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**DETERMINANTS OF THE
UTILIZATION OF MATERNAL AND
CHILD HEALTH SERVICES.**

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National Institute of Population Research and Training (NIPORT)
Azimpur, Dhaka-5
In collaboration with :
United States Agency for International Development (US AID)

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A C K N O W L E D G E M E N T

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ABSTRACT:

1. The study on "Determinants of the Utilization of MCH Services and its Effect on Contraceptive Behaviour" was conducted in the Districts of Jessore and Tangail where MCH Services were provided as different level for more than one and one half ($1\frac{1}{2}$) years before the study. The sample consisted of 1800 consumers (women who have given birth to at least one child) and 37 entrepreneurs (field workers of The Population Control and Family Planning Division) from area of two Maternal and Child Welfare Centres located at the District Headquarters, 2 MCH Units located at the Thana Health Complex and 2 Family Welfare Centres located at the Unions.

The major obstacles in Utilization of MCH Services as perceive by the consumers were :

1. MCH Centres are places where one should visit only at the time of problems.
2. One's home is the best place for delivery.
3. Delivery at the MCH Centres is a matter of shame and the clinic environment is not congenial.
4. Healthy pregnant women & Healthy babies need not be taken to Centres/ Doctors etc. for health check ups.
5. Lack of knowledge and the concept of services provided in these centres.
6. Long distance to travel and lack of company for visit to the clinic.
7. Long waiting time for services.
8. Inadequate supply of medicines.
9. Supply of inferior quality medicine.
10. Unconcerned attitude and misbehaviour of clinic personnel.
11. Demand for money for services.
12. Unfavourable attitude of Husbands/Relatives for delivery at the MCH centres.

Improvement in the utilization of MCH Services, as perceived by the Respondents could be done by :

1. Supply of adequate quantity of quality medicine.
2. Change in the attitude of clinic personnel.
3. Availability of services near to the homes.
4. Avoidance of long waiting time.

The field workers except for the Family Welfare Visitors had a vague concept of MCH Services provided through different MCH centres. They performed few duties related to MCH services and the majority were ignorant about different aspects of MCH care.

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Introduction :

In resolution WHA 31, 35, the thirty first world Health Assembly (May, 1968), urged member states to give high priority to improve the Health of mothers and Children particularly as a part of primary health care. The recommendation was reinforced by Alma Ata declaration which states that primary health care is the key to attaining member states social care, including family planning, as an essential part of primary health care. While discussing the lack of priority given to Maternal and Child Health in developing countries it was observed that one of the important factors was the lack of appreciation for the basic principles of MCH, its importance for health in general and its role in the overall development and improvement in the quality of life. Further, bulk resources were used for urban specialist and hospital care, while facilities for the majority of the population who live in rural areas were lacking. In WHO study conducted in 1975² in one of the large Asian countries, it was reported that only 32% of the rural population lived within a three (3) kilometre radius of any kind of health facility, while the corresponding percentage for the urban population was 98%.

The Bangladesh Health profile of 1977³ reports that the seven million urban population is relatively well covered by government and private health facilities, but a major portion of the 76 million rural population do not have health care facilities of any sort.

Of the 11,489 households questioned during a UNICEF-WHO survey in 1977⁴ 22'3% replied that they did not seek any sort of medical assistance the last time they were sufficiently ill to be confined to a bed. Only 10% consulted a government health facility and 7'9% consulted qualified allopath, the remaining 59'7% unqualified allopaths, homeopaths or religious healer.

The state of affairs shown above is not only related to the availability of health care service facilities but are also depend on many other factors. These are values, culture, attitudes toward health and pregnancy, distance to travel, timing of services dispensation, availability of free and quality medicine, payment of fee for services, attitude and behaviours of clinic personnel to clients and acceptance of the type of persons providing services.

Bangladesh traditionally, is a male dominated society. More than 90% of the population live in rural area and believe for the Islamic faith. Woman in general

do not come out of their homes without a veil (purdah) and do not travel without the company of male family member. They have restriction in talking to males in general and unknown males in particular. They are all deterrents to woman participation in outside activities and the strategy of staffing distant health centres with male doctors has substantial influence on women's decisions whether or not to use the health centre.

A WHO, survey of inpatients and outpatients in Health Complex 1977⁵, showed that relative to their distribution in the general population, women used outpatient facilities less than half as often as did the men and slightly more often than did children aged five years or less. The age sex differentials in Health Complex utilization cannot be explained by differential sickmen role, more likely. The reasons are rooted in the people's culture and in difficulty of transportation.

The age old tradition of delivery of babies at home by relatives and neighbours, the concept of causation of disease and the fatalistic attitudes towards life are factors that keep most rural populations from proper utilization of clinic service facilities. Hospitals or clinics, by the majority of the population, is considered a place for poor sick persons and admission to hospitals is considered as the last hope for survival. A visit to a doctor or clinics is made in an advanced stage of sickness. Minor ailments are mostly neglected or are treated by home made remedies. Pregnancy, which is viewed a normal phenomenon of life, is not taken very seriously and not a phenomenon for which a doctor needs to be consulted or clinic visited. Problems associated with pregnancy are neglected or left for natural cure. In the majority of the cases even at the time of serious illness, most of the treatment is done by religious rituals or referred to Ojha, Homeopaths, Kabiraj, unqualified village doctors or dhoruni.

The clinic environment, including the behaviours of clinic personnel is an important factor in people's use of services. Kind words and reception with smiling face by the doctors/paramedics or other clinic personnel help in making the clients feel welcome at the clinics. Waiting time in the clinics, quality and quantity of free drug supply, cost for services are also important factors in utilization of clinic services. Age and sex of services providers and their skill in treatment of disease are also important.

MCH is now an integral part of the family planning programme in Bangladesh. The integration was based on the philosophy that with good MCH services there would be an improvement in the health of mothers and children leading to a

reduction in maternal and infant morbidity and mortality. If a pregnant women is followed through her pre-natal, natal and post natal period, it is likely that the women will enjoy good health and her product of conception will be a healthy baby, Such a mother will be able to give better attention to her new born child, and will have effective lactation and thus increases the change of survival of her baby.

2. It is now more than 4 years that MCH services have been integrated with the family planning programme, but until today, no definite action has been taken to improve MCH services. It is reported that even today, the workers of two units of services (family planning and MCH) have not taken up the philosophy of integrated services and put it into practice. In many places they work on vertical lines. Further it is not known if field worker, such as FWVs & FWAs have understood the philosophy of MCH based family planning programme as has been envisaged by the programme planners.

3. Different reports⁶ from the field indicates that the existing MCH facilities are very much under-utilized. The concept of a MCH programme is not understood by field level workers. The community is ignorant and has little idea of the MCH programme. The traditional values and cultural factors keep pregnant women away from utilization of MCH services for preventive purposes. Pregnant women and their children who visit MCH centre/FWCs do so for treatment of their ailments, not for preventive services.

4. The study was conducted with the following objectives ;

- (i) To identify knowledge and attitude of consumers towards the MCH Programme.
- (ii) To identify perceived hindrance/constraints in the utilization of MCH services.
- (iii) To identify factors, as perceived by consumers, in popularizing MCH services in the community.
- (iv) To identify knowledge and attitude of field workers, towards MCH and how they perceive the relationship of MCH services and the family planning programme.

Review of Literature :

Shamima Islam in her report "Indigenous Abortion practitioners"⁷ made several important findings. First, she found that "despite the fact that Dhaka district enjoys the maximum facilities for medical termination of pregnancy, various types of person have been identified as abortion practitioners in indigenous ways in the district. It is apparent that urban based clinic-centred facilities have little impact on the nature of utilization of services by rural women who want to meet their own needs within their given socio-economic constraints".

Secondly, Shamima mentions that the usual area of operation of the practitioners vary from the small villages around her residence to the entire thana, depending upon the good will of the family's traditional name as healers and on the mobility of the women. She found a significant involvement of the local influential like Chairman etc. in utilization of their services.

Thirdly, Shamima found that "In terms of health care access women need become subordinate to women's status which is dictated by important family members and more often by husbands who in many instances consider public exposure, like clinic visits or confinement as violation of purdah for the family".

Finally, she also found that, "In a situation where the bed utilization rate is only 30% in thana Health Complex (SFYP-1980-85), where the issue of purdah is a major determinant of women's participation in outside activities, the strategy of staffing the distant health care centres with limited number of trained doctors (most of whom are male) bears little impact on attendance of women at these centres in meeting their own health and family planning needs. The existing MCH centres, are thus not only inadequate for the purpose, but are under-utilized to a great extent.

Quddus, in the study on "performance of Family welfare Assistant"⁸ mentions that two-thirds of the respondents did not have any knowledge of pre-natal care though they were pregnant during the working period of the FWAs. The mean point knowledge was around 3.7 while expected for middle level knowledge was 16 pts, This was the case where field level workers of family planning were supposed to advise mothers on MCH.

Narangwal study⁹ shows that utilization patterns varied widely according to the presence of specific services in the village. In the villages with services for children, the utilization was 60.7%, compared to 40% in control area where there were

mixed services. A similar difference was noted in villages with womens services. Men's use of services was fairly constant across all experiment groups. Women in general used only 50% of the services compared to men. However when services were brought to their door steps, the frequency of women's use of services rose to equal that of male usage.

Further the provision of rural health care services by the project did not entirely displace other source of care. These centres only added to the total use of services. The use of village practitioners were as excellent as before. The use of Government run clinics in control area was found to be the lowest,

While discussing on needs (those who were sick) and utilization of services Narangwal study also found that in some cases about 50% of those who really needed the service did not attend the health centres. Women in general (more than 50%) were recorded as having the greatest unmet need.

Unavailability or inaccessibility was not recognized as a cause of non-utilization of services. In-effectiveness of services was more often given cause of non-utilization. The most frequent cause that the problem (disease) was not seen as important, and the availability of home remedies.

Lastly, Narangwal study found that in selecting a source of care, the greatest importance was accessibility and faith and trust in the health worker. Trust was also mentioned as to why people use private services or Government services. On location services it was reported that the use of private practitioners was most due to availability of services in their own village. **More than 50% of all consultations to private practitioners occurred in the village of residence or an adjacent village.**

Bjotveit in her report on 'MCH/FP clinic in a project' mentions that average number of women visited different clinics for MCH/FP services was 8.8% of the total number of clinic visitors. Of this group, 27% came for ante-natal care, 46.6% for post-natal care, 21.7% for family planning services, 4.7% not written in register. The highest number of post natal visits were related to the supply of a comparatively large quantity of medicine which continued up to six months of delivery. The report mentions that pregnant mothers are more difficult to attract to the clinics than mothers with children.

The attendance of mothers in MCH clinics in CHPC₁₁ centres was 19.2% of the total clinic visitors. These visits included only ante-natal and post-natal visits

The ante-natal visits were 7.6 times higher than the post natal visits. In these clinics there was no abundance of supply of medicine.

Bjotveit mentions that most of the patients (children), both for the 1st visit and for total visits came from the village where the clinics were situated. In most clinics, under 20% of the visitors came from other villages.

She further mentions that the percentages of children who visited the clinics for treatment varied from 28.2% to 50.7% for the wards where the clinics were located. The children from other wards were about 3-4%. In the sub-clinic a large number (33%) of children attended for treatment, but almost all the children came from the village where the clinics were located.

The average number of clinic visits made by the children varied from 1.9 to 2 per patient. Almost all the children attended the clinics for treatment of disease.

In clinics where there was a restriction that medicine will be supplied only to those children who accompanied their mother during a visit, attendance was almost 60% less than those clinics where children visited with other relatives, including father and elder brothers and sister.

The average number of visits made by children in CHCP clinics and BAM 12 clinics Sariakandi were 3.0 & 1.58 respectively.

Companionj Health Project¹³, had the experiences that :

1. Provision of adequate quantity of medicine in the Health centres increased in the number of visitors to sub centres and some motivational work in the area improved the attendance of the clinics from 10-12% to almost 50%.

2. For primary health care services, 51% of the total population preferred to go to village practitioners as against 42% who preferred project professionals.

3. preference for village practitioners was greater among the high socio-economic group.

4. The landless group used services from both the project clinic and from private practitioners. 50% of them mentioned closeness to service facilities and 25% free supply of medicine as reason for utilization. Free supply of medicine was mentioned

by 36% of landless group compared with 12% who had land 3 acres or more as a reason for service usage. Only six percent of the visitors mentioned about availability of qualified doctors as a reason for usage.

TSU in his study of "under Utilization of Health Centres in Rural Mexico"¹⁴, reports that "The relevant factors identified in this study fall into four basic categories : supplies; the availability of nearby, more attractive medical facilities the use of indigenous health care resources as well as or instead of the centres; and personnel problem".

The preference for seeking medical help at facilities other than the health centres reflects a variety of concerns among rural residents. For some it is a matter of economics and their eligibility for prepaid (insured) health care instead of the public service. For others, their choice of a larger centre or a private physician reflects their belief that these providers give sufficiently better medical care to counter balance the inconveniences of travel and often higher costs, cultural values favouring greater age, local origin, and longevity of residence in the area all work against the young physician and his ability to win patients trust during his short tenure.

The rural residents seek scientific medical treatment whenever they consider it to be more effective and when the economic, social or cultural cost are not perceived as being too high. Treatment for mollera caida (fallen fontanel) is an example of this shift in the past four to five years in both China and Olianda, many women have learned that this is a symptom of dehydration for which the medical treatment is more effective, and have abandoned the egg ritual that was traditionally used to treat it. For illnesses such as 'mal-oja' or 'susto', which are not yet recognized as legitimate by western medicine, patients seek out specialists within the country.

In many cultures illness is viewed from a social rather than an individual physiological perspective. Alleviating the physical symptoms without paying attention to the underlying spiritual aspects or without restoring neglected social relationships would leave the individual still "ill" by his own definition. It is precisely these spiritual and social aspects that the indigenous healer is most adept at handling.

Methodology :

Study Area :

The districts of Tangail and Jessore were selected for this study. These two districts have had functioning Maternal and Child Health centres in urban, semi-

urban and rural areas for more than two and one half years, These two districts are relatively representative of the country in so far as population characteristics and communication are concerned. The district of Tangail is located at a distance of 60 miles from Dhaka and is connected with an all weather paved road. The district of Jessore is located at a distance of about 250 miles from Dhaka and is connected with an all weather pacca road and also connected by regular daily flights of Bangladesh Biman.

The following areas were selected for the study :

Jessore district :

1. Municipal area of the district town.
2. All the unions around the thana headquarters of Jhikargacha (all villages within a radius of $2\frac{1}{2}$ miles).
3. Union of Nabaron under Jhikargacha police station.

Tangail district :

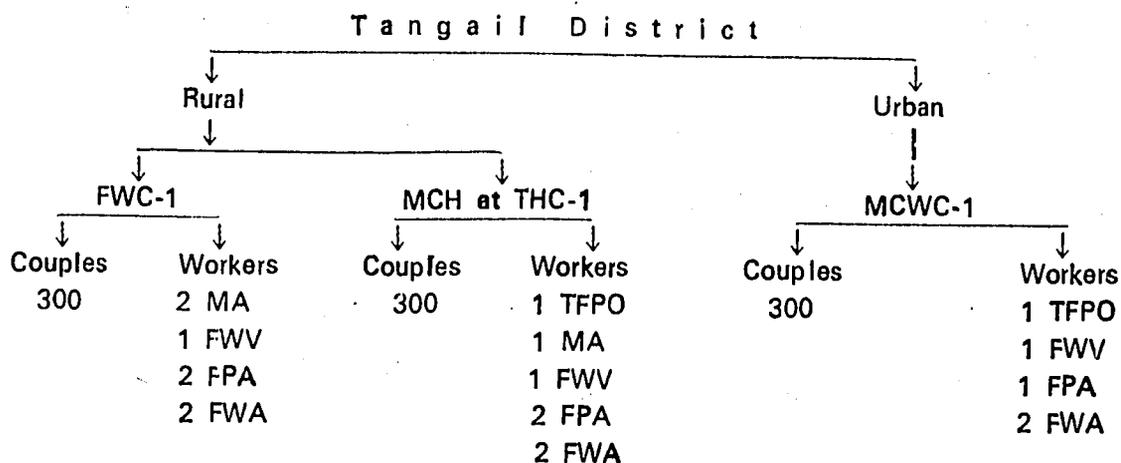
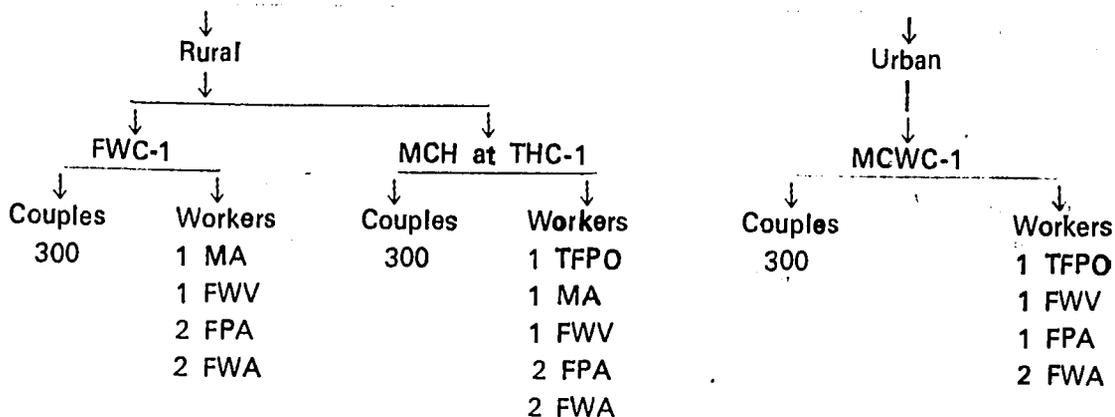
1. Municipal area of the Tangail district town.
2. All the unions around the thana headquarters of Ghatail (all villages within a radius of $2\frac{1}{2}$ miles).
3. Union of Digor under Ghatail police station.

Sample Design :

Two field workers under the PC&FP Division are responsible for MCH&FP activities in a ward of about 6000 population. These field workers maintain lists of villages, households and couples in the house.

The sample was drawn out of the area where there were functioning FWCS, MCH Units at the THCs, and MCW centres in the districts of Tangail and Jessore. The sample area consisted of around 2 FWCS, 2 MCH Units attached to THCs, and 2 MCW centres in the Municipal areas. A total of 1800 respondents were interviewed, six hundred from each group.

The sample of the field workers included TFPOs, MAs, FPAs, FWVs and FWAs of the centres where from the sample of MCH Units were selected. The total number of field workers related was 37 of which 4 are TFPOs, 5 MAs, 6 FWVs, 10 FPAs, and 12 FWAs.

