

CHAPTER 5 COMMUNITY SURVEY

5 COMMUNITY SURVEY

5.1 INTRODUCTION

Over the years Government of India has been making concerted efforts to make improvements in the National Family Welfare Programme. Several Bilateral and International Agencies, sharing the concerns, have also been providing the GOI with technical and financial assistance in these efforts. The programme aimed primarily at reducing national population growth and addressed along with improvement in maternal and child health care services. As the concentration of programme was more on family planning by offering incentives and disincentives, the reproductive health issues did not get the due attention of the programme planners/implementers. In the past few years the government as well as those concerned came to recognize that the existing strategies were resulting in neglect of quality related to reproductive health services. People were not being served well, and the programme was failing on many accounts, especially on reproductive health front. People were not satisfied with the public health care delivery services – and large proportion of them remained under served or poorly served by the health system. The 1994 International Conference on Population and Development in Cairo helped focus the attention of governments on making programmes more client-oriented with an emphasis on the quality of care and services and care. In line with the conference recommendations, the Government of India acknowledged the need to abandon the use of targets for monitoring its family welfare programme. It recognized that the top-down target approach does not reflect user needs and preferences and de-emphasizes the quality of care provided. The Reproductive and Child Health (RCH) programme, which began in 1996, integrates all family welfare and women and childcare services with the demand explicit objective of providing beneficiaries with need-based, client-centered, demand-driven, high quality integrated RCH services.

Women in Madhya Pradesh did not receive an antenatal check-up for almost two out of every five births in the three years preceding the survey. Mothers of only 28 percent of births received at least three antenatal check-ups (down slightly from 30 percent in NFHS-1) and 15 percent had four or more check-ups. The proportion of births for which mothers received two or more tetanus toxoid injections during pregnancy rose from 45

percent in NFHS-1 to 55 percent in NFHS-2, but is lower than the all-India average of 67 percent. Mothers in Madhya Pradesh received IFA supplements for 49 percent of their births (a proportion which is lower than all-India average of 58 percent) (NFHS-1 47 percent). 20 percent of births in Madhya Pradesh took place in health facilities (much lower than the national average of 34 percent for the country as whole), up only slightly from 16 percent at the time of NFHS-1. Thirty percent of births in the three years preceding the survey were attended by a health professional (much lower than the national average of 42 percent of deliveries attended by a health professional) in NFHS-1 it was 26 percent. Only 10 percent of the non-institutional births were followed by a check-up within two months of the delivery. 34 percent of ever-married women reported at least one type of problem related to vaginal discharge, and 22 percent reported symptoms of a urinary-tract infection.

Overall, 54 percent of women in Madhya Pradesh have some degree of anemia slightly higher than the average for the country as a whole (52 percent) 38 percent of women are mildly anemic, 16 percent are moderately anemic and 1 percent are severely anemic

IMR of 86 for the period 0-4 years before NFHS-2 is almost unchanged from the IMR of 85, 0-4 before NFHS-1. The under-five mortality rate of 130 for the period 0-4 years before NFHS-2, is somewhat higher than the under-five mortality rate of 130 for the period 0-4 years before NFHS-1. It indicates that 1 in every 12 children born during the five years before NFHS-2 dying within the first year of life, and 1 in every 7 children dying before reaching age five.

It is clear that reproductive and child health programmes in Madhya Pradesh need to be intensified in order to achieve further reductions in infant and child mortality and better coverage of individual components of reproductive health services.

Before initiating intervention programmes in the proposed 5 districts, JICA proposed to undertake a study regarding (1) Health Referral System and Human Resources, (2) Client Exit Interview Survey, (3) Knowledge, Attitude and Practice (KAP) study on health care seeking behaviour, and (4) Community survey in five districts in MP. Towards this objective, the ORG Center for Social Research Ltd. has been entrusted with the responsibility of conducting a study on reproductive health in Madhya Pradesh.

The present report gives findings on the community level characteristics of the study area. An attempt was made not only to look into the socio-economic and demographic characteristics of the study area but also to grudge the availability of various infrastructure in these districts so that the action plans developed for the RCH interventions would be well directed and take into consideration the local level needs and requirements.

5.1.1 Objectives of the Community study

The study objectives were:

- To obtain basic information on the study area including political and health administrative structures in the community, community history, socio-economic conditions, demographic information, social conditions, infrastructure, etc.
- To understand conditions and identify issues that may influence women's reproductive health and women's awareness on their health, including the social environment, economic condition, status of women in society and traditional customs for giving birth and/or bringing up children.
- To identify community organizations, particularly women's organizations, their activities and capacity.
- To identify health services providers, their types and volume of services, and assess their quality of care of RCH.

5.2 METHODOLOGY

5.2.1 Study Area

The study was conducted in the selected rural and urban areas of five districts of the Sagar Division of Madhya Pradesh namely Sagar, Damoh, Tikamgarh, Chhatarpur and Panna.

5.2.2 Target Group

Information was collected from the following target groups:

- Opinion Leaders, Panchayati Raj representatives and community members.
- Women group members
- Community level health provider
- Community members (Male, Female, Adolescent Boys & Girls)

5.2.3 Research Technique

Structured pre-tested questionnaire was used to gather the required information from the community members of the selected communities both in rural as well as the urban areas.

In order to know the health seeking behavior in the community members focus group discussions were conducted among various target groups.

5.2.4 Proposed Sample Size

The study proposed to cover a sample of 93 communities in these five districts. Both the rural and urban areas were considered for the coverage of the study.

5.2.5 Sampling Design

Study sites were selected from all five districts of Sagar Division. Villages were selected using probability proportional to size (PPS) to carry out the survey in these five Districts of the Sagar Division. The distribution of the urban area and villages in each district is given in the following table. One ward was selected from the capital city and two towns from small population size towns (there is no middle population size town) in each of these two districts to represent urban areas. In Panna, Chhatarpur and Sagar districts one village was selected from each block, and one ward was selected from each of the capital cities and towns with small population size.

Table 5-1: Sample coverage

District	Number of Communities	
	Urban (town/ward)	Rural (village)
Damoh	4	35
Tikamgarh	3	24
Sagar	2	10
Chhatarpur	2	6
Panna	2	5
Total	13	80

For convenience and to save time and cost, the community study was conducted in the same sites as the household survey in Damoh and Tikamgarh.

The study items included:

Community level discussion: Study items for interviews of village heads, other opinion leaders, and leaders of women's groups:

- History of community
- Social and political structure (distribution of ethnicity, caste, religion, etc.)
- Distribution of community infrastructure and services, their availability and utilization (water supply, sanitation, schools, health service providers and facilities, etc.)
- Education (status of education, enrollment, retention, dropout, etc. of primary education)
- Major industry, economic conditions
- Livelihood patterns, access to natural and human resources, living condition

In-depth Discussion: Study items included the types of reproductive and child health problems prevalent at the community level, the types of services available for the problems, views on the quality of service delivery, etc. Information was also obtained on the prevalent treatment-seeking behaviors for reproductive and child health problems. Issues covered in the in-depth discussions with health providers in the community are as follows:

- Types of services provided
- Day and time they provide the services
- Utilization of services and number of clients and numbers of clients
- Drugs and contraceptives available
- Sanitary conditions and environmental facilities
- Knowledge and skills in RCH care

- Coordination among health service providers in the community
- Problems faced in delivering the services in the community.

Focus Group Discussion: FGDs were conducted as a part of the community survey. Main objective of the FGD was to study the health seeking behaviors, perception of the population on the health and health providers, alternative government health care services, RCH practices by the community, adolescents' sexual health behavior etc. The issues those were covered during the focus groups are:

- Health care seeking behaviors, perception of health and health providers, and related factors which influence their health and health care seeking behaviors, and RCH practices by the community
- Alternative health care services or government services used
- Knowledge and perception on adolescents' sexual health and adolescents' sexual health seeking behaviors and sexual health care seeking behaviors and problems

Total 22 FGDs were conducted in different rural and urban communities of Sagar division. The table below shows the coverage of different groups with whom FGDs were conducted.

Table 5-2: Coverage of FGD in the study area

Group Types	(in number)									
	Tikamgarh		Damoh		Sagar		Chhattarpur		Panna	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Women	1	1	1		1		1		1	
Men	1		1	1	1		1			1
Adolescent Girls	1		1		1			1	1	
Adolescent Boys	1		1			1	1		1	
Total	4	1	4	1	3	1	3	1	3	1

5.3 CHARACTERISTICS OF STUDY AREA

5.3.1 Population Characteristics

The demographic facts presented in the table below shows, as expected an adverse trend for the women in this area. The gender ratio for the all the five districts is below the state ratio of 920. The worst scoring district in this respect is Chhattarpur followed by Sagar and Tikamgarh. Correspondingly the girl child (under 5 yrs. of age) mortality rates for these districts, except for Sagar, is also very high. Infant mortality for these districts is also very high in comparison to the state average. All these facts clearly highlight the poor RCH intervention for these areas as well as poor health seeking behaviour of the population living in these areas.

The other indicators as given in the tables also show an adverse picture for these areas in comparison to the rest of the areas in the state. The scores of these districts as per health HDI is also very poor and they stand in lower positions in the overall HDI of the districts in comparison to other districts of the state. The ranking for the gender related HDI for these districts is also poor among the districts of the state.

The literacy rates for the women, as expected, are very low in comparison to the male in all the districts in the study area. Except for Sagar rest of the four districts have a poor female literacy rates in comparison to the state figures of 50.3%.

Urbanization rates for these districts also are very low in comparison to the state rates. Only Sagar district shows higher urbanization of 29% lowest is being Panna at 13%. The concentration of the Scheduled Tribe population all these districts is very low. Only in case of Panna a

substantial portion of the population belong to ST categories. Presence of SC population is more or less same in all these districts.

Women workforce participation is comparatively high as most of these women are either engaged in agriculture activities or are engaged as casual labour. A substantial proportion of the working women in Damoh and Sagar are found to be engaged in piece meal worker in the BIDI rolling industries.

Table 5-3: Demographic characteristics of population in the study area vis-à-vis the state – some indicators

INDICATORS	TIKAMGARH	DAMOIH	SAGAR	CHHATARPUR	PANNA
Gender Ratio (2001)	886	902	884	869	907
Literacy Rates (2001)					
Male	68.83	75.05	79.96	65.50	74.02
Female	40.98	47.51	54.5	39.38	47.84
Total	55.80	62.06	68.08	53.44	61.61
Density of Population (2001)	238	148	197	170	120
Decadal Growth Rate (1991-2001)	27.88	20.46	22.70	27.33	24.17
% Urban Population (1991)	16.90	18.10	29.20	19.30	13.00
% SC Population (1991)	22.80	20.10	21.10	23.70	20.40
% ST Population (1991)	4.10	12.40	8.50	3.80	14.90
Infant Mortality rates (1991)	132	123	116	150	133
Girl Child Mortality (Up to 5 yrs. of age) – 1991	205	173	169	227	207
Female Worker Participation Rate	33.00	28.00	26.00	29.00	29.00
HDI – Health (MP HDR, 1998)	0.449	0.428	0.475	0.429	0.409
HDI – Education (MP HDR, 1998)	0.392	0.479	0.561	0.398	0.386
HDI – Income (MP HDR, 1998)	0.531	0.462	0.446	0.477	0.484
Index of Deprivation (MP HDR, 1998)	0.543	0.544	0.506	0.565	0.574
Overall HDI	0.457	0.456	0.494	0.435	0.426
HDI RANK in MP	34	35	29	40	43
Gender related Development Index (GDI)	0.532	0.561	0.595	0.503	0.513
GDI RANK in MP	36	31	20	41	40

5.3.2 Geographic Location of Selected Communities

Table 5-4 shows the geographic location of the selected communities. It can be seen from the table more than two-third of the communities are located in plain areas and a higher proportion of the rural communities are situated in the hill side in comparison to the urban areas. As expected a higher proportion of the urban communities are situated along the paved road in comparison to 23 per cent of the villages, which clearly gives a poor picture of connectivity for the rural areas.

Table 5-4: Geographic location of communities

		URBAN		RURAL		Total	
		N	%	N	%	N	%
Topography	Plain	9	69.2	54	67.5	63	67.7
	Hillside	2	15.4	37	46.3	39	41.9
	Mountains	1	7.7	4	5.0	5	5.4
	Along a paved road	9	69.2	18	22.5	27	29.0
	Along an unpaved road			44	55.0	44	47.3
	Along the river			9	11.3	9	9.7
	No response	3	23.1	1	1.3	4	4.3

Note: Multiple response

The land area covered by various categories like forest, agriculture land, residence etc. is represented in Table 5-5. It can be observed from the table that either the urban area are not having most of the geographical tenants like forest, agriculture land etc. or the community members showed their inability to mention exactly the extent of areas covered by them. It can also be observed that not all the villages either has forests, river & ponds and hills within their communities.

Table 5-5: Land Area

Categories	Area in hect.	URBAN		RURAL		Total	
		N	%	N	%	N	%
Forest	< 20			9	17.3	9	17.3
	21-50			14	26.9	14	26.9
	50-100			6	11.5	6	11.5
	100+			23	44.2	23	44.2
Total	N			52	100.0	52	100.0
FOREST - AREA	Avg. in hect.				126.5		126.5
Agriculture	< 100			22	27.8	22	27.8
	101-200			26	32.9	26	32.9
	201-400			15	19.0	15	19.0
	400+			15	19.0	15	19.0
	No response			1	1.3	1	1.3
Total	N			79	100.0	79	100.0
AGRICULTURE AREA	Avg. in hect.				243.8		243.8
Grazing (Banjar)	< 10			11	14.7	11	14.7
	11 to 20			16	21.3	16	21.3
	21-40			15	20.0	15	20.0
	40+			33	44.0	33	44.0
Total	N			75	100.0	75	100.0
GRAZING AREA	Avg. in hect.				79.1		79.1
Residential	1 to 2			14	18.4	14	18.2
	3 to 4			11	14.5	11	14.3
	5+	1	100.0	51	67.1	52	67.5
Total	N	1	100.0	76	100.0	77	100.0
RESIDENTIAL AREA	Avg. in hect.		10.0		26.0		25.8
Wall/Build./Road	1 to 2	1	7.7	8	10.0	9	9.7
	3 to 4			7	8.8	7	7.5
	5+			27	33.7	27	29.0
	No response	12	92.3	38	47.5	50	53.8
Total	N	13	100.0	80	100.0	93	100.0
WALL/BUILDING/ROAD AREA	Avg. in hect.		2.0		23.2		22.7
River/Pond/Nalla	1 to 2			5	15.2	5	15.2
	3 to 4			5	15.2	5	15.2
	5+			23	69.7	23	69.7
Total	N			33	100.0	33	100.0
RIVER/POND/NALLA AREA	Avg. in hect.				27.8		27.8
Hill	3 to 4			1	6.3	1	6.3
	5+			5	93.8	5	93.8
Total	N			6	100.0	6	100.0
HILL AREA	Avg. in hect.				80.6		80.6

5.3.3 Population Distribution by Religion and Caste

Table 5-6 and 5-7 gives the percent distribution of households by religion and caste of head of the household. Majority of the household's heads was Hindu in both the urban (90.5%) and rural (94%) areas. Presence of Muslims in the study area although very low is higher in case of urban areas as compared to the rural communities. Presence of other religious groups like Jains, Sikhs and Christians is negligible in the study area. Overall, 44 percent of household head belonged to other backward caste category, this proportion being 48 percent in urban and 44 percent in rural areas, respectively. About 24 percent of household heads belonged to scheduled caste in the study area. The same for the urban and rural areas is 18 and 25 percent, respectively. While a

higher proportion of general caste population is residing in the urban areas in case of the rural areas the proportion of SC and ST is more pronounced in comparison to the urban areas. Household heads belonging to scheduled caste and tribe were relatively more concentrated in rural areas than urban areas.

Table 5-6: Distribution of the HHs by Religion groups

Religion type	Urban		Rural		Total	
		%		%		%
Hindu		90.5		94.0		93.4
Muslim		6.1		2.5		3.1
Jain		1.8		1.7		1.7
Buddhist		-		<0.1		-
Sikh		1.5		<0.1		0.2
Christian		0.1		1.7		1.5

Table 5-7: Distribution of the HHs by caste categories

Caste Types	Urban		Rural		Total	
		%		%		%
General Caste		31.3		21.0		22.6
Scheduled Caste		17.5		24.8		23.7
Scheduled Tribe		3.6		10.3		9.3
Other Backward Caste		47.6		43.9		44.4

8 gives the distribution of the studied communities as per the presence of the Scheduled population. It can be observed from the table that in comparison to the urban areas the concentration of the scheduled population is more in the rural areas. 40 per cent of the rural communities studied have a scheduled population more than 40 per cent.

