the radio as sources, and urban men mentioned they had read about women's health.

Slightly fewer men, 45.7% of rural and 27.3% of urban men, stated they had never heard or read anything about children's health. Among those who had some exposure, the same sources were mentioned as for women's health.

Table 4-50 Source of Information about Women's and Children's Health

(Unit: %)

Source	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Source of information about women's health care during pregnancy									
<i>(Base: All interviewed husbands)</i>									
Never heard	28.4	51.6	47.7	32.9	52.0	49.2	30.5	51.8	48.5
Television	48.1	18.7	23.7	35.6	13.8	17.0	42.2	16.2	20.3
Friend, relative, neighbour	23.5	17.2	18.3	8.2	23.0	20.9	16.2	20.2	19.6
Doctor	22.2	11.0	12.9	20.5	20.0	20.0	21.4	15.6	16.5
ANM/MPW/ Sub-centre	11.1	12.5	12.2		16.6	14.2	5.8	14.6	13.2
Radio	17.3	13.2	13.9	5.5	7.1	6.9	11.7	10.1	10.3
Read about it	13.6	6.7	7.9	23.3	8.8	10.9	18.2	7.8	9.4
Nurse	16.0	4.5	6.4	2.7	4.3	4.0	9.7	4.4	5.2
Anganwadi worker		4.7	3.9	1.4	1.7	1.6	0.6	3.2	2.8
Teacher	1.2	0.5	0.6		0.5	0.4	0.6	0.5	0.5
Other		1.0	0.8	4.1	2.4	2.6	1.9	1.7	1.7
N	81	401	482	73	421	494	154	822	976
Source of information about children's health (Base: All interviewed Husbands)									
Never heard	22.2	44.9	41.1	32.9	46.6	44.5	27.3	45.7	42.8
Friend, relative, neighbour	24.7	17.2	18.5	9.6	24.5	22.3	17.5	20.9	20.4
Television	51.9	19.7	25.1	39.7	14.0	17.8	46.1	16.8	21.4
Doctor	19.8	15.5	16.2	23.3	20.4	20.9	21.4	18.0	18.5
ANM/MPW/Sub Centre	11.1	13.2	12.9		16.4	14.0	5.8	14.8	13.4
Radio	19.8	14.5	15.4	2.7	7.1	6.5	11.7	10.7	10.9
Read about it	16.0	5.5	7.3	24.7	7.6	10.1	20.1	6.6	8.7
Nurse	13.6	4.5	6.0	1.4	4.5	4.0	7.8	4.5	5.0
Anganwadi worker	1.2	5.7	5.0		3.6	3.0	0.6	4.6	4.0
Teacher		0.5	0.4		0.5	0.4		0.5	0.4
Other		0.7	0.6	2.7	2.6	2.6	1.3	1.7	1.6
N	81	401	482	73	421	494	154	822	976

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

(4) Information Source about Health Care and Trust

Women were asked what persons and what media they trust most to give them good information about their health and that of their children.

The doctor is the person whom urban and rural women most trust. Urban women place greater faith in a private doctor than government, but rural women reported the two about equally. The only other person whom the women reported trusting to any degree is their husband. No one else was mentioned by more than 6% of women.

The television is the media most women trust, particularly urban women, 88% of whom mentioned it. Radio is also trusted by both urban and rural women (36% and 28%), and was the second most often mentioned. Urban women also mentioned trusting the newspaper (23%), while many rural women (23%) mentioned other sources.

Table 4-51 The Most Trusted Person and Media Channels for Information about Health
(Unit: %)

Person/Media channel	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
The most trusted person (Base: All ever-married women aged 15-49 yrs)									
Private doctor	53.3	23.9	28.8	37.2	33.9	34.4	45.5	29.0	31.7
Govt. doctor	25.6	25.0	25.1	37.2	30.0	31.1	31.3	27.5	28.1
Husband	16.7	24.1	22.8	17.4	19.6	19.2	17.0	21.8	21.0
ANM/LHV		9.9	8.2		3.9	3.3		6.9	5.7
Mother/mother in-law	3.3	5.6	5.2		1.7	1.5	1.7	3.7	3.3
Nurse	1.1	4.1	3.6	1.2	3.0	2.7	1.1	3.5	3.1
Other/relative friend		2.3	1.9	3.5	2.6	2.7	1.7	2.4	2.3
Private paramedic		0.2	0.2	3.5	0.2	0.7	1.7	0.2	0.5
Male MPW		0.7	0.6		0.2	0.2		0.4	0.4
Anganwadi worker		0.5	0.4		0.4	0.4		0.4	0.4
Other government worker					0.2	0.2		0.1	0.1
NGO worker		0.2	0.2					0.1	0.1
Dai					0.2	0.2		0.1	0.1
No one/self		2.3	1.9		3.5	2.9		2.9	2.4
Others		1.4	1.1		0.4	0.4		0.9	0.7
Trusted media channels (Base: All ever-married women aged 15-49)									
Television	91.1	56.3	62.2	87.2	66.5	69.8	89.2	61.5	66.0
Radio	21.1	35.1	32.8	51.2	20.0	24.9	35.8	27.4	28.8
Newspaper	13.3	4.1	5.6	12.8	3.0	4.6	13.1	3.5	5.1
Magazine	6.7	0.5	1.5	11.6	1.5	3.1	9.1	1.0	2.3
Hoarding/wall painting		4.5	3.7		2.2	1.8		3.3	2.8
Poster		2.3	1.9	1.2	0.4	0.5	0.6	1.3	1.2
Cinema		0.5	0.4		0.2	0.2		0.3	0.3
Drama/folk dance/street play		0.9	0.7		0.2	0.2		0.6	0.5
Others	7.8	21.8	19.5	4.7	25.0	21.8	6.3	23.5	20.6
N	90	444	534	86	460	546	176	904	1,080

Note: * Percentages are not added to 100, as it was a multiple response question

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

4.6.6 Accessibility

(1) Nearest Facility

People generally seek services in the facility closest to their homes, and the government's health system for rural areas is premised on the population's seeking services first at the sub-centre, then at higher levels. However, only 30.9% of rural women and 26.8% of rural men in Tikamgarh and Damoh reported the sub-centre as the nearest facility.

Men and women in rural areas of Damoh were much more likely to report the SC as the nearest facility than those in Tikamgarh. More than half of rural women (57.4%) and men (50%) reported the PHC as the nearest facility, and 10.6% cited the district hospital. Women and men in urban areas, where there are no sub-centres, mentioned the PHC and district hospital as the nearest health facility.

Table 4-52 Women's Awareness of Nearest Government Health Facility

(Unit: %)

	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
All ever-married women aged 15-49 yrs									
Whether aware of nearest government health facility									
Yes	100.0	85.8	88.2	94.2	95.4	95.2	97.2	90.7	91.8
Type of this government health facility (Base: Those women aware of government health facility)									
SC		21.5	17.4		39.0	32.9		30.9	25.5
PHC	52.2	67.5	64.5	28.4	48.7	45.6	40.9	57.4	54.6
District Hospital	43.3	9.4	15.9	71.6	11.6	21.0	56.7	10.6	18.6
UFWC	3.3		0.6				1.8		0.3
Don't know	1.1	0.5	0.6		0.7	0.6	0.6	0.6	0.6
N	90	381	471	81	439	520	171	820	991
All interviewed husbands									
Whether aware of nearest government health facility									
Yes	100.0	92.3	93.6	95.9	94.1	94.3	98.1	93.2	94.0
Type of this government health facility (Base: Those husbands aware of government health facility)									
SC		15.4	12.6	1.4	37.4	32.0	0.7	26.8	22.5
PHC/CHC	50.6	75.4	71.0	32.9	48.0	45.7	42.4	61.2	58.1
District Hospital	49.4	7.3	14.9	65.7	13.6	21.5	57.0	10.6	18.2
Don't know		1.1	0.9		1.0	0.9		1.0	0.9
N	81	370	451	70	396	466	151	766	917

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

(2) Travel Time

On average women reported the travel time to the nearest health facility as 23 minutes in urban areas and 33 minutes in rural areas. Nevertheless, 13.4% of women in Tikamgarh and 17.1% in Damoh had never visited the nearest facility, with little difference between urban and rural populations.

Women were twice as likely never to have visited the nearest health facility if it was the SC rather than the PHC or district hospital, although the time to travel to the SC is about 60% the time to the PHC or district hospital. In the beneficiary survey 90% reported the location of the facility was convenient, and the mean travel time was just over 16 minutes, another indication that those who use health facilities are those who live nearby.

(3) Cost to Travel

The cost to travel to the service delivery point is an additional factor in accessibility. Fully 95% of beneficiaries seen at an service delivery point reported they spent nothing to travel to the facility, and the mean for all was under one rupee.

In Damoh and Tikamgarh districts over half the women in the household survey reported they travel to the health facility on foot, although the higher the facility's level in the health system, the less likely the woman is to travel on foot. Public transport and bicycle or motorcycle were the only

other common forms of transportation for health care, and usage of these increases at higher levels in the system.

(4) Timings

Working hours of the facilities are a factor in accessibility. In the beneficiary interview survey, more than 90% of women seen in all levels of the system reported the working hours of the facility are convenient for them. When asked what hours are most convenient 90% of respondents mentioned the time around noon, between 11 a.m. and 1 p.m.

The service delivery point must be open and staffed during normal working hours to be accessible, and 85% of service users reported they had never been turned away. There were no differences by type of facility. All the women who had been unable at some time to get services from the sub-centre reported the reason as the absence of the provider, which is to be expected since the MPWs are supposed to spend a large proportion of their time in the field.

(5) Community Health Workers

1) JSR

One of the major strategies of the government of Madhya Pradesh to assure universal access to primary health care for the rural population is to train a JSR for every village. To that end the state government plans to train 20,000 JSRs in the current Five-Year Plan. Only 15% of rural women knew of a JSR in their village, and just under half of these had ever used the services of the JSR (or the Village Health Guide of the predecessor programme).

Nevertheless, all of these and a few women who had not visited the JSR reported that the JSR is an important source of health care for the woman or her children.

Table 4-53 Availability and Importance of Village Health Guide or JSR in the Village

(Unit: %)

Details	Tikamgarh (Rural Area)	Damoh (Rural Area)	Combined (Rural Areas)
Available in the village? (Base: All ever-married women aged 15-49 yrs)			
Yes	13.3	16.1	14.7
No	69.8	56.3	62.9
Don't know	16.4	27.4	22.0
Not Applicable	0.5	0.2	0.3
N	444	460	904
Ever used the services? (Base: Those women reported availability of VHJ/JSR in their village)			
Yes	47.5	48.6	48.1
No	52.5	51.4	51.9
N	59	74	133
Important source of health care? (Base: Those women reported availability of VHJ/JSR in their village)			
Yes	57.6	48.6	52.6
No	28.8	35.1	32.3
Don't know	13.6	16.2	15.0
N	59	74	133

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

2) Trained Dai

Another state strategy for improving access to reproductive health care is to assure the presence of a trained Dai in every village. In Tikamgarh 56.8% of rural women reported the presence of a Dai in their village, and 51.0% of these reported the Dai was trained, although 16.3% said they did not know the Dai's training status. In Damoh 70.2% of rural women reported the presence of a Dai, 51.6% of whom were reported as trained (with the same proportion who did not know).

