CHAPTER-V

KNOWLEDGE, OPINIONS AND PROBLEMS OF BENEFICIARIES AND BENEFICIARIES

Health workers are deputed in villages to provide services and making them aware of various health facilities available for the at PHC level or within their reach

KNOWLEDGE, ATTITUDES AND OPINIONS OF THE BENEFICIARIES

To meet the one of the objective of the study as to measure the knowledge, attitudes and opinions of the beneficiaries towards the services and the functionaries responsible for making the RCH Programme reachable and accessible to them, questions were asked to sampled beneficiaries and responses so gathered/data collected has been analyzed and presented below.(Table-F).

Table F

Knowledge, attitudes and opinions of the beneficiaries

Question	Class	Class Frequency	Percentage
36. a) Are you satisfied with the location of the PHC?	Yes	192	53.33
	No	168	46.67
	Total	360	100.00
36.b. Do you know about the Reproductive and Child Health Programme and Services provided	Yes	178	49.44
	No	182	50.56
	Total	360	100.00

37. a) Do you know about various anti-natal and post-natal care?	Yes	205	56.94
	No	155	43.06
	Total	360	100.00
37.b. Are you satisfied with the service delivery of ANM/LHV during your pregnancy?	Yes	189	55
	No	156	45
	Total responded	345	100
37.c. Are you aware of TT immunization and Iron tablets to be taken during pregnancy?	Yes	345	95.83
	No	15	4.17
	Total	360	100.00
37.d. Are you aware of safe practices during delivery at home?	Yes	292	81.11
	No	68	18.89
	Total	360	100.00
38. a) Do you know about Nutritional Anaemia, its causes and its preventive measures?	Yes	213	59.17
	No	147	40.83
	Total	360	100.00
38.b. Do you think ANM/LHV provided enough knowledge and education to you about Nutritional Anaemia	Yes	213	59.17
	No	147	40.83
	Total	360	100.00
39. a) Do you have adequate knowledge about adolescent reproductive health?	Yes	146	40.56
	No	214	59.44
	Total	360	100.00
39.b. Do you have enough knowledge about the Safe sex, RTIs, STIs, HIV/AIDS, and STDs?	YES	114	31.67
	NO	246	68.33
	Total	360	100
40. Do you know why and where abortion will take place?	Yes	210	58.33
	No	150	41.67
	Total	360	100
41. Do you provide equal care and support to all your Children?	Yes	345	95.83
	No	15	4.17
	Total	360	100
42. a) Have you received adequate knowledge and education on the following?	Breastfeeding	201	55.83
	Essential New Born Care and New born risks	234	65
	Food items for 1-6 years age group of children	284	78.89
	Low birth weight	284	78.89
	Total responded	360	100
42.b. Do you know about the spacing of birth?	Yes	338	93.89
	No	22	6.11
	Total responded	360	100.00
43. a) Do you know anything about the following?	Fast breathing of Child	213	59.17
	Chest drowsing	118	32.78
	Both	178	49.44
	Total responded	360	100
43. b. Do you know the precautionary measures for Pneumonia?	Yes	175	48.61
	No	185	51.39
	Total responded	360	100
44. Do you know about the management of child with diarrhea	Yes	188	52.22
	No	172	47.78

at home?	Total responded	360	100
45. Do you know how to prepare ORS at home and its doses?	Yes	67	18.61
	No	293	81.39
	Total responded	360	100
46. Are you aware of immunization of children and its schedule?	Yes	312	86.67
	No	48	13.33
	Total responded	360	100
47. Do you know about the benefits of family planning and its various methods?	Yes	189	52.5
	No	171	47.5
	Total responded	360	100

(*Source*: Primary Data).

As can be seen from the above table, 53.33 per cent of the respondent reported satisfaction with the location of the PHC leaving 46.67 per cent unsatisfied and below half of them i.e. 49.44 per cent reported for not having knowledge and awareness about the RCH Programme and its services. It was also found that only 56.94 per cent of them were educated for ante-natal and post-natal care and near to that 55 per cent were satisfied with the service delivery during pregnancy by ANMs/LHVs. The immunization of pregnant women by TT during pregnancy, almost 96 per cent of beneficiaries responded that they are aware of that and 81 per cent of them were also agreed that they are aware of safe practices during delivery at home.

