STUDY OF INITIATIVES

FOR

INCREASING COMMUNITY INVOLVEMENT

IN

KARNATAKA & TAMILNADU

BY

INSTITUTE OF SOCIAL STUDIES TRUST,
BANGALORE

JUNE, 1997

6005

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INTRODUCTION

As India approaches the 21st century, the achievements in health in some respects have been noteworthy, but key factors like mortality, undernutrition, morbidity still remain high. The marked disparities in the rural urban divide, caste, class and gender continue to persist. Different policies have attempted to address them, but failed to look into the components of a genuine health and development strategy. India today remains midstream in its demographic transition.The three stages of the health problem prevalent in India are a) Health problems associated with underdevelopment (poor and disadvantaged) b) The emergence of diseases of affluence (especially among the urban middle class) c) New environmental and behavioural threats among all population groups. Despite vast investments in educational infrastructure, public distribution system and primary health care, there is a growing number of illiterates, lack of effective food resources, and unaffordable and unaccessible health facilities to a vast majority.

Health of a woman has a profound implication for the development and well being of a nation. Poverty, health and development are closely interlinked. "While poverty is multifaceted and the level of health status itself is a manifestation as well as a symptom of poverty". Poverty relates not only to economic deprivation but also to social and human development, and India's performance in literacy, education, the role and status of women and health care

has not been notable. One aspect of the poverty along with the social status health nexus to be studied is the question of gender.

Women's health needs were circumscribed as their needs as mothers (at home, fields or factory where special services had to be provided). With this came the family planning programmes where contraceptive technology aimed at the womb. With a plethora of products, the policy shifted to one of the targets to reduce population growth which was in practice till two years ago. The emergence of the "new reproductive health" strategy in the 90s ushered in a ray of hope to most women all over the world. Researchers, women's movement activists and population control advocates challenged the use of certain drugs used as contraceptives especially on developing countries to counter population growth. Finally, the sexual, emotional and the physical need of the women were changing the tenor of the health policy with life goals taking precedence over demographic targets. Reproductive rights provide women with the freedom to control their bodies and obtain much needed health services. A critical aspect of women's reproductive rights is their right to control reproduction to ensure meaningful, informed and voluntary reproductive choice which is within the scope of the international human rights treaties and conventions.

The ICPD conference document gave central importance to woman's empowerment and to the importance of creating an enabling policy

enviornment and conditions in all countries for promoting basic health, including reproductive health. The challenge now, is to hold our government accountable to the principles pledged at Cairo. The need is to maximise the reach and breadth of the reproductive health services and to improve their quality, using appropriate technology and regulatory arrangements. We have to explore a mechanism to shift the current focus on curative care to a broader approach that includes preventive care.

Independent India saw its health programmes in the form of maternal and child health as a priority concern. India is one of the very few countries where men outnumber women. Sex ratio today is 927 female for 1000 males. The maternal mortality rates have come down significantly over the past two decades, but in rural areas it is one of the highest in the world -437 per thousand live births. Over 30% of all deaths in India occur among children under 5years. The urban IMR (45 per 1000 births) have come down, but the rural IMR (82 per 1000 live births) is almost double than the urban areas. 30% of Indian females between the age of 15-19 are married. The fertility rate for the country is 3.4 children per woman. The IMR among girls were higher than among boys for India as a whole in 8 out of the 17 states. Age specific death rates among girls below 4 years of age was higher than among boys in 1991. The National Family Health Survey of India estimates that in the early 90s, close to 1,10,000 women died each year from causes related to pregnancy and childbirth.

The health of a woman in India is inextricably bound up with social and cultural factors that influence and affect all aspects of life. Reliable data on mortality and morbidity in pregnancy are scarce. Yet some of the studies have shown a high rate of mortality and morbidity among women and girls. This is due to a greater vulnerability to infectious diseases like heamorrhage, eclamsia, malnutrition giving rise to severe anaemia, maternal and perinatal causes - obstructed labor, abortion and reproductive tract infections. The primary reasons for this are unequal access to food and the heavy work demand on women. The poor women are often caught in the cycle of illhealth, exacerbated by child bearing and hard physical labour.

Despite the girl child's innate biological advantages, more girls die than boys. There is a perceptible preference for sons which leads to female infanticide and sex-selective abortion. Neglect of the girl child - who is weaned early, receive less food and medical care, and removed early from school is married young. Childbirth closely follows marriage which tends to occur at (15-19) ages. Closely spaced pregnancies at this age poses significant health risk.

The benefits of educating woman are widely accepted. Yet we have a low literacy rate like 39% as compared to 64% among males. In 93-94, gross enrolment ratios among boys at the primary school level exceeded 100% in 26 out of 31 states and Union territories of

the countries, but for girls it exceeded 100% only in 15 out of the 31 states and Union territories. Girls account for 40% of students enrolled in the education system. The unhappy factor of this is that girls aged (6-14 yrs) who are not attending school is as high as 41% (92-93). There is also a sharp decline in the enrollment ratio among girls from 93% in the age group (6-11 yrs.) to 55% in the age group (11-14 yrs.)

Very often girls are pulled out of schools to look after the young siblings who themselves are a little older and not knowledgeable about the health and hygenie of children. This perpetuates the vicious circle of ill-health leading to greater infant and child mortality.

Economic needs force several women to go out for strenuous physical tasks. Productive responsibilities are high on childbearing women - who work late into pregnancies, resume work before recovering from child birth and have children in close succession. This coupled with domestic chores, child rearing and hard labor saps her physical strength and results in maternal depletion.

Health Infrastructure in India

The government is the primary source of preventive services like immunization and Family Planning which is offered through hospitals, dispensaries, PHCs and sub centres. Specific health

and nutritional needs of Indian women are provided through the Family Welfare program launched in 1952 of the Ministry of health and family welfare. The department introduced the Child Survival and Safe Motherhood program in 1992 to accelerate improvements in providing services to women and children. The ICDS programme is offered by the Ministry of Human Resource Development. Under the 7th plan the family welfare subcentre was set up and was staffed by one male and one female ANM worker, which serve a population of 5,000. PHCs served a population of 30,000 and is staffed by a medical officer, field supervisors and associated facility staff. CHW (Community Health Workers) covered a population of 1,00,000 and the Community health Center is staffed by specialists in pediatrics, surgery and OBG which act as refferal units. In 1992, theé were 22,441 PHCs, 1,31,318 sub centres and 2015 CHC in the country.

In 1995, the government decided to revamp the Family Welfare Programme. Moving away from a social marketing of IUDs and target sterilisation the government decided to take the women's total health into focus by introducing the reproductive health strategy. Apart from upgrading facilities and improving staff strengthening links with communities and NGOs is slated to be achieved by expanding information, education and communication (IEC).

The private sector provides 80% of health care in India and is the principle source of curative care largely based in the urban areas.

In rural areas it is the informal private sector like the traditional healers, faith healers, the sidda and ayurveda practioners who flourish. They are more trusted by the people, as they deal with the etiology of a condition and the social consequences and spend more time on their patients.Convenience of accessibility, reliability, and affordability keep these some times non qualified practioners thriving in most Indian villages and towns.

Patients are dissatisfied with the government services they receive for reasons that include the cost of the normally free services and drugs, rude and improper behaviour of the health staff at the PHC and the sub-centre,staff shortage ,lack of supplies of drugs, and long waiting hours to see a doctor. For women it is also the lack of female staff accentuated by cultural practises that restrict her from seeking medical help.

The number of women who receive antenatal and post partum care through family welfare programme is still relatively low. Only 51% of women have been receiving folic acid tablets. Institutional deliveries are still low in the country (11%- Instl, 48% TBA, 40% others). There is a pre-dominance of sterilisation which accounts for more than 85% of total modern contraceptive use. Female sterilisation accounts for 90% of sterilisations. Illegal abortions which are local and unsafe account for twice as much as legal abortions. This is because only 10% of eligible centres

actually have a trained provider and the necessary equipment.

A variety of socio-economic factors are responsible for women's lower educational attainment, including direct costs, the need for female labor, low expected returns and social restrictions. Unless we strengthen this strong linkage between female education and health, the status of the vast majority will continue to be the same.

Changes to improve women's health, demand strong commitment of the government to formulate favorable policies,have regulatory mechanisms to maximise resources of both the public and the private sector, allocate adequate resources for programmes, evolve a more gender sensitive approach and a cost effective prevention and treatment facilities.

Field study in Bijapur and Madurai district of Karnataka and Tamil Nadu states.

The project 'study of initiative for increasing community involvement" in the south for the States of Karnataka and Tamil Nadu was undertaken by the ISST team, Bangalore.

Objectives

The objectives of this study was to

a) review the experience of one district from each state in community involvement initiatives for the new strategy of the government of India. GOI is intending to use the panchayat raj structure to plan and implement FW activities.

b) to formulate operationally useful guidelines for effective training of panchayat functionaries.

c) a communitation strategy and communication package for training.

Design of the Survey

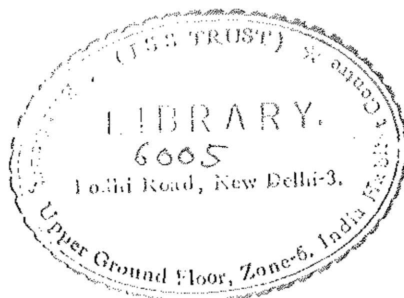
One district in each state have been selected for the study - Bijapur in Karnataka and Madurai in Tamil Nadu. The districts chosen were selected in the category A & B as categorised by the department of Family Welfare, Government of India in its draft concept paper. Karnataka falls under category B States which are evenly placed in regard to hospital and home-based deliveries (say 50% & 50%), whereas Tamil Nadu falls under category A - states which have a very high proportion of home based deliveries (say 70%

- 80%). Within each district, two taluks were selected on the basis of random sampling. But for the purpose of guaging the extent of spread of the health care facilities we chose one taluk near the district headquarters and the other some distance away from district headquarters. In each taluk, two to three gram panchayats were selected using the same procedure.The districts were identified by the Govt of Karnataka and by the Govt of tamil Nadu by the respective Dept of Health and Family Welfare.

The government functionaries who were subjected to formal and indepth interviews are as follows:

At the district level -	i)	The district Health Officer
At the taluk level	i)	The Block Development Officer
	ii)	The Medical Officer at the PHC
	iii)	A taluk Panchayat member
At the Gram level	i)	The Adhyaksha of the GP
	ii)	One male Panchayat member
	iii)	One Female Panchayat member
	iv)	An ANM at the sub-centre

Total number of persons interviewed in Bijapur district was 28. In Madurai due to time constraint we could not cover the whole sample. In addition to this, 3 focus group discussions - one for girls (11-18) age group, one for women of (18-45) age group and a men's group were held in each district. The discussions were facilitated by a member of the local NGO.