Table 5-8: Distribution of Communities by SC+ST Population

Caste category	URBAN		RURAL		Total	
	N	%	N	%	N	%
% SC/ST < 20	8	61.5	14	17.5	22	23.7
Population 20-40	1	7.7	34	42.5	35	37.6
40-60	1	7.7	24	30.0	25	26.9
60+	2	15.4	8	10.0	10	10.8
No Response	1	7.7			1	1.1
Total	13	100.0	80	100.0	93	100.0

5.3.4 Population Distribution by Economic Classification

As expected the rural communities are represented by poorer HHs in comparison to the urban communities, as around 43 per cent of the rural HHs are coming under the BPL categories as compared to 21 per cent in case of urban areas. From the Table 5-9 it can also be observed that a higher proportion of HHs belonging to the SC and ST categories are coming under the BPL in both urban and rural areas. Poverty is more pronounced in case of the other religion groups residing in the rural areas whereas these households are economically better off in the urban areas.

Table 5-9: Percentage distribution of households by economic categories

	Urban		Rural		Total	
	APL	BPL	APL	BPL	APL	BPL
General Caste	86.2	13.8	79.2	20.8	80.6	19.4
SC	67.3	32.7	46.9	53.1	48.5	51.5
ST	46.0	54.0	35.3	64.7	35.7	64.3
OBC	83.4	16.6	59.3	40.7	60.5	39.5
Other Reli.Grp	88.4	11.6	58.7	41.3	62.4	37.6
Total	79.3	20.7	56.8	43.2	58.7	41.3

As can be seen from the table below majorities of the studied rural communities are having more than 40 percent of their households in the BPL category. Nearly two-third of the urban communities covered could mention the proportion of BPL households in their locality.

Table 5-10: Distribution of Communities by percentage BPL HHs.

		URBAN		RURAL		Total	
		N	%	N	%	N	%
% BPL HHs.	<20	3	23.1	5	6.3	8	8.6
	20-40	2	15.4	28	35.0	30	32.3
	40-60			22	27.5	22	23.7
	60+			21	26.3	21	22.6
	No response	8	61.5	4	5.0	12	12.9
Total		13	100.0	80	100.0	93	100.0

Table 5-11 indicates that around 43 percent of the household members in rural areas and 21 percent in urban areas had reported 'agriculture' as their main occupation. This proportion was more than double for the rural areas than the urban areas as agriculture is the main occupation for substantial proportion of the HHs in the rural India. The proportion of population in agriculture is still showing a substantial number as some of the urban areas selected for the survey till date continuing with rural characteristics and at the fringe of the urbanization process. 'Agricultural as well as non-agricultural labour was reported as main occupation by 27 percent of household members in urban areas as against about 36 percent in the villages. As expected a higher proportion of the HHs are engaged in different kinds of services both private and government in the urban areas, which is very low for the rural communities. Participation of HHs in small scale and petty business although is very low in comparison to other activities like agriculture, labor and services is higher for the urban areas in comparison to the villages. Few of the HHs both in the urban and rural areas is artisans.

Table 5-11: Number of HHS. by occupation

Type of occupation (main)	URBAN		RURAL	
	HH No.	%	HH No.	%
Agriculture	456	21.2	9863	43.2
Labour (Ag. & Non-Ag.)	590	27.4	8153	35.7
Service	760	35.3	1180	5.2
Small Scale Business	195	9.1	614	2.7
Petty Business	53	2.5	385	1.7
Forest Dependent	20	0.9	722	3.2
Carpenter	44	2.0	209	0.9
Mason	8	0.4	358	1.6
Barbers	14	0.7	382	1.7
Laundry Person	10	0.5	244	1.0
Fisherman	3	0.1	323	1.4
Livestock Keeper	.		112	0.5
Others	.		270	1.2
Total	2153	100.0	22815	100.0

5.3.5 Population Distribution by Age Group and Sex

Table 5-12 represents the distribution of the population of the study area by age and sex. The age distribution of population shows that the rural areas are having a younger population in comparison to the urban areas. The proportion of children under 14 years of age for the rural areas is 32 per cent in comparison to 12 per cent in urban areas. The sex distribution of population shows an adverse sex ratio for both the areas. However, the sex ratio for the rural areas is more adversely represented in comparison to the urban areas. The same is only 833 in the villages in comparison to a higher sex ratio of 941 for the urban communities. As expected the average population of the urban communities is much higher in comparison to the rural areas thus representing a higher density of population for the urban areas.

Table 5-12: Population distribution by age group and sex

Area Type	% of children below 14 yrs.			% of population above 15yrs.			Avg. Population per community	Sex ratio
	Male	Female	% to total Pop.	Male	Female	% to total Pop.		
Urban	52.8	47.2	12.4	51.3	48.7	87.6	4851	941
Rural	52.8	47.2	32.3	55.4	44.6	67.7	1785	833
Total	52.6	47.4	31.0	55.0	45.0	69.0	1874	840

5.4 AVAILABILITY AND ACCESSIBILITY TO DIFFERENT INFRASTRUCTURE AND FACILITIES

Availability and accessibility to various institutions and services is an important indicator not only to gauge the relative development of the area but also an important requirement to plan strategies to implement any development program in the area. Accessibility to institutions like Panjayati Raj is especially important under the present thrust for decentralization under the development strategy of GoMP.

5.4.1 Institutions

It can be observed from Table 5-13 that more than four-fifth of the villages in the study area is not having access to the banking facilities within the village. Again two-third of those not having this facility have to travel more than 6 km. to access the same. As expected more than two-third of the urban communities in the study area are having banks within the locality and those not having the same have only to travel less than 5 kms to access it.

The table also reveals that 80 per cent of the surveyed villages have Gram Panchayat within the village and three-fourth of those not having GP within the locality have the same at a distance of less than 4 kms.

Higher proportions of the urban communities (62%) are having a community hall in comparison to the villages (51%). In case of both the urban and rural areas more than 60 per cent of communities not having community hall have to cover a distance of more than 5 kms. to avail this facility.

While more than three-fourth of the urban communities is having one or other type of co-operative societies within the locality, the same is very less in case of the villages (35%).

Table 5-13: Availability of and Access to various Institution Organization / Service at the Community Level

Institutions	Status	Urban		Rural		Total	
		No. of communities	%	No. of communities	%	No. of communities	%
BANK – WITHIN VILLAGE	YES	9	69.2	13	16.3	22	23.7
	NO	4	30.8	67	83.8	71	76.3
Total	N	13	100.0	80	100.0	93	100.0
Distance – Bank	< 5	4	100.0	25	37.3	29	40.7
	6 to 10			24	35.8	24	33.8
	11 to 15			10	14.9	10	14.1
	15+			8	11.9	8	12.7
Total	N	4	100.0	67	100.0	71	100.0
DISTANCE – BANK	Avg	1.3		9.1		8.8	
GRAM PANCHYAT – WITHIN VILLAGE	YES	8	61.5	64	80.0	72	77.4
	NO	2	15.4	16	20.0	18	19.4
	NO RESPONSE	3	23.1			3	3.2
Total	N	13	100.0	80	100.0	93	100.0
Distance – Gram Panchayat	1 to 2	2	100.0	6	37.5	8	44.4
	3 to 4			6	37.5	6	33.3
	5+			4	25.0	4	22.2
	Total	N	2	100.0	16	100.0	18
DISTANCE – GRAM PANCHYAT	Avg	1.0		4.8		4.6	
COMMUNITY HALL- WITHIN VILLAGE	YES	8	61.5	41	51.3	49	52.7
	NO	5	38.5	39	48.8	44	47.3
Total	N	13	100.0	80	100.0	93	100.0
Distance – Community Hall	1 to 2	3	60.0	3	7.7	6	13.6
	3 to 4			10	25.6	10	22.7
	5+	2	40.0	26	66.7	28	63.6
	Total	N	5	100.0	39	100.0	44
DISTANCE – COMMUNITY HALL	Avg	2.3		7.8		7.4	
CO-OP.SOCIETY- WITHIN VILLAGE	YES	10	76.9	28	35.0	38	40.9
	NO	3	23.1	52	65.0	55	59.1
Total	N	13	100.0	80	100.0	93	100.0
Distance – Co-Op.Society	1 to 2	3	100.0	8	15.4	11	20.0
	3 to 4			18	34.6	18	32.7
	5+			26	50.0	26	47.3
	Total	N	3	100.0	52	100.0	55
DISTANCE – CO-OP.SOCIETY	Avg	1.5		7		6.8	

5.4.2 Health

In the past few years the government as well as those concerned recognized that the existing strategy of concentrating on the family planning aspects of health sector development resulted in the neglect of quality related to reproductive health services. People were not being served well, and the programme is failing on many accounts, especially on the reproductive health front. Health indicators such as Maternal and Child morbidity and mortality were still high. People are not satisfied with the public health care delivery services- and large proportion of them remained under served or poorly served by the health system. Keeping this in focus the survey tried to assess the availability of and accessibility to various health facilities, availability of health providers etc. under the community survey.

From Table 5-14 it can be observed that the HHs belonging to the urban areas have better accessibility to various health facilities than the rural areas. In urban areas there is the presence of better and well-equipped health facilities. Distance covered to access the facilities is much lower in the urban areas in comparison to the rural areas.

HHs in the rural areas is having better access to Sub-centres and PHCs, where as the urban HHs are having better access to the District Hospital, CHC and PHC. Private clinics are available in larger numbers in urban areas (62%of the urban communities are having this facility within their locality) than the rural communities (33%). Availability of medicines within the community is also very high in urban areas (54%) than the rural communities (13%). The H Hs in the rural has to travel a greater distance to avail the medicines.

Table 5-14: Accessibility to Health Services

Types of health facilities		Urban		Rural		Total	
		No. of communities	%	No. of communities.	%	No. of communities.	%
TEACHING HOSPITAL - WITHIN VILLAGE	YES						
	NO	13	100.0	80	100.0	93	100.0
Total	N	13	100.0	80	100.0	93	100.0
Teaching Hospital - distance	<=10	3	23.1	5	6.3	8	8.6
	11 to 20			11	13.8	11	11.8
	21-50	3	23.1	32	40.0	35	37.6
	50+	7	53.8	32	40.0	39	41.9
Total	N	13	100.0	80	100.0	93	100.0
TEACHING HOSPITAL - DISTANCE (KM)	Avg	33.1		43.6		42.4	
DISTRICT HOSPITAL - WITHIN VILLAGE	YES	2	15.4			2	6.5
	NO	11	84.6	80	100.0	87	93.5
Total	N	13	100.0	80	100.0	93	100.0
District Hospital - distance	<=10	4	36.4	5	6.3	9	9.9
	11 to 20			11	13.8	11	12.1
	21-50	3	27.3	36	45.0	39	42.9
	50+	4	36.4	28	35.0	32	35.2
Total	N	11	100.0	80	100.0	91	100.0
DISTRICT HOSPITAL - DISTANCE (KM)	Avg	30.3		43.8		42.1	
CHC - WITHIN VILLAGE	YES	5	38.5	7	8.8	12	12.9
	NO	6	46.2	67	83.8	73	78.5
	NO RESPONSE	2	15.4	6	7.5	8	8.6
Total	N	13	100.0	80	100.0	93	100.0
CHC - distance	<=10	4	66.7	16	23.9	20	27.4
	11 to 20	1	16.7	30	44.8	31	42.5
	21-50			18	26.9	18	24.7
	50+	1	16.7	3	4.5	4	5.5
Total	N	6	100.0	67	100.0	73	100.0
CHC - DISTANCE (KM)	Avg	13		19.2		18.7	
PHC - WITHIN VILLAGE	YES	6	46.2	5	6.3	11	11.8
	NO	6	46.2	74	92.5	80	86.0
	NO RESPONSE	1	7.7	1	1.3	2	2.2
Total	N	13	100.0	80	100.0	93	100.0
PHC - distance	<=5	5	83.3	14	18.9	19	23.8
	6 to 10	1	16.7	18	24.3	19	23.8
	11 to 25			36	48.6	36	45.0
	25+			6	8.1	6	7.5
Total	N	6	100.0	74	100.0	80	100.0
PHC - DISTANCE (KM)	Avg	3.2		13.3		12.5	
SUB-CENTRE - WITHIN VILLAGE	YES	3	23.1	23	28.8	26	28.0
	NO	8	61.5	56	70.0	64	68.8
	NO RESPONSE	2	15.4	1	1.3	3	3.2
Total	N	13	100.0	80	100.0	93	100.0
Sub-Centre - distance	1 to 2	4	50.0	5	8.9	9	14.1
	3 to 4	1	12.5	23	41.1	24	37.5
	5+	3	37.5	28	50.0	31	48.4
Total	N	8	100.0	56	100.0	64	100.0
SUB-CENTRE - DISTANCE (KM)	Avg	9.6		7.1		7.4	
PVT.CLINIC - WITHIN VILLAGE	YES	8	61.5	26	32.5	34	36.6
	NO	5	38.5	53	66.3	58	62.4
	NO RESPONSE			1	1.3	1	1.1
Total	N	13	100.0	80	100.0	93	100.0

Types of health facilities		Urban		Rural		Total	
		No. of communities	%	No. of communities.	%	No. of communities.	%
Pvt. Clinic - Distance	< 1	1	20.0			1	1.7
	1 to 2	4	80.0	4	7.5	8	13.8
	3 to 4			10	18.9	10	17.2
	5+			39	73.6	39	67.2
Total	N	5	100.0	53	100.0	58	100.0
PVT.CLINIC - DISTANCE (KM)	Avg	1		8.5		7.9	
PHARMACY/MEDICINE - WITHIN VILLAGE	YES	7	53.8	10	12.5	17	18.3
	NO	5	38.5	67	83.8	72	77.4
	NO RESPONSE	1	7.7	3	3.8	4	4.3
	Total	N	13	100.0	80	100.0	93
Pharmacy/Medicine - distance	1 to 2	5	100.0	4	6.0	9	12.5
	3 to 4			10	14.9	10	13.9
	5+			53	79.1	53	73.6
Total	N	5	100.0	67	100.0	72	100.0
PHARMACY/MEDICINE - DISTANCE (KM)	Avg	1.4		12		11.2	

As expected the presence of grassroots level health providers is very high in the rural areas in comparison to the urban communities. Utilization of the services of these providers in urban areas being low might be the reason why the respondents in these areas are not aware of their presence within the locality. Presence of private practitioners is very high in the urban areas in comparison to the villages. However, utilization of the services of the traditional practitioners is very high in the villages.

Table 5-15 delineates the above explanation, also incorporating the number of "No responses", as it is considered to be one of the most important parameters to gauge awareness. Approximately 50 percent of the rural communities indicate the presence of ANM whereas other 50 percent do not respond to the question. Similar is the response pattern for availability of Multi purpose worker and Village health guide as approximately 50 percent of the communities are not able to respond to the question of availability of these health providers. It is noticed that the proportion of communities having trained Dais is more than the proportion of communities having untrained Dais. Predictably, as indicated earlier, presence of private doctors is more pronounced in urban areas vis-a-vis rural areas. But again, it is observed that more than 60 percent of urban as well as rural communities do not respond to the question of availability of private doctors.

Table 5-15: Communities having Health Providers

Type of health providers	Availability of the providers	URBAN/RURAL		Total
		URBAN	RURAL	
ANM - NO.IN VILLAGE	No response	11	41	52
	No. of communities having	2	39	41
	Total no. of providers	3	40	43
	Avg	1.5	1.0	1.0
MULTI PURPOSE WORKER (MALE) - NO.OF VILLAGE	No response	12	42	54
	No. of communities having	1	38	39
	Total no. of providers	1	46	47
	Avg	1.0	1.2	1.2
VILLAGE HEALTH GUIDE - NO.IN VILLAGE	No response	13	40	53
	No. of communities having	0	40	40
	Total no. of providers	0	68	68
	Avg	0.0	1.7	1.7
TRAINED DAI - NO.IN VILLAGE	No response	13	31	54
	No. of communities having	0	49	49
	Total no. of providers	0	86	86
	Avg	0.0	1.8	1.8
UN-TRAINED DAI - NO.IN VILLAGE	No response	13	50	63
	No. of communities having	0	30	30
	Total no. of providers	0	71	71
	Avg	0.0	2.4	2.4
PVT.DOCTOR - NO.IN VILLAGE	No response	8	57	65
	No. of communities having	5	23	28
	Total no. of providers	15	46	61
	Avg	3.0	2.0	2.2
TRAD.PRACT.- NO.IN VILLAGE	No response	13	70	83
	No. of communities having	0	10	10
	Total no. of providers	0	33	33
	Avg	0.0	3.3	3.3
LHV - NO.IN VILLAGE	No response	12	79	91
	No. of communities having	1	1	2
	Total no. of providers	2	2	4
	Avg	2.0	2.0	2.0

5.4.3 Caste composition of the health providers

Table 5-16 details the caste composition of the health providers. It is observed that most representation of OBC is high in all the categories except for Trained and untrained Dais. More than 60 percent of Trained and untrained Dais belong to SC population. Predictably, large proportion (43 percent) of Private doctors belongs to general community. Major proportion of MPWs and Village health guides belong to General community.

