Gap Between Maternal and Child Health Service Delivery and Utilisation in Orissa: A Micro-Level Exploratory Study

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Preface

The recent draft of the Planning Commission of India has identified infant and maternal mortality and morbidity as some of the major concerns of 'human development'. The same is among the priority areas in the MDGs of UNDP. Some studies have shown that many of the supply (financial constraint, geo-physical disadvantages) and demand (poor awareness level) factors can influence significantly the utilization of available health services. To understand the magnitude and quality of health service delivery to and utilization by any population, one needs to examine some of the important components systematically. They are: the household socio-economic condition, health status and treatment seeking behaviour, amount and source of health information to people, utilization of specific health services, service delivery components, work environment of service providers (governance), attitude of service providers, suggestion management and integration (convergence) of the suggested components for overall development.

The frequent coincidence of poor maternal and child health situations with that of lower level of service utilization as well as delivery in the state of Orissa raises much doubt about possible causal relationships between them. This also leads to apprehend a possible hidden gap between maternal and child health service delivery system as well as utilization at the community level. Against these backdrops a research study, based on primary data from one district of Orissa as a case, was undertaken following an Anthropological approach. It was aimed at understanding the social, economic and cultural factors associated with health situation vis-à-vis service delivery and utilization. This also tries to examine plausible gaps between the *supply, demand and utility* factors of the maternal and child health services in Orissa.

This publication is the outcome of a five-year long concept developed and researched by the author and the final systematic analysis of field based primary data. It is divided into seven chapters. The first three chapters present the rationale behind this work and the study objectives as well as methodology in details. These also give an account of the geo-physical characteristics of the study and the profile of the respondents. The fourth chapter is all about the health service utilization by the people. This goes into details about the health status and treatment seeking behaviour of the people. This also covers some other important aspects of service utilisation as well as governance such as health information- availability and sources, maternal and child health service utilisation and quality of care.

The fifth chapter presents the importance of health governance for better health service to people. The health service providers' work environment is studied in details with a qualitative approach. The sixth chapter discusses about the convergence of perceptions at different levels such as community, health service providers and policy makers (senior officials) and their possible incorporation to implementation stage. The seventh and the final chapter present the summary and implications of the study.

This study and the concept being one among the few ones based on primary data and on micro level governance issues in health, will be useful for researchers, academicians and NGOs working on maternal and child health service delivery and utilisation.

Dr. Satyajeet Nanda

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Dr. Satyajeet Nanda

Gap Between Maternal and Child Health Service Delivery and Utilisation in Orissa: A Micro-Level Exploratory Study

Chapter I

Introduction

1.1 Rationale and Background of the Study

In order to check the alarming rates of mortality and morbidity a sizeable number of programmes have been devised in post-independence India. The situation being grave as regards the health of women and children, programmes like ICDS, CSSM, MCH and RCH have already been launched. Unfortunately, despite a plethora of such programmes and multiplicities of researches in this area, the progress on this front is far from satisfactory, particularly, when we compare our achievements with that of the developed world and many other developing countries. In fact, the recent draft of the Planning Commission of India has identified infant and maternal mortality and morbidity as some of the major concerns of 'human development'.

The maternal and child health conditions in Orissa have continued to be grave over the decades. The maternal and child mortality rates in Orissa have been at a much higher magnitude than the national averages and infant mortality rate (IMR) is the highest among all the states of India (IMR was 83 in the year 2003[1]). A study (Nanda *et al.*, 1999) has shown that many of the supply (financial constraints, geo-physical disadvantages) and demand (poor awareness level) factors can influence significantly the utilisation of available health services.

In a report on Governance: Local Public Health Governance Performance Assessment (2006), the National Public Health Performance Standard Programme says any public health agency is responsible for fulfilling three core functions:

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1 *SRS Bulletin*, April 2005.

Assessment includes

1. Monitoring the health status to identify community health problems, diagnose and investigate health problems
2. Inform, educate and empower people about health issues.

Policy Development includes developing policies and plans that support individual and health efforts.

Assurance includes

1. Enforcing laws and regulations that protect health and ensure safety
2. Link people to the needed personal health services
3. Assure a competent public healthcare staff
4. Evaluate effectiveness and accessibility
5. Research for new insights and innovations.

The findings of a report on Infant and Child Mortality in India by Pandey *et al.*, (1998) suggests that: Health intervention programmes should focus on illiterate mothers and on households that are poor, especially SCs & STs and that lack access to a flush or pit toilet. Among health-care interventions, immunisation of pregnant women against tetanus has a substantial effect in reducing neonatal mortality.

At a conceptual level, Kennedy's adaptive behaviour model and Rossenstock's health belief model converge with the researcher's viewpoint. Kennedy suggests that within any workable environment, human beings display different kinds of behaviour that provide a workable adaptation to the threat of a disease and other health-related problems. Similarly, Rossenstock is of the view that a person feels motivated to opt for preventive practices to avoid disease only if he/she believes that he/she is susceptible to the disease and that the occurrence of the disease would have severe repercussions on him/her.[2] It implies that availability of health services in the neighbourhood may act as one of the prime factors which influence the individual families' approach towards seeking/utilising RCH services. Thus there is the possibility of the existence of a linkage between the trinity of *supply, demand and utility* of RCH services due to the presence of certain intervening factors.

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2 For further understanding, see S.R.Mehta, 1987.

The high levels of infant mortality and morbidity, maternal mortality and morbidity, malnutrition, etc. in Orissa lead one to apprehend a possible hidden gap between maternal and child health service delivery system as well as service utilisation at the community level. Now it is high time to find out the problems from the viewpoints of the health service providers as well as from the perspectives of the communities where the maternal and child health situation continues to be appalling. There is, hence, a need for an anthropological approach to study the social, economic and cultural factors associated with the problem. This will help to understand the plausible gaps between the *supply, demand and utility* factors of the maternal and child health services in Orissa.

1.2 Objectives

The current study aims to carry out investigation at two levels, viz.

1. The Health System
2. The Community

The specific objectives of the study are,

Health System

- To study the health service system, particularly the specific programmes and facilities with regard to maternal and child health.
- To study the problems faced by service providers at different levels of health care system and possible solutions as reported by them.
- To study the contribution and effectiveness of parallel health care systems in terms of maternal and child health service delivery and utilisation.

Community Level

- To study the level of maternal and child health service utilisation and problems faced by the people in public and private sector health systems.
- To examine the validity of the solutions suggested by the community members for improving the maternal and child health service utilisation and the feasibility of implementation of such solutions.

1.3 Methodology

1.3.1. Secondary Data Analyses

Before working out the detailed methodology (sampling, database, tools and techniques), a comprehensive desk analysis was undertaken making use of the available secondary data on Orissa at state (NFHS and Census) and district (RCH Survey of IIPS, Mumbai) level. This provides an idea about the comparative maternal and child health situation in the districts of Orissa. The relative indices were worked out for each district and for each indicator to find their ranks. The composite indices for all the districts of Orissa could then give a holistic idea regarding the situation. This exercise however, could not provide any information on the quality of delivery, utility and the demand regarding maternal and child health services at sub-district level. Moreover, not many such micro-level and village/community-based studies are available for reference. All these problems prompted researchers to go straight to the field (health system and villages) rather than relying on insufficient secondary data sources and study the ground situation before making the final framework of the research project.

1.3.2 Pilot Study

With an unbiased and open-ended guideline a short-term (16 days) pilot study was conducted in Orissa. Visits were made to the Orissa state capital Bhubaneswar, other cities, selected district and block headquarters and a few villages.

The inputs obtained from the pilot study helped to conceptualise the framework for carrying out a micro-level study on the *supply, demand and utility* factors of maternal and child health services in Orissa. A detailed methodology has been worked out based on secondary data analysis and pilot study.

1.3.3 Database

In view of the set objectives and inputs from secondary data analysis and pilot study, basically six exercises were undertaken.

1. A retrospective review of secondary data on the maternal and child health situation.
2. A primary study of the subject-specific health facilities and programmes available in the health system in Orissa.

3. Data (quantitative and qualitative) collection from health service providers at various levels to study their attitudes towards and experiences in service delivery system (technical facilities, skills, problems and solutions).
4. Study of the parallel health care systems regarding service delivery and utilisation.
5. Data (quantitative and qualitative) collection from the community to study the degree of and problems in service utilisation and their suggested possible solutions.
6. Some information was also collected from senior level officials associated with policy making in the light of validity and feasibility of reported solutions of health service providers as well as acceptors and their possible implementation in government plan documents.

1.3.4 Sampling Design, Tools and Techniques of Data Collection

Aiming for a five-tier data collection procedure a 'multi-stage sampling design' was followed for selecting the sample units (PSUs and SSUs) of this study. Taking into consideration the level of the maternal and child health condition, the 'Sambalpur' district of Orissa state was selected for study. The district is divided into 9 blocks. On the basis of available health system and infrastructure, maternal and child health condition and remoteness from the urban area, two blocks nearer to and two blocks far from the district headquarter were chosen for study. So out of 9 blocks, four blocks such as Dhankauda, Maneswar, Jujomura and Rengali were selected. Then from these selected blocks some villages (PSUs) were identified following PPS (probability proportion to size) sampling method. So a total of 10 villages were selected. On an average, 25 households (SSUs) were identified for interview selected from each village through the Systematic Random Sampling method. So a total of 250 households were interviewed.

