

## CHAPTER-IV

### **IMPACT OF THE REPRODUCTIVE AND CHILD HEALTH PROGRAMME ON BENEFICIARIES**

In order to effectively improve the health status of women and children and fulfill the unmet need for Family Welfare services in the country, especially the poor and under served by reducing infant child and maternal mortality and morbidity, Government of India during 1997-98, following The International Conference on Population and Development (ICPD) held at Cairo in 1994 recommended a comprehensive Reproductive Health (RH) programme to replace demographically oriented Family Planning (FP) programmes, launched the RCH Programme for implementation during the 9th plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other reproductive and child health (RCH) services. The RCH Programme is partly funded by World Bank, UNICEF, UNFPA and European Commission etc. Reproductive and Child Health Program is in 8th year of its operation and is currently operational in entire country. The program follows a differential strategy with inputs under the program linked to the needs of the area coupled with the capacity for implementation. The program was reviewed extensively not only in context of achievements during mid-term stage, but also in context of National Population Policy. Efforts were made to strengthen the routine immunization as well as PPI by launching a project for Immunization Strengthening with the World Bank assistance.

This chapter deals with analysis of data collected and findings on the various component of the RCH Programme in respect to the accessibility, utilization of services by the beneficiaries, delivery of services by health functionaries and their opinions and knowledge about the services provided under the RCH Programme. It also deals with the findings on effectiveness of the services in improving the health status of mother and children, who are prime target of this programme.

Before presenting the findings and analysis of data on the various component of the programme, as proposed in the study, the demographic and socio-economic background of the beneficiaries (respondents) is presented below.

While talking about the demographic and socio-economic profile of the beneficiaries, it was found that high majority i.e. 73.61 per cent of the beneficiaries were from 16-25 age group followed by 15.28 per cent were from 26-35 age group. In regards to the religious composition 52.22 per cent and 47.78 per cent of the beneficiaries were belongs to Hindu and Muslim religion respectively. Caste wise distribution of the beneficiaries is dominated by the general caste i.e. 58.67 per cent followed by Schedule caste 30.83 per cent. Educationally highest 33.61 per cent were educated up to middle school followed by 20.56 per cent, 18.06 per cent, 12.50 per cent 7.5 per cent, 4.44 per cent and 3.33 per cent of them were educated up to Primary, High School, Higher secondary, Illiterate, degree and post graduate level respectively. From the marital status point of view 99.44 per cent of them were married with only 0.56 per cent were widows. Nuclear family has been the highest i.e. 65.28 per

cent with rest of them were from joint family, as far as type of family of beneficiaries is concerned. In respect to the Size of the family of beneficiaries the 47.78 per cent of them were having the size 3-4 members followed by 45.83 per cent of them with the size of 5-6 members. When family occupation of the beneficiaries is analyzed, it has been observed that highest i.e. 36.67 per cent of them were from small business background followed by 30.83 per cent of them from Daily wage earner and other occupational background and family income wise 42.22 per cent of families of the beneficiaries earns Rs-1000/-3000/ per month followed by 49.44 per cent earns above Rs-3001-5000/ and only 8.33 per cent of them earns more than Rs-5000/ per month. (Table-1).

Table-1			
Demographic and Socio-economic Profile of the beneficiaries			
Descriptions	Class	Class frequency	Percentage
AGE	Below 15	0	0
	16-25	265	73.61
	26-35	55	15.28
	36-45	25	6.94
	46 and above	15	4.17
	Total	360	100
Religion	Hindu	188	52.22
	Muslim	172	47.78
	Christian	0	0
	Others	0	0
	Total	360	100
Caste	SC	111	30.83
	ST	23	6.39
	OBC	15	4.17
	OC	211	58.61
	MOBC	0	0
	Total	360	100
Education	Illiterate	27	7.50
	Primary	74	20.56
	Middle School	121	33.61
	High School	65	18.06
	Higher Secondary	45	12.50
	Degree	16	4.44

	Any other (specify)	12	3.33
	Total	360	100
Marital Status	Married	358	99.44
	Unmarried	0	0
	Widowed	2	0.56
	Divorced	0	0
	Separated	0	0
	Total	360	100
Type of Family	Nuclear	235	65.28
	Joint	125	34.72
	Total	360	100
Size of the family	Two	15	4.17
	Three - four	172	47.78
	Five - Six	165	45.83
	Seven & above	8	2.22
	Total	360	100
Family Occupation	Coolie	0	0
	Own Agriculture	61	16.94
	Service (Govt./Private)	56	15.56
	Business	132	36.67
	Any other (specify)	111	30.83
	Total	360	100
Family Income	Below Rs-1000/	0	0
	Rs-1001/-3000/	152	42.22
	Rs-3001/-5000/	178	49.44
	Rs-5001/ and above	30	8.33
	Total	360	100

(Source: Primary Data.)

It has been clear from the analysis of socio-economic and demographic data that majority of the mother beneficiaries are from lower age group, which may be due to the early marriage and low educational background. On combining primary level and middle school level educated beneficiaries exceeds more than fifty percent of the beneficiaries and all most half of them have given birth to more than two child. Even with this pattern of size of the family, their monthly earnings are up to the level needed for maintaining good and healthy life as compare to the current cost of living.

After analyzing and interpreting all the collected data from different sources, the findings on the different components of the Reproductive and Child

Health Programme, are now being presented in the following parts of the chapter.

## PART-A

### **SAFE MOTHERHOOD**

In India, more than one lakh women die annually for reasons related to pregnancy. Indian women are 100 times more likely to die due to pregnancy than their counterparts in developed world. In addition many more suffer from life long disability like chronic pelvic infections, infertility, dysfunctional uterine bleeding, fistula etc. The major causes of maternal deaths in India are haemorrhage, sepsis, anaemia, obstructed labour, and toxemia. Fortunately most of them are preventable. Under RCH, safe motherhood programme aims to prevent pregnancy related deaths and disability. This needs care and understanding by the family and community. The family and community need to ensure that all pregnant women get essential care like good and adequate nutrition, hygienic practices, safe delivery, regular checkup, TT immunization, adequate breast feeding to new born, timing of pregnancy and supplementary iron. Such simple measures can prevent most of the pregnancy related deaths and disability.

In this section of the chapter, information on safe motherhood practices by the mother beneficiaries (respondents), services received by them during pregnancy and care taken during pregnancy have been analyzed and presented under different sub-headings.