Sample Design**Jessore District****A. F. W. C.**

The union was selected on random sampling basis. A list of villages were prepared out of the list of field workers. From this list, 12 villages were selected randomly from the union. From those selected villages all the fertile women who delivered at least one child were interviewed. Interviewing was stopped after completing 300 women.

B. MCH Unit at THC :

This sample was selected from within a $2\frac{1}{2}$ miles radius of the MCH units at the THC area. A list of the villages of the unions arounds the centres both in Ghatail and Jhikargacha thana was prepared from the list of field workers. In each area 9 villages were selected randomly. From the sample villages all the fertile women who delivered at least one child were interviewed. The interview was stopped after interviewing 300 women in each area.

C. MCWC :

The sample in the Municipal area was drawn out of the couple registration list of the field workers on simple random sampling basis.

Tangail Municipal area consists of 4 unions with each union being divided into three blocks. A sample of 25 fertile women who delivered at least one child were selected from each of 12 blocks of 4 unions. Similarly Jessore Municipal area consist of five unions and each union is divided into three blocks and an equal number of samples were drawn from each block of the area to complete 300 respondents.

Recruitment and training of the staff :

The Project was developed and supervised by the Project Director in consultation with the Project Committee consisting of family planning and population experts. A Research Associate with Master's Degree in Social Science and experience in population work was selected for the field work. Two male supervisors and six female investigators were selected by a selection committee. All the supervisors and investigators were Masters degree holder in Social Science. The supervisors were responsible for supervising the work of the interviewers, helping the investigators to interview the respondents properly and editing the completed questionnaires.

The supervisors and the investigators all had some experience in data collection. However, a training programme was conducted by population and family planning experts for two weeks to acquaint the field investigators with the objectives of the research, techniques of data collection and supervision. The training consisted of theory and practice for 10 days in Dhaka and 5 days in a rural setting for field practice. The Research Associate was mainly responsible for organizing the training.

Questionnaires :

Two sets of questionnaires were prepared. One for female respondents and the other for field workers. The questionnaires were prepared in English and circulated to the consultants and other experts for comments. The questionnaires were then pretested and finalized. Later the questionnaires were translated into Bengali and these were also finalized after pre-testing in the field.

Field Operation :

The field work was started in early January, 1981. The investigators were divided into two groups under the supervision of a supervisor. Sample design and selection were done by the Research Associate in the field. All FPAs and FWAs helped the investigators and supervisors to identify the samples in the field.

Field Problems :

The field workers did not face any major obstacles during their work. The help of Research Associate and Project Director was not required to solve any problem. Minor problems of non-cooperation were handled by the supervisors.

At the initial stage of the field work rain caused some problems in the movement of the field workers. This delayed the work for a few weeks. One of the investigator left the work for personal reasons. To replace her, one investigator was recontracted and trained. For this, data collection was delayed. The programme was also delayed for five days due to a bus strike.

5. Findings :

5.1. Socio-Economic & Demographic Characteristics :

Age : The median age of the respondents around are FWC, MCH Unit at THC & MCWC areas were 27.94, 27.99 and 27.00 years respectively. The respondents from two extreme age groups 19 years and under & 40 years & over, constituted 36.7%, and 0.33% 4.67%, and 1.67%, 3.83% and 3% of the population around MCWC, MCH unit at THC & FWC areas respectively (Table 1a)

Education :

A majority of the respondents in all the three areas were illiterate. The more rural the area, the higher the illiteracy rate was. The percentage of illiteracy in the MCWC, THC and FWC areas were 39.33%, 61%, 70.83 res-

pectively. The rate of literacy in these areas was more than the national average. There was a fair number of high school graduates (Matriculates) in the rural areas. In the FWC area they were 7.17%, & in the THC area they were 9.33% compared to 31% in MCWC (urban) area (Table 1b).

Husbands' education :

The rate of literacy was much higher among the husbands of the respondents. In the MCWC area, 77.33% of the husbands were literate, while in the THC and FWC area 59.67% and 57.17% of the husbands literate respectively. In all the three areas a fairly large proportion of the husbands were either matriculate or had under-gone upto University education. The percentage of Matriculates in MCWC, THC & FWC areas were 30.67%, 28.33% and 23% respectively (Table 1c).

Occupation of husbands :

The percentage of cultivators and day labours were much higher in THC & FWC area than the MCWC area. The percentage of service holders and skilled labours were higher in the MCWC area. The differences were likely because MCWCs are located in urban area and THCs & FWCs are located in rural areas (Table-1d).

Land Holding :

A large majority (76.67%) of the respondents in MCWC area were landless compared to 38.17% of the respondents in THC area & 36.83% of the respondents in FWC areas who were landless. Respondents having land holding of decimal 500 or more, were 2.33% in MCWC area, 4.72% in THC area and 8.21% in FWC areas respectively. In the agrarian society most of the land holders reside in rural areas (Table-1e).

Family Income :

The family income of the respondents in the MCWC area was higher than the respondents of THC & FWC area. Respondents with family income Taka 200 & less were 2% in the MCWC area, 10% in the THC area and 7.17% in the FWC area. The respondents with family income above Taka 2000 (two thousands) were 5.66% in the MCWC area 2.83% in the THC area and 1.50% in the FWC area (Table 1f).

Number of live births :

The median number of live births for the respondents in MCWC, THC and FWC areas was 3.53, 3.73 and 3.73 respectively. The number of respondents with 7

or more live births was much higher for respondents in THC & FWC areas than MCWC areas. These were 19.67% for THC areas, 20.67% in FWC areas, and 9% in MCWC areas (Table 1g).

Number of living children :

Average number (median) of living children for the respondents in MCWC, THC, and FWC areas were 3.41, 3.47 and 3.51 respectively. The percentages of respondents with 1-2 living children were 34.67% in MCWC area, 34.5% in THC and 31% in FWC areas, while the percentages of respondents with 7 or more living children were 6.67% in MCWC areas, 11.66% in THC areas and 12.66% in FWC areas respectively. This shows that women in urban area had less living children per family than the women in rural area. When compared to live births, child mortality was found to be higher in the FWC area than the other two areas. There was more than one child loss in FWC area (Table 1h).

Number of pregnancies :

The median number of pregnancies per respondent in the MCWC, THC and FWC areas were 3.70, 3.81 and 3.83 respectively. This shows that the average pregnancy wastage per woman in MCWC area was 0.29, in THC areas, 0.24 and in FWC areas it was 0.34 (Table 1i).

Knowledge and Attitude :

Worried about pregnancy even if **Healthy & Measures taken for coping with worry :**

1. F.W.C. The respondents of the FWC area in a great majority (78.17%) were worried about the effect of pregnancy on health. Only 20.83% did not feel worried, while 1% did not have any opinion (Table 2a).

The respondents who were worried in most cases (66.73%) did not take any measure to prevent the effect of pregnancy on Health. They even did not consult any one for advice. Of those who took some measure, 11.94% took nutritious food, 11.3% used medicines including vitamins and iron tablets, 5.54% consulted passed doctors and 1.71% consulted Hakim/Kabiraj. The rest, used other remedies. Of those who did not feel worry, about 10% of them took some action, including 4% who took nutritious foods and 8.2% who used medicine (Table 3a)

2. MCH Unit at THC :

Similarly 73.17% of the respondents in the THC area mentioned that they were worried about the effect of pregnancy on their health, even though they considered themselves healthy during pregnancy. The percentage of respondents who were not worried was 25.5% and 1.33% did not have any opinion (Table 2b).

When their concern about the effect of pregnancy on health was related to action taken by them to some remedial measures, it was observed that 65.83% did not take any remedial measures to get rid of their worry, 10.93% took nutritious food, 15.72% used some drugs including vitamins and iron tablets, 4.33% consulted doctors 1.14% consulted Kabiraj/Hakim, 1.59% consulted Ojha/Moulovies and 0.46% took other measures (Table 3b).

3. MCWC :

Pregnancy caused concern in the mind of 75% of the respondents even though they considered themselves in good health. 23.17% did not have worry about the effect of pregnancy on health and 1.83% did not have any opinion (Table 2c).

When their concern about the effect of pregnancy of health was related to action taken by them to some remedial measures, it was observed that 50.67% of the respondents did not consult any doctor or trained person nor did they took any measures to help them in the prevention of expected bad effects of pregnancy. 12% of the respondents used nutritious foods, 19.56% used some drugs including vitamins and iron tablets, 15.56% consulted passed doctors, 0.67% Ojha/Moulovies and 1.56% used other measures (Table 3c).

Time to consult Doctor/Trained person during pregnancy :

FWC :

A great majority (48.83) of the respondents opined that one should visit a doctor/trained person when there were mild problems. This was followed by 38% of the respondents who mentioned that one should visit only at the time of severe problems, while 11% mentioned that one should visit them for check up even if there was no problems and 2.17% of the respondents did not have any opinion (Table 4a).

MCH Unit at THC :

In the THC area, 58.12% of the respondents favoured a visit to the doctor/trained person with minor problems, 23.67% mentioned with severe problems,

15% mentioned to contact doctor/trained person for check up even if one did not have any problem and 3'16% did not have any opinion on visit to doctor/trained person for advice. From the response it shows that only a minor fraction of the respondents were concerned for promotive or preventive health (Table 4b).

MCWC :

A Majority (49'83) of the respondents mentioned that even for minor problems one should consult a doctor/trained person, while 26% mentioned that one should consult a doctor/trained person only at the time of severe problem, 23'34% mentioned that even if there were problem one should consult doctor/trained person and 0'83% did not have any opinion (Table 4c).

Opinion of respondents on causes of Deaths related to pregnancy :

FWC :

Majority of respondents (32'67%) knew that death during pregnancy occurs due to different diseases. 30'67% mentioned that these are related to effect of pregnancy, 12'33% mentioned weakness and 11'83% mentioned evil eye as the cause of death during pregnancy. Torture by husbands and his family members was mentioned by 1'5%. Of the respondents, more than 11% did not have any opinion (Table 5a).

MCH Unit at the THC :

Majority (35'67%) mentioned that effect of pregnancy was the important cause of death during pregnancy while 22% knew that different diseases during pregnancy were the causes. 16'5% mentioned weakness 8'33% evil eyes and 3'67% mentioned torture by husband and his family members as the causes of death during pregnancy. More than 13% did not have any opinion (Table 5b).

MCWC :

Majority (29'33%) of the respondents were of the opinion that the causes of deaths during pregnancy were different diseases, while 27'83% mentioned effect of pregnancy as the cause. Weakness as cause of death was mentioned by 17'17% of the respondents while evil eye was mentioned by 8'67% and torture by husband/his family members were mentioned by 1'67%. More than 12% of the respondents did not have any opinion (Table 5c).

Knowledge of causes of deaths during pregnancy was not clear to majority of the respondents. Fair number of respondents considered that weakness, evil eye and torture of husband and his family member were the causes of death during pregnancy.

Opinion of the respondents on consultation with doctors/trained person during lactation :

1. FWC :

More than 50% of the respondents expressed that the lactating women should consult a doctor/trained person to check up their health even if they were healthy. Similarly, 65.33% respondents mentioned that health check up of new born babies was a good idea to observe the progress and development of the growth of babies (Table 6a & 7a).

2. THC :

A similar pattern was observed in the THC area. The majority (60.5%) of the respondents favoured a visit to a doctor/trained person by lactating women for check up their health and 75% favoured visits for check up of the health of new born babies even if they were considered to be healthy (Table 6b & 7b).

This shows that the respondents had a positive attitude towards visiting a doctor/trained person for check up of health of lactating mothers and new born babies as a matter of routine, a concept of preventive and promotive health.

3. MCWC :

The views of respondents on visit of lactating women to a doctor/trained person for check up of their healths and the health of their new born babies even if they considered to be healthy was favoured by majority of the respondents.

A check up on the health of lactating women was favoured by 63.33% and check up of health of new born babies was favoured by 76.33%. The rest of the respondents in the two groups did not favour the idea of visit to a doctor/trained person for check up of health or health person (Table 6c & 7c).

Opinion on visit to doctor/trained person by actual visit to doctor/trained person :

FWC :

The respondents (50%) who expressed that the lactating women should visit doctor/trained person for health check up, even when one is considered to be healthy, only 4.92% women visited doctors/trained person. None of those who had negative attitude to visit a doctor/trained person for advice etc. Visited the doctors/trained person (Table 8a).

Similarly, of the respondents (65.33%) who mentioned that one should take their new born babies for a health check up even if he/she was healthy, only 2.81% took their children to doctors/trained person for a health check up. None took their babies to doctor/trained person who had negative attitude (Table 9a).

MCH Unit at THC :

Those respondents (60.5%) who had positive attitude that lactating women should visit a doctor/trained person even if they were healthy, only 11.85% visited a doctor/trained person. Similarly of those (75%) who favoured visits for check up for the health of babies only 10.22% took their babies to doctor/trained person. None of the respondents in both the groups who had a negative attitude towards visiting a doctor/trained person, either visited for themselves or took their new born babies to doctor/trained person (Table 8b & 9b).

This indicates that expression of positive attitude does not mean that this will be translated to action.

MCWC ;

Of the 63.33% respondents who had a positive view on visits to a doctor/trained person for check up of the health during lactation even though one was healthy, only 15.26% visited a doctor/trained person, while of those who did not favour the idea, none of them visited a doctor/trained person. (Table 8c).

Similarly, those (76.33%) who had a positive attitude for visit to a doctor/trained person for check up of the health of new born babies, only 7.86% took their babies to doctor/trained person for check up their health even though they were considered healthy. None of those who had negative attitude, took their new born babies for health check up (Table 9c).

Permission taken to visit clinics, doctor/trained persons :

FWC :

Husbands' permission was mentioned by 85.17% of the respondents as a requirement to visit clinics, or doctor/trained person. Permission from husband and mother-in-law was necessary for 7% of respondents, while 0.33% had to take permission from Husband and Father-in-law (Table 10a).

MCH Unit at THC :

In the THC area, 89.83% of the respondents had to take permission from husbands to visit clinic or doctor/trained person for consultation. 4% took permission from mother-in-law, 2.83% from a father-in-law and 2.5% from husband and mother-in-law. The rest took permission from a different person (Table 10b).

MCWC :

A majority of respondents 90% had to take permission from husbands, 3% from mother-in-law and 5% from both husbands and mother-in-law to visit a clinic or doctor/trained person. Only 0.67% mentioned about permission of father-in-law and husbands. This shows that husbands play an important role for visit of wives to clinic or doctor for treatment/advice. The influence of fathers-in-law and mothers-in-law does not play an important role to visit a clinic or doctor/trained person (Table 10c).

Attitude of family members on consultation with Doctor/trained person at the time of illness :

FWC :

According to the respondents more than 90% of the husbands and close relation did not have any objection to visit to doctors/trained person for advice or treatment. This attitude was shown by 53.83% of mother-in-laws and 28.67% of father-in-laws (Table 11a).

MCH unit at the THC :

According to the respondents in this area more than 94% of the husbands and relatives favoured the idea of visiting doctors/trained persons for advice or treatment at the time of illness. A large portion of mother-in-laws (55.33%) and father-in-laws (28.5%) favoured the idea of visit (Table 11b):

MCWC :

According to the respondents more than 92% of the husbands and close relations favored the visit to a doctor/trained person for advice or treatment at the time of sickness. This idea was favoured by 46.33% of mother-in-laws and 32.33% of father-in-laws (Table 11c).

In Bangladesh number of female doctors/female trained persons are very limited. Even then the trend in all the three areas shows that husbands and relation favoured the visits in more than 90% cases. The attitude of mother-in-laws is more positive than the father-in-laws though their percentage apparently was low. However, the table shows that 39.17% of mother-in-laws and 66.6% of the father-in-laws were dead at the time of interview. So the positive attitude of this group would also comprise to more than 90% according to proportion of positive attitude of the living in laws, mentioned by the respondents.

Person consulted during last three pregnancies for advice/treatment :

FWC :

A majority of the respondents did not consult anyone during the last three pregnancies. Those who did not consult anyone in the last pregnancy, constituted 82.67%, in the last but one pregnancy they were 88.31% in the last but two pregnancy they were 90.52%. The number of respondents who visited passed doctors, were 8.33% in last pregnancy, 5.08% in last but one pregnancy and 3.09% in last but two pregnancies. Those who visited a Hakim/Kabiraj and village doctors were 2% and 5%, 1.52% and 3.73%, 1.24% and 3.91% in the last, last but one and last but two pregnancies respectively (Table 12).

MCH unit at THC :

In the THC area the percentages of respondents who visited some one for treatment and advice during last three pregnancies was more or less the same to that of the respondents of FWC area in all the groups. They were 11.37%, 12.48% and 17% respectively. Those who visited the passed doctor for services were 8.33%, 4.68% and 3.79% in their last, last but one and last but two pregnancies, respectively. Similarly those who went to village doctors for services, constituted on 4.17%, 3.47% and 4.21 in last, last but one and last but two pregnancies respectively (Table 12).

MCWC :

The percentage of respondents who visited passed doctors in their last, last but one and last but two pregnancies were 29.67%, 20.69% and 17.21% respectively.

Visits to village doctors were made by 2.5%, 1.55% and 2.4% while visits to Kabiraj and Hakim were made by 0.5%, 0.69%, 0.65% and visits to Dai/TBA were made by 0.33%, 0.52%, & 0.22% of the respondents in their last, last but one and last but two pregnancies respectively (Table-12).

The trend of visits by respondents to some one for advice in different pregnancies increased from previous pregnancies to the latest pregnancy.

It was observed that a majority of the respondents did not visit anyone in their last three pregnancies for treatment or advice. However the percentage of visit for advice/treatment to some one in their last pregnancy, increased in all the areas compared to last but one pregnancy and last but two pregnancy. This could be the effect of change in community attitudes and availability of services. The trend was shown in all the three areas. The role of TBA/Dai was most negligible in all the areas.

Persons who delivered babies in last three pregnancies :

FWC :

The majority of the deliveries in all the pregnancies were conducted by Dai/TBA. Dai/TBA conducted 47.17% of all the deliveries in the last pregnancy, 42.71% in the last but one pregnancy and 35.26% in the last but two pregnancies. Neighbours/relatives conducted 47% of the deliveries of the last pregnancy, 51.67% in the last but one pregnancy and 60.2% in the last but two pregnancies. Passed doctors conducted 2%, 1.67% and 1.24% and self conduction of deliveries were made in case of 3.5%, 2.54% and 3.3% in the last, last but one, and last but two pregnancies. The role of village doctors in delivering babies was negligible (Table-13).