Both quantitative as well as qualitative tools and techniques were used for data collection. A well-designed, pre-coded and pre-tested structured questionnaire was used for interview in the survey. In addition to sample survey, some qualitative methods, such as focused group discussions (FGD), non-participant observation, in-depth interviews and vediography were used to collect necessary information from community members and key-informants to supplement the data.

- For the interview of health staff some sub-centres, PHC, CHC, DH (Dist. Hospital) and non-government/private hospital/clinic/centre were selected

from the district. From each such health centre, around 10 per cent (with minimum one) of all staff at doctor, pharmacist/nursing and clerical/ attendant level were interviewed. Necessary information was also collected from some Anganwadi workers (AWW), WCD (Women and Child Development) department staff in the district. Mostly qualitative methods (observation, informal and in-depth interview and photography) were used to collect necessary information.

- The information on available health facilities and programmes designed for maternal and child health care services were gathered from health centres by following some standard checklists.
- Some qualitative information on parallel health systems such as untrained birth attendants, village informal doctors and unqualified practitioners were collected through photography, observation and informal interview techniques.
- Subsequent formal discussions were conducted with some senior level officials from health departments as well as WCD department associated with policy making.

The interviewers were given extensive training about different aspects of health and service system. A pilot study was conducted in a neighbouring village that was not our sample village, to pre-test the questionnaires. The data collection was carried out during the months of December 2005, January 2006 and February 2006 in the 10 sample villages located in four blocks of Sambalpur district in Orissa. By and large completed schedules were almost immediately checked to ensure that high quality is maintained. The data was processed using suitable computer packages.

The investigators were clearly instructed to follow basic ethical principles while contacting the respondents and conducting the interviews or focus group discussions. While the respondents were not mandated to sign a consent form, they were clearly informed that the information that they provided would not be divulged to anyone, that it would be used for research purposes only and that they were free not to respond to all or any of the questions put to them. Their decision not to respond would be respected and this decision would in no way harm them or be held against them at any point.

Chapter II

General Characteristics of the Area of Study

2.1. Physical Characteristics of the Study Area

Orissa is one of the 25 states of India situated on the eastern coast along the Bay of Bengal and bounded by Bihar in the north, MP in the west, West Bengal in the northeast and Andhra Pradesh in the south. It has a long history with various names like Utkal, Kaling, etc. which were inhabited by great kings like Ashoka and Kharvela. It was visited by religions such as Hinduism, Buddhism, Jainism, and big wars. In modern India, Orissa became a separate administrative unit as a state and as a distinct linguistic province only in the year 1936, which may be regarded as one of the landmarks in the state's history. In independent India, Orissa comprised 13 districts till the year 1993, and there are 30 districts at present. According to the 1991 Census, the total land area of Orissa is 155,707 sq. kms and the total population was 31.7 million. The state has 3.7 per cent of the total population and 4.7 per cent of the total land area of the country.

In the geographical map of India, Orissa falls between 17^0 49' N to 22^0 34' N latitude and 81^0 29' E to 87^0 29' E longitude. It can be divided into two natural divisions: 1. The inland divisions comprising the western, northern and part of southern districts, and 2. Coastal divisions comprising the eastern and part of southern districts. Physiographically, Orissa can be divided into coast planes, the middle mountainous countries and plateaus, and the rolling uplands. The coast plains of Orissa stretch westward from the eastern coast of India, and run from the river Subarnarekha in the northeast to the river Rushikulya in the southeast creating the fertile green tract suitable for rice cultivation. The mountainous portions of Orissa cover about three-fourths of the entire state and hence have a significant impact on the economic fortunes of the state. The rolling uplands are lower in elevation and vary between 150-300 metres. These are rich in soil nutrients and wet areas afford good opportunities for paddy cultivation. Sambalpur, the study area is one of the 30 districts of Orissa situated in the central region of the state and at a distance of around 320 kms west from the state capital Bhubaneswar. The National Highway No. 6 and 42 passes through the district. Literacy in rural areas for males is 75.89 per cent and females is 49.53 per cent.

2.2. Climate of the Study Area

The Orissa state lies in the tropical zone and is subject to high temperature. Being in the belt of medium pressure, it has medium rainfall with moderate variation in different parts of the state. The state has a mean annual temperature of 26^0 C. The district 'Sambalpur has an extreme climate, temperature goes up to 47° Celsius in May and to 11.8° Celsius in December.

2.3. Ethnography of the Study Area

Ethnography is a special subsection in the study of Social Sciences and more specifically in Anthropology, where an overall qualitative study of all aspects of human life is undertaken. According to the *International Encyclopaedia of Social Sciences,* the making, reporting and evaluation of the customary behaviour are the tasks of ethnography.

The groups 'Scheduled Caste (SC)' and 'Scheduled Tribe (ST)' studied in this research work are subdivisions of 'caste'. Caste is an age-old stratification of people particularly in Hindu society, based on occupation. 'Scheduled Caste (SC)' and 'Scheduled Tribe (ST)' are the two types of such categorisation, which has been mainly defined by the Constitution of India, afresh after the year 1956 according to special directives of the President of India. These two groups are often comparatively at a lower level of socio-economic development than the remaining group of people in the society. Scheduled Tribes are the tribal aborigines.

In district Sambalpur, the proportion of Schedules Caste population to total is 17.04 per cent and that of Scheduled Tribe population is 34.5 per cent. There are around 64 types of Scheduled Castes and 50 types of Scheduled Tribes in the district. Among the Scheduled Tribes, Kisans, Orams, Mirdhas, Hos, Mundas and Kharias, Gonds, Khanda, Binjhal, Kudas are the major ones. Among the Schedules Castes, 'Pano' and 'Hadi' castes constitute the major proportion and the others are 'Dhoba', 'Kela', 'Keuta' and 'Domb'.

Unlike other Scheduled Tribe groups in the sample, Kondh, Munda and Kissan tribes seemed to be more or less the primordial aborigines of the district. The Scheduled Tribes have a kind of formal social structure with a set of societal folkways. Marriage between tribes is not common. Within a tribe, marriage between kinship relations are found, though is not a hard and fast rule. Bride price is not common if not rare among the tribes. The somatic structure of the tribes shows that they have a middle stature and black to brown complexion. The food habits, marital lifestyle, rituals in life-cycle events (puberty, marriage,

childbirth and death) are often influenced by societal norms. Even sexual behaviour such as abstinence, frequency, etc. are also affected by cultural values.

In contrast, compared to Schedules Tribes, the Schedules Castes now, don't have such a rigid formal social structure with rigid societal norms followed. Marriage and sharing of lifestyle outside their own caste are also common among Scheduled Castes. The family system is still a joint one in terms of the function mainly in tribes. The Schedule Castes, however, are different from the Scheduled Tribes in many aspects. These differences in behaviour often affect the demographic features and so are particularly important from the point of view of fertility behaviour, reproductive health and child survival.

Chapter III

Profile of the Respondents

Before going into the analysis of the health service utilisation and delivery among the population in the area, it is essential to present a profile of the study population, households and service providers. It comprises age-sex structure, socio-economic status of the studied population as well as the households and some of the characteristics related to mothers and children living in the study households. The profile of service providers comprise their age, caste, family size, years of working as health staff, etc.

3.1. Profile of Sample Households and Population

The univariate analyses have been carried over the data on family particulars and household level to obtain different characteristics of the households and population respectively. This forms the profile of the respondents.

TABLE 3.1
HHs Covered under Blocks

Blocks	*Frequency*	*Percent*
Rengali	16	6.4
Dhan Kauda	112	44.8
Maneswar	96	38.4
Jujomura	26	10.4
Total	**250**	**100**

Table 3.1 shows that the study has been conducted in the four blocks of Sambalpur District of Orissa, covering 250 households. The name of the blocks are Dhankauda, Maneswar, Jujomura, and Rengali.

TABLE 3.2
HHs Covered under Villages

Variables	*Frequency*	*Percent*
Gurupali	16	6.4
Sindurpank	26	10.4
Putibandh	19	7.6
Khandual	25	10.0
Babubandh	25	10.0
A.Katapali	25	10.0
Golabandh	26	10.4
Ladukhai	24	9.6
Kaisir	38	15.2
Mundher	26	10.4
Total	**250**	**100**

Table 3.2 shows the number and percentage of households selected for interview are from 10 villages situated in four different blocks mentioned above.

TABLE 3.3
Sample Population by Sample Villages

Villages	*Frequency*	*Percent*
Gurupali	89	6.7
Sindurpank	142	10.6
Putibandh	107	8.0
Khandual	140	10.5
Babubandh	119	8.9
A.Katapali	139	10.4
Golabandh	147	11.0
Ladukhai	124	9.3
Kaisir	207	15.5
Mundher	123	9.2
Total	**1337**	**100.0**

Table 3.3 shows the name of all the 10 villages and the number of people covered in each village for the sample survey. These villages are situated in four different blocks of Sambalpur district of Orissa, viz. Dhankauda, Maneswar, Jujomura, and Rengali. The differential number of households selected based on the population proportion and household size of the selected households, reflect the population figures for each village.

TABLE 3.4
Age Structure of the Sample Population

Years	*Frequency*	*Percent*
0	77	5.8
1-5	263	19.6
6-14	189	14.1
15-49	652	48.8
50 +	156	11.7
Total	**1337**	**100.0**

Table 3.4 shows the age structure of the sample population covered for the survey. Around 49 per cent of the total population of the sample household are in the reproductive age group, i.e. 15-49 years, while more than 40 per cent of the total population are below 15 years of age. Little less than 12 per cent of all have crossed the age of 50. This table shows that 40 per cent of the total sample population are dependent on the rest of the people who are earning members. Of the total more than 25 per cent are children below the age of six.

