"Women's Access to and Utilisation of Reproductive Health Services in Bharharwand Khurd PHC: Dist Sawai Madhopur Rajasthan".

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirement for the award of the degree of

MASTER OF PHILOSOPHY

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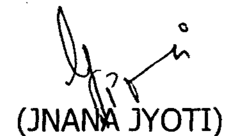
CERTIFICATE

This is to certify that this dissertation entitled "**Women's Access to and Utilisation of Reproductive Health Services in Bharharwand Khurd PHC, Dist Sawai Madhopur Rajasthan".** Is submitted in partial fulfillment of Six credits for the degree of Master of Philosophy of this University. This dissertation has not been submitted for any other degree of this university or any other university and is my original work.



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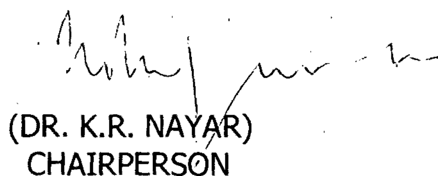

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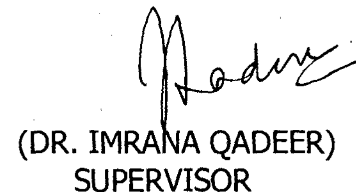

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Dedicated to

my loving parents

&

My Guru

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Introduction

The magnitude of women's reproductive health problem is immense in India. Women's major concern in terms of reproductive health needs have been largely neglected for years. It would be pertinent to note that the maternal mortality ratio in India is estimated fifty times higher than the developed countries. Health status of women in India is not merely associated with biological factors; rather it embodies a whole gamut of socio- economic factors often addressed by many scholars. Women in rural areas are more vulnerable to ill health due to many reasons. These are lack of food, poor living and working conditions, repeated child bearing and lack of access to health care. Socio-economic backwardness not only creates among women reproductive illnesses but also associated with lack of access to facilities.

Till date national and international organisation have been devising Programmes and Policies to intervene with the problem from time to time. Policies adopted by WHO, "Health for all by 2000 A.D." (The Alma Atta Declaration), UN conference on Population and Development Cairo and the Beijing conference on women's Health among them, aimed at dealing with the problems at national and international level. Accordingly, government of India took up the task to strengthen Reproductive Health. Agencies such as Primary Health Centre, Anganwadi Centre have been devised to cater basic health care at grass root level. Among these Primary Health Centre have been

envisaged as vital unit, to provide Reproductive Health services through which client based services are provided. Instead of repeated efforts made by the government, the women in the rural area remain deprive from services and lack this facilities owing to many reasons such as their poverty, poor quality of service or distances. Inefficiency and ineffectiveness doubled by non-availability of medicine, staff and prerequisite infrastructure at the Primary Health Centre level, determines accessibility and utilization of reproductive health services in rural area.

Problem like reproductive health is more associated with the socio-economic condition related to poverty, illiteracy, malnutrition etc, impoverish the living condition of women. Due to socio-cultural practices, traditional values, belief system and taboos, her problems of reproductive health and inaccess to services increase. For example, women in Indian society feed her husband and children first whatever little remains she takes herself; this determines maldistribution of food and leads to malnutrition of women. Health services available at the PHC do not consider women's unmet need and her socio-cultural and economic condition that leads to in access and non-utilisation or under utilisation of these services. These institutions blame women for their ignorance. Involvement of ANM in other economic activities and her disinterest in health of women is again another factor that leads to non-availability, many times in the moment of need.

The Present study seeks to address some of these issues that influences access to reproductive health services in Primary Health Centre specifically, and in Anganwadi's broadly. The study focuses on the factors such as economic, physical, socio-cultural factor and behavioural aspects. It explores the nature of service provisioning by PHC and factors responsible for determining access to reproductive health services among the women.

This exploration of access to services has been done within an economic framework. Thus, the study compares the users and non-users of Reproductive Health Services in different economic groups to see what is more critical, their socio-economic conditions or the services in the outcome of illness and child bearing.

The First chapter discusses studies and reviews earlier works and literature to understand the concept and definition of reproductive health. Besides the historical perspective on Reproductive Health in relation to India and west it examines Indian five-year plan and their influence on women's reproductive health.

In the second chapter conceptualization of the problem of accessibility and methodology related to the study are discussed.

The third chapter covers the study area, the primary health centre and its conditions of services.

The fourth chapter discusses the prime issue of access to and utilization of reproductive health service and case studies of women and conclusions from their experience are drawn. This chapter also

discusses the socio-economic conditions of the women and their reproductive health and the influence of socio-economic conditions on access to reproductive health.

The fifth chapter is the last and it summerises the conclusion.

Chapter I

Review of Literature

To understand the problem of access to Reproductive Health care (RHC) we need to understand the evolution of this concept and its contemporary understanding. We therefore divide the review in three sections.

1. Historical perspective: - In historical perspective we divide this section into two sections (i) the first section looks at the global situation of Reproductive Health (RH) and, and (ii) the second looks at specifically, the Indian context of Reproductive Health.
2. The concept of reproductive health.
3. The barriers to women's access to reproductive health service.

1.1 Global Context of Reproductive Health

In the eighteenth century, the thinker Thomas Malthus feared that overpopulation would deplete natural resources and result in overall scarcity and deprivation. He therefore showed an utter contempt for the poor and unemployed who were, for him, only a burden on society and the main cause of overpopulation. He further said that poverty and social discontent were attributed to the growth of population. The Neo-Malthusians proposed family planning as one of the strategies for economic development in the third world.

Women's movement however criticised and consistently opposed the population bomb hysteria. The Neo-Malthusian ideology diverts

attention from the unequal distribution of resources to the poor and criticizes their over breeding tendencies as the main cause of underdevelopment. Women's groups not only opposed the Neo-Malthusian views but also stressed on the need for birth control and family planning. This they pointed out, was to be in terms of women's choice and the right to decide the number of children women wanted as well as the method of contraception they liked to use.

Today the right of women to control their fertility is seen as a distinct and basic one in opposition to conservative and religious sentiments and campaigns. It distinguishes sex and sexual pleasure from procreation while most religions glorify motherhood as a natural, and necessary biological event in women's lives. The concept of reproductive freedom, which has become synonymous with rights or choices, has a universal and popular appeal and an easy acceptability within the women's movements. However, in eighteenth century, no one made the distinction between women's own need, their right to control their reproductive capacities, and population control.

In the late 1800s and early 1900s there were three separate movements for reproductive control. The Voluntary Mother-hood Campaign, the Neo-Malthusian League and the Emerging Eugenic Movement. Linda Gordon's (1976) book "Women's Body, Women's Rights" is a historical analysis of the birth control movement in the United States from the middle of the nineteenth century onwards. Mid- nineteenth century feminist movements emphasise on women's rights. The movement for birth control began as a campaign for social

purity and Voluntary Motherhood Campaign in the 1870s argued that willing mothers would be better wives and mother. Thus they believed in the right of women to choose when to become pregnant and how many children they could care for properly. Independent farmers, artisans and professional families, envisioning the restoration of stable pre-industrial family, advocated the Voluntary Motherhood Campaign. In 1918, the National Union of Women's Suffrage Societies in England expanded its objectives to include legislative reforms in various field like divorce and legitimacy and also pressed for both voluntary and public birth. (Fee, Elizabeth 1983).

On the other side of the Atlantic, Francies Place and Richard Carlie initiated the Neo-Malthusian birth control campaign in England during 1820s and 1830s calling for the need to educate and inform the poor masses on contraception and by writing pamphlets on birth control for the working class. (Quoted in Gupta J. 2000). In 1915 Emma Goldman and Margaret Sanger deliberately defied obscenity laws in the US by distributing pamphlets on birth control, and initiated the movement there. (Fee, Elizabeth 1983)

In India (Bhawan, N., 1993), some medical writers advocated birth control in 1928. With the support of many influential people, including high court judges, a Neo-Malthusian league was formed in Madras city. In 1923, Professor R.D. Karve opened the first family planning clinic in Poona. Although thanks to its enlightened Prime Minister, the native state of Mysore opened the first government clinic in Bangalore in 1930, it attracted few clients. In 1935 a society for the

study and promotion of family hygiene was formed in Bombay and at the same time the All India Women's Conference also advocated the adoption of voluntary birth control. The impact of these efforts was limited to very small sections of the population, but private interest in spreading family limitation culminated in the formation of the Family Planning Association of India in 1949. The Universal Human Rights was first ratified in the UN Charter of 1945 and UN Universal Declaration of Human Rights in 1948 affirmed equality among sexes as a basic principle.

In US, compulsory sterilization laws were common in the majority of states. As many as 45,000 people in US were sterilized between 1907 and 1945, and many of them were poor. In 1942, the American birth control league, under the leadership of Margaret Sanger changed its name to the Federation of Planned Parenthood, (PPF). After 1950s, various spacing methods came into existence in birth control pills and condom, which had a high side effect.

From 1960s onwards, western policy makers, particularly from the United States, were responsible for spreading the idea of over - population as the major problem of the world responsible for poverty and instability in the third world. The West was concerned about family planning and development of contraception's and its provision, without much concern about women's welfare. The influence of western policy makers was significant on Indian family planning.

Indian planners also adopted certain incentives and disincentives offered within the National Family Planning Programme.

Various Indian women's groups have played an important role in promoting Family Welfare programmes. For instance the Chhatisgarh Mahila Mukti Morcha has played an educative role on the need for birth control, the effects of repeated pregnancies on women and children, the different methods of contraception offered in the Family Planning Programme and their consequences. Chatra Yuva Sangharsh Vahini places considerable emphasis on the use of contraceptive method to avoid abortions and to plan families. Women's groups have reached out to women through exhibitions, slide shows, etc. and have been surprised to find women and men eager to discover what makes their body work. (Nandita Gandhi, N. Shah, 1991).

In the West, the women's movement took a strong decision on reproductive rights. At the International Women's Year conference in 1975 in Mexico, women spoke against the contraceptive research and services as human rights violation and were focused on the issue of the right to reproductive choice based on a notion of bodily integrity and control. This led to the CEDAW (Convention on the Elimination of all forms of Discrimination Against Women), ratified in 1979 which failed to specify a number of women's reproductive rights, except to affirm women's right to family planning information, counseling and services and to have equal right with men to decide on the number and spacing of their children (C. Sonia, 1994).

"The concept of reproductive rights was first formalized at the Women's International Tribunal and meeting on reproductive rights convened by the International Campaign on Abortion, Sterilisation

and Contraceptives in Amsterdam in July 1984 just before the World Population Conference in Mexico city. Its slogan was on population control. Number of women decided that the Amsterdam meeting should be considered the cradle of the international reproductive health and rights movement" (Garcia, Moreno 1994).

The concept of reproductive rights draws on the human rights' principle of freedom and entitlement. It also draws on the feminist principle of a woman's right to control her own body, that is, her right not to be alienated from sexual and reproductive capacity, and the right to the integrity of her physical person (Dixon Muller 1993).

Thus the issues of reproductive health/rights has been on the agenda of feminist movements across the world since the beginning of the twentieth century. Jyotsna Agnihotri Gupta,(2000) reviewing the development of reproductive rights and health argues the terms like population control, birth control, reproductive control or fertility control and family planning are inter-changeably used without regard to what, in her opinion, are fundamental differences in their meaning and implications, particularly for women (Gupta, 2001). Historically, the two most commonly used terms are – birth control, followed by family planning. Gupta uses Kate Young's definition for population and birth control. For her, population control is the emerging attempt to exercise number control by national government, international agencies and the church, over the family's right to make decisions about the desired number of children.