### Age at First Pregnancy:-

In case of pregnancy related deaths and disability, it has been observed worldwide that pregnancy before 18 years of age remains one of the causal factors and under the RCH Programme activities have been implemented to generate awareness among general people about the difficulties of pregnancy before 18 years of age. Here below are the analysis and findings of the data collected from mother beneficiaries (respondents) on age at first pregnancy are being presented in the table below.

<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
What was your age at first pregnancy	1. Below 15 years	15	4.35
	2. 16-18 years	55	15.94
	3. 19-22 years	176	51.01
	4. 23-25 years	72	20.87
	5. 26 years and above	27	7.83
	Total		345

(Source: Primary Data)

It can be seen from the above table that 95.83 per cent of the women beneficiaries were mother beneficiaries, who had given birth to one or more children out of total 360 women beneficiaries interviewed under the study. Out of these mother beneficiaries, 4.35 per cent, 15.94 per cent, 51.01 per cent, 20.87 per cent and 7.83 per cent of the them had attained the first pregnancy at the age of below 15 years, 16-18 years, 19-22 years, 23-25 years and 26 years and above respectively. The average age of first pregnancy among these mother beneficiaries is 21.17 years. (Table No-A-1.1).

By combining the age of pregnancy of beneficiaries in the age group below 18 years constitute more than 20 per cent, which indicates the high probability of occurrence of pregnancy related deaths and disability leading to high rate of infant mortality, maternal mortality and child mortality etc. It is also fact that the average age of pregnancy is 21 years and nearly half of them had given birth to 3-4 children and 8 of the mother beneficiaries given birth to more than 5 children.

#### **ANM/LHV visit during Pregnancy:-**

Every sub-centre, PHC and CHC are being staffed with Auxiliary Nursing Midwives and Lead Health Visitors to supervise them. They are deputed to visit each house holds in their SC/PHC or CHC area to provide health care services to expecting mothers, nursing mothers and the community as a whole. Its must on the part of every women once conceived to register with ANM and get at least three ante-natal check-ups during pregnancy. The AMNs/LHVs must ensure their check-ups on regular times as per the ANC card maintained record the weight, blood pressure, blood group, hemoglobin and urine. In view of this all the mother beneficiaries (respondents) were asked whether they had been visited by ANMs/LHVs or gone for regular check-ups during their pregnancy and analysis of the responses are presented below.



Table-A-1.2			
ANM/LHV visit during Pregnancy			
Question	Class	Class Frequency	Percentage
13.a. Did ANM/LHV visited you during pregnancy	Yes	340	98.55
	No	5	1.45
	Total	345	95.83
13.b. How frequently ANM/LHVs visited you	Once in a week	23	6.67
	Once in a fortnight	64	18.55
	Once in a month	258	74.78
	Total	345	100.00
13.c. How many times did you go for medical check-up during pregnancy	One Times	51	14.78
	two times	155	44.93
	three times	62	17.97
	four times	42	12.17
	five times & above	35	10.14
	Total	345	100.00
13.d. Did ANM check-ups and records the following during pregnancy	Weight	160	46.38
	Blood pressure	101	29.28
	Blood group	0	0.00
	Hemoglobin	0	0.00
	Urine	12	3.48
	Total	273	79.13

(Source: Primary Data)

As can be seen from above table, the high majority i.e. 98.55 per cent of these beneficiaries responded that they had been visited by ANM or LHV during pregnancy and out of that 74.78 per cent of them were replied on visit by ANM/LHV once in a month during the reference period. On medical check-ups during pregnancy, the highest percentage of women i.e. 44.93 per cent of the beneficiaries had gone for two times medical check-ups during their pregnancy period leaving only 17.97 per cent for three times. Out of the total beneficiaries visited by the ANM/LHV, 46.38 per cent, 29.28 per cent and 3.48 per cent of them were checked and recorded for Weight, Blood pressure and urine respectively. (Table No-A-1.2),

The above analysis reveals that services are more acceptable and accessible when reaches to beneficiaries, but in case of utilization of services by

approaching the health institutions, the outcome is below the desired level. This may be because of their hesitations, family bindings or the services provided at Govt. Health centres are not as per their comfort level. This hesitation resulted in low coverage on measurement of weight, blood pressure, blood group, hemoglobin and urine as ANMs/LHVs cannot carry the required measurement kits during their home visits.

### **TT Immunization & Intake during Pregnancy:-**

Immunization is an important cost effective Public Health weapon for disease control. It reduces both morbidity and mortality among the people. On 19th November, 1985, Govt. of India launched Universal Immunization Programme (UIP) with the objectives to bring down the incidence of six killer diseases of the children as well as to eliminate Maternal & Neonatal tetanus by immunizing pregnant women with tetanus vaccine. During initial phase of this program, the coverage of UIP vaccines was not satisfactory, but it reached a very high level during 1990. In 1992, UIP was incorporated with CSSM program and later on with the RCH program in 1997. The coverage of infant and pregnant women with the UIP vaccines reached a very high level.

Under the RCH Programme, since inception, the focus has been on the immunizing all pregnant women by two doses of Tetanus Toxide at the intervals of one month and take supplementary iron in the form of Iron and Folic Acid Tablet(IFA)-Large, Daily for 100 days. These tablets are distributed free of cost to pregnant women by ANMs during antenatal check-ups. These women also

must take one extra meal Daily and the food should contain green leafy vegetables, pulses, fruits and milk. Below, we are going to have the analysis of data collected and findings on the coverage of TT Immunization, IFA (L) tablets and food intake by mother beneficiaries (respondents) during their pregnancy/pregnancies in the below mentioned table.

Question	Class	Class Frequency	Percentage
13.e. During pregnancy did you get two TT immunization?	yes	345	100
	No	15	0
	Total	360	100
13.f. During pregnancy did you take Iron Folic Acid tablets?	Yes	310	89.86
	NO	35	10.14
	Total	345	100.00
13.g. How many Iron Folic Acid tablets did you take during pregnancy?	<100	112	36.12
	>100	198	63.87
	Total	310	100
13.h. Did you take Green leafy veg/pulses/fruits/Milk during pregnancy	Yes	345	100
	NO	0	0
	Total	345	100

(Source: Primary Data.)

Out of the 345 mother beneficiaries interviewed, the responses on immunization by two doses of TT were 100 percent. In case of supplementary nutrition in the form of IFA (L) tablets 89.86 per cent had taken during their pregnancy and out of them, only 63.87 per cent of them took more than 100 tablets. As regard to the intake during pregnancy is concerned all of them took green leafy vegetables, pulses, fruits, and milk during pregnancy. (Table No-A-1.3).