MCH Unit at THC :

In all three pregnancies the majority of the respondents were delivered by relatives and neighbours. Relatives and neighbours delivered 53% of babies in last pregnancy, 57.02 in last but one pregnancy, and 65.05% in last but two pregnancies. This was followed by delivery of babies by TBA/Dais who delivered 42.83% babies of the last pregnancy, 38.99% of the last but one pregnancy and 32.21% of the babies of the last but two pregnancies. Delivery of babies by passed doctors was 1.83% in last pregnancy, 2.08% in last but one pregnancy, and 0.84% in last but two pregnancies. About 2.00% of the deliveries were conducted by self in all the three pregnancies. The figures show that the delivery by relatives are decreasing in subsequent pregnancies and delivery by TBA/Dai is showing an upward trend (Table-13).

Role of doctors (passed or unpassed) in delivering babies is not significant in rural setting. This could be due to non-availability of doctors in rural area.

MCWC :

In the urban area, more than 52.00% of the deliveries in all three pregnancies were conducted by Dai/TBAs, while more than 14% were conducted by passed doctors. Relatives and neighbours conducted more than 17% of the deliveries in all the three pregnancies. Deliveries conducted by Dai/TBA were 58.67%, 59.66% and 52.94%, by relatives/neighbours these were 17.33%, 19.66%, 29.41% and by passed doctor these were 23%, 19.14% and 14.6% in last, last but one and last but two pregnancies respectively (Table 13). In this case deliveries conducted by passed doctors show an upward trend from last but two pregnancies to last pregnancy. while deliveries conducted by relatives shows a downward trend from the last but two pregnancies to last pregnancies. This suggests, people have started to prefer trained person for delivery of their babies (Table 13).

Place of delivery in last three pregnancies :

FWC :

More than 69% of the deliveries were conducted at the home of the respondents. This was followed by deliveries conducted in the father's home. Deliveries conducted at home and the father's home were 89.83% and 9%, 83.22% and 16.1%, 69.69% and 29.69% respectively in last, last but one and last but two pregnancies respectively. Deliveries conducted in hospitals and clinics constituted 0.5% and 0.67%, 0.34%, 0.42% and 0.21% in last, last but one and last but two pregnancies respectively. No delivery was conducted in the FWC (Table 14).

MCH Unit at THC :

About 98% of all the last three deliveries were conducted at the respondents' own home or their father's home. At their own home 87.83% of the respondents delivered in their last pregnancy, 75.9% in their last but one pregnancy and 68.42% in their last but two pregnancies. Compared to delivery at their father's home these were 11.84% in last pregnancy, 23.05% last but one pregnancy and 30.32% in last but two pregnancies. Respondents who were deliver in the MCH unit of the THC constituted 0.33% in their last pregnancy, 0.87% in their last but one pregnancy and 0.84% in their last but two pregnancies (most of these cases had some problems). A minor fraction of deliveries were conducted in doctors' clinics. It is also observed that for the first few deliveries the respond attend their father's home. Delivery at MCH Units are almost non-existent (Table 14).

MCWC :

More than 70% of the babies in all the last three pregnancies were delivered at their own home or their father's home. The deliveries at home were 71.33% for last pregnancy, 75.51% for last but one and 70.59% for last but two pregnancies. A sizable number of deliveries were conducted in hospitals or private clinics. In hospitals 9.33% respondents were delivered in the last pregnancy, 8.97% in their last but one pregnancy and 5.55% in their last but two pregnancies. Similarly, 5.67% of respondents delivered in the clinics in their last pregnancy, 3.1% in their last but one pregnancy, and 1.09% in their last but two pregnancies. Respondents who delivered at their father's home decreased from last but two pregnancies to last pregnancy. These were 19.39% in last but two pregnancies, 7.59% in last but one pregnancy and 6.67% in last pregnancy. In the MCWC 7% of the respondents were admitted for delivery in their last pregnancy, 4.83% for their last but one pregnancy and 3.27% for their last but two pregnancies. The figures show that respondents attended clinics/hospitals i.e. MCWC for delivery of babies in their last pregnancy, compared to their previous two deliveries. The number was almost one and one half times more than previous deliveries. They may be the influence of culture that the first few pregnancies are delivered in the parents' homes instead of their own homes. That is why increase in the number of pregnancies correlates with the number of deliveries at home (Table 14).

Willingness to visit MCH centres for delivery of their next child, where all facilities are provided :

FWC :

A majority (92%) of the respondents were not willing to attend MCH centres for delivery of their next baby. Only 8% wanted to be admitted in the FWC for delivery (Table 15a).

MCH Unit At THC :

More than 90% of the respondents did not want to be delivered in the MCH unit at the THC. Only 9.33% expressed their willingness to be delivered in the MCH unit at THC (Table 15b).

MCWC :

With the MCWC being located in an urban area, the number of respondents willing to be delivered was about three times higher than the respondents of the rural or semi-rural areas (FWC & THC area). Those who wanted to be delivered in the MCWC, constituted to 27.33% and those who denied to be delivered in this MCWC were 72.0% (Table 15c).

The number of respondents willing to be delivered in the clinics increased according to urbanization of the area where the clinics were located.

Causes of non-visit to clinic for next delivery :

FWC :

Of the respondents who were not willing to deliver in the FWCs, 35.51% mentioned that one should not deliver in the clinics unless there is some problem associated with the pregnancy/deliver 14.86% mentioned that to deliver in the clinic is a matter of shame and they were afraid of the clinic environment. A fair proportion the respondents (23.8%) did not like to deliver in FWC, 8.33% prefer to deliver at home and 7.25% mentioned that they do not want to be pregnant next time or already ligated, while 1.99% mentioned that the clinic personnels demand money (Table 16a).

MCH Unit at the THC :

The largest group (27.02%) of the respondents mentioned that one should not go to the clinic for delivery unless there is some problem with pregnancy/delivery. 19.85% mentioned that, to be delivered in the clinic is a matter of shame and they were afraid of the clinic environment. A fair portion of the respondents (19.11%) want to be delivered at home and 13.24% did not like the idea of delivery at the clinic. About 13% of the women did not want to have next pregnancy or already have undergone sterilization operation, while 4.96% did not have any opinion, and 2.94% of the respondents mentioned that the clinic personnel demand money (Table 16b).

MCWC :

Of the respondents, 27.02% opined that one should not delivery in the clinic unless there are problems associated pregnancy/delivery, 13.3% considered it a matter of shame to be delivered clinic and were afraid of the clinic environment. Home as a better place of delivery was mention 21.79% of the respondents, while 11.24% of the respondents, did not like to deliver at the clinic. A fair portion of the respondents (12.87%) did not like to be pregnant again or were already sterilized, 4.82% did not have any opinion and 5.05% mentioned that the clinic personnels demand money (Table 16c).

A majority of the respondents in all areas felt that delivery at the clinic should be considered only at a time of some problem related to pregnancy and delivery. This was followed by those who considered that for delivery, one's home is the best place. A fair number of respondents mentioned to deliver at the clinic is a

matter of shame and were afraid of the clinic environment. These could be due to presence of male doctors and behaviour of the clinic personnel etc.

A large number of the respondents did not want to be pregnant any more or had undergone sterilization operation.

Opinion of family members on delivery of babies in clinics :

FWC :

As reported by the respondents the husbands were the major group (16%) who favoured the idea of delivery in the clinic/hospital compared to 12.2% of the close relatives. Of the living in laws, 2% father-in-laws and 4.7% mother-in-laws favoured the idea of delivery in hospitals and clinics (Table 17a).

MCH Unit at THC :

Husbands were the major group (17.7%) who favoured delivery of their wives in hospitals/clinics, followed by the group of close relatives (15.7%). Of the living in laws, 3.7% of the father-in-laws and 5.7% of the mother-in-laws favoured the idea of delivery in hospital and clinics (Table 17b).

MCW :

The major group who favoured the idea of delivery in hospital/clinics was the husbands (51.3%) followed by the group of close relatives 38.5%. Of the living in laws 11.2% of the father-in-laws and 15.8% of the mother-in-law favoured the idea of delivery in the clinics/hospital (Table 17c).

The trend in different area shows that the people in rural areas are more traditional and do not favour the idea of delivery of baby in hospital/clinic while this was more favoured by the urban people (MCWC area).

Persons desired to be consulted for advice/treatment during illness :

FWC :

More than 70% of the respondents desired to consult village doctors for treatment of their ailments. Of the remaining 18.67% wanted to call on passed doctors, 6.33% relatives and neighbours and 2.17% Hakim/Kabiraj for treatment/advice when they were sick. Only 1% did not want to consult anybody and more wanted to go to the Dai/TBA (Table 18a).

MCH Unit at THC :

More than 90% of the respondents wanted to consult either passed doctors (41.67%) or village doctors (48.67%) for advice or treatment of their ailments, 5.83% wanted to consult relatives and neighbours 1.33% Moufovies / Ojha, and 1.33% did not want to consult anybody. No respondent wanted to consult Dai/TBA (Table 18b).

MCWC :

Among the respondents of the MCWC areas, 69% wanted to consult passed doctors, 18.17% village doctors, 4.71% relatives/neighbours and 0.83% wanted to go to the Hakim/Kabiraj for treatment of their ailments or for advice. Those who wanted to consult "Others" constituted 6% while 1% did not want to consult anybody. In all the three areas, about 90% of the respondents wanted to consult doctor (passed or not passed) for treatment of illness. Perhaps availability of passed doctors made the difference in desire for consulting them in different areas.

Persons to be consulted at the time of problematic delivery :

FWC :

The respondents in a majority of the cases (60.33%) desired to consult passed doctors in cases of problematic delivery. Of those who wanted to consult the other groups, 10% desired to consult Hakim/Kabiraj, 9.33% Dai/TBAs, 11.67% village doctors, 5.17% relatives/neighbours and 3.5% Moulavies/Ojha.

MCH Unit and THC :

The majority (69%) of the respondents expressed their desire to consult passed doctors at the time of difficult delivery, while 7.83% wanted to consult Dai/TBA, 7.33% relatives and neighbours, 7.5% village doctors, 4.5% Hakim/Kabiraj and 3.83% Ojah/Moulavies (Table 19b).

MCWC :

With the MCWC being located in an urban area, 86.33% of the respondents expressed their desire that they would consult passed doctors for problematic deliveries. Of the remaining groups, 3% wanted to consult Dai/TBA, 3.67% Ojha/Moulavies, 2.33% relatives/neighbours and 2% to village doctors (unpassed) (Table 19c.)

Person desired to be contacted at the time of complicated delivery and general treatment :

FWC :

Of the respondents who desired to visit some one either at the time of a complicated delivery and for treatment of diseases, 15.67% mentioned passed doctors, 1.33% Hakim/Kabiraj, 3.5% relatives and neighbours, 0.17% Ojha/Moulavies, and 10.67% village doctors (Table 20a).

MCH Unit at THC :

In the THC area, 36.67% of the respondents desired to visit passed doctors both at the time of complicated delivery and treatment of disease. Of the remaining groups, 0.33% wanted to visit Hakim/Kabiraj, 3.67% wanted to visit relatives/neighbours, 0.17% Ojha/Moulavies and 6.17% to village doctors (Table 20b).

MCWC :

In MCWC areas, 68.67% of the respondents expressed their desires to consult passed doctors for both complicated deliveries and treatment of diseases. Those who wanted to consult relative/neighbours constituted 0.67%, and 0.5% wanted to consult village doctors (unpassed) (Table 20c).

It appears from the response of all the three areas that major groups of the respondents prefer passed doctors to help them at the time of complicated delivery and treatment of diseases. The low percentage in the rural area could be due to non-availability of passed doctors.

5.2. MCH Facilities :

Knowledge on different services provided in the Centres :

The respondents were asked about their knowledge on type of services provided by the different centres in their areas.

FWC :

Of the respondents, 61.83% knew that these centres provided services for treatment of different diseases, 48.33% knew about facilities for advice and treatment for pregnant mothers, 61.33% knew that these centres provided services for advice and treatment of children and 78.5% knew that these centres provided services for different contraceptives (Table 28a).

MCH Unit at THC :

More than 90% of the respondents (in each case) knew that these centres provided services for treatment of different diseases and care for pregnant mothers and children including their treatment while 99% of the respondents knew about different family planning services provided in these centres (Table 28b).

MCWC :

Though knowledge about different services provided in these centres was very high (more than 80%) in each case yet these were less than the know-

ledge of the respondents visiting the MCH unit at the THC. In this case 95% of women had knowledge of services on treatment of different disease in this centres. 89.67% knew about contraceptives services, 89.33% knew about advice and treatment for children and 84.33% knew about treatment of pregnant mothers (Table 28c).

From observation in 3 different areas it is seen that in the THC area the knowledge of respondents on provision of different services including MCH services, is higher than the two other areas. The knowledge on services provided in FWC is comparatively poor, particularly on services for pregnant mothers and children. The knowledge of respondents in FWC area on provision of MCH services is less than 50% to that of the other areas.

Visits to the Centres last year :

The respondents were asked if they visited the centres any time and if so how many times they visited in last one year.

FWC :

Only 25.17% of the respondents visited the FWC last year. Of those who visited FWC 47.68% of the respondents visited one time, 28.8% visited twice, 20.53% visited thrice, 1.99% visited 4 times and 1.32% visited 6 times. Average number of visits was 2.2 times (Table 29a).

THC :

Only 45.33% of the respondents visited the THC some time in the past. Of them one visit was made by 30.4% of the respondents while 25.64% of the respondents visited two times and 15.75% for a 3rd time. Only 0.73% visited 6 times. More than 22% of the respondents did not visit the clinics last year. They visited the centres year before last (Table 29b).

MCWC :

Only 43.33% of the respondents visited the MCWC some time in the past. Of those 38% of the respondents visited once, 18.38% visited twice, 5.88% visited thrice and 1.47% visited 4 times. More than 36% did not visit the clinics during last year (Table 29c).

It is observed that the number of non-visitors was more in the FWCs compared to THC and MCWC. The FWCs were established only about two years ago. 36.03% of the respondents from the area of MCWC and 22.71% of the respondents

from the area of THC did not visit the clinics last year though they visited clinic earlier. This could be due to their dissatisfaction related to clinic services or distance to travel or clinic timing or staff behaviour.

Purpose and frequency of visits to the services :

FWC :

Most of the visits in FWCs were made for treatment of their own diseases and treatment of their children. Of the respondents who visited clinics for treatment of their own disease 36.42% visited once, 36.14% visited twice and 25.71% visited thrice. Of those who want for treatment their children 56.29% attended clinics once, 62.65% attended twice and 74.29% for 3rd time. 3.97% women visited the centre once for treatment while pregnant, 1.20% women visited twice and only 1.86% attended the centre for family planning services. None of the respondents attended the clinics for MCH care or give company to their relatives/neighbours (Table 30a).

MCH Unit at THC :

Of those who visited the THC, a majority of the respondents visited the THC for treatment of their children and for treatment of their own ailments. Only few of the respondents visited the centres for family planning services, for treatment of ailments during the pregnancy period and a very small fraction of respondents want to the centres in the company of their relatives. Those who visited the centres for treatment of their children, 52.38% visited once, 56.34% visited twice and 61.4% visited three times. And those who visited for treatment of their own ailments, 30.4% visited once, 27.46% visited twice and 22.81% visited for third time (Table 30b).

MCWC :

Of these who visited the MCWC, the respondents in most cases visited the centres for treatment of their own ailments. Those who visited for treatment of their own ailments, 25% visited for one time 11.11% visited 2nd time, 36.36% visited for third time. In case of treatment of the children, 37.5% visited once, 68.88% visited twice and 54.55% visited for 3rd time. 15.44% women made one visit for treatment during pregnancy and 4.41% attended for family planning services once and 6.67% twice. No visit was made a 3rd time. 17.65% of the women accompanied their relatives one time, 1.21% a 2nd time and 9.09% a 3rd time for treatment of diseases (Table 30c).

In all the three areas it is observed that most of the visits to the centres were made for treatment of children, followed by treatment for self. Visit the centres for MCH care or family planning services were negligible.

Timing for clinics :

FWC :

The concept on time in the rural area is not very clear. Only 151 respondents who visited the centre answered this question. Of the majority of the respondents knew that the opening time of the FWC was 8:00 a. m. (58) and a large majority did not have any idea of the opening time (41). About the time of closure of the clinics, a majority (44) mentioned it to be 2:00 P. M. while 21 persons mentioned 4:00 P. M. 18 mentioned 12:00 noon and 15 mentioned about 3:00 P. M. A large number (48) did not know about the time of close of the FWC. From cross tabulation it is indicated that almost all the respondents were ignorant on the time of opening and closing of the FWCs. Only two of the respondents had correct information about opening time and closing-time of the clinics (Table 31a).

THC :

Only 273 of the respondents who visited the centres answered the question. The majority (103) of the respondents knew that the clinics open at 10:00 A. M. This was followed by those (92) who reported opening time at 8:00 A.M. About closing time 70 respondents mentioned 12:00 noon as closing time of the centres, followed by those (49) who mentioned 2:00 P.M. as closing time while 32 respondents mentioned closing time at 4:00 P.M. and 26 at 1:00 P.M. A little more than one third of the clients mentioned that they did not have any idea of closing or opening time of the centres. Only 26 respondents knew about the exact time of opening and closing of the centres (Table 31b).

MCWC :

Only 272 of the respondents who visited the centres answered this question. Of all the respondents, a majority (84) knew that the centres open at 10:00 A.M. while 50 mentioned that it opens at 8:00 a.m., 120 respondents did not have any knowledge of opening time of the centres. Similarly, a majority of 34 respondents in each category knew that it closes at 12:00 noon and 5:00 P.M. 134 respondents did not know the time of closing of the centres (Table 31c).

From the respondents of the three areas, it is evident that a large majority of the respondents either do not know about the opening and closing time of centres or do not have correct information on this point.

Distance to travel to go to clinics :

FWC :

More than 40% of the respondents who visited the FWC lived within a distance of one and one half miles from the centres. The second major group (32%), came from $1\frac{1}{2}$ — $2\frac{1}{2}$ miles and 13.24% of the respondents came from $2\frac{1}{2}$ miles and more. Those who visited from within a quarter mile, constituted 25% of the respondents (Table 32a).

THC :

Similar to the FWCs, more than 50% of the respondents who visited the centres were residing within one and one half ($1\frac{1}{2}$) miles from the THC. The next major group of respondents (39.19%) who visited the THC were residing between $1\frac{1}{2}$ — $2\frac{1}{2}$ miles from the centres. None of the respondents visited the centres who were residing outside miles from the centres (Table 32b).

