FACT SHEET, HARYANA
NATIONAL FAMILY HEALTH SURVEY, 1998–99

Sample Size

Households	2,841
Ever-married women age 15–49	2,908

Characteristics of Households

Percent with electricity	89.1
Percent within 15 minutes of safe water supply[1]	66.2
Percent with flush toilet	30.4
Percent with no toilet facility	60.9
Percent using govt. health facilities for sickness	16.1
Percent using iodized salt (at least 15 ppm)	71.0

Characteristics of Women[2]

Percent urban	28.8
Percent illiterate	55.2
Percent completed high school and above	20.0
Percent Hindu	89.1
Percent Muslim	4.1
Percent Sikh	6.5
Percent regularly exposed to mass media	66.9
Percent working in the past 12 months	12.6

Status of Women[2]

Percent involved in decisions about own health	67.2
Percent with control over some money	70.8

Marriage

Percent never married among women age 15–19	76.7
Median age at marriage among women age 20–49	17.4

Fertility and Fertility Preferences

Total fertility rate (for the past 3 years)	2.88
Mean number of children ever born to women 40–49	4.4
Median age at first birth among women age 25–49	20.1
Percent of births[3] of order 3 and above	41.7
Mean ideal number of children[4]	2.5
Percent of women with 2 living children wanting another child	18.4

Current Contraceptive Use[5]

Any method	62.4
Any modern method	53.2
Pill	2.1
IUD	3.6
Condom	6.8
Female sterilization	38.7
Male sterilization	2.1
Any traditional method	8.9
Rhythm/safe period	4.5
Withdrawal	4.4
Other traditional or modern method	0.3

Unmet Need for Family Planning[5]

Percent with unmet need for family planning	7.6
Percent with unmet need for spacing	2.9

[1]Water from pipes, hand pump, covered well, or tanker truck
[2]Ever-married women age 15–49
[3]For births in the past 3 years
[4]Excluding women giving non-numeric responses
[5]Among currently married women age 15–49

Quality of Family Planning Services[6]

Percent told about side effects of method	56.8
Percent who received follow-up services	84.4

Childhood Mortality

Infant mortality rate[7]	56.8
Under-five mortality rate[7]	76.8

Safe Motherhood and Women's Reproductive Health

Percent of births[8] within 24 months of previous birth	29.5
Percent of births[3] whose mothers received:	
Antenatal check-up from a health professional	58.0
Antenatal check-up in first trimester	32.8
Two or more tetanus toxoid injections	79.7
Iron and folic acid tablets or syrup	67.0
Percent of births[3] whose mothers were assisted at delivery by a:	
Doctor	27.9
ANM/nurse/midwife/LHV	14.0
Traditional birth attendant	57.8
Percent[5] reporting at least one reproductive health problem	38.2

Awareness of AIDS

Percent of women who have heard of AIDS	44.3

Child Health

Percent of children age 0–3 months exclusively breastfed	47.2
Median duration of breastfeeding (months)	24.3
Percent of children[9] who received vaccinations:	
BCG	86.8
DPT (3 doses)	71.1
Polio (3 doses)	74.3
Measles	72.2
All vaccinations	62.7
Percent of children[10] with diarrhoea in the past 2 weeks who received oral rehydration salts (ORS)	25.7
Percent of children[10] with acute respiratory infection in the past 2 weeks taken to a health facility or provider	87.9

Nutrition

Percent of women with anaemia[11]	47.0
Percent of women with moderate/severe anaemia[11]	16.1
Percent of children age 6–35 months with anaemia[11]	83.9
Percent of children age 6–35 months with moderate/ severe anaemia[11]	65.9
Percent of children chronically undernourished (stunted)[12]	50.0
Percent of children acutely undernourished (wasted)[12]	5.3
Percent of children underweight[12]	34.

[6]For current users of modern methods
[7]For the 5 years preceding the survey (1994–98)
[8]For births in the past 5 years (excluding first births)
[9]Children age 12–23 months
[10]Children under 3 years
[11]Anaemia–haemoglobin level < 11.0 grams/decilitre (g/dl) for children and pregnant women and < 12.0 g/dl for nonpregnant women. Moderate/severe anaemia –haemoglobin level < 10.0 g/dl.
[12]Stunting assessed by height-for-age, wasting assessed by weight-for-height, underweight assessed by weight-for-age

SUMMARY OF FINDINGS

The second National Family Health Survey (NFHS-2), conducted in 1998–99, provides information on fertility, mortality, family planning, and important aspects of health, nutrition, and health care. The International Institute for Population Sciences (IIPS) coordinated the survey, which collected information from a nationally representative sample of more than 90,000 ever-married women age 15–49 from 26 states of India. These states comprise more than 99 percent of India's population.