As RCH has the measures to educate women about nutritional anaemia, 59 per cent of the responded found the education provided by ANM/LHV on nutritional anemia was enough and they are aware of that. The responses of the beneficiaries were poor in case of having knowledge on adolescence reproductive health and safe sex, RTI, STI, HIV/AIDS, STD, which were 40 per cent and 31 per cent respectively. Abortion as a matter of concern under RCH, the 58 per cent of the beneficiaries find themselves aware of when and where the abortion should take place. The RCH also had initiatives to minimize the

gender discrimination among children; it was found that 95 per cent of the beneficiaries did not discriminate while taking care of their children in any respect. The knowledge and education to be received on breastfeeding, essential new born care and risks, food items for children of age 1-6 years and low birth weight, it was found that 58 per cent, 65 per cent, 78 per cent and 78 per cent respectively of the beneficiaries did receive such knowledge and education. The awareness level about the precautionary measures and symptoms of pneumonia, below half of the beneficiaries were responded positively such as 48 per cent and 49 per cent respectively. This low awareness trends also found in case of management of children with diarrhoea at home as only 52 per cent replied that they know, but the condition is worse when they were asked about their knowledge on how to prepare ORS at home and it doses, as low as 18 per cent replied positively. The awareness level of beneficiaries on children immunization and the schedule of immunization, they were still below the desired level as only 86 per cent of them know when and why to get their children immunized. The family planning as an integral part of RCH Programme, lots of efforts had been taken and on that 52 per cent of the beneficiaries were found aware of various family planning methods and their benefits.

From the analysis of above findings, it can be said the level of awareness among beneficiaries about the various services of RCH Programme is not uniform and which indicates functionaries are not making equal efforts to render the services holistically rather than partially. It also visible that in comparison to the awareness the outcome is poor, that makes it very clear that people are aware of various disease, but hesitate to accept or follow the preventive

measures or practice them. It is also seen that there is still social stigma attached when the issues related to sex are taken in to account. As regard to the service delivery of health functionaries to the community, there is lacking of efforts to make people motivated not only accept the knowledge but increase the percentage of people to follow the same.

KNOWLEDGE, OPINIONS AND PROBLEMS OF THE FUNCTIONARIES

In the rural areas, Primary Health Care services are provided through a network of service delivery units called Sub-Centres, Primary Health Centres and Community Health Centres. Primary Health Care pays particular attention to the point of initial contact between members of the community and the health services. Cases needed sophisticated care are referred to the secondary and tertiary levels. In short, it can be said more than 90 per cent of health services availed by the community people in rural areas are delivered by this primary health care service delivery units and thus status of health in rural areas largely depends on the proper functioning of these units.

The effective functioning of these units can be determined by the way of management of these units and their services by the functionaries and how they meet the targets set by the higher authority.

Service provision targets form the basis for most of the primary health care planning in the government health care system in India. These targets are derived at the national level from the desired progress to be made towards achieving goals set for the year 2000 in the National Health Policy (1982). The Ministry at the national level allocates these targets to the states, largely based on population norms. The states repeat this process with the districts which in turn allocate them to primary health centres. Broadly the government's primary health care structure in India consists of primary health centres (PHC), each of

which caters to a population of 30,000 in 20-40 villages. The PHC is manned by a medical doctor and 2-3 paramedical workers. Under each PHC there are four to six sub-centres - one for 5,000 population. Each such sub-centre is staffed by a male and a female multi-purpose health worker. Each district has about 50 PHCs.

To be very specific most of the health services are delivered by the following health care functionaries in rural areas-(i) Auxiliary Nursing Midwives(ANMs) or so called Female Health Workers-delivers the health services at door steps, (II) Lady Health Visitors(LHVs) or so called Female Health Assistant-plays the role of supervisor and guide in effective and proper delivery of services by ANM and (III) Medical Officers(MOs)- who manned a primary health care centre and its services to be delivered.