The government strategy calls for training only existing Dais, which is an important task; however, our study suggests that about 43% of villages in Tikamgarh and 30% in Damoh may not have a traditional Dai to train. Moreover, in some areas the Dais are not very much keen to continue to work as a Dai due to small income from their Dai profession. These are making the government's goal impossible to attain with the current strategy in these districts.

Table 4-54 Availability of Dai in the Village and Preference

(Unit: %)			
Details	Tikamgarh (Rural Area)	Damoh (Rural Area)	Combined (Rural Areas)
Available in the village? (Base: All ever-married women aged 15-49 yrs)			
Yes	56.8	70.2	63.6
No	43.2	29.8	36.4
N	442	459	901
Dai is trained or untrained? (Base: Those women reported availability of Dai in their village)			
Trained	51.0	51.6	51.3
Untrained	32.3	31.1	31.6
Both Near	0.4	0.9	0.7
Don't know	16.3	16.5	16.4
Prefer trained or untrained dai? (Base: Those women reported availability of Dai in their village)			
Trained dai	66.5	78.0	72.9
Untrained dai	6.8	8.4	7.7
Don't know /no opinion	26.7	13.7	19.4
N	251	322	573
Reasons fro preferring trained or untrained dai* (Base: Those women reported availability of Dai in their village and prefer either trained or untrained dai)			
Uses sterile razor to cut the cord	54.3	60.4	58.0
More skilled	38.6	43.5	41.6
Other people say she is better	30.4	23.0	26.0
Charges less	9.2	3.6	5.8
Others	1.6		0.6
N	184	278	462

Note: * Percentages are not added to 100, as it was a multiple response question

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

4.6.7 Reasons for Selection of Institution or Provider

(1) Reasons for Selection

In focus groups men stated that economic reasons dominate in the selection of a provider. Other important factors are distance, availability of medicines, and the provider's skill and behaviour.

In the household survey three-quarters of men reported that the reason they like the nearest government facility was the low cost. Women used broader criteria for their assessments. More than half of women in both districts said what they liked about the nearest government facility was the friendly staff, followed by the low or null cost, distribution of medicines, quality of care and cleanliness. There was little variation between the districts in these responses.

(2) Reasons for Not Visit/Liking

Government Facility: The main reason women mentioned for not visiting the nearest government health facility was absence of any illness, which was mentioned by a third of women, followed by the poor quality of care, absence of a doctor, lack of medicines, and a preference for a private clinic or doctor.

Sub-centre (SC): When questioned about the SC, more women mentioned the absence of medicines or a doctor as a reason for not visiting.

District Hospital: Poor quality was mentioned by a large proportion of women as the reason not to visit the district hospital, although this happened much more often in Damoh than Tikamgarh.

Nearest government facility: The reason most often mentioned for not liking the nearest government facility was the lack of medicines, mentioned by 43% of women, with little variation between the two districts. Other reasons mentioned were poor facilities (36.9%), poor quality of care (28.4%), lack of cleanliness (22.8%), and unfriendly staff (11.2%). Men mentioned poor facilities (62.4%), lack of medicines (54.2%) and poor quality of care (47.4%) as what they do not like about their nearest government facility.

(3) Place to Go for Curative Care

Women were asked about where they go when they need health care for themselves, for a man in the household, and male and female children under five. The questioning differentiated between major and minor illnesses.

1) Adult Women

Minor illness: In Damoh the preferred provider for both urban and rural women who need care for a minor illness is the private allopathic practitioner. The second choice for urban women is the district hospital, and for rural women, the PHC. In Tikamgarh urban women prefer the district hospital, followed equally by the private allopathic practitioner and the private clinic or hospital. Rural women in Tikamgarh prefer the PHC, followed by the private allopathic practitioner, clinic or hospital. Responses are presented in the table below.

Major illness: In the case of a major illness, the district hospital became the first choice for urban women in both districts, followed by a private clinic or hospital, or private allopathic practitioner. The first choice for rural women was also the district hospital. In rural Damoh, the private clinic or hospital and the PHC were important sources of care for a major illness, while in Tikamgarh, rural women chose the PHC and private allopathic physician after the district hospital. In sum, the district hospital is the SDP of choice in case of a major illness. Responses are presented in the table below.

Table 4-55 Service Delivery Point for Minor and Major Illness of Woman

(Unit: %)

Type of Facility	Minor Illness				Major Illness			
	Tikamgarh		Damoh		Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Private Allopathic Practitioner	27.8	26.6	45.3	51.0	29.1	21.1	25.6	14.6
District Hospital	34.4	11.3	36.0	5.2	38.4	55.0	52.2	46.2
Private Clinic/Hospital	27.8	17.1	17.4	5.2	27.9	15.0	45.6	31.1
PHC	16.7	39.2	14.0	38.1	8.1	31.3	16.7	27.5
CHC	1.1	1.6	2.3	3.5	11.6	3.0	1.1	2.5
SC		5.6		17.9		4.1		1.8
Teaching Hospital	1.1			0.2			1.1	0.9
Civil Hospital		0.5			9.3	5.2	2.2	4.7
Private Ayurvedic Practitioner						0.9		0.2
Traditional Healer		0.9		1.7				
Other	4.4	2.0	3.5	2.4		0.7		
None		1.1	2.3	0.4	2.3	1.1		

Note: *Percents add up to more than 100 since more than one answer was allowed.

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

2) Adult Man

Minor illness: The choice of a source of care for men with a minor illness is more varied between the two districts, and there are urban/rural differences in Damoh. In Tikamgarh men go to the private allopathic practitioner or clinic, the district hospital, and the PHC. The first choice for care for urban men is the private allopathic practitioner and for rural men the PHC. In Damoh the first choice for both rural and urban men is the private allopathic practitioner. This is closely followed by the private clinic or hospital and the district hospital for urban men, and the PHC, district hospital, and SC for rural men. Responses are displayed below.

Major illness: For treatment of a major illness, rural and urban men in both districts seek care at the district hospital, mentioned by approximately half of all men. After the district hospital urban men in both districts and rural men in Tikamgarh go to the private clinic, hospital, or practitioner. Urban men in Damoh also go to the CHC. Other choices for men in rural Tikamgarh include the private clinic, hospital or practitioner, and the PHC. In Damoh rural men also go to the PHC, private clinic, hospital or practitioner, and the CHC. Responses are presented below.

The utilisation patterns are very similar for men and women. For care of a minor illness the first choices for men and women are the private allopathic practitioner or the district hospital. Other important sources of care are private clinics or hospitals and the PHC for urban areas. Rural women in Damoh are less likely than men to go to the district hospital for a minor illness, and both men and women in rural areas of Damoh are more likely to go to the SC than those in Tikamgarh. For a major illness everyone's first choice is the district hospital. In urban areas and rural Damoh the private clinic or hospital is a second choice along with the private practitioner in urban Tikamgarh.

3) Girl Children (under five years old)

Minor illness: When a girl child under five needs care for a minor illness, she is taken to pretty much the same facilities as an adult woman: the private allopathic practitioner, district hospital, private clinic or hospital, or the PHC. In rural Tikamgarh the first choice is the PHC for a young girl, as it is for her mother, while everywhere else it is the private practitioner. In rural Damoh the SC is a fairly important and the district hospital has little importance as a source for care of minor illness for a girl, as is the case for the mother. Responses are presented below.

Major illness: When a girl child under five needs care for a major illness, the district hospital is the first choice. Other source mentioned are the private clinic, hospital or practitioner, the PHC (except in urban Damoh where the CHC in Hatta is preferred), and the private Ayurvedic practitioner (except in urban Damoh). Responses are presented below.

Table 4-56 Service Delivery Point for Minor and Major Illness of Girl Child

(Unit: %)

Type of Facility	Minor Illness				Major Illness			
	Tikamgarh		Damoh		Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Private Allopathic Practitioner	42.2	43.1	46.5	48.6	22.5	14.2	29.4	23.7
District Hospital	38.9	11.8	22.1	6.1	64.0	59.5	45.9	66.7
Private Clinic/Hospital	27.8	19.2	16.3	10.0	41.6	35.4	27.1	18.0
PHC	18.9	44.3	23.3	40.5	19.1	27.3	8.2	31.3
CHC		2.7	4.7	3.3		1.8	16.5	3.0
SC		5.7	1.2	14.4		1.6		4.1
Teaching Hospital		0.5		0.2		0.9		
Civil Hospital		0.9	1.2		1.1	5.9	8.2	6.1
Dai					3.4	1.1	2.4	2.4
Traditional Healer		0.2		1.7				0.4
Private Ayurvedic Practitioner	1.1	0.5			14.6	11.3	5.9	16.3
Private Homeopathic Practitioner						0.2		
MCH Centre		0.2						
None		0.9				0.7		0.2
Other		0.9	2.3	2.2		0.5		2.0

Note: *Percents add up to more than 100 since more than one answer was allowed.

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

4) Boy Children (under five years old)

Minor illness: The same pattern of care is reported for boys under five with a minor illness as for girls. The private allopathic practitioner is the first choice except in rural Tikamgarh where the PHC drew ahead. Other important sources of care are the district hospital and private clinic or hospital, except in rural Damoh where the SC was important but the district hospital and private clinic or hospital are not.

Major illness: When the boy child has a major illness, again we see the district hospital is the preferred source of care except in urban Damoh where the private practitioner occupies first

place (this is not the case with girls). The rest of the utilisation pattern, as reported by women, is the same as for girls. Responses are presented below.

Table 4-57 Service Delivery Point for Minor and Major Illness of Boy Child

(Unit: %)

Type of Facility	Minor illness				Major illness			
	Tikamgarh		Damoh		Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Private Allopathic Practitioner	45.6	32.6	46.5	48.9	25.0	15.4	39.5	22.1
District Hospital	37.8	21.7	24.4	7.4	59.1	48.0	31.4	55.5
Private Clinic/Hospital	22.2	20.8	17.4	7.6	34.1	32.4	22.1	16.9
CHC		2.5	4.7	3.1		1.1	15.1	3.9
PHC	17.8	40.5	20.9	37.3	11.4	23.8	7.0	28.7
SC		4.8		15.9		1.4		4.2
Teaching Hospital		1.1				0.7		
Civil Hospital		0.2	1.2			4.8	7.0	5.5
Traditional Healer		0.7		0.4				
Dai		0.2						
Private Ayurvedic Practitioner		0.7			1.1			
None		0.9		0.2		0.9	0.0	0.2
Other		0.5	1.2	1.3		0.2	0.0	1.5

Note: *Percents add up to more than 100 since more than one answer was allowed.