(TSS TRUST) Centre
LIBRARY
6005
Lodhi Road, New Delhi-3.
Upper Ground Floor, Zone-6, India

Purpose of the interview

Purpose of the interwiew was to

- understand the current functions of the Panchayat to facilitate the implementation of the Family Welfare programme.
- to ascertain the knowledge and attitude of panchayat male and female members with regard to their role in future as facilitators for the FW programmes.

Survey Instruments:

A structured questionnaire was fielded to these intervieews to understand and analyse their perception, knowledge and attitude of the health officials and the panchayat members regarding Family Welfare health programmes. The indepth interview was , to obtain information on the existing status of panchayat and the extent of their involvement in the health programme initiated by the Government of India.

Apart from the interviews, at the district and the state headquarters a significant amount of secondary data had to be collected to place the review of our study in perspective.

The process of data collection was spread out over two months. A tremendous amount of logistical arrangements had to be made, due to the location of the taluks and the Gram panchayts in the districts and the availability of the interviewees. The structured

questionnaires enabled the process of data collection at an interpersonal level, but secondary data was not forthcoming easily at any level.

List of instruments fielded for the project

KARNATAKA			TAMILNADU
Bijapur District			Madurai District
District Profile			District Profile
District Health Dept.			Disrict Health Dept.
Taluk (1)	Taluk Panchayat		Taluk (3)
Badami	Taluk Profile		Madurai East
	Primary health centre		
Taluk (2)	ANMs		Taluk (4)
Sindagi	NGOs		Usilampatti
Gram Panch.	Gram Panch.	Gram Panch.	Gram Panch
Taluk (1)	Taluk (2)	Taluk (3)	Taluk (4)
Patadakal	Malagahan	Valliakundram	Sindupatti
Muttalegeri	Devarahipparagi	Mathur	Melasenpatti
Layadagundi	Yeragal B.K	Chinnamangalam	-

Interviewees (i) Adhyaksha (ii) Male member
(iii) Female member (iv) Anganwadi

Focus Group Discussion with (i) Women
(ii) Girls
(iii) Men

Background of the study

Karanataka's decentralisation dates back to 1983, when for the first time in the country 25% reservation for women in local governance was earmarked. This extended to rural illiterates, SCs, STs and Devadasis. Ten years later in 1993, the 33.33% reservation in the 3-tier Panchayat Raj came into vogue bringing in 36894 women into the political fray at the Gram Panchayat level,1,395 at the Taluk level and 339 at the Zilla Panchayat level.

Tamil Nadu has a weak tradition of Panchayat Raj. It was one of the last states to conduct elections to the 3-tier which was finally held in October 1996. In 1986, the Panchayat elections were held but promptly dissolved after a few years of existence. The AIADMK government then in power postponed it several times inspite of the Supreme Court directives.

Panchayat Raj Institutions

Particulars	Karnataka	Tamil Nadu
Gram Panchayat	5641	12787
Taluk Panchayat	175	387
Zilla Panchayat	20	22
Members of GP	80631	
Members of TP	3340	
Members of ZP	909	
Electorate	20636782	367000

Source : VANI 1995

Inspite of having a large number of women at the grassroots level,there has been a lack of initiative to involve themselves in the implementation and the success of a viable Family planning programe.This is attributed to several reasons-

a)lack of political experience

b)low literacy levels

c)Very often they are proxy candidates furthering the cause of a male member of the family.

There is a tremendous need to educate and train the women through formal and informal means.Apart from interactive need based training programs,informaion services and health facilities need to improve in a large measure.Women's participation in the political system can and should lead to a positive growth by bringing in changes in the familial and sociatel relationships which benefit the society.

Efforts in these and related areas must be undertaken locally. The Panchayat Raj heralds this space for women to act as informed, articulate, and catalytic participants for effective local self governance. If Panchayat Raj has to be the ultimate goal then, these basic issues as that of health (more specifically reproductive health), education etc will have to be activated through the Panchayats.

Health Situation in Karnataka:

The fertility rate

In Karnataka the fertility rate is 2.9 for women inthe age group (15-49). This is about 15% lower than the national average. (Urban TFR=2.4, Rural TFR=3.1.). Also, the NFH survey found out that for woman of age (45-49) the fertility rate was 4.9, 23% of total fertility is accounted for by births in the (15-19) age groups as 38% of women are married by this age.

FAMILY PLANNING

Most women are aware of the family planning methods, but this knowledge is limited to sterilisation. The modern methods are more familiar to the urban populace, while their rural counterparts, confine themselves to sterilisation (almost 41% of currently married women are sterilised). The attitude towards Family planning is by and large positive among women, as most realise a small family is a better one.Their main source of FP messages has been the electronic mass media - through radio (52%) and television (22%).

Infant Mortality Rates

IMR have declined substantially over the past twenty years. Yet one in 11 children die before reaching the age of 5.

YEAR	IMR/ 1000 births	CMR/ 1000 births	Under 5 Mortality Rate
1978-82	93.5	52	141
1988-92	65.4	24	87

Source : UNICEF, 1995

The IMR is 42% higher and the CMR is 78% higher in the rural areas than urban areas. In Karnataka it is found that children of Sc and ST have a higher mortality rate. Neonatal mortality is higher for males than females, but between (1-5) years, female children experience 30% higher mortality rates.

Education of the mother reflect on the nutritional status of their children. Hence the MCH programme's objectives have to include the development of women through a holistic approach.

Health situation in Tamil Nadu

In Tamil Nadu, family welfare services are extended through a network of 1222 Primary health centres, 8558 sub-centres in rural areas and 63 Family welfare centres in urban areas. Services are also extended through 118 Post Partum centres. In addition 41 voluntary organisations and 656 private surgeons approved by the government are involved in providing family welfare and maternal care.Madurai has 41 Primary health centres, 314 sub-centres and 87 NGO's providing health care facilities.

Tamil Nadu has a sex ratio of 974.The adolescent population encompasses only 31% of the total population reflecting lower birth rates.

MARRIAGE

At the age of 15-19 nearly 25% of the women are married. Marriages below 15 have been virtually eliminated. The median age at marriage has been rising in both urban and rural areas.

Less than half of the women are aware of what the legal age of marriage is. 24% of ever married women married a first cousin and 22% married a second cousin, uncle or other blood relative.

FERTILITY PREFERENCE

Knowledge of Family Planing is Universal in Tamil Nadu. 99% of currently married women know of at least one contraceptive method and 98% know where they could go to obtain a modern method.

Knowledge of sterilization is most widespread.40% of women (or their husbands) are sterilized. 82% of women want to either space their next birth or stop having children altogether.

Among women who want another child, there is a preference for having a son as the next one. In Madurai too, a strong preference for having a son is seen, but we also came across cases where a mother got herself sterilized after having two female children.

ATTITUDES TOWARDS FAMILY PLANNING

Education has less of an effect on approval of family planning than expected. Overall 90% of illiterate women approve of family planning compared with 98% of women with at least a high school education. However, joint approval by both husband and wife is lowest (52%) among illiterate women.

The effort to disseminate family planning information through the electronic mass media has succeeded in reaching half of ever married women in Tamil Nadu. 15% of the women have an unmet need for family planning.

MATERNAL AND CHILD HEALTH

Despite the decline in IMR (almost 15% over the 10 year period) one in every 15 children born in 5 years died within 1st year of life

and one in every 12 children died before reaching age of 5.

During 1987-91, the IMR was 16% higher in rural areas than in urban areas. All of the infant and child mortality measures show higher mortality for males than for females. The ratio of male to female mortality is 1.38 for neonatal mortality, 1.15 for post neonatal mortality, and 1.29 for infant mortality, 1.25 for child mortality, and 1.27 for under 5 mortality.

Most pregnant women in Tamil Nadu receive antenatal care (for 95% of births). Mothers receive 2 or more tetanus toxoid injections for 90% of births. Most babies(64%) are delivered in health facilities be it Public or Private health facilities.

Breast feeding is nearly universal in Tamil Nadu, it is high for all groups regardless of residence, education religion, and other background characteristics.
A substantial majority(84%) of women who breast feed squeeze the first milk from the breast before they begin breast feeding their babies. Only 22% of the babies in Tamil Nadu are put to the breast within one hour of birth and only 55% within 24 hours of birth, indicating the need to educate mothers concerning the importance of immediate commencement of breast feeding.
The vaccination rate of children against 6 preventable childhood diseases is the highest among the large States in India. But it is also true that 47% of children are underweight for their age.

Female children are marginally more disadvantaged nutritionally than boys.

From the PHC records it was also seen that the prevalence of female infanticide is widely spread in Tamil Nadu. This does have an effect on the IMR which stands at 56 per 1000 live births (only 4 districts have higher rates). However the state has a comparatively better rates of educational enrolement and retention. Three districts report the lowest sex ratio's in the country. They are Salem(849), Dharmapuri(905) and Madurai(918). This is due to the high incidence of female infanticide in this region. Two thirds of all neo-natal deaths of female infants occur on account of infanticide. Out of 386 blocks in the state, 105 blocks report the occurance of this. One of the reasons is that most delivaries in Tamil Nadu are home-based and it becomes easier to destory a child within the first seven days of birth.Inspite of several interventions,people have managed to give the slip,leaving no threads to pick on by the law enforcing agencies.Thus the practice continues unabated.