IIPS also coordinated the first National Family Health Survey (NFHS-1) in 1992–93. Most of the types of information collected in NFHS-2 were also collected in the earlier survey, making it possible to identify trends over the intervening period of six and a half years. In addition, the NFHS-2 questionnaire covered a number of new or expanded topics with important policy implications, such as reproductive health, women's autonomy, domestic violence, women's nutrition, anaemia, and salt iodization.

In Haryana, NFHS-2 field staff collected information from 2,841 households between 27 November 1998 and 18 May 1999 and interviewed 2,908 eligible women in these households. In addition, the survey collected information on 1,060 children born to eligible women in the three years preceding the survey. One health investigator on each survey team measured the height and weight of eligible women and young children to assess their nutritional status and took blood samples to assess the prevalence of anaemia.

Background Characteristics of the Survey Population

According to the 1991 Census, three-quarters of the population of Haryana lives in rural areas. The age distribution is typical of populations that have recently experienced a fertility decline, with relatively low proportions in the younger and older age groups. Thirty-seven percent of the population is below age 15, and 6 percent is age 65 and above. The *de facto* sex ratio in Haryana is only 872 females per 1,000 males.

The NFHS-2 estimates of the sex ratios of the *de jure* total population, at 867, and the sex ratio of the *de jure* population age 0–6, at 826, are both slightly higher than the corresponding sex ratios provided by the 2001 Census provisional estimates, at 861 and 820, respectively, for a period approximately two years after NFHS-2. Notably, however, the sex ratios of the population age 0–6 from both NFHS-2 and the 2001 Census are 5 percent lower than the corresponding sex ratios for the total population. The sex ratio at birth from NFHS-2 for the six-year period preceding the survey is 870, much higher than the sex ratio of the population age 0–6 years, suggesting that sex-selective abortions are not the only factor responsible for the low sex ratio of the 0–6 population in Haryana. In fact, the sex ratios for nonsurviving children who were born during the seven years preceding the survey (1992–98) show that there are about 1.3 times as many girls as boys among the nonsurviving children. Further, a comparison of the sex ratio at birth for the period 1996–98 (818) with the sex ratio at birth for the period 1992–95 (903) suggests that the importance of sex-selective abortion has grown in the post-1995 period despite passage in 1994 of the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, which prohibits the use of prenatal diagnostic techniques for the purpose of antenatal sex determination.

The survey provides a variety of demographic and socioeconomic background information. In the state as a whole, 89 percent of household heads are Hindu, 4 percent are Muslim, and 7 percent are Sikh. Muslims are more concentrated in rural areas, where they comprise 5 percent of household heads, compared with less than 2 percent in urban areas. Twenty-one percent of household heads belong to scheduled castes and another 21 percent belong to other backward classes (OBCs). There are no officially recognized scheduled tribes in Haryana. Fifty-seven percent of household heads do not belong to any of these groups.

Questions about housing conditions and the standard of living of household members indicate improvements since the time of NFHS-1 in some indicators but not in others. Eighty-nine percent of households in Haryana have electricity and 47 percent have piped drinking water, compared with 85 percent and 48 percent, respectively, in NFHS-1. Sixty-one percent of households do not have any toilet facility, down from 73 percent in NFHS-1.

About four-fifths (79 percent) of males and about three-fifths (57 percent) of females age six and above are literate, an increase of 7 to 11 percentage points, respectively, from literacy rates at the time of NFHS-1. Eighty-nine percent of children age 6–14 are attending school, an increase from 81 percent in NFHS-1. The proportions attending school are rising rapidly at all levels of schooling, particularly for girls, but girls still lag behind boys in school attendance. Moreover, the disparity in school attendance by sex grows with increasing age of children. For example, at age 6–10, 93 percent of boys attend school compared with 90 percent of girls, but at age 15–17, 68 percent of boys attend school, compared with 50 percent of girls.