TABLE 3.5
Sex Structure of the Sample Population

Variables	*Frequency*	*Percent*
Male	694	51.9
Female	643	48.1
Total	**1337**	**100.0**

Table 3.5 shows the sex distribution of the sample population of the households. This clearly shows that the sex ratio of the sample population is tilted slightly in favour of the males. The proportion of males is 52 per cent, while for females it is 48 per cent.

TABLE 3.6
Marital Status of the Sample Population

Variables	*Frequency*	*Percent*
Unmarried	637	47.6
Currently married	647	48.4
Divorced/separated	2	0.1
Widowed/widower	51	3.8
Total	**1337**	**100.0**

The marital status of the sample population is given in Table 3.6. The difference between the number of currently married and unmarried persons is very small as it is less than 1 per cent. The number of currently married persons is slightly less than the 50 per cent mark. The number of divorced/separated is negligible comprising only 0.1 per cent as only two persons out of the total 1337 were found to be divorced or separated. This shows that divorce is not a regular practice among these people even though they toil in poverty and illness. Widowed/widowers comprise 4 per cent of the total sample population under study.

TABLE 3.7
Educational Structure of the Sample Population

Variables	*Frequency*	*Percent*
Illiterate	602	45.0
Class 1-5	291	21.8
Class 6-10	255	19.1
Class 11-12	62	4.6
Graduate	22	1.6
Postgraduate or higher degree	5	0.4
Technical qualification/other professional degrees/diplomas	6	0.4
Literate but no formal education	94	7.0
Total	**1337**	**100.0**

Table 3.7 draws a very clear picture of the educational structure of the sample population. It shows that 45 per cent of the total are illiterate, who do not know how to read and write. While only 2 per cent of the total population have graduates or postgraduate educational qualifications. Less than 0.5 per cent of population have got any technical qualification/other professional degrees/diplomas. Drop out seems to be very high, as one finds in the table the number of students decreasing with every higher class. A very remarkable feature of this table is that 7 per cent of the population are literate without any formal education, which means that AWWs and other agencies have played an important role in providing education to them.

TABLE 3.8
Occupational Structure of the Sample Population

Variables	*Frequency*	*Percent*
Agriculture	76	5.7
Service	52	3.9
Business/self-employed	126	9.4
Wage labour	237	17.7
Others	846	63.3
Total	**1337**	**100.0**

The occupational structure of the sample population presented in Table 3.8 shows that 18 per cent of them are wage labourers, followed by 10 per cent of business/self-employed people. A huge percentage (63.3 per cent) are in Others category which means their occupation is very tentative or they are simply not earning which includes students, housewives, etc. A low level of education is also reflected in the fact that the percentage of the population engaged in services is below 4 per cent. Similarly the percentage of people engaged in agriculture falls below 6 per cent as most of them do not have a piece of land to cultivate.

TABLE 3.9
Caste of Head of the Household (HOH)

Caste/Tribe	*Frequency*	*Percent*
ST	119	47.6
SC	76	30.4
OBC	41	16.4
Others	14	5.2
Total	**250**	**100.0**

Table 3.9 shows the caste profile of the sample households. The maximum number of households belong to Scheduled Tribes who comprise more than 47 per cent of the total household respondents. More than 30 per cent of the respondents are from the Scheduled Castes, while 16.4 per cent belonged to the Other Backward Classes. Only 5.2 per cent of the total households interviewed are from general castes.

TABLE 3.10
Type of Family

Variables	*Frequency*	*Percent*
Nuclear	139	55.6
Joint	50	20.0
Extended	61	24.4
Total	**250**	**100**

Table 3.10 shows the types of families the households live in. Most of the sample households (55 per cent) live in nuclear families. While one-fifth of the total households live in joint families, one-fourth of them live in extended families.

TABLE 3.11
Main Source of Family Income

Variables	*Frequency*	*Percent*
Agriculture	38	15.2
Service	46	18.4
Business/Self-employed	35	14.0
Wage Labour	120	48.0
Others	11	4.4
Total	**250**	**100**

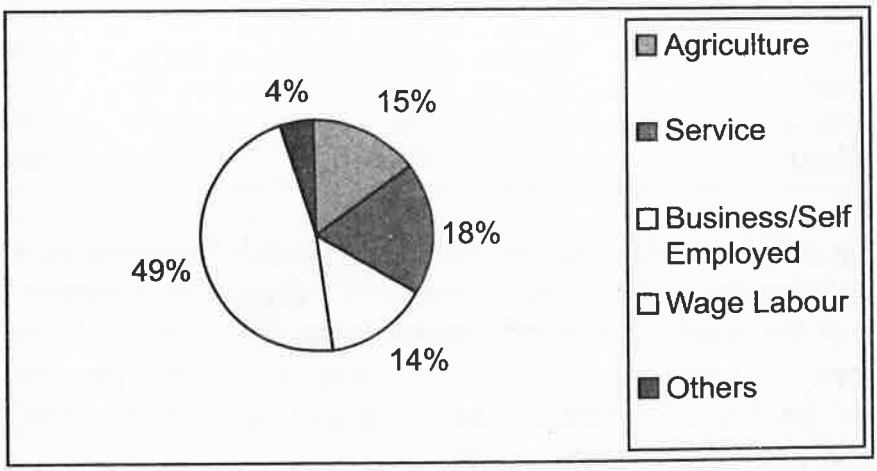

Figure 3.11
Occupational Distribution

Table 3.11 and Figure-1 shows the main source of income of the families under survey. The main source of family income of these people is the wage they earn as daily labourers. Their number is phenomenal as it is close to half of the total (48 per cent). For 18.4 per cent of the households the main source of income is regular service, while 14 per cent of them are engaged in business or self-employment. About 15.2 per cent of the total households are involved in agriculture which shows that many people in this area are small landholders or landless.

TABLE 3.12
House Type

Variables	*Frequency*	*Percent*
Kutcha	174	69.6
Pucca	40	16.0
Mixed	36	14.4
Total	**250**	**100**

Table 3.12 finds the types of houses where the sample population are living. Around 70 per cent of the households live in kutcha houses, symbolising poverty and backwardness. Only 16 per cent of these households can afford to live in pucca houses. About 14 per cent of them have got mixed houses.

TABLE 3.13
No. of Rooms

Variables	*Frequency*	*Percent*
1	72	28.8
2	76	30.4
3 +	102	40.8
Total	**250**	**100.0**

Table 3.13 shows the number of rooms these households use for their living. In the villages under study, 28.8 per cent of the households live in a single room only, a part of which is also used for cooking food. Only 41 per cent of the households have got three or more than three rooms. More than 30 per cent of the households have only two rooms for their use, of which one room is often used as a kitchen.

TABLE 3.14
Separate Room for Kitchen

Variables	*Frequency*	*Percent*
Yes	136	54.4
No	114	45.6
Total	**250**	**100**

Table 3.14 shows the number of households who have got a separate room for the kitchen. Around 54 per cent of the households have separate rooms for the kitchen, while the remaining 46 per cent do not have one, which means 46 per cent use a part of their living room for cooking their food. The latter can have a harmful effect on the child and pregnant mothers' health because of their direct exposure to oxides of carbon coming from cooking fuel (mostly wood in these cases).

TABLE 3.15
Members in HH

Variables	*Frequency*	*Percent*
0-4	128	51.2
5-8	100	40.0
9 +	22	8.8
Total	**250**	**100**

Table 3.15 shows the number of household members of the sample survey. More than 51 per cent of the households have family members of four or less than that. Forty per cent of the households interviewed have family members between five and eight. Only 22 households have 9 or more members.

TABLE 3.16
Annual Expenditure

Rs.	*Frequency*	*Percent*
0-6500	28	11.2
6501-24000	157	62.8
24001-60000	59	23.6
60001 +	6	2.4
Total	**250**	**100**

Table 3.16 gives the details of the annual expenditure of the sample households. Only 2.4 per cent of the total households have an annual expenditure of Rs. 60,000 or more. Most of the households come under the expenditure category of Rs. 6501- 24000 per annum, whose percentage is close to 63 per cent. More than 11 per cent of all sample households come below the poverty line (BPL) spending less than Rs. 6500 per annum (BPL= around Rs. 540 to Rs. 700 expenditure per month, although it varies). Around 24 per cent of the households spend somewhere between Rs. 24,000-60,000 per annum.

TABLE 3.17
Annual Health Expenditure

Rs.	*Frequency*	*Percent*
0-650	33	13.2
651-3000	165	66.0
3001 +	52	20.8
Total	**250**	**100**

Table 3.17 presents the annual health expenditure which is an important variable in the study of health status of population. Only 21 per cent of the total households spend Rs. 3000 or more per annum towards their health, while 13.2 per cent spend less than Rs. 650 in this regard. Sixty-six per cent of the households spend between Rs. 651-Rs. 3000 annually towards health.