Bijapur and Karnataka at a glance

Particulars	Karnataka	Bijapur
AREA:	191800 Sq.km	17100 Sq.km
No. of villages	- 29066	1247
No. of Municipalities	- [illegible]	18
No. of zilla panchayats	20	1
No. of taluk "	175	11
No. of Gram "	- 5645 [illegible]	363
No. of Corporation	- 02	1
POPULATION:		
Total Population	450 lakhs	2928000
Rural	311 "	2239
Urban	139 "	lakhs
Male	230 "	689000
Female	220 "	lakhs
SC	74 "	1491000
ST	19 "	1437000
Sex Ratio	960	51000
Infant Mortality Rate	79	40000
Child Mortality Rate	87	964
MAternal Mortality Rate	4.5	71
Birth Rate	26	
Crude birth rate	9	2.5
% of low birth weight		21
ANC coverage		
Post natal coverage		8
Primary imm,unisation		85%
% of home deliveries (tr)		
% of home deliveries (Untr)		
		93.8
		6.2
EDUCATION:		69.69%
Adult literacy	-	40.06%
Male literacy	-	2511
No.of Primary Schools	23600	444
No. of Middle Schools	16647	128
No. of Secondary Schools	5624	42+10
No.of Colleges & Tech.Edn.	136	-
No. of Universities	12	

OCCUPATIONAL PROFILE:		
Total Main Workers	17292000	1110000
Agri. + Cultivators	10916000	-
Marginal Workers	1596000	109000
Non-workers	26090000	1709000
Other workers	18887000	-
ELECTRICITY:		
% of household covered	100	148 hamlets
No. of electrified villages	26483	-
WATER & SANITATION:		
% of popn. with access to safe drinking water	67.31	-
% of popn. having access to sanitary latrines	-	-
MASS MEDIA:		
No. of newspaper published	-	-
No. of Dailies	-	-
No. of Weeklies	-	-
No. of Cinema Halls	-	36+21
HEALTH FACILITIES:		
District hospitals	20	1
Sub-Div. hospital	-	3
CHC	-	11
PHC	-	100
Sub Centres	-	504
Municipality hospital	-	-
No.of nursing homes	-	-
AGRI.PROFILE:		
Tot. land under agri.	127 lakh hec.	1258241 hec.
Type of agri. produce	-	
No. of different crops grown in a year	-	
Tot. irrigated land	1976 hec.	19 hec.

INDUSTRIAL PROFILE:		
No. of large factories	9856	236
Textiles	3460	138
Chemicals	381	3
Engg.	-	5
Others	1677	90
No. of medium scale indus.	-	-
Industrial estates	-	7
Indistrial sheds	-	134
No. of small scale ind.	88513	6505
COMMUNICATION:		
Total motorable road	659/1000 sq.km	6068 kms.
Transport - Railways		208 km.
Bus	3089 km	
Boat		
Air		

HEALTH POSITION

Particulars	Karnataka	Bijapur
Staff Position:		
Category	Sanctioned Post	Vaccancies
Doctors (Sur.)	25	3
Staff Nurse	39	-
Junior Staff Nurse	6	-
Para Medical	6	2
Social Worker	1	-
Deputy Health Educator	1	-
Senior Pharmacist	1	-
Junior Pharmacist	3	-
Dental Mechanic	1	1
Senior Health Officer	1	-
Class IV Staff	160	28

Item	Number
DELIVERIES REPORTED(April 96-Feb97)	62474
Through ANM	18880
" Trained Dai	19756
" Hospital	23617
" Untrained Dai	221
No. Of PHC	93
No. Of Sub centres	504
Total No.of beds	396
Female beds	80
Gyna. & Obst. Ward	120
No. of beds in Peadiatric & Surgical and Medical Ward	40
Dispensary	4
FW Units	29
State Govt. Hospital	12
Beds	906
Other agencies	1
Beds	32
Indian Systems of medicine	5
Beds	86
Sterilisation	22500
Drug Shops	551
Blood banks	4
Immunisation in 1000s	
~~DTP~~ [illegible]	74
Polio	74
BCG	82
Measles	69
TT	78

ONGOING PROGRAMMES IN THE DISTRICT.	
JRY	28 Lakh Beneficieries
TRYSEM	22000 "
IRDP	9508 "
100 Well Schemes	328 "
Food Grains utilised	1845 tons
Borewells dug during the year	354
Cumulative	6971
Piped water supply scheme	684
Minimum water supply	779
Anganwadi centre	1523
Industrial pumpsets	97257
District income	179609
Percapita income	5880
ZP Plan outlay	7525
State Sector	4229
Central Sector	3296

Madurai and Tamil Nadu at a glance

Particulars	Tamil Nadu	Madurai
AREA:	130058 Sq.ml	7057.3 Sqm
No. of villages	15822	668
No. of Municipalities	104	7
No. of zilla panchayats	28	1
No. of taluk "	384	37
No. of Gram "	12584	560
No. of Corporation	6	1
No. of Town Panchayats	635	24
EDUCATION:		
Adult literacy	54.31	57.55%
Male literacy	32.31	
No. of Pre Schools	68709	1421
No.of Primary Schools	30619	363
No. of Middle Schools	5503	127
No. of Secondary Schools	3574	108
No. of higher Sec. Schools	2734	26
No.of Colleges	347	28
No. of Tech. Sch/Colleges	235	11
No. of Universities	10	1
OCCUPATIONAL PROFILE:	%	%
Total Workers	43.31	43.99
Male	56.39	55.78
Female	29.39	37.77
Primary Sector	61.81	62.09
Secondary Sector	16.18	12.8
Tertiary Sector	22	25
ELECTRICITY:		
% of household covered	100	100
WATER & SANITATION:		
% of popn. with access to		
safe drinking water - Rural	64.28	
Urban	74.17	
MASS MEDIA		
No. of newspaper published	-	28
No. of Dailies	-	18
No. of Weeklies	-	6
No. of fortnightlies	-	4
No. of Cinema Halls	2760	197

HEALTH FACILITIES:		
District hospitals	23	1
Taluk hospital	138	7
CHC	68	-
PHC	1420	41
Sub Centres	8682	314
Municipality hospital	-	7
No.of nursing homes	-	-
No. of NGO providing health care facilities		87
AGRI.PROFILE:		
Tot. land under agri.	6822154 hec.	394637 hec.
No. of crops grown in a year	-	-
Tot. irrigated land	2496561 hec.	169767 hec.
INDUSTRIAL PROFILE:		
No. of large factories		
Textiles		
Chemicals		
Engg.		
Others		
No. of medium scale indus.		
Industrial estates		
Indistrial sheds		
No. of small scale ind.		
COMMUNICATION:		
Total motorable road	141761 km	
Transport - Railways		
Bus		
Boat		
Air		

Description of the sample studied- BIJAPUR

PROFILE OF THE DISTRICT

Bijapur is in the northern part of Karnataka in the deccan plateau. Along with Bidar, Belgaum, Raichur and Gulbarga districts this area represent a monotonous treeless extensive plateau landscape. Bijapur is about 450 meters above the sea level. Nothern part of the district has basaltic soil and the southern part has black cotton soil and patches of red soil.Bijapur is contained in the krishna river basin. Malaprabha, Gathaprabha, Bhima, Domi are the other rivers flowing in this region earning itself the disinction of being the 'Punjab of Karnataka'. The climatic condition is warm as it falls under the rain shadow region. Due to the unpredictable low seasonal rainfall, agricultural production has been considerably low to meet the requirement of its people. This is a drought prone area Jowar is the major cereal of this region. Sugarcane, cotton, groundnuts, pulses are the other commercial crops are grown in this district.

The health situation in the district

The district health education officer of Bijapur complains that not enough research is done on health indicators and thereby data on it, is scattered. A number of improper reporting systems are in vogue which need to be streamlined.

On Reproduction and child health - people are not aware of the

details of the RCH programme.There is a shift in seeking health care. Men are bringing sick children to clinics, but this is not enough. Most men are ignorant about the various aliments of woman,and how to tackle it.

Common illnesses found in this district are diarrhoea, undernutrition, anemia for the vast majority. Apart from this, there are a number of RTI's found in particular among the women of the reproductive age.

Health Services

Health services provided by the government system is simply inadequate. Situated at distances inaccessible by walk, the people take recourse to local healers i.e faith healers, quacks, sidda and ayurveda (unqualified) practitioners. Even if the PHC is close by, most respondents complained off non-availability of the doctors, rude behaviour of staff and inavailability of drugs. The sub-centres are in no way better. Rampant corruption was also reported by people, as most corroborated the fact that free health care is non-existent. Only on payment of a nominal fee does the doctor see the patient at his home. (more often the compounder attends to the minor ailments).

IEC

The programs held so far by the government, has been one of propagating FW methods through the mass media-posters, film shows.

Most people have been exposed to different messages and thereby attribute their knowledge of health to this. Programs have been in small groups but generally in a large gram panchayat it is through mass meetings. One official put forth the view that its time the mass based programs stop and an opportunity is given to the individuals to ask questions about their own health and well-being. Also people are losing interest in film shows and slides as economic necessities take priority. Most of them face the paucity of time to attend a lengthy film or slide show even if it is giving valuable information on their own health.

Panchayat and health

Health has not been a subject entrusted to the Gram Panchayat. Hence initiatives at this level was not forthcoming to address issues concerning health, especially RCH. Their role now is only restricted to awareness generation like providing infrastructure for programs, or motivating people to attend awareness camps. Opinions varied on their role. Some respondents felt that the panchayat has a policy and an administrative role, which it should confine itself too, while others reacted that their involvement in the health programs will help community participation and will give a boost to the programs. Other people who can be involved in any health program are the Mahila Mandal members, dais, CHG/CHV and the school teachers. Apart from the need, to recruit more health educators, the IES program can succeed only if there is effective

services. Otherwise information and education will not help people change attitudes and seek health care when needed.

Training

Training programs are insufficient. No training programs have been conducted for the panchayat members or Mahila Mandals that we visited. Gram Panchayats members had no knowledge about their role in changing the health situation. They have had no training on this subject. The dai's who have had training complain that, even after several months, no kits have been provided. The health officials whom we spoke to feel that the constrains of lack of funds,and infrastructure, impede them from conducting any new need-based program. Everyone agreed that the PHC should develop to be an institution providing holistic care - both preventive and curative.

Taluk Profile

Badami and Sindagi were the two taluks chosen from the district. Badami is situated in the south, 90kms from the district headquarters whereas Sindagi is about 35km away towards the east. Paradoxically, Badami is economically and socially better than Sindagi. The reasons could be that it is rich in mineral resources compared to the northern district. It is also a tourist spot with a proximity to other districts which help trade and commerce. Sindagi is dry with vast expanses of uncultivable land. People have to walk miles to get water. There is no drinking water facilities. They also have to go far to receive health care facilities.