The services designed under the RCH Programme to be delivered to rural population have to be by these functionaries only as a integrated part of their roles and duties. They are the government level health workers and apart from them there NGOs, who are also has been playing active role in delivering RCH services in rural areas under Public Private Partnership concepts and also on their own initiatives. Thus it makes it necessary to have analytical study on their knowledge, opinions and the problems these government health and non-government health functionaries faced in delivering the RCH services to grass root level to meet the prime goal of the study to evaluate the impact of the RCH Programme on the general health status of mother and children.

To meet one of the objectives of this study, below in this part of the chapter will deal with analysis of data collected from the 36 ANMs, 36 LHVs, 12 Medical Officers and 5 NGO workers on their knowledge, opinions and problems faced.

AUXILIARY NURSING MIWIVES (ANMs)

In this section of this chapter, responses were collected from ANMs on the their knowledge, opinions and problems faced in delivering the health care services at the community level have analyzed and presented below

Before going to have analysis of findings on the knowledge, opinions and problems of ANMs, let's have a look on their demographic and socio-economic profile.

Table-2

Demographic and Socio-economic Profile of ANMs

Description	Class	Class frequency	Percentage
AGE	Below 15	0	0.00
	16-25	7	19.44
	26-35	26	72.22
	36-45	3	8.33
	46 and above	0	0.00
	Total	36	100.00
Religion	Hindu	21	58.33
	Muslim	15	41.67
	Christian	0	0.00
	Others	0	0.00
	Total	36	100.00
Caste	SC	6	16.67
	ST	1	2.78
	OBC	1	2.78
	OC	28	77.78

	MOBC	0	0.00
	Total	36	100.00
Education	Illiterate	0	0.00
	Primary	0	0.00
	Middle School	3	8.33
	High School	15	41.67
	Higher Secondary	17	47.22
	Degree	1	2.78
	Any other (specify)	0	0.00
	Total	36	100
Marital Status	Married	29	80.56
	Unmarried	7	19.44
	Widowed	0	0.00
	Divorced	0	0.00
	Separated	0	0.00
	Total	36	100.00
Type of Family	Nuclear	21	58.33
	Joint	15	41.67
	Total	36	100.00
Size of the family	Two	6	16.67
	Three - four	15	41.67
	Five - Six	12	33.33
	Seven & above	3	8.33
	Total	36	100.00
Family Occupation	Coolie	0	0.00
	Own Agriculture	14	38.89
	Service (Govt./Private)	7	19.44
	Business	15	41.67
	Any other (specify	0	0.00
	Total	36	100.00
Family Income	Below Rs-1000/	0	0.00
	Rs-1001/-3000/	0	0.00
	Rs-3001/-5000/	7	19.44
	Rs-5001/ and above	29	80.56
	Total	36	100.00

(*Source*: Primary Data).

The above table on demographic and socio-economic profile of the ANMs, shows that high majority i.e. 72.22 per cent of the ANMs were from 26-35 age group followed by 15.28 per cent were from 16-25 age group. In regards to the religious composition 58.33 per cent and 41.73 per cent of the ANMs were belongs to Hindu and Muslim religion respectively. Caste wise distribution of the ANMs was dominated by the general caste i.e. 77.78 per cent. Educationally

47.22 per cent, 41.67 per cent, 8.33 per cent and 2.78 per cent of them were educated up to Higher secondary, High School, middle school and degree level respectively. From the marital status point of view 80.56 per cent of them were married with only 19.44 per cent were un-married. About 58.33 per cent of the ANMs were from nuclear families with rest 19.44 per cent of them were from joint families. In respect to the Size of the families of ANMs, the 41.67 per cent of them were having the size 3-4 members followed by 33.33 per cent with the size of 5-6 members. Family occupation wise, 41.67 per cent of the were from small business background followed by 38.89 per cent of them live on own agriculture and family income wise 80.56 per cent of families of the ANMs earn more than Rs-5000/ per month followed by 42.22 per cent earn Rs-3000/-5000/ per month. (Table No-2).