Table 5-16: Caste composition of the community health providers

Type of provider	Caste of Health Providers	URBAN		RURAL		Total	
		N	%	N	%	N	%
ANM	GENERAL			16	41.0	16	39.0
	SC	1	50.0	8	20.5	9	22.0
	ST			1	2.6	1	2.4
	OBC	1	50.0	12	30.8	13	31.7
	OTHER RELIGIOUS GRP.			1	2.6	1	2.4
	NO RESPONSE			1	2.6	1	2.4
	Total	2	100.0	39	100.0	41	100.0
MPW (Male)	GENERAL			20	52.6	20	51.3
	SC			4	10.5	4	10.3
	ST			2	5.3	2	5.1
	OBC	1	100.0	11	28.9	12	30.8
	NO RESPONSE			1	2.6	1	2.6
	Total	1	100.0	38	100.0	39	100.0
Village Health Guide	GENERAL			15	37.5	15	37.5
	SC			6	15.0	6	15.0
	ST			3	7.5	3	7.5
	OBC			13	32.5	13	32.5
	NO RESPONSE			3	7.5	3	7.5
	Total			40	100.0	40	100.0
Trained Dai	GENERAL			7	14.3	7	14.3
	SC			35	71.4	35	71.4
	ST			3	6.1	3	6.1
	OBC			1	2.0	1	2.0
	NO RESPONSE			3	6.1	3	6.1
	Total			49	100.0	49	100.0
Un-trained Dai	GENERAL			8	26.7	8	26.7
	SC			19	63.3	19	63.3
	ST			2	6.7	2	6.7
	NO RESPONSE			1	3.3	1	3.3
	Total			30	100.0	30	100.0
Private Doctor	GENERAL	3	60.0	10	43.5	13	46.4
	SC			4	17.4	4	14.3
	ST			1	4.3	1	3.6
	OBC	2	40.0	7	30.4	9	32.1
	NO RESPONSE			1	4.3	1	3.6
	Total	5	100.0	23	100.0	28	100.0
Traditional Practitioner	GENERAL			4	40.0	4	40.0
	ST			2	20.0	2	20.0
	OBC			3	30.0	3	30.0
	NO RESPONSE			1	10.0	1	10.0
	Total			10	100.0	10	100.0
LHV	GENERAL			1	100.0	1	50.0
	OBC	1	100.0			1	50.0
	Total	1	100.0	1	100.0	2	100.0

5.4.4 Utilization status of providers

Table 5-17 elucidates the frequency of usage of the service providers. It is observed that more than 50 percent of the rural populace indicate average usage of ANMs and Multi Purpose workers. Similar is the usage pattern for village health guide also. 53 percent and 43 percent of the communities indicate that trained and untrained Dais respectively, are used most frequently. More than 50 percent of the rural and 80 percent of urban communities indicate "most frequent usage" of private doctors.

Table 5-17: Utilization Status of Service Providers at community level

Type of providers	Utilization status	URBAN		RURAL		Total	
		N	%	N	%	N	%
ANM – FREQ.OF USE	Most frequently use	1	50.0	13	33.3	14	34.1
	Average use	1	50.0	20	51.3	21	51.2
	Not frequently used			5	12.8	5	12.2
	No response			1	2.6	1	2.4
	Total	2	100.0	39	100.0	41	100.0
MULTI PURPOSE WORKER (MALE) - FREQ.OF USE	Most frequently use	1	100.0	10	26.3	11	28.2
	Average use			23	60.5	23	59.0
	Not frequently used			3	7.9	3	7.7
	No response			2	5.3	2	5.1
	Total	1	100.0	38	100.0	39	100.0
VILLAGE HEALTH GUIDE – FREQ.OF USE	Most frequently use			14	35.0	14	35.0
	Average use			19	47.5	19	47.5
	Not frequently used			4	10.0	4	10.0
	No response			3	7.5	3	7.5
	Total			40	100.0	40	100.0
TRAINED DAI - FREQ.OF USE	Most frequently use			26	53.1	26	53.1
	Average use			15	30.6	15	30.6
	Not frequently used			1	2.0	1	2.0
	No response			7	14.3	7	14.3
	Total			49	100.0	49	100.0
UN-TRAINED DAI - FREQ.OF USE	Most frequently use			13	43.3	13	43.3
	Average use			11	36.7	11	36.7
	Not frequently used			3	10.0	3	10.0
	No response			3	10.0	3	10.0
	Total			30	100.0	30	100.0
PVT.DOCTOR - FREQ.OF USE	Most frequently use	4	80.0	13	56.5	17	60.7
	Average use	1	20.0	5	21.7	6	21.4
	Not frequently used			2	8.7	2	7.1
	No response			3	13.0	3	10.7
	Total	5	100.0	23	100.0	28	100.0
TRAD.PRACT.- FREQ.OF USE	Most frequently use			3	30.0	3	30.0
	Average use			4	40.0	4	40.0
	No response			3	30.0	3	30.0
	Total			10	100.0	10	100.0
LH - FREQ.OF USE	Most frequently use	1	100.0			1	50.0
	No response			1	100.0	1	50.0
	Total	1	100.0	1	100.0	2	100.0

Table 5-18 gives the occurrence of various diseases in the two types of the communities by different seasons and the age groups.

Table 5-18: Occurrence of Common Diseases at the Communities by season and age groups

Age group & seasons	Type of diseases	URBAN		RURAL		Total	
		N	%	N	%	N	%
Adult Male-Rainy Season	MALARIA	9	69.2	69	86.3	78	83.9
	FEVER	3	23.1	37	46.3	40	43.0
	COUGH	5	38.5	14	17.5	19	20.4
	PNEUMONIA	2	15.4	9	11.3	11	11.8
	DIARRHOEA/VOMITING	8	61.5	44	55.0	52	55.9
	ITCHING	1	7.7	13	16.3	14	15.1
	POLIO			2	2.5	2	2.2
	TYPHOID			2	2.5	2	2.2
	CATARACT			1	1.3	1	1.1
	TB			2	2.5	2	2.2
	JAUNDICE	2	15.4	6	7.5	8	8.6
	CONJUNCTIVITIS			1	1.3	1	1.1
CHOLERA	1	7.7			1	1.1	
Adult Male-Non Rainy Season	FEVER	10	76.9	53	66.3	63	67.7
	DIARRHOEA/VOMITING	1	7.7	22	27.5	23	24.7
	COUGH	5	38.5	22	27.5	27	29.0
	MALARIA	4	30.8	42	52.5	46	49.5
	CONJUNCTIVITIS			3	3.8	3	3.2
	ITCHING	1	7.7	1	1.3	2	2.2
	TB			4	5.0	4	4.3
	BLOOD PRESSURE			1	1.3	1	1.1
	NIGHT BLINDNESS			2	2.5	2	2.2
	POLIO			1	1.3	1	1.1
	PNEUMONIA	2	15.4	6	7.5	8	8.6
	ASTHMA			1	1.3	1	1.1
	JAUNDICE	1	7.7	15	18.8	16	17.2
	TYPHOID			2	2.5	2	2.2
	BODYACHE			1	1.3	1	1.1
	STOMACHACHE	1	7.7	1	1.3	2	2.2
	CHIKEN POX			1	1.3	1	1.1
	ANEMIA			1	1.3	1	1.1
	CHOLERA	1	7.7			1	1.1
NO RESPONSE	1	7.7			1	1.1	
Adult Male-All Yr.around	FEVER	8	61.5	43	53.8	51	54.8
	DIARRHOEA/VOMITING	6	46.2	31	38.8	37	39.8
	MALARIA	8	61.5	60	75.0	68	73.1
	TB	2	15.4	14	17.5	16	17.2
	COUGH	7	53.8	25	31.3	32	34.4
	ITCHING			5	6.3	5	5.4
	LEPROSY			2	2.5	2	2.2
	TYPHOID	1	7.7	4	5.0	5	5.4
	CHOLERA			5	6.3	5	5.4
	CANCER			1	1.3	1	1.1
	PNEUMONIA			5	6.3	5	5.4
	JOINT PAIN			1	1.3	1	1.1
	JAUNDICE	1	7.7	11	13.8	12	12.9
	SWELLING BODY PAIN			1	1.3	1	1.1
	STOMACHACHE	1	7.7			1	1.1

Age group & seasons	Type of diseases	URBAN		RURAL		Total	
		N	%	N	%	N	%
Adult Female-Rainy Season	MALARIA	8	61.5	64	80.0	72	77.4
	STOMACH UPSET	1	7.7	8	10.0	9	9.7
	FEVER	8	61.5	37	46.3	45	48.4
	COUGH	4	30.8	22	27.5	26	28.0
	DIARRHOEA/VOMITING	6	46.2	40	50.0	46	49.5
	PNEUMONIA	4	30.8	7	8.8	11	11.8
	ITCHING	1	7.7	10	12.5	11	11.8
	POLIO			3	3.8	3	3.2
	TYPHOID			1	1.3	1	1.1
	CATARACT	1	7.7	3	3.8	4	4.3
	TB			1	1.3	1	1.1
	STOMACHACHE			3	3.8	3	3.2
ANAEMIA			1	1.3	1	1.1	
CHOLERA	1	7.7			1	1.1	
Adult Female-Non Rainy Season	FEVER	10	76.9	57	71.3	67	72.0
	DIARRHOEA/VOMITING	2	15.4	21	26.3	23	24.7
	MALARIA	4	30.8	35	43.8	39	41.9
	CONJUNCTIVITIS			6	7.5	6	6.5
	ANEMIA			6	7.5	6	6.5
	ITCHING	1	7.7	3	3.8	4	4.3
	HEADACHE			2	2.5	2	2.2
	STOMACHECHE	1	7.7	5	6.3	6	6.5
	PNEUMONIA			5	6.3	5	5.4
	TB			4	5.0	4	4.3
	ASTHMA			2	2.5	2	2.2
	JAUNDICE	3	23.1	9	11.3	12	12.9
	STOMACH UPSET	1	7.7	4	5.0	5	5.4
	COUGH	5	38.5	18	22.5	23	24.7
	TYPHOID			1	1.3	1	1.1
	BODYACHE			1	1.3	1	1.1
	CHIKEN POX	1	7.7	2	2.5	3	3.2
	CHOLERA	1	7.7			1	1.1
NO RESPONSE	1	7.7			1	1.1	
Adult Female-All Yr.around	FEVER	7	53.8	46	57.5	53	57.0
	DIARRHOEA/VOMITING	6	46.2	27	33.8	33	35.5
	MALARIA	9	69.2	57	71.3	66	71.0
	TB	2	15.4	13	16.3	15	16.1
	COUGH	5	38.5	26	32.5	31	33.3
	ITCHING			4	5.0	4	4.3
	ANEAMIA	1	7.7	4	5.0	5	5.4
	ASTHAMA			1	1.3	1	1.1
	TYPHOID	1	7.7	3	3.8	4	4.3
	STOMACH UPSET			6	7.5	6	6.5
	BLOOD PRESSURE			1	1.3	1	1.1
	CANCER			2	2.5	2	2.2
	PNEUMONIA			7	8.8	7	7.5
	SWELLING BODY PAIN			1	1.3	1	1.1
	STOMACHACHE			1	1.3	1	1.1
	JAUNDICE	2	15.4	6	7.5	8	8.6

Age group & seasons	Type of diseases	URBAN		RURAL		Total	
		N	%	N	%	N	%
Child.(0-15)-Rainy Season	MALARIA	7	53.8	54	67.5	61	65.6
	STOMACH UPSET	1	7.7	4	5.0	5	5.4
	FEVER	5	38.5	33	41.3	38	40.9
	DIARRHOEA/VOMITING	9	69.2	55	68.8	64	68.8
	COUGH	5	38.5	34	42.5	39	41.9
	PNEUMONIA	2	15.4	16	20.0	18	19.4
	ITCHING	3	23.1	12	15.0	15	16.1
	POLIO			2	2.5	2	2.2
	TYPHOID			2	2.5	2	2.2
	CATARACT			1	1.3	1	1.1
	CONJUNCTIVITIS	1	7.7	1	1.3	2	2.2
	TB			1	1.3	1	1.1
	JAUNDICE			4	5.0	4	4.3
STOMACHACHE			1	1.3	1	1.1	
Child.(0-15)-Non Rainy Season	FEVER	8	61.5	53	66.3	61	65.6
	MALARIA	4	30.8	35	43.8	39	41.9
	STOMACH UPSET			4	5.0	4	4.3
	TB			2	2.5	2	2.2
	COUGH	5	38.5	28	35.0	33	35.5
	EYE FLUE			3	3.8	3	3.2
	DIARRHOEA/VOMITING	5	38.5	32	40.0	37	39.8
	ITCHING	1	7.7	4	5.0	5	5.4
	FATIGUE			1	1.3	1	1.1
	PNEUMONIA	2	15.4	9	11.3	11	11.8
	TYPHOID			4	5.0	4	4.3
	BODYACHE			1	1.3	1	1.1
	CHIKEN POX			1	1.3	1	1.1
	JAUNDICE	2	15.4	8	10.0	10	10.8
	STOMACHACHE			1	1.3	1	1.1
	CHOLERA	1	7.7			1	1.1
NO RESPONSE	1	7.7			1	1.1	
Child.(0-15)-All Yr.around	FEVER	9	69.2	46	57.5	55	59.1
	DIARRHOEA/VOMITING	10	76.9	44	55.0	54	58.1
	MALARIA	6	46.2	44	55.0	50	53.8
	COUGH	4	30.8	34	42.5	38	40.9
	ITCHING	2	15.4	8	10.0	10	10.8
	RICKETS			1	1.3	1	1.1
	TYPHOID	1	7.7	4	5.0	5	5.4
	STOMACH UPSET			3	3.8	3	3.2
	PNEUMONIA	2	15.4	7	8.8	9	9.7
	TB	1	7.7	4	5.0	5	5.4
	JOINT PAIN			1	1.3	1	1.1
	STOMACHACHE			3	3.8	3	3.2
	JAUNDICE	1	7.7	13	16.3	14	15.1

Note: Multiple response

From Table 5-19 it can be observed that all the urban communities responded in negative regarding the presence of the health committees within the locality. In contrast a fourth of the villages are having the same. However, during the focus group discussion in the villages it was revealed that most of these committees although formed are not functioning.

Table 5-19: Presence of Health Committees at the community level

		URBAN		RURAL		Total	
		N	%	N	%	N	%
IS THERE HEALTH COMMITTEE IN VILLAGE	YES			19	23.8	19	20.4
	NO	12	92.3	61	76.3	73	78.5
	NO RESPONSE	1	7.7			1	1.1
Total		13	100.0	80	100.0	93	100.0

An attempt was also made to collect information on the deaths of children and women in the last one year to judge the present health status in the studied communities. From the table below it is interesting to note that the average number child death occurred in the urban areas is comparatively higher in the urban areas. The trend was just opposite in case of women's death in the study area. While only 16 percent of the community responded negatively as regarding occurrence of child death during the last one year in their community, majority of the community reported no pregnancy related deaths of women during this period.

Table 5-20: Type and number deaths in the community in the past one year

Type of deaths		Urban		Rural		Total	
		No. of comm.	%	No. of comm.	%	No. of comm.	%
Child Death occurred last year	No deaths	2	15.4	13	16.2	15	16.1
	< 10	4	30.8	57	71.2	61	65.6
	10 to 20	2	15.4	8	10.0	10	10.8
	21+			1	1.5	1	1.1
	No response	5	38.4	1	1.5	6	6.5
	Total N	13	100.0	80	100.0	93	100.0
CHILD DEATH OCCURRED IN LAST ONE YEAR	Total	49		326		375	
	Avg	6.1		4.2		4.3	
Women Death occurred last year related to Preg.	No deaths	7	53.8	43	53.8	50	53.8
	< 5	-		32	40.0	32	34.4
	5+	-		4	5.0	4	4.3
	No response	6	46.2	1	1.2	7	7.5
	Total N	13	100.0	80	100.0	93	100.0
WOMEN DEATH OCCURRED RELATED TO PREGNANCY IN LAST ONE YEAR	Total	0		77		77	
	Avg	0.0		0.97		0.89	

5.4.5 Health care seeking behavior of the community

(1) Health cares seeking behavior

More over all respondents have awareness on different govt. health care providers among whom the more acceptable ones are Sub-centres, PHC, ANM, MPW (M) and JSR. People complained on the irregular field visit of ANM and MPW (M).

