Utilization of RCH services during COVID-19 Pandemic: An assessment

Findings from IIPS-PRC multi-centric study

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(स्थापना/ Established in 1956)
बेहतर भविष्य के लिए क्षमता निर्माण
Capacity Building for a Better Future

INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES
DEEMED TO BE A UNIVERSITY, MUMBAI, INDIA

April, 2021

Report submitted to the Ministry of Health and Family Welfare
(Stats. Division)
Government of India, New Delhi

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Capacity Building for a Better Future

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FOREWORD

It has been over a year since the global pandemic of COVID-19 started impacting almost all spheres of our lives. While the pandemic is expected to last longer despite all our efforts to contain the virus, more attention is important to understand its consequences in the lives and livelihood of the people. The myriad of effects of the pandemic is difficult to measure and comprehend. The lockdown and subsequent closure of all activities brought several challenges. Wherever possible, institutions took it up these challenges and came up with alternatives ways of engagement. For example, work from home, use of virtual platforms to stay connected etc. became a new normal. This opportunity was also used to build skills and capacities of the staff for future growth and development. It was particularly challenging to operate essential services like health institutions by accomplishing the immense responsibilities of the COVID times but by ensuring safety of their employees.

The Statistics Division of the Ministry of Health and Family Welfare, Government of India, reached out to International Institute for Population Sciences, Mumbai by end of March 2020, to organize a comprehensive training workshop for the staff of the Population Research Centres located in various parts of the country. The key motive for the proposed activity was to use the lockdown period to build research capacity of the PRC staff. Subsequently, IIPS organized 4-week long virtual workshop covering all aspects of undertaking a research including research methodology, scientific writing and publishing research papers. The officials from the 18 Population Research Centres located in different States and Union Territories of India attended the training program.

The coordinators of the training program took one step forward and proposed a collaborative research study on a contemporary theme with the PRCs. The main idea was to take the class room learning during the training and implement them in the field to develop and use a standard research methods and study tools. Such attempt will also help in drawing meaningful conclusions for informed policies and porgrammes. Five PRCs, viz. Dharwad, Srinagar, Patna, Guwahati and Pune came forward to undertake the study on "Assessment of Utilization of RCH Services during COVID-19 Pandemic" and complete in a period of nine months (June 2020 to March 2021). The staff of the participating PRCs shared the responsibilities right from start of the study to its completion, including development of study design/methods, study tools, data entry software, data analysis and report writing. I was extremely delighted to listen to the preliminary results of the study when it was presented in a technical session organised as part of IIPS annual seminar during March 18-20, 2021.

I am confident that the findings of the study will provide a strong direction on ameliorating the likely impact of COVID-19 pandemic on essential health services including antenatal, natal and postnatal services; child health, immunization and ICDS services; and family planning services in the rural and urban areas of the five participating states. Certainly, such collaborative efforts will further strengthen the capacity of the PRC staffs in handling research projects more systematically.

I congratulate and appreciate the efforts of the team led by Prof. Usha Ram, IIPS for the successful completion of the study.

Prof. K. S. James
Director and Senior Professor

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n University Established under Section 3 of UGC Act 1956, vide Ministry of Education GOI, Notification No.F.9-14/81-U-3 dtd 14 August 19

Acknowledgement

The study "Utilization of RCH services during COVID-19 Pandemic: An assessment; Findings from IIPS-PRC multi-centric study" is a partnership between the International Institute for Population Sciences, Mumbai, and five Population Research Centres (PRCs), viz. Srinagar, Dharwad, Guwahati, Patna, and Pune under the Ministry of Health & Family Welfare, Government of India. The successful completion of the study is the outcome of sincere efforts of the organization and individuals involved in the study.

The PRC, Srinagar is grateful to Shri D. K. Ojha, Dy. Director General, Ministry of Health and Family Welfare, Government of India and Ms. Anjali Rawat, Director, Ministry of Health and Family Welfare, Government of India, for suggesting the topic 'Impact of Pandemic on other Essential Health Services' to the PRCs and providing the necessary financial support.

The study team acknowledges the contribution of Prof. K. S. James, Director and Senior Professor, International Institute for Population Sciences, Mumbai for approving the PRCs and IIPS collaboration and assistance at various stages of the study. The IIPS brought several PRCs together to work on a specific theme using standardized methods and tool. We are also thankful to Prof. James for providing a special technical session in the IIPS annual seminar held during March 2021 to showcase the results of the study with the wider audience.

PRC Srinagar would like to thank Prof. Effat Yasmin Honorary Director for all the guidance, cooperation and support in completing the project activities. We would like to thank all the administrative staff of PRC, Srinagar for providing the secretarial help while taking up this project.

PRC Srinagar would like to acknowledge support and cooperation from other collaborating PRCs- Dharwad, Patna, Guwahati and Pune for their involvement in this joint venture.

We would also like to thank our field investigators who Special thanks to our respondents who cooperated and provided telephonic interviews even during pandemic situation despite of having their busy schedule.

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TABLE OF CONTENT

LIST OF TABLES AND FIGURES

Research highlights

About the study

- The study is part of a multi-centric study undertaken in five states of Assam, Bihar, Jammu & Kashmir, Karnataka and Maharashtra.
- The study investigates into utilization of the maternal and child health care services including the ICDS and Contraceptive services by the women and children during the COVID-19 pandemic.
- This report present findings from Pulwama district of Jammu and Kashmir
- The study results are based on a survey population of 3066 persons and 512 eligible women in the age group of 15-49 years in the urban (84) and rural (428) areas.

Characteristics of the surveyed eligible women

- Majority of the women live in households that use electricity for domestic cooking. Significant proportion of households use safe drinking water and also have sanitation facilities.
- All the households both in urban and rural households have a designated area for hand washing.
- More than three-fourth of the households had access to internet and only 15% owned a computer.
- Median age of the eligible women was 32.7 and the median years of schooling completed were 9 years.
- Significant minorities of the women (5%) did not have a bank or post office account in their name.

Utilization of antenatal, natal and post-natal care during the pandemic

Antenatal care

- Of the women who had a live birth during the reference period, almost all have registered pregnancy in the first trimester and coverage of four or more antenatal care visits, monitoring of weight, blood pressure, sugar level, haemoglobin level, HIV, fatal growth (use of ultrasound), protection against tetanus during the pregnancy was almost universal.
- The coverage of ANC utilization is relatively lower among currently pregnant women.
- While more than one-half of the women (54%) were tested for COVID-19 during the previous pregnancies, among currently pregnant women, only one one-quarter were tested for COVID-19.
- Almost all mothers received most ANC services from the public health facility; no rural urban differential on public-private use. Among currently pregnant women, 20% received most ANCs from the private health facility.
- Eighty six percent of births were registered at a public health facility; slightly higher in the rural areas.

- In majority of the live births mothers did not face any difficulty in seeking antenatal care services during pandemic. Nonetheless, significant minorities did complain for the same; mostly related with lack of transportation, restrictions on movement and non-availability of the health staff due to the lockdown.
- Over a third of the births (39%) and cone-quarter of current pregnancy (26%), women reported experiencing pregnancy complications. While all of the currently pregnant women sought treatment for the pregnancy complication, in 3% live births mother did not seek treatment.

Natal care

- Almost 83% of the live births during reference occurred in a health facility and 17% in a public health facility.
- Considerably very higher proportions of the births were cesarean (85%).
- In majority cases (88%) mothers used private vehicle to reach to the facility for delivery, in about 38% cases ASHA accompanied the women to the facility.
- Twelve percent live birth mother experienced complications at the time of delivery (mainly blood pressure related, breech presentation, excessive bleeding, prolonged labor, premature rupture of membranes) and all sought treatment for the complication.

Postnatal care

- In few cases (10%), mothers experienced postpartum complication such as bleeding/spotting or lower abdominal cramps and all sought treatment.
- Most of the women had a postnatal checkup within the 24 hours of the live birth at a public health facility by a doctor (98%) and ANM/nurse midwife (2%).
- Fifty-seven percent of women reported that they did not receive the JSY benefit by the time data was collected.

Contact with the health/ICDS workers and Supplementary nutrition from ICDS

- Most of the women who had a live birth during the reference period as well as currently pregnant women reported that the health/ICDS worker visited them during pregnancy as well as after delivery and received help when needed.
- Many mothers reached out to ASHA for help during pregnancy, at delivery and after live birth for assistance and ASHA helped them.
- Among currently pregnant women, 70% reached out to ASHA for help during the pandemic and also received help.
- One-third of women who had a live birth and one-half of currently pregnant women never received supplementary nutrition from the ICDS.
- Closure of the ICDS centres because of lockdown, some due to interruption of supply of food to the ICDS centres or restriction on movements due to lockdown etc. were cited as the reason for not receiving the supplementary nutrition.

Utilization of immunization, child health care and ICDS services during the pandemic

Immunization services

- Over 95% of the eligible children received doses of BCG, Polio-0, Hepatitis-B0, Pentavalent (first, second and third doses) and 88% received measles and rubella
- More than 75% children received rotavirus first, second and third doses and DPT booster and about half of children also received Vitamin-A first dose.
- Majority of the children both in rural and urban areas received their vaccination at a public health facility. Few children (12%) received births dose for BCG, Polio-0 and Hepatitis-BO from a private health facility.
- All the children received vaccination from a place usual choice for vaccination.
- More boys than girls, from rich families, children of mothers with higher education received various vaccinations.

Child health care

- Among children born during the reference period, 54% fell ill (mainly diarrhea, fever, cough and cold) during the pandemic and all were treated for the illness.
- Majority (53%) were treated at a private health facility and 47% (higher in the urban areas – 57%) at a public health facility.
- At the time of survey, 90% children were cured and 10% were still suffering from the diseases.

ICDS services

- While 90% of the children aged below 6 years of age ever attended or registered at the anganwadi centre (AWC), only 60% of the children attended AWC during the pandemic.
- Majority children received food as well as consumed the food; lower during the pandemic period.
- Significant proportion of the children (42%) received food for some days only or never and this proportion was higher during pandemic period (64%). Considerable proportions of mothers cited fear of infection, family did not allow, no staff at the AWC, child refuse to go to the AWC as the main reason for child not attending AWC during the pandemic.
- Majority mothers felt that the quantity and quality of food at AWC remained same or improved in the pandemic, however, 34% (similar in urban and rural areas) reported that the quantity of the food reduced and 260% felt that the quality of food deteriorated during the pandemic.
- About 36% of the mothers informed that the other services from the AWC have been affected during the pandemic.

Contact with the health / ICDS workers for child health needs and difficulties faced during the pandemic

- About 17% and 51% of the mothers, respectively reported that no health / ICDS worker has visited them during the pandemic for child vaccination or health care needs.
- Only 2% of the mothers reported that the anganwadi worker (AWW) has visited them for child vaccination and health care services during the pandemic.

- Majority of mothers informed that ASHA visited them for child vaccination and health care services during the pandemic.
- Nearly 67% and 31% of the mothers, respectively, contacted ASHA for services related to the child vaccination and health during the pandemic and almost all received the help from ASHA.
- About 5% of the mothers reportedly experienced difficulty in seeking vaccination and 20% in seeking child health care during the pandemic, majority did not.

Utilization of contraceptive services during the pandemic

- Of the non-pregnant women, 68% in urban areas and 62% in rural areas reported using a method to delay/avoid pregnancy at the time of survey.
- Condom is the most popular method among modern methods of family planning used by 32% of couple in urban areas and 38% in rural areas. Eleven percent women had adopted female sterilization.
- IUD/PPIUD more popular in rural areas (24%) than in the urban areas (6%).
- Oral pill is less popular in urban areas (9%) than the rural areas (15%).
- Withdrawal is also a very popular method among couples more so among urban areas (41%) than in rural areas (31%)
- All the couples who got sterilized during the pandemic got it from a public health facility.
- Of the modern spacing method users, 70% (100% in urban areas) got their most recent supply from a public health source.
- A small minority of the women reported that they experienced side effects of the method (nausea, irregular bleeding, breast tenderness, irregular period, weight gain) used during the pandemic. 70% took treatment for the side effect.
- Only about 2% on the current non-users attributed pandemic as reason for current non-use of contraception.
- One in 12 women (higher in the urban areas) experienced menstrual problem during the pandemic and only 75% reported they sought treatment for the menstrual problem.

Chapter 1

Introduction

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Introduction

1.1 Background of the Survey

The Ministry of Health and Family Welfare, Government of India requested IIPS to organize a series of training program for the PRC officials in May 2020 immediately after the lockdown to build capacity of the staff on various aspects of research. In response, the IIPS organized the training program for the PRC officials during June-July 2020 via virtual platform spanning over four-weeks. The series covered a total of several themes: Improving Writing Skills: Research Articles & Policy Briefs; Ethical Issues in Population & Health Research; Statistical Packages: SPSS & STATA; Sampling for Survey Research, Sample Size and Sampling Weights; Monitoring and Evaluation; Population Projections; Designing Survey Tools for Quantitative and Qualitative Studies; Development of Research Proposal for OR/Intervention Studies in RH; Qualitative Data Analysis using Nvivo and ATLAS.ti; and Choosing Appropriate Statistical Techniques for Research Data. In one of the course entitled "**Designing the Survey Instruments",** the course coordinators discussed with the participants about considering a joint study post training programs on a theme of common interest to all PRCs. The idea was to translate the learnings during the training programs in to effective outcomes. The PRCs appreciated the idea and decided to move forward making this effort a reality after the conclusion of the training series.

The Collaboration: A total of seven Population Research Centers, viz. Bengaluru (KN), Dharwad (KN), Guwahati (AS), Thiruvananthapuram (KL), Srinagar (JK), Patna (BR) and Pune (MH) came forward and joined the collaboration. The collaboration formally launched in August 2020 with an approval from the Director IIPS. The PRC Bengaluru withdrew after a month due to resource constraints and Kerala PRC could not undertake the fieldwork in the state as they did not get state approval for undertaking the study. Finally, five PRCs continued the collaboration. The study collaboration period was for a total of nine months ending in March 2020-21.

Rationale: The Ministry of Health and Family Welfare (MoHFW), Government of India entrusts the PRCs with a list of research topics to be undertaken by them during a given financial year. Generally, each PRC uses its own methodology and research tools to complete these studies which makes across state comparison of the study results/findings difficult. It was thus thought that using standardized methods and tools across PRCs for a study would not only ensure improved quality of research studies but would be of immense help to allow authorities to compare the results across geographies for area-specific policies and programs.

Theme selection: One of the themes communicated by the MoHFW to the PRCs during the year 2020-21 was "**Impact of lockdown on RCH services**". The participating PRCs agreed to undertake the collaborative research exercise on this theme and decided to move forward for the study on utilization of RCH services during the pandemic.

Expected outcome: The collaboration is expected to further strengthen the capacity of the PRC staffs in developing study designs, sample size and research instruments more effectively with hand on exercise experience. The participating PRCs shared the responsibilities on various aspects of the study

by further forming study subgroups and working collaboratively on assigned tasks and finalizing the methods and tools together.

1.2 About Pulwama District (Jammu and Kashmir)

Pulwama district is located at a distance of about 40 Kilometres from the summer capital of Srinagar. District came into existence in 1979 when it was carved out from Anantnag district. Subsequently, in 2007, the district was bifurcated into two districts namely Pulwama and Shopian. District Pulwama is called the ***Anand of Kashmir*** or "***Dudh-Kul of Kashmir***" on account of its high milk production.

According to 2011 Census, the total population of Pulwama district was 560440 which constitute about 5.6 percent of the total population of the state. The district has a small concentration of ST population (4 percent). Large majority of the population follow Islam. The population growth rate is about 29 percent and the sex ratio is 912. The district has witnessed a dip in child sex ratio during 2001-2011 and according to 2011 Census, Child Sex Ratio was 829. Slightly less than two-third of the population age 7 and above is literate. Male literacy rate (74 percent) is higher than female literacy (52percent). The district consists of 3 medical blocks namely Pulwama, Pampore and Tral. The health services in the public sector are delivered through a network of 141 health institutions which consist of District Hospital, 3 CHCs, 1 TB Centre, 47 PHCs and 89 SCs and equivalent facilities.

As per NFHS-5, sex ratio of the total population for Pulwama is 953 females per 1000 males and sex ratio at birth is 889 females per 1000 males. The district records around 99% households with electricity, 98% having access to safe drinking water, 92% using improved sanitation facility and 77% using clean fuel for cooking. As per NFHS-5, literacy level in the district is 77% for women and 87% for men in the age group 15-49 years. Current use of family planning method among currently married women aged 15-49 years is around 62% and unmet need of family planning is 11.1%.

Under maternal and child health, the district has 97% of first trimester ANC registrations and 96% of pregnant women received at least 4 ANC check-ups. Proportion of institutional deliveries during previous 5 years was 98% in the district of which 92% occurred in public health facilities. Full immunization among children 12-23 months is 89% in the district. Prevalence of diarrhea during previous 2 weeks was 3.7% in the district among children below 5 years. Prevalence of anemia among children below 5 years was 67% and it was 73% among women aged 15-49 as per NFHS-5.

1.3 Survey instruments

The study used one questionnaire for collection of information from women aged 15-49 years. The questionnaire covered the following topics:

Section 1 - Background characteristics:

This section collected information on the main source of drinking water, type of toilet facility, type of cooking fuel, type of house, if the house had a designated area for hand washing and ownership of other selected items. Questions on age, education, religion, caste, marital status, employment status during pre-pandemic and pandemic period of the women were also collected in this section. Additionally, a few questions on the employment status during pre-pandemic and pandemic period of the woman's husband is included in the section. The details of the woman's reproductive history in

terms of children ever born, children surviving and children dead of the woman is also included in the section. Finally, the section also collected information was obtained from each woman about her current pregnancy status at the time of survey and number of abortions, stillbirths and live births by the women during past two years (between January 1, 2019 and survey date).

Section 2 - Current pregnancy:

This section collected information about antenatal care utilization, pregnancy complications, treatment seeking for pregnancy complications, difficulties experienced in seeking antenatal care and/or treatment for complications during pandemic and reasons for not seeking antenatal care / treatment for complications during the current pregnancy. Information about contact with the health / ICDS worker during the pandemic related to the current pregnancy were also included in the section.

Section 3 - Abortion:

This section collected information about antenatal, natal and postnatal care utilization, pregnancy/post-delivery complications, treatment seeking for pregnancy/post-delivery complications, difficulties experienced in seeking antenatal care and/or treatment for complications during pandemic and reasons for not seeking antenatal care / treatment for pregnancy/post-delivery complications. Information about contact with the health / ICDS worker during the pandemic related to the abortion was also included in the section. Information on ultrasound, sources and quality of antenatal, natal and postnatal services, expenditure on abortion etc. were also collected in this section.

Section 4 & 5 – Stillbirth and Live birth:

This section collected information about antenatal, natal and postnatal care utilization, pregnancy/delivery/post-delivery complications, treatment seeking for pregnancy/delivery/post-delivery complications, difficulties experienced in seeking antenatal care and/or treatment for complications during pandemic and reasons for not seeking antenatal care / treatment for pregnancy/ delivery/post-delivery complications. Information about contact with the health / ICDS worker during the pandemic related to the stillbirth/live birth were also included in the section. Information on ultrasound, sources and quality of antenatal, natal and postnatal services, C-section deliveries, expenditure on delivery etc. were also collected in this section.

Section 6 – Contraception:

The section collected information on ever/current use of methods to delay/avoid pregnancy, method use, place of sterilization, sources of obtaining modern spacing methods, duration of method currently used, side effects of method used, treatment seeking in case of side effects of method, difficulties experienced in accessing method, treatment for side effects, during pandemic, money spent on current method, reasons for non-use of a method to delay/avoid pregnancy.

The women were also asked about menstruation and problems experienced during menstruation and in seeking treatment for menstrual problems during pandemic. Information about contact with the health / ICDS worker during the pandemic related to contraception services were also included in the

section.

Section 7 – Immunization:

The information on immunization/vaccination of children during pandemic, place of immunization, difficulties faced in immunization and reason for change of place of immunization and non-immunization of the children during the pandemic were collected in this section. Information about contact with the health / ICDS worker during the pandemic related to child immunization services were also included in the section.

Section 8 – Child health:

The section gathered information on children who fell ill during pandemic, nature of illness, treatment sought for illness, difficulties experienced in seeking treatment for ill child, reason for not seeking treatment, money spent on treatment included. Information about contact with the health / ICDS worker during the pandemic related to the child health care services were also included in the section.

Section 9 – ICDS services:

Information about children attending ICDS/AWC during pre-pandemic and pandemic, whether children received and/or consumed food given the anganwadi, frequency and quality of food provided by the ICDS were collected. Information on woman perception on change in the quantity and quality of food at the anganwadi, other services by the anganwadi during the pandemic were also collected. Reason for children not attending the anganwadi were also obtained in this section.

1.4 Survey Design and Sample Implementation

It was decided to implement the study in one district of each of the five participating states. The five districts are – Kamrup in Assam, Patna in Bihar, Pulwama in Jammu and Kashmir, Pune in Maharashtra and Dharwad in Karnataka. The same was designed to provide estimates for district as a whole. The sample size of the study is not adequate enough to provide separate estimates for urban and rural areas of the district for all indicators. A target sample of 500 eligible women aged 15-49 years were divided between urban and rural sample by allocating the sample proportionately to the population of these two areas according the district population share in 2011 census. In view of the pandemic conditions, a non-response rate of 30% was used to estimate the sample size to provide reliable estimates of targeted indicators with 95% confidence. As a result, target sample was set at 500 completed interviews of the eligible women in each district. The data was collected by face-to-face interviews and telephone interview as convenient given the pandemic. All interviews in Pulwama were conducted by face-to-face.

Sample Design

We used multi-stage stratified sampling design with probability proportional to size (PPS) within each of the sampling domains of urban and rural areas.

Sample Selection in Rural Areas

In rural areas, three Community Health Centers (CHCs) were selected such that one of the selected CHC was located farthest from the district head quarter, one located at the mid-distance and another closest to the district head quarter. In the next stage, from each selected CHC, we selected two Primary Health Centres (PHCs) based on distance from the selected CHC (one attached to the CHC and another far away from the CHC); making a total of six-PHCs (3x2). From each selected PHC, we next selected two Sub Health Centers (SHCs) based on distance from the selected PHC (one attached to the PHC and another far away from the PHC); making a total of 12-SHCs (6x2). From selected SHC, we selected two villages – one SHC village and another non-SHC village served by the selected SHC; making it 24-villages (12x2). Finally, required number of eligible women were selected from the list of reproductive age group women available with the health worker of the selected SHC with equal probability in each selected village using systematic sampling. The list was updated by the field teams before the launch of the data collection work.

Sample Selection in Urban Areas

Of the three selected CHCs, we first identified the catchment area of the CHC. For each CHC, we selected two catchment areas – one closest to the CHC and another farthest from the CHC. In the next stage, required number of eligible women were selected from the list of reproductive age group women available with the health worker of the selected catchment area with equal probability in each selected catchment area using systematic sampling. The list was updated by the field teams before the launch of the data collection work.

In all, a total of 30 PSUs (Six in urban areas and 24 in the rural areas) were selected for undertaking the data collection work for the study. The field work for the study was between November 2020 and December 2020.

1.5 Recruitment, Training, and Fieldwork

The PRC hired 4 field investigators for the collection of data for the study. Each member of the field teams was trained for four-days on the study instrument before the main data collection. The data collection activities were supervised and monitored by the senior faculty of the PRC.

1.6 Data Processing

The data processing was done by the PRC IT staff who were also trained along with the field team members. The data processing team consisted of office editor, coder, data entry operator. The data entry was done in CSpro. We did 100% double entry to avoid the data entry errors. The data validation was done by the PRCs themselves.

Chapter 2

Background characteristics of the households and respondents

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Background characteristics of the households and respondents

This chapter presents a profile of the demographic and socioeconomic characteristics of households in which interviewed eligible women resided and the characteristics of the surveyed eligible women. The chapter also provides details of the total children ever born, surviving and dead of the eligible women at the time of survey. Additionally, the chapter includes information on the total number of live births, stillbirths and abortions the eligible women had during the period preceding two-years prior to the survey (from January 1, 2019 to the survey date) and if the woman was pregnant at the time of survey.

Table 2.1 provides population by gender and place of residence along with overall sex ratio of the surveyed population from the household's eligible women live. The total population of all surveyed 512 households is 3066 people, of which 1474 are males and 1592 are female. The overall sex ratio of the population is 926 males per 1000 female population. The sex ratio is slightly higher in the rural areas (926) compared to the urban areas (924).

Table 2.1: Population surveyed by gender and place of residence, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Male	218	1256	1474
Female	236	1356	1592
Person	454	2612	3066
Overall sex ratio (males per 1000 female population of all ages)	923.7	926.2	925.8
Total eligible women surveyed	**84**	**428**	**512**

2.1 Housing and Household Characteristics

Table 2.2 and Figure 2.2 provide information on selected housing characteristics of the houses in which the eligible women resided by residence. About 3% of households in Pulwama live in *kachcha* houses made with mud, thatch, or other low-quality materials, 11%percentlivein semi-*pucca* houses made of materials of partly low-quality and partly high-quality, and 86% live in *pucca* houses that were made with high-quality materials used for the roof, walls, and floor. All the women who live in Kachha houses are from rural areas and none of the women in urban areas live in households with a kachha house. Substantially higher proportions of the urban women live in pucca houses (94%) than the rural women (84%).

Water sources, sanitation facilities and fuel used for cooking may have an important influence on the health of household members, especially children and women. The survey gathered information about these aspects. Eighty-two percent of the women live in houses that use piped drinking water; much higher in the urban areas (93%) than the rural areas (80%). Twelve percent of the women live in houses that use tube well/borehole drinking water. Proportions of women in houses using well/borehole drinking water was 14% in rural areas and less than 4% in the urban areas. A significant minority of the women live in houses that use surface drinking water; overall 5%, rural areas 6%.

A very high percentage of households (97%) have a flush or pour toilet (using either piped water or water from a bucket for flushing) followed by dry latrines (2%). There is no urban-rural divide by type of toilet facility as

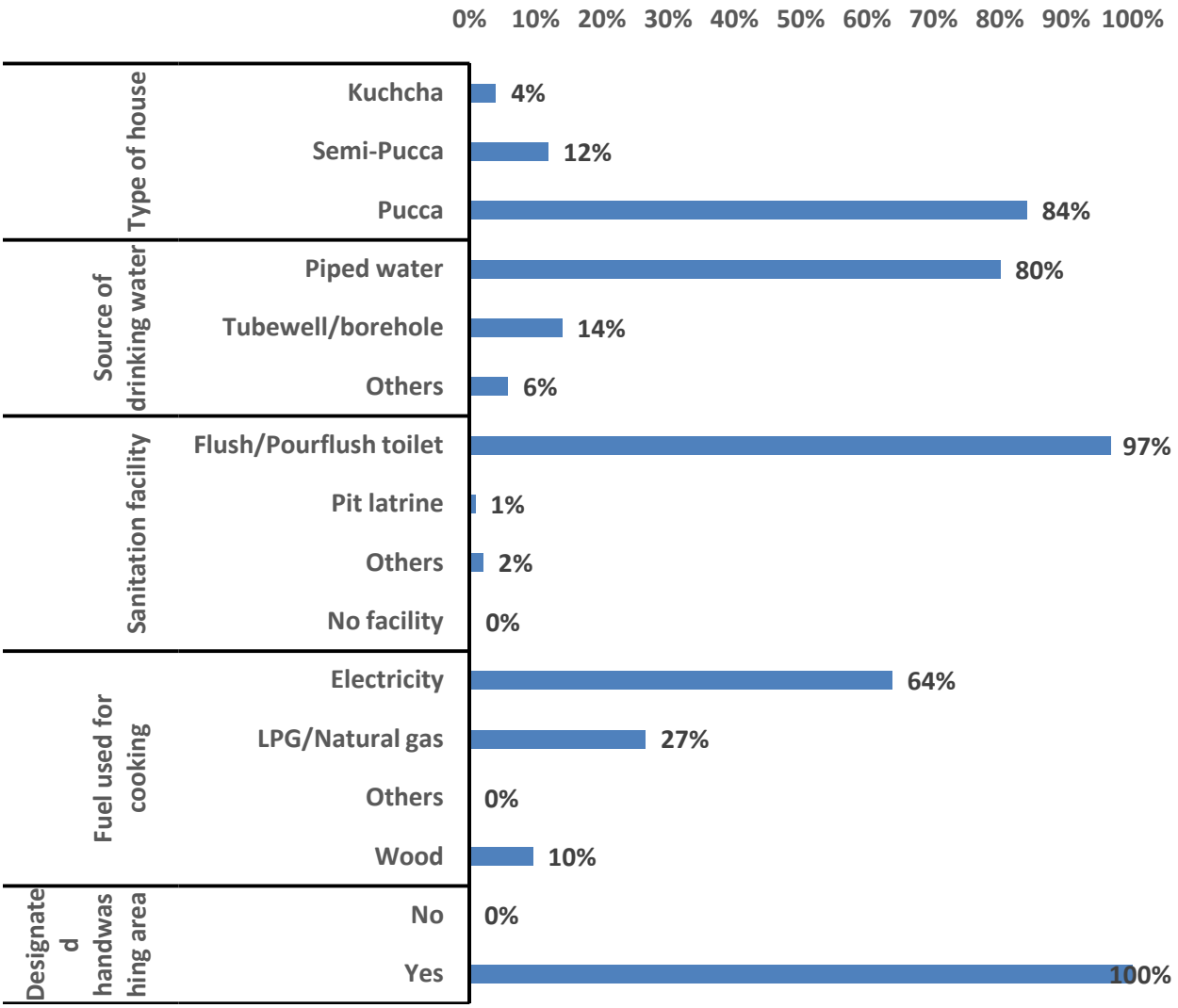
almost 97% of both urban and women live in houses that have a flush/pour toilet. Similarly, 2 % of both rural and urban live in houses that have dry latrine.