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

In focus groups adults stated that there is no discrimination between treatment seeking behaviour for girls and boys.

Among the providers who were rarely or never mentioned are Ayurvedic and homeopathic doctors, shops, traditional healers, and the teaching hospitals that are located in neighbouring districts. The SC is only for minor illnesses in rural areas, more for adult women than men and percentage of women to go or to take their children is not high.

5) Actual Place where Treatment was Sought for a Minor and a Major Illness for Children

To determine whether the stated sources of care for boys and girls coincided with the actual experience the last time treatment was sought for a minor and a major illness, women were asked where they had taken a girl and boy under five the last time they needed such care. When the respondent reported the actual place where children were treated for the last major illness, boys were much more likely to have been cared for by a private practitioner than girls.

Table 4-58 Place/Person Visited Last Time for Treatment of Girl Child

(Unit: %)

Type of Facility	Minor Illness				Major Illness **			
	Tikamgarh		Damoh		Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Private Allopathic practitioner	11.1	7.7	7.0	8.5	10.3	3.3	10.5	6.5
District Hospital	7.8	4.7	7.0	4.8	13.8	20.5	26.3	20.2
Private/NGO hospital	7.8	5.4	3.5	1.3	20.7	17.2	15.8	4.2
PHC	2.2	9.7	1.2	8.3		8.6	10.5	13.1
SC		0.5		4.6		0.7		1.2
Civil Hospital		0.2				0.7		
Civil Dispensary						0.7		
Private Ayurvedic practitioner		0.5	1.2			0.7		
Traditional healer				0.4				
Teaching hospital		0.2				0.7		
Others		0.2		0.4		0.7		0.6
None	3.3	5.0	2.3	8.3	44.8	33.1	26.3	44.6
Don't know						0.7		0.6
Not applicable (no girl child U5)	67.8	66.0	77.9	63.5				

Note: * Percentages are not added to 100, as it was a multiple response question

** Base: All ever-married women aged 15-49 years having girl child below 5 years of age

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

Table 4-59 Place/Person Visited Last Time for Treatment of Boy Child

(Unit: %)

Type of Facility	Minor Illness				Major Illness **			
	Tikamgarh		Damoh		Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
District Hospital	11.1	6.8	1.2	5.2	16.0	21.3	11.1	27.4
Private/NGO hospital	3.3	7.4	1.2	1.7	16.0	19.3		8.6
PHC	2.2	11.7	1.2	10.2	4.0	12.7		8.6
Civil Hospital	7.8	7.4	10.5	7.4		1.5		0.6
Civil Dispensary					4.0	0.5	33.3	0.6
Private Ayurvedic practitioner	3.3	8.3	5.8	9.3		0.5	55.6	0.6
CHC		1.1		3.5				
SC		0.2		0.2		1.5		1.7
Private Allopathic practitioner		0.7		0.2	12.0	8.1		9.1
Traditional healer			1.2					
Teaching hospital						0.5		
None		0.7		0.2	48.0	31.0		41.1
Others						0.5		0.6
Don't know						2.5		1.1
Not applicable (no girl child U5)	72.2	55.6	79.1	62.0				

Note: * Percentages are not added to 100, as it was a multiple response question

** Base: All ever-married women aged 15-49 years having girl child below 5 years of age

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

(4) Difficulties In Access to Health Services

As expected in a region with such poor roads and low levels of vehicle ownership, the greatest difficulty encountered in getting to the service site is the difficult transport (around 49%), followed by the high cost of care (around 27%).

4.6.8 Decision on Care

The decision on care is made by the husband in 63% of households, or in a quarter of the households by the woman and husband jointly, according to women. Men were emphatic that they make the decision about obtaining health care for their wives: 59.4% stated they make the decision alone, 31% jointly with the wife, and only 3% stated the wife makes the decision. There was little rural/urban difference.

Over three-quarters of all men stated they would allow their wife to go to a health facility for antenatal care; more rural (80%) than urban men (67%) responded positively. Of those who would not allow their wife to go to the SC for ANC, 87% said that it was not necessary.

Table 4-60 Person Who Decides About Obtaining Health Care for Wife

(Unit: %)

Person	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Husband/Self	51.9	73.3	69.7	65.8	46.6	49.4	58.4	59.6	59.4
Wife & husband jointly	30.9	17.7	19.9	23.3	44.2	41.1	27.3	31.3	30.6
Jointly with others in household	1.2	2.7	2.5	8.2	4.0	4.7	4.5	3.4	3.6
Wife	11.1	3.2	4.6		2.6	2.2	5.8	2.9	3.4
Others in household	4.9	3.0	3.3	2.7	2.6	2.6	3.9	2.8	3.0
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 the JICA Development Study on Reproductive Health in MP, 2001

Table 4-61 Reason for Not Allowing Wife for Visiting Health Facility for ANC

(Unit: %)

Reason	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Not necessary	92.9	80	81.8	90.9	97.5	94.5	91.5	85.6	87.2
Poor quality of care		11.8	10.1	9.1	2.5	5.5	6.4	8.8	8.1
Costly		7.1	6.1					4.8	3.5
Others	7.1	1.2	2.0				2.1	0.8	1.2
N	14	85	99	33	40	73	47	125	172

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

4.6.9 Home Visits

The MP health system is designed to provide much of the total RCH care in rural areas outside institutions, often in the home.

Over a quarter of rural women in both districts reported having received at least one home visit in the previous three months. Urban women reported home visits only in Tikamgarh. More than three-quarters of the women visited reported the visits were made by the MPW with another 8.9% by Anganwadi Workers. With the exception of urban women in Damoh who received no home visits, these rates of reported home visits compare favourably with national reports from the NFHS-2, in which 10% of rural and 6% of urban women in Madhya Pradesh reported at least one home visit in the previous 12 months. However, the interviews in our study were conducted just after the time when the Community Needs Assessment was supposed to have been carried out, a time when every rural household was supposed to be visited, so the expectation might have been higher.

Over three-quarters reported that the ANM or MPW discussed immunisations, while 18.4% reported family planning, and 16.0% antenatal care.

In focus groups when the ANM or M-PWM was mentioned, it was almost invariably in terms of her visits to the village to provide immunisations, sometimes to provide IFA tablets and educate pregnant women on nutrition, and occasionally to chlorinate the wells. Some mentioned they wanted to receive methods in the village when the MPWs did not bring them.

Table 4-62 Home Visit by Health Care Provider in Last Three Months and Topics Discussed

(Unit: %)

Detail	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Home visit by any health care provider in last three months (Base: All ever-married women aged 15-49yrs)									
Yes	8.9	26.6	23.6		28.3	23.8	4.5	27.4	23.7
No	91.1	73.4	76.4	100.0	71.7	76.2	95.5	72.6	76.3
N	90	444	534	86	460	546	176	904	1,080
Type of health care provider visited home in last three months*									
<i>(Base: Those ever-married women aged 15-49 reported to be visited by any health care provider at home)</i>									
ANM	12.5	75.4	71.4	84.6	84.6		12.5	80.2	78.1
Anganwadi worker		12.7	11.9	9.2	9.2			10.9	10.5
Dai		5.1	4.8	1.5	1.5			3.2	3.1
MPW-M		2.5	2.4	6.2	6.2			4.4	4.3
NGO worker		5.9	5.6					2.8	2.7
Others	87.5	7.6	12.7	0.8	0.8		87.5	4	6.6
Topics discussed during the visit*									
<i>(Base: Those ever-married women aged 15-49 reported to be visited by any health care provider at home)</i>									
Immunisation	87.5	72.0	73.0	83.1	83.1		87.5	77.8	78.1
Family Planning	75.0	20.3	23.8	13.1	13.1		75.0	16.5	18.4
Antenatal care		16.9	15.9	16.2	16.2			16.5	16.0
Food & Nutrition		7.6	7.1	2.3	2.3			4.8	4.7
Deliveries		5.9	5.6	0.8	0.8			3.2	3.1
Water & sanitation	12.5	1.7	2.4	1.5	1.5		12.5	1.6	2.0
Others		6.8	6.3	3.1	3.1			4.8	4.7
N	8	118	126	130	130		8	248	256

Note: * Percentages are not added to 100, as it was a multiple response question

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

4.6.10 Client Satisfaction

On the whole users of the health services (SC, PHC and CHC, not include hospital) interviewed individually during the beneficiary interview survey expressed satisfaction with the services they received. This contrasted with the poor opinions generally expressed in group discussions and the logical inference one would make from the low level of utilisation of the services. Nevertheless, this report covers the clients' responses to questions about their recent experience in receiving services in search of potential lessons to inform development of strategies for improvement.

Table 4-63 Whether Received Information and Services Clients Wanted?

	(Unit: %)					
	Tikamgarh	Damoh	Sagar	Chhatarpur	Panna	Total
Yes	97.8	77.2	80.0	92.2	97.6	87.0
No	0.7	15.6	8.0	2.0	2.4	7.4
Partially	1.5	3.0	12.0	2.0		3.6
Don't know		4.2		3.9		1.9
N	135	167	75	51	42	470

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

The users reported overwhelmingly that they were very satisfied (26.8%) or somewhat satisfied (65.2%) with the recent service. Only 7.3% admitted to being dissatisfied (One percent had no opinion). There were no statistically significant differences by type of facility that served them or whether they received the service in the home or in a service delivery point. Women were more likely to be dissatisfied if they felt the provider did not respond to their questions to their satisfaction, the time the provider spent with them was too short, or they had a question they felt the provider did not let them ask. They were also dissatisfied, but to a lesser degree, if they felt the privacy was inadequate or they did not get any medicine or injection.

Table 4-64 Clients' General Satisfaction with Visit to Health Facility and Visit by Health Care Provider

	(Unit: %)					
	Tikamgarh	Damoh	Sagar	Chhatarpur	Panna	Total
Were you satisfied or dissatisfied with visit today?						
Very satisfied	49.1	12.1	9.6	32.5	31.3	26.8
Somewhat satisfied	50.3	72.5	77.1	65.0	65.6	65.2
Dissatisfied	0.6	14.0	12.0	2.5	3.1	7.3
No opinion		1.4	1.2			0.7
N	167	207	83	80	64	601

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

Consultation time: The great majority of clients felt that the time the provider spent with them in the recent visit was neither too long nor too short but about right.

Client-provider communication: Nearly all who had a question were allowed to ask it, and 81.4% were satisfied with the provider's response. In Damoh and Sagar, this level is lower than other districts (68.2% and 60.3%). Although one might expect that staff at higher levels in the health system might respond more to the client's satisfaction, there was no significant difference among the types of facilities.