Across all the groups it was found that people comparatively give more preference to private hospitals and private practitioners. They opined that services and treatment in private hospital is better. There is value for money paid at private nursing home.

The common complaints against govt. hospitals are:

- Treatment at govt. hospital is bad
- No quick relief by treatment from govt. hospital – treatment in govt. hospital takes longer time to recover from illness
- Many a time people have to pay for the services received in Govt. hospital
- Behaviour of govt. doctor depends on the paying capacity of the patient
- Field visits of ANM and MPW is very irregular
- People have to spend more or less the same amount as paid in case of the private clinics even if treated in govt. hospital
- Many of them complained timing, especially in the urban areas as the main factor why they do not use the govt. facility

(2) Factors influence to choose a provider

Cost and distance are two major factors influencing poor people to choose a provider where as economically better off think for quality of treatment and care rather than the cost. Many a time people in the urban areas find behaviour of the doctors and the supporting staffs as an important indicator for preferring any type of facility/provider. For poorer section and especially majority from the rural areas availability of medicine is an important factor for utilising any facility/provider. Many of the groups opined that for them the private doctors are more efficient than the government ones and in most cases even if they consulted a govt. doctor they end of getting treatment at the private clinics of these doctors for which they had to pay an amount.

(3) Reproductive health cares

Both trained and untrained Dais are acceptable and consulted among all communities, even in urban areas, as most of the people prefer deliveries at home as it costs much less than that of at govt. or private hospitals. It was a good finding that people has less faith on traditional healers or quacks. Trained or untrained Dai do maximum deliveries at home where as few emergency or critical cases are referred to govt. hospitals or private hospitals.

(4) Awareness and use of FP methods

Awareness on permanent and temporary method of FP is found to be average among adolescent boys and girls. Both boys and girls have no knowledge on natural methods like rhythm or withdrawal. It is found that in rural villages unmarried girls have not even seen condoms in their life.

Tubectomy is most acceptable method for permanent FP operation, which is generally done in the govt. camps. Immunization of child and pregnant mother is done by ANM. Condoms and Oral pills are available at Sub- Centers and PHC but not in plenty as per requirement. Economically sound people buy condoms and pills from open market. For abortion people prefer to visit private doctors. Bad roads and distance are also major obstacle for rural people to access govt. hospitals for reproductive health care. Women respondents complained on the side effects after FP operation and use of Copper-T is not successful.

(5) Ideal marriage age of girls

People have awareness regarding the legal marriage age of girls and they agreed that ideal age should be 18 years. In rural areas most of the girls get married at the age of 14 to 16 years, however Gauna happens only after 2-4 years. In urban areas people have gradually started preferring to marry off their daughters at a later age.

(6) Reasons of early marriage

People are aware on the ideal age of girl to get married and they were knowledgeable on the disadvantages of early marriage but still in villages girls usually get married at an early age. Followings are the major reasons why people marry of their daughters at early age:

- Poverty , Illiteracy, social and traditional customs are major factors
- In rural areas it would be difficult to get a suitable match for the girl at a later age
- Demand of dowry would be higher from the boy's side if girl is older
- Parents consider grown up daughters to be liability and they do not like daughters to sit ideal at home
- Women think at 14 to 15 girls are physically matured to get married
- Mothers think giving higher education to girls is meaningless
- Parents apprehend that young unmarried girls may develop illicit relationship with other boys

- People particularly among the Brahmins and Upper caste community believe that the SACREDNESS (PUNYA) of KANYA DAAN (to marry one's daughter off) is only possible for the parents of the daughter, if they marry their daughter off before her menstruation cycle starts.
- They believe if some one marry off his daughter after starting of her menstruation cycle he will share the profanity (Pap)
- People tease and comment to the unmarried elder girls and her parents

(7) Ideal time to have first baby

All most all the respondents feel that after marriage couple should wait at least 2-3 years to have their first child. According to them couple should enjoy the initial 2 to 3 years of the married life, which is not possible after the birth of a baby as they have to save some for the future of their child. To further strengthen their arguments they say during 2-3 years a girl becomes physically fit to conceive and give birth to healthy child. Regarding disadvantage it is apprehended that in case of delay in first issue some times people may comment and make fun of the boy that he is incapable to reproduce. Village women also blame the girl, that she is 'Banz' (infertile). Some people think if first child born earlier he would grow early and would help his parents in routine works like animal rearing, farming etc.

(8) Ideal gap between first and second baby

Both women and men respondents think that there should be at least 3 years gap between first and second baby. According to them there are many advantages in spacing where as all of them feel that there is no disadvantage. Followings are the advantages as opined by them.

- Mother would be physically able for safe delivery of second baby
- First child would be mature enough to manage independently so that a proper care can be assured to both the children
- Less gap causes weakness to both husband and wife
- Longer gap keeps health of both mother and child good
- Better education, care and nutrition can be given to children
- For economic point of view it is beneficial as cost of living is becoming higher day by day
- Both the children would get adequate breast feeding and the mother can give proper care to both the children

(9) Family life education

During discussions different groups expressed different sources where they learn family life education before and after marriage.

Table 5-21: Family life education

	Women and Adolescent girls	Men and Adolescent Boys
Before marriage	<ul style="list-style-type: none"> • Bhabi (Wife of elder brother) teaches a lot • Cousin sisters of the same age • Married friends help most • Sometimes married elder sisters also guide • Book and magazines are of no use as most of the women are illiterate • Now a days girls learn a lot on family life education from TV and Radio 	<ul style="list-style-type: none"> • Literate people learn about family life education from book, magazines • Married friends are best guides • TV and Radio also provide family life education to the adolescent boys
After marriage	<ul style="list-style-type: none"> • Jethani (Wife of husband's elder brother) is the best guide • Mother-in-law teaches on ANC and PNC • Married friends also help 	<ul style="list-style-type: none"> • Sex related matters are generally discussed with the married friends • For sexual problem people like to consult with doctors • For pregnancy, delivery and child care related issues the elders in the family help a lot

(10) Formal Programme on Family life education

During discussion with all the 22 groups across the 5 districts it was found that no such formal programme on family life education is running in their areas. Group respondents expressed the following views for the betterment of health facilities

- There is need of formal program in their community on the regular basis, which can educate the adolescent boys and girls
- There should be program for adult male and female also
- JSR is required in those village which are inaccessible to govt. formal health facilities
- Establishment of govt. Health Center to be accessible to all remote villages where with lower prices all health related facilities should be available to all
- Requirement of Lady Gynecologist in all govt. hospitals
- Health messages should be spread through public address system, wall painting, posters and advertisement in Radio and TV
- Social workers from NGOs should be motivated who can visit the communities to counsel with the people on health
- Requirement of health education center with specialised doctors with whom both men and women can consult regarding sex education
- Mini PHC should be established in those areas which are far away from Block PHC
- ANM and MPW should be regular and sincere to their responsibilities. In addition to their jobs they should conduct awareness programmes on family planing and RCH
- Existing Angan Wari Centres should be equipped properly
- Women groups demanded that all untrained Dais should be given proper training
- Adolescent boys expressed that doctors from local hospital should field visit once in a week for counseling with village people

(11) Life before marriage

According to boys incidence of unmarried girls become pregnant is common in villages where as girls expressed that though there is rare incidences but the truth seldom comes to light. They were also not aware of any unmarried or married girls keep sex relationship for money. In villages

sex relationship is established in mutual consent between boy and girl and there is rare cases of rape or molestation. Pregnancy occurs as young girls have less knowledge on safe sex and usually they do not use condoms during sex.

Pregnancy before marriage is not approved in the societies. If both boy and girl are from same caste then society forces their parents for their marriage. There is incidences that girl's family has been out caste by the community. If the boy is from upper caste or his father is powerful then the case is suppressed by giving some money to the father of the girl. Generally abortion is done in private hospitals.

(12) Knowledge on STI

It is observed that both adolescent boys and girls have less awareness on STI. Girls have Very wrong conception on STI. They think TB spreads through sexual relationship. They also believe that if the couple make sex during menstruation period the male will be suffered from TB and female will be affected by white discharge. Among the adolescent there is wrong conception that nightfall and early ejaculation is caused due to STI. White discharge is found to be common problem among village women. For treatment of white discharge village women prefer to consult with traditional healer rather than doctors as they feel ashamed of to consult with govt. doctors in this regard.

5.4.6 Anganwadi Centers (AWC)

Availability: The survey revealed that 90 percent of the villages studied had an AWC within the village. In contrast none of the urban communities reported presence of AWC in their locality.

Accessibility: 88 percent of the villages where AWC is not situated have to cover a distance more than 5 kms to avail the facility, which is 70% for the urban communities. During the discussion it was revealed that the beneficiaries belonging to these communities generally do not avail the facilities due to the distance factor.

Since the requirements asks for a population of 1000 to open an AWC the big villages are provided with additional Pariyawari (sub-AWC) to cater to the beneficiaries. These centres are provided in the hamlets of the village far away from the main cluster. The survey revealed that on an average a village has 4.3 centres. More than four-fifth of the villages has a single AWC.

(in percentage)

Table 5-22: Availability of and Accessibility to Anganwadi Centre

Status of AWC		Urban		Rural		Total	
		N	%	N	%	N	%
Is there anganwadi centre in village	Yes			72	90.0	72	77.4
	No	10	76.9	8	10.0	18	19.4
	No response	3	23.1			3	3.2
Total	N	13	100.0	80	100.0	93	100.0
Distance to nearest AWC (in kilometers)	1 to 2	3	30.0			3	16.7
	3 to 4			1	12.5	1	5.6
	5+	7	70.0	7	87.5	14	77.8
Total	N	10	100.0	8	100.0	18	
No. of AWC in village	1 to 2			60	83.3	60	83.3
	3 to 4			5	6.9	5	6.9
	5+			5	6.9	5	6.9
	No Response			2	2.8	2	2.8
Total	N			72	100.0	72	100.0
HOW MANY ANGANWADI WORKERS IN VILLAGE	Total AWC			332		332	
	Avg. /			4.6		4.6	

An inquiry was also made to learn about the facilities available in these centres and the satisfaction level of the beneficiaries on availing these benefits. As discussed in the table below

while a higher proportion of the villages replied that facilities like nutrition support to mothers and children, growth monitoring are available in the centres, comparatively a lower proportion of them revealed the provision of pre-school education, Iron and Vitamin A. The beneficiaries also showed a higher satisfaction level towards the provisions like nutrition support and growth monitoring than the other benefits.

Table 5-23: Facilities Available in the Anganwadi Centre & Satisfaction Level

Type of facility/provisions	Status/satisfaction level	No. of villages RURAL	
		N	%
Nutrition support to mothers	Yes	63	87.5
	No	4	5.6
	No response	5	6.9
	Total	72	100.0
Nutrition support to mothers -- level of satisfaction	Very satisfied	7	11.1
	Satisfied	47	74.6
	Somewhat satisfied	6	9.5
	Not very much satisfied	3	4.8
	Total	63	100.0
Nutrition support to children	Yes	63	87.5
	No	4	5.6
	No response	5	6.9
	Total	72	100.0
Nutrition support to children- level of satisfaction	Very satisfied	7	11.1
	Satisfied	47	74.6
	Somewhat satisfied	6	9.5
	Not very much satisfied	2	3.2
	Not satisfied at all	1	1.6
Total	63	100.0	
Growth monitoring	Yes	57	79.2
	No	10	13.9
	No response	5	6.9
	Total	72	100.0
Growth monitoring - level of satisfaction	Very satisfied	11	19.3
	Satisfied	31	54.4
	Somewhat satisfied	9	15.8
	Not very much satisfied	4	7.0
	Not satisfied at all	2	3.5
Total	57	100.0	
Pre-school education	Yes	52	72.2
	No	15	20.8
	No response	5	6.9
	Total	72	100.0
Pre-school education -- level of satisfaction	Very satisfied	7	13.5
	Satisfied	31	59.6
	Somewhat satisfied	10	19.2
	Not very much satisfied	3	5.8
	Not satisfied at all	1	1.9
Total	52	100.0	
Distribution of iron tablets	Yes	50	69.4
	No	16	22.2
	No response	6	8.3
	Total	72	100.0
Distribution of iron tablets -- level of satisfaction	Very satisfied	7	14.0
	Satisfied	32	64.0
	Somewhat satisfied	7	14.0
	Not very much satisfied	2	4.0
	Not satisfied at all	2	4.0
Total	50	100.0	
Distribution of Vitamin-A to children	Yes	36	50.0
	No	30	41.7
	No response	6	8.3
	Total	72	100.0
Distribution of Vitamin-A to children -- satisfaction level	Very satisfied	5	13.9
	Satisfied	21	58.3
	Somewhat satisfied	4	11.1
	Not very much satisfied	2	5.6
	Not satisfied at all	4	11.1
Total	36	100.0	

It can also be seen from the table below that programme/activities like mother's meeting and immunization is more pronounced in the study area. However, running of other important programmes like training of adolescent girls, weight measurements and cooking support to mothers is comparatively low. The satisfaction levels also differ accordingly.

Table 5-24: Provision of various programmes in the AWC

Types of activities	Response	No. of villages			
		RURAL		Total	
		N	%	N	%
Mothers meeting	Yes	54	75.0	54	75.0
	No	12	16.7	12	16.7
	No response	6	8.3	6	8.3
	Total	72	100.0	72	100.0
Mothers meeting - level of satisfaction	Very satisfied	8	14.8	8	14.8
	Satisfied	25	46.3	25	46.3
	Somewhat satisfied	8	14.8	8	14.8
	Not very much satisfied	9	16.7	9	16.7
	Not satisfied at all	4	7.4	4	7.4
	Total	54	100.0	54	100.0
Adolescent girls prg.	Yes	35	48.6	35	48.6
	No	30	41.7	30	41.7
	No response	7	9.7	7	9.7
	Total	72	100.0	72	100.0
Adolescent girls prg.- level of satisfaction	Very satisfied	8	22.9	8	22.9
	Satisfied	18	51.4	18	51.4
	Somewhat satisfied	5	14.3	5	14.3
	Not very much satisfied	4	11.4	4	11.4
	Total	35	100.0	35	100.0
Immunization	Yes	59	81.9	59	81.9
	No	5	6.9	5	6.9
	No response	8	11.1	8	11.1
	Total	72	100.0	72	100.0
Immunization - level of satisfaction	Very satisfied	22	37.3	22	37.3
	Satisfied	30	50.8	30	50.8
	Somewhat satisfied	5	8.5	5	8.5
	Not very much satisfied	2	3.4	2	3.4
	Total	59	100.0	59	100.0
Weight measurement	Yes	27	37.5	27	37.5
	No	22	30.6	22	30.6
	No response	23	31.9	23	31.9
	Total	72	100.0	72	100.0
Weight measurement – level of satisfaction	Very satisfied	10	37.0	10	37.0
	Satisfied	15	55.6	15	55.6
	Somewhat satisfied	2	7.4	2	7.4
	Total	27	100.0	27	100.0
Cooking support to mother	Yes	20	27.8	20	27.8
	No	34	47.2	34	47.2
	No response	18	25.0	18	25.0
	Total	72	100.0	72	100.0
Cooking support to mother – level of satisfaction	Very satisfied	20	52.6	20	52.6
	Satisfied	16	42.1	16	42.1
	Somewhat satisfied	2	5.3	2	5.3
	Total	38	100.0	38	100.0

5.4.7 Water and Sanitation

The availability of safe and adequate drinking water and sanitary measures has a direct bearing on the working conditions and health of the people and their capacity for optimum production. The provision of safe drinking water and proper disposal of wastes is a pre-environmental control measure against the transmission of most water borne diseases. According to WHO statistics 80 percent of all diseases in developing countries are related to unsafe water supply and inadequate

sanitation. Water-borne and water-related diseases are responsible for high infant mortality, low life expectancy and poor quality of life.