The Taluks at a glance

State: Karnataka

District: Bijapur

Taluks: Sindagi and Badami

Particulars	Sindagi	Badami
Number of villages	141	156
Date of first formation	1993	1993
Date of last formation	1993	1993
Population Profile		
Total	2,80,900	2,56,600
Male	1,44,400	1,28,600
Female	1,36,500	1,28,000
SC	52,000	32,700
ST	3,200	2,100
Education		
Literacy	52.57%	58.75%
Male literacy	67.16%	75.09%
Female literacy	37.16%	42.55%
No. of Primary & High Schools	23	27
No.of secondary schools	5	8
No. of colleges (non tech)	3	6
No. of technical schools	2	3
Occupational Profile		
Total workers	1209	1155
Non-workers	1602	1411
Agricultural Profile		
Total land under agriculture	166948 hec	85862 hec
No.of different crops grown in a year	25	25
Total irrigated land	2480 hec	20176 hec
Industrial Profile		
No.of large scale industries	1	-
No. of medium scale industries }	36	79
No. of small scale industries		
Communication		
Motarable Road	331	867Km
Railways	-	36km
Electricity		
No. of villages electrified	100%	100%

Water & Sanitation		
% of population covered under safe drinking water	NA	NA
% of population having access to sanitary latrines	NA	NA
Mass Media		
No. of cinema halls	2	5

Health facilities in the Taluk

Particulars	Sindagi	Badami
PHC	10	8
No.of sub centres (ANM)	58	46
NGO	-	110
Nursing home	-	1
No. of village practitioners		NA
No. of trained dai		110
No. of CHG/CHV		110
No of other health practitioners	10	approx
allopathy		30
homeopathy		30
ayurvedic		40
Siddha		-
ICDS block	yes	yes
Anganwadi	219	140
Mahila Mandal	13	21
No. of Govt hospitals	1	2
No. of beds	30	55
No. of Dispensary	1	-
Other progrms		
100 well scheme	27	31
IRDP	1288	922
TRYSEM	106	98
JRY	847 houses	827 houses

Both the Taluk Panchayats had not carried out any activities with regards to health. Only the Public health engineering department was at work, that too occasionally for spraying DDT in the eventuality of an outbreak of malaria. The Muthelgiri gram panchayat of Badami Taluk has the dubious distinction of being the only village with guninea worms in the country. Here the Panchayat joined hands with the UN agency to eradicate this influx in different stages. The Panchayat members could not articulate the health situation, but the BDO was optimistic. They maintain that, their hospitals and dispensaries were working satisfactorily, though problems abound. Health services and more awareness need to be generated to instill a certain level of health seeking behaviour in the people.

Profile of the Gram Panchayat

The Gram Panchayats visited in Sindagi Taluk were Devarahippargai. Yeragal BK and malaghana while at Badami, the three GP's were Muthalegeri, Patadahal and Layadagundi. Layadagundi Gram Panchayat fall under the malaria belt and Muthelgiri is known for the guninea worm disease. At the GP we met the Adayskha (President). One male member and one women member. They were randomly chosen to field the questionnaires however the local NGO SABALA identified the villages for us in Sindagi.

Quiet sadly, the women and the men elected representatives were at

a loss to answer several questions. The demographic details of population, literacy and year of formation are not known to the majority of interviees. The apathy of the situation was also that the elected representatives could not enunciate the collaborating agencies who came together to conduct any public awareness activities (like the PHC, ICDS etc).

The common health problems are known to most of the people. The women are aware of the different diseases, which could afflict the children and the woman. But the women were shy to answer the diseases/ailments that could affect the men. The men inturn complained that women do not disclose their health condition to them and so they are ignorant about it. (See Annexure IV).

The health seeking behaviour of people were again loaded towards local practitioners due to the non-availability of the health services. The PHC/sub-centres are not working satisfactorily. So the first choice of people are the local healers (who is one who combine most systems of medicine). the women members are unaware of how the community could be mobilized to accept scientific methods for they complain that even if information is given, no services are there to avail off. Most of the respondents wanted the PHC to improve, by having a regular doctor who will be available for consultancy all the time. Also people wanted investigative facilities which in their opinion is necessary to understand bodily ailments.

As panchayat members, most respondents could not answer the questions even on their role as people's representatives. They are not aware of the health situation in their areas, nor could they envisage their roles to better the situation. They opined that unless they are exposed to some form of training, their ignorance about their own power's and functions will come in the way of development.

The panchayats have discussed some of the health problems at their meetings, but since health is not a subject in the agenda they are unable to take unilateral decisions, Their suggestions are not implemented as it gets lost in bureaucratic discussions. Yet the panchayat members agree that their role as watchdogs is important for the effective functioning like - ensuring health staff do their duty, and conduct more camps to raise the awareness of its people.

Health awareness of people are low. Hence the panchayat members can collaborate with other agencies (PHC, Sub-centres, ANM's local doctors) to conduct programs. This can be brought about only if their roles, power's and functions are transparent to one another. Apart from this the panchayat should involve local leaders, mahila mandal members and youth groups in this planing and conducting programs to instill a feeling of belonging and responsibility to better the health status of the community. This also becomes a focal point where research at the local level with these groups can help in the planning process.

MADURAI- A PROFILE OF THE DISTRICT

Tamil Nadu has a very ancient history in language, culture and civilization, which dates back to 6,000 years. It represents the nucleus of Dravidian culture in peninsular southern India. Tamil Nadu with an area of 130,058 KM sq, is spatially the 11th largest state in India. The 1981 census definition divides the state into four regions on the basis of geo-physical characteristics

1. The Coromandal Plains and the Alluvial Plains of the Cauvery Delta
2. The Dry Southern Plains.
3. The mountainous Region.
4. The central Plateau Region.

Madurai comes under "The Dry Southern Plains". The river Vaigai Flows right across Madurai district. Today the district is biforcated into vaigei and Madurai.

Tamil Nadu is one of the more urbanised states in India. 34% of the population live in urban areas (26% India). It is also one of the industrially developed states contributing 1/10th of the manufacturing share of national income. Around 40% of rural population and 21% of the urban population live under poverty. In 1990-91, Per Capita real income was 1965 Rs, compared to 3,588 Rs for all India. Although 61% of workers in the state are engaged

in agriculture frequent drought and lack of effective irrigation are largely responsible for the poor functioning of agricultural sector in the state.

The chief crops grown in this area are the Cereals, Pulses, Cotton, Sugarcane, Coconut, Oilseeds and Plantation crops. A large population of the district is involved in agriculture. And there is a large percentage of women in this sector.

Caste plays a dominant role in the economic and social development of the states. Very often this becomes the bait of manupulative politicians. Ritualistic practices abound where people sometimes inflict pain on themselves to sing the glory of different deities. We were witness to a banned practicer of 'cock fight' as part of a temple festival.

Health situation in the district

Madurai has the advantage of having a medical college and thereby most of the taluks are taken for the rural postings of the interns. The PHC doctor's do not show a reluctance to stay in the surrounding places because Madurai is a well developed town, with extremely good trade and commerce. Tourism also bring people to this temple town. Good transport facilities and infrastructure was observed in the talu ks we visited. The PHC's maintain good records and that the health seeking behaviour of the people was very positive.

But people were not aware of the repoorductive and child health program. The doctor at Thirumangalam PHC wondered why a better district like Madurai was chosen for the RCH program when places like Ramanathapuram who is even poorer existed. The officials are aware of this programe.

The panchayat members had no idea about this program though their personal knowledge of the health situation was farily good.

Health Services

Health services provided by the state was satisfactory. Yet the people wished that facilities and accesibility to health care could be improved. Faith healers exist in parallel to the health system, but they are usually taken recourse at the terminal stages. Women who are illiterate show a preference for them but, by and large allopathy is the preferred mode of treatment.

Panchayat Union Profile

Madurai east and Usilampathi were the two panchayat unions in Tamil Nadu identified for the project. Madurai east was about 30km from Madurai town, Usilampathi was situated on the banks of vigai river, 70kms from Madurai.

Both PHC have a good health infrastructure and other facilities. But Madurai east PU face water shortage. Economically they are poor, but health seeking behaviour coupled with various health

schemes of the government, have made people more aware of their health needs. Socially, there is a perceptible influence of male patriarchy and ritualistic practices in the villages. However this study could not draw up a conclusive remark on its influence on health and in particular women's health.

Panchayats and Health

Panchayats are relatively young in Tamil Nadu.The year of panchayat formation goes back to 1955 but the GP's initiation to the 73rd Amendment was only in Oct 96. Thus the panchayat members have not had any exposure or traning programs. Therefore, the woman who are the first entrants opined that their knowledge about panchayat was indeed negligible. The delusion of the erst while landlord-caste Panchayat is still on the minds of the people.

While talking to the President of Vellikundram Gram panchayat, her husband who also happens to be the vice-president and a presiding landlord of the village told us that the register comes home to be signed by his wife and that he runs the affairs of the pachayat. The wife did not even answer half of the queries posed to her. Thus, it will be a onerous task on the part of the administration to effect decentralisation, if such occurances are common.

None of them could articulate their role as panchayat members. On involving panchayat members in the health programs, there were mixed reactions. While the health officials maintained that, if they are involved, they could politicise the system, the others

maintained that a chance should be given and a strategy evolved to see if they can collaborate efforts in this direction. At the moment no activities have been conducted by the Panchayat except for providing infrastructure like buildings for the TINP (Tamil Nadu Integrated Nutrition Project) or immunisation programs.

I E C

Being a well-informed populace, mass media has played a very important part in propagating health messages. While stressing the continued efforts in this, the people also opined that information on AIDS, and cancer need to be aired to the people through various media. Contraception is well known but knowledge on reproductive health was expressed as a felt need.

Taluks at a Glance.

State : Tamil Nadu

District : Madurai

Taluks : Madurai East & Usilampatti

Particulars	Madurai East	Usilam Patti
Number of villages		
Date of first formation		
Date of last formation		
Population Profile		
Total	89,503	1,00,000
Male	44,917	55,000
Female	44,586	45,000
SC	21,172	10,000
ST	21	2,000
Education		
Literacy	N.A	38,000
Male literacy	N.A	20
Female literacy	N.A	18
No. of Primary Schools	34	30
No. of High Schools	62	15
No.of secondary schools	4	1
No. of colleges (non tech)	1	1
No. of technical schools	1	1
Agricultural Profile		
Total land under agriculture	13706 sqkm	10000sqkm
No.of different crops grown in a year	2	2
Total irrigated land	12940	500
Industrial Profile		
No.of large scale industries	2	1
No. of medium scale industries }	2	5
No. of small scale industries	510	112
Communication		
Motarable Road	70	100
Transport	Bus	Bus
Electricity		
No. of villages electrified	30	30

Water & Sanitation		
% of population covered under safe drinking water	70	50
% of population having access to sanitary latrines	50	50
Mass Media		
No. of cinema halls	5	4

Health facilities in the Taluk

Particulars	Madurai East	Usilam patti
PHC	1	2
No.of sub centres (ANM)	3	5
NGO	-	1
Nursing home	-	1
No. of village practitioners	-	NA
No. of trained dai	10	20
No. of CHG/CHV	-	-
No of other health practitioners	8	-
allopathy	7	5
homeopathy	-	-
ayurvedic	-	-
Siddha	1	-
ICDS block	yes	yes
Anganwadi	"	"
Mahila Mandal	"	"
No. of Govt hospitals	"	"
No. of beds	"	"
No. of Dispensary	"	"
Other progrms 100 well scheme IRDP TRYSEM JRY		

CONCLUSION

The Karnataka Panchayat Raj Act 1988 says that the amenities committees are to perform functions in respect of education and public health, right to construct drains for every house, and participation in implementation of the FW projects/program.
The ZP's oversee the management of hospitals and dispensaries excluding those under the management of layouts and implementation of all other programs.