Privacy: Privacy received a less positive response: 59.1% reported they had enough privacy during the visit, but only 39.4% who said they did not have enough privacy were dissatisfied with the visit, while three-quarters were somewhat satisfied.

Among women who were seen in the facility, rather than at home, they were more likely to report they did not have enough privacy at higher levels of in service delivery points: only 26% felt they did not have enough privacy at the SC, compared with 47% in the sector level PHC, 52% in the Block PHC, and 71% at the CHC. Privacy is clearly a matter that needs attention in CHCs and PHCs.

Table 4-65 Client Opinions about Recent Service*

		(Unit: %)
Client's opinion		
Waiting time	- Time was too long	11.7
	- Time was too short	12.7
	- Time was about right	73.6
	(Average waiting time: 11.2 minutes)	
Consultation time (Time spent for client by health care provider)	- Time was too long	5.0
	- Time was too short	10.8
	- Time was about right	82.2
Client-provider communication (Health care provider's response to client's question)	- Provider let client ask questions	95.0
	- Provider did not let client ask questions	5.0
	- Provider responded to client's satisfaction	81.4
	- Provider did not respond to client's satisfaction	13.3
Privacy	- Had enough privacy	59.1
	- Did not have enough privacy	39.4
N		601

Note: *Those with no opinion are included in the percentages but are not displayed.

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

4.6.11 Nutrition and Anaemia

Proper nutrition is important to children's growth and development, and it is key to assuring safe motherhood. Our study explored the intake level of various food groups and beliefs that might have an impact on a woman's nutritional status. The study also looked at the weight and height for children under three.

(1) Food Intake among Women

1) Frequency and Time of Food Intake

In Both Tikamgarh and Damoh Districts, slightly over half of all women are vegetarians. Usually women eat twice (47% of women) or thrice (52% of women) a day. Women eat after the family, which is very common particularly in rural areas.

Table 4-66 Whether Vegetarian, Frequency and Time of Meal

(Unit: %)

Details	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Whether vegetarian or not (Base: All ever-married women aged 15-49 years)									
Yes	57.8	50.5	51.7	55.8	53.5	53.8	56.8	52.0	52.8
No	42.2	49.5	48.3	44.2	46.5	46.2	43.2	48.0	47.2
Frequency of eating meal (Base: All ever-married women aged 15-49 years)									
One time		0.2	0.2	1.2	0.4	0.5	0.6	0.3	0.4
Two times	58.9	47.1	49.1	53.5	43.5	45.1	56.3	45.2	47.0
Three times	41.1	51.8	50.0	45.3	54.3	52.9	43.2	53.1	51.5
Four times or more		0.9	0.8		1.1	0.9		1.0	0.8
Time of eating meal (Base: All ever-married women aged 15-49 years)									
Before the family	5.6	5.9	5.8	2.3	3.5	3.3	4.0	4.6	4.5
With the family	41.1	20.9	24.3	44.2	18.9	22.9	42.6	19.9	23.6
After the family	52.2	71.6	68.4	53.5	76.3	72.7	52.8	74.0	70.6
Others	1.1	1.6	1.5		1.3	1.1	0.6	1.4	1.3
N	90	444	534	86	460	546	176	904	1080

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

2) Intake Level of Various Foods

The frequency of eating various food groups was investigated. Foods studied include some that are high in iron, others that promote iron absorption, and others than are major components of the typical diet in this region. The frequency of intake of the various foods is presented in the table below.

This area of the country grows and consumes wheat. Various breads are part of the staple diet, and people report in focus groups that in difficult times bread may be the only food they eat. This tendency is reflected in the consumption patterns found in this study where 89% of women eat rice/potatoes/bread daily. Other foods eaten at least once a week include dairy products, pulses or beans, and green leafy vegetables. Meat, fish, chicken, and eggs are eaten occasionally or never by four-fifths of the population, even more than profess to be vegetarians. Orange coloured and other fruits and vegetables, which are promoted for pregnant women and promote iron absorption, are eaten less than weekly by about 70% of women, and women report that fruits and vegetables are too expensive. Basically the diet consists of bread, pulses or beans, green leafy vegetables, and dairy products for the majority of women. This could not be considered a well-rounded diet.

Table 4-67 Frequency of Food Consumption of Women in Tikamgarh and Damoh District

(Unit: %)

	Daily	Weekly	Occasionally	Never	Total
Tikamgarh District (Base: All ever-married women aged 15-49 years. Total N=534)					
Milk, curd, cottage, cheese or yoghurt	37.5	26.8	29.8	6.0	100.0
Pulses or beans	64.6	28.1	7.1	0.2	100.0
Green leafy vegetables	44.2	29.4	25.5	0.9	100.0
Orange colored fruits or vegetables	4.5	22.8	65.9	6.7	100.0
Other fruits and vegetables	6.0	21.2	66.3	6.6	100.0
Eggs	1.7	21.2	21.5	55.6	100.0
Chicken, meat or Fish	3.2	21.3	23.0	52.4	100.0
Rice, potatoes, naan or other bread	88.8	5.8	3.2	2.2	100.0
Damoh District (Base: All ever-married women aged 15-49 years. Total N=546)					
Milk, curd, cottage, cheese or yoghurt	25.3	31.5	38.6	4.6	100.0
Pulses or beans	72.7	24.5	2.2	0.5	100.0
Green leafy vegetables	56.6	28.9	13.6	0.9	100.0
Orange coloured fruits or vegetables	6.0	22.7	65.2	6.0	100.0
Other fruits and vegetables	4.2	21.4	66.7	7.7	100.0
Eggs	1.3	13.7	30.2	54.8	100.0
Chicken, meat or Fish	1.8	15.2	29.5	53.5	100.0
Rice, potatoes, naan or other bread	89.4	8.2	0.7	1.6	100.0

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

The food intake patterns of women who use the health services have some similarities and some differences from women in the general population. Among women users of health services, 63% are vegetarian, compared to 53% in the general population. Slightly over half eat two meals per day, and 54% eat after the family, both closely resembling the urban population of women in the household survey.

Health service users eat dairy products, pulses or beans, green leafy vegetables, orange coloured and other fruits and vegetables much more frequently than women in the general population. As mentioned elsewhere in this report, users of services in this study were much more likely to be urban than women in the general population. Their urban residence likely entails a higher per capita income, and improvements in food intake are generally a result of economic improvements. The food intake of service users is displayed below.

Table 4-68 Frequency of Food Consumption of Service Users (Women) in Sagar Division

(Unit: %)

	Daily	Weekly	Occasionally	Never	Total
Tikamgarh District (Base: Health service users - women aged 15-49 years. Total N=167)					
Milk, curd, cottage, cheese or yoghurt	55.1	18.6	22.8	3.6	100.0
Pulses or beans	74.3	17.4	8.4		100.0
Green leafy vegetables	82.2	14.4	5.4		100.0
Orange coloured fruits or vegetables	6.0	43.7	49.1	1.2	100.0
Other fruits and vegetables	19.8	42.5	35.9	1.8	100.0
Eggs	0.6	19.2	18.0	62.3	100.0
Chicken, meat or Fish	2.4	10.8	25.1	61.7	100.0
Rice, potatoes, naan or other bread	97.0	1.2	1.2	0.6	100.0
Damoh District (Base: Health service users - women aged 15-49 years. Total N=207)					
Milk, curd, cottage, cheese or yoghurt	60.4	23.2	11.1	5.3	100.0
Pulses or beans	80.2	17.4	2.4		100.0
Green leafy vegetables	44.0	51.2	3.9	1.0	100.0
Orange coloured fruits or vegetables	8.2	69.6	18.8	3.4	100.0
Other fruits and vegetables	37.7	39.1	19.3	3.9	100.0
Eggs		29.0	16.9	54.1	100.0
Chicken, meat or Fish		18.8	27.5	53.6	100.0
Rice, potatoes, naan or other bread	90.8	6.3	2.4	0.5	100.0
Sagar Division (Base: Health service users - women aged 15-49 years)					
<i>(Total N=601: Tikamgarh-167, Damoh-207, Sagar-83, Chhatarpur-80, Panna-64)</i>					
Milk, curd, cottage, cheese or yoghurt	55.9	22.6	18.0	3.5	100.0
Pulses or beans	76.5	16.5	7.0		100.0
Green leafy vegetables	56.1	36.6	7.0	0.3	100.0
Orange coloured fruits or vegetables	6.7	52.2	39.3	1.8	100.0
Other fruits and vegetables	25.3	42.1	28.1	4.5	100.0
Eggs	0.2	21.3	16.3	62.2	100.0
Chicken, meat or Fish	1.5	14.0	22.1	62.4	100.0
Rice, potatoes, naan or other bread	93.2	4.7	1.5	0.7	100.0

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

(2) Knowledge and Beliefs about Food Intake during Pregnancy and after Delivery

Women have little knowledge of proper nutrition during pregnancy and lactation, particularly rural women.

1) Food Intake during Pregnancy

Two-thirds of urban women know that intake of some foods should be increased during pregnancy, while almost two-thirds of rural women do not.

Women correctly report foods that should be increased as green leafy vegetables (82%), dairy products (66%), and beans and pulses (43%). Fewer know that intake of orange fruits and vegetables, that help absorption of iron, should be increased (32%). Fewer still reported other fruits and vegetables (24%), rice/potatoes/wheat-based foods (11%), eggs (7%), or chicken/meat/fish (4%). Daliya, the food supplement provided in the ICPD Programme, was

2) Foods to be Avoided in Pregnancy

The situation was similar regarding foods to be avoided in pregnancy: 60.8% of urban (Tikamgarh: 74.4%, Damoh:46.5%) and 45.5% (Tikamgarh: 46.2%, Damoh:44.8%) of rural women reported there are foods a pregnant woman should avoid.

Chief among these are hot spicy foods, mentioned by 63.1% of women, cold foods (a traditional classification not related to temperature) mentioned by 47.7% of urban and 29.0% of rural women), and unclean foods and pickles, each mentioned by a quarter of women. Chicken, meat, and fish were reported as foods to be avoided by 16% of women, more often by urban than rural women, as were stale foods (another traditional categorisation) and jaggery, a type of sugar and molasses.

More urban than rural men reported women should avoid certain foods during pregnancy (56% vs. 48%), although a third did not know. The foods they said should be avoided are pickles (47%), hot spicy foods (46%), beans and pulses (25%), eggs (24%), stale foods (17%), and cold foods (11%). There is a clear need for nutrition education for men and women since both, but especially men, mentioned foods that should be increased as ones to avoid during pregnancy.