Table 2.2: Selected background characteristics of the households' women resided in, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Type of house			
Kuchcha	3.3	. 0.0	4.0
Semi-Pucca	10.9	6.0	11.9
Pucca	85.7	94.0	84.1
Source of drinking water to the household			
Piped water	82.2	92.9	80.1
Tube well / borehole	12.3	3.6	14.0
Dug well	5.5	3.6	5.8
Cart with small tank	0.0	0.0	0.0
Surface water (river, dam, lake, pond, stream, canal, etc.)	0.0	0.0	0.0
Bottled water	0.0	0.0	0.0
Community RO plant	0.0	0.0	0.0
Sanitation facility			
Flush or Pour flush toilet	96.9	97.6	96.7
Pit latrine	0.8	0.0	0.9
Twin pit / Composting toilet	2.1	2.4	2.1
Dry latrine	0.2	0.0	0.2
No facility/ open space/field	0.0	0.0	0.0
Type of fuel used for cooking			
Electricity	63.5	61.9	63.8
LPG/Natural gas	28.5	38.1	26.6
Biogas	0.0	0.0	0.0
Kerosene	0.0	0.0	0.0
Wood	8.0	0.0	9.6
Has a designated area for hand washing			
No	0.0	0.0	0.0
Yes	100.0	100.0	100.0
Total (%)	**100.0**	**100.0**	**100.0**
Total eligible women surveyed	512	428	84

Households in India use several types of fuel for cooking, ranging from wood, kerosene, biogas, natural gas, electricity etc. But in Pulwama, 63% of the households use mainly electricity for cooking followed by liquid petroleum gas/natural gas (28%). Less than 8% of the households use wood for cooking. Once again, rural-urban divide is insignificant. For example, 62% of the households in urban areas and 64% use electricity for cooking.. Conversely, 38% of the urban households compared to 27% of urban households used liquid petroleum gas/natural gas for cooking.

Figure 2.1: Household characteristics of the surveyed women, Pulwama (2020-21)



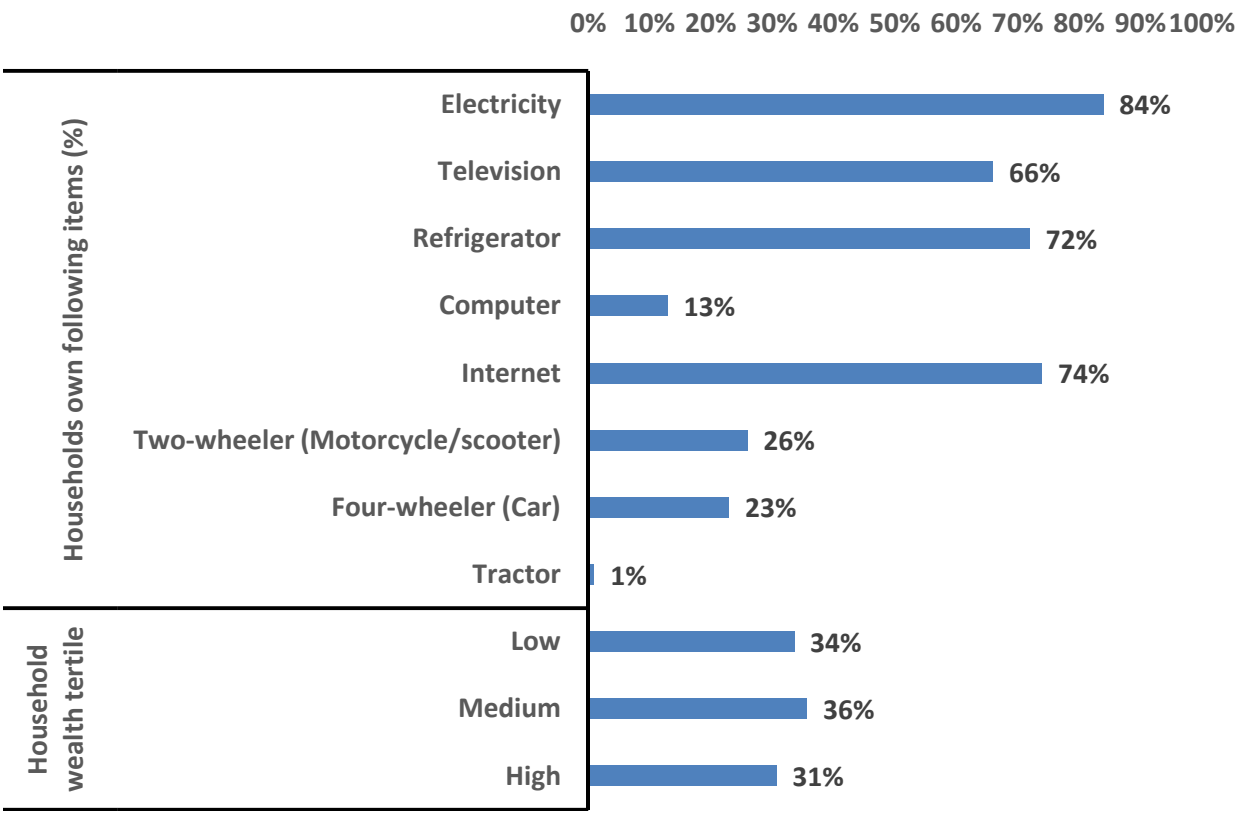
Hand washing practices are considered to be one of the most effective ways to stop spread of infections. In the present study, we gathered information on whether the houses had a designated area for hand washing. Our study found that all the surveyed households had a designated area in the house for hand washing.

Table 2.3 and Figure 2.2 show percentages of the households possessing durable goods, an indicator of a household's socio economic level. The data shows that all the households both in urban and rural areas in Pulwama have electricity. More households in urban areas have television (79%) than rural households (58%). About 72% of the households have refrigerators; higher in urban areas (86%) than the rural areas (70%). Six percent of the households have computer and 79% have internet. More urban households than the rural households have computer and/or internet. Nearly 30% of the households have motorcycle both in rural areas (30%) and urban areas (31%). The percentage of households who own a car is 29%. Higher proportion of rural households (29%) than urban households (27%) have car and less than 2% of households have tractor.

Table 2.3: Ownership of selected consumer durable goods and households by wealth tertiles by the households, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Households own following items (%)			
Electricity	100.0	100.0	100.0
Television	78.6	57.7	61.1
Refrigerator	85.7	69.9	72.5
Computer	15.5	4.0	5.9
Internet	88.1	77.6	79.3
Two-wheeler (Motorcycle/scooter)	31.0	29.9	30.1
Four-wheeler (Car)	27.4	29.4	29.1
Tractor	1.2	1.9	1.8
Household wealth tertiles			
Low	16.7	36.9	33.6
Medium	45.2	33.9	35.7
High	38.1	29.2	30.7
Total (%)	100.0	100.0	100.0
Total eligible women surveyed	**428**	**84**	**512**

Figure 2.2: Ownership of consumer durable goods and household wealth tertiles, Pulwama (2020-21)



We constructed wealth tertiles using data on following items: source of drinking water (classified as piped, well, and other sources), type of toilet (classified as Flush/Pour, Pit, no toilet), type of fuel used

for cooking (classified as LPG. Coal and other sources), type of house (classified as *pucca*, Semi-*pucca*, *kachcha*), have a designated area in the house for hand washing, electricity in the house, possession of durable goods including television, refrigerator, computer, internet, motorcycle/scooter, car and tractor. We used Principal component analysis (PCA) and predicted scores for each item and created household wealth tertiles. The results are included in Table 2.3. Slightly less than one-third of the households in Pulwama belong to high wealth tertile and another one-third in low wealth tertile. Thirty-seven percent of the rural households and 17% of the urban households belong to low tertile. Conversely, 38% of urban household and 29% of the rural households belong to high wealth tertile.

Table 2.4 provides information of utilization of the e-*sanjeevani* national consultative online service of the Government of India and NIMHANS helpline for managing mental stress. The data shows that the uptake of both the services was abysmal among the surveyed households. None of the households had used e-*sanjeevani* and/or NIMHANS helpline for managing the mental stress during the pandemic.

Table 2.4: Utilization of e-Sanjeevani and NIMHANS helpline for managing mental stress by the households, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Used e-Sanjeevani, National Consultative Online Service of the Government of India			
No	100.0	100.0	100.0
Yes	0.0	0.0	0.0
Used NIMHANS helpline for managing mental stress?			
No	100.0	100.0	100.0
Yes	0.0	0.0	0.0
Total (%)	**100.0**	**100.0**	**100.0**
Total eligible women surveyed	**84**	**428**	**512**

2.2 Background characteristics of the respondents

The background characteristics of the women such as their age, marital status, religion, and caste, education, and work status has association with women's demographic and health-seeking behavior. For example, influence of educational attainment and engagement in economic activities has been found to be significant catalysts for favorable changes in demographic and socioeconomic changes. They promote positive reproductive attitudes and utilization of available health care services including reproductive and child health services and thereby improving health and well-being of women themselves, their families and more importantly of their children. Similarly, age at marriage has strong correlation with the reproductive and child health outcomes in a population. In this section, we discuss key background characteristics of the surveyed women. The survey collected information on age, educational attainment, religion, caste, marital status, age at marriage, work status and if woman owned a bank/post office account and also operated the same. Besides, information on the work status of her husband was also collected. The results are presented in Table 2.5 and Figure. 2.3.

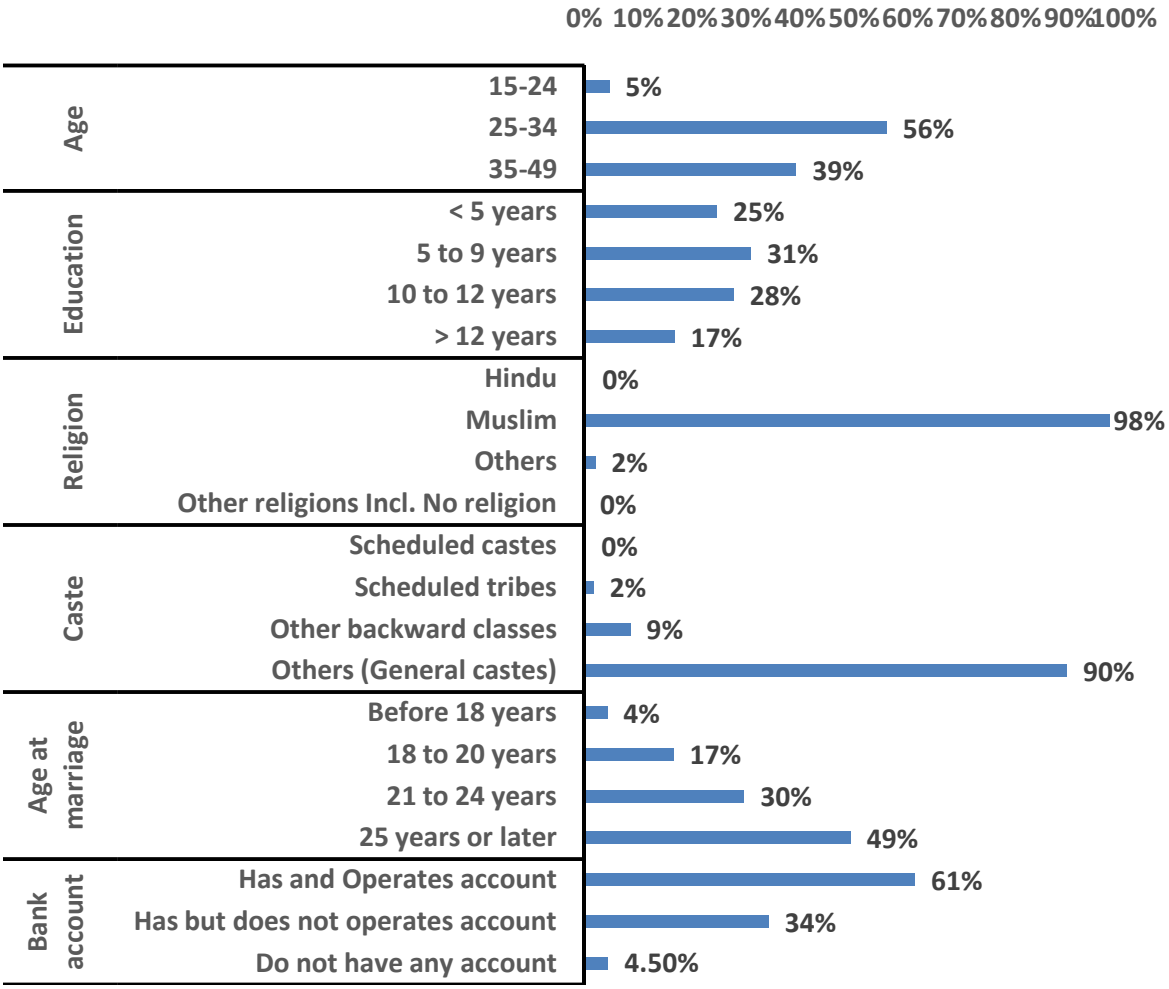
The median age of the surveyed women in Pulwama was 32.7 years. The median age of the urban was 0.38 years more than their counterparts in rural areas. The proportion of respondents in broad age groups suggests that about less than 5% of the surveyed women were aged 15–24 years which increased to 56% for the age group 25-34 years. A little less than 40% of the surveyed women were aged 35 years or older. As many as 54% of the urban women were in the age group 25-34 years

compared to 56 in the rural areas. Almost 42% of urban women were aged 35 years and above, whereas, their share was 39% in the rural areas.

Table 2.5: Selected background characteristics of the surveyed eligible women, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Woman age			
15-24	4.8	4.7	4.7
25-34	53.6	56.5	56.1
35-49	41.7	38.8	39.3
Median age of the women	33.09	32.71	32.77
Woman education			
Fewer than 5 years incl. never went to school	4.8	28.5	24.6
5 to 9 years	38.1	29.4	30.9
10 to 12 years	32.1	26.9	27.7
More than 12 years	25.0	15.2	16.8
Median years of schooling	10.2	8.9	9.2
Woman religion			
Hindu	2.4	0.0	.4
Muslim	97.6	97.4	97.5
Christian	0.0	0.0	0.0
Other religions Incl. No religion	0.0	2.6	2.1
Woman caste			
Scheduled castes	0.0	0.2	0.2
Scheduled tribes	0.0	2.1	1.8
Other backward classes	0.0	10.3	8.6
Others (General castes)	100.0	87.4	89.5
Woman marital status			
Never married	0.0	0.0	0.0
Currently Married	100.0	100.0	100.0
Widowed/Divorced/Separated/Deserted	0.0	0.0	0.0
Woman age at marriage			
Before 18 years	0.0	5.1	4.3
18 to 20 years	20.2	15.9	16.6
21 to 24 years	26.2	30.4	29.7
25 years or later	53.6	48.6	49.4
Woman current work status			
Currently working	23.8	14.7	16.2
Housewife / Not working	76.2	85.3	83.8
Woman husband current work status			
Currently working	95.2	93.2	93.6
Househusband / Not working	4.8	6.8	6.4
Bank account			
Has and Operates account	70.2	59.6	61.3
Has but does not operates account	26.2	35.7	34.2
Do not have any account	3.6	4.7	4.5
Total (%)	**100.0**	**100.0**	**100.0**
Total eligible women surveyed	**84**	**428**	**512**

Figure 2.3: Selected background characteristics of the surveyed eligible women, Pulwama (2020-21)



Fewer than one-fifth of the women had completed more than 12 years of schooling and about one quarter completed fewer than five years of schooling (including those who never attended school). About one-third completed 5 to 9 years of schooling and remaining 28% completed 10 to 12 years of schooling. Notably higher percentages of women in the urban areas than the rural areas have completed more than 12 years of schooling (25% as against 15%). Large majority of the women were Muslim – 97%. Non-Muslims (Hindus and Sikhs constituted) only 3% of the eligible women. Muslims women constituted 97% both in rural and urban areas but in rural areas Sikhs accounted for 3% of women and in urban areas Hindus constituted about 3% of our respondents. Almost 90% of the women belonged to the other castes (general category) followed by other backward classes (8%). The scheduled tribe women comprised of 2% of all respondents. All the women who belonged to other backward classes and scheduled tribes were from rural areas. All the women from urban areas belonged to the other castes (general category).

Table 2.6 provides details on the children ever born, surviving, dead by gender of the child of the respondents. Mean number of sons ever born was 0.78 and mean number of daughters born was 0.83. Mean number sons/daughter born was slightly higher in the rural areas as compared to the urban areas.

Table 2.6: Children ever born, children surviving, and children dead by sex of the child and place of residence, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Total sons ever born			
None	47.6	39.7	41.0
One son	36.9	43.2	42.2
Two sons	15.5	14.7	14.8
More than 2 sons	0.0	2.3	2.0
Mean sons ever born	0.68	0.80	0.78
Total daughters ever born	47.6	43.5	44.1
None	38.1	34.8	35.4
One daughter	9.5	15.7	14.6
Two daughters	4.8	6.1	5.9
More than 2 daughters	47.6	43.5	44.1
Mean daughters ever born	38.1	34.8	35.4
Total sons surviving			
None	48.8	41.1	42.4
One son	35.7	42.1	41.0
Two sons	15.5	14.7	14.8
More than 2 sons	0.0	2.1	1.8
Mean sons alive	0.67	0.78	0.76
Total daughters surviving			
None	48.8	44.4	45.1
One daughter	36.9	34.1	34.6
Two daughters	9.5	15.4	14.5
More than 2 daughters	4.8	6.1	5.9
Mean daughters alive	0.70	0.85	0.82
Total sons dead			
None	98.8	98.1	98.2
One son	1.2	1.9	1.8
Total daughters dead			
None	98.8	98.8	98.8
One daughter	1.2	1.2	1.2
Total (%)	**100.0**	**100.0**	**100.0**
Total eligible women surveyed	**84**	**428**	**512**

All the women were married at the time of survey. A significant minority of the respondents (4%) were married before age 18 years. Another 17% were married at ages 18 to 20 years (higher in urban areas – 20% than the rural areas – 16%). Almost 30% of the women were married at ages 21 to 24 years and nearly one-half married at ages 25 years or later. The share of women married at ages 25 years or later was considerably higher in the urban areas (54%) than the rural areas (49%).

Nearly 84% of the women reported that they were economically not active at the time of survey and were housewives; Only 16% were economically active. Slightly higher proportion of urban women

than the rural women were economically active at the time of survey (14% as against of 15%). In comparison, majority of the women 94% reported that their husbands were working. Interestingly, about 5% of the urban women reported that their husbands were not working at the time of survey. Sixty-one percent of the women have account in their names and also operated the account, whereas, about one-third reported that they have an account in their name but never operated it. Four percent of the women did not own a bank or post office account in their names. More women in urban areas than in the rural areas women have account in their names and also operated the account and conversely more women in rural areas than in urban did not own any account (5% compared to 7%).

Forty-two percent and 35% of the women, respectively, had one son or one daughter alive at the time of survey. Further, 41-44% women neither had no son or a daughter alive at the time of survey. About 2% women had more than two sons and 6% had more than 2 daughters alive at the time of survey. While majority of the women did not experience any child loss, there were 2% of the women who had lost one or more sons and 1% who lost one or more daughters. Share of women who experienced child loss was slightly higher in the rural areas compared to the urban areas.

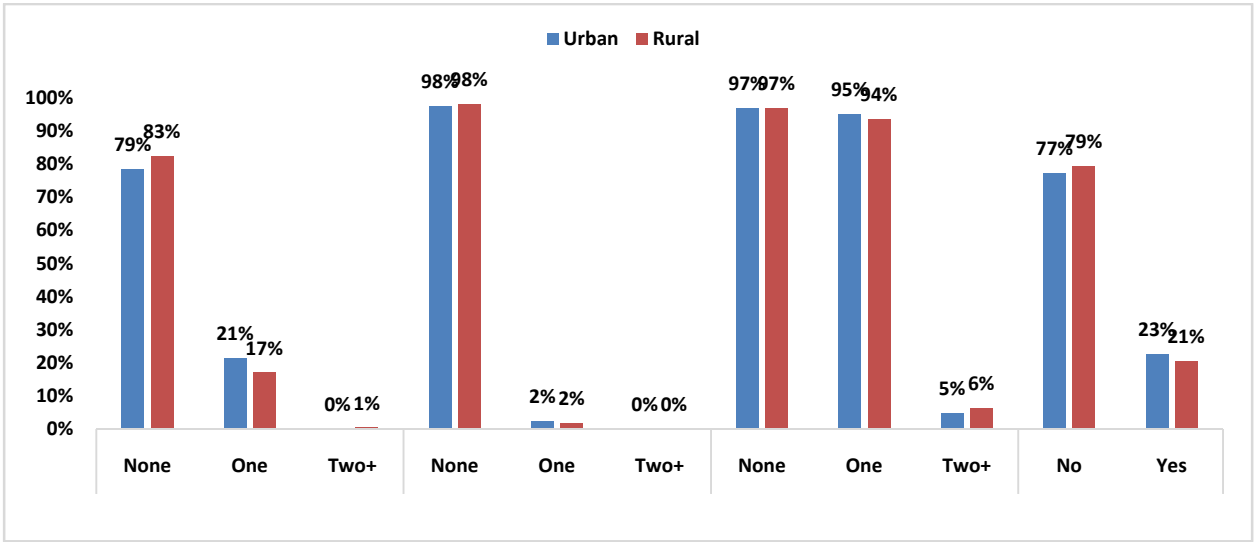
2.3 Live births, Abortions, Stillbirths during the reference period and current pregnancy status

Table 2.7 and Figure 2.4 provide distribution of women who had one or more live births, stillbirths and abortion during the past two years preceding the survey date, that is, from January 1, 2019 to the date of survey. The pregnancy status of the women at the time of survey is also included in the table. This information is useful for gathering information on subsequent sections on utilization of reproductive and child health care services including nutrition during the pandemic. Less than 20 percent of the women had at least one live birth during the reference period and 2% had one or more still births. Higher percentages of urban women (21%) than rural women (17%) had one or more live births. About 6% of the women reported that they had one or more abortions during the reference period. About 21% women were pregnant at the time of survey; notably lower in the rural areas (21%) than the urban areas (23%).

Table 2.7: Number of live births, stillbirths, abortions women had during January 2019 to survey date and her current pregnancy status, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Live births since January 1, 2019			
None	78.6	82.5	81.8
One	21.4	17.1	17.8
Two or more	0.0	0.5	0.4
Stillbirths since January 1, 2019			
None	97.6	98.1	98.0
One	2.4	1.9	2.0
Abortions since January 1, 2019			
None	95.2	93.7	93.9
One	4.8	6.3	6.1
Currently pregnant			
No	77.4	79.4	79.1
Yes	22.6	20.6	20.9
Total (%)	**100.0**	**100.0**	**100.0**
Total eligible women surveyed	**84**	**428**	**512**

Figure 2.4: Percentages of women who reported one or more live births, stillbirths, abortions during January 2019 to survey date and current pregnancy status for rural and urban areas, Pulwama (2020-21)



Chapter 3

Utilization of the maternal health care services by mothers for live births

Chapter 3

Utilization of the maternal health care services by mothers for live births

The present study obtained information from the eligible women about the utilization of health care -services during pregnancy, delivery and during the post-partum period from women who had one or more live birth during the two years prior to the survey (from January 1, 2019). The questions covered range of issues – starting from registration of pregnancy, early registration, number of antenatal care visits, various services received by the women during antenatal, place of service, complications experienced and treatment seeking for complications, difficulties faced by the women in seeking services during antenatal, natal and post-natal period etc. Information was also collected about services provided by the health workers, especially ASHAs during pandemic and if women received supplementary nutrition from the anganawadi centers/ICDS. This chapter presents results for all live births that occurred during the reference period.

3.1 Background characteristics of the live births

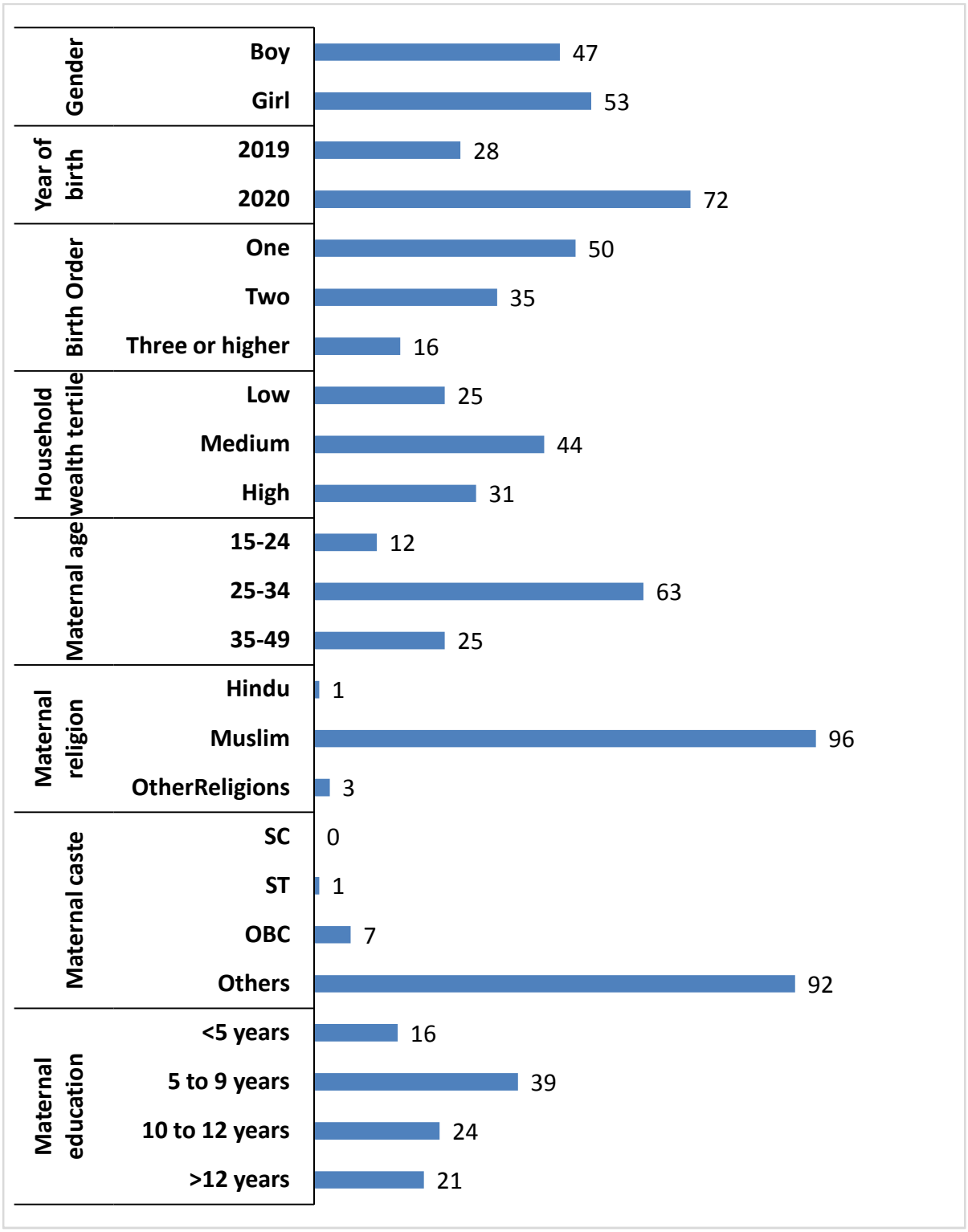
The Table 3.1 and Figure 3.1 provide distribution of all live births enumerated during the reference period by selected maternal and household background characteristics for Pulwama. A total of 95 live births enumerated (19%; 18 in urban areas and 81%; 77 in the rural areas) among 504 surveyed eligible women. Twenty-eight percent of the live births in Pulwama occurred in 2019 and 72% in 2020. About 47% of the live births were male and 53% female. Male births constituted slightly lower share of all live births in the rural areas (47%) than the female births (53%). Almost one half of the births were of first birth order. About 16% were of birth order three or higher (lower in urban areas than the rural areas; 6% and 18%, respectively). Nearly one-fourth of all births were pre-term births (gestation of less than nine months). Share of pre-term births was higher in the urban areas (33%) compared to the rural areas (26%).