In the western context of women's movement, birth control is the right of women and men to make decisions about their reproductive capacities. Women have a prior claim to full exercise of control. Population control is achieved by 'population policy', which refers to measures at the broader level of a group, community or nation, while 'birth control' refers to measures at the individual level. Reproductive control of fertility control and regulation are more comprehensive terms, which include besides contraception, abortion and the prevention of infertility. Family Planning in its forbids the use of all artificial methods of contraception (Dixon Muller 1993). Furthermore, the term 'family planning' has come to be associated with a top down approach, suggested by the word planning. Also historically, it has been associated with state intervention and population control. The government programmes in some countries led to coercion disregarding, the wishes and rights of the women or men concerned. This trend was opposed by women's movements all over the world. Thus 'reproductive rights' as espoused by women's health movements were mainstreamed by the International Conference on Population and Development (ICPD) held at Cairo in 1994. The ICPD marked a turning point in the history of population-policy making and programmes. Lastly, the World Population plan of Action adopted at the ICPD in Cairo (1994) for the decade-shifted attention away from fertility and population growth rate to issues of gender equity, and women's reproductive rights and health. Thus, the reproductive health is now seen as a part of women's reproductive rights (Gupta J. 2000).

The emergence of reproductive health as an issue is evidence of a fundamental shift in the population, policy debate. It now incorporates a pledge to respect women's rights as a result of the efforts of the international women's movement for reproductive rights. Implicit in the various campaigns on women and health through this entire historical period was the beginnings of a dialogue and understanding of women, reproduction and choices.

1.2 : Women's Health in Five Year Plans:

Throughout the long history of health provisions in India, the planners primarily in the context of motherhood have perceived women's health. At the time of independence, there were important documents, which influenced the first Five Year Plan and its health planning. The first report was based on the recommendations of the National Health and Development Committee (1946), more commonly known as the Bhore Committee.

The Bhore Committee observed, "if the nation's health is to be built, the health programme should be developed on a foundation of preventive health work and such activities should proceed side by side with those concerned with the treatment of patients". The committee made certain important recommendation, which included:-

(a) Integration of preventive and curative services at all administrative levels.

(b) Development of Primary Health Centers (PHC) in two stages.

As a short-term measure, it was proposed that each Primary Health Center in the rural area should cater to a population of 40,000 and would be under a Secondary Heath Center. The Secondary Health Center was to serve as a supervisory, coordinating and referral institution for a set of Primary Health Centre. For each PHC, two medical officers, four Public Health nurses, one nurse, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen other class-four employees were recommended.

As a long term programme (also called the 3 million Plan) setting up Primary Health Units with 75-bed hospitals for a population of 10,000 to 20,000 and secondary units with 650-bed hospitals were recommended. These were to be under the 2,500 bed district hospital.

Maternal health was highlighted in the recommendations of the Bhore committee where the importance of primary health care unit was recognized and discussed. This was because the Bhore committee was concerned about the high incidents of morbidity and mortality among mothers and children. The recommended measures were directed towards a reduction in women's illnesses by setting a high priority on preventive promotives and curative care in health services development.

In the First Plan (1951-56); the health care services for women were mostly focused on Maternal and Child Health Care. There was also an effort to promote acceptance of Family Planning Programme.

The Second Plan (1956-61) focused on the importance of institutional facilities, specially the proposed Primary Health Units and training of manpower. In these plans, 2,100 Maternal and Child Welfare Centers became an integral part of the general health services in the rural areas with missionary and charitable institutions continuing to supplement the Extension projects of the Central Government.

1961 census revealed that population was growing at a very high pace. There was also a gap between knowledge of contraceptives, their high priority Programme, with the control of communicable disease. The Third Plan's (1961-66) emphasis was on preventive and curative aspects. Referral services for Maternal and Child Health were extended at the Primary Health Units. Orientation of the hospital staff engaged in maternal and child health work was also improved during this period, but the Bhore committee's recommendation of one woman doctor, four public health workers, four midwives and four trained Dais at the Primary Health Units covering 20,000 population, was never achieved.

In 1956 a committee was set up called Mudaliar Committee. The committee was appointed to survey the progress made in the field of health since the submission of the Bhore Committee Report and to make recommendations for future development and expansion of health service. During this time Auxiliary Nurse Midwife were responsible for both MCH and family planning work among rural

women while family planning health assistants were doing family planning advocacy among men.' In the meanwhile, Chaddha Committee report of 1963 proposed that the Vertical Malaria programme be integrated into General Health Services and basic health workers, each serving a population of 10,000 should be trained by using malaria workers. In 1965 however, the Mukherjee Committee put an end to this integration and declared that the serial Family Planning Programme must be separate.

Thus the Third plan witnessed attempt at integration of the services for family planning, control of communicable diseases and MCH at the Primary Health Centre level. However, it was not successful.

From 1966 – 69 there were annual plans. The Fourth Five Year Plan (1969-74) focused on a clear shift from a health and welfare programme to one of population control. Also, initiatives to improve the health and nutritional status of women and children were undertaken. The major initiatives to tackle malnutrition and its adverse consequences in women and children were; -

- The massive dose of Vitamin – A: this programme aimed at prevention of nutritional blindness;
- The anemia prophylaxis programme aimed at reducing anemia and associated ill health;

With the improvement in basic health care, the infrastructure of health care improved. The Kartar 'Singh Committee in 1974 – 75 proposed the Multipurpose Worker Scheme.

With the improvement in primary health care infrastructure, access to health care improved and the Family Planning Programme assumed top priority. Following the 1971 census that showed marked increase in population, sterilization, Intra Uterine Device and Condoms were available through hospital based post-partum programme, which, had provided contraceptive service to women having delivered in hospitals. The Medical Terminate Pregnancy Act 1971 was also implemented to enable women deal with unwanted pregnancies and obtain safe abortion service.

In the Fifth Plan (1974-79), the Maternal and Child Health Services were paid considerable attention. The plan launched a Minimum Needs Programme with the aim of meeting the needs of the package. It provided elements of health, Family Planning, nutrition, environmental improvement and water supply apart from elementary adult education etc. in rural area. In keeping with the people oriented strategies of the new government, the programme of Community Health Volunteers (CHV) was added to the PHC to make service more meaningful for the community. Also, and the 'Dai' training programme was reinforced to support the Maternal and Child Health programme.

The Sixth Plan (1980-85) also made provisions for a minimum needs package which was to be provided to all and included health employment, housing etc. In 1980, two additional programmes were added. First the Integrated Child Development Scheme and then the programme to provide comprehensive Primary Heath care based on The Alma Ata Declaration. The government of India attempted to restrict its services. However Western Critics quickly stifled these initiatives. They saw Primary Health Care as cost ineffective. The WHO and UNICEF launched a package of Selective Primary Health Care, where child survival, safe motherhood and immunization were seen as cost effective strategies. It was assumed that maternal and infant mortality declines will influence fertility and population growth. Maternity health was completely taken over by population control by this time. Despite all the efforts maternal mortality remained stagnant (Krishna Suman**) and infant mortality was still high despite relative decline. This was the time when the concept of Reproductive Heath evolved and claimed to broaden the maternity health concept (Pachauri, 1995). Towards the end of the 1980s, the Indian Government adopted the World Bank's strategy of structural adjustment of the economy, which called for cuts in social sector spending and opening up of the economy to foreign investment.

Towards the end of the Seventh Plan (1985-90) the government and the health ministry officials began to acknowledge that the massive Family Planning Programme had been a failure. From 1985 onwards, there was more emphasis on the status of women. In

accordance with the pressure the mother and child health goals were set in the National Health Policy of 1983. A Universal Immunization Programme (UIP) for infants and pregnant women was launched to reduce infant and child mortality and maternal mortality in September 1989.

In the Eight Plan (1992-97) population control was one of the most important objectives. Facing severe criticism from progressive sections and women's group as well as international agencies on the emphasis on the programme on female contraception and sterilization and the neglect of health, the government adopted the Reproductive Health approach. But this was merely a putting the old wine of Family Planning into a new bottle.

The Ninth Plan further consolidated the Reproductive Community Health approach. It incorporated child survival and safe motherhood strategies with an expanded focus on sexually transmitted diseases, reproductive tract infections (RTI's), fertility regulating method, maternal and child health and reproductive health services for both men and women. In addition Panchayati Raj institutions were to play a key role in providing Reproductive Health Services.

1.2 The Concept Of Reproductive Health (RH)

Health is defined in the W.H.O. constitution as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity". International Conference on

Population and Development (ICPD) defined reproductive health as, "it implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so". This definition paved a pathway for planners and policy makers to understand the linkages of Reproductive Health. Implicit in this definition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. They have the choice of adopting methods for regulation of fertility, which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Fathatlla points out that reproductive health has the following basic elements: (Fathatlla, 1988).

(a) That people have ability to reproduce as well as to regulate their fertility.

(b) That women are able to go through pregnancy and childbirth safely,'

(c) The outcome of pregnancy is successful in terms of maternal and infant survival and well being. In addition, the couple should be able to have sexual relations free of the fear of pregnancy and contracting disease.

For women it is based on the principle that every woman has a right to reproductive health, that is, to regulate her fertility safely and effectively, to remain free of disease (sexually transmitted diseases and reproductive tract infections), disability or death associated with her sexuality and reproduction, and to safely bear and raise healthy children. Reproductive health also refers to a woman's ability to understand and enjoy her own sexuality by gaining knowledge of her own body, her sexual capacities, and her sexual rights. Reproductive and sexual health are thus indissolubly linked (Dixon, Muller 1993).

On the other hand some international women's groups have stated, "Reproductive Health is not known and never has been, simply a matter of preventing disease. This is because women's ability to bear children is linked to the continuity of families, clans and social groups; the control of property, the interaction between human communities and their environment; the relationship between men and women; and the expression of sexuality. It is therefore a valuable currency in every society and the object of regulation by families, religious institutions and governmental authorities" (Ravindran 1998).

Pachouri argues that the reproductive health approach extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during various stages of the life cycles. In addressing the needs of women and men, such an approach places an emphasis on developing

programmes that enables clients to make informed choices such as receiving screening, counseling service and education for responsible and healthy sexuality, access to services for preventing unwanted pregnancy, safe abortion, maternity care and child survival, and for the prevention and management of reproductive morbidity. Thus, reproductive health programmes are concerned with a set of specific health problems, identifiable clusters of client group, and distinctive goal and strategies (Pachauri. S., 1994).

While the reproductive health strategy spread its net wide to include women who are not just mothers, their widening is not accompanied by additional investment. Besides, it focuses on a narrow aspect of their lives, that is, their reproductive health. In doing so, it de-links all other influences on their health and dismembers them into different body system. Ideally a gender sensitive strategy needs to reach women and girls of all ages and not just with regard to their reproductive systems but with regard to the way they live their lives in all its complexity (Qadeer 1998).

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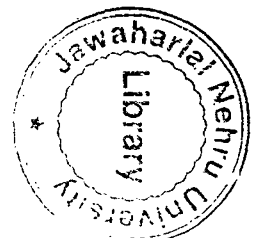
Qadeer further argues that the concept of reproductive health and reproductive rights evolved largely among the western women's movement. The context and the major concerns of women of India are somewhat different. It has been argued that in projecting the issues of reproductive health and rights as women's central concern across the world, the varying social contexts of women from different countries



with differing life situation have been obliterated in favour of an artificial, meaningless homogeneity (Qadeer 1996).

1.3 The Barriers to Women's Access to Reproductive Health Care

Women have health needs but not all of these receive medical attention. The various studies, which show the accessibility of reproductive health services, focus on the socio-cultural and economic factors as reasons for not accessing Reproductive Health Services (RHS).