3) Foods to be Avoided in the Postpartum Period

An even larger proportion of women stated there are foods to be avoided in the postpartum period; again more urban than rural women reported this to be so (87.5% vs. 69.4%). Over half stated that cold foods should be avoided. Nearly a third report that hot, spicy foods should be avoided in the postpartum period. Other foods to be avoided include jaggery, beans and lentils, green leafy vegetables, stale foods, and unclean foods. Again more than a third of men did not know, while just over half said there are foods to be avoided in the postpartum period. The urban-rural difference is found among the men also but to a much lesser degree.

The foods men believe should be avoided are pickles, cold foods, hot spicy foods, beans and pulses, chicken/meat/fish, stale foods, and eggs. Again we see that both sexes, but especially men, believe in avoiding some of the foods that are actually the ones that should be increased during lactation.

This level of ignorance about women's nutrition among men is not surprising: 52% reported they have never heard or read anything about nutrition for women, and 80% report they have never heard of anaemia. Men reported they were amenable to having women eat with the family, rather than after, if they were not getting enough of the right foods eating afterwards (84%), an indication of a willingness to change traditional behaviour if there is a health benefit for women.

Table 4-70 Types of Foods to be Avoided during Pregnancy

(Unit: %)

Detail	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Women's Opinion									
Whether women avoid some foods during pregnancy									
<i>(Base: All ever-married women aged 15-49 years)</i>									
Yes	74.4	46.2	50.9	46.5	44.8	45.1	60.8	45.5	48.0
No	12.2	26.6	24.2	27.9	35.4	34.2	19.9	31.1	29.3
Don't know	13.3	27.3	24.9	25.6	19.8	20.7	19.3	23.5	22.8
N	90	444	534	86	460	546	176	904	1080
Type of food to be avoided during pregnancy (Base: Those ever-married women aged 15-49 years reporting avoiding food during pregnancy)									
Hot, spicy foods	70.1	62.4	64.3	60.0	62.1	61.8	66.4	62.3	63.1
Cold foods	37.3	35.1	35.7	65.0	22.8	29.7	47.7	29.0	32.8
Unclean foods	23.9	14.1	16.5	42.5	34.5	35.8	30.8	24.3	25.7
Pickle	31.3	22.4	24.6	12.5	29.1	26.4	24.3	25.8	25.5
Chicken, meat or fish	23.9	14.1	16.5	27.5	13.6	15.9	25.2	13.9	16.2
Stale foods	20.9	11.2	13.6	37.5	15.5	19.1	27.1	13.4	16.2
Jaggery	13.4	13.2	13.2	22.5	9.2	11.4	16.8	11.2	12.4
Eggs	11.9	8.8	9.6	15.0	5.3	6.9	13.1	7.1	8.3
Other vegetables	3.0	4.9	4.4	2.5	11.2	9.8	2.8	8.0	6.9
Pulses or beans	3.0	5.4	4.8	10.0	8.7	8.9	5.6	7.1	6.8
Others	3.0	7.8	6.6		3.9	3.3	1.9	5.8	5.0
Papaya, Pine apple	7.5	7.3	7.4		2.4	2.0	4.7	4.9	4.8
Milk, or curds		4.9	3.7		1.5	1.2	0.0	3.2	2.5
Green leafy vegetables	1.	2.4	2.2	2.5	1.9	2.0	1.9	2.2	2.1
Fruits	2.	0.5	0.4	2.5		0.4	0.9	0.2	0.4
N	67	205	272	40	206	246	107	411	518
Husbands' Opinion									
Whether wife should avoid some foods during pregnancy (Base: All husbands)									
Yes	60.5	43.4	46.3	47.9	53.4	52.6	54.5	48.5	49.5
No	17.3	25.2	23.9	12.3	12.4	12.3	14.9	18.6	18.0
Don't know	22.2	31.4	29.9	39.7	34.2	35.0	30.5	32.8	32.5
N	81	401	482	73	421	494	154	822	976
Types of food wife should avoid during pregnancy									
<i>(Base: Those husbands reported that wife should avoid food during pregnancy)</i>									
Pickle	40.8	39.7	39.9	42.9	55.1	53.5	41.7	48.4	47.2
Hot, spicy foods	63.3	44.3	48.4	31.4	46.2	44.2	50.0	45.4	46.2
Chicken, meat or fish	36.7	54.0	50.2	40.0	29.8	31.2	38.1	40.4	40.0
Pulses or beans	36.7	25.9	28.3	17.1	23.6	22.7	28.6	24.6	25.3
Eggs	28.6	40.2	37.7	11.4	12.9	12.7	21.4	24.8	24.2
Stale foods	18.4	12.1	13.5	11.4	20.4	19.2	15.5	16.8	16.6
Cold foods	26.5	16.7	18.8	2.9	14.7	13.1	16.7	15.5	15.7
Unclean foods	14.3	9.2	10.3	25.7	8.9	11.2	19.0	9.0	10.8
Other vegetables	12.2	8.6	9.4	5.7	12.0	11.2	9.5	10.5	10.4
Jaggery		11.5	9.0	5.7	4.0	4.2	2.4	7.3	6.4
Papaya, Pineapple		3.4	2.7	28.6	2.2	5.8	11.9	2.8	4.3
Milk, or curds	6.1	2.3	3.1	2.9	5.3	5.0	4.8	4.0	4.1
Green leafy vegetables	4.1	3.4	3.6	2.9	1.8	1.5	2.4	2.5	2.5
Fruits	2.0	2.3	2.2		0.4	0.4	1.2	1.3	1.2
Others	2.0	0.6	0.9		4.9	4.6	2.4	3.0	2.9
N	49	174	223	35	225	260	84	399	483

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

Table 4-71 Types of Foods to be Avoided in the Postpartum Period –

(Unit: %)

Details	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Women's Opinion									
Whether women avoid some foods after giving birth (Base: All ever-married women aged 15-49 years)									
Yes	95.6	68.2	72.8	79.1	70.4	71.8	87.5	69.4	72.3
No	1.1	15.5	13.1	17.4	15.9	16.1	9.1	15.7	14.6
Don't know	3.3	16.2	14.0	3.5	13.7	12.1	3.4	14.9	13.1
N	90	444	534	86	460	546	176	904	1080
Types of food to be avoided after giving birth (Base: Those ever-married women aged 15-49 years reporting avoiding food after giving birth)									
Cold foods	65.1	59.4	60.7	47.1	55.6	54.1	57.1	57.4	57.4
Hot, spicy foods	44.2	28.1	31.6	45.6	29.0	31.9	44.8	28.5	31.8
Pickle	25.6	22.4	23.1	30.9	38.0	36.7	27.9	30.5	30.0
Jaggery	19.8	16.2	17.0	27.9	27.5	27.6	23.4	22.0	22.3
Pulses or beans	12.8	19.8	18.3	20.6	20.1	20.2	16.2	19.9	19.2
Other vegetables	18.6	10.6	12.3	11.8	16.4	15.6	15.6	13.6	14.0
Green leafy vegetables	10.5	9.9	10.0	4.4	17.6	15.3	7.8	13.9	12.7
Stale foods	12.8	7.9	9.0	16.2	13.0	13.5	14.3	10.5	11.3
Chicken, meat or fish	15.1	9.9	11.1	14.7	9.0	9.9	14.9	9.4	10.5
Unclean foods	9.3	11.9	11.3	20.6	6.8	9.2	14.3	9.3	10.2
Milk, or curds	2.3	10.6	8.7	4.4	6.2	5.9	3.2	8.3	7.3
Eggs	3.5	7.9	6.9	8.8	2.8	3.8	5.8	5.3	5.4
Papaya, Pine apple	4.7	4.6	4.6	1.5	3.1	2.8	3.2	3.8	3.7
Fruits	1.2	3.3	2.8	1.5	0.6	0.8	1.3	1.9	1.8
Others	9.3	23.8	20.6	14.7	12.7	13.0	11.7	18.0	16.8
N	86	303	389	68	324	392	154	627	781
Husbands' Opinion									
Whether wife should avoid some foods after giving birth (Base: All husbands)									
Yes	60.5	49.6	51.5	49.3	53.9	53.2	55.2	51.8	52.4
No	18.5	16.5	16.8	4.1	4.8	4.7	11.7	10.5	10.7
Don't know	21.0	33.9	31.7	46.6	41.3	42.1	33.1	37.7	37
N	81	401	482	73	421	494	154	822	976
Types of food that wife should avoided after giving birth (Base: Those husbands reported that wife should avoid food after giving birth)									
Pickle	42.9	53.3	51.2	55.6	56.8	56.7	48.2	55.2	54.0
Cold foods	36.7	35.7	35.9	66.7	27.3	32.7	49.4	31.2	34.2
Hot, spicy foods	49.0	36.2	38.7	22.2	25.1	24.7	37.6	30.3	31.5
Chicken, meat or fish	26.5	37.2	35.1	16.7	15.9	16.0	22.4	25.8	25.2
Pulses or beans	40.8	19.1	23.4	25.0	26.9	26.6	34.1	23.2	25.0
Stale foods	26.5	15.1	17.3	8.3	12.8	12.2	18.8	13.8	14.7
Eggs	14.3	25.1	23.0	2.8	5.3	4.9	9.4	14.6	13.7
Milk, or curds	16.3	9.0	10.5	22.2	9.7	11.4	18.8	9.4	11.0
Other vegetables	14.3	5.5	7.3	8.3	14.5	13.7	11.8	10.3	10.6
Unclean foods	12.2	9.5	10.1	16.7	3.1	4.9	14.1	6.1	7.4
Jaggery	4.1	5.0	4.8		1.3	1.1	2.4	3.1	2.9
Green leafy vegetables	2.0	3.0	2.8		3.1	2.7	1.2	3.1	2.7
Papaya, Pine apple	4.1	3.0	3.2	2.8	0.4	0.8	3.5	1.6	2.0
Fruits	0.0	2.0	1.6		1.8	1.5	3.5	1.9	1.6
Others	6.1	6.0	6.0		18.5	16.0	8.5	12.7	11.2
N	49	199	248	36	227	263		426	511

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

Table 4-72 Source of Information about Nutrition for Women among Husbands

(Unit: %)

Source	Tikamgarh			Damoh			Combined		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Never heard	24.7	52.4	47.7	38.4	58.9	55.9	31.2	55.7	51.8
Friend, Relatives, Neighbour	28.4	18.2	19.9	12.3	20.2	19.0	20.8	19.2	19.5
Television	45.7	17.7	22.4	32.9	13.3	16.2	39.6	15.5	19.3
Govt. Doctor	24.7	7.2	10.2	12.3	16.6	16.0	18.8	12.0	13.1
Radio	21.0	12.2	13.7	1.4	6.9	6.1	11.7	9.5	9.8
Read about it	13.6	7.0	8.1	21.9	8.8	10.7	17.5	7.9	9.4
ANM/MPW/Sub Centre	4.9	9.0	8.3		11.9	10.1	2.6	10.5	9.2
Nurse/Private Doctor.	11.1	1.7	3.3	5.5	3.1	3.4	8.4	2.4	3.4
Anganwadi worker		6.0	5.0		2.1	1.8		4.0	3.4
UFWL					0.2	0.2		0.1	0.1
Other		1.0	0.8		0.2	0.2		0.6	0.5
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 the JICA Development Study on Reproductive Health in MP, 2001

(3) Anaemia among Women

1) Socio-demographic Characteristics and Anaemia

An important health problem among adolescent girls and women of childbearing age is anaemia generally caused by the low intake of foods rich in iron and/or foods that promote iron absorption. Women's haemoglobin levels were tested by a paramedic using an apparatus (HEMOCUE) that provided the results immediately. Our study explored socio-demographic characteristics and three cultural factors - vegetarianism, number of meals eaten daily, and eating after the family – that could be related to anaemia.