Knowledge, opinions and problems on the job.

The majority 88.89 per cent of the were found working in their native place and 63 per cent faced one or other problems while delivering their duties at community level. Among the problems faced were non-cooperation from the community, higher authority, beneficiaries and political problems. Experience wise, 38.89 per cent and 33.33 per cent of them were working as ANM for last 4-5 years and 2-3 years respectively and more than half 63.89 per cent of them opined that they are satisfied with this job and like to continue the same. Out of these ANMs 72.22 per cent of them received adequate on the job training.

Knowledge, opinions and problems on the services delivery and the RCH Programme.

The 77 per cent of the interviewed ANMs opined that the beneficiaries are fully aware of various services of the RCH Programme available at community level health facility and to be availed when needed.

All of them expressed that they are conducting mothers meeting regularly with highest, 52 per cent of them conducted monthly followed by 33 per cent conducted fortnightly.

It was also found that all of them explained the family planning and its methods to the beneficiaries during their regular home visits and in the mothers meetings and as per their opinion, the most preferred methods of family planning by the beneficiaries were condoms, oral pills and tubectomy and 86 per cent of them had been able to motivate 5-10 couples to adopt family planning methods.

Educating the women beneficiaries on the intake and quality of food to be taken during ante-natal and post-natal period as one of their major responsibility, cent percent of them responded that they have educated them on the same.

All these targeted ANMs responded positively as regard to the distribution of IFA tablets (for women and children) and Vitamin tablets or drops for children, maintaining health card (for women and children) and weighing the children monthly regularly in their respective communities.

The home visits to women beneficiaries during post natal period, they did go and 86 per cent of them went 5-6 times to every woman beneficiaries during their post-natal period in their duty areas. According to their opinion the most common childhood diseases prevails in their areas are typhoid, mumps, fever, dysentery etc and a great number of children also suffered from malnourishment.

On community participation, only 19 per cent of them replied of having any community organizations or associations functioning for the welfare of children and women in their locality and as far as cooperation from the villagers is concerned, 72 per cent of them find the villagers are cooperative in the delivery of primary health acre services as a whole.

To asses the guidance and visit by the higher authority such as Medical Officer, 75 per cent of them reported that the medical officers visited them once in three months. When they were asked, whether they attend the sectoral meetings regularly, it was found that they all do so. It is encouraging to note that 91 per cent of the reported with the receipt of help from other government departments and only 13 per cent of the faced any problem due to village conflicts or village politics in delivering the services at grass root level in the community. They also came out with the noteworthy replies that 86 per cent of them were satisfied with cooperation getting from the higher authority.

From the above analysis of the responses collected, the delivery of services to the beneficiaries by the ANMs is satisfactory. But, there are few areas of concern arises out of their expression of opinions such as conduction of

mother meetings, adoption of family planning, malnourishment of children, involvement of community organizations and visits by higher authority.

LEADY HEALTH VISITORS (LHVs)

In this section of this chapter, responses were collected on the their knowledge, opinions and problems faced from LHVs in delivering the health care services at the community level have analyzed and presented below

Before going to have analysis of findings on the knowledge, opinions and problems of LHVs, let's have a look on their personal profiles from the table below.(Table-3).

Table-3

Demographic and Socio-economic Profile of LHVs

Description	Class	Class frequency	Percentage
AGE	Below 15	0	0.00
	16-25	0	0.00
	26-35	0	0.00
	36-45	3	8.33
	46 and above	33	91.67
	Total	36	100.00
Religion	Hindu	28	77.78
	Muslim	7	19.44
	Christian	1	2.78
	Others	0	0.00
	Total	36	100.00
Caste	SC	6	16.67
	ST	2	5.56
	OBC	2	5.56
	OC	26	72.22
	MOBC	0	0.00
	Total	36	100.00
Education	Illiterate	0	0.00
	Primary	0	0.00