Thus the GP's are left with no power to initiate any planning of the implementation of the programs concerning health. Also there is no stipulation to include woman in the health committees at the Gram Panchayat level. Therefore health concerns of the village especially that of woman and her reproductive health are not reflected in the programs that come from the top.

There is a growing necessity to have training programs for the panchayat members in both the districts and to motivate them to initiate them to articulate and demand health services. Panchayat members themselves have opined this during our survey. Also such forums throws open a plethora of avenues to discuss and change prevailing attitudes that implede woman's development . The training programs should be gender-sensitive in content and form. The trainers need to be sensitive to the needs of the group.
At the village level the institution of Gram Sabha need to be strengthened with the participation of woman. Patriarchal

constraints can be gradually weened through community based programs. But all this demands committed support from the government especially given the magnitude and reach of their programmes. The NGO's are to be involved in the planning stages as their research skills are valuable while drawing up a strategy. In Tamil Nadu,women need training in all aspects of Panchayat raj because they are only one year old.

CONSTRAINTS OF THE STUDY

Given the sample size, any conclusion is difficult to evolve because representation of a particular group was low. However this study could through secondary information collate the existing field reality.

Secondary data on health is hard to come by because the government in Karnataka and Tamil Nadu are still in the process of analysing and publishing them. The National Family Health Survey and the Census Book were the main source of information for this study.Census book for Tamil Nadu was not available to us.

There were instances of politically correct answers given by the health officials which didnot match with the views of the panchayat members. Therefore any collaboration for the Family Welfare program should be in the light of this. Also there is a need to break the long held attitudes of the people against the health system.

Increased educational status is associated with a better bargaining power, control over resources, knowledge of skills and above all the confidence for decision-making. Such a situation is utopian to the vast majority. Hence understanding of power relations between men and women is essential to draw up a program or strategy that will empower the women to take decisions on her health, family, children and above all her reproductive health. The panchayat can intervene to give support systems and disseminate information at the local level. The IEC program should go beyond selective media methods to interpersonal communication to create a more favourable environment for imbibing the enormity and necessity of Family Welfare Programmes.

The panchayat can mobolise people to demand for services, but prior to this the Gram Panchayat members have to have exposure to training and other forms of learning. They have to be knowledgeable of the existing material and to improvise it according to the needs of the society. If we achieve this the panchayats will go a long way in becoming a body of a truly decentralised democracy.

ANNEXURE - I

NON GOVERNMENTAL ORGANISATION

Name of the Organistaion: Sharada Vidya Samasthe.

Address : Sharada VidyaSamasthe, Tippapeta,
Guledagudda, BadamiTaluk,
Bijapur District- 08355
Karnataka State.

BRIEF HISTORY OF THE ORGANISATION:

The Organisation took shape under the tutelage of Mr. Virupakshapa Tippar in 1982. He had a 5 member team. Today it has gained firm roots and has a working group of 15 members. The organisation works in Badami and Bagewadi Taluks of Bijapur district. There are 25 members working in the field with farmers, children and the economically backward masses. The activities are co-ordinated by S.C. Bangapur since the last couple of years.

ACTIVITIES OF THE ORGANISATION AS REGARDS HEALTH:

The organisation has a Samudaya Arogya Krama which helps the Agricultural households and organises self help groups and Mahila Sangha they also have a co-operative society helping women with small savings. They also conduct awareness programmes. They have a language school were they teach Hindi and Sanskrit. When asked why they have a Sanskrit school, they said that it was to keep the

ancient Indian language alive as the new generation is immersed in learning other foreign languages.

COMMON HEALTH PROBLEMS

The common health problems of women in the 18-45 age group are anaemia and under nutrition apart from these commonly found problems, there are occurances, of cervical cancer, white discharge and excess bleeding. Since Bijapur falls under the high risk area for AIDs this organisation has detected some of them and is now spreading awareness about this killer disease to others in the community

The common health problems of girls between 15-18 yrs are pain during menstruation, anaemia and mal nutrition.

COMMON SEXUAL HEALTH PROBLEMS

The common sexual health problems of women between 18-45yrs are mmennohrea and Leucorrohoea. It was also found that early delivery was leading to a high Maternal mortality rate in the villages.

The common Sexual health problems of girls in the age group of 11-18yrs are painful menustruation and leucorrohoea.

Mrs. Sunanda who represented Sharada Vidya Samaste has just heard about the RCH programme but she does not know the details of it.

SERVICES PROVIDED TO WOMEN AND CHILDREN AT PHC LEVEL

The PHC provides for the treatment of common illness to the women and children. They also have antenatal check ups, attend delivery cases and postnatal care. They also treat sexual health problems brought to their notice.

The PHC is provided with adequate supply of medicines and FP methods/measures but there is a need to improve the infra structure of the PHC for effective functioning. The PHC staffs behaviour with the patients are not cordial. The staff also complain that there is no supply of medicines and infra structure. The PHC have very poor follow up facilities. They make use of NGO's to effect a programme. There is a need to motivate the staff. The PHC service can be improved by working closely with Panchayats and the NGO's, who can demand services and motivate people to seek health care from the PHC's. Mrs. Sunanda feels that the PHC should bring about newer ways of mobilising people for their mass programs.

I E C

The strength of any awareness programme should be that the people are informed well ahead and also arrange the programme at a place which is easily accessible. They should use good materials and

also give an opportunity to the people to interact.

The weakness of the awareness programme so far conducted are that the people are not informed in time, they are not held at places which is easily accessible. They have poor audio visual materials and give no opportunity for interaction.

To make the awareness programme more effective they should involve women panchayat members, Mahila Mandal members and also ICDS anganwadi workers.

The PHC and the NGO's co-operate in organising programmes, health camps and pulse polio programme. Though this co-operation is not of a sustained nature as the NGO's do not have long term project with the PHC. The reason for this is mainly that the people who need health care are not demanding services from the PHC.

The NGO has mobolised people before on various occasions, so now it is a thought process at work about mobilising them on issues of reproductive health.

Name of the Organisation: SABALA

Address : SABALA
Samatha Building,
Kirthi Nagar,
Basavana Bagewadi Road,
Bijapur- 586 101.

BRIEF HISTORY OF THE ORGANISATION:

This organisation was started in 1986 by Mallamma.S.Yellawar along with seven friends. She worked alone in five villages for 6 months. Initially, she was funded by CAPART & OXFAM for 3 years. During this time 3 people worked in 41 villages and in 11 tandas. At present she has 28 field staff who work full time and 46 who come in when needed for different tasks. Today the major part of the funds come from Zilla Panchayat and HEXS. The organisation's main thrust is to help the poor and economically backward population especially women to develop skills of small trade and earn through them which checks migration to a large extent. They also empower women through Sangha's by throwing light on social issues, rights etc., to combat problems of daily life.

ACTIVITIES OF THE ORGANISATION AS REGARDS HEALTH:

The organisation has a training program for Dais they also motivate the mothers to seek health care by intiating programmes co-ordinated by the local PHC and FPAI for the Mother and Child's Health.

COMMON HEALTH PROBLEMS

Common health problems of women from 18-45 years that they could identify was anaemia and undernutrition. Apart from this, also there is the high incidence of white discharge, infant motality and maternal motality.

The common health problems of girls in the 15-18yrs are undernutrition, anaemia, mmenorohoa and leucohrea.

COMMON SEXUAL HEALTH PROBLEMS

Leucorrohoea is a common sexual health problem of women in the age group of 18-45 yrs apart from this heavy bleeding during the menstruation cycle and an occurance of the cycle in a span of 20 days is also commonly seen.

Painfull menstruation and leucorrhoea are the common sexual health problems of girls in the age group of 11- 18yrs.

Ms. Mallamma is aware of the RCH programme, but is unable to enumerate the details.

SERVICES PROVIDED TO WOMEN AND CHILDREN AT PHC LEVEL.

The services provided to women and children at PHC level are treatment for common illness and immunization to the children. They treat women for antenatal care, during pregnancy and postnatel care . At the PHC level postnatal care and referral services are not adequate. There is a need to educate the masses through visual aids.

The PHC have inadequate supply of medicines, FP methods and infrastructure . Their behaviour is indifferent and they have very poor follow-up facilities, referral, and target oriented. The health staff do not visit the PHC regularly.

The PHC's can be improved by having an adequate and regular supply of medicines, vaccines and FP methods. The health staff should visit the PHC regularly and behave well with the clients. Also PHC can be improved by working with Panchayats, NGO's and local sanghes.

I E C

The PHC takes up family planning issues including antenatal and postnatal care though not sufficient. They have spread awareness on AIDS also.

The strengths of any awareness programme should be that people are informed well ahead of time. This should be conducted at a convenient and a spacious place.

The weak point of the awareness programme here is that the people are not informed, and is not convient for most people to attend. Materials which they use is of poor quality. There is need for materials which is user friendly

The awareness programme can be made more effective by involving trained dais for spreading messages and having more community based interaction. More of visual aids are necessary for reinforcement of messages. Also the panchayat women members and the Mahila Mandal members should be involved in various programmes aimed at the community.

There has not been any issues on which the PHC and NGO's have co-operated with each other. They are unable to do so because, the PHC is a hierarchical and bureaucratic. They expect NGO's to take the initative in all the programs. The NGO's have no benefit in this scheme of functioning.

Name of the Organisation: Society for Integrated Rural Development

Address : SIRD

Periya Sommeltupatti,

Meikilurpath (P.O.)

Usilampathi Taluk - 626 532

Madurai District, Tamil Nadu.