Anaemia was diagnosed in 31.1% of women tested: 17.5% with mild anaemia, 11.0% with moderate anaemia, and 2.7% with severe anaemia. The highest proportions of some degree of anaemia were found in pregnant women. In this study 12% of women were pregnant, and 43% of them had some degree of anaemia, compared with only 29% of non-pregnant women. Rural women were more likely to be anaemic than urban women. Anaemia was not associated with age, district, employment status or any other background characteristic except pregnancy and rural residence.

No statistically significant relationship was found between consumption of any category of food at least weekly and being anaemic to any degree. Anaemia was prevalent in 30.1% to 34.2 % of women who ate any category of food described above at least weekly. Religion and marital status were not studied because the numbers of women who were not Hindu or not currently married were very small.

Overall anaemia levels in our study were lower than levels found by the NFHS-2 for the entire state, although the prevalence of severe anaemia is greater.

Table 4-73 Women with Anaemia and Degree by Selected Background Characteristics

		(Unit: %)			
Characteristic		% Any Degree of Anaemia	% Mild Anaemia (10.0-10.9 g/dl)*	% Moderate Anaemia (7.0-9.9 g/dl)*	% Severe Anaemia (<7.0g/dl)*
Age	15-19	35.8	20.9	11.9	3.0
	20-24	32.9	14.6	17.5	0.8
	25-29	32.6	19.0	10.0	3.6
	30-34	32.6	19.1	9.6	3.9
	35-39	25.4	20.5	2.5	2.5
	40+	26.4	13.6	10.0	2.9
Residence	Urban	22.8	13.7	6.5	2.6
	Rural	32.6**	18.2	11.8	2.7
District	Tikamgarh	33.8	17.4	13.3	3.1
	Damoh	28.4	17.5	8.6	2.3
Employment	Employed	30.8	20.2	7.6	3.0
	Not Employed	31.2	16.0	12.7	2.5
Contraception	User	28.7	19.1	7.1	2.4
	Non-User	31.2	14.9	12.6	3.7
Pregnancy	Pregnant	43.4	21.2	21.2	9.0
	Not Pregnant	29.4***	16.9	9.6	2.9
Total		31.1	17.5	11.0	2.7

Note: * Haemoglobin level in the blood

** significant at the p=0.017 level, *** significant at the p=0.009 level

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

2) Cultural Factors and Anaemia

None of the three factors under study was correlated with anaemia in women.

Vegetarianism: In our study, 52.8% of women reported they are vegetarians with no difference between urban and rural women. Thus more than half of women do not eat meat, which has more readily available iron than plant foods. Nevertheless, vegetarianism was not statistically associated with haemoglobin levels.

The number of meals eaten daily: Just under half of all women respondents (47.0%) reported eating two meals per day, and just over half (51.5%) eat three meals per day. Unexpectedly, urban women are more likely to eat two meals daily (56.3%), while rural women are slightly more likely to eat three (52.8%). The number of meals eaten daily, however, was not statistically associated with haemoglobin levels.

Eating after the family: In India many women eat after they feed the men and children, possibly contributing to inadequate total intake of food and other nutritional deficits. The majority of urban and rural women eat after the family (52.8% and 74.0%). Urban women were more likely than their rural counterparts to eat with the family (42.6% vs. 19.9%). However, there was no correlation between eating after the family and haemoglobin levels.

In sum, the proportions of women from all walks of life have anaemia to some degree is excessive. However, it is especially prevalent among pregnant and rural women. The strategy of the government to require distribution of IFA to all pregnant women is justified by the data here, and steps should be taken to expand the programme to ensure universal coverage. Rural areas should receive priority attention.

4.6.12 Nutritional Status of Children

Nutritional status is a major determinant of the health and well being of children. Inadequate or unbalanced diets and chronic illness are associated with poor nutrition among children. To assess their nutritional status, measurements of weight and height/length were obtained for children born in the three years preceding the survey. Data on weight and height/length were used to calculate the following three summary indices of nutritional status:

- Weight-for-age
- Height-for-age
- Weight-for-height

The table below gives the nutritional status of children below 3 years of age in the study area. Nearly 60 percent of the children below 3 years, covered during the survey, are underweight i.e. having Z scores below -2 standard deviation. The data compares well with the NFHS-2 data that shows more than 55% of the children in the state are underweight. There is not much difference in the proportion of children who are underweight in Tikamgarh (59.8%) and Damoh (58.3%). More than two-thirds of the children are stunted (68.2%) and the proportion is significantly higher in Tikamgarh (73.4%) than in Damoh (63.1%). As per the NFHS-2 around half of the children below 3 years in the state are stunted (51%). Poor socio-economic status of tribal district of Tikamgarh may have contributed to a higher proportion of stunted children in the survey. Nearly a quarter of the children below 3 years were wasted (23.2%) and the data compares well with the NFHS-2 data (19%). The proportion was marginally higher in Damoh (26.7%) as compared to Tikamgarh (19.6%).

Table 4-74 Anthropometric Measurements of Children under 3 Years of Age

(Unit: %)

Nourishment Status	Tikamgarh			Damoh			Combined			
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	
Height for Age	Undernourished	54.6	77.1	73.4	61.5	63.2	63.1	56.5	69.6	68.2
	Normal	45.5	22.9	26.6	38.5	36.8	36.9	43.5	30.3	31.9
	N	33	166	199	13	193	206	46	359	405
Weight for Age	Undernourished	66.7	58.4	59.8	53.9	58.5	58.3	63.0	58.5	59.0
	Normal	33.3	41.6	40.2	46.2	41.5	41.8	37.0	41.5	41.0
	N	33	166	199	13	193	206	46	359	405
Weight for Height	Undernourished	27.3	18.1	19.6	38.5	25.9	26.7	30.4	22.3	23.2
	Normal	72.7	81.9	80.4	61.5	74.1	73.3	69.6	77.7	76.8
	N	33	166	199	13	193	206	46	359	405

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

4.7 DONORS AND NGOS PROGRAMMES IN MP AND TARGET DISTRICTS

Several donors and a small number of NGOs are present in MP. The principal ones active in RCH sector are shown in Table 4-75.

Table 4-75 List of Donor Supported Programmes/Projects in Health Sector and Health Related Sectors

Central Sponsored Scheme in MP		
1	Basic Health Services Phase III	DANIDA
2	RCH Programme	IDA
3	RCH through State Sector Reform Bureau	EC
4	Integrated Population Development Programme	UNFPA
5	Malaria Project	WB
6	TB Project	WB
7	Leprosy Project	WHO
8	Blindness Project	WB
9	HIV/AIDS Control Project	WB
10	Health Sector Reform	EC
11	Border Cluster Districts Project	UNICEF
Externally Aided Programmes/Projects in MP		
1	Public Resources Management Programme	ADB
2	District Poverty Initiative Programme	WB
3	Rajghat Canal Irrigation	JBIC
4	Conservation & Management of Bhopal Lake	JBIC
5	Rewa Hospital	OPEC

The followings is a brief description of the programmes and projects of international donor agencies and NGOs in MP. There are two types of approaches among international donor agencies: a sector approach and a district focus approach. UNFPA and UNICEF take the latter approach (with more grassroots involvement), while the EC, DFID and DANIDA use the former.

4.7.1 International Donor Agencies

(1) United Nations Population Fund (UNFPA)

UNFPA is supporting the Integrated Population and Development (IPD) Project of the government of Madhya Pradesh. Two districts of Sagar Division, Chhatarpur and Panna, have IPD activities supported by UNFPA. These activities are oriented to provider training, improving management, increasing the availability of trained primary care workers, some provision of equipment, strengthening emergency obstetrical and neonatal care, improving the quality of family planning services, enhancing RTI management and access to medical termination of pregnancy, and strengthening HIV/AIDS control and prevention.

(2) United Nations Children's Fund (UNICEF)

UNICEF is one of the Government of MP's principal development partners. Its assistance focuses on primary education, water and sanitation, child protection where child prostitution is a tradition (in the Bedia and Bachhra communities), protection of child labourers, training for local governance bodies, and health and nutrition focusing on under-fives and safe motherhood. In

RCH one of the programmes is *the Border District Cluster Project* which is strengthening the teamwork of the Dai, Auxiliary Nurse Midwife (ANM), Jan Swasthya Rakshak (JSR), and Anganwadi worker (AWW) in some of the most remote districts, including Tikamgarh in Sagar Division.¹

(3) The Department for International Development (DFID)

DFID is a relative newcomer to MP, operating in the state only since November 1999. DFID is focusing on three areas of poverty elimination in MP: health, rural livelihood, and civil service development. In health DFID proposes to support government activities, as opposed to implementing separate projects. Funding is expected to become available around the end of 2001. Currently DFID is providing technical assistance to the government for the development of an economically oriented development strategy focusing on economic reform and secondarily human development. DFID is collaborating with the secretariat of the Chief Minister on development of a survey of every household in the state on health problems, which is intended more to mobilise communities (it is not clear whether a survey report is even planned).

(4) DANIDA

DANIDA has been active in Madhya Pradesh for almost 20 years and has one of the most extensive programmes planned for MP. DANIDA is in the first year of a 5-year plan for support to the health sector, principally in the area of training and development of systems. The major components of DANIDA's assistance for the next five years are:

- Training for Dais and paramedical workers and developing competency of the training staff; upgrading training facilities; strengthening the State Institute for Health Management and Communication (SIHMC).
- Information, Education and Communication, specifically training IEC Bureau staff, equipping the IEC Bureau, annual planning workshops development of materials, mass media campaigns.
- Drug distribution, specifically technical assistance to establish a drug policy, formulation of PHC essential drug list, construction of warehouses to support an improved distribution system, development of warehouse management distribution system, equipment and training for drug testing lab, and production of standard treatment guidelines.
- Management needs assessment, training in management, and strengthening of the HMIS and the Planning and Monitoring Unit.
- Support to local bodies that are responsible for health planning under decentralisation.