One-Fourth of the births occurred to the mothers in the poor households and about 31% in the rich households. In urban areas share of birth in rich households was higher compared to the rural areas (33% and 29%, respectively). In contrast, 27% of the births in the rural areas were in the poor households, whereas their share in urban areas was 17%. With respect to maternal age, 63% of all births took place among older mothers (aged 25-34 years) and 25% were among oldest mothers aged 35-49 years). Share of births among young mothers was considerably lower (12%). Share of births among young mothers was considerably lower in the rural areas (10%) than in the urban areas (17%). Majority of the births belong to Muslim mothers (96%). In rural areas, share of births among Muslim mothers was considerably higher than in the urban areas (96% as against of 94%). Roughly 90% of the births were among mothers of general castes followed by other backward classes (7%). Nearly 20% of the births were among mothers who had completed 10 to 12 years of schooling and 39% among mother with 5 to 9 years of schooling.

Table 3.1: Distribution of live birth during the reference period by year of birth, gender, birth order and duration of gestation and a few maternal characteristics by place of residence, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Year of birth			
2019	5.6%	33.8%	28.4%
2020	94.4%	66.2%	71.6%
Gender			
Boy	50.0	46.8	47.4
Girl	50.0	53.2	52.6
Birth Order			
One	66.7	45.5	49.5
Two	27.8	36.4	34.7
Three or higher	5.6	18.2	15.8
Completed months of pregnancy at birth			
7 months			
8 months	33.3	26.0	27.4
9 months	66.7	74.0	72.6
Household wealth tertile			
Low	16.7	27.3	25.3
Medium	50.0	42.9	44.2
High	33.3	29.9	30.5
Maternal age			
15-24	16.7	10.4	11.6
25-34	61.1	63.6	63.2
35-49	22.2	26.0	25.3
Maternal religion			
Hindu	5.6	0.0	1.1
Muslim	94.4	96.1	95.8
Christian			
Other Religions	0.0	3.9	3.2
Maternal caste			
Scheduled castes	0.0	0.0	0.0
Scheduled tribes	0.0	1.3	1.1
Other backward classes	0.0	9.1	7.4
Others (General castes)	100.0	89.6	91.6
Maternal education			
Fewer than 5 years incl. never went to school	5.6	18.2	15.8
5 to 9 years	50.0	36.4	38.9
10 to 12 years	5.6	28.6	24.2
More than 12 years	38.9	16.9	21.1
Overall (%)	**100.0**	**100.0**	**100.0**
Number of live births	**18**	**75**	**95**

Figure 3.1: percent distribution of the births during the reference period by background characteristics, Pulwama (2020-21)



3.2 Antenatal care

Table 3.2 provides information on several antenatal care services utilized by the mothers during pregnancy for births during the reference period.

Registration of the pregnancy and ANC visits and services received during the visit

It is encouraging to note that the pregnancy was not only registered for all the 95 births, but registered in the first trimester itself for 97% of live births. The mothers received four or more antenatal care visits during pregnancy for almost all births. Nonetheless, in less than 2% cases in the rural areas, mothers made three or fewer ANC visits during the pregnancy. In 99 percent or the cases, mothers received a mother and child protection (MCP) card, have their abdomen examined, weight taken, Blood pressure measured, blood sugar and/or hemoglobin tested, received one or more tetanus injections, tested for HIV, and had an ultrasound/sonography done during the pregnancy. Almost 85-90 percent of women received and consumed IFA tablets/Syrup. However, COVID-19 test was done in about 55% of the cases.

Table 3.2: Utilization of various antenatal care services, place from where most of the ANC services received and place pregnancy registered, Pulwama (2020-21)

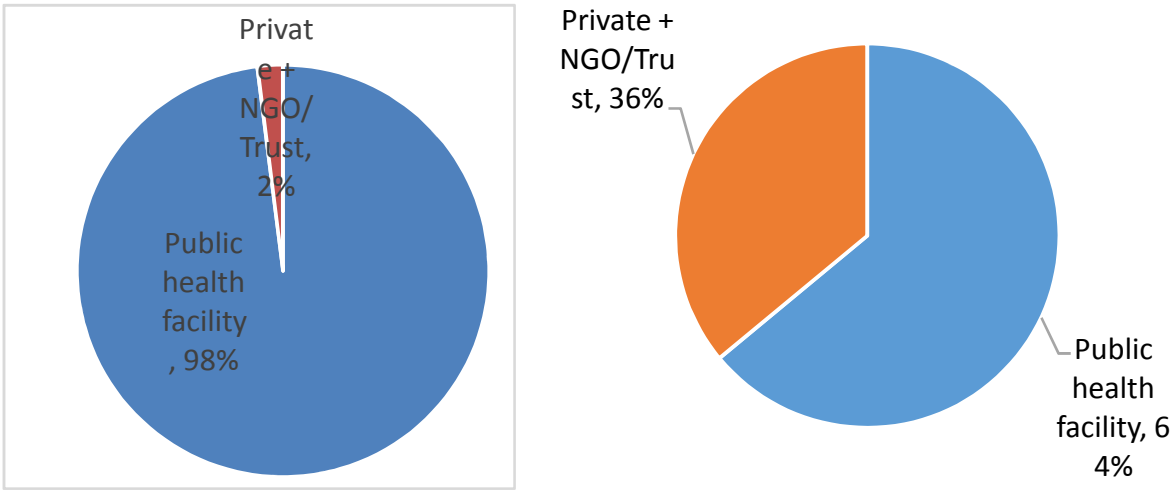
Characteristics	Urban	Rural	Combined
Pregnancy registered in first trimester or later			
Registered in the first trimester	94.4	97.4	96.8
Registered in the second/third trimester	5.6	2.6	3.2
Not registered yet			
Number of antenatal care visits			
Three or fewer	0.0	1.3	1.1
Four or more	100.0	98.7	98.9
Percentages mothers who received:			
MCP card	100.0	100.0	100.0
Abdomen examines	100.0	98.7	98.9
Weight taken	94.4	100.0	98.9
Blood pressure measured	100.0	100.0	100.0
Blood sugar tested	100.0	100.0	100.0
Haemoglobin tested	100.0	100.0	100.0
Tested for COVID-19	66.7	51.9	54.7
Tested for HIV	100.0.	100.0.	100.0.
Received IFA tablets/Syrup	94.4	89.6	90.5
Consumed IFA tablets/Syrup	94.1	85.7	86.3
Had an ultrasound/sonography	100.0	100.0	100.0
Received one or more TT injection	100.0	100.0	100.0
Place from where most ANC services received			
Public health facility incl. ICDS center	100.0	97.4	97.9
Private facility, service providers incl. NGO/Trust	0.0	2.6	2.1
Registered pregnancy, place pregnancy registered			
Public health facility incl. ICDS center	83.3	87.0	86.3
Private facility, service providers incl. NGO/Trust	16.7	13.0	13.7
Number of live births	**18**	**77**	**95**

Place of ANC services

Information has been collected about the place from where they received most of the ANC services during pregnancy for all births during the reference period. The data shows that of all births which registered pregnancy, almost 98% received most of the ANC services from a public health facility (including State/municipality hospital, district hospital, community health center, primary health center, health sub-center, and ICDS/anganwadi center). Remaining 2% received the services from a private health facility including trust/NGO hospitals. All the women from urban areas received most of the ANC services from public health facilities and in rural areas 3% received most services from public private health facilities.

However, it is encouraging to note that of the births that were registered in the first trimester of pregnancy, 86% were registered in a public health facility however, 14% reported getting most ANCs from a private health facility. In rural areas, slightly higher proportions of birth were registered in a public health facility than in the urban areas; conversely, share of private health facilities was higher in the urban areas.

Figure 3.2: Share of births by place from where most ANC services received and facility pregnancy registered, Pulwama (2020-21)



Difficulties experienced in getting ANC services during the pandemic

Table 3.3 provides results on whether mothers experienced any difficulties while seeking antenatal care during the pandemic and if so, what was the nature of difficulty experienced. In large proportions of cases, mothers did not experience any difficulty (68%).

Table 3.3: Difficulties experienced by the mothers in seeking ANC during the pregnancy due to pandemic, how often mothers faced difficulties and nature of difficulty, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Frequency of experiencing difficulties			
Every time/Most of the time	22.2	18.2	18.9
Sometimes/Rarely	22.2	10.4	12.6
Never	55.6	71.4	68.4
Nature of difficulty experienced (%)			
No transport facility	62.5	72.7	70.0
Family did not allow due to COVID-19	0.0	9.1	6.7
Family refused to accompany due to COVID-19 fear	0.0	0.0	0.0
Facility closed	0.0	4.5	3.3
No staff at facility	0.0	13.6	10.0
Staff refused to provide service due to COVID-19	25.0	40.9	36.7
ASHA/ANM not available	0.0	0.0	0.0
No money	12.5	27.3	23.3
Health facility converted to COVID hospital	0.0	9.1	6.7
Too much time for travel due to COVID restrictions/checks	12.5	9.1	10.0
Too long wait at facility due to COVID protocol	12.5	4.5	6.7
Stressed due to strict COVID protocols	37.5	22.7	26.7
Stress due to COVID infection while waiting at facility	12.5	13.6	13.3
Number of live births	**8**	**22**	**30**

Nonetheless, one in nineteen cases mothers reported that they faced difficulty every time /most of the time they sought ANC during the pandemic; slightly higher in urban areas. Another about 13% cases they experienced difficulty sometimes or rarely. Non-availability of the transport to reach facility for the ANC was the most common difficulty experienced by the mothers (70%). Higher proportion of rural mothers reported this than the urban mothers (73% versus 62%). Significant proportion of the cases, mothers reported difficulties faced due to pandemic related reasons in urban and rural areas both and from family side as well as from facility side. For example, several cases it was reported that staff refused to provide services due to COVID-19, or stressed due to strict COVID protocols, stressed due to fear of COVID infection while waiting at the facility, families did not allow them to go out or facility was closed or staff was not available or long waiting/travel time at facility due to pandemic protocols/lockdown or the facility they usually seek ANC was converted to a COVID-19 facility.

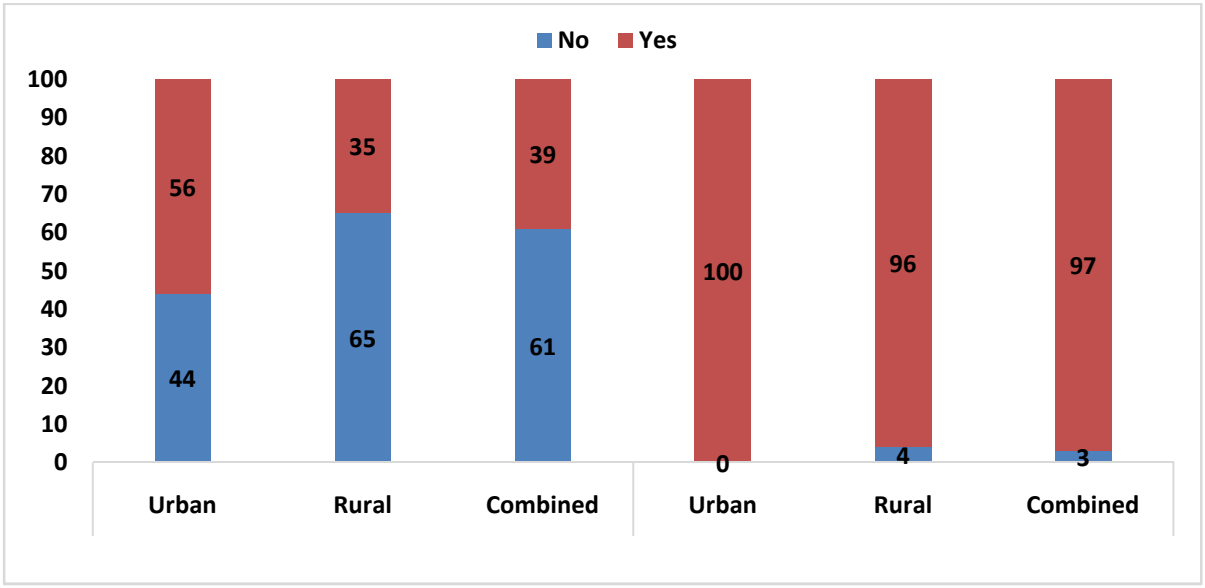
3.3 Pregnancy complications and treatment seeking

Table 3.4 and Figure 3.3 provide results on whether the mothers experienced any complication when they were pregnant, type of complications experienced and if they sought treatment for complication(s). The data suggests that in 39% (slightly higher in urban areas – 56%) mother experienced one or more pregnancy complication during the pregnancy. Overall, in 40% cases, mothers suffered from excessive vomiting followed by weakness/excessive fatigue (27%) and abdominal pain (19%) and headache (16%). Significant minorities of the mothers suffered from swelling of legs, face or body (11%) and bleeding/spotting (8%). About 3-5% cases each, mothers suffered from, weak/no fetus movement, abnormal fetus position, and vaginal discharge. Other complications were also experienced by 40% of women.

Table 3.4: Experienced pregnancy complication, type of complication experienced and treatment sought for pregnancy complication, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Experienced any complications during pregnancy			
No	44.4	64.9	61.1
Yes	55.6	35.1	38.9
Type of pregnancy complication (%)			
Difficulty with vision during daylight	0.0	0.0	0.0
Convulsions (not from fever)	0.0	11.1	8.1
Swelling on legs, body, face	10.0	11.1	10.8
Bleeding / Spotting	0.0	11.1	8.1
Excessive vomiting	40.0	40.7	40.5
Headache	10.0	18.5	16.2
Weakness / Excessive fatigue	20.0	29.6	27.0
Weak or no fetus movement	10.0	3.7	5.4
Abnormal fetus position	0.0	0.0	0.0
Vaginal discharge	0.0	3.7	2.7
Abdominal pain	10.0	22.2	18.9
Other complications	40.0	40.7	40.5
Number of live births	**10**	**27**	**37**
Sought treatment for pregnancy complication(s)			
No	0.0	3.7	2.7
Yes	100.0	96.3	97.3
No. of births, mother experienced complication	**10**	**27**	**37**

Figure 3.3: Experienced pregnancy complication and sought treatment for pregnancy complication, Pulwama (2020-21)



Roughly about equal proportion of the cases in rural and urban areas reportedly experienced excessive vomiting and other complications. Higher percentages of mothers suffered from excessive fatigue and abdominal pain and headache in the rural areas (30%, 22% and 18% respectively) than in the urban areas (20, 10 and 10%, respectively). Similarly, vaginal discharge and bleeding/spotting or convulsions, not from fever, convulsions were more also common in the rural areas. On the other hand, more mothers in the urban areas reportedly suffered from weak or no fetus (10%) than in the rural areas (4%). Although, in majority of cases, mothers sought treatment for pregnancy complication, there were 3% cases when mothers did not seek treatment for the complication. All the women who did not seek treatment for pregnancy complication were from rural areas.

In seven cases when mothers suffered from a pregnancy complication, did not seek treatment. Five of the mothers (all in the rural areas) cited 'Complication not severe' as the most important reason for not seeking treatment. One each (in urban areas) did not seek treatment due to 'Too long wait at facility due to COVID-19 protocol' and 'Stressed due to strict COVID-19 protocols'.

3.4: Natal care

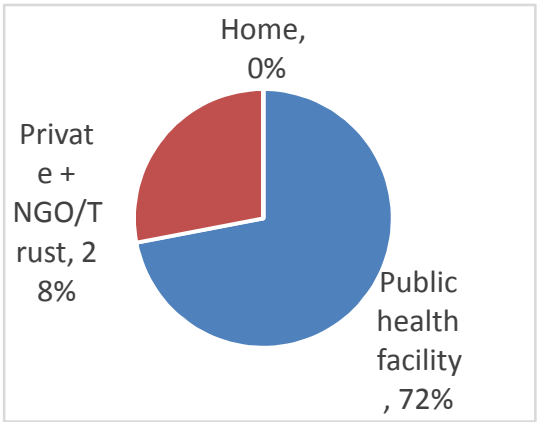
Table 3.5 AND Figure 3.4 provide results on place of delivery, type of delivery and assistance at the time of delivery. All births took place in a health facility. However, while 83% of the births took place in a public health facility, 177% took place in a private health facility. Share of private facility deliveries were higher in the urban areas (28%) than the rural areas (14%). Eighty-five percent of the births were delivered through C-section. This is not surprising as Pulwama is known to have a very high C-section delivery rates. Only 15% of the deliveries were normal. C-section is much higher in the urban areas (94%) than in rural areas (83%). Barring one birth in a village all births were assisted by a doctor.

Table 3.5: Place of delivery, type of delivery and assistance at the time of delivery by place of residence, Pulwama (2020-21)

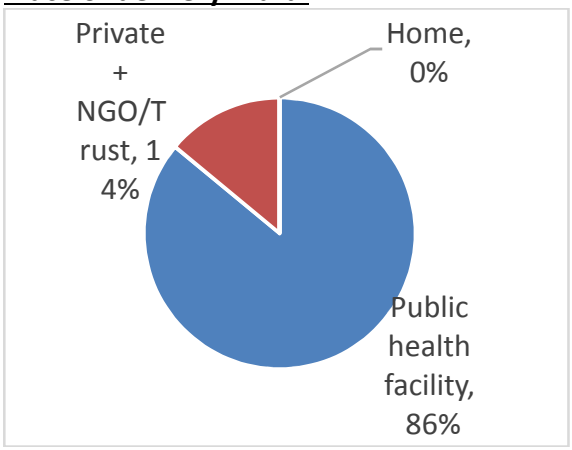
Characteristics	Urban	Rural	Combined
Place of delivery			
Public health facility	72.2	85.7	83.2
Private health facility incl. NGO/Trust	27.8	14.3	16.8
Home	0.0	0.0	0.0
Type of delivery			
Normal	5.6	16.9	14.7
C-Section	94.4	83.1	85.3
Assistance at delivery			
Doctor	100.0	98.7	98.9
ANM/Nurse/LHV	0.0	0.0	0.0
Traditional Birth Attendant	.0.0	0.0	0.0
Friends / Relatives	0.0	1.3	1.1
Overall	**100.0**	**100.0**	**100.0**
Number of live births	**18**	**77**	**95**

Figure 3.4: Place, type and assistance at delivery by place of residence, Pulwama (2020-21)

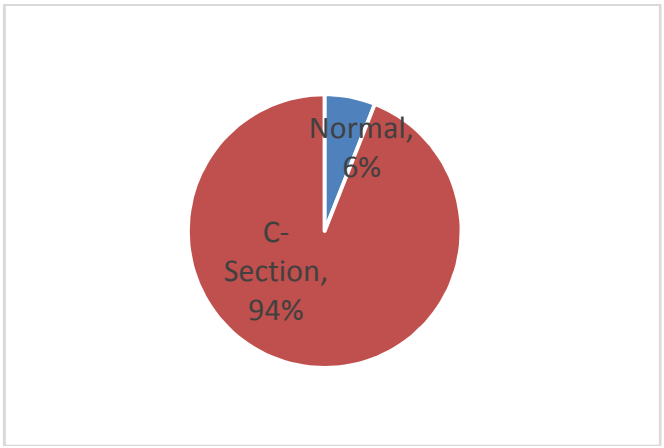
Place of delivery: Urban



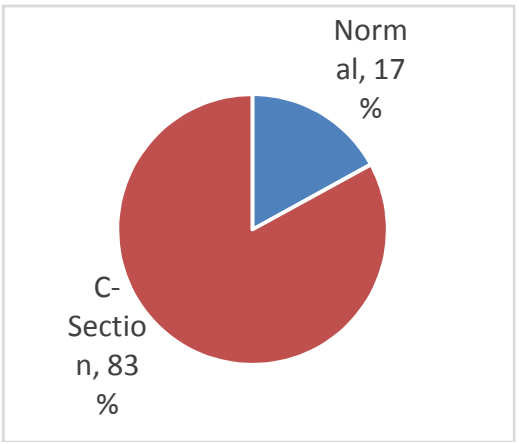
Place of delivery: Rural



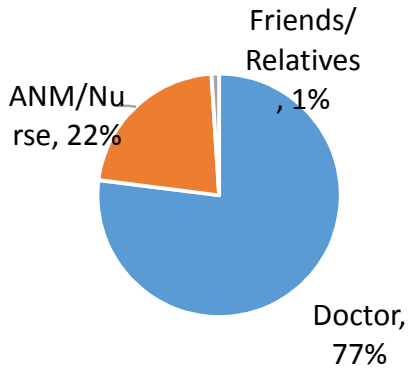
Type of delivery: Urban



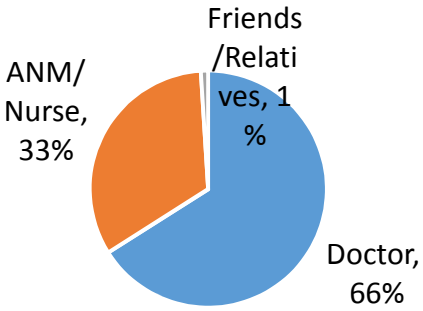
Type of delivery: Rural



Assistance at delivery: Urban



Assistance at of delivery: Rural



The results in Table 3.6 show that a private vehicle was used to reach health facility for delivery in majority of the cases (88%). Public transport was used in only 10% of the cases. Private vehicle use was much higher in the urban areas (94%) and 6% of the women in urban areas reached the health facility on foot. On the other hand, in rural areas, public transport was used by 87% of women and 13% used a public transport at the time of delivery. ASHA accompanied mother to the hospital in about 38% of the cases; higher in the urban areas (56%). In about 60% of the cases mother was discharged from the health facility in 2-3 days. Further, in a little over 24% cases mother was discharged after five days after delivery.

Table 3.6: Transport used to reach facility, ASHA accompanied to facility and duration of stay at hospital after delivery, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Mode of transport used to reach facility			
Government vehicle	0.0	13.0	10.5
Private vehicle	94.4	87.0	88.4
NGO/Charity/Trust vehicle			
Walking/On foot	5.6	0.0	1.1
Other modes used	0.0	0.0	0.0
Did ASHA accompany to facility			
No	44.4	66.2	62.1
Yes	55.6	33.8	37.9
Duration of stay in the health facility			
Discharged same day/stayed for one day	11.1	10.4	10.5
2- 3 days	66.7	58.4	60.0
4-5 days	16.7	26.0	24.2
More than 5 days	5.6	5.2	5.3
Overall	100.0	100.0	100.0
Number of live births	**18**	**77**	**95**

3.5: Delivery complications and treatment seeking

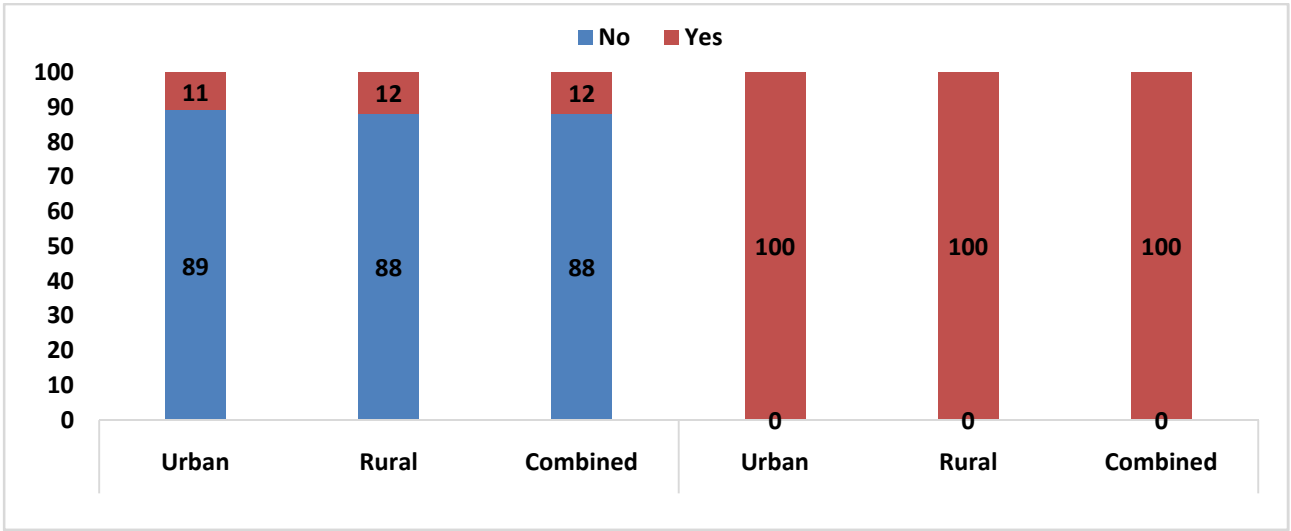
Table 3.7 provides results on whether the mothers experienced any complication at the time of delivery, type of complications experienced and if they sought treatment for complication(s). The data suggests that in 12% (slightly higher in rural areas – 12%) mother experienced one or more delivery complication. Overall, in 45% cases, mothers suffered from excessive bleeding , followed by blood pressure problem (36%) and placenta problem (18%). Prolonged bleeding lasting longer than 12 hours was reported by 9% of women. Other complications suffered at delivery were like vaginal discharge, preterm labor, sepsis/fever etc were experienced by 9%.

While blood pressure and placenta problem were more commonly reported complications in the urban areas, excessive bleeding, prolonged bleeding lasting longer than 12 hours were common in the rural areas. In all cases of delivery complications mothers sought treatment.

Table 3.7: Experienced complication at delivery, type of complication experienced and sought treatment for delivery complication for live births, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Experienced any complication at the time of delivery			
No	88.9	88.3	88.4
Yes	11.1	11.7	11.6
% Experienced delivery complication(s)			
Prolonged bleeding lasting longer than 12 hours	0.0	11.1	9.1
Excessive bleeding	0.0	55.6	45.5
Breech presentation (abnormal fetus position)	0.0	0.0	0.0
Umbilical cord prolapse	0.0	0.0	0.0
Perinatal asphyxia	0.0	0.0	0.0
Blood pressure problem	50.0	33.3	36.4
Placenta problem	50.0	11.1	18.2
Vaginal discharge	0.0	0.0	0.0
Weak/No fetus movement	0.0	0.0	0.0
Premature rupture of membranes	0.0	0.0	0.0
Preterm labor	0.0	0.0	0.0
Obstructed labor	0.0	0.0	0.0
Sepsis / Fever	0.0	0.0	0.0
Other complications	0.0	11.1	9.1
Number of live births	18	77	95
Sought treatment for delivery complications			
No	0.0	0.0	0.0
Yes	100.0	100.0	100.0
No. of births mother suffered complication	**2**	**9**	**11**

Figure 3.5: Experienced complications at delivery and sought treatment for complication by place of residence, Pulwama (2020-21)



3.6 Post-delivery complications and treatment seeking

Table 3.8 provides results on whether the mothers experienced any complication post-delivery during post-partum, type of complications experienced and if they sought treatment for complication(s). The data suggests that in 9% (higher in rural areas – 10%) mother experienced one or more post-delivery complication. Overall, in 22% cases, mothers suffered from bleeding/spotting followed by Prolonged bleeding lasting longer than 12 hours, Swelling on legs, body, face, Nausea /Vomiting and Low blood pressure. It was reported by 22% of mothers that they also suffered some other post delivery complications.