A household study of women's morbidity and utilization in a moderately developed district of Maharashtra shows that 43% women in rural areas neglect treatment. This trend was highest between the ages 18 years and 45 years, and among those who bore the double burden of productive and reproductive labour in both urban and rural area. The findings were that lack of finance was a major reason for non-utilization; Largely, women tended to leave untreated conditions that were chronic but not incapacitating like mental worries, reproductive problems, weakness and aches and pains. The level of non utilization among women was as high as 50% to 80%. The reasons cited were that either the medical care would have no impact on illness or the illness was not serious enough to warrant medical care (Madhiwalla 1998). In another study of the treatment of reproductive morbidity, it is shown that women are particularly susceptible to invisibility because of feeling of "shame and guilt". Studies focusing on reproductive morbidity, both self reported and

clinically verified show even higher levels of untreated ailments. Women below the age of 35 years belonging to different socio-economic group in rural Karnataka reported levels of untreated reproductive morbidity that ranged from 44% to 57% (Bhatia and Cleland 1995).

Thus the purchasing power of the individual and the household determines the level of utilization of health care services. During illness women may pay no attention to their own health due to the priority they give for the care of the others in the family. Sometimes, there may be denial of access to health care providers overtly or covertly. The many subtle and obvious layers of discrimination that may operate in households thus complicate the access of women to health care.

Utilization of health care is determined by factors like affordability, time, work, distance traveled and faith in the abilities of the health provider. In 1993, women approached public health facilities in larger numbers in poorer states like Orissa and Rajasthan (Sundar 1995). The study of a group of rural women in a drought prone area of Maharashtra, for instance, spoke of distance and time in terms of the money they would have to pay for transport on loss of wage, (Gupta et al 1997). The loss of time was significant as long waiting hours in queues, especially in public health institution and inconvenient timings resulted in loss of wage or in disruptions of household chores and childcare.

Affordability and cost of treatment are extremely crucial in determining women's access to health care and especially so in the case of poor women. The availability of finance is linked not only to utilization of private facilities but also to the use of public facilities. Women, in particular, would use public facilities more, if these were not so severely dysfunctional. There would be expenses even to access health care in public hospitals. In a study, (Sundar 1995) "expenditure on medicine and doctors fees", generally formed a sizeable chunk of total expenditure even in those states that show very high levels of public sector utilization for patient care. Their findings are that women and men tended to depend on public hospitals where costs were significantly lower. In 1993, more than 60% of the men and women using hospital facilities went to public hospitals. 100% utilization of public hospital facilities were found in rural West Bengal, rural Himachal Pradesh as well as rural and urban Assam and urban Rajasthan.

Significantly fewer women went to hospital. Expenditure incurred on the treatment of women tended to be lower than that incurred on the males in that household despite greater morbidity amongst women. Except in the case of acute illnesses, their difference was significant for all categories of illnesses treated in and outside of hospital environment in 1993. Thus these studies show that there is an inadequate budget allocation for health care to women, which severely restricts health care facilities and aggravates women's health

problems. The Primary Health Care (PHC) services and their quality also determine the status of women's' reproductive health.

A study of the Indian Council of Medical Research (ICMR, 1989), covering 198 Primary Health Care centres and an equal number of subcentres spread over 15 states on the quality of maternal and child health and family planning services provided by them, reveals a fairly depressing picture. For example, in about half the Primary Health Centre over 60% of the pregnant women were not registered with Auxiliary Nurse Midwifes. Similarly, in about two-thirds of the Primary Health Centres, over 60% of the women were not protected against tetanus, while in half of the PHC centers, 60% or more pregnant women were not provided with iron and folic acid (IFA) tablets.

These studies reviewed also say that it takes lengthy procedures, involves a loss of time and wages for the women to access reproductive health care. Added to this is the insensitive and brusque attitude of hospital staff, which, instead of soothing patients, tends to aggravate their anxiety. And then there are arrangements, that women have to make for household chores to be taken care of, which also acts as a deterrent. In Rakku's story (Sheila Zurbrigs, 1984) illustrates how many obstacles operate in poor women's lives to prevent their reaching out to the available health services (1984).

ICMR conducted an evaluation study in 398 PHC from 199 districts in 18 states and one union territory during 1987-89. It focused on the quality of family welfare services at PHC level. It

observed that resources in terms of physical facilities were comparatively satisfactory at Primary Health Centre but not in Sub-Centres which is the first contact point for the community.

Thus Indian Council for Medical Research study (1999) reveals that the quality of health care administered by the Auxiliary Nurse Midwife in the field indicated that the coverage of ante-natal care was inadequate: where the services were provided these were limited to administration of tetanus toxoid and distribution of iron/folic acid tablets. Recording of births and deaths essential for monitoring and delivery of care was not being carried out. This was reflected by the total absence of records in one-third of Primary Health Centre and in others it was grossly deficient. The quality of services related to family planning was better than the Maternal and Child Health component in terms of coverage and follow up care. However, the outreach of family planning services both for spacing and terminal methods required substantial improvement.

Multi-indicator cluster survey (MICS, 1999) and Neo-natal lanes survey in the selected districts – Jaipur, Dausa, Bikaner, Bundi, Jalore, Chittorgarh, Bhilwara, Banswara and Sawai Madhopur – was conducted to monitor the progress towards the goals set for survival, protection and development of children and women with special emphasis on health, education, nutrition and family planning practices. It has shown that one-fourth of pregnant women were not immunized with tetanus toxoid, and only 17% have institutional

delivery. One-third children were fully immunized. The incidence of neo-natal tetanus was 2.4 per thousand live births.

In other studies such as the rapid household survey of 1999 on "Reproductive and child health in Rajasthan; Phase – II", conducted in 15 district of Rajasthan by the Ministry of Health and Family Welfare Government of India, New Delhi 1999, important insights are offered. In that Ante-natal Care coverage was about 52% and coverage with tetanus toxoid was only 40% with two doses.

Baseline study for districts in Rajasthan under the Canadian grant in 1999 is a benchmark survey. It was conducted in the selected blocks of Barmer, Jaisalmer, Sawai Madhopur, Karauli districts. Neemkathana block of Sikar was also taken into account. The study aimed to provide nutritional status availability and utilization pattern of supplementary nutrition and, prevalence of iron deficiency anemia among children less than 6 years of age and pregnant women. Prevalence of low birth weight, regularity of supply and consumption of Iron Folic Acid tablet by children under six year of age and pregnant women, regularity of supply of vitamin-A mega doses and de-worming tablets among children under six years of age were assessed.

Some of the salient findings of study are as follows. More than 90% of women and children were found to be anemic, between 23-53% women received one of the ANC services where as between 23-57% of the women during their current and last pregnancy received Tetanus Toxied 1; supplementary nutrition was received by 7-14%

women during their current and last pregnancy where as about 6-10% women received supplementary nutrition during their last lactation period.

Indian Institute of Population Science (IIPS, 1994) studies on delivery show that, institutional deliveries attended by trained personnel remains low. About one-fourth of deliveries in India occur in a public institution. The majority of deliveries (74%) take place without health facilities; around 35% are attended by Dais and some 30% by the other persons such as a female relative or neighbours. The proportion of deliveries attended by doctors is particularly low in states like Rajasthan (11%).

However, in India, still a large number of deliveries take place at home with meager medical attention. In 1994, trained personnel like doctors, nurses and Dais attended to only 28% of all deliveries in India (Registrar General of India, 1997), and out of these the Dai attended most of these deliveries.

The major problem for obtaining professional help in rural areas is the absence of women doctors and other women health personnel apart from the cultural beliefs. Census (1981) figures show that a mere 4% of all practicing doctors in rural areas were women. The proportion of qualified and practicing obstetrician and gynecologists would be even more insignificant. In a study (Gupta, 1988) major constraints related to the fact that the Primary Health Centre were at some distance away, involved travel, food as well as paying for a

companion, an amount that could be as high as Rs.300-500. Thus delivery at home is not because the couple wants it that way, but because there are no other affordable alternatives.

Iyer and Jesani (1995) says that Auxiliary Nurse Midwifes are unable to make any significant dent in the face of a general sense of insecurity brought on by poor training, a vulnerable social position together with poor professional supervision and infrastructure. Due to lack of support from the Primary Health Centre and from institutions beyond, Dais and relatives have continued to be midwives in a majority cases. There are also socio-cultural beliefs and a host of fears also contrive to keep women away from institutions. This is particularly evident among women residing in North India. For example women migrants from Uttar Pradesh who reside in a slum in Delhi feared that they would be forcibly sterilized after the delivery. Alternatively, with the prevailing obsession for a male child, women suspect that if a male child is born to them, it could be exchanged for a female child born to another women to escape victimization by her family (Iyer, Jesani, 1995).

According to National Family Health Survey; phase I carried out in 1992-93 (IIPS 1995), sterilization is the predominant contraceptive method in use. It accounts for 96% of all users. Women were aware of at least one method of contraception, and knowledge of female sterilization was highest while that of the non-terminal methods was much lower.

According to Mavalankar, (1993) women do not use contraceptives before their first child, since it defeats the very purpose of marriage. There are greater pressures to get pregnant quickly. Further, with the high value placed on a male child, contraception use would be limited if the first child were female. A related concern is that of child survival – especially survival of the male child. Women choose to wait for their sons to grow up before adopting any method of contraception. (International Institute for Population Sciences, 2000) Rapid household survey Phase–1,1998. On "Utilisation of Government Health Facilities" gives a picture on home visit of health workers. This shows the percentage of eligible women from rural areas that were visited by government health workers during the period of three months prior to that survey, by the category of health worker and selected background characteristics of the women. About 19 percent of the rural women reported that government health workers visited them at their residence at least once in the past three months. Of these, in 94 percent of cases Auxiliary Nurse Midwife made the visit.

Chapter II

Methodology

This chapter is divided into two sections. Section 1 conceptualization of the problem of accessibility and Section II, Methodology related to the study are discussed.

2.1 Conceptualization: -

Rural areas in our country are characterized by poor condition of health status along with socio-economic backwardness of a large majority. Health service as a need of the citizens in rural area has not been appropriately covered by the state health services due to many factors. For example, concentration of specialised, curative health care services is higher in urban area than in rural area. Even the little health services that are available in privately owned clinics of rural areas give emphasis on exclusively curative services. Private Hospital ignores the public health care services and focus on curative health care service and excessive use of new technology of health care. This becomes very costly. It does not suit the socio-economic condition in our society.

Publicly owned hospital and Primary Health Centre network that cater health service on preventive and promotive in nature are weak and inadequate. Thus access has been a crucial issue. It needs to be addressed for the sake of the poor and lower sections. These economic and social groups have lower access to health care services comparatively in both private and government hospitals more so in private sector.

To cater health care services three tier system of health care has been operationalised. The community Health Centre at block level, Primary Health Centre at Intermediary level and sub centre at grass root level in the village. Primary Health Centre as intermediary units provide first level institutionalized care on Community Health Centre the first level referral care. Reproductive Health Services are being provided by the primary Health Centres, encompasses all component of reproductive health services like antenatal care, postnatal, neonatal care and various sexuality transmitted disease and also health education for adolescent girls and family planning.

This study focus on women's access and utilization of reproductive health in rural area. There are several factor that influences accessibility and utilization of women's reproductive health services as shown by over review of literature These are broadly categorized as physical, economic and socio-cultural, organizational and treatment. The physical factors, which indicate distances, transportation, time spent for appointment with doctor and medication, non-availability of medicine and staff, long distance of hospitals and Primary Health Centre create need of transportation. In rural areas facilities of transportation is not easily available. One has to travel around 2-20KM on an average to avail and access the services, and stand in a long queue are another problem. Hence time spent for appointment and working hours of Primary Health Service do not suite women. There is shortage of medicine. So, people have to purchase it from outside. Auxiliary Nurse Midwife provides from

Primary Health Service is often inadequate. Due to these reason Primary Health Centre services suffer from under utilization.

Economic factors include level of household income and cost born for treatment. Accessibility in terms of ability and capacity to pay for health care services thus becomes another key factor. Lower income group is hardly in a position to afford the cost of treatment from privately owned health care services. So purchasing power influence access and utilization of services provided as very often the Primary Health Centre doctor also prefer patients to come to their private clinic. Economic factor also influence poor families by limiting their ability to travel. Women and female children's access to care is relatively more affected as they have a secondary status.