From above, the coverage by two doses of TT immunization during their pregnancy responses were full, this may be due to the fact that TT doses can

also be administered by the ANMs/LHVs during their home visits .On the other hand the intake of IFA (L) tablets by them was not full and also up to 100 tablets for 100 days was low. This low consumption of IFA (L) tablets can be related to the negligence of beneficiaries and also cannot be directly observed by any health workers as these are to be taken by beneficiaries themselves at home. Further, the intake of food as extra meal during pregnancy containing green leafy vegetables, pulses, fruits and milk, the beneficiaries responded positively, but not as extra meal with regular food.

**Place of Delivery and safe practices during delivery:-**

Place of delivery and safe practices during delivery have been given high importance under RCH Programme, as the national records reveals that the prevalence of IMR and MMR are high in case of delivery at home without attended by trained Dais or trained birth attendants.

The main aim behind the promotion of institutional deliveries under RCH Programme has been to have safest deliveries in an institution with appropriate medical facility. Delivery in a hospital also ensures newborn and postnatal care, therefore can reduce IMR and MMR substantially. In such an institution emergency conditions such like bleeding; obstructed labor requiring operation can be promptly attended. Such events may not be predicted in advance and also cannot be attended at home. In case the delivery in institution is not possible, the second best option is to conduct delivery by trained health persons like ANMs, LHVs or a trained Dai. The programme also envisages to promote the safe practices during deliveries at home such as use of clean sheets, hand

washing with soap and clean water, use of new blade to cut the cord and clean string to tie, Keeping above in mind, the mother beneficiaries (respondents) were asked on the place of their deliveries and practices during their deliveries at home and the findings are analyzed and presented in the table below.

<b>Place of Delivery and safe practices during delivery</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
14.a Place of Delivery	1. PHC	57	16.52
	2. CHC	35	10.14
	3. At Home	292	84.64
	4. District Hospital	66	19.13
	5. Medical College	12	3.48
	6. Private nursing Home	10	2.90
	TOTAL	345	100
14.b. Attender during delivery at home	1. Family members	38	13.01
	2. relatives/neighbors	28	9.59
	3. Village Dai	95	32.53
	4. Trained Dai	112	38.36
	5. ANM	9	3.08
	6. Any other (specify)	10	3.42
	Total	292	100
14.c. Practice safety measures during delivery at home	Yes	254	86.99
	No	38	13.01
	total	292	100

(Source: Primary Data.)

It is evident from above that in case of place of delivery of child birth, out of the 345 mother beneficiaries, majority of them i.e. 84.64 per cent had given birth to one or more children at home with maximum 41.36 per cent attended by ANMs and trained Dais or trained birth attendant followed by 32.53 per cent attended by Village Dai. Only 15.36 per cent occurred as institutional deliveries. As far as practice of safety measures during delivery at home is concerned the majority i.e. 86.99 per cent replied positively on the practice of safety measures during delivery at home. (Table No-A-1.4)

The responses were very high for deliveries at home and also the safe delivery at home as to be conducted by trained health persons like ANMs, LHVs or a trained Dais also less than the half of the total deliveries at home and rest are conducted by village Dais, which is not the safe one. This implies the risks of infant deaths and maternal deaths. As regard to the safe practices during the deliveries at home, a very high percentage of the mother beneficiaries were positive, but it is doubtful as compare to the percentage of deliveries at home conducted by trained health persons like ANMs, LHVs or a trained Dais. All these may responsible for location and availability of health institutions with appropriate facilities, timing of delivery, communication facilities and low level of awareness about the benefits of institutional delivery and high preference and belief on traditional village Dais in rural areas.

#### **Breast feeding & intake during lactating Period:-**

During the post natal period, the new born baby and mother are vulnerable to new sets of risks. Because of this reasons, the RCH Programme has been giving more and more focus on the breast feeding and nutritious intake by mother during lactating period. Just after delivery both the mother and new born child are physically weak and in need of proper rest and nutrition to recover from labor. Therefore, following supports have been recommended under the RCH Programme as necessary for restoration of the health of the mother and proper care of the new born.

- Start of breast feeding immediately after birth.

- Feeding the newborn on demand during day as well as at night.
- Feeding should be done at least 7 times a day.
- Do not stop the breast feeding if the mother or child is sick.
- Intake of Vegetables, fruits, milk and other iron rich food by mother during their lactating periods

To promote these healthy and nutritious feeding habits, the programme has been delivering a wide array of activities up to the sub-centre level to the beneficiaries. Likewise data were being collected from the mother beneficiaries (respondents) on these healthy practices and presented below after analysis.

Question	Class	Class Frequency	Percentage
15.a. When did you start breast feeding to your new born baby?	1. Immediately after birth	201	58.26
	2. 6 hours later	113	32.75
	3. 12 hours later	21	6.09
	4. 24 hours later or more	10	2.90
	Total	345	100.00
15.b. How many times did you breast feed your Child in a day?	1. 1-3 times	23	6.67
	2. 4-6 times	15	4.35
	3. 7 times or more	0	0.00
	4. As and when child required	307	88.99
	Total	345	100.00
15.c. Did you take fresh Veg, fruits, milk and others during lactating period	Yes	336	97.39
	No	9	2.61
Total	345	100.00	

(Source: Primary Data)

As can be seen from the above table, more than half of the mother beneficiaries i.e. 58.26 per cent started breast feeding to their new born child immediately after birth followed by 32.75 per cent of them started 6 hours later after birth and high majority i.e. 88.99 per cent of them preferred breast feeding

as and when the new born required or demanded. During their lactating period 97.39 per cent of these mother beneficiaries took fresh Vegetables, fruits, milk and others in their nutritional intake. (Table No-A-1.5)

Taking into consideration, all the recommendations on breast feeding and nutritional intake by mother beneficiaries, It was observed that more than two third of the beneficiaries were not doing breast feeding to new born immediately after birth, which is harmful to new born, but, in case of number of times they breast feed, the responses were very high for feeding on demands. As regard to nutritional intake the responses were almost cent percent. All these make it clear that still beneficiaries in rural areas are not aware of appropriate time of start breast feeding or may be prevented by the traditional believes.



## NUTRITIONAL ANAEMIA

Anaemia is condition in which concentration of Hemoglobin in red blood cell reduced. Hemoglobin is essential for life. It carries oxygen to all parts of the body for its development and day-to-day functions. Iron is the most important element required for formation of hemoglobin. As iron cannot be synthesized in the body, it is made available through food. Anaemia due to such nutritional deficiency is called nutritional Anaemia.