Women in Haryana tend to marry at an early age. Twenty-three percent of women age 15–19 are already married, including 1 percent who are married but *gauna* has yet to be performed. The proportion married at age 15–19 is much higher for women in rural areas (27 percent) than in urban areas (14 percent). Older women are more likely than younger women to have married at an early age: 27 percent of women who are now age 45–49 married before they were 15, compared with only 4 percent of women age 15–19. Although this indicates that the proportion of women who marry young is declining rapidly, a considerable proportion of women in Haryana still marry before reaching the legal minimum age of 18 years. On average, women are 4.8 years younger than the men they marry.

As part of an increasing emphasis on gender issues in NFHS-2, the survey asked women about their participation in household decisionmaking. In Haryana, almost all women (97 percent) are involved in decisionmaking on at least one of four selected topics. A much lower proportion (67 percent), however, are involved in decisionmaking about their own health care. Only 13 percent of women in Haryana do work other than housework, but more than three-quarters (77 percent) of these women work for cash. The majority of women (58 percent) who earn cash can decide independently how to spend the money that they earn. Forty-three percent of working women report that their earnings constitute about half or more of total family earnings, including 14 percent who report that the family is entirely dependent on their earnings.

Fertility and Family Planning

Fertility continues to decline in Haryana. At current fertility levels, women will have an average of 2.9 children each throughout their childbearing years. The total fertility rate has declined substantially from 4.0 children per woman at the time of NFHS-1, but it remains far above the replacement level.

Efforts to encourage the trend toward lower fertility might usefully focus on groups within the population that have higher fertility than average. In Haryana, rural women, illiterate women, Muslim women, scheduled-caste women, and women from low standard of living households have much higher fertility than other women. Childbearing among young women remains a significant problem. The median age at first childbirth is 20 years, and women age 15–19 account for 16 percent of total fertility. Studies in India and elsewhere have shown that health and mortality risks increase when women give birth at such young ages—both for the women themselves and for their children. Family planning programmes focusing on women in this age group could make a significant impact on maternal and child health as well as reducing overall fertility in the state.

The appropriate design of family planning programmes depends, to a large extent, on women's fertility preferences. Women may have large families because they want many children, or they may prefer small families but, for a variety of reasons, may have more children than they actually want. For 6 percent of births over the three years preceding NFHS-2, mothers report that they did not want the pregnancy at all, and for another 6 percent of these births, mothers say that they would have preferred to delay the pregnancy. When asked about their preferred family size, nearly one-half (45 percent) of women who already have three children and more than one-fourth (28 percent) of women with four or more children respond that they consider the two-child family ideal. This gap between women's actual fertility experience and what they want or would consider ideal suggests a need for expanded or improved family welfare services to help women achieve their fertility goals. In Haryana, 90 percent of women want at least one son and 81 percent want at least one daughter. A strong preference for sons is indicated by the fact that 38 percent of women want more sons than daughters but only a negligible proportion want more daughters than sons.

If many women in Haryana are not using family planning, it is not due to lack of knowledge. Knowledge of contraception is universal: almost all currently married women know at least one modern family planning method. Knowledge of all modern contraceptive methods is high (more than 90 percent for each method) in Haryana. Knowledge of modern spacing methods has increased by 10–18 percentage points since the time of NFHS-1, although use rates for these methods remain extremely low.

Sixty-two percent of married women are currently using some method of contraception, an increase from 50 percent at the time of NFHS-1. Contraceptive prevalence is slightly higher in urban areas (67 percent) than in rural areas (60 percent). Female sterilization is by far the most popular method: 39 percent of currently married women are sterilized, a substantial increase from 30 percent at the time of NFHS-1. By contrast, only 2 percent of women report that their husbands are sterilized, a decrease from 5 percent in NFHS-1. Overall, sterilization accounts for 65 percent of total contraceptive use. Use rates for the pill (2 percent), IUD (4 percent), and condom (7 percent) remain relatively low.

There are substantial variations in contraceptive prevalence among socioeconomic groups. Muslim women stand out as having much lower contraceptive prevalence than Hindu or Sikh women. Rural women, scheduled-caste women, and poor women are also less likely than other women to use contraception. Rural women are more likely to use sterilization but less likely to use modern temporary methods than urban women. Use of each of the three modern spacing methods increases with education and living standard.