All the women who suffered from lower abdominal cramps and during the post-partum period are from urban areas. While as other above mentioned problems were mainly experienced by rural women. It is encouraging to note that all mothers who suffered from a post-delivery complication sought treatment for the complication.

Table 3.8: Experienced complication after delivery during post-partum, type of complication experienced and sought treatment for complication for live births, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Experienced any complication post delivery			
No	94.4	89.6	90.5
Yes	5.6	10.4	9.5
% Experienced post-delivery complication(s)			
Difficulty with vision during daylight	0.0	0.0	0.0
Convulsions (not from fever)	0.0	0.0	0.0
Prolonged bleeding lasting longer than 12 hours	0.0	12.5	11.1
Swelling on legs, body, face	0.0	12.5	11.1
Bleeding / Spotting	0.0	25.0	22.2
Lower abdominal cramps	100.0	0.0	11.1
Foul smelling coucha	0.0	0.0	0.0
Urine perforation	0.0	0.0	0.0
Nausea / Vomiting	0.0	12.5	11.1
Red, Sore and Tender breasts	0.0	12.5	11.1
Fever	0.0	0.0	0.0
Low blood pressure	0.0	12.5	11.1
Rapid breathing	0.0	0.0	0.0
Other complications	100.0	12.5	22.2
Number of live births	**18**	**77**	**95**
Sought treatment for post-delivery complications			
No	0.0	0.0	0.0
Yes	100.0	100.0	100.0
No. of births, mother suffered complication	**1**	**8**	**9**

3.7: Health checkups during Post-partum period

Table 3.9 provides results on health checkups for mother during post-partum, place of health checkup, person conducted health checkup and total number of health checkups within the first two weeks and two months after delivery. It is encouraging to note that nearly 87% of the mothers had their first post-

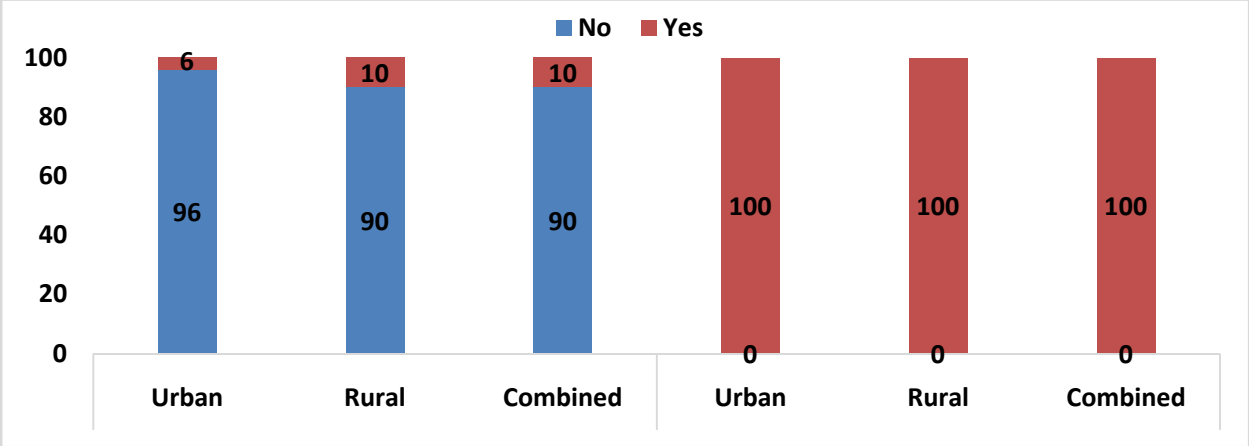
natal checkup within 24 hours of delivery and another 7% (higher in the rural areas, 9%) received the same after 24 hours. Five percent of the mothers in the rural areas did not receive any post-natal checkup by the time data was collected. Further, 84% of the mothers had their first post-natal checkup at a public health facility and the remaining at a private health facility. Higher proportion of the mothers in the rural areas had their first post-natal checkup in a public health facility (87%) compared to the mothers in the urban areas (72%). Conversely, higher proportions of the mothers in the urban areas had their first post-natal checkup at a private health facility. In 98% of the cases, mother was checked by the doctor and remaining 2% by a nurse/midwife. All the women from urban areas reported that they received their first post-natal checkup from a doctor while as all women who received a post-natal check up from a nurse/midwife belonged to rural areas.

Table 3.9: Health checkups for mother during post-partum, place of health checkup, person conducted health checkup and total number of health checkups within first two weeks and two months after delivery, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Time since delivery mother had first PNC checkup			
Within 24 hours	94.4	85.7	87.4
After 24 hours	0.0	9.1	7.4
Did not have PNC checkup	5.6	5.2	5.3
Place of first post-delivery PNC checkup			
Public health facility incl. ICDS center	72.2	87.0	84.2
Private facility, service providers incl. NGO/Trust	27.8	13.0	15.8
Person who did first post-delivery PNC checkup			
Doctor	100.0	97.4	97.9
ANM/Nurse/LHV	0.0	2.6	2.1
Traditional Birth Attendant	0.0	0.0	0.0
Others	0.0	0.0	0.0
Number of PNC checkup within first two weeks			
One	0.0	7.8	6.3
Two	11.1	6.5	7.4
Three or more	88.9	85.7	86.3
Number of PNC checkup within first two months			
One	0.0	7.8	6.3
Two	11.1	6.5	7.4
Three or more	88.9	85.7	86.3
Number of live births	**18**	**77**	**95**

It is encouraging that more than 85% of women both in rural and urban areas received three or more post-natal checkups and another 7% received two post-natal checkups within the first two weeks after the delivery. Six percent of mothers received only one post-natal checkups within first two weeks. Similarly, 86% of the mothers had three or more post-natal checkups within the first two-months after the delivery and another 7% had two post-natal checkups during the same period. A minority of women (6%) mainly in rural areas had only one post-natal checkups within the first two months after the delivery.

Figure 3.6: Experienced complications post-delivery and sought treatment for complication by place of residence, Pulwama (2020-21)



3.8: Money spent on delivery, benefits received under JSY

Table 3.10 provides results on money spent on delivery, received JSY benefits and amount received under JSY by the mothers. An average of Rs. 8438 was spent on delivery; higher in the urban areas (11361/-) compared to the rural areas (7754/-). Although JSSK covers all women in J&K and all services are provided free under this scheme but none of the women reported that the delivery was entirely free and women have incurred expenses on delivery. An amount of Rs 2001-5000 was spent in 61% of the cases (50% in urban areas and 64% in rural areas). Further, an amount of more than 5000 was spent in as many as 25% of births (28% in urban areas and 25% in rural areas). In more than 50 percent of cases, mothers had not received JSY benefits. More urban mothers reported not receiving JSY benefits than the rural mothers (61% versus 56%). Among mother who received JSY benefits, they got an average of Rs. 1286 only. All women in rural areas received recommended amount of Rs. 1400, while as urban women received on an average Rs. 1286.

Table 3.10: Money spent on delivery, received JSY incentives and amount received under JSY, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Money spent on live birth (in Rs.)			
None	0.0	0.0	0.0
Up to 2000	22.2	11.7	13.7
2001-5000	50.0	63.6	61.1
More than 5000	27.8	24.7	25.3
Do not remember	**11361**	**7754**	**8438**
Mean money spent on delivery	***1286***	***1400***	***1286***
Received JSY benefits			
No	61.1	55.8	56.8
Yes	38.9	44.2	43.2
Number of live births	**18**	**77**	**95**

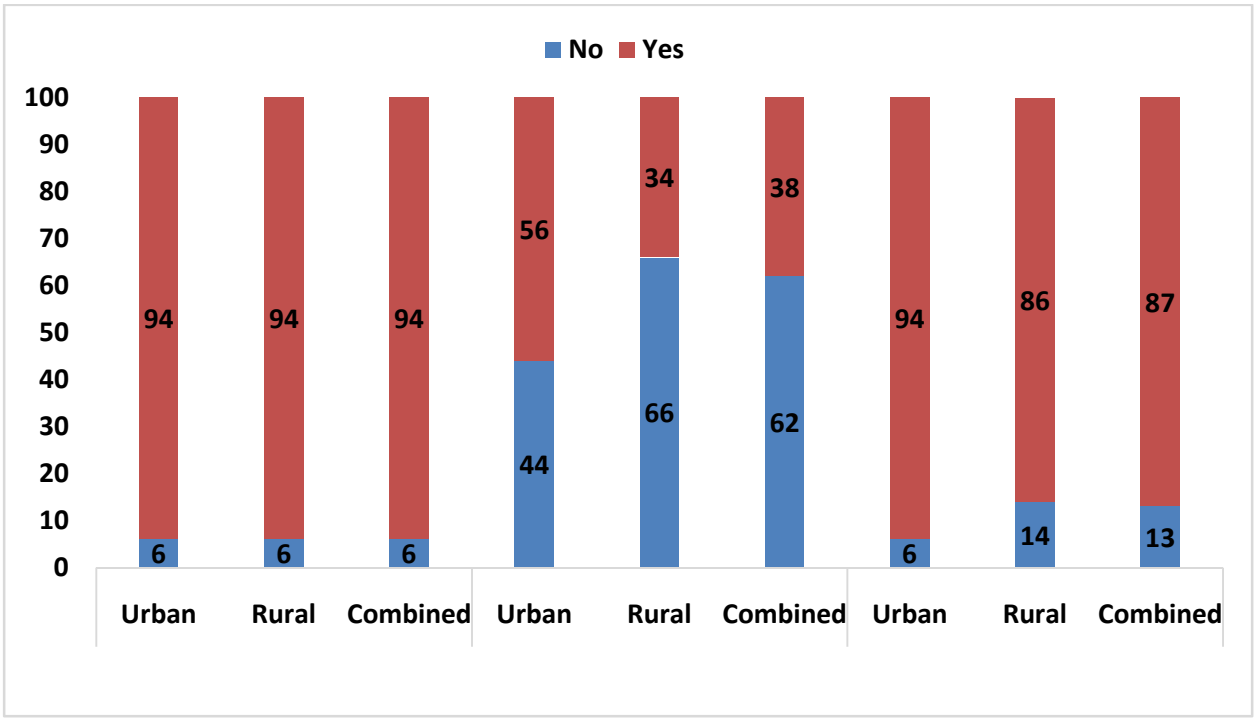
Amount received under JSY			
Up to 600 Rs.	0.0	0.0	0.0
601 to 1400 Rs.	100.0	100.0	100.0
More than 1400 Rs.	0.0	0.0	0.0
Do not remember amount	0.0	0.0	0.0
Mean money received under JSY	***1286***	***1400***	***1380***
No. of birth for which mothers received JSY money	**18**	**77**	**95**

3.9 Contact with the health worker/ASHA

Table 3.11 provides results on woman's contact with the health worker and services they received from the health worker when contacted during the pregnancy/delivery or post-delivery. Overwhelmingly large proportions of the mothers (94%) reported that a health and/or an ICDS worker has visited them during the pregnancy. Further, almost the mothers (99%) reported that the health worker visited them during their pregnancy and 62% reported health workers visited after the delivery. However, 38% of the mothers reported that health worker visited them at the time of delivery.

The urban-rural gap was wider for health worker visit at the time of delivery. Majority of the mothers (93%) reported that the ASHA provided them advice about various issues related to pregnancy, delivery and child care. Relatively fewer mothers (34%) reported that ASHA accompanied them to the facility and another 3% reported that the ASHA arranged vehicle for them during the pregnancy when needed. In 38% of the cases, ASHA accompanied the mothers to the hospital for delivery; much higher in the urban areas (56%).

Figure 3.7: Health worker, ASHA visit to women during pregnancy or pandemic and whether accompanied women to facility for delivery, Pulwama (2020-21)



The information was also collected on whether ASHA contacted mothers and if they contacted ASHA for any help related to birth of the child during the pandemic and whether ASHA helped them. Slightly more than four-fifth of the mothers reported that the ASHA visited them during the pandemic to check about the pregnancy/childbirth related matters. Proportions of mothers who were visited by ASHA during COVID pandemic was much higher in the urban areas (94%) than the rural areas (86%). About 75% of the mothers contacted ASHA for help during the pandemic and also received help from her. Nonetheless, there were a few mothers who reached out to ASHA but did not get needed help. Further, a considerable proportion of the mothers (25%) reported that they did not reach out to ASHA for any help related to the pregnancy/childbirth during the pandemic.

Almost 90% of all mothers reported that ASHA advised them when they contacted her. Further, one-third of the mothers, (one-fourth in rural areas and two-third in urban areas) who contacted ASHA during pandemic reported that ASHA accompanied them to a health facility and 3% mentioned that they also arranged for a vehicle to go to facility.

Table 3.11: Health worker(s) visited mother, mother contacted ASHA for pregnancy related help and type of help ASHA provided during the pandemic, Pulwama (2020-21)

	Urban	Rural	Combined
ASHA/ANM/AWW/TBA visited during pregnancy			
No	5.6	6.5	6.3
Yes	94.4	93.5	93.7
% visited by the health worker:	100.0	100.0	100.0
During pregnancy	100.0	98.6	98.9
At the time of delivery	52.9	34.7	38.2
After delivery	64.7	61.1	61.8
Type of help ASHA provided during pregnancy			
Arranged vehicle to go to facility	0.0	4.2	3.4
Accompanied to facility	64.7	26.4	33.7
Gave advice	88.2	94.4	93.3
Other help	0.0	0.0	0.0
ASHA accompanied to health facility for delivery			
No	44.4	66.2	62.1
Yes	55.6	33.8	37.9
ASHA visited during pandemic			
No	5.6	14.3	12.6
Yes	94.4	85.7	87.4
Mother contacted ASHA for help and if ASHA helped			
Contacted ASHA and got help	78.0	74.0	75.0
Contacted ASHA, did not get help	0.0	0.0	0.0
Did not contact ASHA	22.0	26.0	25.0
Number of live births	**14**	**57**	**71**
Type of help ASHA provided when contacted			
Got medicine	0.0	0.0	0.0
Arranged vehicle to go to facility	0.0	4.2	3.4
Accompanied to facility	64.7	26.4	33.7
Gave advice	88.2	94.4	93.3
Number of births, mother contacted ASHA	**14**	**57**	**71**

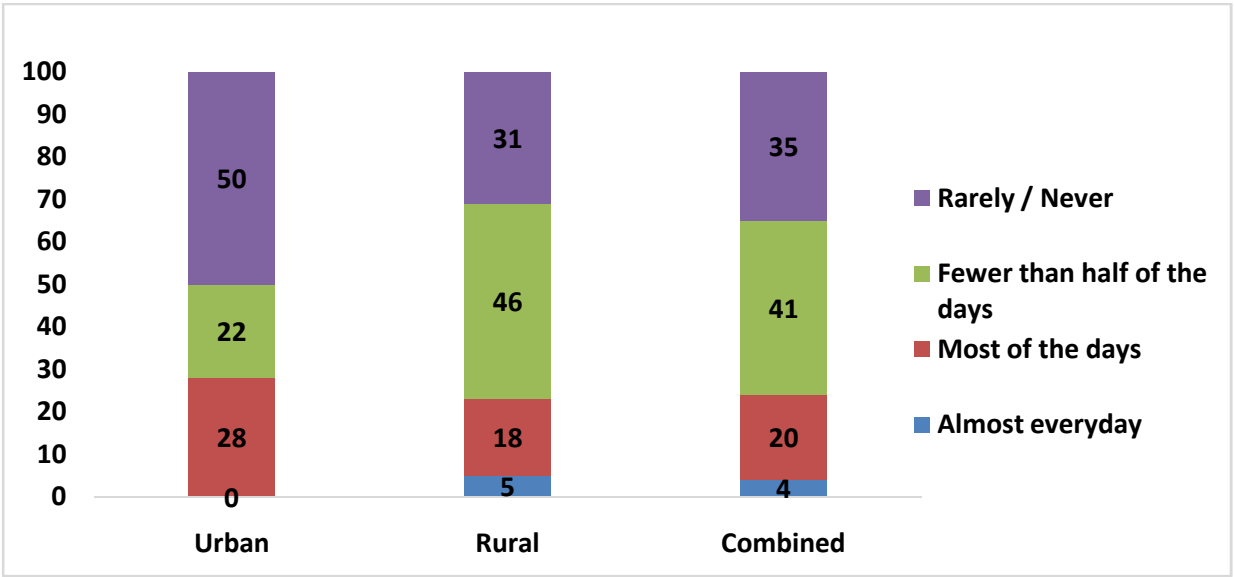
3.10 Supplementary nutrition

Table 3.12 provides results on distribution of the live births by whether mothers received supplementary nutrition during pandemic from the anganwadi and the reason if they did not receive the supplementary nutrition. Less than 5% of the mothers reported that they received supplementary nutrition almost every day from the ICDS during the pandemic when they were pregnant and another 20% got it on most of the days. Nonetheless, 35% of the mothers reported that they rarely/never received the supplementary nutrition and 41% received for fewer than half of the days. The mothers who reportedly rarely/never received the supplementary nutrition were further asked about the reason for the same.

Table 3.12: Pregnant mothers received supplementary nutrition (SN) from the ICDS during the pandemic, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Received supplementary nutrition from ICDS/AWC			
Almost everyday	0.0	5.2	4.2
Most of the days	27.8	18.2	20.0
Fewer than half of the days	22.2	45.5	41.1
Rarely / Never	50.0	31.2	34.7
No. of live births			
Reason mothers rarely/never received SN			
ICDS/AWC closed due to COVID-19	11.1	20.8	18.2
AWW did not provide at home	11.1	12.5	12.1
Not allowed to go to AWC due to COVID-19	0.0	0.0	0.0
AWC did not receive supply due to COVID-19	0.0	16.7	12.1
Other reasons	77.8	50.0	57.6
Number of births, mothers rarely/never received SN	**9**	**24**	**33**

Figure 3.8: Mothers received supplementary nutrition (SN) from the ICDS during the pandemic, Pulwama (2020-21)



Of those who rarely/never received supplementary nutrition, 18% reported that ICDS Centre was closed due to COVID19 and 12% were not allowed to go to AWC due to COVID and another 12% mentioned that AWC did not receive supplies due to COVID.

3.11 Selected indicators by socio-demographic characteristics

Table 3.13 results data on the percentages of births by place of residence, household wealth tertile, woman's age, religion, caste, and her educational status for selected indicators including if mothers faced difficulty in getting ANC services during pandemic, if mothers received most ANC services or delivered at a public health facility, experienced any complication during pregnancy, at the time of delivery and after delivery during the post-partum period, and if they received JSY money.

Table 3.13: Selected maternal health care indicators for births during reference period by selected background characteristics, Pulwama (2020-21)

Background characteristics	% faced difficulty in getting ANC	% had most ANC from a PHF*	% delivered in PHF*	% had C-section delivery	% had a pregnancy complication	% had a delivery complication	% had a post-delivery complication	% received JSY money	No. of live births
Place of residence									
Urban	44.4	83.3	72.2	94.4	55.6	11.1	5.6	38.9	18
Rural	28.6	87.0	85.7	83.1	35.1	11.7	10.4	42.9	77
Household wealth tertile									
Low	33.3	91.7	91.7	75.0	37.5	20.8	12.5	50.0	24
Medium	26.2	85.7	83.3	85.7	47.6	11.9	9.5	45.2	42
High	37.9	82.8	75.9	93.1	27.6	3.4	6.9	31.0	29
Age									
15-24	9.1	81.8	63.6	72.7	27.3	9.1	0.0	63.6	11
25-34	31.7	88.3	86.7	88.3	38.3	10.0	13.3	33.3	60
35-49	41.7	83.3	83.3	83.3	45.8	16.7	4.2	54.2	24
Religion									
Hindu	.0	100.0	100.0	0.0	0.0	0.0	0.0	0.0	3
Muslim	33.0	86.8	84.6	85.7	40.7	12.1	9.9	42.9	92
Caste									
Scheduled castes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Scheduled tribes	0.0	100.0	100.0	0.0	0.0	0.0	0.0	100.0	1
Other backward classes	.0	85.7	57.1	85.7	0.0	14.3	0.0	57.1	7
Others (general castes)	34.5	86.2	85.1	86.2	42.5	11.5	10.3	40.2	87
Education									
< 5 years	33.3	100.0	100.0	60.0	26.7	13.3	0.0	60.0	15
5 to 9 years	21.6	83.8	75.7	83.8	37.8	10.8	8.1	32.4	37
10 to 12 years	26.1	95.7	82.6	100.0	52.2	8.7	8.7	43.5	23
More than 12 years	55.0	70.0	85.0	90.0	35.0	15.0	20.0	45.0	20
Overall	31.6	86.3	83.2	85.3	38.9	11.6	9.5	42.1	**95**

***PHF = public health facility**

Relatively more mothers in the urban areas, older (35-49 years), Muslim, scheduled castes mothers, mothers who belong to the households with a high wealth tertile and those with relatively higher education reportedly experienced difficulties in getting ANC services during the pandemic than their respective counterparts. Further, higher percentages of the mothers from rural areas, in poor households, young mothers, Non-Muslim, from deprived caste/tribe categories and with fewer years of schooling delivered at a public health facility than their respective counterparts. Conversely, mothers in rich households, older age, and general castes delivered at a public health facility. Nonetheless, substantially higher percentages of the illiterate mothers delivered at a public health facility; 100% among mother who had fewer than five years of schooling compared to 85% among those with more than 12 years of schooling. Older mothers, those from rich households, from other backward classes and with more education had a caesarian deliveries compared to their respective counterparts.

Higher proportion of the rural mother, elder in age, and with higher education experienced pregnancy complication. More mothers in urban areas, in households with medium wealth tertile, older mothers, Muslim, and with higher education reported they experienced complications at the time of delivery. Post-delivery complications were more common among urban mothers, poor mothers, middle age mothers and mothers with a more than 12 years of education than their respective counterparts. Finally, higher percentages of rural mothers and from poor households, younger mothers, Muslims, and mothers with less than 5 years of education received JSY money than their respective counterparts.

Chapter 4

Utilization of the maternal health care services during currently pregnancy, abortion and stillbirth

Chapter 4

Utilization of the maternal health care services during currently pregnancy, abortion and stillbirth

Over the past few decades, the Indian government has heavily placed it emphasis and promoted maternal and child health services extensively in order to reduce maternal and childhood morbidity and mortality by enhancing level of utilization of services including nutrition related services. The main objective of these efforts is to ensure a minimum level of public health services for the expectant/lactating mothers and infants and children. Last 10-15 years have particularly been important as under the national health mission several programs and interventions have been launched to curtain the higher childhood and maternal morbidity and mortality rates. The antenatal care (ANC) refers to pregnancy-related health care provided by a doctor or a health worker in a medical facility or at home.

An important aspect of the antenatal care is to ensure monitoring of a pregnancy for any signs of complications, detect and treat the complication(s). The pregnant women with pre-existing conditions should be advised and counselled on preventive care, diet during pregnancy, delivery care, postnatal care, and other related issues. As per the current Reproductive and Child Health Program, a pregnant woman must receive two doses of tetanus toxoid vaccine, adequate amounts of iron and folic acid tablets or syrup to prevent and treat anemia, and must have a minimum of four antenatal check-ups that include testing for blood pressure, sugar levels, HIV, anemia, fetal growth etc. For the natal care, the program emphasizes on promotion of institutional deliveries and skilled birth attendance for all home deliveries where institutional deliveries are difficult. Further, the program emphasizes on the follow-up of the mother and newborn children during the post-partum period by way of having a minimum of three post-natal check of the mother and the newborn within the two months of delivery, of which first health checkup should happen with 24 hours of the delivery and by health personnel.

The public health facilities that provide health care services for maternal and child health have been substantially strengthened, especially in the rural and remote areas of the country. The female paramedical worker, auxiliary nurse midwife (ANM) and Accredited Social Health Activists (ASHA) are posted at health sub-centers to provide basic maternal health, child health, and family welfare services to women and children in homes or health clinic. The National Population Policy 2000 adopted by the Government of India in emphasizes the commitment of the government to the safe motherhood programs. The present study obtained information from the eligible women about the utilization of health care -services during pregnancy, delivery and during the post-partum period. The information was collected separately for the currently pregnant women for their currently pregnancy, abortions, stillbirths and live births among the women during the past two years prior to the survey (from January 1, 2019). The questions covered range of issues – starting from registration of pregnancy, early registration, number of antenatal care visits, various services received by the women during antenatal, place of service, complications experienced and treatment seeking for complications, difficulties faced by the women in seeking services during antenatal, natal and post-natal period etc. Information was also collected about services provided by the health workers, especially ASHA during pandemic and if women received supplementary nutrition from the anganawadi centers/ICDS. This chapter presents some of these aspects for the women who were pregnant at the time of data collection.

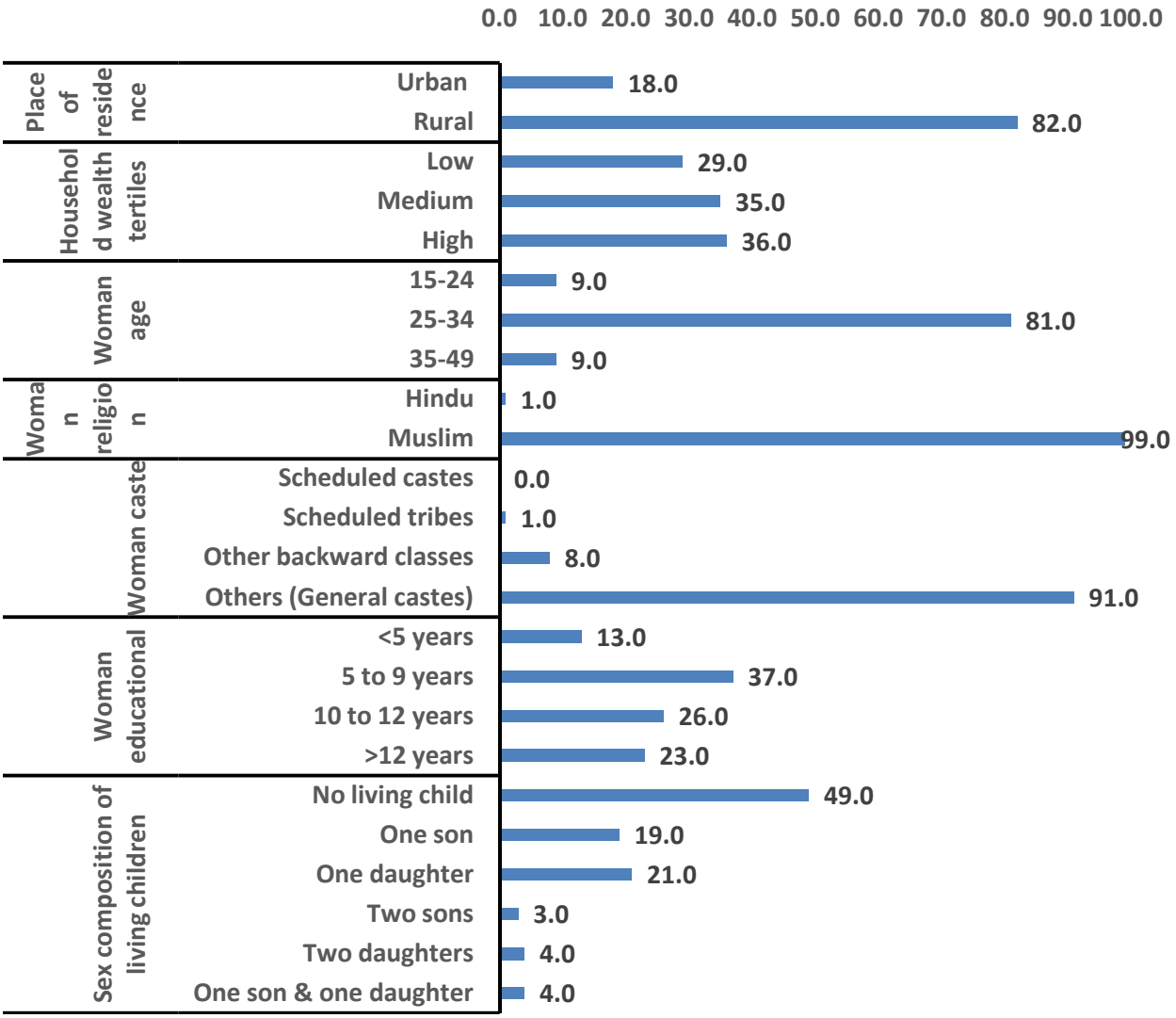
4.1 Background characteristics of the currently pregnant women

The table 4.1 provides distribution of the pregnant women by selected background characteristics for Pulwama. Eighty-two percent of the pregnant women in Pulwama live in rural areas and remaining 18% in the urban areas. Twenty nine percent of the pregnant women live in poor households and only 36% live in economically rich households.