Three-fourth of the urban communities use private tap for drinking water purposes where as the main source of drinking water in the rural areas is a hand pump (both deep and shallow ones). Use of water from the open well is common in both the urban

and rural areas. Presence of sanitary wells is negligible. In few of the villages tube-well is also used for drinking water purposes besides irrigation. (Table 5-25)

Table 5-25: Availability & Accessibility to Drinking Water

Source of drinking water	Community No.	URBAN		RURAL		Total	
		N	%	N	%	N	%
Hand Pump - Deep	< 3	2	15.4	8	10.0	10	10.8
	3 to 4	1	7.7	15	18.8	16	17.2
	5+	6	46.2	37	46.3	43	46.2
	No Response	4	30.8	20	25.0	24	25.8
	Total	13	100.0	80	100.0	93	100.0
Hand Pump - Shallow	< 3			9	11.3	9	9.7
	3 to 4			3	3.8	3	3.2
	5+	3	23.1	15	18.8	18	19.4
	No Response	10	76.9	53	66.3	63	67.7
	Total	13	100.0	80	100.0	93	100.0
Tube Well	< 3	2	15.4	9	11.3	11	11.8
	3 to 4	1	7.7	2	2.5	3	3.2
	5+	1	7.7	6	7.5	7	7.5
	No Response	9	69.2	63	78.8	72	77.4
	Total	13	100.0	80	100.0	93	100.0
Sanitary Well	< 3			4	5.0	4	4.3
	3 to 4			1	1.3	1	1.1
	5+	1	7.7	3	3.8	4	4.3
	No Response	12	92.3	72	90.0	84	90.3
	Total	13	100.0	80	100.0	93	100.0
Private Tap	3 to 4			2	2.5	2	2.2
	5+	10	76.9	6	7.5	16	17.2
	No Response	3	23.1	72	90.0	75	80.6
	Total	13	100.0	80	100.0	93	100.0
Public Tap stand	< 3	4	30.8	4	5.0	8	8.6
	3 to 4	1	7.7	2	2.5	3	3.2
	5+	1	7.7	10	12.5	11	11.8
	No Response	7	53.8	64	80.0	71	76.3
	Total	13	100.0	80	100.0	93	100.0
Open Well	< 3	3	23.1	14	17.5	17	18.3
	3 to 4	1	7.7	13	16.3	14	15.1
	5+	7	53.8	45	56.3	52	55.9
	No Response	2	15.4	8	10.0	10	10.8
	Total	13	100.0	80	100.0	93	100.0
River	< 3	1	7.7	27	33.8	28	30.1
	3 to 4	1	7.7			1	1.1
	5+			1	1.3	1	1.1
	No Response	11	84.6	52	65.0	63	67.7
	Total	13	100.0	80	100.0	93	100.0
Pond	< 3	3	23.1	23	28.8	26	28.0
	3 to 4	1	7.7			1	1.1
	5+			1	1.3	1	1.1
	No Response	9	69.2	56.0	70.0	65	69.9
	Total	13	100.0	80	100.0	93	100.0
Nalla (Natural stream)	< 3			2	2.5	2	2.2
	No Response	13	100.0	78	97.5	91	97.8
	Total	13	100.0	80	100.0	93	100.0

In case of all the urban communities there is household latrines, where as in case of only one-third of the villages household latrines are found. Mostly villagers in the study area prefer open defecation. Higher proportions of the HHs (93%) in the urban areas have HH latrine in comparison to the rural households (7.3%).

In both the rural as well as urban areas single and double pit latrines are increasingly used. Septic tank latrines are more in use in urban areas (16%) in comparison to the rural areas (8%) where more than four-fifth of the latrines is either single or double pit. Use of community latrines is high in urban areas in comparison to the rural areas.

Table 5-26: Availability of Sanitation facilities

Type of latrine	Status	Urban		Rural		Total	
		No. of Comm./HH	%	No. of Comm./HH	%	No. of Comm./HH	%
ARE THERE ANY HH LATERINES IN THIS VILLAGE	YES	13	100.0	31	38.8	44	47.3
	NO			48	60.0	48	51.6
	NO RESPONSE			1	1.3	1	1.1
	Total N(community)	13		80	100.0	93	100.0
Single Pit Latrine	<= 5 HHs			9	39.1	9	27.3
	6 to 10 HHs			4	17.4	4	12.1
	10+ HHs	10	100.0	10	43.5	20	60.6
	Total N(community)	10	100.0	23	100.0	33	100.0
	Total HHs	2214	46.5	675	31.6	2889	41.9
Double Pit Latrine	<= 5 HHs			4	26.7	4	19.0
	6 to 10 HHs	1	16.7	3	20.0	4	19.0
	10+ HHs	5	83.3	8	53.3	13	61.9
	Total N(community)	6	100.0	15	100.0	21	100.0
	Total HHs	681	14.3	1139	53.7	1820	26.4
Service Latrine	10+ HHs	1	100.0	1	100.0	2	100.0
	Total N(community)	1	100.0	1	100.0	2	100.0
	Total HHs	1100	23.1	125	5.9	1225	17.8
Connect to Sewerage	10+ HHs			1	100.0	1	100.0
	Total N(community)			1	100.0	1	100.0
	Total HHs			35	1.6	35	0.5
Septic Tank	<= 5 HHs			1	12.5	1	10.0
	6 to 10 HHs			2	25.0	2	20.0
	10+ HHs	2	100.0	5	62.5	7	70.0
	Total N(community)	2	100.0	8	100.0	10	100.0
	Total HHs	765	16.1	160	7.5	925	13.4
Any Latrine	<= 5 HHs			11	40.7	11	28.9
	6 to 10 HHs			2	7.4	2	5.3
	10+ HHs	11	100.0	14	51.9	25	65.8
	Total N(community)	11	100.0	27	100.0	38	100.0
	Total HHs	4760		2134		6894	
No. dependent on Comm. Latrine	< 50 HHs	3	100.0	8	88.9	11	91.7
	50-100 HHs			1	11.1	1	8.3
	Total N(community)	3	100.0	9	100.0	12	100.0
NO.OF HHS DEPENDENT ON COMMUNITY LATERINE	Total HHs	52		181		233	

In majority cases in rural areas the households have the practice of disposing the garbage either in the agriculture field (which is used later as manure) or in open field outside the village. Urban households enjoy the services of the municipalities and other urban bodies in this respect. The practice of disposing garbage in the backyard is prominent in both the urban (46%) and rural (41%) areas. Having own garbage pit for garbage disposal away from home is also observed in both the areas, which is prominent in urban areas than the rural.

Table 5-27: Disposal of Garbage by the communities

Type of garbage disposal	Number of communities/villages					
	URBAN		RURAL		Total	
	N	%	N	%	N	%
In an open field outside the village	6	46.2	45	56.3	51	54.8
Own garbage pit away from the house	5	38.5	23	28.8	28	30.1
Agricultural field			58	72.5	58	62.4
Own garbage pit near or backside of house	6	46.2	33	41.3	39	41.9
Taken away by municipality	4	30.8	1	1.3	5	5.4
Burnt			1	1.3	1	1.1

Note: Multiple responses

5.4.8 Electricity

As per the survey surprisingly a higher proportion of the rural communities is having electricity connection in comparison to the urban communities. The main reason for the same can be the selection of the urban wards instead of the total urban area for the survey purpose, as some of the wards selected are having a predominant population of the lower income groups i.e., JJ clusters (Jhhugi/Jhopri or Slum), unauthorized colonies etc. The table below also reveals that as expected a higher proportion of the urban households is having electricity connection in comparison to their counterparts in the rural areas. However, the proportion of rural households having illegal connection is very high. As expected it was also revealed that the duration of the power supply is more than double in the urban areas (17 hours a day) as compared to the rural areas (8.2 hours).

Table 5-28: Availability of Electricity in the communities

Status	Urban		Rural		Total		
	No. Of. Comm./HH	%	No. Of. Comm./HH	%	No. Of. Comm./HH	%	
Does village have electricity supply	Yes	10	76.9	76	95.0	86	92.5
	No			4	5.0	4	4.3
	No Response	3	23.1			3	3.2
Total N	13	100.0	80	100.0	93	100.0	
Legal connections (Pvt.) - no. of HHs	2864	70.1	8399	29.8	11263	34.8	
One lamp connection (govt.)	308	7.5	4672	16.6	4980	15.4	
Illegal connection - no. of HHs	655	16.0	10178	36.1	10833	33.5	
Total HHs	4088	100.0	28226	100.0	32354	100.0	
No. of hrs. per day electricity supplied	< 1			1	1.3	1	1.1
	1 to 2			6	7.6	6	6.6
	3 to 4	1	8.3	22	27.8	23	25.3
	5 to 6			12	15.2	12	13.2
	7+	11	91.7	38	48.1	49	53.8
How many hrs. per day	Avg.	17.1		8.2		9.4	

5.4.9 Education

As expected in the study area the availability of higher levels of education is better in case of the urban communities in comparison to the villages. In contrast the villages are well covered with the

lower level of education facilities like pre-primary, primary, middle and non-formal schools. The main reason for the same can be attributed to the process of selecting a urban ward in a town/city. Since the question is asked whether the facility available within the locality, in case of most of the urban communities (wards) the answer was negative. This can be misleading that is the reason why the question of accessibility was asked to judge the actual availability of the educational institutions. It can be seen from the table below that the accessibility to the institutions is comparatively easier in the urban areas in comparison to the villages.

The table also reveals that a higher proportion of the rural communities in the study area have a better presence of lower level educational institutions. The gap of the availability is reduced with the increase in the level of educational institutions and urban areas show a better availability when the level is beyond middle school level.

Schemes like non-formal and adult education is running better in the rural areas in comparison to the urban areas. It seems awareness regarding EGS is lacking in the study area, especially in the villages or else presence of primary schools in large number in the study area might be the reason why EGS schools are not opened in the villages.

Table 5-29: Accessibility to Educational Institution

Educational Institution Status		Urban		Rural		Total	
		No. comm.	%	No. comm.	%	No. comm.	%
PRE-PRIMARY - WITHIN VILLAGE	YES	4	30.8	34	42.5	38	40.9
	NO	2	15.4	13	16.3	15	16.1
	NO RESPONSE	7	53.8	33	41.3	40	43.0
Total	N	13	100.0	80	100.0	93	100.0
Pre Primary (Distance)	< 1			1	7.7	1	6.7
	1 to 2	1	50.0	4	30.8	5	33.3
	3 to 4			4	30.8	4	26.7
	5+	1	50.0	4	30.8	5	33.3
	Total	N	2	100.0	13	100.0	15
Average distance		3.0		3.9		3.8	
PRIMARY (1-5) - WITHIN VILLAGE	YES	5	38.5	64	80.0	69	74.2
	NO	5	38.5	13	16.3	18	19.4
	NO RESPONSE	3	23.1	3	3.8	6	6.5
Total	N	13		80		93	
Primary School (1-5) (Distance)	1 to 2	3	60.0	10	76.9	13	72.2
	3 to 4			2	15.4	2	11.1
	5+	2	40.0	1	7.7	3	16.7
	Total	N	5	100.0	13	100.0	18
Average distance		4		2.4		2.8	
MIDDLE (6-8) - WITHIN VILLAGE	YES	4	30.8	36	45.0	40	43.0
	NO	5	38.5	43	53.8	48	51.6
	NO RESPONSE	4	30.8	1	1.3	5	5.4
Total	N	13	100.0	80	100.0	93	100.0
Middle School (6-8) (Distance)	1 to 2	5	100.0	14	32.6	19	39.6
	3 to 4			13	30.2	13	27.1
	5+			16	37.2	16	33.3
	Total	N	5	100.0	43	100.0	48
Average distance		1.2		5.3		4.9	
SECONDARY (9-10) - WITHIN VILLAGE	YES	3	23.1	14	17.5	17	18.3
	NO	7	53.8	66	82.5	73	78.5
	NO RESPONSE	3	23.1			3	3.2
Total	N	13	100.0	80	100.0	93	100.0
Secondary School (9-10) (Distance)	< 1			1	1.5	1	1.4
	1 to 2	3	42.9	5	7.6	8	11.0
	3 to 4	1	14.3	12	18.2	13	17.8
	5+	3	42.9	48	72.7	51	69.9
	Total	N	7	100.0	66	100.0	73
Average distance		5.6		10.2		9.7	
COLLAGE/UNIVERSITY- WITHIN VILLAGE	YES	3	23.1	1	1.3	4	4.3
	NO	6	46.2	75	93.8	81	87.1
	NO RESPONSE	4	30.8	4	5.0	8	8.6
Total	N	13	100.0	80	100.0	93	100.0
Collage/University (Distance)	1 to 2	4	66.7	1	1.3	5	6.2
	3 to 4	1	16.7	2	2.7	3	3.7
	5+	1	16.7	72	96.0	73	90.1
	Total	N	6	100.0	75	100.0	81
Average distance		2.5		25.1		23.4	

Educational Institution Status		Urban		Rural		Total	
		No. comm.	%	No. comm.	%	No. comm.	%
NON FORMAL SCHOOL- WITHIN VILLAGE	YES	2	15.4	17	21.3	19	20.4
	NO	1	7.7	21	26.3	22	23.7
	NO RESPONSE	10	76.9	42	52.5	52	55.9
	Total N	13	100.0	80	100.0	93	100.0
Non Formal School (Distance)	< 1			4	19.0	4	18.2
	1 to 2	1	100.0	3	14.3	4	18.2
	3 to 4			4	19.0	4	18.2
	5+			10	47.6	10	45.5
	Total N	1	100.0	21	100.0	22	100.0
Average distance		2		7.5		7.2	
ADULT EDU.CENTRE- WITHIN VILLAGE	YES	3	23.1	24	30.0	27	29.0
	NO			14	17.5	14	15.1
	NO RESPONSE	10	76.9	42	52.5	52	55.9
	Total N	13	100.0	80	100.0	93	100.0
Adult Edu.Centre	< 1			3	21.4	3	21.4
	1 to 2			2	14.3	2	14.3
	3 to 4			2	14.3	2	14.3
	5+			7	50.0	7	50.0
	Total N			14	100.0	14	100.0
Average distance				8.1		8.1	
EGS - WITHIN VILLAGE	YES	2	15.4	28	35.0	30	32.3
	NO	1	7.7	16	20.0	17	18.3
	NO RESPONSE	10	76.9	36	45.0	46	49.5
	Total N	13	100.0	80	100.0	93	100.0
EGS	< 1			1	6.3	1	5.9
	1 to 2			4	25.0	4	23.5
	3 to 4	1	100.0	5	31.3	6	35.3
	5+			6	37.5	6	35.3
	Total N	1	100.0	16	100.0	17	100.0
Average distance		3		5.1		4.9	

Table 5-30 reveals that the presence of different educational committees is higher in case of the villages in comparison to the urban areas. This might be due to the thrust of different government education programmes to form these committees to enhance awareness towards education and monitoring the existing institutions at community level in the rural areas. However, discussion with the community members revealed that mere formation of these committees are not enough to achieve its objectives as in reality most of them are defunct.

Table 5-30: Education Committees within Village/communities

Type of committees		URBAN		RURAL		Total	
		N	%	N	%	N	%
VEC	Yes	1	7.7	70	87.5	71	76.3
	No	7	53.8	7	8.8	14	15.1
	No response	5	38.5	3	3.8	8	8.6
	Total	13	100.0	80	100.0	93	100.0
PTA/MTA	Yes	1	7.7	13	16.3	14	15.1
	No	7	53.8	63	78.8	70	75.3
	No response	5	38.5	4	5.0	9	9.7
	Total	13	100.0	80	100.0	93	100.0
VCC	Yes			34	42.5	34	36.6
	No	8	61.5	40	50.0	48	51.6
	No response	5	38.5	6	7.5	11	11.8
	Total	13	100.0	80	100.0	93	100.0

In order to achieve the universalisation of primary education the GoI is running various educational programmes. The main objectives of these programmes are to increase enrolment, decrease drop out rates and increase in the regularity in school attendance. Some of these programmes are also giving thrust to girl child education as well as to provide education to the children from the deprived section of the society i.e., ST and SC. In this connection information was also gathered to gain knowledge on the present status of different educational programmes in the study area. It can be seen from the table below that programmes like DPEP, Adult Education and MDM are running in a higher proportion of the villages in comparison to the urban communities. However, it was also revealed that the provision for promoting girl's education is limited in case of both the urban and rural areas.

Table 5-31: Education program within the Village

Type of educational program		URBAN		RURAL		Total	
		N	%	N	%	N	%
Educational Program running*							
	District primary edu. prg. (DPEP)	8	61.5	69	86.3	77	82.8
	Adult edu. prg	2	15.4	29	36.3	31	33.3
	Operation Black Board			4	5.0	4	4.3
	Free Mid-day Meal prg.	6	46.2	69	86.3	75	80.6
	Joyful Learning prg.			2	2.5	2	2.2
	EGS only			3	3.8	3	3.2
	No response	5	38.5	2	2.5	7	7.5
	Total	13	100.0	80	100.0	93	100.0
Any program for promoting female edu.							
	Yes	1	7.7	11	13.8	12	12.9
	No	11	84.6	69	86.3	80	86.0
	No response	1	7.7			1	1.1
	Total	13	100.0	80	100.0	93	100.0

Note: * Multiple response

5.4.10 Market Accessibility

Availability and accessibility to market is yet another important indicator to judge the development process of any area, especially the rural areas. Dependence of the rural areas in the market is very high as in majority cases the villagers depend on daily purchases, instead of bulk purchases as is the case in urban areas. The economies of the rural areas mostly depend on the sale and purchase of crops, which is why the accessibility to the market is one of the major components on the growth process of the rural economy. Availability of PDS and informal credits are yet two important facets of the economic life of the rural mass.