Socio cultural factor denotes social stratification such as caste and socio-cultural practices like values, belief system etc. These influence access to reproductive health. All women especially women belonging to lower social group have least access to health care. The health personal belonging to upper social groups in terms of reproductive health ignores them.

Non-availability of female doctors also reduces the accessibility to reproductive health services, as women do not prefer to visit Primary Health Centre and see male doctor. Belief systems in term of family planning, child as gift of god, and women being constitutionally prone to weakness affects access. Even women have some traditional beliefs that diseases are created by evil sprits.

Due to early marriage women are more prone to reproductive health problem but values like *purdah* system and traditional families women cannot communicate their reproductive health problem to other. That again influences access to reproductive health services. Generally women do not perceive reproductive health as important health problems due to lack of knowledge about it. Quality of health care provided by Primary Health Centre has been perceived as very low, so the women has different attitudes towards the Primary Health Centre services. These social factors influence women and lead to their not accessing the reproductive health services.

In addition quality of services, attitude of health personnel especially doctors and nurses has a lot to do with access. Our study then proposes to explore all these physical, economic and soci0-cultural and health service quality factors. We discuss in the next section the design of the study. Our objective is "to explore the problems of access to Reproductive Health Care for rural women in Rajasthan".

2.2 Research Design

The areas chosen for the study is Khandar Block. It is situated in the eastern part of Sawai Madhopur District. In this block the village chosen for the study is Bharharwand Village, which is situated 18 Km. From Block head officer Khandar village.

Source Of Data

The data was collected from primary sources through interview of 60 women and secondary source from annual reports and records of Primary Health Centre were collected.

Selection Of Household

The Reproductive & Child Health Services were being provided through the Primary Health Centre as well as the Anganwadi Centre. At the Primary Health Centre only user were registered. However at the Anganwadi there were many registered, as Anganwadi workers have an outreach programme. They go to household and register all pregnant and lactating mothers. However, not all of these women came to the centre. Therefore, Anganwadi register has been used for selecting households with women who use the services as well as those who did not use the services.

The register list of one Anganwadi was taken out of which 30 users and 30 non-users were chosen. No attempt was made to take representative sample. As it was an exploratory study, women who co-operated and agreed to give their time for the researcher, were chosen.

To have an in-depth understanding to the problem in utilization of services, a schedule was used and applied. It was open-ended. Questions were asked and women permitted to answer in their own style.

Selection Of Health Personnel

As the study also gives emphasis on Primary Health Centre functionaries such as doctor, Auxiliary Nurse Midwife, Lady Health Visitor and Anganwadi Worker, were selected for interviews to understand the problem related to functioning and implementation of the Primary Health Centre Anganwadi Worker.

Tools Of Data Collection

For collection of data semi structured open- ended interview schedule was provided to the selected women in the household. Auxiliary Nurse Midwife, Lady Health Visitor and Doctor were also studied through questionnaire. The questionnaires consist for questions pertaining to the variables related to the issue of access. Besides these, non-participations observation and case studies were used to gather qualitative information regarding women's utilization of reproductive health services. Social life, health problem, deaths, child birth, condition of PHC, shelter characterisation of villages along with their day to day life.

Data Collected

The nature of data collected, which related to the study are as follows:

- **Socio-Demographic Data:** This includes information regarding family composition, household income, occupation, religion, social group (caste), education of the household samples and

health functionary (Doctor, Lady Health Visitor, Auxiliary Nurse Midwife).

- **Re-productive Health Problem:** This includes questions related to women's reproductive health delivery, nutrition and problem such as Sexually Transmitted Infection, (STI), Reproductive Tract Infection (RTI), and problems like back ache, other gynecological disserves, infertility and family planning.
- **Health Infrastructure:** This includes physical infrastructure such as PHC building, laboratory, instruments and availability of medicine.
- **Utilization of PHC:** This includes availability and utilization of a primary health services and women's view towards it. Information related to quality of services as perceived by women.
- Problem related to reproductive Health Services delivery was also collected from Auxiliary Nurse Midwife and Primary Health Centre doctor. Experience and perception about PHC services was supported through case studies.

Process Of Data Collection

The researcher- visited daily, before starting the main work the effort was made to get to know people in different sections and explain the purpose of the study. Rapport was also developed with health workers. The PHC and Anganwadi Centre were visited and one Anganwadi Centre was selected for consulting the registered.

Data Analysis

The quantitative data was coded and analysised and then integrated with qualitative information particularly those collected. The interview with health professionals were used to assess the quality of work at primary health centre.

Limitations Of Study

Given the time constraints and the language problem it was not possible to have a larger number of women for the study or cover more primary health centre. This limits the study, as the variations cannot be adequately captured. Also, the study is only exploratory in nature and qualitative, representative sampling was attenuated.

Chapter III

Community Profile

मानचित्र पंचायत समिति खण्डार

जिला- सवाईमाधोपुर (राज०)

पैमाना - NTS

पंचायत समिति सवाई माधोपुर

District Profile

District Sawai Madhopur lies in the Eastern part of Rajasthan. It is bounded on the West and North-West by Tonk and Dausa, on the North and East by Karauli, on the South-East river Chambal forms a natural boundary with Morena district of Madhya Pradesh, and on the South it is bounded by Kota and Bundi districts. In 1996, when Dausa district was created out of Jaipur, Mahwa block was transferred from Sawai Madhopur. So, instead of 10, now the district has only 5 Community Development Blocks. The 1991 census figures represent the undivided district. According to it, the population of the district was 2 million with 25 per cent tribal population, and a growth of 27 per cent over 1981-91. The population density of the district was 186 persons per square km with around 15 per cent urban population. Sex ratio in the district was 857 females per 1000 males. The literacy rate in the district was 36 and female literacy was merely 15.

Of the 1614 inhabited villages in undivided Sawai Madhopur, 26 per cent had post and telegraph facilities, 21 per cent had communication facility, and 57 per cent and had power supply. According to the 1991 census, there were 5 colleges and 1299 schools, of which 90 were higher secondary/secondary schools. The district at present has 5 hospitals (including the District Hospital) and 22 Primary Health Centre.

Demography Of District

The density of population in the district stood at 186 people per sq. km. The sex ratio indicated that there are 854 females per 1000 males, which is lower than the state average of 910 females per 1000 males.

The literacy rate was 36.27%, which is higher than the state average of 38.55% among females and was relatively lower than the state average of 20.44% the same was 54.6% amongst males. According to the 1991 census report the percentage of scheduled caste population among the total population was 21.87%, while that of scheduled tribe amounted to 22.59%. Rapid household survey of 1998 gives data on marriage, birth, infant death and morbidity in the household surveyed. The mean age of marriage for boys and girls married since January 1995 in rural areas shows that 61% girls in rural areas and 46% in urban areas married before attaining the age of 18 years, which is below the minimum legal age at marriage.

The birth rate for Sawai Madhopur district during the reference period was 35 per 1000 population. The figure for rural areas is 36.9. The rural fertility is higher. The percentage of births was also higher in rural areas. There were 22 infant deaths, which comprised of 21 deaths from rural areas. 14 of them occurred during the neo-natal period. Out of 22 infant deaths 8 infants were reported to have died due to tetanus in rural area of Sawai Madhopur.

Bharharwand Khurd village profile

Bharharwand Khurd is located about 14 km; from the district headquarter in Khandar block of Sawai Madhopur district in Rajasthan. It is located in a remote area of 1023.09 hectors. It consists of a population of 3929; population of this area consists of 1392 schedule caste and 10 schedule tribes, a higher concentration of schedule caste. To portray the profile of Bharharwand Khurd some aspects such as demography, economic, socio-cultural, geographical infrastructure etc. have been considered and are given below.

Economic Aspects of Bharharwand Khurd:

Economy is a considered as the backbone of every society. Bharharwand Khurd being a village, the economic activities of the people are basically agricultural along with other trade and commercial activities. People belonging to OBC are involved basically in agriculture culture and people belonging to SC and ST are basically involved in informal occupation such as contribution labour, sanitation etc. They are also involved in other occupations that have been identified as cultivation, manufacturing, agricuiture processing, construction, transport, communication, cattle hoarding and rearing etc. Majority of the male members are engaged in these economic activities. Women have lesser contribution due to domestic work at the household level. There are around 1077 male workers against 452 female workers as per the 1991 census. According to the 1991 census there were 100 workers, who engaged in cultivation, about 64 male

workers and 36 females. It is very interesting that in construction work 16 male and 6 female workers are involved. Trade and commerce has 126 males & 51 females and transportation and commerce involves 7 males without female participation. Other services consist of 121 male 7 female. Additional marginal workers include only 491, female and non-workers 1049 males and 1160 females.

Socio-Cultural Background

Being a particularly male dominated society the health status of women is strongly influenced by the socio-cultural factors, which includes cultural practices of marriage, level of education, strong preference for son etc. Due to the prevailing norms and attitudes of society regarding their needs and capital. These attitudes influence the provision and utilization of preventive and curative healthcare facilities, including maternal care services.

The socio-cultural norms that particularly affect women's health are attitudes to education, marriage, age of marriage, fertility rate, sex of the child, the pattern of family organization, the place of women in the family and its importance, and the expected role of the women which influences the utilisation of reproductive health services.

The level of education among women in rural areas is lower than urban areas revealed by the census. There are 336 literate women in the population of 1803 women in Bherwanda Kurd village. The main reason for not accessing education is early marriage. Rajasthan is famous for child marriage. In Bharharwand Kurd child

marriage takes place in a group, every year in the months of March and April till the 26th. It is called as "Akhatiyi". It is the custom that the girl is taken from her natal home to live with her husband after puberty. They are dominated not only by the men they have married but also by their in laws especially the older females who force women to have children. After marriage childbirth continues to be a social norm because of strong preference for son. After marriage, a woman lives under the pressure of her mother-in-law and generally has little or no autonomy or voice in decision-making even regarding her own fertility. Women have to follow physical seclusion or purdah system to cover their faces from elders.

This is because, the village society, daughters are generally considered a net liability, they often require dowry for marriage. This results in strong preference for sons. Sons are valued for their labour in the family farm and as a support for their parents during old age. As in Hindu tradition, sons perform sacred final funeral rites of the parents they are valued. Besides this, son is considered as an heir to the property, for which the female child is not considered in the patriarchal structure of Bharharwand Khurd.

In the most extreme form their preference leads to female infanticide and sex-selective-abortion. The preference for son is apparent in the relative neglect of female children who receive smaller quantities of nutritive food and are given less medical care and education. Their inequitable treatment continues till adult hood.

Where women eat after men even during pregnancy then diet is inadequate.

Isolation and limited freedom in regards to education and marriage contribute to this dependence and restricts their access to Reproductive health services.

Further it is observed that risks of pregnancy and childbirth are considered to be natural processes that do not require special attention. Women's poor general wealth further complicates the situation of pregnancy.

Bharharwand Khurd PHC (Primary Health Centre)

The PHC was established in 1982 in Bharharwand Khurd. It is 14 kms from the main Community Heath Centre (CHC) Khandar Block. The PHC covers seven sub centres (villages) and the villages are covered by subscentres varying from seven to eight km. 32 villages are covered by this PHC and the population covered by the 1991 census is 28.495 in these 32 villages. The population of only Bharharwand Khurd consists of 3929 according 1991 census.

The PHC work depends on its various facilities like manpower physical infrastructure, equipment and supply of medicines, Reproductive health services. We describe these here:

Manpower

Bharharwand Khurd PHC has one medical officer and no specialist doctor like Gynecologists. The paramedical staff consists of

only one LHV (Lady Health Visitor) and eight Auxiliary Nurse Midwife (Auxiliary nurse midwife). In the last one-year there were only 3 Auxiliary Nurse Midwife who were the working, rest of them was on maternity leave. Female doctor's post is sanctioned but the post has been vacant since 1982 till now. The PHC has one compounder and one lab technician.