MCWC :

In this area more 60% of the visitors of the centres were residing within $1\frac{1}{2}$ — miles away from the centres 27.94% residing between $1\frac{1}{2}$ — $2\frac{1}{2}$ while 9.55% the visitors lived at a distance of $2\frac{1}{2}$ miles or more (Table 32c).

The figures of the three centre areas show that a large major of the centre visitors came from an area within $1\frac{1}{2}$ miles (40-60%). In FWC and THC area it was observed that about one fourth of the visitors were residing within a distance of quarter miles.

Status of Medicine Supply :

FWC :

More than 66% of the respondents were supplied with medicine from the centres while 19.87% were supplied with few medicines and were also asked to purchase additional medicine from the market. 13.9% of the respondents were not supplied with any medicine and they were asked to purchase medicine from the market (Table) 33a).

Of those who received medicines, 62.31% received those after 2-3 visits, 3.85% had to visit more than 3 times, and 31.54% visit once only.

Of those who received medicine from clinics, 67·69% mentioned that the quality of medicine was good, while 31·54% mentioned that the quality was bad (Table 35a).

THC :

More than 50% of the respondents received medicine from the centres and 34·43% received a partial supply and were advised to purchase additional medicine from outside. 14·29% of the respondents did not receive any medicine from the centres and were asked to purchase those from the market (Table 33b).

About 60% of the respondents visited 2-3 times for medicine, while 29·49% visited only once (Table 34b).

Of those who received medicine, 58·12% respondents mentioned that the quality of medicine was good, while 41·45% reported that the quality was bad (Table 35b)

MCWC :

In these centres, 41·18% of the respondents were supplied with medicine and 32·35% received a partial supply and were asked to purchase additional medicine from the market (Table 33c).

Of those who received medicine, 56% visited the clinics 2-3 time to receive the full quota of medicine, while 38% visited once only. More than 3 visits were made by 6% of the respondents (Table 34c).

Of those who received medicine, 59% mentioned that the quality of medicine was good while 39% mentioned that the quality of medicine was bad (Table 35c.)

It appears from the findings of different centres that about one half of the respondents were either not supplied with medicine or were supplied with an insufficient quantity. About one third were not satisfied with the quality of medicine. Further, the respondents had to visit several times to procure medicine.

Why people do not like to visit centre :

The respondents were asked to give their opinion as to why people in the community do not visit the centres. The answer were many. All the answer were coded in ten categories.

FWC :

The four major causes of non-visit to centres were :

1. Insufficient supply of medicine (34.44%)
2. Bad medicine (44.37%).
3. Bad staff behaviour (33.22%) and
4. Long waiting period (38.41%).

Long distance to travel was mentioned by 21.19% : untimely opening and closing of centres was mentioned by 17.22%, lack of attention by clinic personnel by 22.52% and demand for many by clinic personnel was mentioned by 24.5% of the respondents. Those who did not have any opinion and "others" constituted 23.18% and 6.62% respectively (Table 36a).

THC :

The four major causes in this area were :

1. Insufficient supply of medicine (42.86%),
2. Bad quality of medicine (45.5%)
3. Demand for money by centre personnel (32.97%),
4. Long waiting time (39.56%).

Long distance to travel was mentioned by 13.53% of the respondents. Untimely opening and closing of the clinics was mentioned by 10.26%, bad staff behaviour by 19.5% and lack of attention by clinic personnel by 27.84%. Those who did not have any answer and "others" constituted 10.26% and 5.86% respectively (Table 36b).

MCWC :

The four major causes in this situation were :

1. Insufficient supply of medicine (41.18%),
2. Bad medicine (56.62%),
3. Lack of attention of clinics personnel (42.65%)
4. Demand for money by centre personnel (27.94%).

Long distance to travel was mentioned by 8.82% of the respondents, untimely opening and closing of clinics by 6.62%, bad staff behaviour by 26.47% and long time to wait by 25.74% of the respondents. Those who did not have any opinion were 21.32% and "others" constituted 1.47% (Table 36c).

From the answers of the respondents of different centres it appears that the most important cause of not visiting the centres a lack of sufficient quantity of medicine, quality of medicine, behaviour of the clinic personnel, long waiting time and long distance to travel. For clients of rural areas, closing and opening time of clinics did not appear to be an important cause of non attendance.

Views of the respondents to improve visits to the centres :

FWC :

Four major areas identified by the respondents to improve visits to the centres were :

1. Supply of good medicine (46.35%),
2. Adequate supply of free medicine (49.67%)
3. Proper attention of centre personnel towards clients (25.17%) and
4. Avoidance of long waiting time (19.21%).

Timely opening of clinic was mentioned by 14.57% and 13.19% did have any opinion (Table 37a.)

THC :

Four major areas identified by the respondents to improve the visits to the centres were :

1. Supply of good medicine (56.78%),
2. Supply of adequate quantity of free medicine (54.95%),
3. Proper attention of clinic personnel to clients (28.21%),
4. Good behaviour of clinic personnel 24.1%. Timely opening of clinics was mentioned by 4.3% and avoidance of long waiting time by 8.6% of the respondents (Table 37b).

MCWC :

Four major factors to improve the visits to the centres recommended by the respondents were :

1. Supply of good quality medicine (37.5%)
2. Adequate quantity of free supply of medicine (52%)
3. Proper attention of centre personnel towards clients (45.59%) and
4. Good behaviour of centre personnel (29.41%)

A long waiting time was mentioned by 11.3% and timely opening centre by 9.56%. More than 25% did not have any opinion (Table 37c).

From the opinion of the respondents in all the three areas it is evident that free and adequate quantity of medicine supply, good quality of medicine, good staff behaviour and proper attention of clinic personnel is likely to improve the clinic attendance. Waiting time was given importance by the group in rural areas while long distance to travel and opening time of the clinics was not considered important by any group. Only one or two of the respondents mentioned this.

Opinion of respondents about indoor facilities :

Bed facilities are not available in the FWCs, so the respondents were limited to the MCH unit at the THC and MCWC areas.

THC :

Only 16 respondents were admitted in the THC hospital of them respondents mentioned that they were supplied with free food, 11 mentioned free supply of medicine, and 12 respondents mentioned that the beds were clean. Five of the respondents mentioned that no free food was supplied to them, 3 respondents were asked to purchase medicine from outside, while 4 respondents mentioned that the beds were very dirty. One had to pay money for medicine to the hospital staff (Table 38a).

MCWC :

Only 50 respondents were admitted in those centres. Of them, 42 mentioned free supply of food, and 8 did not get any food. Free supply of medicine was received by 10 respondents, 14 purchased medicine from the market, while 24 were supplied an inadequate quantity of medicine and they had to purchase medicine from the market. 38 respondents mentioned the beds and lines in the clinics were clean 8 mentioned dirty lines and beds, and 4 mentioned that they slept on the floor. Two had to pay for medicine to the staff (Table 38b).

This findings suggest that the experiences of admitted patients in the inpatient unit were more or less good. However, supply of free food and free drugs would help in more admission of patient. Three of the clients had to pay for medicine to the clinic persons. No opinion on behaviour of the staff was mentioned by any respondents.

Visiting status of clients to MCWC/FWC/MCH Unit at THC :

The percentage of clinic visitors at the rural FWCs was 25.17% MCH units located at the thana Health Complex was 45.5% and MCWC in the District Headquarters was 45.9%. It shows that more women in the urban and semi-urban (Thana) areas have visited the MCH centres. The percentage of visitors to the MCH clinics in urban and semi-urban area is almost double than that of the rural FWC.

Socio-Demographic Characteristics of visitors :

FWC :

Women between ages 20-39 are the largest group who have visited the clinics at least for one time. Of them, women in the age group 30-34 have visited the clinics most (29.58%) followed by women in age group 35-39 (27.17%), while women aged 25-29 were 26.67% and 20-24 year (22.01%). Women at the two extreme groups of age 15-19 year and 40-44 years have the lowest visits to the clinics at 8.7% and 11.11% respectively (39a (a)).

MCH Unit at THC :

The age pattern of the women who visited MCH Unit at the THC is similar to that of the visitors of the FWCs. 54.79% of women aged 30-34 years, 48.93% aged 35-39 years, 43.15% aged 25-29 years and 38.4% aged 20-24 years, visited the MCH unit at the THC at least once. In the two extreme groups of age 15-19 and 40-44 years the percentage of women who visited the MCH centres was 28.57% and 60% respectively. There is a tendency that the women in old and middle age make more visits than the younger ones (Table 39a (b)).

MCWC :

In the MCWC area there is a tendency for older women to make more visits to the MCH centres than younger women. With an increase in age, the number of visitors in each age group also increased. The percentage of visitors in age groups 15-19, 20-24, 25-29, 30-34, and 35-39 were 9.09%, 37.36%, 40.21%, 58.73% and 67.57% respectively (Table 39a (c)).

This shows that women in their middle age generally visited the clinics for services. This group, usually has 3-4 living children and have a role in family decision making. These women generally do not need their husbands a guide to go out of their homes. Young sons are usual company for such women.

Number of living children :

Rural FWC :

The majority of the respondents who visited clinics at least once had 5-6 living children (32.17%). This was followed by women who had 9 or more living children (31.43%) and 3-4 living children (25.56%) respectively (Table 39h (a)).

MCH Unit at THC :

Women with 3-4 and 7-8 living children visited the centres most often 51.76% and 51.02% respectively. The percentage of women with 1-2 living children who visited the centres was the lowest (38.65%) followed by women with 9 and more living children (42.86%) (Table 39h (b)).

MCWC :

The largest group (61.54%) of visitors had 1-2 living children and the group who visited the least (38.89%) had 7-8 living children. The respondents having 3-4, 5-6 and 9 or more living children visited the centres in more than 46% cases in all the groups (Table 39h (c)).

Women in their middle age having 3 or more children, visited the centres more than the women in the young age group with 1-2 children. This tendency was reversed in urban area, here majority of the women had 1-2 children.

Literacy and visits to clinics :

Rural FWC :

It was observed that only 16.28% of the women who were high school graduates attended the clinic for services, compared to 26.12% who were illiterate and 25.98% who read up to primary school level. Two of the women who had some college, education did not visit FWC (Table 39b(a)).

MCH unit at THC :

The trend of visitors at the MCH unit in the THC was similar to FWC visitors. 47.16% of the visitors were educated upto the primary level, 46.99% were illiterate while 30.36% were high school graduates (Matriculate). Out of two respondents from the college groups, one attended the clinics (Table 39b(b)).

MCWC :

Though the number of the university educated group were few yet it shows that majority (66.67%) of them visited the MCWC. This was followed by those

who read upto primary level (50·6%). The percentage visitors from the college educated group, was the lowest (33·33%) followed by the illiterate group (44·7%) (Table 39b (c)).

The trend in the two centres at FWC/THC area show that educated groups do not visit the centres for services. This trend is reversed in the MCWC area. In this society a majority of the higher educated group consult private doctors or some trained persons for services. The clinics in general are considered as place for poor people. The visits to MCWC in Urban area could be due to the popularity of the centres.

Occupation and visits to the clinics :

Rural FWC :

It was seen that wives of day labourers and skilled labourers have visited the centres most often at 36·13% and 34·48% respectively. This was followed by the wives of businessmen, cultivators and service holders, 28·1%, 18·18% and 17·33% respectively. The wives of landless cultivators visited least at 8·33% (Table 39d(a)).

MCH Unit at THC :

A majority of the visitors in these centres were the wives of landless cultivators (63·16%) followed by wives of day labourers (58·16%). Among the other groups, wives of cultivators were 46·11% wives of service holders were 42·86%, wives of skilled labourers were 40·48% and wives of businessmen were 38·93% (Table d (b)).

MCWC :

There were six cultivators among the respondents. Of them all visited the clinic. So the percentage of visit by cultivators wives was 100%. Among the other groups, wives of businessmen visited the most (49·12%). This was followed by the wives of service holders and day labourers 46·61% and 41·67% respectively. Wives of skilled labourers visited the least at 29·17% (Table 39d (c)). Except the difference in the number of visits made by the wives of landless cultivators in MCWC, MCH unit in THC and in the FWC., the trend of visits for other groups in the three centres are almost similar.

Land holding and centre visits :

FWC :

A majority of the visitors in these clinics were landless or had small land holdings (57·86%). Except for the group having 400-500 decimal of land, the per-

centage of visitors to the clinics were more or less similar in different groups of land holding (12.2%). The visitor to the clinics by the group with land holding 400-500 decimal was the lowest (6.25%) (Table 39e (a)).

MCH unit at THC :

Majority of the visitors in those clinics were from the groups with land holding of 400-500 decimal (60%), followed by the group with land holding of 300-400 (50%) and below 100 decimal (50%). The group with land holding of 200-300 decimal was the lowest (26.80%) (Table 39e(b)).

MCWC :

Majority of the visitors in these clinics were from the group with land holding 601 decimals and above (66.67%). This was followed by the group with land holding (200-300) decimals (57.14%). Least visitors (25%) to these clinics were from the group holding (400-600) decimals (Table 39c (c)).

No specific trend was observed between land holding and attendance to the clinics.

Income and visit to centres :

FWC :

The majority of the visitors were the wives having income less than Tk. 200 per month (37.21%). This was followed by wives whose family income was Tk. 201-400 (26.2%) and 401-600 (25.33%). The lowest number of visitors were from the wives whose family income was Tk.801-1000 and 1001-2000 (18.64%) and (18.75%) respectively. The trend shows that the wives of high income group visit the clinics least (Table 39f (a)).

MCH unit at THC :

A similar trend was observed in the MCH unit at the THC. The wives of low income groups had visited clinics the most. The wives with family income upto Tk. 200 had visited the clinics most (51.67%) followed by those whose family income per month was Tk. 201-400 (50.51%). The lowest number of visitors were from family income group Tk. 3001-5000 per month (22.23%) (Table 39f (b)).

This shows that rich persons do not like to visit the clinics because in this culture clinics are considered as a place for poor persons. Further, this group of people do not like wait for long hours for advice and treatment.

MCWC :

A major portion of the visitors to the MCWC were from the wives whose family income was Tk. 601-800 per month, (58.33%) while the less proportion of the visitors were from the wives in the income group Tk. 2001-3000 (33.33%). There is no definite relations between income and number of visits to the clinic in this area (Table 39f (c)).

This shows that rich persons do not like to visit the clinics because in this culture clinics are considered as a place for poor persons. Further this group of people do not like to wait for long hours for advice and treatment.

Number of live births and visits :

FWC :

The women with 7-8 live births have visited the clinics most (34.12%) followed by those with 3-4 live births (26.89%). The women with 9 or more live births have visited the clinics the least (15.38%). Respondents with 1-2 live births who visited clinics constituted 22.55% (Table 39h (a)).

MCH unit at THC :

In these clinics most of the visitors were from the group with 3-4 live births (52.55%), followed by those with 9 or more live births (50%). Lowest number of visitors were from the group with 1-2 live births (34.18%) (Table 39h (b)).

MCWC :

The major group of the visitors of the clinics was from women with 9 or more live births (83.33%), followed by those with 1-2 live births (56.52%). The lowest number of visitors were from the group with 7-8 live births (47.62%). There is no specific trend between the number of live births and the number of visits to the clinics in this area. (Table 39h (c)).

It is observed in all areas that the women with their 1st live birth avoided the visit to clinics. These could be due to the younger age of the women and the influence of other peers.

5.4. Provider of services :

Age : Thana Family Planning Officers on the average were about 35 years of age and about 50% of the FWVs and FPAs were in this age group. Medical Assistant and Family Welfare Assistants were younger and almost all of them were below 34 years of age. (Table A).

Marital Status :

More than 83% of the field workers were married. Among the married group the Medical Assistants constituted to 60% (Table A-2).

Number of living children :

About 70% of the respondents had 3 or less living children, while 16.13% of the respondents had 5 or more living children and 6.45% did not have any child (Table A-4).

Knowledge and attitude :

Received written job description :

Written job description were received by 87.78% respondent while 16.22% did not receive those. On those who did not receive written job description some of the field workers were newly recruited and a fair portion could not give satisfactory answers (Table B-1)

Opinion about jobs allotted to the field workers :

This question wanted to evaluate the adequacy of work load and training related to job performance. It was observed that 72.97% of field works considered the work load adequate 83.78% considered that the training was adequate to perform their job efficiently. 21.62% of the respondent felt that the work load was too much and 8.11% felt that their training was not adequate (Table B-2)

MCH jobs performed by field workers :

TFPOs (total 4) : The jobs performed by TFPOs were counselling and advice to mothers on healthful living during pregnancy and laceration (mentioned by 4 TFPOs) supervise the works of the field workers was mentioned by 1 and hold discussion meeting with staff on the services delivery was mentioned by 1 TFPOs (Table B-3)

MAs (total 5) : Jobs performed by them were counselling and motivation of pregnant mothers on healthful living and child care (2) provided treatment to women and children (2) care for mothers during any natal and post natal period (1) and advice on child care (1). One Medical Assistant did not perform any MCH job (Table B-3).

FWV :

Out of 6 FWVs interviewed, the answers were as follows : Advice to mother about MCH (4) provide treatment to mothers (2), of natal and post natal care (2)

attend delivery (1), make home visits (2), advice on nutrition (1) and advice on child care (2) (Table B-3),

FPAs and FWAs :

Almost all mentioned about educational and motivational work to mothers on healthful living, hygiene of pregnancy, child care proper nutrition during pregnancy.

It shows that about 72% of the jobs, related to MCH, performed by different categories of works are educational. Only 8.19% of the workers — worked for ante-natal and post natal care of more and 10.81% provided treatment of different diseases. Except the FWVs the other field workers hardly perform any effective job on MCH Care (Table B-3).

Knowledge of field workers on

Types of Maternal care services women came for :

Knowledge on availing of MCH services in different centres by the pregnant women were very poor amongst the field level workers (FWA and FPAs). All the FWAs and most of the family planning assistants were ignorant about the types of services provided on MCH in different centres. Similarly the TFPOs were also ignorant about most of the types of MCH services provided in the MCWC, MCH Unit the THC and FWCs. The response show that FWVs have better understanding about different types of services women avail in the MCWC, MCH at the THC and FWCs. Compared to FWVs the knowledge of Medical Assistants were very poor. The knowledge of all the categories of workers on types of MCH services availed by women are very poor this is more true in the case of the field workers (Table B-4).

Knowledge on Types of services on child care, available in the child :

The FWAs as a whole were ignorant about the type of services provided in these clinics on child care. Only 2 FPAs and 2 TFPOs had some idea on the types of services on child care provided in these clinics. The FWVs and MAs knew that these clinics provide services for child care on check up of growth and development, treatment on different diseases and "others". The knowledge of field workers on child care services provided in these clinics were poor for all the categories of workers, particularly the FWAs and FPAs. The knowledge of FWV and MA is also limited (Table-B5).