Given the emphasis on sterilization, women tend to adopt family planning only after they have achieved their desired family size. As a result, contraceptive use can be expected to rise steadily with age and with number of living children. In Haryana, contraceptive use does indeed go up with age, peaking at 84 percent for women age 35–39. Use also goes up with the number of children, peaking at 80 percent for women with three living children. A strong preference for sons is evident for women at every parity. Women who have one or more sons are much more likely to use contraception than are women who have the same number of children but have only daughters. For example, 9 out of 10 women with three children and at least two sons use some method of contraception. However, only 2 out of 10 women with three children all of whom are daughters use contraception.

Three percent of currently married women are not using contraception but say that they want to wait at least two years before having another child. Another 5 percent are not using contraception although they do not want any more children. These women are described as having an 'unmet need' for family planning. The unmet need is higher among younger women, who are primarily interested in spacing their births. These results underscore the need for strategies that provide spacing as well as terminal contraceptive methods in order to meet the changing needs of women over their lifecycle.

For many years, the Government of India has been using electronic and other mass media to promote family planning. Exposure to mass media is quite high in Haryana, where 100 percent of rural residents live in villages that are electrified. Among the different types of media, television has the broadest reach across all categories of women, including those who are poor and illiterate. Overall, 61 percent of currently married women watch television at least once a week. Nevertheless, one-third of women are not regularly exposed to television, radio, or other types of media. Seventy-seven percent of women saw or heard a family planning message in the media in the few months before the survey. Exposure to family planning messages is relatively low among some socioeconomic groups, including women from households with a low standard of living (43 percent), Muslim women (48 percent), and illiterate women (63 percent).

Four-fifths (80 percent) of women who use modern contraception obtained their method from a government hospital or other source in the public sector. Only 15 percent obtained their method from the private medical sector. The private medical sector, along with shops, is an important source for pills and condoms, however. The private sector plays a larger role in urban areas (supplying 32 percent of women who use modern methods) than in rural areas (supplying only 8 percent).

An important indication of the quality of family planning services is the information that women receive when they obtain contraception and the extent to which they receive follow-up services after accepting contraception. In Haryana, 45 percent of users of modern contraceptives who were motivated by someone to use their method were told about any other method by that person. Moreover, at the time of adopting the method, 57 percent were told by a health or family planning worker about possible side effects of the method they adopted. Eighty-four percent of the users of modern contraceptive methods received follow-up services after accepting the method.

Infant and Child Mortality

NFHS-2 provides estimates of infant and child mortality and factors associated with the survival of young children. During the five years preceding the survey, the infant mortality rate was 57 deaths at age 0–11 months per 1,000 live births, a considerable decline from 73 infant deaths per 1,000 live births in NFHS-1. The child mortality rate, at 21 deaths of children age 1–4 years per 1,000 children reaching age one, has also declined considerably from 27 in NFHS-1. Despite the improvement in child survival in recent years, 1 in 18 children in Haryana still die in the first year of life, and 1 in 13 die before reaching age five. Child-survival programmes might usefully focus on specific groups of children with particularly high infant and child mortality rates, such as children who live in rural areas, children whose mothers are illiterate, children belonging to scheduled castes, and children from poor households.

Along with various socioeconomic groups, efforts to promote child survival need to concentrate on female children, very young mothers, mothers with four or more children, and mothers whose births are closely spaced. Infant mortality is 32 percent higher among children born to mothers under age 20 than among children born to mothers age 20–29 (73 deaths, compared with 55, per 1,000 live births). Infant mortality is twice as high among children born less than 24 months after a previous birth as among children born after a gap of 48 months or more (84 deaths, compared with 42, per 1,000 live births). Clearly, efforts to expand the use of temporary contraceptive methods for delaying and spacing births would help reduce infant mortality as well as fertility.

Health and Health Care

Promotion of maternal and child health has been one of the most important components of the Reproductive and Child Health Programme of the Government of India. One goal is for each pregnant woman to receive at least three antenatal check-ups plus two tetanus toxoid injections and a full course of iron and folic acid supplementation. In Haryana, mothers of 42 percent of the children born in the three years preceding NFHS-2 received no antenatal check-up, and mothers of only 37 percent of these children received three or more antenatal check-ups. For 80 percent of these children, however, mothers received the recommended number of tetanus toxoid vaccinations, and for 67 percent, mothers received iron and folic acid supplementation. Coverage by all three interventions is somewhat lower for women in disadvantaged socioeconomic groups than for other women. Muslim mothers are the most disadvantaged group on all three antenatal interventions. Coverage is also low for women who already have four or more children.