Table 4.1: Background characteristics of the currently pregnant women by gestation period completed, Pulwama (2020-21)

Characteristics	Completed gestation (in months)		All
	<=6 months	> 6 months	
Place of residence			
Urban	21.2	4.5	17.8
Rural	78.8	95.5	82.2
Household wealth tertiles			
Low	27.1	36.4	29.0
Medium	36.5	27.3	34.6
High	36.5	36.4	36.4
Age			
15-24	7.1	18.2	9.3
25-34	81.2	81.8	81.3
35-49	11.8	0.0	9.3
Religion			
Hindu	0.0	4.5	0.9
Muslim	100.0	95.5	99.1
Caste			
Scheduled castes	0.0	0.0	0.0
Scheduled tribes	1.2	0.0	0.9
Other backward classes	8.2	9.1	8.4
Others (General castes)	90.6	90.9	90.7
Education status (completed years of schooling)			
Fewer than 5 years incl. never went to school	11.8	18.2	13.1
5 to 9 years	36.5	40.9	37.4
10 to 12 years	29.4	13.6	26.2
More than 12 years	22.4	27.3	23.4
Sex composition of living children			
No living child	50.6	40.9	48.6
One living child only			
Son	21.2	9.1	18.7
Daughter	15.3	40.9	20.6
Two living children			
Both sons	2.4	4.5	2.8
Both daughters	4.7	4.5	4.7
One son and one daughter	5.9	0.0	4.7
Overall (%)	100.0	100.0	100.0
Number of currently pregnant women	**85**	**22**	**107**

Figure 4.1: Distribution of currently pregnant women by selected background characteristics, Pulwama (2020-21)



Over four-fifth of the pregnant women belong to 25-34 years of age. Nine percent of the pregnant women each were aged 15-14 years and 35 years or older. Barring one all the pregnant women were Muslims. Nine-one percent of the currently pregnant women belong to general caste category followed by other backward classes (9%). almost one-quarter of the currently pregnant women have completed 10 to 12 years of schooling and another 23% have more than 12 years of education. There were 13% of the women who had fewer than 5 years of schooling. Almost half of the pregnant women did not have any living child at the time of survey. Almost 20 percent of the pregnant women each have only one son or daughter living at the time of survey. Five percent of the women who were pregnant have 2 living daughters only and 3% have two living sons only.

4.2 Antenatal care

Table 4.2 provides information on several antenatal care services utilized by the currently pregnant woman during this pregnancy.

Registration of the pregnancy

Ninety-five percent of the currently pregnant women registered their pregnancy in the first trimester, however, there were about 2% who registered pregnancy after completing three-months of pregnancy. A significant minority of the pregnant women (3%) did not register pregnancy. Notably higher percentages of pregnant women in the third trimester reported that they registered the pregnancy only after completing first trimester.

Table 4.2: Utilization of various antenatal care services, place from where most of the ANC services received and place pregnancy registered, Pulwama (2020-21)

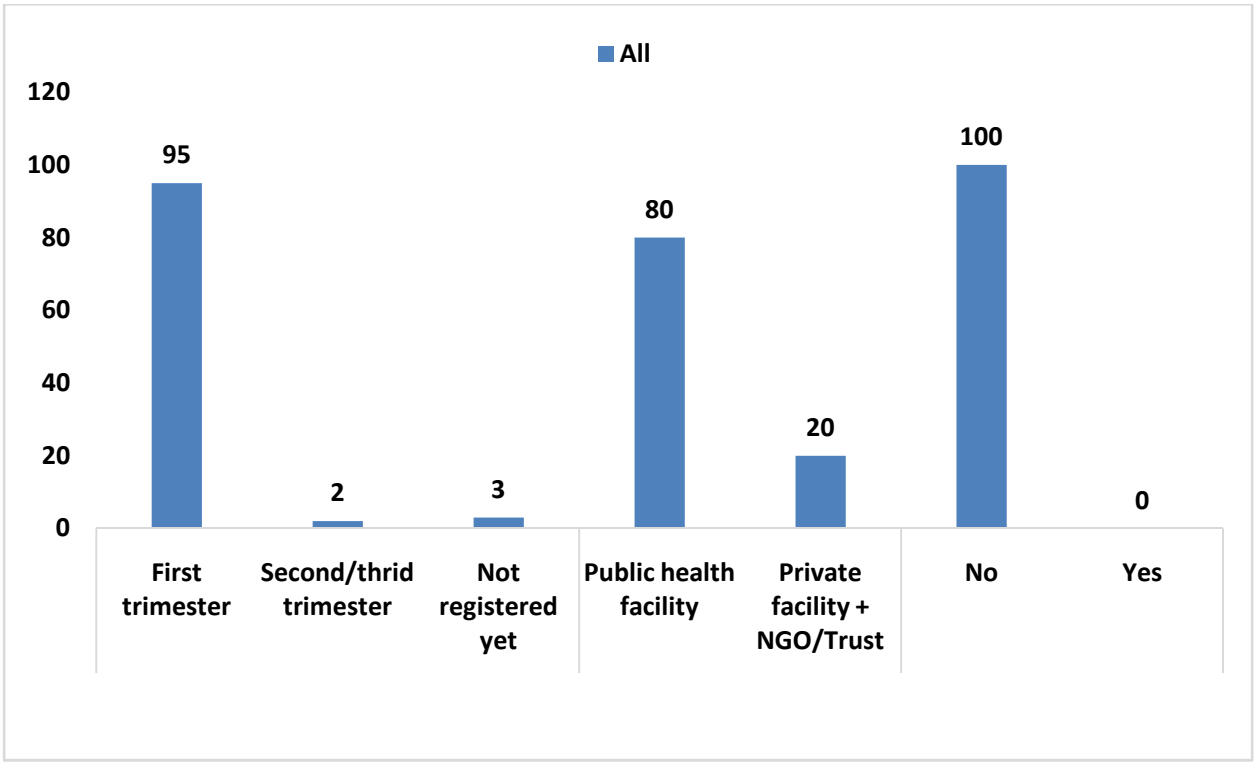
Characteristics	Completed gestation (in months)		All
	<=6 months	> 6 months	
Registered in first trimester			
Registered in the first trimester	94.1	100.0	95.3
Registered in the second/third trimester	2.4	0.0	1.9
Not registered yet	3.5	0.0	2.8
Number of antenatal care received so far			
Three or fewer	37.6	4.5	30.8
Four or more	62.4	95.5	69.2
Percentages women who received:			
MCP card	92.8	95.5	93.3
Abdomen examines	88.0	100.0	90.5
Weight taken	96.4	100.0	97.1
Blood pressure measured	96.4	100.0	97.1
Blood sugar tested	94.0	100.0	95.2
Haemoglobin tested	92.8	100.0	94.3
Tested for COVID-19	20.5	45.5	25.7
Tested for HIV	89.2	100.0	91.4
Received IFA tablets/Syrup	71.1	86.4	74.3
Consumed IFA tablets/Syrup	59.0	86.4	64.8
Had an ultrasound/sonography	84.3	100.0	87.6
Received one or more TT injection	69.9	100.0	76.2
Place from where most ANC services received			
Public health facility incl. ICDS center	83.1	68.2	80.0
Private facility, service providers incl. NGO/Trust	16.9	31.8	20.0
Number of currently pregnant women	**85**	**22**	**107**
Registered pregnancy, place pregnancy registered			
Public health facility incl. ICDS center	98.8	95.5	98.1
Private facility, service providers incl. NGO/Trust	1.2	4.5	1.9
Number of women registered pregnancy	**85**	**22**	**107**

ANC visits and services received during the visit

Slightly more than two-third of the currently pregnant women have made four or more antenatal care visits in this pregnancy. Ninety to 97% of the currently pregnant women have received a mother and child protection (MCP) card, have their abdomen examined, weight taken, Blood pressure measured, ,

have blood sugar and/or haemoglobin tested and tested for HIV. Seventy-four percent received and consumed IFA tablets/Syrup, 76% received one or more tetanus injections and 26% of the currently pregnant women have been tested for COVID-19. Further, 88% of the women reported that they have undertaken ultrasound/sonography during this pregnancy.

Figure 4.2: Pregnancy registration in the first trimester place received most ANC services and if faced any difficulty in getting ANC services due to pandemic, Pulwama (2020-21)



Place of ANC services

Information has been collected from all the currently pregnant women about the place from where they received most of the ANC services so far during this pregnancy. The data shows that out of the currently pregnant women who registered pregnancy, relatively higher (80%) received most of the ANC services from a public health facility (including State/municipality hospital, district hospital, community health centre, primary health centre, health sub-centre, and ICDS/anganwadi centre). Remaining 20% received the services from a private health facility including trust/NGO hospitals. Slightly higher percentages of the pregnant women who were in first or second trimester (32%) reported getting most ANCs from a private health facility. Of all pregnant women who registered their pregnancy, 98% registered at a public health facility and remaining 2% at a private health facility. Lesser women in advance stage of pregnancy (third trimester) reportedly registered their pregnancy at a public health facility (95%) than those in the first or second trimester (99%).

4.3 Pregnancy complications and treatment seeking

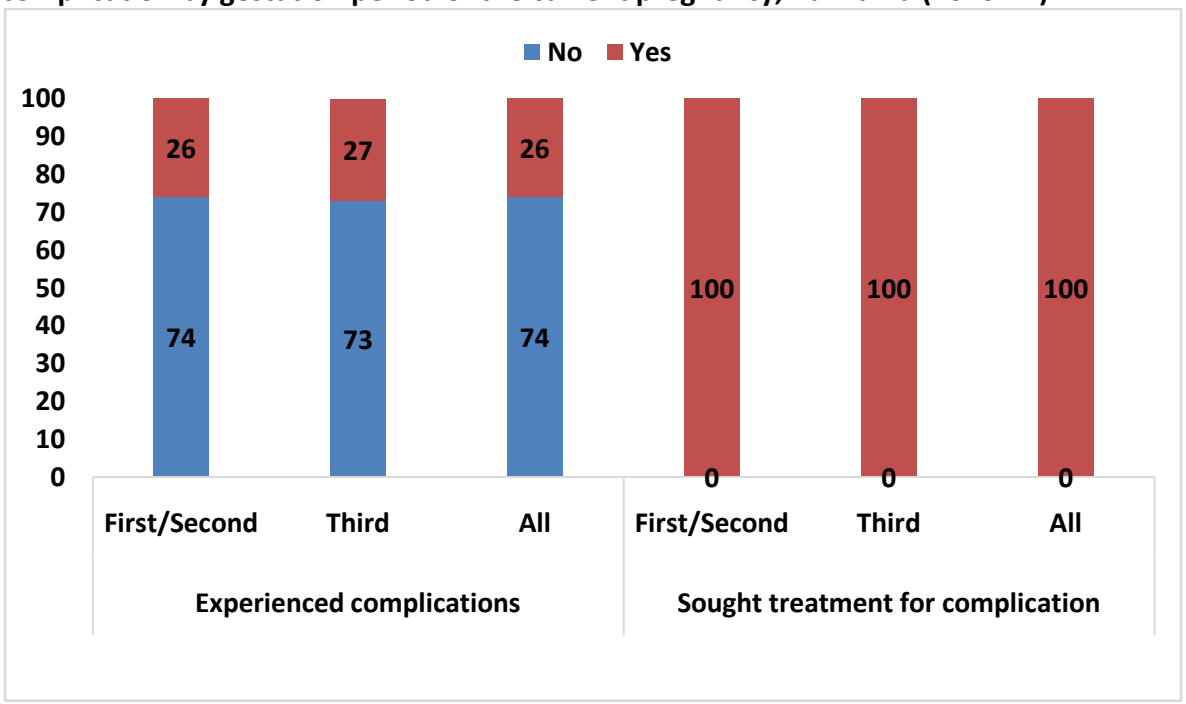
Table 4.3 provides results on whether the currently pregnant woman experienced any complication during this pregnancy, type of complications women experienced and if she sought treatment for complication(s). The data suggests that about one-fourth of the currently pregnant women (26%) have experienced one or more pregnancy complication till the survey date. Slightly higher proportion of

women in the third trimester (27%) than those in the early stages of pregnancy (26%) reportedly experienced pregnancy complications. Roughly, one in two currently pregnant women suffered from excessive vomiting followed by abdominal pain (18%). Significant minorities of the women suffered from headache. Other complications were also reported by 28% of pregnant women. Among women who suffered from a pregnancy complication, all sought treatment.

Table 4.3: Pregnant women experienced pregnancy complication, type of complication experienced and sought treatment for pregnancy complication, Pulwama (2020-21)

Indicator	Completed gestation (in months)		All
	<=6 months	> 6 months	
Experienced any complications during pregnancy			
No	74.1	72.7	73.8
Yes	25.9	27.3	26.2
Type of pregnancy complication (%)			
Excessive vomiting	31.8	83.3	42.9
Headache	4.5	16.7	7.1
Weakness / Excessive fatigue	0.0	0.0	0.0
Abnormal fetus position	0.0	0.0	0.0
Abdominal pain	13.6	33.3	17.9
Other complications	31.8	16.7	28.6
Number of currently pregnant women	**85**	**22**	**107**
Sought treatment for pregnancy complication(s)			
No	0.0	0.0	0.0
Yes	100.0	100.0	100.0
Number of women experienced complications	22	6	28

Figure 4.3: Women experienced pregnancy complication and sought treatment for pregnancy complication by gestation period of the current pregnancy, Pulwama (2020-21)



4.4 Contact with the health worker/ASHA

Table 4.4 provides results on woman's contact with the health worker and services they received from the health worker when contacted. Overwhelmingly large proportions of the currently pregnant women (92%) reported that a health and/or a ICDS workers has visited them during the pandemic related to the current pregnancy. Majority of the pregnant women (70%) who reached out to the ASHA for help related to the pregnancy during the pandemic and reported that the ASHA helped them. However, 29% of the women reported that they did not reach out to ASHA for any help related to the pregnancy during the pandemic.

More women in the advanced stage of pregnancy (96%) than those in the early stage (91%) contacted ASHA and also got help. All women reported that ASHA advised them during their contact. Further, 29% of the women who contacted ASHA during pandemic reported that ASHA accompanied to the health facility. Proportion of women who were accompanied to the facility was higher among women in the early stage of pregnancy (32%) than those in the advanced stage (22%). It may be noted that no women reported that ASHA arranged for the vehicle when they contacted her for help during the pandemic.

Table 4.4: Health worker(s) visited pregnant women, woman contacted ASHA for pregnancy related help and type of help ASHA provided during the pandemic, Pulwama (2020-21)

Characteristics	Completed gestation (in months)		All
	<=6 months	> 6 months	
Health worker (ASHA/ANM/AWW/TBA) visited during pregnancy			
No	9.4	4.5	8.4
Yes	90.6	95.5	91.6
Between March 1, 2020 to survey date, contacted ASHA for help and if ASHA helped			
Contacted ASHA and got help	67.1	81.8	70.1
Contacted ASHA, did not get help	1.2	0.0	0.9
Did not contact ASHA	31.8	18.2	29.0
Overall (%)	100.0	100.0	100.0
Number of currently pregnant women	**85**	**22**	**107**
Type of help ASHA provided when contacted			
Got medicine	0.0	0.0	0.0
Arranged vehicle to go to facility	0.0	0.0	0.0
Accompanied to facility	31.6	22.2	29.3
Gave advice	100.0	100.0	100.0
Other help	0.0	0.0	0.0
Overall (%)	100.0	100.0	100.0
Number of pregnant women contacted ASHA	**58**	**18**	**76**

4.5 Supplementary nutrition

Table 4.5 provides results on distribution of the currently pregnant woman whether they received supplementary food during pandemic from the anganwadi and the reason if they did not receive it. It

was found that not even a single of the currently pregnant women had received supplementary nutrition from the ICDS during the pandemic related to the current pregnancy almost every day and 18% got it on most of the days. Nonetheless, one-half of the women reported that they received the supplementary food rarely/never and 31% received for fewer than half of the days.

The women who reportedly rarely/never received the supplementary nutrition were further asked about the reason for the same. The reported reasons were – anganwadi worker did not provide at home, not allowed to go to the anganwadi due to pandemic or the anganwadi did not receive the supply due to pandemic and some other reasons but not related to COVID19 pandemic.

Table 4.5: Pregnant women received supplementary nutrition (SN) from the ICDS during the pandemic, Pulwama (2020-21)

Characteristics	Completed gestation (in months)		All
	<=6 months	> 6 months	
Received supplementary nutrition from ICDS/AWC			
Almost everyday	0.0	0.0	0.0
Most of the days	12.9	36.4	17.8
Fewer than half of the days	25.9	50.0	30.8
Rarely / Never	61.2	13.6	51.4
Overall (%)	**100**	**100**	**100**
Number of currently pregnant women	85	22	107
Reason women rarely/never received SN			
ICDS/AWC closed due to COVID-19	5.8	0.0	5.5
AWW did not provide at home	13.5	0.0	12.7
Not allowed to go to AWC due to COVID-19	0.0	0.0	0.0
AWC did not receive supply due to COVID-19	11.5	33.3	12.7
Other reasons	69.2	66.7	69.1
Number of women rarely/never received SN	52	3	**55**

4.6 Selected indicators by socio-demographic characteristics

Table 4.6 results data on the percentages of pregnant women who registered for ANC, registered in the first trimester, faced difficulty in getting ANC services during pandemic and women who received supplementary nutrition by place of residence, household wealth tertile, woman's age, religion, caste, and her educational status. Relatively lower percentages of the women from urban, low wealth tertile, from general caste categories, and with fewer years of education registered pregnancy for the ANC than their respective counterparts. Relatively lower percentages of women from the urban, medium household wealth categories, older women aged 35-49 years, Muslim religion, from scheduled castes, and with less education registered the pregnancy in the first trimester than their respective counterparts. Higher proportion of the from poor households, women aged 15-24 years, Muslim women, general castes, and with less education experienced difficulties in getting ANC during the pandemic than their respective counterparts. Further, lower percentages of women in the urban areas, from poor households, Muslim and with 5-9 years of schooling received supplementary nutrition during the pandemic than their respective counterparts.

Table 4.6: Selected indicators of antenatal care for currently pregnant women by selected background characteristics, Pulwama (2020-21)

Background characteristics	% registered for ANC	% registered in the first trimester	% faced difficulty in getting ANC	Got SN All/Most days	No. of pregnant women
Place of residence					
Urban	94.7	94.4	10.5	5.3	19
Rural	97.7	98.8	10.5	20.5	88
Household wealth tertile					
Low	93.5	100.0	13.8	16.1	31
Medium	97.3	97.2	13.5	13.5	37
High	100.0	97.4	5.1	23.1	39
Age					
15-24	100.0	100.0	20.0	20.0	10
25-34	97.7	98.8	10.5	18.4	87
35-49	90.0	88.9	0.0	10.0	10
Religion					
Hindu	100.0	100.0	0.0	0.0	106
Muslim	97.2	98.1	11	10.6	1
Caste					
Scheduled castes	0.0	0.0	0.0	0.0	**0**
Scheduled tribes	100.0	100.0	100.0	100.0	1
Other backward classes	100.0	100.0	0.0	0.0	9
Others (General castes)	96.9	97.9	10.5	18.6	97
Education					
Fewer than 5 years + never went to school	92.9	92.3	15.4	21.4	14
5 to 9 years	100.0	97.5	12.5	12.5	40
10 to 12 years	100.0	100.0	7.1	25.0	28
More than 12 years	92.0	100.0	8.3	16.0	25
Overall	97.2	98.1	10.5	17.8	**107**

4.7 Abortions and Stillbirths: Background characteristics

The table 4.7 provides distribution of abortions and stillbirths by selected background characteristics of the women for Pulwama. Almost 87% of the abortions/still births are in rural and remaining 13% urban. Thirty-five percent each are from poor households and rich households, and about three-fourth are for women aged 25-34 years. Barring one, all abortions took place among Hindu women, and all 10 stillbirths occurred among Muslim women. General caste women and those with less than 10 years of education and those who have no living child reported more abortions and still births.

Table 4.7: Abortions and Still births by selected background characteristics of the women, Pulwama (2020-21)

Characteristics	Abortions		Stillbirths
	%	Number	Number
Place of residence			
Urban	12.9	4	2
Rural	87.1	27	8
Household wealth tertile			
Low	35.5	11	5
Medium	29.0	9	3
High	35.5	11	2
Age			
15-24	6.5	2	1
25-34	74.2	23	8
35-49	19.4	6	1
Religion			
Hindu	3.2	1	0
Muslim	100.0	31	10
Caste			
Scheduled castes	0.0	0	0
Scheduled tribes	0.0	0	0
Other backward classes	3.2	1	0
Others (General castes)	96.8	30	10
Education			
Fewer than 5 years incl. never went to school	29.0	9	3
5 to 9 years	29.0	9	3
10 to 12 years	19.4	6	1
More than 12 years	22.6	7	3
Sex composition of living children			
No living child	32.3	10	9
One living child only			
Son	19.4	6	1
Daughter	29.0	9	0
Two living children			
Both sons	0	0	0
Both daughters	9.7	3	0
One son and one daughter	3.2	1	0
Overall / no. of abortions / stillbirths	**100**	**31**	**10**

4.8 Abortions: Maternal health care utilization

Except one, all women who had an abortions, have registered pregnancy for antenatal care and 21 have made three or fewer antenatal visits before abortion and 10 have made 4 or more ANC visits. Relatively higher women had received a MCP card, had their abdomen examined, weight taken, blood pressure measured, blood sugar tested, received and consumed IFA tablets or had an ultrasound done

as a part of the antenatal care. About two-third of the women had been tested for COVID-19 or HIV. Most of the women received most ANC services from the public health service providers/facility. Four of the 31 women faced difficulty in seeking antenatal care and mainly due to COVID-19 related conditions.

Thirty-five percent of the women experienced a pregnancy complication, mainly bleeding/Spotting (8), abdominal pain, excessive vomiting (2 each), vaginal discharge (1). In one cases, abortion took place in homes using emergency contraceptive pills or other home remedies. It was reported by 6 women that it took place in a private health facility including the NGO/Trust hospitals and in case of 22 it took place in a public health facility. One of the women experienced spontaneous abortion reported that it took place at their residence. Of the 28 abortions that took place in a health facility, 29% of women were discharged on the same day and 10% stayed for 2 to 3 days in the hospital after abortion. Of 3 abortions that took place outside health facility, the reason in all the cases was mainly - not necessary (3 cases) .In all cases, women sought treatment for pregnancy complications.

Four of the 31 cases (13%), women experienced post-abortion complication; bleeding/spotting (1), rapid breathing (1) and other complications (2) and two of the four women sought treatments for the post-abortion complications. None of the woman reportedly encountered any problem in seeking treatment for the post-abortion complications. In 5 of the 31 cases, woman did not receive any post-abortion health checkup; nonetheless, 15 informed that they had a post-abortion checkup within 24 hours and another six after one day. Twenty-five of the 26 women who received a post-abortion checkup had it in a public health facility and all from a doctor. One woman had her post-abortion checkup in a private health facility from a doctor.

Twenty-five of the 31 women reported that a health worker visited them; 24 were visited during pregnancy, two at the time of abortion and all eleven after delivery. Twenty-six of the 31 women reported that ASHA visited them during pandemic (between March 1, 2020 and survey date). Twenty of the women contacted ASHA for help during the pandemic and all received help from ASHA. Twenty-one of the 31 women did not receive any supplementary food from the ICDS during pregnancy. Two of the women reported that they did not receive supplementary nutrition as ICDS did not receive the supply due to the pandemic and another 3 reported that it was due to non-supply of food at home by the ICDS.

4.9 Stillbirth: Maternal health care utilization

Of 10 stillbirths, all have registered pregnancy for antenatal care in the first trimester of the pregnancy in a public health facility and all have made four or more antenatal visits before delivery. With the only exception of one women, all have received MCP card, had their abdomen examined, weight taken, blood pressure measured, blood sugar tested, had received one or more TT injection, had an ultrasound done as a part of the antenatal care. Seven received most ANC services from the public health facility and remaining 3 from the private health service providers/facility. Three of the 10 women faced difficulty in seeking antenatal care and mainly due to COVID-19 related conditions.

Five women experienced a pregnancy complication; excessive vomiting (1), Week fetus movement (3), headache (2) and bleeding/spotting (1) and all sought treatment for complication. All the women who

had a still birth delivered in a public health. Nine of the 10 women had used a private vehicle and one used government vehicle to reach health facility for delivery. Only four women said that ASHA accompanied her to the facility for delivery. Five women stayed in the health facility 2-3 days and 4 stayed for longer than three days after the delivery.

One woman each suffered from excessive bleeding, breech presentation, placenta problem and 2 from blood pressure during delivery. One each woman suffered from prolonged bleeding lasting longer than 12 hours, perinatal asphyxia, weak/no fetus movement or other complications. Two of the women suffered from post-delivery complications – cramping / lower abdominal pain (1) and other complications (2) like weakness and High Blood pressure. Except one, women sought treatment for delivery / post-delivery complications.

All 10 women received post-natal health checkup after delivery within 24 hours from a public health facility. All 10 women got their post-natal checkup done by a doctor.

All the 10 women reported that a health worker visited them; all were visited during pregnancy, 3 at the time of delivery and 4 after the delivery. In a case ASHA accompanied the woman to the health facility and also arranged transportation for delivery in all cases 2 cases she advised the women. All the women reported that the ASHA visited them during the pandemic related to this pregnancy. However, another 7 women said that they contacted ASHA for help during the pandemic related to this pregnancy and also got help from ASHA. None got medicines from ASHA or she helped in arranging the vehicle but ASHA accompanied one woman to the facility. Only 6 5 women received supplementary food from the ICDS during pregnancy. However, four women reported that she received supplementary nutrition only on few days.

Chapter 5

Utilization of immunization, child health and ICDS services

Chapter 5

Utilization of immunization, child health and ICDS services

This chapter discusses level of utilization of immunization, child health care and ICDS services among children during the pandemic period. The Government of India has made remarkable efforts over the past two-three decades particularly to strengthen maternal and child health services in India. These include enhanced activities of the Family Welfare Programme, introduction of the Child Survival and Safe Motherhood Programme by the Ministry of Health and Family Welfare (MoHFW). The MoHFW has sponsored special projects that include the Oral Rehydration Therapy (ORT) programme, the Universal Immunization Programme, and the Maternal and Child Health Supplemental Programme within the Postpartum Programme. While the government-run Primary Health Centres and Health sub-centres are mainly responsible to deliver the maternal and child health services in rural areas, in urban areas, they are available mainly through government or municipal hospitals, urban health posts, hospitals and nursing homes operated by nongovernmental organizations (NGOs), and private nursing homes and maternity homes.