Opinion of field workers on clinic attendance of the clients for MCH Services :

More than 75% of the TFPOs mentioned that they were satisfied with the attendance in the centre for MCH services, while this opinion was expressed by 66% of the Medical Assistant, 50% of the FWAs and 20% of the FPAs. About 70% of the FPAs and more than 80% of the FWAs did not have any opinion (Table B-6).

This shows that majority of the staff do not have any idea if these services are at all utilized by the community. Most of them are ignorant of the types of services on child care provided in these clinics.

Purpose of field visits by the field workers :

TFPO :

Majority of the TFPOs mentioned, supervision as the most important purpose of field visit. The other purposes were sterilization camp, follow up of clients and meet local leaders (Table B-7)

Medical Assistants :

Out of 5 Medical Assistants, 3 did not make any field visit, while 2 visited for follow up of clients (Table B-7).

FWVs (6) :

Majority. (2 in each case) made field visit for follow up of clients and MCH care, while others mentioned about sterilization camp, check up of pregnant mothers, motivation on nutrition and healthful living as the purpose of field visits (one in each case). One did not make any home visits (Table B-7).

FPAs :

They made field visits for supervision (5), follow up of clients (2) motivation (5) and check up of couple registration card (2) (Table B-7).

FWAs :

Majority (7) mentioned that they made field visits for supply of contraceptives, 6 mentioned motivation, 1 went for MCH care and 4 for home visits and other causes (Table B-7)

Number of days spent for field visits in a month :

TFPOs generallyly make field visit for about 15 days a month FWVs 8-12 days and FPAs and FWAs at least 20 days a month. MAs generallyly do not make field visits (Table B-8).

Opinion of field workers on obstacles in utilization of MCH services :

The majority (32.43%) of the staff considered inadequate supply of medicine as a great obstacle in utilization of MCH services, while 19.82% considered long distance to travel as hindrance 8.11% considered lack of motivation and 5.41% (in each case) opening and closing time of clinics as obstacles in utilization of MCH services. A great majority (48.65%) of the staff did not have opinion (Table B-9).

Facility needed to improve MCH services :

Majority, 62.1% of the staff mentioned adequate supply of medicine for improvement of MCH services, while 24.32% mentioned provision of child food (milk), 18.92% mentioned provision of beds in centres and 13.51% mentioned supply of vitamins for improvement in utilization of MCH services (Table B-10a).

The field workers also mentioned for few facilities to workers as measures for improvement of MCH services. The major recommendation were supply of umbrella and bag (27.3%), transport (16.22%) increase in number of staff (8.11%), TA for training and house rent quarters (5.41%) each.

About 21.66% of the field workers mentioned that proper counselling of the staff and motivation through group discussion etc. will improve the attendance of clients for MCH care (Table 10b).

Contraceptive use status :

The current users contraceptives were 16.33% and ever users were 29.5%. Among the current users, 38.78% were using oral pills, 36.73% have undergone ligation operation, 11.22% were using traditional methods, or herbal medicines 3.6% using IUD, 7.14% using safe period, 1.2% using condom and husbands of 1.02% respondents have undergone vasectomy operation (Table 21a & 22a).

MCH unit at THC :

Current users of contraceptives were 20% and ever users 33.83%. Of the current users of methods, 54.17% are using oral pill, 8.33% condoms, 22.5% have nnder-

gone ligation operations, 5.83% using traditional methods, or herbal medicine 5% safe period, 2.5% Emko/Foam and husbands of 1.67% respondents have undergone a vasectomy operation (Table 21b and 22b).

MCWC :

The current users of contraceptives were 34.83% and ever users were 50.66%. Of the current users, 55.02% were using oral pills, 6.83% condoms, 12.44% have undergone ligation operation, 6.22% safe period, 2.39% traditional methods or herbal medicine, 0.17 are using Injection and husbands of 0.96% of respondents have undergone vasectomy operation (Table 21c and 22c).

It is observed that the number of contraceptive users increased by 60% from rural areas to urban areas. However, more than 40% of the users in all the areas have discontinued use of contraceptives. This needs an investigation to identify the cause of discontinuation and the level of dissatisfaction. The use of oral pill and ligation is high. Ligation is popular in rural areas and oral pill in urban areas, IUD is not being used in THC & MCWC area.

Duration of use of contraceptives by current users :

FWC/THC/MCWC :

About 40% of the current users in the three areas are using contraceptives for less than 6 months and more 35% are using for one year or more (Table 23)

Causes of discontinuation of use of contraceptives :

Those respondents who discontinued the use of contraceptives mentioned the following as causes of discontinuation.

FWC :

Major causes were, dizziness 31.65%, Menstrual problem 27.8 unwanted pregnancy 11.39%, improper use 8.86%, weakness 15.19% and wanted child 6.06% (Table 25a).

THC :

Major causes were dizziness 31.33%, Menstrual problems 28.92% unwanted pregnancy 12.05%, improper use 10.84% weakness 9.44% and wanted child 2.41% (Table 25b).

MCWC :

Major causes of discontinuation of contraceptives were dizziness 28.42%, weakness 20%, Menstrual problem 22.11%, unwanted pregnancy 12.63%, irregular use 9.47% and wanted child 7.37% (Table 25c).

Most of the causes mentioned for discontinuation of use of contraceptive could easily be prevented by proper counselling and regular visit to respondents as a measures of raising confident.

Source of supply methods to current users :

FWC :

The family planning workers supplied contraceptives to 19.33% of the current users, 15.31% bought these from the market and 4.63% obtained from centres. More than 18% obtained contraceptives from other sources (This includes kabiraj and self practice (Table 26a).

MCH unit at the THC :

The family planning workers supplied contraceptives to 31.67% of the current users, while 27.5% bought them from the market, 30% obtained these from the clinic/hospital, 5.83% from kabiraj and 5% self practiced method (Table 26b).

MCWC :

The family planning workers supplied contraceptives to 37.00% of the current users, while 31.1% bought from market 11.96% obtained from clinics/hospitals, 10.53% from voluntary organizations, 6.22% practice safe periods and 2.32% got these from kabiraj (Table 26c).

This shows that a fairly large majority of this respondents lived contraceptives from PC&FP Divisions supply source. A fair number practice traditional methods.

Causes of non use of contraceptives :

FWC :

Of the respondents who never used any contraceptives, 31.4% wanted more children, 17.26% mentioned that husbands did not like 17.26% were afraid of the side effects, 12.44% mentioned religion a factor, 8.04% were willing to use, 3.31% mentioned non-availability, while 5.2% had either recently delivered a baby or were pregnant (Table 27a).

THC :

In this area, 33·5% of the respondents wanted more children 11·08% mentioned that their husbands did not like it, 28·21% were afraid of side effects, 12·59% mentioned religion as a factor, 1·70% mentioned non availability, 14·52% were either pregnant or recent delivered a baby and 3·27% wanted to use method (Table 27b).

MCWC :

Major causes of non use of contraceptives were, wanted more children 27·03%, afraid of side effects 25·05%, religion as a factors 9·46%, recent child delivery or pregnancy 7·77% and non availability 2·03% (Table 27c).

From all the three areas it is evident that major causes of non use were wanted more children, afraid of side effects, husband did not like these and these were against religion. Very few mentioned non-availability of contraceptives and a few wanted to practice contraceptives.

6. Summary

Consumers :

1. Knowledge about MCH Services.

More than 90% of the respondents in MCWC and THC areas mentioned that these centres provide services for treatment of different diseases including treatment of pregnant women and children. This knowledge varied from 50-60% in the FWC areas. About 78% of the respondents in the FWC area and more than 95% of the respondents in the THC areas knew about availability of contraceptive services in these clinics. The knowledge on provision of MCH services was poor in all areas about it was markedly poor in the FWC areas.

2. Attitude towards Utilization of MCH Services :

In rural and semi urban areas more than 90% of the respondents did not want to be delivered in the MCH centres while this figure was around 72% in the urban areas (MCWC). The women in general mentioned that only problematic pregnancies or deliveries should be treated in MCH centres. A large portion of the respondents considered delivery at the MCH centres as matter of shame or were afraid of the clinic environment.

The majority of the respondents in all areas wanted to consult doctors (passed and not passed) for treatment of their diseases and consultation on pro-

blematic pregnancy and delivery. A fair number of the respondents wanted to visit Kabiraj/Hakims. However for routine check up of health of self and of babies or for delivery only a few desired to visit doctors. The women in urban (MCWC) areas were less conservative than their sisters in rural or semi urban areas.

3. Status on Clinic Visits :

The number of clinic visitors increased with the urbanization of the area where the MCH centres were located. More than 45% of the respondents in urban (MCWC) and semi urban areas (THC) visited the centres, compared to about 25% of the women of the rural areas (FWC).

Of the visitors to clinics, it was observed that more than 36% respondents in MCWC areas and 27% in THC areas did not visit the clinics last years although they may have before the last year.

Most of the visitors attended the centres for treatment of their disease or treatment of their children. Only a small fraction of the respondents visited for MCH care. The percentages of visitors for MCH services were more in urban areas than in the rural areas (FWC).

More than 50% of the respondents did not receive adequate supplies of medicine. Most of them had to buy most of the medicine from the market and some of them had to pay for medicines to the clinic staff.

Majority of the visitors of the MCH centres (40-60%) lived within a distance of one and one half miles from the centres.

The major causes of non visit to the MCH centre were lack of supply of sufficient medicines of different quality, misbehaviour of clinic persons, long distance to travel and long waiting time. The respondents were of the views that improvement in the supply of adequate quantity of quality medicines and proper behaviour of clinic personnel will improve upon the utilization of MCH services.

The visitors of the rural and semi urban centres were in their middle age having 3-4 children, compared to women of urban area who had 1-2 living children. The majority of the visitors were illiterate, but in urban area a fair number of the educated women visited the MCWC. Most of the visitors in the rural and semi urban areas were people in the low income group (monthly income less than Tk. 200) compared to the visitors of the urban area, who were in the lower middle income group (monthly income Tk. 600-800).

4. Contraceptives practice :

Current users of contraceptives in FWC area was 16.33%, in THC area it was 20% and in the MCWC area it was 34.83%. Those who discontinued use of contraceptives, did it for dizziness, Menstrual problems, weakness, unwanted pregnancy and desire for more children.

Major sources of supply of contraceptives were family planning field workers and clinics. A large majority bought these from market.

Those who did not use any contraceptives, mentioned desire for more children, afraid of side effect of contraceptives, disapproval of husbands and religion as important causes for no use.

5. Response of field workers :

Except the FWVs the knowledge of other field workers on MCH services facilities available in different MCH centres were very poor. The front level field workers (FWAs & FPAs) did not have concept of MCH or knowledge on type of services available on MCH care in different centres. The knowledge of Thana Officers were also vague. From the answers of different categories of workers it seems that no motivational work on MCH care or utilization of services are provided by the field workers. Almost all the field workers though provided with the job description, are ignorant about their roles. This was mostly due to lack of interest. The knowledge of were poor so far MCH concerned. Further, their role as community health workers was not perceived by them. They considered their role more or less like a M.B ,B.S. doctor of Thana Health Complex. The FPAs behave more as a supervisor than a support worker of the FWAs The concept of field supervision is not very clear with the Thana Family planning Officer.

Like the response of the community respondents the field workers of the view that good quality medicine with adequate supply will help in improvement of MCH service delivery system.

7. Discussion on Programme Implication :

Non-utilization of MCH services relates to lack of knowledge on availability of services, indifferent attitudes of self and family members on delivery of babies at centres and values on positive health. Inadequate supply of medicine and its poor quality, ill behaviour of clinic personnel, distances to travel, long waiting time and lack of trained doctors were also some of the important factors in non utilization of MCH services.

The lack of understanding and knowledge of the field workers on MCH service delivery and on the concept of MCH are important factors in management of the centres and motivational work on the MCH service delivery system. It is more true for the grassroot level workers who are responsible for all sorts of motivational work on MCH, nutrition and healthfull living.

It was observed that more than 40% of the respondents discontinued the use of contraceptives. The major reasons were side effects, wanted child and irregularity in use. The respondents who did not use any method, majority mentioned about disapproval of husband in use of contraceptives and they were concerned about the side effects arising out of the use of contraceptives.

Of the 40% discontinued users, majority who mentioned about side effects as the cause of discontinuation mentioned dizziness, weakness, irregularity in bleeding etc. All these related to lack of motivation, proper counselling and follow-up of clients. The programme does not have sufficient personnel for motivation to the husband.

As in the case of Narangwal study it was also observed in this study that major causes of non utilization of services were, in effective rather than unavailability or in accessibility of services.

Continuous training of field workers with effective supervision is expected to help in attitude change of the field workers leading to improvement of motivational work and efficient implementation of programme. A well designed programme with input of family health education, community participation, home visits, regular opening and closing of centres and adequate quantity of good medicine may help in improvement of the utilization of MCH services. Introduction of the services of trained Birth Attendant and inclusion of tetanus toxoid in the programme is expected to reduce maternal & infant morbidity and mortality which may bridge over the credibility gap between entrepreneur and consumers leading to better utilization of MCH services and improved acceptance of contraceptives.

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List of Abbreviation

1. FWC	Family Welfare Centre
2. MCH	Maternal Child Health.
3. THC	Thana Health Complex.
4. MCWC	Maternal Child Welfare Centre.
5. TFPO	Thana Family Planning Officer.
6. M.A.	Medical Assistant.
7. FWV	Family Welfare Visitor.
8. FPA	Family Planning Assistant.
9. FWA	Family Welfare Assistant.
10. TBA	Traditional Birth Attendant.

Notes

1. Passed Doctor.	A qualified doctor (MB/MBBS/LMF)
2. Village doctor	A non-qualified village practioner.
3. Dai	A non-qualified village women who assists FWV/FWA in delivery cases and family planning activities.
4. Hakim/Kabiraj	A village quack who uses herbal Medicines for treatment.
5. Moulavi	A religious leader who uses religious verses and prescribes tabij/water etc. for treatment.
6. Ujha	A village hermit who use own methods based on religious verses as well as local verses for treatment.

**Tables on Socio-Economic & Demographic Characteristics of
the Respondents**

Table—1 (a)
Distribution of Respondents by Age

Age	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Age (in year)	23	28	22
15-19	(3·83)	(4·67)	(3·67)
20-24	145 (24·17)	125 (20·83)	182 (30·33)
25-29	180 (30·00)	197 (32·83)	194 (32·33)
30-34	142 (23·67)	146 (24·33)	126 (21·00)
35-39	92 (15·33)	94 (15·67)	74 (12·33)
40-44	18 (3·00)	10 (1·67)	2 (0·33)
Median	27·94	27·99	27·00

Table—1 (b)
Distribution of Respondents by Education

Educational Level.	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Illiterate	425 (70·83)	366 (61·00)	236 (39·33)
Upto Primary	130 (21·67)	176 (29·33)	166 (27·67)
High School	43 (7·17)	55 (9·33)	186 (31·00)
College	2 (0·33)	2 (0·33)	6 (1·00)
University	—	—	6 (1·00)

Table—1 (c)
Distribution of Respondents' Husband by Education

Educational Level of Husband	H U S B A N D S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Illiterate	257 (42.83)	242 (40.33)	136 (22.67)
Upto Primary	162 (27.00)	146 (24.33)	124 (20.67)
High School	138 (23.00)	170 (28.33)	184 (30.67)
College	24 (4.00)	26 (4.33)	94 (15.67)
University	19 (3.17)	12 (2.00)	68 (10.00)
Madrasha	— (0.33)	5 (0.83)	2 (0.33)

Table—1 (d)
Distribution of Respondents' Husband's by Occupation

Occupation of Husband	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Cultivator	209 (34.83)	193 (32.17)	6 (1.00)
Land Less Cultivator	12 (2.00)	19 (3.17)	—
Day Labourer	119 (12.83)	98 (16.33)	72 (12.00)
Skilled Labour	29 (4.83)	42 (7.00)	48 (8.00)
Business	153 (25.5)	149 (24.83)	228 (38.00)
Service	75 (12.5)	91 (15.17)	238 (39.67)
Others	8 (0.5)	8 (1.33)	3 (0.5)

Table—1 (e)
Distribution of Respondents by Land Holding of the Family

Land Holding of the Family	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Land Less	221 (76·83)	229 (38·17)	460 (76·67)
Below 100	193 (23·17)	148 (24·67)	60 (10·00)
100-200	93 (23·17)	101 (16·83)	38 (6·33)
200-300	45 (7·5)	41 (6·83)	14 (2·33)
300-400	34 (5·67)	30 (5·00)	6 (1·00)
400-500	16 (2·67)	20 (3·33)	8 (1·33)
500-600	13 (2·16)	3 (0·5)	8 (1·33)
600-& above	39 (6·5)	28 (4·67)	6 (1·00)

Table— (f)
Distribution of Respondents by Monthly Income of the Family

Family Monthly In come (in taka)	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Upto 200	43 (7·17)	60 (10·00)	42 (2·00)
201-400	229 (38·17)	196 (32·67)	126 (21·00)
401-600	158 (26·33)	165 (27·5)	156 (26·00)
601-800	70 (11·67)	79 (13·17)	96 (16·00)
801—1000	59 (9·83)	49 (8·17)	108 (18·00)
1001-2000	32 (5·33)	35 (5·83)	68 (11·33)
2001-3000	5 (0·83)	7 (1·17)	18 (3·00)
3001-5000	4 (0·67)	9 (1·50)	14 (2·33)
5001 & above	—	1 (0·16)	2 (0·33)

Table-1 (g)
Distribution of Respondents by No. of Live Births

No. of Live Births	RESPONDENTS		
	FWC (a) N=600	THC (c) N=600	MCWC (c) N=600
1-2	142 (23·67)	158 (26·33)	184 (30·66)
3-4	212 (35·33)	196 (33·17)	220 (30·67)
5-6	122 (20·33)	128 (21·33)	142 (23·67)
7-8	85 (14·17)	72 (12·00)	42 (7·00)
9- & above	39 (6·50)	46 (7·67)	12 (2·00)
Median	3·73	3·73	3·53

Table-1 (h)
Distribution of Respondents by No. of Living Children

No. of Living	RESPONDENTS		
	FWC (a) N=6000	THC (b) (N=600)	MCWC (c) N=600
1-2	186 (31·00)	207 (34·5)	208 (34·67)
3-4	223 (37·17)	199 (33·17)	224 (37·33)
5-6	115 (19·17)	124 (20·67)	128 (21·33)
7-8	62 (10·00)	49 (8·16)	36 (6·00)
9- & above	14 (0·33)	21 (3·5)	4 (0·67)
Median	3·51	3·47	3·41