	Middle School	0	0.00
	High School	4	11.11
	Higher Secondary	29	80.56
	Degree	3	8.33
	Any other (specify)	0	0.00
	Total	36	100.00
Marital Status	Married	36	100.00
	Unmarried	0	0.00
	Widowed	0	0.00
	Divorced	0	0.00
	Separated	0	0.00
	Total	36	100.00
Years in Service in the present job	0-1 years	0	0.00
	2-5 years	0	0.00
	5-10 years	15	41.67
	10 years & above	21	58.33
	Total	36	100.00
Years in Service in the previous job	0-1 years	3	8.33
	2-5 years	5	13.89
	5-10 years	0	0.00
	Ten years & above	0	0.00
	Total	36	100.00
Training Undergone	Yes	36	100.00
	No	0	0.00
	Total	36	100.00

(*Source*: Primary Data).

Out of all the LHVs interviewed, as high as 91 per cent of them were above 46 years of age, 77 per cent belongs to Hindu community followed by 19 per cent from Muslim community and caste wise majority, 72 per cent of them were from general caste and 19 per cent of them from schedule caste. Educationally, 80 per cent of them were completed their education up to higher secondary and cent percent of there were married.

Knowledge, opinions and problems on the job.

Almost 58 per cent of them were performing this job since last 10 years and above followed by 41 per cent since more than 5 years and all of them

undergone on the job training and would like to continue the same job as they find themselves satisfied with the job.

Knowledge, opinions and problems on the services delivery and the RCH Programme.

On the coverage of villages and sub-centres, they reported that 72 per cent of the covers more than 10 villages each and 6-7 sub-centres and 58 per cent of their villages are connected through motorable roads. The rest 42 per cent of villages under their coverage, they find it very difficult visit regularly and wished to improve the road conditions to deliver the required health care services effectively, specially during rainy season. About 78 per cent of them have visited their respective villages and sub-centres with the frequency of once a week and during their visit, they provide the guidance to the ANMs on routine immunization, antenatal and postnatal cares, newborn care, adolescent reproductive health and village surveys.

All of the takes the lead in conducting the village surveys and they have already completed survey of their allotted villages. During the village surveys, they provide all required guidance and supports to their subordinate functionaries in identifying the target groups, data collection on child births and deaths, maternal deaths, childhood diseases prevailing and malnourishment of children and women etc.

They were also found that 91 per cent of the remains actively involved in conducting community meeting with beneficiaries and community leaders, visiting village level organizations (if any),family visits and maintaining

relationships with the functionaries of other government departments. As high as 95 per cent of the holds the periodic meetings with ANMs and initiate their contacts and meeting with Medical Officers.

They are also entrusted with the responsibility of planning for delivery of services in a effective manner, 91 per cent of them expressed that they always mobilize human and materials resources from the local communities, other government departments and from other available sources with the help of ANMs while to ensure active community participation and effective delivery of services in the areas of health education, nutrition, immunization and overall heath care.

As the implementation of RCH and primary health care services at grass root level largely depends on their active involvement, almost all of them were responded on their full participation in the same by the way of identifying the common disease of women and children, ensuring community support and participation, periodic review of health programme progress in their respective areas of work.

They were also found active in supervising the ANMs through field visits and provide guidance in the areas of maintenance of registers, records, stock register, materials register, weighing children, distribution of simple medicines, referring a risk children and mothers to hospitals and writing reports etc. Based on the observations during their field visits, the forward all sorts of guidance to rectify any mistakes found.

In regards to the receipts of help and supports from local leaders, panchayat members, youth clubs, mahila mandals, village co-operatives and schools and other Government and Welfare functionaries, 72 per cent of the were found satisfied with help and supports they received.

In spite of all their positive efforts, 41 per cent of them opined on the changes and improvement in the administrative management of the health care services from the higher level authority. Problems they most suffered, were reported of 13 per cent village politics, 13 per cent community conflict and above these 33 per cent of them also opined that the responses they are getting from the beneficiaries is not satisfactory.

This analysis of responses received from these LHVs, revels that they took all active efforts to make the RCH services available and accessible to the beneficiaries. But, the services were still not fully utilized and accessible to the beneficiaries due to certain conditions such as lack beneficiary's response, raod conditions, village conflicts and misadministration.