Nutritional Anaemia is the world's most common nutritional deficiency. It is also a serious public health problem in India. Although it is wide spread in the country, it especially affects women in reproductive age, young children and adolescent girls.

Nutritional Anaemia can easily be preventable by the consumption of iron rich foods such as Green leafy vegetables, Cereals( such as wheat, ragi, jowar and bajra), Pulses, Lemon/Orange, Meat by the pregnant and lactating women, family members in the age group of 0-19 years and specially by children under 5 years. IFA (Large) tablets for pregnant and lactating women (one tablets/day for 100 days) and IFA( small) tablets for children under 5 years(one tablets/day for 100 days) should be given and inclusion of green leafy vegetables in weaning of food of infants also highly recommended to prevent Nutritional Anaemia among them.

Because of the seriousness of Nutritional Anaemia, the RCH Programme made it mandatory on the part of the Govt. health care centres and workers to

aware people and promotes consumption of iron rich foods and free distribution of both the IFA tablets. To assess the level of awareness about Nutritional Anaemia and consumption of iron rich foods to prevent the same, data were collected from the mother beneficiaries (respondents) has been analyzed and presented in the table below.

<b>Table-A-2</b>			
<b>Nutritional Anaemia</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
16.a. Did you take Green leafy veg, Cereals, Pulses, Lemon/Orange, Meat during pregnancy to avoid Nutritional Anaemia	Yes	289	83.77
	No	56	16.23
	Total	345	100.00
16.b. Do your family members take Wheat, Ragí, Jowar, Bajra, Pulses, Meat, Leaves, Cereals in the age group of 0-19 years?	Yes	297	82.50
	No	63	17.50
	Total	360	100.00
16.c. Do you provide green leafy vegetables in the weaning of foods of your children during infancy	Yes	302	87.54
	No	43	12.46
	Total	345	100.00
17.a. Do you get Iron Folic Acid (small) for children (1-5 years) from ANM/LHV ?	Yes	28	8.12
	No	317	91.88
	Total	345	100.00
17.b. How many IFA(small) for children did you get	50-100 tablets	28	100.00
	100 & more	0	0.00
	Total	28	100.00

(Source: Primary Data).

The intake of Green leafy vegetables, Cereals( such as wheat, ragi, jowar and bajra), Pulses, Lemon/Orange, Meat during pregnancy by the mother beneficiaries was as high as 83.77 per cent and by the family members in the age group of 0-19 years was 82.5 per cent. Talking on Nutritional Anaemia of children, it was revealed that high majority i.e. 87.54 per cent of the mother beneficiaries given green leafy vegetables in the weaning of food during infancy to their children, but at the same time a very few i.e. 8.12 per cent of the beneficiaries received 50-100 Iron and Folic Acid tablets (small) for their children

of age 1-5 years. as against the intake by mother during pregnant and lactating period was 63.87 percent mentioned earlier. (Table No-A-2),

From the above it is clear that intake of iron rich food in the families of the beneficiaries is high as compared to the low consumption of IFA(L) tablets by women and very negligible in case of IFA( Small) consumption by children. This may be due to the fact that the food habits of the beneficiaries are rich in iron and they are relying on that only. In case of giving IFA tablets to children, the mother beneficiaries are not aware of that or neglecting the same by giving importance to only their traditional diet system for children as they all are belong to rural areas.

## ADOLESCENT REPRODUCTIVE HEALTH

Adolescence generally means the age group of 10-19 years. This period is characterized by physical, mental, social and emotional changes to prepare for adult roles in almost all aspects of life, including marriage, themselves as well as adults, motherhood and earners. These changes are generally not well understood by adolescents

The enormity of the problem faced by the adolescents could be appreciated when one views that 20 per cent of the total population in India is in this bracket. Of this growing large number, half are either sexually active or married. The percentage of married adolescent girls is nearly double in rural India. As a result, this large adolescent population faces all the problems of early motherhood, specifically risk of death and disability for both the mother and new born. This segment of population is also more prone to acquiring sexually transmitted diseases, STIs, RTIs and other infections or dysfunctions resulting out of unsafe sex.

To safeguard them, the RCH Programme has been made compulsory for every Govt. health centres in rural areas to aware all the adolescents about their reproductive health, safe sex and other risks factors through providing health education and conducting adolescence girls meeting by ANMs or LHVs in their respective duty areas. Under this study, the beneficiaries (respondents) were asked about the knowledge and education they received on adolescents reproductive health from ANMs/LHVs to assess their level of awareness and the data so collected are being analyzed and presented in the table below.

<b>Adolescent Reproductive Health</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
18. Receive knowledge & Education on Protected sex, STI, RTI, STD from ANM/LHV	Yes	115	31.94
	No	245	68.06
	Total	360	100.00
19.b. Conduction of Adolescence girls meeting by ANM/LHV(how frequently)	Once in a week	0	0.00
	Once in a fortnight.	28	7.78
	Once in a month.	118	32.78
	No meeting.	214	59.44
	Total	360	100.00

(Source: Primary Data)

When the respondents were asked about the adolescent Reproductive Health it was found that 68.06 per cent of the beneficiaries did not receive any education and knowledge on safe sex, STIs, RTIs, STDs and only 31.94 per cent received such knowledge and education from ANMs/LHVs. On the conduction of adolescence girls meeting by ANMs/LHVs, majority 59.44 per cent of the beneficiaries refused of conduction of such meeting and only 32.78 per cent replied on conduction of such meetings once in a month. (Table No-A-3).

This reveals that out of all efforts made the adolescents reproductive health is a neglected area of public health in rural areas. This negligence may be the result of our prevailing culture where talking and discussing on sex and sex related matters especially by girls are still considered as shame or ill-cultured.

## Abortion

Abortion is one of the leading causes of maternal mortality and it contributes significantly to maternal morbidity. Therefore, provisions have been laid down under the RCH Programme for safe and legal abortions. To elicit the information from the mother beneficiaries (respondents) on abortion data were collected from them, analyzed and presented in the table below.

<b>Table-A-4</b>			
<b>Abortion</b>			
Question	Class	Class Frequency	Percentage
20.a. Did you or any of your family members gone for abortion	Yes	0	0
	No	360	100
	Total	360	100
20.c Place of Abortion	PHC	0	0
	Block Hospital	0	0
	Civil Hospital	0	0
	Medical C&H	0	0
	Regional Hospital	0	0
	Private nursing home	0	0
	Any other (specify)	0	0
	8. NA	360	100
	Total	360	100

(Source: Primary Data).