BRIEF HISTORY OF THE ORGANISATION

The organisation was started in the year 1979. The organisation first started with a health program, then they moved o0n to Youth development and now concentrate on economic development. The activities of the organisation are co-ordinated by Mr. Jeeva. Activities of the Organisation as regards health.

The organisation runs a free health centre. Since female infanticide is very common, most activities address this issue too.

COMMON HEALTH PROBLEMS

Common health problems of wopmen between 18-45 yrs age group are anaemia and undernutrition. White discharge is also very common health problem.

Common health problems of girls in the age group of 15- 18yrs are under nutrition and pain during menustration. Jaundice is a frequently occuring disease.

One of the common sexual health problems of girls is painful menustruation.
Mr. Jeeva is aware of RCH, but would like to know more about it.

SERVICES PROVIDED TO WOMEN AND CHILDREN AT PHC LEVEL

At the PHC level the women and children are treated for common illness and immunization. They also deal with Antenatal, delivery and Postnatal care and have referral services.

Adequate supply of FP methods/measures are the strengths of PHC which should provide basic health care facility.

The problems faced at PHC is they don't behave well with the patients, the staff donot visit the PHC regularly, they have very poor follow up facilities, there is not enough supply of medicines and infrastructure. Some doctors ask the clients to meet them at their clinic if any problem is discussed.
The PHC can be improved by having enough medicines, vaccines and FP methods, the doctor should be regular and the staff should behave well with the patients. The PHC should also work with the Panchayats and NGO's.

I E C

The PHC have taken immunization, Antenatal and Postnatal issues for the awareness generation camp.

Awareness programme can be made more effective by involving women panchayat members and Mahila Mandal members, and the NGO's, They should also involve the dias to give some important messages and community held guides for personal interaction. In the awareness programme they should use good audio and colourful ~~and~~ visual aids to make it more effective. They should have a regular follow up of the programme.

The PHC should co-operate with the NGO's to get donations and traning.

ANNEXURE - II

AUXILLIARY NURSE MIDWIFE

We met two ANM's in Bijapur district and one in Madurai District. The ANM's at Bijapur could not articulate much, it required deep probing, even then their answers were very evasive. It looked as though they were scared to answer. This was not the case with the ANM at Madurai, she was willing to answer and she had information about the various health activities. (this could also be because we had chosen a model PHC)

Adolescent girls suffered from problems like excess bleeding, white discharge, stomach ache, back ache, difficult labour etc. Women betwen the age of 18 and 45 too suffered from the same problems in addition to cervical cancer,maternal deaths, prolapse of uterous etc.

The sub-centres provide services like immunization of mothers and children, distribution of folifer tablets and ORS packets, and antenatal check-up. They also disseminate information on (i) nutrition of pregnant mother and (ii) importance on immunisation of pregant mother, child immunisation, oral rehydration, family planning, personal hygiene and safe delivery.

In Madurai district they follow the door to door method as part of

dissemination of information and regular follow-ups are also made. In Bijapur district,the community is involved, ie, regular health camps are held to disseminate information.

Lack of motivation and awareness among people is a major problem which curtails the proper functioning of the Sub-Centre because services are free. Villagers prefer to go to a private practioner who would charge them a fee for the services rendered. (the psychology behind this is -the service is bad when no fee is charged) The ANM at Madurai also complained that she has a large population to cover and time is not enough to cover such a large population.

PHC as such does not get any support from the panchayat for rendering health services ie,there has been no cases (so far) of providing infrastructure etc, by the panchayat to the PHC or sub-centre. But they help to motivate people to attend camps and also inform them when and where the camps wil be held etc. Same is done by the ICDS also. They bring mothers and children for immunisation, hold awareness programmes on health and motivate people to avail health facilities.

The ANM's think that the panchayat should motivate people and bring them to attend camps and avail of the facilities available for them at the sub-centre. By doing this the panchayat would be doing a great service to the community.

The ANM's think that addresing a group and creating awareness among the people is the best way of disseminating information. So health related camps like AIDS day, pulse polio etc, is very effective. Also materials like posters, pamphlets, filp charts and booklets are very effective.

Lack of interest among the people to listen to health talks and non-availability of a space where discussions could be held with women are problems they face while conducting awareness programmes.

The ANM's beleive that the panchayat can give monetary help to their people i.e, in cases where people are poor and don't have the required amount of money for treatment, then the panchayat can lend/donate money to them. Also, since they have day-to-day contact with the villagers they can detect any disease and advice and motivate them to take immediate treatment. They feel the same about ICDS staff also.

Timing of awareness programmes is very important, the language used should be simple, and should be interesting. These were the suggestions given for improvement of health awareness of people.

ANNEXURE - III

ANGANWADI WORKER

The Anganwadi workers were aware of the RCH programme and knew its components such as Antenatal care, postnatal care, safe delivery, immunisation, breast feeding, weaning, oral rehydration therapy and family planning.

According to them adolescent girls have the following common reproductive health problems: weakness, body ache, stomach and back ache, white discharge and mensturation problems. The women in the age group of 18- 45 also face similar problems in addition to delivery problems, maternal morbity, cervical cancer etc.
Children of the age group of 0-6 suffer from measels, polio, diptheria, wooping cough, fits, jaundice etc. Women above the age of 45 suffer from diabeties, blood pressure, T.B. heart problems menopausal problems, cancer etc. Men too suffer from B.P., diabetis, heart attack, kidney problems etc.

Most of the villagers take recourse in Ayurvedic medicine, (all the villages we visited had a Ayurveda practitioner) They also go to the nearby government hospital (PHC) and where private hospital (private Practitioners) exist they visit it more often. They also believe in faith healers ie., for most common problems they first visit the faith healer and then only do they go to the doctors.

They motivate people to attend health camps and seek medical treatment, support and help in conducting awareness programmes on health, bring mothers and children for immunisation, educate mothers on child nutrition and give the mid-day meal to the children at the anganwadi.

Conducting group meetings is effective in creating awareness, individual contact is also made at times. They create awareness on maternal and child health, cleanliness, nutritious food, breastfeeding, environmental pollution, immunisation and sanitation.

Posters, flip charts, demonstration and slides are made use of extensively for creating awareness. The ANM's feel that there is a lack of A/V materials and printed materials for various programmes. They do not receive adequate support from G.P members for awareness generation.

The anganwadi workers have undergone training (orientation) in MCH. They are aware of RCH programe but have not yet got any training for it.

ANNEXURE - IV

PRIMARY HEALTH CENTRE

Achievements as per health Indicators.

Health Indicators	Madurai PHC	Bijapur PHC
IMR	64.00	20.8
0-4 mortality rate	11.00	8.0
maternal mortality rate	4.2	0.66
birth rate	21.0	32.2
crude death rate	8.5	4.8
percentage of low birth weight	2.3	6.0
ANC coverage	100.0	64.3
PNC coverage	99.0	62.1
couple protection rate	63.0	43.5
primary immunisation coverage (1-2) years	100.0	92.5
percentage of home deliveries	25.0	64.4
percentage of home deliveries by trained personnel	60.0	47.0

The PHC provides services like antenatal care, treatment of common illness at OPD, immunisation, indoor facility, distribution of folifer and ORS packets, delivery cases, treatment of common sexually transmitted diseases, treatment of RTI and referral.

Diarrhoea, respiratory tract infection (cough and cold) fever, undernutrition, worms are the common health problems of children 0-6. Girls of 11-18 yrs suffer from anemia, dysmenorrhoea, leucorrhoea, undernutrition etc. where as women between the age

18-45 yrs suffer from pelvic infection, anemia, health problems during pregnancy like anemia and threatened abortion, after delivery affects like anemia and PPH and lower backache after sterilization.

Inadequate infrastructure, inadequate vehicular service,broken down vehicle,inadequate supplies, too many vacancies,moderately trained staff are the weakness of the PHC's health services. The medical officers believe that the functioning of the PHC and the services offered can improve a lot if these weaknessess are rectified.

So far the PHC's have organised health awareness camps regarding immunisation, family planning, filariasis, T.B., oral rehydration therapy and others like PPI, cataract surgery, Goiter control programme. They conduct these programmes in either small groups or mass meeting for which the panchayat provides infrastructure, motivates people to attend camps etc,. The other personnel involved in these programmes are the ICDS staff, NGO's, dias, CHG/CHV, school teachers and mahila mandal members.

The main drawback of these programmes are (1) lack of community involvement and (2) orientation training camps are held once in a year with no follow-up camps. The camps must be with a purpose i.e, it must be need based. Depending on the needs of the particular Block/district the awareness programmes should be conducted. Eg. in district with high female infanticide the IMR can

be brought down only by focussing on the female infanticide problem.

The Madurai PHC has conducted training programmes for school teachers on screening of health education among school children and for the panchayat members on how to control impending epidemics etc, during fares and festivals.

The strengths of the training programmes are the use of A\V aids, it is need based, there's scope for interactions and there is also good participation.

The same things becomes weakness in other cases i.e, poor participation by trainees, not need based, not enough scope for interaction etc.

The PHC believes that the dias, panchayat members, mahila mandal members,and the village practioners should be trained for they belong to the community and it becomes so much easy.

ANNEXURE - V

FOCUS GROUP DISSCUSSIONS

The focus group discussions were initiated to explore and ascertain the knowledge and attitudes of panchayat male and female members on health and to analyse current functions of the panchayat in facilitating the implementation of the Family Welfare programme. Also it was an effort to understand the community's feelings\knowledge about the RCH programmes which is introduced by the GOI for the first time.

This exercise was expected to throw light on the appropriateness of the outlined programme by identifing practical problems encountered by the beneficiaries.This is envisaged to lead to a successful intervention of the agency when required to rectify failures in the conceptual framework.

WOMEN'S GROUP

The members in the group were drawn from different backgrounds.This group was adequately represented by 2 ANM,14 young women in their 20's and 8 women in their 30's.Laxmi Bai Puttani- an articulate woman,in her early 40's working for the NGO-SABALA at Bijapur for 5 years now.Since she was one among them,she had no barriers of language or understanding of the participants to initiate them into the discussion.Not much time was spent on the ice-breaking session

as they had a good rapport.Plunging into questions of health which concern their own lives,a heated discussion ensued.This was an indication of the fact that, given a forum these women were willing to talk about their health.The older women (some of them illiterates) were less educated than the younger women.But this did not have any significant impact on the nature of participation because some of the older women were members of the local NGO.The older women have not less than 4 children while the younger women have a single child or two.This is a marked difference in terms of their empowerment.