In Bharharwand Khurd PHC it has been observed that resources in terms of physical facilities were not comparatively satisfactory. The labour room and operation theatre at the Primary Health Centre, essential for delivery and quality of family welfare services were poorly equipped and maintained. This PHC has only 6 beds and only two are with blankets and mattresses. The IUD room and routine blood testing is available. However, these are rarely used.

As for the status regarding the equipments and supply of medicine, it has been observed that X-ray machine is not available in PHC. The Autoclave and steam steriliser are available. For MTP, suction aspirator is not available. The maintenance of cold chain was not satisfactory as availability of transport-facilities and water and electricity were not satisfactory. There is no regular electricity and no generator is available.

It is observed that PHC is expected to have kit A (essential drugs supplied to the subcentre). However, medicine and emergency drugs like cortico steriods and intra venous fluids were often not there in the

PHC. Nutritional supplements were also inadequate in supply both at Primary Health Centre and subcentre.

According to Alma-Ata declaration. eight essential components of primary health care service have been outlined. They are as follows:

- Medical care
- Maternal and child heath including family planning
- Safe water supply and basis sanitation
- Productive and control of locally endemic disease.
- Collection and reporting of vital statistics.
- Health Education through information and educational activities.
- National health programme as relevant.
- Referral services.
- Training of health guides, health workers

Out of this service PHC provides only medical care, maternal and child health including family planning, prevention and control of locally endemic diseases. National health programme undertaken were those for immunization, tuberculosis control and Malaria.

Reproductive Health Services

Bharharwand Khurd Primary Health Centre covers a population of around 28,495 in 32 villages according to the 1991 census. There are about 3929 people in the village Bharharwand Khurd where PHC is located. This PHC has been providing reproductive and child health

service since 1997 in the villages. The reproductive health services provided by this PHC are maternal care, natal care; postnatal care MTP, RTI/STI treatment, Family Planning service and distribution of fuel tablets. The level of performance and utilization of reproductive health services have been far from the expected. Since there is a lack of official record due to non-maintenance of information in the Primary Health Centre, it was not possible to get full hospital record data the level of service delivery and utilisation has been discussed below.

There were total 867 ANC cases registered in 1998, 891 ANC cases in 1999 and 830 cases in 2000 the total number of ANC cases registered has declined since 1999 to 2000. There is no information regarding number of high-risk pregnancy. Number of TT doses administered during pregnancy was found around 867 in 1998, 810 in 1999 and 721 in 2000. It is evident from this data that there was decline in the number of TT doses administered. Thus indicates that were of those the women who didn't want to visit PHC for the ANC were increasing. This could be due to lack of information and knowledge about the importance of ANC of poor services.

The number of pregnant women treated for anemia was 434 in 1998, 405 in 1999 and 930 cases in 2000. It is apparent from the official data that the anemia treatment has increased. This may be caused by the prevalence and occurrence of anemia. According to the doctors. We however, found that if the women are provided with IFA

tablet from the PHC they did not take it, insisted they threw it away without using it. This has been causing low birth weight, high incidence of anemia and other obstetric problems.

Natal care is determined by number of home deliveries administered by birth attendants. It was reported that there were 826 home deliveries in 1998, which reduced to 770 in 1999; this shows that number of home deliveries is reducing. Auxiliary Nurse Midwife and an untrained birth attendant conduct usually home delivery. However as we see later the stuff is towards private institutional delivery and not in the PHC.

Women of Bharharwand Khurd

As we have seen in the over all profile the women mostly are engaged in household work. Only the jat women whose families own land and work themselves, go to the fields to help their men. Other backward castes do not exist in the village. Between the SC's and ST's, both women work at home and in the field. They work as daily wagers and earn about Rs.20 a day.

Thus women bear the double burden of work inside as well as out side the house. Yet the men take the major decisions and women only comply. Now some families are sending girl children to school but literacy among women is not prevalent. In the next chapter we explore some details of their lives.

Chapter IV

Reproductive Health Services :

Women Experiences

This chapter is divided into two sections. Section I examines socio economic background of women, and the distribution of childbirth, death and Reproductive Health services. Section II presents some case studies on reproductive experiences of women and their access to services.

The sixty women who were studied by the researcher were aged between 15-45 yrs. They came from schedule caste schedule tribes, other backward classes, and general caste. None of these women could be said to belong to rich household, as the maximum income of the household was 2000Rs. In this chapter we present some socio-economic features and distribution of births, deaths, reproductive illness, causes of death, and utilization patterns of reproductive health.

Level Of Income Among The Respondent

Table No. 4.1: Income levels of users of non-users

	USER	NON-USER
Level of Income		
500-1000	10	10
%	33.3%	33.3%
1001-1500	16	20
%	53.3 %	66.66%
1501-2000	4	-
%	13.3%	-
Total	30	30

Earlier it was mentioned that the study attempts to compare the differences of groups that chose utilization or non-utilization of health

services. The table 4.1 portrays the level of income of both user and non-user taken for the study. Among the 60 women's, 30 were users and 30 were non-users, each shows almost similar levels of income expect that users have 13% in highest income groups as against income in non-users. Among the user it was observed that the majority of the respondent about 53.3% belong to income category of 1001-1500Rs. and 13.13% belong to the category of 1501-2000 Rs.33.3% belong to the category of Rs.500-1000 in both cases, where as for the non-user highest, that is 66.6%, belong to income category of 1001- 1500.

To assess the accessibility and utilization pattern it is very important to see the level of income between the two different groups. From the table 4.1 it is evident that there is only a marginal economic difference between the two groups where the users of Reproductive Health Services have 4 women in highest income group.

Caste background of women

Table No. 4.2: Caste and income among users & non-users.

Income / Category	**Users**				**Non- users**			
	500: 1000	1001- 1500	1501- 2000	**Total**	500: 1000	1001- 1500	1501- 2000	**Total**
SC/ ST	8	10	1	19	6	15	-	21
%	80%	62.5%	25%	63.3%	60%	75%	-	70%
OBC	1	5	2	8	3	4	-	7
%	10%	31%	50%	26.6%	30%	20%	-	23.3%
General	1	1	1	3	1	1	-	2
%	10%	6.25%	25%	10%	10%	5%	-	6.6%
Total	10	16	4	30	10	20	-	30

The women covered in this study basically belong to different social groups are Scheduled Caste (SC), Scheduled Tribe (ST), Other Backward Classes (OBC) and General Category. Above table shows

income wise distribution of women from different social groups between users and non-users. It was found that majority of women belongs to lower social and lower income group. This section is economically poor, cannot afford the cost of living along with health care.

Table 4.2, shows that in both groups, users & non-users SC / ST are primarily located in the poorer income groups whereas the OBC families increase in proportions as we more from poorer to better off groups. It is pertinent to note that as incomes increase the table shows that the proportion of general caste increases from 10% in 500-1000 to 25% in 1501- 2000. Thus caste classes are linked as in well known.

Age at Marriage

Out of the 60 women 15 women were 15- 20 years of age, 23 women were 20-35 years old and 22 women were between 35 to 45 years old.

Table No: 4.3: Age at Marriage in different income groups among the user and non- users

Income / **age at marriage**	**Users**				**Non- users**			
	500: 1000	1001- 1500	1501- 2000	**Total**	500: 1000	1001- 1500	1501- 2000	**Total**
6-11	6	9	2	17	5	14	-	19
%	60%	56.25%	50%	56.6%	50%	70%	-	63.3%
12-16	3	5	1	9	5	6	-	11
%	30.0	31.25%	25%	30.0%	50%	30%	-	36.6%
17.21	1	2	1	4	-	-	-	
%	10%	12.5%	25%	13.3	-	-	-	
Total	10	16	4	30	10	20	-	30

(% is taken for columns)

Age at marriage has tremendous impact on reproductive health of women. It was observed that quite a majority of women got married in early age of their life. Age of marriage that is 6-11 years seem to have the highest percentage of women in both the user and non-users. Early marriage have got highest chances of fertility and repeated pregnancy. Due to repeated pregnancy during a women's life span, she becomes vulnerable to ill health condition. Table 4.3 shows that, the age group of 6-11 years in both users and non-users account for highest number of marriage in contrast, to age group of 17-21 years shows lowest percentage of women. Among users there were 4 such women and among non-users none. The very reason behind this is traditional practice of child marriage locally known as "Akayati' where a group of child are married usually between March and April every year.

Another reason is that female child is considered a burden in the family in terms of money and morale. Absences of upper income category among non-users make analysis difficult, as there is no difference in age of marriage across income groups. Actually marriages in 6-11 years old actually increase among non-users from 50 to 70% but in users they decrease 12 in proportions with increasing incomes. However, the numbers are small to say this statistically.

Place of Delivery

Table No. 4.4: Income wise place of delivery among the users and non-users.

Income / Delivery place	Users				Non- users			
	500: 1000	1001-1500	1501-2000	**Total**	500: 1000	1001-1500	1501-2000	**Total**
Institutional delivery	2	3	0	5	10	2		12
%	20	18.75%	50%	16.7	100	10		40
Home delivery	8	13	4	25	0	18		18
%	800	81.25	100.0	83.3	0	90%		60
Total	10	16	4	30	10	20		30

(% is taken for vertical group)

Place of delivery is a crucial factor to influence reproductive health of a women. Majority of the deliveries have done at home rather than health care institutions. Place of delivery is determined by the awareness about care that needs to be taken and economic aspect. Institutional delivery means delivery done at a private health care institution or public institution such as Primary Health Centre, sub center under supervisor of trained attendant or doctor. Shy nature and high cost of delivery discouraged women to go for institutional delivery. Traditional practices of delivery offer them security due to non-availability of women doctor in Primary Health Centre. Women preferred home delivery conducted by Auxiliary Nurse Midwife, Lady Health Visitor (LHV), traditional Dai and relatives. It was observed that

most of the deliveries done at home were in the lower income groups (Table 4.4).

Non-institutional deliveries were conducted with the help of traditional both attendants, family members and the only exception was the middle income group of non-users where all 10 went for institutional delivery. In this case however they accessed private institutions. It is quite interesting that women belonging to upper income group show no institutional delivery among the non-users. It can be analysed that besides economic aspects there are other aspects such as customary practice, traditional belief non-availability of female doctor in Primary Health Centre inconvenient time schedule and lack of transportation. These determine place of delivery. Data provided in table 4.4 be only suggestive due to the small numbers yet, the notable happening is that the place of delivery has not significant difference in terms of users and non-users.

What is peculiar is that despite the non-users having no women in high-income group the proportion going to private is high.

Death of Children

Table No. 4.5: Age wise death among children in various income group of uses and non-users.

Income / Mortality / Women	500: 1000	1001-1500	1501-2000	Total	500: 1000	1001-1500	1501-2000	Total
0-6 months	2	5	-	7	3	5	-	8
%	33.3%	50%		43.75%	50%	71.4%		61.5%
7 to 13 month	1	2	-	3	2	-	-	2
%	16.6%	20%		18.75	33.3%			15.3%
13 and above	3	3	-	6	1	2	-	3
%	50.6%	30%		37.7%	16.6%	2.85%		23%
Total death	6	10	-	16	6	7	-	13
No of women	10	16	4	30	10	20	0	30

When we look the women's experiences of child death, we find that the local experience of death of children for the women in the same for the very poor and the middle income groups among users and non-users. For examples, 10 women each in lowest income group lost 6 children in each group and 16 and 20 women in middle-income groups. Lost 10 and 7 children respectively (62% and 60%). However when we look at age group, we find that the non-user cost 50% of children when they were 6 months or less in age. For user the loss of

children in this age group was 33.3% the in fact cost more children 13 and above (24%). This may be due to the ANC, PNC that the user gets. Deaths among children over one year are primary due to environmental causes and Reproductive Health Services cannot change them.