The Table 5-32 shows the availability of and accessibility to the market in both the rural and urban communities in the study area. It can be seen from the table that different kinds of markets are available within the community in the urban areas and the picture is bleak for the villages. Not very high proportion of the villages are having weekly markets (21%), market for major purchases (6.3%) and market to sell and buy crops (12.5%) within the villages. The average distance traveled to access these markets is also very high for these communities.

This is not enough even access to the markets is often limited during the rainy season due to the absence of all weather roads. It was also revealed during discussion that because of swelling nallahs (canals) villagers are unable to get easy access to the market. It was also reported that even in other seasons the villagers have to travel a long distance to approach the nearest bus stop. The lack of roads and communication facilities and the long distance contributed to this inaccessibility. Indeed, purchase and sell of home produces are generally undertaken in the nearest market in case of the majority of the villages in the study area. In case of those villages for whom market accessibility is most difficult the only markets available are the traders that visit the villages.

The traders and the moneylenders dominate the credit markets and some goods market. Credit market plays a crucial role in the livelihood of the poor households in the study area. The

discussion brought forth the fact that a significant section of the population in the study area depends on credit for multiple purposes like marriage, health treatments, food purchases and even to pay previous debt. By and large access to formal credit is very limited to the poorer section because they lack collateral securities and household durable, and they also have histories as defaulters. As a result they rely heavily on informal credit where loans are usually sanctioned at exorbitant rates of interest.

Availability of PDS is yet another important indicator since in rural areas the poor households depends on the same as it provides 10-15% of their food requirements. This is particularly important, as it is another potential resource for the poorer households both in the urban and the rural areas to meet their food security. The survey revealed that almost all the urban communities and 57% villages have easy access to the PDS. However, average distance travel to avail this facility is very high for those villages not having a PDS outlet.

Table 5-32: Market Accessibility

Type of market	Availability status	Urban		Rural		Total		
		N	%	N	%	N	%	
Small Shop	Within Village	13	100.0	65	81.3	78	83.9	
	< 1			1	1.3	1	1.1	
	1 to 2			4	5.0	4	4.3	
	3 to 4			1	1.3	1	1.1	
	5+			9	11.3	9	9.7	
	Total N		13		80	100.0	93	100.0
SMALL SHOP – NEAREST DIST.	Avg. Distance			10.4		10.4		
Weekly Market	Within Village	10	76.9	17	21.3	27	29.0	
	< 1	0	0.0	1	1.3	1	1.1	
	1 to 2	3	23.1	8	10.0	11	11.8	
	3 to 4			11	13.8	11	11.8	
	5+			43	53.8	43	46.2	
	Total N		13	100.0	80	100.0	93	100.0
WEEKLY MARKET – NEAREST DIST.	Avg. Distance			8.2		7.9		
Major Purchasing	Within Village	7	53.8	5	6.3	12	12.9	
	1 to 2	2	15.4	1	1.3	3	3.2	
	3 to 4		0.0	4	5.0	4	4.3	
	5+	4	30.8	70	87.5	74	79.6	
	Total N		13	100.0	80	100.0	93	100.0
	MAJOR PURCH. – NEAREST DIST.	Avg. Distance	25.4		23		23.1	
Selling or Buying Crop	Within Village	7	53.8	10	12.5	17	18.3	
	< 1	1	7.7		0.0	1	1.1	
	1 to 2	2	15.4	5	6.3	7	7.5	
	3 to 4		0.0	7	8.8	7	7.5	
	5+	3	23.1	58	72.5	61	65.6	
	Total N		13	100.0	80	100.0	93	100.0
SELL/BUY CROP – NEAREST DIST.	Avg. Distance	18.4		17.1		17.2		
PDS (Fair Price Shop)	Within Village	13	100.0	46	57.5	46	57.50	
	< 1			1	1.25	1	1.25	
	1 to 2			8	10.0	8	10.00	
	3 to 4			4	5.0	4	5.00	
	5+			21	26.25	21	26.25	
	Total N		13	100.0	80	100.0	80	100.00
PDS – NEAREST DIST.	Avg. Distance			11.4		11.4		
Informal credit	Within Village	12	92.3	48	60.0	60	64.5	
	1 to 2	1	7.7	3	3.8	4	4.3	
	3 to 4		0.0	4	5.0	4	4.3	
	5+		0.0	25	31.3	25	26.9	
	Total N		13	100.0	80	100.0	93	100.0
	INFORMAL CREDIT- NEAREST DIST.	Avg. Distance	1		11.9		11.6	

5.4.11 Media and Communication

Availability and accessibility to media and communication is particularly important to develop IEC strategy for the implementation any health programme. In order to assess the present situation of media accessibility and availability of communication in the study area few questions were asked to the community members regarding their media habits, availability of communication facilities within the communities and the ongoing IEC programmes. The study revealed that (Table: 3.20) use of various media mediums like radio, TV, News Papers and telephone is very high among the urban households in comparisons to their counterparts in the villages. However, the details of the timing, duration, channels/programmes etc. used by the community were covered during the household survey. It can also be seen from the table below that in urban areas TV is the most preferred medium, which is radio in case of the villages. Lack of affordability can be the major reason why TV as a medium of communication could not make proper in roads in the rural areas. Since habit of reading newspaper depends on the educational attainment of the population rightly people in the rural areas being less educated/literate use this medium scantily.

It is observed that in urban areas access to television is more pronounced than access to Radio. Approximately 71 percent of the communities have access to Television whereas only 27 percent have access to Radio. 33 percent of urban population have access to Newspaper whereas 19 percent have access to Telephone.

Predictably, rural scenario is poor vis a vis urban scenario. It is disheartening to note that only 18 percent of rural communities have access to radio. Approximately 24 percent of the communities have access to Television. Access to newspaper and Telephone is very poor as not even 10 percent of the communities indicate access to these sources.

Table 5-33: Number and proportion of households by Media accessibility

Type of media mediums		Urban		Rural		Total	
		HHS/Vill	%	HHS/Vill	%	HHS/Vill	%
Radio	No Response	0		1	1.2	1	1.1
	0-10%	4	30.8	31	38.8	35	37.6
	More than 10-20%	3	23.1	20	25.0	23	24.7
	More than 20-30	1	7.7	10	12.5	11	11.8
	More than 30-50%	4	30.8	11	13.7	15	16.1
	More than 50-70 %	1	7.7	4	5.0	5	5.4
	More than 70-90%	0	0.0	3	3.8	3	3.2
	More than 90-100	0	0.0	0	0.0	0	0.0
Total		13		80		93	
RADIO - NO. & % OF HHS		1553	27.0	5320	18.0	6873	19.7
TV	No Response	0	0.0	1	1.2	1	1.1
	0-10%	0	0.0	52	65.0	52	53.9
	More than 10-20%	1	7.7	13	16.3	14	15.1
	More than 20-30	1	7.7	5	6.3	6	6.5
	More than 30-50%	3	23.1	5	6.3	8	8.6
	More than 50-70 %	4	30.8	4	5.0	8	8.6
	More than 70-90%	4	30.8	0	0.0	0	0.0
	More than 90-100	0	0.0	0	0.0	0	0.0
Total		13		80		93	
TV - NO. & % OF HHS		4056	71.0	4223	14.0	8279	23.7
Newspaper	No Response	0	0.0	42	52.5	42	45.2
	0-10%	3	23.1	36	45.0	39	41.9
	More than 10-20%	3	23.1	1	1.2	4	4.3
	More than 20-30	3	23.1	1	1.2	4	4.3
	More than 30-50%	3	23.1	0	0.0	3	3.2
	More than 50-70 %	1	7.7	0	0.0	1	1.1
	More than 70-90%	0	0.0	0	0.0	0	0.0
	More than 90-100	0	0.0	0	0.0	0	0.0
Total		13		80		93	

Type of media mediums	Urban		Rural		Total	
	HHs/Vill	%	HHs/Vill	%	HHs/Vill	%
NEWSPAPER- NO. & % OF HHS	1911	33.0	772	3.0	2683	7.7
Telephone	0	0.0	46	57.5	46	49.5
0-10%	4	30.8	33	41.3	37	39.8
More than 10-20%	6	46.2	1	1.2	7	7.5
More than 20-30	2	15.4	0	0.0	2	2.2
More than 30-50%	1	7.7	0	0.0	1	1.1
More than 50-70 %	0	0.0	0	0.0	0	0.0
More than 70-90%	0	0.0	0	0.0	0	0.0
More than 90-100	0	0.0	0	0.0	0	0.0
Total	13		80		93	
TELEPHONE- NO. & % OF HHS	1071	19.0	604	2.0	1675	4.8

Table 5-34 reveals the availability of and accessibility to various IEC mediums in the study area. It is heartening to note that nearly two-third of the rural communities is not having any access to these mediums.

Table 5-34: IEC accessibility by communities

IEC Mediums	Number of communities					
	URBAN		RURAL		Total	
	N	%	N	%	N	%
CINEMA	7	53.8	18	22.5	25	26.9
DRAMATIC PRESENTATIONS			4	5.0	4	4.3
PUPPET SHOWS			4	5.0	4	4.3
LIVE MUSICAL PERFORMANCES	2	15.4	3	3.8	5	5.4
OTHER			2	2.5	2	2.2
NONE	4	30.8	52	65.0	56	60.2
NO RESPONSE	2	15.4	2	2.5	4	4.3
Total	13	100.0	80	100.0	93	100.0

Accessibility to various communication facilities like post office, telephone (PCO/STD/ISD), fax, private couriers' etc. is given in Table 5-35. It can be seen from the table that in the study area accessibility for the urban communities to these facilities is much better than the rural communities. The distance covered to access them is also very high for the villages.

Table 5-35 : Communication Accessibility

Communication types	Status	Urban		Rural		Total	
		N	%	N	%	N	%
POST OFFICE – WITHIN VILLAGE	YES	8	61.5	32	40.0	40	43.0
	NO	5	38.5	48	60.0	53	57.0
	Total N	13		80		93	
Post office	1 to 2	4	80.0	7	14.6	11	20.8
	3 to 4			20	41.7	20	37.7
	5+	1	20.0	21	43.8	22	41.5
	Total N	5		48		53	
Average distance(km)		7.2		5.4		5.6	
PANCHYAT TELEPHONE - WITHIN VILLAGE	YES	10	76.9	29	36.3	39	41.9
	NO	3	23.1	51	63.8	54	58.1
	Total N	13		80		93	
Panchyat Telephone	1 to 2	2	66.7	5	9.8	7	13.0
	3 to 4	1	33.3	13	25.5	14	25.9
	5+			33	64.7	33	61.1
	Total N	3		51		54	
Average distance(km)		2		8.8		8.4	
PCO – WITHIN VILLAGE	YES	12	92.3	7	8.8	19	20.4
	NO	1	7.7	73	91.3	74	79.6
	Total N	13		80		93	
PCO	1 to 2			2	2.7	2	2.7
	3 to 4			6	8.2	6	8.1
	5+	1	100.0	65	89.0	66	89.2
	Total N	1		73		74	
Average distance(km)		38		14.9		15.2	
STD/ISD – WITHIN VILLAGE	YES	12	92.3	5	6.3	17	18.3
	NO	1	7.7	75	93.8	76	81.7
	Total N	13		80		93	
STD/ISD	1 to 2			2	2.7	2	2.6
	3 to 4			6	8.0	6	7.9
	5+	1	100.0	67	89.3	68	89.5
	Total N	1		75		76	
Average distance(km)		38		16.1		16.3	
FAX -- WITHIN VILLAGE	YES	8	61.5	1	1.3	9	9.7
	NO	5	38.5	77	96.3	82	88.2
	NO RESPONSE			2	2.5	2	2.2
	Total N	13		80		93	
Fax	1 to 2	2	40.0	1	1.3	3	3.7
	3 to 4			3	3.9	3	3.7
	5+	3	60.0	73	94.8	76	92.7
	Total N	5		77		82	
Average distance(km)		15.2		23.9		23.4	
PVT.COURIER – WITHIN VILLAGE	YES	8	61.5	2	2.5	10	10.8
	NO	5	38.5	76	95.0	81	87.1
	NO RESPONSE			2	2.5	2	2.2
	Total N	13		80		93	
Pvt. Courier	1 to 2	3	60.0	1	1.3	4	4.9
	3 to 4			3	3.9	3	3.7
	5+	2	40.0	72	94.7	74	91.4
	Total N	5		76		81	
Average distance(km)		12.2		23		22.3	

5.5 PROGRAMMES AND THEIR EFFECTIVENESS

Table 5-36 and 2-37 details the development programmes by identifying their respective implementing agencies. It is observed that Nagarpalika (Municipality) and PWD are the two major implementing agencies in the urban areas. These two agencies are basically involved in improvement of infrastructure, which include road, Electricity, sewerage etc. Provision of Tube wells and Hand pumps are the responsibilities of Municipality.

In rural areas Panchayat is involved in direct implementation of an array of programmes but primarily in improving infrastructure of the village. District Rural Development Agency (DRDA) which implements programmes and Watershed Mission and District Primary Education Programme are the other important implementing agencies. RES is involved in installation of tube wells and hand pumps whereas Health department is primarily involved in campaigning for Family Planning.

Table 5-36: Development Programmes by Implementing Agency (Urban)

Activity Details	URBAN (Figures in percentage)		Total
	Nagarpalika (Municipality)	PWD (Public Works Department)	
Improvement in Infrastructure (like Electricity, sewerage)	44.4	33.3	42.8
Cleaning of Wells	-	-	-
Campaigning of Family Planning issues	-	-	-
Provision of Artificial Pond/Canals	-	-	-
Prov.of School & other related Infrastructure	-	-	-
Provision of road Infrastructure	27.8	66.7	33.3
Provision of Handpump / Tubewell	27.8	-	23.8
Provision of Bus Stand	-	-	-
DK	-	-	-
Launch of Scheme Lime	-	-	-
Total (Number of responses)	18	3	21

Table 5-37: Program Activities by Implementing Agency (Rural)

Activity Details	RURAL (Figures in percentage)							Total
	Panchayat	Other Govt. Departments	RES**	Watershed Mission*	Health	PWD	Primary Education Programme *	
Well Excavation	8.0	10.0						7.6
Infrastructure (like Electricity, sewerage)	42.7	40.0		37.5				41.2
Cleaning Wells	6.1				50.0			5.5
Campaigning of Family Planning	0.5				50.0			0.8
Artificial Pond/Canals	5.6	20.0		12.5				6.3
School & other Infrastructure	13.6	10.0					100.0	13.0
Road Infrastructure	12.7	20.0		37.5				13.4
Handpump/Tubewell	7.0		100.0	14.3		50.0		8.0
Bus Stand	1.4					50.0		1.7
DK	0.9							100.0
Launch of Scheme	1.4							1.3
Total (Number of responses)	213	10	1	8	2	2	1	1

* Being Implemented through District Rural Development Agency (DRDA)

** Rural Engineering Services

Table 5-38 delineates people's perception about effectiveness of programmes. It is observed that programmes have been rated as effective more by the rural communities. Approximately 24 percent of urban and 23 percent of rural populace rate infrastructure related activities as average. Only 2.1 percent of the rural population have rated activities as "Not so effective".

Table 5-38: Program Activities Evaluation

	Urban			Rural			Total				
	Effect	Aver	Total	Effect	Aver	Not so effect	Total	Effect	Aver	Not so effect	Total
Well Excavation				5.5	2.1		7.6	5.0	1.9		6.9
Infrastructure (like Electricity, sewerage)	19.0	23.8	42.9	18.9	22.3		41.2	18.9	22.4		41.3
Cleaning Wells				2.9	1.7	0.8	5.5	2.7	1.5	0.8	5.0
Campaigning of Family Planning					0.4	0.4	0.8		0.4	0.4	0.8
Artificial Pond/Canals				3.4	2.9		6.3	3.1	2.7		5.8
School & related Infrastructure				7.1	5.9		13.0	6.6	5.4		12.0
Road Infrastructure	19.0	14.3	33.3	9.2	4.2		13.4	10.0	5.0		15.1
Handpump/Tubewell	19.0	4.8	23.8	2.9	4.2	0.8	8.0	4.2	4.2	0.8	9.3
Bus Stand				1.3	0.4		1.7	1.2	0.4		1.5
DK				0.8	0.4		1.3	0.8	0.4		1.2
Launch of Scheme				1.3			1.3	1.2			1.2
Total percentage	57.1	42.9	100.0	53.0	44.5	2.1	100.0	54.0	44.0	1.9	100.0
Total (Number of responses)	12	9	21	127	106	5	238	139	115	5	259

Table 5-30 and 2-40 details the development programmes related to Health by identifying their respective implementing agencies. It is observed that District Hospital and Health departments are the main agencies whereas UNICEF plays a supportive but pivotal role especially in implementing programmes like National Immunization Programme.