MEDICAL OFFICERS (MOs)

In this section, the responses were collected from the Medical Officers (MOs) to asses their knowledge, opinions and problems faced in making the RCH services reachable to beneficiaries and these responses are analyzed and presented below.

Table-4			
Demographic and Socio-economic Profile of MOs			
Description	**Class**	**Class frequency**	**Percentage**
AGE	Below 15	0	0.00
	16-25	0	0.00
	26-35	0	0.00
	36-45	4	33.33
	46 and above	8	66.67
	Total	12	100.00
Religion	Hindu	11	91.67
	Muslim	1	8.33
	Christian	0	0.00
	Others	0	0.00
	Total	12	100.00
Caste	SC	3	25.00
	ST	0	0.00
	OBC	0	0.00
	OC	9	75.00
	MOBC	0	0.00
	Total	12	100.00
Education	Illiterate	0	0.00
	Primary	0	0.00
	Middle School	0	0.00
	High School	0	0.00
	Higher Secondary	0	0.00
	Degree	4	33.33
	Any other (specify)	8	66.67
	Total	12	100.00
Marital Status	Married	12	100.00
	Unmarried	0	0.00
	Widowed	0	0.00
	Divorced	0	0.00
	Separated	0	0.00
	Total	12	100.00
Years in Service in the present job	0-1 years	0	0.00
	2-5 years	7	58.33
	5-10 years	5	41.67
	10 years & above	0	0.00
	Total	12	100.00
Years in Service in the previous job	0-1 years	0	0.00
	2-5 years	10	83.33
	5-10 years	2	16.67
	Ten years & above	0	0.00
	Total	12	100.00
Training Undergone	Yes	12	100.00
	No	0	0.00
	Total	12	100.00

(*Source*: Primary Data).

From personal profiles of these medical officers as presented in the table above it was found that 67 per cent of them were above 46 years of age and 33 per cent of them were in the age group of 36-45 years, a high majority, 91 per cent belongs to Hindu community and caste wise majority, 75 per cent of them were from general caste and rest of them were from schedule caste. Educationally, 67 per cent and 33 per cent of them were completed their education up to MBBS and Post Graduate and cent percent of there were married. (Table-4)

Knowledge, opinions and problems on the job.

Out of them, 58 per cent of them were performing this job since last 2-5 years followed by 42 per cent since last 5-10 years and all of them undergone on the job training and 56 per cent would like to continue the same job as they find themselves satisfied with the job.

Knowledge, opinions and problems on the services delivery and the RCH Programme.

As heads of the Primary Health Centres, all of them manage the planning and administration of their respective PHCs in the areas of recruitment, training, organization and functions of the centres and other staff. They were also reported with the leading in planning and implementation of health care services to the beneficiaries with the help of other functionaries working under them. It was also found that they all were actively involve themselves in creating community level awareness by attending community meetings, health check-up

camps, awareness programmes, visiting villages and sub-centres and clarifies the roles of health functionaries to the community and the role of communities in improving the overall health status.

Apart from the planning and administration of the PHCs, information were also collected on their co-ordination activities and it was reported that they all try to maintain co-ordination among village level, PHC level and Block level committees in order to ensure community participation and ownership. In this processes of co-ordination activities, they always maintain linkages with other voluntary organizations and between district level and state officials.

As far as guidance and support provided to LHVs, ANMs and other field level functionaries, it was fount that they always extend the same to them in effectively performing their duties. 67 per cent of the were found that they make individual and team visits to the villages and sub-centres at least once in two months to check records and registers.

As a part of the staff development and reporting activity, 84 per cent of the were responded that they regularly collects reports from LHVs/ANMs and other field level health functionaries, analyze these reports and transmit them to higher district and state level authority. From the findings of the analysis of these reports, they find out the point of focus to be given in order to develop the staff.