On asking if members could articulate the problems faced by children under 6 years,they eloquently listed very many.Apart from fever,cold,measles,epilepsy,diarrhoea,pneumonia,chicken pox,some of them are seasonal but new borns are more affected by these.One is because of their living conditions and secondly due to poverty but largely due to ignorance,timely medical help does not reach them.Superstitious beliefs still rule their lives.Child mortality and Infant mortality is still prevalent in the community.When asked about problems faced by girls the older women could not recollect as it was long time ago,while the younger women could not vividly remember for two reasons.i) they were married so young that the period between puberty and conception was very short ,ii)even before they could understand their bodily changes,they have found themselves with childbearing and childcare.After a great deal of probing they responded saying that painful menstruation ,backache,excess bleading ,severe crams,headache,dizziness and

weakness are some of the health problems faced by girls. Some girls are sent to school. Some women said that child marriages are still widely practiced in the district. Most of it being within the family. The reasons given for this are i) Poverty- if the girl is married outside then dowry should be given. ii) Ignorance- the people believe that if the boys are educated then they grow up to look out for better avenues outside the villages. Thus they move away.

On attaining puberty, the girl is sent to her married home. The women said it takes two years to conceive. Thus by 20 she has finished her family (probably 2-3 children) and will have also undergone sterlization/tubectomy (more out of the monetary consideration).

The women are educated by the dai or the nurse about the different family planning methods. They are both the teachers and providers. Yet quackery exist in plenty. This is again for reasons of a) non availability of a doctor at the PHC. b) If they are present then they charge for 'free' medicines. c) Prescribed medicines are expensive to get. Women after child birth are so lost in looking after the house and the hearth, that she neglects her health. Most of them are afflicted by severe backache, asthma, jointpains, excess bleeding, cervical cancer and weakness leading to leuchorrea. In some cases, by 35 women are losing eyesight. This is partially due to heavy physical burden and low intake of

nutritious food. The older women (who are above 35) still think that children are a gift of god and that nature should take its own course. The ANM's and the anganwadi teachers and the dais opined that, it takes a lot of convincing for women to take to any of the family planning measures.

Women take recourse in home remedies in the eventuality of any health ailments. Only in times of emergency do they visit the doctor in the PHC or the sub centre, though the first preference is the village healer. Their major grievance being that the doctor prescribes medicines which has to be fetched outside at a high price. The people are vexed at the attitude of the medical practitioners. They are unanimous in saying that preference is given to the rich people though the medical personnel present there refuted this argument. Yeragal B.K Gram Panchayat in Zindagi,has not been visited by the ANM in the last 4 years.The other women present there said that this was the case in most of the villages.

One women said that the ANM's don't visit the SC colony, give them polio drops or any other medical aid. The group came out with their own suggestions. They wanted a dispensary in every village with a regular doctor and a nurse. The health professionals need to improve their attitude and behaviour to the poor. The women also opined that the GP members should be more active, especially the female members. They admit that male members have not done the needful when they held office so now the EWRs can do much, as they

can empathise with other women. But they also signalled the danger, if they went the men's way. They want more representation for women as they say that one woman among four men cannot do anything effectively. Some women were bitter about the fact that few women are proxy candidates, who further the man's agenda. After elections, they forget the promises made.

Government schemes are drawn without planning or consulting the very people it is meant to serve. Toilets are so badly designed that, it cannot bye used by people. Dhobi Ghats are constructed where there is no water. The Administration is compelled to meet the Budgetarty deadline, (March 30) thereby wasting money.

Most people mis-trust the ANM because some of them do not make an effort to understand their problems and explain to them. They feel that their attitude towards the poor should change. To this the ANM retorted saying that people are hostile to them and that there are not enough or basic facilities for them to stay or transportation facility for them to commute from village to village.

The trained dais feel left out of the system. They complain that they do not get their due respect and that the ANM appropriates their functions and take money for their work. No kits are provided to them even after 3 years of training.

The NGOs experience with the health department was not a successful one. The main reason being one of a skeptical feeling towards the NGO's.If the department hands out any programmes,then it is very target oriented.They don't co-operate with the NGO"s in the implementation of any project like providing infrastucture (personnel, money, vehicals). Their result oriented approach contrives the qualitative progress of the health programmes. The poor(SC, ST, Kurubbas) are still outside the purview of most programmes, because they have to go to the fields during the day and cannot attend to any of them. To them sustenance is the basic question.

Suggestions to improve the current scene

i) There should be a local dispensary in every village
ii) NGOs should be involved because through Mandals they impart education, training and a forum to discuss issues that they want to
iii) Health awareness programmes more by the NGOs than the govenment as they suspect the latter's commitment
iv) Training to men, so that they understand women's health better
v) Better access to medical facilities(doctor, medicines, para-medical need in the village)
vi) Greater representation to women, to push the women's agenda in the Gram Panchayat.

THE MEN'S GROUP

This group of 20 was represented by men in the ages of (25-54) range. Their educational level ranged between 7th standard to the M.A.level. Their socio-economic background was from poor, middle class families as most of them worked as daily wage labourers. There was one social worker, a health educator and the director of the local NGO along with Gram Panchayat and Taluk Panchayat members.

The group was hesitant in the begining when the subject and the objectives of this exercise was introduced to them. But as they began discussing the RCH programme, they expressed the need to know more. When questioned about women's health, the common refrain was that they did not know what was happening with their women. They also complained that their women do not discuss their problems with them. Some of them could recollect instances and list out the ailments their women and child suffered from.

For the children under 6 years of age the common problems were a) polio b)pneumonia c)tuberculosis d)measles e)diphtheria f) beri-beri g)diarrhoea h)cough & cold. But for the girls of 11-18 years, the men said menstrual pain and weakness due to malnourishment only. They did not comprehend other possible ailments a girl could suffer. The women were married by the age of

18. Hence the men were more knowledgeable about some of the problems of the age group of (18-45) years. They enlisted white discharge, anaemia and weakness as common problems.Cervical cancer and mouth cancer can be seen occassionaly in the village. Most men have heard that women have difficult deliveries though they cannot understand as to why this is happening.

The sources of knowledge is through various mediums like TV, Radio and books. But the major source still is the health personnel, doctors, govenment, the anganwadi workers, the ANM and the VHW. They did express the view that they discussed sexual health with their friends more than the wife/family.

Their experience with the health system has been a bad one. Most of them had to encounter bad behaviour of the health staff and often their non-availability in the local PHC or sub centre.Apart from this there is a total lack of infrastructure in these centres which force many of them to go to the village practitioner. One reason why they continue to repose faith in them is the family doctor approach and second their medicines are not expensive. Also the men complained that doctors are involved in private practise and therefore they are not available in the PHCs.

The reason why ANMs and doctors do not stay in the village is due to lack of a safe dwelling. This is where, they feel, that the panchayat can intervene and provide some basic facililties in the

village. They also felt that as panchayat members, they should be given the power to demand basic health services from the health system.

To improve the situation, they all agreed that more public health awareness programmes are needed. The orientation should involve the men, as it helps understand the health needs of the women and children. The PHC and the sub centre needs to be decentralised and the staff should change their attitude. There has to be buffer funds at the panchayat level to deal with special health needs of the villagers and also the autonomy to spend it discretionally.

Basic health needs of people continue to be neglected like safe-drinking water, accessible transport and medical facilities and sanitation. The men are vehement in stating that the panchayat members should cater to these needs thereby paving way to a healthy living of its people.

GIRLS GROUP

This group of was represented by 26 girls (unmarried) in the age group of 12-22. (we took a wider group to get a better response - the group specified by CINI was 15-18). Their educational level ranged between 4th std. to 2nd year B.A.. More than 75% have studied upto 7th std. of which 9 have completed their PUC.(It was noticed that girls from Badami Taluk were more educated) The

girls belonged to economically backward families where their mother's has to go to the agricultural fields leaving behind the little kids at home. The eldest daughter thus takes responsibility of all the household activities and looks after their younger sibblings. They even leave school to meet this demand.

There was one School Supervisor, a Librarian, a Social Worker, an ANM, and an Anganawadi worker. Sunanda,an articulate women in her late 20s,working for the NGO (Sharada Vidya Samasta) at Badami did the job of the moderator. Since she was one among the group she had no language barrier. It was not difficult for her to initiate the group for the discussion. But it was observed that only about ten girls in the group actively participated in the exercise. The others were shy and looked lost, unable to comprehend the proceedings.

After all the introductions the girls were asked to list out 5 common problems faced by girls of their age. They listed out weakness, pre-menstrual pain, backache, lower stomach ache, white discharge, exessive bleeding, trouble in breathing etc. They also said that a lot of girls faced psychological problems.When we asked them to explain this they said that most of the girls get married before the age of 15,so when one girl does not get married by this age the society begins to talk about it, she also begins to feel lonely as all her playmates are married and have gone to their husbands house. She becomes very moody and gets irritated

very fast, this brings a strain in the relationship she shares with her family members. According to the group this is a major problem among girls of this age group.

The girls were very keen on sharing their knowledge on home remedies for common health problems. They also said that they visited the hospitals only if the problem becomes too severe. The girls felt that a good massage was best for backache. The girls are told by the elders that they have white discharge when they eat betelnut.The group then wanted to know what their counterparts in the cities did in similar situations.

The group felt that the ideal age for marriage was either 18yrs or 5yrs after menstruation and one should have the first child after the age of 21yrs. About 50% of the group felt the right gap between two children is 2yrs while the other half felt it to be 3yrs. Most of them were of the opinion that 2 children was ideal for a family. The group took some time for responding when we asked them about pregnency. At first they said that they did not know anything, then after some probing thay said that the women should start visiting the hospital from the time she realises she is preganant. They also said that the women should have regular checkups (once a month) and most preferably have the delivery conducted at the hospital. They also felt that if everything was normal then the deliivery could be conducted at home but it still could lead to complications in the last minute. They also said

that the dais did not use the clean methods prescribed for home delivery. The ANM explained to the group about the "5 cleans" to be maintained for home delivery and also told them that every trained dai is given a kit for this purpose. The girls also said that the dias does not make use of this and still use bad blades etc. They also complained that the elders do not take them seriously when they try to tell this to them.

These girls thought that 3 doses of T.Toxid has to be given to the women during preganancy. The ANM corrected them and explained that it has to be taken twice during this period.

The girls knew that the first food to be given to the child is breast milk and that it has to be given after half an hour after birth. They also added that in the villages people still give the chill jaggery water or honey and do not breast feed the child for 3 days. The baby should be exclusively fed breast milk upto 2-3 months and then supplement food should be given only after a year. They were aware that the child has to be immunised against diseases like TB, Poliomyelites, wooping cough, mumpks etc.