Danida recently concluded a series of potentially very useful studies of the health care system, and the results of these studies have been taken into account in this report.

(5) The European Commission (EC)

The EC is utilising a Sector Investment Programme (a form of Sector Wide Approach). It is releasing funds to the general budget for health for the state consequent to the state's achieving a series of benchmarks or performance indicators. It is also providing technical assistance for operational policy reform. The EC focuses on Guna and Sidhi districts in MP.

¹ "UNICEF in Madhya Pradesh, Programme Profile." 1999-2002.

4.7.2 NGOs

The GOI has implemented a small-scale programme to involve NGOs in the RCH programme for advocacy, counselling, raising community demand for RCH services, and service delivery. The programme is completely operated by the GOI to the almost total exclusion of the state. The state in-charge, for example, has the names of five of the six NGOs operating under the programme in Madhya Pradesh, but not their addresses or telephones, nor does she receive reports on their activities. This is a major flaw in the programme. The flow of funds is also directly from the central level to the NGO. According to a recent World Bank Mid-Term Evaluation of the RCH Program, the "existing rules and their cumbersome applications don't seem to offer the NGOs a fair ground for competition." Improvements can and should be made, particularly to involve the state and district personnel.

Other innovative schemes have been tried successfully in India and elsewhere to tap into the strengths of NGOs and help them to expand their reach. Such schemes must be flexible and respect the individuality of the individual NGO's agenda to be effective. The state HIV/AIDS programme is implementing one such scheme, that of contracting with NGOs to provide educational and preventive services to their beneficiary high-risk population. This should be tried in IEC for primary health, perhaps contracting with individual NGOs to assist them to cover an entire Block. Another strategy again borrowed from previous HIV/AIDS programmes, implemented in India and elsewhere, is the competitive small grants programme in which NGOs submit proposals for activities they want to carry out, and the best are awarded funds to do so. In this way, the NGO has great ownership of the programme since they develop the plans themselves.

(1) Family Planning Association of India (FPAI)

FPAI of Madhya Pradesh is active only in Bhopal, Raisen, Sagar, and Vidisha. It has no activities in either Tikamgarh or Damoh district. The FPAI implements a variety of programmes in line with the Cairo concepts. Their key family planning programme is called "small family by choice," which is an integrated (everything but the kitchen sink) programme of health care, family life education, and work on the status of women.

(2) CARE

Care supports an Integrated Nutrition and Health Programme in 19 districts of Madhya Pradesh (before bifurcation) for pregnant women and children under six working through the Anganwadi Centers; Improved Health Care for Adolescent Girls in Urban Slums in Jabarpur; Maternal and Infant Survival Project in Hashnagabad and Harda; Credit Rotation for Empowerment and Development through Institution-Building and Training in Dentewaswa; and Orientation of Key Truckers, Associates and Transporters on AIDS in Raipur (now in Chhattisgarh state). CARE is not active in Sagar Division.

(3) The Voluntary Health Association of India (VHAI)

VHAI is actually a network of more than 4,000 NGOs. It operates through 24 state associations, including MP. The association works in the areas of capacity building of public and private sector health agencies, policy research, dissemination of information on a wide range of health aspects, and only occasionally as an implementer of health services. It has produced a number of useful documents for training and updating of health personnel and policy-makers. The

Madhya Pradesh state association is headquartered in Indore, the commercial capital of the state.

(4) JANANI

Janani works in three states, Bihar, Uttar Pradesh, and Madhya Pradesh. They purchase condoms, pills and essential medicines, which they sell at a subsidized price to retailers. Their brands are the Mithun condom and the Apsara pill. They conduct the work through five regional centres (the Bhopal centre covers Sagar Division except Tikamgarh).

1) Social Marketing.

In urban areas Janani places contraceptives in small shops.

In rural areas, the regional centre sends area inspectors to identify potential depot holders in the village using the following criteria:

- already involved in distributing medicines
- work out of the home
- if male, the wife is able to participate in training with man
- preferably between 35-40 years of age.

The registered medical practitioners (RMPs) thus identified (can be JSRs and some are women) receive three days of training after which they receive marketing materials, pregnancy tests, essential medicines, and subsidised contraceptives. They earn money by selling contraceptives and making referrals for MTP or surgical contraception to Janani clinics (for which they receive an incentive). They are supervised and re-supplied every three months.

2) Clinics

Janani has a lovely clinic in Old Bhopal, Surya Clinic, that is a full-service family planning clinic. They train private physicians in the model for a fee and sell them contraceptives at a subsidised price. There are ten or 12 of these clinics in Madhya Pradesh currently and a total of 150 in India. There are none yet in Sagar Division. The doctors benefit from the subsidised prices and the referrals from the RMP network.

(5) Other Small NGOs

Although there are hundreds of small NGOs in Madhya Pradesh, there is little formal information on their activities. NGOs that are involved in health generally provide health education and/or advocacy, but few provide services. There are few strong NGOs in the health sector in the state. They perceive that they have a poor human resource base, resulting in poor capabilities, especially in health. Some NGOs, however, are playing a role with growing importance.

NGOs are regarded as having access to communities that is far superior to that of the government, and they are able to mobilise communities in ways the government cannot. Those that work in health generally have educational and promotional activities but rarely provide services beyond simple distribution of a product. Nonetheless, this is a limited but untapped potential resource. One such NGO is described below.

1) Viveka Nand Sahityite Sanskritik Samajik Navak Mandal, an NGO in Tejgarh
(Viveka Nand Historical, Cultural, Social, Youth Group)

Tejgarh is a town of about 3,000 inhabitants in Tendukera Block of Damoh district. Gramin Vikas Samithi was a small NGO operating in the town of Tejgarh and neighbouring villages until its director moved away two years ago. One of its volunteers, a teacher Mr. Dikshit, then decided to continue the organisation and its social activities under a new name. The NGO works to combat many of the social weaknesses of the communities, including the low age at marriage, casteism, lack of income generating skills among young women, large families, and low rates of immunisation.

The NGO has no facilities of its own. The director keeps its records and belongings in his one-room home, and activities are carried out in public places or volunteers' homes. The organisation recently received an award from the Ministry of Sports and Youth Affairs and was awarded Rs. 10,000 (about US\$220) from the district collector to carry out its activities.

Mr. Dikshit feels there is a need for NGOs to work in health despite the presence of an ANM and a JSR in his town. The ANM, he reports, is overloaded. She visits each surrounding village once every two weeks, but this schedule does not allow her to be present when she is needed. The JSR previously had a private practice, but the community believes a patient died from a medicine the JSR provided, and he no longer practices, although he helps the ANM organise camps and special health activities.

4.7.3 Donor Programmes in Target Districts

(1) The Integrated Population and Development (IPD) Project

The Integrated Population and Development (IPD) Project was formulated based upon the UNFPA's fifth Country Program (1997-2002) which claims to replace the target-oriented approach and to incorporate population and development with emphasis on women's health and empowerment. The UNFPA is supporting this IPD project in six states, which are MP, Rajasthan, Maharashtra, Kerala, Orissa and Gujarat, and five districts (Chhatarpur, Panna, Rewa, Satna and Sidhi) are selected in MP.

1) Project Goals

- To enable individuals and couples to achieve their personal reproductive intentions and to ensure survival of their infants and children
- To eliminate discrimination against girls and to improve their health, nutritional and educational status
- To enable men to take responsibility for their sexual and reproductive behaviour
- To achieve gender equality and equity between men and women and to enable women to realise their full potential

2) Project Purposes

- To have enhanced access to quality reproductive health services in the project districts
- To have contributed to improved programme management
- To have contributed towards promoting gender equity and equality
- To have enhanced community-based organisations and women's participation in decision making

The IPD project has local planning and community participation as a basic concept and has been implemented by a full-time organisation of the Project Management Unit at the state level (5 persons) and the district level (3 persons each) under Department of Health and Family Welfare. The funding mechanism for this project uses the "society" system, and the SCOVA at the state and RCH society at the district level have co-ordinated on other activities. As a consequence, in our target area, Chhatarpur and Panna, the RCH programme has been practically replaced by the IPD project because of substantial duplication of components.

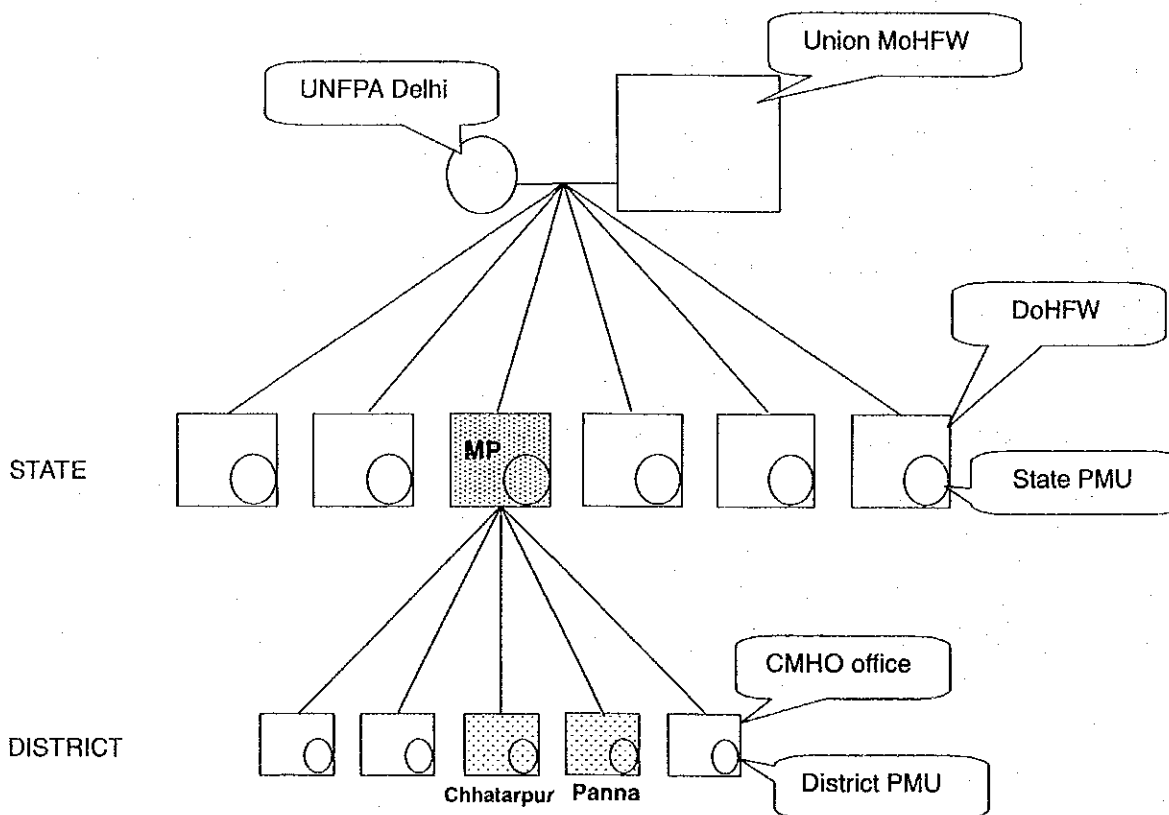


Figure 4-12 Management Structure of IPD Project in MP (UNFPA)

Since the commencement of this project was delayed till April 2000, there are limited data available on actual expenditures. In our target districts, Rs. 1.25 million for Chhatarpur and approximately Rs. 2 million for Panna were spent for the year 2000, the first year of the project. However, each district is preparing to receive more than Rs. 10 million for 2001 as all the components should be operational as planned in the second year.