In rural areas district hospital is found to be involved in many of the health related activities. Community Health Centre (CHC), Primary Health Centre (PHC) and Sub centres (SC) also play important role in providing health care facilities. UNICEF's presence is being felt in Immunization Programme and arranging for health care camps like Eye Camp etc. Family Planning Association of India (FPAI) is involved in organizing health care camps for children

Table 5-39: Program Activities (health) by Implementing Agency (urban)

Activities	District Hospital %	UNICEF %	Health Dept %	Municipality %	SHC %	Total
IMMUNIZATION,PULSE POLIO)	42.1	21.1	15.8			78.9
CHECK-UP OF PREG WOM				5.3		5.3
DISTRIBUTION OF MEDICINE						
LEPROSY CAMP	5.3					5.3
FAMILY PLANNING CAMPS						
CLEANING OF WELLS						
EYE CAMPS			5.3			5.3
CHECK-UP FOR CHILDREN						
IMPROVE INFRASTRUCTRE AT SUB CENTRE					5.3	5.3
Total percentage	47.3	21.1	21.1	5.3	5.3	100.0
Total (Number of responses)	9	4	4	1	1	19

Table 5-40: Program Activities (health) by Implementing Agency (urban)

(%)

	Hospital	UNICEF	Health	PHC	CHC	FPAI	SHC	Panchayat	Total
(IMMU,PULSE POLIO)	40	17.6	3.5	8.8	1.2		0.6	1.2	72.9
CHECK-UP OF PREG WOMEN	1.2			2.4					3.5
DISTRIBUTION OF MEDICINE				0.6					0.6
LEPROSY CAMP	5.3	0.6		4.7	1.2				11.8
FAMILY PLANNING CAMPS	3.6	0.6	0.6	1.2	0.6				6.5
CLEANING OF WELLS	0.6							0.6	1.2
EYE CAMPS	0.6	0.6			0.6				1.8
CHECK-UP FOR CHILDREN						0.6			0.6
IMPROVE INFRASTRUCTRE AT SC	1.2	52.4							1.2
Total percentage	52.4	19.4	4.1	17.6	3.5	0.6	0.6	1.8	100.0
Total (Number of responses)	89	33	7	30	6	1	1	3	170

Table 5-41 delineates people's perception about effectiveness of health related activities/programmes. It is observed that programmes have been rated as effective more by the rural communities. Approximately 89 percent of urban and 82 percent of rural populace rate activities as effective. Only 1.8 percent of the rural population has rated activities as "Not so effective".

Table 5-41: Program Activities by Villagers Evaluation

	URBAN			RURAL			Total
	Effective	Average	Total	Effective	Average	Not so effective	
NATIONAL PROGRAMS (IMMU,PULSE POLIO)	78.9		78.9	65.0	7.1	0.6	72.7
CHECK-UP OF PREGNANT WOMEN	5.3		5.3	1.8	1.8		3.9
DISTRIBUTION OF MEDICINE						0.6	0.6
ORGANISED LAPROACY CAMP		5.3	5.3	7.1	4.1	0.6	11.8
ORGANISED FP CAMPS				4.7	1.8		6.5
CLEANING OF WELLS				1.2			1.2
ORGANISED EYE CAMPS		5.3	5.3	1.2	0.6		1.8
CHECK-UP FOR CHILDREN				0.6			0.6
IMPROVE INFRASTRUCTRE AT SC	5.3		5.3		1.2		1.2
Total percentage	89.5	10.5	100.0	82	16.5	1.8	100.0
Total (Number of responses)	17	2	19	139	28	3	170

5.5.1 Problems and Prospective

The following table elucidates the problems identified by the respondents. In urban areas the three most important problems identified are as follows:

- (1) Drinking Water
- (2) Community Latrines /Hall/AWC/FPS/Housing Problems
- (3) Road Problem/Drainage/Culvert /Bridge / Bus Stop

The major problems identified in rural areas are not different from urban areas but education related problems have been given more weightage in rural areas.

The three most important health related problems identified in the study districts are:

- (1) Absence of Lady doctor
- (2) Separate hospital in ward/village
- (3) Inadequate supply of drugs/medicine

Rural population has assigned more weightage to "Separate hospital in village" as this is the basic requirement and other problems are appended to it.

Table 5-42: Major Problems identified

Problem description	URBAN		RURAL		Total	
	N	%	N	%	N	%
Overall Problems						
Road Problem/Drainage/Culvert/Bridge/Bus Stop	3	23.1	34	42.5	37	39.8
Govt./Middle/High/Girls Primary School	3	23.1	21	26.3	24	25.8
Community Latrines/Hall/AWC/FPS/Housing Problems	5	38.5	19	23.8	24	25.8
Drinking Water/Irrigation/Drinking Water for cattle	7	53.8	55	68.8	62	66.7
Nothing/Marking of land by Revenue Dept./Harijan Problems	1	7.7	1	1.3	2	2.2
Employment problems	1	7.7	8	10.0	9	9.7
Health Problems/Veterinary			6	7.5	6	6.5
Light (Elec.)/Bank	2	15.4	11	13.8	13	14.0
Communication Problem	1	7.7	6	7.5	7	7.5
Total	13	100.0	80	100.0	93	100.0
Health Problems						
Separate hospital in ward/village	5	38.5	59	73.8	64	68.8
Lady doctor absent	7	53.8	53	66.3	60	64.5
Inadequate supply of drugs/medicine	4	30.8	34	42.5	38	40.9
No response	3	23.1	3	3.8	6	6.5
Lack of emergency/regular services	1	7.7	16	20.0	17	18.3
Inadequate medical shop			2	2.5	2	2.2
Poor health facilities	1	7.7	6	7.5	7	7.5
Lack of awareness on hygiene	1	7.7	1	1.3	2	2.2
Lack of equipment			1	1.3	1	1.1
Total	13	100.0	80	100.0	93	100.0

5.6 WOMEN'S GROUPS IN SAGAR DIVISION

5.6.1 Background

The issues of poverty alleviation and women's empowerment are oft-debated concepts in the realm of social sciences. The deliberations have logically assumed significant proportions in Madhya Pradesh, primarily owing to the fact that large section of her population remain entrenched far below the poverty line and gender disparities have become synonymous with underdevelopment.

The formation of self-help groups or Mahila Mandals among the marginalised populace, especially women, has been one of the most significant strategic options exercised in the state. These groups, be they economic groups or those having conglomerated as a response to a pressing social issue, are formed through various means.

Thrift and credit groups are financed, among others, through NABARD after the local banks assess the credit worthiness. The bank has also been financing economically gainful activities where money is meant to be used for purchasing productive assets.

Apart from NABARD, women's groups, which numerically are larger than the men's groups, have been receiving financial assistance from the Mahila Arthik Vikas Nigam of Madhya Pradesh. The assistance could be in terms of matching loan w.r.t. savings or for capital expenditure.

The mode of formation of such groups is usually through an external facilitator, viz. NGOs who are responsible for motivational activities, organization identification of activities and forward linkage support. The funds reaching the worthy SHGs are channeled through these committed organizations and they are perceived to be the most critical role players in the implementation process at the grassroots.

The Rajiv Gandhi Mission for Watershed Development is also another agency, which is involved in financing SHGs in the watershed areas. The SHGs functional in the watershed areas are confined to the small and marginal farmers and agriculture labourers. The rationale behind formation of these SHGs (some of which are exclusively for women) was that employment should be guaranteed for those underprivileged sections for a period of four years thanks to watershed activities.

It is the watershed committees, which decides on the list of group members and the type of activities that are later approved by the Gram Sabha. Usually the activities undertaken are production of agro-based or non agro-based products. While there is a provision of loans to be provided to the groups under the Mission, the role of the Govt. is to provide support in terms of training, exposure visits, marketing, etc.

Finally, another agency, which finances SHGs exclusively in the urban areas, is the UBSP programme under UNICEF. Community Development Societies, which are registered bodies, receive plans from Neighborhood Committees (prepared for the lowest units of slums) and gets it approved from DUDA. The SHGs, which are formed within each NHCs, are exclusively for women and a sum of Rs. 5000/- is provided per NHC by DUDA. According to UNICEF sources, only 3 towns, viz. Bhopal, Jabalpur and Rajnandangaon have shown significant progress in SHG formation under this scheme.

Keeping the above deliberation into consideration, it becomes quite apparent that the state as a whole has taken significant steps towards providing assistance to the marginalized sections of the society, especially women, and the various agencies involved have recognized the concept of SHGs/women groups as an effective instrument for addressing the issues of women's empowerment.

In this line JICA asked ORGCSR to conduct a survey among the women groups in the study area to assess their involvement level and the types of activities carried out by them. The main objective of conducting this survey is to identify community organizations, particularly women's organization, their activities and capacity. Accordingly, the survey tried to find out all the functioning women groups in the selected five districts of Sagar Division. In all 43 such groups were identified to be functioning in the selected communities in the study area.

Both Focus Group Discussion as well as canvassing of semi-structured questionnaire was undertaken among the members and office bearer of the groups to acquire first hand knowledge about the following issues:

- Genesis of the groups (how have they evolved)
- *Activities undertaken and identification procedure*
- Present strength of members and profile of members
- Frequency of meetings and attendance
- Modalities of functioning and regulatory systems, if any
- Role of promoting agencies and networking

- Present financial status and no. of beneficiaries
- Extent of assistance received from various sources (Govt. Non-Govt.), including finance, training, networking, marketing assistance, etc.
- Degrees of dependency on the facilitating organization and or collaboration with other local level institutions
- Problems faced and the needs of the members, etc.

5.6.2 Community Based Organization

During the community survey an effort was made to identify the presence of functioning community-based organizations in the selected communities. Table 5-43 reveals the presence of Community based Organisation (CBO) in the study area. It can be observed from the table that presence of CBO is more marked in case of the villages in comparison to the urban communities. The presence of a higher number of groups and community activities in the villages can be attributed to the homogeneous character of population and also social bonds within a particular community and among communities. Presence of Mahila and Kirtan Mandals is very prominent in the surveyed villages of the study area. However, presence of the NGO in the study area, both urban and rural, is almost negligible. Encouragement to NGOs for participation in the development process at the grassroots level is particularly important for the implementation of any development strategy in the study area.

Table 5-43: Distribution of Communities by the presence of CBOs

CBO types	Status	URBAN		RURAL		Total	
		N	%	N	%	N	%
Mahila Mandal	Yes	1	7.7	35	43.8	36	38.7
	NO	12	92.3	45	56.3	57	61.3
	Total	13	100.0	80	100.0	93	100.0
Youth Society	Yes			4	5.0	4	4.3
	NO	13	100.0	76	95.0	89	95.7
	Total	13	100.0	80	100.0	93	100.0
Nehru Yuva Kendra	Yes			4	5.0	4	4.3
	NO	13	100.0	76	95.0	89	95.7
	Total	13	100.0	80	100.0	93	100.0
NGO	No	13	100.0	80	100.0	93	100.0
	Total	13	100.0	80	100.0	93	100.0
Self Help Group	Yes			6	7.5	6	6.5
	NO	13	100.0	74	92.5	87	93.5
	Total	13	100.0	80	100.0	93	100.0
Kirtan Mandal	Yes	1	7.7	46	57.5	47	50.5
	NO	12	92.3	34	42.5	46	49.5
	Total	13	100.0	80	100.0	93	100.0
Others	Yes			2	2.5	2	2.2
	No	13	100.0	70	87.5	83	89.2
	No Response			8	10.0	8	8.6
	Total	13	100.0	80	100.0	93	100.0

5.6.3 Characteristics of the Women's Groups

The characteristics of the identified groups in the study area are presented in Table 5-44. It can be observed from the table that more than 90% of the groups are Mahila Mandals out of which only 16% of the groups formed as credit and thrift group i.e. SHG. Very few of them are formed exclusively to look into the health aspects of the community, especially women's and child's

health. There is also presence of other groups like kirtan mandals, cultural groups etc. in the study area.

As can be seen from the table below majority of the women groups are formed within the last 3 years and a third of them are 3 to 10 years old. Surprisingly more than a tenth of them are formed 10 years before, which is a good example of sustainability. From the discussion with the group members it was understood that while the older groups are initially formed as socio-cultural groups the most recent ones were formed due to the persuasion of either the AWW or the Panchayat representatives and were primarily started with the objectives of thrift and credit. All the 5 older groups were found in Damoh district. A higher proportion of groups in Sagar and Chhatrapur are of recent origin.

The registration status of these groups shows that only 30 per cent of them were formally registered under Societies Act. It can also be observed from the table that none of the groups in Tikamgarh are registered.

More than two-third of the groups were formed due to the initiatives taken by the AWW, while 21 percent of them were started due to the voluntary efforts made by the women in the villages and most of them were the groups formed earlier. Interestingly only 14 per cent of the groups had their own building. Ownership of building by the groups is higher for groups from Tikamgarh and Panna.

Table 5-44: Characteristics of the Women's groups

Characteristics		TIKAMGARH		DAMOH		SAGAR		CHHATRAPU R		PANNA		N	%
		N	%	N	%	N	%	N	%	N	%		
Type Of Group	Mahila Mandal	7	100.0	18	85.7	8	100.0	5	100.0	2	100.0	33	93.0
	Self-Help Group			3	14.3	3	37.5	1	20.0			7	16.0
	Women Health Group			1	4.8							1	2.3
	Others			2	9.5							2	4.7
	Total		7	100.0	21	100.0	8	100.0	5	100.0	2	100.0	43
Duration of Group formation	<1	1	14.3	4	19.0	2	25.0	1	20.0	-	-	8	18.6
	1 to 3 years	2	28.6	6	28.6	4	50.0	2	40.0	1	50.0	15	34.9
	4 yrs to 10 yrs.	4	57.1	6	28.6	2	25.0	2	40.0	1	50.0	15	34.9
	10 + years	-	-	5	23.8	-	-	-	-	-	-	5	11.6
Total		7	100.0	21	100.0	8	100.0	5	100.0	2	100.0	43	100.0
Is it registered ?	Yes			7	33.3	3	37.5	2	40.0	1	50.0	13	30.0
	No	7	100.0	14	66.7	5	62.5	3	60.0	1	50.0	30	70.0
Total		7	100.0	21	100.0	8	100.0	5	100.0	2	100.0	43	100.0
Who constitute d the group?	Anganwadi Worker	6	85.7	11	52.4	7	87.5	3	60.0	2	100.0	29	67.0
	Gram Panchayat			3	14.3	1	12.5	1	20.0			5	12.0
	Voluntary effort by willingness	1	14.3	7	33.3			1	20.0			9	21.0
Total		7	100.0	21	100.0	8	100.0	5	100.0	2	100.0	43	100.0
Do you have own building?	Yes	2	28.6	2	9.5	2	25.0					6	14.0
	No	5	71.4	19	90.5	6	75.0	5	100.0	2	100.0	37	86.0
Total		7	100.0	21	100.0	8	100.0	5	100.0	2	100.0	43	100.0

Table 5-45 gives the membership details of the women's groups in the study area. In the study area on an average a group had 15 members. The membership per group was being higher in case of Tikamgarh and Damoh and lowest in Sagar district. Nearly two-third of the groups studied was having a membership of 11 to 20 members.

Table 5-45: Membership details of the women groups

Membership details		TIKAMGARH	DAMOH	SAGAR	CHHATRAPUR	PANNA	Total	
Total members	<= 5	N	2				2	
		%	9.5				4.7	
6 to 10	N	2	4		2		8	
	%	9.5	50.0		40.0		18.6	
11 to 20	N	6	11	4	3	2	26	
	%	85.7	52.4	50.0	60.0	100.0	60.5	
20+	N	1.0	6				7	
	%	14.3	28.6				16.3	
Total	N	7	21	8	5	2	43	
	%	100.0	100.0	100.0	100.0	100.0	100.0	
Total no of members		Avg.	16.4	16.9	11.4	14.2	13	15.3

5.6.4 Profile of the Members

Within the broad fabrics of Sagar division, groups were seen functioning at various levels of socio-economic hierarchy. In the villages where women's groups were seen operating, memberships ranged from high castes & big landholding families to land less and lower caste. The general traits observed was that barring a few groups most of the groups are homogeneous in nature both from the caste composition and economic background point of view. The members even argued homogeneity is the key word for sustainability.