TABLE 3.18
Proportion of Health Expenditure to Total Annual Expenditure

Percent of Total Expenditure	*Frequency*	*Percent of Households*
0-15	168	67.2
15.1-25	49	19.6
25.1-40	16	6.4
40.1 +	17	6.8
Total	**250**	**100**

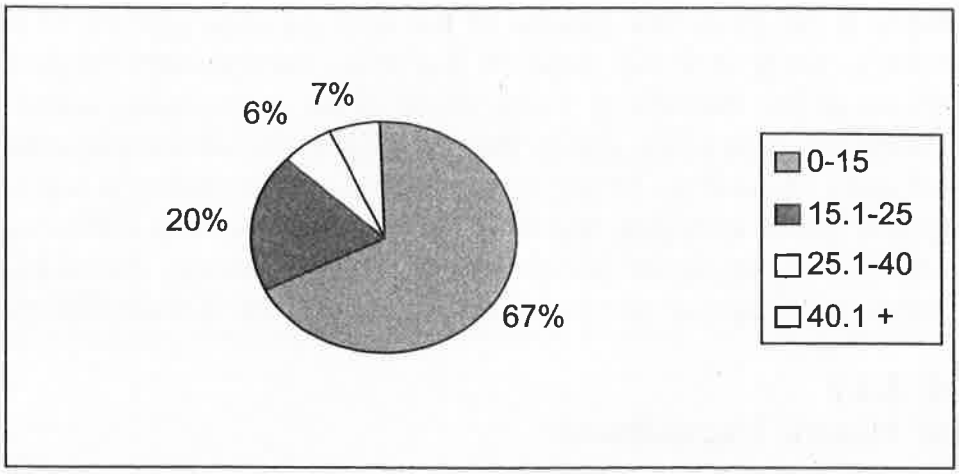

Figure 3.18
Proportion of Health Expenditure

Table 3.18 as well as Figure 3.18 show the proportion of total expenditure the sample households spend towards their health only. A majority of them spend within 15 per cent, whereas around one-fifth of all sample households spend between 15-25 per cent of total annual expenditure towards health. Even around 7 per cent of all reported to have spent as high as 40 per cent or more in this respect.

TABLE 3.19
Living Place for Livestock

Variable	*Frequency*	*Percent*
Inside/beside house	28	43.7
Outside separate house	36	56.3
Total	**64**	**25.6**

Only 64 out of 250 total sample households reported to have some kind of livestock with them. Table 3.19 gives us a picture of the living place for the livestock of these households. Little more than 43 per cent of all households who own any livestock keep their animals inside/beside their houses as they do not have separate living places for them. This may have a plausible harmful effect on the health of people living in these households, especially children and pregnant mothers in terms of unhygienic conditions leading to infections like skin ailments or disorders, sepsis, etc.

TABLE 3.20
Main Sources of Drinking Water

Variables	*Frequency*	*Percent*
Personal pipe	15	6.0
Public pipe	10	4.0
Public hand pump	193	77.2
Personal well	5	2.0
Public well	17	6.8
Pond/spring/river	10	4.0
Total	**250**	**100**

Table 3.20 provides us details about the main sources of drinking water of the sample households. It shows that the public hand pump is the main source of drinking water for these households whose number well passes 77 per cent. Only 6 per cent have been able to have a personal pipe, and another 2 per cent have got their personal wells. Around 7 per cent use public wells, whereas 4 per cent use public pipes as the main source of drinking water. Overall, it was found that still around 13 per cent of people have no access to safe drinking water (pipes and hand pumps).

TABLE 3.21
Main Sources of Lighting

Variables	*Frequency*	*Percent*
Kerosene/oil	96	38.4
electric light	154	61.6
Total	**250**	**100**

Table 3.21 shows the main sources of lighting of the sample households. It was found that around 62 per cent of all households use electric light, whereas the remaining 38 per cent use kerosene or oil 'dibri'/ lantern. Thus a large number of people still do not have access to electricity.

TABLE 3.22
Fuel Used for Cooking

Variables	*Frequency*	*Percent*
Wood	206	82.4
Cow-dung cake	7	2.8
Charcoal	3	1.2
Biogas	1	0.4
LPG cylinder	2	0.8
Heater	27	10.8
Others	4	1.6
Total	**250**	**100**

Table 3.22 describes the fuel used for cooking by the sample households. For cooking purposes, more than 82 per cent of households mainly use wood as fuel, whereas only 1.2 per cent could afford to use biogas or LPG gas cylinders. More than 10 per cent of the households use electric stoves to cook food and 3 per cent who are mostly poor households use cow dung cakes for the same purpose.

TABLE 3.23
Sewage Disposal

Variables	*Frequency*	*Percent*
Inside house	65	26.0
Outside house non-concrete drain	135	54.0
Outside concrete drain	39	15.6
Others	11	4.4
Total	**250**	**100**

The sewage disposal is an important aspect of health as sanitation in and around the living place can lead to many health problems right from malaria to diarrhoea and skin infections. Table 3.23 shows the sewage disposal facility of the sample households. The majority of the households (54 per cent) use any non-concrete drains outside the house for their sewage disposal. Only 15.6 per cent of the households have access to outside concrete drains. More than one-fourth of all households dispose of sewage inside their houses which has grave consequences for the health of the household.

TABLE 3.24
No. of Currently Married Women in 15-45 Year Age Group

Number	*Frequency*	*Percent*
0	13	5.2
1	200	80.0
2 +	37	14.8
Total	**250**	**100**

Table 3.24 shows the number of currently married women in the 15-45 year age group in the sample households during the survey. More than 80 per cent of all households have at least one currently married woman in the 15-45 year age group. Even 15 per cent of all households have two or more such women. It was found that in more than 5 per cent of the households there is not a single currently married woman in the 15-45 year age group.

TABLE 3.25
No. of Pregnant Women in the HH

Variables	*Frequency*	*Percent*
0	225	90.0
1	25	10.0
Total	**250**	**100**

Table 3.25 presents the number of currently pregnant women in the sample households at the time of the survey. It was found that in 10 per cent of the sample households, there is one pregnant woman, while in 90 per cent of the cases there are no such women.

TABLE 3.26
No. of Children 0-5 Years in the Sample Households

Number	*Frequency*	*Percent*
0	41	16.4
1	124	49.6
2	61	24.4
3 +	24	9.6
Total	250	**100**

Table 3.26 tells us about the number of children between 0-5 years in the sample households. Around 50 per cent of all households have children of age one, while 25 per cent of the children belong to the two-year-old category. Little more than 16 per cent of all households have infant children.

TABLE 3.27
No. of Child Deliveries/Abortions in the Last Two Years

Number	*Frequency*	*Percent*
0	103	41.2
1	125	50.0
2	20	7.2
3	2	1.6
Total	**250**	**100**

Table 3.27 shows the number of child deliveries/abortions in the sample households that have taken place in the last two years. This table shows that in 50 per cent of the sample households there has been one child delivery/abortion in the last two years. In more than 40 per cent of the cases there has been no pregnancy/abortion in the last two years. Around 9 per cent of the households say that in the last two years there have been two deliveries/ abortions in the last two years, which reflect a higher fertility rate for these households.

3.2. Profile of the Health Service System and Providers

Health and Family Welfare

- District Headquarters Hospital 1
- Subdivisional Hospital 2
- JP Maternity Hospital 1
- PHC 2
- UGPHC 1
- CHC 5
- Sub – Centres 162
- PHC (new) 26

TABLE 3.28
Health Indicators of Sambalpur, Orissa and India

	Sambalpur	*Orissa*	*India*
1. Total Fertility Rate	2.00	3.3	3.5
2. Crude Birth Rate 2002	18.7	23.1	25
3. Crude Death Rate 2002	9.9	9.8	8.1
4. Infant Mortality Rate 2002	47.3	87	64
5. M.M.R (Per one lakh birth)	397	367	407
6. Percent of Institutional Delivery (Govt.)	30.5 (RCH- 29.2)	23.4 (RCH)	
(Private)	13.8		
7. Percent received full ANC	50.1 (RCH)	32.5 (RCH)	
8. Percent of Safe Delivery	60.6 (RCH- 38.1)	32.7 (RCH)	
9. Percent of Complete Immunisation	71.1 (RCH- 76.6)	57.8 (RCH)	

Source: Sample Registration System Report, District Medical Office, 2005 and RCH-RHS, 1998-99

Socio-economic Profile of Health Service Providers in Sambalpur District Covered under This Study:

A study on caste structure of different health service providers in Sambalpur District covered under this study showed that most of the TBAs (traditional birth attendants) belong to Scheduled Castes (SC) or Scheduled Tribes (ST). However, other health staff belong to all caste groups, but mostly OBC (Other Backward Castes) and general castes. Their age varies from 37 to 59 years. The number of years of their marriage is around 11 to 22 years. Regarding their family size, most have two children varying between one to four children. The health service providers have been working for the last 10 to 20 years.

Chapter IV

Health Service Utilisation

4.1. Introduction

The health of mother and child as have already been described in the first chapter is an essential aspect of development. The status of health is dependent on many aspects. Some of the important ones are quality and quantity of utilisation of available services and service delivery. This chapter deals with the maternal and child health services utilisation by the community in the rural set-up. To know the utilisation fully, one needs to start with the kind of illness to mother and children or their health status, treatment seeking, information to people about services and illness, quality of available care or service structure and, more importantly, people's perceptions, their problems and reported suggestions.

4.2. Health Status of Mother and Children

To know the health status of the mother and children in sample households, the researcher examined the prevalence of illness, people's perception about illness, reporting frequency of illness, etc. in great detail. All these aspects have been studied keeping a short reference period of one year to avoid the problem of recall lapse. The findings are presented below.