In order to assess the occurrence of abortions and place of abortions among the mother beneficiaries, they were asked and surprisingly not a single beneficiary replied that gone for abortion. (Table No-A-4).

These facts point out the possibilities of the non arrival of need for abortion and the beneficiaries were expressing to maintain secrecy due to stigma attached to abortion.

## **PART-B**

### **REPRODUCTIVE TRACT INFECTIONS AND SEXUALLY TRANSMITTED INFECTIONS**

Reproductive Tract Infections includes a variety of bacterial, viral and protozoal infections of the lower and upper reproductive tract of both sexes. Many RTIs are sexually transmitted reproductive tract infections pose threat to women's lives and well being through out the world. RTIs includes Sexually Transmitted Infections (STIs) related to procedures such as unsafe deliveries and abortions or IUD infections and infection due to over growth of organism normally found in the genital tract. Men also experience RTIs, particularly STIs but the prevalence and the consequences for women are much more severe. A high incidence of infertility, tubal pregnancy and poor reproductive outcome is an indirect reflection of high prevalence of RTIs/STIs in India. Giving priority to threats due to RTIs/STIs to the reproductive health of women and girls and to the health of new born, the RCH Programme has been rendering services to raise the awareness among the community people about the RTIs/STIs and their preventive measures.

In this section of this part of the chapter deals with the analysis of data collected from the beneficiaries to asses the prevalence of RTIs/STIs among the beneficiaries (respondents) and the findings of the analysis done are being presented below.

Table-B-1			
Reproductive Tract Infections/Sexually Transmitted Infections			
Question	Class	Class Frequency	Percentage
21.a. Did you or any of your family members ever faced any sexual dysfunction?	Yes	0	0
	No	360	100
	Total	360	100
21.b. Is there anybody in your family having any or more of the following?	HIV/AIDS	0	0
	RTI/STI	0	0
	Any other STDs	0	0
	Total	360	100
21.c. If faced than where treated	PHC	0	0
	Block Hospital	0	0
	Civil Hospital	0	0
	Medical C&H	0	0
	Regional Hospital	0	0
	Any other (specify)	0	0
	Total	360	100

(Source: Primary data).

It has been observed from the table above that neither the mothers nor any of their family members faced any sexual dysfunctions, STDs, STIs, RTS or HIV/AIDS. (Table No-B-1).

As we seen earlier the percentage of beneficiaries received knowledge and education on RTIs, STIs, STDs from health workers were very low, this may be due to that they might had suffered from these infections or diseases but could not identify or not been reported as still in rural areas there are prevailing stigmas attached to these sexual diseases of infections and also people retaliate others and reluctant to discuss such issues.



## Gender Issues

when we go for a comparison on the health status and overall development between male and female children, it always projects the fact of differences leaving behind the females from their counterpart.(reframe) To ensure equal care and support to all children without gender discrimination, the RCH Programme made it an essential matter of focus to motivate people specially in rural areas to take equal care to their all children. Health workers were also oriented on these issues and asked to deliver efforts to mitigate this gender discrimination. Thus as a point of this study, the analysis of data so collected from the beneficiaries on gender issues are presented below.

<b>Table-B-2</b>			
<b>Gender Issues</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
22.a. Do you take equal care to all your children	Yes	345	95.83
	No	15	4.17
	Total	360	100.00
22.b. If no, than reasons for discrimination	As preferred by husband	0	0.00
	As male child wil be productive in future.	0	0.00
	As preferred by all family members	0	0.00
	NA	360	100.00
	Total	360	100.00
23.a. Any body in your family favours male child	yes	11	3.06
	No	349	96.94
	Total	360	100.00
23.b. Have you ever gone for sex identification during pregnancy	Yes	0	0
	No	345	100
	Total	345	100

( Source: Primary Data).

In reference to the table above, on asking all the mother beneficiaries replied that they takes equal care to all their children of either sex and in case of family members, it was found that only 3.06 per cent of them favours male child for being productive in future as against female child. On the other hand no body of them went for sex identification during their pregnancy. (Table No-B-2)

Thus from above analysis it has been clear that mothers were very fair in their dealing with their children and they find their all children equal and likewise takes equal care and supports too. But, in few cases where the discrimination reported, these were by the other family members and they need to be aware of the fact that every child has the rights of equal treatment. In no case the sex identification before birth was found making it clear they were not so interested in doing so irrespective of legal obligation attached to this act.

## PART-C

### **INFANT AND CHILD MORTALITY**

Infant and child mortality rate are the important indicators which generally reflects the status of survival of children. The experienced gained within the country and outside the country has amply established the fact that the health of women in their reproductive age and of small children under the age of 5 years is of crucial importance for effectively tackling the problem of population growth. This is because if parents are assured of good health of their children they take initiative to keep their family small. Most effective way of ensuring good health of child is by ensuring good health of the mother.

Knowing the infant mortality and child mortality rates is important because it reflects the impact of various interventions currently being implemented as part of the RCH Programme. The understanding of the cause of death and trying to know which of these causes is more prevalent in a particular area is also important as these will indicate the focus that is required to be given to a particular intervention in a particular area.

In this section of this chapter, the information on death of children less than 5 years of age and causes of their death are analyzed and presented below in the Table No-C-1.

<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
24. a.No. of children given birth by the beneficiary	One	46	13.33
	Two	71	20.58
	Three	165	47.83
	Four	35	10.14
	Five and more	28	8.12
	Total	345	100
24. c.(i) No. Children Died	0-1 years	5	41.67
	1-5 years	7	58.33
	Total	12	100.00
24. c.(ii) Place of Death	At Home	10	83.33
	Hospital	2	16.67
	Other	0	0
	NA	0	0
	Total	12	100
24. c.(iii) Reasons for death	Fever and any other disease	9	75
	Complication during birth	1	8.33
	Diarrhoea	1	8.33
	Vit-A deficiency	0	0.00
	Nutritional Anaemia	0	0.00
	Pneumonia	1	8.33
	NA	0	0
	Total	12	100

(Source: Primary Data)

In terms of no. of children given birth by mother beneficiaries 13.33 per cent, 20.58 per cent, 47.83 per cent, 10.14 per cent and 8.12 per cent of them given birth to one, two, three, four, and five or more children respectively. Total children died out of the total children given birth by the mother beneficiaries was 12 and among these children, 41.67 per cent died in the age of 0-1 years and 58.33 per cent died in the age of 1-5 years and majority of them i.e. 83.33 per cent of them died at home, 75 per cent of the died due to fever and other diseases unknown to the beneficiaries. By calculating the number of infant deaths and child deaths in last one year from the day of interview and it was found that IMR and CMR were 81 and 41 respectively. (Table-C-1).