The Reproductive and Child Health Programme encourages women to deliver in a medical facility or, if at home, with assistance from a trained health professional and to receive at least three check-ups after delivery. During the three years preceding NFHS-2, less than one in four (22 percent) births in Haryana were delivered in a medical facility. Forty-two percent of the births were assisted by a health professional and 58 percent by a *dai* (a traditional birth attendant). Only 16 percent of noninstitutional births were followed by a postpartum check-up within two months of delivery. Overall, these results show that health services in Haryana are reaching many more women during pregnancy than during delivery or after childbirth. They also point to the important role of traditional birth attendants for the substantial proportion of births that occur at home.

The Government of India recommends that breastfeeding should begin immediately after childbirth and that infants should be exclusively breastfed for about the first four months of life. Although breastfeeding is nearly universal in Haryana, very few children begin breastfeeding immediately after birth—only 12 percent in the first hour and 31 percent in the first day. Moreover, for more than three-quarters of births (77 percent), mothers squeeze the first milk (colostrum) from the breast before breastfeeding begins, thereby depriving the baby of natural immunity against diseases that colostrum provides. Only 47 percent of children under four months of age are exclusively breastfed, as recommended at that age. The median length of breastfeeding is 24 months, but the median length of exclusive breastfeeding is only 1.2 months. At age 6–9 months, children should be receiving solid or mushy food in addition to breast milk. However, only 43 percent of children age 6–9 months receive the recommended combination of breast milk and solid/mushy foods.

NFHS-2 uses three internationally recognized standards to assess children's nutritional status—weight-for-age, height-for-age, and weight-for-height. Children who are more than two standard deviations below the median of an international reference population are considered underweight (measured in terms of weight-for-age), stunted (height-for-age), or wasted (weight-for-height). Stunting is a sign of chronic, long-term undernutrition, wasting is a sign of acute, short-term undernutrition, and underweight is a composite measure that takes into account both chronic and acute undernutrition.

Based on these measures, more than one-third (35 percent) of children under age three years are underweight, one-half (50 percent) are stunted, and 5 percent are wasted. Nutritional status of children in Haryana has not changed much since the time of NFHS-1. The proportion underweight and the proportion stunted are higher in rural areas and among children from disadvantaged socioeconomic groups, but the proportion wasted does not vary much by background characteristics. The prevalence of undernutrition is about the same for girls as for boys. More than four-fifths (84 percent) of children age 6–35 months are anaemic, including a large majority of children in every subgroup of the population.

Child immunization is an important component of child-survival programmes in India, with efforts focusing on six serious but preventable diseases—tuberculosis, diphtheria, pertussis, tetanus, polio, and measles. The objective of the Universal Immunization Programme (UIP), launched in 1985–86, was to extend immunization coverage against these diseases to at least 85 percent of infants by 1990. In Haryana, 63 percent of children age 12–23 months are fully vaccinated, another 27 percent have received some but not all of the recommended vaccinations, and 10 percent have not been vaccinated at all.

Immunization coverage, although far from complete, has improved cosiderably since NFHS-1, when 54 percent of children were fully vaccinated and 18 percent had not been vaccinated at all. In fact, child immunization coverage in Haryana is higher than would appear from information on full coverage alone. Eighty-seven percent of children age 12–23 months have been vaccinated against tuberculosis, 71 percent have received three doses of DPT vaccine, 74 percent have received three doses of polio vaccine, and 72 percent have been vaccinated against measles. Dropout rates for the series of DPT and polio vaccinations are a considerable problem. Ninety percent of children received the first DPT vaccination, but only 71 percent received all three doses; 90 percent received the first polio vaccination, but only 74 percent received all three doses of polio. It is also recommended that children under age five years

should receive oral doses of vitamin A every six months starting at age nine months. However, only 45 percent of children age 12–35 months have received any vitamin A supplementation and only 21 percent received a dose of vitamin A in the six months preceding the survey.