The vaccination of children against six preventable diseases, viz. tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles has been an important component of the child survival program in India. The Expanded Programme on Immunization (EPI), initiated in 1978, aimed at reducing morbidity, mortality, and disabilities from these six diseases among children by making free vaccination services to all children eligible. The mothers were asked to report if their child had received the listed vaccine or not. The specific vaccines included in the present study are: BCG, Polio-0, Hepatitis-B0, Pentavalent (first, second and third doses), Measles and Rubella, Rotavirus (first, second and third doses), DPT booster and Vitamin-A (first and last doses). The mothers were asked to report place of vaccination, if the place of vaccination has to be changed and the reason for the change of place and reason for not vaccinating the child. This information was collected for each child and for each vaccine separately. Besides, mothers were also asked if they experienced any difficulty in getting child vaccinated during pandemic and the nature of difficulties experienced. Finally, the mothers were asked if a health worker visited them for child vaccination or if they contacted ASHA for any help related to child vaccination during the pandemic.

With respect to child health, the study collected information on if child fell ill and the type of disease(s) child suffered during the pandemic. For all children who suffered from an illness during the pandemic information was collected about the treatment, place of treatment, any difficulty experienced in seeking treatment of ill child and reason for not seeking treatment for ill child. Further information was obtained on if a health worker visited them for child health related matters if they contacted ASHA for any help related to child health care during the pandemic and the assistance received from ASHA. The information on child immunization and child health and health-care utilization for illness from mothers for all children born since 1 January 2019.

The study also collected information on the utilization of ICDS services by the children below six-years of age. All mothers were asked to report if their child attended or registered at the angnawadi center before and during pandemic and whether children received and/or consumed food given to them by the anganwadi. Information was also collected on main reason for not attending the anganwadi for all

children who never attended/registered under ICDS. The mothers who reported that their children received food from the anganwadi during both periods (that is, pre-pandemic and pandemic), information was collected about their views on change in the quantity and quality of food given to the children and change in other services provided to the children by the anganwadi during the pandemic.

5.1 Child Immunization

Table 5.1 gives age distribution of the children by age (in months), gender and birth order by place of residence. A total of 95 children (18 in the urban areas and 77 in the rural areas) were enumerated who were born between January 1, 2019 and the survey date. Of these, a little over one-half were aged up to six months and another about one-quarter were aged 7 to 12 months and 22% were more than 12 months of age. Forty-seven percent were boys and 53% were girls; share of girl children was higher in the rural areas (53%) than the urban areas (50%). Roughly half of children were of order first and another 16% of these children were of third or higher order. Share of third or higher order birth was higher in the rural areas (18%) than in the urban areas (6%).

Table 5.1: Distribution of surviving children born during the reference period by age, gender and birth order by place of residence, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Age of the child			
0-6 months	55.6	54.5	54.7
7-12 months	38.9	19.5	23.2
More than 12 months	5.6	26.0	22.1
Gender			
Boy	50.0	46.8	47.4
Girl	50.0	53.2	52.6
Birth Order			
First	66.7	45.5	49.5
Second	27.8	36.4	34.7
Third or higher	5.6	18.2	15.8
Overall (%)	100.0	100.0	100.0
Number of children	**18**	**77**	**95**

Figure 5.1: Distribution of children born during the reference period by selected background characteristics, Pulwama (2020-21)

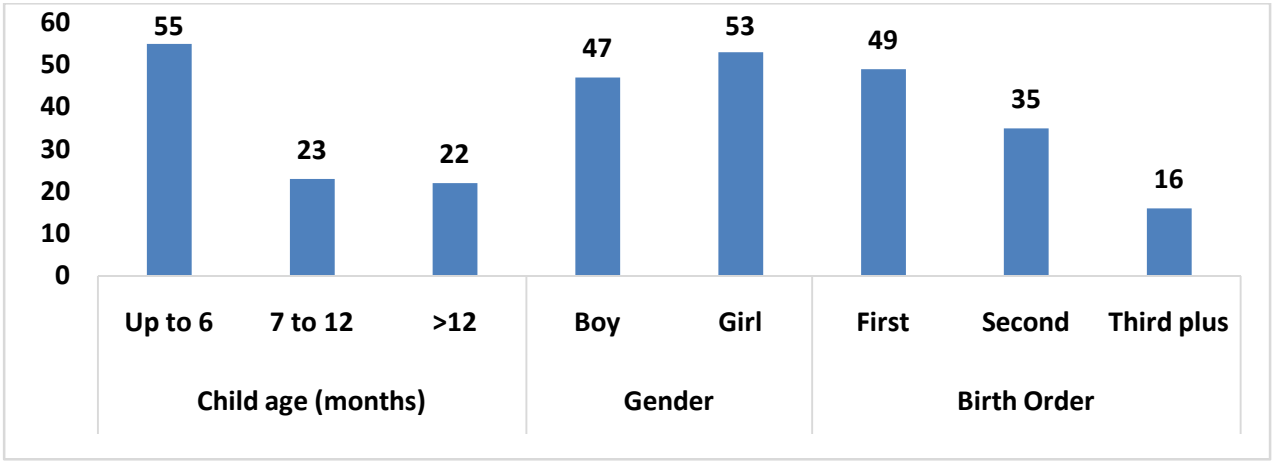


Table 5.2 provides details of each vaccine children received during the pandemic. In the same table we have also given the age of the child considered for vaccination. The information is presented for urban and rural areas separately and combined. Over 100% of the children received doses of BCG, Polio-0, and Hepatitis-B0. Pentavalent-1 was received by 96% and Pentavalent-2 and 3, Measles & Rubella-1 Rotavirus-1 and 2 were received by 86% of infants. Relatively fewer children received third doze of Rubella (81%), only about 63-65% children received rotavirus first, second and third doses and less than 59% children received DPT booster. About 52% children received Vitamin-A first dose and only 11% received Vitamin-A last dose. Almost all the children received various doses of vaccination at a public health facility; however few children (14%) received the birth doses from a private facility as well. The place of immunization during the pandemic was same as the usual place of choice for all children. Once again, majority mothers reported the reason for not vaccinating the child was not related to the pandemic. The situation across rural and urban areas was more or less similar.

Figure 5.2: Percentages of children received selected vaccines, received vaccine at a public health facility (PHF) and percentage women reported that the place of immunization was not usual place of choice for all areas, Pulwama (2020-21)

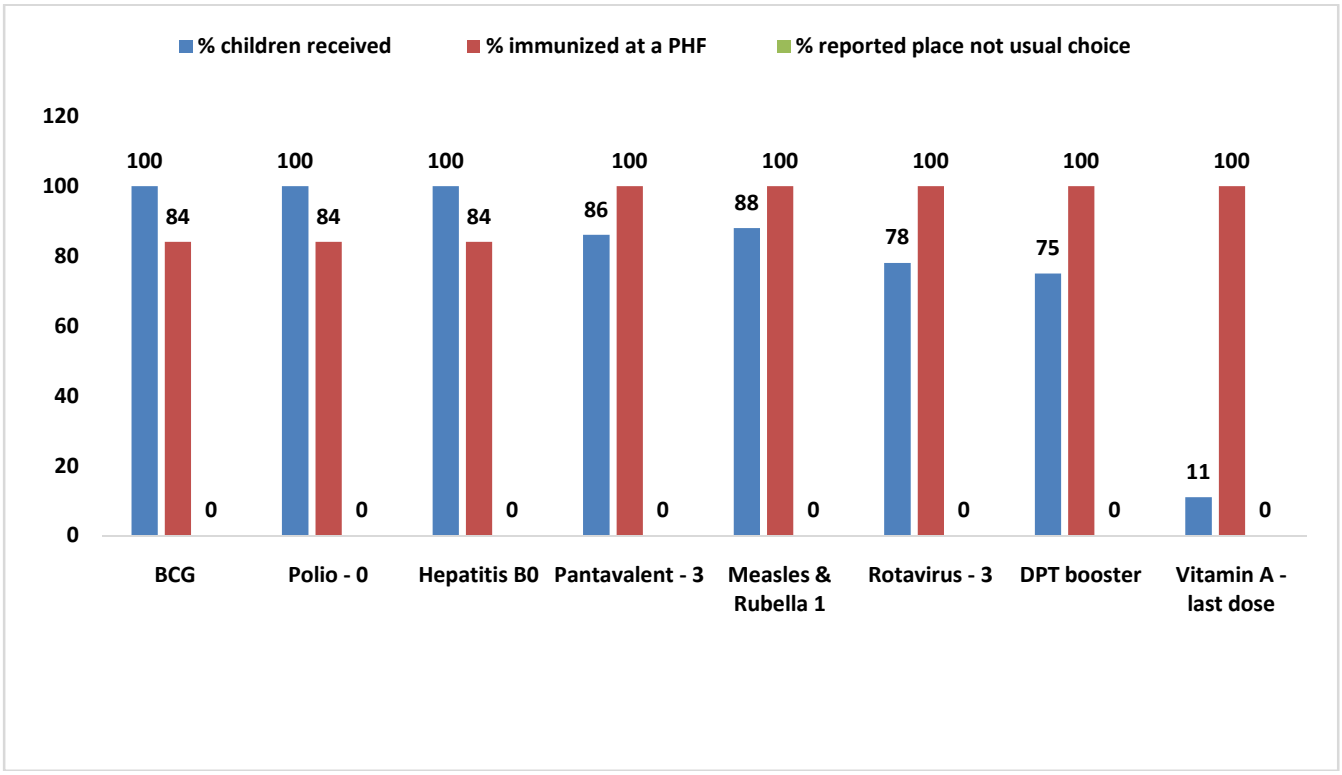


Table 5.2: Percentages of children immunized, received immunization at a public health facility, place of immunization was not place usually chosen for the same, children were not immunized due to pandemic related reason and number of children for each vaccine by place of residence, Pulwama (2020-21)

Vaccination	Age eligibility	% children received	% immunized at a PHF	% reported place not usual choice	% changed place due to pandemic	% did not immunize due to pandemic	No. of eligible children
Combined							
BCG	At birth	100.0	84.2	100.0	0.0	0.0	**95**
Polio - 0	At birth	100.0	84.2	100.0	0.0	0.0	**95**
Hepatitis B0	At birth	100.0	84.2	100.0	0.0	0.0	**95**
Pentavalent - 1	2 months	96.3	100.0	100.0	0.0	0.0	**82**
Pentavalent - 2	3 months	86.2	100.0	100.0	0.0	0.0	**78**
Pentavalent - 3	4 months	86.2	100.0	100.0	0.0	0.0	**65**
Measles & Rubella 1	9 months	88.2	100.0	100.0	0.0	0.0	**34**
Rotavirus - 1	2 months	86.6	100.0	100.0	0.0	0.0	**82**
Rotavirus - 2	3 months	85.9	100.0	100.0	0.0	0.0	**78**
Rotavirus - 3	4 months	78.5	100.0	100.0	0.0	0.0	**65**
Vitamin A – 1st dose	6 month	51.9	100.0	100.0	0.0	0.0	**54**
DPT booster	15 months	75.0	100.0	100.0	0.0	0.0	**16**
Vitamin A - last dose	11 months	11.1	100.0	100.0	0.0	0.0	**27**
Urban							
BCG	At birth	100.0	72.2	100.0	0.0	0.0	**18**
Polio - 0	At birth	100.0	72.2	100.0	0.0	0.0	18
Hepatitis B0	At birth	100.0	72.2	100.0	0.0	0.0	18
Pentavalent - 1	2 months	92.3	100.0	100.0	0.0	0.0	**12**
Pentavalent - 2	3 months	91.7	100.0	100.0	0.0	0.0	12
Pentavalent - 3	4 months	80.0	100.0	100.0	0.0	0.0	**10**
Measles & Rubella 1	9 months	66.7	100.0	100.0	0.0	0.0	**3**
Rotavirus - 1	2 months	84.6	100.0	100.0	0.0	0.0	**11**
Rotavirus - 2	3 months	91.7	100.0	100.0	0.0	0.0	**10**
Rotavirus - 3	4 months	80.0	100.0	100.0	0.0	0.0	10
Vitamin A – 1st dose	6 month	20.0	100.0	100.0	0.0	0.0	10
DPT booster	15 months	100.0	100.0	100.0	0.0	0.0	**1**
Vitamin A - last dose	11 months	100.0	100.0	100.0	0.0	0.0	**1**
Rural							
BCG	At birth	100.0	87.0	100.0	0.0	0.0	**77**
Polio - 0	At birth	100.0	87.0	100.0	0.0	0.0	77
Hepatitis B0	At birth	100.0	87.0	100.0	0.0	0.0	77
Pentavalent - 1	2 months	97.1	100.0	100.0	0.0	0.0	**69**
Pentavalent - 2	3 months	90.9	100.0	100.0	0.0	0.0	**66**
Pentavalent - 3	4 months	87.3	100.0	100.0	0.0	0.0	**55**
Measles & Rubella 1	9 months	90.3	100.0	100.0	0.0	0.0	**31**
Rotavirus - 1	2 months	87.0	100.0	100.0	0.0	0.0	**69**
Rotavirus - 2	3 months	84.8	100.0	100.0	0.0	0.0	**66**
Rotavirus - 3	4 months	78.2	100.0	100.0	0.0	0.0	**55**
Vitamin A – 1st dose	6 month	59.1	100.0	100.0	0.0	0.0	**44**
DPT booster	15 months	73.3	100.0	100.0	0.0	0.0	**15**
Vitamin A - last dose	11 months	100.0	84.2	100.0	0.0	0.0	**26**

Table 5.3 provides results of selected indicators by background characteristics. Considerably higher percentages of male children received measles rubella, rotavirus-3 and DPT booster vaccine compared to the female children. In contrast, higher percentage of female children received last dose of Vitamin-A. There is no difference in place of vaccination by gender of the child. Higher proportions of the children in rich families received rotavirus-3 whereas higher percentages of children from households with a medium wealth tertile got Measles Rubella and DPT booster and last dose of Vitamin-A. Interestingly, children from households with a high wealth tertile received the vaccine at a public health facility. Children born to older mothers aged 35-49 years were advantaged compared to the children born to younger mothers. Similarly, children born to Hindu mothers, mothers from Scheduled tribes and other castes generally had advantage. Further, children born to mothers with more education, in general, had advantage in Measles Rubella and Rotavirus 3 and this advantage favored women with fewer years of education in case of DPT booster.

Table 5.3: Immunization indicators by selected background characteristics, Pulwama (2020-21)

Characteristics	% received Measles Rubella	% received Rotavirus3	% received DPT booster	% received Vitamin-A last dose	% received BCG at PHF
Gender					
Male	94.1	86.7	80.0	6.7	84.4
Female	82.4	71.4	66.7	16.7	84.0
Household wealth tertile					
Low	80.0	81.3	66.7	0.0	91.7
Medium	93.3	67.7	85.7	16.7	85.7
High	88.9	94.4	66.7	12.5	75.9
Maternal age					
15-24	100.0	75.0	66.7	0.0	72.7
25-34	81.0	73.8	71.4	6.7	86.7
35-49	100.0	93.3	83.3	28.6	83.3
Maternal religion					
Hindu	100.0	100.0	100.0	100.0	100.0
Muslim	87.5	77.4	85.7	12.0	85.7
Other religions	100.0	100.0	0.0	0.0	33.3
Maternal caste					
Scheduled tribes	100.0	100.0	0.0	0.0	100.0
Other backward classes	100.0	100.0	0.0	0.0	71.4
Others (General castes)	100.0	75.9	85.7	12.5	85.1
Maternal education					
Fewer than 5 years	83.3	70.0	100.0	0.0	100.0
5 to 9 years	86.7	72.0	83.3	9.1	78.4
10 to 12 years	90.0	85.7	66.7	22.2	82.6
More than 12 years	100.0	87.5	66.7	0.0	85.0
Overall	**88.2**	**78.5**	**75.0**	**88.9**	84.2

Figure 5.3A: Percentages of children received measles and rubella by selected characteristic for all areas, Pulwama (2020-21)

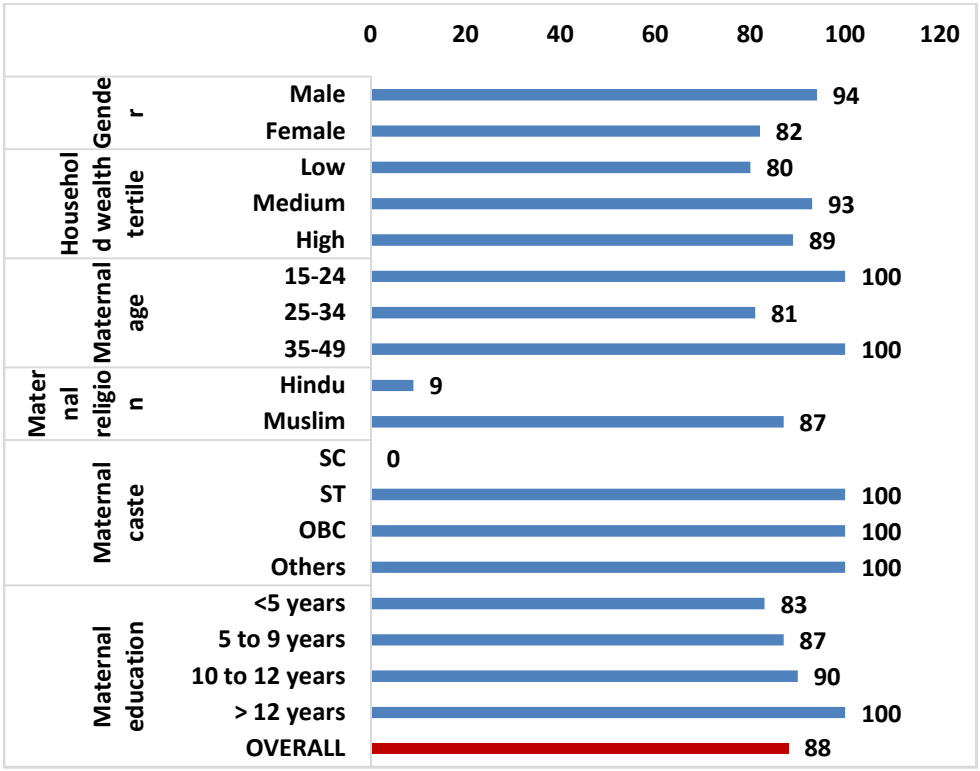


Figure 5.3B: Percentages of children received Rotavirus 3rd dose by selected characteristic for all areas, Pulwama (2020-21)

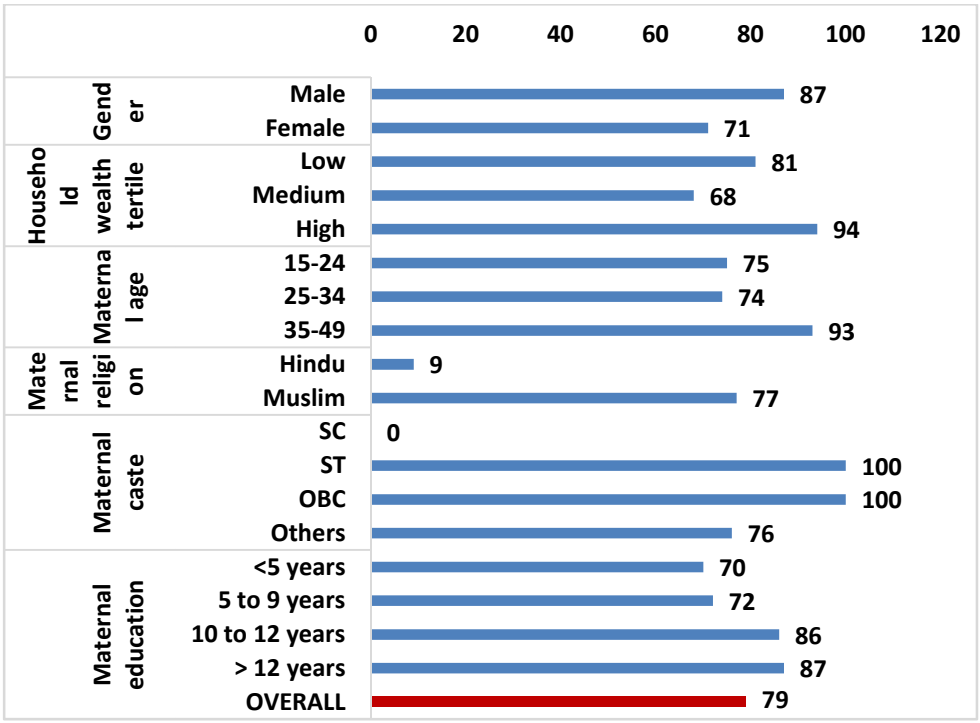
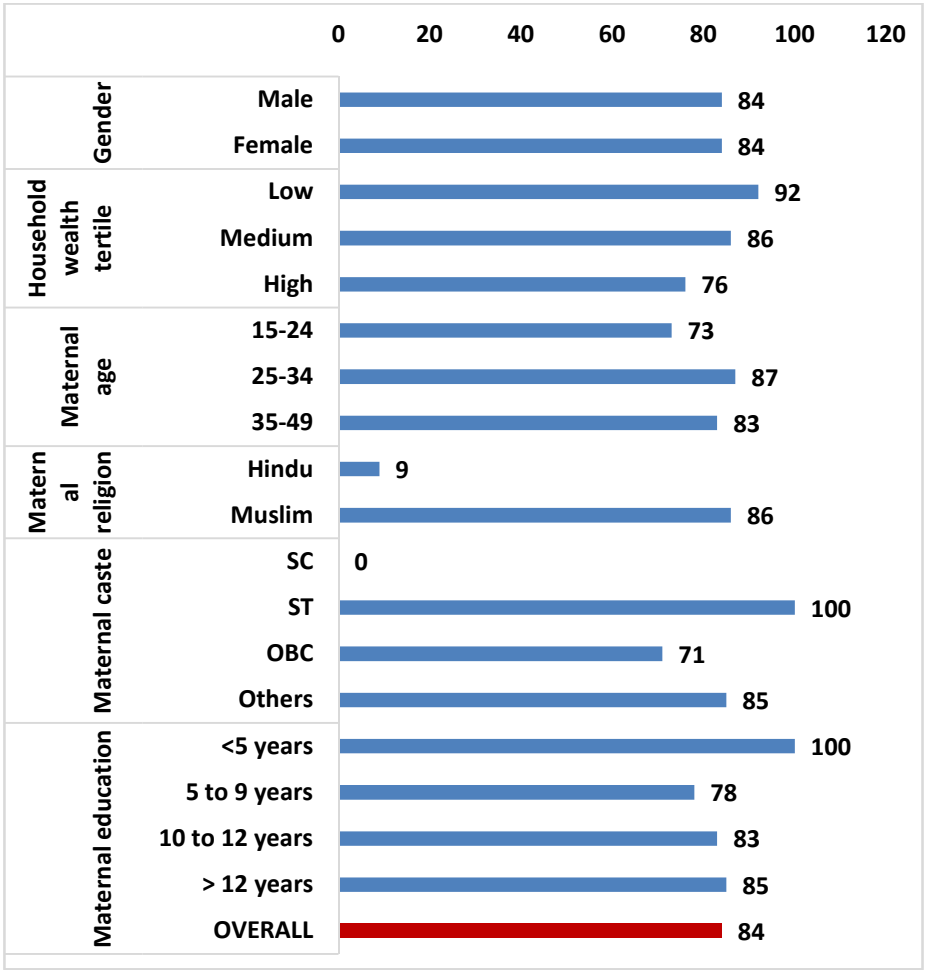


Figure 5.3C: Percentages of children received DPT booster by selected characteristic for all areas, Pulwama (2020-21)



5.2 Child illness and treatment seeking

Table 5.4 shows the percentages of children who suffered from an illness during the reference period, type of illness they suffered from, if they received treatment for illness, place of treatment, money spent on treatment and the current status of the disease at the time of survey by gender. About 54% of all children surveyed suffered from an illness during the pandemic. Slightly higher percentages of girls (60%) than the boys (47%) suffered from an illness. Cold and cough was the most common disease children suffered followed by fever and diarrhea. For example, 88% of the children (90% for boys and 87% for girls) suffered from could and cough. Further, 48% of girls 71% of boys suffered from fever and 5-10% of boys and girls suffered from diarrhea. Three percentages of the girls suffered from jaundice and 17% suffered from other diseases mainly Low birth weight, skin problem/rashes and vomiting. None of the child suffered from breathlessness/asthma malaria, dengue, COVID-19, fall/accident, or influenza.

It is overwhelming to note that all children, regardless of gender, type of illness received treatment for illness. Nonetheless, one-half received the treatment from a public health facility. Forty-seven percent of the children received treatment at a private health facility and 4% utilized home remedies. More

male children than the female children received treatment at a private health facility. In majority of the cases (90%) the child is free from the disease; however, 7% of the children were still suffering from the disease. The treatment for child illness was not free in case of any of the sick child. The cost of treatment was more than Rs. 1500 in case of 14% of sick child and for about 55% of sick children it was between Rs. 500-1500 and for 31% of the cases an amount upto Rs. 500 was spent on the treatment. The median money spent on treatment was Rs. 1000 both in urban and rural areas.