This analysis shows that child mortality is high than the infant mortality and very high percentage of the children died at home that means the parents were not given important to the illness that caused the death and did not take the child to the nearest health institutions. It is also evident that a measurable portion of the did not know the cause of death which is very serious issue of concern

## BREAST FEEDING

Breast milk is the ideal food for the newborn. Exclusive breast-feeding can save many lives by preventing malnutrition and reducing risk of infections during early infancy.

Feeding anything other than breast milk, even water is not only unnecessary, but is also potentially harmful during first 6 months of life. Keeping in view the importance of breast feeding in the all round development of child, the RCH Programme has made massive strive since its inception to make the people aware and inculcate the habit of exclusive breast feeding to new born up to the age of 6 month minimum. In this section, we are going to have the analysis and presentation of data collected from the beneficiaries i.e the mother beneficiaries about their breast feeding to children

Table-C-2			
Breast Feeding			
Question	Class	Class Frequency	Percentage
25.a.Length of breast feeding to children	6 months	183	53.04
	1 year	116	33.62
	1 & 1/2 year	46	13.33
	Total	345	100

(Source: Primary Data).

The table above shows that when the mother beneficiaries were asked on the length of breast feeding to their newborns, they came out the replies that 53.04 per cent of them continued breast feeding to their children up to 6 months followed by 33.62 per cent and 13.33 per cent up to 1 year 1.5 years respectively. (Table No-C-2)

The above analysis clearly indicates that all of the mother beneficiaries were keen to breast feed their children as long as they can and thus reflecting on the positive and good performance in this regard by the initiatives of RCH Programme. This achievement may be attributed to the fact that breast feeding to children is completely depends on mothers and their choice and no mother wants the harm of their children..

## NUTRITION

Good nutrition forms the basis for good health of a child, more so for girls. However, malnutrition is still widely prevalent in our country. Malnutrition reduces body resistance to fight against infections, retards intellectual and physical development. This also leads to increased morbidity and mortality in children.

Nutrition is required for a child to grow, develop, keep active and to reach the adulthood as well. Several of these nutrients are essential and their deficiencies lead to various problems. These essential nutrients are carbohydrates, proteins, fats, vitamins and minerals (or micro-nutrients), which are necessary to maintain growth, development and tissue integrity.

<b>Table-C-3- Nutrition</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
25.b. Age of start of semi-solid food to child	When the baby was 3 mths old	6	1.74
	4-5 months	183	53.04
	6-7 months	116	33.62
	8 months and above	40	11.59
	<b>Total</b>	<b>345</b>	<b>100</b>
25.c. food given to child of age 1-2 years ( under this response recorded as '0' mean replied No and any number means yes)	Cereals	0	0
	Dals	0	0
	Vegetables	0	0
	Fruits	25	7.25
	Oils	0	0
	Fresh food	0	0
	Eggs	16	4.64
	Milk and Milk Powder	0	0
	Nuts	5	1.45
	Others	0	0
	<b>All</b>	<b>299</b>	<b>91.01</b>
<b>Total</b>	<b>345</b>	<b>100</b>	
25.d. food given to child of age 3-6 years	More semi-solid	46	13.33
	More Solid	17	4.93
	Equally mixed	282	78.33
	<b>Total</b>	<b>345</b>	<b>100</b>

(Source: Primary Data).



While went for finding about the giving nutritional food to children, it is evident from the above table that 53.04 per cent of the mother beneficiaries started giving semi-solid food to their children at the age of 4-5 months followed by 33.62 per cent and 11.59 per cent at the age of 6-7 months and 8 months or above respectively. It was also observed that 91 per cent of them were giving nutritious food such as cereals, dal, vegetables, fruits, oils, fresh food, eggs, nuts, milk and milk powder to their children in the age of 1-2 years and 78.33 per cent of the were giving equally mixed food to their children of 3-6 years of age. (Table No-C-3)

This analysis represents that percentage of beneficiaries starting semisolid food at the proper age is low as compare to the percentage of beneficiaries giving nutritious food such as cereals, dal (pulses), fruits etc after one year or three years of age is high. This difference can be related to the fact that in rural areas people consumes more these foods as their regular food, indicating that they do not take any extra efforts for giving nutritional food for their children rather they force their children to adopt the regular food habit once they attain the age of 1 years and above.

## PART-D

### **NEWBORN CARE AND CHILDHOOD DISEASES**

More than half of the deaths during infancy occur during neonatal period (first 28 days of life). Even within these periods, it is the first week of child's life when most of the deaths takes place due to birth related complications and infections. Babies born with low birth weight (less than 2500 gms.) are at high risk of dying due to these causes. By taking care of health of the mother during pregnancy and by providing essential newborn care in the health facility and even at home, the neonatal mortality can be reduced.

Care of the mother during antenatal period and delivery; and the provision of essential newborn care at birth and during neonatal period can reduce IMR significantly. Under the CSSM Programme and now under the RCH Programme, the interventions aimed at improving survival of infants and children have been undertaken. Under the RCH Programme following interventions have vigorously undertaken.

- Ensuring antenatal care to all pregnant women.
- Promoting safe delivery practices at home
- Providing and promoting essential care to all newborns.
- Identification and referral of newborns "at risk".
- Promoting identification, management and prevention of common childhood diseases at home and community.

In this chapter attempt has been made to measure the level of safe practices during at home, essential newborn care taken and management of childhood diseases by the beneficiaries. The data were so collected from them on these specific issues has been analyzed and presented below.

<b>Table-D-1.1</b>			
<b>Care Taken During delivery at home</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
26.a.Practice safety measures during delivery at home	Clean hands	254	86.99
	Clean surface	254	86.99
	Clean razor blade	254	86.99
	Clean cord tie	254	86.99
	Clean cord stump	254	86.99
	Total	292	100
26.b. Attender during delivery at home	Village Dai	95	32.53
	ANM	9	3.08
	Trained Dai	112	38.36
	Medical Practitioner	0	0
	Family members	38	13.01
	Neighbors	28	9.59
	Any other	10	3.42
	Total	292	100

(Source: Primary Data).