TABLE 4.1
Frequency of Illness to Women/ Children during the Last One Year

Variables	*Frequency*	*Percent*
1-3 times	75	30.0
4-7 times	97	38.8
More than 7 times	66	26.4
Never	12	4.8
Total	**250**	**100**

Table 4.1 focuses the frequency of illness to women/children of the sample households during the last one year. In as high as 38.8 per cent of the sample households, women/children fall sick 4-7 times, while only 5 per cent of them have said that not any women /children have fallen ill in the last one year. In more than 26 per cent of the households, women/children fell ill more than 7 times in the last one year.

TABLE 4.2
Prevalence of Illness (percentage do not add to 100 due to multiple answers)

Variables	*Frequency*	*Percent*
Fever	114	45.6
Diarrhoea/Dysentery/Loose Motion	103	41.2
Malaria	63	25.2
Cold/cough	114	45.6
Anaemia/Weakness	16	6.4
Back pain during pregnancy/in general	32	12.8
Gastric problem	4	1.6
Itching	14	5.6
Menstruation	11	4.4
Brain Malaria	3	1.2
Measles	7	2.8
Jaundice	11	4.4
Vomiting	1	.4
TB	2	.8
Gynaecological/Obstetrical problem	11	4.4
Other	31	12.4

Table 4.2 gives a detailed account of the various illnesses/ diseases the women/ children of sample households have been frequently infected with. Among the diseases, fever tops the list which 45 per cent of all affected (with any illness) households members reported. Diarrhoea/Dysentery/Loose Motion are the second most frequently occurring diseases reported by 41 per cent of the total patients. This may be the reason why diarrhoea has been identified as one of the main causes of many of the child deaths occurring in Orissa. Cold/cough is found to be very common in the areas under survey. More than one-fourth of the patients are infected by deadly malaria. Even back pain, menstrual and gynaecological problems have been reported by some people.

TABLE 4.3
Perception Difference in Reporting Illness (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
Spontaneous answers	227	90.8
On probe	58	23.2

Table 4.3 shows the perception difference of the sample population in reporting illnesses to the women/ children of the sample households. It is found that more than 90 per cent of the people give spontaneous answers regarding their diseases, while 23 per cent of the people give answers on probing reflecting a lower level of awareness/ concern about their own health problems.

TABLE 4.4
Women and Children of Sample Households Who Have Been Reported to Have Illness during Reference Period (percentage do not add to 100 due to multiple answers).

Women/ children	*Frequency*	*Percent*
Women	203	81.2
Children	164	65.6

Table 4.4 focuses on the illnesses that have occurred whether to the women or the children of the sample households. The findings show that more women (81.2 per cent) are reported to have been affected by different illnesses/ diseases than the children. However, as high as more than 65 per cent of all children are affected by various diseases.

TABLE 4.5
Frequency of Illness (percentage do not add to 100 due to multiple answers).

No. of Times Suffered	*Frequency*	*Percent*
1	155	62.0
2	107	42.8
3 or more times suffered	108	43.2

Table 4.5 gives the frequency of illness suffered by the women/children of the sample households. There is not much difference in the frequency of women/ children suffering twice and three or more times. However the percentages are as high as 42.8 per cent and 43.2 per cent respectively. A total of 62 per cent reported that they have fallen ill only once in the last two years.

TABLE 4.6
Days of Suffering from Illness
(Percentage do not add to 100 due to multiple answers)

No. of days	*Frequency*	*Percent*
1-5 days	51	20.4
6-10 days	52	20.8
11or more days	69	27.6

Table 4.6 shows the number of days of suffering by women and children. More than 27 per cent of the patients suffered for more than 10 days. It reflects the quality of treatment and immunity level available with the affected mothers and children of the sample households. More than one-fifth of all women and child patients suffered for 1-5 days and 6-10 days, the percentages being 20.4 per cent and 20.8 per cent respectively.

4.3. Treatment-Seeking Behaviour

It is important to know about the treatment-seeking behaviour in order to understand the health service utilisation. To know this the frequency of treatment, sources and reasons for not treating, etc. have been examined in detail. All these aspects have been studied keeping a short reference period of one year to avoid the problem of recall lapse. The findings are presented below.

TABLE 4.7
Frequency of Medicines/Treatment Taken by Women/ Children in the Last Two Years

Variables	*Frequency*	*Percent*
1-3 times	121	48.4
4-7 times	71	28.4
More than 7 times	46	18.4
Never	12	4.8
Total	**250**	**100**

Table 4.7 looks into the frequency of medicine/treatment taken by women/ children in the last two years. Only 18.8 per cent of the households sought any medicine for affected women/children more than 7 times compared to more than 26 per cent of them who fall ill frequently (as shown in the first table of this chapter) . Thus a large number of people are not going for treatment even

though they are ill. Only 5 per cent of the respondents have said that they have never sought any medicine/treatment for their women/children.

TABLE 4.8
Source of Treatment (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
No treatment	72	28.8
Allopathic	224	89.6
Ayurvedic	3	1.2
Other professionals	1	0.4
Hakims	9	3.6
Self-treatment	3	1.2
Other	1	0.4

Table 4.8 gives a detailed account of the source of treatment of the sample population. About 90 per cent of them go for treatments from allopathic doctors, while only 1.2 per cent prefer Ayurvedic doctors. An important finding of this table is that nearly 29 per cent of them go without any treatment.

TABLE 4.9
Reasons for Not Seeking Treatment (% do not add to 100 as multiple answers)

Variables	*Frequency*	*Percent*
No knowledge of service	7	2.8
Not necessary	18	7.2
Financial constraints	35	14.0
No support structure to go out	7	2.8
Other reasons	4	1.6

Table 4.9 cites the reasons of women/children not seeking any treatment for their diseases. Financial constraints have obstructed the majority (14 per cent) of the patients from taking any treatment. However, 7.2 per cent did not feel the necessity of taking any treatment, no knowledge of service has been the reason for 3 per cent of them for not seeking any treatment.

4.4. Health Information

It is very important to impart correct, clear and precise information about illness, treatment and available health services so as to get a healthy population. This area is most inadequate in many parts of India leading to poor health status. All these aspects have been studied keeping a short reference period of two years to avoid the problem of recall lapse.

TABLE 4.10
Information on Mother and Child Health Services in the Last Two Years ?

Variables	*Frequency*	*Percent*
Yes	206	82.4
No	44	17.6
Total	**250**	**100**

Table 4.10 shows whether in the last two years the sample population has received any information regarding any services related to mother and child health. More than 82 per cent of the population have received some kind of information regarding mother and child health services. But it is shocking to find that more than 17 per cent is absolutely not aware of any health services provided to them.

TABLE 4.11
Sources of Health Information (% do not add to 100 due to multiple answers)

Sources	*Frequency*	*Percent*
TBA	4	1.6
Village health workers/ANM	47	18.8
Media	32	12.8
Government doctors	36	14.4
Private doctors	23	9.2
People	58	23.2
NGOs	4	1.6
AWWs	127	50.8

Table 4.11 provides the details of the sources of information for people regarding mother and child health services. More than half of the respondents say that they receive health information from the Anganwadi workers (AWWs).

While 23.2 per cent of the respondents obtain information from people, around 19 per cent are benefited from village health workers/ANM in this respect. The table also suggests that more than 14 per cent of the sample population get information from the government doctors. The media has a limited contribution and NGOs have almost no contribution in providing health information to people.

TABLE 4.12
Kind of Mother and Child Health Information Received (% do not add to 100 due to multiple answers)

Variables	*Frequency*	*Percent*
Family planning	45	18.0
ANC (TT, IFA, BP, Weight, Nutrition)	118	47.2
Safe delivery	26	10.4
PNC(breast-feeding, nutrition, infant and women's health care)	14	5.6
Immunisation	105	42.0
Treatment of infertility	4	1.6
Abortion	4	1.6
Treatment of reproductive morbidity, STI/STD	4	1.6
Others	21	8.4

Table 4.12 shows the kind of information people under survey receive from different sources. It is found that ANC and immunisation are known comparatively more to the people, although as low as 47 per cent and 42 per cent respectively in view of the government's goal for 100 per cent coverage. Only 18 per cent of the respondents have received any information about family planning, and 10 per cent about safe delivery. It seems information on treatment of infertility, abortion, and treatment of reproductive morbidity are not provided to these people as reflected from their number as below 2 per cent.

TABLE 4.13
Proportion of People Who Have Heard about Mother and Child Health Services/Schemes Available in the District (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
Girl child benefit schemes	65	26.0
ORS	156	62.4
Family planning	13	5.2
ANC	45	18.0
PNC	6	2.4
Immunisation	62	24.8
Hepatitis-B	9	3.6
Jaundice	4	1.6
Menstrual problems	3	1.2
STI/STD/HIV-AIDS	1	0.4
Janani Surakshya Yojana	4	1.6

In the study information was collected from the hospital and other official sources about the specific schemes currently functional for the mother and child health programme. Table 4.13 gives the details about available services/ schemes (in Sambalpur district) for mother and child health that people heard about. ORS seems to be the most popular which is known to more than 62 per cent of the sample population. One-fourth of the population has heard about immunisation while a little more, that is 26 per cent know about the Girl Child Benefit scheme in which a mother gets some money on delivering a girl child. However this is not functional now.