Table 4-76 Expenditures of IPD project in Chhatarpur and Panna

(Unit: Rs.)

	Chhatarpur	Panna
2000 (total expenditure)	1,251,591	1,945,447
2001 (total budget)	11,671,151	10,028,702

Note: IPD project started April 2000 and implemented components were limited. The plan for 2001 includes full-set of project menu.

Source: District PMU in Chhatarpur and Panna

The project has been designed to enhance access to quality reproductive health services, and to promote gender equity and equality with the strategies and interventions listed in Table 4-77.

Table 4-77 IPD Project Strategies and Interventions

1. Reproductive Health	
STRATEGY	INTERVENTION
Strengthening maternal and neonatal services	Infrastructure renovations and repair, training, equipment and supplies, additional FHW, training and appointment of community midwives
Strengthening family planning services	Provision of equipment, training, dissemination of service delivery guidelines, provision of condom, IUD, minilaparotomy and laparoscopy
Introducing RTI and STD	Training of lab technicians and medical officers at PHC, provision of drugs and lab equipment
Strengthening facilities for prevention and management of complications due to unsafe abortion	Training of PHC medical officers, provision of sterilisation equipment and gynaecologist services
Introducing incremental reproductive health services through small pilot projects	Preparing extra space for labour patients, additional FHW and helper, training in syndromic management for RTI and infertility counselling, provision of IEC materials/cupboards/ drugs at SC
Improving adolescent health	Improving knowledge of anaemia, provision of iron supplements
Establishing structure for community participation	
Strengthening services for population of remote areas	Provision of mobile services
Strengthening the programme management of RH services	Support for stationery, computer, data entry operator and re-orientation training for MIS improvement
Comprehension of IEC activities	Training in media skills, development of materials based on communication needs assessment study, introduction of folk media
2. Gender and Development	
STRATEGY	INTERVENTION
Strengthening community based mechanisms for addressing RH and gender issues	Capacity building through training and provision of supportive materials, co-ordination of district core team of trainers among various departments
Development of self help group	Support for income generation of women's group
Awareness generation and monitoring activities with PRI members	Support for orientation programme for main members of PRI system
Setting women and adolescents as special target	Support for training with Women and Child Development Department
Training of adolescents girls	Training under AG-I and AG-II schemes
Establishment of family counselling centre and shelter home	Construction of family counselling centre and shelter home (with co-operation of Police Department), organising legal literacy camps
Study on commercial sex workers	Implementation of the study
Co-ordination with other departments	Co-operation with Forest Department

Table 4-78 Budget for main components of IPD, 2001 in Chhatarpur and Panna

	(Unit: Rs., %)			
	Chhatarpur		Panna	
Reproductive Health	1,287,236	11.0	1,102,867	11.0
Safe Motherhood	502,000	4.3	350,000	3.5
Abortion	19,560	0.2	19,560	0.2
Child Care	43,125	0.4	43,125	0.4
Family Planning	974,990	8.4	897,050	8.9
RTI/STD – HIV/AIDS	590,000	5.1	337,000	3.4
Adolescents	1,299,000	11.1	802,500	8.0
Gender	765,300	6.6	640,300	6.4
Monitoring & Evaluation	40,000	0.3	25,000	0.2
Infrastructure	5,316,000	45.5	5,009,000	49.9
Project Management	833,940	7.1	802,300	8.0
TOTAL	11,671,151	100.0	10,028,702	100.0

Source: District PMU in Chhatarpur and Panna

As aforementioned, the performance of the IPD project for the year of 2000 was very limited and it is difficult to evaluate the outcomes and the effects of the project in this study. However, the following features could be underlined as its key characteristics that differ from the RCH programme.

- district-target approach
- management unit of full-time staffs within the government (states and districts)
- co-ordination with other departments through existing institution (society)
- integration of various interventions under respective strategy
- training-cored formation
- gender-focused strategy

(2) The Border Districts Cluster Strategy Project

The Border Districts Cluster Strategy (BDCS) project was developed by UNICEF to improve the capability of health service delivery for selected district clusters at states' borders where there often is a problem of access to the major services. The strategy is to improve the sub-centre's function by organising existing local human resources, such as Anganwadi workers (AWW), members of Mahila Swasthya Sangh, schoolteachers, Dais (TBAs) etc., for strengthening the RCH programme. UNICEF is planning to launch this scheme in 48 districts including Tikamgarh in the 15 states concerned.

1) Project Objectives

- To develop the curative care capacity of the public health care system at the community level including referral of mothers and children
- To improve the present logistics system to assure availability of drugs and other supplies at the community level

UNICEF releases funds in any sector to the entity that is actually taking action based on its five-year Master Plan of Operation (2000-2004). Thus the funds for the BDCS project go directly to the district level. Although the Government of India prefers passing funds through SCOVA, as the RCH or the IPD do, to let both states and districts share the responsibilities, UNICEF intends

to retain this policy to avoid all the administrative red tape that often causes delay in disbursements. Additionally, as the nodal ministry of this project is the Ministry of Women and Child Development, intra-governmental co-ordination is necessary.

The BDCS project has ten "field officers" from UNICEF at the concerned states' capitals, such as Bhopal, to manage and co-ordinate the project and collect reports from all the communities once in three months (field officers meet twice a year in Delhi). At the district level, the CMHO's office prepares the Action Plan annually, and the RCH officer works closely with the project since it is considered a component of the RCH programme. The BDCS also hires a part-time consultant as "an extender" in each district to help develop the Action Plan and monitor/evaluate project outputs. In a village, the Community Health and Nutrition Team (CHNT) is organised with the existing health workers to implement all the activities and a Community Advisory Board (CAB), which consists of various community members (PRI, NGO etc.), is in charge of managing the project.

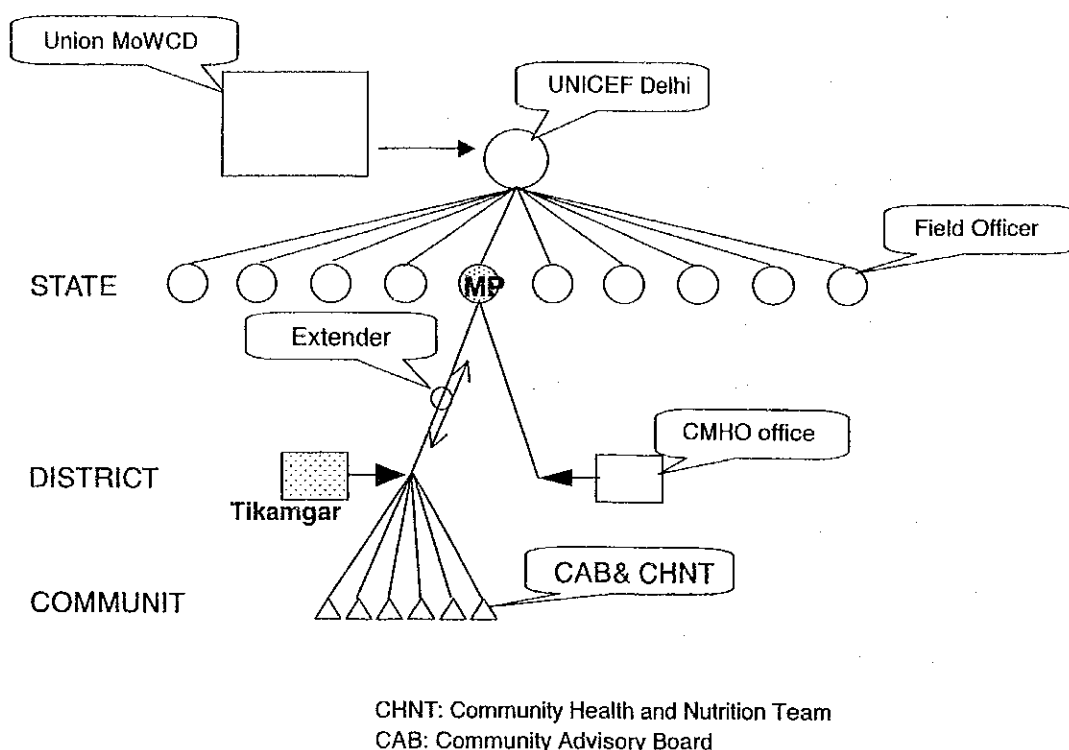


Figure 4-13 Management Structure of BCDS Project (UNICEF)

UNICEF contributes approximately US\$ 100,000 a year for each district in the project to complement the RCH programme and requires reports on the activities, which is a simple record of expenditures, date and numbers of participants in the activities, and so on. A detailed audit is not considered necessary because components under this project are very small, such as local training, meeting, painting and cleaning etc., and all the prices for these items are already identified and recorded in the guidelines.

The project has been designed to respond to community needs better than the public health system and enhance the capability of local health workers at the community level. The strategies and interventions are as follows.

Table 4-79 Strategies and Interventions of BCDS Project

STRATEGY	INTERVENTION
Community needs driven Sub-centre service delivery	Fixed hours/small number village service, posting of health worker(male) or second ANM, building health and nutrition team, mapping health care services and utilization
Community based monitoring and management of Sub-centre including financing	Establishment of Community Advisory Board (CAB); empowerment of service utilization, referral of cases, availability of medicines, maintenance of building, review of meetings
Supportive monitoring and supervision including strengthened mobility	Supervisors' provision of support and guidance to the field level functionaries, co-ordination with Integrated Child Development Strategy through joint training and meetings
Strengthen drug supply and logistics	Review and modification of list of drugs and supplies
Improving referral services	Raising awareness, review and preparation of transportation
Capacity development of health functionaries through training	Training

It is not possible to discuss the strengths and weaknesses of this project because it has not even started because of it's district-driven planning. The distinctive features could be listed as follows.

- Community-target approach
- New input to support existing resources (field officer – state, extender – district, reorganisation of community members)
- Simple management and monitoring mechanisms (for community level) with *small-scale components*
- Local initiatives
- Gender-focused strategy