It has been observed from the table placed above that out of 345 mother beneficiaries 292 (84.6 per cent) had given birth at home. incase of practice of safety measures such as clean hand, surface, razor blade, cord tie and clean cord stump during delivery at home, the majority i.e. 86.99 per cent replied positively with maximum 38.36 per cent attended by trained Dai followed by 32.53 per cent attended by Village Dai. (Table No-D-1.1)

Table-D-1.2			
Care Taken To New Born			
Question	Class	Class Frequency	Percentage
26. c. Care taken to new born baby( under this response recorded as '0' mean replied No and any number means yes)	Cleaning of eyes	345	100
	Clean cord tie	307	88.99
	Bath after one week	345	100
	Close physical contact to Mother( to prevent hypothermia)	70	20.29
	All	32	9.28
	Total	345	100
	27. a. Did you gave birth to Child with Birth Weight	equal & above 2500gms	280
Less than 2500 gms.		65	18.84
Total		345	100
27. b. Treatment of child with low birth weight	At home	5	7.69
	PHC	25	38.46
	Civil Hospital	24	36.92
	Any other (specify)	11	16.92
	Total	65	100

(Source: Primary Data).

As far as, the Care of new born babies is concerned, from the table above, it has been observed that all of them did cleaning of eyes and bath after one week with a high majority 88.99 per cent of them tied the cord cleanly of their new born babies leaving only 20 per cent of the mother beneficiaries did keep their new born babies in close contact with them to prevent hypothermia. A very low 9.28 per cent of mother beneficiaries took all required care to the new born babies. As far as the birth weight is concerned only 18.84 per cent (65 Children) of the mother beneficiaries given birth to one child each with birth weight less than 2500 gms and 38.46 per cent and 36.92 per cent of the had been treated at PHC and civil hospital respectively. (Table No-D-1.2).

Table-D-1.3			
Knowledge on Spacing of Birth & New born risks			
Question	Class	Class Frequency	Percentage
28. (a & b) from Whom received knowledge about spacing of birth	ANM	165	45.83
	LHV	57	15.83
	AWW	55	15.28
	PHC Doctor	36	10.00
	Local Practitioner	15	4.17
	Any other (specify)	10	2.78
	Total	338	93.89
29. Did you get education on new born risks from ANM/LHV	Yes	235	65.28
	No	125	34.72
	Total	360	100

(Source: Primary Data).

In connection to knowledge received from health functionaries on spacing of birth, from the above table, it is found that majority of them (93.89 per cent) knew about spacing of birth and the highest 45.83 per cent of the beneficiaries received the knowledge and education from the ANMs and 65.28 per cent of the beneficiaries received the education on new born risks from the ANMs/LHVs. (Table No-D-1.3).

From the table below, it also came out that the 11.38 per cent ( 41 children) of the beneficiaries interviewed reported one or more children of their families suffered from Acute Respiratory Infection (ARI). Out of these 41 children, 60.97 per cent(25), 34.14 per cent(14) and 4.97 per cent (2) of them suffered from fast breathing, chest drowsing and both respectively and for treatment 36.58 per cent(16) of them consulted doctors,26.82 per cent(11) were hospitalized and rest were treated at home. Talking about the education on the precautionary measures to be taken at home to the child with pneumonia such as keeping the infant warm and away from draught, exclusive breast feeding up

to 4 months of age, DPT and Measles vaccination at the appropriate age and hand washing while feeding and touching the child, 48.88 per cent, 55 per cent, 59.72 per cent and 59.72 per cent of the beneficiaries replied that they had received education from ANM/LHV respectively. (Table No-D-2),

<b>Table-D-2</b>			
<b>Control of Acute Respiratory Infection (ARI)</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
30.a One or more Children suffered in family	Fast Breathing	25	60.97
	Chest Drowsing	14	34.14
	Both	2	4.87
	Total	41	100
30.b.Place of treatment when suffered	At Home	14	34.14
	Consulted Doctor	16	36.58
	Hospitalized	11	26.82
	Total	41	100
30.c.Did ANM/LHV educate you about following precautionary measures to be taken at home for child with Pneumonia?	Keeping infant warm & away from draught	176	48.88
	Exclusive breast feeding up to 4 months of age	198	55
	DPT & Measles vaccination at the appropriate age	215	59.72
	Hand washing while feeding & touching the Child	215	59.72
	Total families responded	360	100

(Source: Primary Data)

For children under 5 years of age suffered from diarrhea, the table mentioned below clarifies that a significant number i.e. 47.25 per cent of mother beneficiaries replied that their one or more children suffered the same and out of them 38.4 per cent, 33.74 per cent of the treated at PHC and at home respectively. On asking about the getting education from ANM/LHV about increased quantities of fluid to the child and continued breast feeding for the management of diarrhoea, 58.61 per cent and 47.77 per cent of the received so,

but on early signs of dehydration the response was nil and only 18.61 per cent of them learnt how to prepare ORS and its doses from ANMs/LHVs. (Table no-D-3)

<b>Table-D-3</b>			
<b>Diarrhoea</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
31.a. One or more Children under 5 years of age suffered from Diarrhoea in family	Yes	163	47.25
	No	182	52.75
	Total	345	100.00
31.b. Place of treatment when suffered	At home	55	33.74
	PHC	62	38.04
	Civil Hospital	18	11.04
	Medical C& H	18	11.04
	Any other (specify)	10	6.13
	Total	163	100.00
31.c. Did ANM/LHV educate you about following for management of child with Diarrhoea	Increased quantities of fluids to the child	211	58.61
	Continue feeding the child during Diarrhoea	172	47.77
	About early signs of dehydration	0	
	How to prepare ORS & its doses	67	18.61
	Total	360	100.00

(Source: Primary Data).

<b>Table-D-4</b>			
<b>Control of Vitamin –A Deficiency</b>			
<b>Question</b>	<b>Class</b>	<b>Class Frequency</b>	<b>Percentage</b>
32.(a & b). No. of Children Suffered from Vit-A deficiency in the family	One	35	10.14
	Two to Three	0	0.00
	Four to Five	0	0.00
	Six & above	0	0.00
	NIL	310	89.86
	Total	345	100.00
33. Care Taken to prevent Vit-A deficiency	Consumption of Vitamin-A rich food	164	47.54
	Exclusive breastfeeding	36	10.43
	Both	78	22.61
	NIL	67	19.42
Total	345	100.00	

(Source: Primary Data).

The above presented table projects that among the mother beneficiaries, only 10.14 per cent of all the mother beneficiaries reported with one of their children suffered from Vitamin-A deficiency. Out of all the mother beneficiaries, 47.54 per cent, 10.43 per cent and 22.61 per cent of the took care of their children in consumption of Vitamin-A rich food, exclusive breast feeding and both respectively. (Table no-D-4)

The above analysis shows that the home delivery attended by other than trained Dai or any other health functionary dominates in rural areas. In case of essential newborns care such as cleanly tied of cord, eye care, bath percentage of is high, but for all required care to be taken the percentage is very low. As a precautionary measure of hypothermia, keeping the newborn close to mother's contact, the awareness level is very as well the application of the same.