Table—1 (i)

Distribution of Respondents by No. of Pregnancy

No. of Pregnancy.	R E S P O N D E N T S		
	FWC (a) N—600	THC (c) N—600	MCWC (c) N—600
1-2	129 (21·5)	141 (23·50)	140 (23·33)
3-4	207 (34·5)	198 (33·00)	230 (38·33)
5-6	131 (21·83)	138 (23·00)	136 (22·67)
7-8	81 (13·5)	70 (11·67)	52 (0·67)
9-10	35 (5·83)	35 (5·83)	28 (4·67)
11 & more	17 (2·83)	18 (3·00)	14 (2·35)
Median	3·83	3·81	3·70

Table—2

Distribution of Respondents by Worriedness About Her Pregnancy Even in Good Health

Worriedness	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Feel worried	469 (78·17)	439 (73·17)	450 (75·00)
Not feel worried	125 (20·83)	153 (25·50)	139 (23·17)
Don't know	6 (1·00)	8 (1·33)	11 (1·83)
Total	600 (100·00)	600 (100·00)	600 (100·00)

Table—3 (a)

**Distribution o. Respondents By Worriedness About Her
Pregnancy and Measures Taken to Keep Good Health Even
In Good Health
(FWC)**

Worriedness	MEASURES TAKEN							Total
	Do nothing	Take Good food	Use medicine	Consult passed Doctor	Consult Hakim/ Kabiraj	Visit Ujha/ Moulvis	Other Ujha/ Moulvi	
Worriedness	313 (66·73)	56 (11·94)	53 (11·30)	26 (5·54)	8 (1·71)	4 (0·85)	9 (1·92)	469 (100·00)
Not feel worried	112 (89·5)	5 (4·0)	4 (3·2)	1 (0·8)	2 (1·6)	—	4 (0·8)	125 (100·00)
Don't Know	5 (83·33)	—	—	—	—	1 (16·67)	—	6
Total	430 (71·67)	61 (10·17)	57 (9·5)	27 (4·5)	10 (1·67)	5 (0·83)	10 (1·67)	600 (100·00)

Table—3 (b)

**Distribution Of Respondents By Worriedness About Her Pregnancy And
Measures Taken To Keep Good Health Even In Good Health (THC)**

Worriedness	MEASURES TAKEN							Total
	Do nothing	Take Good food	Use medicine	Consult passed Doctor	Consult Hakim/ Kabiraj	Visit Ujha/ Moulvi	Others	
Feel worried	289 (65·83)	48 (10·93)	69 (15·72)	19 (4·33)	5 (1·14)	7 (1·59)	2 (0·46)	439 (100·00)
Not feel worried	129 (84·31)	6 (3·92)	9 (5·88)	4 (2·61)	3 (1·96)	2 (1·31)	—	153 (100·00)
Don't know	7 (87·5)	—	1 (2·5)	—	—	—	—	8 (100·00)
Total	424 (70·83)	54 (9·00)	79 (13·17)	23 (3·83)	8 (1·33)	9 (1·50)	2 (0·34)	600 (100·00)

Table—3 (c)

**Distribution Of Respondents By Worriedness About Her Pregnancy
and Measures Taken To Keep Good Health Even In Good Health
(MCWC)**

Worriedness	M E A S U R E S							Total
	Do nothing	Take Good food	Use Medicine	Consult passed Doctor	Consult Hakim Kabiraj	Visit Ujha/Moulivi	Others	
Feel	228	54	88	70	—	3	7	450
Worried	(50·67)	(12·00)	(19·56)	(15·56)	—	(0·67)	(1·56)	(100·00)
Not feel	71	34	24	10	—	—	—	139
Worried	(51·08)	(24·46)	(17·27)	(7·19)	—	—	—	(100·00)
Don't know	4	2	2	—	3	—	—	11
	(36·36)	(18·18)	(18·18)	—	(27·28)	—	—	(100·00)
Total	303	90	114	80	3	3	7	600
	(50·5)	(15·0)	(19·0)	(13·33)	(0·5)	(0·5)	(1·17)	

Table—4

**Distribution Of Respondents By The Opinion As To When A Pregnant Mother
should go to a Doctor/Trained Persons for Her Problems Related To Pregnancies**

Opinion	FWC (a)	THC (b)	MCWC (c)
With mild problem	293	349	299
	(48·83)	(58·12)	(49·83)
With severe problem	228	142	156
	(38·00)	(23·67)	(26·00)
With no problem	66	90	140
	(11·00)	(15·00)	(23·34)
Don't know	13	19	5
	(2·17)	(3·16)	(0·83)
Total	600	600	600
	(100·00)	(100·00)	(100·00)

Table—5
**Distribution Of The Respondents By The Opinion On The
 Causes Of Death Of The Mother During Pregnancies**

Causes of Death	FWC (a)	THC (b)	MCWC (c)
Different diseases	196 (23·67)	132 (22·00)	176 (29·33)
Difficulties related to pregnancy	184 (30·67)	214 (35·67)	167 (27·83)
Weakness	74 (12·33)	99 (16·50)	103 (17·17)
Husband/Family members' torture	9 (1·85)	22 (3·67)	10 (1·67)
For evil eye	71 (11·83)	50 (8·33)	52 (8·67)
God knows	25 (4·17)	31 (5·17)	13 (2·17)
Don't know	41 (6·83)	49 (8·17)	60 (10·00)
Others	—	3 (0·50)	19 (3·16)
Total	600 (100·00)	600 (100·00)	600 (100·00)

Table—6

**Distribution Of The Respondents By Opinion To Consult Doctor/
 Trained Person For Regular Check Up Of Lactating Mothers.**

Opinion	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Positive opinion	305 (50·83)	363 (60·50)	380 (63·33)
Negative opinion	295 (49·19)	237 (39·50)	220 (36·67)
Total	600 (100·00)	600 (100·00)	600 (100·00)

Table—7

**Distribution Of Respondents By Opinion To Consult Doctor /
Trained Person For Regular Check Up Of Her Child.**

Opinion	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Good Practice	392 (65·33)	450 (75·00)	458 (76·33)
Bad Practice	288 (34·67)	150 (25·0)	242 (23·67)
Total	600 (100·00)	600 (100·00)	600 (100·00)

Table—8

**Distribution Of Respondents By Opinion To Consult Doctor /
Trained Person For Regular Check Up Of Health Of Lactating
Women By Their Visit To Doctor/ Trained Person.**

	R E S P O N D E N T S					
	FWC (a)		THC (a)	MCWC (c)		
Visiting Status	+ive opinion	-ive opinion	+ive opinion	-ive opinion	+ive opinion	-ive opinion
Visited	15 (4·92)	-	43 (11·45)	-	58 (15·26)	-
Not visited	290 (95·08)	295 (100·00)	320 (88·15)	237 (100·00)	322 (84·74)	220 (100·00)
	305 (100·00)	295 (100·00)	365 (100·00)	237 (100·00)	380 (100·00)	220 (100·00)

Table—9

Distribution Of Respondents By Opinion To Consult Doctor/Trained Person For Regular Check Up Of Her Child By Their Visiting To Doctor/Trained Person

Visiting Status	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Good Practice	Bad Practice	Good Practice	Bad Practice	Good Practice	Bad Practice
Visited	36 (7·86)	—	46 (10·22)	—	11 (2·81)	—
Not Visited	422 (92·14)	142 (100·00)	404 (89·78)	150 (100·00)	381 (97·19)	208 (100·00)
Total	458 (100·00)	142 (100·00)	450 (100·00)	150 (100·00)	392 (100·00)	208 (100·00)

Table—10

Distribution Of Respondents By Type Of Persons They Seek Permission For Consultation To Doctor/Trained Person In Ill Health

Consulting Person	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Husband	540 (90·00)	539 (89·83)	511 (85·17)
Father in law	6 (1·00)	17 (2·83)	12 (2·00)
Mother in law	18 (3·00)	24 (4·00)	28 (4·67)
Husband & Father in law	4 (0·67)	2 (0·33)	2 (0·33)
Husband & Mother in law	30 (5·00)	15 (2·5)	42 (7·00)
Father in law & Mother in law	2 (0·33)	3 (0·5)	5 (0·83)
Total	600 (100·00)	600 (100·00)	600 (100·00)

TABLE—11
Distribution Of The Respondents By The Attitude Of Their Family
Members On Consultation To Doctor / Trained Persons During Ill Health.

Family member	FWC (a)			THC (b)			MCWC (c)		
	+ive attitude	-ive attitude	dead	+ive attitude	-ive attitude	dead	+ive attitude	-ive attitude	dead
Mother in law	323 (53·3)	42 (7·00)	235 (39·17)	332 (55·33)	30 (5·00)	238 (39·67)	278 (46·33)	68 (11·33)	254 (42·34)
Father in law	172 (28·67)	28 (4·67)	400 (66·66)	171 (28·50)	24 (4·00)	405 (67·50)	194 (32·33)	23 (3·83)	383 (63·84)
Husband	548 (91·33)	52 (8·67)	—	570 (95·00)	30 (5·00)	—	571 (95·17)	29 (4·83)	—
Close relative	513 (90·17)	95 (9·83)	—	566 (94·33)	34 (5·67)	—	552 (92·00)	48 (8·00)	—

TABLE—12

**Distribution Of Respondents By Persons With Whom They Consulted During Last Three
Pregnancy Periods.**

Consulted Person	R E S P O N D E N T S								
	Last Pregnancy			Last but Pregnancy			Last but two Pregnancy		
	MCWC (c)	THC (b)	FWC (a)	MCWC (c)	THC (b)	FWC (a)	MCWC (c)	THC (b)	FWC (a)
Passed Doctor	178 (29·67)	50 (8·33)	50 (8·33)	120 (20·69)	27 (4·68)	30 (5·08)	79 (17·21)	18 (3·79)	15 (3·09)
Dai/TBA	2 (0·33)	2 (0·33)	2 (0·33)	2 (0·52)	2 (0·35)	2 (0·34)	1 (0·22)	2 (0·42)	-
Village doctor	15 (2·5)	25 (4·17)	30 (5·00)	9 (1·55)	20 (3·47)	22 (3·73)	11 (2·40)	20 (4·21)	19 (3·91)
Kabiraj/Hakim	3 (0·5)	7 (1·17)	12 (2·00)	4 (0·69)	11 (1·91)	9 (1·52)	3 (0·65)	5 (10·5)	6 (1·24)
Ojha/Moulavi	2 (0·33)	3 (0·5)	1 (0·17)	2 (0·34)	5 (0·87)	2 (0·34)	1 (0·22)	2 (0·42)	2 (0·42)
Others	7 (1·17)	15 (2·5)	9 (2·5)	10 (1·72)	7 (1·21)	4 (0·68)	9 (1·96)	7 (1·47)	4 (0·82)
Not consulted	393 (65·5)	498 (83·0)	496 (82·67)	432 (74·48)	505 (87·52)	521 (88·31)	355 (77·34)	421 (88·63)	439 (90·52)
	600 (100·00)	600 (100·00)	600 (100·00)	580 (100·00)	577 (100·00)	590 (100·00)	459 (100·00)	475 (100·00)	485 (100·00)

Table—13

Distribution Of Respondents By Persons Who Delivered Their Babies In Last Three Pregnancies

Delivered	R E S P O N D E N T S								
	Last Pregnancy			Last but one pregnancy			Last but two pregnancy		
	MCWC (c)	THC (b)	FWC (a)	MCWC (c)	THC (b)	FWC (a)	MCWC (c)	THC (b)	FWC (a)
DAI/TBA	352 (58·67)	257 (42·83)	283 (47·17)	346 (59·66)	225 (38·99)	252 (42·71)	243 (52·94)	153 (32·21)	171 (35·26)
Passed doctor	138 (23·00)	11 (1·83)	12 (2·00)	111 (19·14)	12 (2·08)	10 (1·67)	67 (14·60)	4 (0·84)	6 (1·24)
Village doctor	4 (0·67)	—	2 (0·33)	6 (1·03)	1 (0·17)	3 (0·51)	9 (1·96)	—	—
Relatives/ Neighbours	104 (17·33)	318 (53·00)	282 (47·00)	114 (19·66)	329 (57·02)	310 (51·67)	135 (29·41)	309 (65·05)	292 (60·20)
Alone	2 (0·33)	14 (2·33)	21 (3·5)	3 (0·52)	10 (1·73)	15 (2·54)	5 (1·09)	9 (1·89)	16 (3·30)
Total	600 (100·00)	600 (100·00)	600 (100·00)	580 (100·00)	577 (100·00)	590 (100·00)	459 (100·00)	475 (100·00)	485 (100·00)

Table—14
Distribution Of Respondents By Places Of Delivery In Last Three Pregnancy Period

R E S P O N D E N T S									
Place	Last Pregnancy			Last but one pregnancy			Last but two pregnancy		
	MCWC (c)	THC (b)	FWC (a)	MCWC (c)	THC (b)	FWC (a)	MCWC (c)	THC (b)	FWC (a)
Own home	428 (71·33)	527 (87·83)	539 (89·83)	438 (75·51)	483 (75·90)	419 (83·22)	324 (70·59)	325 (68·42)	338 (69·69)
Father's home	40 (6·67)	71 (11·84)	54 (9·00)	44 (7·59)	133 (23·05)	95 (16·10)	89 (19·39)	144 (30·32)	144 (29·69)
Clinic	34 (5·67)	—	4 (0·67)	18 (3·10)	1 (0·17)	2 (0·34)	5 (1·09)	2 (0·42)	1 (0·21)
Hospital	56 (9·33)	2 (0·33)	3 (0·5)	52 (8·97)	5 (0·87)	2 (0·34)	26 (5·66)	4 (0·84)	2 (0·42)
MCH Centre	42 (7·00)	—	—	28 (4·83)	—	—	15 (3·27)	—	—
Total	600 (100·00)	600 (100·00)	600 (100·00)	580 (100·00)	577 (100·00)	590 (100·00)	459 (100·00)	475 (100·00)	485 (100·00)

(65)

Table—15
**Distribution of Respondents By Willingness To Visit MCH
Centres For Next Delivery If All The Facilities For Delivery Provided**

Willingness	RESPONDENTS		
	MCWC (c)	THC (b)	FWC (a)
Willing to visit	164 (27·33)	56 (9·33)	48 (8·00)
Not Willing to visit	436 (72·67)	544 (90·67)	552 (92·00)
Total	600 (100·00)	600 (100·00)	600 (100·00)

Table—16
**Distribution Of Respondents By Causes Of Not Visiting The
Clinics For Next Delivery If All Facilities Of Delivery Provided.**

Causes	RESPONDENTS		
	MCWC (c)	THC (b)	FWC (a)
Own home is better	95 (21·79)	104 (19·11)	46 (8·33)
Don't like	9 (11·24)	72 (13·24)	127 (23·80)
Want money	22 (5·05)	16 (2·94)	11 (1·99)
Without difficulties not Willing go to	128 (27·02)	147 (27·02)	196 (35·51)
Matter of shame/afraid	58 (13·30)	108 (19·85)	82 (14·86)
Ligated/don't want child	63 (12·87)	70 (12·87)	50 (9·06)
Don't know/God knows	21 (4·82)	27 (4·96)	40 (7·25)
Total	436 (100·00)	544 (100·00)	552 (100·00)

Table—17
**Distribution Of Respondents By Attitude Of Family Members' to Visit The
Hospital Clinic For Delivery**

Family Members	MCWC (c) (N=600)				THC (b) (N=600)				FWC (a) (N=600)			
	+ive attitude	—ive attitude	Don't know	Dead	+ive attitude	—ive attitude	Don't know	Dead	+ive attitude	—ive attitude	Don't know	Dead
Husband	308 (51·3)	288 (48·0)	4 (0·67)	—	106 (17·7)	489 (81·5)	5 (0·8)	—	96 (19·0)	498 (83·0)	6 (1·0)	—
Father in law	67 (11·2)	145 (21·2)	5 (0·8)	383 (68·8)	22 (3·7)	166 (27·7)	7 (1·2)	405 (67·5)	12 (2·0)	196 (32·7)	4 (0·7)	388 (64·7)
Mother in law	95 (15·8)	245 (40·8)	6 (1·0)	245 (40·8)	34 (5·7)	319 (53·2)	9 (1·5)	238 (39·7)	28 (4·7)	331 (55·7)	1 (0·2)	240 (40·0)
Close relatives	231 (38·5)	349 (58·2)	20 (3·3)	—	94 (15·7)	585 (80·8)	21 (3·5)	—	73 (12·2)	519 (86·2)	8 (1·3)	—

(67)

Table—18
**Distribution (f Respondents By Type of Persons Consulted
 For Treatment Of General Illness.**

Persons Consulted	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (c) N=600
Passed doctor	112 (18.67)	256 (41.67)	414 (69.0)
Hakim/Kabiraj	13 (2.17)	7 (1.17)	5 (0.83)
Dai/TBA	—	—	—
Relatives/Neighbours	38 (6.33)	35 (5.83)	25 (4.17)
Ujha/Moulovi	3 (0.5)	8 (1.33)	6 (1.00)
Village doctor	428 (71.33)	292 (48.67)	109 (18.17)
Nobody	6 (1.00)	8 (1.33)	6 (1.00)
Others	—	—	36 (6.00)

Table—19
**Distribution of Respondents By Type Of Persons Desired To
 Consult At The Time Of Problematic Delivery (If Arise) :**

Consulting Persons	R E S P O N D E N T S		
	FWC (a) N=600	THC (b) N=600	MCWC (a) N=600
Passed doctor	326 (60.33)	414 (69.00)	518 (86.33)
Hakim/Kabiraj	6 (10.00)	27 (4.50)	10 (1.67)
Dai/TBA	56 (9.33)	47 (7.83)	18 (3.00)
Relatives/neighbours	31 (5.17)	4 (7.33)	14 (2.33)
Ujha/Moulovi	21 (3.5)	23 (3.83)	22 (3.67)
Village doctor	70 (11.67)	45 (7.50)	12 (2.00)
Others	—	—	6 (100.00)

Table—20 (a)

**Distribution of Respondents by Persons Consulted at the time
of General Disease and Problematic Delivery (FWC)**

General Disease	PROBLEMATIC DELIVERY							Total
	Passed Doctor	Hakim/ Kabiraj	Dai/ TBA	Relatives/ Neighbours	Ujha/ Moulvi	Village Doctor	No- body	
Passed doctor	94 (48·45)	7	6	2	1	2	—	112
Hakim/Kabiraj	—	8 (4·12)	2	2	—	1	—	13
Dai/TBA	—	—	—	—	—	—	—	—
Relatives/ Neighbours	6	6	2	21 (10·82)	—	3	—	—
Ujha/Moulvi	1	—	—	1	1 (0·52)	—	—	3
Village Doctor	260	39	43	4	18	64 (33·99)	—	428
Nobody	1	—	3	1	1	—	—	6
Total	326	60	56	31	21	70	—	600 (32·33)

* Out of 600 Respondents only 194 desired to visit consulting persons for advice and Treatments of Problematic Delivery and Different Diseases.