TABLE 4.14
Sources of Information about Available Mother and Child Health Services/Schemes in the District (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
Posters	4	2.0
Radio/ TV	36	17.6
People	80	39.0
TBA/ANM/ Village health workers	4	2.0
Hospitals	34	16.6
Any other (specify)	47	22.9

Table 4.14 shows the source of information of the people regarding the services/scheme they have known about. Thirty-nine per cent of all respondents have said that they get information from the people. Around 18 per cent of the sample population gets health information from the Radio/TV, while 17 per cent of them get to know from the hospitals.

4.5. Maternal and Child Health Service Utilisation and Quality of Care

It is important for health programmes that the people get adequate (quantity) health services as well as good quality of care. To examine this in the study population, we have elicited information about different health services available, actual use of them, essential mother and child health services such as safe delivery and immunisation, etc. The findings are presented below.

TABLE 4.15
Proportion of People Seeking any Health Service in the Last Two Years

Variables	*Frequency*	*Percent*
Yes	205	82.0
No	45	18.0
Total	**250**	**100.0**

Table 4.15 shows the number of people seeking any health service in the last two years. Eighty-two per cent of the respondents have said that they did seek some health services in the last two years, while the ramaining 18 per cent say that they did not seek any health services.

TABLE 4.16
Utilisation of Available Mother and Child Health Services/Schemes in the District (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
ORS	111	44.4
ANC	46	18.4
Immunisation	53	21.2
Family planning	15	6.0
Jaundice	3	1.2
Girl child benefit scheme	3	1.2

Table 4.16 gives the details of the mother and child health services/schemes actually used by the people under survey. Around 45 per cent of the total respondents have used the ORS scheme followed by the immunisation programme of the government which more than 21 per cent of the people have used. Though ANC covers 18.4 per cent of the total service utilisation, programmes like Girl Child Benefit, Jaundice, etc. have not been used so much by people.

TABLE 4.17
Reasons for Not Using Different Available Mother and Child Health Services/Schemes (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
No information about services	89	35.6
No time to use services	9	3.6
Do not perceive the need	7	2.8

Table 4.17 shows the reasons of services/schemes not being used by people that are available to them. More than 35 per cent of the respondents could not utilise the services because no information was provided to them regarding the available services. While 4 per cent have no time to go to the health centre, 3 per cent of them do not feel the necessity to use those services.

TABLE 4.18
Proportion of Health Centres People Visit Frequently (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
SC	3	1.2
PHC	16	6.4
CHC	11	4.4
DH	91	36.4
Private Allopathic Clinics	150	60.0
Homeopathy	1	.4
Traditional healers	17	6.8

Table 4.18 provides us the information regarding the proportion of people who visit different health centres for services. This study finds that 60 per cent of people seek health services from the private allopathic clinics, while more

than 36 per cent prefer to visit the DHs. Around 7 per cent of the sample population still rely on the traditional village healers for their treatment which shows lack of information and awareness among the people regarding health services. Although government plans to strengthen the SC and PHC, the services are used less even by villagers.

TABLE 4.19
Whether Women Received TT Injections for All Pregnancies in the Last Two Years?

Variables	*Frequency*	*Percent*
Yes	102	70.4
No	43	29.6
Total	**145**	**100**

Table 4.19 presents the number of households where women received TT injections for their pregnancies in the last two years. It is found that women in more than 70 per cent of the households have received TT injections during their pregnancies, while the remaining 30 per cent of them go on to give birth to a child without receiving a TT injection.

TABLE 4.20
Proportion of Households Where Women Were in Contact with Health Staff for ANC

No. of contacts	*Frequency*	*Percent*
1-3	81	57
4+	61	43
Total	**142**	**100**

Table 4.20 shows the proportion of the households where women were in contact with the health staff for ANC. This survey shows that 57 per cent of the total households have contacted the health staff for ANC services 1-3 times, but 43 per cent of the households have contacted the health staff more than 4 times for each pregnancy.

TABLE 4.21
Proportion of Households by No. of Injections Women Received Per Pregnancy

No. of TT Injections	*Frequency*	*Percent*
One	54	37.5
Two	75	52.0
Three	15	10.5
Total	**144**	**100**

Proportion of households by number of TT injections women received per pregnancy is given in Table 4.21. Women in 52 per cent of the households receive 2 TT injections per pregnancy while as high as 38 per cent of them receive only one injection per pregnancy which is not normal. A little more than 10 per cent of them receive three injections per pregnancy.

TABLE 4.22
Proportion of Households Where Women Received IFA Tablets

Variables	*Frequency*	*Percent*
Yes	123	88.4
No	16	11.6
Total	**139**	**100**

Table 4.22 indicates the proportion of the households where women received IFA tablets. It is found that more than 88 per cent of the households where women were pregnant received IFA tablets. The remaining 12 per cent of them do not take any IFA tablets and go on to give birth to a child.

TABLE 4.23
Proportion of Households by Place of Last Child Delivery

Variables	*Frequency*	*Percent*
Home	44	38.6
Government hospital/PHC/SC	56	49.1
Private hospital	8	7.0
Informal health service provider	6	5.3
Total	**114**	**100.0**

Table 4.23 gives details regarding the place of delivery by the women of the sample households. Women in close to half of the sample households deliver

in a government hospital or PHC/SC. A huge number of 39 per cent of them give birth to a child in their homes only. This figure appears far from the government goal of having 100 institutional deliveries. Only 7 per cent of them go to the private hospitals, whereas 5.3 per cent rely on informal health service providers.

TABLE 4.24
Reasons for No Delivery in Hospitals (percentage do not add to 100 due to multiple answers).

Variables	*Frequency*	*Percent*
Very far	14	9.3
No proper roads	2	1.3
No transport facility	14	9.3
Financial constraints	14	9.3
Male doctors	3	2.0
Others	25	16.7

Table 4.24 gives the reasons why women do not go to any hospital for their delivery. For around 10 per cent of women not going to a hospital for delivery three reasons are of equal importance. The distance of the hospital from their place, lack of proper transport facilities to the hospital, and severe financial constraints forces them not to go to the hospital for the delivery. These findings are extremely important for programme managers while taking care of health planning.

TABLE 4.25
Status of Delivery Attendants

Variables	*Frequency*	*Percent*
Untrained dai	10	8.9
Trained dai	30	26.8
Government doctor	50	44.6
Private doctor	7	6.3
Nurse/LHV/ANM	15	13.4
Total	**112**	**100.0**

Table 4.25 probes the status of the delivery attendants of the sample household women. Government doctors attend around 45 per cent of the women, while only 6.3 per cent go to the private doctors for delivery. Still more

than one-third of all deliveries take place by dais. Trained dais attend 27 per cent of the cases but 9 per cent of the women are attended by untrained dais which may be dangerous for both the mother and the baby.

TABLE 4.26
Proportion of Households by Children 0-5 Years Who Have Received all the Required Immunisations

Variables	*Frequency*	*Percent*
Yes	190	89.6
No	22	10.4
Total	**212**	**100.0**

Table 4.26 shows the proportion of households by children 0-5 years who have received all the required immunisations. Children 0-5 years of around 90 per cent of the sample households have confirmed receiving all the required immunisations. But in just above 10 per cent of the cases it is found that children grow up without any kind of required immunisations.

Chapter V

Health Governance and Service Delivery

5.1. Introduction

The term ***governance*** deals with the processes and systems by which an organisation or society operate. Frequently a government is established to administer these processes and systems. The word derives from Latin origins that suggest the notion of 'steering'. This sense of 'steering' a society can be contrasted with the traditional 'top-down' approach of governments 'driving' society or the distinction between 'power to' in contrast to governments 'power over'.

The World Bank defines governance as

The exercise of political authority and the use of institutional resources to manage society's problems and affairs.

An alternate definition suggests that governance is

The use of institutions, structures of authority and even collaboration to allocate resources and coordinate or control activity in society or the economy.

As part of understanding the plausible gaps between the *supply, demand and utility* factors of the maternal and child health services in Orissa, it was considered necessary to examine the health delivery system or, in other words, the 'health governance' prevailing in the area. Unlike the study of service utilisation at community level, these kind of studies on service providers have practical and inherent problems depending on the nature of bureaucratic environment, access to and availability of primary as well as secondary information. In addition the methodological shortcomings can be associated with the availability of time and space. However, an exploratory attempt has been taken in this research project to obtain some information mainly using some qualitative research tools and techniques such as informal interviews, observations, photography and unstructured and open ended interview guidelines. It has also been endeavoured to correlate some of the information obtained from the community sample survey.

In this line, the very specific objectives are:

- To study the currently functional programmes and facilities mainly targeted towards maternal and child health.

- To study the profile, work environment, attitude and problems faced by service providers at different levels of health care system and subsequent suggestions reported by them.
- To carry out some indirect study on the contribution and effectiveness of parallel health care systems in terms of maternal and child health service delivery and utilisation, although technically somewhat difficult considering the available time and space.

To get an insight, before going for the final phase of data collection on health governance or service delivery, a pilot study was carried out in places other than our selected district. The findings are as follows,

Pilot Study

In Bhubaneswar and Cuttack cities, relevant pieces of information were sought from the Directorate of Health Services, Economics and Statistics, NIC (National Informatics Centre), Tribal Research Centre, UNICEF, UNDP, SIHFW (State Institute of Health and Family Welfare) and some NGOs. Official formalities were so time-consuming that one had to undertake several visits to the same office to get a single piece of information. The sub-district information for all the districts were, however, not available in the state level offices. The researcher was advised by officials to visit each of the district offices (District Medical Officers) separately for such information. Left with no other option, the researcher visited a few districts which were selected on the basis of the available time, funds and the prior secondary data analysis. Three districts such as Khurda, Bargarh and Sambalpur were visited. In these districts, relevant information was sought from ADMOs, senior as well as field nurses (Health Worker-Female). The partial access to some sub-district level data could be possible after a long wait and time-consuming official procedures and informal requests. They were recorded manually on the field note in the possible short space.

