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AN ASSESSMENT OF NRHM PERFORMANCE AND THE ROLE OF FRONT LINE HEALTH WORKERS IN PROVIDING MCH SERVICES IN RURAL NORTH KARNATAKA

JYOTI S. HALLAD, B. M. RAMESH, ARIN KAR, R. V. DESHPANDE AND B. I. PUNDAPPANAVAR

Introduction

Recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India resolved to launch the National Rural Health Mission (NRHM) in 2005 to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care.

One of the key components of NRHM is the provision of a female health activist in each village and its major goals include reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR) as well as universal access to public health services such as women's health, child health, water, sanitation & hygiene, immunization, and nutrition. Major core strategies of the NRHM are to train and enhance capacity of the Panchayat Raj Institutions (PRIs) to own, control and manage public health services and promote access to improved health care at household level through the Accredited Social Health Activists (ASHAs). All the above mentioned key components, goals and core strategies of NRHM emphasize the role of Front Line Health Workers (FLWs) like ANM, ASHAs and Anganwadi workers (AWW), especially in providing maternal and child health (MCH) care services. Every village/ large habitat has an ASHA - chosen by and accountable to the Panchayat- to act as the interface between the community and the public health system. ASHA would act as

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TRENDS AND DIFFERENTIALS IN PARITY PROGRESSION AMONG WOMEN IN NORTHERN AND SOUTHERN INDIA

K.K. SINGH AND SHRUTI VERMA

Introduction

The quantum and tempo of fertility can be explained if we specify the processes: first, how women space their children and second, how many women of a particular parity proceed to the next parity. It is evident that the conglomerated result of these decisions will determine the fertility behavior in a population. The closed birth intervals (CBI), which represent the child spacing behavior of women are taken as indicators of reproductive performance of those women who are still in the reproductive life cycle. CBI can be used for the estimation of different parameters such as fecundability, incidence of foetal wastage, post-partum amenorrhea etc., through the use of appropriate models. Nevertheless, such data on birth intervals do not give any idea about the behavior of couples or women who want to have no more children, what proportion of couples or women will not proceed to the next birth after the birth of a particular order. Thus, it can be understood that two populations having the same pattern of birth spacing may have different fertility performances, if child stopping or limiting behavior of these two populations is different. So looking only at the birth interval characteristics of a population, it will not be feasible to assess the fertility rates prevailing in any population. Such stopping or limiting behavior is well explained with the help of parity progression ratios (PPR) which is nothing but the conditional probability of the ith birth, given that a woman already has given $(i-1)$ births.

There are several reasons for why PPR is one of the most important tools for understanding the process of fertility transition. First, they grab the prevailing nature of fertility behavior, since the decision of women about having or not

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ON EXAMINING SURVIVORSHIP DIFFERENTIAL BY MARITAL STATUS: AN ILLUSTRATION FROM INDIA

ANNIE GEORGE

Introduction

Survival possibility/likelihood differential is commonly examined in terms of sex and residence using information on mortality, dis-aggregated according to these two variables. However, there is an absence of concurrent evidence as regard the survivorship differential by marital status categories although the existing literature suggests marriage as a key factor and one of the first non biological ones inducing one's survival. The survival advantage among the married population as compared to other marital categories has been well noticed over several decades by a large number of studies carried out in developed countries. The explanation offered vary from better mental and emotional health in view of the tendency to take fewer risks with their health care to social and material support they receive from within the marital relationship.[1] A single individual is more likely to be wrecked on his/her voyage than the lives joined together in matrimony . . .' before concluding that '. . . marriage is a healthy estate'.[2] However, several studies, suggest that the 'ever married' are worse than the never-married,[3,4,5] although a number of uncertainties surround the pattern of differentials among the elderly age groups particularly older women. Some studies report a lower mortality among older widows than among married women of the same age group,[6-7] while a number of investigations into health differentials, rather than mortality, with reference to American and British populations observe that at older ages, never-married women enjoy as good a health or better health than their married counterparts.[8,9,10,11] It has been suggested that this might reflect stronger non-marital social networks among never married older women, which may help them in later life, especially because by

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DETERMINANTS OF CONTRACEPTIVE USE IN NON-EAG AND EAG STATES OF INDIA IN THE ERA OF NRHM : EVIDENCE FROM GUJARAT AND ODISHA, 2009-10

MANOJ KUMAR RAUT AND T.V. SEKHER

INTRODUCTION

India is the second most populous country in the world, with a population of 1.2 billion and a decadal population growth rate of 17.64 per cent compared to 1.34 billion people and a decadal growth rate of just 5.43 per cent in case of China. It is projected to become the most populous country in the world in the near future. It is a land of multiplicities and diversities. It is characterized by regional imbalances like a large north-south divide in health and development. Population is a perennial problem in India as well as some of its constituent states. India was the first country to initiate a family welfare programme way back in the 1950s. It is alarming that historically during the last 110 years between 1901 and 2011, the population of India has grown by about five times. More than one out of six persons in the world hails from India. It accounts for only 2.4 percent of the world surface area, while is home to 17.5 percent of the world's population. There is large scale disparity in the fertility and mortality indicators. The Total Fertility Rate ranges from 3.5 births per woman in Uttar Pradesh to 1.7 in Tamil Nadu. The Infant Mortality Rate ranges from 62 in Madhya Pradesh to 10 infants deaths per thousand live births in Goa. The Maternal Mortality Ratio ranges from 390 in Assam to 81 per one lakh live births in Kerala. High mortality also leads to high fertility.