NFHS-2 collected information on the prevalence and treatment of three health problems that cause considerable mortality in young children—fever, acute respiratory infection (ARI), and diarrhoea. In Haryana, 24 percent of children under age three were ill with fever during the two weeks preceding the survey, 12 percent were ill with ARI, and 14 percent had diarrhoea. For 9 out of 10 children who became ill with ARI or diarrhoea, treatment was sought from a health facility or health provider. Twenty-six percent of children with diarrhoea received a solution made from oral rehydration salt (ORS) packets, an increase from 8 percent at the time of NFHS-1, suggesting that there has been substantial improvement in the management of childhood diarrhoea.

The survey collected information on the prevalence of tuberculosis, asthma, malaria, and jaundice among all household members. Disease prevalence based on reports from household heads must be interpreted with caution, however. The survey found that less than 1 percent of the population suffers from tuberculosis, 2 percent suffers from asthma, 2 percent suffered from malaria during the three months preceding the survey, and 1 percent suffered from jaundice during the preceding 12 months. Prevalence of all four conditions is higher in rural areas than in urban areas. Men are more likely than women to suffer from tuberculosis, asthma, and jaundice, but women are more likely to suffer from malaria.

Based on a weight-for-height index, about one-fourth (26 percent) of women in Haryana are undernourished. Nutritional deficiency is particularly serious for women in rural areas and women in disadvantaged socioeconomic groups. Women who are undernourished themselves are also much more likely than other women to have children who are undernourished. Overall, 47 percent of women in Haryana have some degree of anaemia, and 16 percent are moderately to severely anaemic. Anaemia is a serious problem among women in every population group, with prevalence rates ranging from 37 to 57 percent.

Three out of 10 households (29 percent) in Haryana do not use cooking salt that is iodized at the recommended level of 15 parts per million**,** suggesting that iodine deficiency disorders are likely to be a serious problem. Rural households and households with a low standard of living are less likely than other households to be using adequately iodized cooking salt.

Thirty-eight percent of currently married women in Haryana report some type of reproductive health problem, including abnormal vaginal discharge, symptoms of urinary tract infections, and pain or bleeding associated with intercourse. Among these women, more than half (56 percent) have not sought any advice or treatment. These results suggest a need to expand reproductive health services and information programmes that encourage women to discuss their problems with a health-care provider.

In recent years, there has been growing concern about domestic violence in India. NFHS-2 found that in Haryana, there is widespread acceptance among ever-married women that the beating of a wife by her husband is justified under some circumstances. One out of four women (26 percent) accept at least one of six reasons as a justification for a husband beating his

wife. Violence against women is also fairly common in Haryana. Thirteen percent of ever-married women in Haryana have been beaten or physically mistreated since age 15. Most of these women have been beaten or physically mistreated by their husbands.

A large majority of household respondents in Haryana (83 percent) said that household members usually go to private hospitals or private doctors for treatment when they get sick. Only 16 percent normally use any type of government health facility. Use of public-sector services is low irrespective of place of residence or standard of living. Most respondents are generally satisfied with the health care they receive. Respondents are more critical of the staff's attitude and cleanliness of public-sector facilities than of private-sector or NGO/trust facilities. Median waiting time is also longer in public-sector facilities.

Overall, only 2 percent of women in Haryana received a home visit from a health or family planning worker during the 12 months preceding the survey. Even those women who did receive home visits received only two visits, on average, in the year preceding the survey. Virtually all of these women express general satisfaction with the services they received at home from health or family planning workers.

NFHS-2 also collected basic information on selected lifestyle indicators for household members. According to household respondents, 41 percent of adult men in Haryana smoke, 21 percent drink alcohol, and 8 percent chew *paan masala* or tobacco, while only 4 percent of adult women smoke and only 1 percent chew *paan masala* or tobacco. The proportion of women who drink alcohol is negligible.

Although the spread of HIV/AIDS is a major concern in India, more than half (56 percent) of women in Haryana have never even heard of AIDS. Awareness of AIDS is particularly low among poor women (6 percent), Muslim women (13 percent), women who are illiterate (20 percent), scheduled-caste women (27 percent), and women in rural areas (32 percent). Among women who have heard of AIDS, 91 percent learned about the disease from television and 32 percent from radio, suggesting that the government's efforts to promote AIDS awareness through the electronic mass media have achieved some success. Among women who have heard of AIDS, however, 29 percent do not know of any way to avoid infection. NFHS-2 results suggest that health personnel could play a much larger role in promoting AIDS awareness. In Haryana, only 3 percent of women who know about AIDS learned about the disease from a health worker.