The caste composition of members of these groups showed that 45 per cent of the members belongs to the other backward castes and they dominate the groups in Sagar and Damoh. In Panna district nearly two-third of the members were from general castes or the upper castes. Scheduled Castes had a marked presence in Tikamgarh and Chhatarpur districts.

Table 5-46: Social background of Member

Caste categories	DISTRICT					Total
	TIKAMGARH	DAMOH	SAGAR	CHHATRAPUR	PANNA	
General caste members	33.9	24.0	14.3	36.6	61.5	27.2
SC members	31.3	10.7	15.4	43.7	30.8	19.3
ST members	13.9	9.9	1.1	-	-	7.9
OBC members	20.0	55.4	69.2	19.7	7.7	45.4
Other religious group member	0.9	-	-	-	-	0.2
No. of Total members	115	354	91	71	26	657

Economic background of the members showed that a majority of the members belong to the BPL category, proportion of BPL members being significantly high for Sagar and Chhatarpur districts. This when matched with caste composition of members rightly justifies that since a higher proportion of the members in these two districts belong to the SC and OBC categories that is the reason why a higher proportion of them are BPL.

Table 5-47: Economic background of Member

Economic status	DISTRICT					Total %
	TIKAMGARH %	DAMOH %	SAGAR %	CHHATRAPUR %	PANNA %	
APL MEMBERS	47.0	45.2	24.2	39.4	57.7	42.5
BPL MEMBERS	53.0	54.8	75.8	60.6	42.3	57.5
No. of Total members	115	354	91	71	26	657

Educational attainment of the members in Table 5-48 shows that 41 per cent of the members are illiterate and another 13 per cent are literate without formal education. 15 per cent of the members had education under various literacy programmes.

Table 5-48: Educational background of Members (in percentage)

Educational status	DISTRICT					Total
	TIKAMGARH	DAMOH	SAGAR	CHHATRAPUR	PANNA	
Total illiterate members	35.7	50.3	17.6	47.9	0.0	40.9
Total literate (but did not have any formal edu.) member	18.3	5.6	34.1	22.5	0.0	13.4
Total literate (got adult edu. Or literacy prog.) member	25.2	11.0	8.8	11.3	65.4	15.4
Total class 1-5 members	5.2	26.0	18.7	12.7	15.4	19.5
Total class 6-8 members	5.2	4.5	12.1	1.4	3.8	5.3
Total class 8-10 members	10.4	1.7	5.5	2.8	11.5	4.2
Total more than class 10 members	0.0	0.8	3.3	1.4	3.8	1.2
Total members	115	354	91	71	26	657

Age distribution of the members shows that majority of the members belong to the middle age group of 30-49 years of age. Majority members in Tikamgarh and Panna districts are younger in comparison to the other districts. More than one-fifth of the members in Damoh was aged above 49 years, which substantiated the fact that the groups in the district were very old.

Table 5-49: Age Range of Members

Age Groups	DISTRICT					Total
	TIKAMGARH	DAMOH	SAGAR	CHHATRAPUR	PANNA	
Below 30 years members	50.4	12.4	41.7	43.7	57.7	28.3
30-49 years members	40.9	66.4	53.8	53.5	34.6	57.5
Over 49 years members	8.7	21.2	4.4	2.8	7.7	14.2
No. of total members	115	354	91	71	26	657

5.6.5 Group Objectives

Usually in rural areas, women's groups are characterised by the absence of any form of specialization and all pertinent issues of the community are considered. Because of typically restrictive socio-economic realities being faced by the average rural women, they can hardly differentiate between social issues and money matters. As evidenced in one of the SHG study in Madhya Pradesh by ORG, the rural women are less adept in handling money on a group basis and this study also brought forward the requirement of some level of confidence building amongst the members so that they can handle and utilize the common funds. In fact this need to be made comfortable with the concept of pooling of resources. This is mainly because of the fact that the rural poor have historically had a poor experience of co-operatives or any other form of group activities, and an element of suspicion very much plays a role primarily due to a history of exploitation. The present study also identified this to be the main reason why very few of the

groups are practicing credit and thrift and most of them were formed with socio-cultural upliftment in mind.

In line with the same it was also observed in the study area that only a third of the groups were started with the objective of developing self-help group or to improve the economic condition of women through savings. A majority of the groups opined (Table 5-50) that the main objective of forming the group is to bring awareness among women on various socio-cultural issues. Surprisingly, a fifth of them informed that one of their objectives is to carry out religious activities in the community. Nearly 10 per cent these groups had the main objective of looking for the over all development of the village.

Table 5-50: Objectives of forming the Women's Groups

Objectives	TIKAMGARH	DAMOH	SAGAR	CHHATRAPUR	PANNA	Total
	%	%	%	%	%	
To improve the economic condition of women through saving	14.3	28.6	50.0	20.0		28.0
To preach religious activities		33.3			50.0	19.0
To bring awareness among women on various issues	100.0	57.1	50.0	60.0		61.0
To enable women to resolve problems related to health ,edu.		33.3		20.0	100.0	23.0
To developed self help group		9.5				4.7
To utilize the leisure time		4.8				2.3
For overall development of village	57.1					9.3
To provide employment to women			62.5			12.0
No. of total members	7	21	8	5	2	43

5.6.6 Criteria of Membership and Election

From Table 4.9 it can be observed that 30 per cent of the groups have no fixed criteria whatsoever for recruiting the members. 56 per cent opined membership is open only to literate, respectable and capable persons. Another one-third preferred active, adult and self-confident women to be members.

Two-third of the groups informed that new members showed their interest to be part of the group only because of the activities carried out by the groups. Nearly a fourth of the groups opined that generally the group members motivate others to join the group. Only 12 per cent opined that self-motivation is the only factor for the membership.

On asking regarding the procedures adapted to select the leaders a majority of the groups replied the leader is usually selected after the discussion among the members and another 12 per cent select their leader informally after arriving at a consensus. Surprisingly, 40 per cent of the groups informed that they generally select a person as leader, who should be knowledgeable, well behaved, known/respected and above all economically sound.

Table 5-51: Criteria for membership & election of head of Group

Criteria of Membership	TIKAMGARH %	DAMOH %	SAGAR %	CHHATRAPUR %	PANNA %	Total
No criteria	14.3	42.9	12.5	20.0	50.0	30.0
Only BPL family members are selected	14.3	4.8	12.5			7.0
Only literate, respectable & capable person selected	71.4	38.1	75.0	80.0	50.0	56.0
Active, adult & self-confident women are selected	57.1	42.9	12.5			33.0
Should be a citizen of India		4.8				2.3
One who pledge to abide by the rules & regulation of group		4.8				2.3
Total	7	21	8	5	2	43
Motivates to be Member						
No opinion/DK/CS/NR				20.0		2.3
Motivated by the members of group	57.1	19.0	12.5		50.0	23.0
Self motivated		4.8	25.0	40.0		12.0
Motivated by group activities (religious, health, saving etc.)	28.6	85.7	75.0	40.0	50.0	67.0
Motivated by Anganwadi Worker	14.3					2.3
Total	7	21	8	5	2	43
Elect Head of Group						
Do not elect head		9.5				4.7
Informal election/consensus		14.3	25.0	20.0		14.0
Knowledge., educated , Well behaved/known, respected & econ. Sound	42.9	28.6	50.0	80.0		40.0
After discuss with other members of group	57.1	52.4	50.0	40.0	100.0	54.0
Total	7	21	8	5	2	43

5.6.7 Financial Management and Functioning

As can be seen from table 4.10 more than three-fourth of the groups did not have an account in the bank. The main reason could be the informal kind of functioning of these groups and very few of them were practicing thrift and credit. Only in case of Sagar districts nearly two-third have an account as they were formed recently and most of them are thrift and credit groups. More than four-fifth were also not having the concept of membership fees mostly due to the reasons cited above and are mostly undertaking socio-cultural activities and not economic activities. In case of those groups that collect membership fees in a majority of cases the contributions were less than Rs. 50/-. Rightly very few of the groups actually received any loan from other organizations.

Table 5-52: Finance details of the groups

Financial details		TIKAMGARH	DAMOH	SAGAR	CHHATRAPUR	PANNA	Total
		%	%	%	%	%	
Is there a bank account in the name of group?	Yes		19.0	62.5	20.0		23.0
	No	100.0	81.0	37.5	80.0	100.0	77.0
	Total	7	21	8	5	2	43
Amount deposited in Bank A/c	< 10000		75.0	100.0	100.0		90.0
	10000-20000		25.0				10.0
	Total	-	4	5	1	-	10
Is there any system of membership fees?	Yes	28.6	9.5	25.0	40.0		19.0
	No	71.4	90.5	75.0	60.0	100.0	81.0
	Total	7	21	8	5	2	43
Whether fee is collected	Monthly	50.0	100.0	50.0	100.0		75.0
	One Time			50.0			13.0
	No Fix Timing	50.0					13.0
	Total	2	2	2	2	-	8
Amount of Membership Fees	< 50	50.0	100.0	100.0	100.0		88.0
	101-150	50.0					13.0
	Total	2	2	2	2	-	8
Have you received any contribution of loan from other orga?	Yes		4.8	12.5	20.0		7.0
	No	100.0	95.2	87.5	80.0	100.0	93.0
	Total	7	21	8	5	2	43

Table 5-53 presents the functioning of the groups. Nearly two-third of the groups has meetings at least once a month and another 14 per cent even hold meetings once a week. Very few of the groups actually reported irregularity in conducting the meeting. As reported, due to the absence of own building in most cases, meetings were mostly held in the AWC. Another 21 per cent of the groups hold the meeting any of the member's houses. It is encouraging to note that the in 72 per cent of the cases the minutes of the meetings were recorded and in majority cases the minutes were documented by the manager/president of the groups.

Table 5-53: Meetings & Recording

		TIKAMGA RH %	DAMOH %	SAGAR %	CHHATRAPUR %	PANNA %	Total
How often do the group have meetings?	Once a week	28.6	19.0				14.0
	Once a month	71.4	52.4	50.0	100.0	100.0	63.0
	As required		4.8	25.0			7.0
	Irregular		4.8	25.0			7.0
	Regular		19.0				9.3
Total		7	21	8	5	2	43
Where do you have a meeting?	Own building		4.8				2.3
	Any members house		28.6	37.5			21.0
	Panchayat building					50.0	2.3
	AWC	71.4	33.3	37.5	60.0	50.0	44.0
	Community hall		4.8		20.0		4.7
	Under tree	14.3					2.3
	Temple	14.3	23.8	25.0	20.0		21.0
Sub centre		4.8				2.3	
Total		7	21	8	5	2	43
Do you maintain the minutes of meetings?	Yes	100.0	52.4	87.5	100.0	50.0	72.0
	No		47.6	12.5		50.0	28.0
Total		7	21	8	5	2	43
Who documents the meetings?	Anganwadi worker		27.3	14.3	60.0	100.0	26.0
	Manager/president of group	85.7	72.7	71.4	40.0		68.0
	Other members of group	14.3		14.3			6.5
Total		7	11	7	5	1	31

Nearly a half of the groups were observed to be working in collaboration with other community level organization and govt. organization. While all the groups in Chhatarpur and Panna districts had a collaboration of some short none of the groups in Sagar were doing the same. The main collaborating agencies in this case were AWC (67%) and Gram Panchayat (29%). Few of them were also collaborating with the Sub-centres mainly to conduct various health programmes like immunization, eye camps, family planning camps etc.

Table 5-54: Collaboration with other village organization

		TIKAMGA RH %	DAMOH %	SAGAR %	CHHATR APUR %	PANNA %	Total
Do you have any collaboration with other vill. orga. ?	Yes	42.9	52.4		100.0	100.0	49.0
	No	57.1	47.6	100.0			51.0
	Total	7	21	8	5	2	43
Organization collaboration	AWC	33.3	63.6		80.0	100.0	67.0
	Sub-centre	33.3	18.2				14.0
	Gram Panchayat	66.7	27.3		20.0		29.0
	School	66.7	9.1				14.0
	Nehru Yuva Kendra		9.1		20.0		9.5
	Total	3	11	-	5	2	21
Kind of collaboration	Organize meeting		54.5		20.0	50.0	38.0
	Preparing agenda of meeting		54.5		60.0	50.0	48.0
	Providing understanding of subject concerned (health, edu. etc	100.0	18.2		20.0		29.0
	Donation				20.0		4.8
	Total	3	11	-	5	2	21

Regarding any type of training received by these groups 88 per cent of them replied in the negative. However, when they were asked whether they are interested to receive any training nearly two-thirds of the groups replied in the positive. Nearly four-fifth of those who were interested to receive any training showed their interest in getting training to start small business and another 46 per cent were interested to get training on any kind of income generating activities. Only a few of the groups were interested to get training on the ways to manage the group activities.

Table 5-55: Training need

Training needs and types of training		TIKAMG ARH %	DAMOH %	SAGAR %	CHHATR APUR %	PANNA %	Total
Does your organization receive any training?	Yes		14.3	12.5	20.0		12.0
	No	100.0	85.7	87.5	80.0	100.0	88.0
	Total	7	21	8	5	2	43
Do you need to receive more training program?	Yes	42.9	66.7	62.5	80.0	100.0	65.0
	No	57.1	33.3	37.5	20.0		35.0
	Total	7	21	8	5	2	43
Type of Training needed	Agriculture training	33.3	7.1				7.1
	Livestock training	33.3	7.1	20.0			11.0
	Training for starting new small business	66.7	85.7	80.0	100.0		79.0
	Cooking			20.0			3.6
	Making new income generating activities	33.3	42.9	20.0	75.0	100.0	46.0
	Managing group	33.3	7.1				7.1
	Total	3	14	5	4	2	28

An inquiry was made to have a first hand knowledge on the major concern and daily needs of the women during the discussion among the group members. It can be observed from the table

below that some of the major concerns of these women were child's education and health as well as their own health. Interestingly many of the group members also showed their concern and need with respect to various community level aspects like sanitation and drinking water problems. The groups belonging to all the districts particularly highlighted these concerns, which was especially more pronounced in Tikamgarh and Sagar.

Table 5-56: Major Concern in improvement of women life & daily needs

	TIKAMGA RH %	DAMOH %	SAGAR %	CHHATRAP UR %	PANNA %	Total %
Women's interest & Daily needs						
General income	57.1	57.1	62.5	60.0	50.0	58.0
Children's health	100.0	81.0	87.5	100.0	100.0	88.0
Children's education	100.0	71.4	75.0	100.0	100.0	81.0
Own health	85.7	85.7	87.5	60.0	100.0	84.0
Village sanitation	71.4	52.4	75.0	40.0		56.0
Village drinking water	14.3	14.3	37.5	20.0	50.0	21.0
Family issues	28.6	33.3	50.0	40.0	50.0	37.0
Legal awareness on women's status		4.8	12.5			4.7
Husband cooperation and understanding towards hh chore	14.3	4.8	12.5			7.0
Husband alcoholism				20.0		2.3
Family's happiness	28.6	61.9	25.0	40.0	50.0	47.0
Child's marriage		28.6		40.0	50.0	21.0
Total	7	21	8	5	2	43

Table 5-57 gives in detail the kind of problems faced by these groups in their day to day functioning and the suggestions to solve them. It can be observed from the table that a majority of the groups had no problem whatsoever in the day to day functioning. Both the 2 groups in Panna had some problems or other. Those groups who had any kind of problem reported lack of resources, instruments, building etc. as the major concern. A fifth of them also cited incapable leadership as a major concern and only for 16 per cent of the groups finance was a problem. To solve these problems the groups suggested supply of infrastructure, timely sanction of financial support and educating women on the thrift and credit activities as the important solutions.

Table 5-57: Problem faced to run the group

		TIKAMG ARH	DAMOH	SAGAR	CHHATR APUR	PANNA	Total
		%	%	%	%	%	
Do organization face any problem to run the group?	Yes	42.9	47.6	37.5	40.0	100.0	47.0
	No	57.1	52.4	62.5	60.0		54.0
Total		7	21	8	5	2	43
Type of problems faced	Financial crises		19.0	12.5	40.0		16.0
	Lack of resources, instruments, building, hand pump, latrine	100.0	57.1	25.0	60.0	50.0	58.0
	Women do not deposit money in thrift groups		14.3	37.5			14.0
	Incapable leadership		14.3	50.0	20.0	50.0	21.0
Total		7	21	8	5	2	43
Suggestion to solve problems	Timely sanction of loans/credit from financial inst./banks	14.3	33.3	37.5	20.0	100.0	33.0
	Supply of necessary equipment, instruments	100.0	57.1	25.0	80.0		58.0
	Educate women on objective of thrift group/saving groups	14.3	14.3	50.0	20.0		21.0
	Elect capable leadership		4.8				2.3
	Employment should be provided			12.5	20.0		4.7
Total		7	21	8	5	2	43