About the problems they faced in delivering the RCH services to beneficiaries, they were reported that they find it very difficult to handle the both the management and clinical aspects of PHCs and also the PHCs are overloaded and staff in position is less than the required. To tackle these

problems, the forwarded the suggestions of more and more NGOs/VOs involvement in the grass root level delivery of services. They also pointed out that the response to a specific problem from the higher authority is slow and the beneficiaries also lack interest in approaching the services.

These all indicates that the medical officers are working under the pressure and that sometime compel them to compromise the quality of services.

NGO WORKERS

As mentioned in the beginning of this chapter, apart from these government health functionaries, five NGO workers also been interviewed, who were delivering the RCH services with the support of government under the programme or on their own.They were mainly interviewed to elicit the information on community participation and awareness level. In this section, the information gathered from NGO workers has been analyzed and presented below.

Table-5

Demographic and Socio-economic Profile of NGO Workers

Description	Class	Class frequency	Percentage
AGE	Below 15	0	0.00
	16-25	2	40.00
	26-35	3	60.00
	36-45	0	0.00
	46 and above	0	0.00
	Total	5	100.00
Religion	Hindu	5	100.00
	Muslim	0	0.00
	Christian	0	0.00
	Others	0	0.00
	Total	5	100.00
Caste	SC	1	20.00
	ST	0	0.00

	OBC	0	0.00
	OC	4	80.00
	MOBC	0	0.00
	Total	5	100.00
Education	Illiterate	0	0.00
	Primary	0	0.00
	Middle School	0	0.00
	High School	0	0.00
	Higher Secondary	0	0.00
	Degree	3	60.00
	Any other (specify)	2	40.00
	Total	5	100.00
Marital Status	Married	1	20.00
	Unmarried	4	80.00
	Widowed	0	0.00
	Divorced	0	0.00
	Separated	0	0.00
	Total	5	100.00
Years in Service in the present job	0-1 years	2	40.00
	2-5 years	3	60.00
	5-10 years	0	0.00
	10 years & above	0	0.00
	Total	5	100.00
Years in Service in the previous job	0-1 years	0	0.00
	2-5 years	1	20.00
	5-10 years	0	0.00
	Ten years & above	0	0.00
	Total	5	100.00
Training Undergone	Yes	3	60.00
	No	2	40.00
	Total	5	100.00

(*Source*: Primary Data).

On personal profile as reflected by above table, out of the 5 NGO workers 60 per cent (3) of them were from the Mother NGOs directly supported by the department of health and family welfare, Govt. of Assam to deliver the RCH services and rest 40 per cent (2) were from the NGOs independently working for the RCH services at community level. Educationally, they were graduate and working in the field of rural development since last 3-5 years. (Table-5).

About the community participation in delivering of RCH services at grass root level, 60 per cent of them felt that the in spite of implementing a well

designed and expensive programme, the health status of mother and children of these areas are far below the expected level due to lack of community participation and involvement. Moreover, the beneficiaries were more reluctant to reach the nearest health facility in need and also did not value the benefit of good health on their socio-economic conditions.

They opined that beneficiaries were not able to avail the required services as and when needed as in rural areas still the decision making power is with the male members or head of the families. This makes the women and children more vulnerable than others.

Almost all of them opined that the another reason of poor performance in the field of RCH in these areas as compared to other parts of the country was the low level of awareness of beneficiaries about the availability of RCH services near to them and the necessity of keeping the good health of mother and children for all round development of their families and the community as a whole.

The also pointed out the ill affect of social stigmas and superstitions prevailing in rural areas. The found that beneficiaries were not coming forward to discuss all the aspects of health especially in case of sexual health of mother and adolescent girls. They still considered these issues are the matter of shame irrespective of their benefits of discussions on their health status.

The poor economic and low educational conditions of beneficiaries were among the other causes of low performance in the field of RCH, they expressed. Half of them also opined that the efforts of government health functionaries in the

effective and proper delivery of RCH services were not up to the mark, making it more difficult for the beneficiaries to come closer to these services

This analysis points out that the lack of awareness and health education on the mother and child health by the beneficiaries and on the availability of services and how to access these. It is also need to be mentioned that the performance of health functionaries also not up to the desired level.