Table No. 4.6: Income wise reason for child death among users & non users.

	Users			Non users		
Income / Reason	500-1000	1001-1500	1501-2000	500-1000	1001-1500	1501-2000
Delivery related	4	6	-	-	6	-
%	66.6%	60%			54.5%	
Unidentified Disease	1	1	-	1	1	-
%	16.6%	10%		50%	9.09%	
Fever	1	3	-	1	4	-
%	16.6%	30%		50%	36.36%	
Total	6	10	-	2	11	-

% are for the column

In both group of user and non-users majority death occurred was delivery related causes. The second most important cause was fever. While among non-users – 50% and 36.36% of death in the first two incomes group due to fever. Among the users it was 60% and 30%

for poor and middle-income groups. This again indicates poor delivery services and lack of child care services. Specially control of communicable diseases. Most of these fever death perceived to be due to very high fever it could be malaria seucephlitis, and typhoid according to health.

PHC Service Utilization

Table No. 4.7: Income wise service utilization among the users

Income	500: 1000	1001-1500	1501-2000
ANC	2	4	1
%	20%	25%	25%
PNC	2	3	1
%	20%	18.75%	25%
FP	4	6	2
%	40%	25%	50%
TT	1	1	-
%	10%	12%	-
RTI	1	1	-
%	10%	1.6%	-
Total	10	16	4

(% is taken for column)

Utilization of services was studied only for the users and we found that low and middle-income group largely used services. As

table 4.7shows that there is not much difference in the proposition of women utilising the range of services given in the table. It is evident, however that the maximum, utilization in all income group was off Family Planning services, ANC, PNC was utilized by only 20% women and T.T were not taken by more than 12% by the women. This funding questions our previous assumption that lower infant mortality among 10 women in lower union group was probably due to these services. However, when we check four specific we found that the death were not from among them.

Reason For Not Using PHC

Table No. 4.8: reasons for not using PHC among the users & non-users in different income groups.

	Users			Non users		
Income / Reason	500-1000	1001-1500	1501-2000	500-1000	1001-1500	1501-2000
Distance	-	-	-	1	4	-
%	-	-	-	10%	20%	-
Long queue	-	-	-	3	4	-
%	-	-	-	30%	20%	-
Non availability medicine	4	3	-	-	4	-
%	40%	18.75%	-	-	-	-
Change money	2	4	2	-	-	-
%	20%	25%	50%	-	-	-
Ineffective treatment	4	9	2	-	-	-
%	40%	56.25%	50%	-	-	-
Shyness	-	-	-	6	8	-
%	-	-	-	-60%	40%	-
Total	**10**	**16**	**4**	**10**	**20**	**-**

(% is taken for vertical group)

In rural areas PHC are expected to provide primary health care services along with reproductive health services. In view of this the

woman respondents were asked why they did not prefer to visit Primary Health Centre. The reasons for not visiting Primary Health Centre are distance, long queue, and non-availability of medicine, charges money, ineffective treatment, and shyness. Among users and non-users the reason for not visiting Primary Health Centre are not always similar. Users though they visited once or more then once to Primary Health Centre for services, they reported reason for not visiting Primary Health Centre as non -availability of medicine, charges money and ineffective treatment. Nonusers however, distance, non-availability of medicine, and inability to talk a male doctor.

Eleven women complained that Primary Health Centre doesn't provide medicine, they were asked to purchase it form outside. Moreover whatever medicine they provided were ineffective considered low quality by the women. It was found that whatever services Primary Health Centre provides such as ANC, PNC women showed disinterest in availing these service, they considered it unimportant. Women are also charged money around twenty rupees for check up and thirty rupees for injection. About 20% in the lower, 25% in the middle and 50% in the upper income group of women reported that charges discourage them from visiting Primary Health Centre (table 4.8). They complained that if they had to pay for service in government hospital like Primary Health Centre it would better to go for private clinic where quick and immediate care can be availed.

The above table 4.6 shows the reasons primarily responsible for death among children. These are, delivery related, fever, and other unidentified disease. It has been observed that majority of the death among infants and economically poor women among the users and non-users of Primary Health Centre report children. In both group of user and non-users majority death occurred was delivery related causes. The second most important cause was few. While among non users- 50% and 36.36% of death in the first him income gray due to few. Among the users if was 60% and 30% for poor and middle unions groups. This again indicate poor delivery services and lack of wild case services specially condors of communication disease. Most of these fewer death preserved to be due to high fever it could be malaria seucephlitis, and typhoid according to health.

Availability Of Medicine

Table No. 4.9: Income wise availability and procurement of medicine among users and non-users

	Users				Non users			
Income	**500: 1000**	**1001-1500**	**1501-2000**	**Total**	**500: 1000**	**1001-1500**	**1501-2000**	**Total**
PHC	4	7	-	11	-	-	-	-
%	40%	43%	-	36.6	-	-	-	
Chemist	6	9	4	19	8	14	-	22
%	60%	57%	100%	63.4	80%	70%	-	73.3
No response	-	-	-		2	6	-	8
%	-	-	-		20%	30%	-	26.6
Total	10	16	4	30	10	20	0	30

(Percentage is taken for vertical group)

Examining the procurement of medicines, we find that both uses as well as non-user in the poor income and middle-income groups take help of the chemist when in need of medicine. The non-user of Reproductive Health Service does so more often then to users (Table No. 4.9).

Also the among the non-user 8 women (26.6%) did not respondent to the questions. Primary Health Centre as a source of medicines was reported only 11 women were lower and middle-income group (40% & 43% respectively in each group).

This data shows the degree of popularity of private source of medicines and indicates that perhaps the Primary Health Centre doesn't have adequate store of medicine to provide to women. This is

reflected by the fact that women complained that medicines are not readily available in the Primary Health Centre and medicine supplied to PHC are sold out to chemists through which they can earn commission along with net profit. Women felt that medicine procured from Primary Health Centre are not effective. Moreover they are always asked to purchase it form outside the Primary Health Centre.

Thus, we see that major proportion of poor depend upon the chemist. However, in the income group of Rs.1501-2000 all four women (100%) said that they went to the chemist our data shows that even the poor were forced to go the private, as they had perhaps no other option.

Reproductive Health Problem

Table No. 4.10: Income wise distribution of reproductive health problems among users and non-users

	Users				Non users			
Income / R H	500: 1000	1001- 1500	1501- 2000	Total	500: 1000	1001- 1500	1501- 2000	Total
Menstrual Problem	2	2	2	6	2	7	-	9
%	20%	12.5%	50%	20%	20%	35%	-	30%
UTI	1	3	-	4	1	4	-	5
%	10%	18.7%	0	13.3%	10%	20%	-	16.6%
White Discharge	5	8	2	15	6	7	-	13
%	50%	50%	50%	50%	60%	35.0%	-	43.3%
UTI / WD	2	3	-	5	1	2	-	3
%	20%	18.7%	0	16.6%	10%	10%	-	10%
Total	10	16	4	30	10	20	-	30
	100%	100%	100%		100%	100%		

(Percentage is taken for vertical group)

Our data on Reproductive Heath problem among user and non-users of Reproductive Health care shows that when we compared the column percentage of different groups, the prevalence of problems between user and non-users is not very different for eg.. for both users and non-users of the lowest income group have 20% women each who suffers from menstrual problems, 10% each suffering from UTI & 50% & 60% suffering from white discharge (table No.4.10). Only the group of women reporting both white discharge & urinary tract infections was doubled among users compared to non-user. This cannot be

explained on the bases of services, but it is perhaps due to very small number that we have in this group.

The middle-income group also does not show much difference, through most problem are the slightly higher in the non-users. The lowest propositions of reproductive health problem were in the highest income group. Again table 4.10 find that services don't make much difference as far as reproductive health is concerned white discharge is the most common problem.

4.2 Case Studies

Case: 1

Kamala aged 38, got married at the age of 13yrs to Haribalwa who works as a teacher in senior secondary school at Bharwanda Khurd. She did not go to school, because in her village, there was no school. To attend school she had to go to another village which was situated 14 Km away from her residence. Kamala has been staying for 15 years in B.K. village after her marriage. She is a mother of five children's (three sons and two daughters). All the male children's are going to school but her daughters are not going, because they help their mother in household work. Out of five children one child died at the time of birth, the child's head was in a breach position, so the nurse could not tackle the situation properly. There was a lot of delay and the child was taken out forcibly from the womb, and was found to be dead. Inspite of the high risk of this delivery the Auxiliary Nurse Midwife did not insist that she be taken to the hospital or the

community health centre, which is 14km away from Bharharwand Khurd. The Primary Health Centre has not got any lady doctor. The doctor was available at the Primary Health Centre at that time. But the doctor was not called nor was the women sent to Primary Health Centre. The nurse was scared to say she was not able to handle the case. With the consent of the husband, Kamala after her 5th child under went laproscopic operation for family planning. The Auxiliary Nurse Midwife persuaded her. After the operation, she started suffering form health problems like feeling of weakness, white discharge, gastric problems where she cannot have food. So she went to a private hospital, she spent Rs.200 for medicine and consultant's fees per visit. But she was not satisfied with the treatment, which she received from there. She complained that the medicines given to her were not effective. So she stopped going to the private hospital and now she does not want to visit public hospital. The reason being the non-availability of medicine, no female doctor to discuss freely, long waiting for getting checkup and for medicine. The utility pattern of health care services that Kamala uses are as follows: for minor illness, she goes to the registered medical practitioner in the village, for major illness she goes to the district headquarter to a privately owned hospital. She prefers to go to the Primary Health Centre if it would provide effective medicine with proper treatment.

Case: 2

Santra age 24, got married at the age of 13 yrs to murari who works as a cultivator in another field. Santra and her husband are staying for 8 years in the village. Santra has three children (daughters). Santra want to have a son. She becomes pregnant for the fourth time. The auxiliary nurse midwife in her field visit met Santra and noticed that she appeared to be very weak and her eyes were pale. She advised her to go to the primary Health centre for check up. But Santra did not go to the primary health centre. Santra's husband stopped her from visiting the clinic, since she had already had three normal deliveries and the children were born healthy at home. He said that there was no need to rush to the doctor this time. Santra said that her husband has a negative feeling towards the Primary Health Centre, because the doctor takes money for every visit, does not examine properly, and does not provide medicine. When the researcher went and asked her husband about not taking Santra to Primary Health Centre though she is suffering form weakness, he replied that such changes were to be expected due to her aging and did not expect his wife to get younger. Santra became severely anemic after her delivery at home and had to be put on oxygen and given blood transfusion in the community health centre. Even now she is weak and does not go to the hospital.

Case: 3

Karla age 25 yrs got married to Kanya at the age of 8yrs and was brought to her husband place after her puberty. Her husband is an agriculturist and belongs to the Jats who come under OBC. She had not gone to school earlier, Karla has two children and her first child died during birth at home the Dai had done the delivery. During the Auxiliary Nurse Midwife field visit the Auxiliary Nurse Midwife took her to the hospital where she was diagnosed as a problem of anemic. The doctor examined her, and advised her to go to the hospital for regular checkups as well as for her delivery. She did not go to the hospital regularly for checkups or for her delivery. Karla said that she couldn't go to the hospital alone, she wanted her husband go with her to Primary Health Centre for the checkup. Her husband did not show any interest and he did not have time. Finally she delivered a premature baby at home and died. The baby survived for a few more days and also died.