However, much of the information collected through the pilot study turned out to be an eye-opener, as some of the concepts of the health system and community level known earlier have changed and new aspects have been introduced by now.

- Besides the conventional health structures such as SC, PHC, CHC, DH etc., some sort of "sector hospitals" in the government system have been functional and could have differential effects on maternal and child health service delivery.

- Each district has been divided into a number of sectors merely on a territorial basis without taking into account the population of the area. As a result of this, there is a probability of mismatch in the service provider to population ratio of different sectors even within the same district.
- In villages of Orissa, parallel service providers are different from those in other states; and within the same district, there are variations among communities.
- It has been found that many of the traditional service providers like TBA are almost non-existent and no regular training is provided to the existing ones.
- Many of the child deliveries are conducted by the women's relatives or kin group rather than by trained health workers.
- There is almost no supply of delivery-kits to nurses or TBAs from PHCs. One senior nurse even said that she had never heard about the provision of delivery-kits.

Main Study for Sambalpur District

Information was collected from some health staff from sub-centres, PHC, CHC, district hospital and Anganwadi. The respondents were doctors, pharmacists/nursing and clerical staff, and AWWs. The information on available health facilities and programmes/schemes was collected from district medical and WCD offices. Some qualitative information on parallel health systems such as untrained birth attendants, was collected through photography and informal interviews. Formal discussions were conducted with some senior level officials from health departments and the WCD department at Sambalpur district and state capital Bhubaneswar regarding policy and programmes.

5.2. Health Service Providers' Work Environment

To understand the work environment of health service providers, it is important to know their background. In this connection to start with, qualitative information was collected about the root of the inspiration for which they entered into the health service system. Then their actual experience in terms of material supply, coping strategy, and finally the problems they face and their suggestions for better service delivery were further explored.

TABLE 5.1
Inspiration to Work as Health Service Providers

Variable	*Responses*
What inspired them for being health staff	Encouraged by somebody Social service Just for career

Table 5.1 presents the information on the point of inspiration for the health service providers to work, in which the majority reported that they were encouraged by somebody. It was mainly by family members and friends. Some, of course, came in for social service.

TABLE 5.2
Supply of Health Equipment and Material

Variable	*Responses*	*Percent*
Do you get sufficient supply ?	Yes	58.8
	No	41.2

Table 5.2 gives an account of whether they get an adequate supply of health equipment and material. It was observed that a bigger proportion of all service providers do not get adequate supply material. This can definitely hamper and affect the quantity and quality of service to people.

TABLE 5.3
Do They Meet Inadequate Supply?

Variable	*Responses*	*Percent*
Do you meet requirement when there is less supply?	yes	53.8
	no	46.2

Table 5.3 presents whether the service providers meet the inadequate supply. Still a higher proportion of them do not meet or cover the shortage. This shows the poor picture of the infrastructure. Even the people who meet the needs, face several problems (Table 5.4). Most get the need from other health centres or purchase as a stop-gap arrangement as credit from some medicine stores. Often quantity and quality are compromised.

TABLE 5.4
How Do They Meet Inadequate Supply?

Variable	*Responses*
How do you overcome short supply ?	Get from other health centres/purchase Sample given to poor people Service quality becomes poor

TABLE 5.5
Problems in Service Delivery

Variable	*Responses*
Technical problems you face	Inadequate supply No proper training to use Poor quality equipment Higher burden Road problems Less payment Target pressure Family/personal problems

The information regarding the kind of problems, technical or personal the service providers face while providing service, were collected and presented in Table 5.5. They found a long list. However the majority reported that 'inadequate supply', 'less payment', 'poor quality equipment' and 'higher burden' were the most common problems they face. These observation need to be taken care of by programme managers particularly the manpower and supply.

Some information was collected regarding the prevalence of parallel service providers through indirect techniques. When asked 'Why people go to private doctors/healers', many government health service providers answered 'because of traditional belief' and 'availability in nearby urban area which means private clinics' (Table 5.6).

TABLE 5.6
Perception of Government Service Providers about Private/Informal Service Providers

Variable	*Responses*
Why people go to private doctors/healers?	People go to neighbouring urban areas Belief in traditional system Availability of other services in their locality

Chapter VI

Convergence and Implementation

6.1. Perception of People (Problems and Suggestions) Regarding Health Services

The perception about health services, staff, infrastructure and transport, are all very important in terms of mother and child health service utilisation. Hence this section presents the finding of the analysis of information collected from sample households.

TABLE 6.1
Perception of People (Proportion of Households) Regarding Who Feel the Services Provided by the Government Health Centres are Adequate/ of Good Quality for Women and Children

Variables	*Frequency*	*Percent*
Yes	48	32.4
No	100	67.6
Total	**148**	**100.0**

Table 6.1 presents the perception of the people regarding the adequacy and quality of health services provided to them by the government health centres. More than 67 per cent of the total households surveyed expressed their dissatisfaction over the services provided by the government while just above 32 per cent of them say that the services are of good quality and adequate.

Table 6.2 cites the reasons of dissatisfaction of the people over the services they get from the government health centres for women and children. Negligence of the doctors is found to be the main reason for this inadequate and low quality of health services. While more than 21 per cent of the households complain that there are no doctors in time, for 14 per cent of them there are no fixed times for health centres and doctors. One-tenth of the households are dissatisfied with the rude and arrogant behaviour of the health staff, whereas 6 per cent feel that the medicines are not effective and are of substandard quality.

TABLE 6.2
Reasons Why People (Proportion of Households) Feel the Services Provided by the Government Health Centres are Not Adequate/ Not of Good Quality for Women and Children (percentage do not add to 100 due to multiple answers)

Variables	*Frequency*	*Percent*
No doctor in time	32	21.3
No fixed time of doctors/health centres not always open	21	14.0
Doctors not listening properly/not serious	8	5.3
No medicine in health centres	4	2.7
Medicines are of poor quality and not effective	9	6.0
Hospitals not neat and clean	11	7.3
Behaviour of staff not good	15	10.0
Staff take bribes/money	10	6.7
Medicines from government hospitals are not sealed	1	.7
Government doctors encourage people to attend private clinics	2	1.3
Doctors give no proper information about illness	7	4.7
Unnecessarily admit wage loss	9	6.0

TABLE 6.3
Suggestions for Overcoming the Problems in Proper Utilisation of Available Government Health Services (percentage do not add to 100 due to multiple answers)

Variables	*Frequency*	*Percent*
Doctors/nurses in village or nearby village	34	22.7
Medicines should be available in villages	8	5.3
Medicines should be of good quality/high standard	16	10.7
Free medicine and consultancy	37	24.7
Doctors should listen to patients properly	2	1.3
Bribing should be checked	2	1.3
Hospitals should be neat and clean	5	3.3
Pediatrician should be available round the clock	9	6.0
Weekly health camp in village	6	4.0
Transport facility	3	2.0

Table 6.3 elaborates the suggestions of people for overcoming the problems they face in using the government health services. One-fourth of them are of the view that the government should supply free medicines to them. About 23

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per cent of the people want doctors/nurses in their village or nearby village, while 11 per cent of them believe that medicines supplied by the government should be of good quality.

6.2. Perception (Problems and Suggestions) of Service Providers

In order to understand the health governance, service delivery and utilisation it is not important only to study the community perceptions, but it is also equally necessary to examine the perception of health service providers at different functional levels. This is because both community (service acceptor) and service providers are both 'the sides of a single coin'. Hence this section presents the findings of the analysis of information collected from health service providers selected in this study.

TABLE 6.4
Suggestions for Improvement in Service Delivery

Variable	*Responses*
Suggestions for improving service delivery	Refresher course
	Drugs should be given in SC
	Promotion as per qualification/class
	Sensitisation to health staff on responsibility
	Accommodation facility for staff
	Increase staff number
	Strengthening government system than present condition
	Awareness/information to people

Table 6.4 presents the suggestions given by service providers at different levels about improving service delivery. Various suggestions could be obtained from this study. They cover both the supply and demand side of health service, right from accommodation, staff strength to awareness programmes. However most of the service providers suggested that increasing the number of staff, promotion, etc. can be better governance measures and awareness of people about services and problems of staff would be a good community measure for better service delivery as well as utilisation.

TABLE 6.5
Suggestions of Senior Level Health Staff about Improvement in Service Delivery

Variable	*Responses*
Suggestions for improving service delivery	Refresher course
	Burden should not be provided
	More IEC
	Stability of job
	Dai training should be given
	ASHA training will reduce gap between service delivery and utilisation
	Specific programmes to specific group of people (tribal, etc.) through IEC activities rather than common programmes to all
	There should be involvement of health staff with villagers
	Local bodies should monitor local health service
	Mobile clinics and medicine can be provided in villages

Finally, after encountering the community and service providers, the perceptions were presented before senior level officials at policy level and their suggestions were taken. Table 6.5 presents them in detail. It was observed that the senior policy and programme level staff converge at both service acceptor as well as providers' suggestions and perceive that involvement of health staff with, monitoring of programmes and reaching the community can be the best model or framework for a better service delivery and utilisation of mother and child health care. In this context new developments like ASHA training and specific programmes for specific groups are reported to be innovations.