Table 5.4: Illness among children, type of illness, treatment seeking for illness, place of treatment, money spent on treatment and health status of the child at the time of survey by gender, Pulwama (2020-21)

Indicator	Boy	Girl	Both
Children fell ill during pandemic			
No	53.3	40.0	46.3
Yes	46.7	60.0	53.7
No. of Children	**45**	**50**	**95**
Out of those fell ill, % suffered from:			
Diarrhea	4.8	10.0	7.8
Fever	71.4	46.7	56.9
Cough and Cold	90.5	86.7	88.2
Malaria	0.0	0.0	0.0
Dengue	0.0	0.0	0.0
Jaundice	0.0	3.3	2.0
Breathlessness/Asthma	0.0	0.0	0.0
COVID-19/CORONA	0.0	0.0	0.0
Fall/Accident	0.0	0.0	0.0
Influenza	0.0	0.0	0.0
Other diseases	0.0	16.7	9.8
Sought treatment for illness			
No	0.0	0.0	0.0
Yes	100.0	100.0	100.0
Place of treatment			
Public Health facility incl. ICDS/NGO/Trust/E-sanjeevani	38.1	56.7	49.0
Private health facility including online consultation	57.1	40.0	47.1
Home remedy including others	4.8	3.3	3.9
Disease status at the time of survey			
Disease cured	90.5	90.0	90.2
Child still suffering	9.5	10.0	9.8
Child condition worsened	0.0	0.0	0.0
Money spent on treatment			
Free	0.0	0.0	0.0
Up to 500 INR	23.8	36.7	31.4
501 to 1500 INR	66.7	46.7	54.9
More than 1500 INR	9.5	16.7	13.7
Do not remember	0.0	0.0	0.0
Median money spent (In Rs.)	1000	1000	1000
No. of children fell ill during reference period	**21**	**30**	**51**

Figure 5.4: Percentages of children fell ill during pandemic and percentages suffered from diarrhea, fever and could-cough, Pulwama (2020-21)

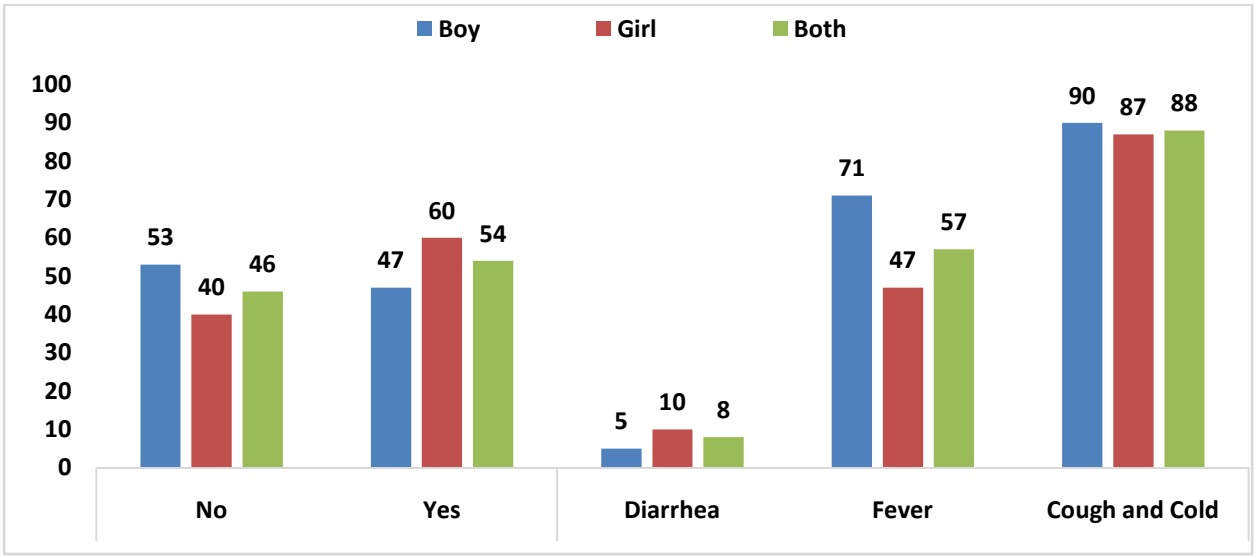
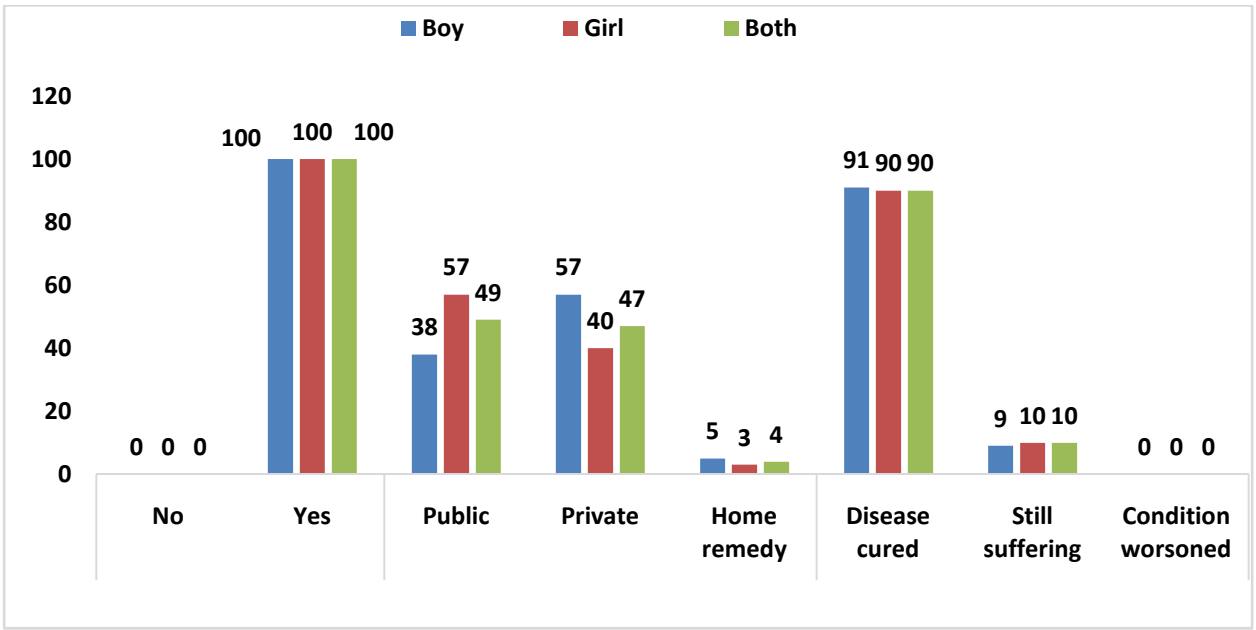


Figure 5.5: Percentages of ill children received treatment, place of treatment and child health at the time of survey, Pulwama (2020-21)



Selected indicators of child health care utilization by background characteristics are provided in Table 5.5. The data suggest that higher percentages of children in the urban areas suffered from an illness and sought treatment from a public health facility compared to the children in the rural areas. More urban mothers contacted ASHA for child health matters during the pandemic than the urban mothers. Further, relatively higher percentages of children in poor and medium wealth tertile households or born to mothers age 25-34 suffered from an illness and/or received treatment at a public health facility.

The prevalence of illness during the reference period was more common among the children born to Hindu mothers, from scheduled tribes and mothers who had less than 5 years of education. More children in poor households and born to Muslim mothers, younger mothers and with fewer than 5 years of education were treated at a public health facility than their respective counterparts.

Table 5.5: Selected child health indicators by background characteristics, Pulwama (2020-21)

Characteristics	% children fell ill during pandemic	% sought treatment from a public health facility	% Mothers contacted ASHA for child health
Place of residence			
Urban	55.6	60.0	40.0
Rural	53.2	46.3	29.3
Household wealth tertile			
Low	58.3	57.1	28.6
Medium	59.5	48.0	24.0
High	41.4	41.7	50.0
Maternal age			
15-24	36.4	100.0	25.0
25-34	56.7	41.2	29.4
35-49	54.2	53.8	38.5
Maternal religion			
Hindu	0.0	0.0	0.0
Muslim	54.9	48.0	32.0
Christian	0.0	0.0	0.0
Other religions Incl. No religion	33.3	100.0	0.0
Maternal caste			
Scheduled castes	0.0	0.0	0.0
Scheduled tribes	100.0	100.0	100.0
Other backward classes	57.1	100.0	0.0
Others (General castes)	52.9	43.5	32.6
Maternal education			
Fewer than 5 years	66.7	70.0	50.0
5 to 9 years	45.9	41.2	11.8
10 to 12 years	47.8	45.5	36.4
More than 12 years	65.0	46.2	38.5
OVERALL	53.7	49.0	31.4

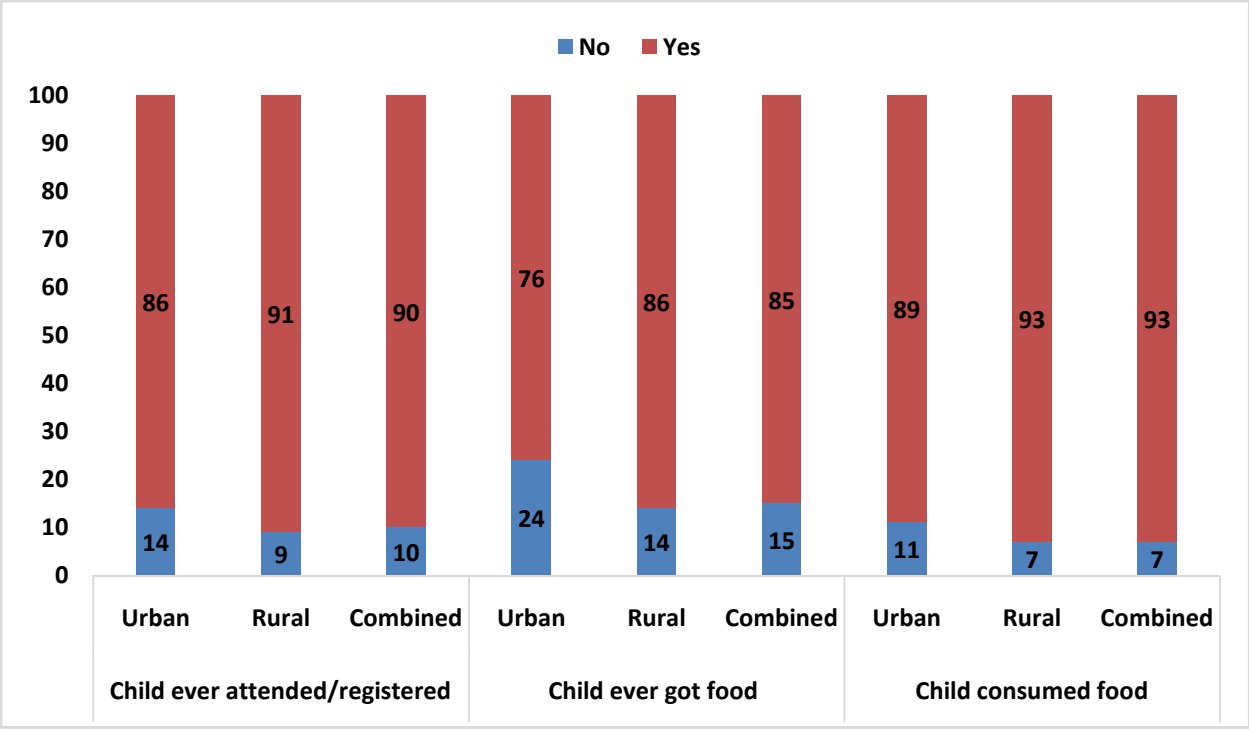
5.3 Utilization of ICDS services

Table 5.6 provides results on children attended ICDS and services they received along with information reason for not attending ICDS. The data suggests that 90% of the children ever attended/registered AWC and 62% attended during the pandemic (between March 1, 2020 and survey date). Significantly higher percentages of children in the rural areas than the urban areas attended AWC ever as well as during pandemic. Eighty-six percent of the children received food from the AWC ever, however, as against of only 70% during the pandemic period. The urban-rural differences were particularly wide during the pandemic period. Further, a very high proportion of children (64%) received food from AWC only on some days and another 2-3% never received food from AWC. Overwhelmingly higher proportions of the children consumed given to them by the AWC, however, there were about 6% of the children who did not consume the food received by them during pandemic. Relatively higher percentages of children in urban areas reportedly did not consume food they received from AWC.

Table 5.6: Children under age six years attended/registered with anganwadi center (AWC) ever and during pandemic, received and consumed food given by the AWC by place of residence, Pulwama (2020-21)

Indicator	Ever			During pandemic		
	Urban	Rural	Combined	Urban	Rural	Combined
Child ever attended/registered						
No	14.0	8.9	9.7	44.2	36.9	37.9
Yes	86.0	91.1	90.3	55.8	63.1	62.1
Child ever got food from AWC						
No	24.3	13.8	15.2	44.2	27.5	30.3
Yes	75.7	86.2	84.8	55.8	72.5	69.7
No. of children below 6 years	43	257	300	43	257	300
Frequency of food from AWC						
Almost everyday	7.1	7.5	7.5	0.0	2.2	1.9
Most of the days	50.0	49.5	49.6	37.5	30.3	31.1
Some days only	42.9	41.5	41.7	62.5	64.3	64.1
Rarely / Never	0.0	1.5	1.3	0.0	3.2	2.9
Child consumed food						
No	10.7	7.0	7.5	12.5	4.9	5.7
Yes	89.3	93.0	92.5	87.5	95.1	94.3
Child ever received food from AWC	37	232	269	24	185	209
Main reason not attending AWC						
Unaware of ICDS / AWC	0.0	0.0	0.0	0.0	0.0	0.0
No ICDS in the village/area	0.0	3.6	2.9	0.0	2.9	2.2
No staff at the AWC	0.0	0.0	0.0	5.3	2.9	3.4
AWC too far	0.0	1.8	1.4	0.0	1.4	1.1
No facility at the AWC	0.0	0.0	0.0	0.0	1.4	1.1
Too many children at the AWC	0.0	0.0	0.0	10.5	2.9	4.5
Family did not allow	0.0	0.0	0.0	0.0	1.4	1.1
Child too small	66.7	70.9	70.0	52.6	55.7	55.1
Child refused to go	0.0	0.0	0.0	5.3	7.1	6.7
Fear of getting infection	0.0	0.0	0.0	26.3	24.3	24.7
Other reasons	33.3	23.6	25.7	0.0	2.9	2.2
No. of children did not attend AWC	**15**	**55**	**70**	**19**	**70**	**89**

Figure 5.6: Percentages of children below six years of age ever attended/registered for ICDS, received food and consumed food given under ICDS, Pulwama (2020-21)



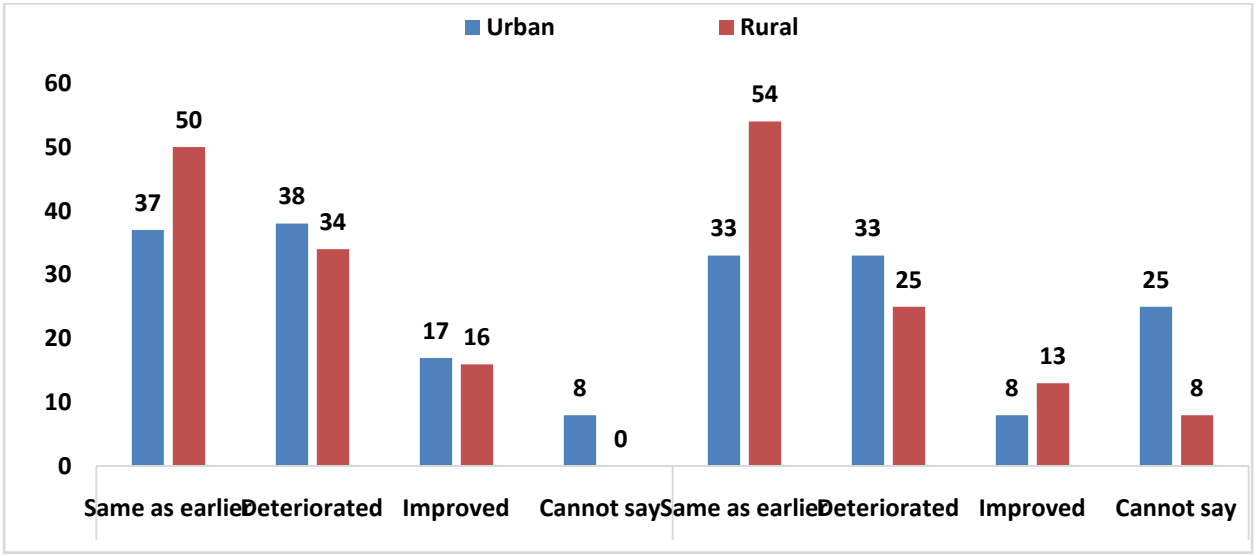
For the children who did not attend/registered with AWC, information was collected on the main reason. It may be noted about 55% of the cases (53% in urban areas and 56% in the rural areas) mothers reported that the main reason for child not attending the AWC during pandemic heir child was that they felt that their child was 'too small' to go to the AWC. Further one quarter of mothers feared that the child may get infected with COVID19 at ICDS Centre. The main reasons for child not ever attending the AWC during pandemic were slightly different. For example, 70% of the mothers informed that their child did not ever attend AWC as the child was 'too small'; much higher in the rural areas (71%) than the urban areas (67%). One-quarter of the women much higher in urban areas than in rural areas gave other reasons reported for child not attending in ICDS Centre.

Table 5.7 provides results of perception of mothers about change in quantity and quality of food and other services given by the AWC during the pandemic. About 15 percent of the mothers expressed that the quantity of the food has improved during the pandemic and 12% also mentioned the quality of the food has also improved during the pandemic; considerably higher in the rural areas (13%) than in the urban areas (8%). Another half of mothers felt that the quantity and quality of food has remained same as it was prior to the pandemic (33-37% in urban areas and 50-54% in the rural areas). Nonetheless, there were about 34% and 26% of mothers, respectively, who felt that the quantity and quality of the food has deteriorated during the pandemic. A very small percentage of mothers were not able comment anything on this. With respect to the other services, a significant percentage (53%) felt that the other services have remained same as earlier and 36% mentioned that they have reduced/deteriorated and only 5% reported mainly in rural areas reported the services have improved during pandemic.

Table 5.7: Perception of mothers on change during pandemic in comparison to the pre-pandemic period in the quantity and quality of food served and other services provided by the ICDS during the pandemic, Pulwama (2020-21)

Characteristics	Urban	Rural	Combined
Change in the quantity of food served			
Same as earlier	37.5	50.3	48.8
Deteriorated	37.5	34.1	34.4
Improved	16.7	15.7	15.8
Cannot say	8.3	0.0	1.0
Change in the quality of food served			
Same as earlier	33.3	54.1	51.7
Deteriorated	33.3	24.9	25.8
Improved	8.3	13.0	12.4
Cannot say / NA	25.0	8.1	10.0
Quantum of other services provided			
Same as earlier	41.7	54.1	52.6
Deteriorated	37.5	35.7	35.9
Improved	0.0	4.9	4.3
Cannot say / NA	20.8	5.4	7.2
No. of children attended during pre and pandemic periods	**19**	**70**	**89**

Figure 5.7: Perceptions of mothers regarding quantity and quality of food from ICDS during the pandemic in comparison to the food before the pandemic, Pulwama (2020-21)



5.4 Contacts with health worker during the pandemic

The health or ICDS workers are required to visit the household in the area under their service jurisdiction and monitor various aspects of the health of women and children, provide information related to health and family welfare, counsel and motivate women/mothers to promote better practices and deliver other selected services as needed. These visits work as catalyst and enhance the

credibility of services and inculcate client faith in the public health delivery system. The results on the mother's contact with the health and ICDS workers are provided in the Table 5.8.

For child vaccination

One in eight mothers (82%) reported that the ASHA visited them for child vaccination during the pandemic. The AWW visited about 2% of the mothers for the same. ANMs have not visited any of these mothers for vaccination. Then, there were 17% mothers who said that no one from the system visited them for child vaccination during the pandemic. Two-in three mothers contacted ASHA for help with child vaccination during the pandemic; higher in the rural areas (70%) than the urban areas (56%). Almost all mothers who reached out to ASHA for help received the help.

Table 5.8: Health worker(s) visited mother, mother contacted ASHA for vaccination related issues and type of help ASHA provided during the pandemic, Pulwama (2020-21)

Indicator	Vaccination			Child health care		
	Urban	Rural	Combined	Urban	Rural	Combined
Health worker visit						
No one	16.7	16.9	16.8	50.0	51.2.2	51.0
AWW	0.0	2.6	2.1	0.0	2.4	2.0
ANM	0.0	0.0	0.0	0.0	0.0	0.0
ASHA	83.3	81.8	82.1	50.0	48.8	49.0
No. of mothers/ No. of children	**18**	**77**	**95**	**10**	**41**	**51**
Mothers contacted ASHA for help						
No	44.4	29.9	32.6	60.0	70.7	68.6
Yes	55.6	70.1	67.4	40.0	29.3	31.4
No. of mothers / ill children	**18**	**77**	**95**	**10**	**41**	**51**
ASHA helped mother						
No	0.0	0.0	0.0	0.0	2.3	1.8
Yes	100.0	100.0	100.0	100.0	97.7	98.2
Type of help ASHA provided						
Gave medicine				0.0	0.0	0.0
Arranged vehicle to go to facility				0.0	0.0	0.0
Accompanied to facility				25.0	8.3	12.5
Gave advice				100.0	100.0	100.0
Other help				0.0	0.0	0.0
Mothers contacted ASHA for help	**10**	**54**	**64**	**4**	**12**	**16**

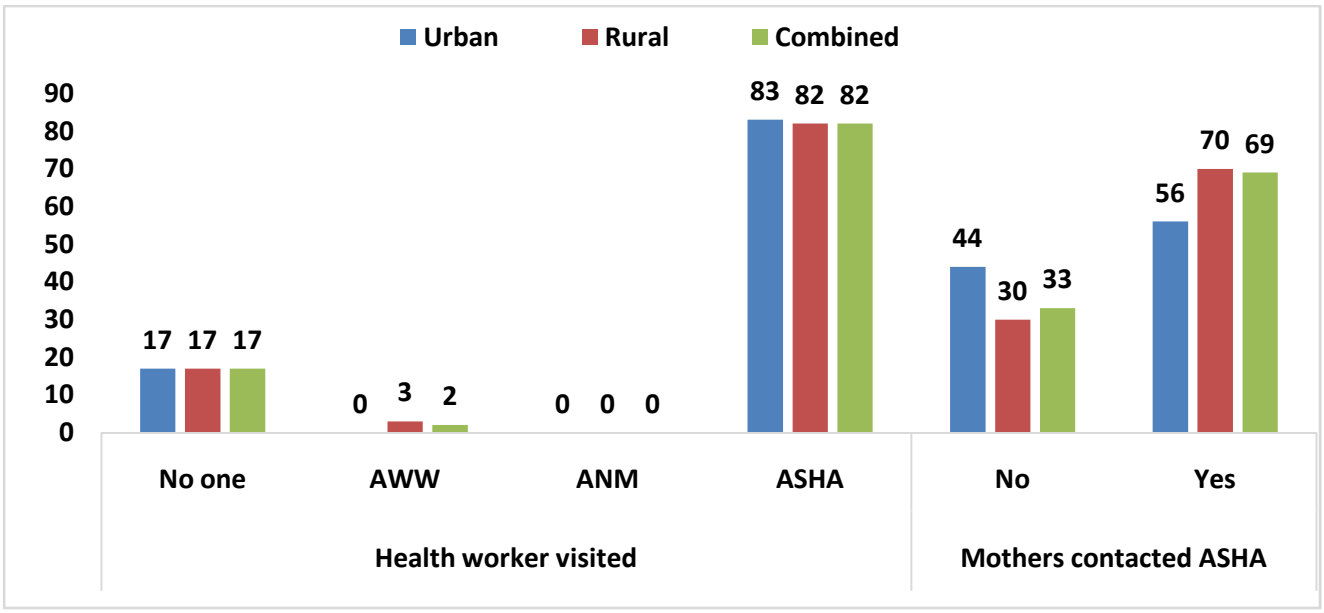
For child health care

Roughly half of children both in urban and rural areas had a visit to their homes from ASHA. In about 2% cases, AWW visited children's households for child health care related matters during the pandemic. ANMs once again did not visit any child during pandemic. However, almost half of children (51%) children were not visited by any grass root level worker during the pandemic. This percentage was slightly lower in the urban areas as compared to the rural areas (50% versus 51%). Slightly, more than one quarter of mothers (29%), reached out to ASHA for help related to the care of their ill child

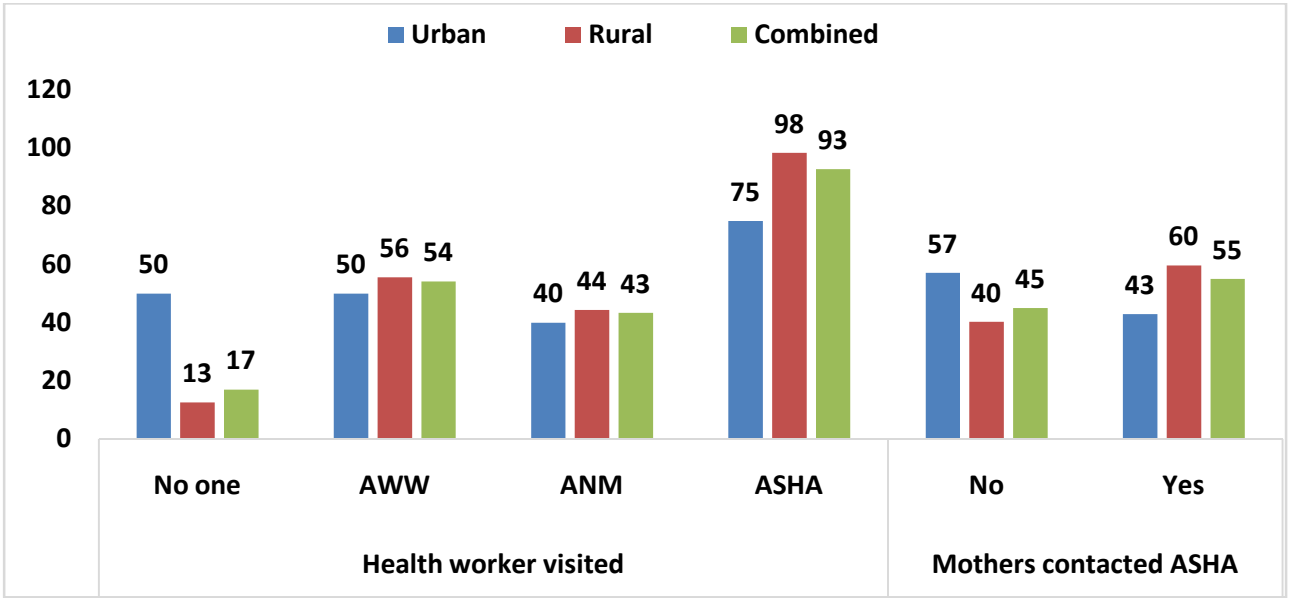
and except 2% cases, ASHA helped mothers when they contacted. In about 12% of the cases, ASHA accompanied mothers to the health facility for health care of the ill children. All such women mentioned that they received advice from ASHA during this interaction.

Figure 5.8: Health worker / ASHA contact with mothers for child vaccination and child health during the pandemic, Pulwama (2020-21)

A: Child vaccination



B: Child health



5.5 Experienced difficulties in getting vaccination or child health care services

Table 5.9 provides data on mother whether mothers experienced any difficulty in seeking vaccination of their children and/or health care for their ill child during the pandemic. It is encouraging to note that 95% of the mothers did not face any difficulty during the pandemic related to these aspects. However, about 5% of the mothers each reported that they encountered difficulties in seeking services for their children. The mothers were further asked about the nature of difficulty. Out of five mothers who faced difficulties in vaccinating their children, four attributed the difficulty to the pandemic related reasons. Similarly, six of the ten mothers attributed difficulties in seeking care for ill child to the pandemic related reasons.

Table 5.9: Cases when mothers faced difficulties in getting the child vaccinated or health care for ill children and the nature of difficulties experienced by place of residence, Pulwama (2020-21)

Indicator	Difficulties related to vaccinating child			Difficulties related to treatment of ill child		
	Urban	Rural	Combined	Urban	Rural	Combined
Faced difficulties during pandemic						
No	94.4%	94.8%	94.7%	70.0	82.9	80.4
Yes	5.6%	5.2%	5.3%	30.0	17.1	19.6
No. of children / No. of ill children	**18**	**77**	**95**	**10**	**41**	**51**
Nature of difficulties due to						
COVID-19 pandemic related	100.0%	75.0%	80.0%	66.3	57.1	60.0
Non-COVID-19 related	.0%	25.0%	20.0%	33.4	42.9	40.0
No. mothers faced difficulties	**1**	**4**	**5**	**3**	**7**	**10**

Chapter 6

Utilization of contraceptive and menstrual services by the women

Chapter 6

Utilization of contraceptive and menstrual services by the women

Couples can use family planning methods / contraceptives to delay and/or avoid pregnancy so as to space or limit number of children they want to have and the time when they want to have a child. This chapter presents information on ever and current use of contraceptive methods (including traditional methods), sources of obtaining contraceptive methods during pandemic, choice of place for obtaining the methods, difficulties experienced in obtaining the method, side effects of the method and money spent on method during the most recent time and reason for currently using contraceptives. We included both modern as well as traditional methods of family planning. The modern methods included Sterilization (male or female), Intrauterine device/Post-partum intrauterine device (IUD/PPIUD), Injectable (including Anthara), Oral pills, Condom (Nirodh), Female condom, Diaphragm, Foam/Jelly, and any other modern methods used by the couple. The traditional methods included Standard days method, Lactational amenorrhea method (LAM), Rhythm method, Withdrawal, or any other local method used by the couple to delay/avoid pregnancy. The information was collected from the women about the method used by her and/or her spouse/partner.

In the same chapter, we have also discussed if the menstruating women suffered from any menstrual problem during the pandemic and whether they sought treatment for the problem and the reason in case they did not seek treatment for the menstrual problem they suffered.

6.1 Ever and current FP users

Of 512 eligible women interviewed in the study in Pulwama, 31% reported that they/their husband never did something/used a method to delay/avoid pregnancy (Table 6.1). The remaining 69% said they/their husband ever used a method to delay/avoid pregnancy. Significantly higher percentages of rural women than the urban women (70% and 65%, respectively) ever used a method to delay/avoid pregnancy. The information on current method use is collected from the non-pregnant women. A total of 405 of the 512 women interviewed were not pregnant at the time of data collection. Of these non-pregnant women, a little over 63% are using a method to delay/avoid pregnancy at the time of survey. Contrary to ever use, higher proportions of the non-pregnant women in urban areas reported using a method to delay/avoid pregnancy than those in the rural areas (68% as against of 62%).

Currently use: modern methods

More than one third of couples (37%) are using condom. Condom use is slightly higher in rural areas (38%) than in urban areas (32%). Fifteen percent of the couples are currently

using Oral pill and only 10% of the couples used female sterilization and none of the couple reported use of male sterilization. The percentage of couples who used oral pill is considerably higher in the rural areas (16%) than the urban areas (9%). Further 2% of the couples used IUD/PPIUD. The percentage of couples who used IUD/PPIUD is considerably higher in the urban areas (5%) than the rural areas (2%). Less than 2% of the couple reportedly use injectable to delay/avoid pregnancy. None used female condom, diaphragm, or foam/jelly.