The difference is also striking in Gujarat and Odisha. Odisha belongs to the Empowered Action Group (EAG) states and the Gujarat belongs to a Non-EAG group of states. Gujarat is an industrialized, prosperous and urbanized State and Odisha is predominantly a rural and poor state. According to the final totals of the Census 2011, Gujarat has a population of

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EMERGENCY CONTRACEPTION: AN EASY AND EFFECTIVE POST COITAL CONTRACEPTIVE

USHA KRISHNA

Introduction

Fertility regulation is a key component of the Reproductive and Child Health Programme in India. The government of India has launched this programme in the year 1997 and hopes to achieve the Total Fertility Rate of 2.1 by 2020 and stabilise the population by the year 2045.

The high incidence of unwanted pregnancy and unsafe abortion and their hazardous consequences are related to inadequate provision of reproductive health care and family planning services. Women have to bear the hardship and agony of unwanted pregnancy or undergo induced abortion. It is estimated that 10-12 million abortions take place annually in India with a large percentage being unsafe contributing substantially to maternal mortality. It is estimated that almost 78 percent of conceptions are unplanned and 25 percent are unwanted. Women would certainly prefer to prevent an unintended pregnancy than have an abortion. Although methods of contraception are available more than half of the women in our country do not use the same satisfactorily. Therefore, Emergency Contraception (EC) is useful as a back-up method for unprotected intercourse. The Emergency Contraception methods are effective, safe and simple to use. It is necessary to bring sufficient awareness about this method and introduce the same in the family planning programme and distribute these through clinic and non-clinic channels of distribution. Information, education, communication (IEC) activities are most essential to promote the use of EC and prevent unwanted pregnancies and unsafe abortions.

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MATERNAL COMPLICATIONS IN EASTERN STATES OF INDIA WITH SPECIAL REFERENCE TO WEST BENGAL

BHASWATI DAS AND DIPIKA SUBBA

Introduction

"Maternal Health" refers to the health of women during pregnancy, childbirth and the postpartum period (WHO). These three periods are considered as the most important event in the life of women. But for many women they are associated with suffering, ill-health and even death. Since the late 80s improvement on maternal health and reducing maternal mortality became an area of concern at several international summits and conferences. Globally, maternal mortality is the leading cause of death among women in the reproductive age. It is the consequences of pregnancy and childbirth or the consequence of treatment received during pregnancy or childbirth. Over 300 million women in the world currently suffer from long term illness brought about by pregnancy or childbirth. More than 1500 women die each day from pregnancy related causes resulting in an estimated 550,000 maternal deaths annually.[1] In 2010, estimates developed by the WHO, UNICEF, UNFPA and the World Bank suggest that worldwide, about 260 women die per 100,000 live births. Of the estimated total of 358,000 maternal deaths worldwide, developing countries accounted for 99 percent (355,000). Nearly three fifths of the maternal deaths (204,000) occurred in the sub-Saharan Africa region alone, followed by South Asia (109,000). Women in developing countries experience a well documented increase in a health-risk related to childbearing.[2] Analysis of the data from the government statistics for different countries shows that complications from pregnancy and childbirth were the leading causes of death in young women aged 15 to 19 years in poorer countries.[3] In most developing countries, pregnancy and childbirth are accepted as normal events of life and the problems associated with pregnancy are also accepted without

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FAMILY PLANNING AMONG THE TEA GARDEN LABOUR COMMUNITY OF ASSAM: A STUDY ON LEVEL AND DETERMINANTS OF EVER USE OF CONTRACEPTIVES

AMARJYOTI MAHANTA AND HOMESWAR GOSWAMI

Introduction

The independent impact of practice of family planning on fertility was argued in past literature.[1,2] More recent studies in India have also explored the fertility inhibiting impact of contraceptive use.[3,4,5,6,7] Sometimes married women in the reproductive age do not have precise knowledge of family planning; at other times they have unmet need for contraception and inability to use family planning methods despite their willingness to use.[8] Poor contraceptive prevalence, in most of the cases, is the reason for unwanted pregnancy, rising incidence of abortion and deteriorating reproductive health.

Contraceptive adoption is associated with a set of background characteristics of the population and individuals.[9] Socio-economic development of communities can dictate the level of contraception[10] and hence, appropriate socio-economic changes can increase the demand for family planning.[11] Factors like education,[12] knowledge of family planning and number of male living children,[13] occupational status of the wives,[12] husband-wife communication and religious beliefs etc.[14] are said to have significant impact on the use of contraceptives. However, contrasting findings on the association between income and prevalence of contraceptive have been reported. While some studies[15] have found direct relation, some others[16] have stated poor economic condition as the important reason for acceptance of family planning.

Studies, thus, have linked adoption of contraceptives with socio-economic attributes. The tea garden population of Assam also has some unique socio-economic features. The forefathers of the tea garden labour population of Assam were brought by the British Planters to

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THE JOURNAL OF FAMILY WELFARE
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To create awareness, disseminate knowledge and education, provide counselling and services where appropriate on all aspects of reproductive, child and sexual health including family planning and HIV/AIDS, with free and informed choice, gender equality and equity, the empowerment of women, male involvement, child and adolescent health, and their inter-relationships with social development and environmental concerns in order to advance basic human rights, of all men, women and youth, family and community welfare, the achievement of a balance between population, resources and the environment and the attainment of a higher quality of life for all people.

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