The prevalence of child birth with low birth weight among the beneficiaries is near to a countable figure and treatment of these children in a health institution also not so satisfactory. Suffering from acute respiratory infections by the children of the beneficiaries and the treatment by the doctor of in a health facility is not upto the mark. The percentage of beneficiaries receiving knowledge and education on precautionary measures of pneumonia from ANMs/LHVs is only nearing half of them and knowledge of management of children suffering from diarrhea at home is also low among these beneficiaries as against the fact that under 5 years children suffered from diarrhea is high. It is also seen that there were quite a good percentage of children suffering from Vitamin-A deficiency and below half of them were given iron rich food by their mothers/parents.



These all findings indicates towards the fact that the level of awareness and the efforts for taking care of newborns in general and at risks is still lacking leaving them at high risks of infant mortality and child mortality. It is also necessary to mention that service delivery of grass root level health functionaries in rural areas not up to the expected level and need to be geared up.

## **PART-E**

### **Immunization**

The vaccination of children against six killer diseases has been an integral part of child health care programme in India.

The National Immunization Programme has been implemented as per the National Health Policy. The Expanded Programme on immunization (EPI) was started by the Government of India in 1978. The main objectives were to reduce the morbidity, mortality and disabilities. The Universal Immunization Programme was also introduced during 1985-86. The standard immunization schedule developed for the child immunization programme specifies the age at which vaccine is to be administered and the number of doses to be given.

Since then the Children Immunization against six killer diseases has become the integral part of all national and regional initiatives on child health and the RCH Programme has no exception to that.

In this section of this part of the chapter, the data on immunization status of children and source of information received on immunization from the beneficiaries were collected, analyzed and presented below.

Table E-1			
Immunization			
Question	Class	Class Frequency	Percentage
34.a. Whether all your children Immunized	Yes	312	90.43
	No	33	9.17
	Total	345	100
34.b. From whom did you know about immunization	ANM/LHV	215	62.32
	AWW/Supervisor	178	51.59
	Family Planning Worker	22	6.38
	Private Doctor	56	16.23
	Local Practitioner	46	13.33
	Mass Media	297	86.09
	Total responded	312	90.43
34.c. Whether all your children Immunized (completely) by the following	BCG	172	49.86
	Polio	172	49.86
	Measles	172	49.86
	DTP	172	49.86
	TT	172	49.86
	Total	172	49.86
34.d. Place of Immunization	PHC/HSC	101	58.72
	At home by ANM	45	26.16
	Civil Hospital	16	9.30
	Private Doctor/Nursing Home	8	4.65
	Any other (specify)	2	1.16
	Total responded	172	100

(Source: Primary Data).

In respect to the immunization of children from the above table, it has been observed that the high majority i.e. 90.43 per cent of the mother beneficiaries replied that all of their children were immunized and 86.06 per cent of them came to know about immunization from mass media and along with 62.32 per cent from ANMs/LHVs. As far as complete immunization by the all doses of BCG, DTP, Polio, TT and Measles only 49.86 per cent of the replied positively and majority i.e. 58.72 per cent of them were immunized at PHC/HSC. (Table No-E-1).

The above facts and figure shows that immunization status of children is high and mass media is the source of information on immunization for the majority of the beneficiaries. But, when complete immunization by all vaccines is concerned, only half of them replied positively, making it as very serious issues in rural areas. This may be also because of the fact that out of remaining half of them, many were not aware of what is called complete immunization and what are the vaccines and when to be given even their children had already received the same

## CONTRACEPTIVES

Although, the National Family Welfare Programme was initiated in 1952 and expanded with increasing efforts and inputs in successive plans, the crude death rate is still 27.2/10000 population (SRS-97) with a growth rate of 2.14 which is still very high. To keep the Net Reproductive Rate (NRR) of unity which is the country's long-term goal for the replacement level fertility by 2000-2016, greater efforts will be needed. It is estimated that only 46 per cent of currently married women use a contraceptive method which only about 6 per cent are using spacing methods. By far the most popular method of contraception is sterilization which is used by 67 per cent of current contraceptive users. In sterilization about 98 per cent are women and men contribution is very little.

There for to bring the birth rate down the RCH Programme has been adopted Contraceptives as component of the programme since inception. Under this programme focus has been given to increase the couple protection rate, attention to younger couple with 2 or less children, increasing the male participation in family planning by way of increased awareness and adoption of family planning methods. In this section, beneficiaries were asked questions to measure the use of family planning methods and their level of awareness about family planning and their responses analyzed and presented below

Table E-2			
Contraceptives & Family Planning			
Question	Class	Class Frequency	Percentage
35.a. Did you received knowledge on Family Planning & methods	Yes	189	52.50
	No	171	47.50
	Total responded	360	100
35.b. From whom you received the knowledge & education on Family Planning	ANM/LHV	86	45.50
	PHC doctor/staff	75	39.68
	Civil Hospital	13	6.88
	Private doctor	11	5.82
	Local Practitioner	0	0.00
	Family Planning Worker	4	2.12
	Total	189	100
35.c. Did you adopted any family planning methods	Yes	45	13.04
	No	300	86.96
	Total responded	345	100
35.d. Which method adopted	Condom/Nirodh	15	30.61
	Oral pills	21	42.86
	Intra Uterine Device(IUD)	4	8.16
	Tubectomy	2	4.08
	Vasectomy	3	6.12
	Laparoscopic	0	0
	Total	49	100

(Source: Primary Data).

The above table reflects that on the level of awareness on family planning, 52.50 per cent of the beneficiaries know about family planning and its various methods. Out of them 45.50 per cent and 39.68 per cent of the beneficiaries received knowledge and education from ANM/LHV and PHC doctors/staff respectively. As far as adoption of any family planning methods concerned, only 13.04 per cent of all the mother beneficiaries went for the same and out of these 42.86 per cent, 30.16 per cent, 8.16 per cent 6.12 per cent and 4.08 per cent of them adopted Oral Pills, Condom/Nirodh, IUD, Vasectomy and Tubectomy respectively. (Table No-E-2).

These findings represent that still in rural areas people are not fully aware of family planning and its various methods and moreover, those who know the family planning, the adoption of any methods among them is very negligible and the most preferred method is the oral pills making it very clear that male participation in family planning is low. All these facts imply that there is a wide gap between the awareness generated and the following of the same.