Table—20 (b)

**Distribution Of Respondents By Persons Consulted At The Time
Of General Disease And Problematic Delivery (THC)**

General Disease	PROBLAMATIC DELIVERY							Total
	Passed doctor	Hakim/ Kabiraj	Dai/ TBA	Refatives/ Neighbours	Ujha/ Moulovi	Village Doctor	No- body	
Passed doctor	220 (78·01)	3	9	4	7	7	2	250
Hakim/Kabiraj	2	2 (0·71)	1	—	1	1	—	7
Dai/TBA	—	—	—	—	—	—	—	—
Relatives/ Neighbours	10	2	1	22 (7·80)	—	—	—	35
Ujha/Moulovi	1	—	1	5	1 (0·35)	—	—	8
Village Doctor	179	20	34	9	13	37 (13·12)	—	292
Nobody	2	—	1	4	1	—	—	8
Total	414	27	47	44	23	45	—	600 (47·00)

* Out of 600 respondents only 282 desired to visit consulting persons for advice and treatments of problematic delivery and different diseases.

Table — 20 (c)

**Distribution Of Respondents By Persons Consulted At The Time Of
General Disease And Problematic Delivery (MCWC)**

General Disease	PROBLEMATIC DELIVERY							Other	Total
	Passed doctor	Hakim Kabiraj	Dai/TBA	Relatives/ Neighbours	Ujha/ Moulovi	Village doctor			
Passed Doctor	394 (97.77)	—	2	6	10	2	—	414	
Hakim/Kabiraj	2	—	2	—	—	—	1	5	
Dai/TBA	—	—	—	—	—	—	—	—	
Realitives/Neighbours	2	2	14	4 (0.99)	2	—	1	25	
Ujha/Moulovi	4	1	—	—	—	1	—	6	
Village Doctor	90	7	—	4	2	3 (0.74)	2	109	
Nobody	4	—	—	—	2	—	—	6	
Other	22	—	—	—	6	6	2 (0.49)	36	
	518	10	18	14	22	12	6	600* (67.17)	

* Out of 600 respondents only 403 desired to visit consulting per for advice and Treatments of problematic delivery and different disease.

Table—21

Distribution of Respondents by Contraceptive use Status

Contraceptive use Status	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Current user	98 (16·33)	102 (20·0)	209 (34·83)
Past user	79 (13·17)	83 (13·83)	95 (15·83)
Never user	423 (70·5)	397 (66·17)	296 (49·33)
Total	600 (100·00)	600 (100·00)	600 (100·00)

Table—22

Distribution of Current Contraceptive users by Methods.

Methods	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Pill	38 (38·78)	65 (54·17)	155 (55·02)
Condom	1 (1·02)	10 (8·33)	41 (6·83)
Coil/IUD	3 (1·02)	—	—
Vasectomy	1 (1·02)	2 (1·67)	2 (0·96)
Ligation	36 (36·73)	27 (22·33)	26 (12·44)
Injection	—	—	1 (0·17)
Emko/Foam	1 (1·02)	3 (2·5)	6 (2·86)
Safe Period	7 (7·14)	6 (5·0)	13 (6·22)
Kabiraj/Herbal Medicine	11 (11·22)	7 (5·83)	5 (2·39)
Total	209 (100·00)	120 (100·00)	98 (100·00)

Table—23

Distribution Of Contraceptive Users By Period Of Using Contraceptive Method

Period	U S E R S		
	FWC (a)	HC (b)	MCWC (c)
0-2 months	17 (17·35)	18 (15·0)	49 (23·44)
3-5 months	23 (23·47)	24 (20·0)	40 (19·14)
6-11 months	20 (20·41)	33 (27·5)	34 (16·27)
1- <u>2</u> year	21 (21·43)	24 (20·0)	46 (22·01)
2- <u>4</u> year	17 (17·35)	20 (16·67)	36 (17·22)
4 years & above	-	1 (0·83)	4 (1·91)
	98 (100·00)	120 (100·00)	209 (100·00)

Table—24 (a)

**Distribution Of Contraceptive Users By Contraceptive Methods
And Period Of Using (FWC)**

Methods	P E R I O D						Total
	0 - 2 months	3 - 5 months	6 - 11 months	1 - <u>2</u> years	2 - <u>4</u> years	4 years & above	
Pill	8 (21·05)	12 (31·58)	7 (18·42)	4 (10·53)	7 (18·42)	—	38
Condom	—	—	— (100·00)	—	—	—	1 (100·00)
Coil/IUD	1 (33·33)	1 (33·33)	1 (33·34)	—	—	—	3 (100·00)
Vasectomy	—	—	—	1 (100·00)	—	—	1 (100·00)
Ligation	5 (13·89)	5 (13·89)	7 (19·44)	12 (33·33)	7 (19·44)	—	36 (100·00)
Emko/Joy	—	1 (100·00)	—	—	—	—	1 (100·00)
Injection	—	—	—	—	—	—	—
Safe period	2 (28·57)	1 (14·29)	2 (28·57)	1 (14·29)	1 (14·29)	—	7 (100·00)
Kabiraji	1 (9·09)	3 (27·27)	2 (18·18)	3 (27·27)	2 (18·18)	—	11 (100·00)
Total	17 (17·35)	23 (23·47)	20 (20·41)	21 (21·42)	17 (17·35)	—	98 (100·00)

Table—24 (b)
**Distribution Of Contraceptive Users By Contraceptive Method
 And Period Of Use (THC)**

Method	P E R I O D						Total
	0—2 months	3—5 months	6—11 months	1—/2 years	2—/4 years	4 years & above	
Pill	12 (18·46)	15 (23·08)	19 (29·23)	10 (15·38)	8 (12·31)	1 (1·54)	65 (100·00)
Condom	1 (10·00)	2 (20·00)	4 (40·00)	3 (30·00)	—	—	40 (100·00)
Coil/IUD	—	—	—	—	—	—	—
Vasectomy	—	—	—	—	2 (100·00)	—	2 (100·00)
Ligation	4 (14·81)	2 (7·48)	6 (22·22)	9 (33·33)	6 (22·22)	—	27 (100·00)
Injection	—	—	—	—	—	—	—
Emko/Joy	—	—	1 (33·33)	1 (33·33)	1 (33·34)	—	3 (100·00)
Safe Period	1 (16·67)	2 (33·33)	1 (16·67)	—	2 (33·33)	—	6 (100·00)
Kabiraji	—	3 (42·86)	2 (28·57)	1 (14·29)	1 (14·29)	—	7 (100·00)
Total	18 (15·00)	24 (20·00)	33 (27·5)	24 (20·00)	20 (16·67)	1 (0·83)	120 (100·00)

Table—24 (c)
**Distribution Of Contraceptive Users By Contraceptive Method
 And Period Of Users (MCWC)**

Method	P E R I O D S						Total
	0—2 months	3—5 months	6—11 months	1—/2 years	2—/4 years	4 years & above	
Pill	24 (20·87)	27 (23·48)	18 (15·65)	26 (22·61)	18 (15·65)	2 (1·74)	115 (100·00)
Condom	14 (34·15)	10 (24·39)	3 (7·32)	8 (19·51)	5 (12·20)	1 (2·44)	41 (100·00)
Coil/IUD	—	—	—	—	—	—	—
Vasectomy	—	—	—	1 (50·00)	1 (500·00)	2	2 (100·00)
Ligation	3 (11·54)	1 (3·85)	9 (34·62)	5 (19·23)	7 (26·92)	1 (3·85)	26 (100·00)
Injection	1	—	—	—	—	—	1 (100·00)
Emko/Joy Foam	1 (16·67)	—	1 (16·66)	1 (16·67)	3 (50·00)	—	6 (100·00)
Safə Period	3 (23·08)	1 (7·67)	2 (15·38)	5 (38·46)	2 (15·38)	—	13 (100·00)
Kabiraji	3 (60·00)	1 (20·00)	1 (200·00)	—	—	—	5 (100·00)
Total	49 (23·44)	40 (19·14)	34 (16·27)	46 (22·01)	36 (17·21)	4 (1·91)	209 (100·00)

Table—25

**Distribution Of Past Contraceptive Users By Causes
Of Discontinuation.**

Causes Of Discontinuation	P A S T U S E R S		
	FWC (a)	THC (b)	MCWC (c)
Weakness	12 (15·19)	8 (9·64)	19 (20·00)
Dizziness	25 (31·65)	26 (31·33)	27 (28·42)
Menstrual irregufarty	22 (27·85)	24 (28·92)	21 (22·11)
Improper use	7 (8·86)	9 (10·84)	9 (9·47)
Un-wanted pregnancy	9 (11·39)	10 (13·05)	12 (12·63)
Want child	4 (5·06)	2 (2·41)	7 (7·37)
Others	—	4 (4·82)	—
	79 (100·00)	83 (100·00)	95 (100·00)

Table— 26

**Distribution Of Contraceptive Users By Source Of Supply
Of Contraceptives.**

Sources	U S E R S		
	FWC (a)	THC (b)	MCWC (c)
FP Workers	19 (19·39)	38 (31·67)	79 (37·80)
Market	15 (15·31)	33 (27·5)	65 (31·10)
Clinic/Hospital	64 (14·63)	36 (30·00)	25 (11·96)
Kabiraj	11	7 (5·83)	5 (2·39)
Vofuntary Org.	—	—	22 (10·53)
Self	7 (6·22)	6 (5·00)	13
	98 (100·00)	120 (100·00)	209 (100·00)

Table—27
Distribution Of Non Contraceptive Users By Causes

Causes	NON — U S E R S		
	FWC (a)	THC (b)	MCWC (c)
Want child	133 (31·44)	133 (33·5)	80 (27·03)
Husband does not like	73 (17·26)	44 (11·08)	37 (12·5)
Afraid of side effect	7 (17·26)	112 (28·21)	74 (25·0)
Religious belief	21 (12·44)	20 (12·59)	28 (9·46)
Weakness/other problems	21 (4·96)	20 (5·04)	25 (8·45)
Pregnant/Recently delivered	22 (5·20)	18 (4·53)	23 (7·77)
Willing to use	34 (8·04)	13 (3·27)	23 (7·77)
Not available	14 (3·31)	7 (1·76)	6 (2·03)
Total	423 (100·00)	397 (100·00)	296 (100·00)

Table—28
Distribution Of Respondents By Knowledge About Facilities Provided In The Centres.

Types of Facilities	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Known	Un-known	Known	Un-known	Known	Un-known
Treatment of different diseases	371 (61·83)	229 (38·17)	587 (97·83)	13 (2·17)	570 (95·00)	30 (5·00)
Advice/treatment of pregnant mother	209 (48·33)	310 (51·67)	547 (91·17)	53 (8·33)	506 (84·33)	94 (15·67)
Advise/treatment of children	368 (61·33)	232 (38·67)	568 (94·67)	32 (5·53)	536 (89·33)	64
Contraceptive services.	471 (78·50)	129 (21·50)	594 (99·00)	6 (1·00)	538 (89·67)	62 (10·33)

Table—29

Distribution Of Respondents By Number Of Visits In One Year (Last Year)

Number of visits	R E S P O N D E N T S		
	FWC (a) N = 600	THC (b) N = 600	MCWC (c) N = 600
All	151 (100·00)	273 (100·00)	272 (100·00)
1	72 (47·68)	82 (30·00)	104 (38·00)
2	43 (28·48)	70 (25·64)	50 (18·38)
3	31 (20·53)	43 (15·75)	16 (5·88)
4	3 (1·99)	11 (4·03)	4 (1·47)
5	—	3 (1·10)	—
6	2 (1·32)	2 (0·73)	—
Before one year	— (36·03)	62 (22·71)	49

TABLE—30
Distribution Of Visitors Of The Centres By The Purpose & Frequency of Visits

Purpose of Visit	V I S I T O R S								
	FWC (a)			THC (b)			MCWC (c)		
	1st visit	2nd visit	3rd visit	1st visit	2nd visit	3rd visit	1st visit	2nd visit	3rd visit
Treatment of different disease	55 (36·42)	30 (30·14)	9 (25·71)	82 (30·04)	39 (27·46)	13 (22·81)	68 (25·00)	10 (11·11)	8 (36·36)
Treatment related Pregnancy	6 (3·97)	1 (1·20)	—	21 (7·69)	12 (8·45)	7 (12·28)	42 (15·44)	2 (2·22)	—
Treatment for Children	85 (56·29)	52 (62·65)	26 (74·29)	143 (52·36)	80 (56·34)	35 (61·40)	102 (37·50)	62 (68·88)	12 (54·55)
Sterilization/Coil/Operation Stich outting	5 (1·85)	—	—	11 (4·03)	5 (3·52)	—	12 (4·41)	6 (6·67)	—
Treatment of relative	—	—	—	16 (5·86)	6 (4·22)	2 (3·51)	48 (17·65)	10 (1·21)	2 (9·09)
Total	151 (100·00)	83 (100·00)	35 (100·00)	273 (100·00)	142 (100·00)	57 (100·00)	272 (100·00)	90 (100·00)	22 (100·00)

(79)

Table--31 (a)

**Idea Of The FWC Visitors On Opening Time And Closing
Time Of FWC**

Opening time	C L O S I N G T I M E							Don't know	Total N=600
	12 Noon	1 p.m.	2 p.m.	3 p.m.	4 p.m.	5 p.m.			
8 A.M.	12	1	33	4	6	—	2	58	
9 A.M.	2	1	—	—	2	—	1	6	
10 A.M.	4	1	11	10	13	2	5	46	
11 A.M. & more	—	—	—	1	--	—	—	1	
Don't know	—	—	—	—	—	—	40	41	
Total	18	3	44	15	21	2	48	151	

Table — 31 (b)

**Knowledge Of The THC Visitors On Opening Time And
Closing Time Of The THC**

Opening time	C L O S I N G T I M E							don't know	Total N=600
	12 Noon	1 pm.	2 pm.	3 pm.	4 pm.	5 pm.			
8 A.M.	33	17	26	2	7	3	4	92	
9 A.M.	2	1	—	—	1	—	1	5	
10 A.M.	35	8	23	2	21	3	11	103	
11 A.M. & more	—	—	—	—	3	—	—	3	
Don't know	—	—	—	—	—	—	70	70	
Total	70	26	49	4	32	6	86	273	

Table—31 (c)

**Knowledge Of The MCH/Hospital Visitors By Opening Time
And Closing Time Of The MCH/Hospital (MCWC)**

Opening Time	C L O S I N G T I M E						Don't know	Total N=600
	12 noon	1 p.m.	2 p.m.	3 p.m.	4 p.m.	5 p.m.		
3 A.m.	14	—	16	2	2	10	6	50
9 A.M.	8	6	2	—	—	2	—	18
10 A.M.	12	6	20	—	16	22	8	84
11 A.M. & more	—	—	—	—	—	—	—	—
Don't know	—	—	—	—	—	—	120	120
Total	34	12	38	2	18	34	134	272

Table—32

Distance Of Centre From The Visitor's Home

Distance (in mile)	FWC (a)	THC (b)	MCWC (c)
Below 0.25	39 (25.83)	16 (5.86)	40 (14.71)
0.25 — 1.00	14 (9.27)	40 (14.65)	34 (12.5)
1.00 — 1.50	29 (19.21)	97 (35.53)	96 (25.29)
1.50 — 2.00	17 (11.26)	27 (9.89)	48 (17.65)
2.00 — 2.50	23 (21.19)	80 (29.30)	28 (10.29)
2.50 — 3.00	4 (2.65)	10 (3.66)	8 (2.94)
3.00 — 3.50	11 (7.28)	3 (1.10)	18 (6.61)
3.50 — above	—	—	5 (3.31)
Total	151 (100.00)	273 (100.00)	272 (100.00)

Table—33

**Distribution of Respondents By Their Responses If They Were
Supplied With Medicine Or Asked To Purchase From Outside**

Responses	RESPONDENTS		
	FWC (a)	THC (b)	MCWC (c)
Medicine Supplied	100 (66·23)	140 (51·28)	112 (41·18)
Partially Supplied and partially purchased	30 (19·87)	94 (34·43)	88 (32·35)
Asked to purchase	21 (13·90)	39 (14·29)	72 (26·47)
Total	151 (100·00)	273 (100·00)	272 (100·00)

Table—34

Number Of Visits Made For Medicines

Number of Visits	RESPONDENTS		
	FWC (a)	THC (b)	MCWC (c)
Visited 2/3 Times	81 (62·31)	140 (59·83)	112 (56·00)
One time	41 (31·54)	69 (29·49)	76 (38·00)
Visited more than three times	5 (3·85)	10 (6·27)	12 (6·00)
Others	3 (2·31)	15 (6·41)	— —
Total	130 (100·00)	234 (100·00)	200 (100·00)

Table—35

**Distribution Of Respondents By Their Idea About The
Quality Of Supplied Medicine :**

Idea	R E S P O N D E N T S		
	FWC (a)	THC (b)	MCWC (c)
Good	88 (67·69)	136 (58·12)	118 (59·00)
Bad	41 (31·54)	97 (41·45)	78 (39·00)
Don't know	1 (0·78)	1 (0·43)	4 (2·00)
Total	130 (100·00)	234 (100·00)	200 (100·00)

Table—36

**Distribution Of Respondents By Their Opinions As To
Why People Do Not Like To Visit Centres.**

Opinions	R E S P O N D E N T S		
	FWC (a) N=151	THC (b) N=273	MCWC (c) N=272
Long distance to travel	32 (21·19)	37 (13·55)	24 (8·82)
Opening/Closing time is not correct	26 (17·22)	28 (10·26)	18 (6·62)
Insufficient Medicine	52 (34·44)	117 (42·86)	112 (41·18)
Bad Medicine	67 (44·37)	123 (45·05)	154 (56·62)
Bad staff behaviour	22 (33·22)	52 (19·05)	72 (26·47)
Doctor's Non-attention	34 (22·52)	76 (27·84)	116 (42·65)
Demand money	37 (24·50)	90 (32·97)	76 (27·94)
Long waiting period	58 (38·41)	108 (39·56)	70 (25·74)
Don't know	35 (23·18)	28 (10·26)	58 (21·32)
Others	10 (6·62)	16 (5·86)	4 (1·47)

Table—37

**Distribution Of The Respondents By Their Opinion
To Improve Clinic Visits**

Opinion	R E S P O N D E N T S		
	FWC (a) N=151	THC (b) N=273	MCWC (c) N=272
Good medicine	75 (46.35)	155 (56.78)	102 (37.5)
Adequate supply of free medicine	75 (49.67)	150 (54.95)	136 (52.00)
Proper attention of clinic personnel	38 (25.17)	77 (28.21)	124 (45.59)
Good staff behaviour	22 (14.57)	66 (24.18)	80 (29.41)
Avoidance of waiting time	29 (17.21)	22 (8.06)	30 (11.03)
Timely opening	21 (13.90)	11 (4.03)	26 (9.56)
Don't know	24 (15.89)	21 (7.69)	68 (25.00)

Table—38

**Distribution Of Respondents By Opinion About Indoor Facilities Of MCH
Units At The THC & MCWC.**

Opinion	R E S P O N D E N T S	
	THC (b)	MCWC (c)
i. Food Free	10	42
On payment	—	1
No food	5	8
ii. Medicine		
Free supply	11	10
Supply on payment	1	2
Asked to purchase from outside	3	14
Some free/Some on payment	1	24
iii. Bed & Linens		
Clean	12	38
Dirty	4	8
No Bed (slept on floor)	—	4

Table—39(a)
Socio-Economic and Demographic Characteristics : By Visiting Status
Distribution Of Respondents By Age.