When asked what should be fed to a child suffering from diarrhoea they replied that tender coconut was the best remedy. They also said that some home made medicines like Sabun rice water or a mixture of water and dried pomogranet skin boiled together are very effective. If the child does not show any improvement and if

the frequency of the stool increases or vomiting starts then the child has to be moved to the hospital. A child having difficulty in breathing should be rushed to the hospital. The vital signs are rapid breathing or when the child breaths with mouth open or when the child shows no movement.

Their main source of knowledge was the health camps held in the villages by the PHC, documentaries on T.V., the ANM's, Angawadi workers or the elders etc. On the whole the group has the required knowledge that an individual can have. Also it raised the expectation of the facilitator about the fact that it was a potential group, where more information could be given to develop and promote good health attitudes and practises in the villages.

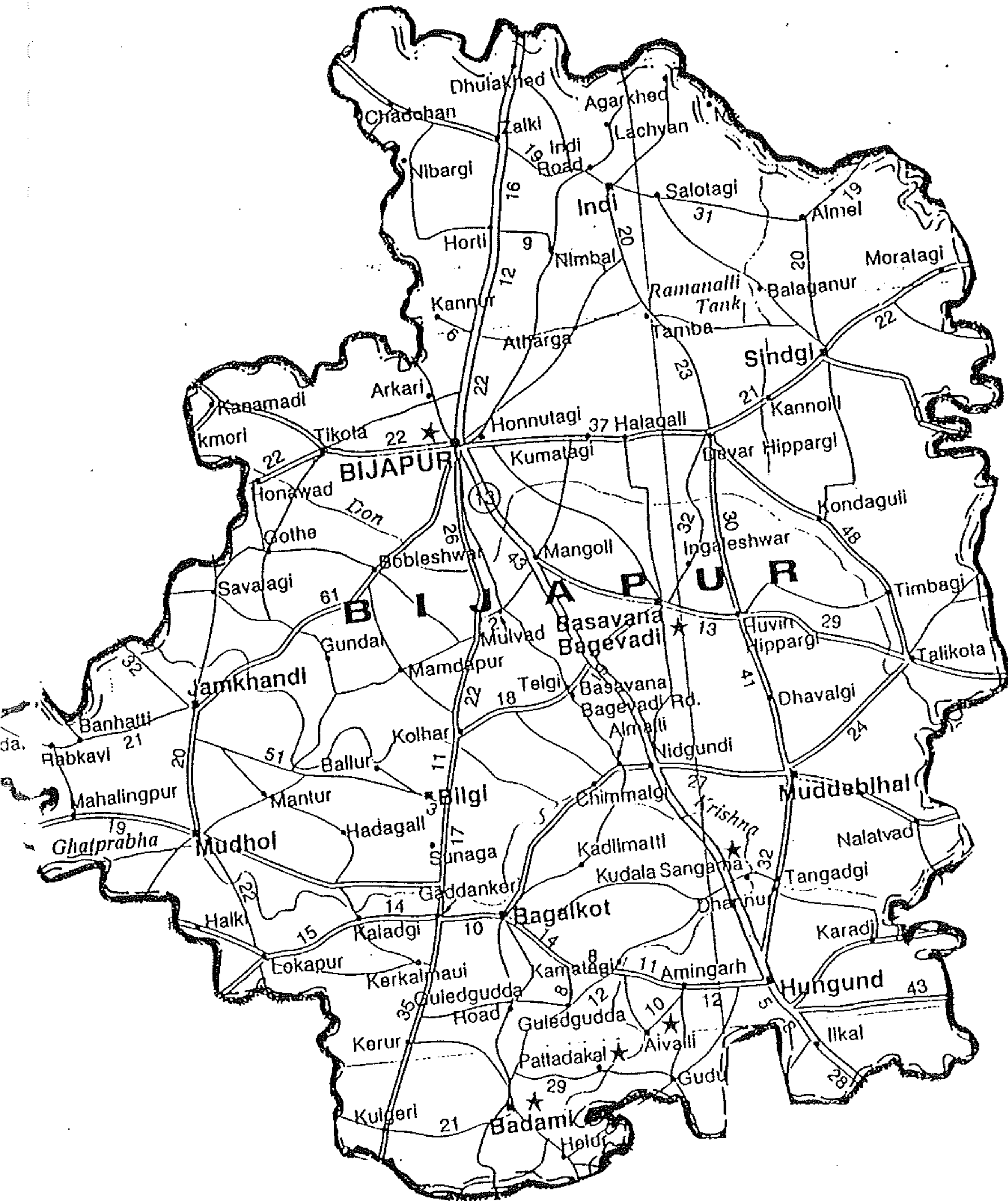
In Tamil Nadu the group consisted of seven members of which 5 were engaged in economic activities like coolie work, agricultural labourers, helper in rice mill and an animator in a N.G.O.(SIRD). 3 of them were(coolie worker and milk helper) illiterate, while 3 of them were tenth class passed. The girls knew what the common problems were but were hesitant to talk aloud. They required a lot of persuation to speak out.

They mainly depended on herbs for most of the common health problems and went to the hospital only when things get out of control. They knew that a girl should get married not before 21 years and that the ideal age to have the first child is between 23

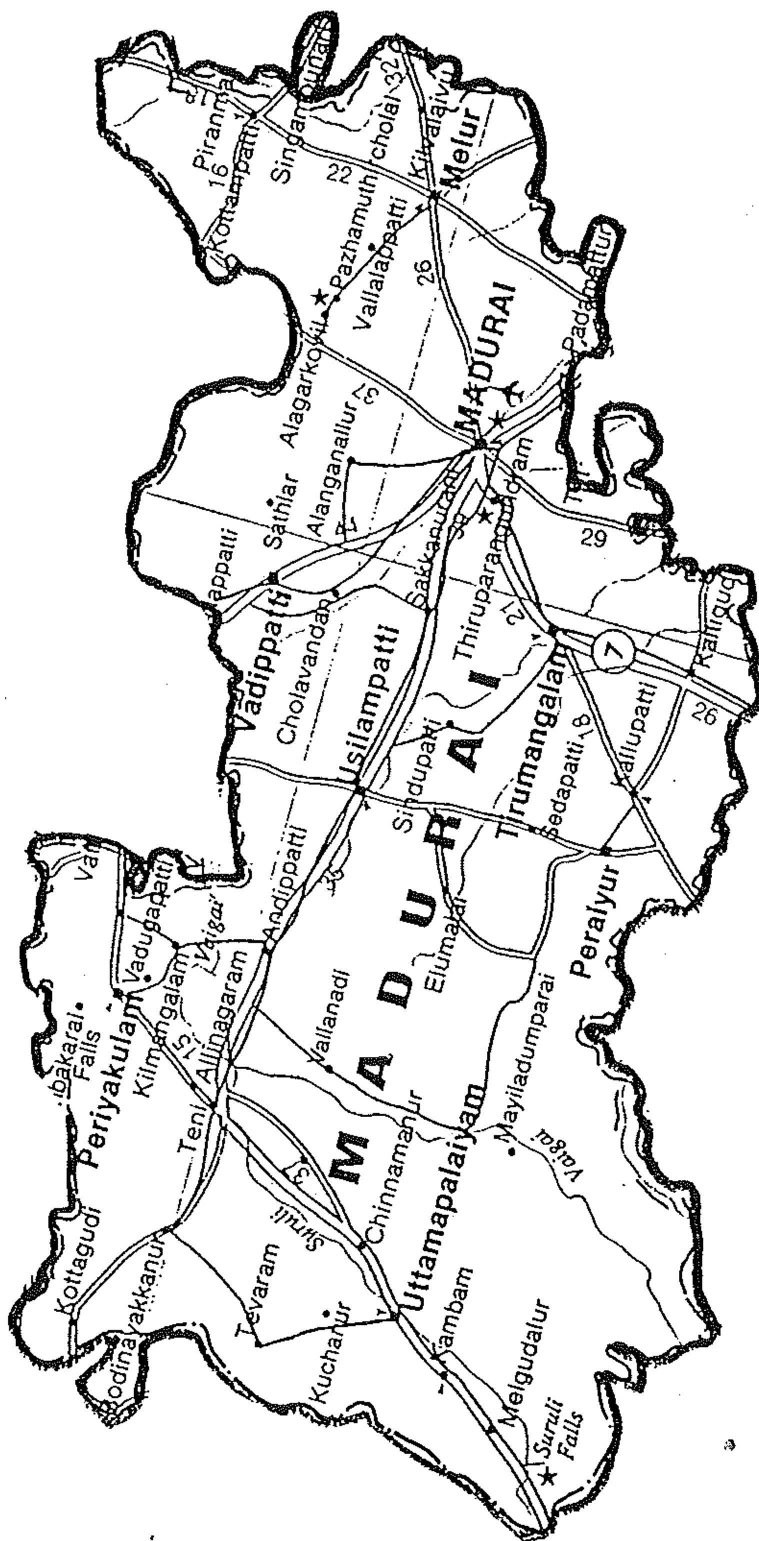
and 25 years. With a gap of 3 years for the next child. The girls were unaware of the danger signs of pregancy and when she should be removed to the hospital, doses of T.Toxid doses to be taken etc.

On a whole the girls lacked knowledge of pregnancy and also child care. And even the girls who knew about it were very shy to expouse it.

Map Of Bijapur District, Karnataka



MAP OF MADURAI DISTRICT, TAMIL NADU



BIBLIOGRAPHY

1. Chunkath, Sheela R and V.B Athreya:"Female Infanticide in Tamil Nadu", Economic and Policital Weekly, Vol.XXXII,No.17 April 26- May 2, 1997.

2. Gupta, Chen And Krishnen:"Health,poverty and development in India,Oxford University Press,1996

3. "Improving Women's Health in India ":World Bank,1996

4. International Institute for Population Sciences (1995):National Family Health Survey 1992-93,Bombay

5. "State Panchayat Act's-A Critical Review":VANI,1995

6. Statistical Outlline of Karnataka(1993-94):Directorate of Economics and Statistics,Bangalore,1996

7. Statistical Outline of Tamil Nadu (1996):Directorate of Census, Madras, 1996.

8. "The Karnataka Panchayat Raj Act- 1993";Govt of Karnataka,1994

9. "The progress of Indian States";UNICEF,1995

10. Raghuram, Shobha and Anika Rahman: "On Women's Health and Rights: Rethinking population", HIVOS 1995.