Figure 6.1A: Family planning use - Ever users and Current users (out of non-pregnant women) by place of residence, Pulwama (2020-21)

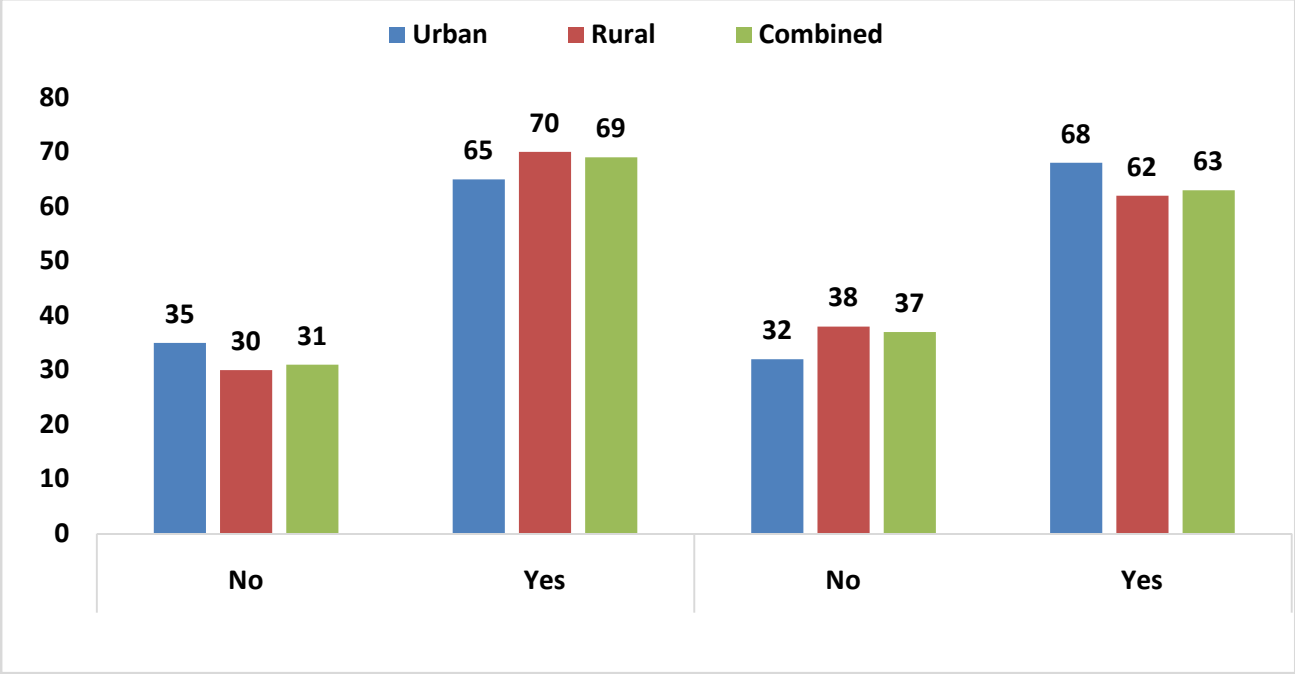


Figure 6.1B: Current users by method by place of residence, Pulwama (2020-21)

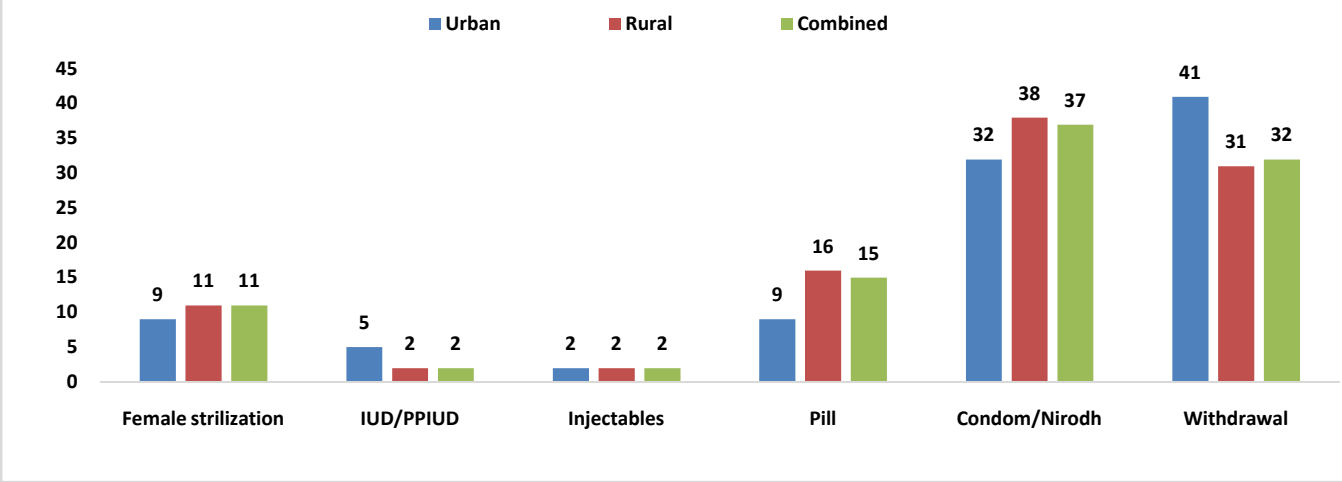


Table 6.1: Ever and current users of family planning method and method currently used by place of residence, Pulwama (2020-21)

Indicator	Urban	Rural	Combined
Ever used anything to delay/avoid pregnancy			
No	34.5	30.4	31.1
Yes	65.5	69.6	68.9
Number of women	**84**	**428**	**512**
Currently using anything to delay/avoid pregnancy			
No	32.3	37.9	37.0
Yes	67.7	62.1	63.0
Number of women currently not pregnant	**65**	**340**	**405**
Method currently using			
Female sterilization	9.1	10.9	10.6
Male sterilization	0.0	0.0	0.0
IUD/PPIUD	4.5	1.9	2.4
Injectable (Anthara)	2.3	2.4	2.4
Oral Pill	9.1	15.6	14.5
Condom/Nirodh	31.8	38.4	37.3
Female condom	2.3	0.0	.4
Diaphragm	0.0	0.0	0.0
Foam/Jelly	0.0	0.0	0.0
Standard days method	0.0	0.0	0.0
Lactational amenorrhea method	0.0	0.0	0.0
Rhythm method	0.0	0.0	0.0
Withdrawal	40.9	30.8	32.5
Other traditional method(s)	0.0	0.0	0.0
Other modern method(s)	0.0	0.0	0.0
No. of women currently using a method	**44**	**211**	**255**

Currently use: traditional methods

The data shows that the traditional methods are relatively highly common in the study area. A very high percentage of couples are using withdrawal. Withdrawal use is much higher in urban areas (41%) than in rural areas (31%). None of the women reported using rhythm method, Lactational amenorrhea method or any other traditional/local method to delay/avoid pregnancy.

6.2 Sterilization use during pandemic

Table 6.2 provides information on the timing of sterilization (before or during pandemic), place of sterilization, choice of place for sterilization, money spent on sterilization and cash incentive received for sterilization by the women who underwent sterilization during the pandemic by place of residence.

Out of the 27 users of sterilization (both male and female), 89% had been sterilized before pandemic, that is, before March 1, 2020. The remaining 11% got sterilized during the pandemic, that is, between March 1, 2020 and survey date. Considerably higher proportion of women in the urban areas (25%) than the rural areas (9%) informed that they got sterilized during the pandemic. All the couples post pandemic were sterilized at a private health facility and none was sterilized at a public health facility including NGO/charitable trust hospitals.

Table 6.2: Timing of sterilization, place of sterilization, choice of place for sterilization, money spent on sterilization and cash incentive received for sterilization by the women who underwent sterilization during the pandemic by place of residence, Pulwama (2020-21)

Indicator	Urban	Rural	Combined
Timing of sterilization			
Before pandemic (Before March 1, 2020)	75.0	91.3	88.9
During pandemic (March 1, 2020 or later)	25.0	8.7	11.1
No. of women using sterilization (male+female)	4	23	27
Place of sterilization during pandemic			
Public Health Facility including Anganwadi	0.0	0.0	0.0
Private Health Facility incl. NGO/Trust & Others	100.0	100.0	100.0
Place of sterilization same as preferred place normally			
No	0.0	36.4	23.5
Yes	100.0	63.6	76.5
Money spent on sterilization			
Free	0.0	50.0	33.3
Up to 1500	100.0	.0	33.3
More than 1500	0.0	0.0	0.0
Do not remember	0.0	50.0	33.3
Received incentive for sterilization			
No	100.0	100.0	100.0
Yes	0.0	0.0	0.0
No. of couples got sterilized during pandemic	**1**	**2**	**3**

Although the place of sterilization during pandemic was same as the usual place of choice for majority of the couples (76%), 36% of the couples (all in the rural areas) reported that the place where they had their sterilization done was not a usual place of choice. About 33% of the women, all from rural areas reported that they did not spend any money on sterilization. However, 33% reported that they spent upto Rs. rupees 1500; much higher in the urban areas (100%). The median money spent on sterilization was rupees 3000. None of the woman received cash incentive of rupees 600 for sterilization by the time data was collected.

6.3 Modern spacing method use during pandemic

Table 6.3 provides relevant data on the time of initiation of use of modern spacing method (before or during pandemic), source of obtaining the method, money spent on the method and difficulties faced in obtaining the method during the pandemic by place of residence. The data suggest that of all current users of modern spacing methods, 88% had started using the method before March 1, 2020 and remaining 12% started using method during pandemic.

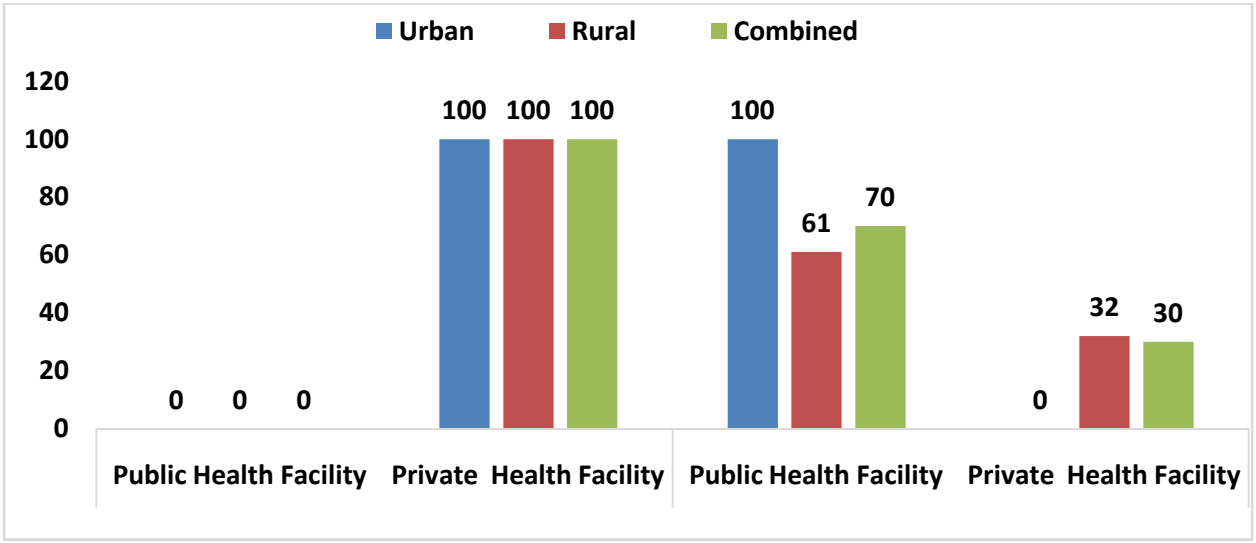
Considerably higher percentages of urban women than the rural women (18% versus 11%) started to use method during the pandemic. The women were further asked about the place from where they received the method the last time. About 71% reported that they obtained the method the last time from a public health facility (including ICDS), 6% got it from the private health facility including NGO/Charitable trust hospitals or medical shop etc. A substantial proportion (24%) mainly in rural areas received the method from other sources like husband/friends/relatives/etc.

Table 6.3: Timing of initiation of modern spacing method, source of obtaining the method, money spent on the method and difficulties faced in obtaining the method during the pandemic by place of residence, Pulwama (2020-21)

Indicator	Urban	Rural	Combined
Initiation of use of modern spacing method			
Before pandemic (Before March 1, 2020)	81.8	89.4	88.3
During pandemic (March 1, 2020 or later)	18.2	10.6	11.7
User of modern spacing methods at the time of survey	**22**	**123**	**145**
Place obtained the method the last time			
Public Health Facility including Anganwadi	100.0	61.5	70.6
Private Health Facility incl. NGO/Trust & Others	0.0	7.7	5.9
Husband/Friends/Relatives/Others	0.0	30.8	23.6
Money spent on spacing methods			
Free	100.0	61.5	70.6
Some money spent	0.0	30.8	23.5
Do not remember	0.0	7.7	5.9
Experienced difficulty in getting method			
No	100.0	100.0	100.0
Yes	0.0	0.0	0.0
No. of couples obtained method during pandemic	**4**	**13**	**17**

About Seventy-one percent of the women did not spend any money on the method as they got it for free, however, 23% did spend some money. All women in the urban areas got the method from the public health facility and for free. None of the women reported experiencing any difficulty in obtaining the method during the pandemic, true for urban and rural areas as well.

Figure 6.2: Place of sterilization and source of modern spacing method for most recent use during the pandemic by place of residence, Pulwama (2020-21)



6.4 Side effects of method used during pandemic

Table 6.4 provides information about whether women experienced any side effect of the method they were using at the time of survey and the type of the side effect experienced. The table also has information if women sought treatment for the side effect and the reason for not seeking treatment, if they did not seek treatment. Although majority of the women did not experience any side effect of the method they use during the pandemic, there were about 6% who experienced side effects due to method. Slightly higher percentage of women in the urban areas (7%) experienced side effects of method than the women in the rural areas (6%). When asked about type of side effect, 13% each reported inter-menstrual spotting, irregular bleeding, (13%) , 27% each reported breast tenderness , Weight gain (27%) and 20% had experienced infection.

Figure 6.3: Side effects of the method and treatment sought by place of residence, Pulwama (2020-21)

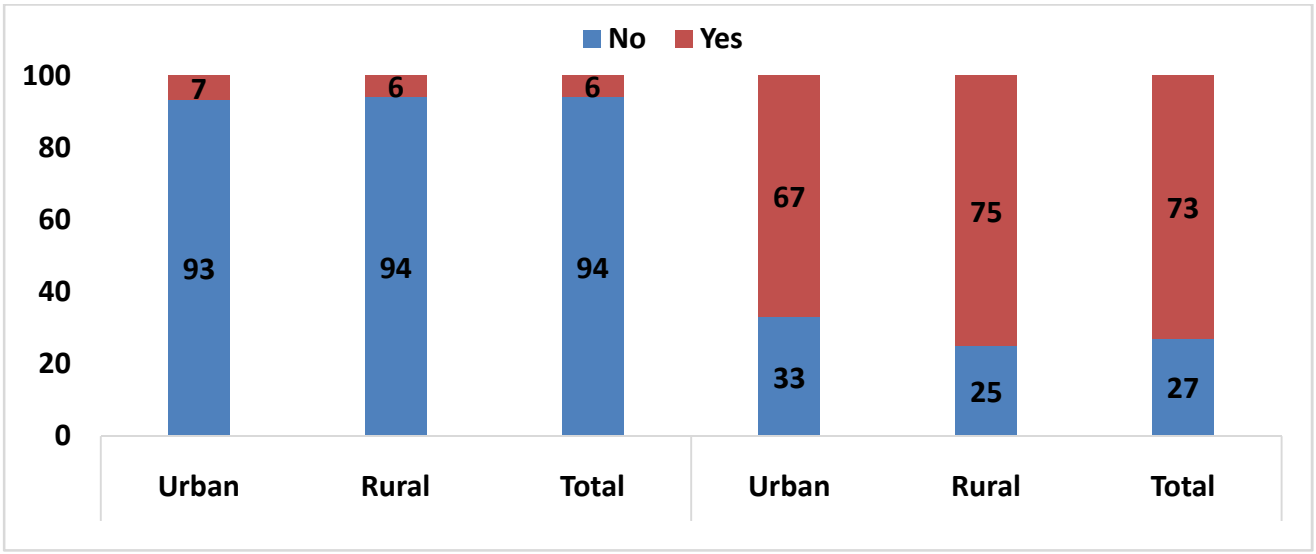


Table 6.4: Side effects of method currently used, type of side effects, and treatment seeking for side effects during the pandemic by place of residence, Pulwama (2020-21)

Indicator	Urban	Rural	Combined
Experience side effects of method in use			
No	93.2	94.3	94.1
Yes	6.8	5.7	5.9
Type of side-effects (%)			
Inter-menstrual spotting	0.0	16.7	13.3
Nausea	33.3	25.0	26.7
Breast tenderness	0.0	0.0	0.0
Weight gain	33.3	25.0	26.7
Missed period	0.0	0.0	0.0
Decreased libido	0.0	0.0	0.0
Acne	0.0	0.0	0.0
Irregular bleeding	0.0	16.7	13.3
Mood changes	0.0	16.7	13.3
Cramping / Pelvic pain	0.0	0.0	0.0
Hair loss	0.0	8.3	6.7
Infection	33.3	16.7	20.0
Other side effects	66.7	25.0	33.3
Number of current users of method	**44**	**211**	**255**
Sought treatment for side-effects			
No	33.3	25.0	26.7
Yes	66.7	75.0	73.3
No. of women faced side effects of the method	**3**	**12**	**15**

Of the 15 current users of spacing methods who experienced side effect only 4 did not seek treatment for side effects. The reason for not seeking treatment were - facility closed, no transport, doctor not available, scared to visit facility due to fear of infection, stressed due to strict COVID-19 protocol in the urban areas. In rural areas, the reported reasons were – difficulty in reaching facility, and stressed due to COVID-19 infection as long waiting time at facility.

6.5 Reason for current non-use of FP

Table 6.5 provides information on reason for not using any family planning at the time of survey by place of residence. We have presented the results in the six broad categories of – reasons related to pandemic, method related reasons, lack of knowledge of method and/or source of obtaining the method, opposition from family, spouse or self, due to personal preferences or not required. Pandemic related reasons included – non availability of services, fear of infection if go to hospital, difficulty in reaching facility, non-availability of transport, non-availability of staff, restrictions on movement etc. The method related reasons included – pain/bleeding after use of method, health problems, fear of side effects, lack of access, cost of method, difficulty/inconvenience in getting/using the method,

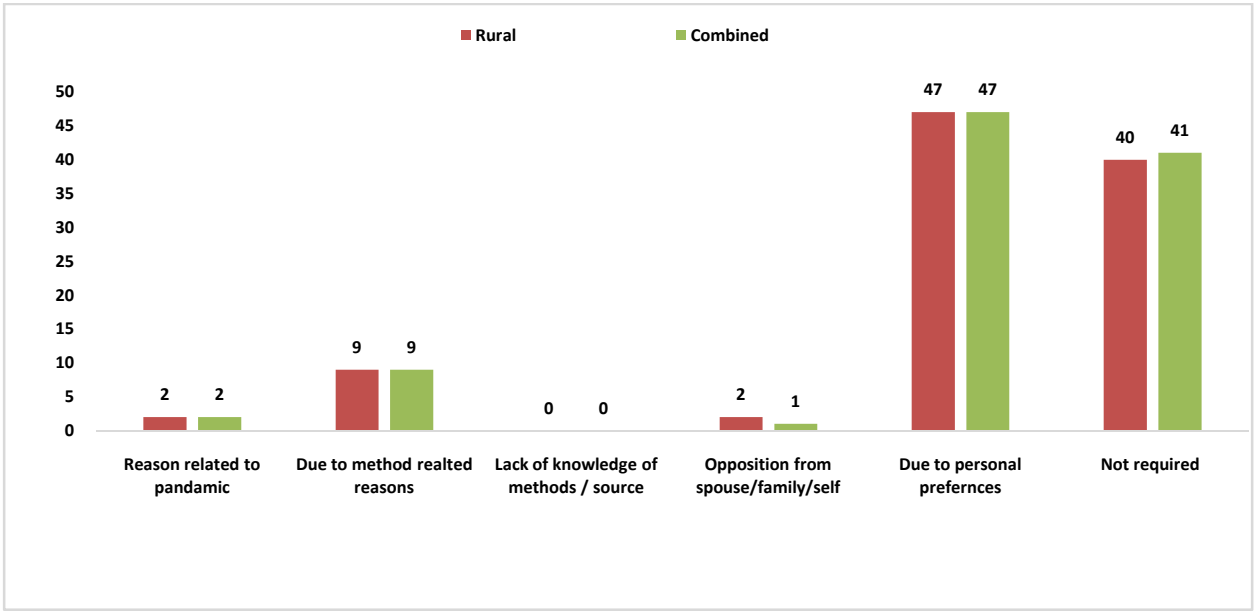
interference of the method with normal processes of the body. Opposition to use method included opposition by woman herself, husband, other family members, religious prohibition. Personal preferences included – do not like existing methods, afraid of sterilization/method. Not required included - want to have child, not having sex, infrequent sex, husband away, up to God, menopause, hysterectomy, sub-fecund/infecund, post-partum amenorrhea.

The data shows that 47% women reportedly did not use a method due to personal preferences followed by 'not required' (41%). Further, 9% of the women reported nonuse due to method related reasons and 1% attributed to opposition from family/spouse/self. Only 2% women reasoned nonuse due to pandemic conditions.

Table 6.5: Reason for currently not using any method to delay/avoid pregnancy by place of residence, Pulwama (2020-21)

Indicator	Urban	Rural	Combined
Reason related to pandemic	0.0	2.3	2.0
Due to method related reasons	4.8	9.2	8.6
Lack of knowledge of methods / source	0.0	0.0	0.0
Opposition from spouse/family/self	0.0	1.5	1.3
Due to personal preferences	47.6	47.3	47.4
Not required	47.6	39.7	40.8
No. of non-users	**21**	**131**	**152**

Figure 6.4: Reasons for currently not using family planning method by place of residence, Pulwama (2020-21)



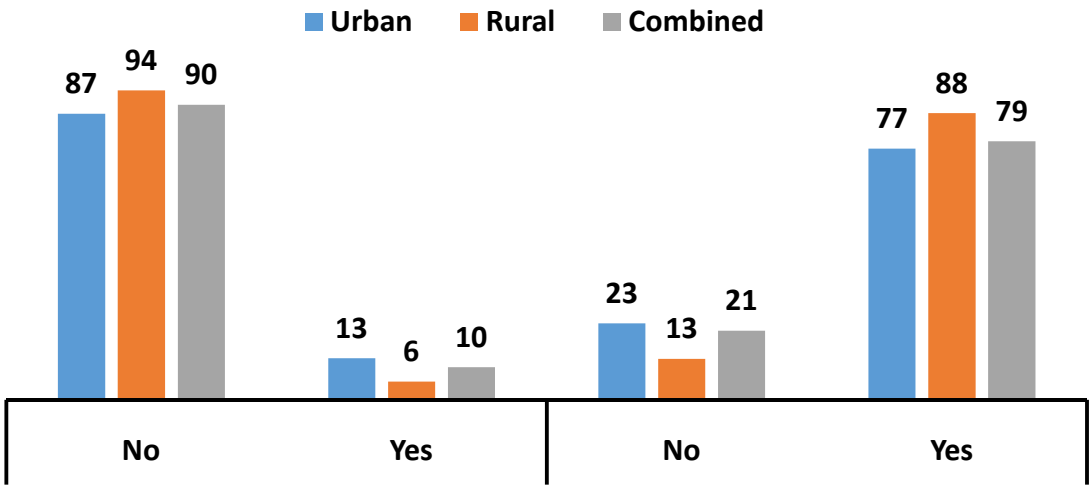
6.6 Menstrual problems and treatment seeking during pandemic

Table 6.6 provides information on the current menstruation status of the women, their experience of any menstrual problem, type of menstrual problems experienced and treatment seeking, and the reason for not seeking treatment for menstrual problem during pandemic by place of residence. Of 406 non-pregnant women, 89% were menstruating at the time of survey. Eight percent of the menstruating women experienced any menstrual problem during the pandemic with not much variation between rural and urban areas.

Table 6.6: Experience of any menstrual problem, type of menstrual problem and treatment seeking during pandemic by place of residence, Pulwama (2020-21)

Indicator	Urban	Rural	Combined
Currently menstruating			
No	4.6	12.0	10.8
Yes	95.4	88.0	89.2
No. of women	**65**	**341**	**406**
Experienced any menstrual problem during pandemic			
No	93.5	92.0	92.3
Yes	6.5	8.0	7.7
No. of menstruating women	**62**	**300**	**362**
Sought treatment for the menstrual problem			
No	25.0	25.0	25.0
Yes	75.0	75.0	75.0
No. experienced menstrual problem during pandemic	**4**	**24**	**28**

Figure 6.5: Women experiencing menstrual problem and treatment seeking during pandemic by place of residence, Pulwama (2020-21)



Three-fourth of the women sought treatment for menstrual problem; however, 25% did not seek any treatment. The percentage of women not seeking treatment for menstrual problem is same both in urban and rural areas. Of 4 women who did not seek treatment for menstrual problem during pandemic reported that the problem 'was not severe' and one woman in the urban areas did so as her family did not allow them to go outside due to fear of COVID-19 infection.

6.7 Selected indicators by background characteristics

Table 6.7 provides information on a few indicators by the background characteristics of the women. Higher percentages of women from middle class households, women age 15-24, and women from general castes and women with fewer than 5 years of education ever a method to delay/avoid pregnancy than their counterparts in other groups. Current use was higher among women with low education, poor women and younger women. Use of sterilization was higher among middle class households, those aged 35 years or older, Muslim women, those from scheduled castes or other backward classes and those with less 10-12 years of education compared to their respective counterparts. In contrast, spacing method use was more common among women from poor households, younger women, general castes, Muslims and those with higher education. Younger women, those from rich households, Muslims or general caste , and those who less than 5 years of schooling reported higher experience of side effects due to use of a contraceptive method(s). Relatively higher levels of menstrual problems during the pandemic were reported by the women in rich households, relatively middle age women, Muslim women, and those with fewer than five-years of schooling than their respective counterparts.

Table6.7: Percentages of ever user, current users, users of sterilization, modern spacing methods, current user experienced side effects of method used, women experienced menstrual problem and sought treatment for menstrual problem during pandemic by place of residence, Pulwama (2020-21)

Characteristics	Ever used a method (%)	Currently using a method (%)	Currently using sterilization (M+F) (%)	Currently using modern spacing method (%)	Current users experienced side effects (%)	% experienced menstrual problem
Household wealth tertile						
Low	20.9	33.3	9.4	66.7	4.2	9.2
Medium	36.1	47.3	12.1	52.7	4.4	4.6
High	20.9	51.5	10.3	48.5	10.3	9.8
Woman age						
15-24	58.3	0.0	0.0	100.0	16.7	7.1
25-34	39.0	42.3	5.8	57.7	4.8	8.4
35-49	16.4	45.5	14.5	54.5	6.2	7.1
Woman religion						
Hindu	0.0	0.0	50.0	50.0	0.0	0.0
Muslim	30.9	50.0	10.0	57.4	6.0	8.0
Christian	0.0	0.0	0.0	0.0	0.0	0.0
Other religions	45.5	50.0	25.0	25.0	0.0	0.0

Woman caste						
Scheduled castes	0.0	0.0	0.0	0.0	0.0	0.0
Scheduled tribes	100.0	100.0	0.0	66.7	0.0	11.1
Other backward classes	72.7	71.4	16.0	60.0	0.0	5.9
Others (General castes)	67.9	61.2	10.4	56.1	6.8	7.8
Woman education						
< 5 years	77.8	63.4	12.7	60.6	7.0	11.8
5 to 9 years	69.6	61.0	5.6	59.7	6.9	7.7
10 to 12 years	69.7	68.4	14.1	46.2	5.1	6.0
More than 12 years	53.5	55.7	8.8	67.6	2.9	3.6
Overall	68.9	63.0	10.6	56.9	5.9	7.7