Age	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
15-19	21 (91·30)	2 (8·70)	8 (28·57)	20 (71·43)	2 (9·99)	20 (90·91)
20-24	32 (22·07)	113 (77·93)	48 (38·4)	7 (61·6)	68 (37·36)	114 (62·64)
25-29	48 (26·67)	132 (73·33)	85 (43·15)	112 (56·85)	78 (40·21)	116 (59·79)
30-34	42 (29·58)	100 (70·42)	80 (54·79)	66 (45·21)	74 (58·73)	52 (41·27)
35-39	25 (27·17)	67 (72·83)	46 (48·93)	48 (51·06)	50 (67·57)	24 (32·43)
40-44	2 (11·11)	16 (88·89)	6 (50·00)	4 (40·00)	—	2 (100·00)

Table—39(b)
Distribution Of Respondents By Education

Education Level	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
Illiterate	111 (26·12)	314 (73·88)	172 (46·99)	194 (53·01)	104 (44·07)	132 (55·93)
Upto Primary	33 (25·98)	97 (74·62)	83 (46·16)	93 (52·84)	84 (50·60)	82 (49·40)
High School	7 (16·28)	36 (83·72)	17 (30·36)	39 (69·98)	78 (41·94)	108 (58·06)
College	—	2 (100·00)	1 (50·00)	1 (50·00)	2 (33·33)	4 (66·67)
University	—	—	—	—	4 (66·67)	2 (33·33)

Table—39 (c)

Distribution Of Respondent's Husband By Education

Education level of husband	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
Illiterate	76 (29·57)	181 (70·43)	125 (51·65)	117 (48·35)	60 (44·12)	76 (55·88)
Upto primary	39 (24·07)	123 (75·93)	71 (48·63)	75 (51·37)	54 (43·55)	70 (56·45)
High school	27 (19·41)	111 (80·43)	69 (40·59)	101 (59·41)	86 (46·74)	98 (53·26)
College	5 (20·83)	19 (79·17)	7 (26·92)	19 (73·08)	50 (53·19)	44 (46·81)
University	4 (21·05)	15 (78·95)	2 (16·67)	10 (83·33)	20 (33·33)	40 (66·67)
Madrasa	—	—	—	5 (100·00)	2 (100·00)	—

Table—39 (d)

Distribution Of Respondent's By Husbands' Occupation.

Occupation of Husband	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-Visitor	Visitor	Non-visitor
Cultivator	38 (81·18)	171 (18·82)	89 (46·11)	104 (53·89)	6 (100·00)	—
Landless Cultivator	1 (8·33)	11 (19·57)	12 (63·16)	7 (36·84)	—	—
Day labour	43 (36·13)	76 (63·87)	57 (58·16)	41 (41·84)	30 (41·67)	42 (58·33)
Skilled labour	10 (34·48)	19 (65·52)	17 (40·48)	25 (59·52)	14 (29·17)	34 (70·83)
Business	43 (28·10)	110 (71·90)	58 (38·93)	91 (61·07)	112 (49·12)	116 (50·88)
Service	13 (17·33)	62 (82·67)	39 (42·86)	52 (57·14)	110 (46·61)	128 (21·33)
Others	3 (100·00)	—	1 (12·5)	7 (87·5)	—	8 (100·00)

Table—39 (e)

Distribution Of Respondents By Land Holding Of The Family

Land Holding	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
Landless	77 (34·84)	114 (45·16)	11 (48·47)	118 (51·53)	206 (44·78)	254 (55·22)
Below 100	32 (19·35)	107 (76·68)	74 (41·58)	74 (58·42)	34 (56·67)	26 (43·33)
101-200	18 (19·35)	75 (80·65)	42 (41·58)	59 (58·42)	16 (42·11)	22 (57·89)
201-300	9 (20·00)	36 (80·00)	11 (26·83)	30 (73·17)	8 (57·14)	6 (42·86)
301-400	7 (20·69)	27 (79·41)	15 (50·00)	18 (50·00)	—	6 (100·00)
401-500	1 (6·25)	15 (93·75)	12 (60·00)	8 (40·00)	2 (25·00)	6 (75·00)
501-600	2 (15·38)	11 (84·62)	—	3 (100·00)	2 (25·00)	6 (75·00)
601 & above	5 (12·82)	34 (87·18)	8 (28·57)	20 (71·43)	4 (66·67)	2 (33·33)

Table—39 (f)

Distribution Of Respondents By Monthly Income Of The Family

Family monthly Income (in taka)	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
Upto 200	16 (37·21)	27 (62·79)	31 (51·67)	29 (48·33)	6 (50·00)	6 (50·00)
201-400	60 (26·26)	169 (73·80)	99 (50·51)	97 (49·49)	56 (44·44)	70 (55·56)
401-600	41 (25·95)	117 (74·05)	73 (44·24)	92 (55·76)	68 (43·59)	88 (56·41)
601-800	17 (24·29)	53 (75·71)	33 (41·77)	46 (58·23)	56 (58·33)	40 (41·67)
801-1000	11 (18·64)	48 (81·36)	23 (46·94)	26 (53·06)	48 (44·44)	60 (55·56)
1001-2000	6 (18·75)	26 (81·25)	12 (34·29)	23 (65·71)	24 (35·29)	44 (64·71)
2001-3000	—	5 (100·00)	—	7 (100·00)	6 (33·33)	12 (66·67)
3001-5000	—	4 (100·00)	2 (22·23)	6 (66·67)	8 (57·14)	6 (42·86)
5001 & above	—	—	—	1 (100·00)	—	2 (100·00)

Table—39 (g)
Distribution Of Respondents By Number Of Live Birth.

No. of Live Birth	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
1-2	32 (22·55)	110 (77·46)	54 (34·18)	104 (65·82)	104 (56·52)	80 (48·48)
3-4	57 (26·89)	155 (73·11)	103 (52·55)	93 (47·45)	120 (54·55)	100 (54·45)
5-6	27 (22·13)	95 (77·87)	59 (46·09)	69 (53·91)	74 (52·12)	68 (47·88)
7-8	29 (34·12)	56 (65·88)	34 (47·22)	38 (52·78)	20 (47·62)	22 (52·38)
9 & above	6 (15·38)	33 (84·32)	23 (50·00)	23 (50·00)	10 (83·33)	2 (16·67)

Table—39 (h)
Distribution Of Respondents By Number Of Living Children.

No. of Living Children	R E S P O N D E N T S					
	FWC (a)		THC(b)		MCWC(c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
1-2	40 (21·51)	146 (78·49)	80 (38·65)	127 (61·35)	128 (61·54)	80 (38·46)
3-4	57 (25·56)	166 (74·44)	103 (51·76)	96 (48·24)	124 (55·36)	100 (44·64)
5-6	37 (32·17)	78 (67·83)	56 (45·16)	68 (54·84)	60 (46·88)	68 (53·12)
7-8	14 (22·58)	48 (72·42)	25 (51·02)	24 (48·98)	14 (38·89)	22 (61·21)
9 & above	3 (21·43)	11 (78·57)	9 (42·86)	12 (57·14)	2 (50·00)	2 (50·00)

Table—39 (i)
Distribution Of Respondents By No. Of Pregnancy.

No. Of Pregnancy	R E S P O N D E N T S					
	FWC (a)		THC (b)		MCWC (c)	
	Visitor	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
1—2	33 (25·58)	26 (74·42)	44 (31·21)	97 (68·79)	54 (38·57)	86 (61·43)
3—4	53 (25·60)	154 (74·40)	97 (50·00)	99 (50·00)	100 (43·48)	130 (56·52)
5—6	27 (20·61)	104 (79·39)	68 (49·28)	70 (50·27)	60 (44·12)	76 (55·88)
7—8	27 (33·33)	54 (66·67)	34 (48·57)	36 (51·43)	26 (50·00)	26 (50·00)
9—10	8 (22·86)	27 (77·14)	17 (48·57)	18 (51·43)	20 (71·43)	8 (28·57)
11 & more	4 (23·39)	13 (76·47)	11 (61·11)	7 (38·89)	12 (85·71)	12 (14·29)

Table — 39 (j)
Distribution Of Respondents By Contraceptive Use Status.

Contraceptives Use Status	R E S P O N D E N T S					
	FWC (a)					
	Visitors	Non-visitor	Visitor	Non-visitor	Visitor	Non-visitor
Present user	51 (52·04)	47 (47·96)	63 (52·80)	57 (47·05)	107 (51·20)	102 (48·80)
Past user	21 (25·58)	58 (73·42)	44 (53·01)	39 (46·99)	44 (46·32)	51 (53·68)
Never user	79 (18·68)	344 (81·32)	166 (41·81)	231 (58·19)	121 (40·88)	175 (59·12)

Table—A1
A. Demographic Characteristics of Field Workers :
Distribution of Field Workers By Age :

Field Workers							
Age	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12	Total N=37	%
Age in year							
15-19	—	—	—	—	—	—	—
20-24	—	2	—	—	3	5	13·51
25-29	—	3	1	5	6	15	40·54
30-34	1	—	2	—	2	5	13·51
35-39	2	—	—	3	—	5	13·51
40-44	1	—	2	1	1	5	13·51
45-49	—	—	1	1	—	2	5·42

Table—A2
Distribution of Field Workers By Marital Status :

Field Workers							
Marital status	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12	Total N=37	%
Married	3	2	6	9	11	31	83·78
Un-married	1	3	—	1	—	5	13·51
Widow	—	—	—	—	1	1	2·71

Table—A3
Distribution of Field Workers By Number Of Live Birth

Field Workers							
Live Birth	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12	Total n=37	%
None	—	1	—	11	—	2	6·45
1	—	—	1	3	2	6	19·35
2	—	1	—	—	3	4	12·90
3	—	—	3	1	3	7	22·58
4	2	—	—	3	2	7	22·58
5	—	—	1	—	—	1	3·23
6	1	—	1	—	1	3	9·68
7 & more	—	—	—	1	—	1	3·23
Total	3	2	6	9	11	31	100·00

Table—A4
Distribution of Field Worker By Number of Living Children

No. of Living Children	Field Workers					Total N=37	%
	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12		
None	—	1	—	1	—	2	6·45
1	—	—	1	3	2	6	19·35
2	—	1	—	1	3	5	16·13
3	1	—	3	1	4	9	29·03
4	1	—	—	2	1	4	12·90
5	—	—	1	—	—	1	3·23
6	1	—	1	1	1	4	12·90
Total	3	2	6	9	11	31	100·00

* Un-married respondents have not been considered.

Table—B 1.
B. Attitude and Knowledge of Field Workers :
Distribution of Field Workers By Job Description.

Job description	Field Workers					Total N=37	%
	T.F.P.O. n=4	M.A. n=5	F.W.V. n=6	F.P.A. n=10	F.W.A. n=12		
Received	4	3	2	10	12	31	87·78
Not received	—	2	4	—	—	—	16·22

Table—B 2

**Distribution of Field Workers By Opinion About Their Jobs
Alloted to Them**

Opinion	Field workers					Total N=37	%
	T.F.P.O. n=4	M.A. n=5	F.W.V. n=6	F.P.A. n=10	F.W.A. n=12		
work load is to Much	3	—	1	1	3	8	21·62
Work load is adequate	1	4	3	9	10	27	72·97
Work load is to less	—	—	—	—	—	—	—
Trained adequ- ately to perform all job	2	4	5	3	12	31	83·78
Not trained adequately	2	—	—	1	—	3	18·11

Table—B3

Distribution Of Field Workers By MCH Jobs Performed By them

MCH Jobs performed	Field Workers					Total N=37	%
	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12		
Supervise field staff	1	—	—	—	—	1	2·70
Advice mother about MCH	4	2	4	7	10	27	72·97
Discussion with field staff about MCH	1	—	—	—	—	1	2·70
Treatment of different diseases	—	2	2	—	—	4	10·81
Post natal & Anti-natal care	—	1	2	—	—	3	8·11
Motivation people about MCH	—	—	—	4	—	4	10·81
Home visit	—	—	2	—	—	2	5·41
Attend delivery case	—	—	1	—	—	1	2·70
Advise on nutrition	—	—	1	—	5	6	16·22
Advice child care	—	2	3	—	2	4	10·81
No. MCH job	—	1	—	1	1	3	8·11

Table—B4
Distribution of Field Workers By Services For
Whic Women Come For Maternal Care

Types of Services	Field Workers					Total N=37	%
	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12		
Ante-natal care	1	4	4	1	—	10	27·03
Delivery	1	—	4	—	—	5	13·51
Post natal care	2	4	4	1	—	11	29·79
Treatment of different disease	—	5	4	1	—	10	27·03
With complication of pregnancy	1	1	4	1	—	7	18·92
Others	—	1	4	—	—	5	13·51
No answer	1	—	—	7	12	20	54·05

Table—B5
Distribution Of Field Workers By Services For
Which Women Come For Maternal Care :

Types of services	Field Workers					Total N=37	%
	T.F.P.O. n=4	M. A. n=5	F. W. V. n=6	F. P. A. n=10	F. W. A. n=12		
For check up of growth & development	—	4	4	1	—	9	24·32
Treatment of different disease of children	2	4	4	1	—	11	29·73
Others	—	2	3	2	—	5	10·81
No. answer	2	—	—	8	12	22	59·46

Table—B 6
Distribution Of Field workers By Their Opinions About The
Attendants for MCH care

Opinions	F I E L D W O R K E R S						Total N=37	%
	T.F.P.O. n=4	M.A. n=5	FWV n=6	FPA n=10	FWA n=12			
Sufficient	—	1	1	—	1	3	8.12	
Satisfactory	3	4	3	2	—	12	32.43	
Poor	1	1	2	1	1	6	16.22	
No answer	—	—	—	7	10	17	49.95	

Table—B 7
Distribution Of Field Workers By Purpose of Field visits In A Month

Purpose of Field visits	F I E L D W O R K E R S						Total n=37	%
	TFPO n=4	MA n=5	FWV n=6	FPA n=10	FWA n=12			
For Sterilization Camp	1	—	1	—	—	2	5.41	
Field Supervision	2	—	—	5	—	7	18.92	
Follow up the Clients	1	2	2	2	—	7	18.92	
To meet local leaders	1	—	—	—	—	1	2.70	
Motivation	—	—	1	5	6	12	32.43	
Check Pregnant mothers	—	—	1	—	—	1	2.70	
MCH Cares	—	—	2	—	1	3	8.11	
Nutrition education	—	—	1	—	—	1	2.70	
Check couple registration card	—	—	—	2	—	2	5.41	
Supply contraceptives	—	—	—	—	7	7	18.92	
Home visit	—	—	—	—	4	4	10.81	
No visit	—	3	1	—	—	4	10.81	

Table- B8

Distribution Of Field Workers By Number Of Field Visits In A Month

FIELD WORKERS							
Number of Field Visit	TFPO n=4	MA n=5	FWV n=6	FPA n=10	FWA n=12	Total N=36	%
4 days	—	1	—	—	—	1	2.70
8 days	—	—	2	—	—	2	5.41
12 days	—	—	3	—	—	3	8.11
14 days	1	—	—	—	—	1	2.70
15 days	2	—	—	—	—	2	5.41
16 days	—	—	—	—	—	1	2.70
20 days	1	—	—	8	10	1	51.35
24 days	—	—	—	2	—	4	10.81
No visit	—	3	1	—	—	4	10.81

Table—B9

Distribution of Field Workers By Idea About Hindrances In the Utilization of MCH Services

FIELD WOKERS							
Hindrances	TFPO n=4	M A n=5	FWV n=6	FPA n=10	FWA n=12	Total N=37	%
Opening time	—	1	1	—	—	2	5.41
Closing time	—	1	1	—	—	2	5.41
Inadequate Medicine	2	3	4	2	1	12	32.43
Distance to travel	—	2	2	2	1	7	18.92
Lack of Motivation	2	—	1	—	—	3	8.11
Others	1	—	1	—	—	2	5.41
No. answer	—	—	—	8	10	18	48.65

Table—B 10 (a)
**Distribution Of Field Workers By Facilities For Clinics
 Needed To Improve MCH Programme.**

Facilities For Clinics	F I E L D W O R K E R S						Total n=37	%
	TFPO N=4	MA n=5	FWV n=6	FPA n=10	FWA n=12			
Enough medicine	4	3	3	4	9	23	62.16	
Supply of Vitamin	—	1	1	2	1	5	13.51	
Supply of Glowcose	—	—	1	—	—	1	2.70	
Supply of Chifd Food	2	—	3	4	—	9	34.32	
Improve bed condition	1	1	1	4	—	7	18.92	
Suppy of MCH Kit	—	1	1	—	—	2	5.41	

Table---B 10 (b)
**Distribution Of Field Workers By Facilities For Workers
 Needed To Improve MCH Programme**

Facilities For Workers	F I E L D W O R K E R S						Total n=37	%
	TFPO n=4	MA n=5	FWV n=6	FPA n=10	FWA n=12			
Umbrella/Bag	—	1	4	—	5	12	27.03	
More staff/More work	—	3	—	—	—	3	8.11	
T.A. for training	—	—	1	—	1	2	5.41	
Transport	3	1	2	—	—	6	16.22	
House Rent/Quarter	—	1	1	—	—	2	5.41	
Training/groug discussion	—	2	1	4	2	8	21.62	