6.3. Case Studies

CASE STUDY NO. 1

Informant's

Age:	28 years
Sex:	female
Occupation:	basket making
Caste:	ST
Village:	Mundher

Kuntala, the respondent was married at the age of eight in the year 1998. She has delivered four children out of which only one survives till now and the rest have died during infancy. She delivered her first infant son in April 1999. The baby survived for only two days. After birth the infant survived for only two days. Immediately after birth the baby suffered from high fever and skin rashes. The child delivery had taken place in the home. There was no doctor in the village or nearby to treat him. Nobody in the whole village could diagnose the illness, not even the traditional healer. The respondent and her husband being poor basket makers could not afford to go to doctors in town. Financial constraints, lack of transport facilities and subsequently no medical treatment led to the tragic death of the two day-old infant son.

This was not the first incident for Kuntala. She had to face a similar trauma of losing another child who was a baby daughter. The daughter was born a year after the death of her first infant son. This time the new born daughter died even earlier, i.e. within 24 hours after birth. Kuntala was very weak and anaemic during her second pregnancy. The infant daughter was light weight and anaemic too. This delivery too had taken place at home, and "....probably that is the reason why the infant daughter died within 24 hours without getting any medical supervision.....".

Kuntala's third child still survives and is now a four-year-old boy. But the fourth one born after this is another sad story. Last year in June 2005 she delivered a baby boy who died of jaundice seven days after his birth.

Three cases of infant mortality in one family. Poor Kuntala had to face all these tragic incidents owing to lack of medical and transport facilities. Extreme poverty added to the family's problems.

CASE STUDY NO. 2

Name of the Informant:	Pramila Bag
Occupation:	Housewife
Age:	30 years
Village:	Golabandh
Caste:	Keuta

Mrs. Pramila Bag is a resident of the village Golabandh which comes under the Maneswar block of Sambalpur district of Orissa. She is a victim of the deadly disease cancer, i.e. ovarian cancer. She has two children, one boy, who is eight years old and another girl child who is four. According to her version all deliveries were normal and took place at home in the village under

the medical supervision of the ANM of Golabandh. Pramila says, after one year of her second delivery, she suddenly developed a pain in her lower abdomen. In course of time when the pain became intolerable, she went to Sambalpur. But as she was poor and uneducated the doctors recommended some medicines without performing any medical tests. She bought some medicines and took them for ten days and then stopped them as the medicines were very costly. Her lower abdominal pain persisted. Pramila was advised by the ANM to seek treatment in Burla Medical Hospital. Pramila went to Burla and she was advised to go in for some medical tests by the gynaecologist. After the medical tests it was confirmed that she suffered from ovarian cancer. She is still surviving but has no money for further treatment of this disease. There is no doctor in her village and the medicines prescribed are expensive. Nobody knows how long she will survive.

Chapter VII

Summary and Implications of the Study

With the alarmingly high rate of maternal and child mortality and morbidity vis-à-vis poorer level of Orissa's overall performance in the health sector, it was considered important to carry out an exploratory study on service delivery and utilisation. It was aimed to study the health governance including the programmes and service delivery on one hand, and the service utilisation by community on the other. The Sambalpur district of Orissa State was taken as a case study, in which the samples were drawn from 250 households from ten villages situated in four blocks. Information were collected from both community and health staff.

7.1 Major Findings

Analyses showed that most of the people, that is little less than half belong to the reproductive age group of 15-49 years and one-fourth are infant and child population. The sex ratio is disadvantageous towards females. Little less than half are currently married. On education, 45 per cent of the total are illiterates, who do not know how to read and write. That is the reason why the percentage of the population engaged in services is below 4 per cent. Similarly the percentage of people engaged in agriculture falls below 6 per cent as most of them do not have a piece of land to cultivate or small landholders. The primary occupation of most people is wage labour. More people live in nuclear families. Most households live in kutcha houses, symbolising poverty and backwardness. As high as 28.8 per cent of the households live in single rooms, a part of which is also used for cooking food. As high as 45 per cent do not have a kitchen separate from bed/ living room. This can have a harmful effect on the children and pregnant mothers' health because of their direct exposure to oxides of carbon coming from cooking fuel (mostly wood in these cases). More than 11 per cent of all sample households are below the poverty line (BPL). Still one-third of all spend more than 15 per cent of total expenditure only towards health. As high as 43 per cent of households keep livestock inside/ beside their houses which can have a harmful effect on health, especially children and pregnant mothers in terms of unhygienic conditions leading to infections like skin infections, sepsis, etc. Still around 13 per cent of all households have no access to safe drinking water (pipes and hand pumps). More than one-fourth of all households dispose of the sewage inside their houses which may have grave consequences for the health of the household members.

7.2 Implications of the Study

The disadvantageous situation with regard to house type, kitchen, place for livestock, sewage disposal and drinking water, all these have been substantiated with the reported finding of diarrhoea and skin infections. The health service providers are mostly between 37-59 years of age, working for the last 10-20 years. On health status, as high as 38.8 per cent of the sample households, women/children fall sick 4-7 times. Close examination of people's actual reporting of illness and treatment behaviour reveals that many people seem to be less aware in perceiving their illness and also about treatment. Malaria and diarrhoea are the most frequently occurring diseases reported by households. This may be the reason that diarrhoea has been identified as one of the main causes of many child deaths occurring in Orissa. Patients suffered for more than 10 days. It reflects the quality of treatment and immunity level available with the affected mothers and children. Large numbers of people are not going for treatment even though they are ill. Nearly 29 per cent of them go without any treatment. Financial constraints have obstructed most (14 per cent) of the patients from taking any treatment.

It is shocking to find that more than 17 per cent are absolutely unaware of any health services provided to them. Half the respondents say that they receive health information from the Anganwadi workers. The media has a lower contribution and NGOs have almost no contribution in providing health information. In terms of health information, only 10 per cent got information about safe delivery, being one of the most important aspects of mother and child health care. ORS seems to be the most and may be the only popular health service available. Most people seek health services from the private allopathic clinics. Although government plans to strengthen the SC and PHC, the services are less used even by villagers. The coverage of TT, IFA, institutional delivery and child immunisation, etc. warns us that we are still far from our government's goal of 100 per cent coverage. Further distance of health facilities, lack of proper transport facility and severe financial constraints are responsible for these. These findings are crucial for programme managers while taking care of health planning.

On the health governance front, it was observed that health staff report inadequate supply; many do not meet them and if at all, have to face great difficulty. In addition, poor quality of service materials, higher work burden and less payment are reported to be the stumbling blocks for better service delivery. Regarding the community's perception about service quality, utilisation and governance, most people expressed their dissatisfaction with the available

service. Specifically 'negligence of the doctors', 'poor quality of services', 'no doctors in time', and 'no fixed time for health centres and doctors' were reported to be the main reasons. People (community) suggested that 'government should supply free medicines and consultancy' and also 'doctors/nurses in their or nearby village'. In health service providers' perception, health staff suggested that increasing the number of staff, promotion, etc. can be better governance measures and awareness of people about services. Problems of staff would be a good community measure for better service delivery as well as utilisation.

Finally, the policy and programme level staff converge at both service acceptor as well as providers' suggestions and perceive that involvement of health staff with, monitoring of programmes and reaching the community can be the best model or framework for a better service delivery and utilisation of mother and child health care. In this context new developments like ASHA training, specific programmes for specific groups are reported to be innovations. This reminds us the very concept of democracy as ".....of the people, by the people and for the people.....". ❑

References

Government of India (2001): *Census of India: Provisional Population Totals*, Series 22: Orissa Paper 2 , Directorate of Census Operations, Orissa.

International Institute for Population Sciences and ORC Macro (2000): *National Family Health Survey (NFHS-2)*, 1998-99: India. Mumbai: IIPS.

International Institute for Population Sciences (2002): *RHS-Reproductive and Child Health, Orissa 1998-99*, Mumbai: IIPS.

Local Public Health Governance Performance Assessment Instrument (2006): http://www.cdc.gov/od/ocphp/nphpsp/Documents/GovernanceEvaluation.pdf (visited on May 12, 2006).

Mehta, S.R. (1987): *Society and Health: A Sociological Perspective*, Rawat Publications.

Nanda, S. and S. Niranjan (1999): Utilisation of Antenatal Care (ANC) Service by the Scheduled Tribes in India, *Journal of Human Ecology*, 10 (2): 99-104.

Orissa Human Development Report (2004): *Some Measures of Human Development: An Inter-district Analysis*, Directorate of Economic and Statistics, Orissa.

Pandey, Arvind, Minja Kim Choe, Norman Y. Luther, D. Sahu and Jagdish Chand (1998): Infant and Child Mortality in India, National Family Health Survey Subject Reports No. 11, International Institute for Population Sciences, Mumbai, India and East-West Centre Programme on Population, Honolulu, Hawaii, USA.

Patil, A.V. *et al.*, (2002): Current Health Scenario in Rural India, *Australian Journal of Rural Health*, 10(2), 129-135.

'Programming Reproduction? Maternal Health Services' (2005): http://www.hsph.harvard.edu/organisation/healthnet/SAsia/suchana/0804/rh347.html (visited on July 27, 2005).

Registrar General of India (2005): *SRS Bulletin*, Sample Registration System, 39 (1).

Sanghvi, T.G. (2004): Reaching Every Child Now, *Global Health Link*, May-June, p.12. ●

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