Case: 4

Rukumani aged 36 years old, she got married at the age of 8 years and was brought to her husbands place after her puberty. She did not go to school; she belongs to SCs category like in Kathik community. Her husband Prasad, works as a construction labour that brought them earning 900 Rs. per month. Rukumani family is staying for 20 years in Bharwanda Khurd. She is mother of 6 children (3 sons and 3 daughters). Out of these 6 children, two children i.e one eldest

daughter and middle son died. The eldest daughter died due to typhoid at the age of 1 year. As she was having high fever, Rukumani took her to registered medical practitioner near to her house. She paid Rs. 10 consultant fee with medicine but it was not effective. She could not take her to the hospital (Primary Health Centre) because she said there will be a long queue and extra money will have to be paid. The second son died within a week of birth. He was weak. As they believed that bad evils (Mata) come inside this child, in that situation she felt going to the hospital would be a waste. Instead she performed puja and practiced religious rituals to get rid of that evil. Rukumani said that generally pregnancies are not planned and she and her husband wanted sons because a son is future security to look after the family and a heir to property. Her husband is also concerned to have control over the family size. Though neither she nor her husband have knowledge about family planning. Later she opted with the advice of Auxiliary Nurse Midwife. Laproscopic method of sterilization for family planning with her husband knowledge.

Case: 5

Rambha age 38 got married and so did not go to school. She got married to Mahawar, who does white washing in the local area. She belongs to Katik community. She stays in a mud house and is the mother of 5 children i.e. 3 daughter and 2 sons. No children are going to school. Dhais assisted all the deliveries. She did not take the tetanus injection from the Primary Health Centre as anti natal care.

Rambha and her husband wanted to control their family size. Once Rambha went for temporary contraception like pills. It did not work and she was pregnant again. As she was not knowing the correct method to take pills. She took the contraceptive pills from the Anganwadi worker. At last she went for permanent method with advice of Anganwadi worker. After the operation she started having lots of reproductive problems like continuous bleeding. It starts every 15 days and continues for a week. Due to this she went to a public hospital for check up. The Primary Health Centre doctor gave medicines. She took it but it was not helpful. Again Rambha went to a private hospital and spent Rs.500. It was also not helpful. She is so tensed that who ever comes to ask about in health problems, she usually tells that please give me medicine for stopping the bleeding.

Case: 6

Draupadi is aged 43 she got married at the age of 13 years with Shanker who sells vegetables in Behrawanda Khurd. She belongs to Kathik community (SC). She did not go to school because her parents did not send her to school. She is the mother of 5 children (3 daughters and one son). All the children were born at home and the Dai did the delivery. She was not taken to the hospital for delivery because of economic condition of the family. She said there would be lots of expenditure on delivery. So they paid Rs.500 to Rs.600 to the Dai to get each delivery done. She was suffering from white discharge and itching for many years but she could not recollect when exactly it

began Durpadi went to the Primary Health Centre to show to doctor. She was given medicine but she did not like the medicine because she needed a "deshi dawai". Durpadi did not take the medicine properly she did not visit the Primary Health Centre second time because she felt shy. There was no female doctors to discuss carefully the problems in detail and Durpadi could not go to the private hospital due to economic problems. She did not discuss it with her husband.

Case: 7

Dulari age 38 years got married Khemraj at the age of 8 years and went to her husband's place after maturity. She belongs to Chamar community. She gave birth to few children. Although she did not want too many children. She went and met Auxiliary Nurse Midwife and asked about oral pills. The Auxiliary Nurse Midwife provided Oral Contraceptive Pills to Dulari. She took for two week and left taking Oral Contraceptives Pills. She was again pregnant for the sixth time. She was having a problem of burning in passing urine as well as gastric problems. So she left taking tablets, but her husband refuses to use conventional contraceptives. He has a negative effect of using condoms he says it is useless.

Thus in Dularis case, she wants to limit the children but it is not in her hand to take decision about her fertility.

Analysis Of The Case Studies

Analysis of case studies on reproductive Health shows social-cultural, economic organizational and technical facts or which are

highlights here. In general, education level of women is very low and education level of children is also low. Usually, daughters are not sent to school, they are taken out of school earlier than the sons. The main reason being "marriage" or "economic reasons". Helping at home taking care of younger siblings is their main duty. Women get married early because customs and social norms dictate the age of marriage. Due to early marriage a high number of infant death, death of two children during birth, and after one year due to fever. It is observed that in all the cases the antenatal care was inconsistent and incomplete check-ups were given during pregnancy. Among those who did go to the doctor reported taking Tetanus vaccination but nutritional support or calcium, iron supplements are not rigorously provided. Most of the births take place at home with an untrained Dai and Auxiliary Nurse Midwife.

However, the women's utilisation of reproductive health care from Primary Health Centre is low in antenatal care, natal and postnatal care. Pregnancies are not generally planned and many have had children one to one and half year apart. All this reflects the indifferent quality of Reproductive Health Care. Female sterilization (surgical or laproscopic method) is the most prevalent of family planning method utilized by women. However size of the family varies from 4 to 5 children per couple. Many expressed the social and family pressure to have son and hence the delay in family planning for limiting family size.

The men generally do not bother about the women's health as shown by case no. 2. They are either useless or indifferent and given their lack of power women do not have the courage to either take independent action or pressurize the husband. They are very dependent. Religious beliefs and understanding of illness also influences the action taken.

Apart from the social factors the economic condition also matters. Women have low nutritional status due to lack of food. Women face risks like anemia, child deaths and common reproductive health problems. Some women went to private clinic but women have to spent Rs. 200 per visit and this is too expensive for them. Women do not prefer to go to Primary Health Centre because no female doctor is there and they cannot discuss the reproductive health problems freely.

In this particular Primary Health Centre, even though the doctor is available and helpful, his team is not very efficient. As a result there are negative experience of women, which creates a negative impression.

Chapter V

Conclusion

This chapter is aimed at bringing together some of the important findings and conclusions which are derived from the study. The major findings emerging from the descriptions and analysis focus on the factors that determine the accessibility of Reproductive Health Services in a village of (Bharahwanda Khurd).

The Bharahwanda Khurd village is situated in the eastern part of Khandar block, Sawai Madhopur District, Rajasthan. It consists of seven Panchayats and thirty two villages and its population according to 1991 census is 28,495. The Bharahwanda Khurd, village population according to 1991 census is 3929. The population of males being 1816, and that of female being 1613. The in the village according to the 1991 censes are scheduled caste and scheduled Tribes, number 1392 and 10 respectively. The remaining caste are Jat and Brahmins. The of Bharahwanda Khurd village consists of 756 households.

When we put the two sets of data, and the qualitative and the quantitative, put together then some features are distinctly visible. The Primary Health Centre has the doctor and it is close by but the Doctor being a male, women feel shy and do not discuss their problems with him openly. Thus, despite physical availability and accessibility, women do not avail of the Reproductive Health services. In other words there exist a social barrier between the women and the medical provider is critical. Secondly, despite the doctor's availability,

the medicines are not available. People depend on chemists for medication. This again reduces the value of Primary Health Centre. The two factors put together push women to either seek private help or depend on traditional dais.

It is therefore not surprising that our quantification of data shows that being a user or non-user of services has less impact on reproductive health problems, child mortality and causes of death. The income of family plays a greater role. This problem of inadequate utilization of services is also linked to social factors.

Socio-cultural factors in the utilisation of reproductive health services are the main issues in both the user and non -user women. These socio-cultural factors are; early marriages, and unequal family dynamics. It has been observed that among the user and non-user the majority got married at the age 6-11 years. The younger age of marriage compels women to under go repeated pregnancies and a higher chance of child bearing during her reproductive age. Repeated pregnancies make women more vulnerable to reproductive health problems. Unequal family dynamics such as women's lack of authority, freedom to make health care decisions for themselves scarce availability of food and seclusion practices have been restricting their mobility outside the household and also affect their reproductive health.

Economic factors, which limit access to services for both users and non-users, are because of backward agricultural background of

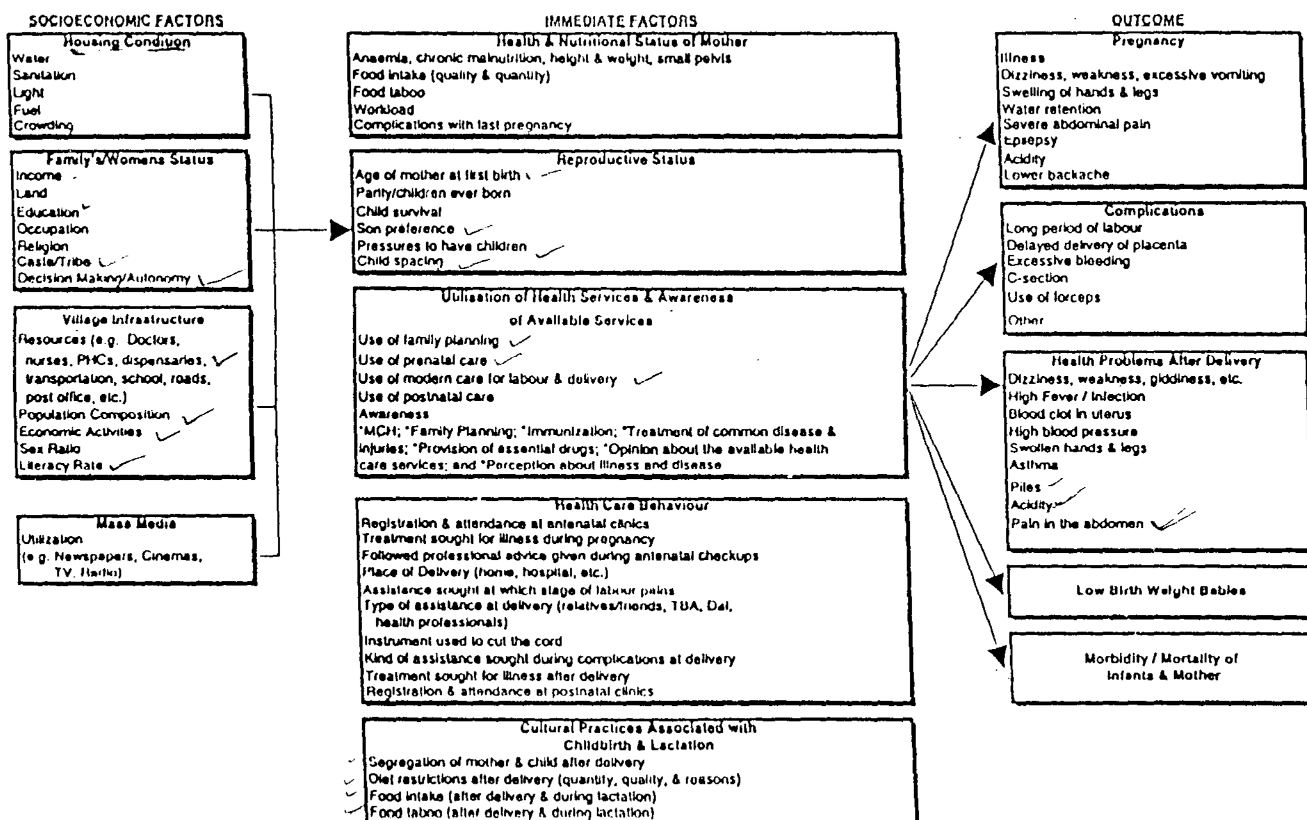
families. They are not in a position to afford the cost of treatment due to their poverty and lack of adequate supporting institution. Women do not have access to appropriate health services. They themselves did not go for family planning. Usually, they are motivated and forced by Auxiliary Nurse Midwife or Anganwadi workers. This because the Auxiliary Nurse Midwife is compelled to fulfill the targets of family planning. Not but not the least is the issue of staff, medicine, distance of Primary Health Centre and inconvenient time schedule; timely and effective provision of emergency obstetric care is particularly essential. The problem is compounded by the fact that Drugs are out of stock and lacking, and equipments are also out of order. This poor quality of resources at the primary health care and their ineffectiveness further reinforces the negative perception of Primary Health Centre in the patriarchal society of the village. For example, in case study 2, Santra's husband rejected the Primary Health Centre because the doctor took money for every visit, but did very little in terms of treatment.

The general apathy of family men in particular is also consolidated by the quality of the medical care provider. This also comes out clearly in the case studies. The attitudes of the health worker are indifferent towards women and do not succeed in ensuring sufficient level of confidence among women.

As a result they themselves neglect their health and do not consider the Primary Health Centre a worthwhile place to go.

Religion and political structure also promote forced demand for male child and repeated pregnancies, If a women is unable to give birth to a male child all, adds up to the pressure on her to reproduce more without the necessary support she badly needs. The double burden of production household work and farm work along with reproductive responsibilities that women face, leads to an increase in their health problems.

These sociao-economic linkages of ill health have been clearly delineated by Bandhopadya (1998).



Framework for analysing maternal health in rural India

Bandopadhya focused on socio-economic factors that play a major role in determining health status of women in India particularly in rural areas of the country. These factors exist within the country's urban as well as rural areas. Socio-economic status operates not merely at the individual level but also at the family and community level. For women in rural India, status in the family and at the community level is often related to levels of education, their occupation, their incomes or wealth, their decision-making power or autonomy to take an independent decision to use health services and have the number of pregnancies they desire. Moreover, the community resources like also contributory factors that should not be ignored. These community resources like housing conditions, poor source of water, sanitation, source of light, space available in the house etc., also affect maternal health adversely.

Socio-economic status does not necessarily affect a woman's health directly but operates through a set of immediate determinants that affect the outcome of pregnancy and illness. It may indirectly lead to low birth weight, morbidity and mortality of the infant and mother. Women's educational attainments are very much related to women's empowerment. They influence a woman's attitudes and health care behaviour. Economic independence and education give a woman more autonomy in issues such as access, mobility and power to decide on processes regarding her self and her children's health. Religion and cultural practices too play an important role in utilization of health care services and health care behaviour. Cultural practices such as

food taboos, which are in practice, also affect health. Chronic malnutrition affects adversely on women's health.

This Study supports these observations fully. Access to and Utilisation of Reproductive Health Services in rural areas are not only a function of quality services but also of socio-cultural structures and processes.

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Questionaire for PHC DOCTER

CSMCH/JNU

Name of the PHC
Adds-

Designation of the Interviwee -

Q.1. What are the services provided by the PHC for reproductive health ? Please mention.

Q.2. Do you provide all essential drugs to the patient ? Yes/No

Q.3. Do the PHC equipped with infrastructure ?

A. Laboratory
i) Microscope - Y/N
ii) Reagents - Y/N
iii) Lab Asstt. - Y/N

B. Operation Theatre equipment

C. TB drugs

D. Iron/Folic Acid

E. Vaccines

F. Sterilisers

Q.4. How many registered ANM have been working for 2 years.

1999	2000	2000

Q.5. No. of ANM had participated in service training for skill upgradation in last three years.

1999	2000

Q.6. Do the PHC availed with RTI/STI treatment facilities ? Y/N

Q.7. Does the PHCs have male and female specialist for RTI/STI treatment - Y/N

Q.8. No. of pregnent women had been visiting PHC in the last 2 years.

Purpose	1999	2000
Animia		
ANC		
Delivery		
General Disease		
Gynae Problem		
Abortion		
IUD		
Contreceptive Counselling		

Q.9. Total No. of cases referred from PHC in last 2 years

Purpose	1999	2000
RTI		
ANC		
IUD		
Contreceptive Counselling		
Pregnent Check-up		
Immunisation		

Q.10.No. of domiciliary delivery conducted by health practitioner -

Year	ANM/LHV	Trained Dai	Untrained Dai	Others
1999				
2000				

Q.11. No. of institutional delivery at service centre

Year	No. of Delivery	Target
1999		
2000		

Q.12. No. of high risk delivery cases referred to

	1999	2000
No. of cases referred		
Follow up cases		

Q.13. Did you organise any reproductive health related camp in last 2 years ?

Name of the Camp	No. of Camp	Population covered
Immunisation		
Maternal care		
Contraceptive Counselling		
AIDS awareness		
RTI/STI		
Health Education		

Q.14. No. of health manpower in the PHC for last 2 years.

Category	1999	2000
Medical Officer		
Public Health Nurse		
Midwife		
LHV		
Lab Technician		
Health Assistant		
Statiscian		

Q.15. Do the PHC has MTP facilities? Yes/NO

QUESTIONNAIRE FOR ANM

Name :

Address:

Education:

Age:

Monthly Income:

Caste:

Q.1. What are the services do you provide to women?

Q.2. Did you register your name? Yes No

Q.3. Have you received any required training ? Yes / No

Q. 4. How many facilities do you visit day?

Q.5. How long do you spend for visiting a family?

Q.6. Does any family take you in the time of emergency?

Q.7. Do you keep health kits during your visit? Yes/ No

Q.8. What do you keep in health kits?

Q.9. What kind of health care system do women believe in?

Q. 10. How many deliveries had you conducted in the families in last two years?

Year	No. of delivery	Target
1999		
2000		

Q.11. What kind of problem related to reproductive health had been observed in the last two years.

Disease	No. of reported cone		No of treatment	
	1999	2000	1999	2000

RTI/ STI

HIV/ AIDS

Anemia

Regional Discharge

Infertility

Q. 12. Did had you organize any health comp in last two years.

Q. 13. How do you view about reproductive health services, please mention?

प्रपत्र (ए.न.म. के लिए)

जवाहर लाल नेहरू विश्वविद्यालय

नाम :

पता :

शिक्षा :

मासिक आय :

अतिरिक्त आय:

वर्ग :

प्र.1 आप महिलाओं को क्या-क्या सेवायें प्रदान करती हैं?

प्र.2. क्या आपने अपना नाम पंजीकृत किया है? हाँ/ना

प्र.3. क्या आपने किसी प्रकार का आवश्यक प्रशिक्षण प्राप्त किया है? हाँ/नहीं

प्र.4. आप दिन में कितने परिवारों से मिलने जाती हैं?

प्र.5. आप कितना समय एक परिवार को देखने में बिताती हैं?

प्र.6. क्या आपको कोई परिवार आपातकालीन परिस्थिति में लेने आते हैं? हाँ/नहीं

प्र.7. क्या आप मिलने के समय स्वास्थ्य झोला साथ रखती हैं? हाँ/नहीं

प्र.8. आप स्वास्थ्य झोला में क्या सामान रखती हैं?

प्र.9. [illegible] में किस तरह की चिकित्सा पद्धति पर [illegible] ?

अ· हेल्थ वीजीटर
ब· दाई
स· प्राइमरी स्वास्थ्य केन्द्र की डाक्टर
द· निजी डाक्टर
 · परिवार के किसी सदस्य से

प्र·14· आपको परिवार नियोजन के बारे में किससे जानकारी मिला ?

अ· सहेली
ब· ए·न·म·
स· हेल्थ विजीटर
द· पी·एस·सी· डाक्टर

QUESTIONNAIRE FOR WOMEN

Q1. Name:

Address:

Category:

Q2. Family Status

Name	Age	Sex	Education	Occupation		Income
				Main	Additional	

Q3. Status of Birth

No. of birth	Status of Child	Reasons for death	Place of birth	Who delivered

Caste- A, Alive, D- Death

Q4. What was your age during marriage?

Q5. Do you visit nearby health centre for treatment? Yes/ No

a. ANC

b. Delivery

c. General Disease

d. Family Planning

e. Immunization

Q6. Where do you get medicine for treatment?

a. Private Clinic

b. General Hospital

c. Sub-centre

d. Chemist Shop

Q.7 What is the distance of PHC from your residence?

a. 1-2 km

b. 3-4 km

c. 4-5 km

Q.8 What are the reasons for not visiting PHC?

a. Long distance

b. Long queue

c. Non-availability of medicine

d. Absence of Doctor

e. Problems of Transportation

f. Lack of money

g. Others

Q9 Does ANM visit to your family regularly? Y/N if yes please mention.

Q10. Does ANM carry health kit along with her? Y/N

Q11. Does ANM or Doctor Change money and advice? Y/N if yes please mention.

Q12. Do you get preventable medicine from PHC? Y/N If yes Please mention.

a. Iron/IFA tablet
b. Vitamin
c. OCP
d. Medicine for RTI/STI

Q13. Who do you communicate first whenever you suffer from problems related to sexual health?

a. Health visitor
b. Dai
c. PHC doctor
d. Private doctor
e. My family member

Q14. Where do you get information about family planning?

a. Peer/Friends
b. ANM
c. Health visitor
d. PHC doctor

प्रपत्र (महिलाओं के लिए)

जवाहर लाल नेहरू विश्वविद्यालय

1• नाम :

2• पता :

वर्ग :

2• पारिवारिक स्थिति :

नाम	आयु	लिंग	शिक्षा	व्यवसाय		आय
				मुख्य	अतिरिक्त	

3• जन्म की स्थिति :

जन्म की संख्या	शिशुओं की स्थितियां*	मृत्यु का कारण	जन्म स्थान	किसने जनन किया
1•				
2•				
3•				
4•				
5•				
6•				
7•				
8•				

* कोड : ए - जीवित डी - मृत

4• विवाह के समय आपकी आयु क्या थी?

5• क्या आप इलाज के लिये निकटतम स्वास्थ्य केन्द्र जाते हैं ? हां/नहीं

अ• जननपूर्व सेवायें
ब• जनन
स• साधारण बिमार

द• महिला सम्बन्धित बिमारी
य• परिवार नियोजन
क• टिकाकरण

प्र•6 आपको इलाज के लिए दवाईयां कहां से मिलता है?

अ• निजी क्लीनिक
ब• सरकारी अस्पताल
स• सब सेंटर
द• दवाई की दुकान

प्र7• आपकी आवास से पी•एच•सी• की दूरी क्या है?

अ• 0–4 कि•मी•
ब• 5 –9 "
स• 10–14 "
द• 15 से अधिक

प्र•8• आपके प्राइमरी स्वास्थ्य केन्द्र न जाने का क्या कारण है?

अ• अधिक दूरी
ब• लम्बी कतारे
स• दवा नहीं मिलता
द• डाक्टरों की अनुपस्थिति
य• यातायात की असुविधा
क• धन के अभाव
ख•

प्र•9• क्या ए•न•म• आपके परिवार में समयानुसार आती है? हाँ/नहीं
अगर हाँ तो उल्लेख किजीये •

प्र•10 क्या ए•न•म• हेल्थ किट साथ लाती है? हाँ/नहीं

प्र•11 क्या ए•न•म• या डाक्टर इलाज या सलाह के लिये पैसा लेते है? हाँ/नहीं
अगर हाँ तो कितना ····

प्र•12 क्या आपको रोग हटानेवाली औषधि(प्रोफेलेक्सीस) मिलती है? हाँ/नहीं
अगर हाँ तो उल्लेख कीजिए

अ• आयरन/फोलीकसीड
ब• विटामिन
स• ओ•सी•पी
द• आर•टी•आई/एस•टी•आई की दवा

प्र•13 [illegible] आप जनन सम्बन्धित स्वास्थ्य समस्या से पीड़ित [illegible] आप
पहले [illegible] है?

प्र•10• आपने पिछले 2 सालों में कितने परिवारों के बच्चों को जनन किया है?

वर्ष	जनन की संख्या	लक्ष्य
1999		
2000		

प्र•11• पिछले 2 सालों में रिप्रोडेक्टिव हेल्थ सम्बन्धित कौन सी बिमारी अधिक देखा गयी है?

बिमारी			इलाज की संख्या	
	1999	2000	1999	2000
अ• आर•टी•आई/एस•टी•आई				
ब• एच•आई•वी•/एडस				
स• एनीमिया				
द• वैजीनल डिस्चार्ज				
य• इनफर्टिलिटी				

प्र•12• क्या आपने 2 सालों में कोई हेल्थ कैम्प आयोजित किया है?

प्र•13• आपके रिप्रोडेक्टीव हेल्थ सर्विस के बारे में क्या विचार है उल्लेख कीजिए ?